

American Psychiatric Association

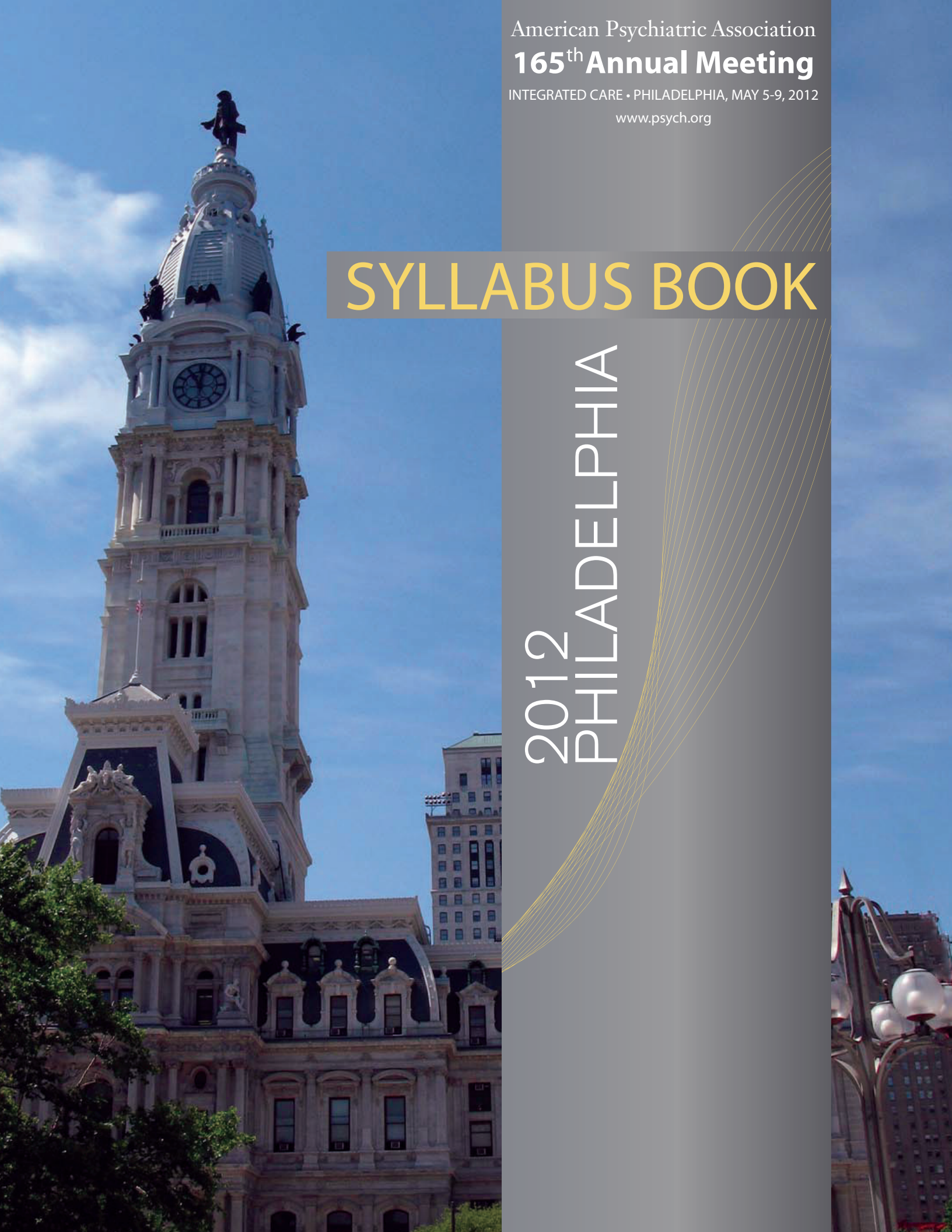
165th Annual Meeting

INTEGRATED CARE • PHILADELPHIA, MAY 5-9, 2012

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SYLLABUS BOOK

2012
PHILADELPHIA



SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

THE ONE HUNDRED AND SIXTY FIFTH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION

Philadelphia, PA
May 5-9, 2012

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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 165th 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.

KENNETH R. SILK, M.D., *Chairperson, Ann Arbor, MI*
MICHAEL F. MYERS, M.D., *Vice-Chairperson Brooklyn, NY*
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EMBARGO: News reports or summaries of APA 2012 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.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.

2012 Annual Meeting • Philadelphia, PA

INTEGRATED CARE



The theme of this year's meeting is Integrated Care—psychiatrists working collaboratively with primary care physicians and other health care professionals to coordinate quality patient care. Numerous sessions will be addressing integrated care issues, including a Presidential Symposium on New Approaches to Integration of Mental Health and Medical Health Services chaired by Wayne J. Katon, M.D., and Jurgen Unutzer, M.D., M.P.H.; a symposium on Integrated Psychiatry Primary Care Services chaired by Britta Ostermeyer, M.D.; and a workshop on Integrating Psychiatric and General Medical Care: Military and Civilian Models, chaired by Sheila Hafter-Gray, M.D.

We are delighted to partner once again with the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to highlight advances in treating co-occurring disorders, the use of technology and medication, and integrating treatment in primary and psychiatric care. The NIAAA Plenary Lecture will be presented by Bankole Johnson, DSc., M.D., Ph.D., M.Phil., Chair, Department of Psychiatry and Neurobehavioral Sciences at the University of Virginia. John Krystal, M.D., Chair, Department of Psychiatry at Yale-New Haven Hospital and Director, NIAAA Center for the Translational Neuroscience of Alcoholism, will deliver a Frontiers of Science Lecture as part of the NIAAA track.

Other special tracks include the DSM-5, Ethics, and the military. Look for symbols throughout the Program Book to help you find sessions in a variety of topical tracks that may relate to your interests.

Special guest lecturers include Kay Redfield Jamison, Ph.D., psychiatry professor at Johns Hopkins Medicine and author of *An Unquiet Mind*; and Sherwin B. Nuland, M.D., author of several books including *The Art of Aging: A Doctor's Prescription for Well-Being*.

FocusLive, *Advances in Medicine*, and *Advances in Research* all return by popular demand. The always popular *MindGames*, APA's national Jeopardy-like competition for residents, will take place on Tuesday at 6:30 in the evening to allow more people an opportunity to attend.

Many thanks go out to the Scientific Program Committee for its outstanding work under the leadership of chair Kenneth R. Silk, M.D., and vice chair Michael F. Myers, M.D. and to the APA staff members who have worked so persistently to develop an outstanding program at the 2012 Annual Meeting.

Exceptional educational and networking opportunities await you at our 165th Annual APA meeting. Have a wonderful, enlightening week!

Sincerely,

A handwritten signature in black ink that reads "John M. Oldham". The signature is written in a cursive, flowing style.

John M. Oldham, M.D.

Dear Colleagues and Guests:

Welcome to the 165th Annual Meeting of the American Psychiatric Association in historic Philadelphia, the "City of Brotherly Love."

The meeting 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 meeting also includes more than 50 courses and 5 master courses on such topics as practical cognitive behavior therapy, essential psychopharmacology, and child psychopharmacology.

The Opening Session on Sunday, May 6 will feature a unique event with two masters of psychotherapy, Aaron T. Beck, M.D. and Glen O. Gabbard, M.D., who will discuss in conversational format the commonalities and differences between cognitive therapy and psychodynamic therapy. Another highlight is the Convocation of Fellows, which will be on Monday evening. We are honored to have as the speaker Edward Kennedy, Jr., president of Marwood Group & Co., a healthcare-focused financial services firm. Mr. Kennedy is also an active advocate for the needs of persons with disabilities.

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MAY 06, 2012

ADVANCES IN MEDICINE 1

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

Chair: Robert M. McCarron, D.O.

Presenter(s): Robert M. McCarron, D.O., Thomas W. Heinrich, M.D., Sarah Rivelli, M.D., Margaret W. Leung, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

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; 3) Review “up to date” and evidence based practice patterns for medical / psychiatric conditions.

OVERALL 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.

No. 1

“OUCH!” CHRONIC LOWER BACK PAIN: WHAT THE PSYCHIATRIST NEEDS TO KNOW

Robert M. McCarron, D.O.

SUMMARY:

Dr. McCarron will discuss current updates on the medical and psychiatry approach to chronic lower back pain.

No. 2

ENDOCRINOLOGY: A CLINICALLY RELEVANT REVIEW OF MEDICAL AND PSYCHIATRIC CONDITIONS

Thomas W. Heinrich, M.D.

SUMMARY:

Patients referred from colleagues in medicine, neurology, and surgery for psychiatric evaluation are often complex with multiple co-morbid conditions which confound the presentation and diagnostic assessment. Furthermore, the

clinical question which is posed by the referring clinician is often superficial and, at times, frankly confusing in tone and content. In this case vignette, we will follow the evaluation of one such patient in an attempt to elucidate the cause (or causes) for his presentation.

No. 3

MEDICAL/PSYCHIATRIC UPDATES FOR THE PSYCHIATRIST

Margaret W. Leung, M.D., M.P.H.

SUMMARY

Dr. Leung will present a clinical “Med Psych” vignette that illustrates the importance of addressing the medicine/psychiatric interface. She will provide a multi-organ system updates in medical practice for the psychiatrist.

No. 4

MEDICAL/PSYCHIATRY UPDATES: JUST WHAT THE PSYCHIATRIST NEEDS TO KNOW

Sarah Rivelli, M.D.

SUMMARY

Dr. Rivelli will discuss the interplay between organic illness, medication effects and psychiatric symptoms. Multiple organ systems will be discussed and clinical information will be presented in way that is relevant to psychiatrists.

MAY 07, 2012

ADVANCES IN MEDICINE 2

TOP 10 MEDICAL ARTICLES OF 2011: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize the publications in the Internal Medicine literature from the past year which are most likely to impact clinical practice; 2) Apply knowledge of the most recent Internal Medicine literature to enhance the care of patients with comorbid medical and psychiatric diagnoses; 3) Apply knowledge of the most recent Internal Medicine literature to enhance the care of patients with comorbid medical and psychiatric diagnoses.

SUMMARY:

This session will provide a review of the medical literature

and guidelines in Internal Medicine published in 2011. Areas covered will include those representing important findings likely to impact clinical medical practice, with a special focus on topics common to patients with comorbid psychiatric and medical illness. Additionally, a critical appraisal of the evidence presented in these publications will be offered.

ADVANCES IN MEDICINE 3

PAIN MEDICINE: AN EVOLVING FIELD FOR PSYCHIATRY

Chair: Martin D. Cheatle, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define the three types of pain and pharmacologic options for each type; 2) Identify two primary differences between DSMIVTR and DSM5 criteria for rendering the diagnosis of opioid use disorder in pain patients; 3) List two evidencedbased psychosocial interventions for pain.

SUMMARY:

The prevalence of chronic pain continues to rise in the United States causing individual suffering and contributing to higher rates of morbidity, mortality and disability and burgeoning economic and societal costs. It is estimated that over 116 million Americans suffer from chronic pain (Tsang, 2008). A recent Institute of Medicine report (IOM 2011) estimated that the annual cost of chronic pain in the United States approaches \$600 billion including the cost of healthcare (\$261300 billion) and lost productivity (\$297336 billion). That report concluded that effective pain management is a “moral imperative;” pain should be considered a disease with distinct pathology, there is a need for interdisciplinary treatment approaches and there is a “serious problem of diversion and abuse of opioid drugs” (IOM 2011, pg S 3). Patients with chronic pain typically have complex etiologies and psychiatric comorbidities and utilize more healthcare resources. Ideally these complicated cases should be assessed and treated in a specialty clinic, but the majority of these patients are managed in the primary care setting where these practitioners lack the time, resources and training to effectively monitor and treat these patients. Given the high incidence of mood disorders and in some cases substance use disorders in this patient population, psychiatrists have a unique opportunity to contribute to the care of these patients. This symposium will provide a review and update on the field of pain medicine including assessment and pharmacologic and nonpharmacologic interventions. Special attention will be devoted to the patient with pain and cooccurring substance use disorders.

ADVANCES IN MEDICINE 4

ADVANCES IN MEDICINE: PALLIATIVE MEDICINE

Chair: John L. Shuster, Jr., M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Summarize the latest clinical developments in the field of palliative medicine; 2) Identify recent developments in palliative medicine relevant to psychiatric practice.

SUMMARY:

Once the prospect of cure becomes an unreasonable expectation in advanced and serious illness, the focus of care shifts to relief and reduction of suffering, building and maintenance of meaning and healing and wholeness for the patient and family. This is the palliative approach to care. Palliative medicine is the medical subspecialty dedicated to providing this care. Psychiatrists have important contributions to make to excellent palliative care, including assessment and management of suicidal ideation and diminished will to live, mental disorders and distress at the end of life, mental disorders and distress in families, suffering, quality of life, meaning, loss and bereavement. This session will focus on recent advances and developments in palliative medicine, with a focus on those developments most relevant to the practice of psychiatry.

MAY 08, 2012

ADVANCES IN MEDICINE 5

UPDATE ON SLEEP DISORDERS: WHAT'S NEW UNDER THE MOON

Chair: Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVES:

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; 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.

ADVANCES IN MEDICINE 6

CARDIAC ARRHYTHMIAS IN THE PSYCHIATRIC PATIENT: WHAT TO KNOW AND HOW TO TREAT?

Chair: Rajat Deo, M.D.

EDUCATIONAL OBJECTIVES:

8 At the conclusion of the session the participant should be able to: 1) Identify psychiatric medications and drug interactions that increase the risk for lifethreatening arrhythmias; 2) Recognize arrhythmia patients that are at an increased risk of psychiatric conditions; 3) Manage psychiatric care in the patient with complex arrhythmias.

SUMMARY:

Unavailable at time of publication.

MAY 07, 2012

ADVANCES IN RESEARCH 1

ADVANCES IN RESEARCH

*Chair: Herbert Pardes, M.D.**Presenter(s): William T. Carpenter, M.D., Steven P. Roose, M.D., Sarah H. Lisanby, M.D., Steven Paul, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the potential in brain stimulation treatments, the degree of evidence that backs the value of several of them, and the knowledge of current directions in research either substantiating the importance of such treatments or challenging their alleged value; 2) Know much more about the critical nature of accurate diagnosis of the various subtypes of depressive disorders, how to use self-report scales to enhance the clinician's information about the given patient, and the value and nature of interaction between pharmacological and psychotherapeutic interventions The participant also will have much greater information on patient expectancy; 3) Have a much greater understanding of the linkage between new paradigms in the focus on schizophrenia and the enhanced focus toward potential pathophysiological factors such as neural circuits and their relationship to impaired behavior in people suffering from schizophrenia; 4) In like fashion, there will be a clarification of the status of our attack on Alzheimer's disease and the various key genetic and other factors critical in understanding its pathogenesis; 5) Highlight science translated in understandable terms for those who do not focus on laboratory work but need the best updates as to our progress in these areas.

SUMMARY:

This symposium will bring together outstanding leaders in four areas of major interest in clinical psychiatry. Certainly, when one looks at psychiatric care, the overall rubric of schizophrenia, Alzheimer's disease and depression dominate the concern of our field. Also, novel therapeutics as represented by recent work in the field of brain stimulation and neuromodulation is suggesting the possibility of additional treatment approaches which may widen the potential help our field can provide patients with these disorders. Our understanding of schizophrenia has shifted many times over the years. Critical in our approach to schizophrenia has been an evolving set of concepts regarding the diagnostic system and an anticipation of new paradigms. This presentation will focus on some of those new developments and highlight issues of particular interest such as the early changes in brain structures, the focus on

domains of pathology rather than diagnostic class, etc. The approach to depression as affected deeply by its linkage to the organization of diagnosis will be featured. At the same time, an understanding of the relationship between psychopharmacological and psychotherapeutic interventions will be highlighted. Also, the presentation will review new treatments such as augmenting agents. Brain stimulation is currently a focus of much attention by investigators. Encouraging is the fact that there has been recent FDA approvals for some such treatments of psychiatric disorders. Work will be presented to explore scientific approaches as well as the pragmatic application to clinical care of patients offered these interventions. Alzheimer's is a critical public health problem, particularly with the ageing of the population. Latest research developments will be highlighted, both efforts to slow the progression of the disease and eventually to accomplish total prevention. Today, there is a much better understanding of genetic factors as well as neuropathological abnormalities; these will be illuminated in this presentation. In reviewing these four complex topics, ones of critical importance in psychiatry and psychiatric care, the four experts will bring us uptodate and focus on the highlights in research on which all of us as active psychiatrists in the field should be knowledgeable.

No. 1

SCHIZOPHRENIA: ADVANCING KNOWLEDGE WITH A PARADIGM SHIFT

William T. Carpenter, M.D.

SUMMARY:

Schizophrenia is a heterogeneous syndrome and investigations in the context of a single disease entity have limited the acquisition of knowledge. The shift from the Kraepelin/Bleuler avolition/dissociative pathology construct to the DSM-III reality distortion construct failed to resolve the syndrome status and may have increased overlap among disorders associated with psychosis. New paradigms are anticipated with DSM5. This includes domains of pathology rather than diagnostic class as fundamental to research and clinical care. Therapeutic and prevention shifts to early detection. NIMH has given focus to deconstruction of syndromes with the Research Domains Criteria shifting emphasis away from syndromes to neural circuit pathophysiology that relates to impaired behaviors across disorders. Advances in knowledge within these paradigm developments will be illustrated with recent study results. Included here are: a] early and progressive changes in brain structures; b] genetic analyses distinguishing between schizophrenia subgroups; c] efficacy data on early intervention in the attenuated psychosis syndrome; d] new concepts of anhedonia and reward processing; and e] novel therapeutic discovery.

No. 2

NEUROMODULATION IN PSYCHIATRIC PRACTICE*Sarah H. Lisanby, M.D.***SUMMARY:**

A growing number of new brain stimulation treatments are appearing in the literature, and some have gained FDA approval for psychiatric disorders. These neuromodulation treatments span noninvasive and surgical approaches to stimulating brain circuits for the treatment of medication refractory conditions. Together, these interventions form a family of novel therapeutic approaches for our field. This talk will focus on what the practicing clinician needs to know about new developments in neuromodulation treatments, and will provide practical guidance about how to incorporate these interventions into clinical practice. Particular focus will be placed on those interventions that have already received FDA approval (e.g. transcranial magnetic stimulation, vagus nerve stimulation) and those on the horizon that are undergoing trials (e.g. deep brain stimulation, magnetic seizure therapy). These tools offer great promise to patients for whom other interventions have been ineffective or difficult to tolerate, and for clinicians who encounter patients with severe, medication resistant conditions. Guidance will be given to help clinicians decide when to refer their patients to these interventions, and how to weight their efficacy against other available alternatives, such as the gold standard electroconvulsive therapy.

No. 3

ALZHEIMERS DISEASE: GENES, DIAGNOSTICS, AND THERAPEUTIC ADVANCES*Steven Paul, M.D.***SUMMARY:**

Alzheimer's disease (AD) is the most common form of dementia affecting 1 in 8 adults in the U.S. The risk of developing AD increases dramatically with age with a prevalence rate of approximately 40% for those 85 years old and older. In addition to age, certain genes play an important role in determining one's risk for developing AD. The apolipoprotein E alleles are the most important genetic risk factors for the most common late-onset form of AD with the $\epsilon 4$ allele increasing and the $\epsilon 2$ allele decreasing risk (as well as age of onset) respectively. How these apoE alleles so dramatically alter one's risk (and age of onset) for developing AD is not completely understood but there is compelling evidence the apoE has multiple actions within the CNS and one (or likely more) of these contribute to its etio-pathophysiological role in AD pathogenesis. Work in our laboratory has shown

that apoE alters the metabolism and clearance of amyloid- β peptides in brain and in an isoform-dependent manner ($E2 > E3 > E4$). The latter contributes to the age-dependent and apoE isoform-dependent accrual and deposition of these peptides to form neuritic (amyloid) plaques one of the neuropathological hallmarks of the disease. Our data on apoE-dependent brain amyloid burden in animals are strikingly reminiscent of recent pet neuroimaging data in cognitively normal humans and patients with AD carrying different apoE alleles. More recent studies in our lab suggest that apoE has amyloid-independent (but isoform-dependent) actions to promote tau aggregation/ phosphorylation and neurodegeneration, two other neuropathological hallmarks of the disease. I will discuss recent findings on the disease biology of AD, including recent neuroimaging data in AD patients and those at high risk to develop the disease; and underscore the implications of these findings for early diagnosis and therapeutic intervention.

No. 4

UPDATE ON TREATMENT OF UNIPOLAR DEPRESSION*Steven P. Roose, M.D.***SUMMARY:**

This talk will cover 5 developments that are critical to the effective treatment of the patient with MDD. In addition to the need for accurate diagnosis of the type, unipolar vs. bipolar, and subtype, delusional, atypical, melancholia, of MDD, there is increasing data that psychiatric co-morbidities, e.g. GAD, and other co-morbidities, e.g. mild cognitive impairment, significantly affect treatment outcome. The availability of easy to use self-report scales gives the clinician the information needed to connect their patient to the evidence from clinical trials. STAR-D, REVAMP and other studies make it clear that the treatment of depression frequently requires the systematic sequential prescription of pharmacological or psychotherapeutic interventions at an optimal dose for an optimal duration. There is also information on how long a trial needs to be before the clinician can accurately predict response or non-response. The data on new treatments such as augmentation with an atypical antipsychotic or ketamine. New data on how patient expectancy, the mechanism of the placebo response, influences treatment response. What we say to the patient makes a significant difference.

MAY 06, 2012

ADVANCES IN SERIES 1

ADVANCES IN ADDICTION PSYCHOPHARMACOLOGY

*Chair: Henry R. Kranzler, M.D.**CoChair: Domenic Ciraulo, M.D.**Presenter(s): John A. Renner, M.D., Frances R. Levin, M.D., Kyle M. Kampman, M.D., Domenic Ciraulo, M.D., Henry R. Kranzler, M.D., Caryn Lerman, Ph.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the pharmacology of nicotine, alcohol, opioids, cannabinoids, and cocaine and other stimulants; 2) Demonstrate knowledge of medications that are approved by the US Food and Drug Administration for the treatment of nicotine, alcohol, and opioid dependence; 3) Demonstrate knowledge of medications that are being developed to treat nicotine, alcohol, and opioid dependence, as well as dependence on cannabinoids and cocaine and other stimulants.

SUMMARY:

This course will review the pharmacology of the five major classes of addictive substances: nicotine, alcohol, opioids, cocaine and other stimulants, 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, longacting injectable naltrexone, 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 modafanil,

and immunologicallybased treatments. 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

OVERVIEW OF MEDICATIONS DEVELOPMENT

Domenic Ciraulo, M.D.

SUMMARY:

The increased research activity in medication development for addictions is a relatively recent phenomenon. Despite the availability of disulfiram and methadone for several decades, the finding that naltrexone had efficacy in alcoholism stirred new interest in the field. Both NIAAA and NIDA have invested substantial resources into medication development, but in general the pharmaceutical industry has not focused on addiction medications as a profitable area of drug development. Recent studies have identified new neural targets for pharmacotherapeutics and genetic studies have offered the promise of identifying patients most likely to respond to treatment. An update on the current state of the addiction medication development and potential future targets for medications will be discussed.

No. 2

MEDICATIONS TO TREAT ALCOHOL DEPENDENCE

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. 3

MEDICATIONS TO TREAT CANNABIS DEPENDENCE

Frances R. Levin, M.D.

SUMMARY:

This lecture will discuss the pharmacology of marijuana, including cannabinoid ligands that bind to cannabinoid receptors and their potential therapeutic and adverse effects. The human laboratory models used to test single and combined medications will be reviewed. Results of clinical trials testing pharmacologic treatments for cannabis-dependent individuals, a rapidly evolving area of research, will also be presented. Promising pharmacogenetic approaches will also be discussed.

No. 4

MEDICATIONS TO TREAT COCAINE AND OTHER STIMULANT DEPENDENCE

Kyle M. 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. 5

MEDICATIONS TO TREAT NICOTINE DEPENDENCE

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. 6

MEDICATIONS TO TREAT OPIOID DEPENDENCE

John A. Renner, 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.

ADVANCES IN SERIES 2

ADVANCES IN POSTTRAUMATIC STRESS DISORDER

Chair: Gary Wynn, M.D.

CoChair: David M. Benedek, M.D.

Presenter(s): David M. Benedek, M.D., David Benedek, M.D., Charles C. Engel, M.D., M.P.H., Gary Wynn, M.D., Paula Schnurr, Ph.D.

EDUCATIONAL OBJECTIVES:

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

CLINICAL PRACTICE GUIDELINES

David M. 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.

No. 2

COMPLEMENTARY AND ALTERNATIVE MEDICINE

Gary 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. 3

EPIDEMIOLOGY AND ETIOLOGY

Gary Wynn, M.D.

SUMMARY

This presentation will review the most recent findings and up to date understanding of the epidemiology and etiology 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. The etiology presentation will cover recent findings and understanding in neuroimaging and neurobiology.

No. 4

PHARMACOTHERAPY

Gary Wynn, M.D., and David Benedek, M.D.

SUMMARY:

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. 5

PSYCHOTHERAPY

Gary Wynn, 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.

MAY 07, 2012

ADVANCES IN SERIES 3

ADVANCES IN MENTALIZATION BASED THERAPY

Chair: Anthony W. Bateman, M.D.

CoChair: John G. Gunderson, M.D.

Presenter(s): Robin L. Kissell, M.D., Peter Fonagy, Ph.D., Dawn L. Bales, M.A., M.Sc., Lois W. ChoiKain, M.D., M.Ed., Anthony W. Bateman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the relationship of mentalization to psychiatric phenomenology; 2) Identify clinical interventions to enhance mentalizing; 3) Recognize the steps for integration of mentalizing in general psychiatric practice and treatment for borderline personality disorder; 4) Understand service and training in mentalization based therapy.

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). The ability to mentalize is rooted in childhood and there is accumulating

evidence for a model of aetiology of psychiatric pathology, for example borderline personality disorder (BPD), being related to vulnerabilities to loss of mentalizing capacity. The construct of mentalizing highlights the way genetic vulnerability may interact with attachment experiences to create specific cognitive and interpersonal vulnerabilities. This developmental approach to psychopathology will be discussed along with evidence for the value of applying mentalization based therapy (MBT) principles to conditions associated with high risk for BPD in infancy and childhood and adolescence. Basic mentalising techniques will be discussed along with data about the effectiveness of MBT in day hospital and outpatient treatments. Whilst this evidence suggests that MBT is a useful treatment method it remains possible that the effective components are nonspecific. General Psychiatric Management (GPM), is a less specialized approach to BPD founded in a welldeveloped formulation of the disorder, rather than a highly specified technical psychotherapeutic procedure. Like Dialectical behaviour therapy and MBT, GPM has been proven effective in reducing selfharm, suicidality, utilization of intensive psychiatric services as well as other secondary psychiatric symptoms. All three treatments organize around: 1) helping relationship, 2) emotion focus, 3) current experiences 4) validation and empathy, 5) interpersonal and emotion regulation capacities, and 6) group and individual therapies. 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. 1**PSYCHOPATHOLOGY AND MENTALIZING**

Peter Fonagy, Ph.D.

SUMMARY:

Longitudinal studies have confirmed the importance of early attachment relationships in the etiology of borderline personality disorder. A theoretical model that links relationship quality and vulnerability to early trauma to the development of personality disorder involves mechanisms underpinning self-organization, emotion regulation, attentional control and mentalization. Behavioural and neuroimaging evidence will be reviewed in this talk suggesting emergent failures of social cognition lead to adult psychopathology.

No. 2**MENTALIZING INTERVENTIONS IN EVERYDAY CLINICAL PRACTICE**

Anthony W. Bateman, M.D.

SUMMARY:

The focus of mentalizing interventions is on the patient's subjective state of mind. The clinician needs to take a not-knowing or mentalizing stance to explore the patient's internal states. This requires the clinician to be authentically curious about the patient's mental states and to refrain from making assumptions or telling the patient about his mind states whilst actively promoting reflection. Basic mentalizing techniques that can be used in everyday clinical practice will be described.

No. 3**INTEGRATING GENERAL PSYCHIATRIC MANAGEMENT WITH MBT AND DBT**

Lois W. ChoiKain, M.D., M.Ed.

SUMMARY:

MBT and DBT and General Psychiatric Management all organize treatment around: 1) helping relationship, 2) emotion focus, 3) current experiences (as opposed to the past), 4) validation and empathy, 5) increasing stability of interpersonal and emotion regulation, and 6) group and individual therapies. 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. 4**TRAINING AND THE DEVELOPMENT OF AN MBT SERVICE FOR BPD**

Robin L. Kissell, M.D.

SUMMARY:

An outpatient MBT clinic has been established at UCLA. This Borderline Personality Disorder Initiative, is comprised of a clinic staffed by attending-level clinicians, a resident-training clinic and a program within the University's Student Psychological Services. What goes into the development of a self-sustaining outpatient MBT program will be discussed. Factors include training, staffing requirements, work as a team, patient selection, finances and the interface with insurance companies.

No. 5**EFFECTIVENESS OF MBT: AN INDEPENDENT REPLICATION STUDY AND OTHER EVIDENCE FROM THE NETHERLANDS**

Dawn L. Bales, M.A., M.Sc.

SUMMARY:

Outcomes from a cohort study of 45 Dutch borderline patients treated with MBT showed that MBT can effectively be implemented in an independent treatment institute outside the UK. 31 were compared with matched patients following other psychotherapeutic treatments (n=155). One third of the MBT patients could not be matched. Both groups showed improvement on treatment outcomes. MBT treated patients showed more improvement. This data will be presented.

ADVANCES IN SERIES 4

ADVANCES IN MOTIVATIONAL INTERVIEWING

Chair: Petros Levounis, M.D., M.A.

CoChair: Bachaar Arnaout, M.D.

Presenter(s): Edward V. Nunes, M.D., Susan Tross, Ph.D., Deborah L. Haller, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the fundamental principles of Motivational Interviewing; 2) Understand the different models of Motivational Interviewing including: (1) single session (2) “peer” delivered (3) stand alone, “front loaded”, “blended”, and “distance” (telehealth); 3) Demonstrate the knowledge of the efficacy of Motivational Interviewing for different clinical populations (for whom should it be used?); 4) Implement tools and techniques that aid in training in Motivational Interviewing and that facilitate and maintain the acquisition of counseling behaviors; 5) Understand the uses of Motivational Interviewing approaches for HIV prevention, testing, counseling, and treatment.

SUMMARY:

Motivational Interviewing is deeply grounded in humanistic psychology, especially the work of Carl Rogers. William R. Miller and Stephen Rollnick propose that change is a natural and ubiquitous process that is intrinsic to each person, and may occur without any outside intervention. Motivational Interviewing seeks to hasten this natural change process by creating an interpersonal situation, wherein the patient can engage in a collaborative dialogue that supports behavioral change from the patient’s perspective. Fundamentally, Motivational Interviewing is not exactly a method or a “bag of tricks,” not something that can be done to someone, but something that is done with someone, a way to be with another person that increases the likelihood they will consider and become more committed to change. Clinicians adopt a style or “spirit” of interacting and communicating with patients such that they a) honor the patient’s experiences and perspective (collaboration),

b) affirm the patient’s right and capacity for self-direction (autonomy), and c) draw out the patient’s goals, values, and perceptions that support change (evocation). This empathic stance conveys respect and acceptance of the patient and presumes that the resources for enhancing motivation reside within the patient. By creating a therapeutic atmosphere grounded in this spirit, clinicians help patients feel more open to exploring their ambivalence about change and empowered by the self-direction afforded to them. In this session, we will first review the fundamental principles of Motivational Interviewing followed by three presentations by Drs. Haller, Nunes, and Tross, who will elaborate on the most current thinking of to best apply Motivational Interviewing approaches in diverse clinical settings and training programs. In closing, we will screen two clips from popular movies that illustrate the Motivational Interviewing and the “antiMotivational Interviewing” approaches to treatment.

No. 1

MOTIVATIONAL INTERVIEWING APPROACHES TO CHALLENGES OF HIV

Susan Tross, Ph.D.

SUMMARY:

Motivational Interviewing is a proven approach to behavior change – which has been applied to HIV challenges. With HIV’s complex demands for decision-making and action, Motivational Interviewing is a compelling strategy for identifying conflicting motives, problem-solving and action steps. Researchers have adapted Motivational Interviewing techniques to HIV (sexual/drug use) risk reduction, acceptance of HIV testing, and engagement in HIV care and treatment. Empirical literature will be reviewed. Results, lessons learned and future implications will be discussed.

No. 2

TRAINING IN MOTIVATIONAL INTERVIEWING

Edward V. Nunes, M.D.

SUMMARY:

An overview of models for training in Motivational Interviewing, including workshops and supervision, will be provided, along with a review of the literature on clinical trials that have compared the effectiveness of different training methods. Methods to improve Motivational Interviewing proficiency among clinicians following training will be discussed.

No. 3

USING MOTIVATIONAL INTERVIEWING IN A RESEARCH CONTEXT TO ANSWER IMPORTANT CLINICAL QUESTIONS AND GUIDE TREATMENT

Deborah L. Haller, Ph.D.

SUMMARY:

This presentation will describe how the efficacy of various Motivational Interviewing interventions is determined. Topics will include: (1) elements of Motivational Interviewing research (e.g., change talk, importance/confidence/readiness); (2) efficacy of different models of Motivational Interviewing (e.g., single vs. multiple sessions, stand-alone vs. blended); and (3) efficacy for different populations/problems. Research studies that employed different models of Motivational Interviewing with different populations will be described.

MAY 08, 2012

ADVANCES IN SERIES 5

ADVANCES IN CHILD PSYCHOPHARMACOLOGY

Chair: Molly K. McVoy, M.D.

CoChair: Robert L. Findling, M.D.

Presenter(s): Molly K. McVoy, M.D., Nitin Gogtay, M.D., Solomon Zараа, D.O., Tiffany Thomas, M.D., Moira Rynn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand types of psychiatric illness affecting children and adolescents; 2) Understand the most current data on effective treatments for psychopharmacologic treatment in children and adolescents; 3) Understand most effective treatment strategies for the major psychiatric illnesses affecting children and adolescents.

SUMMARY:

Significant advances have been made in understanding the pharmacologic treatment of child and adolescent psychiatric illnesses over the last several years. A practical understanding of these advances will help clinicians treat child and adolescent psychiatric disorders safely and effectively. Presenters will discuss the latest treatment advances in psychopharmacologic management of mood disorders, psychotic disorders, anxiety disorders and disruptive behavior disorders in children and adolescents. Treatment recommendations, in addition to side effect management will be addressed. Clinical pearls and practical clinical information

will be the focus of the presentation. Attendees will obtain a clinically applicable understanding of the advances in psychopharmacologic research in the pediatric population.

No. 1

TREATMENT OF ADHD AND DISRUPTIVE BEHAVIOR DISORDERS

Solomon Zараа, D.O.

SUMMARY:

The latest in new stimulant formulations, and alternative to stimulant medications will be discussed in regards to ADHD. In addition updates will be given on the newest information on short and long term side effects of ADHD treatment. Finally, psychopharmacologic options for the treatment of disruptive behavior disorders will be discussed.

No. 2

TREATMENT OF PEDIATRIC MOOD DISORDERS

Tiffany Thomas, M.D.

SUMMARY:

Significant controversy has surrounded both the diagnosis and treatment of pediatric mood disorders, and, related to this, much progress has been made researching the diagnosis and treatment of depression and bipolar disorder in children. Dr. Thomas will inform the audience on the latest advances in the psychopharmacologic treatment of mood disorders in children and adolescents.

No. 3

PSYCHOPHARMACOLOGY OF AUTISM AND PDD

Molly K. McVoy, M.D.

SUMMARY:

Research into pharmacologic and alternative treatments for the core symptoms of autism will be discussed. In addition, the audience will be updated on advances in psychopharmacologic treatments for comorbid conditions frequently associated with autism and PDDs.

No. 4

TREATMENT OF PEDIATRIC ANXIETY DISORDERS

Moira Rynn, M.D.

SUMMARY:

Anxiety disorders are common and impairing in the pediatric population. Updates on SSRI treatment for anxiety disorders, in addition to research into new psychopharmacologic treatments for anxiety disorders, including GAD, OCD, PTSD, will be discussed.

No. 5**EARLYONSET PSYCHOTIC DISORDERS,
EVALUATION, AND TREATMENT**

Nitin Gogtay, M.D.

SUMMARY:

Significant research has been done in recent years into the treatment of early onset psychotic disorders. Several large cohorts of youth with early onset psychotic disorders have now been studied. Dr. Gogtay will discuss the latest advances into the psychopharmacologic treatment of this impairing condition.

SUNDAY, MAY 6, 2012

CASE CONFERENCE 1

A CASE OF BIPOLAR SPECTRUM DEPRESSION

Chair: Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Depressions within the so-called bipolar spectrum and their clinical characteristics; 2) Key elements of differential diagnosis and other relevant aspects of assessment and evaluation 3) Treatment options, particularly with respect to how the approach to treatment may differ from other forms of depressive disorder.

SUMMARY:

Some people who experience recurrent and/or chronic depressions have aspects of their history, phenomenology, or other clinical characteristics that are, at the least, suggestive that they may well have bipolar affective disorder. Some experts suggest that depressive disorders be viewed as occurring on a continuum of bipolarity, with the term bipolar spectrum disorder used to describe those depressive episodes that, although not characterized by a history of mania or discrete hypomanic episodes, may be viewed as falling within the bipolar spectrum. Among the clinical hallmarks of a bipolar spectrum depression, are poorer responses to antidepressants, including both treatment-emergent suicidality and apparent tachyphylaxis after a period of good response to antidepressant therapy. In this case conference, the treatment course and stepwise clinical decisionmaking pertaining to one such patient are examined in detail.

CASE CONFERENCE 2

TREATING COMPLICATED GRIEF

Chair: M. Katherine Shear, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Diagnose the syndrome of complicated grief and assess severity; 2) Describe the overall objectives of complicated grief treatment 3) Identify strategies and techniques for treatment of complicated grief; 4) Understand the possible advantage of combining complicated grief treatment and pharmacotherapy.

SUMMARY:

About 59 million people die every year around the world. The death of a loved one is a uniquely challenging life experience,

one of the most difficult a person can face, yet most people find a way to come to terms with the loss and restore a sense of meaning and purpose in their own lives. However, for an important subgroup mourning is derailed, leading to development of complicated grief (CG). CG can be reliably identified, different from DSM-IV mood and anxiety disorders, and is associated with substantial distress and impairment, including a high risk for suicidal ideation and behavior. Those who don't do so need treatment. Clinicians need to be able to understand, recognize and treat complicated grief. This presentation will use a case example to illustrate the diagnosis and treatment of complicated grief using a recently defined targeted psychotherapy approach. The case will be used to illustrate the attachment theory framework for the treatment as well as the strategies and techniques used to achieve the overarching goal of revitalizing and supporting the natural mourning process. Information about efficacy testing of this treatment approach will be included.

MONDAY, MAY 7, 2012

CASE CONFERENCE 3

“DOCTOR, WOULD YOU PLEASE KILL ME?”: WHAT ARE THE BOUNDARIES OF SELF-TERMINATION AND SUICIDE?

CoChairs: Philip R. Muskin, M.D., M.A., Elizabeth Evans, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Think about the potential difference between self-determination and suicide; 2) Participants will discuss the ethical issues that patients asking for physician-assisted suicide brings up with a focus on balancing patient autonomy and good medical care; 3) Participants will discuss the evaluation process of self-determination versus suicide in a medical setting from the perspective of a trainee.

SUMMARY:

This case conference will discuss the boundaries of self-termination and suicide. Patients in the midst of medical illness, pain, suffering, and depression, may express the desire to die. As psychiatrists, it is our role to explore the patient's motivations, assess their capacity, and provide treatment where we feel it appropriate. Yet, how do we balance this responsibility with the obligation to respect patient's self-determination and autonomy? At what point is it reasonable for a patient to say, this is not life as I know it, I don't want to live this way; and is this suicide or self-determination? How we think about this question is important to determine the boundaries of self-determination and suicide.

Elizabeth Evans, MD will present the case of a former nurse who presented following a hip fracture, and TIA, with suicidal ideations, requesting physician-assisted suicide. The patient reported a longstanding desire to end her life if she could no longer live independently and had been hoarding pills for years in the event this occurred. The psychiatric consultation was requested for assessment of suicidality and safety. Laura Roberts, MD will address the ethical issues in this case with a focus on the ethical responsibilities of clinicians. Deborah Cabaniss, MD will discuss the reemergence of fear of dependency in a later adult, how trainees can see that in a patient, recognize patients' strengths, and use those to help recovery through psychotherapy. Most of us think of independence as strength. When can it become a weakness? People who, for one reason or another, are unable to depend on others can develop serious symptoms when they fear that their independence is threatened as in serious physical illness. Understanding this dynamic and learning to work with it is an essential part of psychotherapy with older patients. She will present an integrated approach to psychotherapy using both supporting and uncovering interventions. Philip Muskin, MD will address how to think about evaluating requests for physician-assisted suicide; how one might differentiate patients whom we are comfortable intervening upon, versus those that we are not, with a focus on the trainee/resident education.

CASE CONFERENCE 4

EARLY INTERVENTION AND CONTINUITY OF CARE FOR THE EARLY STAGE SCHIZOPHRENIC PERSON

Chair: S. Charles Schulz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Review the evaluation strategy for early stage psychosis; 2) Discuss pharmacological approaches to early schizophrenia; 3) Apply strategies to improve medication adherence.

SUMMARY:

Substantial evidence supports the importance of early recognition and appropriate treatment for young people in the early stages of a psychotic illness. The visibility of this topic and the significance of research has emerged substantially in the last decade. However, because schizophrenia is a persistent illness with many challenges in treatment, it is important to address issues of initial evaluation and treatment, the role of medication strategies that may keep a young person in treatment, and developing strategies which maintain adherence. The purpose of this case conference is to present a first episode patient with schizophrenia and to discuss

initial interventions, both psychosocial and pharmacological including the use of longacting medications, and other strategies for maintaining adherence. To address the initial evaluation and first steps in acute treatment, Dr. Charles Schulz will review the recent publications addressing the assessments of first episode and young people with schizophrenia. The medication treatment trials – both efficacy and sideeffects – will be reviewed and integrated. Dr. John Lauriello will then address the issue of use of medications in the next phase of treatment of young people with schizophrenia. He will discuss the issues related to the choice of medication and introduce the concept of using longer acting medications in the early phase of the illness to diminish relapse. Dr. Peter Weiden will then describe CBT treatment programs for better understanding and treating the issue of adherence in people with schizophrenia. Much of the data on clinical trials has clearly shown that many patients will stop their medication treatment – yet there has been insufficient data on how to understand this phenomena and how to approach it in the clinical setting. Dr. Weiden's recent work is an important contribution to maintaining treatment consistency. In conclusion, this case conference will address the important issues of continuity of care through an examination of the initiation of treatment, followed by the approaches to medication treatments in young people and concluding with new strategies for maintaining adherence in treatment.

TUESDAY, MAY 8, 2012

CASE CONFERENCE 5

DEMENTIA WITH BEHAVIORAL DISTURBANCE

Chair: David A. Casey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Common behavioral problems in dementia; 2) Nonpharmacologic approaches to management of problem dementia behaviors; 3) The use of medications in management of dementia behaviors.

SUMMARY:

Cases of dementia with behavioral disturbances will be presented. The audience is invited to participate. Many persons with dementia suffer behavioral disturbance during their illness, sometimes referred to as "behavioral and psychological symptoms of dementia" or BPSD. BPSD contributes to a reduced quality of life for patients, caregivers and others. Placements into hospitals or LTC are influenced by BPSD, increasing the costs of dementia. Management is controversial, hinging on the relative lack of effectiveness of medi-

cations and the risk of adverse effects. Antipsychotics are the greatest area of controversy. The FDA requires a “black box warning” for antipsychotics, highlighting the risks of morbidity and increased mortality in dementia. Management involves characterization of the problem behaviors. Since multiple problems are common, some clinicians prefer to focus initially on the most significant symptom or symptoms, designing a treatment program to measure and address this target. In nonemergent situations, nonpharmacologic management should first be initiated, continuing even if medication is added. The choice of medication is problematic, as no specific medication has been approved for BPSD. “offlabel” prescribing requires documentation and informed consent from the patient or representative. optimal medication management involves avoidance of polypharmacy, use of the smallest effective dose, scrutiny for adverse effects, and regular review with an eye to reduce or stop the medication when feasible. Many common psychiatric medications have been used for BPSD, including antipsychotics, antidepressants, benzodiazepines, and mood stabilizers. Unfortunately, controlled research is lacking for many of these medications. Dementia specific drugs, such as cholinesterase inhibitors and meantime, may have some modest effects in reducing BPSD.

CASE CONFERENCE 6

PTSD AND THE US SOLDIER TODAY

CoChairs: Elspeth C. Ritchie, M.D., M.P.H., Marvin Oleshansky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Know signs and symptoms of PTSD in veterans recently returned from war; 2) Understand how to treat PTSD, with both pharmacotherapy and psychotherapy; 3) Learn common comorbidities, including TBI, substance use, and pain.

SUMMARY:

This case conference will focus on a soldier recently returned from combat in the Middle East, with symptoms of PostTraumatic Stress Disorder (PTSD). Like many soldiers returning from war today, his prominent symptoms include anger and irritability, as well as intrusive thoughts, hyper vigilance and feelings of disconnectedness. The speakers, all Army psychiatrists, will describe challenges and successes of working with these young veterans. A focus will be on what the civilian provider should know before and while treating service members. As PTSD frequently coexists with substance abuse, traumatic brain injury, other injuries and pain, these complexities will also be part of the discussion.

SATURDAY, MAY 5, 2012

COURSE 01**BRAIN STIMULATION THERAPIES IN PSYCHIATRY***Director(s): Ziad H. Nahas, M.D.**Faculty: Linda L. Carpenter, M.D., Darin D. Dougherty, M.D., Husain Mustafa, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Recognize the different brain stimulation modalities like ECT, TMS, VNS, DBS, tDC and others; 2) Understand their role in treating neuropsychiatric conditions.

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. (1 hour) The faculty will then details Convulsive Therapies (ECT [briefly since well covered in other symposia and workshops], Magnetic Seizure Therapy (MST) and Focal Electrically Administered Seizure Therapy (FEAST)). (1 hour) The faculty will then details SubConvulsive Therapies (TMS [briefly since well covered in other CME course], VNS, DBS, Cortical Electrical Stimulation (CES), Focal Electrically Administered Therapy (FEAT), transcranial Direct Electrical Current (tDEC) and Responsive NeuroStimulation (RNS) 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 hours)

COURSE 02**HOW TO DETECT, PREVENT, AND TREAT BULLYING-RELATED MORBIDITY ALONG THE LIFESPAN***Director(s): Jorge Srabstein, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Understand the nature and ecology of bullying across all social settings and along the lifespan; 2) Recognize bullying-related morbidity and mortality risks; 3) Provide clinical detection and intervention to reduce bullying-related morbidity; 4) Advocate for the implementation of public policy for the prevention of bullying-related morbidity along the lifespan; 5) Contribute to the prevention of bullying-related health and safety risks within a whole community strategy.

SUMMARY:

There is increasing evidence that bullying is a very injurious form of maltreatment, prevalent across different social settings, along the lifespan and on a global scale. Bullying can be simultaneously present in different social settings both in and beyond the school milieu. It occurs in schools, "after school" programs, in the neighborhood, over the internet and cellular phones, at home between siblings, in dating relationships, at summer camps, and in organized athletic activities. The developmental link between school bullying and its occurrence in adulthood has challenged health practitioners to extend the range of responsibility for bullying prevention programs through college and into the workplace. Children and adolescents who participate in bullying as bystanders, victims and/or perpetrators are at a significant high risk of suffering from an array of medical and psychiatric morbidity including suicidal attempts. Bullying at the workplace has been linked to cardiovascular disease, fibromyalgia, depression, and posttraumatic stress disorder. The development of social phobia among adults has been shown to be associated with teasing or bullying during childhood. This course will provide several clinical vignettes to serve as a framework of discussion of clinical detection, intervention and treatment of morbidity linked to bullying. In this context it will discuss nature ecology of bullying across social settings along the lifespan and around the world. It will review the array of medical and psychiatric morbidity associated with bullying with special emphasis on suicidal risk and accidental injuries. It will examine the efficacy of available researchbased bullying prevention and intervention programs and explore advocacy strategies for the implementation of public health policies for the prevention of bullying related morbidity along the lifespan.

COURSE 03**OFFICEBASED BUPRENORPHINE TREATMENT OF OPIOIDDEPENDENT PATIENTS***Director(s): Petros Levounis, M.D., M.A.*

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

The purpose of the course is to provide information and training to participants interested in learning about the treatment of opioid dependence, and in particular physicians who wish to provide officebased prescribing of the medication buprenorphine for the treatment of opioid dependence. Federal legislative changes allow officebased treatment for opioid dependence with certain approved medications, and Food and Drug Administration (FDA) approved buprenorphine for this indication. The legislation requires a minimum of eight hours training such as the proposed course. After successfully completing the course, participants will have fulfilled the necessary training requirement and can qualify for application to utilize buprenorphine in officebased treatment of opioid dependence. Content of this course will include general aspects of opioid pharmacology, and specific aspects of the pharmacological characteristics of buprenorphine and its use for opioid dependence treatment. In addition, other areas pertinent to officebased treatment of opioid dependence will be included in the course (e.g., nonpharmacological treatments for substance abuse disorders, different levels of treatment services, confidentiality). Finally, the course will utilize casebased, small group discussions to illustrate and elaborate upon points brought up in didactic presentations.

COURSE 04

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

Director(s): Lori Raney, M.D., Jurgen Unutzer, M.D., M.P.H.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the typical roles for the consulting psychiatrist on an integrated care team and their interactions with the other team members; 2) Develop a workflow for the integrated practice that takes into consideration the modality of consultation, methods of communication and

efficiencies; 3) Describe the practice environment in which integrated care teams must function and the needs and challenges in providing behavioral health services in primary care; 4) Describe the spectrum of integration models in primary care settings and the research base that exists for collaborative care; 5) Identify specific strategies to address comorbid medical illnesses in mental health settings.

SUMMARY:

The integration of primary care and behavioral health has gained considerable momentum recently and will continue to grow and develop with the advent of health care reform. To prepare for this, 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 officebased practice to “consultant specialists” who can be effective on a population level will require psychiatrists to develop a new skill set. The educational opportunities for psychiatrists have not kept up with this movement although they are highly sought after members of integrated care teams and provide an essential link to our primary care colleagues. This gap in knowledge is hampering the ability of psychiatrists to join these teams in well informed and meaningful ways. This educational opportunity will prepare attendees for functioning along the collaboration continuum, which includes addressing mental health issues in primary care and comorbid medical problems in mental health settings. This course will provide the attendee with a practical skill set for the psychiatrist working with primary care at various levels of integration. Six Modules will be presented including 1) Introduction to Primary Care Consultant Psychiatry, 2) Building a Collaborative Care Team, 3) Psychiatric Consulting in Primary Care, 4) Behavioral Interventions and Referrals in Primary Care, 5) Medical Patients with Psychiatric Illness, and 6) Psychiatric Patients with Medical Illnesses. This curriculum will be taught by a faculty experienced in both research and daily practice in integrated settings and includes Drs. Lori Raney, Jurgen Unutzer, Anna Ratzliff and John Kern.

COURSE 05

KUNDALINI YOGA MEDITATION FOR ANXIETY DISORDERS INCLUDING OCD, DEPRESSION, ATTENTION DEFICIT HYPERACTIVITY DISORDER, AND POSTTRAUMATIC STRESS DISORDER

Director(s): David ShannahoffKhalsa

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be

able to: 1) Have skills with specific meditation techniques for treating OCD, anxiety disorders, depression, grief, fear, anger, addictions, PTSD, and ADHD be familiar with novel yogic concepts and techniques in mindbody medicine now published in peerreviewed scientific journals; 2) Be familiar with published results showing efficacy for new and treatment refractory OCD and OC spectrum disorders and comorbid patients; 3) Be familiar with novel yogic concepts and techniques in mindbody medicine now published in peerreviewed scientific journals.

SUMMARY:

A short review of two clinical trials will be presented that used Kundalini yoga meditation techniques for treating OCD. The first is an open trial with a 55% improvement on the YBOCS (International Journal of Neuroscience 1996) and the second is a randomized controlled trial (CNS Spectrums: The International Journal of Neuropsychiatry 1999) with a 71% mean group improvement on the YBOCS. Wholehead 148channel magnetoencephalography brain imaging of 2 yogic breathing techniques (one for treating OCD and its inactive related control) will be presented along with other novel studies in mindbody medicine based on yogic concepts and techniques. Participants will practice and learn to implement select disorder and conditionspecific meditation techniques for inducing a meditative state, “energizing,” facing mental challenges, one specific for OCD, several breathing techniques for generalized anxiety disorders, a 3minute technique to help manage fears, an 11minute technique for anger, a 3minute technique to help focus the mind, 2 different meditation techniques specific for depression (one for 11 minutes and the other for 15 minutes), an 1131 minute technique for addictions, a 1131 minute technique for ADD/ADHD, one for releasing childhood anger, and one protocol useful for PTSD and other traumatic events. The participants will also be taught how to formulate short protocols for patients that want to include these techniques in their treatment protocol as either a complement to medication, medication resistance, or electing to forgo medication. Complete protocols will be taught for OCD, ADHD, PTSD, and major depressive disorder. Ample time will be given to answer questions and to discuss the participant’s personal experiences of the techniques during the course. Note, there is some overlap in the review of the scientific materials in the early part of this course with the course on “Kundalini Yoga Meditation Techniques for Schizophrenia, the Personality Disorders, and Autism.” However, the majority of the meditation techniques are different and the protocols are also completely different.

COURSE 06

NEUROPSYCHIATRIC MASQUERADES: MEDICAL AND NEUROLOGICAL DISORDERS THAT PRESENT

WITH PSYCHIATRIC SYMPTOMS

Academy of Psychosomatic Medicine

Director(s): Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize the most common clues of presentation suggesting an “organic cause” for psychiatric symptoms; 2) Understand the incidence, epidemiology and clinical features of the most common endocrine, infectious and metabolic disorders masquerading as psychiatric illness; 3) Understand the incidence, epidemiology and clinical features of the most common autoimmune and neurological disorders masquerading as psychiatric illness; 4) Understand the neurobiology of delirium and learn about prevention and treatment strategies.

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.

COURSE 07

BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY I

American Association of Psychiatric Administrators

Director(s): Barry K. Herman, M.D., Douglas M. Brandt, M.D.

Faculty: L. Mark Russakoff, M.D., Shivkumar S. Hatti, M.D., M.B.A., Sy A. Saeed, M.D., M.S., David K. Nace, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate a working knowledge of basic concepts in theoretical, human resources, fiscal, and information technological aspects of administrative psychiatry; 2) Apply these concepts to psychiatric service systems.

SUMMARY:

This is the first course of a twocourse series providing an overview of the theories, principles, concepts and developments relevant to administrative psychiatry. The first course covers broad areas of (1) Administrative Theory and Human Resources, (2) Fiscal Management, and (3) Advances in Information Technology. The first area includes the contributions of major management theorists; basic principles of delegating authority; management methodologies; program evaluation and computer utilization; organizational behavior; problem solving; decisionmaking and implementation; principles and practices of human resources (including recruitment and selection, staff development and continuing education, performance evaluation, and labormanagement relations); and an overview of health technology as it applies to psychiatric administration. Fiscal management includes the role and function of the financial manager within the mental health organization; the corporate structure and tax status of mental health facilities; methods and mechanisms for financing mental health care, including Medicare and Medicaid; accounting concepts; budgeting policies; program budgeting; zerobase budgeting; costeffectiveness; fiscal controls; and automated financial systems. Health technology includes clinical support technologies; safety and privacy; connectivity strategies, population health, and personalized medicine. This course is intended to inform and assist psychiatrists developing administrative aspects of their careers. Part II of the course addresses psychiatric care management, marketing tools and principles, legal and ethical aspects of administrative practice, and professional and career issues relevant to psychiatric administrators.

MASTER COURSE 1

PSYCHIATRY REVIEW

The American College of Psychiatrists

Director(s): Arden D. Dingle, M.D., Robert J. Boland, M.D.

Faculty: Arden D. Dingle, M.D., Anthony L. Rostain, M.D., M.A., Avram H. Mack, M.D., Richard Balon, M.D., Carl C. Bell, M.D., Vishal Madaan, M.D., Marcia L. Verduin, M.D.

EDUCATIONAL OBJECTIVES:

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 multiplechoice 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; 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 multiplechoice 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 and audience response system to respond to the multiple choice format before correct answers and full explanations and references will be covered. The price includes a copy of the reference book.

MASTER COURSE 2

CHALLENGES IN PSYCHODYNAMIC PSYCHOTHERAPY

Director(s): Glen O. Gabbard, M.D.

Faculty: Mantosh J. Dewan, M.D., Valdesha Ball, M.D., Gabrielle Hobday, M.D., Holly CrispHan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know when to interpret transference in dynamic therapy; 2) Use strategies to address racial issues in dynamic therapy; 3) Know how to maximize effectiveness of brief dynamic therapy.

SUMMARY:

This course provides an overview of strategies to address common challenges in psychodynamic psychotherapy. Dr. Gabbard will review the recent research on the use of transference work in psychotherapy. The implications of that research will be discussed in terms of timing and the state of the therapeutic alliance. The formulation of transference interpretations will also be discussed. Dr. Dewan will explain and discuss the challenges in brief dynamic therapy. Dr. Ball and Dr. Gabbard will focus on the racial and ethnic issues as they emerge in psychotherapy. Dr. CrispHan and Dr. Hobday will present vignettes that feature clinical dilemmas for the therapist in dynamic therapy. Dr. Gabbard will illustrate the varieties of termination. The distinction between myths about termination and the stark realities of contemporary

practice will be discussed.

COURSE 08

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

Director(s): Alfred J. Lewy, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

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 them with appropriately timed bright light exposure (evening or morning, respectively) and/or lowdose melatonin as well as other melatonergic drugs in this newest class of antidepressants; 3) Understand the most recent research findings regarding light treatment.

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, nonseasonal 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 phaseresetting agent at the appropriate time. Phaseadvanced disorders are treated with evening bright light exposure and/or lowdose (= 0.5 mg) morning melatonin administration. Phasedelayed disorders are treated with morning bright light and/or lowdose 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 lowdose melatonin before and after travel. Books instruct-

ing the use of light treatment will also be reviewed, as well as the most recent research findings. The use of melatonin and the other melatonergic agents in this newest class of antidepressants will be explained in detail.

COURSE 09

NEUROANATOMY OF EMOTIONS

Director(s): Ricardo M. Vela, M.D.

EDUCATIONAL OBJECTIVES:

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.

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 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 one another contributes, to the expression of emotions and attachment behavior. Threedimensional 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 and schizophrenia will be discussed.

SUNDAY, MAY 6, 2012

COURSE 10

MINDFULNESS: PRACTICAL APPLICATIONS FOR PSYCHIATRY

Director(s): Susan E. Abbey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define “mindfulness”; 2) Describe indications & contraindications for referral to mindfulness based therapeutic programs (MBTP) (e.g. MBSR, MBCT & MBEAT) or use with individuals; 3) List common characteristics of MBTPs; 4) Explain how mindfulness approaches may be tailored to meet the needs of patients with specific psychiatric disorders (e.g. psychotic disorders, ADHD, etc.); 5) Identify mindfulness practices that may reduce their own professional & personal stress.

SUMMARY:

Mindfulness based therapeutic approaches are receiving increasing attention. They are used in both individual and group formats for a wide variety of common psychiatric problems. Most psychiatrists have received no training with respect to mindfulness and have little understanding of its value or of the clinical indications and contraindications for its use. This course will provide clinicians with a basic understanding of mindfulness and how it can be applied in the therapeutic context. The course will provide participants with both didactic material and the opportunity for experiential learning and small group discussion of common mindfulness practices. The course will provide an overview of the two most common mindfulness based therapeutic group interventions (MBSR & MBCT) and the empirical evidence for their use. Indications and contraindications will be reviewed. Participants will learn what to look for in programs prior to referring patients. The course will review how a mindfulness perspective can inform work with bodily sensations (e.g. pain) as well as distressing cognitions and affects. Recent neurobiological data on the impact of mindfulness interventions on brain biology will be summarized. Participants will learn about resources to allow them to develop their knowledge base and skills in this area. They will learn simple mindfulness practices that can reduce their own professional and personal stress and are easy to teach to patients.

COURSE 11

MENTALIZATION BASED TREATMENT FOR BORDERLINE PERSONALITY DISORDER: INTRODUCTION TO CLINICAL PRACTICE

Director(s): Anthony W. Bateman, M.D., Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVES:

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) Rec-

ognize mentalizing and nonmentalizing interventions; 3) Develop and maintain a mentalizing therapeutic stance; 4) Use some basic mentalizing techniques in their 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 followup. A trial of MBT in an outpatient setting shows effectiveness when applied by nonspecialist practitioners. 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 nonmentalizing interventions.

COURSE 12

MOTIVATION AND CHANGE: THE THEORY AND PRACTICE OF MOTIVATIONAL INTERVIEWING

APA Council on Addiction Psychiatry

Director(s): Petros Levounis, M.D., M.A., Bachaar Arnaout, M.D.

Faculty: Gary Katzman, M.D., Carla B. Marienfeld, M.D., Marianne T. Guschwan, M.D.

EDUCATIONAL OBJECTIVES:

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) Use specific MI approaches to help patients move through the stages of change; 3) Apply MI principles to a number of clinical and nonclinical settings from treating patients who participate in 12step programs to helping change the culture of an organization.

SUMMARY:

This 4hour course provides the busy clinician with the fundamentals of the theory and practice of Motivational Interviewing. With a special focus on substance use disorders and addiction, course equips its participants with a full 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. The course: Is built on the main theoretical platforms of two groundbreaking innovations in addiction treatment: 1) Prochaska and DiClemente's transtheoretical or stages of change model and 2) Miller and Rollnick's Motivational Interviewing; Provides actual case studies and roleplay exercises presented by psychiatrists working directly with patients with substance use disorders; Explores the fundamentals of motivation and change, the stages of those changes, and how to treat patients at various stages of change; Reviews the intersection of motivational work with other interventions from psychopharmacology to Alcoholics Anonymous Our audience is primarily the general psychiatrist. However, we expect that this course will also be helpful to family practitioners, internists, pediatricians, medical students, allied professionals, and anyone else who may be interested in issues of motivation and change. The course is offered at a level that can be understood by clinicians who have an interest in this area but who do not have specialized knowledge or expertise in addiction treatment.

COURSE 13

CLINICIAN'S GUIDE TO ASSESSING AND MANAGING BEHAVIOR DISTURBANCES IN PATIENTS WITH DEMENTIA WITH AN EMPHASIS ON THOSE WITH MODERATE TO SEVERE SYMPTOMS

Director(s): Maureen C. Nash, M.D., M.S.

Faculty: Sarah Foidel, OTR/L

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Have a framework for conceptualizing, diagnosing and treating significant behavior disturbances in the most common types of dementia with both behavioral and pharmacological interventions; 2) Identify and understand cognitive and functional assessments leading to accurate

diagnosis of people with dementia; 3) Have an understanding of current literature and practical applications of current nonpharmacological and pharmacological interventions for people with dementia; 4) Understand and differentiate between delirium and behavior disturbance in those with dementia as well as describe appropriate active management of delirium; 5) Be able to define, recognize and encourage use of appropriate interventions to improve quality of life in people with dementia, especially those with advanced disease.

SUMMARY:

This course is designed for psychiatrists, primary care providers, and advanced practice nurses who desire to learn about how to assess and manage behavioral disturbances in those who have 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 situation 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 indepth 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 14

THE DETECTION OF MALINGERED MENTAL ILLNESS

Director(s): Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVES:

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

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, depression, and the reluctance of psychiatrists to diagnose malingering. The limitations of the clinical interview and psychological testing in detecting malingering will be covered. The course will delineate 12 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 the so called “compensation neurosis,” malingered mutism, and feigned posttraumatic stress disorder in combat veterans.

COURSE 15

CULTURALLY APPROPRIATE ASSESSMENT REVEALED: THE DSMIVTR OUTLINE FOR CULTURAL FORMULATION DEMONSTRATED WITH VIDEOTAPED CASE VIGNETTES

Director(s): Russell F. Lim, M.D., Francis Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe interviewing techniques to assess the various aspects of cultural identity after assessing their own, and viewing videotaped interviews using the DSMIVTR Outline for Cultural Formulation; 2) Describe methods to elicit the cultural explanation of the individual illness or explanatory model after viewing a videotaped vignette, and a discussion of the different types of explanatory models; 3) Describe methods to elicit the stressors and supports of a patient by using a focused developmental and social history; 4) Discuss and identify ethnocultural transference and countertransference after discussing a journal article and viewing a videotaped vignette of a patient and therapist experiencing both phenomenon; 5) Describe how to formulate a case and how to negotiate a treatment plan with a patient after watching and discussing a videotaped vignette of an interview and its summarizing statement.

SUMMARY:

Being able to perform a culturally competent assessment is a skill required by current RRC requirements and ACGME core competencies for all graduating psychiatric residents. In addition, the US Census Bureau has predicted that by 2025, Latinos will represent the majority population in California, Arizona, New Mexico and Texas and 33% of all U.S. children. In addition, the Institute of Medicine’s report, “Unequal Treatment,” showed that patients belonging to minority populations received a lower level of care than mainstream patients, when matched for socioeconomic status. The Supplement to the Surgeon General’s Report

on Mental Health, entitled “Mental Health: Culture, Race and Ethnicity, stated that “culture counts,” and that patients belonging to minority populations had less access to care, and working with these patients requires clinician to not only provide proper language interpretation services, but also the clinician needs to bring an awareness of the cultural differences between the clinician and patient that will allow both to understand each other better and to provide better mental health care. The DSMIVTR Outline for Cultural Formulation (OCF) is an excellent tool for the assessment of culturally diverse individuals, broadly defined to include ethnicity, culture, race, gender, sexual orientation, religion and spirituality, and age, and has been included in the DSMIV since 1994, and in addition, was included in the 2006 APA Practice Guidelines on the Psychiatric Evaluation of Adults, Second edition. The course will also present Hay’s ADDRESSING framework, as well as demonstrate Arthur Kleinman’s eight questions to elicit an explanatory model, and the LEARN model to negotiate treatment with patients. Attendees of the course will learn how to assess their own and their patient’s cultural identities, and how the ethnicity of the clinician and of the patient affects transference and countertransference. Clinicians require culturally informed interviewing skills to accurately evaluate culturally diverse individuals to treat them both appropriately and effectively. The course will teach clinicians specific skills for the assessment of culturally diverse patients. Participants will participate in a small group exercise on their own cultural identities, and then will view mini lectures on the five parts of the DSMIVTR Outline for Cultural Formulation, as well as instruction on interview skills, supplemented by the viewing of taped case examples. Discussion of the case vignettes will enable attendees to gain an understanding of the skills demonstrated in the videotaped vignettes. Participants will be encouraged to share their own approaches, and then modify their approaches based on material presented in the course. Clinicians completing this course will have learned interviewing skills useful in the culturally appropriate assessment and treatment planning of culturally and ethnically diverse patients.

COURSE 16

MOOD DISORDERS IN LATER LIFE

Director(s): James M. Ellison, M.D., M.P.H., Yusuf Sivrioglu, M.D.

Faculty: Donald A. Davidoff, Ph.D., Brent P. Forester, M.D., James M. Ellison, M.D., M.P.H., Joanna Salmon, Ph.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Implement a systematic approach for evaluat-

ing patients with late life mood disorders; 2) Guide treatment planning by drawing upon a range of evidencebased somatic and psychotherapeutic approaches; 3) Understand more fully the interrelationships between mood disorders and cerebrovascular disease in older adults.

SUMMARY:

Clinicians who work with older adults must be able to detect, accurately diagnose, and effectively treat late life mood disorders. These disorders are widespread and disabling, and clinicians are more frequently faced with affected patients as a result of increasing longevity, greater acceptance of mental health care seeking by older adults, and advances in diagnostic and treatment resources. This course provides an interdisciplinary overview of late life unipolar and bipolar mood disorders. The attendee should acquire an organized approach to assessment, a systematic and evidencebased approach to treatment planning and choice among various modalities, an updated understanding of the relationship between cerebrovascular disease or other medical factors and geriatric mood disorders, and a greater awareness of the interactions between mood and cognitive symptoms. The discussion of psychotherapy for older adults with mood disorders will review evidencebased approaches with particular emphasis on cognitive behavior therapy. The faculty will lecture, using slides, with time for interactive discussions between attendees and faculty members. This course is designed primarily for general psychiatrists seeking greater understanding and expertise in treating older patients. For psychiatric residents, this will be an advanced introduction. For geriatric psychiatrists, we will provide a review and update. This course will be of greatest practical value to attendees who treat older adults and already possess a basic familiarity with principles of pharmacotherapy and psychotherapy.

COURSE 17

CURRENT PROCEDURAL TERMINOLOGY CODING AND DOCUMENTATION

APA Committee on RBRVS, Codes and Reimbursement

Director(s): Ronald M. Burd, M.D.

Faculty: Chester W. Schmidt, M.D., Tracy R Gordy, M.D., Ronald M. Burd, M.D., David K. Nace, M.D., Jeremy S. Musher, M.D., Allan A. Anderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the use of psychiatric evaluation codes, therapeutic procedure codes, and evaluation and management codes; 2) Document the provision of services denoted by the above sets of codes.

SUMMARY:

This course is for both clinicians (psychiatrists, psychologists, social workers) and office personnel who either provide mental health services or bill patients for such services using “Current Procedural Terminology (CPT) codes, copyrighted by the American Medical Association. Course attendees are encouraged to obtain the most recent published CPT Manual and read the following sections: 1) the Guideline Section for Evaluation and Management codes, 2) the Evaluation and Management codes themselves, and 3) the section on “Psychiatric Evaluation and Therapeutic Procedures.” The objectives of the course are twofold: first, to familiarize the attendees with all the CPT codes used by mental health clinicians and review issues and problems associated with payer imposed barriers to payment for services denoted by the codes; second, the attendees will review the most up to date AMA/CMS guidelines for documenting the services/procedures provided to their patients. 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.

COURSE 18

TREATMENT OF SCHIZOPHRENIA

Director(s): Philip G. Janicak, M.D.

Faculty: Stephen Marder, M.D., Philip G. Janicak, M.D., Rajiv Tandon, M.D., Morris B. Goldman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the psychopathological dimensions and neurobiological underpinnings of schizophrenia; 2) Describe the clinically relevant pharmacological aspects of first and second generation antipsychotics; 3) Understand their use for acute and chronic schizophrenia; 4) Describe recent approaches to integrating antipsychotics with psychosocial and rehabilitation programs.

SUMMARY:

Treatment of schizophrenia and related psychotic disorders has rapidly evolved since the reintroduction 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 CULASS trials), continues to be clarified. Increasingly, safety

and tolerability issues are the focus of attention, as well as strategies to improve cognition, mood and negative symptoms. The integration of cognitive therapeutic approaches, as well as psychosocial and rehabilitation programs, with medication is also critical to improving longterm outcomes (e.g., recovery). Our increased understanding of the neurobiology and psychopathology of schizophrenia will guide the development of yet another generation of agents and more effective use of maintenance strategies.

COURSE 19

KUNDALINI YOGA MEDITATION TECHNIQUES FOR SCHIZOPHRENIA, THE PERSONALITY DISORDERS, AND AUTISM

Director(s): David ShannahoffKhalsa

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Have skills with techniques for treating schizophrenia, the 10 APA defined personality disorders, and autism; 2) Gain familiarity with case histories of schizophrenics, personality disorder patients, and autism; 3) Be familiar with background studies published showing the efficacy of Kundalini yoga meditation for OCD and OC spectrum disorders; 4) Be familiar with novel yogic perspectives for treating personality and autism disorders.

SUMMARY:

A short review of two clinical trials will be presented that used Kundalini yoga meditation techniques for treating OCD. The first is an open trial with a 55% mean group improvement on the YBOCS (International Journal of Neuroscience 1996) and the second is a randomized controlled trial (CNS Spectrums: The International Journal of Neuropsychiatric Medicine 1999) with a 71% mean group improvement on the YBOCS. Wholehead 148channel magnetoencephalography brain imaging of 2 yogic breathing techniques (one for treating OCD and its inactive related control) will be presented along with other novel studies in mindbody medicine that were based on yogic concepts and techniques. These studies will be presented to help build greater confidence in yogic medicine. Participants will practice and learn to implement select disorder and conditionspecific meditation techniques for the following three disorders (1) the 9 variants of the psychoses, (2) the 10 APA DSM IVTR defined personality disorders, and (3) autism. For the psychoses, the techniques will include one for inducing a meditative state, "A Protocol for Treating the Variants of Schizophrenia" that includes a 10part yogic exercise set, a meditation technique to help eliminate negativity, a meditation to help combat delusions and to help stabilize a healthy sense of selfidentity, and a 4part miniprotocol

for helping to terminate hallucinations. The techniques for the personality disorders will include 3 protocols that are specific for the respective 3 APA defined Clusters of A, B, and C, and each of the 3 primary clusterspecific protocols will also include a meditation that can then be substituted for the respective 10 personality disorders. There will also be a unique Kundalini yoga meditation approach for treating autism that can also be applied to Asperger's Syndrome patients. This autismspecific approach is called The Dance of the Heart. There will also be simple and more advanced techniques taught that can be utilized in this "dance" depending on the severity of the patient. There are also an array of more advanced meditation techniques that can be used as substitutes for the variants of the psychoses, the personality disorders, and for the more improved autistic patient. Case histories of each disorder will be presented. Ample time will be given to answer questions and to discuss the participant's personal experiences of the techniques during the course.

COURSE 20

BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY II

American Association of Psychiatric Administrators

Director(s): Douglas M. Brandt, M.D., Wayne L. Creelman, M.D.

Faculty: Arthur L. Lazarus, M.D., M.B.A., Jeri Davis, M.B.A., William H. Reid, M.D., M.P.H., Robert M. Atkins, M.D., M.P.H., Alan Axelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate a working knowledge of basic concepts in psychiatric care management, marketing tools and principles, legal and ethical aspects of administrative practice, and professional and career issues relevant to psychiatric administrators; 2) Apply these concepts to psychiatric service systems.

SUMMARY:

This is the second course in a twocourse series providing an overview of the theories, principles, concepts, and developments relevant to administrative psychiatry. This course covers the broad areas of 1) psychiatric care management; 2) law and ethics; 3) marketing; and 4) professional and career issues relevant to psychiatric administrators. The first area includes: clinical program issues; multidisciplinary service delivery; programs for special populations (e.g., substance abusers, older adults, and children and adolescents); medical and psychiatric care coordination; principles of disease management; accreditation readiness (e.g., NCQA

and The Joint Commission); utilization management, performance improvement, and provider credentialing. Law and ethics includes: commitment procedures and patient's rights; confidentiality and privilege; competency and guardianship, civil versus criminal proceedings; record keeping; disclosure and duty to warn; and case law affecting administrative practice. The marketing portion of the course focuses on techniques for creating an organizational culture that represents quality values; ways to translate quality services into external perceptions and initiatives that build a strong positive organizational reputation; identification, from a psychiatric administrator's perspective, of "stakeholders" and their needs; and implementation of ideas and tools to help market the organization. The last part of the course 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. Parts I and II of "Basic Concepts in Administrative Psychiatry" provide an overview of areas considered prerequisite for managing the medical/industrial complex.

COURSE 21

ESSENTIALS OF ASSESSING AND TREATING ATTENTION DEFICIT HYPERACTIVITY DISORDER IN ADULTS AND CHILDREN

Director(s): Thomas E. Brown, Ph.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize impairments caused by attention deficit disorders in adults or children; 2) Assess and diagnose adults and/or children for ADHD using appropriate instruments and methods; 3) Select and manage appropriate medications for ADHD and comorbid disorders; 4) Design appropriate multimodal treatment programs for adults or children with ADHD.

SUMMARY:

Once understood as a disruptive behavior of childhood, ADHD is now recognized as developmental impairment of the brain's executive functions. Although initial diagnosis of ADHD is usually in childhood or adolescents, many individuals do not recognize their ADHD impairments until they encounter the challenges of adulthood. Yet many of these adults are not correctly diagnosed or effectively treated, especially if they are bright and their ADHD does not include hyperactivity. This comprehensive basic course

for clinicians interested in treatment of adults and/or children and adolescents, will offer research and clinical data to provide: 1) an overview of the ways ADDs are manifest at various points across the lifespan with and without comorbid disorders; 2) descriptions of how ADDs impact upon education, employment, social relationships, and family life of adults; 3) a model that utilizes updated clinical and standardized psychological measures to assess ADDs; 4) research-based selection criteria of medications for treatment of ADDs and various comorbid disorders; and 5) guidelines for integration of pharmacological, educational, behavioral and family interventions into a multimodal treatment plan tailored for specific individuals with ADHD.

COURSE 22

DAVANLOO'S INTENSIVE SHORTTERM DYNAMIC PSYCHOTHERAPY IN CLINICAL PRACTICE

Director(s): James Q. Schubmehl, M.D., Alan R. Beeber, M.D.

Faculty: Alan R. Beeber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the forces underlying human psychopathology, including the crucial elements of the healing process; 2) Describe the main elements of Davanloo's technique, and apply them in their own clinical practices; 3) Know the contraindications for Davanloo's ISTDP and understand the reason(s) for each.

SUMMARY:

Highly resistant, poorly motivated patients are a major challenge to every clinician, especially when the clinical picture includes a complex mixture of character pathology and symptom disturbances. Davanloo's Intensive Short Term Dynamic Psychotherapy has shown rapid effectiveness with difficult to treat conditions, including functional disorders, depression, panic and other anxiety disorders. This course, for those who practice or make referrals to psychotherapy, will demonstrate the range of applications of this technique, with specific technical interventions for particular conditions. There will be extensive use of video recordings of patient interviews to demonstrate the innovative techniques and metapsychology underlying the activation of the therapeutic alliance, even with hard to engage patients. The "unlocking of the unconscious" will be demonstrated. Davanloo's revolutionary discovery of removing the resistance in a single interview will be shown, along with how this enables the patient to have full neurobiological experience of the impulses and feelings that have fueled the unconscious guilt that drives their suffering. This frees the patient from these destructive forces, starting in the in the first session, lead-

ing to symptomatic relief and characterologic change. The course will provide participants with an overview of this uniquely powerful way of understanding human psychic functioning and the related techniques which empower the therapist to help patients change.

COURSE 23

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

Director(s): David L. Mintz, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the evidence base linking meaning factors and medication response; 2) Construct an integrated biopsychosocial treatment frame; 3) Recognize common psychodynamics of pharmacologic treatment resistance; 4) Use psychodynamic interventions to address psychodynamic sources of resistance to medications; 5) Recognize and contain countertransference contributions to pharmacologic treatment resistance.

SUMMARY:

Though psychiatry has benefited from an increasingly evidence based perspective and a proliferation of safer and more tolerable treatments, outcomes are not substantially better than they were a quarter of a century ago. Treatment resistance remains a serious problem across psychiatric diagnoses. One likely reason is that, as the pendulum has swung from a psychodynamic framework to a biological one, the impact of meaning has been relatively neglected, and psychiatrists have lost some of our potent tools for working with the most troubled patients. Psychodynamic psychopharmacology is an approach to psychiatric patients that explicitly acknowledges and addresses the central role of meaning and interpersonal factors in pharmacologic treatment. While traditional objectivedescriptive psychopharmacology provides guidance about what to prescribe, psychodynamic psychopharmacology informs prescribers how to prescribe to maximize outcomes. The course will review the evidence base connecting meaning and medications, and will review psychodynamic concepts relevant to the practice of psychopharmacology. Then, reviewing faculty and participant cases, and with a more specific focus on treatment resistance, common psychodynamic sources of pharmacologic treatment resistance will be elucidated. This is intended to help participants better to be able to

recognize those situations where psychodynamic interventions are likely to be necessary to enhance pharmacologic outcomes. Faculty will outline technical principles of psychodynamic psychopharmacology, providing participants with tools for working with psychodynamic resistances to and from psychiatric medications. This course is designed to help clinicians who prescribe psychiatric medications or who provide therapy to patients on medications to be able to recognize and treat psychodynamic impediments to healthy and effective use of medications.

MASTER COURSE 3

PRACTICAL COGNITIVE BEHAVIOR THERAPY

Director(s): Jesse H. Wright, M.D., Ph.D.

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

EDUCATIONAL OBJECTIVES:

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; 3) Use basic cognitive and behavioral methods for anxiety disorders.

SUMMARY:

Cognitivebehavior therapy (CBT) is a highly pragmatic, problemoriented 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 cognitivebehavioral model, the collaborativeempirical 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.

MONDAY, MAY 7, 2012

COURSE 24

EXPLORING TECHNOLOGIES IN PSYCHIATRY

American Association for Technology in Psychiatry

Director(s): Robert S. Kennedy, M.A., John Luo, M.D.

Faculty: Carlyle H. Chan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the various current technologies and connections that are possible in medicine psychiatry; 2) Review the emerging technologies and how they will impact the practice of medicine in the near future; 3) Recognize the pros and cons of electronic physicianpatient 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 uptodate 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 personal digital assistants such as tablets and smartphones and the impact of mobile and cloud technology. A discussion of social media, new trends and how physicians can manage their online identity in the changing online landscape. 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 25

THE PSYCHIATRIST AS EXPERT WITNESS

Director(s): Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify ways that psychiatrists give more effective expert witness testimony; 2) Recognize and understand

the rules of evidence and courtroom privilege; 3) Identify and 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 pretrial conferences and depositions. Participants will learn to cope with crossexaminers who attack credentials, witness bias, adequacy of the examination, and the validity of the expert's reasoning. Issues of power and control in the witness crossexaminer relationship will be explored. Participants will learn how to answer questions about fees, pretrial conferences, questions from textbooks. The use of jargon, humor, and sarcasm will be covered. Different styles of testimony and crossexamination 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 60 suggestions for witnesses in depositions, 15 trick questions by attorneys, and 58 suggestions for attorneys crossexamining psychiatrists.

COURSE 26

ADVANCED ASSESSMENT AND TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER

Director(s): Thomas E. Brown, Ph.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand emerging new models of ADHD as developmentally impaired executive function of the brain; 2) Explain high rates of comorbidity of ADHD with other psychiatric disorders; 3) Adequately assess more complicated cases of ADHD; 4) Describe how medication treatments should be modified to deal with psychiatric or medical complications; 5) Develop treatment plans to address effectively complicated cases of ADHD across the lifespan.

SUMMARY:

This advanced course provides an update on researchbased understandings of ADHD across the life cycle. It highlights the role of impairment in executive functions and the importance of modifying medications and other treatment

strategies to deal with comorbid psychiatric and medical disorders that often complicate ADHD. Case examples of adults, adolescents and children are discussed to demonstrate the variety of ways in which ADHD can be complicated not only on initial presentation, but also over the course of treatment.

COURSE 27

ADVANCES IN NEUROPSYCHIATRY: THE NEUROPSYCHIATRY OF EMOTION AND ITS DISORDERS

Director(s): C. Edward Coffey, M.D.

Faculty: Michael Trimble, M.D., Robert G. Robinson, M.D., Matthew A. Menza, M.D., M. Justin Coffey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the neurobiology of emotion; 2) Demonstrate knowledge of the pathophysiology of mood disorders; 3) Demonstrate knowledge of the 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 certain neurological illnesses. These mood disturbances may have important implications for the clinical presentation, management, and prognosis of the neurological illness. On the other hand, the recognition and treatment of these mood disturbances may themselves be impacted by the underlying neurological illness. This course will discuss the evidencedbased 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 brainbehavior relations in general, with particular reference to the neurobiology of emotional behavior.

COURSE 28

ECT PRACTICE UPDATE FOR THE GENERAL PSYCHIATRIST

Director(s): Laurie M. McCormick, M.D.

Faculty: Andrew Krystal, M.D., Peter B. Rosenquist, M.D., Laurie M. McCormick, M.D., Charles Kellner, M.D., Donald P. Eknoyan, M.D.

EDUCATIONAL OBJECTIVES:

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 ultrabrief pulse width stimuli; 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 nonpsychotropic medications. Emphasis will be placed on newer ideas such as ultrabrief 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 29

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

Director(s): John W. Tsuang, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the issues relating to the treatment of dual diagnosis patients; 2) Popular street drugs and club drugs will be discussed; 3) Discuss the available pharmacological agents for treatment of dual diagnosis patients; 4) Learn the harmreduction versus the abstinence model for dual diagnosis patients.

SUMMARY:

According to the ECA, 50percent 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 stateofheart 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 31

DISASTER PSYCHIATRY

APA Committee on Psychiatric Dimensions of Disasters

Director(s): Anand Pandya, M.D., Frederick J. Stoddard, M.D.

Faculty: David M. Benedek, M.D., Kristina Jones, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Adapt the standard psychiatric evaluation to assess common postdisaster problems; 2) Describe evidencebased interventions for psychiatric problems after a disaster; 3) Describe the psychological impacts of disasters on children and interventions to mitigate this impact; 4) Describe the systems issues that affect postdisaster psychiatric practice.

SUMMARY:

Attention to disaster psychiatry continues to expand tremendously since the September 11th attacks, the Indian Ocean Tsunami, Hurricane Katrina, and the earthquake in Haiti. Recent studies and reports chart the range of postdisaster psychiatric problems and the opportunities for assisting response teams and survivors. Today, psychiatrists who wish to serve in disasters need to gain an understanding of risk communication and psychological first aid, fields barely known a decade ago. This course will review these topics and other core clinical areas and will use interactive scenarios to give participants a vivid sense of the systems issues and the treatment environment confronting disaster psychiatrists. Participants will learn who is at risk for psychiatric problems and a broad range of postdisaster interventions from experienced faculty who have edited and authored a variety of books in the field including the new APPI Clinical

Manual of Disaster Psychiatry which will be included with the course as an enduring resource for all participants.

COURSE 32

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

Director(s): Kimberly A. Stigler, M.D., Alice R. Mao, M.D.

Faculty: Mathew Brams, M.D., Eric Courchesne, Ph.D., James Sutcliffe, Ph.D., Julie A Chilton, M.D., Stephanie Hamarman, M.D., Jennifer Yen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand how to more accurately diagnose autism spectrum disorders (ASDs); 2) Assist parents with the development of an integrated biopsychosocial treatment plan; 3) Discuss emerging research findings on the genetics of autism; 4) Review new neurobiological findings in autism; 5) Review the psychopharmacology of ASDs and describe educational and behavioral interventions for ASDs over the lifespan.

SUMMARY:

Autism spectrum disorders (ASDs) are lifelong neuropsychiatric disorders characterized by impairments in social skills and communication, as well as repetitive interests and activities. Children and adolescents presenting with symptoms suggestive of an ASD require careful clinical assessment and diagnostic clarification. After diagnosis, parents often experience uncertainty regarding the selection of appropriate biopsychosocial interventions. Furthermore, the lack of a clear understanding of the etiology of autism and related disorders often is a source of parental distress. Although the cause of autism is unknown, investigators are actively researching the neurobiology of autism, via modalities such as genetics and neuroimaging, to enhance our understanding of this complex disorder. In addition to the core impairments of ASDs, youth and adults also frequently exhibit interfering behavioral symptoms, including hyperactivity and inattention, repetitive behavior, and irritability, that require pharmacologic and behavioral interventions. This course will provide the practicing psychiatrist with an essential knowledge base important to making accurate diagnoses, understanding key neurobiological findings, developing comprehensive biopsychosocial treatment plans, and treating maladaptive behaviors in children, adolescents and adults with ASDs.

COURSE 33

CAN'T WORK OR WON'T WORK? PSYCHIATRIC DISABILITY EVALUATIONS

Director(s): Liza H. Gold, M.D.

Faculty: Marilyn Price, M.D., Donna Vanderpool, J.D., M.B.A., William J. Stejskal, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Analyze 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) Identify uses of psychological testing in disability evaluations; 5) Understand potential liability associated with performing disability evaluations and develop related risk management skills.

SUMMARY:

This course will review the complex relationship between psychiatric impairment and work disability in competitive employment contexts through presentations by a multi-disciplinary faculty utilizing case examples and interactive discussion. Psychiatrists often provide disability evaluations for their patients or for third parties such as insurance companies, attorneys, or administrative agencies. Legal or administrative disability decisions regarding awards of public or private insurance benefits, legal damages, ADA accommodations, and fitness for duty 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. Some individuals with relatively mild symptoms may have severe impairments and disability; others with severe symptoms may have no work disability at all. 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 consideration of these factors and the development of case formulations. We will review the most frequently asked questions psychiatric disability examinations are asked to answer. We will demonstrate how to utilize the “work capacity” model and a case formulation to assist psychiatrists

in providing the opinions to the frequently asked questions in disability evaluations, including causation, motivation, and malingering. We will also review the only professionally endorsed guidelines for psychiatric disability assessment, and discuss practical application. Finally, we will discuss and review relevant psychological testing and testing related issues, HIPAA issues, legal liability in the provision of disability evaluations, and risk management of these important practical aspects of disability evaluations.

COURSE 34

TRAUMAINFORMED CARE: PRINCIPLES AND IMPLEMENTATION

Director(s): Sylvia Atджian, M.D.

Faculty: Joan Gillece, Ph.D., Tonier Cain,

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) List traumaspectrum disorders; 2) Understand the prevalence and impact of trauma on symptom formation and behavioral manifestations in individuals with psychiatric illness; 3) Recognize the importance of creating environments that facilitate selfsoothing in the healing of trauma survivors; 4) Identify practical strategies to implement traumainformed care in all settings that treat individuals with mental illness.

SUMMARY:

Interpersonal trauma is very prevalent in individuals with psychiatric illness. Trauma may lead to many psychiatric disorders that often go undetected or misdiagnosed. Adaptations to trauma are often at the center of symptom formation and behavioral responses. Treatments that do not address the impact of trauma may be ineffective and may even retraumatize survivors of trauma. TraumaInformed Care places trauma at the center of understanding symptoms and behaviors and looks to facilitate healing without the use of coercion, violence, seclusion or restraints. The course will review the principles of traumainformed care including traumaspectrum disorders, symptoms as adaptations, the neurobiology of trauma and the facilitation of selfsoothing. A trauma survivor will recount her experiences in mental health treatment before, during and after her admission to a traumainformed treatment program. A videotape of four women treated at that program will be shown to discuss the impact of traumainformed care on treatment outcome. Finally, the course will describe the implementation and outcomes of traumainformed services in different mental health settings.

COURSE 35

A PRACTICAL APPROACH TO RISK ASSESSMENT

Director(s): William H. Campbell, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify risk factors for suicide and violence; 2) Formulate risk assessments for suicide and violence; 3) Develop risk reduction plans for suicide and violence.

SUMMARY:

This course shows participants how to employ a systematic approach to risk assessment in psychiatric patients. Risk and protective factors for suicide and violence will be reviewed and a paradigm will be presented with which to organize historical data. Videotaped interviews of patients with suicidal and homicidal ideation will be shown. Following each of these videotapes, participants will develop a risk reduction plan under faculty supervision. Psychiatric negligence and malpractice reduction in regard to risk assessment will also be reviewed.

COURSE 36**ADULT SEXUAL LOVE AND INFIDELITY**

Director(s): Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize and articulate the meanings and processes of love; 2) Define and use the power of psychological intimacy to promote the lives of couples; 3) Recognize the private mental and behavioral experiences with infidelity; 4) Calmly think about extradyadic sex without reflexive moral censure.

SUMMARY:

The course will begin with a detailed description of nine interlocking meanings of sexual love. The means of attaining psychological intimacy will be illuminated. Its aphrodisiac properties will be explained and its use as a therapy tool will be presented. The next presentation will stress love as an evolving process through three stages falling in love, being in love, and staying in love. The recent findings on the biology of love will be reviewed. After each topic segment there will be short periods of discussion. Participants will be asked to read case histories during the lunch break. The diverse forms of and motivations for extradyadic sex will be conceptualized followed by a long audience discussion of situations of infidelity using provided case materials. The emphasis will be on remaining calm and clear in the face of the affective storms of patients. The course will stress the

role of therapist as an informed, lifelong student of the varied ways individuals seek to attain of love's ideals and how they deal with their disappointments.

MASTER COURSE 4**ESSENTIAL PSYCHOPHARMACOLOGY**

Director(s): Alan F. Schatzberg, M.D., Charles Debattista, M.D.

Faculty: Natalie L. Rasgon, M.D., Ph.D., Charles Debattista, M.D., Ira Glick, M.D., Kiki Chang, M.D., Terence A. Ketter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of treatment for depressive disorders; 2) Demonstrate knowledge of and treatment of bipolar disorders, schizophrenia and child psychopharmacology; 3) Demonstrate knowledge and treatment of special issues associated with disorders in women.

SUMMARY:

Rapid advances in neuroscience, drug development and clinical research have made it very difficult to keep up with advances applicable to clinical psychopharmacology, evidencebased practice. This master's course, designed for psychiatric clinicians, will focus on the cuttingedge issues every clinician needs to know to ensure quality of practice. Advances over the last year will be highlighted. The content focuses on five of the fields most commonly encountered in practice: depressive disorder, bipolar disorders, child/adolescent disorders, women's health disorders and treatment, and schizophrenia. Course methodology will include not only carefully crafted overviews by experts in the field, but also immediate follow up of lecturers (with course participants) following the lecture. This follow up will be in a smallgroup breakup session of 30 minutes.

COURSE 37**REPETITIVE HEAD INJURY IN SPORTS AND OTHER LIFE ACTIVITIES: A PSYCHIATRIC PERSPECTIVE: WHAT TO KNOW AND HOW TO TREAT**

Director(s): Michele T. Pato, M.D.

Faculty: David A. Baron, D.O., Steven H. Baron, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate the similarities between single episode TBI and repetitive TBI/head injury in patients; 2) Compare the differences between single episode TBI and

repetitive TBI/head injury in patients; 3) Improve diagnosis through the use of neurocognitive and neuroimaging measures; 4) Apply treatment options for TBI/head injury alone and with comorbid conditions.

SUMMARY:

Interest in head injuries in adults, adolescents and children has grown with the awareness that these injuries often occur in the pursuit of sports. 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 sports psychology 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 patients TBI (diagnosed or undiagnosed) may present to their office.

COURSE 38

INTERPERSONAL PSYCHOTHERAPY (IPT)

Director(s): John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVES:

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

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 19th 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 39

MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN

Director(s): Shaila Misri, M.D., Diana Carter, M.D.

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

EDUCATIONAL OBJECTIVES:

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; 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 motherbaby 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 nonpharmacological 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.

COURSE 40

TRANSFERENCEFOCUSED PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER

Director(s): Frank E. Yeomans, M.D., Ph.D., Otto F. Kernberg, M.D.

Faculty: John F. Clarkin, Ph.D.

EDUCATIONAL OBJECTIVES:

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 disorder; 2) Understand the need to appropriately structure therapy with borderline patients in order to decrease acting out and direct emotions into the treatment; 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:

This course will help therapists increase their understanding and ability to meet the challenge of treating patients with borderline personality disorder. The course will describe and demonstrate Transference Focused Psychotherapy (TFP), an evidence based psychotherapy for Borderline Personality Disorder presented in a treatment manual published by the American Psychiatric Press. The course will begin by explaining an understanding of personality and personality disorders based on internal representations of self and others, as proposed DSM V conceptualization of Axis II. It will then go on to describe the techniques used in TFP to address and treat the symptoms and underlying personality structure of BPD. The course will follow the model of and refer to our APPI book and will present a demonstration video session that we have created to illustrate the techniques of the therapy in action.

COURSE 41

INTERMEDIATE CPT CODING: EVALUATION AND MANAGEMENT (E/M) CODES IN DEPTH

APA Committee on RBRVS, Codes and Reimbursement

Director(s): Ronald M. Burd, M.D.

Faculty: Chester W. Schmidt, M.D., Ronald M. Burd, M.D., David K. Nace, M.D., Jeremy S. Musher, M.D., Allan A. Anderson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Determine when it is more appropriate to use an E/M code rather than a code specific to psychiatry; 2) Appropriately select E/M codes to accurately reflect the nature of the patient encounter; 3) Appropriately document for E/M coding so that no difficulty will be encountered if an

audit is conducted.

SUMMARY:

Attendees will be presented with a thorough understanding of the E/M codes, which are used by all physicians, and their appropriate use. After a basic introduction to the codes and the required documentation, hands on work will be done using vignettes and documentation templates to determine appropriate code choice and necessary documentation based on the CMS 1997 Documentation Guidelines for E/M Coding. A large part of the course will consist of responding to attendees questions based on their clinical experiences.

TUESDAY, MAY 8, 2012

COURSE 42

ADHD IN ADULTS FROM CLINICAL RESEARCH TO CLINICAL PRACTICE

Director(s): Craig B. Surman, M.D.

Faculty: Paul G. Hammerness, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the evidence basis that informs assessment and treatment of ADHD in adulthood; 2) Demonstrate efficient methods for assessing ADHD symptoms and impairment; 3) Develop a personalized treatment plan for adults with ADHD; 4) Optimize pharmacologic management of the condition; 5) Implement cognitive behavioral and other therapies for adults with ADHD.

SUMMARY:

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 approximately 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 recently published in the Journal of the American Medical Association. Uptodate 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 symp-

toms, and practice applying medication and nonmedication treatments to virtual cases. 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) stepbystep instruction on personalizing treatment for ADHD patients, including optimal pharmacologic and nonpharmacologic supports; 4) evidence basedcognitive behavioral therapy strategies; 5) principles for managing common complex presentations, including patients with nonattention 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.

COURSE 43

RISK ASSESSMENT FOR VIOLENCE

Director(s): Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify risk factors for violence; 2) Improve interview techniques in the assessment of dangerousness; 3) Classify different types of stalkers.

SUMMARY:

This course is designed to provide a practical map through the marshy minefield of uncertainty in risk assessment for violence. 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 syndrome, 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. Instruction will be given in the elucidation of violent threats and “perceived intentionality.” A classification of five types of stalkers will be discussed with implications for risk assessment. Finally, a videotape will be shown to allow participants to identify risk factors and develop a violence prevention plan for a man who planned to kill his boss.

COURSE 44

COGNITIVEBEHAVIOR THERAPY FOR SEVERE MENTAL ILLNESS

Director(s): Jesse H. Wright, M.D., Ph.D.

Faculty: David G. Kingdon, M.D., Douglas Turkington, M.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand cognitive behavior; 2) Learn about CBT procedures; 3) Discuss applications of CBT.

SUMMARY:

In recent years, cognitivebehavior therapy (CBT) methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptomatology. This course presents these newer CBT applications for the treatment of persons with chronic or treatment resistant depression, schizophrenia, and bipolar disorder. Cognitivebehavioral conceptualizations and specific treatment procedures are described for these patient groups. Several modifications of standard CBT techniques are suggested for the treatment of severe or persistent mental illnesses. Participants in this course will learn how to adapt CBT for patients with problems such as psychomotor retardation, hopelessness and suicidality, hallucinations, delusions, hypomania, and nonadherence to pharmacotherapy recommendations. CBT procedures are illustrated through case discussion, role plays, demonstration, and video examples. Worksheets that can facilitate application of CBT techniques are provided. Participants will have the opportunity to discuss application of CBT for their own patients.

COURSE 45

EVIDENCE BASED GROUP AND INDIVIDUAL PSYCHOSOCIAL TREATMENTS FOR ADULT ADHD: THEORY AND PRACTICE

Director(s): Anthony L. Rostain, M.D., M.A.

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

EDUCATIONAL OBJECTIVES:

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 AttentionDeficit Hyperactivity Disorder (ADHD); 2) Describe similarities and differences among 2 group interventions (Solanto, et al (2008, 2010, 2011); Philipsen, et al (2007, 2010)) and 2 individualfocused interventions (Safren & Sprich (2005, 2010); Ramsay & Rostain (2006, 2008) all of which are reasonably effective for treating adults with ADHD; 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 evidencebased 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 twohourlong smallgroup 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. References: Philipsen A, Richter H, Peters J, et al (2007). Structured group psychotherapy in adults with attention deficit hyperactivity disorder: results of an open multicentre study. *J Nerv Ment Dis* 195:10139. Philipsen A, Graf E, Tebartz van Elst L, et al (2010). Evaluation of the efficacy and effectiveness of a structured disorder tailored psychotherapy in ADHD in adults: study protocol of a randomized controlled multicentre trial. *Atten Defic Hyperact Disord* 2(4):20312. Ramsay JR, Rostain AL (2008). *Cognitive Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach*, New York: Routledge, Taylor & Francis Group. Ramsay, J. R., Rostain, A. L. (in press). CBT without medications for adult ADHD: an open pilot study of five patients. *J Cogn Psychother*. Rostain AL, Ramsay JR (2006). A combined treatment approach for adults with ADHD: results of an open study of 43 patients. *J Atten Disord* 10:1500158. Safren SA, Otto MW, Sprich S, et al (2005a). Cognitivebehavioral therapy for ADHD in medication-treated adults with continued symptoms. *Behav Res Ther* 43:831842. Safren SA, Perlman CA, Sprich S, Otto MW (2005b). *Mastering Your Adult ADHD: A CognitiveBehavioral Treatment Program Therapist Guide (Treatments That Work)*. New York: Oxford University Press. Safren SA, Sprich S, Mimiaga MJ, et al (2010). Cognitive behavioral therapy vs. relaxation with educational support for medication-treated adults with ADHD and persistent symptoms: a randomized controlled trial. *JAMA* 304:87580. Solanto, M. V., Marks, D. J., Mitchell, K. J., et al (2008). Development of a new psychosocial treatment for adult ADHD. *J Atten Dis*, 11, 728736. Solanto MV, Marks DJ, Wasserstein J, et al (2010) Efficacy of MetaCognitive Therapy for Adult ADHD. *Am J Psych* 167(8):95868. Solanto MV (2011). *Cognitive Behavior Therapy for Adult ADHD: Targeting Executive Dysfunction*. New York: Guilford Press.

COURSE 46

SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY AND PROBLEM SOLVING (STEPPS) TREATMENT PROGRAM FOR BORDERLINE PERSONALITY DISORDER

Director(s): Donald W. Black, M.D.

Faculty: Nancee S. Blum, M.S.W., L.C.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe BPD as an emotional intensity disorder (EID); 2) Define and understand a systems approach to treatment of BPD; 3) Provide persons with BPD, care providers, and others in the person's "system" with a common language; 4) Describe a variety of setting in which STEPPS or key elements of STEPPS can be applied; 5) Discuss empirical data supportive of STEPPS.

SUMMARY:

This course describes and illustrates the STEPPS (Systems Training for Emotional Predictability and Problem Solving) treatment program for BPD, which can be implemented effectively by facilitators from diverse training backgrounds and in a variety of settings (e.g., partial hospitals, residential facilities, prisons, etc.). The typical format is a 20week (2 hrs./week) outpatient psychoeducational, cognitivebehavioral, skills training approach. BPD is characterized as an emotional intensity disorder (EID) that clients learn to manage with specific emotion and behavioral management skills. (Modifications of the program or application of key elements in a nonoutpatient setting will also be highlighted). Key professionals, friends, and family members referred to as the client's "reinforcement team" also learn to support and reinforce these skills. The program has three components: awareness of illness, emotion management, and behavior management skills. A detailed facilitator and client manual with specific lesson plans will be described. Poetry, artwork, relaxation exercises, and music supplement the worksheets and homework assignments, and examples will be shared in the workshop, as well as examples of specific components of the program. This program has been supported by both controlled and uncontrolled studies in the US and The Netherlands. Data show that clients with BPD have improvement in multiple domains, including mood, behavior, and health care utilization variables. The description of the treatment program will be preceded by an overview of empirical data supportive of STEPPS.

COURSE 47

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

Director(s): Eric M. Plakun, M.D.

Faculty: Edward R. Shapiro, M.D., David L. Mintz, M.D., Donald E. Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the importance of treatment resistant disorders; 2) Understand the basics of psychoanalytic object relations theory, primitive defenses, and how they contribute to treatment resistance; 3) Utilize psychodynamic principles to improve outcomes in work with patients with treatment refractory mood disorders comorbid with other disorders, including prominent Axis II pathology.

SUMMARY:

Although algorithms help psychiatrists select biological treatments for patients with treatment refractory mood disorders, the subset with prominent Axis II pathology often fails to respond to medications alone. These treatments frequently become chronic crisis management, with significant risk of suicide. Residencies have begun to reemphasize mastery of psychodynamic concepts that may be useful in integrating a treatment approach to these patients. This course offers a comprehensive overview of the approach to this subset of treatment refractory patients derived from a longitudinal study of patients in extended treatment at the Austen Riggs Center. Ten psychodynamic principles extracted from study of successful treatments are presented. These include listening beneath symptoms for repeating themes, putting unavailable affects into words, attending to transference/countertransference paradigms contributing to treatment refractoriness, and attending to the meaning of medications. This psychodynamic 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 case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients, and to help training directors improve their grasp of and ability to teach psychodynamics to residents.

COURSE 48**YOGA OF THE EAST AND WEST: EXPERIENTIAL BREATH WORK, MOVEMENT, AND MEDITATION**

Director(s): Patricia L. Gerbarg, M.D., Richard P. Brown, M.D.

Faculty: Richard P. Brown, M.D., Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVES:

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 to use it for patients; 3) Experience the effects of Qigong movements with breathing on stress and tension; 4) Experience open focus meditation for stress reduction, improved attention, relief of physical and psychological distress.

SUMMARY:

Participants will learn the theoretical background and applications of two powerful selfregulation strategies to improve their own wellbeing and the mental health of their patients. A program of nonreligious practices will enable participants to experience Coherent Breathing, Resistance Breathing, Ha breath, Qigong movements with breathing, and Open Focus meditation. Through a sequence of repeated rounds of breathing and meditation with gentle movements and interactive processes, participants will discover the benefits of mind/body practices. How to build upon this knowledge and use it in clinical practice will be discussed. Adaptation of mind/body programs for disaster relief will be discussed in relation to the Southeast Asian tsunami, the September 11th World Trade Center attacks, the 2010 earthquake in Haiti, and for survivors of mass trauma, war and genocide in Rwanda and Sudan. This course is suitable for novices as well as experienced practitioners.

MASTER COURSE 5**UPDATE ON PEDIATRIC PSYCHOPHARMACOLOGY**

Director(s): Christopher J. Kratochvil, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Current clinical guidelines for the use of pharmacotherapy in pediatric psychiatric disorders; 2) Practical clinical use of psychopharmacology and management of adverse effects; 3) Recent research on pharmacotherapy in common psychiatric disorders of childhood.

SUMMARY:

The primary objective of this course is to provide practical information to clinicians on the use of psychotropic medications in the treatment of children and adolescents in their practices. Methods: This course will provide an overview and discussion of recent data in pediatric psychopharmacology, with a focus on mood disorders, attention deficit/hyperactivity disorder, anxiety disorders, and autism spectrum disorders. The role of pharmacotherapy in the treatment of these disorders will be addressed, as will practical clinical aspects of using psychotropic medications in the treatment of children and adolescents. Management of adverse effects

will be reviewed as well. Awareness of recent research data will help to facilitate an understanding of the basis for current clinical guidelines for the treatment of these psychiatric disorders. Clinically relevant research will be reviewed, within the context of clinical treatment. Conclusion: Awareness of recent research and practice parameters on the use of pediatric psychopharmacology, and the application of this information to clinical practice, can inform and positively impact patient care.

COURSE 49

THE EXPERT WITNESS IN PSYCHIATRIC MALPRACTICE CASES

Director(s): Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify practical pitfalls of being an expert witness; 2) Write better malpractice opinion reports; 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 64 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 50

HEALTHY BRAIN AGING: EVIDENCE BASED METHODS TO PRESERVE AND IMPROVE BRAIN HEALTH

Director(s): George T. Grossberg, M.D.

Faculty: Abhilash K. Desai, M.D.

EDUCATIONAL OBJECTIVES:

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; 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 51

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

Director(s): John G. Gunderson, M.D.

Faculty: Brian A. Palmer, M.D., M.P.H., Paul S. Links, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Provide hope and reassurance when disclosing the borderline diagnosis; 2) Appreciate the value of being uncertain, cautious, contained and "not knowing"; 3) Recognize how the borderline patients changing phenomenology (e.g., depressed, cutting, dissociated) is reactive to the interpersonal context; 4) Offer medication with less risk of noncompliance or overdosing.

SUMMARY:

Introductory Overview: This course will teach psychiatrists what they need to know to become capable and derive satisfaction from treating patients with borderline personality disorder (BPD). The content will expand upon, revise, and update the APA Guidelines for Treatment of BPD (2001). The basic text is being written as a Handbook for the presentations and it will be offered to participants. That Handbook is intended to become a basic “how to” text for residents and all nonspecialist psychiatrists. Feedback from participants will be used to further refine the text of that Handbook in preparation for its publication. In addition, clinical vignettes interrupted by discussion of decision points will be presented and used for interactive learning.

FOCUS LIVE: ANXIETY DISORDERS

Special interactive multiple choice Q&A session using an Audience Response System

R. Bruce Lydiard, M.D., Ph.D, Ralph H. Johnson VA Medical Center, Charleston, SC

Moderators

Deborah J. Hales, M.D., Director, American Psychiatric Association, Division of Education

Mark Hyman Rapaport, M.D., Chairman, Psychiatry and Behavioral Sciences, Emory University School of Medicine, and Chief of Psychiatric Services, Emory Healthcare System, Atlanta GA.

American Psychiatric Association Practice Guideline For The Treatment Of Patients With Panic Disorder Second Edition. American Psychiatric Association. 2009. <http://psychiatryonline.org/guidelines.aspx>

EDUCATIONAL OBJECTIVES

As a result of participation in this interactive *FOCUS Live* workshop, participants will review multiple choice questions, self-assess their knowledge of the clinical management of patients, and have increased understanding of approaches to the treatment of Anxiety Disorders in order to apply the knowledge to their own practice.

ABSTRACT

Anxiety disorders are among the most common mental health problems in the United States, affecting 18% of adults in a given year and almost 30% at some point during their lifetime. They are associated with a wide range of distressing psychological and somatic symptomatology, as well as disability across broad domains of work, social and family function. There are a number of effective pharmacological and psychosocial interventions with which to treat individuals affected with anxiety disorders, although there remains a significant unmet need for more effective, well-tolerated, and readily administered interventions that can move more patients from symptomatic to remitted status. This multiple-choice question based presentation will provide participants with an opportunity to test their knowledge about diagnosis and treatment of these disorders. An expert clinician will lead a 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 cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment strategies, treatment resistance, and new developments.

REFERENCES

Lydiard RB. Assessment and management of treatment-resistance in panic disorder FOCUS 2011;9:253-263.

Stein MB, Goin MK, Pollack MH, Roy-Byrne P, Sareen J, Simon NM, Campbell-Sills L; Work Group On Panic Disorder:

MONDAY MAY 5, 2008

FOCUS LIVE: SCHIZOPHRENIA

Special interactive multiple choice Q & A session using an Audience Response System

Peter F. Buckley, M.D., Professor and Chairman, Department of Psychiatry and Behavioral Health, Medical College of Georgia, Augusta, Georgia

Brian J. Miller, M.D., Ph.D., M.P.H., Department of Psychiatry and Health Behavior, Georgia Health Sciences University, Augusta, GA

Moderators

Deborah J. Hales, M.D., Director, American Psychiatric Association, Division of Education

Mark Hyman Rapaport, M.D., Chairman, Psychiatry and Behavioral Sciences, Emory University School of Medicine, and Chief of Psychiatric Services, Emory Healthcare System, Atlanta GA.

OBJECTIVES:

This FOCUS LIVE session will assist physicians in testing their knowledge and having an increased understanding of schizophrenia. Participants will answer board-type questions designed to inform and identify areas where they might benefit from more study.

ABSTRACT:

Schizophrenia is commonly a chronic, debilitating disorder with life-long consequences for affected individuals. The clinical course is often characterized by recurrent relapses, which are associated with adverse outcomes, including treatment-resistant symptoms, cognitive decline, and functional disability. Physical and substance use comorbidity, as well as medication nonadherence are also the rule rather than the exception in schizophrenia. These are major risk factors for illness relapse, and contributors to premature mortality in the disorder. The combination of onset in early adulthood and persistent dysfunction create enormous personal costs. Symptoms of the illness are variable from person to person, with positive symptoms of delusions, hallucinations, and thought disorganization and negative symptoms of blunted affect, social dysfunction, and lack of motivation, along with cognitive impairments, and mood disturbance. The biological basis is known to include genetic, environmental, and developmental factors. In this FOCUS LIVE session, participants test their knowledge with an interactive audience response system, which presents the audience responses as a histogram on the screen. Multiple choice questions covering current issues in schizophrenia will be presented: antipsychotic medications, metabolic disturbances, suboptimal medication adherence, switching and

combining of medications, side-effect management strategies, immune system abnormalities including inflammation, and substance use. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen.

LITERATURE REFERENCES

Miller BJ, Buckley PF. Is relapse in schizophrenia an immune-mediated effect? FOCUS 2012 9: (2)

Freudenreich O, Cather C. Antipsychotic medication non-adherence: risk factors and remedies. FOCUS 2012 9: (2)

SATURDAY, MAY 5, 2012

FORUM 1

DSM5: RESEARCH AND DEVELOPMENT

Chair: David J. Kupfer, M.D. Presenters: Darrel A. Regier, M.D., M.P.H. Lawson R. Wulsin, M.D. David P. Goldberg, D.M., D.P.M. William E. Narrow, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify relevant proposed changes to DSM5's organizational structure and how those were made in concert with development of ICD11; 2) Describe recent harmonization efforts between DSM5 and ICD11; 3) Discuss plans for creation of DSM5PC for primary care settings and involvement by the World Health Organization to facilitate these efforts; 4) Identify the clinical implications associated with proposed revisions to DSM5's disability assessment, multiaxial system, and coding structure.

SUMMARY:

As the May 2013 deadline for DSM5 publication grows nearer, revision efforts are increasingly emphasizing bringing greater harmonization between DSM5 and the World Health Organization's forthcoming 11th edition of the International Classification of Diseases (ICD11), as well as development of the primary care versions of both texts (DSM5PC and ICD11PC). In this research forum, presenters will provide a brief update on DSMICD alignment efforts. Presenters from both the ICD11 Primary Care Consultation Group as well as from the DSM5 Primary Care Work Group will each discuss recommendations for psychiatric screening in primary care and specialty medical settings. The forum will also provide an overview on clinical aspects of nondiagnostic specific revisions to DSM5 that may have important implications for the use of DSM internationally, such as proposed revisions to DSM5's disability assessment, multiaxial system, and coding structure.

FORUM 2

ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH: THE NIAAA PRACTITIONER'S GUIDE

U.S. National Institute on Alcohol Abuse and Alcoholism

Chair: Vivian Faden, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the epidemiology of alcohol use disorders among adolescents and youth; 2) Use the NIAAA

Guide to Screen for alcohol use disorders; 3) Successfully manage alcohol use disorders among adolescents and youth in the context of a child psychiatry practice.

SUMMARY:

The purpose of this workshop is to teach participants to use the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Alcohol Screening and Brief Intervention for Youth: A Practitioners Guide. Aimed at both primary care and mental health clinicians working with adolescents and youth, the Guide provides a streamlined, researchbased approach to identifying and managing the care of adolescents and youth who consume alcohol. Use of the Guide sends a message of concern; provides an opportunity for youth to ask knowledgeable adults about alcohol; and is a chance to intervene early before alcohol problems become serious. This tool provides a way to screen adolescents and youth who exhibit the full range of alcohol problems from experimentation to hazardous use to abuse and dependence. This tool also provides stepbystep guidance on providing brief advice that is tailored to particular venues such as mental health clinics, pediatrician's offices, and sports teams. The screening questions are tailored to three age groups: under 11, 11-14, 14-18 and there are two screeners—one for friends and one for the patient. Future plans encouraging the use of this valuable tool by psychiatrists will also be discussed.

SUNDAY, MAY 6, 2012

FORUM 3

THE FUTURE IS NOW: THE EVOLVING ROLE OF PSYCHIATRY IN THE INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE

Chair: Lori Raney, M.D. Presenters: Jurgen Unutzer, M.D., M.P.H. Roger G. Kathol, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the role of psychiatrists on collaborative care teams and the significant impact this can have for both health care reform and the psychiatric workforce shortage; 2) Appreciate the important effect psychiatrists can have on improving the health of patients with mental illness in public sector settings; 3) Identify the concerns with psychiatrist compensation on collaborative care teams and several funding structures being pursued to solve this problem.

SUMMARY:

The overwhelming evidence base for the use of collaborative care models to improve the health of patients in both primary care and mental health settings puts us beyond

the “tipping point” in the discussion of psychiatrists joining their primary care and behavioral health colleagues in this venture. Programs are emerging across the country, adopting the Core Principles of Integrated Care which include patientcentered care teams providing evidence based treatments to a defined population of patients using a measurement based, treat to target approach. The widespread dissemination of these models is gaining momentum and excitement as they can assist in achieving the heralded “Triple Aim” in health care reform and provide payment structures to compensate psychiatrists in their role as leaders and “consultant specialists” to these teams. This Forum “The Future is Now: The Evolving Role of Psychiatry in the Integration of Behavioral Health and Primary Care”, will provide an opportunity for participants to have an in depth conversation with several of the top experts in the rapidly developing field of primary care collaboration. Drs. Wayne Katon, Jurgen Unutzer, Roger Kathol and Ben Druss will open the discussion with brief overviews of their work in this field, their opinions on ways to prepare ourselves for this brave new world, and their vision of the future for psychiatrists, recognizing the future is now in many parts of the country. Following these introductions, the audience will be invited to share their experiences and ask questions of the panel and each other. Dr. Wayne Katon has been a pioneer in the world of collaboration with primary care, working over his 30 year career in diverse settings developing models including IMPACT and TEAMCare . He will offer his perspective on this wealth of experience and share his forecast for psychiatrists. Dr. Jurgen Unutzer, Principal Investigator of Project IMPACT, one of the most widely used models in outpatient primary care settings, will discuss leadership opportunities for psychiatrists in treating mental illness in primary care. Dr. Ben Druss, whose research and advocacy work focuses on improving health and healthcare in persons with serious mental disorders in public sector settings, will describe his vision of psychiatrists’ responsibilities in recognizing and treating other physical health issues in this population. Dr. Roger Kathol’s discussion will focus on his efforts in achieving integrated medical and mental health program sustainability through payment reform and will describe his ideas of payment models for integrated care and how we might be compensated to work in this field. Dr. Lori Raney, Chair APA Workgroup on Integrated Care, will moderate this session. This Forum encourages and anticipates ample audience participation as these experts answer your questions, pose questions for the audience and imagine as a group what our field may look like in the future.

MONDAY, MAY 7, 2012

FORUM 4

COMBATRELATED PTSD: INJURY OR DISORDER?

CoChairs: John M. Oldham, M.D., M.S., Matthew J. Friedman, M.D., Ph.D. General Peter W. Chiarelli (U.S. Army Retired), Other Robert J. Ursano, M.D. LGen the Hon. Romeo A. Dallaire (Ret’d), Senator

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the effects of posttraumatic stress disorder (PTSD) specific to military personnel, particularly combat veterans; 2) Learn the different perspectives that have informed recent public discussion about whether PTSD should be considered a psychiatric diagnosis versus a medical injury; 3) Describe some of the purported specific benefits to reclassifying PTSD as a stress-related injury rather than a psychiatric illness.

SUMMARY:

Posttraumatic stress disorder (PTSD) is a disorder of high public health concern and is particularly relevant to the mental health of military members and their loved ones. In addition to the potential burdens on physical and emotional functioning, military members with PTSD also contend with issues of stigma. As a result, individuals who otherwise might benefit from treatment may be reluctant to seek services, believing that doing so may inhibit career advancement or otherwise result in stigmatization or discrimination. This important and informative session offers a valuable opportunity for audiences to actively engage with leading experts in combat-related PTSD as well as General Officers in both the U.S. and Canadian Armed Forces who have had command responsibility for their troops. Specifically, the session will focus on expanding the dialogue about whether combat-related PTSD should be designated as one form of post-traumatic stress disorder (as is now the case), or whether it should be classified as a combat-induced injury, similar to traumatic brain injury, and the possible impact to military service members of doing so. Each panel member will provide brief opening remarks, and the majority of the session will be devoted to open discussion with forum attendees.

FORUM 5

WITNESS TO AN EXTREME CENTURY

CoChairs: R. Rao Gogineni, M.D., Abraham L. Halpern, M.D. Presenters: Robert J. Lifton, M.D. Steven S. Sharfstein, M.D., M.P.A. Henri Parens, M.D

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Enhance understanding of the extremities of destruction and horror of last century; 2) Describe post traumatic effects of war and destruction on people and sol-

diars; 3) Identify the moral and ethical perspectives on acts of destruction; 4) Obtain an understanding of human rights in the war on terror; 5) Identify the long lasting effects of the Holocaust on childhood victims.

SUMMARY:

Robert Jay Lifton, a psychiatrist, psychohistorian, Nobel lecturer, and Gandhi Peace Prize winner, has authored several books including: “Death in Life: Survivors of Hiroshima,” “The Nazi Doctors: Medical Killing and the Psychology of Genocide,” “Thought Reform and the Psychology of Totalism: A Study of Brain Washing,” and his most recent, “Witness to an Extreme Century” a memoir. His work on totalism, written after his discharge from the Korean War, focuses on thought reform (or “brain washing”) of Chinese refugees. His work and writings on nuclear disaster describe the effects of the atomic bomb on survivors in Hiroshima. His investigations of genocide and Holocaust focused on survivors’ mental adaptations after having experienced extreme atrocities; this includes his concept of “psychic numbing.” Lifton’s passions include disarmament and social justice as it relates to humane, lifeaffirming (rather than destroying) behavior. His latest, “Witness to an Extreme Century,” is a work of intellectual autobiography in which he describes his life and work in the context of larger events. His discussion of genocide, trauma, violence, and manmade disaster will include possibilities for alternative lifeenhancing directions. This forum is cosponsored by American Association for Social Psychiatry and World Association for Social Psychiatry. The presentations will be followed by a “Humanism” award to Dr. Lifton.

FORUM 6

THE MIND AND MUSIC OF BEETHOVEN

Chair: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the role of sublimation in the creative process; 2) Understand the impact of deafness on Beethoven’s artistic development; 3) Discuss the relationship between mental illness and artistic inspiration.

SUMMARY:

No composer exerts a more powerful hold on the imagination than Ludwig van Beethoven, and no one has surpassed his extraordinary ability to express dramatic conflict and resolution. But the full scope of Beethoven’s genius was slow to emerge. As a young composer, he embraced the styles and conventions of his contemporaries. Eventually, however, his quest to discover a personal voice led him to reshape preexisting musical language in order to express

the full range of human experience despair and aggression as well as triumph and transcendence. Psychiatrist and concert pianist Dr. Richard Kogan will perform musical examples from Beethoven’s early, middle and late periods to illuminate the connection between the composer’s psyche and his creative output.. There will be an exploration of the impact of significant biographical factors (his brutal childhood, his studies with Haydn, the onset of deafness, the thwarted quest for the “Immortal Beloved”, the crusade to gain guardianship of his nephew) on his artistic development. With his unruly appearance, his volatile temperament and his turbulent music, Beethoven is for many the model for the image of the “mad genius”. Dr. Kogan will discuss the relationship between mental illness and artistic inspiration and he will speculate on whether Beethoven suffered from bipolar disorder.

TUESDAY, MAY 8, 2012

FORUM 7

THE ADDICTION PERFORMANCE PROJECT PRESENTS LONG DAY’S JOURNEY INTO NIGHT

Chair: Nora Volkow, M.D. Presenters: Charles O Brien, M.D., Ph.D. Herbert D. Kleber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Better identify and more successfully treat or refer drugaddicted 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; 3) Use empathy, knowledge, and supporting tools to improve communication skills and confidence in conducting Screening, Brief Intervention, and Referral to Treatment (SBIRT).

SUMMARY:

NIDA’s Addiction Performance Project is a unique event featuring professional, awardwinning actors performing a dramatic reading from Eugene O’Neill’s Pulitzer Prizewinning 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 facilitatorguided 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>.

SATURDAY, MAY 5, 2012

LECTURE 01**DEEP BRAIN STIMULATION: RethinkinG DEPRESSION AND ITS TREATMENT***APA Frontiers of Science Lecture Series**Lecturer: Helen S. Mayberg, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Recognize the neuroimaging findings in patients with depression and brain changes associated with classic antidepressant treatments; 2) Understand the scientific rationale for targeting the subcallosal cingulate white matter using deep brain stimulation (DBS) as a potential treatment for otherwise treatment-resistant depression; 3) Identify the preliminary safety and efficacy data supporting further study of subcallosal DBS for intractable depression.

SUMMARY:

Critical to development of deep brain stimulation as a novel therapy for treatment resistant depression has been the evolving characterization of brain systems mediating normal and abnormal mood states as well as those mediating successful and unsuccessful response to various antidepressant interventions. Building on converging functional imaging evidence implicating the subcallosal cingulate as a critical node within this depression network, we targeted this region adapting neuromodulation techniques routinely used to treat Parkinson's disease and other movement disorders. The theoretical and data-driven foundation for piloting this new procedure as well as long-term clinical and imaging findings from ongoing experimental studies will be presented.

LECTURE 02**COMMUNICATING PSYCHIATRIC KNOWLEDGE: FROM KITES TO KINDLE***APA Judd Marmor Award Lecture**Lecturer: Robert E Hales, M.D., M.B.A.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Understand communication principles; 2) List ways that psychiatric knowledge is currently being communicated; 3) Outline future ways that psychiatric information will be communicated.

SUMMARY:

Psychiatrists, like other medical specialists, face the constant challenge of staying up to date in their field. The American Psychiatric Association (APA) has developed cutting-edge ways to inform psychiatrists of the latest advances in mental health, neuroscience and behavioral medicine through 1) an annual meeting; 2) publishing enterprises; and 3) electronic media. This paper will provide some background information on communication principles and summarize the APA's innovative approaches. Communication requires a sender, a message and a recipient. It also requires that the communicating parties share an area of communication commonality. The process is complete only when the receiver understands the message and then provides feedback to the sender. This fundamental concept is important because the communication of psychiatric knowledge has changed a great deal over the years. There are three communication modalities for conveying psychiatric knowledge: oral, written and technological. Traditional communication includes the presentation of lectures, courses, symposiums and workshops. These oral formats have proven effective at meetings, grand rounds and other face-to-face contact between the person or persons presenting the sessions and the psychiatrists who attend them. Written communications have traditionally taken the form of books, journals and newsletters. In today's increasingly high-tech environment, such publications are appearing in electronic forms such as ebooks, electronic papers in advance of print for journals and electronic newsletters substituting for written formats. Technology is transforming the communication of knowledge in other ways. Most organizations have their own websites and anyone can scan through ebooks to look at chapters or to obtain specific information. In addition, publishers have been creating online book and journal collections that give purchasers access to many publications. In today's environment social media are increasingly important for communicating knowledge. Many institutions and organizations have joined social networking sites such as Facebook and Twitter, while YouTube is helping make video information easily obtainable around the world. Portable devices such as the iPhone, iPad, and Kindle have transformed the publishing arena since books may be downloaded onto them and supplemented with videos. With regard to oral communication, the APA annual meeting remains an important source of knowledge. Yet in today's current economic environment, it can be challenging to encourage psychiatrists to attend annual meetings. Among my goals during my tenure as scientific program chair were increasing interactions between experts and attendees, educating the membership about scientific findings, including patients in programs, introducing member's international perspectives, combining written and oral communication and updating psychiatrists on advances in medicine.

LECTURE 03

UNDERSTANDING PATIENTS WITH BORDERLINE PERSONALITY DISORDER*APA International Psychiatrist Lecture Series**Lecturer: Sabine Herpertz, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Understand the complex neurobiological nature of borderline personality disorder; 2) Treat patients in accordance to the specific psychopathology of borderline personality disorder; 3) Recognize the characteristics of affect dysregulation and social dysfunction in borderline personality disorder.

SUMMARY:

Borderline personality disorder (bpd) is a highly prevalent psychic disorder that is less stable than traditionally thought but that leads to low social functioning. Emotional dysregulation, impulsivity, and anger proneness are the hallmarks of this disorder. Patients with bpd exhibit high baseline emotional arousal as well as intense, rapidly rising emotional responses which attenuate slowly. They are hypervigilant to social stimuli, especially to signals of social threat or rejection. They show dysfunctional affect regulation strategies such as selfharming behaviour and dissociation. Neuroimaging data indicate that emotional dysregulation is associated with structural and neurofunctional abnormalities in the amygdala and its prefrontal interconnections representing automatic and intentional aspects of emotion regulation, the orbitofrontal and the anterior cingulate cortex in particular. It looks as if prefrontal amygdalar dysfunction rather reflects affect dysregulation as a personality domain than being specific to bpd. Emotional hyperreactivity interferes with the cognitive evaluation of social stimuli, e.g. Facial emotion recognition, thereby leading to a specific pattern of altered emotion recognition in bpd. Dysfunctional serotonergic and probably glutamatergic neurotransmission appear to underlie impulsivity located in prefrontal areas some of which are also involved in emotional regulation. Recently, the role of neuropeptides (e.g. Opioids, oxytocin) for social cognitive functioning in bpd has been discussed. Up to now, there is little knowledge how the complex interplay of biological predispositions with environmental stressors as well as with caregivers' response to the child's temperament hits upon the developing brain systems. The presentation of behavioural and neuroimaging data will be followed by detailed implications for therapy.

LECTURE 04**DIALECTICAL BEHAVIOR THERAPY: WHERE IT STARTED, WHERE IT WENT, WHERE IT MAY BE****NOW, AND WHERE ARE WE GOING?***APA Frontiers of Science Lecture Series**Lecturer: Marsha M. Linehan, Ph.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Recognize the benefits of using Dialectical Behavior Therapy (DBT) to treat BPD and other Axis I and II disorders; 2) Identify key characteristics of DBT 3) Recognize modifications to the treatment since its inception.

SUMMARY:

Borderline personality disorder (BPD) is a serious public health problem. Individuals meeting criteria for the disorder constitute up to 40% of the highest utilizers of mental health services, comprising 8 to 11% of outpatients and 14 to 20% of inpatients. Ten percent of individuals with BPD die by suicide. Clinical outcomes for treatment of other Axis I conditions are significantly compromised by the presence of BPD. Dialectical Behavior Therapy (DBT) is a comprehensive cognitivebehavioral treatment program developed at the University of Washington (UW) in the early 1980s for highly suicidal individuals and later expanded to treat those with BPD. Since then, DBT has expanded to treat individuals with other Axis I and Axis II disorders. The treatment integrates principles of behavioral science with those of Zen practice to provide a synthesis of change and acceptance both at the level of the treatment provider's actions and at the level of new behaviors taught to clients. DBT was the first efficacious psychosocial intervention for BPD, as demonstrated by rigorous randomized clinical trials (RCTs). Since the original RCTs, multiple independent RCTs demonstrating its effectiveness as well as numerous non-randomized controlled trials have been conducted around the world. This talk will briefly outline key characteristics of DBT, and will review the various outcomes found in clinical trials of BPD and other disorders.

LECTURE 05**TEACHING ILLNESS SELFMANAGEMENT TO IMPROVE THE INTEGRATION OF CARE AMONG HISPANICS***APA Simon Bolivar Award Lecture**Lecturer: Alex Kopelowicz, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Understand the vulnerabilitystressprotective factors model that underlies illness selfmanagement; 2)

Describe the various evidencebased practices for Hispanics with serious mental illness; 3) List the key aspects of cultural adaptations for Mexican American populations.

SUMMARY:

The psychopathology and associated disabilities experienced by persons with serious and persistent mental illness have only partially responded to conventional pharmacological and psychosocial treatment approaches. Biobehavioral treatment and rehabilitation employs behavioral assessment, social learning principles, skills training, and a focus on the recovery process to amplify the effects of pharmacotherapy. An integrated biobehavioral therapy directed toward early detection and treatment of psychotic symptoms, collaboration between patients and caregivers in managing treatment, family and social skills training, and teaching coping skills and selfhelp techniques has been documented to improve the course and outcome of severe mental disorders, as measured by symptom recurrence, social functioning, and quality of life. The treatment and rehabilitation of individuals with schizophrenia can be guided by a multidimensional and interactive model of the disorder that includes stress, vulnerability, and protective factors. The noxious effects of stress superimposed on vulnerability can be modulated or diluted by protective factors, either among the personal attributes of the individual (e.g., maintenance of an antipsychotic medication, social competence, ability to cope with stressors) or in the individual's social environment (e.g., supportive and tolerant family members who provide abundant reinforcement for increments of adaptive behavior and responsive community treatment services). An often overlooked source of protection is an individual's culture. Just as antipsychotic medications buffer the psychological vulnerability and underlying biochemical disturbances in neurotransmitter systems, a variety of cultural factors can confer coping capacities and thereby strengthen the individual's and caregiver's personal protection against stress and vulnerability. This presentation will review the process of culturally modifying illness selfmanagement techniques using several examples including recently completed work designed to improve treatment adherence in Mexican Americans with schizophrenia. Particular attention will be paid to the utility of Ajzen's Theory of Planned Behavior, which formed the conceptual foundation for the cultural adaptation and to McFarlane's multifamily group approach, which was the structural basis for the treatment.

LECTURE 06

SCHIZOPHRENIA AS A LEARNING AND MEMORY DISORDER

APA Distinguished Psychiatrist Lecture Series

Lecturer: Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Evaluate the overlapping risk genes found in schizophrenia and psychotic bipolar disorder; 2) Analyze results from BSNIP study and how outcomes will be pertinent to questions of diagnosis and treatment; 3) Discuss the question of whether or not serious mental illness with psychosis is one syndrome or the two most common diagnoses.

SUMMARY:

The distinctions and overlaps between schizophrenia and psychotic bipolar disorder are the focus of considerable study based, most recently, upon the overlapping risk genes that have been associated with the syndromes. Both association and family studies have identified more common genes for these two syndromes than distinctive genes. There are many aspects of illness that are the same across diagnoses, including some aspects of symptom manifestations and many endophenotypic characteristics, like brain volume reductions, eye tracking movements and cognitive dysfunction. While level of function is still said to distinguish these diagnoses, there is considerable pressure to analyze differences between these two psychotic conditions in a common and rigorous fashion. We have carried out a multisite phenotyping study called bsnip between 5 different laboratories around the US in order to characterize a large enough population of affected individuals to firmly determine which areas of function overlap and distinguish these diagnoses. These outcomes will be pertinent to questions of diagnosis and treatment, in addition to questions about disease pathophysiology and etiology. It is time to answer the question posed a century ago about whether or not serious mental illness with psychosis is one syndrome or is more correctly left as its two most common diagnoses.

LECTURE 07

MUSINGS ON DECADES OF PROGRESS IN ALCOHOLISM TREATMENT RESEARCH

U.S. National Institute on Alcohol Abuse and Alcoholism

Lecturer: Bankole A. Johnson, M.D., Ph.D.

SUMMARY:

Treatment of few neurobiological diseases has been laden with so much myth as alcoholism, the 5th most important health problem in the world. Debunking these myths has been painstaking through much development in the neurobiological sciences. Whilst alcohol does not actually bind to a receptor, the changes evinced by its intake lead to a cascade of perturbations in multiple neuronal systems. Notably, a firmer scientific understanding of the role of the opioid, GABAergic, glutaminergic, and serotonergic systems,

and more recently small molecules, has led to the development of several compounds, notably naltrexone (and Vivitrol), acamprosate, topiramate, and ondansetron. Important lessons learned by these developments will be explained. Also, these developments will be framed in the context of ongoing medications development research and how these efforts will bring about new vistas in treatment. Essentially, for many, alcohol dependence is an eminently treatable disease, and the recognition of subtypes, both psychosocial and molecular, has led to the growing rise of personalized medicine that offers the promise of even more powerful or targeted medicines. Some practical guidelines on treatment will be provided, and recent publications on this topic shall be distributed. Insights on defining who really “gets better” and by how much with treatment for alcoholism shall be discussed. New data will be presented on attempts to synergize and enhance medication effects, understand the placebo response, and backengineer the development of new molecules through rapid screening techniques. The application of advanced math models to uncover treatment solutions in alcoholism will be described. New data will be presented on how personalized approaches may be used to recognize those who will respond to active medicine, placebo, or nothing at all. The growing importance of molecular biomarkers will be introduced. Musings on how the alcoholism disease can be categorized in stages — understood as an interaction between an external agent, alcohol, its neurobiological effect, and the environment, and the interactive effect of treatment — will be provided. The concept of multiple drug and multimodal behavioral treatments, and at various stages of the disease, will be introduced.

SUNDAY, MAY 6, 2012

LECTURE 08

THE CRIMINALIZATION OF MENTAL ILLNESS

APA Patient Advocacy Award Lecture

Lecturer: Steve Leifman, J.D., B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand what factors led to the criminalization of mental illness; 2) Identify the response by the justice system to the overrepresentation of people with mental illnesses in the criminal justice system; 3) Explore new and effective strategies to transform the mental health system and the role the psychiatric community can play in this transformation.

SUMMARY:

200 years ago, people with severe and disabling mental illnesses in the United States were often confined under

cruel and inhumane conditions in jails. During the 1800’s a movement known as “Moral Treatment” emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them. Unfortunately, overcrowding at these institutions, inadequate staff and lack of effective treatment programs resulted in facilities being able to provide little more than custodial care. Furthermore, physical and mental abuses became common and the widespread use of physical restraints such as straightjackets and chains deprived patients of their dignity and freedom. The asylums intended to be humane refuges for the suffering instead became houses of horrors. By the mid1900’s, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and everexpanding crisis. This period marked the beginning of the community mental health movement. As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the deinstitutionalization of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals. For many individuals unable to access care in the community, the only options to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems. There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways. First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstitutionalized from state psychiatric hospitals to jails and prisons. Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses. In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses.

LECTURE 09

PERINATAL PSYCHIATRY: REFLECTIONS OVER THREE DECADES OF RESEARCH

APA Alexandra Symonds Award Lecture

Lecturer: Katherine L Wisner, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify reproductive –related psychiatric disorders; 2) Characterize the scientific progress in perinatal psychiatry across the last three decades; 3) Understand the impacts of pharmacologic treatment and maternal mental illness from a larger public health perspective.

SUMMARY:

Mental health is fundamental to health, particularly in pregnant and postpartum women! After several decades of clinical work and research in perinatal psychiatry, a recurring series of questions demonstrate that psychopharmacologic treatment of mental illnesses in pregnant women creates substantial controversy. In this lecture, these controversies will be reviewed with the goal of improving the sophistication our questions and placing them in the context of broader public health ethics and policy. Supporting women and families through treatment choices during this crucial developmental life stage is the epitome of the art of psychiatry.

LECTURE 10

RESILIENCE AS A DYNAMIC CONCEPT

APA International Psychiatrist Lecture Series

Lecturer: Michael Rutter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the wired variation in people's responses to severe adversity; 2) Understand the nature and implications of the differences between sensitization and steeling effects; 3) Understand the role of geneenvironment interplay.

SUMMARY:

The concept of resilience has as its starting point the recognition that there is huge heterogeneity in people's responses to all manner of environmental adversities. Resilience is an inference based on evidence that some individuals have a better outcome than others who have experienced a comparable level of adversity; moreover the negative experience may have either a sensitizing effect or a 'steeling' effect in relation to the response to later stress or adversity. After noting the crucial importance of first testing for the environmental mediation of risk through 'natural experiments', findings are reviewed on 'steeling effects' in animal models and humans. Geneenvironment interaction findings are considered and it is noted that there is some evidence that the genetic influences concerns responsivity to all environments and not just bad ones. Life course effects are reviewed in relation to evidence on turning point effects associated

with experiences that increase opportunities and enhance coping. Attention is drawn to both research implications and substantive findings as features that foster resilience.

LECTURE 11

MY INTEREST AND EXPERIENCE IN WORKING WITH INTERNATIONAL MEDICAL GRADUATES [IMGS]

APA George Tarjan Award Lecture

Lecturer: Milton Kramer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be: 1) Informed about a research and scholarly program for psychiatric residents; 2) Informed about the educational needs IMGs in psychiatric residencies are reported to have; 3) Informed about the value to supervisors that understanding the culture of the residents have for the supervisory process.

SUMMARY:

The initial focus of the report is on my experience working educationally with and for IMGs in the psychiatric residency at the Maimonides Medical Center. The first half deals with my experiences while teaching and supervising IMG residents and concludes with a description of my role with the residents as director of research. The scholarly and research program is described and the output of the program some 64 reports, presentations and publications of the 26 residents I supervised over 4 years. The second half of the report is a review of the educational needs and problems of IMGs in psychiatric residency with a particular focus on learning psychodynamic psychotherapy. Suggestions have been made on how to meet the educational challenges of International Medical graduates (IMGs) such as learning to do psychodynamic psychotherapy. These suggestions include providing a more structured instruction with explicit feedback. More frequent demonstration of interviewing by faculty and greater opportunity to do practice interviews are necessary. Language, slang, and accent reduction training needs to be incorporated into the training program. Courses in American culture are essential for IMGs. Focusing on board preparation with special courses might well improve pass rates. Including psychological theory from the start of the residency and discussing the psychological aspects of the doctorpatient and staff encounters in many clinical settings will place the psychological issues on a sounder footing. IMGs could benefit from having a mentor to work with in joint projects and is also available to discuss both personal and professional issues.

LECTURE 12

WORKPLACE VIOLENCE IN MENTAL AND GENERAL HEALTHCARE SETTINGS: DEVELOPMENT AND CONCEPTS

AAPL/APA Manfred S. Guttmacher Award Lecture

Lecturer: Michael R. Privitera, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the completion of this session participants will be able to: 1) Recognize the impact of WPV on staff, institution and quality of patient care; 2) Identify ways to lower the impact of potential or real WPV; 3) Diagnose organizational contributions to WPV; 4) Recognize how the workplace environment may affect the conversion of micro violence (incivility, unreasonable expectations, active or passive aggressive behaviors) to macro violence (threats, assaults, homicide).

SUMMARY:

Circumstances that lead to the development of this book and workplace violence concepts will be discussed. Workplace violence (WPV) continues to take its toll on the well-being of staff, patients and visitors. Various myths have perpetuated that contribute to premature dismissal, or lack of sustained attention on efforts to ameliorate root causes of WPV. Examples include: being threatened or assaulted by a patient is “part of the job”; WPV does not occur in experienced staff, root cause analysis stops at the patient-staff dyad. Work by Bowie (2002) expands the WPV typology from the current Cal/ OSHA typology of criminal intent, customer/client violence, worker on worker violence, personal relationship violence at work, to also include organizational contributions to WPV (OV). These contributions include to direct role that organizations can play in allowing and stimulating WPV. A “black hole” in literature existed on what to do right before, during, or right after potential or real violent event. Interventions during this focused period of time will be termed “Periventions”. Human free will and choice can alter outcomes from a potentially or true violence event that do not exist when studying biology of infection and transmission, physics of automobile crashes, etc.; hence, primary, secondary, and tertiary prevention terms fall short. Much of medical and nursing education on violence tends to focus on risk factors, diagnostic issues, pharmacologic and some non-pharmacologic issues, usually taught within one profession. Once violence occurs, staff and administration quickly find themselves dealing with issues beyond their expertise, including interprofessional cooperation, police, legal issues, insurance, workers comp and healthcare issues. Privitera, Bowie, and Bowen (2012) further subcategorize OV to more rapidly diagnose these contributions to WPV. Well intended organizational quality improvement processes that have gone awry to toxic processes, will be termed “friendly fire”. Management and

business processes that began as legal and ethical, but are purposely and obscurely manipulated for the purposes of greed or power, (including incivility, bullying etc.) will be termed “enemy fire”. Both of these terms were meant to imply the inherent toxicity and hence violent impact, but are differentiated by intent.

MONDAY, MAY 7, 2012

LECTURE 13

WHY SHOULD PSYCHIATRISTS CARE ABOUT NEUROSCIENCE?

APA Distinguished Psychiatrist Lecture Series

Lecturer: Mayada Akil, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate some of the exciting developments in neuroscience that are potentially clinically relevant; 2) Rethink the relationship between neuroscience and clinical psychiatry; 3) Identify ways to learn and teach neuroscience in a manner that helps inform clinical work.

SUMMARY:

An interest in psychiatry suggests a curiosity about the mind and a fascination with its workings in people with or without mental illness. Neuroscience knowledge is exploding at all levels from genetics to systems neuroscience and can inform clinicians’ understanding of cognition, emotion, behavioral regulation and social interactions, all critical aspects of people’s lives that are dramatically affected in psychiatric disorders. However, many psychiatrists are not exposed to current neuroscience concepts and discoveries. Moreover, neuroscience can seem esoteric and distant from the clinic and psychiatrists may wonder why they should care. This presentation will review some findings that illustrate the promise of neuroscience for clinical psychiatry. For example, our understanding of cellular and local circuit perturbations in the prefrontal cortex of patients with schizophrenia can lead to the development of novel therapeutics for cognitive impairments in these patients. Examples of how the humanistic approach of clinical psychiatry can be enriched and complemented by the scientific knowledge imparted by areas of neuroscience such as social neuroscience, systems neuroscience, cognitive neuroscience and the study of gene environment interactions will be provided. For example, the effects of postnatal experiences on stress response and disease vulnerability and the neurobiology of attachment and pair bonding are some of the areas of neuroscience research that can enrich our understanding of our patients’ experiences. Integrating neuroscience in the training of psychiatrists is a challenging but important endeavor.

The language used by neuroscientists is foreign to clinicians and even “translational” research may be in need of translation. Nonetheless, creative and concerted efforts are being made to identify the most relevant knowledge areas of neuroscience and to bring them to psychiatrists in a clear and engaging manner and will be described in this presentation. In summary, neuroscience is the basic science of psychiatry and it can and should be effectively taught to psychiatrists in training in an integrative, patientcentered fashion as part of the biopsychosocial model of care.

LECTURE 14

THE CHARIOT AND THE COUCH: WESTERN PSYCHOTHERAPEUTIC MODELS AND EASTERN INSIGHTS

Frontiers of Science Lecture Series

Lecturer: Matcheri S. Keshavan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize insights from eastern scriptures (The BhagavadGita, Upanishads and Buddhism) relevant for understanding of the human mind in health and disorder; 2) Identify insights from eastern scriptures that have implications for westernbased psychotherapeutic models such as Cognitive Behavior Therapy, Metacognitive Therapy, and Positive Psychology; 3) Identify examples of clinical situations where psychotherapeutic insights from eastern scriptures can be of value.

SUMMARY:

Ancient Hindu scriptures such as the BhagavadGita (the Gita) offer important insights to the mind and mental health in ways that are complementary to those derived from western psychology. In the Gita, the mind and body are viewed in nondualistic terms; mental health is defined not merely as the absence of illhealth, but by the positive attributes of happiness noncontingent upon external gratification. Psychopathology is viewed as resulting from too much or misplaced attachment and a faulty concept of the self, leading to an excessive selfreference bias. The prescription for such instability is by skilled actions free from attachment and selfreflection. Many parallels may be drawn between the Gita and the principles of western psychotherapeutic models such as cognitive and metacognitive therapies. However, apart from insights into psychopathology, the Gita sheds light on enhancing positive mental health as well. The Gita embodies several modern concepts from positive psychology such as flow, intrinsic motivation, reappraisal of the self concept and development of compassion. We propose that psychotherapeutic insights from the

Gita and other ancient Hindu scriptures offer a comprehensive stepwise psychobiological metacognitive approach to prevention, intervention and promotion of well-being. These approaches may help the individual to optimally control lower brain circuits by optimum selfregulation of higher brain regions. More needs to be learned to develop comprehensive and culturally compatible psychotherapeutic models by integrating eastern and western psychotherapeutic models

LECTURE 15

A LIFE IN MOODS

APA Guest Lecture Series

Lecturer: Kay Redfield Jamison, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of subjective experience of bipolar illness; 2) Understand public disclosure of mental illness (consequences); 3) Understand differences between depression and grief.

SUMMARY:

The lecture will focus in the speaker’s professional and personal experiences associated with having a serious form of bipolar manicdepressive illness; the difficulties of functioning within a professional world defined by its clinical, teaching and research responsibilities while at the same time dealing with the daytoday reality of living with mental illness; the subjective/personal distinctions between grief and depression; and the complicated decision to write a memoir about mental illness (as well as the consequences of public disclosure). The pleasure and frustration of reconciling a writing life in academic psychiatry will also be discussed.

LECTURE 16

MICE, MEN, AND MENTAL ILLNESS: ANIMAL MODELS OF COGNITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

APA Adolf Meyer Award Lecture

Lecturer: Eric R. Kandel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize How animal models are used to study the details of the cognitive and negative symptoms of schizophrenia; 2) Possible genetic mechanisms of the cognitive and negative symptoms of Schizophrenia.

SUMMARY:

In the last two decades molecular genetics has transformed neurology. Diagnoses of neurological disorders are no longer based only on signs and symptoms, but also on tests for the dysfunction of specific genes, proteins, and nerve cell components as well as brain scans for disturbances of neural systems. Molecular genetics also has led to the discovery of 1) several newly defined molecular diseases caused by mutations in specific genes, such as the channelopathies and 2) new mechanisms of pathogenesis such as the trinucleotide repeat and the prion disorders. To date, however, molecular biology has had only a modest impact on psychiatry. I propose to address this issue by illustrating that whereas neurology has long been based on the location of disease in the brain, there is not a comparable strong neuropathology of mental illness. In addition, tracing the genetic causes of mental illness is a much more difficult task than finding the gene for Huntington's disease. There is no single gene for schizophrenia, or most other mental illnesses. Most psychiatric disorders have a combined multigenic and environmental basis. As a result of these limitations, psychiatry has not been able to benefit from animal models of mental illness. I will suggest that during the next few years things may change. We also are beginning to know something about the neural circuits affected by these diseases. As a result, we can now develop satisfactory animal models of components of these disorders. I will devote most of the lecture to describe attempts to develop mouse models of cognitive and negative symptoms of schizophrenia.

LECTURE 17**RETHINKING BIPOLAR DISORDER: WHERE WE'VE BEEN, WHERE WE ARE, WHERE WE NEED TO GO**

APA Distinguished Psychiatrist Lecture Series

Lecturer: David J. Kupfer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize older treatment strategies for manic depressive (bipolar) disorder; 2) Identify the specific comorbid (psychiatric and medical) disorders associated with bipolar disorder; 3) Recognize current major gaps in differential diagnosis and initiating early interventions.

SUMMARY:

Beginning with the availability of pharmacologic treatment for bipolar disorder in the late 1960s through the 1980s, we conceptualized bipolar disorder as a very serious, but relatively easy to treat condition with a good longterm prognosis. We focused on what we today refer to as bipolar disorder and paid little attention to so-called milder forms.

Between 1990 and 2008, treatment of bipolar disorder moved from a few highly specialized clinics to more general availability in academic medical centers and community practice. With this shift, clinical epidemiology and RCTs and, subsequently, large effectiveness studies, revealed that this was a much more complex and difficult-to-treat illness than previously appreciated. The phenotypes proved to be highly varied, comorbidities especially the addictive and anxiety disorders – made the achievement of sustained remission a rare event, and a range of medical problems particularly in the metabolic arena seriously complicated treatment and further compromised patients' functioning. As we enter the second decade of the 21st century, more sophisticated diagnostic conceptualizations in both the APA's DSM5 and the NIMH's RDOC, FMRI studies of functional abnormalities associated with bipolar disorder, focused investigations of metabolic and immune function in bipolar disorders, more attention to the huge challenge presented by bipolar depression, development of interventions for those at-risk, but not yet ill, treatment paradigms that integrate physical and psychiatric medical care and a greater appreciation of what behavioral and psychosocial interventions can add to the clinician's toolbox, all promise a better future for our patients with bipolar disorder and their at-risk offspring.

LECTURE 18**THE PERSISTENT ENIGMA OF ANOREXIA NERVOSA**

APA Distinguished Psychiatrist Lecture Series

Lecturer: B. Timothy Walsh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the factors leading to the diagnosis of anorexia nervosa 2) Recognize current practices in the treatment of anorexia nervosa 3) Explain recent developments in understanding the cognitive psychology of anorexia nervosa.

SUMMARY:

Anorexia Nervosa is the "oldest" of the eating disorders, having been clearly described and named in the late 19th century. The fundamental features of Anorexia Nervosa are remarkably consistent across individuals, and the frequency and manifestations of this syndrome have not changed greatly in recent years. Many of its features are striking and enigmatic. The illness is prone to affect young people who have often shown little evidence of serious psychopathology prior to the beginning of the eating disorder. Yet, once initiated, the pathological restriction of food intake and, often,

commitment to excessive exercise, “gain momentum,” and, over time, may become remarkably persistent. Anorexia Nervosa is potentially life-threatening, but most individuals with the disorder do not restrict food intake with the intent of self-harm. Thought processes about nutritional requirements are grossly distorted, arguably even delusional, but thinking in other spheres is intact. While much has been learned about Anorexia Nervosa, progress in improving treatment has been slow. A notable exception is the growing acceptance of early interventions for younger individuals that rely on parents as the primary agents of change. Older individuals, especially those who have had the illness for some years, are often refractory to both psychological and pharmacologic interventions. This lecture will provide an update on current knowledge about and recent research on Anorexia Nervosa. It will conclude with the description of a model of Anorexia Nervosa based on neurobiological underpinnings of motivated behavior that may help explain the illness’ enigmatic persistence.

LECTURE 19

CONVOCATION LECTURE

Edward M. Kennedy, Jr

BIO

Mr. Kennedy is the president and co-founder of Marwood Group & Co., a healthcare focused financial services firm with offices in New York City, Washington, D.C., London and Kuwait specializing in proprietary healthcare research, asset management and private equity advisory services. Previously, Mr. Kennedy served as an Associate and later as Counsel to the law firm of Wiggins & Dana located in New Haven, CT. Mr. Kennedy’s health law practice focused primarily on state and federal regulatory and reimbursement issues affecting hospitals, home care agencies, long-term care providers, physicians, and mental health providers. In addition, Mr. Kennedy served as Director of Legal and Regulatory Affairs at the Connecticut Hospital Association, counseling acute care providers and policy-makers on a wide variety of emerging health care issues. Mr. Kennedy has also been an active leader in the civil rights movement for persons with disabilities. In his disability law practice, he advised companies about how to best expand opportunities for persons with disabilities and how to avoid liability under the Americans with Disabilities Act. He continues to serve on the corporate and advisory boards of numerous disability organizations and lectures nationwide on topics relating to health and disability law. Mr. Kennedy received an undergraduate degree from Wesleyan University, a master’s degree from Yale University’s School

of Forestry and Environmental Studies, and a law degree from the University of Connecticut School of Law.

TUESDAY, MAY 8, 2012

LECTURE 20

DOES PSYCHODYNAMIC PSYCHOTHERAPY HAVE A FUTURE AS A PSYCHOTHERAPEUTIC MODALITY? A FUTURE PERSPECTIVE ON PAST OUTCOMES

APA Frontiers of Science Lecture Series

Lecturer: Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know the major elements of the evidence base for psychodynamic therapy; 2) Identify patients for whom this approach may not be suitable; 3) Understand some of the processes of change which have been identified over recent years; 4) Form better interdisciplinary and crossmodality links with psychodynamic therapists.

SUMMARY:

Psychodynamic psychotherapy is not doing well and may be even experiencing somewhat of a crisis in many training and practice centers of psychiatric practice across the world. The lecture will examine the nature of the problem, some of the challenges facing practitioners of this modality of psychotherapy and offer suggestions for addressing the issues. A paradoxical situation will be explored. The presentation will review studies which suggest that many of the basic theoretical presuppositions of a dynamic approach to treatment are empirically sound and have the potential for development and enrichment through cross fertilization with scientific advances particularly in neuroscience and genetics. Similarly, efficacy and effectiveness studies are establishing psychodynamic approaches to be as, if not more effective than other approaches to treating severely and chronically ill patients. Yet many clinical and intellectual leaders of the profession of psychodynamic therapy appear disinterested and contribute to the skepticism about the field by the disparagement of the links that have been developed to scientific thought. The talk will contrast the rapid data drive evolution of cognitive behavioral approaches with the sluggish development of psychodynamic therapeutic technique and aim to identify reasons for the disparity and suggest ways in which the excitement about this approach may be rekindled.

LECTURE 21

RACIAL AND ETHNIC INFLUENCES ON MENTAL HEALTH: THE EVOLVING EVIDENCE

*APA Solomon Carter Fuller Award Lecture**Lecturer: James S. Jackson, Ph.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this presentation, participants will be able to: 1) Discuss the nature of mental disorders by race and ethnicity in the United States' black population; 2) Discuss the multiple influences and mental substance abuse disorders; 3) Summarize some of the major issues on health disparities research.

SUMMARY:

Immigration has always been a major force shaping the composition and dynamics of the United States population. Poorer health outcomes and the acquisition of risk behaviors are markedly higher among first generation immigrants who have spent more time within the US. The last few decades have witnessed an increasing number of immigration of blacks from the Caribbean and Africa. After a wane in the 1920s, there was a seven-fold increase in the migration of these populations to the United States between 1960 and 1980, and a tripling of numbers between 1980 and 2005, with two thirds coming from the Caribbean. The increasing proportion of Caribbean immigrants of the second and third generation and beyond has created a need to understand the health and mobility outcomes associated both with their acculturation in the United States and with their health and mobility outcomes in their countries of origin. Focusing on black Caribbean immigrants and nationals, in comparative perspective to native African Americans, grounded within a life-course perspective, is crucial to understanding the potential independent influences of racial and ethnic group influences on mobility disparities and physical and mental health in the United States. This intersectional approach is essential in disaggregating the impact of material disadvantage, gender, culture, racial and ethnic group membership, and immigration-related variables, on psychiatric and substance abuse disorders. In this presentation I will explore racial and ethnic group disparities in health and mobility outcomes over the life course among immigrants, different national groups, and individuals in different generational positions.

LECTURE 22**DEVELOPMENTAL RISK FOR ANXIETY AND DEPRESSION: A TRANSLATIONAL NEUROSCIENCE APPROACH***APA Distinguished Psychiatrist Lecture Series**Lecturer: Ned H. Kalin, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Identify the importance of anxious temperament and the relevance of the early identification of children with this significant risk factor; 2) Recognize the neural circuitry underlying adaptive and maladaptive anxiety as it relates to the neural substrate of anxious temperament; 3) Relate the importance of examining molecular brain changes, such as patterns of gene expression, in the brain regions underlying the pathophysiology of anxiety, depression, and anxious temperament.

SUMMARY:

Understanding the mechanisms underlying the early expression of anxiety and depression is important because it affords an opportunity for the development of novel, neuroscientifically based childhood interventions. Anxious temperament (AT) can be identified early in life and is a robust predictor of the later development of anxiety disorders, depression and comorbid substance abuse. To understand mechanisms underlying the development of dispositional anxiety, we developed a reliable model of AT in young Rhesus monkeys. Using *in vivo* high resolution FDGPET imaging, we identified the neural circuit that underlies AT and have determined that the central nucleus of the amygdala (CeA) and anterior hippocampus are key components of this circuit. Moreover, we found that young primates with high AT have increased metabolism in these regions when studied in both stressful and nonstressful contexts (). Heritability analyses demonstrated that the AT phenotype is significantly heritable. Interestingly, we found differential heritability of the CeA and anterior hippocampal function that underlies AT. The monkey model allows for the longitudinal study of AT and its underlying neural substrates using functional brain imaging in conjunction with *ex vivo* molecular analyses of relevant brain regions. This has allowed us to determine the influences of genetic variation on the expression of this risk phenotype and its underlying brain substrate. In addition, using functional imaging guided biopsy of the CeA region; we performed transcriptomewide analyses that have identified AT-relevant alterations in gene expression involved with neuroplasticity. These findings have led us to propose a neurodevelopmental hypothesis relevant to the development and maintenance of AT and have identified novel potential treatment targets for further exploration.

LECTURE 23**BASIC SCIENCES AND INTERVIEWING SKILLS: EDUCATIONAL CONUNDRUMS?***APA Vestermark Award Committee**Lecturer: Bryce Templeton, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) List three methods for determining the necessary knowledge of basic sciences needed for graduation from medical school and for entering the practice of psychiatry.

2) List three major problems in assessing psychiatric interviewing skills and three major methods of improving the assessment of these skills.

SUMMARY:

The presentation will include (1) the current method of assessing the knowledge of basic medical sciences as required by our medical licensing procedures; (2) available evidence regarding the retention of basic science knowledge during the clinical medical school years, by resident trainees and by practicing physicians; and (3) a review of evidence-based approaches which might improve the validity of the current assessment methods. The presentation will also (1) review the current method of assessing physician interviewing skills; (2) some of the problems in defining those skills via professional and lay agreement; and (3) and several evidence-based approaches which might improve the validity of such assessments.

LECTURE 24**VALUEBASED MENTAL HEALTH CARE DELIVERY**

APA Guest Lecture Series

Lecturer: Michael Porter, M.B.A., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the definition of value as patient health outcomes achieved relative to costs expended; 2) Demonstrate knowledge of a strategic agenda for creating a valuebased mental health care delivery organization; 3) Demonstrate knowledge of examples of mental health care systems that have improved value by integrating mental health care into primary care settings.

SUMMARY:

Across the world, delivery systems are struggling to satisfy the increasing demand for mental health care services. The traditional model of treating mental health in isolation of physical health is failing the many patients who experience both. Standard treatment models ignore that mental health challenges are often brought on by physical illness, or that treatment of mental health care is commonly associated with physical complications. The status quo of locating mental health care in separate facilities, financing through

separate “carve out” mechanisms, and stigmatizing the demand for mental health care services is destroying value. Moving to a valuebased delivery system requires providers to reorganize around the needs of the patients. Care should be delivered by a team of health care professionals with expertise in addressing the interacting physical and mental health conditions that commonly present together. For most moderate to severe mental health conditions, teams should encompass psychiatrists, psychologists and internists or family practitioners, among others. For example, providers treating patients with moderate to severe depression should design treatment plans that include pharmacological treatments, lifestyle changes, and psychological therapy, all likely to be delivered by different individuals. Valuebased health care delivery also requires a shift in how providers measure value. The proper way to measure value is the patient health outcomes achieved per dollar spent. Outcomes are defined around patients and their medical conditions, and are inherently multidimensional. Outcomes encompass what matters most to patients. In addition to measuring life expectancy, outcomes also include degree of health status obtained, complications of treatment, and the longterm sustainability of health. As mental and physical health care practitioners reorganize around the condition of their patients and begin to collect the outcomes of their work, root causes of poor health will be identified, and the dramatic opportunity for improving value in the care delivery process will become clear.

LECTURE 25**CAN WE SAFELY DELIVER THE DSM5 INTO THE 21ST CENTURY?**

APA Distinguished Psychiatrist Lecture Series

Lecturer: Steven E. Hyman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the major shortcomings of the DSMIV for clinical practice; 2) Understand the risks posed by the current classification to scientific progress, including treatment development; 3) Understand the ways in which modern genetic understandings collide with the 1970s science that undergirds the DSMIV; 4) Describe steps to modernize the DSM without damaging current clinical and administrative uses.

SUMMARY:

The DSMIII (APA, 1980) represented a major advance for psychiatry. The development of new treatments during the mid20th century brought a pressing need for inter-rater reliability in diagnosis. The DSMIII met this challenge by

developing and disseminating field tested, operationalized diagnostic criteria. Unfortunately, the science of the 1970's on which the DSMIII rested, long antedated modern cognitive and social neuroscience, functional imaging, molecular and systems neurobiology, and genetics. Moreover, serious problems have emerged with the DSM's fundamental structure that signify the need for deeper change than the refinement of existing sets of criteria as new information emerges. These problems include the nearly exclusive, and scientifically increasingly problematic use of categorical diagnoses, remarkably high levels of comorbidity, and a widespread need to employ NOS diagnoses. Precisely because it is a much needed shared language, however, the modern DSM system has inadvertently created epistemic blinders that impede progress toward valid diagnoses. Beyond detailing the current predicament, I will describe a strategy for opening the DSM system to "disruptive" scientific progress without precipitously damaging the critically important clinical and administrative enterprises to which it is central.

LECTURE 26

THE GOODNESS OF THE PHYSICIAN: FROM HIPPOCRATES TO HITECH

APA Guest Lecture Series

Lecturer: Sherwin Nuland, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss the history of medical morality; 2) Identify the factors hindering the doctor/ patient relationship; 3) Recognize the role of technology in the 21st century doctor/ patient relationship.

SUMMARY:

Since the ancient Hippocratic authors, the physician's personal goodness and morality have been thought to play a significant role in healing. This concept faded in the 18th and 19th century as scientifically based concepts entered increasingly into diagnostic methods. It gradually returned in the late 19th and early 20th century, only to be engulfed by the advent of medical biotechnology after the 1960's. Medicine at a distance has increasingly become the standard of care. The speaker suggests new approaches to mitigating the associated loss of the bond between doctor and patient.

LECTURE 27

GLUTAMATE, DOPAMINE, AND ALCOHOLISM: FROM VULNERABILITY TO TREATMENT

APA Frontiers of Science Lecture Series

Lecturer: John H. Krystal, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of data suggesting that the capacity of alcohol to block NMDA glutamate receptors contributes to the experience of "intoxication"; 2) Demonstrate knowledge of data suggesting that two groups at risk for heavy drinking (alcohol dependent patients and healthy individuals with a family history of alcoholism) have an increased risk for alcoholism that is related to enhancement of NMDA glutamate receptor function. This alteration reduces their experience of intoxication when drinking; biases their reward circuitry to respond to immediate rewards while devaluing the delayed negative consequences of drinking; and promotes alcohol-related learning; 3) Demonstrate knowledge of data suggesting that treatments aimed at the rewarding effects of alcohol and the habitual aspects of alcohol consumption differentially affect drinking.

SUMMARY:

This presentation will attempt to integrate over 15 years of studies that implicate the ability of ethanol to block NMDA glutamate receptors in the risk for alcohol dependence and alcoholism treatment. This presentation has three components. In the first part, it will review evidence that up regulation of NMDA receptor contributes to the risk for alcoholism by attenuating the dysphoric features of ethanol intoxication, promoting heavy drinking. In the second component, it will review recent data suggesting the enhanced NMDA receptor function associated with familial alcoholism distorts corticostriatal function, reducing activation of the ventral striatum in anticipation of reward. It will also highlight shifts in dopamine release as people shift from goal-oriented to habitual alcohol release. In the third component, this presentation will highlight findings emerging from alcohol self-administration studies that suggest that the differential effects of NMDA receptor antagonists and opiate receptor antagonists on goal-oriented and habitual alcohol consumption.

LECTURE 28

TRANSLATIONAL STUDIES OF PRECONSCIOUS INHIBITION: WHAT WE'VE LEARNED IN THE BLINK OF AN EYE

APA Award for Research in Psychiatry

Lecturer: Neal R. Swerdlow, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify one or more neuropsychiatric disorders

characterized by symptoms – including intrusive thoughts, sensations, images, and urges – that suggest deficits in the automatic, preconscious inhibition (“gating”) of intero and/or exteroceptive information; 2) Recognize one or more laboratorybased operational measures of sensorimotor gating, and disorders in which these measures detect significant deficits; 3) Identify one or more brain regions that regulate sensorimotor gating, and one or more genes associated with reduced sensorimotor gating in healthy individuals and/or schizophrenia patients.

SUMMARY:

As Psychiatrists, we see patients struggle with intrusive thoughts, sensations, images and urges. In a stimulus-laden environment, the ability to automatically inhibit, or “gate”, information from entering conscious awareness has adaptive value. Deficits in this automatic process might contribute to deleterious effects of intrusive intero and exteroceptive information in individuals with any one of several different brain disorders. Operational measures of sensorimotor gating, including prepulse inhibition of startle (PPI), are used to elaborate the neural and genetic control of very simple forms of preconscious information processing, in order to generate and test hypotheses for the biology of more complex inhibitory deficits in brain disorders, including schizophrenia (SZ). Crossspecies studies have characterized forebrain circuitry that regulates PPI, elucidated the preclinical and clinical pharmacology of PPI, and have begun to clarify neural mechanisms through which heritable patterns of sensorimotor gating are transmitted. Forward and reversetranslational strategies using PPI and related measures as endophenotypes have identified genes associated with simple gating processes, their deficits in SZ and related animal models, and plausible neural mechanisms underlying some of these gene effects. PPI deficits in SZ are associated with real-life function and neurocognition, and are being used to predict the impact of pharmacologic and psychotherapeutic interventions in this disorder. One emerging conclusion from these crossspecies studies is that SZ-linked deficits in even this simple operational form of preconscious inhibition may reflect the impact of a long and growing list of “risk” genes on early brain development that shapes distributed gatingregulatory forebrain circuitry. That many genetic and neural roads may lead to sensorimotor gating deficits in SZ is consistent with increasing evidence for heterogeneous genetic antecedents and dispersed and variable neural circuit disturbances in this disorder. This evidence underscores the limits of simple genetic and pharmacologic approaches to SZ and its symptoms, as well as the importance of developing new strategies for understanding neural circuit disturbances and the means by which they might be ameliorated in this disorder.

SATURDAY, MAY 5, 2012

MEDIA WORKSHOP 1

THE CELLULOID CLOSET: A DOCUMENTARY ABOUT THE DEVELOPMENT OF GAY MOVIE CHARACTERS AND ITS RELATION TO THE COMING-OUT PROCESS

CoChair(s): Eric Yarbrough, M.D., Christopher A. McIntosh, M.D., M.Sc.

Presenter(s): Eric Yarbrough, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand how gay and lesbians have been portrayed in cinema for the past 100 years, 2) Understand how film portrayals of gays and lesbians have affected the overall culture, 3) See the parallel between the development of gay and lesbian characters over the years and how it might relate to the coming out process, 4) Use information gained on gay cinema to understand where our patients are in the coming out process and to guide our treatment based on this knowledge

SUMMARY:

For as long as there have been movies, there have been gay characters in movies. In early depictions, gay and lesbian characters were seen as the comic relief, and later as villains. Sometimes they would be referred to only indirectly, or via gendervariant signifiers. In the last two decades, they have been portrayed more realistically, with the same depth of humanity as straight characters. Movies play an important role in our culture, society, and ultimately our lives. Movies are artistic illustrations of how we see others and reflections of how we see ourselves. Unfortunately, portrayals of the gay and lesbian population in movies have often contributed to shame and internalized homophobia in this community. By reflecting on the history of gay cinema, we can observe parallels between the evolving view of the entertainment industry and the process individuals go through in coming out.

MEDIA WORKSHOP 2

LUCY OZARIN, M.D.: AN INSPIRING LIFE OF ONE WHO CONTINUES ON HER PATH OF LEARNING AND GIVING

Chair: Leah J. Dickstein, M.D., M.A.

Presenter(s): Leah J. Dickstein, M.D., M.A., Gary A. McMullan, M.A., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify one woman's personal and professional experiences as a woman entering medicine generally and psychiatry in particular at a time when it was still rare and unexpected, 2) Discuss the historical role of women in psychiatry, and 3) Recognize that a career in psychiatry can take many forms and paths for an enriching lifelong experience in the profession

SUMMARY:

With Dr. Lucy Ozarin's complete consent for its presentation at the meeting, this video of her experiences made in Sept. 2010 at the APA Melvin Sabshin Library & Archives, will inform and inspire attendees with her courage, leadership and accomplishments. Dr. Ozarin was born August 18, 1914 and has a wealth of knowledge and experiences to share with others, for example, at one point early in her career, she was assigned to care for the one thousand woman patients at a state hospital, when her male colleague caring for one thousand men patients received another assignment, she was simply told to care for his patients as well. As a woman naval medical officer, she continued her pioneering accomplishments, including consultation to governments worldwide about public health issues. In more recent decades she wrote the Psychiatry History column for Psychiatric News after careful research at the National Library of Medicine, where she continues her professional research and writing. She makes time to volunteer at her local VA hospital and participates in her local faith community walking just a few miles to get there weekly.

MEDIA WORKSHOP 3

HERE ONE DAY: A FILM ABOUT BIPOLAR DISORDER AND SUICIDE

CoChair(s): Kathy Leichter, Michael F. Myers, M.D.

Presenter(s): Franz Leichter, Josh Leichter, Stephen M. Goldfinger, M.D., Ira Glick, M.D., Kathy Leichter,

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss the how this film can aid in your understanding of how a family comes to terms with a family member diagnosed with bipolar disorder, 2) Identify the ways in which this family coped with the sudden loss by suicide of a family member, and 3) Recognize ways in which this film might influence your individual practice and management of families coping with a similar diagnosis or loss of a family member.

SUMMARY:

HERE ONE DAY tells the story of the filmmaker's mother, Nina, a charismatic teacher, poet, mother of two, and the wife of a New York State Senator. After twenty years of rapid mood swings between mania and depression and a diagnosis of bipolar disorder, Nina committed suicide at age sixtythree. The film retraces the circumstances that brought Nina to take her own life and intimately portrays the members of her family in the aftermath of her death. Shot by Kirsten Johnson, winner of the 2010 Excellence in Cinematography Award at The Sundance Film Festival, this unsensationalized, beautiful film paints a captivating portrait of how people cope with mental illness, loss, and the possessions the dead leave behind, both real and emotional.

SUNDAY MAY 6, 2012

MEDIA WORKSHOP 4

KINGS PARK: STORIES FROM AN AMERICAN MENTAL INSTITUTION

Chair: JeanPierre Lindenmayer, M.D.

Presenter(s): Lucy M. Winer, Benjamin J. Sadock, M.D., Jean-Pierre Lindenmayer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the painful legacy of the America's state hospital system and the crisis left by its demise, 2) Understand how filmmaker Lucy Winer, who was committed to Kings Park State Hospital as a teenager, is able to come to terms with this profoundly difficult period of her life by reaching out to other former patients and staff, and learning about the evolution of our public mental health care system, and 3) Learn from the lessons from the past in order to more effectively and creatively face the challenges of our present mental health care system

SUMMARY:

On June 21, 1967, at the age of seventeen, Lucy Winer was committed to the female violent ward of Kings Park State Hospital on Long Island following a series of failed suicide attempts. Over thirty years later, now a veteran documentary filmmaker, Lucy returns to Kings Park for the first time since her discharge. Her journey back sparks a decadelong odyssey to confront her past and document the story of the now abandoned institution that once held her captive. Her meetings with other former patients, their families, and the hospital staff reveal the painful legacy of our state hospital system and the crisis left by its demise. The film culminates with a vision of today. Stories are told of the often drastically executed "emptying out" of the hospital. We follow Lucy in her effort to see how mental health care has changed since the hospital's closure. Scenes shot at small centers, commit-

ted to the recovery of their members despite limited resources; let us see the progress that's been made. In contrast, footage shot at the local jail reveals a very different reality, where the penal system has replaced the state hospital as the default "provider" for people with serious mental illness locally and nationwide. We are left with a profoundly personal glimpse of a devastating past, stigma challenged and questions raised about the distance we've come and how far we have left to go.

MONDAY, MAY 7, 2012

MEDIA WORKSHOP 5

BEGINNERS: CONUNDRUMS OF HUMAN BONDING, YOUNG AND OLD, LGBT, AND OTHERWISE

CoChair(s): Petros Levounis, M.D., M.A., Jack Drescher, M.D.

Presenter(s): Mary E. Barber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss complexities of "coming out" across the life span, 2) Identify core issues in LGBT parenting in the new legal context of LGBT families, and 3) List two countertransference concerns in working with LGBT patients and their families

SUMMARY:

Based on a true story, "Beginners" (2010, 105 minutes) explores the confusion and surprises of love through the evolving consciousness of Oliver (Ewan McGregor). Oliver meets the irreverent and unpredictable Anna (Melanie Laurent) only months after his father Hal (Academy Award nominee Christopher Plummer) has passed away. This new love floods Oliver with memories of his father who following 44 years of marriage came out of the closet at age 75 to live a full, energized, and wonderfully tumultuous gay life. Now Oliver endeavors to love Anna with all the bravery, humor, and hope that his father taught him (adapted from imdb.com). In this media workshop, we will use "Beginners" as a springboard to explore core issues in LGBT mental health. Dr. Jack Drescher will discuss the complexities of "coming out" across the life span. As there are many closets, there are many different ways to come out. There is no single correct way to do so, a fact that may be overlooked by a therapist in a wellintentioned effort to affirm a patient's homosexuality. A therapist's recognition and respect for individual differences will allow a multiplicity of possibilities in the coming out process. In this way, patients may find their own way and define their own identities. Dr. Mary Barber will address issues of parenting from both straight parentgay child and gay parentstraight child perspectives.

As LGBT parenting becomes more normative and accepted, LGBT parents may increasingly face the same pressure that straight people have had to cope with from time immemorial. Gay and lesbian couples may begin to hear pointed questions from parents about “When will we become grandparents?” and suggestions from friends about starting a family. Dr. Petros Levounis will discuss sexual identity in patient-physician relationships. While it’s unclear if therapists are obligated to separate their personal and professional lives to a greater degree than other professionals, keeping one’s sexual identity completely out of the public domain has become nearly impossible. Ultimately, direct or indirect disclosure of sexual identity for therapists today is determined by (a) their training and theoretical beliefs; (b) their anxiety or comfort with their own sexual identity, and (c) their own solutions to integrating their sexual identity into their “public identities,” both as professionals and as individuals in the private sphere. Following these brief presentations, the discussants will lead the workshop participants in an open discussion about the film and the psychiatrist’s role in working with LGBT patients and their families. The workshop is open to all psychiatrists who would like to learn more about LGBT mental health but is particularly targeted towards members in training and early career psychiatrists.

MEDIA WORKSHOP 6

SIXTY-FIVE YEARS AFTER WORLD WAR II: A FAMILY SECRET

Chair: Gerald Schneiderman, M.D.

Presenter(s): Gerald Schneiderman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Family Secrets can be classified by content and family dynamics are further compromised by the Holocaust, 2) Exposure of the secret leads to ultimate relief of trauma, guilt and shame and feeling more whole, and 3) Each individual has to deal with his or her own personal history and attempts to forgive and change our own personal growth. Knowledge of Judaism is often pursued.

SUMMARY:

When something good happens to people, they want to tell someone about it. Instinctively healthy people want to communicate. However some events, such as World War II and its consequences or facts are painful and stressful and we may have fear in disclosing such a thing, particularly to a spouse, parents or children and this will carry a high risk. Thus, we hold back such things and they become secrets. Sometimes they become a ball and chain which burdens us for our whole lives. Webster has defined the secret as some-

thing known to a certain person or persons and purposely kept from the knowledge of others. Secrets disrupt the normal and instinctive drive to communicate. War, conflicts with religious or political institutions, the breakdown of families and increasing distances between relatives have diminished the traditional avenues of confession and sharing. The secret kept over time may exact a considerable toll from the individual and particularly in a subject complicated by the consequences of war. This film deals with 2 individuals interviewed who talk about their family secret that they were born Jewish. This was withheld from them since birth, but was subsequently discovered, having consequences to them as part of their growth and development and their lives. The interviews were conducted at the Faculty of Psychology, Warsaw University Poland in November 2009 and now are part of the film library at the Holocaust Museum, Washington, D.C.

MEDIA WORKSHOP 7

UNMOURNED LOSS IN SARABAND: INGMAR BERGMAN’S LAST FILM

Chair: Bruce Sklarew, M.D.

Presenter(s): Annelle B. Primm, M.D., M.P.H., Bruce Sklarew, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the effects of an unmourned loss on a threegenerational family, and 2) Understand the intergenerational transmission of psychopathology.

SUMMARY:

After Bergman directed his autobiographical Fanny and Alexander, he announced it would be his last film. However, he then directed After the Rehearsal and scripted four films. Saraband, the last film he directed, was billed as a 30year sequel to the 1972 Scenes from a Marriage with Liv Ullmann as Marianne and Erland Josephson as Johan. Marianne’s hopeful but doomed visit to Johan’s country house provides the format for Bergman to continue to portray the angst of Scenes from a Marriage in Johan’s threegeneration family. “No one leaves me”, protests Henrik, Johan’s son from a previous marriage, repeatedly faced with the threat that his wife Anna would leave him and his daughter Karin’s assertion, “I am leaving you”. This clarion protest against loss reverberates throughout the film as its central theme of unresolved mourning. The focal character, Anna, who died two years before, is never viewed, even in flashbacks, but only seen in still photographs. She is the daughterinlaw of Johan, mother of the 19yearold Karin and wife of Henrik. For Bergman she seems to represent Ingrid, most cherished

and fifth wife for 24 years until her death in 1995. The film is dedicated to Ingrid, and it is her image that appears in the still photo of Anna in the film. Bergman presents an unusual and stately structure of ten duets between the four characters in the film – Marianne, Johan, Henrik, and Karin whom Henrik insists on relentlessly overwhelming with his method of cello tutoring. In the end Johan climbs into bed with Marianne, but his failure in empathy is displayed by a humiliating withdrawal. Like Henrik who shares a bed with his daughter, Johan's need for solace and comfort is exacerbated by the loss of his beloved daughter-in-law Anna. As narrator and Greek chorus, Marianne leads the viewer into a mournful narrative of bitterness, competitiveness, and engulfment, replete with anguished revelations and lacerating confrontation. *Saraband* is Bergman's final filmic instance of dealing with his childhood traumas by inflicting angst, destituteness, and uncertainty upon his audience using projective identification. One feels a shattering helplessness and heaviness. The experience is harrowing and bleak, not catastrophic. In *Saraband*, as in *The Seventh Seal*, *Winter Light*, *Cries and Whispers*, and *Autumn Sonata*, nothing is settled. *Saraband* is a culmination of Bergman's struggles with sadomasochism, fatherhood, mourning, and impending death. In his last years Bergman spoke of reuniting with Ingrid in death. It is as though one motive for Bergman's making this film was to state a reassuring wish, just as Henrik fulfills his fantasy, that he find his cherished wife in death, another form of protest, "No one leaves me."

TUESDAY, MAY 8, 2012

MEDIA WORKSHOP 8

THE CYCLE OF INNERCITY VIOLENCE IN BUNUEL'S *LOS OLVIDADOS*

Chair: Bruce Sklarew, M.D.

Presenter(s): Annelle B. Primm, M.D., M.P.H., Bruce Sklarew, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Develop an appreciation for the effect of deprivation, loss and overstimulation on early adolescent development, and 2) Develop an appreciation for the psychodynamics of cycles of retaliatory violence

SUMMARY:

In 1950 Luis Bunuel burst onto the International scene with a film combining gritty, neorealistic and surrealist images and ideas *Los Olivados*, translated as *The Young and the Damned* or *The Forgotten*. This harsh, somber, and painful film is replete with unrelenting and retaliatory like John Singleton's *Boyz 'N the Hood*. Except for the shooting of

the *Jiabo* by the police, many boys – as well as chickens and roosters – are gruesomely bludgeoned to death by sticks and stones, and others are injured or threatened. Bunuel links this Mexico City street life of overstimulation, deprivation and violent trauma with dissolving images of other cities: New York, Paris, and London. The primary characters – the roosterlike *Jiabo*, just escaped from a reform school; Pedro, whose mother identifies him with his deserting father and deprives him of food and is excessively blaming; and a peasant boy, *Little Eyes*, who was told by his father to endlessly wait at a given spot in the market until his return – are all deprived of fathering. The only character with a father, Julian, regularly retrieves him from a bar. The only mother depicted is alternately punitive, depriving and seductive. *Little Eyes* and Pedro yearn for the older *Jiarbo* as a potential father, but identify with him in his conscienceless, relentless violence and nefarious manipulations. A striking oedipal dream covers Pedro's seeking a preoedipal mother. Through symbolic representations Pedro's friend develops a sexual liaison with his mother. Abandonment, Deprivation and derogation by caretakers lead to rage and a negative ego ideal of selfcriticism, selfdenunciation, and feelings of worthlessness and depression. Unable to bear these feelings these youths eternalize and project to others who seemingly hate them so they can then feel justified and driven to oppose and attack them. They also provoke others to actually attack and punish them, a form of selfdestructiveness. The film illustrates the Shengold's view that "deprivation can lead to the same traumatic and sadomasochistic imbalance as overstimulation". Bunuel implies that because of a lack of loving, consistent parental relationships, internal aggression cannot be mediated and that individual aggression is reinforced by the humiliation and injustice of an aggressive society.

PRESIDENTIAL SYMPOSIA

SATURDAY, MAY 5, 2012

PRESIDENTIAL SYMPOSIUM 1

TEACHING PSYCHODYNAMIC PSYCHIATRY IN THE 21ST CENTURY

CoChairs: Carol Nadelson, M.D., John M. Oldham, M.D., M.S.

Discussant: Robert Michels, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify the importance of psychodynamic training for psychiatrists, 2) Understand the complex educational dilemmas that limit training, 3) Analyze proposed educational solutions.

SUMMARY:

Since psychiatric residencies must prepare residents to be competent in “applying supportive, psychodynamic, and cognitive behavior psychotherapies to both brief and longterm individual practice,” according to ACGME (Accreditation Council for Graduate Medical Education), 2008 requirements, training programs are challenged to comply. This symposium will focus on education in psychodynamic psychotherapy, addressing the reasons for its continuing importance for psychiatric training, how it can be taught given the realities of training, patient populations, time and location constraints. The presenters will discuss how this requirement has been met by some programs, using specific examples.

PS11.

ESTABLISHING A THERAPEUTIC DIALOGUE: THE SPECIFICS

Presenter: Steven Levy, M.D.

SUMMARY:

Training in psychodynamic psychotherapy often begins with learning to establish a therapeutic relationship by assuming an analytic/therapeutic attitude of relative anonymity, neutrality and abstinence along with careful listening and the building of treatment boundaries. Specific objectives or goals for getting a dynamic treatment underway as well as how to accomplish these goals are often poorly articulated and taught. This presentation will outline the crucial tasks and goals in establishing a therapeutic dialogue and will specify how to conduct the early psychotherapy sessions, what to say and how to say it, in order to help the patient

accommodate to therapeutic demands and opportunities. Principles underlying these technical skills will be described and difficulties in teaching and learning them noted.

PS12.

TEACHING PSYCHOTHERAPY

Presenter: Deborah Cabaniss, M.D.

SUMMARY:

Psychodynamic psychotherapy is often taught and supervised in an unstructured way that leaves residents confused and supervisors unclear about what and how they are supposed to supervise. Many training programs lack faculty with specialty training in psychodynamics, challenging nondynamically trained faculty to teach material with which they are unfamiliar or uncomfortable. Many psychodynamically trained psychotherapists feel that they can only teach psychodynamics with “the right patients” (i.e. relatively high functioning patients in longterm psychotherapy) leaving most residents unable to find “suitable” patients and giving residents the impression that psychodynamic psychotherapy cannot apply to other patients or situations. This paper will address the need for a range of faculty members to teach psychodynamics and apply the principles to patients in any setting. This means utilizing educational best practices including learning objectives, standardized assessment and operationalized teaching methods in order to improve didactic learning, supervision, and assessment.

PS13.

EVERYONE IS A PSYCHOANALYST

Presenter: Richard F. Summers, M.D.

SUMMARY:

Every psychiatry resident has an intuitive appreciation of the importance of emotion, relationships, and the power of the past. They may not know how to articulate this and may be uncomfortable with it. Our job is to help them preserve this awareness, and extend and grow it. The ability to teach about psychodynamic ideas using simple, jargon-free language and common sense and pragmatism can get lost in our discussions of the sprawling, layered theory and practice ideas of the past century. Teaching a theoretically uncluttered and coherent model, stripped of outmoded concepts, and based to a reasonable degree on the current evidence base, creates an emotional and intellectual space for residents to develop their personal understanding and unique practice. A clear and practical model, and the permission to indulge their humanity, empowers residents to delve into their relationships with patients in a genuine way, and encourages them to selfreflect, which is the ultimate

mode of learning.

PS14.

MAKING IT SO: CREATING A PSYCHODYNAMIC RESEARCH CLINIC

Presenter: Kimberlyn Leary, Ph.D., M.P.A.

SUMMARY:

Meeting ACGME guidelines to include psychodynamic psychotherapy in graduate medical education is often difficult. This is especially so with everincreasing demands for evidencebased accountability. This paper will describe the development of a Psychodynamic Research Clinic, where we created a “virtual clinic,” linking it to a research initiative collecting data on psychodynamic formulations, patient outcomes, and therapy process. Emphasis will be placed on the practical steps of the collaboration, capacity building, and challenges negotiated during the three years in which the clinic has operated.

PRESIDENTIAL SYMPOSIUM 2

MINDFULNESSBASED PRACTICES IN THE TREATMENT OF STRESS AND PSYCHIATRIC ILLNESS

Chair: Kathy M. Sanders, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of mindfulness based treatments for stress reduction and psychiatric disorders, 2) Demonstrate knowledge of how and why to prescribe mindfulness based treatments, 3) Demonstrate knowledge of the recognition of the impact of mindfulness practices on the brain structures involved in stress and depression

SUMMARY:

Mindfulness and meditative exercises have been used for years to help handle stress and chronic medical conditions. More recently, these treatments have been developed for the psychiatric disorders. Stress is related to patient wellbeing, quality of life with chronic medical and psychiatric conditions as well as in the development of psychiatric illness. It is important for the practicing psychiatrist to understand what mindfulness practices are and how they are used in the treatment of stress, anxiety and depressive disorders. This symposium will focus on understanding mindfulness based treatments in clinical and research settings especially with regard to treatment of stress, anxiety and depression. Dr. KabatZinn will begin the symposium with his understanding of the history of the mindfulness based stress reduction program and its connection to our deeper understanding of

what mindfulness is and its clinical importance in healing psychiatric conditions. Dr. Bieling will highlight the findings of mindfulness based cognitive therapy developed as a relapse prevention treatment in depression comparable to maintenance psychopharmacotherapy. Dr. Denninger will highlight the decades of research associated with the use of the Relaxation Response in health, illness, and stress. Finally, Dr. Lazar will present the current understanding of the neuroanatomy of consciousness and the brain changes associated with mindfulness practices.

PS21.

MINDFULNESSBASED STRESS REDUCTION (MBSR): WHAT IT IS AND ITS CLINICAL APPLICATIONS FOR STRESS, PAIN, AND CHRONIC ILLNESS

Presenter: Jon KabatZinn, Ph.D.

SUMMARY:

Dr. KabatZinn will describe the theoretical foundation, origins, rationale, and design of MBSR, and review a broad range of clinical outcomes, as well as the emergence of other mindfulnessbased interventions modeled on it. He will discuss mindfulness as the heart of Buddhist meditative practices, and emphasize its general applicability as an effective firstperson approach to adventitious suffering, as well as developing diagnosis-specific hypotheses for understanding the possible mechanisms by which mindfulness training may be exerting specific clinical effects. He will emphasize that mindfulness, as a rigorous meditative discipline, can easily become denatured if it is thought of or delivered as merely as one more cognitive behavioral intervention or technique. It rests on a very different epistemological foundation, that of the consciousness disciplines and contemplative traditions. The potential for a profound transformation in psychology, psychiatry, and medicine, and in our patients, depends on the convergence of these complementary epistemological streams, and thus on an understanding of mindfulness from the inside out. In other words through firstperson, embodied experience, and the recognition of its universal applicability as a systematic secular training in attention, awareness, and selfacceptance.

PS22.

MINDFULNESSBASED COGNITIVE THERAPY (MBCT) IN THE TREATMENT AND PREVENTION OF RELAPSE IN MAJOR RECURRENT DEPRESSION

Presenter: Peter Beiling, Ph.D.

SUMMARY:

Mindfulnessbased cognitive therapy is an emerging stand alone psychosocial treatment that was designed specifi-

cally for relapse prevention in depression. Since 2000 there have been four positive RCTs that have tested the efficacy of MBCT for relapse prevention in depression, and interest is growing in the application of the approach to more acute depression, bipolar disorder, anxiety disorders and other chronic mental illness. Combining about equal parts of mindfulness (Vipassana) meditation and cognitive behavioral principles, the treatment is eight weeks of two hour sessions for a group. In this paper, data will be presented from a recently published fiveyear NIMH funded RCT of MBCT, Maintenance Antidepressant Medication (MADM) and Placebo (PLA) in the prevention of depressive relapse in patients who have achieved remission via antidepressant treatment. Five hundred thirty two patients were screened, 214 met our inclusion criteria for current MDD. We adopted a treatment algorithm based on STAR*D, providing patients with treatment by two separate classes of antidepressant medication (citalopram or sertraline in Step 1 and venlafaxine or mirtazapine in Step 2). A total of 84 patients met our criteria for sustained remission and were randomized to 1) MADM, 2) discontinuation + MBCT, 3) discontinuation + PLA. Longitudinal follow up was conducted for 18 months using monthly BDI and bimonthly HRSD. Intention to treat analyses identified a significant interaction between the quality of acute phase remission and subsequent prevention effects in randomized patients ($p = .03$). Among unstable remitters (defined as one or more HRSD >7 during remission), patients in both MBCT and MADM showed a 73% decrease in hazard compared to PLA ($p = .03$), whereas for stable remitters (all HRSD = 7 during remission) there were no group differences in survival. Emerging data from this study on the “effective ingredients”, mediators of change in MBCT, will also be described; during the maintenance phase of the study only patients receiving MBCT showed significant increases in the ability to monitor and observe thoughts and feelings as measured by the wider experiences and decentering. Moreover, changes in wider experiences and curiosity predicted lower HRSD scores at six months follow up. In addition to this research evidence, the presenter will focus on applications of the approach within tertiary care centers for a broad spectrum of psychiatric populations typical in m

PS23.

PROBING THE MOLECULAR MECHANISM OF MINDBODY PRACTICES WITH GENOMIC AND TRANSLATIONAL TECHNIQUES

Presenter: John W. Denninger, M.D., Ph.D.

SUMMARY:

MindBody techniques such as meditation and yoga have been practiced by humankind for thousands of years. Although the psychological, spiritual and health benefits

of these techniques are well known, the molecular details of how these benefits arise have remained poorly understood. Genetic expression profiling, a method of examining what genes are turned on and off, has allowed us to glimpse which genes and gene families are most affected by mindbody practices. Combined with translational work using animal models of chronic stress, we are beginning to develop specific genetic and biochemical hypotheses that may provide an understanding of the common mechanisms underlying mindbody practices. Immune regulatory pathways, such as those upstream and downstream of the transcription factor NF- κ B and pathways involved in mitochondrial energy metabolism are among the pathways that our work has suggested are central to the effects of mindbody practices.

PS24.

CHANGES IN NEURAL STRUCTURE AND FUNCTION ASSOCIATED WITH MINDFULNESS TRAINING PROGRAMS

Presenter: Sara Lazar, Ph.D.

SUMMARY:

Mindfulness meditation is wellknown to reduce stress and clinical symptoms associated with several psychiatric conditions. However, little is known about the neural correlates of these improvements. I will present data from two neuroimaging studies demonstrating changes in brain structure and function following participation in the MindfulnessBased Stress Reduction (MBSR) program, the original and most widely implemented mindfulness training program. In the first study anatomical MRI images were acquired from stressed but otherwise healthy, meditationnaïve participants before and after they underwent the eightweek MBSR program, compared to a waitlist control group. Changes in several brain regions were identified in the MBSR group compared to the controls, and changes in amygdala gray matter were correlated with changes in stress (Hölzel et al 2010, 2011). In the second study, 26 GAD patients were randomized to an MBSR (N=15) or an active control intervention (N=11). Functional MR images were acquired as patients viewed pictures with emotional facial expressions. Changes were observed in multiple limbic regions. I will discuss how these changes in neural structure and function might relate to enhanced emotion regulation and lead to longterm changes in psychological health and wellbeing.

MONDAY, MAY 7, 2012

PRESIDENTIAL SYMPOSIUM 3

NEW APPROACHES TO INTEGRATION OF MENTAL HEALTH AND MEDICAL HEALTH SERVICES

CoChairs: Wayne J. Katon, M.D., Jurgen Unutzer, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand new models of care that have been found to improve anxiety and depression outcomes of primary care patients, 2) Understand new models of care that have been found to improve medical outcomes of patients with severe mental illness, 3) Understand new models of care that have been found to improve both depression and medical disease control (i.e. HbA1c, systolic blood pressure and LDL levels) in patients with depression and comorbid diabetes and/or heart disease

SUMMARY:

This symposium will describe the development and dissemination of evidencebased models that have been shown to improve the quality of mental health care of primary care patients and acute trauma victims as well as the medical care of patients with severe mental illness. Dr Katon will describe the TEAMcare intervention which has been found to improve both depression outcomes and medical disease control in patients with comorbid depression and/or heart disease. Dr Unutzer will describe his success in disseminating the IMPACT model of care that has been shown to improve quality of care and outcomes for depressed primary care patients to a large number of federally qualified primary care clinics in Washington state. Dr Druss will describe an evidencebased model for improving preventative and primary care for patients with severe mental illness and his success with disseminating this model of care in community mental health systems. Dr Zatzick will describe a model of care that has been shown to improve quality of screening and increase exposure to evidence based PTSD and substance abuse care for victims of motor vehicle trauma. Dr Engel will describe his large dissemination project, RESPECTMIL, which is improving screening of troops postdeployment from Iraq and Afghanistan as well as providing a unique model of collaborative care for PTSD and depression for these troops. Dr Williams will describe the implementation and initial results from the DIAMOND project which is disseminating collaborative depression care to multiple primary care clinics covered by the 6 largest insurers in the state of Minnesota. Presenter: Jurgen Unutzer, M.D., M.P.H.

SUMMARY:

The Mental Health Integration Program (MHIP; <http://integratedcarew.org>) is a statewide program of patient-centered, integrated care for safety net patients served in over 100 community health centers and 30 community health centers in the State of Washington. Patients served

include adult patients on short term disability, uninsured patients, Veterans and family members of Veterans, older adults, children, and high risk mothers. Since its inception, the program has served over 23,000 patients ranging in age from 1 to 100 with a variety of behavioral health problems including depression, anxiety disorders, bipolar disorder, alcohol and substance abuse problems. More than 20 psychiatrists are serving as consultants to the program statewide, and the program is a mature example of a large-scale implementation of evidencebased collaborative care for common mental disorders. We will discuss experience with implementing this program statewide and report on clinical program outcomes. We will also discuss the role of a payforperformance component of the program which has been associated with substantial improvements in clinical outcomes since its initiation in 2009.

PS31.

NATIONWIDE INTEGRATION OF BEHAVIORAL HEALTH SCREENING AND INTERVENTION FOR TRAUMARELATED DISORDERS IN ACUTE CARE MEDICAL SETTINGS

Presenter: Douglas F. Zatzick, M.D.

SUMMARY:

The American College of Surgeons Committee on Trauma tightly regulates United States trauma center care through policy mandates and clinical guideline best practice recommendations. College mandates are reinforced through verification site visit implementation criteria. The American College of Surgeons has successfully linked trauma center funding to verification site visits and other quality indicators. This presentation will describe a unique investigativepolicy collaboration whereby federally funded empiric research on posttraumatic stress disorder (PTSD) and alcohol/drug screening and intervention has been directly translated to policy mandates and clinical guidelines for acute care medical trauma centers nationwide. The presentation will describe the randomized clinical trial evidence base supporting alcohol and PTSD screening and intervention in acute care medical settings. The presentation will also include a discussion of the ongoing American College of Surgeons Committee on Trauma policy dialogue targeting behavioral health care integration for acute care trauma centers nationwide.

PS32.

THE MENTAL HEALTH INTEGRATION PROGRAM: A STATEWIDE EFFORT TO IMPROVE MENTAL HEALTH CARE FOR SAFETYNET PATIENTS

Presenter: Jurgen Unutzer, M.D., M.P.H.

SUMMARY:

The Mental Health Integration Program (MHIP; <http://integratedcarew.org>) is a statewide program of patient-centered, integrated care for safety net patients served in over 100 community health centers and 30 community health centers in the State of Washington. Patients served include adult patients on short term disability, uninsured patients, Veterans and family members of Veterans, older adults, children, and high risk mothers. Since its inception, the program has served over 23,000 patients ranging in age from 1 to 100 with a variety of behavioral health problems including depression, anxiety disorders, bipolar disorder, alcohol and substance abuse problems. More than 20 psychiatrists are serving as consultants to the program statewide, and the program is a mature example of a large-scale implementation of evidence-based collaborative care for common mental disorders. We will discuss experience with implementing this program statewide and report on clinical program outcomes. We will also discuss the role of a payforperformance component of the program which has been associated with substantial improvements in clinical outcomes since its initiation in 2009.

PS33.**APPROACHES TO INTEGRATING HEALTH CARE IN SPECIALTY MENTAL HEALTH SETTINGS**

Presenter: Benjamin G. Druss, M.D., M.P.H.

SUMMARY:

This presentation will provide a public health perspective on the problem of excess morbidity and mortality in patients with serious mental illnesses. It will provide an historical perspective on the problem; the factors contributing to it; research models for integrating care and improving patient engagement in primary care; and implications of new health policies on the physical health of this vulnerable population.

PS34.**DISSEMINATING EFFECTIVE INTEGRATED MENTAL HEALTH AND PRIMARY CARE SERVICES FOR PTSD AND DEPRESSION IN THE U.S. MILITARY**

Presenter: Charles C. Engel, M.D., M.P.H.

SUMMARY:

About 2.2 million US military personnel have deployed to the armed conflicts in Iraq and Afghanistan. Of those, roughly 20% report PTSD or depression on return, with rates rising for at least the first six to 12 months back. Most of those with mental health problems receive inadequate assistance because of stigma, barriers to care, possible harm

to career, and other factors. Since 2007 Army primary care clinics have worked to address these challenges using an integrated mental and physical health care model called "RESPECTMil" (ReEngineering Systems of Primary Care Treatment for PTSD and Depression in the Military). RESPECTMil is a systems approach that relies on three key components to improve access to and outcomes of PTSD and depression care: (1) Prepared primary care providers and practices (e.g., webbased clinician training, routine screening, clinical diagnostic and symptom severity aids); (2) Optional care management followup (e.g., measurementbased followup of symptom status, adverse treatment effects, treatment adherence and continuity); and (3) Enhanced and efficient interface with mental health specialty care (e.g., weekly case review with each care manager, feedback to the primary care clinician using the electronic record). The transition to RESPECTMil's team care approach has been phased and gains have been consistent and steady. After 54 months, 74 clinics at 32 worldwide installations were implementing RESPECTMil with 3 of the remaining 4 installations preparing to launch. 1,221,811 visits (79% of visits to participating clinics) were screened for PTSD and depression, 12.7% of those visits screened positive for one or both disorders, and 48% of screen positive visits received a PTSD or depressionrelated primary care diagnosis. Suicide risk was reported in 1.1% (13,177) of screened visits. Care managers followed 11,884 patients, and while the number of care manager contacts was strongly linked to symptom improvement, only 40.5% received had more than three monthly contacts. In summary, RESPECTMil is feasible and acceptable option for military patients with mental health needs who are seen in primary care. Systematic efforts to engage a greater proportion of patients for longer in care management may improve clinical outcomes. A randomized effectiveness trial of "RESPECTMil Plus" is starting at 18 Army clinics to see if additional patient engagement strategies and primary carebased psychosocial options will improve care con

PS35.**COSTEFFECTIVENESS OF A MULTICONDITION COLLABORATIVE CARE INTERVENTION**

Presenter: Wayne J. Katon, M.D.

SUMMARY:

This paper will describe the cost effectiveness of the TEAMcare intervention which was tested in 214 patients with comorbid depression and poorly controlled diabetes and or heart disease. Compared to usual care, this intervention was found to improve depression, HbA1c, systolic blood pressure and LDL outcomes over a one year period. The intervention was also associated with significant improvements in functioning, quality of life and satisfaction

with both depression and medical care. The TEAMcare intervention was found to be associated with an approximately 600 dollar cost savings per patient over a two year period. Interventions that show incremental cost effectiveness below 20,000 dollar per QALY have been recommended for rapid dissemination. Our cost effectiveness acceptability analysis found a 99.7% probability that the incremental cost per QALY of the TEAMcare intervention would fall below this 20,000 dollar per QALY threshold.

PS36.

THE DIAMOND PROJECT: IMPROVING OUTCOMES FOR DEPRESSION IN PRIMARY CARE AND CHANGING THE MODEL OF REIMBURSEMENT FOR THAT CARE

Presenter: Mark D. Williams, M.D.

SUMMARY:

The Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) program was designed in 2007 by the Institute for Clinical Systems Improvement (ICSI) to be a sustainable model of collaborative care for depression in primary care settings in Minnesota. Since implementation in 2008, over 8000 patients have been cared for in a wide variety of primary care clinics with consistently better results than practice as usual. The project was designed by practices and healthcare payers working together to change both the delivery, and reimbursement of care around a common mental health condition in adult patients. This presentation will review the design and implementation, early outcomes, and challenges encountered in translation of an evidencebased model into many practices outside of a research framework.

TUESDAY, MAY 8, 2012

PRESIDENTIAL SYMPOSIUM 4**PREVENTION IN GERIATRIC PSYCHIATRY**

Chair: Dilip V. Jeste, M.D.

Discussant: Ruth O Hara, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Use strategies to enhance personal wellbeing and reduce cognitive decline in later life, 2) Implement management approaches to reduce the risk of PTSD following traumatic events, 3) Develop treatment plans to lower the incidence of laterlife depression in highrisk groups

SUMMARY:

The next 25 years will witness the largestever increase in the numbers of older adults in the human history. The goal of this session is to inform the audience that prevention of psychiatric morbidity in later life is not a futuristic fantasy but is possible and even practical in several cases today. The state of science in this arena varies considerably across disorders. Thus, there are more data available on prevention of several types of depression than on prevention of schizophrenia. Nonetheless, the evidence base for preventive interventions is becoming increasingly robust. Dilip Jeste will discuss successful psychosocial aging in the general population as well as in adults with schizophrenia. He will emphasize the role of positive psychological traits including resilience, optimism, and wisdom. In older persons with schizophrenia psychosocial interventions such as cognitive behavior therapy combined with social skills training improve functioning. Murray Raskind will present PTSD prevention research with a focus on preventing or ameliorating development of PTSD by intervening after a severe traumatic event has occurred. He will review pharmacologic and psychotherapeutic studies of this type, and offer hypotheses to test in future research. George Alexopoulos will show how the theory of vascular depression served as the research platform for strategies that led to findings at the levels of etiology, predisposition, and mediation of depressive syndromes. He will then discuss literature on treatment and prevention of vascular depression. Charles Reynolds will give an overview of the feasibility, effectiveness, and costeffectiveness of depression prevention strategies. He will also describe challenges confronting the field, and suggest steps for taking depression prevention strategies to the next stage. Gary Small will identify factors that may delay the onset, slow the progression, or prevent cognitive decline in old age. He will present evidence showing that physical exercise and healthy diet can prevent diabetes, and may indirectly prevent Alzheimer's disease as well. Finally, Ruth O'Hara will tie the various presentations together from the perspective of examining the strengths and limitations of the available research on prevention of mental illnesses in later life. She will summarize the clinical and research implications of the existing work.

PS41.**SUCCESSFUL PSYCHOSOCIAL AGING**

Presenter: Dilip V. Jeste, M.D.

SUMMARY:

This presentation will focus on successful psychosocial aging in the general population as well as in people with one of the most serious mental illnesses, schizophrenia. While successful aging involves both mental and physical health, the critical component is healthy brain and mind. At UCSD we have studied successful aging in several thousand

communitydwelling seniors as well as in several hundred middleaged and older adults with schizophrenia. Our results suggest that selfrated successful aging is not primarily dependent on physical illness and disability. Significant associations of successful psychosocial aging include an absence of depression, high overall level of physical and cognitive activities, and number of friends, resilience, and a positive attitude toward aging. On other hand, ethnicity, gender, education, income, and number of physical illnesses have no significant relationship with successful aging. There is growing evidence that optimism, resilience, positive attitude toward aging, spirituality, and wisdom are related to better subjective quality of life in older age. Among aging individuals with schizophrenia, subjective mental health improves and psychotic relapses as well as psychiatric hospitalizations become less common, despite increase in physical comorbidity and medical hospitalizations. Psychosocial interventions such as cognitive behavior therapy combined with social skills training improve functioning in later life.

PS42.

PREVENTION OF POSTTRAUMATIC STRESS DISORDER

Presenter: Murray A. Raskind, M.D.

SUMMARY:

Traumatic events are common, but the psychological distress that may follow usually subsides naturally. For some individuals, however, distress develops into posttraumatic stress disorder (PTSD). PTSD is one of the very few behavioral disorders (and perhaps the only one) for which the etiology is clear – i.e., experiencing one or more life threatening events. That said, preventing exposure to war, rape, physical assault, and other severe stressors is extremely difficult and often not achievable. The focus in PTSD prevention research has been to attempt to prevent or ameliorate development of PTSD by intervening after a severe traumatic event has occurred. PTSD lends itself to the application of prevention strategies for atrisk individuals. The identification of a causal event may make prevention efforts for PTSD more feasible and effective than for other psychological disorders. For PTSD, these efforts target those traumatized persons who are beginning to exhibit symptoms of PTSD. This presentation will review such pharmacologic and psychotherapeutic studies, and offer hypotheses to test in future studies. These interventions could also target individuals meeting criteria for acute stress disorder with the goal of preventing chronic PTSD.

PS43.

THE “VASCULAR DEPRESSION” HYPOTHESIS:

MECHANISMS, TREATMENT DEVELOPMENT, AND PREVENTION

Presenter: George S. Alexopoulos, M.D.

SUMMARY:

The current concept of “vascular depression” has been articulated in the form of a hypothesis in 1997 and postulated that “cerebrovascular disease may predispose, precipitate or perpetuate some geriatric depressive syndromes.” While the hypothesis could not be tested in its entirety, it generated findings that clarified the clinical presentation and mechanisms and led to treatment and prevention strategies for many patients with laterlife depression. There is now empirical evidence that cerebrovascular disease confers vulnerability to a variety of syndromes, including depression, other mood syndromes, and psychosis, but also cognitive impairment and peripheral neurologic signs. The clinical presentation of vascular depression has been characterized and resembles that of a medial frontal lobe syndrome with psychomotor retardation, apathy, and pronounced disability. Depression of patients with vascular stigmata or cerebrovascular compromise expressed as subcortical white matter hyperintensities and microstructural white matter abnormalities has poor outcomes, including persistence of depressive symptoms, unstable remission of depression, and increased risk for dementia. Executive dysfunction, slow psychomotor speed and small volume of the dorsal anterior cingulate gyrus were shown to predict poor response to antidepressants highlighting the relationship of the cognitive control network to antidepressant response. Each of these predictors was associated with vascular risk factors lending support to the “vascular depression” hypothesis. The relationship of vascular risk factors and lesions to a difficulttotreat depression led to the development of novel biological and nonbiological interventions and prevention strategies. Drugs acting in other than the serotonin systems 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, introduction of antidepressants soon after stroke has been shown to prevent later development of depression. From the clinical point of view, identification of vascular risk factors and attention to clinical manifestations of “vascular depression” (retardation, apathy, executive dysfunction, disability) may identify a population in need of treatment mitigating progress

PS44.

DEPRESSION PREVENTION STRATEGIES IN LATER LIFE: OVERVIEW OF A YOUNG FIELD

Presenter: Charles Reynolds, M.D.

SUMMARY:

Major depression is among the leading contributors to the global burden of illness related disability and is predicted to be the greatest contributor to illness burden by 2030. Thus, it is a matter of public health significance to identify people at high risk for depression and/or already mildly symptomatic, and to discover ways of implementing timely and rational risk reduction strategies to preempt major depression. In this presentation the published literature will be reviewed to summarize what is known about depression prevention in older adults and, ultimately, to inform future research. The overview will address: (1) the public health case and need for depression prevention, (2) the feasibility, effectiveness, and costeffectiveness of depression prevention, and (3) challenges confronting the field, including integration of biomarkers to enhance assessment of risk and effectiveness, and taking depression prevention strategies to scale.

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PS45.

CAN WE PREVENT ALZHEIMER'S DISEASE?

Presenter: Gary W. Small, M.D.

SUMMARY:

People are living longer than ever. With greater longevity, a critical question becomes whether or not our memories will endure across the lifespan. It is important to identify the factors that may prevent cognitive decline or at least delay onset or slow its progression. With increasing awareness of Alzheimer's disease and related dementias, patients, families, and clinicians are eager for concise and accurate information about the effects and limitations of preventative strategies related to lifestyle choices that may improve cognitive health. A recent NIH consensus panel could not draw firm conclusions regarding the relationship between decreasing risk factors for Alzheimer's disease and slowing cognitive decline. However, the panel did note 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. To definitively prove effectiveness of Alzheimer's prevention strategies, we need longterm doubleblind studies on thousands of volunteers. However, physical exercise and healthy diet can prevent diabetes, and since diabetes is a major risk for Alzheimer's disease, then these strategies should indirectly prevent Alzheimer's disease as well. These issues have considerable public health implications. Recent projections of the effect of risk factor reduction on Alzheimer's disease prevalence suggest that risk factor reduction could prevent up to three million cases of Alzheimer's disease worldwide.

SCIENTIFIC AND CLINICAL REPORTS

SATURDAY, MAY 5, 2012

SCIENTIFIC AND CLINICAL REPORT SESSION 01

AIDS/HIV

SCR01-1

CONTRIBUTORY EFFECTS OF CHILDHOOD TRAUMA TO WHITE MATTER TRACT INJURY IN HUMAN IMMUNODEFICIENCY VIRUS IN INFECTED AND UNINFECTED WOMEN*Chair: Soraya Seedat, M.D., Ph.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand the associations of early childhood trauma to HIV infection; 2) Understand the utility of diffusion tensor imaging in examining white matter tracts in HIV; 3) Understand the differential effects of HIV and early childhood trauma on white matter integrity.

SUMMARY:

Background: Early childhood adversity is a common risk factor for adult psychopathology (e.g. major depression, posttraumatic stress disorder) in HIV. Infected individuals are also prone to diverse neurocognitive abnormalities with cerebral white matter damage a sequela of cognitive compromise. While a relationship between cognitive impairments and alterations in specific white matter tracts in HIV has been demonstrated, the potential impact of childhood trauma on white matter injury in HIV is not known. We used diffusion tensor imaging (DTI) to assess the vulnerability of neural pathways to childhood adversity in infected women and hypothesized that the latter would have specific deleterious effects on white matter. Methods: 57 antiretroviral naïve, HIVpositive women (37 with childhood trauma and 20 without, mean age 31.8 ± 6.9 years) and 34 HIVnegative women (12 with childhood trauma and 22 without, mean age 26.8 ± 6.4 years), matched for education, handedness, ethnicity and language, were assessed for childhood adversity using the Childhood Trauma Questionnaire (CTQ). Psychiatric diagnostic and neurocognitive status was also ascertained. Diffusionweighted images were acquired on a 3T Siemens Allegra MRI (magnetic resonance imaging) scanner. Using multiple linear regression, we predicted fractional anisotropy (FA), a quantitative measure of white matter integrity, with HIV, childhood trauma, and the HIV x trauma interaction, and controlled for age. We examined this model in a voxelwise fashion and with regions of interest. Significant regions were defined in central white matter tracts in a common template and included left and

right anterior internal capsule, left and right cingulum. We assessed whether regional differences in FA were accounted for (i) in the whole sample (N=91) by HIV and trauma and (ii) in the traumaexposed only sample (N=49) by HIV and type of adversity (physical, sexual and emotional abuse and physical and emotional neglect). Results: Overall, alterations in FA in the right anterior internal capsule (AIC) and right cingulum was significantly associated with HIV status and with the interaction between HIV status and trauma, while mean FA in the left AIC was associated with trauma and with interaction between trauma and HIV. In traumaexposed women, emotional neglect predicted FA in the left AIC while sexual abuse predicted FA in both the right AIC and the left cingulum. Conclusions: HIV combined with early trauma disproportionately affects alterations in white matter. Among traumatized women this effect may be dependent on the type of early adversity. Although this is a preliminary study, white matter alterations resulting from early life stress may have implications for associated psychopathological and neurocognitive disturbances in HIV and warrant further exploration.

SCR01-2

MENTAL HEALTH OUTCOMES FOR ORPHANS BY AIDS COMPARED TO ORPHANS BY OTHER MEANS*Chair: Carla Sharp, Ph.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Distinguish between the mental health outcomes for orphans by AIDS versus orphans by other means in low-resource countries like South Africa; 2) Discuss the effect of HIV/AIDS on the psychosocial functioning of children; 3) Make decisions about the best measures to use to detect psychiatric disorder in children in low resource countries affected by HIV/AIDS.

SUMMARY:

Background: A major challenge facing South Africa as a result of the HIV/AIDS epidemic is the increase in the number of orphans and other vulnerable children (OVC). Orphan numbers are predicted at 2.3 million in 2020 (Dorrington et al., 2005) and it is estimated that by 2015 approximately 15% of all children under the age of 15 will be orphaned (Johnson & Dorrington, 2001). The devastating impact of this poses significant challenges for primary care services in addressing the mental health needs of children and adolescents affected by AIDS. Only three studies (all by the same group) have examined the mental health outcomes of OVC in South Africa. None of these studies have compared mental health outcomes of children orphaned by AIDS vs. children orphaned by other means. Methods:

Against this background, we used parent and selfreport Strengths and Difficulties Questionnaires (SDQ; Goodman et al., 2005) which are wellvalidated screens of psychiatric problems in children and adolescents to examine the mental health outcomes of $N = 187$ orphans (mean age 9.14; $SD = 1.3$; 51.2% female) in the Mangaung township in South Africa, of which $n = 87$ were orphaned by AIDS and $n = 100$ were orphaned by other means. Results: The results of a series of oneway ANOVAs demonstrated no differences for orphans by AIDS vs. orphans by other means, except for parentreported hyperactivity ($F = 5.75$; $p = .01$). Conclusions: These results are important because it suggests that orphan status by HIV/AIDS does not put children at increased risk compared with other means of becoming orphaned. Future studies need to compare this group with nonorphaned children and importantly, need to take into account whether poverty may be a more important correlate of poor mental health outcomes than orphan status per se.

SCR01-3

THE OUTPATIENT CLINIC FOR HIV AND MENTAL HEALTH: PATIENTS' CHARACTERISTICS AND COMPARISON WITH HOMOSEXUAL NONHIV INFECTED PATIENTS

Chair: Annemiek Schadé, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize mental health problems in HIVinfected patients and be aware of the importance to assess and treat mental health problems in HIVinfected patients; 2) Become more aware of the risks of drug use during sexual contact which may lead to an increased risk of getting and spreading HIV; 3) Learn that we could not identify many differences in depressive symptoms and other mental health symptoms for depressed homosexual men with HIV and depressed homosexual men without HIV. However, there are some differences in characteristics of the depression.

SUMMARY:

Objectives: HIV is a lifelong, still highly stigmatized, chronic disease with a substantial cooccurrence of mental health problems. On one hand, patients with mental health problems are at increased risk of getting HIV. On the other, HIVinfected patients are at increased risk of developing mental health problems compared to the general population. Mental health problems in HIVinfected patients have a negative influence on the treatment, adherence and prognosis of the HIVinfection. Therefore, it is important to realise an optimal treatment condition. The main objectives of this study are to describe the clinical and demographic characteristics of patients with HIV who seek treatment for their

mental health symptoms and to compare them with the general HIVinfected population. Secondly, we test whether HIV infected homosexual patients and noninfected homosexual patients with depressive or dysthymic disorder differ on 1) severity of depressive symptoms, and characteristics of the depressive or dysthymic disorder, 2) comorbid use of alcohol and drugs, and 3) personality traits. Methods: We compared a cohort of 196 patients who visited the outpatient clinic for HIV and Mental Health in Amsterdam, the Netherlands, with HIVinfected patients from the general population (ATHENAstudy) and homosexual nonHIV infected mental health patients (NESDAstudy). DSMIV diagnoses were determined, and several selfreport questionnaires were used to assess mental health symptoms. Results: Depressive disorders are the most occurring diagnoses in the cohort, and drugs are frequently used. Especially immigrants are underrepresented at the outpatient clinic. There is no difference in severity of depressive symptoms between HIVinfected and non HIVinfected homosexual men with a depressive or dysthymic disorder. However, the HIVinfected patients show more feelings of anger and guilt and experience more suicide ideation. The very common use of drugs and different personality traits as neuroticism and conscientiousness are a risk factor of getting and spreading HIV. Conclusion: Assessment and treatment of mental health problems can probably contribute in preventing HIV. General practitioners and internists should be trained in recognizing mental health problems in HIVinfected patients, especially in immigrants.

SCIENTIFIC AND CLINICAL REPORT SESSION 02

ATTENTION SPECTRUM DISORDERS

SCR02-1

PREVALENCE OF ADHD AND COMORBID PSYCHIATRIC DISORDERS IN A VETERANS ADMINISTRATION OUTPATIENT CLINIC

Chair: Robert A. Kayser, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the importance of evaluating veterans for Attention Deficit Hyperactivity Disorder; 2) Recognize common comorbid psychiatric disorders in veterans with ADHD; 3) Understand the challenges involved when diagnosing veterans with ADHD.

SUMMARY:

ADHD was once considered a disorder of children and adolescents. Now there is evidence that twothirds of children with ADHD continue to have symptoms and behaviors of ADHD that persist into adulthood. The prevalence

of ADHD in the general adult population is estimated at 4.4%. The prevalence of ADHD in adult outpatient psychiatric clinics is substantially higher, ranging from 17.22%. The prevalence of comorbid psychiatric disorders in adults with ADHD is high, with 92% of patients having one or more psychiatric comorbidities, and 53% of patients having four or more psychiatric comorbidities. The prevalence of ADHD and comorbid psychiatric disorders among veterans in outpatient mental health clinics has not been well studied. The objective of this study was to determine the prevalence of ADHD among veterans referred for psychiatric evaluation in the mental health section of a community based outpatient clinic, and to determine the prevalence and types of comorbid psychiatric disorders in these patients with ADHD. Method: Medical records of 782 consecutively evaluated patients were reviewed to determine the prevalence of ADHD. All of these patients were referred by primary care providers for psychiatric evaluation between May 31, 2007 and December 31, 2010. The records of patients diagnosed with ADHD were then reviewed to determine the types and prevalence of comorbid Axis I psychiatric disorders. All patients were evaluated by a single psychiatrist, and diagnoses were based upon DSM-IV criteria. Results: The prevalence of ADHD in this sample of patients was 20.3%, substantially higher than the prevalence in the general adult population. This prevalence was consistent with findings of other studies of adult psychiatric outpatients. However, the prevalence in this sample may actually be higher than 20.3% because several patients were lost to follow up before the diagnosis of ADHD was ruled out. Also, at the time this abstract was written, several patients were identified as “possibly” or “probably” having ADHD but the diagnosis was not yet confirmed. Over 95% of patients with ADHD had one or more comorbid psychiatric disorders. Higher psychiatric comorbidity contributed to a delay in diagnosing ADHD. Conclusions: These findings suggest the diagnosis of ADHD may be underrepresented among veterans in outpatient mental health clinics. This could have important prognostic and treatment implications. Therefore, it is reasonable to recommend that all veterans seen in mental health clinics be evaluated for ADHD. Diagnostic ambiguity due to overlap of symptoms between ADHD and other psychiatric disorders is one of several factors that contribute to the challenge of diagnosing ADHD in veterans.

SCR02-2

ADULT ATTENTION DEFICIT/HYPERACTIVITY DISORDER AND ANXIETY DISORDERS: PREVALENCE IN A CLINICAL SAMPLE

Chair: Michael Van Ameringen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be

able to: 1) Participants will become familiar with the prevalence of ADHD in an anxiety disorders clinic population; 2) Participants should gain an understanding of the relationship between comorbid anxiety, mood and other psychiatric disorders in anxiety disorders clinic patients who have ADHD as compared with those who do not; 3) Participants should gain an understanding of the impact of a diagnosis of ADHD on functional impairment in anxiety disorders.

SUMMARY:

OBJECTIVES: Adult Attention Deficit Hyperactivity Disorder (ADHD) is a lifelong, chronic disorder, affecting 8.1% of the community. ADHD appears to be highly comorbid with other psychiatric disorders, however little is known about the prevalence of ADHD in anxiety disorder clinical samples. **METHOD:** Consecutive patients referred to an anxiety disorders clinic in Hamilton Canada, completed the Adult ADHD self-report scale and assessed with a Structured Clinical Interview for DSM-IV, and the ADHD module of the Mini International Neuropsychiatric Interview (MINI). **RESULTS:** Of the 264 patients, the rate of lifetime ADHD was 37.5 % (48.5% male, 51.5 % female, $p < .05$). ADHD was significantly associated with a primary diagnosis of impulse control disorder and bipolar disorder, and most commonly associated with social phobia (57.6%, NS) and Major Depressive Disorder (56.6%, NS). Those with ADHD had a significantly higher number of comorbid disorders than those without ADHD, (3.8 ± 1.8 vs. 3.1 ± 1.5 , $p < .001$). Symptom severity measure scores on the Padua Inventory, Yale-Brown Obsessive Compulsive Scale ($p < .05$), Sheehan Disability Scale (SDS) ($p < .05$), Anxiety Sensitivity Index (ASI) ($p < .05$), the QUIDS depression rating scale ($p < .001$), the Penn State Worry Questionnaire ($p < .05$) and the Davidson Trauma Scale ($p < .001$) were significantly higher in the ADHD group. Individuals with ADHD, plus comorbid generalized anxiety disorder, had higher Clinical Global Impression Severity Scores (CGIS) ($p < .05$) and those with ADHD and comorbid panic disorder with agoraphobia had higher CGIS, SDS and Quality of Life and Enjoyment Scale scores ($p < .001$). High ADHD severity (defined by symptom count on the MINI), was associated with a higher number of lifetime comorbid diagnoses ($p < .05$), and higher scores on the CGIS, QUIDS and ASI. Males were more likely than females to have received ADHD treatment in the past. Seventy-six percent (75/99) of those diagnosed with Adult ADHD on the MINI had never received the diagnosis previously, and 17.2% had received ADHD treatment in the past. Of the patients who had received previous ADHD diagnoses, 25% were diagnosed in childhood. **CONCLUSIONS:** The prevalence of lifetime ADHD was higher in our anxiety disorders clinic sample than that found in the general population. Individuals with ADHD had more severe OCD, depressive, generalized anxiety, and disability symptoms than those without ADHD. Despite meeting DSM-IV

criteria for lifetime ADHD, most patients in this sample had never been diagnosed or treated. The presence of comorbid ADHD appears to have a significant impact on the severity and impact of comorbid anxiety disorders.

SCR02-3

DURATION OF ACTION OF LISDEXAMFETAMINE DIMESYLATE IN CHILDREN AND ADOLESCENTS WITH ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Chair: David R Coghill, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the duration of therapeutic action throughout the day of the prodrug stimulant lisdexamfetamine dimesylate in alleviating the symptoms of ADHD in children and adolescents.

SUMMARY:

Objective: To evaluate the duration of therapeutic action throughout the day of lisdexamfetamine dimesylate (LDX), the first longacting, prodrug stimulant therapy for attention deficit/hyperactivity disorder (ADHD), on symptoms and behaviors in children and adolescents with this disorder. **Methods:** This randomized, doubleblind, placebocontrolled trial of an optimized daily dose of LDX (30mg, 50mg or 70mg) was conducted in children and adolescents (6–17 years of age) with ADHD at 48 sites in the European Union. The trial consisted of a 4week dose optimization period followed by a 3week dose maintenance period. An abbreviated version of the Conners' Parent Rating Scale – Revised (CPRS–R) was used to assess the duration of therapeutic action of LDX, with assessments made in the morning (10:00), early afternoon (14:00) and early evening (18:00), following a single early morning dose of LDX (approximately 07:00). Osmotic release oral system methylphenidate (OROSMPH) was included in the study as a reference arm. **Results:** Of 336 randomized patients, 317 were included in the full analysis set (LDX, n=104; placebo, n=106; OROSMPH, n=107) and 196 patients completed the study. At baseline, mean (SD) CPRS–R total scores were similar across treatment groups: LDX, 50.9 (16.4), n=100; placebo, 53.0 (15.7), n=102; OROSMPH, 51.4 (17.5), n=102. At endpoint, the mean (SD) change from baseline in CPRS–R total score for LDX was –24.9 (17.8) and for placebo was –5.0 (13.3). The difference in leastsquares (LS) mean change from baseline (95% confidence intervals [CI]) between LDX and placebo (–21.3 [–25.5, –17.0]) was statistically significant ($p<0.001$). The difference in LS mean change from baseline (95% CI) between LDX and placebo was also statistically significant ($p<0.001$) in the morning (–21.5 [–25.8, –17.1]), early

afternoon (–22.1 [–26.7, –17.6]) and early evening (–21.2 [–25.8, –16.5]) and effect sizes (the difference in LS mean change between active drug and placebo divided by the root mean square error) were maintained throughout the day (morning, 1.424; early afternoon, 1.411; early evening, 1.300). In the OROSMPH reference arm, the mean change from baseline in CPRS–R total score at endpoint was –19.1 (20.5) and difference between OROSMPH and placebo in LS mean change from baseline was statistically significant (–15.1 [–19.3, –10.9], $p<0.001$). Differences in LS mean changes from baseline in the morning (–15.6 [–20.0, –11.2]); early afternoon (–15.3 [–19.7, –10.9]) and early evening (–15.0 [–19.7, –10.3]) were also significant ($p<0.001$ at all time points). Effect sizes for OROSMPH were 1.036 in the morning, 0.976 in the early afternoon and 0.922 in the early evening. **Conclusion:** Improvements versus placebo in ADHD related symptoms and problem behaviors in children and adolescents receiving a single early morning dose of LDX were maintained throughout the day until early evening (18:00). Clinical research was funded by Shire Development Inc. Biological.

SCIENTIFIC AND CLINICAL REPORT SESSION 03

STUDIES OF BRAIN FUNCTIONING

SCR03-1

BRAIN DERIVED NEUROTROPHIC FACTOR MODERATES EFFECTS OF JOB STRESS ON THE SEVERITY OF ALCOHOL DRINKING IN KOREAN 20S OFFICE WORKERS

Chair: BoAh Kim, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Stressors were highly predictive of alcohol uses, because alcohol uses were considered to reduce the negative impact of events arising in social roles; 2) In biological aspect, brain derived neurotrophic factor (BDNF) is implicated in susceptibility to depression via its indirect moderation of the effects of stress; 3) In recent years, BDNF as a moderator of diverse environmental influences, with individuals homozygous for BDNF methionine alleles being more vulnerable to stress.

SUMMARY:

Methods: We tested whether the association between job stress and severity of alcohol drinking would be moderated by the BDNF Val66Met polymorphism in Korean subjects. We hypothesized that individuals homozygous for BDNF methionine alleles would be more susceptible and therefore more affected by both low and high job stress than those carrying the valine allele. 133 Korean subjects (mean age

28.2 ± 1.1) were investigated about severity index of drinking and job stress through a self-reported questionnaire and genotyped for rs 6265 at nucleotide 196(G/A), which produces an amino acid substitution at codon 66 (Val66Met). Results: There was no significant relationship between job stress and severity of alcohol drinking. Although BDNF polymorphism was not significantly associated with severity of alcohol drinking, there was a significant gene x environment interaction. Individuals homozygous for BDNF methionine alleles were more severe in alcohol drinking when job stress was high, less severe in alcohol drinking when job stress was low ($F=4.47$, $p=0.038$). Also higher level of job stress was associated with higher severity of alcohol drinking in homozygous for BDNF methionine alleles ($B=.411$, $p=.002$). These results were associated only in men. Conclusion: The interaction between BDNF genotype and job stress was significant in men homozygous for BDNF methionine alleles. Findings of a significant gene x environment interaction were supportive of a vulnerability model, with individuals homozygous for BDNF methionine alleles being more vulnerability to adverse environmental influences.

SCR03-2

SIGNIFICANT ASSOCIATION BETWEEN IQ AND DEGREE OF OVERALL CORTICAL GYRIFICATION

Chair: Venkataramana Bhat, M.D.

EDUCATIONAL OBJECTIVES

At the conclusion of this session, the participant should be able to: 1) Identify that, Index of gyrification (GI) calculated over the whole brain is significantly correlated with Full Scale IQ when corrected for total brain volume and surface area; 2) Impact of GI on IQ could stem from the fact that gyrification is driven by underlying patterns of neural connections; 3) Exploration of this significant association would be relevant in the setting of Psychiatric disorders associated with significant alterations in IQ.

SUMMARY:

Objective: The cortical patterns of gyri and sulci greatly increase surface area of the brain and have been shown to be driven by hydrostatic pressures of neuronal connections. Thus, increased degree of cortical gyrification likely reflects an increase number of neuronal connections and hence, possibly greater potential for the creation of complex network of neurons within the cortex. The objective of this study was to examine the association between cortical gyrification, calculated over the whole brain (Gyrification Index: GI) and Intelligence Quotient (IQ). **Method:** This study was done as part of The NIH MRI Study of Normal Brain Development, which is a multicentre project that

aims to establish a normative database of longitudinal brain development in relation to behavior. Among the 431 healthy subjects aged between 4 to 18 recruited across the United States using a populationbased sampling method to reduce selection bias, 197 subjects had the relevant IQ and brain imaging data available and passed quality control of imaging data. The Wechsler Abbreviated Scale of Intelligence was administered to children in order to obtain IQ estimates (Full Scale IQ: FIQ, Verbal IQ:VIQ, Performance IQ: PIQ). Automated software at the McConnell Brain Imaging Centre was used to calculate the Gyrification patterns of the left and right hemispheres and to obtain an index of general gyrification across the brain. A univariate general linear model was carried out for each ID scale with GI as the independent variable, total brain volume (TBV) and surface area (TSA) as covariates. Results: The study had 197 females and 90 males. There were no significant differences in the demographic parameters (race, handedness, socioeconomic status, gender) between the initial 431 subjects and the final 197 subjects except for age which was slightly higher in the 197 subjects ($11.7 \pm .23$ vs. $10.3 \pm .19$). GI was significantly associated with FIQ ($F=5.22$, $df=192$, $p=0.02$) and with PIQ ($F=6.77$, $df=192$, $p=0.01$) but not with VIQ ($p=0.20$). Conclusions: The results show a strong association between GI and FIQ. This could be due to the potential for a greater number of neurons as well as diversity in neural networks with increased GI. However, the fact that GI affects PIQ but not VIQ could mean that specific neural networks might be more affected than the others. It would be interesting to explore if the significant association holds during longitudinal brain development. Finally, the impact of GI would be important to study in the setting of psychiatric disorders which affect IQ. Research Funding: National Institutes of Health.

SCR03-3

IMPAIRED SEMANTIC OBJECT RECALL FROM FEATURES IN SCHIZOPHRENIA AND BIPOLAR DISORDER

Chair: Sharna Jamadar, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the object recall from features (ORF) process that previous studies suggest is impaired in schizophrenia; 2) Indicate that individuals with bipolar disorder and schizophrenia show abnormal performance and fMRI activity relative to healthy controls during an ORF task; 3) Indicate that abnormal fMRI activity during ORF is related to symptomatology in schizophrenia but not bipolar disorder.

SUMMARY:

Semantic representations at the object and feature level are encoded separately. The object recall from features (ORF) process is triggered when a set of features that combines to activate a previously stored semantic object representation (e.g. 'honey' and 'stings' activate the object 'bee'). Individuals with schizophrenia (SZ) overrecall objects from features (i.e. combining nonrelated features to retrieve an object) and both over and underactivate different cortical regions responsible for ORF (Assaf et al., 2005, 2006). In this study, we extend previous findings in a larger sample and also examine whether this effect is apparent in another psychotic illness, bipolar disorder (BP). Participants [n=239, healthy controls (HC)=133 (mean age 32yrs SE 1.05, 68 male, full scale IQ (FSIQ)=108), SZ=74 (mean age 36yrs, SE 1.4, 59 male, FSIQ=98), BP=32 (mean age 36yrs, SE 2.1, 15 male, FSIQ=105)] completed the ORF (92 trials, 46 'recall', 46 'norecall') task while undergoing fMRI scanning. We examined reaction time (RT) and accuracy outcomes, and fMRI activity for Recall vs. NoRecall (threshold $p < .05$ FWE corrected, $k=5$ voxels). RT for hits was significantly faster than misses, and recall trials were performed faster than norecall trials (both $p < .001$). The significant group effect ($p < .001$) was attributable to faster performance of HC vs. SZ and HC vs. BP (Tukey's HSD $ps < .002$); there was no significant RT difference between SZ and BP ($p = .16$). Recall trials were performed more accurately than norecall trials ($p < .001$); the significant effect of group ($p < .001$) was attributable to better accuracy in HC vs. SZ and BP vs. SZ (Tukey's HSD $ps < .04$) with no significant difference between HC & BP ($p = .16$). Recall vs. NoRecall trials activated a distributed frontoparietotemporal network consistent with previous studies. The main effect of group showed significant activity in bilateral inferior parietal lobule (IPL) that remained significant after accounting for group differences in age, gender and FSIQ. Tukey's HSD revealed that fMRI activity was larger in HC vs. SZ and HC vs. BP ($ps < .014$) with no difference between SZ and BP ($p > .05$). Activity in right IPL was positively related to positive symptoms and formal thought disorder (FTD) in SZ ($r = .328, .312$ respectively) but not BP. Thus SZ and BP showed impaired performance on the ORF task relative to HC. HC showed the fastest and most accurate performance, SZ showed the slowest and least accurate performance with RT and accuracy for BP falling between HC and SZ. This pattern was also obtained in fMRI: HC showed highest activation in bilateral IPL, followed by BP, with SZ showing the least activation in these regions. fMRI activity in the IPL was related to positive symptoms and FTD in SZ only, suggesting that the relationship between impaired semantic object retrieval from features and positive symptoms/FTD is specific to schizophrenia and not common across psychotic illness.

SCIENTIFIC AND CLINICAL REPORT SESSION 03

BIPOLAR DISORDERS PART 2

SCR04-1

THE CLINICAL DEMOGRAPHICS OF THE MAYO CLINIC BIPOLAR DISORDER BIOBANK

Chair: Manuel E. Fuentes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To quantify the initial clinical demographics of patients who have participated in the Mayo Clinic Bipolar Disorder Biobank; 2) To understand the utility of a genetic biobase for bipolar disorder; 3) To learn about the process of construction of the Mayo Clinic Bipolar Disorder Biobank.

SUMMARY:

Introduction: The identification of genetic risk factors associated with disease onset can potentially lead to early diagnosis and interventional treatment. This is particularly important in bipolar disorder as onset of any treatment is often delayed by more than a decade, and those with the earliest presentations have some of the poorest outcomes controversies surrounding diagnosis. Additionally, the identification of pharmacogenomic predictors of treatment response could provide greater selectivity to treatment recommendations, early interventions, or future drug development via low cost genotyping. The Bipolar Biobank has been developed by a collaborative network (Mayo Clinic, Austin Medical Center – Mayo Health System, Lindner Center of Hope and University of Minnesota) **Methods:** The clinical phenotype is currently being identified by two research instruments: The Structured Clinical Interview for DSMIV (SCID, Module D: Lifetime Mood) and the Bipolar Biobank Clinical Questionnaire (BiBCQ). The BiBCQ recorded past illness variables, past treatments and demographics variables and it is useful for genotype/phenotype studies and retrospective pharmacogenomic probe studies. Venipuncture was performed using standard techniques. 45 mL of blood was collected from each subject. Blood was drawn into two 10mL EDTA tubes, one 10mL noadditive serum tube, one 10mL sodium heparin tube, and one 4.5mL sodium citrate tube. All tubes were labeled with a study identifier, collection date, and time of draw. After collection, samples were electronically accessioned at the Biospecimens Accessioning Processing (BAP) Shared Resource at the Mayo Clinic Advanced Genomics Technology Center (AGTC). These samples were undergo subsequent fractionation, DNA extraction, analysis, and storage. **Results:** The general demographic and illness characteristics were similar to those in many bipolar samples and epidemiological surveys. The sample size is, at the moment, 533 patients. The majority were women (54.4%) the mean age was 43.8 years, 56% were unemployed, 97.1% were white Caucasian.

The most common diagnosis were Bipolar I (72.4%) and Bipolar II (18%), the most common recent episode was depression (42.1 % for BIP1 and 57.64% for BIP2). There was a 5.7% of mania induced by antidepressants, 55.9% of the patients exhibited rapid cycling and 19.9% ultrarapid cycling. The more common comorbidities were general anxiety disorder (42.8%), nicotine dependence and alcohol abuse (36.9/35.7%) and panic disorder (31.6%). Conclusion: The onset of a Bipolar biobank could be an important tool for future clinical, genetic and epidemiological analysis. The clinical and demographics characteristic will be important phenotypes to quantify prior to genomic studies.

SCR04-2

DIAGNOSTIC STABILITY OF DSMIV CLINICAL DIAGNOSIS OF BIPOLAR DISORDER

Chair: Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Compare rates of diagnostic stability in BP to stability in MDD, SA, and SZ, 2) describe the patterns of change in diagnosis for the BP group; 3) Discuss the variables associated with BP diagnostic stability.

SUMMARY:

Objective: Stability of DSMIV diagnoses is of clinical and research interest. This study examined a large sample of inpatients with a clinical diagnosis of bipolar disorder (BP) to (1) determine the proportion subsequently diagnosed BP (diagnostic stability), (2) compare BP diagnostic stability to that for major depressive disorder (MDD), schizoaffective (SA) and schizophrenia (SZ), and (3) identify variables associated with BP diagnostic stability. **Method:** The sample was consecutive inpatient discharges 2000-2010, age 18-60, with a diagnosis of BP (n=1363), MDD (n=2876), SA (n=2150) or SZ (n=1413) who were rehospitalized within 6 months of discharge. "Stability" was defined as having the same diagnosis at discharge from both the index hospitalization and the readmission hospitalization. Demographic and treatment variables associated with BP stability were identified with stepwise logistic regression. **Results:** Diagnostic stability in MDD, SA and SZ was significantly greater than in BP (80.8%, 86.3%, and 85.5%, respectively, vs. 75.3%, $p < .001$). Diagnosis of BPI was more stable than BPII (53.1% vs. 34.8%, $p < .001$); diagnosis of BP manic was more stable than BP depressed or mixed (55.0% vs. 25.35%, $p < .001$). Within the category "BP Disorder" change in diagnosis was most often to BP "other" (BP NOS and BPI Most Recent Episode Unspecified, 17.734.6%). Likelihood that the readmission diagnosis continued to be a BP diagnosis was increased in patients who were female (OR=1.44),

white (OR=1.85) or BPI at index hospitalization (OR=2.61). A change to a nonBP diagnosis was most commonly to SA (10.1%) or MDD (7.4%) and rarely to SZ (1.5%). Change from BP to SA was associated with a prescribed antipsychotic (OR=2.152.87) and LOS > 10 days (OR=1.65). Of those with a diagnosis change to MDD, 52.5% (n=53) were readmitted within one month of index discharge and 38.6% (n=39) had psychotic features at index; this change in diagnosis was significantly more likely in patients with BPII (12.9%) and BP "other" (10.8%) vs. those with BPI Depressed (4.4%), BPI Mixed (4.5%) and BPI Manic (1.4%, $p < .05$). **Conclusions:** Diagnostic stability for this BP sample was significantly lower than for MDD, SA, and SZ samples drawn from the same facility and lower than reported in prior studies. The increased likelihood of a change in diagnosis to SA in those with a longer LOS and in those prescribed antipsychotics suggests that this subset had more difficult to treat symptoms and/or more complex presentations; a similar conclusion could be drawn about the subset readmitted with MDD. This study identified a number of predictors of diagnostic stability relevant to planning for DSMV and to future research.

SCR04-3

SHOULD THE DIAGNOSTIC CRITERIA FOR BIPOLAR DISORDER BE BROADENED?

IMPLICATIONS FROM LONGITUDINAL STUDIES OF SUBTHRESHOLD CONDITIONS

Chair: Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be familiar with the results of longitudinal studies examining the prognostic significance of subthreshold bipolarity for future manic or hypomanic episodes; 2) Be aware that diagnoses based on DSM diagnostic criteria are associated with false positive and false negative results; 3) Be familiar with the arguments supporting and refuting recommendations to expand the threshold to diagnose bipolar disorder.

SUMMARY:

Background: DSMIV is a categorical system that provides descriptive diagnostic criteria for psychiatric syndromes. These syndrome descriptions are imperfect representations of underlying disease entities; thus, the criteria could be conceptualized as a type of test for the pathophysiologicalydefined illnesses. Accordingly, as with any other diagnostic test, diagnoses based on DSMIV produce some false positive and some false negative results. That is, some patients who meet the criteria will not have the illness (i.e., false

positives), and some who do not meet the criteria because their symptoms fall below the DSMIV diagnostic threshold will have the illness and incorrectly not receive the diagnosis (i.e., false negatives). In this context, I consider the controversy over whether the diagnostic threshold for bipolar disorder should be lowered. **Methods:** Longitudinal studies of the prognostic significance of subthreshold bipolar disorder are reviewed. **Results:** Subthreshold bipolarity is a risk factor for the future emergence of bipolar disorder, but the majority of individuals with subthreshold bipolarity do not develop a future manic or hypomanic episode. **Conclusions:** The diagnostic threshold for bipolar disorder should not be lowered for 4 reasons. First, the results of the longitudinal studies suggest that lowering the diagnostic threshold for bipolar disorder will result in a relatively greater increase in false positive than true positive diagnoses. Second, there are no controlled studies demonstrating the efficacy of mood stabilizers in treating subthreshold bipolar disorder. Third, if a false negative diagnosis occurs and bipolar disorder is underdiagnosed, diagnosis and treatment can be changed when a manic/hypomanic episode emerges. And fourth, if bipolar disorder is overdiagnosed, and patients are inappropriately prescribed a mood stabilizer, the absence of a future manic/hypomanic episode would incorrectly be considered evidence of the efficacy of treatment, and the unnecessary medications that might cause medically significant side effects would not be discontinued.

SCR04-4

MISUSE OF THE MOOD DISORDERS QUESTIONNAIRE AS A CASEFINDING MEASURE AND A CRITIQUE OF THE CONCEPT OF USING A SCREENING SCALE FOR BIPOLAR DISORDER

Chair: Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the conceptual problem with using a screening scale for bipolar disorder in mental health settings; 2) Recognize how inappropriate conclusions have been drawn regarding the prevalence, morbidity, and diagnostic underrecognition of bipolar disorder in studies that rely on the MDQ as a diagnostic proxy; 3) Recognize the different needs of psychiatrists and primary care providers regarding bipolar screening.

SUMMARY:

Background: Underrecognition of bipolar disorder is common and incurs significant costs for individuals and society. Clinicians are often encouraged to use screening instruments to help them identify patients with the disorder. The Mood Disorder Questionnaire (MDQ) is the most widely

studied measure for this purpose. Some studies, however, have used the MDQ as a casefinding instrument rather than a screening scale. Such inappropriate use of screening scales risk distorting perceptions about many facets of bipolar disorder, from its prevalence to its consequences. **Method:** Studies using the MDQ are reviewed to identify those reports that have used the scale as a casefinding measure rather than a screening scale. **Results:** Multiple studies were identified in the bipolar disorder literature that used the MDQ as a diagnostic proxy. Consequently, the findings were misinterpreted because of the failure to make the distinction between screening and casefinding. **Conclusions:** Inappropriate conclusions have been drawn regarding prevalence, morbidity, and diagnostic underrecognition of bipolar disorder in studies that rely on the MDQ as a diagnostic proxy. A conceptual critique is offered against the use of self-administered screening questionnaires for the detection of bipolar disorder in psychiatric settings.

SCIENTIFIC AND CLINICAL REPORT SESSION 05

BIPOLAR DISORDERS PART 1

SCR05-1

IS ANTIDEPRESSANT USE IN BIPOLAR DISORDER ASSOCIATED WITH HIGHER READMISSION RATES?

Chair: Megan J. Ehret, Pharm.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the relevance of these findings to current prescribing guidelines for the treatment of BP; 2) Discuss the controversy about the use of antidepressant in BP I; 3) Discuss the risk of inducing mania with the use of antidepressants.

SUMMARY:

Objective: Given the current controversy about the use of antidepressants (AD) in the treatment of bipolar disorder (BP), the authors examined hospitalized patients (pts) with a diagnosis of BP I or II to determine the (1) proportion for whom AD were prescribed at discharge from the index admission, (2) readmission rates at 1, 3, and 6 months in AD vs. non AD treated pts, and (3) demographic and clinical features associated with readmission and with AD use. **Methods:** The sample was consecutive inpatient admissions aged 18-60 discharged 2/0012/10 with a diagnosis of BP I, current episode depressed (n=357) or BP II (n=592). Demographics, codiagnoses, psychotropics at discharge, and time to readmission were recorded. Variables associated with readmission were identified with stepwise logistic regression. Chisquare analysis and ttests were used to com-

pare demographic and clinical features of BP I to BP II pts and to characterize those treated with AD versus not. Results: The sample consisted of 592 (62%) BP II subjects and 357 (38%) BP I subjects. Significantly more BP II pts were white ($p < 0.001$) and had borderline personality disorder (BPD) ($p < 0.005$), BP I pts were more likely black ($p = 0.05$) and Latino ($p < 0.001$). There was no difference in AD prescribing for BP I ($n = 272$, 76.2%) vs. BP II ($n = 457$, 77.2%), or mood stabilizer (MS) prescribing for BP I ($n = 281$, 78.7%) vs. BP II ($n = 457$, 77.2%). Pts with BP I were readmitted more frequently than BP II pts at 1 month (18.2% vs. 10.0% $p < 0.001$), 3 months (29.1% vs. 16.9% $p < 0.001$), and 6 months (38.1% vs. 22.3% $p < 0.001$). There was no significant difference in readmission rates between AD and nonAD treated patients at any time point in either BP I or II pts. Regression analyses revealed that those readmitted at 1 month were more likely to have a diagnosis of BP I (OR=1.9) or to be on a first generation antipsychotic (FGA) (OR=1.99); similar ORs were found for readmission at 3 and 6 months. At 6 months, readmission was also associated with index discharge on a benzodiazepine (OR=1.47) and with a BPD codiagnosis (OR=1.62). Conclusions: In this BP inpatient sample, AD use was common in both BP I and II pts but not associated with readmission. That increase in risk of readmission was associated with the use of an antipsychotic or benzodiazepine and with a codiagnosis of BPD suggests that severity/comorbidities may be relevant to these issues. Further research is needed to explore the possibility that subgroups of BP patients are at high risk of readmission especially those with BP I.

SCR05-3

INCREASED LIFE EVENTS IN BIPOLAR II PATIENTS PARTICIPATING IN BIPOLAR BIOBANK

Chair: Mohit Chauhan, M.B.B.S

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Have an enhanced understanding of the occurrence of life events immediately preceding onset of Bipolar Mood Disorder; 2) Understand the concept of epigenetic and the critical piece of standardizing life stressors; 3) Recognize potential bipolar subtype differences in stress and illness.

SUMMARY:

Objective: To quantify positive and negative life events in the year prior to 1st episode and most recent episode for patients with Bipolar I or II disorder participating in the Mayo Clinic Bipolar Disorder Bipolar Biobank. **Introduction:** Gene environment interactions appear to play an important role in onset and course of recurrent unipolar de-

pression (Caspi et al 2003). While the role of early psychosocial stressors (i.e. early childhood trauma) in the onset of bipolar illness has been reported (Leverich et al 2002), few studies have examined the role of more immediate stressors in triggering mood episodes, or quantifying stressors at critical points of illness expression as a surrogate marker for epigenetic analyses. **Methods:** Subjects enrolled in the Mayo Clinic Bipolar Disorder Biobank provided informed consent for DNA repository. Clinician, including structured diagnostic interview, and patient questionnaires about diagnosis and life stressors were completed. The mean numbers of positive and negative stressors, endorsed with at least mild severity, were analyzed in the first year prior to illness and the year preceding most recent episode by gender and bipolar subtype pattern. **Results:** The demographics of the first 475 subjects (55% women) analyzed had a mean age of 44 ± 16 years with 91% self reporting Caucasian race. 381 (78%) had diagnosis of Bipolar Type I, 96 (20%) had Bipolar II and 11 (2%) had Schizoaffective Disorder. There was no significant difference in the mean age, gender and racial distribution amongst the diagnostic groups. The mean number of stressors in the first year of illness were significantly different for bipolar I vs. II disorder. Subjects with Bipolar Disorder II reported significantly higher number of positive and total life events but negative life events were not significantly different between the two groups. There was no significant difference in negative, positive or total number of life events either during first or current episode by gender. **Conclusion:** It is increasingly recognized that life stressful events will be an important concept in bipolar illness onset, course, and triggers for acute destabilization. These data would suggest greater report of these stressful life events in bipolar II vs. bipolar I disorder. This will have clear epigenetic implications that warrant further study.

SCIENTIFIC AND CLINICAL REPORT SESSION 06

BORDERLINE PERSONALITY DISORDER, DIAGNOSTIC ISSUES

SCR06-1

IS DIMENSIONAL SCORING OF BORDERLINE PERSONALITY DISORDER ONLY IMPORTANT FOR SUBTHRESHOLD LEVELS OF SEVERITY?

Chair: Mark Zimmerman, M.D

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be aware of the categorical versus dimensional debate regarding the classification of personality disorders; 2) Be aware that dimensional ratings are more strongly associated measures of psychosocial morbidity for patients who do not have borderline personality disorder than for

patients who meet the DSMIV diagnostic threshold; 3) Be aware that for individuals with borderline personality disorder the number of criteria met are not associated with indices of psychosocial morbidity and therefore do not represent a valid method of quantifying the severity of borderline personality disorder.

SUMMARY

Studies comparing dimensional and categorical representations of personality disorders (PDs) have consistently found that PD dimensions are more reliable and valid. While comparisons of dimensional and categorical scoring approaches have consistently favored the dimension model, two reports from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project have raised questions as to when dimensional scoring is important. In the first study, Asnaani and colleagues (2007) found that once the diagnostic threshold for borderline PD was reached the number of criteria met was not significantly associated with indices of psychosocial morbidity. In the second study, Zimmerman and colleagues (in press) found that patients with 1 criterion of borderline PD had significantly more psychosocial morbidity than patients with 0 criteria. The findings of these two studies suggest that dimensional ratings of borderline PD may be more strongly associated with indicators of illness severity for patients who do not versus do meet the DSMIV criteria for borderline PD. In this third report from the MIDAS project, we tested this hypothesis in a study of 3,069 psychiatric outpatients evaluated with semistructured diagnostic interviews. In the patients without borderline PD the number of borderline features was significantly associated with each of 6 indicators of illness severity, whereas in the patients with borderline PD 3 of the 6 correlations were significant. The mean correlation between the number of borderline PD criteria and the indicators of illness severity was nearly three times higher in the patients without borderline PD than the patients with borderline PD (0.23 versus 0.08), and 4 of the 6 correlation coefficients were significantly higher in the patients without borderline PD. These findings suggest that dimensional scoring of borderline PD is more important for “subthreshold” levels of pathology and are less critical once a patient meets the diagnostic threshold. The implications of these findings for DSM5 are discussed.

SCR06-2

DISTINGUISHING BIPOLAR II AND BORDERLINE PERSONALITY DISORDER: A REVIEW OF CURRENT LITERATURE

Chair: Katy Crow

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the current issues in the debate over whether BPD is distinct from the bipolar spectrum or not; 2) Understand the similarities and differences between BPD and BPII; 3) Understand the clinical implications of misdiagnosis of these two disorders.

SUMMARY:

A review of the literature on the relationship between bipolar II disorder (BPII) and borderline personality disorder (BPD) reveals two distinct polarities – that BPD is part of the bipolar spectrum and an extension of an affective disorder, or that BPD is not associated and is distinct from the bipolar spectrum, specifically BPII (Benazzi 2006, 2008). Some researchers have suggested that the relationship is not quite so black and white and that there are certainly some overlaps between the disorders that contribute to high comorbidity rates (Henry et al. 2001) and misdiagnosis between the two disorders (Ruggero et al. 2010). These factors hold significant clinical implications, as BPII and BPD require different treatments to see improvement. BPII treatment relies heavily on pharmacologic interventions while BPD treatment relies heavily on psychosocial interventions with a much lighter emphasis on medication (Stone 2006). Perhaps these two disorders have similar etiologies and significant overlap in family histories, but they may not be as significantly associated as has been suggested. Affective dysregulation appears to be a trait found in both disorders, but the quality of this trait may be distinct but difficult to define, especially in clinical settings (Henry et al. 2001, Benazzi 2006). John Gunderson, MD (2010) and others working together to help redefine the BPD diagnosis for DSMV have suggested changing the symptom “affective dysregulation” to “negative emotionality” characterized by chronic dysphoria. Currently in the literature on this subject, many researchers have identified that affective dysregulation is found in BPII and BPD and contributes to the perceived association between the two disorders. However, affective dysregulation has an angry and aggressive quality in BPD that is not found in BPII. Changing the language from “affective dysregulation” to “negative emotionality” in the DSMV may help strengthen the distinct nature of BPD from bipolar disorders and help clinicians in making differential diagnoses, increasing efficacy of treatment for both disorders.

SCR06-3

BORDERLINE PERSONALITY DISORDER AND ATYPICAL DEPRESSION: CONTROVERSIES AND CONVERGENCES

Chair: Ana Marie Rodriguez Villa

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the two distinct theories represented in the literature that differently answer the question: do borderline personality disorder and atypical depression share core temperamental characteristics or is BPD best understood as a heterogeneous syndrome? While current literature proposes differing and absolute answers to this question, perhaps the relationship between BPD and AD is more nuanced; 2) Recognize the similar clinical presentations of both BPD and AD and how the shared characteristics of both borderlines and atypical depressives can lead to misdiagnosis and ineffective treatment; 3) Understand that borderline personality disorder has demonstrated a unique and heterogeneous responsiveness to medication. Further research is needed to elucidate the importance of distinct disorders to treatment outcome and to more clearly define the similarities and dissimilarities of BPD and AD.

SUMMARY:

Borderline Personality Disorder and the subtype of MDD, Atypical Depression, are both characterized by mood reactivity and interpersonal sensitivity. Minimal research has attempted to address their similarities and outline the discrete differences of these disorders. The understanding of BPD and AD as either overlapping or distinct disorders has great implications for treatment and is therefore of great diagnostic relevance. Major depression in borderlines is common and yet resistant to medication. In fact, improvements in depression are dictated by prior improvements in borderline personality disorder. This literature review aims to provide the reader with a more complete understanding of the similarities and differences of borderline personality disorder and atypical depression. Laboratory, comorbidity and pharmacological studies as well as prior literature analyses have been reviewed in order to outline the scope of existing research and to establish a direction for future inquiry. We believe the articles included completely encompass the scope of existing research and that their summary and analysis will inform diagnostic criteria and emphasize the importance of a clinical distinction.

SCIENTIFIC AND CLINICAL REPORTS

SUNDAY, MAY 6, 2012

SCIENTIFIC AND CLINICAL REPORT SESSION 07

Collaborative Care

SCR07-1

DO PSYCHOPHARMACOLOGISTS SPEAK TO PSYCHOTHERAPISTS ABOUT THEIR MUTUAL PATIENTS? A SURVEY OF PRACTICING CLINICIANS

Chair: Thomas P. Kalman, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define “SplitCare”; recognize other terms for this outpatient treatment arrangement; and understand the variables responsible for its development and popularity ; 2) Discuss the advantages and disadvantages of “SplitCare” as compared to psychotherapy and medication being provided by a single clinician (integrated care model); 3) Describe the results of surveys assessing whether or not communication takes place between professionals participating in splitcare; and consider the relationship between such communication and treatment outcome.

SUMMARY:

The provision of psychotherapy and psychotropic medication by two different professionals (splitcare) has become prevalent in U.S. mental health care delivery, as more Americans receive prescriptions and psychiatrists provide less psychotherapy. Historically, communication between professionals treating the same patient has been an accepted principle of optimal care, but there has been only one formal assessment (presented at the APA, 2010) of whether or not such communication actually takes place in the private sector. This paper supplements the prior survey of psychotherapists with a survey of psychopharmacologists. **SUBJECTS AND METHODS:** An eightitem survey was mailed to practicing psychiatrists in Manhattan and New Jersey. Anonymously completed questionnaires provided data about duration of practice, how many patients were seen in the prior month for medication only, and how many patients were also in psychotherapy with another professional. Frequency of communication with therapists on behalf of these patients and for patients in treatment for six months or longer was assessed. Lastly, information was compiled on which professional more frequently initiated communication. **RESULTS:** Sixtyone psychiatrists, averaging 26.7 years in practice, returned surveys. For all respondents, the total number of medicationonly patients seen in the last full month was 1903, of which 785 (41.25%) were in psychotherapy with another mental health professional. Respondents reported a total of 875 splitcare patients in treatment for six months or longer, with no communication with the psychotherapist being reported on behalf of 24% of these individuals. Respondents indicated that they had initiated 68.4% of the most recent contacts with the other professional, and just 10 of 55 responding psychiatrists reported quarterly communication with their splitcare patients’ psychotherapists for all shared patients. **CONCLUSIONS:** This study confirms the commonality of splitcare and that communication between professionals in such situations is not taking place for many patients. Corroborating the findings of the earlier survey, questions remain both about guidelines for splittreatment and about the importance

of communication between professionals engaged in this therapeutic arrangement.

SCR07-2

ASSESSING THE PRACTICES AND PERCEPTIONS OF DUALYTRAINED PHYSICIANS: A PILOT STUDY

Chair: Gaurav Jain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Know about the current demographics of physicians who are duallytrained in Psychiatry and Internal Medicine (IMP) or Family Medicine (FMP); 2) Find out the current practice information of these physicians; 3) Learn about their perceptions of dualtraining; 4) Know their perceptions about current work and opportunities; 5) Become acquainted about their attitudes toward the field of dual practice.

SUMMARY:

Background and Objective: Combined Psychiatry and Internal Medicine (IMP) or Family Medicine (FMP) training programs are relatively uncommon, and only a few medical students elect to pursue combined training at medical school graduation. One possible explanation for the low numbers of medical graduates pursuing combined training in IMP or FMP is lack of awareness regarding what duallytrained physicians do. This pilot study was conducted to assess the following information from physicians who are duallytrained in: 1) current demographics; 2) practice information; 3) perceptions of training; 4) perceptions of current work; and 5) attitudes toward their field. Methods: An IRBapproved survey with demographic, attitudinal, and experiential questions was distributed at the 2010 Association of Medicine & Psychiatry Conference. Of the 34 eligible duallytrained physicians, 28 (82.4%) returned surveys. Results: The duallytrained physicians surveyed report being generally pleased with their training and current positions (Mean=4.54; SD=0.64; range=3 to 5; mode=5) and expressed similar opinions about their work accomplishments (Mean=4.68; SD=0.55; range=3 to 5; mode=5). The large majority (78%; n=21) report working in academic settings with multiple practice responsibilities. They provide care to complex medically and psychiatrically ill patients but are unsatisfied with systemic limitations in the current healthcare environment which prevent them from fully utilizing their dual training. A large majority of respondents (92.5%; n=26) reported that, if they had to choose again, they would choose a combined training program. Limitations: Our study population is small and was drawn from conference attendees. As such, we cannot draw conclusions about differences between IMP and FMP physicians, nor

can we assess differences by training pattern (sequential vs. combined). In May 2011, the American Board of Medical Specialties reported 419 dualboarded IMP and 241 FMP physicians. We plan to survey these individuals to obtain nationally representative data that better characterizes the range of opportunities available to duallytrained physicians and provides insight into possible areas for improved integration in combined training programs. Conclusions: Overall, this work provides an initial understanding of the roles, satisfaction, and complex mix of Psychiatry and Primary Care practiced by duallytrained physicians. In the face of ongoing healthcare reform, the important role of integrated care and combined training programs should be evident. Creating more opportunities for combined training can be seen as an important priority for patientcentered comprehensive care models and should be encouraged. The combined training can lead to a fulfilling and worthwhile career.

SCR07-3

CHARACTERISTICS OF PATIENTS ENROLLED IN A COLLABORATIVE CARE PILOT FOR PATIENTS WITH CHRONIC MEDICAL ILLNESS AND DEPRESSION AND/ OR HARMFUL DRINKING

Chair: Henry Chung, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about a Collaborative Care Model to improve care for patients with both chronic medical conditions and depression and/or harmful drinking through integration of onsite and off-site behavioral health services; 2) Understand the opportunities and challenges of implementing such a program in a poor and ethnically diverse urban setting; 3) Have an understanding of how clinically relevant metrics like the PHQ9 and the AUDITC can be used in a treattotarget approach.

SUMMARY:

Background and Objectives: Chronic medical illness and mental disorders are associated with excess morbidity and mortality and are not often addressed in an integrated treatment approach. This pilot project aims to improve clinical outcomes and decrease costs for patients with depression and/or harmful drinking and chronic medical illness (diabetes, CAD, and HF). This presentation will provide a report of our ongoing work as well as our preliminary findings. Method: We identified a cohort of patients who have the conditions of interest and screened them for current depressive and alcohol severity using the PHQ9 for depression and AUDITC for harmful drinking. The integrated model incorporates the activities of a NCQA certified patient cen-

tered medical home with both on site and off site behavioral health and care management services. A social worker therapist, mental health nurse, and psychiatric consultant work with the PCP to develop a treatment plan based on medical and behavioral severity scores and then provide on-site consultation and short term treatment. Off-site care managers provide telephonic medical and behavioral interventions to support the treatment plan. Regular Electronic Medical Record (EMR) case review by a psychiatrist and telephonic psychotherapy by behavioral health clinician are also two additional features of the project. Results: The initial cohort of 268 patients meeting initial criteria identified through EMR have these characteristics: mean age of 63; 56% female 43% male; CAD Diagnosis: in 24.5%, CHF Diagnosis: 14.2%, Diabetes Diagnosis: 74.3%, Depression Diagnosis: 76.5% Alcohol Disorder Diagnosis, 22.8%; mean PHQ 9 of 10.4 indicating moderate depression; and a mean Framingham Risk Score: 20.7% (predictor of major coronary event or death within 10 yrs.) Conclusion: The clinical characteristics of this target population indicate high risk for poor CV outcomes even though the Framingham risk score does not account for depression or harmful drinking. This type of collaborative pilot is an important approach to implement given the national movement towards patient centered medical homes and accountable care organizations as a major method of achieving high quality and lower cost.

SCIENTIFIC AND CLINICAL REPORT SESSION 08

DEPRESSION

SCR08-1

WHY DO SOME DEPRESSED OUTPATIENTS WHO ARE IN REMISSION ACCORDING TO THE HAMILTON DEPRESSION RATING SCALE NOT CONSIDER THEMSELVES TO BE IN REMISSION?

Chair: Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the limitations with the current approach towards defining remission from depression; 2) Be aware that many patients that are in remission according to the Hamilton Depression Rating Scale do not consider themselves to be in remission; 3) Recognize differences between patients in remission according to the Hamilton Depression Rating Scale who do and do not consider themselves to be in remission.

SUMMARY:

Objective: In treatment studies of depression remission is defined narrowly—based on scores on symptom severity scales. Patients treated in clinical practice, however, define

the concept of remission more broadly and consider functional status, coping ability, and life satisfaction as important indicators of remission status. In the present report from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project, we examined how many depressed patients in ongoing treatment who scored in the remission range on the 17-item Hamilton Depression Rating scale (HAMD) did not consider themselves to be in remission from their depression, and amongst the HAMD remitters we compared the demographic and clinical characteristics of patients who did and did not consider themselves to be in remission. Methods: We interviewed 274 depressed outpatients in ongoing treatment. The patients completed measures of depressive and anxious symptoms, psychosocial functioning, and quality of life. Results: Approximately half of the patients scoring 7 and below on the HAMD did not consider themselves to be in remission. The self-described remitters had significantly lower levels of depression and anxiety than the patients who did not consider themselves to be in remission. Compared to patients who did not consider themselves to be in remission the remitters reported significantly better quality of life and less functional impairment due to depression. Remitters were significantly less likely to report dissatisfaction in their mental health, had higher positive mental health scores, and reported better coping ability. Discussion: Some patients who meet symptom-based definitions of remission nonetheless experience low levels of symptoms or functional impairment or deficits in coping ability thereby warranting a modification in treatment. The findings raise caution in relying exclusively on symptom-based definitions of remission to guide treatment decision making.

SCR08-2

EVALUATION OF POSTPARTUM DEPRESSIVE DISORDERS

Chair: Dimitry Ivashinenko, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Analyze postpartum depression prevalence in Tula region, Russian Federation; 2) Study attitude of female with postpartum depression to the psychiatric care; 3) Assess psychopathological structure of depressive disorders combined with obstetrical pathology; 4) To compare characteristic medicosocial properties in patients with PD and healthy women; 5) Find some risk factors which may have influence on depression development in females during postpartum period.

SUMMARY:

Background: Mother's attitude and care influence so much

the child's evolution, especially during the first months of his life. That is the reason why we underline the problem of postpartum depression (PD). We consider that it is of a great importance to determine a group of mothers who has PD signs for further care and treatment. Purposes: 1. to analyze PD prevalence in Tula region (Russian Federation); 2. to study women attitude to the psychiatric care; 3. to assess psychopathological structure of depressive disorders combined with obstetrical pathology; 4. to compare characteristic medicosocial properties in patients with PD and healthy women; 5. to find some risk factors which may have influence on depression development. Materials and methods: The study included 80 women, aged 19-38 years. We held retrospective analysis of 80 obstetric medical cards and labor and delivery records, prospective analysis of 80 developed questionnaires. The last one included some standard methods: Montgomery-Asberg Depression Rating Scale (MADRS), Edinburgh Postnatal Depression Scale (EPDS) and the multidimensional SF36 health status survey questionnaire (SF36). All females were examined in the late postpartum period. The criterion of PD high risk was more than 15 points in MADRS, more than 12 points – in EPDS. Data processing was carried out by methods of the mathematical statistics (software Statistica 7.0 and MS Excel 2003). Results: Among 80 women 14 patients (17.5%) had postpartum depressive disorder. During the research females were divided into the basic group (females with PD, N=14) and control group (healthy women, N=66). Vitality rate ($p=0.001$) and mental health rate ($p=0.03$) were significantly lower in the basic group in comparison with healthy females. The group with PD showed such symptoms as: sleep problems (78.6%), appetite disorders (57.1%), anxiety (64.3%), subjective feeling of regret and sadness (35.7%), wasting (21.4%) and crying (57.1%). 100% females with PD reacted negatively on the suggestion about psychiatric and psychotherapeutic care and treatment. According to the correlation analysis data, abortions in anamnesis ($r=0.35$, $p=0.003$), gynecopathies ($r=0.30$, $p=0.01$), preterm birth ($r=0.35$, $p=0.005$), chronic pyelonephritis ($r=0.24$, $p=0.01$), fetal complications ($r=0.14$, $p=0.001$) increased PD development probability. There was no correlation between postpartum depressive disorders and gestosis. Conclusion: Situation in our region is not satisfactory: PD prevalence is about 17.5%; females with PD had lower health status rates, but didn't want to change this situation.

SCR08-3

LIGHT TREATMENT IN AFRICAN AMERICAN VERSUS CAUCASIAN PATIENTS WITH SEASONAL AFFECTIVE DISORDER

Chair: Hyacinth N. Uzoma, M.B.B.S

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize reduced remission rates in Seasonal affective disorder African American patients, although symptomatic improvement with light treatment is similar as in Caucasian patients; 2) Understand that African American patients with seasonal affective disorder are as compliant with light treatment as their Caucasian counterparts; 3) Consider metabolic factors distinguishing African American and Caucasian patients and potentially contributing to reduced remission rates in African Americans.

SUMMARY:

Background: Our previous work suggested similar rates of seasonal affective disorder (SAD) as previously reported at similar latitudes, but lower awareness of the condition and thus lower likelihood to seek professional help and benefit from largely available and effective treatment options (Agumadu et al 2005). No previous study focused on bright light treatment in African Americans with SAD. We compared adherence and outcome with light treatment in African American versus Caucasian patients with SAD. Methods: 51 African Americans and 27 Caucasians with a diagnosis of recurrent mood disorder with seasonal pattern by a Structured Clinical Interview for DSM-IV were enrolled in an open label study of daily bright light treatment. The trial lasted six weeks, over three winter seasons 2007 – 2010. Treatment started with 60 minutes of daily light therapy in the morning, with duration and timing tailored weekly to response and side effect profile. Outcome measures were remission (score =8) and response (50% reduction) on the Structured Interview Guide for the Hamilton Rating Scale for Depression (SIGHSAD) as well as symptomatic improvement on SIGHSAD and Beck Depression Inventory-II (BDII). Adherence was measured using log journal kept by participants. The two groups were compared using t tests, chi square, linear and logistic regressions. Results: Remission rates in African Americans were significantly lower than in Caucasian patients (African Americans 46.3%; Caucasians 75%; $p = 0.02$). No differences were found in symptomatic improvement, treatment response, or adherence. Conclusions: A lower remission rate with light treatment in African Americans does not appear to be mediated by lower adherence, and requires additional research to identify possible biomarkers acting as mediators of this difference. Differences between race groups in vitamin D, insulin resistance, ghrelin and leptin (as possible mediators of the difference in remission rates) will be analyzed and the results presented during the meeting. A similar adherence, response and symptomatic improvement between race groups support the need to increase awareness of SAD, its diagnosis and its treatment in the African American community.

SCIENTIFIC AND CLINICAL REPORT SESSION 09

DIAGNOSTIC ISSUES**SCR09-1****PATIENTS WITH INTELLECTUAL DISABILITY AND PERSONALITY DISORDERS: CLOSER TO PERSONALITY DISORDERS OR INTELLECTUAL DISABILITY?**

Chair: Regi T. Alexander, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the difficulties in diagnosing personality disorders in people with intellectual disadvantage; 2) Understand the treatment outcomes of people with these conditions who are treated within forensic settings in the UK; 3) How people with both these conditions compare with those with either one of them alone.

SUMMARY:

Within forensic services in the UK, for people with intellectual disability, the prevalence of personality disorders is around 50%. Few studies have systematically examined how patients with both intellectual disability and personality disorders (the IDPD group) differ from either those with an intellectual disability alone (the ID group) or those with a personality disorder alone (the PD group). The study groups were drawn from a database of 1182 discharges from secure intellectual disability services in the UK and were compared on a number of pre and post treatment variables. Findings suggest that within the secure hospital system, those with intellectual disability alone and personality disorder alone are strikingly distinct on most of the examined parameters. The IDPD group had significantly higher scores on the PCL:SV and the HCR20 than both the ID group and the PD group. In terms of outcomes, this group appeared to follow a path closer to those with intellectual disability.

SCR09-2**THE FREQUENCY OF COMORBID AXIS I DIAGNOSIS IN SOCIAL ANXIETY DISORDER PATIENTS**

Chair: Ahment Koyuncu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) The treatment seeking rates are lower in SAD patients. Our patients were primarily diagnosed with SAD and specifically asked for the treatment of SAD; 2) Our study indicates a big population consists of 247 patients; 3) The comorbidity of mood disorder in SAD patients was found 90%.

SUMMARY:

It has been reported that, psychiatric comorbidity was common in Social Anxiety Disorder (SAD) patients. In particular, mood disorders and substance use disorders have been reported frequently. Primary aim of this study is to find the Axis I comorbidity rates of the SAD patients. 247 SAD patients were determined with DSMIV (SCIDI) and comorbidity status of these patients were evaluated. The demographic and clinical data form filled with these patients. Total of 247 patients, 85 patients were female (%34.4), 162 were male (%65.6). The average age was 27.61 ± 6.22 ; the average age of onset of SAD was $13.64 \pm$. 89.9% of the patients had at least one lifetime comorbid disorder, 40.9 % patients had at least two comorbidities, and 10.1 % patients had three comorbidities. The most frequent co morbidity was major depression (current 61.1%, lifetime 74.5%); the frequency of lifetime prevalence of bipolar disorder was 15.4% (2% of bipolar II, 13.4 % of bipolar NOS). Current and lifetime any anxiety disorder additional diagnoses were 21.5% and 27.5% respectively. The most common comorbid anxiety disorder was specific phobia (current or lifetime 14.6%), the others were Obsessive Compulsive Disorder (current 4.9%, 9.3% lifetime), panic disorder (current 3.2%, 6.1% lifetime), Generalized Anxiety Disorder (0.8% current or lifetime), Post Traumatic Stress Disorder (lifetime 4.0%). The lifetime prevalence of substance or alcohol use disorder, eating disorder and somatoform disorder were found 7.7%, 1.2% and 1.2% respectively. 10.1 % of the patients did not have any co morbid disorder. The comorbidity rates especially mood disorders were common in SAD patients. Alcohol, substance use disorder comorbidity rate was less than expected. The reason for this may be cultural differences. The new studies are needed for to investigate the effect of the co morbidity of mood, and alcohol and substance use disorders on SAD clinic and course.

SCR09-3**ASSESSMENT OF MIXED DEPRESSION IN BIPOLAR DEPRESSION UTILIZING A MODIFIED HYPOMANIA CHECKLIST**

Chair: Manuel E. Fuentes, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Better identify and quantify subsyndromal symptoms of hypomania in depression; 2) Learn about the utility of the modified hypomania checklist; 3) Learn about the importance to detect mixed symptoms during a current depressive episode.

SUMMARY:

Introduction: Recent data suggest that mixed depression in bipolar disorder is a common, dimensional, and recurrent phenomenon. The Hypomania Checklist32 is a self-rating questionnaire to assess for lifetime manic/hypomanic symptoms (Angst J. et al 2005) The purpose of this study is to pilot a modification of this scale (mHCL32) to assess for the concurrent prevalence of manic/hypomanic symptoms in patients with current depression. Methods: This IRB multisite study recruits currently depressed in and outpatients from in Mayo Clinic, Bakirköy Hospital, Dokuz Eylül University, and University of Los Andes. Each subject underwent a structured diagnostic interview to confirm unipolar or bipolar depression and completed the Modified Hypomania Checklist (mHCL). Clinical assessment included the Young Mania Rating Scale (YMRS) and the Hamilton Rating Scale for Depression (HAM-D24). Chisquare and Spearman (check spelling) correlations were utilized to assess for differences between diagnostic groups / gender and correlation between the mHCL and HAM-D. Results: In this preliminary analysis of bipolar (n=17) and unipolar (n=11) depressed patients, there was no difference in the mean age or symptom severity as measured by the mHCL and HAM-D. There was a significant correlation between the mHCL and HAM-D (n=17, r=0.6, p=0.02) and trend correlation between YMRS and HAM-D (r=0.44, p=0.07) in bipolar patients that was not identified in unipolar depressed patients (n=11, r=0.17, p=0.6 and r=0.05, p=0.87). Conclusion: The presence of a statistically significant difference in the correlation of mHCL32 and HAM-D24 in bipolar depressed and not in unipolar depressed patients would suggest that the mHCL32 could be a useful tool to detect mild symptoms of mania/hypomania in depressed patients. A larger sample size and future study are further encouraged to assess prevalence of mixed symptoms and generalizability to major depression. Angst J, Adolfsson R, Benazzi F, Gamma A, Hantouche E, Meyer TD, Skeppar P, Vieta E, Scott J. The HCL32: towards a self-assessment tool for hypomanic symptoms in outpatients. *J Affect Disord* 2005; 88: 21733.

SCIENTIFIC AND CLINICAL REPORT SESSION 10

EPIDEMIOLOGY

SCR10-1

IMPROVING ACCESS AND EFFICIENT CARE FOR PATIENTS WITH PSYCHIATRIC ILLNESSES IN AN ACADEMIC TEACHING MEDICAL CENTER

Chair: Michael W. Kaufmann, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the applicability of lean methodol-

ogy to the delivery of psychiatric care in a large regional academic health system; 2) Recognize strategies to improve patient flow without the need for new resources; 3) Describe the access to care improvements in psychiatric programs as a result of as a result of alignments achieved between four quality improvement projects; 4) Learn how to maximize the value of a Department of Psychiatry in a general hospital.

SUMMARY:

We describe a transformation process of four quality improvement projects that Lehigh Valley Health Network (a three hospital system with 889 inpatient beds) has undertaken to improve psychiatric patient flow. We describe four projects 1) Transfer of patients from medical/surgical units to inpatient psychiatry units 2) decreasing length of stay on inpatient psychiatric units 3) decreasing number of tests and laboratory work for patients on inpatient psychiatric units 4) decreasing length of stay by psychiatric patients in the Emergency Department. METHODS: A combination of Lean Methodology and Kotter's eight steps for change were used to develop standardization processes designed to improve access to care. RESULTS: All four projects showed measurable improvements in access to care and efficiency in use of resources in psychiatric as well as medical surgical programs of the Academic Medical Center. CONCLUSIONS: Using a collaborative change paradigm that includes medical specialties in addition to psychiatry, improves psychiatric patient flow resulting in improved cost effective care.

SCR10-2

CHARACTERIZATION OF PERSONS RECEIVING PRIMARY CARE SERVICES IN A MENTAL HEALTH CLINIC

Chair: James R. Shackelford, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Demonstrate knowledge of what a mental health home model is and why it is important; 2) Define the characteristics of psychiatric patients who receive primary care services in the mental health specialty clinic setting; 3) Describe the characteristics of mental health patients that might benefit the most from receiving primary care services in a mental health clinic.

SUMMARY:

Background: Primary Care and Behavioral Health (PCBH) integration is an emerging key to the health reform movement. For mental health conditions, such as depression, collaborative care between the two disciplines improves

both quality and patient outcomes, enhances screening, and promotes cost savings compared to standard treatments. However, despite the advantages of adopting a PCBH integration model, there remains a significant population of persons with serious mental illness (SMI) incapable of negotiating large primary care clinics. This group may be best served in a model of care where they can directly receive primary care in their home specialty mental health clinic. As such, many mental health administrators are collaborating with primary care to develop satellite clinics embedded within the larger specialty mental health clinics. However, few studies have examined whether such clinics reach the target SMI populations needing colocated care. Objectives: This study documents the characteristics of persons receiving medical care in a colocated primary care satellite clinic embedded within a large urban underserved public mental health clinic. This population will be compared to patients receiving only psychiatric services at the same clinic. Methods: Study Design: Retrospective Analysis Study Subjects: Psychiatric outpatients at South of Market Mental Health Clinic in the San Francisco Community Behavioral Health System. Procedures: Electronic and paper records for all patients receiving care at the colocated primary care clinic were reviewed from the medical clinics inception to present. As a comparison, an equal number of randomly selected patients receiving psychiatric services only were reviewed. Demographic, diagnostic, and medication variables were collected. In addition, other patientspecific variables were chosen to determine level of functioning (e.g., ED visits, hospitalizations, IM medications, total cost to system, and presence on the city's highutilization database). Data analysis: Chi Square analyses and ttests will determine differences in demographic, diagnostic, and patientspecific factors associated with increased functional impairments. Results: Since the inception in 2005, 150 clients received care at the colocated primary care clinic. We are currently in data collection phase only. Conclusions: This study aims to characterize the population of patients receiving primary care services in a mental health specialty clinic. A longterm objective is to determine which SMI subpopulations would benefit the most from this mental health care home model.

SCR10-3

NATIONAL TELEMENTAL HEALTH OUTCOMES IN 98,609 PATIENTS

Chair: Linda S. Godleski, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List hospitalization outcome rates following initiation of Telemental Health Services; 2) Cite factors that may contribute to positive outcomes in Telemental Health patients; 3) Discuss the importance of large scale population

studies when assessing Telemental Health outcomes.

SUMMARY:

This is the first report to assess large scale hospitalization outcomes of telemental health services. 98,609 new patients were enrolled in clinical videoconferencing telemental health services in the US Department of Veterans Health-care Administration (VHA) between 2006-2010. Using VHA performance assessment monitoring dashboards, hospitalization days and admissions in all newly enrolled patients were compared for an average of six months before and after initiation of telemental health services. Psychiatric admissions decreased in telemental health patients by 24.2%, with an annual range of decrease between 16.3%–38.7%. The number of days of hospitalization for telemental health patients decreased by 26.6% overall, with an annual range of 16.5%–43.5%. Analysis of subgroups demonstrated consistent decreases in both numbers and days of hospitalization across all male and female subpopulations, and across 83.3% of the age groups. Decreases were not mirrored in the overall VHA mental health patient population, supporting the hypothesis that entry into the telemental health program was an important aspect of the decrease in hospitalization rates. Specific factors contributing to these decreases may include increased access to remote care delivery provided by telemental health services for patient education groups, evidence based psychotherapy, and closer management of medications leading to increased treatment adherence. Additionally for patients on the verge of decompensation, remote clinical videoconferencing provides mental health clinicians with opportunities for immediate intervention which may circumvent the need for hospitalization. The availability of large scale data bases within the (VHA) are the first to provide unique opportunities to analyze large populations of telemental health patients to identify outcomes and patterns of practice. The results in this report support the expansion and further evaluation of telemental health services.

SCIENTIFIC AND CLINICAL REPORT SESSION 11

GENETIC STUDIES

SCR11-1

HIGH PREVALENCE AND SIGNIFICANT PHARMACOKINETIC IMPLICATIONS OF THE CYP2C19 GAINOFFUNCTION ALLELE *17 IN PSYCHOTROPIC TREATED PATIENTS

Chair: Gualberto Ruaño, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence and significance of

CYP2C19 loss and gain of function drug metabolism alterations; 2) Assess the utility of CYP450 combinatorial genotyping in characterizing an individual's metabolic phenotype; 3) Utilize CYP450 combinatorial genotype values to improve psychotropic management.

SUMMARY:

Objective: To establish the frequency of the CYP2C19 *17 gain of function promoter polymorphism (806 C>T, rs12248560, increased transcription) and determine its combinatorial genotypes with CYP2C9 and CYP2D6. A patient homozygous for *17 is classified as an ultrarapid metabolizer for the CYP2C19 isoenzyme, and the CYP2C19 *17 allele has been associated with escitalopram therapeutic failure. **Method:** We examined 199 European American psychiatric patients referred to the Genomas Laboratory of Personalized Health at Hartford Hospital for intolerance or resistance to psychotropics. Their DNA was genotyped to detect 10 alleles in CYP2C19, including *17 (AutoGenomics Infinity® assays) and 26 alleles in CYP2C9 and CYP2D6 (6 and 20, respectively, Luminex xTag® assays). **Results:** The CYP2C19 *17 allele frequency was 18.6%, consistent with previous reports. Of the 199 patients, 52 were CYP2C19 *17 heterozygotes, 12 were compound heterozygotes of *17 and null function alleles, and 5 were homozygotes. The number of patients with non-reference alleles in CYP2C19, CYP2C9, and CYP2D6 (triple gene alterations) was 20. Of these, 14 patients were CYP2C19 *17 carriers and 6 were carriers for CYP2C19 null alleles. Ultrarapid metabolizer status for isoenzyme CYP2C19 was assigned to the 5 patients who were *17 homozygotes. Of these, 1 patient was an ultrarapid metabolizer for both CYP2C19 and CYP2D6, which correlated with therapeutic failures to multiple psychotropics. The other 4 CYP2C19 ultrarapid metabolizers were deficient or poor metabolizers for CYP2D6, resulting in pronounced functional disparity between the CYP2C19 and CYP2D6 isoenzymes, which are the two major routes for psychotropic metabolism. **Conclusions:** The *17 allele significantly increases the polymorphism of CYP2C19 and contributes to a suprafunctional status for the isoenzyme, leading to an ultrarapid metabolizer status in 34% of patients. In combination with CYP2C9 and CYP2D6 polymorphisms, the CYP2C19 *17 more than doubled the prevalence of individuals with triple gene alterations. The pharmacogenetic profile of psychiatric patients is critically enhanced by incorporation of CYP2C19 *17 in the diagnostic allele panel.

SCR11-2

TOXOPLASMA GONDII ANTIBODY TITERS AND HISTORY OF SUICIDE ATTEMPTS IN PATIENTS WITH SCHIZOPHRENIA

Chair: Olaoluwa Okusaga, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Become aware of the previously reported link between *T. gondii* and schizophrenia; 2) Demonstrate an awareness of the literature on the association of *T. gondii* with suicidal behavior in nonschizophrenia patient samples; 3) Demonstrate knowledge of the recent first report of an association of *T. gondii* with suicidal behavior in schizophrenia patients; 4) Become aware of possible psychoneuroimmunological mechanisms by which *T. gondii* could be associated with suicidal behavior.

SUMMARY:

Introduction: The widespread neurotropic parasite *Toxoplasma gondii* (*T. gondii*), has previously been associated with schizophrenia and also with suicidal behavior. However, to our knowledge, the association of *T. gondii* with suicidal behavior in schizophrenia patients has not been examined. **Hypothesis:** We hypothesized that *T. gondii* seropositivity and serointensity will be associated with history of suicide attempts in patients with schizophrenia. **Methods:** We recruited 950 schizophrenia patients from the Munich area of Germany and they all underwent the Structured Clinical Interview for DSM-IV. Plasma antibodies to *T. gondii*, Cytomegalovirus (CMV), Herpes Simplex Virus Type 1 (HSV1) and gliadin was measured using Solid-phase enzyme immunoassay methods. We used Logistic regression models to analyze the association of *T. gondii* seropositivity and serointensity with history of suicidal behavior. **Results:** In the schizophrenia patients younger than the median age of the sample, 38, *T. gondii* serointensity was associated with history of suicidal behavior ($p = 0.02$), but in the older patients (i.e. those equal to or older than 38) the relationship was not significant ($p = 0.21$). Also seropositivity for *T. gondii* was associated with history of suicide attempt in younger patients, odds ratio 1.59 (95% CI 1.06 to 2.40), $p = 0.03$. There was no association between seropositivity for CMV ($p = 0.22$), HSV1 ($p = 0.36$) or gliadin ($p = 0.92$) with history of suicide attempt in the entire sample or any age subgroup. **Discussion:** *T. gondii* serointensity and seropositivity were associated with a history of suicide attempt only in the subgroup of patients younger than 38, a noteworthy finding, considering prior reports of elevated suicide risk in younger schizophrenia patients compared with older ones. In addition, *T. gondii* titer was not associated with illness severity, though illness severity was associated with history of suicidal behavior and this makes it unlikely that *T. gondii*'s effect is mediated through direct worsening of symptoms. **Conclusions:** With the current shift toward personalized medical care, *T. gondii* serology might become a candidate biomarker for a subgroup of schizophrenia patients prone to attempting suicide especially when interaction with vulnerability genes is taken into consideration.

SCR11-3

THE EFFECTS OF TRIALLELIC SEROTONIN TRANSPORTER GENE AND STRESSFUL LIFE EVENTS ON DEPRESSION IN PATIENTS WITH ALCOHOL DEPENDENCE*Chair: Jang HyunChung, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) The serotonin transporter gene has been regarded as a candidate gene in depression and alcohol dependence; 2) The lower expression allele of the serotonin transporter gene 5' promotor region polymorphism is reported to be related with susceptibility to depression in response to stressful life event; 3) Investigate the gene by environment interaction between the triallelic serotonin transporter gene and stressful life events on depression in alcohol dependence.

SUMMARY:

Methods: Ninetyfive hospitalized patients (73 male, 22 female) were diagnosed as alcohol dependence and thirtytwo among the total patients were also diagnosed as major depressive disorder and dysthymic disorder by Structured Clinical Interview for DSMIV. Stressful life events scale and depression scale (Beck depression inventory) were assessed. Alcoholism with depression (N=32) and alcoholism without depression (N=63) were genotyped for the triallelic serotonin transporter gene (LA: higher expressing allele, LG/S: lower expression allele). Results: There was no significant difference in the allele frequency between depression group and no depression group ($X^2=0.345$, $p=0.842$). The lower expressing alleles have more comorbid depression in the higher score of stressful life events scale (LG/S allele : $MHX^2=4.442$, $p=0.035$). But there is no significant difference of comorbidity according to score of stressful life event scale in the higher expression alleles (LA allele: $MHX^2=0.062$, $p=0.804$). Conclusion: Alcohol dependence with lower expressing serotonin transporter allele is more susceptible to depression than higher expressing serotonin transporter allele in response to stressful life events.

SCIENTIFIC AND CLINICAL REPORT SESSION 12**GERIATRIC PSYCHIATRY**

SCR12-1

EVENT RELATED POTENTIALS AS A BIOMARKER FOR ALZHEIMER'S DISEASE: THE COGNISION ERP SYSTEM*Chair: David A. Casey, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand and define event related potentials as a type of EEG signal; 2) Understand the role of biomarkers in the diagnosis of Alzheimer's disease; 3) Understand the use of ERP in Alzheimer's disease.

SUMMARY:

Current diagnostic approaches in Alzheimer's disease rely primarily on cognitive symptoms. Proposed changes in the disease criteria place more emphasis on the use of biomarkers such as neuroimaging findings or CSF markers. Event related potentials (ERP) represent a promising biomarker approach. ERP is a specialized form of EEG, and may be thought of as a subset of evoked potentials. ERP are EEG waveforms provoked by sensory stimuli, often auditory or visual. ERP represent the brain's higher cortical analysis of these initial signals. ERP is a cognitive biomarker demonstrating slowing in cognitive processing. ERP is typically performed using the "oddball paradigm". This involves giving two different stimuli in random order, with one occurring less frequently. The subject is asked to discriminate between the less frequent (target) and the more frequent (standard) stimuli. In this situation, the target stimulus elicits a P300 response, whereas the standard stimulus does not. P300 is a widely used ERP signal which reflects the higher cognitive processes required to make this discrimination. In Alzheimer's the typical ERP response involves longer P300 latency and lower amplitude. Advanced ERP systems feature a wearable electrode caps rather than individual EEG electrodes with gel or scalp abrasion. New technologies allow for the use of several different ERP signals, cortical areas, and types of stimuli in combination. Some of these systems use advanced pattern recognition software to automatically evaluate the ERP test data. A new system of this type is the Neuronetrix COGNISION System which is currently undergoing clinical trials. This is a handheld, wireless auditory ERP device which can be used in an office environment. Test data and classification results are stored in an online electronic patient record system. A sufficient data base exists to allow for discrimination of AD vs. normals early in the course of illness. Changes in the ERP signal over time may allow for monitoring progression or following response to therapies. The potential applications of ERP in AD diagnosis include research and drug development. The portability, noninvasive technology, and relative lack of expense also make it a promising tool for officebased early clinical diagnosis.

SCR12-2

THE INTERPLAY BETWEEN NEUROTICISM AND ATHEROSCLEROSIS IN LATELIFE DEPRESSION SUPPORTS A HYPOTHESIS OF VASCULAR APATHY

Chair: Radboud Marijnissen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand that cerebrovascular damage leads to frontostriatal dysfunction what in turn leads to vascular apathy. This apathy reduces the impact of neuroticism on laterlife depression; 2) Interpret that there is an association between neuroticism and depressive symptoms in the older people. So neuroticism is a vulnerability factor in laterlife depression; 3) Realize that the association between depressive symptoms and subclinical atherosclerosis is primarily driven by the somatic affective symptoms of the laterlife depression.

SUMMARY:

Background: Neuroticism and cardiovascular disease are both major vulnerability factors in laterlife depression, but have hardly been examined in relation to each other. Objective: To examine the interplay between subclinical atherosclerotic disease and neuroticism in explaining variance in laterlife depressive symptoms. Based on preliminary results, we hypothesize that the association between neuroticism and depressive symptoms decreases in the presence of more severe atherosclerotic disease. Method: This study was part of Nijmegen Biomedical Study (NBS), a population based survey, including 1250 participants aged 50 through 70. Depressive symptoms were measured by Beck Depression Inventory (BDI). Principal components analysis of the BDI items yielded two factors, representing a cognitive affective symptom cluster and a somatic affective symptom cluster. Atherosclerosis was measured by Intima Media Thickness of carotid arteries (IMT). Neuroticism was measured by revised Eysenck Personality Questionnaire (EPQRSS). Multiple linear regression analyses of IMT and neuroticism and their interaction were regressed on different measures of depressive symptoms. Results: Neuroticism was strongly associated with sum score of the BDI as well as with the two depressive symptom clusters (p values $<.001$). We found a significant association between BDI sum score and IMT ($p < .040$). However, IMT was only associated with the somatic affective symptom cluster ($p = .001$), but not the cognitive affective symptom cluster ($p = .44$). Interestingly, we found a negative interaction between neuroticism and IMT in explaining the severity of the cognitive affective symptom cluster (Beta = .41, $p = .007$), but not with respect to the somatic affective symptoms. Conclusion: Neuroticism is strongly associated with depressive symptoms, whereas the association of subclinical atherosclerosis is driven by the somatic affective symptom cluster. The negative interaction between neuroticism and atherosclerosis in explaining the cognitive affective symptoms of depression indicates that neuroticism is less strongly associated with cognitive depressive

symptoms in the presence of more severe atherosclerosis. This may be explained by apathy due to cerebrovascular damage of frontostriatal pathways and fits with a hypothesis of vascular apathy.

SCR12-3

OLANZAPINE AS A RAPIDLY AND STRIKINGLY EFFECTIVE AUGMENTING STRATEGY FOR ANTIDEPRESSANT RESISTANT GERIATRIC OUTPATIENTS WITH MAJOR DEPRESSIVE DISORDER

Chair: Irl Extein, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the potential role of atypical antipsychotics in treatment resistant geriatric MDD patients; 2) Identify the usual dose range, timeframe, and magnitude of response with effective use of olanzapine to augment antidepressants in treatment resistant geriatric MDD patients; 3) Identify potential side effects with the use of atypical antipsychotics to augment antidepressants in geriatric MDD patients.

SUMMARY:

The STAR*D study reported in 2006 showed that further strategies to augment antidepressants in major depressive disorder (MDD) would be important. The atypical antipsychotics olanzapine (with fluoxetine), aripiprazole, and quetiapine are now FDA approved to augment antidepressants in treatment resistant MDD. A recent review reported pooled remission rate of 30.7% for atypical antipsychotic augmentation compared to 17.2% for placebo augmentation of antidepressants. Atypical antipsychotic augmentation of antidepressants has not been reported in a geriatric population. To explore my impression from my predominantly geriatric office practice that olanzapine is an effective augmenting medication in antidepressant resistant MDD in geriatric patients I conducted a retrospective chart review of a four year period that identified 22 geriatric patients with MDD without dementia or psychosis (mean age 76) who had failed an SSRI or SNRI and had olanzapine (mean dose 4.9 mg/day) added to the antidepressant. Decrease in severity of depression on the Clinical Global Impression (CGI) scale from a mean of 4.68 ("moderately" to "markedly" ill) before olanzapine to 3.32 ("mildly") ill at the time of maximum improvement after olanzapine was statistically significant ($p < 0.0001$ on two tailed t test). Mean Clinician's Global Impression of Change (CGIC) scale score was 2.1 ("much improved"). Improvement was often dramatic. Fifteen ("68%") of the patients were rated "much" or "very much" improved on the CGIC. Maximum improvement was noted within two weeks in 12 of those 15 patients. The improvement did not seem to reflect simply sedation, as many

patients reported better energy. Side effects were minimal. Three patients complained of increased appetite. A possible mechanism of action of olanzapine augmentation is suggested by studies in rat brain showing that olanzapine has a synergistic effect with fluoxetine on monoamines. Though the findings here suggest a clinically useful strategy, the potential for cardiovascular, metabolic, and neurological sideeffects (especially with longer term use of olanzapine), as well as the FDA warning of increased mortality with use of atypical antipsychotics in dementiarelated psychosis dictates caution.

SCIENTIFIC AND CLINICAL REPORT SESSION 13

LONGITUDINAL COURSE OF BORDERLINE PERSONALITY DISORDER

SCR13-1

THE COURSE OF ANXIETY DISORDERS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND AXIS II COMPARISON SUBJECTS: A 10YEAR FOLLOWUP STUDY

Chair: Merav H. Silverman,

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that anxiety disorders other than PTSD are common in borderline patients; 2) Recognize that these disorders are also intermittent in Borderline patients; 3) Recognize that developing new treatments that specifically target anxiety symptoms among Borderline patients is important given the high prevalence rates and enduring nature of these symptoms.

SUMMARY:

Background: The first objective of this study is to assess the rates of comorbid anxiety disorders other than PTSD in borderline patients and axis II comparison subjects over ten years of prospective followup. The second is to determine timetoremission, recurrence, and new onset of these anxiety disorders. **Methods:** The Structured Clinical Interview for DSMIIIR Axis I Disorders (SCID I) was administered to 290 borderline patients and 72 axis II comparison subjects at baseline and at five contiguous twoyear followup waves. **Results:** The rates of anxiety disorders for those in both study groups declined significantly over time, although these rates remained significantly higher among borderline patients. By tenyear followup, the rates of remission for borderline patients who met criteria for these disorders at baseline ranged from 100% for agoraphobia and GAD to 77% for OCD. Recurrences among borderline patients who had experienced a prior remission ranged from 30% for agoraphobia and simple phobia to 65% for panic disorder. Rates

of new onsets ranged from 15% for agoraphobia to 47% for panic disorder. **Conclusions:** These results suggest that anxiety disorders are intermittent conditions for borderline patients as remissions and recurrences are common. They also suggest that anxiety disorders are almost ubiquitous as new onsets add to high baseline prevalence rates.

SCR13-2

THE RELATIONSHIP BETWEEN CHILDHOOD ADVERSITY AND DYSPHORIC INNER STATES AMONG BORDERLINE PATIENTS FOLLOWED PROSPECTIVELY FOR 10 YEARS

Chair: Lawrence I. Reed, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the severity of specific affective and cognitive states in borderline patients over a 10year course of prospective followup; 2) Recognize the impact of adverse childhood experiences on dysphoric inner states present in borderline patients over a 10year course of prospective followup; 3) Recognize the clinical impact of understanding experiences of dysphoric inner states common among and specific to borderline patients.

SUMMARY:

Objective: The current study aimed to assess the relation between reported adverse childhood experiences of abuse and neglect and the severity of dysphoric states among patients with borderline personality disorder (BPD) over a 10year course of prospective followup. **Method:** The Revised Childhood Experiences Questionnaire (CEQR) was administered at baseline to 290 patients meeting DIBR and DSMIIIR criteria for BPD. The Dysphoric Affect Scale (DAS) – a 50item selfreport measure of affective and cognitive states thought to be common among borderline patients and specific to the disorder – was administered at fives waves of prospective followup. **Results:** Out of eleven adverse childhood experiences examined, ten were found to be significant bivariate predictors of dysphoric states over the five followup periods: emotional abuse, verbal abuse, physical abuse, sexual abuse, emotional withdrawal, inconsistent treatment, denial of patient's feelings, lack of a real relationship, placing patient in parental role, and failure to protect patient. Three of these predictors – verbal abuse, placing patient in parental role, and failure to protect patient – remained significant in multivariable analyses. **Conclusions:** In sum, these results suggest that adverse childhood experiences of both an abusive and neglectful nature are significant risk factors for severe affective and cognitive difficulties reported by borderline patients. The results also suggest that sexual abuse is neither necessary nor sufficient for the development of these trou-

bling inner states.

SCR13-3

PERSONALITY TRAIT CHANGES IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND OTHER PERSONALITY DISORDERS OVER 16 YEARS

Chair: Christopher J. Hopwood, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the general trajectory of change in normative personality features among individuals with personality pathology; 2) Understand how the underlying personality traits of borderline and nonborderline Axis II patients can be expected to differ over time; 3) Appreciate the clinical importance of both the cross-sectional and dynamic relationship between borderline personality and trait neuroticism.

SUMMARY:

Objective: Borderline Personality Disorder (BPD) has traditionally been characterized in part by instability in mood, interpersonal behavior, and identity. This instability may be a function of changes in the underlying personality systems of borderline patients. We tested this hypothesis by comparing longterm changes in normative (fivefactor) personality traits among borderline and nonborderline Axis II comparison participants in a clinical sample followed for 16 years. Method: Threehundred and sixtytwo inpatients were categorized into borderline (N=290) and other Axis II (N=72) conditions based on semistructured interviews of PD as assessed during their index admission. These subjects were also assessed with the NEOFFI, a selfreport measure of normal personality traits, at baseline and every two years over 16 years. Trajectories of change on normal personality traits were compared across the groups. Results: Results for neuroticism indicated that while both groups declined significantly over 16 years of followup, the declines were greater for borderline patients than axis II comparison subjects. Borderline patients were less extraverted than axis II comparison subjects but scores for both groups were similarly stable over time. For openness, there were no significant differences between the groups or over time. Borderline patients were less agreeable and conscientious than axis II comparison subjects but both groups had a similar increase in these scores over time. Conclusion: Taken together, the results of this study suggest that a) PD patients generally decline on neuroticism and increase on agreeableness and conscientiousness and b) borderline patients show greater levels of decline over time on neuroticism than do Axis II comparison participants.

SCIENTIFIC AND CLINICAL REPORT SESSION 14

INPATIENT PSYCHIATRY

SCR14-1

CLINICAL AND DEMOGRAPHIC PROFILE OF REPEATEDLY VIOLENT PATIENTS IN AN ACUTE PSYCHIATRIC HOSPITAL: A ONEYEAR RETROSPECTIVE STUDY

Chair: Rozy Aurora, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To determine if psychiatric patients who engage in multiple episodes of inpatient violence demonstrate different demographic profile than nonviolent patient; 2) Determine, if psychiatric patients who engage in multiple episodes of inpatient violence demonstrate different clinical profile than nonviolent patients; 3) Find out whether repeatedly violent patients have a history of multiple psychiatric hospitalizations and diagnosis of comorbid AxisII e.g. mental retardation.

SUMMARY:

Despite extensive research on inpatient violence, only a limited number of studies have examined demographic and clinical profiles of psychiatric patients who are repeatedly violent (Lussier et al, 2010, Flannery, 2002, Blow, 1999). Several studies (Quanbeck, 2007, ElBardi, 2006, Davis, 1991, and Beck et al., 1990) have shown that repeatedly violent patients may have different clinical characteristics from the patients who are less violent. However, these findings are not consistent across setting and patient populations. Given these discrepancies, the objective of this study was to determine if psychiatric patients who engaged in multiple episodes of inpatient violence demonstrate different demographic and clinical profiles from nonviolent inpatients.

SCR14-2

THE IMPACT OF HOSPITALISTS IN PSYCHIATRY

Chair: Julian Beezhold, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what hospitalists in psychiatry are and do; 2) Discuss the evidence, based on "hard" outcome measures, for the effectiveness of psychiatric hospitalists; 3) Evaluate service designs and changes to inpatient practice with greater rigour.

SUMMARY:

The use of dedicated inpatientonly psychiatrists hospitalists is becoming increasingly common. Yet there is an almost complete lack of published evidence evaluating the impact and outcomes of hospitalist systems. This poster presents “hard” outcomes data from a study of (n=5409) admissions to acute inpatient units in Norfolk, United Kingdom over the period 20022010. The data is from a quasiexperimental naturalistic before and after controlled study. It examines a range of outcomes including length of stay, rates of deliberate self harm, absconding, and other objectively measurable data. The study also addresses the issue of whether using hospitalists has led to any adverse consequences such as increased admission rates or increases in the number of suicides. The results present compelling evidence suggesting that psychiatric hospitalists may offer a means to significantly improved patient outcomes, such as an 80% reduction in deliberate self harm.

SCR14-3

INPATIENT PSYCHIATRIC CARE: CONSEQUENCES OF SHORT LOS

Chair: Harold I. Schwartz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe variables associated with short LOS; 2) Identify predictors of readmission; 3) Discuss implications of the results of this study for healthcare policy.

SUMMARY:

Objective: Current managed care policies and reimbursement methodologies restrict use of psychiatric hospitalization, raising questions about the potential impact on outcomes when length of stay (LOS) is brief. The investigators examined a large sample of inpatients to determine the (1) clinical and demographic characteristics associated with LOS =4 days and (2) associations among LOS, patient variables and risk of readmission. **Method:** For inpatients treated during 200009 ages 1860 (n=10,145) the first discharge was identified for each patient; data from that admission were joined with data from all readmissions within 2 years. These steps were repeated with all patients age >60 (n=2169) and <18 (n=1973) and the three age groups were compared on multiple measures. We assessed associations between (1) index LOS and readmission (yes/no), (2) index LOS and demographic/clinical data (e.g., diagnoses, days to first readmission, readmission incidence by 1, 3, 6, 12 and 24 months), and (3) readmission and demographic/clinical data. Analyses included bivariate (ttest, chisquare, ANOVA, relative risk), stratified and Cox regression (hazards ratios [HR]). **Results:** LOS =4 days was most common for ages 1860 (35.4% vs. 14.7% and 9.9% in ages <18 and >60,

respectively, $p<.01$); readmission was also most common in this group (34.1% vs. 25.7% for younger and older groups, $p<.01$). However, risk of readmission was associated with LOS =4 days only in patients >60 (significant at 112 months, HRs=1.5 to 2.4), in blacks or Latinos (at 324 months for ages 1860, HRs=1.21.3 and for ages <18, HRs=1.3 and 1.8) and in patients with personality disorders (ages 1860 at all time periods, HRs=1.2). **Conclusions:** Increased readmission rates were associated with LOS =4 days for some but not all patients. Variables other than LOS also appear to be important predictors of outcome, and the association between short LOS and readmission for patients with personality disorder may be an especially salient clinical predictor. Facilities may be able to determine risks for readmission for their specific populations based on variables explored in this study (e.g. age, race/ethnicity, diagnoses and treatments given), but further research is needed to assess the contributions of additional factors to risk of readmission (e.g., illness severity, socioeconomic status, social supports, quality of life, treatment adherence, employment). Longterm followup studies are needed to determine if the subset with LOS =4 days had less severe conditions that made them lowrisk for readmission or if, being poorly served by this treatment model, were lost to the healthcare system and therefore never readmitted.

SCIENTIFIC AND CLINICAL REPORTS

MONDAY, MAY 7, 2012

SCIENTIFIC AND CLINICAL REPORT SESSION 15

INDIVIDUAL THERAPY AS TREATMENT

SCR15-1

CHALLENGES IN THE TREATMENT OF A PHYSICIAN PATIENT WITH PSYCHOSIS

Chair: Jacob L. Freedman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the legal and ethical obligations of treating a physician patient both in regards to the physician patient themselves and to the public; 2) A participant should be able to discuss the problem of insight in the psychotic physician patient and how this impacts treatment; 3) Discuss the transference and countertransference issues associated with treatment of a fellow physician.

SUMMARY:

The authors present a case of a 31 year old psychotic female patient who is a former graduate of a locally prestigious medical school and has subsequently been diagnosed with

schizophrenia. The patient entered treatment in a community mental health clinic after being discharged from her 11th hospitalization in the past five years. This hospitalization had been initiated after the patient's physician friend had called the police and notified them that the patient was significantly disorganized to warrant further evaluation for involuntary hospitalization. The patient's treatment was characterized by significant transference and countertransference reactions amongst her clinicians—both treatment-promoting and treatment-interfering—based on her status as a graduate of a local medical school. The problem of insight was a significant hurdle in the treatment of the patient as her medical knowledge of mental illness was substantially greater than her insight into her own mental illness. Throughout the treatment, a number of medical-legal and ethical issues were raised in the treatment of the patient. Initially, the question was raised as to the legality of the actions by the patient's friend—this individual had made a clinical assessment without having a clinical role in the patient's care. Additional issues were raised as the patient's clinical status improved and she sought to reenter the medical field as a resident. What were the roles of the patient's treaters in maintaining patient confidentiality and simultaneously ensuring the safety of any possible patients that the psychotic physician might potentially care for? This case highlights universality of psychiatric vulnerability. The problem of insight in psychosis as well as the transference and countertransference issues involved in caring for a psychotic physician are discussed at length. Additionally, a thorough medical-legal discussion addresses the various complexities of caring for a psychotic physician.

SCR15-2

ADOLESCENCE AND THE REORGANIZATION OF INFANT DEVELOPMENT: A NEUROPSYCHOANALYTIC MODEL

Chair: Frans F. Stortelder, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the consequences for the treatment of adolescent psychopathology in clinical practice based on the knowledge of the neurobiological and psychological development in adolescence; 2) Have an overview of a research-based all-encompassing psychic developmental model from a neuropsychanalytic perspective; 3) Work in clinical psychoanalytic practice with a psychotherapeutic model of transforming mirroring.

SUMMARY:

Abstract: The psychoanalytic view of adolescence as a phase of turbulence and reorganization occupied a central posi-

tion 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, neuropsychanalytic 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.

SCR15-3

THE CLINICAL RELEVANCE AND APPLICATION OF THE REAL RELATIONSHIP IN PATIENT TREATMENT

Chair: Patrice M. Duquette, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the real relationship and identify how it may be experienced and expressed in varied patient encounters and therapeutic modalities; 2) Identify specific ways in which attention to the expression and functional application of the real relationship affects the quality and progression of patient treatment; 3) Develop awareness of the process of determining possible sources and expression of countertransference for the clinician in common patient situations.

SUMMARY:

Psychotherapy involves more than explicit communications, interpretations, or exchanges of content. Across theoretical orientations, it is now widely accepted that the therapeutic process must initiate sufficient change in the neural pathways and processes to effect change in the patient's habitual ways of experiencing the world. Greater value is being placed on the quality of the therapeutic relationship, attention to affective experiences and implicit exchanges between the therapist and patient, and on the personality of the therapist. In many therapeutic modalities, the real relationship, the realistic and genuine elements of the therapeutic relationship, is an important resource to both patient and therapist. It can strengthen the therapeutic attachment, allow greater access to developmental bias, facilitate the process of emotional regulation, promote higher mentalization processes, and provide leverage for further psychoneurobiologic change in the patient. As the therapist becomes increasingly attuned to his or her affective experience and the shifts in it as part of the real relationship, the exchanges between patient and therapist develop a new experiential tone, better anchoring the patient during affective storms, while progressively steadying baseline functioning and emotional processes for deeper and richer affective integration. The real relationship supports the patient's differentiation between internal experience and external reality, yielding consequent improvement in relationships, selfobservation, clarity of thought, and higher tolerance for distress. Research has shown that the strength of the real relationship is positively associated with progress and treatment outcomes, and is associated with the perception of effectiveness of sessions. In this presentation, a thorough consideration will be made of the clinical necessity to evaluate, monitor, and address the real relationship consistently in any modality of psychiatric treatment. The necessity of the clinician's awareness and persistent monitoring of countertransference, and ways to further the real relationship with reference to the proper use of selfdisclosure will be addressed. Early life antecedents, possible neurobiological imperatives, and anatomic sites related to the genesis and therapeutic impact of the real relationship will be considered. Clinical vignettes will illustrate the form and expression of the real relationship, from the perspectives of the therapist and patient, to help the attendees envision and clarify the expression and use of the real relationship in their own clinical practice. Participants will learn how the real relationship is relevant in modalities as diverse as psychoanalysis, psychotherapy, supportive therapy, medication review, and diagnostic evaluations and how close attention to the real relationship can improve the process and outcome of treatment with their patients.

SCR15-4

AN INTRODUCTION TO PSYMENTOLOGY, A NEW PERSIAN ETHNOPSYCHIATRIC METHOD FOR THE

TREATMENT OF MENTALLY ILL PATIENTS

Chair: Mohammad Shekari Yazdi, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the basic concepts of interuniversal mystic, upon which metatherapy has been developed;; 2) Understand the principles of metatherapy for the treatment of physically ill patients; ; 3) Define and report about psymentology which is the mental application of metatherapy;; 4) Become familiar with some researches which have been done in basic sciences using metatherapy;; 5) Explain the clinical applications of psymentology.

SUMMARY:

Interuniversal consciousness is a century's old school of thought among Iranian Gnostics which has been developed and modernized by Iranian scholar Dr. Mohammad Ali Taheri. Some of the basic tenets of Interuniversal consciousness which is compatible with modern physics and postmodern thought are as follows: 1. The material world is made from intelligence. 2. Although intelligence is neither matter nor energy, but matter and energy originate from intelligence. 3. Intelligence doesn't need time and space. 4. The Interuniversal consciousness determines the intelligence of its components and they affect each other. 5. Every componentintelligence encompasses the whole intelligence too. In Faradarmani it is believed that if we connect to the Interuniversal consciousness, then the process of healing begins by the connection between the component and whole consciousness. Faradarmani is thought officially in 8 terms, every of them including at least 6 core teaching sessions. Psymentology begins after that which specifically focuses on mental diseases. According to psymentology a human being has different bodies. Among them are physical, psychological and mental. It is believed that brain is an organ that translates mental and psychological states into physical through different neurotransmitters. Psymentology has developed its own theory and treatment methods for psychiatric diseases and has been quite successful. His success has been documented in special editions of Iranian journal "Daneshe Pezeshki: Medical science". This journal has many reports of treatment for physically and mentally ill patients by Faradarmani and psymentology. It has a basic science special edition about the effect of interuniversal consciousness on cells and plants which is astonishing. With an example I try to make it more understandable. In psymentology homosexuality could have three causes which from mild and transient to more severe and persistent are: 1. Environmental and situational (e.g. prison) which corrects itself by a change in the situation. 2. Possession by another mental body which needs its corresponding treatment. 3. Software problems which could be of two types: A.

Through conditioning of unconscious from childhood. B. Retaliation of the patient against excessive and intolerable order (e.g. patriarchal family and/or highly industrialized and regulated cities).

SCIENTIFIC AND CLINICAL REPORT SESSION 16

MENTAL HEALTH CARE IN OTHER COUNTRIES

SCR16-1

MENTAL HEALTH INTERVENTIONS IN NONPSYCHIATRIC SETTINGS: EXAMPLES FROM A YOUTH CLINIC IN GENEVA, SWITZERLAND

Chair: Shqipe ShehuBrovina, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Gain knowledge about innovative approaches to address young people's mental health issues in a nonpsychiatric setting; 2) Analyze the interprofessional collaboration opportunities that are available in a multidisciplinary academic youth clinic; 3) Provide examples of early interventions for complex situations during medicopsychiatric interviews.

SUMMARY:

The prevalence of mental health disorders increases during adolescence affecting up to 25% of young people attending primary care facilities. Nevertheless, mental health needs of young people often go unrecognized for various reasons: poor mental health literacy in the community, inappropriate beliefs about mental health, impaired access to services or lack of youth friendly services (including insufficient training of health professionals), and finally stigma associated with psychiatric illness. Multidisciplinary youth clinics have an essential role to play in improving access of youth to adequate mental health care: screening in collaboration with existing community services, offering a non-stigmatizing point of entry through primary care services, distinction between common mental health problems and severe psychiatric disorders (as most mental disorders begin between the ages of 12-24 years), offering alternative forms of care for vulnerable youth. Our specialized multidisciplinary academic unit (pediatricians, general internists, gynecologists, nurses, psychiatrists trained in adolescent health) has increasingly been recognized as a key partner in Geneva's network: active collaboration on depression screening in school health services, networking with social services as well as with specialized psychiatric services, raising awareness about mental health disorders through training of professionals and research projects in primary care. Through a global approach we use every opportunity to address mental health issues in a comprehensive way during regular medi-

cal visits and nurse preventive visits (e.g. immunizations, walk-in consultations, sexual and reproductive health care visits, group sessions,..) The psychiatrists provide support about mental health issues to other team members during weekly team meetings, regular individual and group supervision and medicopsychiatric consultations with patients. These interventions lead to complementary views of clinical situations and help refine the psychological and somatic evaluations in a global approach for adolescents and their families. Interprofessional team collaboration and medicopsychiatric consultations are of particular value for early interventions in complex situations: newly arrived refugees, complex family situations, functional disorders, stigma of psychiatry. Successful medicopsychiatric consultations need flexible, experienced and engaged professionals capable and interested in meta communicating in front of patients and families; a common pitfall would be to reduce this method to two parallel medical evaluations. It allows a broader view not only on the content of the interview (diagnostic and intervention issues) but also on the ongoing process (therapeutic relationship, interactions...) Research is needed to better understand the specificities of these interventions and their long term impact on the mental health of young people.

SCR16-2

NEW ZEALAND MENTAL HEALTH: AN AMERICAN PERSPECTIVE

Chair: James D. Reardon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the psychiatric consultants role in providing specialist mental health services in New Zealand; 2) Understand the systems designed to care for the chronically mentally ill in New Zealand; 3) Understand the different changes in mental health care over the years, as compared to changes in American psychiatric care; 4) Understand how the New Zealand model of integrated care imposes a single, generic care system on all mental health patients; 5) Understand the impact of stigma and computerized health care information systems on one care organization.

SUMMARY:

The aim of this paper is to address the New Zealand mental health system as it relates to American practice. The author's 45 years experience in American mental health care give him a unique perspective with which to observe the historical development and current organization of clinical services in New Zealand. Conclusions: The current mental health system is bureaucratically managed and burdened

by a managerial style that is nonmedical and based on the concept of caring for the chronically mentally ill. There is little recognition of the changed treatment modalities for mental patients that reflect the long term effects of deinstitutionalization.

SCR16-3

A RETROSPECTIVE ANALYSIS OF HEALTHCARE UTILIZATION IN PSYCHIATRIC OUTPATIENTS IN A STAFF MODEL HMO: APPLICATIONS OF A PHARMACOGENETIC ALGORITHM

Chair: Aida Mihajlovic, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify pharmacokinetic and pharmacodynamic genes that may have an impact upon psychiatric and healthcare services utilization; 2) Discuss the use of pharmacogenetic algorithms as related to total psychiatric and health care visits; 3) Discuss potential economic impact of pharmacogenetic testing for patients treated at an outpatient psychiatric services clinic.

SUMMARY:

Introduction: Antidepressants are among the most widely prescribed medications; however, only 35-45% of depressed patients have a complete remission of their illness when initially treated with these medications. Mayo Clinic's Genomic Expression and Neuropsychiatric Evaluation group has developed a pharmacogenomics (PGx) based depression treatment algorithm that incorporates published PGx information related to antidepressant safety and effectiveness. The PGx testing platform utilized with the algorithm expands on CYP450 genotyping and also includes markers linked to therapeutic response with SSRI antidepressants. Both copies of six informative genes are genotyped: CYP2D6; CYP2C19; CYP1A2; CYP2C9; SLC6A4, and 5HT2R. Though this algorithm is not yet part of the universal standard of care, mental health clinicians have found it helpful in guiding antidepressant treatment decisions at Mayo Clinic. **Objective:** (1) To determine if there are improved outcomes with medication treatment in subjects whose therapy aligns with PGx testing information, (2) evaluate the impact of the PGx report on utilization of healthcare services within the Union Health Services (UHS) healthcare system, and (3) assess the economic impact of PGx variability in this population. **Method:** This retrospective trial occurred at UHS, a staff model HMO in Chicago, IL, that provides outpatient psychiatric services. The trial enrolled 100 subjects between the ages of 18 and 65 who were prescribed at least one of the 26 most commonly used antidepressants or antipsychotics. Subjects had a mental health diagnosis,

including depressive and anxiety disorders, but excluding bipolar disorder, schizophrenia, and schizoaffective disorder. These subjects were gathered from the primary author's psychiatric practice and divided into two cohorts. Cohort 1 consisted of those who received pharmacotherapy treatment for their illness and achieved remission within a six month period. Cohort 2 consisted of those who received pharmacotherapy treatment for their illness and did not achieve remission within a six month period. Results will be analyzed to determine if there is any significant difference in frequency of clinically important PGx variation between two cohorts and frequency of medication choice that aligned with the individual's PGx profile. Additionally, patient records will be analyzed in light of PGx results to determine if PGx appropriate treatment provides any clinical or economic benefit for patients who have been treated with psychiatric medication for their illness. **Results:** Data collection and analysis is ongoing and will be completed for the APA 2012 Annual Meeting.

SCIENTIFIC AND CLINICAL REPORT SESSION 17

METABOLIC SYNDROME AND RELATED PROBLEMS

SCR17-1

IS POSTTRAUMATIC STRESS DISORDER ASSOCIATED WITH INCREASED RISK OF METABOLIC SYNDROME AMONG INPATIENTS WITH MOOD DISORDERS?

Chair: John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Summarize the literature addressing the association of Posttraumatic Stress Disorder (PTSD) and Metabolic Syndrome (MetS); 2) Describe the prevalence of PTSD and of MetS in inpatients with major depressive (MDD) versus bipolar (BP) versus schizoaffective (SA) disorders; 3) Describe and compare the variables associated with MetS in patients with MDD, BP, or SA and a codiagnosis of PTSD.

SUMMARY:

Objective: Recent reports suggest that posttraumatic stress disorder (PTSD) is associated with increased rates of metabolic syndrome (MetS). In the present study the investigators (1) determined the prevalence of PTSD among inpatients with major depressive (MDD), bipolar (BP) and schizoaffective (SA) disorders and (2) examined the associations of PTSD with MetS, overall and in each diagnostic group. **Method:** Subjects were all inpatients ages 18-59 discharged 4/05/11 with MDD (n=2844), BP (n=1789) or SA (n=1213). Within each diagnostic group ttests and chi

square analyses compared those with vs. without PTSD; logistic regressions examined the associations of MetS (and of each of the 5 ATPIII MetS criteria) with diagnostic, demographic and treatment variables. Results: PTSD was significantly more common in MDD than in BP or SA (14.5% vs. 10.7% and 8.7%, respectively, $p < .001$). For all 3 diagnoses PTSD patients were more likely to be female and have a personality disorder ($p < .001$); for MDD and BP but not SA, patients with PTSD were more likely to be Latino ($p < .05$). PTSD patients had shorter LOS ($p < .001$) but their GAF scores on index admission and discharge were not significantly different from nonPTSD patients. All 5 MetS criteria were common in the sample as a whole (WC 47.6%, HDL 39.2%, triglycerides 29.3%, glucose 17.0%, hypertension 18.1%, MetS 25.3%) but PTSD was not associated with MetS (i.e., the full syndrome). PTSD was associated with increased risk of a metabolic disturbance on 2 of the 5 metrics examined (WC and HDL, OR=1.26 and OR=1.19, respectively), although these increases in risk were small compared to those associated with several demographic variables: the WC criterion risk was greater for females (OR=3.08) and the HDL criterion risk was greater for both females (OR=1.43) and Latinos (OR=1.51). Second generation antipsychotics (SGA) were not associated with increased risk on any metabolic measure. Conclusions: These results are only partially consistent with previous PTSD studies: an association between PTSD and MetS was not found and the increased risks on 2 of the 5 MetS criteria were modest compared to other known factors (gender, ethnicity). Few previous studies have examined the association between PTSD and MetS in large samples of inpatients with coexisting mood disorders; the inconsistencies in study findings may be due to differences in patient samples and the variables evaluated. Further research is needed to explore the effects of severity of PTSD and type of trauma, of age at symptom onset, and of the relationships among symptoms attributed to mood disorder vs. those secondary to trauma.

SCR17-2

PREDICTORS OF MONITORING OF METABOLIC PARAMETERS IN ADOLESCENTS ON ANTIPSYCHOTICS

Chair: Sameer Ghate, M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the extent of monitoring of metabolic parameters among adolescents on antipsychotics in a predominantly primary care setting; 2) Compare the frequency of monitoring of metabolic parameters among adolescents on antipsychotics to an age and gender matched comparison group; 3) Be aware of the predictors of regular

monitoring of metabolic parameters.

SUMMARY:

Objective: To assess the frequency and predictors of regular monitoring of metabolic parameters in adolescents (12–19 years old) receiving second generation antipsychotics (SGA) compared to an age and gender matched comparison group. **Methods:** A retrospective cohort study design was conducted using an ambulatory care electronic medical record database in the United States from January 2004 to July 2009. The exposure group consisted of adolescents with first prescription for SGAs (denoted as index date) with no evidence of antipsychotic prescription during 180 days pre index and monotherapy during the 395 days followup period. The comparison group, selected from those without antipsychotics, was matched (3:1) to the antipsychotic medication group on age, gender, and month of index antipsychotic prescription. Baseline and followup metabolic measurements were assessed and patients were categorized as being regularly monitored if the number of measurements was ≥ 7 for BMI, ≥ 3 for blood pressure, ≥ 2 for total cholesterol, and ≥ 3 for fasting blood glucose as recommended by the American Diabetes Association (ADA)/ American Psychiatric Association (APA) guidelines over the 395 days followup. Logistic regression was conducted to assess the predictors of regular monitoring adjusting for demographic characteristics, baseline medications, and comorbid conditions. **Results:** The exposed and comparison group consisted of 3,038 and 9,114 subjects respectively (mean age 15.53 years, 54% males). The frequency of monitoring of BMI, lipids, total cholesterol, and fasting blood glucose, as recommended by guidelines, among antipsychotic users was significantly higher (25%, 55%, 1.7%, and 2%) compared to the matched comparison group (9.5%, 37.4%, 0.8%, and 0.8% respectively) ($p < .05$). Antipsychotic treatment was associated with 1.5 to 4.3 fold increase in the likelihood of metabolic monitoring compared to controls ($p < .05$). Other predictors of monitoring included oral antidiabetic use for BMI monitoring (Odds Ratio [OR], 3.65; 95% confidence interval [CI], 2.19–6.08); and dyslipidemia for blood pressure (OR, 3.17; 95% CI, 2.02–4.08), total cholesterol (OR, 11.85; 95% CI 6.09–23.05), and fasting blood glucose (OR, 7.81; 95% CI, 3.62–16.86). **Conclusion:** The majority of adolescents on antipsychotics remain undermonitored for BMI, lipids and glucose levels. Type 2 diabetes and dyslipidemia were the strongest predictors of regular monitoring of metabolic parameters.

SCR17-3

MONITORING METABOLIC SIDE EFFECTS OF ATYPICAL ANTIPSYCHOTICS IN PEOPLE WITH INTELLECTUAL DISABILITY

Chair: Priyanka Tharian,

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the side effects associated with atypical antipsychotic treatment in people with intellectual disabilities and mental health problems; 2) understand the audit standards governing practice in this area; 3) Discuss ways of improving compliance on these standards

SUMMARY:

Background: Typical antipsychotics have longterm extra pyramidal sideeffects that limit their use. In comparison, while atypical antipsychotics are relatively well tolerated, they are associated with metabolic sideeffects including weight gain, hyperglycaemia, new onset diabetes and dyslipidemia. Because these sideeffects correlate with the development of cardiovascular disease, monitoring and intervention are important. **Aim:** To reaudit the monitoring of sideeffects of prescribed atypical antipsychotics within 8 Community Health Teams for people with intellectual disabilities in Birmingham, UK. **Methods:** We sampled 26 patients' case notes from each one of the eight teams, compiling 208 patients' case notes in total. The audit criteria were chosen based on guidance from the ADA, APA, AACE and NAASO and included the recording of personal/family history of obesity, dyslipidemia, hypertension, diabetes and cardiovascular disease, presence of baseline/ongoing weight monitoring and fasting lipid and plasma glucose monitoring. Using a questionnaire, we marked each set of notes for compliance with each of the criteria outlined above. **Results and Conclusions:** The first audit conducted in November 2007 had found that 15% of psychiatrists satisfied the entire baseline monitoring audit criteria while 77% satisfied some. None had satisfied the entire ongoing monitoring audit criteria while 85% satisfied some. Recommendations for better monitoring arrangements had been made. This reaudit in 2010, showed that while there was an improvement in the baseline recording of family history of metabolic syndrome, the recording of the baseline personal history as well as the baseline and ongoing weight monitoring had declined. We discuss potential barriers to effective sideeffect monitoring and suggest methods, like inserting a tick box set of reminders within casenotes, for improving monitoring by psychiatrists.

SCIENTIFIC AND CLINICAL REPORT SESSION 18**NONPHARMACOLOGIC TREATMENT OF DEPRESSION****SCR18-1****FMRI GUIDANCE ENHANCES TARGETING OF TRANSCRANIAL MAGNETIC STIMULATION (TMS)**

Chair: David A. Gorelick, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify psychiatric disorders for which TMS might be effective treatment; 2) Analyze advantages and disadvantages of TMS as a psychiatric treatment; 3) Evaluate advantages and disadvantages of using fMRI guidance vs. anatomical landmarks for targeting TMS treatment.

SUMMARY:

Transcranial magnetic stimulation (TMS) is a noninvasive method of brain stimulation approved for treatment of major depression and being studied for treatment of additional psychiatric and neurological disorders. Its efficacy depends on accurate targeting of TMS pulses to the physiologically responsive brain regions. Current targeting in clinical settings relies on skull landmarks. Individual differences in brain neuroanatomy lead to diminished efficacy for TMS treatment when external topography is used for targeting. We performed a pilot study evaluating fMRIguided TMS modulation of a visuo-motor coordination task as proof of concept for a TMS treatment study for nicotine dependence. Healthy righthanded research volunteers each received a halfhour session of singleblind active (n=5) or sham (n=5) TMS (70mm figure8 coil, Magstim® Rapid2 stimulator), during which they performed a visually cued, repetitive (0.5, 1.0 Hz) tapping task with the right index finger. TMS pulses (energy 120% of resting motor threshold) were applied at random on half the trials to a targeted brain region identified by prior fMRI scan (3T Siemens Allegra MRI scanner). The targeted site was the one that showed maximum BOLD activation during performance of the same task.Brainsight® neuronavigation was used to position the TMS coil over the target region. Its location varied among subjects: left superior (2) and inferior (1) parietal lobule, left precentral gyrus (1), right middle frontal gyrus (3), right precuneus (2), right precentral gyrus (1). There was no significant difference in mean (SD) reaction time between trials with and without pulses during "sham TMS" sessions (264.7±19.8 ms vs. 284.4±16.4 ms, respectively, p=0.18); during active sessions there was a significant difference (236.1±22.5 ms vs. 276±20.0 ms, p=0.02). These findings show that TMS can influence brain function sufficiently to alter performance on a visuo-motor coordination task, and suggest that substantial individual differences in functional brain neuroanatomy relevant to the task could weaken the efficacy of TMS if done without neuronavigation. Support: NIH/NIDA IRP and NIDA Residential Research Support Services Contract HHSN271200599091CADB.

SCR18-2**TAI CHI TREATMENT FOR DEPRESSED CHINESE**

AMERICANS: A PILOT STUDY*Chair: Albert Yeung, M.D., Sc.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand disparities in the treatment of mental illnesses among Chinese Americans and the causes for such disparities; 2) Understand the need for culturally sensitive and effective interventions to treat major depressive disorder in Chinese Americans; 3) Assess whether Tai Chi intervention is feasible, safe, and effective for treating Chinese Americans with major depressive disorder.

SUMMARY:

Objective: To examine the feasibility, safety, and efficacy of using Tai Chi for treatment of Chinese Americans with major depressive disorder. **Method:** Between October, 2008 and March, 2010, thirtynine Chinese Americans with moderate to moderately severe major depressive disorder (MDD) were recruited in three different cohorts from the Chinese community in Boston, Massachusetts. They were randomized into a 12 week Tai Chi intervention or a wait-listed control group in a 2:1 ratio. All subjects were assessed at baseline, week 6 and week 12 using the 17item Hamilton Rating Scale for Depression (HAM-D17), the Clinical Global Impressions Severity (CGIS) and Improvement (CGII) Scale for overall improvement, Adverse Events Log for adverse events, the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ), and the Multidimensional Scale of Perceived Social Support (MSPSS). Positive response to treatment was defined a decrease of 50% or more of a patient's HAM-D17 score, and remission was defined as a score of 7 or less on the HAM-D17 at the week 12 assessment. **Results:** Subjects were 77% female, with a mean age of 55(±10). Twentysix (67%) of the subjects were randomized to receive Tai Chi training, and 13 (33 %) to the waitlisted control group. All 26 subjects in the Tai Chi intervention group and 11 (85%) of those in the control group completed the study. The Tai Chi intervention group, compared to the control group, had improved response rate (21% vs. 0%) and remission rate (19% vs. 0%), although the difference did not reach statistical significance. No adverse events were reported. **Conclusions:** A randomized controlled trial of Tai Chi is feasible and safe in Chinese American patients with moderate to moderately severe depression. The use of Tai Chi as an intervention of MDD warrants further investigation. **Key Words:** Depression, Chinese, Tai Chi, Mind Body Intervention, Randomized Clinical Trial; **Target Audience(s):** Psychiatrists, Psychologists, Social Workers, Primary Care Practitioners, Trainees

SCR18-3

HEALING THE MIND: THE ROLE OF SPIRITUALITY IN DEPRESSION*Chair: Elsa Russom, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) The efficacy of antidepressant with high degree of spirituality; 2) The role of spirituality in treating depression; 3) To investigate the role of spirituality and efficacy on patient with mental illness.

SUMMARY:

Introduction: There is more interest in recent years on spirituality and it plays a major role in the lives of our patients. There has been little work to understand the effect of spirituality on depressive symptoms. Despite the considerable interest in examining spirituality in mental health and its known protective factor against suicide, the role of spirituality in depression is understudied. There is a scarcity of instruments that measure this theory. Although many studies have suggested lower rates of depressive symptoms in those who report spirituality, few have investigated patients on antidepressants and the effect of spirituality on depressive symptoms and the effectiveness of antidepressants on patients who are spiritual. The objective of the study is to investigate if spirituality has any effect on lessening depressive symptoms and improvement on patients that are been treated on SSRI's when compared to non-spiritual patients on SSRI's. **Method:** A convenience sample of adult patients of an urban clinic completed a self-administered questionnaire consisting of Goldfarb et al.1996. In addition the patients were asked whether or not they believed in God. A total 84 patients were followed up for 8 to 12 weeks. The patients were treated with Escitalopram, Sertraline, or Paroxetine. DAS, MADRS and BECK Hopelessness' (BHS) scales was used to measure the depressive symptoms. **Result:** The higher the spirituality score, the lower the degree of depression as manifested by the above scales. Correlations between the prescores of the MADRS ($r=0.343$, $P=0.000$) the BHS ($r=0.42$, $P=0.000$) and DAS ($r=0.44$, $P=0.000$) were all significantly positively correlated with the spirituality score. The higher the initial spirituality score the greater the response to antidepressant treatment. **Conclusion:** The study shows that there is a greater decrease in depression in the patients with a high degree of spirituality and the greater the degree of spirituality the milder the initial depression. . There is a definite correlation between spirituality and improvement of symptoms of depression.

SCIENTIFIC AND CLINICAL REPORT SESSION 19**OCD AND OTHER COMPULSIONS**

SCR19-1**RELATIONSHIP BETWEEN PLASMA CLOMIPRAMINE LEVELS AND OCD SYMPTOMS IN ADULT PATIENTS**

Chair: Donatella Marazziti, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Increase their awareness on the clinical usefulness of routine drug monitoring, especially in OCD patients; 2) Understand how drug plasma levels may serve as predictor of response; 3) Take into account the gender issue when prescribing a given drug, at least in OCD patients; 4) Promote further studies in this field that might have a profound impact on the clinical practice.

SUMMARY:

The aim of this study was to explore the possible relationship between plasma clomipramine (CMI) and its major metabolite (DMCMI) levels and related parameters, and clinical features in OCD patients. Twenty-six OCD outpatients (13 men, 13 women), suffering from OCD were consecutively enrolled in the study. The severity of OCD was assessed by the Yale-Brown Obsessive Compulsive Scale (YBOCS). The measurements were carried out after four weeks and six months from the beginning of the treatment. The drug levels were measured by a HPLC method developed by us. The correlations between biological and clinical parameters were analyzed by means of the Spearman's correlation coefficient. The Mann-Whitney test was used for comparing biological and clinical variables between men and women. The results showed that CMI levels were related to the doses at the two assessment times. A significant and positive correlation was detected at the beginning between the DMCMI/ratio and the YBOCS total score, however this was true only for men, where the similar correlations were measured also with the YBOCS subscale. After six months of CMI, men showed a significant improvement of the compulsions. These findings would highlight the potential impact of assessing CMI plasma levels and their relationships with specific symptoms, as well as the influence of the gender on the drug response.

SCR19-2**PREVALENCE OF STALKING IN GENERAL MEDICAL PRACTICE**

Chair: Kathleen C. Dougherty, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be

able to: 1) List factors in medical practice which are associated with stalking behavior by patients; 2) Describe interventions undertaken by practitioners to manage stalking; 3) Describe educational measures in training which will alert trainees concerning the potential risk of stalking and methods to reduce this risk.

SUMMARY:

Stalking, a behavior initially used to describe predators approaching prey, has become an unwelcome feature of professional life for many psychiatrists and other mental health professionals. Those afflicted by mental illness often seek greater connection with those treating them, to an unwelcome degree. The problem is not confined to those of us treating mental illness; increasingly, medical colleagues are calling on us to help with out of control patients who intrude upon their personal lives and space. Several authors have described the incidence of stalking of mental health professionals, but there is little data among physicians in general. To determine the incidence of stalking among physicians, a survey was conducted of the medical staff at three large hospital centers. A surprisingly large number of physicians responded that they have been stalked, to varying degrees, and following variable courses. Data will be presented concerning incidence, types of stalking, which specialties and levels of training are most affected, and outcomes. We will also review data concerning preparation for stalking behavior in medical training.

SCR19-3**THE LONGTERM TREATMENT OF OBSESSIVE-COMPULSIVE DISORDER WITH SSRIS AND CLOMIPRAMINE WITH AND WITHOUT BENZODIAZEPINES**

Chair: Jyotsna Muttineni, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To evaluate the continued efficacy of pharmacologic treatment in preventing relapse of OCD symptoms; 2) To evaluate the difference between treatments in prophylaxis of OCD symptoms; 3) To assess the degree of OCD symptoms remaining despite medication.

SUMMARY:

Introduction: Obsessive compulsive disorder (OCD) is characterized by obsessions that cause marked anxiety or distress and compulsions that help to alleviate the anxiety (DSM IV TR). SSRIs and clomipramine are the most commonly used drugs to treat OCD, with varying efficacy. To estimate the efficacy of SSRIs and clomipramine and their longterm benefits we conducted a longitudinal evaluation in

a community clinic. Methods: Patients who met the criteria for OCD according to the DSM IV TR criterion were selected from an outpatient clinic in New York (n=103). Patients received either SSRIs or clomipramine with or without benzodiazepine. All patients treated for OCD who responded with a minimum 35% reduction in symptoms and Yale Brown obsessive compulsive scale (YBOC) with a score of 15 or less were selected. Results: 103 were involved in the study with follow up for up to 5 years. The 60 month survival analysis showed that 45 % patients continued to have remission of symptoms after 5 years. There was no significant difference in the medication (SSRIs, Clomipramine or SSRIs and Clomipramine + benzodiazepines) used in prophylactic outcome. Conclusion: A significant portion of patients who were successfully treated with the anti-obsessional regimen relapsed during the follow up period.

SCIENTIFIC AND CLINICAL REPORT SESSION 20

SCR20-1

UNDERSTANDING FATIGUE: THE COMPLEX RELATIONSHIP BETWEEN DEPRESSION AND SLEEP

Chair: Michael Best

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the effect of fatigue on mood and quality of life in patients with treatment resistant depression; 2) Appreciate the impact of sleepdisordered breathing on the severity of fatigue and mood symptoms, as well as on quality of life in patients with TRD;3) Realize the importance of screening individuals with depression for sleep disorders, due to the high prevalence of undiagnosed obstructive sleep apnea among individuals with treatment resistant depression.

SUMMARY:

Introduction: Major Depressive Disorder afflicts approximately 16.5% of individuals at some point in their lives, and is associated with significant functional impairment. Approximately 33% of individuals with depression will not achieve remission of their symptoms, even after multiple treatment attempts, and can be considered treatment resistant. Depression and Obstructive Sleep Apnea (OSA) have many common clinical, neuropsychological and functional features. The interaction between sleep, disordered breathing and mood is complex, multidimensional, and still not fully understood. Previous research demonstrates that persistent fatigue contributes to severe and prolonged impairment in the quality of life in individuals with depression. The current study aimed to (1) explore the effect of fatigue on quality of life in patients with treatment resistant

depression (TRD) and (2) to investigate the association between fatigue and subjective and objective measures of sleep quality in TRD. Method: Fiftysix patients with TRD and no previous diagnosis of sleep OSA completed questionnaires relating to mood and anxiety symptoms, subjective sleep quality, general health and quality of life. POMS fatigue subscale was used as a measure of fatigue and SF36 as a measure of quality of life. Participants underwent at home overnight polysomnography to obtain objective measures of sleep quality. Results: Fatigue scores were significantly correlated with mood ($r = .620$) and anxiety symptoms ($r = .343$, $p = .022$), and the following subcategories of quality of life: physical functioning ($r = .425$, $p = .003$), vitality ($r = .432$, $p = .002$), social functioning ($r = .396$, $p = .005$), mental health ($r = .346$, $p = .016$), overall physical component ($r = .286$, $p = .049$), and overall mental component ($r = .302$, $p = .037$). Participants' fatigue scores were significantly correlated with daytime sleepiness ($r = .388$, $p = .008$), and measures of sleep disordered breathing: apnea/hypopnea index (AHI; $r = .429$, $p = .003$) and respiratory disturbance index ($r = .422$, $p = .004$). In this sample of patients with TRD, 47% had an AHI greater than 5. Individuals in the subgroup of TRD with increased AHI had greater mood disturbance ($p = .006$), greater fatigue ($p < .001$), poorer general health ($p = .012$), lower vitality ($p = .030$), and greater role limitations due to emotional problems ($p = .041$), than patients with normal AHI. Conclusion: Our findings demonstrate a high prevalence (almost 50%) of OSA among patients with TRD. This may be an important contributory factor in the disabling fatigue that leads to severe functional impairment in TRD. We demonstrated that the level of fatigue is associated with more severe impairment in quality of life, when depression is comorbid with OSA. We were not able to show an association between fatigue and subjective sleep quality measures. Thus, screening for OSA and treatment of the sleep disorder is an important consideration for the improvement of quality of life in these patients.

SCR20-2

A CORRELATION OF THE PSYCHOSOCIAL DISTRESS STATUS AND THE PHYSICAL PERFORMANCE OF INDIVIDUALS WITH POLYTRAUMA HISTORY: TWO YEARS AND CHRONIC PAIN

Chair: Armando S. Miciano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine the Psychosocial Distress Status (PDS) of individuals with PolyTrauma history and chronic nonmalignant pain via an objective measure; 2) Assess the physical performance status of individuals with PolyTrauma and chronic pain using validated functional measures; 3) Analyze the effect of Psychosocial Distress, a painrelated

impairment, on the Physical Performance Status of individuals with PolyTrauma and chronic nonmalignant pain.

SUMMARY:

To minimize potential physical performance complications due to painrelated impairments, improving psychosocial distress status may necessitate adequate pain control with psychotherapy in individuals with PolyTrauma History >two years and with chronic pain. The objectives were to determine the psychosocial distress due to painrelated impairment (PRI) of individuals with Polytrauma history (PTM) >two years and chronic nonmalignant pain (CNMP) using the selfreported Psychosocial Distress Status (PDS) subconstruct of the Pain Disability Questionnaire (PDQ), a quantitative assessment of PRI from the AMA Guides to Evaluation of Permanent Impairment 6th Edition, and to investigate the correlation between PDS and scores from clinicianderived Physical Performance Tests (PPT). A retrospective crosssectional study was done in an outpatient Physical Medicine and Rehabilitation (PM&R) clinic on 34 subjects with PTM & CNMP identified by the SelfAdministered CoMorbidity Questionnaire. The 15item PDQ was scored on a 10point scale: mild PRI (070); moderate (71100); severe (101130); and extreme PRI (131150). The Berg Balance Scale (BBS) and 6Minute Walk Test (6MWT) were used as PPT. Pearson correlation coefficients (r) examined PDS and PPT association. An alpha of .01 was used for statistical tests. Total PDQ, subcategorized in PRI severity, resulted in: 27% mild; 38% moderate; 29% severe; and, 6% extreme PRI and was also further divided into Functional Status (FS) versus Psychosocial Distress (PD) Status. The PD scores ranged from 8 to 55/60 points with an average 37/60 points. Comparing the effect of the PD over FS revealed that 25% of the total PDQ score (range 537%) was due to PD of the PTM. A statistically significant negative correlation was found between Total PDQ score and: BBS ($r=.577$, $p=.005$), 6MWT distance ($r=.468$, $p=.005$), 6MWT metabolic equivalents METs ($r=.482$, $p=.004$), & 6MWT speed ($r=.447$, $p=.008$). The PD subscore also had a statistically significant negative correlation with BBS ($r=.472$, $p=.005$), while the FS subscore was negatively correlated with: BBS ($r=.596$, $p=.001$), 6MWT distance ($r=.539$, $p=.001$), METs ($r=.545$, $p=.001$), and speed ($r=.527$, $p=.001$). Most PolyTrauma subjects scored in the moderate pain impairment category, and the psychosocial distress due to the PRI had a statistically significant negative effect on BBS scores. Decreasing the psychosocial distress in PTM with CNMP will significantly improve the dynamic balance deficits in these individuals and overall improve their physical performance. These findings suggest that the selfreported PDS subconstruct is a reliable indicator of physical performance status, and would be valuable as an alternative to PPT in a busy clinical practice. The PDQ is a valid, subjective report and further research into its applica-

tion amongst other patient populations, such as in Chronic Fatigue Syndrome, would be beneficial.

SCR20-3

THE USE OF A NOVEL MULTICOIL RTMS DEVICE FOR THE TREATMENT OF FIBROMYALGIA PAIN: RESULTS OF A FEASIBILITY STUDY

Chair: M. Bret Schneider, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the potential of a novel multicoil rTMS therapy for use in the treatment of fibromyalgia pain; 2) Briefly describe the mechanism of action of the multicoil approach for the treatment of fibromyalgia pain; 3) Understand the difference in effectiveness between low and high frequency rTMS for the treatment of fibromyalgia pain.

SUMMARY:

Limited clinical studies have demonstrated that single coil repetitive transcranial magnetic stimulation (rTMS) may be effective in the treatment of fibromyalgia (FMS) pain. We report the results of a limited clinical study evaluating different coil configurations of a novel multicoil rTMS device (Cervel Neurotech, San Mateo, CA). A multicoil approach enables independent electromagnetic coils to produce direct effects at specific regions of brain both at the cortical surface, and beneath the cortical surface, including the left dorsolateral prefrontal cortex and the dorsal anterior cingulate. The study population included 45 subjects, ages 18-65 with a clinical diagnosis of FMS as defined by American College of Rheumatology criteria and a baseline pain score of > 4 as established by the Baseline Pain Inventory (BPI) administered during each of five baseline visits. Concomitant medications allowed for the treatment of pain and included SNRIs, SSRIs, and oral amitriptyline = 100 mg once daily at bedtime. Each subject received 20 rTMS sessions administered at 120% of motor threshold on consecutive weekdays. Four treatment groups were compared: Fourcoil array at 1Hz (real) $n=17$; fourcoil array at 1Hz (sham) $n=19$; fourcoil array at 10Hz (openlabel) $n=5$; twocoil array at 10Hz (openlabel) $n=4$. The primary effectiveness endpoint was percent change in BPI average pain intensity over the last 24 hours from baseline to visit PT1 (24 to 72 hours after the final rTMS treatment). Subjects treated with the fourcoil 10 Hz configuration significantly improved, with mean reduction in pain scores of 43%. Improvement in each of the other active treatment arms did not exceed that of the sham group. Both multicoil rTMS configurations were well tolerated with few side effects. Further studies to address the limitations, including lack of sham arm in the 10 Hz groups and small numbers, are needed to better understand the

role of this novel rTMS approach for the treatment of FMS pain.

SCIENTIFIC AND CLINICAL REPORT SESSION 21

TBI RESOURCES AND COOCCURRING DISORDERS

SCR21-1

DCOE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY: RESOURCES AND PROGRAMS

Chair: Lolita O'Donnell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Promote resilience, rehabilitation, and reintegration for warriors, families and veterans with psychological health concerns and traumatic brain injuries.; 2) Utilize DCoE resources designed for providers and case managers treating service members with psychological health concerns and traumatic brain injuries; 3) Recognize opportunities and refer service members and their families to DCoE Programs; these include InTransition, the outreach center, and the Real Warriors Campaign.

SUMMARY:

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) works across the entire continuum of care to promote resilience, rehabilitation and reintegration for warriors, families and veterans with psychological health concerns and traumatic brain injuries. Toward this end, DCoE has developed products specifically for providers and case managers treating service members. Most products are available downloadable from the DCoE website, therefore increasing the availability and overall reach. These products include, but are not limited to, the Mild TBI Pocket Guide, CoOccurring Conditions Toolkit, Case Management Guidance for TBI and Concussions, Major Depressive Disorder (MOD) toolkit, and Clinical Practice Guidelines. Additionally, the Substance Use Disorder (SUD) Toolkit is in development. In addition to providing resources, DCoE has established programs and initiatives designed to support service members, families, and health care providers. These include: DCoE Outreach Center, a 24/7 hotline staffed by trained health resource consultants who are able to provide information and resources on topics relating to psychological health and traumatic brain injury. Real Warriors Campaign, which is working to encourage helpseeking behavior for warriors with post-traumatic stress or mTBI. DCoE Monthly Webinar Series, which hosts approximately 250 participants per month and features presentations by subject matter experts. Previous presentation topics have addressed: Support for Caregivers,

Recurrent Concussions, and Reintegration. Sesame Workshop: Listen, Talk, Connect, which addresses issues related to multiple deployments; family changes that occur when a parent is physically or psychologically injured; and the loss of a parent. The Sesame Workshop series uses recognizable characters to explain, in a manner understandable to young children, the situations that military families face. DCoE Chaplain Working Group, which meets quarterly and facilitates collaboration between DCoE and military chaplains in every service. InTransition program, which supports the needs of service members as they relocate, return from deployment, or transition between active duty and reserve. Each service member enrolled in the program is assigned to a Transition Support Coach; the TSC is involved throughout the transition in order to facilitate the continuation of treatment.

SCR21-2

SLEEP DYSFUNCTION: THE TBI AND PSYCHOLOGICAL HEALTH COOCCURRING DISORDERS DILEMMA

Chair: Dorothy Kaplan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the overlapping spectrum of symptoms related to mild TBI and psychological health disorders in the deployed and postdeployment Service member; 2) Be able to diagnose and treat effectively basic sleep problems in the context of concussion and other psychological health disorders such as PTSD, Acute Stress Disorder, Depression, and Attention problems.; 3) Be acquainted with and able to use effectively clinical support tools, such and the Cooccurring Disorders Toolkit: mild TBI and Psychological Health Disorders, in diagnosing and treating patients with complex presentations.

SUMMARY:

Mild Traumatic Brain Injury (mTBI) is one of the most frequent injuries seen in the wars in Afghanistan and Iraq. It is defined by a loss or impairment of consciousness. There is a spectrum of severity of mTBI and defining where a given patient is on that spectrum remains difficult. Additionally while some neurocognitive impairment is the defining sequella of concern for mTBI it is not the symptom most commonly brought to the attention of providers. Symptoms defined as cooccurring disorders that often accompany mTBI are more frequently what bother patients the most. The most common complaints after mTBI are headache and sleep disorders. Psychological health (PH) conditions such as posttraumatic stress disorder (PTSD), acute stress disorder, depression, substance abuse and attention prob-

lems are frequently seen in this same population of service member. It is also not unusual for patients to present with various combinations of these conditions, making diagnosis difficult and treatment complicated. This is further complicated as the symptoms of these disorders are similar and overlapping. Sleep problems are an index example of disorders than can be secondary to both mTBI and PH disorders. As a result of this combination of overlapping symptoms it is not unusual for a patient to see multiple providers including primary care providers, behavioral health providers, neurologists, emergency physicians, sleep specialists and pain specialists. It is easy for the patient to end up with a polypharmacy of medications trying to treat the various disorders. Clinical practice guidelines exist to diagnose and manage most of these disorders, but managing the service member with multiple conditions can be challenging. The “Cooccurring Disorders Toolkit: mTBI and PH disorders” was developed to provide a clinical support tool as a basis for diagnosing and treating these complex patients. Sleep disorders will be used as a bridge to discuss management of these conditions and appropriate use of clinical supports tools such as the toolkit.

SCIENTIFIC AND CLINICAL REPORTS

TUESDAY, MAY 8, 2012

SCIENTIFIC AND CLINICAL REPORT SESSION 22

PREGNANCY AND POSTPARTUM

SCR22-1

INTRAFAMILIAL STUDY OF PREGNANCY COMPLICATIONS IN ATTENTIONDEFICIT/ HYPERACTIVITY DISORDER

Chair: Venkataramana Bhat, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify that: Children with ADHD have a higher prevalence of overall complications during pregnancy as compared to their nonaffected siblings; 2) Identify that: Complications are not significantly different during the different stages of pregnancy, labour, delivery and neonatal period; 3) Identify that: Nonshared environmental factors (experienced by 1 family member to the exclusion of the others) play an important role in the genesis of ADHD.

SUMMARY:

Objective: Epidemiological studies show that the variance in ADHD phenotype has a strong genotypic (75 to 80 %) and environmental (10 to 25%) contribution. The environmental contribution is mainly due to nonshared envi-

ronmental factors (factors such as maternal complications experienced by one member of the family to the exclusion of others) rather than shared environmental factors (factors common to all the members of the family). Case/control epidemiological studies are unable to distinguish between shared and nonshared environmental factors. Our intrafamilial design (comparing children affected with ADHD to their siblings) reduces the number of confounding factors, thus giving a more reliable picture of the environmental and genotypic contributions to the phenotype. Method: Children with ADHD were recruited at the Douglas Mental Health University Institute. The diagnosis of ADHD was based on a structured interview by clinicians and reports from parents and teachers. Restricted Academic Situation Scale (RASS) scores, Continuous Performance Test (CPT), and Child Behavior Checklist (CBCL) were also used as measures of ADHD symptoms in children with ADHD. The Kinney Medical and Gynecological Questionnaire and the McNeil–Sjöstrom Scale were used to assess incidence of Pregnancy, Labor, Delivery and Neonatal Complication (PLDNC) for both children with ADHD and their unaffected siblings. The affected sibling was matched with the unaffected sibling closest in age, and whenever possible of the same gender. This resulted in a total of one hundred and sixteen sibling pairs (n=116) and a Mixed-Model Analysis of Variance (MMANOVA) was carried out. Results: There was a significant difference in rank of birth and gender between children with ADHD and their nonaffected siblings. Thus, the MMANOVA was carried out with rank of birth and gender as covariates among the sibling pairs. There was a significant difference in PLDNC among children affected with ADHD as compared to their unaffected siblings ($F=4.49$, $df=1$, $p=.03$). However, there was no significant interaction between the different stages of PLDNC and presence of ADHD. Conclusions: Children with ADHD have a higher prevalence of overall complications during pregnancy as compared to their nonaffected siblings, and complications are not significantly different during different stages of PLDNC. Thus, PLDNC appear to be among nonshared environmental factors (experienced by 1 family member to the exclusion of the others) implicated in ADHD. Further studies based on a similar intrafamilial design with much bigger sample sizes are necessary. Higher prevalence of PLDNC complications suggest that the period surrounding pregnancy might be of particular relevance to the aetiology of ADHD. Finally, the interaction of relevant genotypes with the pregnancy complications might be of particular importance in the genesis of ADHD. Research Funding: Canadian Institutes of Health Research.

SCR22-2

ANTIPSYCHOTICS DURING PREGNANCY: RELATION TO FETAL AND MATERNAL METABOLIC EFFECTS

Chair: Robert Bodèn, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the association between antipsychotics use during pregnancy and the risk for gestational diabetes and the impact of maternal body mass index; 2) Have a deeper knowledge of the risk associated with antipsychotics use during pregnancy and giving birth to an infant being small for gestational age and the role of maternal confounding factors; 3) Describe the relation between use of antipsychotics with different metabolic profile and anabolic fetal growth and macrocephaly.

SUMMARY:

Knowledge about pregnancy exposure to antipsychotics is limited, especially for the most obesogenic and insulin resistance-prone compounds olanzapine and clozapine. Our objective was to investigate the effects of maternal use of antipsychotics during pregnancy on gestational diabetes and fetal growth. The study was designed as a population-based cohort study based on data from Swedish national health registers. All women giving birth in Sweden between 2005 and 2009 were included. The women were classified according to exposure defined as prescription fills of antipsychotics during pregnancy: olanzapine or clozapine ($n=169$), other antipsychotics ($n=338$) and no antipsychotics ($n=357\ 696$). Odds ratios (ORs) with 95% confidence intervals (CIs) for the following outcome measures were calculated: gestational diabetes, small for gestational age (SGA) and large for gestational age (LGA) for birth weight, length and head circumference. Exposure to olanzapine or clozapine was associated with an increased risk of gestational diabetes (OR 2.39, 95% CI 1.125.13) as was exposure to other antipsychotics (OR 2.78, 95% CI 1.644.70). After adjusting for maternal body mass index the increased risk for gestational diabetes was no longer significant. Infants exposed to antipsychotics had a higher risk of being born SGA on weight; the OR for olanzapine or clozapine was 2.42 (95% CI 1.244.70) and for other antipsychotics 2.11 (95% CI 1.293.47). Further, infants exposed to other antipsychotics had a higher risk of being born SGA for birth length (OR 2.29, 95% CI 1.413.73) and SGA for head circumference (OR 2.19, 95% CI 1.333.62). All risks for SGA were attenuated after adjusting for maternal factors. Contrary to our hypothesis, no increased risks of being born LGA for birth weight and length were observed in infants exposed to olanzapine or clozapine, but there was an increased risk of macrocephaly (OR 2.59, 95% CI 1.384.88). In conclusion, women using antipsychotics during pregnancy had a higher risk of gestational diabetes and giving birth to an SGA infant. Gestational diabetes risk increase was probably mainly mediated through obesity and the risk increase for having

an SGA infant may be explained by maternal confounding factors. Olanzapine or clozapine exposure was not associated with anabolic fetal growth, but macrocephaly.

SCR22-3

DOES NEW JERSEY'S SCREENING LAW INCREASE THE DETECTION OF POSTPARTUM DEPRESSION?

Chair: Jane B. Sofair, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the national antecedents and public health impetus of the New Jersey postpartum depression screening law, s213, passed in 2006; 2) Understand the contents of S213, how s213 has been implemented across the state as well as in this study setting, and to appreciate the law's limitations in the detection of perinatal depression; 3) Understand cultural and timing barriers that can develop while screening for depression among new mothers, and to recognize where additional research is needed.

SUMMARY:

Background: Responding to the public health impact of perinatal depression, in the year 2006, the state of New Jersey mandated depression screening at delivery and within the first six postpartum weeks. Since then, the Edinburgh Postnatal Depression Scale (EPDS) has been adapted as the preferred depression screening tool, though not stipulated by the law. This IRB-approved retrospective chart review was conducted to assess screening compliance and utility of the law, indicated by an increase in detected prevalence of perinatal depression. Methods: Two hundred randomly selected, deidentified charts of healthy pregnant women in two hospitals and a private practice spanning 2005 through 2008 were reviewed. Compliance was measured by determining the percentage of charts with EPDS recorded. Perinatal depression was defined, using the ACOG Ante partum record, as any history of 1) affective symptoms 2) psychotherapy and 3) psychotropic medication immediately prior to, during, and following the current pregnancy, along with an EPDS score > 10 for the postlaw group. Demographic data and depression risk factors were gathered. Pre and postlaw groups were compared for prevalence of perinatal depression and demographic characteristics using the Chi-square test for categorical variables and the *t*-test for continuous variables. All statistical analyses were performed using Minitab® 15.1.1.0. Results: The final study sample was 165, 84 in prelaw and 81 in the postlaw group. Hispanic women comprised 53% of the postlaw group compared to 21% in prelaw ($p = 0.004$). High compliance rate at delivery was observed in the postlaw group as indicated by the high percentage of charts with documentation of EPDS at

delivery, ranging from 83% to 100%. Compliance at six weeks postpartum was lower, ranging from 54% to 67%. Only 8% of the prelaw group and 14% of the postlaw group met perinatal depression criteria ($p = 0.28$). There were no significant intergroup differences regarding history of substance abuse, nor subsequent referral for psychiatric intervention. Discussion: This study showed high compliance at delivery with the New Jersey law for screening depression. Despite a trend toward increased prevalence of perinatal depression, we were unable to demonstrate the impact of the law on increased detection at large. Future studies should address environmental, timing, and cultural barriers, statewide initiatives, and optimal time to screen for a more conclusive evaluation of the law.

SCIENTIFIC AND CLINICAL REPORT SESSION 23

PROFESSIONAL ISSUES

SCR23-1

BURNOUT AMONG PSYCHIATRISTS AND PEDIATRICIANS AT LAC AND USC MEDICAL CENTER

Chair: Torang S. Sepah, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define physician burnout; 2) Identify factors related to burnout among physicians; 3) Identify burnout ratings among psychiatrists and pediatricians at LAC+USC, with comparison among the two groups as well comparison among resident levels.

SUMMARY:

Objective: To identify the prevalence of burnout among staff and resident psychiatrist and pediatricians at LAC+USC Medical Center. **Methods:** The Maslach Burnout Inventory, a 22-question instrument designed to assess three components related to burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA) as well time spent feeling depressed while at work was administered to residents and staff at LAC+USC Medical Center in April 2011 (N=92 with 44 psychiatrist and 48 pediatricians). **Results:** There was a statistically significant difference in depersonalization between psychiatrists and pediatricians, with psychiatrists having a higher level of depersonalization. Among all psychiatrists (residents and staff), there were no statistically significant differences among the three categories (emotional exhaustion, depersonalization or personal accomplishment) by level of experience. Within pediatrics, however, there were statistically significant differences among residents and staff in regards to emotional exhaustion ($p = 0.02$) as well depersonalization ($p < 0.01$), and more days depressed at work ($p = 0.02$), with all three

being higher among residents than staff. Seventy percent of psychiatrists were categorized as having moderate to high levels of burnout. Conclusion: Data suggests that the psychiatrists may be at greater risk for burnout than physicians in other specialties. Also, residency may be less of a factor in burnout for psychiatry than other specialties, such as pediatrics. Psychiatrists at LAC +USC have higher levels of burnout than previously reported for psychiatrists which was 66% by Kumar et. al in 2007.

SCR23-2

LEARNING FROM A CASEBASED WORKSHOP FOR INTERPROFESSIONAL AUDIENCE

Chair: Diana Kljenak, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe how to design a successful workshop for interprofessional audience; 2) Become familiar with interactive casebased education about common countertransference reactions that “difficult” patients invoke; 3) Become familiar with a method of workshop development on how to diagnose and manage “difficult” clinicianpatient interactions for interprofessional audience of six community health centers.

SUMMARY:

Introduction: The literature indicates that as many as 15% of patientphysician encounters are perceived as difficult. Patients who are perceived as difficult are more likely to have a mental disorder. In Canada, and around the world, primary care providers are the main source of mental health services for the majority of patients. Therefore primary care providers are in pivotal position to affect health outcomes. However, they may not have adequate training to enable them to deal with problematic clinicianpatient interactions that are challenging even for the most experienced clinicians. Interprofessional collaboration emphasizes the opportunities for health care providers from different professions and work settings to work together to provide more coordinated and effective services for “difficult” patients. **Methods:** A halfday workshop was designed with the aim to enhance community health care providers’ capacity to diagnose and manage “difficult” patients. The workshop consisted of a didactic presentation and casebased small group learning. The main emphasis was on education about common countertransference reactions that “difficult” patients invoke. Case examples served as a platform for reflection on audience’s countertransference reactions that then helped reframe the problem from “difficult” patient to “difficult” clinicianpatient interaction. **Results:** The workshop was evaluated by participants. 100% of respondents agreed that the work-

shop was relevant to their work and 87.5% of respondents reported that the workshop will alter their clinical practice. Conclusion: Mismanagement of difficult clinician-patient encounters can result in poor outcomes. Educating community health care providers to recognize countertransference feelings that “difficult” patients invoke and learn strategies to manage difficult encounters more effectively has a crucial role in maximizing the care that they provide. The workshop has met participants’ perceived learning needs as well as served as a pilot program for a larger conference for interprofessional audience on managing difficult clinician-patient interactions.

SCR23-3

PSYCHOTHERAPY PRACTICES OF PSYCHIATRISTS IN THE UNITED STATES: PATTERNS, TRENDS, AND REPORTED BARRIERS TO PSYCHOTHERAPY

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand current patterns and trends in the provision of psychotherapy by psychiatrists in routine practice settings in the United States; 2) Characterize current financial, administrative, and other barriers psychiatrists face in practicing psychotherapy; 3) Understand implications and potential responses to the challenges psychiatrists face in providing or arranging for psychotherapy for their patients.

SUMMARY:

Background: Although psychotherapy is an evidencebased treatment which improves patient outcomes for a range of diagnoses, psychotherapy visits decreased from 44% to 29% between 1997 and 2005. Factors related to this decline include changing fee structures, increased pharmacology, and rising caseloads. In 2010, the American Psychiatric Institute for Research and Education, APA’s Committee on Psychotherapy by Psychiatrists, and the Canadian Psychiatric Association collaborated on the “Study of Psychiatrists’ Practices and Barriers to Psychiatric Treatment.” Aims: 1) Report current patterns of psychotherapy provided by psychiatrists in routine practice settings; 2) Examine trends in psychotherapy practices; 3) Characterize barriers to practicing psychotherapy. Methods: For the US study, 3,000 APA members with email addresses, excluding medical students and residents, were invited to complete a 36item electronic survey. After excluding those with undeliverable email addresses, 14% (N=407) responded; 97% (N=394) reported currently practicing psychiatry and treating psychiatric patients. Results: Respondents reported providing psychotherapy to 55% of patients treated in their last typical

work week. Psychotherapy alone was provided for 10% of patients; psychotherapy in conjunction with pharmacotherapy for 46%; and pharmacologic treatment alone for 39%. Although two thirds of all patients received combined pharmacotherapy and psychotherapy, nearly half (47%) received psychotherapy from another clinician. Psychiatrists reported most commonly providing psychotherapy once (29%) or twice (20%) a month, or once a week (27%). More than half (55%) of the psychotherapy visits were greater than 30 minutes. Supportive psychotherapy (80%), cognitive behavioral therapy (50%), and psychodynamic therapy (45%) were the most frequently reported techniques. Major barriers to providing psychotherapy included inability of patients to afford services (49%); low reimbursement levels from third party payers (47%); administrative burdens in dealing with insurance companies and thirdparty payers (45%); pressure to spend more time on diagnostic, pharmacologic or other consultations (27%); and pressure to treat psychotherapy patients for shorter or fewer sessions than required (27%). 45% of psychiatrists reported having problems finding another clinician to accept a new psychotherapy patient. About half reported being reimbursed less for psychotherapy than for pharmacotherapy; a majority (79%) would increase the proportion of psychotherapy patients if they were reimbursed at levels comparable to pharmacotherapy services. Conclusion: US psychiatrists continue to provide psychotherapy for most of their patients, either alone or combined with pharmacotherapy. However, a large proportion of patients do not receive psychotherapy. Psychiatrists interested in providing psychotherapy services to their patients face financial, administrative and other barriers.

SCIENTIFIC AND CLINICAL REPORT SESSION 24

PSYCHOSOMATICS

SCR24-1

FREQUENCY OF DEPRESSION AND ANXIETY IN DISSOCIATIVE CONVERSION DISORDER PATIENTS REPORTING AT A TERTIARY CARE PSYCHIATRIC FACILITY OF FAUJI FOUNDATION

Chair: Mazhar Malik, M.B.B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To estimate the frequency of depression and anxiety in dissociative (conversion disorder) patients reporting at a tertiary care Psychiatric facility of Fauji Foundation Hospital Rawalpindi; 2) To understand different clinical presentations of Dissociative(Conversion) Disorder patients presenting at a tertiary care facility in an Asian setting; 3) To identify important Psychosocial Stressors involved in the psychopathology of development of Dissociative (Conver-

sion)Disorder

SUMMARY:

OBJECTIVES To estimate the frequency of depression and anxiety in dissociative (conversion disorder) patients reporting at a tertiary care Psychiatric facility of Fauji Foundation Hospital Rawalpindi. **METHODS** A descriptive cross-sectional study was carried out in the Psychiatry Department of a tertiary care facility Fauji Foundation Hospital Rawalpindi. 100 consecutive patients (both inpatients and outpatients) of both sexes between ages of 13 to 60 years, diagnosed as conversion disorder from December 2009 to May 2010 were included in the study. The diagnosis was based on the criteria laid down by ICD10 International classification of mental disorders, 10th edition). The patients suffering from physical illnesses, organic brain disease, psychiatric comorbidity other than depression and anxiety, substance abuse, learning disability, those having language barrier, those who refused to participate in study were excluded from the study. Participating patients underwent detailed assessments which included: application of consent form, physical examination, ICD10 diagnostic criteria of conversion disorder, demographic profile assessment, and Hospital Anxiety and Depression Scale (HAD). The data was entered into SPSS package version 10. Different morbid states including anxiety and depression were represented in the form of frequencies. **RESULTS** This study revealed a substantially high frequency of depression and anxiety in dissociative (conversion disorder) patients reporting at a tertiary care psychiatric facility of Fauji Foundation Hospital, Rawalpindi. Majority of patients were young, female, formally educated, rural residents, unmarried, unemployed, having no family history of mental illness and presented through outpatients department. Regarding frequency of type of dissociative (conversion) disorder, dissociative convulsions (63%) were the most common presentation followed by dissociative motor disorder (24%), mixed dissociative disorder (8%), dissociative anesthesia and sensory symptoms (4%) and trance and possession disorder (1%). Hospital anxiety and depression scale analysis revealed that both anxiety and depression scores were clinically significant in majority of patients. **CONCLUSION** The present study showed substantially high rates of depression (61%) and anxiety (60%) in Conversion Disorder patients presenting at Psychiatric facility of a tertiary care facility of Fauji Foundation Hospital Rawalpindi. The sample size was too small to generalize the conclusion that's why further research involving larger sample size and longitudinal follow up is required to elucidate the possible perspective. **Key words:** Conversion disorder, depression, anxiety.

SCR24-2

THE RELATIONSHIP OF HEALTH ANXIETY TO

STATE ANXIETY, DEPRESSION, SOMATIC SYMPTOM BURDEN, AND DISABILITY IN A TERTIARY PSYCHOSOMATIC MEDICINE POPULATION

Chair: Jeffrey P. Staab, M.D., M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define health anxiety; 2) Recognize the utility of identifying health anxiety in patients with psychosomatic presentations; 3) Understand the relationship of health anxiety to other types of state anxiety and depression.

SUMMARY:

Objective: Health anxiety is an empirically derived concept that includes heightened awareness of bodily sensations, excessive worry about causes and consequences of physical symptoms, catastrophic fears about sickness, and difficulty being reassured about health status. It is a more dimensional construct than the categorical diagnosis of hypochondriasis contained in DSMIII/IV and is one criterion for the new diagnosis of complex somatic symptom disorder proposed for DSM5. However, the concept of health anxiety was derived from studies of normal individuals, primary care outpatients, and patients with DSMIII/IV anxiety disorders or hypochondriasis. Its validity has not been established in psychosomatic medicine patients or tertiary care settings, where it could be encountered quite frequently. This study tested the hypothesis that health anxiety captures a dimension of illness beyond the "SAD triad" of somatization, anxiety, and depression in tertiary care psychosomatic medicine outpatients. **Methods:** 800 consecutive patients referred to an outpatient psychosomatic medicine practice at a tertiary medical center from February to August 2011 completed the Patient Health Questionnaire (PHQ9), Generalized Anxiety Disorder Scale (GAD7), short form Health Anxiety Inventory (SHAI), and Sheehan Disability Scale (SDS), plus an institutional review of symptoms (ROS) checklist containing 67 items covering all major body systems. Exploratory factor analyses were performed on all items from the four validated questionnaires and the ROS checklist to examine relationships among elements of health anxiety, state anxiety, depression, somatic symptom burden, and disability. **Results:** Subjects averaged 46±15 years of age (range 18-88), with a 2:1 ratio of women to men. A wide variety of psychosomatic problems and a full range of scores on self-report questionnaires were represented in the study population. The most parsimonious solution contained four factors regardless of factor rotation method. They were [1] affective symptoms (GAD7 plus primary loading of PHQ9 items), [2] disability (SDS plus secondary loading of PHQ9 items), [3] health anxiety (SHAI items loading quite distinctly from GAD7 and PHQ9 items), and [4] somatic symptom burden (ROS items). These factors accounted for

10.6%, 9.8%, 6.5%, and 4.8% of unique variance, respectively. Conclusion: Health anxiety emerged as a unique factor in the clinical presentation of tertiary care psychosomatic medicine patients, separate from state anxiety/depression, somatic symptom burden, and disability. These results support efforts to include health anxiety in DSM5 and suggest a need to develop treatment interventions specifically for health anxiety in psychosomatic medicine outpatients.

SCR24-3

DEVELOPING AN EMERGENCY PSYCHIATRY CONSULTATION SERVICE WITHIN A CL PROGRAM: IMPACT AND CHANGE

Chair: Henry W. Weisman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the differences in assessment, diagnoses and treatment of patients seen in CL and emergency settings; 2) Develop an emergency psychiatry function within a CL/psychosomatic medicine program; 3) Enhance psychiatric residents' skills in emergency psychiatry at the medicalpsychiatric interface; 4) Describe the impact of adding emergency psychiatric functions to a consultationliaison service.

SUMMARY:

Consultationliaison psychiatry and emergency psychiatry share many characteristics. Both require rapid assessment and treatment of individuals facing crises, are often practiced in nonpsychiatric settings, and require that clinicians integrate multiple psychosocial, and medical factors in treating patients. However there are significant differences between the two fields. This project explores the impact of the development of a psychiatric emergency program within a psychosomatic medicine/CL service. As a result of financial considerations, as well as other major changes in our medical center and department, the CL service assumed responsibility for provision of psychiatric care to our busy urban academic medical center's emergency department. We present here the results of a year of this effort. Although the number of residents assigned to the service increased, how would this change effect our service's staffing needs, clinical activities, and the experience of our residents, as well as the relationship between the two departments? What would be the differences in the two programs in terms of patient demographics, diagnoses, interventions and models of services? After 4 months, the numbers of consults provided to the two programs intersected, followed by ER consults taking and maintaining the lead. Consults doubled; however consultations to medical surgical services increased as did child psychiatry consults. Patients seen in the ER were

younger, often had established psychiatric diagnoses, and required more frequent psychiatric admissions. They were more likely to threaten but not to have attempted suicide. Inpatient consults were more likely to have focused on decisional capacity, ethics and pain issues. In terms of resident experiences, the ER program demanded more knowledge of acute use of psychotropics, techniques of testifying in mental health court and interaction with the local mental health authority. In terms of models of service, the consultation model did not work in the ER, and the service evolved more of a liaison focus with frequent comanagement and psychiatric supervision of ER house staff. While the psychosomatic medicine focus was somewhat diluted, a richer, more varied clinical experience emerged, and CL psychiatry assumed a more central visible role within the hospital. The incorporation of emergency psychiatry functions within a psychosomatic medicine service improved the viability of both the service and the residency, without sacrificing the program's clinical and academic integrity.

SCIENTIFIC AND CLINICAL REPORT SESSION 25

SCHIZOPHRENIA PART 1

SCR25-1

EPIDEMIOLOGY OF SCHIZOPHRENIA PATIENTS INITIATING LONGACTING INJECTABLE VERSUS ORAL ANTIPSYCHOTICS AMONG U.S. MEDICARE AND NONMEDICARE POPULATIONS

Chair: Bruce J Wong, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Determine patient epidemiology and demographic characteristics among schizophrenia patients; 2) NonMedicare patients using depot antipsychotics were older with more comorbidities and significant differences in healthcare coverage compared to patients using oral antipsychotics; 3) Medicare oral antipsychotic users were older and had significantly more comorbid conditions than depot antipsychotic users.

SUMMARY:

Background: To determine the demographic and clinical characteristics of schizophrenia patients initiating antipsychotic depot injections or oral antipsychotics, stratified by Medicare coverage status. Method: Schizophrenia patients prescribed longacting injectable (LAI) or oral antipsychotics (AP) were identified from the MarketScan Commercial and Medicare databases, US national health plan claims databases, between 1/1/2005 and 9/30/2010, with the earliest LAI or oral drug usage as the index event. Patients with either Medicare or Commercial health plan (nonMedicare)

coverage were separated into two mutually exclusive LAI and Oral AP initiating cohorts based on the index AP use and were required to have no LAI and Oral AP drug usage, respectively, during the 12 month preindex baseline period. Patients were also required to be ≥ 13 years at the index event and have ≥ 12 months of continuous coverage prior to the index event. For each cohort, patient demographic and clinical characteristics were measured during the baseline period. Results: Among the nonMedicare population, 394 patients initiating LAI and 2,610 patients initiating Oral AP were identified during the study period. LAI patients were older (41.7 vs. 37.1 years; $p < 0.0001$) and a greater proportion had comprehensive healthcare coverage (18.8% vs. 9.8%) while a smaller proportion had HMO (17.8% vs. 26.1%) or point of service (9.6% vs. 13.0%) coverage ($p < 0.0001$). While the Charlson Comorbidity Index (CCI) scores were comparable between LAI and Oral AP cohorts, a greater proportion of LAI patients were diagnosed with diabetes (15.0% vs. 9.7%; $p = 0.001$) or peripheral vascular disease (PVD, 2.3% vs. 1.0%; $p = 0.03$). Among the Medicare population, 147 patients initiating LAI and 518 patients initiating Oral AP were identified. Oral AP patients were older (73.2 vs. 67.2 years; $p < 0.0001$) with higher CCI scores (1.83 vs. 1.24; $p = 0.0004$). Higher proportions of the Oral AP patients were diagnosed with cardiovascular disease (24.5% vs. 12.9%; $p = 0.003$), dementia (19.7% vs. 11.6%; $p = 0.02$), PVD (11.6% vs. 5.4%; $p = 0.03$), and cancer (9.1% vs. 2.7%; $p = 0.01$). Among both the Medicare and nonMedicare populations, a greater proportion of LAI patients live in North Central US (Medicare: 66.7% vs. 44.8%, nonMedicare: 47% vs. 29.5%) while more patients using oral APs are located in the western US (Medicare: 15.6% vs. 2.7%, nonMedicare: 24.9% vs. 9.4%). Conclusions: There are important differences in patient characteristics among those who received LAI and Oral AP between the Medicare and nonMedicare populations. NonMedicare patients using LAI APs were older and had significant differences in healthcare coverage compared to patients using oral APs. Medicare oral AP users were older and had more comorbid conditions than LAI AP users. These differences may have implications on effective schizophrenia management. Disclosure: Funding for this research was provided by Otsuka America Pharmaceutical.

SCR25-2

GLYCINE REUPTAKE INHIBITOR (GRI) ENHANCES NMDA RECEPTOR ACTIVITY: A NOVEL APPROACH TO THE TREATMENT OF SCHIZOPHRENIA

Chair: Daniela Alberati, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the history of the NMDA hypothesis of

schizophrenia; 2) Recognize the potential for a new approach in treatment for schizophrenia, addressing positive, negative and cognitive symptoms by targeting NMDA hypofunction; 3) Describe the effect the GRI RG1678 has demonstrated in patients with schizophrenia and in animal models.

SUMMARY:

Since the late 1950's, researchers have observed that NMDA receptor antagonists such as ketamine and phenylcyclidine (PCP) produce schizophrenialike effects in healthy volunteers. Indeed healthy study participants who received ketamine exhibited effects resembling positive and negative symptoms as well as cognitive dysfunction similar to the pattern seen in schizophrenia. These findings suggest that reduced NMDA receptor signaling underlies key symptom domains of schizophrenia. A promising new approach to treat schizophrenia involves compounds that enhance NMDA receptor function. Glycine and glutamate are both required to activate the NMDA receptor. Synaptic glycine levels are controlled by the glycine transporter 1 (GlyT1), which is colocalized in the brain with NMDA receptors. Glycine reuptake inhibition increases glycine levels and thereby facilitates NMDA receptor signaling, thought to be deficient in schizophrenia. A potent and selective glycine reuptake inhibitor (GRI), RG1678, has been developed by F. HoffmannLa Roche. In animals and healthy volunteers, RG1678 dosedependently increased the glycine concentration in CSF by a similar magnitude. RG1678 has shown efficacy in animal models of dopaminergic over activity. Importantly RG1678 is efficacious in these animal models of schizophrenia, without blocking dopamine D2 receptors, as all current therapies do. Moreover, in an animal paradigm meant to simulate a schizophrenialike state induced by an NMDA receptor blocker, the GRI RG1678 prevented the exaggerated response to an amphetamine challenge. This is interesting as patients with schizophrenia are known to be sensitive to amphetamine. In a phase II study in patients with predominantly negative symptoms of schizophrenia, stabilized on antipsychotic treatment, RG1678 resulted in a significant reduction of negative symptoms in patients who completed 8 weeks of treatment. These promising results are currently being followed up in a comprehensive phase III program exploring efficacy of the GRI RG1678 separately for negative symptoms and suboptimally controlled positive symptoms in patients on a stable dose of an antipsychotic.

SCR25-3

METFORMIN FOR TREATMENT OF ANTIPSYCHOTICINDUCED AMENORRHEA AND WEIGHT GAIN IN FEMALE PATIENTS WITH FIRST EPISODE SCHIZOPHRENIA: A RANDOMIZED, DOUBLE BLIND STUDY

Chair: Renrong Wu, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the efficacy and safety of metformin in the treatment of antipsychotic-induced amenorrhea and weight gain of female patients with first-episode schizophrenia; 2) Understand the hormonal changes during metformin treatment; 3) Understand the factors correlated to the restoration of menstrual cycle during metformin treatment.

SUMMARY:

Antipsychotic-related endocrine adverse effects have become a major concern in the treatment of female patients with psychosis because amenorrhea and weight gain not only influence medication adherence but also are associated with substantial medical comorbidity such as ovarian dysfunction, infertility, diabetes mellitus, and heart disease. There is a relative dearth of interventions to control or reverse the side effects. Method: Eighty-four female patients with first-episode schizophrenia who suffered from amenorrhea during antipsychotics treatment were randomly assigned to receive 1000mg/d of metformin or placebo in addition to their ongoing treatment for 6 months using a double-blind study design. The primary outcomes included the proportion of patients who restored menstruation, and change in body weight and body mass index (BMI). The secondary outcomes were changes in hormone levels which included prolactin, luteinizing hormone (LH), follicle-stimulating hormone (FSH), estradiol (E2), testosterone (TSTO), fasting insulin, and fasting glucose level; as well as change in LH/FSH ratio and insulin resistance index (IRI). Student's t test, Chi-square analysis and analysis of variance were used as appropriate. The repeated outcome measures were analyzed using mixed models repeated measures regression analyses. Results: Of the 84 patients who were randomized, 76 completed the 6-month treatment trial. Significantly more metformin-treated patients (n=28, 66.7%) than placebo-treated patients (n=2, 4.8%) resumed their menstruation (P<0.001). Metformin-treated patients had a mean decrease in BMI of 0.93, and IRI of 2.04. In contrast, placebo-treated patients had a mean increase in BMI of 0.85. The prolactin, LH, and testosterone levels and LH/FSH ratio decreased significantly in the metformin group at months 2, 4, and 6, but the prolactin, LH, and testosterone levels and LH/FSH ratio in the placebo group remained unchanged. Conclusions: Metformin was effective in reducing antipsychotic-induced adverse effects including restoring menstruation, promoting weight loss, and improving insulin resistance in female patients with schizophrenia. Reference 1. Feldman D, Goldberg JF: A preliminary study of the relationship between clozapine induced weight gain and menstrual irregulari-

ties in schizophrenic, schizoaffective, and bipolar women. *Ann Clin Psychiatry* 2002; 14:17212. Wu RR, Zhao JP, Jin H, Shao P, Fang MS, Guo XF, He YQ, Liu YJ, Chen JD, Li LH: Lifestyle intervention and metformin for treatment of antipsychotic-induced weight gain: a randomized controlled trial. *JAMA* 2008; 299: 185193

SCIENTIFIC AND CLINICAL REPORT SESSION 26

SCHIZOPHRENIA PART 2

SCR26-1

DRUG COMPLIANCE AND ASSOCIATED OUTCOMES IN SCHIZOPHRENIA PATIENTS BEFORE AND AFTER THE INITIATION OF DEPOT ANTIPSYCHOTIC AGENTS

Chair: Steve J Offord, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand that schizophrenia patients achieve better drug compliance after initiation of depot antipsychotic agents; 2) Schizophrenia patients initiating depot antipsychotic agents are associated with higher drug compliance than patients initiating oral antipsychotic agents; 3) Overall healthcare outcomes such as hospitalization rates are improved with better drug compliance among schizophrenia patients; 4) Overall drug compliance is lacking among schizophrenia patients.

SUMMARY:

Background: Depot antipsychotic agents are primarily used to manage poor drug compliance in the treatment of schizophrenia. Compliance behavior surrounding the use of depot agents in monitored clinical practice such as registries or clinical trials is difficult to quantify because of the bias introduced by the monitoring (Hawthorne effect). We studied the magnitude of noncompliance in patients prior to the receipt of depot agents and the subsequent healthcare outcomes of compliance using healthcare claims data. The results may aid clinical practice decisions in schizophrenia management. Method: Schizophrenia patients were identified from the MarketScan™ Commercial database, a US national health plan database, between 1/1/2005 and 9/30/2010. Index events were patients initiating treatment with depot antipsychotics compared to patients initiating oral antipsychotics. New oral antipsychotic users were chosen as the comparison group since it is the cohort most likely to exhibit good compliance, creating a conservative comparison cohort. Patients were required to be ≥ 13 years at the index event and have ≥ 12 months of continuous health plan coverage prior to (baseline) and after (followup) the index event. Medication compliance was estimated with

a medication possession ratio (MPR), which represents the time each patient possessed a drug compared to the total expected duration of therapy. MPR are expressed as median \pm standard deviation. A lower MPR indicates lower drug compliance. Statistical analysis was undertaken in SAS. Results: 3,004 patients met inclusion criteria. 394 patients initiated depot agents and 2,610 initiated oral agents with a mean age of 41.7 ± 15.5 and 37.1 ± 15.9 years, respectively. Prior to depot initiation, median MPR was 0.28 ± 0.37 which improved to 0.79 ± 0.34 , while on depot agents, a relative increase of 182%. The median MPR during followup periods was significantly higher in the Depot vs. Oral cohort, 0.79 ± 0.34 vs. 0.58 ± 0.35 , $p < 0.0001$. Hospital visits fell from 1.6 ± 1.66 in the baseline period to 0.7 ± 1.20 admissions per patient following the initiation of depot agents ($p < 0.0001$). The total length of stay also decreased significantly from 16.9 ± 20.7 days to 6.6 ± 14.4 days ($p < 0.0001$). There was no significant change in overall outpatient resource usage including the number of emergency room visits. Conclusions: Upon initiation of depot antipsychotics, patients had significantly improved drug compliance. In addition, patients initiating depot antipsychotic agents for schizophrenia treatment have significantly better drug compliance in comparison with patients initiating oral agents. The improvement in compliance is associated with reduced hospital admissions and short hospital length of stay. Disclosure: Funding for this research was provided by Otsuka America Pharmaceutical, Inc.

SCR26-2

CLINICAL DEFICITS UNDERLYING THE DENIAL OF AGGRESSION AND SYMPTOMS IN PATIENTS WITH SCHIZOPHRENIA RANDOMIZED TO CLOZAPINE, OLANZAPINE, AND HALOPERIDOL

Chair: Menahem I. Krakowski, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand cognitive and psychiatric deficits that are associated with the denial of aggression and symptoms in patients with schizophrenia; 2) Understand various factors that are responsible for the inability of patients with schizophrenia to understand or acknowledge some behaviors and symptoms associated with their illness; 3) Differentiate the role of executive function in the denial of aggression as opposed to its role in lack of insight.

SUMMARY:

Objective: Our goal was to determine what deficits are associated with denial of aggression and denial of symptoms in patients with schizophrenia. Method: Subjects were 97 inpatients with schizophrenia randomly assigned in a

doubleblind 12week parallel trial to clozapine, olanzapine or haloperidol. Patients were interviewed with regard to all past violence including arrest and conviction for violent crimes; the official arrest records were obtained for all the patients. We divided the patients into 3 groups on the basis of the above information: (1) Patients with a history of violent crime who denied the crimes (“deniers”) (N=21) (2) Patients who admitted to the crimes (N=36) and (3) Patients with no violent crime (N=40). Patients were administered tests at both study baseline and endpoint. These included assessment of psychiatric symptoms with the Positive and Negative Syndrome Scale (PANSS) and the BussDurkee Hostility Inventory (BDHI), a selfreport of hostility. A cognitive battery was administered; it included tests of executive function, (Wisconsin Card Sorting Test and Trail Making Part B), verbal and visual memory, psychomotor function, perceptual organization, as well as the Mini Mental Status Exam. Results: There was a significant difference among the three groups in Executive Function ($F=6.1$, $df=2,95$; $p < .01$), with the deniers being more impaired than the other 2 groups. There were no differences on any other cognitive test. The deniers had poorer insight on the PANSS ($F=3.8$, $df=2,95$; $p=.03$). There were no differences on the PANSS Total score or any PANSS factor, except for the Anxiety/Depression factor where “deniers” obtained a significantly lower score ($F=6.5$, $df=2,95$; $p < .01$). They also obtained a much lower score on selfreported aggression and hostility, as measured by the BDHI ($F=8.8$, $df=2,95$; $p < .01$). Conclusion: Denial of aggression was associated with executive dysfunction and poor insight. Lower values on the BDHI and the PANSS Anxiety/Depression factor probably represent a denial of symptoms rather than better functioning in these domains. This interpretation would be consistent with their denying the crimes which they had committed. It would be supported by the fact that scores on the BDHI and the Anxiety/Depression factor “worsened” over the study when patients showed overall improvement. Thus, caution has to be exerted in interpreting patients’ selfreport, which are also often used for clinical assessments.

SCR26-3

PRIMARY POLYDIPSIA IN A CHRONIC PSYCHIATRIC OUTPATIENT POPULATION

Chair: Felicia Iftene, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the occurrence of primary polydipsia in a psychiatric outpatient population ; 2) Demonstrate the feasibility of conducting polydipsia research in a psychiatric outpatient population; 3) Determine the perceptions of outpatient individuals with selfinduced water intoxication.

SUMMARY:

Background: Primary polydipsia prevalence in institutionalized and chronic psychiatric populations range from 3% to 25%. Studies to date have only investigated primary polydipsia in hospitalized psychiatric patient populations. However, reports from community groups have suggested that nonhospitalized patients also experience excessive drinking behaviours. Goals of this prospective, observational study are: To determine the occurrence of primary polydipsia in a psychiatric outpatient population; To demonstrate the feasibility of conducting polydipsia research in a psychiatric outpatient population; To determine the perceptions of outpatient individuals with self-induced water intoxication in relation to their reasons for drinking excess fluids, symptoms experienced, and the behaviours/patterns associated. Methods: the study was run between March 2010 and August 2011. 115 psychiatric outpatients from the Community Outreach Teams in Kingston, Ontario were invited to participate in this study. Patients (or their designated proxy) were given information regarding the study and were asked to provide informed consent. Data collection included chart review, daily weight measurements, structured interviews, and urine collection. Results: 115 subjects were included in the initial clinical assessment. (64% male, age between 30-88, primary DSM IVTR diagnosis was Schizophrenia or Schizoaffective Disorder) 93 patients were enrolled and 22 were excluded after the initial clinical assessment, as follows: eligible but refused participation (n=12), exclusion criteria – medical general comorbidities (n=8), included in other ongoing studies (n=2). The incidence of polydipsia among our study population was 19%. There were interesting findings from the answers to the self-induced water intoxication questionnaire. Conclusion: Excessive water-drinking occurs in psychiatric patient populations outside of institutional/hospital settings. These patients are not fully aware of the severity and possible complications of their problem. Results of this study highlight the consequences of water intoxication among these patients and will be used for the education of patients and staff. This pilot study provided valuable information for future research. Key words: Polydipsia, Outpatients, Schizophrenia. References: Primary polydipsia in schizophrenia reduces life expectancy. Liam Davenport, 27 January 2009, Schizophr Res 2009; 107: 128–133.

SCIENTIFIC AND CLINICAL REPORT SESSION 27**STIGMA****SCR27-1****UTILIZING THEATRE TO MODIFY STIGMA: A KNOWLEDGE TRANSLATION STUDY IN BIPOLAR DISORDER***Chair: Sagar V. Parikh, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Identify measures of stigma in bipolar disorder; 2) Clarify role for knowledge translation in bipolar disorder; 3) Understand impact of theatrical interventions on stigma.

SUMMARY:

Introduction: Both people who live with bipolar disorder (BD) and researchers acknowledge that mental illness stigma can be a very real barrier to quality of life and health. The Mental Health Commission of Canada prioritizes stigma and emphasizes the creation of knowledge translation (KT) mechanisms to improve stigma outcomes. As part of a KT study, we developed interventions designed to depict and modify both public and internalized stigma in BD. Our specific intervention objectives are to educate people with BD and BD health care providers about how to recognize internalized stigma, how to deal with it, and how to recognize and respond to public stigma. Method: We developed, disseminated, and evaluated a new play by established playwright and actress Victoria Maxwell (who lives with BD) to illustrate how internalized and public stigma manifest through theatrical performance. A key innovation in our KT approach is that people with BD and providers viewed the play together, with parallel outcome assessments both immediately after the play and 3 months later. Results: The first intervention, a theatrical performance called ‘That’s Just Crazy Talk’ was premiered in Vancouver and Toronto in July 2011. Research participants included 65 BD health care providers, 54 people with BD and 3 individuals who identified as both, with over 100 additional audience members. A mix of quantitative and qualitative outcomes, ranging from satisfaction and scores on standardized instruments (the ISMI, the MICA4 and Day’s stigma scales) to qualitative interviews, were assessed. Large and statistically significant changes in stigma in providers and modest changes in internalized stigma in people with BD were achieved. Discussion: Beyond traditional psychosocial outcome measures, measurement of stigma and the initial impact of stigma reduction techniques in BD were demonstrated for the first time; the use of theatrical performance was also demonstrated and evaluated.

SCR27-2**QUANTIFICATION OF STIGMA FOR CLINICAL ASSESSMENT: A PARADIGM SHIFT IN ANTISTIGMA INTERVENTION***Chair: Amresh Shrivastava, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Understand that stigma is a clinical risk and barrier to treatment; 2) To understand that intervention for reducing stigma needs to be done in clinics and the approach needs to be clientcentric; 3) Understand that stigma should be quantified to develop evidence based intervention in routine clinical practice.

SUMMARY:

Stigma is a clinical risk and a barrier to treatment. Stigma also influences treatment and results in poor outcomes as those afflicted with mental illness sometimes delay or do not adhere to treatment. We present findings of a 'working group' for the 'Quantification and measurement of stigma'. The report explores the experiences, consequences, causes, and barriers resulting from stigma in mental illness with an emphasis on psychosis. We also argue that stigma must be quantified. We propose to develop a clinical tool (scale) that will be administered by front line healthcare providers and/or clinicians to measure a patient's 'level of stigma'. We believe that stigma originates from four domains; 1) Personal, 2) Family, 3), Social, and 4) Illness. We propose that stigma can be quantified based upon this concept. The purpose of this measurement is to identify candidate patients who have severe stigma. Also, the instrument can be helpful in determining the effectiveness of a particular antistigma intervention. We aim to take the next step forward to bring 'dealing with stigma' into clinics and monitor the patient's journey as it relates to stigma. To that end, we will link the patient's level of stigma to treatment adherence and reduce the patient's stigma by employing customized oneonone intervention techniques. Consequently, this measure will allow the clinician to target specific stigma domains resulting in an improved disease outcome and for the patients to have an increased sense of empowerment over their condition. This effort will ultimately lead to a reduction in the economic burden of the community due to stigma in mental illness.

SCR27-3

CYBERSPACE: A FRONTIER FOR CONFRONTING MENTAL HEALTH STIGMA IN ETHNIC MINORITY POPULATIONS

Chair: Sarah Vinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To appreciate the doublestigma faced by people with mental health problems who are also members of minority computers; 2) To appreciate the potential benefits and challenges of using websites and social networking to foster dialogue regarding mental health in minority communities; 3) To identify online resources online that provid-

ers can refer patients and families to for culturally sensitive information.

SUMMARY:

Ethnic/cultural minorities in need of mental health services and their families can encounter the phenomenon of double stigma. Stigma is a powerful factor, among numerous others, that perpetuates mental health care disparities. For mentally ill ethnic minorities and their families, the marginalization that may be experienced in the greater society is compounded by the marginalization that may be experienced within their minority communities because of mental illness. In minority communities where stigma associated with mental illness is even more pronounced than that found in the general population, patients are at risk for not seeking treatment until symptoms are severe, and then may face less support and understanding from family members when treatment is sought, which has the potential to undermine treatment (particularly in communities that are more familyunit oriented and less individualistic than the mainstream, majority U.S. culture). Finding effective, innovative ways to reach people in minority communities grappling with mental illness is key in addressing mental health care disparities. The internet, with the relative anonymity it affords, its ease of access and its unprecedented ability to connect people, has the potential to be a powerful tool in combating mental health stigma and providing culturally sensitive information to patients and families in minority communities. It is imperative for mental health care providers to understand the prominent role of sigma in mental health care engagement, or lack thereof, for members of minority communities; to recognize some of the potential benefits and challenges of websites and social networking with regards to psychoeducation, peer support and connectedness, and advocacy; and to be aware of potential websites to refer patients and families to for culturally sensitive information.

SCIENTIFIC AND CLINICAL REPORT SESSION 28

SUICIDE

SCR28-1

INSOMNIA, ANXIETY, AND SUICIDAL IDEATION

Chair: Stephen B. Woolley, D.Sc., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the independent effects of insomnia and anxiety on the risk of suicidal ideation; 2) Discuss the interaction of anxiety and insomnia on risk of suicidal ideation; 3) Discuss alternative mechanisms by which anxiety might influence insomnia's effect of suicidal ideation.

SUMMARY:

Background: Many studies have found an association between sleep disturbances and suicidality as well as between anxiety and both sleep disturbances and suicidality. This study examined the interrelationships of these 3 variables in psychiatric patients. Method: Adult in (n=198) and outpatients (n=208) treated for depression with selective serotonin reuptake inhibitors (SSRIs) were recruited during 2001-03. Subjects were interviewed by telephone and asked 1) if they had insomnia (yes/no) and how bothersome it was (none to extreme), 2) about "indications" of a history of anxiety evidenced by selfreported symptoms, treatment or diagnosis of anxiety and 3) if they had "suicidal ideation" including thoughts, wishes or declaration that if they could they would attempt suicide. Odds ratios (ORs) were derived from bivariate analysis and logistic regression. Results: 31% had insomnia and nearly 70% had indications of anxiety, of whom 28% had an anxiety disorder diagnosis; 45% had suicidal ideation. Insomnia was not associated with ideation (OR=1.1, 95% confidence interval=[0.7, 1.7]) but anxiety was associated with both insomnia (OR=1.8 [1.1, 3.0]) and suicidal ideation (OR=2.0 [1.2, 3.1]). Insomnia remained unassociated with ideation in the presence of anxiety, but in its absence insomnia-related risk was slightly elevated (OR=1.3). Regression analyses, controlling for demographics, found no insomnia-suicidal ideation association (OR=1.0 [0.7, 1.6]) and controlling for either anxiety indications or for anxiety diagnosis did not change the associations (OR=1.0 in each model). However, indication of anxiety (but not diagnosis) was associated with increased risk of suicidal ideation (OR=1.6 [1.1, 2.7]). Psychosis did not explain the insomnia-ideation association (OR=1.0 [0.6, 1.5]), and controlling for treatment characteristics (e.g., length of stay, prior admission) did not change this finding (OR=1.0 [0.6, 1.6]). Final models included increased risk in patients "uncomfortable discussing their depression" (OR=1.8 [1.1, 3.0]) and with drug abuse/dependence (OR=2.2 [1.2, 4.1]). Patient characteristics not affecting associations included tremors, bothersome SSRI side effects, poor physical health, worsening of depression, alcohol use, previous admission, and psychiatric comorbidities. Conclusions: In this sample insomnia was not associated with suicidal ideation, and controlling for anxiety did not expose an insomnia-ideation association, suggesting that anxiety did not obscure an association via confounding, interaction or mediation. However, further research is needed to explore potential differences between selfreported experiences and a formal diagnosis of anxiety in analyses of risk of suicidal ideation.

SCR28-2**COPING WITH CHALLENGES OF RISK ASSESSMENT: TOWARDS A NEW SCALE, SISMAP**

Chair: Amresh Shrivastava, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To explore the Concept of risk; 2) To understand advances and limitations of prevailing Concept; 3) Understand risk assessment, & its significance in Clinical Practice; 4) Explore newer ways of Coping with Challenges of Risk Assessment & Discuss about a new scale, SISMAP (The Scale for Impact of Suicidality Management, Assessment and Planning of Care).

SUMMARY:

Risk assessment is an important clinical responsibility, which can be 'lifesaving' in nature. Literature on risk factors has become voluminous; however a traditional risk assessment does not take into account the most relevant factors. This likely reflects the prevailing conceptualization of risk, which has not been fully and completely tied to clinical outcomes. Psychopathology is currently understood in biopsychosocial terms. A more progressive conceptualization of risk should consider the interplay of both risk and protective factors.. The present work proposes a model of risk depending upon 'trait' risk and 'state' risk factors. The joint impact of such a risk is evaluated against protective factors. Further it conceptualizes that risk consists of several domains and each of these domains contribute to causation of suicidal ideation. These domains are biological, psychological, socialenvironmental, spiritual & protective domains. The present study examined the utilization of a new structured clinical interview called the Scale for Impact of Suicidality Management, Assessment and Planning of Care (SISMAP). SISMAP ratings were evaluated against a group of incoming psychiatric patients over a 6month period. Participants consist of adult male and female patients RMHC, St. Thomas, Canada between February and August 2008. Preliminary analysis supported that the SISMAP is a valid and reliable tool to determine the level of psychiatric care needed for adults with suicidal ideation. Clinical cutoff scores were established from the observed mean differences in the patients' total scores and level of care needed. A canonical discriminant function analysis was conducted in order to evaluate whether SISMAP total scores were predictive of admission. The analysis resulted in a total 74.0% of original grouped cases were correctly classified (Wilks Lambda = .749, $p < 0.001$). The specificity of the scale (correctly identifying individuals who did not require admission) was 78.1% while the sensitivity of the scale (correctly identifying individuals who required admission) was 66.7%. The false positive rate was 33.3% while 21.9% of cases resulted in a false negative. The measure also demonstrated moderate-high interrater reliability (between 0.70 and 0.81 ($X = .76$), $N = 20$, $p < .001$).

SCR28-3

SMOKING AND SUICIDAL BEHAVIOR IN PATIENTS WITH SCHIZOPHRENIA*Chair: Jyoti Kanwar, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Become cognizant of the relationship between smoking and suicide; 2) Become aware of the nicotinic deficits in schizophrenia, and smoking as possible self-medication; 3) Be informed that in schizophrenia specifically suicide and smoking are positively associated.

SUMMARY:

Introduction: Several clinical and epidemiological studies have found an association between smoking and suicidal behavior. Schizophrenia patients have also been reported to have higher rates of smoking when compared with the general population or other psychiatric disorders. However there is currently a relative paucity of research on smoking and suicidal behavior, specifically in schizophrenia (Palmer et al, 2005) and the potential mediation of required antipsychotic dosage has not been appropriately explored. **Hypothesis:** We have hypothesized that smoking is associated with suicide in schizophrenia independent of symptoms severity and medication. **Method:** 950 patients (Male 600, Female 350, Age range 38± 11.6) with diagnosis of schizophrenia confirmed by SCID, were recruited in Munich, Germany. History of suicide attempts and smoking were obtained by detailed clinical interviews. Data on PANSS scores, BMI and antipsychotic doses (in chlorpromazine equivalents) were also obtained. Statistical methods included Pearson's chi squares and logistic regression multivariate models with adjustment for demographics, symptom severity and medication use. **Results:** Positive smoking status was significantly associated with a history of suicide attempt (chi square= 4.15, p = 0.042) and the odds ratio for suicide attempt history was 1.402 with a p value of 0.041. Multivariate analysis adjusting for sex, age, total PANSS score and education continued to show statistically significant association between smoking and suicide attempts (p value =0.046). **Conclusions:** Our results replicate in a large sample the previously reported association between history of smoking and suicidal behavior in schizophrenia patients. The strengths of this study include the large sample size, use of SCID for positive and differential diagnosis, and availability of data on several potential confounding variables that were adjusted for in multivariate models. Limitations of our study include the lack of information regarding the number of cigarettes smoked each day. Certain nicotinic deficits have been previously reported in schizophrenia (De Luca et al, 2004) and they may potentially be further elevated in

suicidal schizophrenics. Smoking might indicate an attempt to self-medicate those deficits. This failed self-regulation attempt may carry a heavy price tag, as smoking negatively affects brain function via vascular and endothelial pathology, and induction of inflammatory stimuli previously associated with suicidal behavior. Testing these hypotheses may lead to developing new treatments in suicide prevention. **References:** 1. Palmer B, Pankratz S, Bostwick JM: The Lifetime Risk of Suicide in Schizophrenia: Arch Gen Psychiatry. 2005; 62:247-253. 2. De Luca L, Wong A, Muller D, Wong G, Tyndale F and Kennedy J: Evidence of association between smoking and a7 nicotinic receptor subunit gene in schizophrenia patients, Neuropsychopharmacology (2004) 29, 1522-1526

SCIENTIFIC AND CLINICAL REPORTS

WEDNESDAY, MAY 9, 2012

SCIENTIFIC AND CLINICAL REPORT SESSION 29**TREATMENT EFFECTS AND SIDE EFFECTS**

SCR29-1

ASSESSMENT OF EFFICACY AND SAFETY OF ELECTROCONVULSIVE THERAPY FOR CHILD AND ADOLESCENT PATIENTS WITH SEVERE PSYCHIATRIC ILLNESS*Chair: Soonjo Hwang, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to: 1) Have better understanding regarding treatment criteria of ECT treatment for adolescents and children; 2) Have better understanding regarding efficacy and safety of ECT treatment for adolescents and children; 3) Have a better understanding regarding potential side effect of ECT when administered to adolescents and children.

SUMMARY:

Objective: ElectroConvulsive Therapy (ECT) has been an effective treatment modality for patients with various psychiatric illnesses, including mood disorder, psychosis, and organic mental disorders. Although there has been some case reports and a few studies regarding ECT treatment for children and adolescents, still there is general lacking of more comprehensive knowledge or research regarding ECT treatment for this particular group of population, leaving much of controversy to debate. The aim of this study is to investigate and assess efficacy and safety of ECT treatment for children and adolescents who had received this type of treatment for their psychiatric illnesses. Demographic characteristics and diagnoses for indication of ECT were

assessed, with measuring of clinical outcome and safety, using retrospective chart review. Methods: Study Population The paper and electronic charts for medical/psychiatric treatment and ECT procedure were reviewed retrospectively, using the patient population cohort of Massachusetts General Hospital, Department of Psychiatry, from year 1998 to 2011. 18 patients whose ages under 18 were randomly selected for this purpose. Measurement of Efficacy and Safety Clinical Global Impression (CGI), number of episodes of psychosis, mania, depression, suicide attempt, hospitalizations, and medications before and after the initiation of ECT were measured. Any side effect caused by ECT was also recorded. Results: 8 boys (44.4%) and 10 girls (55.6%) were selected for this study. Mean age of the patients at the time of initiation of ECT was 15.2 (SD=2.5) years, and the mean age of initial diagnosis of psychiatric illness was 8.9 (SD=4.2) years. Mean CGI for severity of illness at the time of initiation of ECT treatment was 6.3 (SD=0.6) (from the scale of 0=Not assessed, 1=Normal, not at all ill, 2=Borderline mentally ill, 3=Mildly ill, 4=Moderately ill, 5=Markedly ill, 6=Severely ill, 7=Among the most extremely ill patients). Mean CGI for severity of illness at the end point of ECT was 2.7 (SD=1.2). The mean of global improvement of CGI was 1.7 (SD=0.7) (0=Not assessed, 1=Very much improved, 2=Much improved, 3=Minimally improved, 4=No change, 5=Minimally worse, 6=Much worse, 7=Very much worse). Also there was significant decrease in numbers of hospitalizations, psychosis, mania, depression, suicide attempts, and number of medications they were taking after the initiation of ECT treatment. Although there were reports of side effects, none of the patients developed significant side effects of ECT that led to cessation of the treatment. Conclusions: This study indicates ECT can be used for children and adolescents with severe psychiatric illnesses with good efficacy and safety. Future study is warranted for more comprehensive understanding and assessment.

SCR29-2

MORTALITY OF NEUROLEPTIC MALIGNANT SYNDROME INDUCED BY TYPICAL AND ATYPICAL ANTIPSYCHOTICS: ANALYSIS FROM A JAPANESE ADMINISTRATIVE CLAIMS DATABASE

Chair: Mitsuhiro Nakamura, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the crude mortality in neuroleptic malignant syndrome; 2) Understand the difference in mortality in neuroleptic malignant syndrome induced by typical and atypical antipsychotics; 3) Understand the factor affecting the mortality of neuroleptic malignant syndrome.

SUMMARY:

OBJECTIVE: Atypical antipsychotic-induced neuroleptic malignant syndrome (NMS) presents atypical clinical manifestations with fewer symptoms compared with typical antipsychotic-induced NMS. However, difference in prognosis between these two types of drug-induced NMS remains unknown. We examined NMS-related mortality in patients who used typical or atypical antipsychotics, using a national administrative claims database. **METHOD:** Using the Japanese Diagnosis Procedure Combination database, we extracted data on patients with a diagnosis of NMS between July and December, 2004-2008. Data included patient background, use of antipsychotics, and in-hospital mortality. Propensity score matching was performed to formulate a balanced 1:1 matched study and to compare in-hospital mortality between typical and atypical antipsychotic-induced NMS patients. **RESULTS:** We identified 423 NMS patients treated with typical antipsychotics and 215 NMS patients treated with atypical antipsychotics. Matching based on propensity scores produced 210 patients in each drug group. In-hospital mortality was substantially lower in the atypical antipsychotic group compared with the typical antipsychotic group, but the difference was not significant (3.3% vs. 7.6%; odds ratio = 0.44; 95% confidence interval = 0.17-1.11; $p = .084$). **CONCLUSION:** The results show that NMS remains a significant source of mortality among patients receiving antipsychotics. A tendency for lower mortality in the atypical antipsychotics group may reflect differences in the pathophysiology. However, to clarify whether there is a difference in NMS-related mortality with the two types of antipsychotics, further studies with larger samples are needed.

SCR29-3

ANTIDEPRESSANTS AND THE RISK OF ABNORMAL BLEEDING DURING SPINAL SURGERY: A CASECONTROL STUDY

Chair: Amirali Sayadipour, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Know that SSRIs and SNRIs would increase the intraoperative blood loss about 2.5 times; 2) Know the alternative antidepressants in situation that depressive patient will go under surgery; 3) Know concomitant use of antiplatelet agents in patients who are on serotonergic antidepressants could potentially increase chance of intraoperative blood loss; 4) Know mechanism of antiplatelet aggregation of SSRIs by inhibition of serotonin reuptake into platelets; 5) Clinician (especially psychiatrists and surgeons) and patients should be aware of the possibility of excessive bleeding with SSRI/SNRI medications and should consider electively tapering the antidepressant prior to the surgery or ordering platelet function assay.

SUMMARY:

Objective: In spite of a generally favorable safety profile of newer antidepressants, several prior studies have suggested an association between use of serotonergic antidepressants and excessive bleeding. This study was designed to determine if there is any association between antidepressant use and the risk of excessive intraoperative blood loss during spinal surgery, and whether particular types of antidepressants are specifically associated with this increased blood loss. **Methods:** A retrospective case control study of 1539 patients who underwent elective spinal fusion by a single surgeon at one medical center during the period of September 2000 to August 2010. The study group consisted of all patients who used an antidepressant medication for at least the two week period prior to spinal surgery. A control group was assembled from a random sample of patients operated on by the same surgeon during the same time period in a two to one ratio with study group. Intraoperative blood loss was the primary outcome variable and was compared between the study and control group and between individuals in the study group taking serotonergic (SSRIs or SNRIs) or nonserotonergic antidepressants. Other variables, including length of hospital stay and surgical category, were also collected and analyzed separately. **Results:** The study group included a total of 528 patients who underwent spinal surgery, including 176 patients taking at least one antidepressant medication and 352 control patients. Overall, the mean blood loss (BL) for the antidepressant group was 298cc, 23% more than the 241cc lost by the procedure and level-matched control group ($p=0.01$). Patients taking serotonergic antidepressants also had statistically significant higher blood loss than the matched control group as a whole (334cc vs. 241cc, $p=0.015$). This difference was also found in subgroups of patients who underwent anterior cervical discectomy and fusion (ACDF), lumbar instrumented fusion, or anterior/posterior lumbar fusion. Blood loss was also higher in the subgroup of patients taking bupropion (708cc, $p=0.023$) compared with the control group. The mean length of hospital stay was 33.3% greater in patients on antidepressant medications compared to patients not taking an antidepressant (mean of 4 days vs. 3 days, respectively, $p=0.0001$). **Conclusions:** Antidepressant medications may be associated with increased intraoperative blood loss during spinal surgery, although the magnitude of the increased blood loss may not be clinically significant in all cases. The increase was greatest in patients undergoing anterior/posterior lumbar fusions in whom the intraoperative blood loss was 2.5 times greater than that in the matched control group. Clinicians treating patients who are planning to undergo elective spinal surgery and are on an antidepressant medication should be aware of this potential effect and should consider tapering off the serotonergic antidepressant prior to the surgery.

SCIENTIFIC AND CLINICAL REPORT SESSION 30**TREATMENT ISSUES IN PERSONALITY DISORDERS****SCR30-1****SIXMONTH OUTCOMES OF DYNAMIC DECONSTRUCTIVE PSYCHOTHERAPY VERSUS DIALECTICAL BEHAVIOR THERAPY FOR BORDERLINE PD AT A UNIVERSITY CLINIC**

Chair: Robert J. Gregory, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn differences in outcome between different kinds of therapy for BPD in a university clinic; 2) Describe the study's limitations; 3) Describe the study's strengths.

SUMMARY:

Objective: Although several manual-based treatments for borderline personality disorder have demonstrated efficacy in controlled trials, studies have been limited by structured research settings, selective recruitment, and low comorbidity. Little is known about the effectiveness of these treatments in real world settings. **Methods:** In a quasirandomized naturalistic design, 56 consecutive clients with borderline personality disorder diagnosed by structured interviews were treated with dynamic deconstructive psychotherapy (DDP; $n = 23$) or comprehensive dialectical behavior therapy (DBT; $n = 19$). The 5 therapists (3 DDP; 2 DBT) had advanced training and at least 4 years' experience applying their respective modalities; weekly group supervision maintained treatment fidelity. An additional 14 clients treated with unstructured psychotherapy (TAU) served as a control. The primary outcome measure was the Borderline Severity over Time (BEST) obtained at baseline and 6 months. **Results:** In intent-to-treat ANCOVA analyses controlling for baseline differences in severity and age, clients treated with DDP displayed significantly greater reductions in BEST scores than those treated with DBT ($p=.017$) or TAU ($p=.006$). Treatment effects of DDP were medium to large relative to DBT in the intent-to-treat sample ($d=.74$) and large in the completer sample ($d=.88$). Scores improved for 61% of DDP clients versus 26% DBT ($p=.025$) and 21% TAU ($p=.020$). In secondary analyses, DDP was characterized by significantly better treatment retention (70% vs. 37%) and improvement in depression ($p=.005$) than DBT, and trended towards greater reductions in self-harm and suicide attempts. **Conclusions:** These early findings suggest that DDP is more effective than DBT for borderline personality disorder in the real world setting of a university clinic.

SCR30-2

PERSONALITY TRAITS PLUS OTHER VARIABLES AND THE EFFECT ON PLACEBO RESPONSE: A NATURALISTIC STUDY

Chair: Noshin Chowdhury, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how certain personality traits and other clinical factors (i.e. no medications) can effect treatment of clinical depression; 2) Acknowledge that placebo effect is commonly encountered in clinical practice; 3) Enhanced placebo effects were seen in patients actively involved in therapy

SUMMARY:

Though randomized control studies provide certain response trends of patients with psychiatric disorders, clinicians often find themselves dealing with multiple confounders that may not relate to their research findings. One confounder encountered in clinical practice is the placebo effect. It is found that some patients do remarkably well to treatment, even on subtherapeutic doses of medication, or sometimes with no medication at all. This could be attributed to the patient's view on whether the treatment would work. **METHOD:** Data was taken in a naturalistic setting, with 139 clinic patients being followed in a community clinic. The patients were part of a 1 of 5 placebo studies involving numerous antidepressants. The patients were treated by an antidepressant versus placebo and were followed in a 46 week period. The patients were evaluated using Hamilton Depression Scale, Beck Scale, CGI Scale in addition to DAS and SIDP Personality Scale. The determination was made if patients were also in therapy. **RESULTS:** There were 45 patients with a 50% reduction in the placebo scale on the placebo arm. Placebo responders had lower initial Hamilton, Beck, and CGI scores, along with lower overall personality scale scores, particularly lower Cluster C scores. DAS scores were also reduced. Placebo responders tended to be in therapy more than placebo nonresponders (23/43 versus 23/96). **CONCLUSION:** Patients who had lower psychopathology scores and personality scores tend to be strong placebo responders.

SCR30-3

COMORBIDITY OF MOOD AND SUBSTANCE USE DISORDERS IN PATIENTS WITH BINGEEATING DISORDER: ASSOCIATIONS WITH PERSONALITY DISORDER AND EATING PATHOLOGY

Chair: Daniel F. Becker, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize common patterns of diagnostic comorbidity among patients with binge eating disorders; 2) Identify the correlates of these comorbidity patterns with respect to personality disorder pathology and eating psychopathology; 3) Understand the potential implications of these patterns for subtyping binge eating disorder; 4) 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 cooccurring mood and substance use disorders. However, the significance of such diagnostic comorbidity is ambiguous. In this study, we compared personality disorder symptom levels, psychological functioning, eating attitudes, and eating behavior in four subgroups of patients with BED: those with mood disorders, those with substance use disorders, those with both mood and substance use disorders, and those with neither. **Method:** Subjects were a consecutive series of 347 treatment-seeking patients (259 women, 88 men) who met DSMIV research criteria for BED. All were reliably assessed with semistructured interviews in order to evaluate: 1) lifetime DSMIV axis I psychiatric disorders (Structured Clinical Interview for DSMIV Axis I Disorders – Patient Edition); 2) dimensional measures of DSMIV personality disorders (Diagnostic Interview for DSMIV Personality Disorders); and 3) eating disorder psychopathology (Eating Disorder Examination). **Results:** Among this study group, 129 (37%) had a cooccurring mood disorder, 34 (10%) had a cooccurring substance use disorder, 60 (17%) had both, and 124 (36%) had neither. These groups differed significantly with respect to personality disorder pathology ($p < .001$), across all personality disorder clusters, with the BED patients who had both mood and substance use disorders showing the highest personality disorder symptom levels. Compared to the other two groups, the groups with comorbid mood disorder and with both mood and substance use disorders demonstrated significantly higher levels of negative affect and lower self-esteem ($p < .001$). Although groups did not differ significantly with regard to body mass index or binge eating frequency, they did differ on eating attitudes—with the groups having comorbid mood disorder and both mood and substance use disorders demonstrating higher eating psychopathology levels than the groups having only substance use disorder or neither comorbidity. While no differences were observed between groups with respect to ages of onset for specific eating behaviors, some differences were observed with regard to ages of disorder onset. **Conclusions:** Mood and substance use disorders occur frequently among patients with BED. Compared with previous work, the additional psychiatric comparison group (those with cooccurrence of both mood and substance use disorders) and the

control group (those with cooccurrence of neither) afforded better discrimination regarding the significance of psychiatric comorbidity among patients with BED. These comorbidities—separately and in combination—are associated with clinically meaningful differences with respect to personality psychopathology, psychological functioning, and eating psychopathology. The findings suggest approaches to subtyping BED patients based on psychiatric comorbidities, and may also have implications for treatment.

SCIENTIFIC AND CLINICAL REPORT SESSION 31

TRIALS OF SPECIFIC APPROACHES TO TREATMENT

SCR31-1

TRIALS OF TECHNOLOGY FOR PTSD IN MILITARY POPULATIONS: PRELIMINARY RESULTS OF FOUR TRIALS

Chair: Robert McLay, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the need for new technologies to treat PTSD in military populations; 2) Be aware of the special challenges in conducting clinical trials in Active Duty Service Members; 3) Have an expanded understanding of the preliminary results for treating PTSD with four new technologies: Virtual Reality, Stellate Ganglia Block, Trans Magnetic Stimulation, and Attention Retraining via at home, computerized therapy.

SUMMARY:

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that, once chronic, can be resistant to both medication and psychotherapy interventions. The ongoing wars in Iraq and Afghanistan have brought forth a wave of new cases of PTSD, but also focused attention and funding on the condition. In particular, military funding sources have been interested in new technologies that have the potential to produce more rapid and effective means of treatment. Performing clinical trials in military populations has, however, proven challenging. This talk will describe four new technologies that have been proposed to treat PTSD: Virtual Reality Exposure Therapy, Stellate Ganglia Block, Trans Magnetic Stimulation, and Attention Retraining via at home, computerized therapy. The speaker will discuss the development of the technologies to treat PTSD, and the results of randomized clinical trials of their use. Also discussed will be special considerations for designing trials in military populations, and administrative and practical considerations in conducting such trials.

SCR31-2

RESULTS OF A FEASIBILITY STUDY OF CULTURALLY ADAPTED COGNITIVE BEHAVIOUR THERAPY (CACBT) FOR PSYCHOSIS IN ETHNIC MINORITY GROUPS

Chair: Shanaya Rathod, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the benefits of culturally adapted Cognitive Therapy in Psychosis; 2) Understand the implications of a culturally adapted therapy to quality of care, patient satisfaction, and policy makers; 3) Understand the evidence available and need for a culturally adapted Cognitive behaviour therapy for psychosis

SUMMARY:

Results of a UK based randomised trial of the effectiveness of a Culturally adapted Cognitive behaviour therapy for Psychosis (CaCBTp) in ethnic minority groups will be presented. Aims of the study: 1.To assess the feasibility of CaCBTp for use in specified Black and minority ethnic (BME) groups.2. Assess fidelity of CaCBTp. The participants were randomised to either the intervention (10 sessions of CaCBTp by trained CaCBTp therapist over a three month period) or treatment as usual. Randomisation was stratified by ethnic group. Primary outcome measure: Reduction in overall CPRS (Comprehensive Psychopathological rating scale) scores at 3 months. Secondary outcome measures: Improvement in insight using adapted David's Insight scale, Acceptability of the intervention as assessed by satisfaction questionnaire, number of sessions attended and dropout rates. Fidelity was measured by review of therapy audio tapes and transcripts by an independent therapist. Implications of the findings on quality of care, patient satisfaction and policy makers will be discussed.

SCR31-3

PLANNING INTEGRATED MENTAL HEALTH HOMES: UNDERSTANDING NEEDS FOR PATIENTS AT GREATEST RISK FOR INTENSIVE SERVICES UTILIZATION

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Characterize factors associated with hospitalization and emergency department visits among Medicaid psychiatric patients; 2) Identify Medicaid psychiatric patients at greatest risk of being hospitalized or treated in emergency

departments; 3) Appreciate the clinical and social service needs of highrisk Medicaid patients who utilize intensive services and understand implications for integrated services delivery models, including Mental Health and Medical Homes

important to improve care. Medical Homes for psychiatric patients should consider interventions such as Assertive Community Treatment and Illness Management and Recovery programs to reduce hospitalization and ED visits for high risk patients.

SUMMARY:

Background: With Medicaid expansions under health care reform, federal and state governments will seek to contain Medicaid costs and utilization to accommodate increasing enrollment in the face of severe budget deficits. Understanding factors associated with costly psychiatric hospitalizations and emergency department (ED) visits so they can be averted and quality of care strengthened is critically important. Systematic analyses of these factors may also help quantify Medical Home needs for psychiatric patients in greatest need. Study Aims: 1) Characterize factors associated with hospitalization and ED visits among Medicaid psychiatric patients; and 2) Identify patients at greatest risk of being hospitalized or treated in EDs. Methods: A total of 4,866 psychiatrists in ten states were randomly selected from the AMA Physician Masterfile. A majority (62%) responded; 32% met study eligibility criteria of treating Medicaid patients and reported clinically detailed data on 1,625 systematicallyselected Medicaid patients. Analyses were weighted and adjusted for the sampling design. Chi square, Wald F tests and logistic regression analyses identified patients at greatest risk of being treated in an ED or hospitalized for a psychiatric illness in the past year. Results: Onethird (33%, SE=1.9) of the patients were treated in an ED and 29% (SE=1.8) were hospitalized. One quarter were treated in both settings (25%, SE=1.7). Patients at greatest absolute risk were more likely to be 1835 years of age (50% ED, 43% hospitalized); African American (39%, 37%); have a diagnosis of a substance use disorder (54%, 52%) or schizophrenia (51%, 49%); and have moderate to severe symptoms of substance use (65%, 60%), psychosis (57%, 54%), or mania (57%, 55%). Patients at greatest risk were also more likely to have been reported by their physician to have experienced suicidal ideation or behavior (78% ED, 76% hospitalized); been homeless for more than 48 hours (72%, 67%); experienced violent ideation or behavior (64%, 64%); been detained or incarcerated in jail or prison (57%, 49%); or experienced a medication access problem in the past year (42%, 34%). Patients in these subgroups generally also had significantly greater lengths of stay and mean numbers of ED visits. Conclusions: These findings identify Medicaid patients at high risk for intensive services use and highlight the need for enhanced interventions and services to address the needs of patients with schizophrenia, substance abuse use disorders, suicidal and violent ideation, and manic symptoms. Given the high rates of homelessness and incarceration, providing housing services and working closely with justice and correction systems will also be

SATURDAY, MAY 5, 2012

SEMINAR 01

SEXUAL COMPULSIVITY AND ADDICTIONS

Director(s): Ken Rosenberg, M.D.

Faculty: Ken Rosenberg, M.D., Patrick Carnes, Ph.D.

EDUCATIONAL OBJECTIVES:

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; 3) Be able to use their preexisting 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 subcategory of Behavioral Addictions, with further subcategories 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 (SASTR) • To utilize the SASTR 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 (SDIR) • To describe gender differences and cooccurring patterns of sexual aversion • To provide overview of Cybersex and Internet pornography • To provide overview of sex addiction treatment • To describe evidencedbased data about recovery • To introduce the concept of taskcentered 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

SEMINAR 02

EVIDENCEBASED PSYCHODYNAMIC THERAPY: A CLINICIAN'S GUIDE

Director(s): Richard F. Summers, M.D., Jacques P. Barber, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate understanding of the evidence base supporting psychodynamic psychotherapy; 2) Diagnose core psychodynamic problems and develop a formulation for appropriate patients; 3) Develop an effective therapeutic alliance, define a focus of therapy, and employ techniques for facilitating change; 4) Recognize the important role of positive emotion and character strengths in the phases of dynamic treatment.

SUMMARY:

This course focuses on the development of psychodynamic psychotherapy skills. We will distill from the tradition of psychoanalysis and psychoanalytic psychotherapy the features of this model that have stood the test of time and have greater empirical support, and show how some newer psychotherapy approaches add to its efficacy. We present Pragmatic Psychodynamic Psychotherapy, a model that emphasizes accurate diagnosis, formulation, goalsetting, pragmatic approaches to change, strengthbuilding and positive emotions, and allows for effective integration with other modes of treatment. The focus of the seminar is on the CLINICAL application of these ideas. We begin with an overview of the process of learning psychotherapy, and the limitations of the traditional model of psychodynamic therapy. We review the outcome data on psychodynamic therapy, and then discuss in detail the following components of psychodynamic treatment which have supporting evidence – the therapeutic alliance, focus of therapy including diagnosis of core psychodynamic problems and psychodynamic formulation, strategies for facilitating change, and the role of positive emotion in psychotherapy. The presentation includes didactic presentation, actual patient video clips, and a small group exercise in diagnosing core psychodynamic problems from clinical case vignettes. The course is based on Psychodynamic Therapy: A Guide to Evidence-Based Practice by Drs. Summers and Barber, published in October 2009 by Guilford Press. Evidence Based Psychodynamic Therapy uses a variety of modes of presentation, including video clips of actual patients, to present a concise

and clear model of psychodynamic therapy based on current scientific evidence which is easier to learn and easier to apply than the traditional model and technique.

SEMINAR 03

THE INTERNATIONAL MEDICAL GRADUATE INSTITUTE

Director(s): Nyapati R. Rao, M.D., M.S., Jacob E. Sperber, M.D.

Faculty: Jacob E. Sperber, M.D., R. Rao Gogineni, M.D., Antony Fernandez, M.D., Mantosh J. Dewan, M.D., Damir Huremovic, M.D., M.P.P., Joan M. Anzia, M.D., Priyanthy Weerasekera, M.D., M.Ed.

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 self-knowledge 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 doctor-patient and interdisci-

plinary 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.

SUNDAY MAY 6, 2012

SEMINAR 04

MIND! LESSONS FROM THE BRAIN

Director(s): Philip T. Ninan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Explore how the human mind emerges from brain function; 2) Examine potential dimensions of disease processes that underlie symptom-based mental disorders; 3) Understand the mediating mechanisms of psychotherapeutic, pharmacologic and device treatments.

SUMMARY:

How does the human mind emerge from brain function? 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 realm of scientific inquiry. This course examines how the brain, from sentient representations, crafts an internal 'virtual' reality that parallels external actuality. It permits simulations – of the past as memories, of the future (e.g. crafting alternative scenarios for planning), and imagination (e.g. fantasies). A fundamental discordance between the two worlds is common in major psychiatric illnesses. A series of postulates for the foundations of the mind are offered: 1. The human brain follows the laws of nature. 2. The human brain is a representational cartographer. 3. Sentiently perceived external reality is recreated into a 'virtual' mental experience. 4. The mind is composed of conscious brain activity. 5. Emotions are activated from early stages of information processing. 6. Content and context compete for dominance. 7. Cognition is a higher order synthesis of information. 8. Executive functions are a pinnacle of evolutionary achievement. 9. Behaviors can be innate, procedural or consciously chosen. 10. The internal simulation of observed behavior forms the basis of the social brain. Much

of brain function is implicitly and nonconsciously processed in parallel systems with massive capacity. These modalities collapse through a bottle neck into a serially processed, experiential singularity that achieves conscious awareness. The circuitry mediating the social brain permits the appreciation of the mental life of the other, while distinguishing it from one's own. In the absence of individual agency (e.g. childhood), mirrored emotions cannot be distinguished from one's own. Modeling the emergent mind from brain functions permits clinicians to potentially reformulate their perceptions of psychopathology. Treatments will be prescribed based on their mechanisms of action and evidence of benefit. Medications and devices work through the brain to influence the mind. Novel treatments can be oriented to modification of basic disease processes, from conventional 'small molecule' medications to biopharmaceutical psychotropics and vaccines. Psychotherapy works through the mind to alter brain function. Psychotherapies involve new learning, with changes in synaptic strength and number. The choice and delivery of specific psychotherapeutic treatments will be enhanced by understanding the ingredients that mediate their benefits. Such knowledge will ultimately revolutionize psychotherapy, whereby the prescription of psychotherapy is not random or an accident of training, but based on knowledge and evidence.

SEMINAR 05

BEST FINANCIAL PRACTICES FOR FISCALLY SOLVENT DELIVERY OF INTEGRATED CARE

Director(s): Roger G. Kathol, M.D.

Faculty: Susan C. Sargent, M.B.A., Chris White, M.D., J.D., Stephen P. Melek, None

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the prevalence of concurrent physical and mental conditions and their impact on health service utilization, impairment, and health care cost; 2) Be aware of current billing practices for integrated services that improve the likelihood of financial solvency and reimbursement changes needed to achieve sustainable integrated care; 3) Develop skills in building fiscally solvent integrated practices.

SUMMARY:

It is impossible to support and sustain mental health services in general medical settings when they are paid from separate funding sources to the rest of medical care. This workshop will step attendees through system level to care delivery level mental health reimbursement from a business/administration perspective, two psychiatrist's care

delivery perspectives, and an actuary's populationbased perspective. It will describe how payment procedures impact the coordination of psychiatric and other medical services. Presenters will then divide the attendees into groups and help them learn how to develop payment strategies for consolidating physical and mental health budgets so that valueadded psychiatric services can be systematically delivered in inpatient and outpatient medical settings and medical services can be delivered in psychiatric settings. Special attention will be given to the development of valueadded integrated clinical programs as a part of accountable care organizations (ACOs) and patient centered health care homes. Note: This is not a coding, billing, and collections seminar but rather a look at envisioned reimbursement approaches that will position psychiatry to make and be paid for contributions to integrated patient health as health reform matures during the next decade.

SEMINAR 06

SEEING THE FOREST AND THE TREES: AN APPROACH TO BIOPSYCHOSOCIAL FORMULATION

Director(s): William H. Campbell, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Develop a comprehensive biopsychosocial formulation based on historical information obtained during a psychiatric interview.

SUMMARY:

This course provides a systematic approach to the development of a comprehensive biopsychosocial formulation. Biological, psychological, and social perspectives will be reviewed and a paradigm will be presented with which to organize historical data. The faculty will present a comprehensive biopsychosocial formulation based on the information provided in a videotaped interview of a patient. An additional videotape of a clinical interview will be shown. Following this videotape, participants will develop a comprehensive biopsychosocial formulation under faculty supervision.

SEMINAR 07

WRITING, BLOGGING, AND PODCASTING ABOUT PSYCHIATRY FOR THE PUBLIC: A GUIDE FOR THE PERPLEXED

Director(s): Steven R. Daviss, M.D., Annette Hanson, M.D.

Faculty: Dinah Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the major steps involved in getting a book published; 2) Identify what a blog is and understand the pros and cons of writing about psychiatry on the Internet; 3) Know about a variety of ways to communicate to the public about the field of psychiatry in a variety of new media formats, including podcasts, Twitter, Facebook, and Google+.

SUMMARY:

I. INTRODUCTION The Accessible Psychiatry Project Who we are Shrink Rap, the blog Shrink Rap News, the blog and the print column for Clinical Psychiatry News Shrink Rap Today, on the Psychology Today website My Three Shrinks, a psychiatry podcast on iTunes Shrink Rap: Three Psychiatrists Explain Their Work, a laypress book published by Johns Hopkins University Press Shrink Rap Book page on Facebook Twitter feeds: ShrinkRapRoy, ClinkShrink, and ShrinkRapDinah II. SLIDE SHOW: THE PUBLIC FACE OF PSYCHIATRY Examples in popular media that depict psychiatrists, psychiatry, and the criminally insane. III. THE PSYCHIATRIST'S BLOG What is a blog? How does one start a blog? This will include basic directions with screen shots of blogs Why would a psychiatrist want to have a blog? An outlet for writing and creative expression A form of public education to correct misperceptions A unique way to interact with the public How to avoid problems Be aware at all times, even if you blog anonymously, that what you say can be made public If in doubt, don't say it It's good to have friends The story of Flea (blogger beware) How to get readers for your blog Commenting on the blogs of others Responding to commenters The blog roll Linking to the work of others in your own posts IV. SOCIAL MEDIA AND FORENSIC ISSUES The intersection of public perception and mental illness correcting misperceptions Blogs/Facebook/Twitter and the psychiatrist who may have to testify III. PODCASTING AND OTHER FORMS OF SOCIAL MEDIA What is a podcast? Getting started: How do you start a podcast? Sites to visit Thinking about equipment Twitter: What is it and what role does it play in psychiatry? Google+: Why it may be better than Facebook as a tool for psychiatrists V. WRITING BOOKS ABOUT PSYCHIATRY FOR THE GENERAL PUBLIC Things to consider when you start to write a book The book proposal Time and money: is it worth it? Do you need an agent? Commercial versus academic press? PrintonDemand Selfpublishing options Marketing plans and books

SEMINAR 08

LOSING A PATIENT TO SUICIDE

Director(s): Michael F. Myers, M.D.

Faculty: Frank Campbell, Ph.D., M.S.W., Carla Fine, M.S.

EDUCATIONAL OBJECTIVES:

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) Appreciate what family members and others close to the deceased might experience; 3) Know what to do to minimize the risk of malpractice litigation and cope with a lawsuit should this occur; 4) Learn how to reach out to grieving families and others; 5) Take action to look after oneself.

SUMMARY:

Suicides occur in clinical practice despite best efforts at risk assessment and treatment. It is estimated that fifty per cent of psychiatrists can expect to have at least one patient die by suicide, an experience that may be one of the most difficult professional times in their careers. Although many residents lose a patient to suicide during their training, some do not; further, scientific literature in academic psychiatry concludes that residents do not always receive adequate support and teaching on this matter. This course is designed to prepare psychiatrists for what is considered an occupational hazard of treating mentally ill patients. The faculty will cover the following issues: 1) psychological reactions to patient suicide, including the myriad variables that characterize the physician-patient relationship; 2) malpractice litigation after suicide – minimizing and dealing with lawsuits; 3) reactions of family and friends to the loss of a loved one to suicide (the survivors' experience); 4) psychiatric morbidity in family members after death by suicide; 5) the clinician's roles and responsibilities after suicide, including outreach to survivors; 6) selfcare after losing a patient to suicide; 7) the role of psychological autopsy in the aftermath of suicide; 8) special circumstances: patient-suicide during residency; suicide death on an inpatient unit, while out on pass or immediately after discharge; suicide death of a child, adolescent or geriatric patient; murdersuicide; physician suicide. Discussion with the faculty and other attendees is an essential feature of this course; registrants can expect to gain much new knowledge and become more comfortable with this very difficult dimension of professional life.

MONDAY MAY 7, 2012

SEMINAR 09

COUNTER-INTUITIVES IN MEDICAL ETHICS

Director(s): Edmund G. Howe, M.D., J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) To consider arguments that are valid in ethical analysis, and, thus, should be "on the table" but which may be counter intuitive, such that participants might be less

likely to come up with them on their own; 2) Appreciate the limitations of ethical analysis in resolving value conflicts; 3) To know such core differences between deontological and consequential values and between private and public morality.

SUMMARY:

This is a seminar presenting counterintuitive but valid and important arguments currently used in ethical analyses. Initially, traditional and adjunctive approaches to resolving ethical conflicts will be presented. The course will then present twenty-six brief paradigmatic cases for discussion and analysis. Each will raise different counterintuitive points in ethical theory. This will be followed by general discussion. Topics will include theoretical principles, medicine, psychiatry, pediatrics, obstetrics, genetics, law, allocation of resources, and research. While the concepts are advanced, this course should be understandable and beneficial to all regardless of their prior knowledge.

SEMINAR 10

TREATING MEDICAL STUDENTS AND PHYSICIANS

Director(s): Michael F. Myers, M.D., Leah J. Dickstein, M.D., M.A.

Faculty: William B Lawson, M.D., Ph.D., Penelope P. Ziegler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the role of stigma and other obstacles to care when treating medical students and physicians; 2) Feel comfortable treating physicians with addictions; 3) Appreciate the challenges when treating physicians with depression; 4) Identify transference and countertransference dynamics.

SUMMARY:

It is well-known that medical students and physicians can pose unique challenges when they become ill. With liberal use of case examples, this course will cover the following issues: 1) engaging the medical student or physician in a treatment alliance and overcoming stigma; 2) advocacy issues when negotiating with deans of medical schools, training directors, licensing boards, and insurance carriers; 3) unique issues for gay and lesbian medical students, despite their longstanding recognition; 4) treating substance-abusing medical students and physicians and working with physician health committees; 5) addressing privacy and confidentiality of medical records; 6) avoiding conflict of interest matters; 7) treating physicians who have been sued or reported to their licensing board; 8) treating medical

students and physicians who are members of racial, ethnic or religious minority groups or physicians who are international medical graduates (IMGs); 9) complexities when treating physicians with mood disorders, including the suicidal physician; 10) treating relationship strain in medical students and physicians; 11) reaching out to family members and significant others of symptomatic medical students and physicians; 12) understanding the many transference and countertransference issues when psychiatrists treat medical students, residents, and colleagues. Participants are encouraged to bring disguised cases from their own practices for small-group discussion.

SEMINAR 11

RECOVERY: HOW TO TRANSFORM YOUR CLINICAL PRACTICE EFFECTIVELY AND EFFICIENTLY

Director(s): Shirish Patel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Differentiate between recovery activities and recovery-oriented care, and illness management and illness self-management; 2) Develop patient-centered, recovery-oriented, multidisciplinary treatment plans; 3) Start the process of systematically transforming a stabilization (medical) model of care to a patient-centered, recovery-oriented, clinical practice.

SUMMARY:

This course will benefit all mental health clinicians in meeting the recommendation of the President's New Freedom Commission (2002) for a "fundamental transformation of the nation's approach to mental health to one that actively facilitates recovery" in the management of mental disorders as well as addictive disorders. It begins with an overview of the four key concepts of recovery: recovery activities, recovery-oriented care, illness management, and illness self-management. Evidence-based models of recovery will be reviewed with primary focus on SAMHSA's Illness Management and Recovery model of care. Key elements of a patient-centered, recovery-oriented treatment plan – goals, objectives, interventions, and outcomes will be presented with examples. Barriers to implementing recovery-oriented care will be discussed from the standpoints of the patient, the practitioner, and the system. Ways of overcoming these barriers and systematically transforming the delivery of mental health care from the traditional stabilization (medical) model of care to a patient-centered recovery-oriented care will be discussed. Finally, tools for measuring effective delivery of recovery-oriented care will be reviewed. Discussion and interaction will be encouraged throughout the course.

SEMINAR 12**EMERGENCY PSYCHIATRY: THEORY TO PRACTICE**

American Association for Emergency Psychiatry

Director(s): Rachel L. Glick, M.D.

Faculty: Rachel L. Glick, M.D., Jon S. Berlin, M.D., Seth Powsner, M.D., Avrim B. Fishkind, M.D., Scott L. Zeller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe what a psychiatric emergency is and in what settings it might occur; 2) Discuss the current models of psychiatric emergency care; 3) Know how to assess the patient for acute precipitants of psychiatric crisis; 4) Know how to perform a comprehensive suicide (and homicide) risk assessment; 5) Describe the approach to management of the agitated patient using verbal deescalation; using psychopharmacologic interventions; 6) Know what medical assessment is needed in emergency psychiatry.

SUMMARY:

One of the most important aspects of clinical psychiatry is the assessment and management of psychiatric crises and emergencies. Psychiatric emergencies may occur in office settings, inpatient settings, and emergency departments, as well as in the community. When they do occur, psychiatrists are often unprepared to deal with the clinical and system issues surrounding the assessment and management of such emergencies. There are often numerous parties involved in this process. Clinicians are challenged in differentiating true clinical emergencies from social emergencies (which also demand intervention strategies, yet with different paradigms). There is also an intricate spectrum of medicolegal and cultural issues that must be appreciated. Psychiatrists can have an extremely important clinical and leadership role in such scenarios. Recognition and classification of these diverse situations is critical to help those affected with appropriate interventions. The notion of emergency psychiatry first gained some prominence with the deinstitutionalization of the chronically mentally ill several decades ago, but over time, as community resources for mental health care have decreased; psychiatric emergency services and emergency departments that serve in that role have become a critical link in the continuum of care for those with mental illness. This seminar will increase awareness of the role of emergency and crisis psychiatry. The course faculty will provide their expertise from extensive clinical and research experience in emergency psychiatry. The participants will learn about the evaluation and risk assessment of patients in crisis. The participants will also learn about the management of psychiatric emergencies including complications

from substance abuse and medical comorbidities. Finally, special issues in emergency psychiatry such as commitment, medicolegal and cultural issues will be discussed. Lecture and discussion formats will impart fundamental and pragmatic skills to identify, assess, triage, and manage the range of psychiatric emergencies.

SEMINAR 13**NARRATIVE HYPNOSIS FOR PSYCHIATRY: EMPHASIS ON PAIN MANAGEMENT**

Director(s): Lewis MehlMadrona, M.D., Ph.D.

Faculty: Barbara J. Mainguy, M.A., M.F.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify five elements of hypnotic technique from listening to a session; 2) Describe three metaphors that can be used for reducing the sensation of pain; 3) Discuss how hypnosis can be used to augment patient motivation and willingness to respond to treatment in relevant conditions; 4) Practice basic hypnosis techniques useful for reducing anxiety, panic, fear, and pain, including preparing individualized scripts.

SUMMARY:

In this course, psychiatrists will be able to learn basic techniques for effective hypnosis, and to incorporate metaphor and story to better individualize work with those suffering from pain due to a variety of chronic and acute conditions including burns, fibromyalgia, arthritis and cancer. What we call hypnosis today has been used for thousands of years as part of the persuasive arts and has been used by traditional healers from time immemorial. Hypnosis has been defined more recently as a state of heightened attention and complete absorption in one situation so as to enhance learning. Hypnosis is augmented through the power of story, for story is what grabs our attention. Story has been used for thousands of years to teach and instruct and to change people's behavior. This may be more than accident, as story is now discussed in scientific literature as the brain's way of optimizing information and making meaning according to current research, 'storying' a situation engages brain areas dedicated to cognition, emotion and executive functioning. (Machado, P & Goncalves, O. (1999). Narrative in Psychotherapy: The Emerging Metaphor. *Journal of Clinical Psychology*, 55(10), 1179-1191. Mar, R. (2004). *The Neuropsychology of Narrative: Story Comprehension, Story Production and Their Interrelation*. *Neuropsychologia* 42, 1414-34.) While we will review the literature briefly, the focus will be to learn and practice some foundational techniques of hypnosis (embedded commands, use of voice

tonality and phrasing, implied causatives, linkages, truisms, interspersal technique) so that psychiatrists attending will be able to do basic hypnosis upon leaving. We will then proceed to explore the power of metaphor and story and its use in hypnosis and the use of the power of words to enrich metaphor and story. We will practice constructing metaphors for use with people in chronic pain for increased hypnotic effectiveness. We will review some stories of chronic pain patients and will brainstorm about how pain can be reduced along with medication consumption.

SEMINAR 14

EEG IN PSYCHIATRY PRACTICE

Director(s): Nash N. Boutros, M.D., Oliver Pogarell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the limitations of EEG and the broad categories of pathophysiology that produce EEG abnormalities; 2) Have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG in a general psychiatric practice setting; 3) Develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy.

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 nonconvulsive 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 underutilization) to help with the differential diagnostic question and to be able to determine when an EEG test was

adequately (technically) performed.

SEMINAR 15

INTEGRATING MENTAL HEALTH SERVICES WITHIN PRIMARY CARE SETTING: EFFECTIVE STRATEGIES AND PRACTICAL TIPS

Director(s): Nick Kates, M.B.B.S

Faculty: Jon S Davine, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the role that primary care plays in delivering mental health care, problems that occur at the interface with psychiatry/mental health and principles to guide collaborative partnerships; 2) Understand how mental health counselors and psychiatrists can work optimally in primary care settings; 3) Implement these changes within their own community.

SUMMARY:

Recent interest in the patientcentered medical home and the role of mental health in that model has highlighted the importance of developing strong links between mental health and primary care services and the need to find ways of building collaborative partnerships. This course draws on experiences in Hamilton, Ontario, Canada in the successful integration of mental health counselors and psychiatrists into the offices of what is now 150 physicians over the last 18 years. It summarizes the role family medicine plays in delivering mental health care and the problems that exist in the relationship between the two disciplines. It describes the key principles that should guide psychiatrists and other mental health clinicians when working collaboratively with family physician colleagues and the role of mental health care in the patientcentered medical home. It will then present practical skills that will enable psychiatrists and counselors to function effectively within primary care settings, the educational opportunities such partnerships present, ways to increase the capacity of primary care providers for delivering mental health care and the key lessons learnt in the Hamilton program over the last 18 years. Finally it will present strategies and practical approaches for adapting and implementing these concepts in any community. The course will emphasize providing practical tips, tools and suggestions that can be introduced in attendees own practice

SEMINAR 16

HOW TO GIVE A MORE EFFECTIVE LECTURE: PUNCH, PASSION, AND POLISH

Director(s): Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, the participant should be able to: 1) Improve techniques for holding audience attention; 2) Know how to involve the audience; 3) Know 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 a flash drive.

SEMINAR 17**PSYCHIATRIC CONSULTATION IN LONGTERM CARE: ADVANCED SEMINAR**

Director(s): Abhilash K. Desai, M.D., George T. Grossberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Evaluate and treat challenging and complex psychiatric disorders using an array of interventions (pharmacological, nonpharmacological, electroconvulsive therapy); 2) Understand endoflife care issues including management of agitation; 3) Learn about innovative strategies to overcome barriers to successful clinical management of psychiatric disorders in long term care residents.

SUMMARY:

This course is designed for psychiatrists and physician extenders who would like to develop and enhance capabilities of becoming a clinical leader and educator in managing psychiatric disorders in individuals living in long term care

(LTC) settings. LTC settings include home care, daycare, assisted living, subacute care (skilled nursing unit), and nursing homes. The course will discuss evidencebased and stateofheart interventions (pharmacological and nonpharmacological) to manage complex and challenging psychiatric disorders and psychiatric aspects of endoflife care. The course will have four sections. Part I discusses management of challenging behaviors and psychiatric disorders such as suicide attempt/suicidal ideas, life threatening depression and physical aggression using clinical vignettes. Part II will discuss evaluation and management of psychiatric symptoms and disorders in individuals with terminal dementia and other terminal conditions and discuss psychiatric aspects of endoflife care. Using clinical vignettes on challenging cases (severe sexual aggression, refractory severe aggression, severe and persistent mental illness); Part III will discuss evaluation of various etiologies of psychiatric symptoms and complex psychopharmacological, nonpharmacological interventions to successfully manage such cases. Part IV will discuss educational, innovative and administrative strategies to overcome barriers to successful clinical management of psychiatric disorders in individuals in long term care settings. Discussion and interaction will be encouraged throughout, and especially at the end of each part. Target audiences include psychiatrists and physician extenders who want to enhance their expertise in management of challenging and complex psychiatric disorders in longterm care residents and assume a leadership role.

SEMINAR 18**INTEGRATIVE TREATMENTS FOR COGNITIVE ENHANCEMENT, TRAUMATIC BRAIN INJURY, ADHD, SEXUAL ENHANCEMENT, AND LIFESTAGE ISSUES FOR MEN AND WOMEN**

Director(s): Patricia L. Gerbarg, M.D., Richard P. Brown, M.D.

Faculty: Richard P. Brown, M.D., Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify integrative treatments, including herbs, nutrients, and mindbody practices for which there is sufficient evidence of safety and efficacy for use in clinical practice; 2) Understand the mechanisms of action, risks, and benefits of those integrative treatments; 3) Have the tools to pursue further information and updates on treatments he or she will consider using in practice.

SUMMARY:

Participants will learn how to integrate complementary treatments with standard treatments in psychiatry practice.

The course focuses on research and clinical applications of complementary treatments for which there is sufficient evidence of safety and efficacy. The authors have selected those treatments that are the most useful for clinicians to integrate into their practices from the following categories: herbs, adaptogens, nutrients, nootropics, hormones, mindbody practices, and cranial electrotherapy stimulation. Evidence for efficacy and clinical practice guidelines for integrative approaches will include the following diagnostic categories: Cognitive Enhancement, Cognitive Decline, Traumatic Brain Injury, Dementia, Stroke, Neurodegenerative Disease (Parkinson's), Attention Deficit Disorder, Sexual Enhancement, Sexual Dysfunctions, Erectile Dysfunction, Hypoactive Libido, Male and Female Fertility, Premenstrual Syndrome, Pregnancy, Menopause. Participants will have an introduction to the experience of breath and movement techniques that rapidly relieve stress and anxiety. Those interested in learning more about how to use mindbody practices for their own wellbeing as well as how to teach breath practices to their patients may also sign up for our course, *Yoga of the East and West: Integrating Breath Work and Meditation into Clinical Practice*. While this course restores the full day schedule, it differs from last year's course in that it will focus on a different set of topics: Cognitive Enhancement, ADHD, and Sexual Function.

SEMINAR 19

A DEVELOPMENTAL APPROACH TO CONTEMPORARY ISSUES IN PSYCHOTHERAPY WITH GAY MEN

Director(s): Robert M. Kertzner, M.D., Marshall Forstein, M.D.

Faculty: Stewart L. Adelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify major psychosocial developmental issues facing gay men across the life span; 2) Identify how early life issues related to a sense of being "different" affect mental health throughout the life span; 3) Identify transference/countertransference issues that arise in working with gay men.

SUMMARY:

The formation of a sexual minority identity (based on sexual orientation) requires additional developmental tasks in the lives of gay men. Beginning in childhood with the experience of being different, gay males experience stigmatization of deeply felt, personal aspirations for attachment, intimacy and sexual expression. In addition to the effect of stigmatization of a sexual minority identity, selfidentifica-

tion and expression of being gay in the areas of play, work and love are influenced throughout the life of gay men by geography, culture, religion, family, and legal status. Gay men who are of racial and/or ethnic/or fundamental religious groups negotiate multiple minority identities. Gay men are thus challenged to integrate these multiple sources of identity with a sexual minority identity. In addition, rapidly evolving historical change such as "gay liberation", the HIV pandemic, and the evolution of civil rights including the legal recognition of marriage affect psychological development. Despite an improving climate of social and legal acceptance, a significant number of gay men are characterized by social and psychological vulnerabilities that increase the risk for mental health disorders that have the potential to disrupt normative developmental growth; for other gay men, the different social context in which developmental tasks are realized creates developmental pathways that may differ from their heterosexual counterparts. Grounded in a developmental perspective, this seminar will explore some common issues that gay men experience and bring to the therapeutic experience in childhood, young adulthood, midlife and late adult life. Cases will be discussed and transference and countertransference issues highlighted.

SEMINAR 20

PERFORMANCE OF THE MENTAL STATUS EXAMINATION: ASSESSMENT OF FRONTAL CORTICAL FUNCTIONING

Director(s): Stephen I. Deutsch, M.D., Ph.D.

Faculty: Stephen I Deutsch, M.D., Ph.D., David R. Spiegel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know the critical elements and have a strategy for performing a reliable, objective, crosssectional, and largely overrated evaluation of the mental status; 2) Understand why this examination is essential to the accurate assessment of neuropsychiatric disorders, appropriate treatment selection, and monitoring course of illness.

SUMMARY:

The ability to perform and record the comprehensive examination of mental status is crucial to the work of the psychiatrist. Not infrequently, however, psychiatrists at all levels of training and experience either lack confidence in their ability to perform this examination or do not have an approach to the organization and presentation of the data collected during its performance. The integration of the crosssectionally performed mental status examination with longitudinal history is a necessary firststep in generating

diagnostic “hypotheses,” determining need for laboratory and imaging studies, and formulating an initial treatment plan. Serial examinations are crucial to evaluating course of illness (e.g., improvement or worsening) and response to treatment. Oftentimes, the psychiatrist’s ability to examine the mental status reliably is her or his most significant contribution to patient management on general medical and surgical inpatient services. The speakers will provide an introduction and framework for conducting and presenting this essential clinical examination. The course and its content are a distillation of more than 20 years of the direct involvement in the teaching and clinical supervision of the performance of the mental status examination by medical students and residents in inpatient and outpatient settings by the faculty.

TUESDAY MAY 8, 2012

SEMINAR 21

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UNDERSTANDING THE PERSON BEHIND THE ILLNESS: AN APPROACH TO PSYCHODYNAMIC FORMULATION

Director(s): William H. Campbell, M.D., M.B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Develop a psychodynamic formulation based on historical information obtained during a psychiatric interview.

SUMMARY:

This course provides a systematic approach to the development of a psychodynamic formulation. Historical data obtained during a psychiatric interview will be organized into eight categories and then synthesized into a psychodynamic formulation. The faculty will present a psychodynamic formulation based on the information provided in a videotaped interview of a patient. An additional videotape of a clinical interview will be shown. Following this videotape, participants will develop a psychodynamic formulation under faculty supervision.

SMALL INTERACTIVE SESSIONS

SUNDAY, MAY 6, 2012

SMALL INTERACTIVE SESSION 01

SPORTS PSYCHIATRY: HELPING TEAMS MANAGE SUICIDE AND SUDDEN DEATH IN ATHLETES*Presenter: David McDuff, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Design an organizational intervention for sports team that experiences the sudden death of one of its players or coaches, 2) Develop skill providing psychological first aid and initial and ongoing psychiatric screening with athletes and coaches following a traumatic loss, 3) Provide grief therapy and memorial service support to athletes, coaches, teams, and family members following a death by suicide, homicide, accident, or health catastrophe

SUMMARY:

The sudden death of an athlete or coach can have a disruptive effect on the emotions and performance of sports teams at any competitive level. Unfortunately, traumatic loss in professional sports is common enough that most teams will experience one to four of these over a ten year period. The most common traumatic losses are deaths by accident, suicide, and homicide. Unfortunately, in the past year there has been a rash of suicides among elite athletes in different sports. Retired professional athletes seem to be at higher risk for traumatic death due to financial ruin, substance misuse, depression, family fragmentation, head injury with cognitive impairment, and loss of structure, purpose and meaning. This interactive workshop will review the experiences of a fulltime sports psychiatrist who has worked with two professional sports teams for sixteen years. An overview of all traumatic losses from both teams will be presented and compared with the experience of others teams in the same sport. In addition, the organizational interventions for two traumatic deaths (a retired player suicide and an active player death from heat injury) will be presented and discussed. Particular attention will be given to developing skills for working with team leadership, providing psychological first aid and grief therapy, monitoring and managing symptom and disorder development over time, creating a team recovery environment and providing family support.

SMALL INTERACTIVE SESSION 02

MEET THE AUTHOR OF THE EVIDENCEBASED GUIDE TO ANTIDEPRESSANT MEDICATIONS*Presenter: Anthony J. Rothschild, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Have a better understanding of the information available in The EvidenceBased Guide to Antidepressant Medications regarding use of antidepressants for major depressive disorder, bipolar depression, psychotic depression, and treatmentresistant depression, 2) Have a better understanding of the information available in The EvidenceBased Guide to Antidepressant Medications regarding use of antidepressants in the management of anxiety disorders, obsessivecompulsive disorder, and specific phobias, 3) Have a better understanding of the information available in The EvidenceBased Guide to Antidepressant Medications regarding use of antidepressants in children and adolescents, medically ill patients, patients with schizophrenia, patients with substance abuse disorders, and geriatric patients.

SUMMARY:

The workshop will be an informal, interactive session with Anthony J. Rothschild, M.D., editor of The EvidenceBased Guide to Antidepressant Medications. The second book in the EvidenceBased Guides series, The EvidenceBased 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 offlabel 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, readerfriendly 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 musthave reference for psychiatrists and other practicing clinicians, residents in training, psychiatric nurses, social workers, and researchers.

SMALL INTERACTIVE SESSION 03

IMPLEMENTING INTERPERSONAL AND SOCIAL RHYTHM THERAPY ACROSS A RANGE OF CLINICAL SETTINGS

Presenter: Ellen Frank, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the basic principles of interpersonal and social rhythm therapy (IPSRT), 2) Develop the rationale for IPSRT with patients, 3) Describe what we have learned about implementing IPSRT in a variety of settings, from individual outpatient therapy to group inpatient treatment, 4) Overcome the most common stumbling blocks in IPSRT implementation

SUMMARY:

Interpersonal and social rhythm therapy (IPSRT), developed by Ellen Frank and colleagues at the University of Pittsburgh as a treatment for bipolar (BP) disorder, combines elements of Klerman and Weissman's interpersonal psychotherapy (IPT) with a behavioral intervention aimed at enhancing circadian system integrity through regularizing daily routines. The goals of the treatment are the recognition of the relationships among social rhythms, circadian/biologic rhythms, interpersonal problems, and mood followed by the achievement and maintenance of stable mood by development of increased capacity for stable social rhythms and the resolution of interpersonal problems related to grief, role transitions or role disputes. IPSRT's efficacy was demonstrated in a singlesite acute and maintenance trial in patients with BPI disorder who were suffering from mania, depression or mixed episodes and in the large multisite STEPBD acute trial in patients with BPI or II disorders who were suffering from bipolar depression. Despite the demonstration of efficacy in these welldefined patient populations, IPSRT's role in other populations and settings has not been established in empirical studies; however, because of its clinical appeal and compelling evidencebase to date, investigators have begun the process of systematically evaluating IPSRT for groups who were necessarily excluded from the original trials. This interactive session, in addition to providing a brief overview of the treatment, will focus on novel applications of IPSRT including IPSRT as monotherapy for individuals with acute BPII depression and adaptation of IPSRT to a group format in order to support its implementation in routine practice settings (both inpatient and outpatient). This session will give clinicians an understanding of the importance of circadian rhythm entrainment to promote mood stability as described in IPSRT across an expanding range of conditions, settings, and formats.

SMALL INTERACTIVE SESSION 04

THE VITALITY OF PSYCHODYNAMIC PSYCHOTHERAPY

Presenter: Jerald Kay, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe in plain language, the key ideas and beliefs that comprise the psychiatrist's psychodynamic approach to psychotherapy, 2) Elucidate the functional components of the therapeutic relationship, 3) Appreciate the core tasks of the psychodynamic psychotherapist

SUMMARY:

Psychodynamic psychotherapy, in all of its forms, remains the psychotherapy most frequently provided by psychiatrists. Although effectiveness and efficacy of dynamic psychotherapy are supported by a growing literature, this interactive session will focus on the clinically useful tenets of the psychodynamic view and the attractive explanatory power this approach offers regarding behavior, motivation, and adaptation. A case of brief dynamic psychotherapy will be presented to provide a stimulus for discussion.

SMALL INTERACTIVE SESSION 05

MENTALIZING IN MENTAL HEALTH PRACTICE

Presenter: Anthony W. Bateman, M.D.

EDUCATIONAL OBJECTIVES:

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

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 motherchild 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.

MONDAY, MAY 7, 2012

SMALL INTERACTIVE SESSION 06

WOMEN IN PSYCHIATRY: PERSONAL PERSPECTIVES

Presenter: Donna M. Norris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the personal characteristics similarities and differences, which influenced the career and leadership development of these women psychiatrists, 2) Recognize that leadership and successful career family balance can be achieved from many different pathways, 3) Reflect on and to utilize these examples when considering their own career decisions

SUMMARY:

The authors anticipate that this book discussion will appeal to professional women and men of all ages who recognize the value of learning from others' experiences regarding career choices and then how best to balance these with professional and family responsibilities. Real life portrayals will offer examples of alternative pathways to productive careers in the face of many challenges. The editors believe that these narratives will inspire the audience to reflect on and to utilize these examples when considering their own career decisions. Because of the evolving nature of these women's careers and their shared personal experiences, we hope that participants will be moved to seek mentorship with some of these women leaders.

SMALL INTERACTIVE SESSION 07

TREATMENT RESISTANT DEPRESSION: CLINICAL GUIDELINES FOR TREATMENT AND PREVENTION

Presenter: John F. Greden, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify and describe clinical features and warning signs of Treatment Resistant Depression, 2) Diagnose and treat utilizing new strategies (a "roadmap") most likely to prevent TRD and attain and maintain wellness, 3) Apply longterm management approaches and newer treatment approaches such as neuromodulation, (rTMS, VNS, DBS) ketamine infusion and new pharmacologic and psychotherapeutic approaches for those who have otherwise failed to respond

SUMMARY:

Major Depressive Disorder affects approximately 1 of every 6 individuals during their lifetime, and Treatment Resistant Depression (TRD) develops among an estimated 30% of the millions that suffer from this disease. TRD is responsible for an estimated 40 – 50% of the burden of depression and a major contributor to health care costs globally. This proposed "roadmap" provides evidencebased sequential steps to diagnose, screen, prevent, and treat TRD. It recommends: 1) screening and severity rating scales to use on a routine basis for earlier detection and uncovering of clinical warning signs of TRD; 2) strategies for defining TRD; 3) stepwise, evidencebased treatment strategies, including how to integrate pharmacotherapy and psychotherapy and current evidence of augmentations or combinations, and nutritional and exercise contributions, 4) clinical barriers to achieving remission among patients and how to address them; 5) guidelines for identifying patients who need indefinite antidepressant treatment to prevent recurrences; 6) when to use the newly approved neuromodulation treatments such as rTMS and VNS or other research treatments such as ketamine infusions; 7) strategies for preventing TRD, as prevention may be the most important step clinicians may take to overcome the huge burdens of clinical depression; and 8) steps that are being taken to develop a Global Network of Depression Centers, building upon the National Network of Depression Centers (www.nndc.org). Global and precompetitive collaborations are needed to generate breakthroughs for TRD.

SMALL INTERACTIVE SESSION 08

TOP 10 GERIATRIC PSYCHIATRY ISSUES FOR THE GENERAL PSYCHIATRISTS

Presenter: Josepha A Cheong, M.D.

EDUCATIONAL OBJECTIVES:

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.

SMALL INTERACTIVE SESSION 09**MAXIMIZING THE TREATMENT RESPONSE FOR DEPRESSION**

Presenter: Richard Shelton, M.D.

EDUCATIONAL OBJECTIVES:

Unavailable at time of publication.

SUMMARY:

Unavailable at time of publication

SMALL INTERACTIVE SESSION 10**WHAT IS BULLYING AND WHY IS IT SUCH A PROBLEM IN SCHOOLS, WORKPLACES, AND HOME POSING AS DOMESTIC VIOLENCE**

Presenter: Stuart W. Twemlow, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Current definitions of bullying, 2) The complexity of bullying as a social process, not a person, 3) The elements necessary for an antibullying program to be successful

SUMMARY:

We welcome this format to discuss a perplexing and very serious public health problem only just being recognized in the USA. Bullying has widely variant definitions in the school literature, with at times almost any negative action being considered as bullying, or can be so narrowly defined that it is very rare in schools and confined to those with psychopathic traits. We have spent 40 years researching these questions and would very much like a discussion with members. Issues like why was America so slow to see this as serious, how has it been modeled by adults in our culture. Can children be trained to mentalize (become reflective about what they do at a young age? Besides these topics, others might be: clarifying definitions, philosophy of approach, essential components for success, sustainability of programs in schools, home and the workplace. A more in depth discussion of our view of this family-school-community connection can be found in the recently published appi press book; preventing bullying and school violence by Stuart W. Twemlow, M.D., and Frank C. Sacco, Ph.D. Chapter 5 outlines the theory in more detail.

SMALL INTERACTIVE SESSION 11**APA MEET THE AUTHOR SESSION LABORATORY MEDICINE: A CASEBASED DISCUSSION**

Presenter: Sandra A. Jacobson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Explain how to use the book Laboratory Medicine in Psychiatry and Behavioral Science to answer questions regarding specific laboratory tests and diseases/conditions relevant to psychiatric practice, 2) Identify key elements of the patient's history and relevant signs and symptoms for the following conditions: antiphospholipid syndrome, diabetes insipidus, metachromatic leukodystrophy, fragile X syndrome, hemochromatosis, depression associated with a general medical condition, anxiety disorder (panic) associated with a general medical condition, and syndrome of inappropriate secretion of antidiuretic hormone (SIADH), 3) List the laboratory tests indicated in the workup of the following conditions: antiphospholipid syndrome, diabetes insipidus, metachromatic leukodystrophy, fragile X syndrome, hemochromatosis, depression associated with a general medical condition, anxiety disorder (panic) associated with a general medical condition, and syndrome of inappropriate secretion of antidiuretic hormone (SIADH).

SUMMARY:

Judicious use of the laboratory improves patient care in psychiatry, just as it does in other fields of medicine. Although laboratory testing is only one component of the complete

patient evaluation, it can be a critical one. The field of laboratory medicine is continually changing, with new tests added, new indications suggested, and new user guidelines proposed. Although it is essential that practicing psychiatrists and other behavioral health clinicians stay up to date on these changes, in fact there are no publications on this topic that are specific to our field. The newly released book *Laboratory Medicine in Psychiatry and Behavioral Science* was written to address just these issues. This workshop will focus on the content of the book, which will be augmented by specific cases from the author's own files as well as visual representations of important physical exam findings and concepts. Students, residents, and experienced clinicians are all welcome to attend.

TUESDAY, MAY 8, 2012

SMALL INTERACTIVE SESSION 12

SPORTS PSYCHIATRY: STRATEGIES FOR LIFE BALANCE & PEAK PERFORMANCE (MTA)

Presenter: David McDuff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe a broad scope of practice that psychiatrists can have with athletes, coaches, and teams at all competitive levels, 2) Diagnose and treat the common problems and disorders of elite athletes, 3) Assist athletes with mental preparation to improve performance consistency using breathing/relaxation, positive selftalk, and activated visualization, 4) Consult with athletic coaches and team leaders about performance barriers, behavioral concerns, or organizational crises, and 5) Utilize stress control strategies in athletes with adjustment anxiety, depression, insomnia, and anger

SUMMARY:

Psychiatrists have unique clinical and consultative skills that are useful in working with athletes and coaches to improve performance, maintain life balance, and/or treat common mental disorders. Utilizing the experiences of a fulltime sports psychiatrist that has worked with two professional sports teams for sixteen years, participants will learn practical skills to expand or begin clinical work with this unique population. This interactive discussion will cover mental skills training, stress recognition and control, sleep and energy regulation, substance use and abuse, injury recovery and pain control, treating common mental disorders, developmental and cultural competence, and working with teams, medical staffs and owners/leaders. Illustrative cases from each area will be used to highlight common problems and solutions.

SMALL INTERACTIVE SESSION 13

THE INTERPLAY OF LOVE AND AGGRESSION

Presenter: Otto F. Kernberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize split idealized and presecutory dyadic relations, 2) Treat transference development based on splitting and projective, 3) Identify sources of couple conflicts

SUMMARY:

The subject of this interchange will be the development of both loving and aggressive reactions in intense, longterm dyadic relationships. The treatment of severe personality disorders, on the one hand, and passionate, longterm love relations, on the other, will serve as illustrations of this dynamic development. This subject matter is a major unifying theme throughout the various subjects explored in my recently published volume, relevant for psychodynamic understanding of mature as well as severely conflictual human relations.

SMALL INTERACTIVE SESSION 14

POSTTRAUMATIC STRESS DISORDER OPEN FORUM: COME DISCUSS PTSD WITH THE EDITORS OF THE RECENT TEXT 'CLINICAL MANUAL FOR MANAGEMENT OF PTSD'

Presenter: David Benedek, M.D.

EDUCATIONAL OBJECTIVES:

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), 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.

SMALL INTERACTIVE SESSION 15**MEET THE AUTHOR SESSION: COGNITIVE BEHAVIOR THERAPY FOR CHILDREN AND ADOLESCENTS**

Presenter: Eva Szigethy, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

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, post traumatic stress disorder, and oppositional defiant disorder, 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 videodemonstrations 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 16**TMS AND ECT IN CLINICAL PRACTICE: Q & A**

Presenter: John O Reardon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Be conversant with the range of clinical problems that come up during ECT & TMS treatment, 2) Be conversant with how to manage serious complications with either treatment, 3) Understand risks & benefits of TMS & ECT treatment in off-label clinical practice

SUMMARY:

This will be a clinical discussion of FAQs (Q & A) for clinicians in practice who want to refer patients for assessment to determine if ECT or TMS is clinically indicated as well as ECT & TMS practitioners. It will be interactive throughout with a brief introduction by the leader at the outset. A wide range of topics is expected in this session together (efficacy & safety of TMS & ECT in routine clinical practice, who will benefit from either or both treatments, safety considerations, use of TMS & ECT in special patient populations the elderly, comorbid medical illness, possible use of off-label TMS longer term maintenance treatment with TMS or ECT, combining TMS & ECT with medications etc.).

SMALL INTERACTIVE SESSION 17**PSYCHOLOGICAL EFFECTS OF THE LONG WAR: STRATEGIES FOR MITIGATION**

Presenter: Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know the psychological effects of war, including PTSD and mild TBI, 2) Understand the breadth of programs to mitigate the psychological effects, 3) Understand how civilian providers can assist.

SUMMARY:

Seven years of war and repeated deployments have led to both physical and psychological wounds. This workshop will discuss both old and new challenges, including suicide, Post-Traumatic Stress Disorder, traumatic brain injury, and pain management. While an array of behavioral health services has long been available to address the strain on our Soldiers and Families, these services are clearly strained. There are other numerous initiatives to provide outreach, education and training, including "BattleMind", Combat and Operational Stress Control, Operational Stress Control and Readiness (OSCAR), RESPECTMIL, the Defense Center of Excellence (DCoE) and the National Intrepid Center of Excellence. Chaplains, Military One Source, and Army Community Service also offer support. There are also mul-

multiple new intervention strategies, which have met with mixed success. These include increased mental health screening, case management, policies to improve pain management and decrease polypharmacy, increased cooperation between the VA and the DoD, and telemedicine. Nonetheless the suicide rate remains high and violence related to combat challenges us all. Civilian providers are essential to taking care of Soldiers and veterans. There continue to be major challenges that will face our service members, their Families and the nation.

SYMPOSIA

SATURDAY, MAY 5, 2012

SYMPOSIUM 001

ONESTOP PSYCHIATRIC SHOPPING: HOW TO INTEGRATE MEDICATION AND PSYCHOTHERAPY IN YOUR PRACTICE*Chair: Daniel J. Carlat, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session the participant should be able to: 1) Understand the features of the major types of psychotherapies (psychodynamic, cognitive/behavioral, supportive) and how they can be integrated into a psychopharmacology practice, 2) Identify specific psychotherapeutic strategies to enhance the effectiveness of medication treatment, 3) Create an individualized training plan for improving your psychotherapeutic skills

SUMMARY:

Recent data indicate that psychiatrists are providing less psychotherapy and more psychopharmacology treatment than in the past. While this trend is in part an appropriate response to advances in psychopharmacology, there is an increasing sense that psychiatrists are losing important psychotherapeutic skills. Studies over the past decade have shown that for many psychiatric disorders, psychotherapy is as effective or more effective than medication treatment. In this symposium, experts in the integration of psychotherapy and psychopharmacology will present practical advice and tips for how psychiatrists can ramp up their use of psychotherapeutic principles in treatment, and how they can create a lifelong system of individualized continuing education for enhancing their psychotherapeutic skills. Specific topics to be covered include the use of high yield cognitive behavioral therapy strategies, the use of psychodynamic principles in enhancing medication adherence, interweaving supportive psychotherapy into medication visits, and the logistical and financial challenges of offering psychotherapy to all patients.

S001-1.**INTEGRATIVE STRATEGIES IN TREATING EATING DISORDERS***Presenter: Joel Yager, M.D.***SUMMARY:**

Assessing and treating patients with eating disorders demands attention to a wide range of biological, psychological, developmental, family and social considerations. This presentation will offer perspectives on integrating evidence-

based and consensusbased guidelines in the care of the individual patient. Clinicians caring for eating disorder patients must attend to each of the affected and pertinent domains. For areas where clinicians possess competencies, they will carry out assessment and treatment on several levels. For areas where the clinician lacks necessary knowledge and skills, developing a collaborative system of care with other health providers will be required.

S001-2.**EXPLORING THE MEANING OF MEDICATIONS***Presenter: David L. Mintz, M.D.***SUMMARY:**

In this presentation, I will focus on one specific aspect of an integrated psychiatric practice: exploring the dynamic meaning of medications. The techniques involved in a psychotherapeutic attention to medications have broad applicability, as they can be applied in the full range of psychodynamic treatments, from intensive psychoanalytic work, to relatively brief and infrequent “medical psychotherapy,” where psychotherapy is provided within the primary context of a so-called “med check.” In exploring this topic, we will consider some of the impediments (cultural, professional, and personal) to achieving an integration of psychotherapy with pharmacotherapy. We will consider how fundamental themes from the patient’s life frequently emerge in relation to medications and/or the psychopharmacologist. We will consider how the dynamic exploration of these hereandnow recreations of past dynamics can both deepen psychotherapies and also promote healthier relationships with medications. Lastly, we will review simple technical approaches to facilitate the integration of psychotherapy with pharmacotherapy.

S001-3.**COMBINING CBT AND PHARMACOTHERAPY IN BRIEF SESSIONS***Presenter: Jesse H. Wright, M.D., Ph.D.***SUMMARY:**

The practical features of cognitivebehavior therapy are well suited for integration with pharmacotherapy in the brief sessions that predominate current psychiatric practice. Methods of integrating CBT with pharmacotherapy in the treatment of mood and anxiety disorders are detailed. Specific suggestions are made for employing highyield CBT methods such as psychoeducation, behavioral activation, exposure and response prevention, and selfhelp exercises in comprehensive treatment plans.

S001-4.**A PRIVATE PSYCHIATRIC PRACTICE IN RURAL VERMONT: A RETURN TO THE OLD FRONTIER**

Presenter: Alice Silverman, M.D.

SUMMARY:

Psychiatric practice has shifted dramatically over the past 2 decades with “split treatment” becoming the norm. Psychiatrists have become more exclusively diagnosticians and psychopharmacologists, and psychotherapy, if offered at all is often provided by non physician psychotherapists from varied backgrounds. This presentation will describe my private psychiatric practice in a rural underserved area of Vermont where I provide combined psychotherapy and medication, if needed, to all patients I see. I will discuss my experience of the advantages of this model in terms of clinical outcomes and job satisfaction as compared to the more typical model of divided or split treatment currently in vogue.

SYMPOSIUM 002**SCOPE, CURRENT EVIDENCE, AND INNOVATIVE APPROACHES IN MANAGING PTSD IN THE MILITARY**

Chair: Farifteh F. Duffy, Ph.D.

Discussant: Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize the scope of mental health problems in military populations, 2) Discuss current evidencebased approaches and challenges in the management of PTSD and other related conditions in military populations, 3) Be familiar with innovative national approaches for improving care for service members with PTSD

SUMMARY:

The scope of service members’ mental health and cognitive problems associated with the wars in Iraq and Afghanistan is well documented. In a recent study of Army service members, rates of PTSD rose from 5% before deployment to 13% after deployment to Iraq, while depression rose from 5% to 8%; up to 28% of soldiers returning from Iraq may meet criteria for anxiety or depression (Hoge et al, 2004). This session will provide up to date information on the extent of mental health problems in military populations; review evidencebased treatment recommendations; and discuss availability and access to care, and challenges in treating PTSD and other mental health conditions in military popu-

lations. Concrete examples of potential innovative national approaches for improving PTSD care in the primary care and specialty mental health sectors, including RESPECT-MIL and the PTSD Care Dissemination Project, will be presented.

S002-1.**EPIDEMIOLOGY AND TREATMENT OF PTSD ASSOCIATED WITH COMBAT: A CRITICAL LOOK AT THE EVIDENCE**

Presenter: Gary H. Wynn, M.D.

SUMMARY:

Numerous studies have assessed the prevalence of PTSD in service members and veterans of the wars in Iraq and Afghanistan. Although there is considerable variability in sampling methods and case definitions, consistency in results have been obtained when studies have been grouped according to the population sample (combat infantry units versus general population samples). Overall, the prevalence of PTSD has been 36% predeployment and 620% postdeployment, depending largely on the frequency and intensity of combat experiences. Given the high prevalence of PTSD, there is considerable need for effective treatment, and two therapeutic modalities, prolonged exposure and cognitive processing therapy, have become the treatments of choices for PTSD in most Veterans Health Administration (VA) and Department of Defense (DoD) clinics. However, the evidence is mixed as to what components of treatment are most effective and why a large percentage of individuals do not recover from PTSD, either because they drop out of therapy or because these techniques are not as effective as we would like. This talk will review the state of the knowledge on PTSD treatment, what we think we know, what we believe the evidence indicates, what the evidence actually tells us, and where the key opportunities are for improving treatment of combatrelated PTSD. The talk will disentangle assumptions/beliefs from facts identified in randomized clinical trials, dismantling studies, and the clinical practice guidelines mental health professionals depend on.

S002-2.**PSYCHOPHARMACOLOGIC TREATMENT FOR PTSD**

Presenter: David M. Benedek, M.D.

SUMMARY:

The APA’s Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder was published in October 2004. As with most published practice guidelines, it supported the use of pharmacologic

agents—particularly SSRIs—for the treatment of PTSD (1). In response to increased attention on U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine also reviewed and summarized the evidence supporting treatment for PTSD. Their 2007 report concluded that existing evidence was sufficient only to establish the efficacy of exposurebased psychotherapies in the treatment of PTSD. However, the report included a dissenting opinion by one author about the strength of the evidence for pharmacotherapy. Recent studies bolster support for pharmacological intervention in many circumstances, but randomized controlled trials have called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans (2). Emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (dicycloserine). Other recent studies suggest that in certain patient populations new pharmacological options, such as prazosin, may be more effective than other widely prescribed medications (e.g., selective serotonin reuptake inhibitors) indicated for PTSD. Increased understanding of the neuromolecular basis for the stress response points to the possibility that new agents with other mechanisms of action may also be helpful, but efficacy has been established in clinical trials.

S002-3.

UNDERSTANDING THE EVIDENCE ON EVIDENCE-BASED PSYCHOTHERAPY FOR PTSD

Presenter: Paula Schnurr, Ph.D.

SUMMARY:

This presentation will provide a review of the latest findings the psychotherapeutic treatment of PTSD in military and civilian populations. There are a number of practice guidelines around the world, with similar, but not identical recommendations. How does a clinician decide what to believe? Understanding psychotherapy research poses unique challenges due to issues such as the difficulty of administering “placebo” therapy (and the need to use of different kinds of control groups) and of blinding patients and providers. Participants will gain skills in reading the psychotherapy treatment literature, understanding what makes a study better or worse, and confidence in applying this knowledge when determining which treatments to use with their trauma patients. Participants also will gain increased knowledge about the latest findings on psychotherapy for PTSD and on relevant guidelines, including the Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of PTSD, the American Psychiatric Association Practice Guideline for the Treatment of Patients with ASD and PTSD, and the Institute of Medicine (IOM) report, Posttraumatic Stress Disorder: Diagnosis and Assessment.

S002-4.

DISSEMINATING EFFECTIVE, INTEGRATED MENTAL HEALTH AND PRIMARY CARE SERVICES FOR PTSD AND DEPRESSION IN THE U.S. MILITARY

Presenter: Charles C. Engel, M.D., M.P.H.

SUMMARY:

About 2.2 million US military personnel have deployed to the armed conflicts in Iraq and Afghanistan. Of those, roughly 20% report PTSD or depression on return, with rates rising for at least the first six to 12 months back. Most of those with mental health problems receive inadequate assistance because of stigma, barriers to care, possible harm to career, and other factors. Since 2007 Army primary care clinics have worked to address these challenges using an integrated mental and physical health care model called “RESPECTMil” (ReEngineering Systems of Primary Care Treatment for PTSD and Depression in the Military). RESPECTMil is a systems approach that relies on three key components to improve access to and outcomes of PTSD and depression care: (1) Prepared primary care providers and practices (e.g., webbased clinician training, routine screening, clinical diagnostic and symptom severity aids); (2) Optional care management followup (e.g., measurementbased followup of symptom status, adverse treatment effects, treatment adherence and continuity); and (3) Enhanced and efficient interface with mental health specialty care (e.g., weekly case review with each care manager, feedback to the primary care clinician using the electronic record). The transition to RESPECTMil’s team care approach has been phased and gains have been consistent and steady. After 54 months, 74 clinics at 32 worldwide installations were implementing RESPECTMil with 3 of the remaining 4 installations preparing to launch. 1,221,811 visits (79% of visits to participating clinics) were screened for PTSD and depression, 12.7% of those visits screened positive for one or both disorders, and 48% of screen positive visits received a PTSD or depressionrelated primary care diagnosis. Suicide risk was reported in 1.1% (13,177) of screened visits. Care managers followed 11,884 patients, and while the number of care manager contacts was strongly linked to symptom improvement, only 40.5% received more than three monthly contacts. In summary, RESPECTMil is feasible and an acceptable option for military patients with mental health needs who are seen in primary care. Systematic efforts to engage a greater proportion of patients for longer in care management may improve clinical outcomes. A randomized effectiveness trial of “RESPECTMil Plus” is starting at 18 Army clinics to see if additional patient engagement strategies and primary carebased psychosocial options will improve care continuity

S002-5.

DOD/APIRE PTSD CARE DISSEMINATION PROJECT

Presenter: Farifteh F. Duffy, Ph.D.

SUMMARY:

The American Psychiatric Institute for Research and Education (APIRE) was awarded the Department of Defense PTSD Research Program Concept Award in order to convene a team of experts in PTSD to identify key evidence-based recommendations from four major treatment guidelines for PTSD, and to develop methods for dissemination of evidencebased best practices. APIRE has collaborated with members of the Workflow Division, Office of the Chief Information Officer, Air Force Medical Support Agency to engage mental health specialty clinicians in a military treatment facility (MTF) to test the best methods for implementing evidencebased approaches in the management of PTSD. This presentation will provide an uptodate report of activities related to this initiative and provide a preliminary report of its findings.

SYMPOSIUM 003**CROSS CULTURAL ISSUES IN THE USE OF PSYCHOTROPIC MEDICATIONS IN CHILDREN**

Chair: David A. Mrazek, M.D.

Discussant: Billina R. Shaw, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Review the issues related to the appropriate use of psychotropic medications, 2) Contrast the variations in policy in the use of psychotropic drugs in children that exist in the United States, Canada, and the UK., 3) Understand the implications of different regulatory policies on the use of psychotropic medications in different countries.

SUMMARY:

Over the past 50 years, there has been a major change in the use of psychotropic medications to treat the full range of child psychiatric disorders. The effectiveness of these medications has been systematically demonstrated and their safety established through regulatory oversight. However, the pattern of utilization of psychotropic medications has varied in different countries despite the reality that the use of psychotropic medications has increased universally. The Council on Children, Adolescents, and Families has assessed that it is of critical importance to be able to use appropriate psychotropic medication in children where there is strong evidence of its efficacy. However, at the same time, it is important that there are safeguards in place to insure appropriate use of psychotropic medications in children.

This symposium is designed to provide an opportunity to compare the evolution of psychopharmacological practice in four different countries. Each of the presentations will initially focus on patterns of utilization of psychotropic medications. In this regard, the use of antidepressants, antipsychotic medications, mood stabilizers, and stimulants will be reviewed. Additionally, the process by which the decision is made to approve the use of medication will be discussed. Next, the implications of different availability of medications for clinical practice in these four countries will be reviewed. Finally, current trends in the use of psychotropic medications in child psychiatric practice in each of these four countries will be discussed. Following these presentations, there will be a discussion of both the utilization of medications in these four countries as well as comment on the process by which the use of psychotropic medications in children is regulated. Two identified discussants will provide an initial response to the presentation. Given the importance of obtaining multiple perspectives on the differences that exist in these countries, there will be an opportunity to elicit comment from the audience. Hopefully, as a consequence of the design of this symposium, there will be an opportunity to consider the advantages and disadvantages of different patterns of utilization of psychotropic medications in children as well as a discussion of the evolution of regulatory oversight.

S003-1.**PERSPECTIVES ON THE USE OF PSYCHOTROPIC MEDICATIONS IN CHILDREN IN THE UNITED STATES**

Presenter: David A. Mrazek, M.D.

SUMMARY:

The Council on Children, Adolescents, and Families has a strong interest in the appropriate utilization of psychotropic medication for treating child and adolescent psychiatric illnesses. The utilization of psychotropic medications in children in the United States has been influenced by the evolution of the policies of the Federal Drug Administration (FDA). The FDA does establish indications for the use of specific psychotropic medications in both adolescent and pediatric populations. However, on examination of the utilization of psychotropic medications in the United States, it is clear that the majority of the psychotropic medications that are prescribed for children are “off label” medications. The utilization of psychotropic medications in the United States has been carefully documented and the pattern has been clearly of increased utilization. However, the “black box warning” for antidepressants issued by the FDA had a paradoxical consequence of increasing utilization of those psychotropic medications that were not subject to this warning and specifically was followed by an increase in the

utilization of atypical antipsychotic medications in children. The implications of this change and possible future trends in psychotropic medication use will be discussed.

S003-2.

PERSPECTIVES ON THE USE OF PSYCHOTROPIC MEDICATIONS IN CHILDREN IN THE UNITED KINGDOM

Presenter: Sue Bailey, M.D.

SUMMARY:

The Royal College of Psychiatrists has a strong child and adolescent component which is invested in improving the standard of practice for children and adolescents in the UK. One component of comprehensive treatment is the appropriate use of psychotropic medications. The current utilization of psychotropic medications for children in the United Kingdom will be reviewed. Additionally, the national oversight mechanisms will be discussed and contrasted with regulation by the FDA in the United States. Current issues related to the use of psychotropic medications will be highlighted and the pattern of current use will be discussed.

S003-3.

PERSPECTIVES ON THE USE OF PSYCHOTROPIC MEDICATIONS IN CHILDREN IN CANADA

Presenter: Alice Charach, M.D.

SUMMARY:

The current utilization of psychotropic medications for children in Canada will be reviewed. Additionally, the national oversight mechanisms will be discussed and contrasted with regulation by the FDA in the United States. Current issues related to the use of psychotropic medications will be highlighted and the pattern of current use will be discussed.

S003-4.

PERSPECTIVES ON THE USE OF PSYCHOTROPIC MEDICATIONS IN CHILDREN IN NEW ZEALAND

Presenter: P. G. Shelton, M.D.

SUMMARY:

The current utilization of psychotropic medications for children in New Zealand will be reviewed and compared to utilization in Australia. Additionally, the national oversight mechanisms will be discussed and contrasted with regulation by the FDA in the United States. Current issues related to the use of psychotropic medications will be highlighted and the pattern of current use will be discussed.

SYMPOSIUM 004

A PRIMER ON PREVENTION IN PSYCHIATRY

Chair: 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 five risk factors for suicide that can be incorporated into routine psychiatric interviews, 3) Describe how secondary prevention, and indicated preventive interventions, are pertinent to schizophrenia and other psychotic disorders

SUMMARY:

Central to advancing the prevention paradigm within psychiatry are the concepts of mental illness prevention and mental health promotion. Preventive interventions that are focused on mental illnesses work by reducing risk factors and enhancing protective factors in order to decrease the incidence and prevalence of various illnesses; prevent or delay recurrences of mental illnesses; and alleviate the impact of illnesses on affected persons, their families, and society. Thus, mental illness prevention encompasses the clinical, community, and policy strategies designed to reduce the burden of mental illnesses by intervening preferably well before illness onset. Mental health promotion aims to impact determinants of mental health so as to increase positive mental health, reduce inequalities, build social capital, create health gain, and narrow the gap in health expectancy among regions and cultural groups. Mental health promotion includes the strategies developed to support resiliency, enhance psychosocial functioning, and protect against the development of mental illnesses. This symposium will provide psychiatrists with an overview of prevention principles and how they can be applied in psychiatric practice settings. The presenters are members of the Prevention Committee of the Group for the Advancement of Psychiatry (GAP) and will draw from their work in developing the Clinical Manual of Prevention in Mental Health (American Psychiatric Publishing, Inc., 2010). The series of presentations will provide a survey of the recent literature on several timely prevention topics for practicing clinical psychiatrists, including what is currently known about applying prevention principles to schizophrenia, suicide prevention, and alcohol and drug abuse prevention.

S004-1.

AN INTRODUCTION TO PREVENTION PRINCIPLES

Presenter: Ruth S. Shim, M.D., M.P.H.

SUMMARY:

Mental illness prevention and mental health promotion are important concepts that are fundamental to public health in the field of psychiatry. This presentation will educate psychiatrists about basic principles and definitions of prevention. We will also discuss classifications of prevention, risk and protective factors, and promotion of mental health. We will promote dialogue among participants and offer suggestions on increasing the focus of prevention in the field of psychiatry.

S004-2.**CONSIDERING SCHIZOPHRENIA FROM A PREVENTION PERSPECTIVE**

Presenter: Michael T. Compton, M.D., M.P.H.

SUMMARY:

Schizophrenia is a serious mental illness that causes major disability and psychosocial impairment. Recent advances in the neurosciences are prompting considerations of schizophrenia from a preventive perspective. An overview of the literature is provided on two important aspects of the development of a prevention orientation in schizophrenia research: elucidation of potential causal risk factors for schizophrenia and research on risk markers. Risk factors for schizophrenia include, but are not limited to, family history, older paternal age, velocardiofacial syndrome, maternal infections during pregnancy, pregnancy and delivery complications, cannabis use in adolescence, and social adjustment difficulties in childhood and adolescence. Potential risk markers include structural brain pathology, minor physical anomalies and dermatoglyphic abnormalities, neurocognitive deficits, eyetracking dysfunction, certain electrophysiologic findings, and olfactory identification deficits. Several early efforts at indicated preventive interventions targeting individuals at particularly high risk for developing the disorder are discussed. The preventive medicine and public health disciplines may have a role in future research and interventions that apply a preventive perspective to schizophrenia and other mental illnesses. Like any other chronic medical condition, schizophrenia can be considered from a preventive perspective.

S004-3.**SUICIDE PREVENTION**

Presenter: Frederick JP Langheim, M.D., Ph.D.

SUMMARY:

This presentation will focus on suicide prevention interventions in clinical practice and in the community. It will ad-

dress how a public health approach has influenced the field, and how psychiatrists can apply some of this knowledge and use prevention principles in daily practice

S004-4.**SUBSTANCE ABUSE PREVENTION**

Presenter: Rebecca A. Powers, M.D.

SUMMARY:

While all agree that prevention in the area of alcohol and substance abuse/dependence can benefit individuals, families, and the community, the type of most effective prevention is in dispute. The risk factors are multifactorial and complex, as are the protective factors. The data we have on risk and protective factors will be presented. This will include genetic, social, environmental, and psychological risk factors, as well as some known protective factors. Universal, selective, and indicated preventive interventions will be offered. Some screening techniques will also be discussed in the context of effective secondary prevention. Dr. Powers will address some differences in prevention among the young and adults. Relapse prevention will also be discussed.

S004-5.**A PRIMER ON PREVENTION IN PSYCHIATRY**

Presenter: Christopher J. Oleskey, M.D., M.P.H.

SUMMARY:

Central to advancing the prevention paradigm within psychiatry are the concepts of mental illness prevention and mental health promotion. Preventive interventions focused on mental illnesses work by reducing risk factors and enhancing protective factors in order to decrease the incidence and prevalence of various illnesses; prevent or delay recurrences of mental illnesses; and alleviate the impact of illnesses on affected persons, their families, and society. Thus, mental illness prevention encompasses the clinical, community, and policy strategies designed to reduce the burden of mental illnesses by intervening preferably well before illness onset. Mental health promotion aims to impact determinants of mental health so as to increase positive mental health, reduce inequalities, build social capital, create health gain, and narrow the gap in health expectancy between countries and groups. Mental health promotion includes the strategies developed to support resiliency, enhance psychosocial functioning, and protect against the development of mental illnesses. This symposium will provide psychiatrists with an overview of prevention principles and how they can be applied in psychiatric practice settings. The presenters are members of the Prevention Committee of the Group for the Advancement of Psychiatry (GAP) and will draw from

their work in developing the Clinical Manual of Prevention in Mental Health (American Psychiatric Publishing, Inc., 2010). The series of presentations will provide a survey of the recent literature on several timely prevention topics for practicing clinical psychiatrists, including what is currently known about applying prevention principles to schizophrenia, suicide prevention, and alcohol and drug abuse prevention.

SYMPOSIUM 005

PERSONALITY DISORDERS: DSM5 AND BEYOND

Co-Chairs: Steven Huprich, Ph.D., Robert F. Bornstein, Ph.D.

Discussant: Andrew E. Skodol, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the current DSM5 proposal for the diagnosis and assessment of personality disorders, 2) Describe the rationale behind the DSM5 personality disorder proposal, 3) Describe three ways in which personality disorder diagnosis and assessment may be improved

SUMMARY:

DSM5 marks the beginning of a new era in the assessment and diagnosis of personality disorders. With several DSMIV personality disorders deleted, and the implementation of a hybrid model combining type ratings with a trait system, DSM5 will look considerably different from its predecessors. This transition has been a difficult one, and many have expressed concerns about the new system's clinical utility and viability. More distally, concerns and questions have arisen about the future of personality disorders and personality pathology within the DSM. This symposium has invited several speakers who have written on these issues, some of whom were on the DSM5 Personality and Personality Disorder Work Group.

S005-1.

FRAMING THE DEBATE FOR DSM5 PERSONALITY DISORDERS

Presenter: Steven Huprich, Ph.D.

SUMMARY:

The DSM5 personality disorder proposal brings about a radical change in the way in which personality disorders will be assessed and diagnosed. These changes were meant to correct for the many extant problems with the current diagnostic schema, and to some extent, the Personality and Personality Disorder Work Group has been able to address these concerns. However, the proposal has evolved since the

Work Group put forth its initial ideas, and many still question whether the new proposal has adequately accomplished what it needs to in order to advance the science and practice of personality disorder diagnosis and assessment. In this paper, I present an overview of the DSM5 proposal for personality disorders and briefly summarize how the proposal has been modified over time. Reflecting upon the personality assessment literature, I will report on how many issues in the domain of personality assessment have not been fully considered for DSM5. I will discuss how personality disorders may be conceptualized and understood from intrapsychic, behavioral/situation, dimensional/trait, and biogenetic frameworks, and how the evolution of the diagnostic system would richly benefit from a further consideration of the rich empirical and theoretical bases of personality pathology more so than has currently happened.

S005-2.

PROPOSED REVISIONS FOR DSM5 PERSONALITY DISORDERS: A PROCESS FOCUSED CRITIQUE AND SUGGESTIONS FOR FUTURE WORK GROUPS

Presenter: Robert F. Bornstein, Ph.D.

SUMMARY:

Many of the revisions proposed by the DSM5 Personality and Personality Disorders (PPD) workgroup have the potential to enhance personality disorder (PD) classification and diagnosis, but some proposed revisions remain controversial. In this presentation I focus on two process issues that have adversely affected the PPD workgroup's proposals. First, the workgroup's review of the empirical literature was incomplete, emphasizing selfreport data rather than focusing on the aberrant psychological processes that characterize different PDs. Second, the decisionmaking process—the process by which the PPD workgroup evaluated evidence and deliberated possible PD changes—failed to draw upon the expertise of other PD researchers, and virtually ensured that the proposed changes would be controversial. Using Dependent Personality Disorder (DPD) as an example, I examine evidence regarding the validity and clinical utility of the DPD diagnosis using the foundational criteria used by all the DSM5 workgroups, Kendler et al.'s (2009) Guidelines for Making Changes to DSMV. A review of the available data confirms that DPD meets the Kendler criteria for clinical utility (i.e., frequency of use, importance in making clinical decisions, impact on treatment programs) and diagnostic validity (i.e., antecedent validators, concurrent validators, and predictive validators). However, despite this supportive evidence DPD will not be included in DSM5. Instead DPD will be represented as a constellation of traits (negative affectivity, submissiveness, and separation insecurity) which do not capture the core elements of pathological dependency. The DSM5 PPD workgroup's reconceptual-

ization of DPD illustrates both process issues that have adversely affected the proposed PD revisions. To prevent similar problems from emerging in future revisions of the DSM, three recommendations are offered: 1) Reconceptualize the empirical foundation of proposed PD changes so that less emphasis is placed on selfreport data, and greater evidence is placed on process data and behavioral outcomes; 2) Embed all proposed PD changes in the broader network of research on personality and interpersonal functioning, so that PD symptoms capture the essential elements of the constructs they represent; and 3) Engage PD researchers with diverse backgrounds, methodologies, and theoretical orientations early in the revision process, to expand the data base for various PDs. References Kendler, K., K

S005-3.

IS THERE SUFFICIENT EMPIRICAL SUPPORT FOR THE PROPOSED CHANGES FOR DSM5 IN DIAGNOSING PERSONALITY DISORDERS?

Presenter: Mark Zimmerman, M.D.

SUMMARY:

The DSM5 Personality and Personality Disorders (PDs) Work Group has recommended a reformulation of the PD section. Questions can be raised about the empirical support for the Work Group's criticisms of the DSMIV approach that were central to the justification for radically changing the diagnostic criteria. The Work Group indicated that comorbidity among the DSMIV PDs is excessive, and to reduce comorbidity they recommended deleting some of the PDs. The studies cited demonstrating high levels of comorbidity were of samples of psychiatric patients. A review of the epidemiological literature shows that comorbidity rates are much lower than in patient samples, and this challenges the proposition that high comorbidity is due to the diagnostic criteria. Moreover, the empirical support for the exclusion of some disorders over others is lacking. The Work Group noted that the diagnostic stability of the PDs is modest. However, modest levels of diagnostic stability may be largely attributable to methodological factors such as test-retest unreliability, state effects, regression to the mean, and measurement error due to repeated assessments, rather than a reflection of inadequacies of the diagnostic system. Thus, modest stability is likely to be found in any approach towards diagnosing PDs. The Work Group indicated that dimensional models are superior to categorical approaches towards classification. However, recent research has suggested that the most important loss of information in a categorical system is the failure to account for subthreshold levels of pathology. DSMIV can be considered to already accommodate a quasidimensional system insofar as individuals who do not meet the threshold for diagnosis can be noted to have traits of the disorder. Research from the

Rhode Island MIDAS project found that the DSMIV 3point rating convention was as valid as scoring methods using more finely graded levels of severity. The present review therefore suggests that several of the core problems linked to the DSMIV approach towards diagnosing PDs lack strong empirical support.

S005-4.

DOES NEUROBIOLOGY SUPPORT DIMENSIONAL DIAGNOSIS OF PERSONALITY DISORDERS?

Presenter: Joel Paris, M.D.

SUMMARY:

Kupfer and Regier (2011) propose that DSM5 should be based on neurobiology, allowing psychiatric diagnosis to be dimensionalized. This longterm goal corresponds to the Research Domain Criteria proposed by the National Institute of Mental Health. However the findings of neuroscience have thus far failed to contribute to any understanding of the etiology and pathogenesis of mental disorders, and no biological markers are known for any major disorder. Personality disorder (PD) has been chosen as a "poster child" for dimensionality. That is because trait psychologists, using selfreport data, have suggested that dimensions account better than categories for variance in normal and pathological personality. However while the trait domains described in DSM5 are theoretically coherent, they have not been tested. Moreover, clinician ratings of traits may or may not correspond to selfreports. Finally, and crucially, we have no data showing that domains with psychometric validity have any relationship to biological processes. The dimensional approach to PD is a heuristic concept that has contributed to research. However the endophenotypes that underlie PDs are unknown, and will remain so for some time to come. This raises the possibility that defining DSM5 trait domains could be premature. It also raises the question as to whether neurobiological reductionism is a useful strategy for PD research, or whether mental processes are emergent phenomena. Kupfer, DJ, Regier, DA (2011): Neuroscience, clinical evidence, and the future of psychiatric classification in DSM5. *American Journal of Psychiatry* 168: 172174

S005-5.

DSM5 PERSONALITY DISORDERS AND BEYOND

Presenter: John Livesley, M.D.

SUMMARY:

The classification of personality disorders is undergoing considerable change. Evaluation of the operating characteristics of the DSMIV classification and research on the structure and origins of personality pathology reveals substantial

limitations to current classifications. The proposed DSM5 classification differs substantially from its predecessors. It provides a more detailed definition of general personality disorder, fewer diagnostic categories, and dimensional system to evaluate clinically significant personality traits. The proposed system will be discussed in terms of the coherence of its internal structure and the extent to which it is consistent with empirical evidence. This evaluation will form the foundation for a consideration of the future directions of diagnostic classification and the challenges confronting the construction of an empirically based, etiologically informed system. It will be argued that a combination of factors arising from the complexity and interconnectedness of the diverse components of personality pathology and from the way cognitive processes are organized, influence the way the classification of personality disorders has traditionally been approached and place constraints on kind of taxonomic construct that is pertinent to classifying personality pathology.

with other forms of personality disorder (OPD). Dr. Mary Zanarini will present data pertaining to remissions and recoveries from BPD and OPD lasting 2, 4, 6, or 8 years in length. She will also present data pertaining to the stability of these outcomes. Dr. Michelle Wedig will present findings pertaining to the most clinically relevant predictors of ongoing suicide attempts. Dr. Alex Keuroghlian will present data pertaining to the use of costly forms of medical care, such as ER visits, medical hospitalizations, and specialist care. Dr. Valerie Photos will present findings pertaining to serious identity disturbance over time, including three subtypes of disturbance and their ability to predict recovery from BPD (which involves good social and vocational functioning as well as symptomatic remission of each subject's primary axis II disorder). Dr. Frances Frankenburg will present data pertaining to the use of prescribed opioids and the best predictors of this not uncommon practice. Dr. Kenneth Silk will be the

Discussant for this symposium, which presents new findings of both a positive and more somber character.

S006-1.

ATTAINMENT AND STABILITY OF SYMPTOMATIC REMISSION AND RECOVERY AMONG PATIENTS WITH BPD AND AXIS II COMPARISON SUBJECTS: A 16YEAR FOLLOWUP STUDY

Presenter: Mary C. Zanarini, Ed.D.

SUMMARY:

Objective: The first purpose of this study was to determine time to attainment of symptomatic remissions and recoveries of 2, 4, 6, and 8 years duration for those with borderline personality disorder (BPD) and comparison subjects with other personality disorders (OPD); the second was to determine the stability of these outcomes. **Method:** 290 inpatients meeting both Revised Diagnostic Interview for Borderlines and DSM-IV criteria for BPD and 72 axis II comparison subjects were assessed during their index admission using a series of semistructured interviews. The same instruments were readministered at eight contiguous two-year time periods. **Results:** Borderline patients were significantly slower to achieve remission or recovery (which involved good social and vocational functioning as well as symptomatic remission) than Axis II comparison subjects. However, those in both study groups ultimately achieved about the same high rates of remission (BPD: 78.99%; OPD: 97.99%) but not recovery (40.60% vs. 75.85%) by the time of the 16-year followup. In contrast, symptomatic recurrence (103.6% vs. 47%) and loss of recovery (20.44% vs. 9.28%) occurred more rapidly and at substantially higher rates among borderline patients than axis II comparison subjects. **Conclusions:** Taken together, the results of this study suggest that remis-

SYMPOSIUM 006

THE LONGTERM COURSE OF BORDERLINE PERSONALITY DISORDER: 16YEAR FINDINGS FROM THE MCLEAN STUDY OF ADULT DEVELOPMENT

Chair: Mary C. Zanarini, Ed.D.

Discussant: Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize that sustained remissions from BPD are almost ubiquitous but sustained recoveries involving good social and vocational functioning as well as concurrent remission from BPD occur more slowly and are less common, 2) Recognize that prediction of ongoing suicide attempts is multifactorial in nature, 3) Recognize that borderline patients use higher rates of costly inpatient and outpatient medical services than axis II comparison subjects, 4) Recognize that there are three subtypes of serious identity disturbance and they each predict recovery from BPD, and 5) Recognize that prescription opioid use is common among borderline patients and predicted by chronic pain disorders as well as an earlier history of drug abuse

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

sion from BPD, regardless of length, is achieved relatively slowly but is basically ubiquitous over a prolonged period of time. They also suggest that recoveries from BPD occur more slowly and are less common than symptomatic remissions.

S006-2.

PREDICTORS OF SUICIDE ATTEMPTS IN PATIENTS WITH BPD OVER 16 YEARS OF PROSPECTIVE FOLLOWUP

Presenter: Michelle M. Wedig, Ph.D.

SUMMARY:

Objective: Repeated suicide threats, gestures, and attempts are common among those with borderline personality disorder (BPD) and given the frequency and dangerousness of this behavior, an understanding of the factors which might increase the likelihood of attempting suicide in this population is important. Though a number of studies have studied this subject in a cross-sectional manner, the goal of this study was to determine the most clinically relevant baseline and time-varying predictors of suicide attempts over 16 years of prospective followup among patients with BPD. **Method:** Two hundred and ninety inpatients meeting DIBR and DSM-III-R criteria for BPD 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. All told, 87% of the surviving borderline patients were reinterviewed at all eight followup periods. **Results:** Nineteen variables were found to be significant bivariate predictors of suicide attempts over time. These variables are: older age, diagnoses of major depressive disorder (MDD), substance use disorder (SUD), and posttraumatic stress disorder (PTSD), the presence of self-harm, higher number of baseline suicide attempts, higher number of hospitalizations at baseline, lower baseline global assessment of functioning (GAF) score, childhood neglect, childhood sexual abuse, adult sexual assault, adult physical assault, being on social security disability insurance (SSDI), having had a caretaker complete suicide, affective instability, more severe impulsivity, more severe dissociation, higher levels of neuroticism, and lower levels of extraversion. However, when examined in a multivariate fashion, eight of these variables remained in the model. These variables are: MDD, SUD, PTSD, self-harm, adult sexual assault, having a caretaker who has completed suicide, affective instability, and more severe dissociation. **Conclusion:** Taken together, the results of this study suggest that prediction of suicide attempts among borderline patients is complex, involving cooccurring disorders, cooccurring symptoms of BPD (self-harm, affective reactivity, and dissociation), adult adversity, and a family history of completed suicide.

S006-3.

UTILIZATION OF INPATIENT AND OUTPATIENT MEDICAL SERVICES BY PATIENTS WITH BPD AND AXIS II COMPARISON SUBJECTS OVER A DECADE OF PROSPECTIVE FOLLOWUP

Presenter: Alex S. Keuroghlian, M.D., M.Sc.

SUMMARY:

Objective: Previous longitudinal prospective research has demonstrated an association between failure to remit from borderline personality disorder and an increased risk of chronic medical illnesses, poor health-related lifestyle choices, and the use of health care services. The purpose of the current study was to determine utilization of health care resources over a 10-year period, comparing patients with borderline personality disorder to subjects with other personality disorders. **Method:** 290 inpatients meeting both Revised Diagnostic Interview for Borderlines and DSM-III-R criteria for BPD and 72 axis II comparison subjects were assessed at six-year followup using the Medical History and Services Utilization Interview, a clinician-administered measure with proven psychometric properties that assesses utilization of a comprehensive array of medical services in both the outpatient and inpatient settings, as well as lifestyle issues concerning health and a broad range of acute and chronic medical comorbidities. The same interview was administered at five contiguous two-year time periods. **Results:** Borderline patients were significantly more likely to both: 1) visit an emergency room and 2) undergo a medical hospitalization than axis II comparison subjects. Borderline patients were also treated by a significantly higher number of medical specialists than were axis II comparison subjects. **Conclusions:** Taken together, the results of this study suggest that borderline patients are significantly more likely to utilize costly health care resources than subjects with other personality disorders. These results also indicate that this increased health care use by borderline patients occurs in both the outpatient and inpatient medical settings.

S006-4.

SUBTYPES OF IDENTITY DISTURBANCE AND THEIR IMPACT ON THE COURSE OF BORDERLINE PERSONALITY DISORDER OVER 16 YEARS OF PROSPECTIVE FOLLOWUP

Presenter: Valerie I. Photos, Ph.D.

SUMMARY:

Identity disturbance is often described as a core sector of psychopathology in borderline personality disorder (BPD). However, few empirical studies have evaluated different aspects of identity disturbance in BPD, and in particular

the longitudinal course of these features remains poorly understood. The goal of this study was to describe three subtypes of identity disturbance: an identity that is organized around inner suffering; an identity rigidly defined by an internal sense of badness; and a painful sense of having no identity. We sought to examine whether these forms of identity disturbance are more pronounced in BPD than in patients with other personality disorders (OPDs), and whether the course of recovery from BPD is influenced by the identity disturbance subtype over 16 years of prospective followup. Two hundred and ninety inpatients meeting DIBR and DSMIIIIR criteria for BPD were assessed during their index admission using semistructured interviews and a fifteenitem identity disturbance selfreport measure with three subscales constructed by a committee of experts from the Dysphoric Affect Scale. Patients were reassessed using the same instruments every two years. All told, 87% of the surviving borderline patients were reinterviewed at all eight followup periods. Patients with BPD endorsed significantly higher scores than axis II comparison subjects on all three forms of identity disturbance. Both groups also endorsed a significant decline in the severity of each form of identity disturbance. For suffering identity, BPD patients reported a 2.72 fold higher score than OPD patients over the course of followup. Both the BPD and OPD group reported a 51% decrease in suffering identity over time. For the bad identity subscale, BPD patients reported a 3.12 times higher score than OPD patients at baseline. Both BPD and OPD patients had decreases in the severity of identity disturbance over time, with BPD patients declining 51% over time versus 31% for OPDs. Finally, for the no identity subscale, BPD patients had scores 2.05 times higher than OPDs at baseline. Again, both BPD and OPD patients reported declines in no identity endorsement over the course of followup, with BPD patients having a stronger rate of decline at 46% compared to the 30% decline in OPDs. While all forms of identity disturbance predicted twoyear recovery in bivariate analysis, when examined in a multivariate fashion, only one form of identity disturbance remained in t

S006-5.

OPIOID USE AMONG PATIENTS WITH BPD FOLLOWED PROSPECTIVELY FOR A DECADE: DESCRIPTION AND PREDICTION

Presenter: Frances R. Frankenburg, M.D.

SUMMARY:

Objective: This study has two purposes. The first purpose of this study was to determine rates of use of prescription opioid medication reported by patients with borderline personality disorder (BPD) and axis II comparison subjects a 10year period of prospective followup. The second purpose of this study was to determine the most clinically

relevant predictors of opioid use among borderline patients. **Method:** The axis I disorders of 290 inpatients meeting both Revised Diagnostic Interview for Borderlines and DSMIIIIR criteria for BPD and 72 axis II comparison subjects were assessed at baseline and eight contiguous twoyear followup periods using the SCID. Medical treatments and conditions were assessed starting at sixyear followup using the Medical History and Services Utilization Interview, a clinicianadministered measure with proven psychometric properties. The same interview was administered at five contiguous twoyear time periods. **Results:** Borderline patients were significantly more likely to use prescription opioid medication over time than axis II comparison subjects. The rates of use increased for borderline patients from 10% to 26% over the decade of prospective followup. The rates of use for axis II comparison subjects were 6% at sixyear followup and 16% at 16year followup. The best predictors of opioid use among borderline patients were the timevarying presence of back pain, fibromyalgia, and osteoarthritis as well as a baseline history of drug abuse. **Conclusions:** Taken together, the results of this study suggest that opioid use is common among borderline patients over a decade of prospective followup. They also suggest that the best predictors of their use are chronic pain conditions as well as an earlier history of drug abuse.

SYMPOSIUM 007

SPECTRUM DISORDERS: THE SYNDROMAL OVERLAP OF ANXIETY, AFFECTIVE SYMPTOMS, AND MEDICAL COMORBIDITY

Co-Chairs: Jeremy D. Coplan, M.D., Singh Deepan, M.B.B.S

Discussant: Jeremy D. Coplan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize the existence and components of different "Spectrum Disorders", 2) Note similarities and differences between the different disorders being discussed, 3) Recognize genetic correlates and possible pathogenic mechanisms of the spectrum disorders

SUMMARY:

The "Spectrum Disorders" comprise syndromal entities of anxiety, mood and medical comorbidities, with or without other psychiatric symptoms. In this symposium we consider four Spectrum Disorders the "Joint Hypermobility Syndrome" (JHS), the "Panic Disorder (PD) Syndrome", the "ALPIM (Anxiety, Laxity, Pain, Immune and Mood) syndrome" and the "Affective Spectrum Disorder". Dr. Antoni Bulbena will describe findings on the Joint Hypermobility Syndrome (JHS) and Anxiety Disorders. He will focus on

data gathered during a 15year prospective cohort study on 158 subjects with and without JHS. The incidence of panic disorder/agoraphobia, social phobia and specific phobia were significantly higher in the JHS group. Dr. Myrna Weissman will discuss a genetic linkage study on “the Panic Disorder Syndrome”. This syndrome includes bladder problems, thyroid disorders, chronic headaches/migraine, and/or mitral valve prolapse. The study was conducted on 19 multiplex families with Panic Disorder which showed that one marker (D13S779) on chromosome 13 gave a logarithm of odds score of more than 4 when individuals with any of the syndrome conditions were analyzed as affected. Dr. Deepan Singh will describe the ALPIM syndrome developed by Dr. Jeremy Coplan. The ALPIM syndrome consists of five domains “A” for anxiety disorders, “L” for joint laxity JHS scoliosis, “double jointedness”, mitral valve prolapse and easy bruising, “P” for pain fibromyalgia, headache, cystitis, prostatitis, irritable bowel syndrome, “I” for immune asthma, allergic rhinitis, hypothyroidism and chronic fatigue syndrome, and “M” for mood unipolar and bipolar affective disorders. Data from 76 subjects were analyzed using logistic regression and cluster analyses. Statistically significant relationships were demonstrated between the different domains included in the ALPIM syndrome. The affective spectrum disorder includes major depression, ADHD, bulimia nervosa, dysthymic disorder, generalized anxiety disorder, obsessive–compulsive disorder, panic disorder, posttraumatic stress disorder, premenstrual dysphoric disorder, social phobia, fibromyalgia, IBS, migraine and cataplexy. Dr. Ann Gardner will present data that suggest mitochondrial dysfunction and inflammation in the pathogenesis of the affective spectrum disorder. Dr. Gardner proposes that interactions among monoamines, mitochondrial dysfunction and inflammation can inspire explanatory models of the spectrum disorders. Dr. Jeremy Coplan will examine the similarities and differences between the different spectrum disorders. These hold multiple similarities which warrant an examination into whether these are distinct entities or overlapping parts of a common syndrome. He will comment that the presence of a common entity implies future nosological significance and may generate further genetic studies.

S007-1.

JOINT HYPERMOBILITY AND ANXIETY: THE CONNECTIVE ISSUE

Presenter: Antonio Bulbena, M.D., M.Sc.

SUMMARY:

The relationship between joint hypermobility and anxiety disorders (panic, agoraphobia and social phobia) was first suggested by casual clinical observation in our clinical practice. Following this observation (Bulbena et al 1988),

our group has conducted several studies (casecontrol, non clinical population, etc). Recently we published a 15year followup which showed that incidence of anxiety disorders during the study period was clearly higher among subjects with the Joint hypermobility syndrome (JHS). Absolute risk for panic disorders among JHS cases was 44.1% versus 2.8% in nonJHS cases. These findings together with the somatic bases will be reviewed.

S007-2.

THE ALPIM SYNDROME: ANXIETY OF THE MIND AND BODY PART I

Presenter: Singh Deepan, M.B.B.S

SUMMARY:

The purpose of this study was to describe a distinct syndrome consisting of anxiety disorders, joint laxity, chronic pain disorders, immune disorders and mood disorders. This was to be established by showing a statistically significant relationship among the different disease entities within domains. The authors have dubbed this conglomeration of signs and symptoms, the ALPIM syndrome after the inclusive categories (Anxiety, Laxity, Pain, Immune and Mood). 76 outpatients, all with a previously diagnosed anxiety disorder were subjected to a questionnaire and examination to detect disease entities inclusive to the ALPIM categories. Data was collected on anxiety disorders, joint laxity, scoliosis, “double jointedness”, mitral valve prolapse, easy bruising, fibromyalgia, headache, cystitis, prostatitis, irritable bowel syndrome, asthma, allergic rhinitis, hypothyroidism, chronic fatigue syndrome, unipolar and bipolar affective disorders and tachyphylaxis. The data was analyzed using logistic regression and cluster analyses. >80% of the patients had a history of panic attacks, tachyphylaxis, fibromyalgia or a major depressive episode and hence these were included in the ALPIM phenotype. The following significant comorbidities were noted: joint laxity with tachyphylaxis (OR=8.5); scoliosis with asthma (OR=5.1); headache with asthma (OR=7.1); bipolar II (OR=6.8) with rhinitis (OR=6.8), asthma with allergic rhinitis (OR=4.4) and bipolar II with chronic fatigue syndrome (OR=3.4). Cluster analysis showed results concurrent with the ALPIM syndrome construct. Statistically significant relationships were demonstrated between the different domains included in the ALPIM syndrome. The results confirmed our objective of identifying a syndromal relationship between different physical and psychiatric comorbidities. The ALPIM syndrome warrants further examination for clinical, treatment and genetic implications.

S007-3.

BEYOND THE SEROTONIN HYPOTHESIS: MITO-

CHONDRIA AND INFLAMMATION IN MAJOR DEPRESSION AND AFFECTIVE SPECTRUM DISORDERS

Presenter: Ann Gardner, M.D., Ph.D.

SUMMARY:

It has been suggested that, as we understand the pathophysiology of brain disorders and psychiatric interventions, we will move from a descriptive to an explanatory model of psychiatric illness, thus moving beyond the epicycle stage where astronomy was before Copernicus [1]. Psychiatric nosology, as in the DSMIV, does not adequately capture the “natural” tendency to health-related as well as psychiatric comorbidity [2] including the substantial comorbidity of mood and anxiety disorders with the functional syndromes (e.g. pain, fatigue, and gastrointestinal dysmotility syndromes). High degrees of overlapping comorbidities and common drug efficacies suggest that major depression belongs to the “affective spectrum disorders” also including migraine, irritable bowel syndrome, chronic fatigue syndrome, fibromyalgia and generalized anxiety disorder, among others. Data from different experimental modalities are presented that suggest components of mitochondrial dysfunction and inflammation in the pathogenesis of major depression and the other affective spectrum disorders. Commonly used mitochondrial targeted treatments are increasingly being shown to demonstrate efficacy in the affective spectrum disorders. Interactions among monoamines, mitochondrial dysfunction and inflammation can inspire explanatory rather than mere descriptive models and suggest a “postCopernican” model of psychiatric disorders that can be tested [3]. The rationales are presented for treatments targeted at mitochondrial function and inflammation using nutrient cocktails and tissue-penetrable near infrared (NIR) phototherapy. [1] Frances AJ, Egger HL. Whither psychiatric diagnosis. *Aust N Z J Psychiatry* 1999;33(2):161–5. [2] Sullivan PF, Kendler KS. Typology of common psychiatric syndromes. An empirical study. *Br J Psychiatry* 1998;173:312–9. [3] Gardner A, Boles RG. Beyond the serotonin hypothesis: Mitochondria, inflammation and neurodegeneration in major depression and affective spectrum disorders. *Prog Neuropsychopharmacol Biol Psychiatry* 2011;35:73043.

SYMPOSIUM 008

INTEGRATING THE FULL SPECTRUM OF ALCOHOL AND OTHER DRUG PROBLEMS IN PSYCHIATRIC AND PRIMARY CARE

Chair: Robert B. Huebner, Ph.D.

EDUCATIONAL OBJECTIVE

At the conclusion of the session the participant should be able to: 1) Apply current models of integrating alcohol treatment into psychiatric and primary care, 2) Understand how to approach the organizational and structural barriers to integrating services, 3) Diagnose and treat patients with cooccurring alcohol and psychiatric disorders

SUMMARY:

Integrating alcohol and other drug treatment for patients with cooccurring psychiatric disorders remains a challenging area for clinical research and practice alike. In a recent review of the literature, Tiet and Mausbusch (2009) concluded that relatively few interventions have shown meaningful effect sizes for both psychiatric and substance use disorders and there appeared to be little effect for the actual “integration” of alcohol and psychiatric services. Challenges to integration of care become more pronounced when attempts are made to integrate behavioral health services with general medical care. Despite these challenges, work on developing conceptual models of integrating care is continuing (Collins et al 2010) and recent studies report effective treatments for patients with alcohol use and psychiatric disorders (Pettinati, 2010). In addition, there appear to be enhanced outcomes when medical care is colocated with psychiatric care (Weisner et al 2009). The purpose of this symposium is to examine a number of clinical and organizational questions relevant to the integration of services for alcohol use disorders, psychiatric disorders, and primary care. For example, what role can psychiatrists play in the ongoing management of alcohol and drug problems from initial screening through remission, maintenance of remission, and potential relapse? What are the current models that successfully navigate the clinical and organizational challenges in implementing integrated models of psychiatric care? And finally, how can psychiatrists link mental health, alcohol use disorders and primary care?

S008-1.

TREATING PATIENTS WITH FIRST EPISODE PSYCHOSIS AND ALCOHOL AND OTHER DRUG USE DISORDERS

Presenter: Robert E. Drake, M.D.

SUMMARY:

People experiencing a first episode of psychosis frequently have cooccurring substance use disorders, usually involving alcohol and cannabis, which put them at risk for prolonged psychosis, psychotic relapse, and other adverse outcomes. Yet few studies of first episode psychosis have addressed the course of substance use disorders and the response to specialized substance abuse treatments. This presentation will present the results of a comprehensive review of the

literature from 1990 and 2009. Included studies addressed two research questions. First, do some clients become abstinent after a first episode of psychosis without specialized substance abuse treatments? Second, for clients who continue to use substances after a first episode of psychosis, does the addition of specialized substance abuse treatment enhance outcomes? Results: nine studies without specialized substance abuse treatment and five with specialized substance abuse treatment assessed the course of substance use (primarily cannabis and alcohol) after a first episode of psychosis. Many clients (approximately half) became abstinent or significantly reduced their alcohol and drug use after a first episode of psychosis. The few available studies of specialized substance abuse treatments did not find better rates of abstinence or reduction. The primary conclusion is that experience, education, treatment, or other factors led many clients to curtail their substance use disorders after a first episode of psychosis. Specialized interventions for others need to be developed and tested.

S008-2.

THE IMPORTANCE OF INTEGRATING ALCOHOL TREATMENT WITHIN MENTAL HEALTH CARE

Presenter: Constance M. Weisner, D.P.H., M.S.W.

SUMMARY:

This is a presentation of results from several NIAAA studies within a large integrated health system which highlight the importance of integrating alcohol treatment within mental health care. Studies in this health system of both adolescents and adults show high rates of cooccurring alcohol and mental health problems (both those with lesser problems identified in primary care, and also those seen in emergency rooms and specialty psychiatry and chemical dependency programs). They also show that for individuals (both adults and adults) who receive psychiatric services, few of those with alcohol problems receive alcohol services in a timely way. However, when both services are received outcomes are improved. In addition, studies of adolescents in the health plan show that mental health problems are identified (perhaps developed) preceding alcohol ones, and even individuals with alcohol problems are often referred first to psychiatry. Thus, identifying mental health problems early and watching for/identifying alcohol problems will optimize outcomes.

S008-3.

SCREENING AND TREATMENT OF ALCOHOL USE AMONG DEPRESSION PATIENTS

Presenter: Derek D. Satre, Ph.D.

SUMMARY:

Hazardous drinking can exacerbate depressive symptoms and have a negative impact on depression treatment outcomes. Likewise, depression is known to be a risk factor for the development of alcohol problems. Many individuals with depression and subdiagnostic alcohol use first seek treatment in mental health settings. Yet prior studies have not examined alcohol use patterns or interventions to reduce alcohol use among patients in treatment for depression. This presentation describes studies of alcohol use in a psychiatric outpatient setting, factors associated with binge drinking among depression patients, and results of an intervention study to reduce binge drinking. Initial prevalence studies among depression patients (N=1183) found that among those who consumed any alcohol in the past year, heavy episodic drinking in the past year was reported by 47.5% of men and 32.5% of women. The intervention study sample consisted of 104 patients ages 18 and over who sought services in a large universitybased outpatient psychiatry clinic. Participants were randomized to receive either 3 sessions of Motivational Interviewing (MI) or to a control condition in which they received a brochure regarding alcohol use risks. Followup interviews were conducted by telephone at 3 and 6 months. 95% of participants completed study followup interviews at 6 months. At baseline, participants had a mean Beck Depression Inventory (BDII) score of 24.7 (sd=10.4). Among participants reporting any hazardous drinking at baseline (N=73), MI-treated participants were less likely than controls to report hazardous drinking at 3 months (60.0% vs. 81.8%, $p = .043$). Lower rate of hazardous drinking at 6 month followup was associated with higher baseline BDII score ($p=.05$). These findings indicate that hazardous drinking is very common in psychiatric settings. MI is a promising intervention to reduce hazardous drinking among depression patients and can be provided as a supplement to usual psychiatric treatment.

S008-4.

PHARMACOTHERAPY OF ALCOHOL DEPENDENCE IN SERIOUS AND PERSISTENT MENTAL ILLNESS

Presenter: Steven L. Batki, M.D.

SUMMARY:

Alcohol use disorders (AUDs), are highly prevalent in patients with schizophrenia and other forms of serious and persistent mental illness (SPMI). Alcohol and other substance abuse exacerbates SPMI and is associated with health problems, violence, crime, and suicide, as well as occupational, housing and economic problems. Treatment adherence a major problem in SPMI is even worse in the presence of alcohol use disorders. Both SPMI and AUDs are associated with cognitive impairment, shown to be an important moderator of substance abuse treatment outcome. Decisionmaking deficits are widely found in alcohol

and other drug dependence. Improving treatments for spmi and comorbid alcohol auds has been identified as a critical need. Psychosocial interventions are essential treatments for auds, yet cognitive impairment may limit the utility of these approaches and many patients may require pharmacological treatments. The effectiveness of pharmacotherapies in patients with spmi has only recently been studied, but data are now available on the use of several different medications to treat alcohol dependence in these patients. This presentation will review the state of the current clinical research on the use of medications to treat concurrent alcohol dependence in patients with spmi. It will discuss the use of oral alcohol treatment medications including the use of directly observed treatment, as well as the use of extended-release parenteral medication. The role of counseling and the use of both self-report as well as biological monitoring will also be discussed. The presentation is designed to inform the use of medications to treat auds in patients with cooccurring spmi, most of whom are treated in community mental health centers rather than in specialized substance abuse treatment programs. Improving the treatment of these patients may improve quality of life and may be cost-effective.

SYMPOSIUM 009

FINANCING SUSTAINABLE INTERDISCIPLINARY CARE IN PSYCHIATRIC AND GENERAL MEDICAL SETTINGS

Chair: Roger G. Kathol, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Appreciate the prevalence of concurrent physical and mental conditions and their impact, 2) Understand current integration models for improving care of patients with comorbid conditions, 3) Recognize the impact that concurrent physical and mental conditions have on total health care cost, 4) Understand general medical and psychiatric claims adjudication procedures, and 5) Understand needed components in creating financially sustainable integrated general medical and psychiatric services

SUMMARY:

It is financially difficult to support and sustain psychiatric services in general medical settings or to create clinically safe and effective onsite medical services in psychiatric settings in our current reimbursement environment. Yet, research has now demonstrated that concurrent general medical and mental conditions in a single patient are common and are associated with medical and mental condition treatment resistance, persistent health problems and illness complications, impairment, disability, and high health-related costs. Importantly, with today's payment practices, access

for patients to coordinated crossdisciplinary services is limited despite the impact of illness comorbidity. This workshop describes the negative impact of general medical and psychiatric illness interaction on health and cost and then explores ways to foster financially sustainable psychiatric care in medical settings and general medical care in psychiatric settings using two payment paradigms: 1) maintaining independent medical and mental condition budgets while identifying reimbursement workarounds that support integrated care and 2) consolidating medical and mental condition budgets into a single budget that allows colocation and coordination of physical and mental health services.

S009-1.

CLINICAL AND SYSTEMSLEVEL MODELS FOR IMPROVING CARE ON THE PRIMARY CARE/MENTAL HEALTH INTERFACE

Presenter: Benjamin G. Druss, M.D., M.P.H.

SUMMARY:

This presentation will review evidence-based models for improving care on the primary care/mental health interface. The presentation will describe key features such as "measured care" patient activation, and team-based models that are important both for improving mental health in primary care, and primary medical care in specialty mental health settings. Financing models must be designed to support these key "active ingredients" of evidence-based care.

S009-2.

THE HIGH COST OF COMORBID CHRONIC MEDICAL AND BEHAVIORAL CONDITIONS: AN OPPORTUNITY FOR CREATIVE PAYMENT REFORM FOR INTEGRATED MEDICALBEHAVIORAL CARE

Presenter: Stephen P. Melek, None

SUMMARY:

Healthcare costs are rapidly rising, and payers (employers and health plans) are seeking new ways to manage these cost increases. Chief among them is improving the health of their insured population. As a result, one of the major areas with increased focus is the effective diagnosis and treatment of behavioral illnesses. We will present data regarding the increased healthcare costs of insured individuals who have a chronic medical condition and comorbid mental health or substance use disorders to determine cost savings opportunities for effective integrated medicalbehavioral healthcare in both psychiatric and general medical settings. The overwhelming majority of this cost increase was in higher medical costs, not directly associated with behavioral healthcare costs. Therefore, implementing effective integrated medi-

cal behavioral healthcare is one way that payers can combat the rising healthcare costs while also increasing the overall health of their insured members, both of which result in positive outcomes. From these potential medical cost offset savings, payers can finance new payment approaches to help sustain integrated medical behavioral solutions. Potential new innovative payment approaches will be presented.

S009-3.

CARVED IN, CARVED OUT AND CUT UP: THE STATUS QUO OF CURRENT FUNDING SCHEMES FOR INTEGRATED PSYCHIATRIC TREATMENT AND PRIMARY CARE

Presenter: Anita S. Everett, M.D.

SUMMARY:

Current medical and mental health claims adjudication practices impact the capacity for services systems to engage in the effective integration of Psychiatric care with Primary care. These insurance practices are discriminatory and inhibit the ability of many practice settings to provide psychiatric and general medical services on the same day. This archaic arrangement is antithetical to current policy trends that encourage care coordination of all individuals, especially those with multiple chronic conditions. While there are some examples of funding arrangements that support care integration, many general practice settings are not able to offer integrated care. An example of successful funding for integrated care is the Federally Qualified Community Health Centers. Currently there are a number of demonstration projects underway as a component of the Accountable Care Act, that provide potential paths for successful financing. Many of these demonstration projects are inclusive of contemporary medical home ideology which includes support through a case rate as well as more traditional fee for service reimbursement. As songwriter Bob Dylan professed nearly 50 years ago: 'The times they are a changin'. This talk will provide a status quo of these fiscal dynamics.

S009-4.

INTEGRATED CLAIMS ADJUDICATION AS A STRATEGY FOR REVERSING THE NEGATIVE EFFECTS OF COMORBID GENERAL MEDICAL AND PSYCHIATRIC DISORDERS

Presenter: Roger G. Kathol, M.D.

SUMMARY:

This presentation will be divided into two components. The first will describe the interaction of general medical and mental conditions and their combined negative effect on health, function, and disability. The second will propose

the consolidation of general medical and mental condition budgets and health benefits as a means to create a fiscal environment that allows the delivery of widely disseminated integrated general medical and psychiatric services. The presentation will accurately define what is meant by combining the medical and mental health budgets, share information results from other health system that have done so, and describe the challenges in getting there from the current system in which behavioral health funds are "carved out" from the rest of medicine. During the presentation, the advantages and disadvantages of consolidating budgets will be discussed and how it could foster growth in psychiatric care in the medical setting, where the majority of psychiatric patients seek all their medical and mental health services. It will also discuss how it would improve access to general medical care in patients who have serious and persistent mental illnesses.

SYMPOSIUM 010

SOCIAL STRESS AND DRUG ADDICTION IN PRE-CLINICAL AND CLINICAL STUDIES: SEX/GENDER MATTERS IN EFFECTS ON BRAIN AND BEHAVIOR AND TREATMENT IMPLICATIONS

CO-CHAIRS: SAMIA D. NOURSI, PH.D., CORA L. WETHERINGTON, PH.D.

DISCUSSANT: RAJITA SINHA, PH.D.

EDUCATIONAL OBJECTIVE

At the conclusion of the session the participant should be able to: 1) Describe types of animal behavioral models (nonhuman primate and rodent) used to study social stress and drug addiction and describe the outcomes in males and females, 2) Describe use of brain imaging to study the relationship between social stress and drug addiction in nonhuman primates and in humans and describe outcomes in males and females, 3) Describe how gender impacts social stress-induced craving, biologic markers and relapse, 4) Describe emerging brain transcranial magnetic stimulation data that support gender and affect-tailored treatment protocols, and 5) Describe how results of laboratory studies on social stress and addiction have implications for gender-tailored drug abuse treatment protocols

SUMMARY:

Drawing upon animal model research, both nonhuman primate and rodent, and human laboratory research, this symposium will explore male/female differences in interactions between several types of social stress and drug addiction in adolescents and adults with a view toward the translational implications. First, Dr. Michael Nader will present surprising data showing that the remarkable

relationships he previously observed between social rank (i.e., dominant versus subordinate), dopamine D2 receptor levels and acquisition of cocaine self-administration in adult male cynomolgus monkeys are opposite in female monkeys. He will also present data showing that social rank impacts both the effects of environmental manipulations deemed enriching or stressful as well as the effects of putative cocaine treatment drugs. Next, Dr. Sari Izenwasser will present adolescent rodent data showing sex differences in the effects of social versus isolation housing and environmental enrichment on cocaine reward, locomotor activity, and basal and cocaine-mediated levels of dopaminergic markers (e.g., tyrosine hydroxylase, dopamine transporter (DAT) protein, DARPP32, and CDK5). Data on modulation of some of these outcomes by preexposure to THC, the active ingredient in marijuana, will also be described. Next, Dr. Colleen Hanlon will present research suggesting that the interaction between social exclusion stress and gender may be related to enhanced neurofunctional coupling within limbic neural circuits of female cocaine users and modulated by baseline depressive symptoms. She will also describe brain stimulation studies demonstrating gender based differences in cortical sensitivity in cocaine users. These data are actively being used to shape treatment trials for addiction using transcranial magnetic stimulation. Then Dr. Sudie Back will describe research examining gender differences in subjective and hypothalamic-pituitary-adrenal (HPA) axis response to two laboratory provocations: (1) a social evaluative stress challenge, the Trier Social Stress Test (TRIER), and (2) an *in vivo* cocaine cue paradigm. She will also present data from research on reactivity to laboratory stress and prescription opioid drug cues. The symposium will conclude with Dr. Rajita Sinha who will serve as the

Discussant. She will integrate and synthesize the symposium findings using the context of her own data showing sex-specific dissociations in autonomic, HPA and neural responses to stress and cues in substance dependent patients, and she will discuss the implications of the symposia research findings for understanding sex differences in the etiology of drug abuse as well as implications for drug abuse treatment in men versus women.

S010-1.

MONKEY MODELS OF SOCIAL STRESS AND COCAINE ABUSE: SEX DIFFERENCES

Presenter: Michael A. Nader, Ph.D.

SUMMARY:

Environmental factors have a huge impact on behavior and the brain. In this presentation, we will describe a homologous animal model involving primate social behavior and cocaine self-administration and the role of brain dopamine

(DA) receptors in mediating these effects. In males, becoming dominant in a social group results in elevations in DA D2 receptor availability, as measured with PET imaging, and these high D2 receptor levels “protect” the dominant monkeys from cocaine reinforcement. In female monkeys, becoming dominant also results in significant increases in D2 receptor availability. However, the dominant females are more vulnerable to cocaine reinforcement than subordinate animals. In other studies, environmental manipulations deemed to be enriching or stressful produce qualitatively different effects on dominant and subordinate monkeys. Similarly, drug treatments that can decrease cocaine self-administration vary depending on the rank of the monkey. These findings highlight the importance of social environment in brain function and drug action and suggest different treatment strategies depending on the influence of socially derived stress and sex of the subject. NIDA DA 10584 and DA 017763

S010-2.

SOCIAL STRESS DIFFERENTIALLY AFFECTS DRUG REWARD IN ADOLESCENT MALE AND FEMALE RATS

Presenter: Sari Izenwasser, Ph.D.

SUMMARY:

Adolescence is a vulnerable period associated with a high incidence of drug abuse initiation and an increased risk for developing dependence and addiction. Factors that modulate the effects of drugs of abuse during this critical period of development will be discussed. There are differential effects on cocaine reward and on basal and cocaine-mediated levels of proteins involved in dopaminergic transmission (e.g., TH, DAT, DARPP32, GSK3 β) in response to social or environmental enrichment. Similarly, the effects of Δ^9 THC, the active ingredient in marijuana produce different effects across sex as a function of housing conditions. In these studies, male and female rats were housed under conditions where both social (number of rats per cage) and environmental (availability of toys) factors were manipulated on postnatal day (PND) 23. Socially isolated rats were housed alone impoverished with no toys (II) or enriched with toys (IE). Social rats were housed 3/cage with (SE3) or without (SI3) toys. In some studies, rats were injected with THC or vehicle for 5 days starting on PND 29, followed by cocaine conditioned place preference (CPP) beginning on PND 37. THC produced different effects on locomotor activity, with only the II female rats significantly habituating to its effects over days. In other studies, rats remained in the housing conditions undisturbed and cocaine sessions began on PND 43. In males, cocaine CPP was highest in II rats and lowest in the rats living three/cage, regardless of toys. Enriched housing (SE3) increased dopamine transporter

(DAT) protein to the same levels as cocaine in the nucleus accumbens compared to II. There also were differential effects of cocaine on tyrosine hydroxylase and DAT depending on housing, with both increased by cocaine in II but not SE3 rats. DARPP32 was unchanged by housing or cocaine, while phosphoThr34DARPP32 was increased by cocaine treatment across conditions. In females, opposite effects were observed with the greatest reward seen in SE3 rats and the lowest in isolated rats. In addition, environmental and social enrichment interacted to alter cocaine reward. Thus, social and environmental enrichment differentially alter the effects of drugs in males and females during adolescence and these changes are mediated by distinct neurochemical changes. These data suggest that drug prevention and treatment strategies need to be specific to adolescent males or females, and need to take into account the

S010-3.

FROM PICTURE TO PRACTICE: THE ROLE OF GENDER AND AFFECT ON THE NEURAL RESPONSE TO SOCIAL STRESS IN COCAINE USERS

Presenter: Colleen A. Hanlon, Ph.D.

SUMMARY:

Being ignored or excluded by groups of individuals in one's presence is one of the most emotionally salient states in the human experience. Women appear to be particularly vulnerable to social stress, which may contribute to drug abuse, dependence and relapse. The first portion of this presentation will discuss recent neuroimaging literature which suggest that the interaction between social stress and gender may be related to enhanced neurofunctional coupling within limbic neural circuits of female cocaine users. Additionally, the strength of this neural response to stress is related to baseline depressive symptoms which are also higher in females. The second portion of this presentation will introduce emerging literature from brain stimulation studies which demonstrate gender based differences in cortical sensitivity in cocaine users. These data are actively being used to shape treatment trials for addiction using transcranial magnetic stimulation. Considered together, data from these investigations provide neurofunctional insight into the known vulnerability of female addicts to the effects of social stress and suggest potential gender tailored treatment strategies.

S010-4.

SEX DIFFERENCE IN REACTIVITY TO LABORATORY INDUCED STRESS AND DRUG CUES

Presenter: Sudie Back, Ph.D.

SUMMARY:

Research consistently shows that stress and drug-associated cues are frequent triggers for relapse to substances of abuse (Sinha et al., 2001). Furthermore, several investigations have shown that reactivity to laboratory-induced stress and drug cue paradigms is predictive of relapse in substance-dependent individuals. Responses to stress and drug-related cues, and the relationship between reactivity and risk for relapse may differ by gender, which would have important clinical implications. The current study examined gender differences in subjective and hypothalamic-pituitary-adrenal (HPA) axis response to two laboratory provocations: (1) a social evaluative stress challenge, the Trier Social Stress Test (TRIER), and (2) an *in vivo* cocaine cue paradigm. Participants were male and female cocaine-dependent individuals and healthy controls (N=100). Before, immediately after, and for 120 minutes following each task, subjective stress reactivity (i.e., stress, craving), cortisol and adrenocorticotropic hormone (ACTH) were assessed. The results demonstrate that craving was significantly higher in response to the cue as compared to the TRIER, but the magnitude of the difference was greater for cocaine-dependent men than women ($p=0.04$). In response to the cue, female cocaine-dependent participants evidenced a more blunted ACTH response than did the other three groups ($p=0.02$). Female cocaine-dependent subjects also had a lower odds of a positive cortisol response to the TRIER as compared to the other three groups (OR=0.84, 95% CI=[0.02, 1.01]). Data from an ongoing study examining reactivity to laboratory stress and prescription opioid drug cues will also be discussed.

SYMPOSIUM 011

FIELD TRIAL TESTING OF PROPOSED REVISIONS TO DSM5: FINDINGS AND IMPLICATIONS

Co-Chairs: David J. 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) Describe the overall design of the two DSM5 Field Trials and their objectives in the DSM5 revision process, 2) Explain the various outcomes assessed in the field trials, including that of diagnostic criteria and dimensional assessments, 3) Provide examples of specific findings from the field trials, 4) Discuss the potential ways in which findings from the field trials may impact the future of clinical care using DSM5.

SUMMARY:

Field trial testing of proposed revisions to DSM5 represent an important and informative method of empirically assessing the reliability, clinical utility, and feasibility of the draft diagnostic criteria and dimensional assessments.

Field trials have been conducted in two general areas: first, amongst largescale, medical and academic settings and second among solo and small practice, routine clinical care settings. Both field trial designs offer the opportunity to collect valuable information on how proposed changes may impact patient care and realworld aspects of psychiatric clinical service, including obtaining patient reported outcomes, effectively engaging in treatment planning, and successfully monitoring course of illness. This session will orient audiences to the overall design and purpose of the DSM5 Field Trials as well as discussing, where available, select results from both the large scale field tests as well as the routine clinical practice trials. Select outcomes related to the diagnostic criteria themselves as well as those pertaining to proposed dimensional aspects of psychiatric diagnosis will be discussed.

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

SUMMARY:

In 2010, the APA initiated testing of proposed changes to DSM5 across 11 medical and academic centers. Over the course of the following 12 months, these institutions gathered data on the reliability, feasibility, and clinical utility of draft diagnostic criteria and other proposed changes to DSM5. Their findings played a significant role in informing decisions by the 13 DSM5 Work Groups, and the novel, innovative method of data collection used in the DSM5 Field Trials represents advancement beyond the field testing strategies utilized during previous revisions of the manual. This presentation will share with audience members detailed findings from the field tests with particular emphasis on results gathered from tests of the diagnostic criteria for Schizophrenia, Major Depressive Disorder, and Attention-Deficit/Hyperactivity Disorder. Discussion will include: descriptions of the proposed revisions and how they differ from current criteria in DSMIV; the rationale of the proposed changes; descriptions of the populations and settings in which tests of these specific disorders were conducted; statistical results from the field trials; and potential implications of adopting these specific disorder changes, clinically as well as in other relevant contexts (e.g., research, insurance coverage, etc.).

S011-1.

DSM5 FIELD TRIALS: NEW METHODS, NEW INSIGHTS

Presenter: Helena C. Kraemer, Ph.D.

SUMMARY:

The basic design of DSM5 field trials will be reviewed, with emphasis on how and why they differ from previous DSM

field trials. Then the impact of the experience and results on the design and execution of future diagnostic field trials will be considered, with emphasis on field trials that may be relevant to DSM5 as a “living document”.

S011-2.

DSM5 FIELD TRIALS IN ACADEMIC OR LARGE CLINICAL SETTINGS: DETAILED FINDINGS FOR SCHIZOPHRENIA, DEPRESSION, AND ADHD

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

SUMMARY:

In 2010, the APA initiated testing of proposed changes to DSM5 across 11 medical and academic centers. Over the course of the following 12 months, these institutions gathered data on the reliability, feasibility, and clinical utility of draft diagnostic criteria and other proposed changes to DSM5. Their findings played a significant role in informing decisions by the 13 DSM5 Work Groups, and the novel, innovative method of data collection used in the DSM5 Field Trials represents advancement beyond the field testing strategies utilized during previous revisions of the manual. This presentation will share with audience members detailed findings from the field tests with particular emphasis on results gathered from tests of the diagnostic criteria for Schizophrenia, Major Depressive Disorder, and Attention-Deficit/Hyperactivity Disorder. Discussion will include: descriptions of the proposed revisions and how they differ from current criteria in DSMIV; the rationale of the proposed changes; descriptions of the populations and settings in which tests of these specific disorders were conducted; statistical results from the field trials; and potential implications of adopting these specific disorder changes, clinically as well as in other relevant contexts (e.g., research, insurance coverage, etc.).

S011-3.

DSM5 FIELD TRIALS IN ACADEMIC OR LARGE CLINICAL SETTINGS: SUMMARY AND IMPLICATIONS

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

SUMMARY:

DSM5 academic field trials were conducted in eleven academic or large clinical settings in the United States and Canada including seven adult and four pediatric sites. This group of academic trials represented an opportunity to examine, in depth, select revisions to a number of psychiatric disorders likely to be of high public health significance (e.g., Mood Disorders, Psychotic Disorders, Substance Use Disorders, etc.) among a range of clinical populations (adult,

pediatric, adolescent, geriatric) and settings (general psychiatry and specialty clinics). This presentation will lay the groundwork for later discussion of detailed findings from field testing by giving audiences an overview of the design and implementation strategy used by DSM5 leadership in conducting these tests. In addition, this session will provide a synopsis of pertinent findings from these field trials, including data on the reliability of the proposed diagnostic revisions as well as the clinical utility and feasibility of the draft changes.

S011-4.

DIMENSIONAL MEASURES IN PSYCHIATRIC DIAGNOSIS: RESULTS FROM THE DSM5 FIELD TRIALS

Presenter: William E. Narrow, M.D., M.P.H.

SUMMARY:

The addition of dimensional measures to DSM5 represents one of the manual's most significant departures from the current diagnostic system. Dimensional assessments were proposed as a method to address some of DSMIV's known shortcomings, including the representation of psychiatric disorders as entities that fall neatly into discrete categories. Although commonly used in clinical research, dimensional approaches are not standard in psychiatric patient care. Developers of DSM5 are hopeful that the proposed integration of dimensional assessments with categorical diagnoses may help address this gap between science and practice. This presentation will describe findings from the DSM5 field trials of proposed crosscutting and diagnosis-specific severity measures, with specific attention given to results from the trials of Schizophrenia, Major Depressive Disorder, and Attention Deficit/Hyperactivity Disorder. Topics will include a brief overview and rationale of dimensional strategies that were tested, and results from the 11 academic field trial sites, including test-retest reliability, clinical utility, and feasibility of the proposed measures. Clinical implications of integrating dimensional and categorical approaches to diagnosis in DSM5 will be discussed.

S011-5.

TESTING DSM5 IN ROUTINE CLINICAL PRACTICE SETTINGS: TRIALS, TRIBULATIONS, AND TRIUMPHS

Presenter: Eve K. Moscicki, Sc.D., M.P.H.

SUMMARY:

The DSM5 Field Trials in Routine Clinical Practice Settings (RCP) examined the feasibility, clinical utility, and sensitivity to change of the proposed DSM5 diagnostic criteria and dimensional assessment measures as used by individual

clinicians in routine clinical practice settings, representing the first time in the history of the DSM that the proposed diagnostic criteria were tested outside of academic settings. In another first, disciplines outside of psychiatry were invited to participate. This presentation will provide an overview of the design, sampling, procedures, and major findings for this important component of the DSM5 Field Trials. Study participants included two samples of clinicians. The first was a representative sample of over 1,200 randomly selected general, child and adolescent, geriatric, addiction, and consultation-liaison psychiatrists. The second sample included nearly 4,000 clinicians from six disciplines who volunteered to participate in the field trials. Volunteers included psychiatrists, advanced practice psychiatric mental health nurses, clinical psychologists, clinical social workers, licensed counselors, and marriage and family therapists. All participating clinicians had to meet strict eligibility criteria in order to participate. Eligible clinicians completed web-based DSM5 training, including practice with the REDCap electronic data capture system, and enrolled at least one new and one existing patient into the field trial. Data characterizing the representative and volunteer samples of clinicians will be presented, including clinical discipline, specialty, caseload, nature of practice, practice setting, and patient caseload characteristics. The presentation will include a summary of major findings and a brief discussion of the unique challenges, opportunities, and successes found in implementing a largescale scientific endeavor in smallscale settings.

SYMPOSIUM 012

REBOUND AND RECOVERY IN THE ATHLETE

Chair: Antonia L. Baum, M.D., M.D.

Discussant: Antonia L. Baum, M.D., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Become familiar with the current means of doping in sports from a biochemical perspective, and to comprehend the impact on the athlete of a doping violation, 2) Understand the impact of injury on the athlete, treatment methods for an injured athlete, and the path to mental and physical recovery from an injury, 3) Recognize the indicators of sexual abuse in the athletic arena, understand the potential impact on the athlete, become familiar with the treatment approach

SUMMARY:

Competitive athletes face unique pressures in the sports arena. Qualities inherent in the athletic temperament may enable athletes to rebound and recover from such stressors. Here we delineate some of these precipitating events. First,

we delve into the use of performance enhancing drugs: the current state of the art and science of these drugs, what propels an athlete to use them, the toll a doping violation has on the athlete and his career, and the way an athlete moves forward from this, ideally assisted by a sports psychiatrist, illustrated by Dave Millar, a Scottish Tour de France competitor caught on a doping violation. Next we address the difficulties an athlete deals with at the point of retirement, often at a young age, and where the loss of identity is profound. Sometimes retirement occurs due to injury; we look at the devastating impact an injury can have on an athlete, the threat to his career, how an athlete handles retirement, and how the sports psychiatrist can help. Finally, we address sexual abuse in the athletic arena, looking at the factors which engender this behavior, the impact on the athlete, how best to treat them, illustrated by Canadian professional hockey player Sheldon Kennedy.

S012-1.

DOPING IN SPORTS: WHAT'S ON THE HORIZON?

Presenter: David A. Baron, D.O.

SUMMARY:

The presentation will provide a history of Doping in sports and explore the latest forms of potential future unethical performance enhancement strategies, gene doping. The impact on the athlete and the culture of sport will be discussed, along with the issues related to any form of Doping.

S012-2.

SEXUAL HARASSMENT AND ABUSE IN SPORTS: WHAT IT IS, HOW TO PREVENT IT.

Presenter: Saul I. Marks, M.D.

SUMMARY:

Sexual harassment & abuse (SHA) occur in all sports and at all levels with an increased risk at the elite level. The physical and psychological consequences of sexual harassment and abuse are significant for the athlete, their team and for the health and integrity of sport in general. The purpose of this presentation is to increase awareness of all aspects and types of SHA in sport. The book "Why I didn't Say Anything: The Sheldon Kennedy Story," will be used to help describe the stages athlete Sheldon Kennedy went through to be "groomed" for his sexual abuse and serve as a basis for discussion. Discussion will revolve around how to increase "respect" in the sports world, which will not only be protective of physical, emotional and sexual abuse, but will encourage a safe and welcoming environment for all who participate in sport, from the child and adolescent recreational athlete to the adult elite athlete. Because this

has been a stigmatized and taboo subject for psychiatry and sports medicine in sport, increasing awareness and respect in sport can only allow for both young and old to use sport to increase mental and physical health for all.

S012-3.

PSYCHOLOGICAL IMPACT OF INJURY ON THE ATHLETE

Presenter: Thomas S. Newmark, M.D.

SUMMARY:

Emotional disturbances can complicate recovery from injuries sustained by athletes. The recovery process typically involves sequelae of denial, anger, depression and acceptance. The discussion will also include a number of key characteristics in athletes who experience difficulty adjusting to injury, such as obsession with return to their sport. Finally, the presentation will highlight treatment strategies, including psychosocial therapies, such as CBT, and the appropriate use of antidepressant medications. The discussion will be enhanced by the participation of a former professional athlete.

S012-4.

DOPING IN ELITE CYCLING: A PSYCHIATRIC PERSPECTIVE ON CAUSES, CONSEQUENCES, RECOVERY AND REHABILITATION

Presenter: Alan Currie, M.B.B.S

SUMMARY:

The circumstances that lead an athlete to dope are seldom simple. Undoubtedly for some it is a clear and cynical decision. However, for many the decision will involve a complex interaction between the athlete's mental state and his environment. David Millar is the only British cyclist to have worn all 4 leader's jerseys in the Tour de France (Best Sprinter, Best Young Rider, King of the Mountains and the coveted Yellow jersey for overall race leader). He first wore the Yellow Jersey in July 2000 at the age of just 23. Within 4 years Millar's career was in ruins due to a doping violation. In an unusual turn he acknowledged his guilt from the outset. However, he has gone on to successfully rehabilitate his career and has positioned himself at the forefront of the battle for a cleaner sport. In an interview with a sports psychiatrist the cyclist discusses the individual and contextual factors that led him to doping. Millar provides valuable insights into the mind of the athlete and the pressures inherent in the sporting environment. The support that allowed him to deal with the consequences of his offense and subsequent ban from the sport will be discussed, as well as the importance of the help he received from his psy-

chiatrist. His journey of physical, psychological and moral rehabilitation is enlightening and uplifting. This will provide a roadmap for psychiatrists working with athletes by illustrating some of the antecedents to doping, the potential psychological impact of doping, and by demonstrating the value of psychiatric expertise to an athlete's recovery and rehabilitation.

SYMPOSIUM 013

TIMELIMITED PSYCHOTHERAPY FOR CANCER: FROM DIAGNOSIS TO REMISSION OR END OF LIFE

Co-Chairs: Anton C Trinidad, M.D., Lorenzo Norris, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify characteristics of those patients who are good candidates for time limited psychotherapies for cancer, 2) Describe a psychotherapeutic treatment plan, working closely with the oncology team, that considers the cancer treatment stage and treatment protocol, 3) Discuss specific interventions that could be utilized in the palliative phase of cancer treatment including the QPM framework (Quality of Life, Pain Management and MeaningsBased Goals), 4) Appreciate case examples that illustrate these treatment modalities

SUMMARY:

Many cancer patients are in psychotherapy for various reasons like depressive symptoms, anxiety, adherence problems and other indications. The role of psychotherapy has been formulated in various ways: as a supportive measure, improvement of adherence to treatment, as an adjunct to pain management and various other reasons. Psychotherapy influences outcomes other than survival such as quality of life, attainment of deeper appreciation and meaning for life and the relief of suffering. There are also several modifications needed to make psychotherapy useful such as crisis intervention, telephone sessions, home visits and bedside psychotherapy. This symposium foregrounds the model of timelimited modalities of psychotherapy, including CBT and supportive psychotherapy, with special emphasis on assessment of needs that considers the specific type and stage of cancer. The focus is to help therapists gain practical frames to set psychotherapeutic goals. The symposium will discuss ways to assist patients through the continuum of cancer care, including the time when death seems imminent. We will present an oncology stagespecific framework to map out a patient's specific needs. Special techniques are needed when the prognosis seems bleak – a specific presentation will detail strategies in those cases. Two cases will be presented to highlight these points.

Presenter: Lorenzo Norris, M.D.

SUMMARY:

In the difficult phase when remission could not be achieved for whatever reasons, the therapist confronts problems with helping the patient explore attendant existential issues of choice and the consolidation of meaning along with practical palliative issues such as helping manage pain, acceptance of hospice or nursing home care and other changes and discomforts. Specific practical strategies will be discussed that use an existentially focused modality along with liaison activities with the rest of the treatment team to achieve maximum comfort and minimize despair. Specific strategies culled from CBT, crisis intervention and interpersonal therapies as applicable to cancer patients will be discussed.

S013-1.

ASSESSMENT AND TREATMENT OF CANCER PATIENTS FOR TIMELIMITED PSYCHOTHERAPY: WHO'S APPROPRIATE AT WHAT STAGE?

Presenter: Anton C Trinidad, M.D.

SUMMARY:

Newlydiagnosed cancer patient often receive information that are overwhelming to them. It is therefore important for the therapist to modify his/her stance in devising a therapeutic strategy not only to help the patient through the stages of treatment but to help educate him/her into the specific vicissitudes of coping strategies required for each stage of the treatment. The therapist thus functions as an integral part of the cancer team and is ideally knowledgeable in the particular oncology treatment protocol. Patient characteristics amenable to brief psychotherapy will be discussed along with issues of patient triaging, crisis management and defining treatment decision trees. The QPM Framework The QPM framework (QPM framework (Quality of Life, Pain Management and MeaningsBased Goals) provides a convenient heuristic to organize psychotherapeutic goals in patients whose prognosis for longevity is not good. Practical ways to alleviate both physical and emotional pain will be explored. The encouragement of constructing a personal meaningsbased perspective will be discussed.

S013-2.

PALLIATIVE PSYCHOTHERAPY – WHEN THE PROGNOSIS SEEMS BLEAK

Presenter: Lorenzo Norris, M.D.

SUMMARY:

In the difficult phase when remission could not be achieved

for whatever reasons, the therapist confronts problems with helping the patient explore attendant existential issues of choice and the consolidation of meaning along with practical palliative issues such as helping manage pain, acceptance of hospice or nursing home care and other changes and discomforts. Specific practical strategies will be discussed that use an existentially focused modality along with liaison activities with the rest of the treatment team to achieve maximum comfort and minimize despair. Specific strategies culled from CBT, crisis intervention and interpersonal therapies as applicable to cancer patients will be discussed.

S013-3.

CASE PRESENTATION I

Presenter: Amanda Crosier, M.D.

SUMMARY:

To illustrate the foregoing principles, two case studies will be presented by Drs. Crosier and Kumar. These cases illustrate a CBT-informed brief psychotherapy and a case of end stage cancer with a palliative focus.

S013-4.

CASE PRESENTATION II

Presenter: Sanaz Kumar, M.D.

SUMMARY:

To illustrate the foregoing principles, two case studies will be presented by Drs. Crosier and Kumar. These cases illustrate a CBT-informed brief psychotherapy and a case of end stage cancer with a palliative focus.

SYMPOSIUM 014

WHEN YOUR PATIENT IS A PARENT: SUPPORTING THE FAMILY AND ADDRESSING THE NEEDS OF CHILDREN

Co-Chairs: Alison M. Heru, M.D., Ellen M. Berman, M.D.

Discussant: Ellen M. Berman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Have an understanding of the needs of children of parents with mental illness, 2) Be able to talk with patients about parenting, 3) Be knowledgeable about the evidence-based treatment for prevention of symptoms in children with depressed parents, 4) Know about online family-focused resources and other resources where a member has mental illness

SUMMARY:

General psychiatrists often avoid talking with their patients about their children. We avoid talking about how the illness might affect the children, what questions the children might have, and what concerns the parent might have, especially about their ability to be a “good enough” parent. We, as psychiatrists, are afraid to say the wrong thing to parents and don’t feel qualified to discuss mental illness with children. Many of these children have caregiving roles with our patients. Some children experience sadness and become depressed. A few symptomatic children are seen by mental health professionals. Most children cope well. This symposium will provide adult psychiatrists with a better understanding of what children who have a parent with mental illness experience. Recognizing the needs of these children is the first step in preventing future psychopathology. We will discuss the concerns of their parents, our patients and how we can best help them be good parents. We will review the evidence-based interventions that have been developed to prevent symptoms in children of depressed parents, including psychoeducation, family support, parenting programs and family therapy. A community activist, who has developed a family-focused organization for families where a member has depression, will discuss her personal experiences with depression in family members. She will also show us how psychiatrists can use her organization’s resources.

S014-1.

OVERVIEW OF NEEDS OF THE CHILDREN OF PARENTS WITH MENTAL ILLNESS

Presenter: Alison M. Heru, M.D.

SUMMARY:

For adult psychiatrists, asking patients about parenting concerns and including children in an appointment might feel daunting. Patients however are frequently parents and have specific parenting needs. The patient and the psychiatrist may collude in the belief that the children don’t notice the mental illness. However, when the children are asked, they tell a different story. The child may have many questions, concerns and possibly false beliefs about the illness, treatment and recovery. Young caregivers want to understand what is happening to their parent and to be part of the decisions made about the family. They want to be respected, included and acknowledged by the professionals treating their parent. The needs of children range from a child who is coping well and needs information to a child whose own health is threatened by the situation and who needs support, treatment and perhaps protection. The extent of a child’s vulnerability depends on many factors, such as the developmental stage of the child and the degree of social isolation.

This presentation will discuss the concerns of children and parents. Research on the needs of children who have a parent with mental illness will be presented and we will provide guidance for psychiatrists in managing the family concerns that arise.

S014-2.

CLINICAL IMPLICATIONS OF EVIDENCEBASED PREVENTIVE INTERVENTIONS FOR FAMILIES WITH PARENTAL DEPRESSION

Presenter: William R. Beardslee, M.D.

SUMMARY:

The occasion of a mental illness in an adult who is a parent presents an important opportunity for adult psychiatrists to strengthen the parenting and inquire about the children. Based on two recent IOM reports that focus on family adversity, depression and effective parenting, Dr. Beardslee will review the evidence for such approaches and describe practical, straightforward, clinical strategies that practitioners can employ. In the recent IOM volume on prevention of mental illness in children and adolescents and their families, programs to strengthen parenting received very strong recommendations and had one of the strongest evidence bases.

S014-3.

A FAMILY PERSPECTIVE FROM JULIE TOTTEN, PRESIDENT AND FOUNDER OF FAMILIES FOR DEPRESSION AWARENESS

Presenter: Julie Totten, M.B.A.

SUMMARY:

Julie was 24 years old when her brother Mark took his life. Shortly after, she helped her father, who had been suffering from undiagnosed depression all his life, get treated for the illness. In dealing with the depression that afflicted her father and brother, she felt alone, lost, and responsible. She thought there must be a lot of other families like hers. So, ten years after Mark's death, Julie founded Families for Depression Awareness, a nonprofit organization, to help families, including family caregivers like herself, recognize and cope with depressive disorders to get people well and prevent suicides. Julie will share her story, how the depression affected her as a young person, the needs of the members of Families for Depression Awareness, ways that psychiatrists can involve the whole family in treatment, and distribute educational materials such as the Depression and Bipolar Wellness Guide for parents.

SYMPOSIUM 015

PROS AND CONS OF SPECT BRAIN IMAGING: WHAT IS THE STATUS OF THE SCIENCE?

Co-Chairs: Theodore A. Henderson, M.D., Ph.D., Joseph C. Wu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify the radiation exposure in a SPECT scan, 2) Understand & interpret the risk from such radiation exposure, 3) Recognize the correlation between neuroimaging findings and specific psychiatric conditions, 4) Interpret the scientific data supporting or prohibiting the use of SPECT neuroimaging, and 5) Make a sound & reasoned medical opinion concerning the use of SPECT neuroimaging in Psychiatry and their own practice

SUMMARY:

Perfusion SPECT is the oldest and most widely available functional neuroimaging technique in the world. A large body of research literature has been compiled over the past 25 years on SPECT findings in a variety of neurological and psychiatric conditions. The results have been mixed and in some cases, inconclusive. Nevertheless, SPECT neuroimaging findings in some conditions have been highly correlated with findings from other functional neuroimaging methods and SPECT has been utilized in some arenas as part of the diagnostic evaluation of psychiatric and neurological conditions. Recently, criticism of the use of perfusion SPECT neuroimaging in the diagnosis and treatment of psychiatric and neurological conditions has increased. However, much of the published critiques fail to present a thorough review of the relevant scientific literature. Given that neuroimaging, in all its forms, is gaining validity in Psychiatry, a thorough review of the scientific data supporting and detracting from SPECT neuroimaging is needed. The purpose of this symposium is to present arguments and data for and against the use of SPECT neuroimaging in the evaluation of psychiatric and neurological conditions. Areas of focus will include: 1) the correlation of neuroimaging findings to DSM IV diagnostic entities or lack thereof; 2) a valid and scientific analysis of the risk from exposure to a radioactive isotope; 3) criteria for selecting a SPECT scan as an aid in the diagnosis of a complex psychiatric condition, particularly when suspected neurological conditions are comorbid; and 4) current and upcoming advances in the technology and statistical analysis of SPECT.

S015-1.

CAPTURING MENTAL ILLNESS IN A BRAIN SCAN: DREAM OR REALITY?

Presenter: Anissa AbiDargham, M.D.

SUMMARY:

Imaging, of all modalities, has contributed greatly to our understanding of the pathophysiology of mental disorders in the last few decades. This talk will focus on two disease categories, schizophrenia and addiction, as well as their comorbidity. In both of these disorders, reliable and reproducible observations have emerged that can be considered characteristic. These observations inform us of the underlying pathology but also are linked to certain symptom domains, and can be used to guide treatment, ultimately leading to biomarkers for diagnostic and treatment purposes. However, most of the findings have not yet been shown to have specificity and sensitivity to allow widespread use and meaningful application for clinical purposes. I will outline the various findings and describe their impact on the field. This will be followed by a description of the remaining steps needed to validate and justify the use of imaging in the routine clinical practice of Psychiatry. While imaging in Psychiatry has contributed to our understanding of various disease categories, more work is needed in order to exploit the full potential in terms of disease classification and treatment.

S015-2.**SPECT IMAGING IN PSYCHIATRIC PRACTICE: READY FOR PRIME TIME?**

Presenter: Jair C. Soares, M.D.

SUMMARY:

This presentation will review findings from SPECT neuroimaging research in Psychiatry, with a particular focus on mood disorders. It will review available research findings, summarize main results and discuss if this is still a research tool or whether there are areas where available findings may support its use to aid clinical practice.

S015-3.**BRAIN SPECT IMAGING IS IMMEDIATELY USEFUL IN CLINICAL PRACTICE**

Presenter: Daniel G. Amen, M.D.

SUMMARY:

With current available technology and knowledge brain SPECT imaging has the potential to add important clinical information to benefit patient care in many different areas of a psychiatric practice. This presentation explores the clinical controversies and limitations of brain SPECT, plus seven ways it has the potential to be immediately useful in clinical practice, including: helping clinicians ask better questions; helping them in making more complete diagno-

ses and preventing mistakes; evaluating underlying brain system pathology in individual patients; decreasing stigma and increasing compliance; visualizing effectiveness of treatment via followup evaluations; helping to decide between treatments and encouraging the exploration of innovative and alternative treatments.

S015-4.**BRINGING SPECT FUNCTIONAL NEUROIMAGING INTO PERSPECTIVE**

Presenter: Theodore A. Henderson, M.D., Ph.D.

SUMMARY:

Many look to neuroimaging to provide a “fingerprint” or pathognomonic sign of a DSM diagnosis. This is an unrealistic expectation. Neuroimaging, with an emphasis on SPECT perfusion imaging, will be explored in the context of the scientific understanding of the neurophysiology of psychiatric symptoms, as well as the nature of diagnostic tests. Comorbidity, selection criteria, and the absence of “gold standards” for diagnosis also will be considered. In addition, the technical aspects of SPECT perfusion scanning will be considered. The risk from radioactivity exposure is often cited as a concern, but this risk is poorly understood by the average clinician. The risk of radioactivity exposure will be discussed in the context of the Linear NoThreshold Model versus the Threshold Model, with a review of pertinent literature concerning large populations exposed to radioactivity. The key points of the prior presenters will be reviewed in the context of the available research literature on SPECT perfusion imaging in psychiatric and neurological disorders.

SYMPOSIUM 016**FORENSIC PSYCHIATRY: INFORMING CLINICAL PRACTICE**

Co-Chairs: Robert I. Simon, M.D., Liza H. Gold, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify forensic issues that may inform or affect clinical practices, 2) Review how these forensic issues are relevant to specific patient populations, 3) Discuss the legal and ethical implications of new developments in psychiatric treatment

SUMMARY:

Psychiatrists increasingly find their practices require some working knowledge regarding a variety of subjects typically considered part of the subspecialty of forensic psychiatry.

Legal and administrative issues regularly intrude into treatment and evaluation of patients with mental illness. Many patients belong to special populations subject to unique legal protections. Children, incarcerated prisoners, patients with psychiatric disabilities, and potentially suicidal patients are examples of these populations. The advents of the internet and advanced neuroimaging techniques have changed the nature of routine psychiatric practice. The symposium faculty will review these clinically relevant and at times controversial subjects from forensic psychiatric perspectives. Suicide risk assessment, disability evaluations, training in child forensic interventions, the status of neuroimaging, the implications of the internet on psychiatric practice, and developments in correctional psychiatry will be explored by experienced clinicians and educators. Presenters will discuss these subjects, reviewing what is known and what needs to be explored further. They will provide suggestions for practice and future investigation. Dr. Robert Simon will discuss the problem of conducting suicide risk assessments when the patient denies suicidality. He will provide suggestions for conducting an observation based assessment of suicide risk. Dr. Liza Gold will review a model for the assessment of psychiatric disability, a subject that arises in every clinician's practice. Dr. Robert Granacher will discuss the status of neuroimaging and its applications in both clinical and forensic practice. Dr. Joseph Penn will explore issues in correctional psychiatry, one of the fastest growing and most challenging areas of psychiatric practice in the United States. Dr. Patricia Recupero will discuss how the internet is changing psychiatric practice and creating issues in treatment, confidentiality, and assessment of problematic online behavior, using cyber bullying as an example. Dr. Cheryl Wills will discuss the need for increased opportunities for training in the type of forensic evaluations and interventions that frequently arise in the course of treating children and adolescents. Attendees will have the opportunity to ask the faculty questions during the course of and following the symposium.

S016-1.

LOOKING BEYOND PATIENTS' DENIAL OF SUICIDAL IDEATION: ASSESSING OBSERVABLE EVIDENCEBASED RISK FACTORS

Presenter: Robert I. Simon, M.D.

SUMMARY:

Approximately 25% of patients at risk for suicide do not admit suicidal ideation to clinicians. Thus, a patient's denial of suicide intent requires the clinician to trust but verify. Evidencebased observable risk factors allow the clinician to make independent assessments of suicide risk.

S016-2.

DISABILITY EVALUATIONS: A MODEL FOR ASSESSMENT

Presenter: Liza H. Gold, M.D.

SUMMARY:

Disability evaluations are functional assessments intended to provide administrative or legal systems with information they can translate into concrete actions such as awards of benefits or legal damages. The presence of a psychiatric diagnosis does not automatically imply functional impairment, and functional impairment, when present, does not necessarily result in disability. This presentation will discuss an assessment model that can assist in developing case formulations and providing opinions for the most frequently asked questions in disability evaluations.

S016-3.

NEUROIMAGING IN FORENSIC PSYCHIATRY: CURRENT STATUS AND FUTURE DIRECTIONS

Presenter: Robert P. Granacher, M.D., M.B.A.

SUMMARY:

This presentation will provide a succinct overview of the current status of structural and functional neuroimaging and their applications to forensic psychiatry. Emphasis will be placed upon the level of scientific certainty currently available to a forensic psychiatrist choosing to use neuroimaging as a portion of a forensic case analysis. Likely future directions of currently available neuroimaging will be discussed and the potential for future applications of neuroimaging in general will be presented. Liberal use of neuroimages will be presented for teaching points during the presentation.

S016-4.

CORRECTIONAL PSYCHIATRY

Presenter: Joseph Penn, M.D.

SUMMARY:

Adults and youths with psychiatric disorders are over-represented within correctional populations. Many challenges exist in the identification, referral, and treatment of these patients. This presentation will review existing data/studies of psychiatric disorders within correctional settings, and factors resulting in recidivism and reincarceration. The legal development of prisoners' rights for medical and psychiatric care and standards of health care within correctional settings will be reviewed. The presenter will describe correctional barriers to access to care, screening and assessment tools and procedures at intake and during

subsequent confinement, and mental health strategies for offenders presenting with suicidal ideation, selfinjurious and/or disruptive behaviors. Appropriate levels of supervision and treatment, unique role/agency issues, and timely strategies regarding the use of psychotropic agents within correctional settings will also be reviewed. The utilization of telepsychiatry and other technologies and directions for future research will be discussed.

S016-5.

THE INTERNET AND PSYCHIATRY: AN UPDATE ON LEGAL AND ETHICAL CONSIDERATIONS

Presenter: Patricia R. Recupero, M.D., J.D.

SUMMARY:

Dr. Recupero will discuss the legal and ethical implications of the internet and its relationship to psychiatry, focusing on two relevant trends: cyberbullying and internetbased treatment. Cyberbullying has drawn attention from the media and general public as a growing concern for today's youth. Doctors may be asked to evaluate targets or perpetrators, so understanding the phenomenon, its legal implications, and emerging research in this area will be important. Online treatment modalities are also poised to become an area of growing interest, as increasing numbers of trials and pilot studies are appearing in the research literature. Case law is evolving rapidly, with doctors being penalized for internetrelated activities. Dr. Recupero will present data and examples from a recent survey of disclaimers and "legalese" on mental health treatment websites to help illustrate legal and ethical implications of internetbased treatments.

S016-6.

CHILD FORENSIC PSYCHIATRY: 21ST CENTURY PRACTICE

Presenter: Cheryl D. Wills, M.D.

SUMMARY:

Many child focused psychiatric assessments and treatments require forensic interventions. The presenter will discuss the future of child forensic psychiatry as it relates to training, scholarship, and the need for more forensic fellowship programs to permit child psychiatrists to concentrate in child forensic psychiatry during the forensic fellowship year. The presentation will explore how training programs can develop rewarding training and funding opportunities for clinical and forensic child psychiatry residents. The presenter will describe various educational and training programs that combine forensic, community and child psychiatric settings, and will discuss ways for psychiatrists to develop these in their own training programs or treatment settings.

SYMPOSIUM 017

STEPS (SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY AND PROBLEM SOLVING): TREATING BORDERLINE PERSONALITY DISORDER IN DIVERSE SETTINGS AROUND THE GLOBE

Chair: Donald W. Black, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe components of STEPPS treatment for borderline personality disorder, 2) Understand the role of STEPPS in the treatment of BPD in diverse populations (therapeutic community, mood disorder patients, offenders, youth), 3) Apply STEPPS treatment in correctional settings (prisons and community), 4) Understand evidence base supportive of STEPPS

SUMMARY:

This symposium describes the international reach of the STEPPS (Systems Training for Emotional Predictability and Problem Solving) treatment program for borderline personality disorder, and describes its use in diverse populations and treatment settings. The program is easily implemented by facilitators from a wide variety of theoretical orientations and training backgrounds. This evidencebased program is typically implemented as a 20week (2 hr/2k) outpatient psychoeducational, cognitivebehavioral, skills training approach. However, STEPPS has readily been adapted for use in widely diverse settings and the manual has been translated into several languages. STEPPS characterizes BPD as an emotional intensity disorder that clients learn to manage with specific emotion and behavior management skills. Key professionals, friends, and family members (clients' "reinforcement team") also learn to support and reinforce these skills, and group participants are encouraged to teach what they are learning to those identified as part of their system. The program has three components: awareness of illness, emotion management, and behavior management skills. A detailed facilitator and client manual with specific lesson plans is used. Suggestions for client selection and effective facilitator responses will be shared. Following a general overview of the program, including a description of the evidence base supportive of STEPPS, presenters will describe STEPPS in the following settings: adult outpatients (US and The Netherlands), new adaptations (UK), corrections (prisons and community), younger populations, a therapeutic community (Italy), and an inpatient mood disorders unit (Italy).

S017-1.

OVERVIEW OF STEPPS TREATMENT PROGRAM

AND ITS IMPLEMENTATION IN CORRECTIONAL SETTINGS (PRISONS AND COMMUNITY CORRECTIONS)

Presenter: Nancee S. Blum, M.S.W., L.C.S.W.

SUMMARY:

The STEPPS treatment program for borderline personality disorder (BPD) is an evidencebased, 20week (2 hr/wk) fully manualized, cognitivebehavioral, skills training approach. BPD is characterized as an emotional intensity disorder (EID) and treatment consists of teaching specific emotion and behavior management skills. Key professionals, friends, and family members whom clients identify as part of their “reinforcement team,” learn to reinforce and support the newly learned skills. An important component is to provide the person with BPD, and those in their system other professionals treating them, and closely allied friends and family members with a common language to communicate clearly about the disorder and the skills used to manage it. The program typically has been implemented in outpatient and residential care settings. However, beginning in 2005, STEPPS training and implementation was provided to the Iowa Department of Corrections (initially with female offenders) and also to correctional facilities in a number of states in the US. Data from 77 participants reveals robust improvements in BPD related symptoms, mood, and negative affectivity, as well as a decrease in disciplinary incidents and selfharm behaviors. The program is well received by group participants as well as therapists.

S017-2.

IMPLEMENTING STEPPS IN DIFFERENT SERVICE SETTINGS IN THE UNITED KINGDOM

Presenter: Renee Harvey, M.A.

SUMMARY:

STEPPS groups have now been well established in numerous sites across the UK at community mental health team level. A UK version of the program is gaining popularity and delivering positive outcomes. The applicability of the program to meet the needs of service users with differing levels of complexity is now being considered and will be presented here. Two areas of development are currently under way. Firstly, STEPPS has been embedded into the programme within a specialist service setting, with added elements of support. This aims to address the additional challenges of multiple diagnoses, greater demands on services, and higher levels of risk, chaotic lifestyle issues, and complex systems/organizational involvement. The outcomes of the first group will be presented, together with the implications this has had within the wider care pathway. Secondly, a modified

version of STEPPS has been developed for use at Primary Care level. This provides a new set of challenges regarding the optimal level to which the program may be shortened and simplified and still remain effective. The modifications being piloted consider both the needs of services, with stringent targets, time, staffing and budget limitations as well as the large numbers of service users for whom a timely intervention could potentially prevent years of disruption, distress and escalation of problems.

S017-3.

STEPPS IN THE NETHERLANDS: THE EFFICACY IN A GROUP OF DUTCH PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND WITH BORDERLINE PERSONALITY FEATURES

Presenter: E. Bas van Wel, M.D.

SUMMARY:

STEPPS was introduced in the Netherlands in 1998. In was translated to Dutch under the acronym VERS (Vaardigheidstraining Emotieregulatiestoornis). Since then more than 600 therapists have been trained in its use and administration. More than half of the Dutch institutions for Mental Health Care are able to provide the training to patients in the course of their treatment program for BPD. The STEPPS manual was translated in 1998 and was revised in 2004. The treatment was investigated in a RCT study on patients with a borderline personality disorder (Van Wel EB, Bos EH, Appelo MT, Berendsen EM, Willgeroth FC, Verbraak MJPM: The efficacy of the Skills training Emotion Regulation Disorder (VERS) in the treatment of borderline personality disorder. A randomized controlled trial. Dutch Journal of Psychiatry 2009;51:291301.) and on patients with borderline personality features (E.H. Bos, E.B. van Wel et al: Effectiveness of Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Borderline personality Problems in a “Real World” sample; Moderation by diagnosis or severity. Psychotherapy and Psychosomatics 2011;80: 173181. Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a group treatment for borderline personality disorder (BPD). The prior RCTs have shown the efficacy of this training. In both RCTs, patients with borderline features who did not fulfill DSMIV criteria for BPD were excluded, which were many. We investigated the effectiveness in a sample representative of routine clinical practice, and examined whether DSMIV diagnosis and/or baseline severity were related to differential effectiveness. Patients considered by their practicing clinician to suffer from BPD were randomized to STEPPS plus an adjunctive individual therapy (STEPPS, n = 84) or to treatment as usual (TAU, n = 84). Results: STEPPS recipients showed more improvement on measures of general and BPD specific psychopathology and quality of life than TAU

recipients, both at the end of treatment and at a 6month followup. Presence of DSMIV diagnosed BPD was not related to differential treatment effectiveness, but dimensional measures of symptom severity were; the superiority of STEPPS over TAU was higher in patients with higher baseline severity scores. The findings show the effectiveness of STEPPS in a 'realworld' sample, and underscore the importance of dimensional versus categorical measures of personality disturbance.

S017-4.

STEPPS TREATMENT OF INPATIENTS WITH MOOD DISORDERS AND COOCCURRING BORDERLINE PD DIAGNOSIS: PRELIMINARY RESULTS FROM A ONEYEAR FOLLOWUP STUDY

Presenter: Andrea Fossati, M.D., Ph.D.

SUMMARY:

The present study was designed to yield preliminary data on STEPPS efficacy in the treatment of Mood Disorder inpatients with cooccurring BPD diagnosis or prominent BPD features. Thirtytwo inpatients who were admitted at the Mood Disorder Division of San Raffaele Hospital gave their informed consent to participate in the study. Twentysix inpatients were female (81.2%); 16 inpatients (50%) received a Major Depression diagnosis, whereas five inpatients (15.6%) were diagnosed as Bipolar I, and 11 inpatients received a Bipolar II diagnosis. The participants' mean age was 44.4 years, SD = 9.3 years. All participants received a BPD diagnosis or a PD diagnosis with prominent (i.e., 34 BPD traits) BPD features according to SCIDII interview. All participants started the STEPPS program when they were inpatient and completed the STEPPS after hospital discharge. At the time the study was carried out, 13 patients were still in the STEPPS program, whereas 17 patients completed the STEPPS program; sixmonth and oneyear followup data were available for 10 and 9 patients, respectively. The dropout rate that was observed in this study was 46.9%, a value that was approximately consistent with previous reports on the dropout rate during the STEPPS program. Friedman ANOVAs results showed that STEPPS produced a significant decrease of emotional intensity daily score over time (chisquare=73.96, df=29, $p<.001$). In this sample, the STEPPS program significantly reduced also the number of hospital admission (Friedman chisquare=18.69, df=3, $p<.001$) and suicide attempts (Friedman chisquare=16.07, df=3, $p<.001$) that were not due to the course of the Mood Disorder diagnoses. As a whole, these data suggest that the STEPPS program may represent a useful implementation in the treatment of inpatients with Mood Disorders and BPD.

SYMPOSIUM 018

NARCISSISTIC PERSONALITY DISORDER IN DSM5: IMPACT ON RESEARCH, DIAGNOSIS, AND TREATMENT

Chair: Elsa Ronningstam, Ph.D.

Discussant: Kenneth N. Levy, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify the diagnostic criteria for Narcissistic Personality Disorder, NPD, in DSM 5, 2) Recognize grandiose and vulnerable pathological narcissism and the difference between depressive personality and hypersensitive narcissism, 3) Specify adjustments and modifications of the diagnostic process and the transference focused psychotherapy with narcissistic patients

SUMMARY:

Narcissistic Personality Disorder in DSM 5 Impact on research, diagnosis and treatment. While narcissism as a dimension was incorporated in the first DSM 5 proposal for personality disorders to capture the range of narcissistic functioning, Narcissistic Personality Disorder, NPD, has now been reintroduced as a diagnostic category in the latest proposal from the DSM 5 Work Group. The new criteria identify problems in self and interpersonal functioning; identity, selfdirection, empathy and intimacy, as well as certain traits associated with antagonism i.e., grandiosity and attention seeking. The first aim of this symposium is to discuss the proposal for NPD diagnosis and how it relates to present research on pathological narcissism, i.e., grandiose and vulnerable expressions, and hypersensitivity and depressivity. The applicability of the NPD diagnosis in clinical practice has been problematic especially because of the difficulties identifying and communicating about narcissistic traits in ways that bypass narcissistic inflexibility, vulnerability and hyperreactivity in patients. Finding ways that accurately and meaningfully connect patients' experiences and descriptions of their problems with established diagnostic features and formulations, as well as with treatment goals and techniques have been especially challenging for NPD. Hence, the second aim of the symposium is to discuss how the DSM 5 NPD diagnosis can apply to an exploratory and interactive collaborative diagnostic process, and to the therapeutic process using the modified techniques of the Transference Focused Psychotherapy, TFP, for NPD.

S018-1.

NARCISSISTIC PERSONALITY DISORDER IN DSM5

Presenter: Andrew E. Skodol, M.D.

SUMMARY:

In DSMIV, pathological narcissism is represented by the category of Narcissistic Personality Disorder (NPD) – a category that describes primarily grandiose, “overt” narcissism. DSM NPD is among the less common PDs in epidemiological and clinical samples, is only moderately impairing, and has little research to support it. Theory, clinical experience, and empirical studies suggest, instead, that pathological narcissism might be better represented as a dimension to capture the natural variation of narcissistic difficulties within and across various personality styles. Thus, no specific category of NPD was included in the initial draft proposal for DSM5. The personality component of DSM5, however, has always included a severity dimension for assessing levels of impairment in self and interpersonal functioning ranging from healthy to extreme impairment to indicate the degree to which narcissistic impairment is present. Typical narcissistic functioning is represented by Level 2 = Moderate Impairment. In addition, narcissistic expressions of character can be identified by means of trait profiles, currently including the traits of grandiosity, attentionseeking, manipulativeness, callousness, hostility, depressivity, submissiveness, and withdrawal. Feedback received from the clinical and research communities bemoaned the loss of an NPD category. The trait representation of NPD was found to be scattered across trait domains in a way that interfered with the perception of an integrated, clinically meaningful construct, to be missing important traits, and to include trait facets with definitions that were too narrow, not clinically meaningful, nor empirically representative. Problems with the narcissistic trait representation have been addressed by reintroducing a category for NPD in the revised proposal for PDs in DSM5. New hybrid criteria combine core “narcissistic” impairments in identity, selfdirection, empathy, and intimacy (the “A criteria”), which include both inflated, grandiose and deflated, vulnerable expressions, and a revised trait of grandiosity (in the “B” criteria), which refers to either overt or covert manifestations. These criteria are being tested in the DSM5 Field Trials for reliability, feasibility, and perceived clinical utility. The ability to more completely and accurately characterize narcissistic issues using the DSM should better assist clinicians in formulating and implementing treatment approaches, and in anticipating

S018-2.

FINDING COMMON DENOMINATORS: UNDERSTANDING THE ASSOCIATION OF DEPRESSION, DEPRESSIVE PERSONALITY, AND HYPERSENSITIVE (VULNERABLE) NARCISSISM

Presenter: Steven Huprich, Ph.D.

SUMMARY:

The DSM system has included Narcissistic Personality Disorder in its official nomenclature, though recent activi-

ties of the DSM5 Personality and Personality Disorder Work Group have seen its future questioned. While Narcissistic Personality Disorder may appear in DSM5, certain aspects of pathological narcissism continue to be underrepresented within the diagnostic framework. These include low selfesteem, dysphoria, and hypersensitivity to criticism, which characterize individuals referred to as hypersensitive or vulnerable narcissists. Interestingly, this construct has many similar features to the DSMIV proposal of Depressive Personality Disorder, including vulnerability to depression, low selfesteem, feelings of inadequacy, shame, hypersensitivity to criticism, tendencies toward selfdefeating actions and activities, and strong hidden desires to be loved, appreciated, and recognized. In this presentation, I will articulate further how these two constructs are related, and to what extent depressive symptoms are manifest in both. Recent studies will be reviewed, which have begun to examine the relationship between Depressive Personality and Hypersensitive Narcissism. Different models will be compared of how features of both constructs are related and to what extent a common factor or set of factors accounts for their similarities. The ramifications of these studies for the future assessment of personality disorders will be addressed, including the need to not prematurely dismiss diagnostic constructs that have clinical utility, as well as the need to enhance the assessment of such constructs.

S018-3.

NARCISSISTIC GRANDIOSITY AND NARCISSISTIC VULNERABILITY: CLINICAL EXAMPLES, CURRENT RESEARCH, AND IMPLICATIONS FOR DSM5

Presenter: Aaron L. Pincus, Ph.D.

SUMMARY:

Recognition of grandiose and vulnerable expressions of pathological narcissism is common in clinical practice, particularly when conceptualizations of narcissistic pathology are not bound to the overly narrow DSMIV category of Narcissistic Personality Disorder (NPD). Narcissistic personalities are dominated by strong needs for validation and admiration that motivate the person to seek out self enhancement experiences in maladaptive ways and in inappropriate contexts (i.e., narcissistic grandiosity). This is coupled with impaired capacity for self and affect regulation when faced with the disappointment of entitled expectations and selfenhancement failures (i.e., narcissistic vulnerability). The DSM5 proposal for personality and personality disorders includes a revised description and criteria set for NPD that broadens content to include aspects of grandiosity and vulnerability. The current paper presents clinical examples of pathological narcissism seen in psychotherapy and reviews current research employing the Pathological Narcissism Inventory to articulate challenges and issues

for improving the conceptualization, diagnosis, and treatment of pathological narcissism. These include examination of the withinperson patterning of grandiose and vulnerable states over time, identifying interpersonal triggers of grandiose and vulnerable feelings and behaviors, and the development of integrative psychotherapeutic interventions for pathological narcissism that target the dynamics of narcissistic grandiosity and vulnerability. This provides a rich context in which to evaluate and improve upon the current DSM5 proposal for NPD.

S018-4.

NARCISSISTIC PERSONALITY DISORDER: AN INTERACTIVE EXPLORATORY DIAGNOSTIC PROCESS

Presenter: Elsa Ronningstam, Ph.D.

SUMMARY:

Narcissistic personality disorder has been particularly challenging to diagnose in psychiatric and general clinical practice. Several circumstances and factors related to the nature of NPD contribute: a) comorbidity of other urgent and readily recognizable major psychiatric conditions; b) compromised ability for selfdisclosure, selfreflection and selfdirected emotional empathy; c) hypersensitivity and defensive reactivity; d) limited ability to recognize own contribution to problems or impact on other people; e) a moderately impairing condition, often accompanied by specific capabilities and high level of functioning; f) limited availability of treatment modalities specifically for pathological narcissism and NPD. With the inclusion of NPD as a diagnostic category in the latest DSM 5 proposal for personality disorders there is a strong incentive to integrate present clinical and empirical knowledge on pathological narcissism and narcissistic personality functioning to improve the diagnostic process. This paper outlines a collaborative and psychoeducational approach to the diagnosis of NPD within the process of building a therapeutic alliance. The aim of this presentation is to discuss specific strategies to explore patients' subjective experiences and interactive patterns that are influenced by pathological narcissism and relevant to the diagnosis of NPD. The proposed outline of NPD in DSM 5, with a twofold approach that addresses problems in both self and interpersonal aspects of personality functioning (identity, selfdirection, empathy and intimacy) as well as personality traits (grandiosity and attention seeking) encourage a more flexible and interactive diagnostic process. The DSM 5 proposal for NPD will be critically evaluated for its applicability and usefulness in a clinically meaningful diagnostic process that serve to identify and agree upon functional problems and descriptive features, and goals and strategies for change.

S018-5.

TRANSFERENCEFOCUSED PSYCHOTHERAPY FOR NARCISSISTIC PERSONALITY DISORDER

Presenter: Diana Diamond, Ph.D.

SUMMARY:

There has been increasing attention to looking at narcissistic pathology as a dimensional disorder with varying degrees of pathology of self and object relations, reflected in the drafts of the DSM5 (Ronningstam, 2009). In this paper, we present Transference Focused Psychotherapy (TFP), a psychodynamic treatment based on object relations theory. Data from a randomized control trial comparing three psychotherapies for borderline personality disorder (Clarkin et al, 2007; Levy et al, 2006) allowed for study of characteristics of the subgroup of patients with comorbid borderline and narcissistic personality disorder. Findings from this data analysis were integrated into the work of a study and supervision group on narcissistic disorders in order to modify the technique to more successfully treat this group of difficult patients. These modifications focus around the rigidity of the pathological grandiose self, whether expressed covertly or overtly, and its central defensive role in psychological structure that makes this group of patients particularly difficult to treat. The paper delineates the modifications of technique at all stages of TFP including: 1) More flexibility in developing a treatment contract which poses a challenge to the patients' grandiosity in the initial phases; 2) Consistent focus on defining the dominant object relational dyad of an omnipotent self in relation to a devalued object that comprises the grandiose self as it is lived out in the transference; 3) Interpretation of the patient's identification with the devalued pole of the grandiose/devalued dyad through an analysis of role reversals in the transference. To achieve these goals it is necessary to have 1) a more prolonged phase of therapistcentered interpretations (that is, interpretations that focus on the patient's immediate experience of the therapist) due to rigidity of the grandiose self and its characteristic defenses of omnipotent control, devaluation and idealization; and 2) consistent attention to increasing reflective functioning or the capacity of to understand behaviors of self and other, in terms of intentional mental states—a capacity that is typically impaired in the NPD patient, and that was observed to improve in our study data. The paper provides illustrative case material to illustrate the phases of TFP and modifications of technique for NPD/BPD patients.

SYMPOSIUM 019

PHILOSOPHICAL AND PRAGMATIC PROBLEMS FOR DSM5

Co-Chairs: Joel Paris, M.D., James E. Phillips, M.D.

Discussant: Michael B. First, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand theoretical and practical issues affecting the development of the new DSM manual, 2) Provide information on the conceptual foundation of DSM5 and its problems, 3) Provide information on problems with the clinical utility of DSM5

SUMMARY:

This symposium will highlight some of the conceptual and philosophical problems underlying DSM5: its theory of mental disorders, as well as the economic impact and clinical utility of psychiatric diagnosis.

S019-1.

THE IDEOLOGY BEHIND DSM5

Presenter: Joel Paris, M.D.

SUMMARY:

While in principle, science should be the basis of any diagnostic system, DSM5 has been seduced by the idea that advances in neuroscience can provide empirical validity for a new system. In reality, we do not know whether most conditions listed in the manual are true diseases. In spite of all the progress that has been made in neuroscience over the last few decades, we are no closer to understanding the etiology and pathogenesis of mental disorders than fifty years ago. Thus, DSM has no choice for the foreseeable future but to continue with a provisional and pragmatic classification system based on phenomenological observation. While the establishment of biological markers must remain a longterm goal, DSM should be written for 2013, not for 2063 or 2113.

S019-2.

THE CONCEPTUAL STATUS OF DSM DIAGNOSES

Presenter: James E. Phillips, M.D.

SUMMARY:

Since the early planning stages of DSM5 the architects of the new manual have recognized that the diagnostic categories of DSMIII and IV are in a state of crisis. As reviewed by Regier and colleagues, the expectation that DSM categories would fulfill the Robins/Guze (1) validating criteria of “separation from other disorders, common clinical course, genetic aggregation in families, and future differentiation by future laboratory tests –which would now include anatomical and functional imaging, molecular genetics, pathophysiological variation, and neuropsychological testing...” (2, p.

645) has been severely disappointed. What we have instead is largescale comorbidity, nonspecific treatment response to psychotropic medications, a failure to identify pathophysiologic underpinnings for specific diagnostic categories, with no biomedical markers, and finally a confusing and complex genetic picture in which genetic patterns overlap with a variety of disorders, with no single genetic foundation for any of the current categories. Thus the DSM diagnostic categories are not the discrete biological conditions they were thought to be. The response of the DSM5 Task Force to this crisis of validity has been to propose measures to improve the scientific status of the DSM, most prominently through the introduction of dimensional measures in the form of severity scales for individual disorders and “crosscutting” measures that cut across disorders. As Regier and colleagues wrote: “The single most important precondition for moving forward to improve the clinical and scientific utility of DSM5 will be the incorporation of simple dimensional measures for assessing syndromes within broad diagnostic categories and supraordinate dimensions that cross current diagnostic boundaries” (2, p. 649). Whatever the merits (or shortcomings [3]) of dimensional measures, they will not resolve questions of the conceptual status of DSM diagnostic categories. In this presentation I will approach the conceptual question from a perspective of viewing them as practical groupings (45) that for the present serve to organize the diagnostic process and, with recognition of their limited validity, provide a reliable structure for ongoing research. I will argue that this is the best scientific strategy for the present, and I will speculate how the NIMH Research Domain Criteria project might change the structure of our nosology in the future. References 1. Robins E, Guze SB: *Establis*

S019-3.

CONSIDERING THE ECONOMY OF DSM ALTERNATIVES

Presenter: John Z. Sadler, M.D.

SUMMARY:

Criticisms of the DSMs over the past 30 years have rarely generated credible alternative classifications of psychopathology, and virtually all rivals have fallen away, as judged by clinical or research impact. This presentation considers why this has been the case. After some historical contextsetting (the American Psychological Association classification attempt, a brief review of alternative nosological proposals, and a brief discussion of the RDoC idea), I propose and defend the following thesis: The DSM prevails because it is, by historical default, an essential component of the “mental health medical industrial complex (MHMIC)” which financially locks out alternatives. The MHMIC, consisting of APA, the pharmaceutical and medical device industry,

NIMH, and public sector/private insurance companies converge fiscal interests to lock the description of psychopathology into a preservethestatusquo stance described by Frances and Pincus in the DSMIV era. The support for this thesis will be graphically displayed through a portrayal of vectors of financial interest involving these stakeholders. The subjugation of scientific, conceptual, or humanistic interests to economic interests is the result, and DSM “pragmatism” will be redescribed as a literal economy of means. Under these considerations, the wish for a whole, comprehensive, alternative nosology is naive. In concluding I opine about the most feasible alternative procedure for developing alternative classifications of psychopathology, NIMH funding of an online infrastructure for “open source” categories, criteria, and taxonomic structures. Such a web infrastructure would provide cheap access (e.g., outside the MHMIC) for any registered user to post formal and informal nosological categories, criteria, and taxonomies. In turn, the international community of clinicians and clinical investigators would democratically determine, by use characteristics, which systems offer the greatest potential. These alternatives could then be formally tested in more rigorous settings, again with dedicated NIMH support.

S019-4.

WHAT ARE THE BENEFITS AND RISKS OF CONSERVATISM?

Presenter: G. Scott Waterman, M.D.

SUMMARY:

It is no accident that the wealthy tend to be more conservative about economic systems than the poor. When something is working well (if only from a parochial perspective), why change it? From the point of view of the poor, the risks inherent in economic change seem far less worrisome. What do they have to lose, after all, other than their poverty? The debate about psychiatric nosology – while certainly not unrelated to economics – revolves around whether we a) believe our current system serves its many purposes, b) have the current capacity to alter it for the better, and c) are more likely to damage the specialty and its goals than to enhance them with efforts to improve the diagnostic system. This presentation will take the position that, while unquestionably complex, the evidence compels us toward major changes to our diagnostic taxonomy. It will describe how in each of the domains of psychiatric endeavor – research, education, and clinical care – our current nosology is generally unhelpful and is, in too many instances, misleading and counterproductive. As the sciences that constitute the foundations of our specialty progress at a rapid pace, the gulf between them and clinical psychiatry grows ever wider, and the contrast between their successes and our failures becomes ever more stark. Conservatives on this topic are

correct in indicating that the neural and behavioral sciences are insufficiently developed to form the basis of a new and complete psychiatric nosology. But they miss the point that the current DSM system actively imposes conceptual handicaps on our discipline that unnecessarily retard needed progress. This presentation will describe how psychiatric diagnostic taxonomy can be reformulated so that it allows us to describe accurately, teach coherently, and investigate productively the phenotypes, etiopathogeneses, prognoses, and treatment responses of our patients, while being sufficiently nimble to incorporate advances in understanding that the persistence of the current nosology endangers. References: Waterman GS, Curley DP. Doing no harm: the case against conservatism, and Waterman GS. Doing no harm redux: the case for (ultra) conservatism? *Bulletin of the Association for the Advancement of Philosophy and Psychiatry* 2010; 17(1):1920, 17(2):2932 Althoff RR, Waterman GS. Psychiatric training for physicians: time to modernize. *Academic Medicine* 2011; 86:285287

S019-5.

THE PRAGMATIC CONTEXT OF PSYCHIATRIC DIAGNOSIS

Presenter: Joseph M. Pierre, M.D.

SUMMARY:

Although the main value of the DSM is as a “good enough guide for clinical work,” psychiatric diagnoses are used for wideranging contexts in research, forensics, healthcare administration, and public policy. Therefore, decisions about what ends up in DSM and how DSM diagnoses are used must be made based upon riskbenefit analyses that seek to optimize contextual utilities in the face of existing scientific knowledge. The challenges of balancing such pragmatic considerations are wellillustrated by the proposed inclusion of “Attenuated Psychosis Syndrome” in DSM5. As the DSM continues to evolve along with increasing focus on the milder end of the mental illness spectrum, careful assessments of contextual utility must likewise be applied to the larger issues of neuroenhancement and diagnostic expansion in psychiatry.

SYMPOSIUM 020

NEW PARADIGMS FOR INVESTIGATING RELATIONAL DISTURBANCES IN BORDERLINE PERSONALITY DISORDER

Chair: Lois W. ChoiKain, M.D., M.Ed.

Discussant: Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand conceptualizations of the interpersonal hypersensitivity of borderline from paradigms including attachment, mentalization, empathy, social exclusion, and rejection sensitivity, 2) Identify different empirical technique for studying the interpersonal features of borderline personality, 3) Describe different treatment approaches implicated by these various paradigms for understanding interpersonal features of borderline personality disorder

SUMMARY:

The relational disturbances of borderline personality disorder (BPD) have been defined in the DSMIV by the criteria of 1) frantic efforts to avoid abandonment and 2) intense unstable relationships marked by vacillations between idealization and devaluation. These interpersonal aspects of BPD constitute the disorders most discriminating and enduring features. Increasing evidence suggest these interpersonal features are familial and heritable, suggesting that disturbed relationships reflect an important phenotype of BPD. Two proposed endophenotypes connecting neurobiological processes organizing interpersonal functioning with the overt symptoms of BPD, include mentalization failures and rejection sensitivity. This symposium aims to review new paradigms for investigating these endophenotypic traits within BPD. New research employing methodologies to assess attachment, empathy, and rejection sensitivity will be presented and discussed to clarify different models of conceptualizing and studying interpersonal disturbances within BPD. Evidence that ties mentalization failures and rejection sensitivity to other specific biological features will be reviewed to consider the possibility that relational disturbances within BPD may be both biologically and environmentally shaped. Implications for further study and treatment will be discussed.

S020-1.

ATTACHMENT AND COGNITION IN BPD: PROBLEMS IN INTEGRATING COMPLEX INFORMATION IN EMOTIONALLY STIMULATED ATTACHMENT CONTEXTS

Presenter: Lois W. ChoiKain, M.D., M.Ed.

SUMMARY:

Both attachment and neurocognitive frameworks have provided alternative ways to explain the specific combination of relational disturbances, emotional instability, and behavioral stress reactivity of Borderline Personality Disorder (BPD). Numerous attachment studies have confirmed a relationship between BPD and insecure attachment, specifically preoccupied, fearful, and disorganized styles. Also, a growing body of neurocognitive research suggests that

differences in the brain function namely in the activity in the limbic areas and related areas in the prefrontal cortex with executive regulatory functions may account for characteristic cognitive style of BPD that includes splitting, dissociation, and black and white thinking. This presentation will report on a study comparing the attachment styles and neuropsychological functioning of rigorously diagnosed age, education, and IQ matched subjects with BPD (n=24) and without BPD (n=30). Results showed BPD subjects to have more insecure and disorganized forms of attachment as well as poorer performance on complex cognitive tasks such as the ReyOsterrieth Complex Figure (ROCF). Otherwise BPD subjects demonstrated similar performance on tasks related to attention, executive function, and memory. These findings suggest that deficits in processing and integrating information about interpersonal interactions may impair a borderline individual's ability to develop coherent, integrated, and realistic views of self and other. The combination of informational processing problems combined and interpersonal hypersensitivity may manifest in ambivalent and disorganized attachment strategies characterized by emotional and behavior dysregulation. Implications of these attachment and neurocognitive findings for treatment of BPD will be discussed.

S020-2.

REJECTION SENSITIVITY AS A DISTINGUISHING FEATURE OF BORDERLINE PERSONALITY DISORDER

Presenter: Valerie I. Photos, Ph.D.

SUMMARY:

Objective: Despite its exclusion from formal diagnostic criteria, rejection sensitivity (RS) is viewed by many as a key feature of borderline personality disorder (BPD). While it is known that RS is associated with features relevant to BPD such as relational hostility and selfdestructive behaviors, limited research has investigated the relationship between RS and BPD using a clinically derived measure in a mixed clinical and community sample. The goal of this research was to assess the relationship between RS and BPD to test our hypothesis that RS distinguishes individuals with BPD from both nonclinical and clinical comparison groups. Additionally, we hypothesized that family members of BPD patients would have higher levels of RS. **Method:** We administered the McLean Assessment of Rejection Sensitivity (MARS) to rigorously diagnosed probands in three groups: BPD (n=132), major depressive disorder (n=90), and nonborderline comparison (n=115), as well as to their firstdegree relatives (FDRs; n=802). **Results:** MARS scores differentiated BPD probands from comparison group subjects and also FDRs of BPD probands from comparison probands. MARS scores in probands predicted BPD

diagnosis and symptoms, and a one-point increase MARS scores in probands was associated with a 0.10 point increase in FDRs' MARS scores, which was a clinically significant difference. MARS scores showed a level of heritability of 26%. Conclusion: Rejection sensitivity is a core personal and familial feature of BPD that may represent a phenotypic psychobiological predisposition to the disorder.

S020-3.

EMPATHY, ATTACHMENT, AND BORDERLINE PERSONALITY: GENETIC, NEUROBIOLOGICAL, AND DEVELOPMENTAL PERSPECTIVES

Presenter: Luis H. Ripoll, M.D.

SUMMARY:

Borderline Personality Disorder (BPD) involves prominent interpersonal dysfunction, rooted in intolerance of aloneness, identity diffusion, and attachment insecurity. Within this broad area of personality functioning, conflicting empirical evidence exists regarding BPD patients' capacities for social cognition and empathic processing. Some studies demonstrate a heightened ability and others demonstrate empathic deficits in BPD, yet changes to DSM5 highlight empathic dysfunction as a core component of the diagnosis. Through a review of social cognitive neuroscience and attachment research, a model of BPD psychopathology emerges involving attachment-related dysregulation of two specific neural circuits involved in empathy and social cognition. By detailing this model, we can begin to bridge between the wealth of theoretical literature on BPD and recent empirical research. Accounting for individual variation and using naturalistic assessments of social cognitive ability are important strategies to understand interpersonal dysfunction more precisely while retaining clinical relevance. Preliminary data are presented regarding the performance of BPD subjects, as compared with schizotypal personality disorder subjects and healthy controls, on a naturalistic Empathic Accuracy (EA) task and the Reading the Mind in the Eyes Test (RMET). BPD subjects demonstrated only subtle differences from other subjects in EA performance, and details of the results are interpreted as indicative of a highly contextualized empathic disturbance, likely limited to provocation of insecure attachment. Self-report measures of attachment and interpersonal functioning provide information regarding the relationship between distinct dimensions of interpersonal functioning and other BPD symptomatology. Diffusion tensor imaging data suggest that adolescents with BPD undergo a distinct developmental trajectory in terms of the structural connectivity of white matter tracts implicated in affective processing and interpersonal functioning. Preliminary data also indicate a relationship of opioid genetic polymorphism on attachment insecurity in BPD. Future treatments for BPD may involve targeting

opioid signaling to modulate the function of the aforementioned neural circuitry associated with empathic processing.

S020-4.

EMERGING INVESTIGATIONAL PARADIGMS FOR THE EMPIRICAL STUDY OF REJECTION SENSITIVITY

Presenter: Alex S. Keuroghlian, M.D., M.Sc.

SUMMARY:

Objectives: The interpersonal symptoms of borderline personality disorder (BPD) constitute one of its most defining and enduring dimensions. Historically, interpersonal hypersensitivity in BPD has been conceptualized within a developmental framework as low tolerance of separation and aloneness, leading to its diagnostic codification as "frantic efforts to avoid real or imagined abandonment" (DSM IVR, 2000). A growing empirical literature, however, instead operationalizes these interpersonal vulnerabilities in terms of rejection sensitivity (RS). The purpose of this presentation is to evaluate the range of investigative paradigms emerging for the empirical study of RS and for its association with cognitive, affective and behavioral features of BPD. Method: A comprehensive literature review was performed to identify empirical studies of RS in both BPD and nonBPD samples. Results: Empirical paradigms for the investigation of RS are broadly classified into four methodological categories: 1) interview measures consisting of prompts in the form of hypothetical scenarios involving rejection to which subjects are asked to respond; 2) diary sampling or other self-report of participants' real-life experiences of and reactions to rejection; 3) priming paradigms that use rejection-themed words, facial expressions, narrations, artwork, or other exposures prior to task performance, physiologic response measurement, or brain imaging for neural correlates; and 4) simulated conditions of rejection and social exclusion, including social exclusion from virtual ball-toss or card games and romantic rejection during online dating, prior to brain imaging for neural correlates. Conclusions: In recent years, a proliferation of paradigms for the empirical investigation of RS has occurred. RS is an easily assessed trait that can help elucidate characteristic relational disturbances in BPD, as well as their association with central problematic cognitive, emotional and behavioral patterns, which may serve as targets for the treatment of borderline patients.

S020-5.

NEUROIMAGING OF SOCIAL EXCLUSION IN BORDERLINE PERSONALITY DISORDER

Presenter: Anthony C. Ruocco, Ph.D.

SUMMARY:

Sensitivity to interpersonal rejection is a hallmark feature of borderline personality disorder (BPD). The neural basis of this interpersonal sensitivity is poorly understood but is thought to involve cortical midline structures associated with self-referential processes. The purpose of the current study was to evaluate functional activation within the medial prefrontal cortex (mPFC) in BPD patients under conditions of social exclusion. Method: BPD subjects (n=10) and IQ and demographically matched nonpsychiatric comparison subjects (n=10) completed a social cognitive task with two confederates instructed to either include or exclude subjects from a circumscribed social interaction. Evoked cerebral blood oxygenation in the mPFC was measured using 16-channel continuous wave functional near-infrared spectroscopy while subjects interacted with the confederates. BPD patients and control subjects reported greater feelings of rejection during the social exclusion condition but there was no difference in rejection ratings between the groups. Relative to controls, however, BPD patients showed increased activation within the mPFC during social exclusion. Activation within this region during social exclusion was associated with dimensional ratings of fears of abandonment. BPD patients show hyperactivation of the mPFC under conditions of social exclusion. These findings suggest possible dysfunction of frontolimbic circuitry underlying sensitivity to interpersonal rejection in this illness.

SUNDAY, MAY 6, 2012

SYMPOSIUM 021**THE FUTURE OF PSYCHIATRIC DIAGNOSIS: UPDATES ON PROPOSED DIAGNOSTIC CRITERIA FOR DSM5 (PART I)**

Co-Chairs: Darrel A. Regier, M.D., M.P.H., David J. Kupfer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the most notable changes being adopted in DSM5 in the sections on Neurodevelopmental Disorders, Childhood and Adolescent Disorders, ADHD and Disruptive Behavior Disorders, Personality and Personality Disorders, and Neurocognitive Disorders, 2) Explain how proposed revisions are addressing gaps in the currently DSMIV nosology, 3) Discuss the ways in which the work groups intend the finalized criteria to facilitate better clinical care of patients

SUMMARY:

Members of the 13 DSM5 Work Groups are currently finalizing draft diagnostic criteria and proposed dimensional

changes to disorders in preparation for the release of the revised manual in May 2013. Final proposals are being informed largely by evidence from the literature, including, where available, secondary data analyses; results from the two designs of the DSM5 Field Trials (large, medical-academic settings and routine clinical practice settings); and feedback from patients, professionals, and the general public. A three-part symposium series will provide audiences with updates on the latest status of proposed revisions to DSM's diagnostic criteria from the chairs of each of the 13 work groups. In this session (Part I), attendees will learn about draft changes among Neurodevelopmental Disorders, Childhood and Adolescent Disorders, ADHD and Disruptive Behavior Disorders, Personality Disorders, and Neurocognitive Disorders. Where available, select results from field trials and specific feedback received via the DSM5 Web site may be shared.

S021-1.**NEURODEVELOPMENTAL DISORDERS, INCLUDING AUTISM SPECTRUM DISORDER, INTELLECTUAL DEVELOPMENTAL DISORDER AND LEARNING DISORDER**

Presenter: Susan E. Swedo, M.D.

SUMMARY:

The diagnosis of neurodevelopmental disorders can be difficult, due to the dependence on retrospective information and secondparty informants, overlapping clinical presentations, and the presence of confounding medical conditions. The task is made more difficult by the lack of criteria sensitive to gender, age and developmental stage. The DSMIV Pervasive Developmental Disorders (PDD), which include autism, PDDNOS and Asperger Disorder, have proven particularly problematic in this regard with the majority of cases receiving an NOS diagnosis, resulting in a very heterogeneous group of affected individuals. The heterogeneity creates difficulties for clinicians and educators who are attempting to standardize therapeutic interventions, as well as for researchers who require homogeneity to separate signal from noise. The criteria for intellectual developmental disorder (mental retardation in DSMIV), communication disorders and learning disabilities have also been found lacking and are often inconsistent with those used by other disciplines. The Neurodevelopmental (ND) workgroup is a multidisciplinary committee comprised of 12 experts in the fields of psychiatry, neurology, psychology, pediatrics and speech/language pathology. The ND workgroup collaborates closely with the other DSM5 workgroups and particularly with the Childhood and Adolescent Disorders Workgroup (chaired by Daniel Pine) and the Disruptive Behavior Disorders Workgroup (cochaired by Xavier Castellanos and David Shaffer). The efforts of the

ND Workgroup are informed by expert knowledge, literature review and secondary data analyses, consultation with selected advisors, and presentation of proposed changes to potential users. The recommendations for DSM5 criteria for Autism Spectrum Disorder (ASD) will be finalized after receipt of the data being collected in field trials currently underway. Updates on any changes to the published ASD diagnostic criteria will be presented, as will the changes being recommended for the neurodevelopmental disorders: 1) Improving diagnostic specificity for the autism spectrum disorder (ASD) by utilizing a dimensional approach to symptom classification 2) Removing Rett disorder as a specific diagnosis 3) Incorporating Childhood Disintegrative Disorder and Asperger Disorder in the diagnostic spectrum of autistic disorders 4) Providing modifiers for age, developmental stage, gender and cultural background 5) Defi

S021-2.

THE DEVELOPMENTAL PERSPECTIVE AND DSM5

Presenter: Daniel Pine, M.D.

SUMMARY:

Considerable research has been conducted on developmental aspects of mental disorders. While these findings have led to many changes in the manner in which psychopathology is viewed, the findings have not been incorporated into current nosology. Dr. Pine's presentation will review three major issues pertinent to this research as it has shaped broad views of DSM5. In the first part of his presentation, Dr. Pine will review the major findings on developmental aspects of mental disorder since the publication of DSMIV. This review will focus on aspects of research that were weighed most heavily in thinking about changes to DSM5. In the second part of his presentation, Dr. Pine will review broad changes in the conceptualization of development between DSMIV and DSM5. This will review the rationale for the either retaining or eliminating a category for disorders first evident in childhood as well as the rationale for creating specific subtypes of pediatric conditions. In the final part of his presentation, Dr. Pine will review data that have informed the creation of new disorders. This will focus most deeply on issues related to bipolar disorder.

S021-3.

DEVELOPMENTAL CONSIDERATIONS: LOOKING FORWARD AND LOOKING BACK

Presenter: David Shaffer, M.D.

SUMMARY:

The orientation of the general psychiatrist to development is to look back to find precursors and exposures associated

with the adult disorder. The child psychiatrist looks forward to longitudinal studies to better understand the frequently nonspecific behaviors and words of a child that might more closely resemble a projective test than the pathognomic descriptions and utterances found in adults. DSM5 has benefitted from a long interval since DSMIV, during which time a number of followup studies have been conducted that have given new insight into childhood disorders. These have resulted in changes in DSM5 that will be reviewed, with particular focus on ADHD, CD, and ODD.

S021-4.

EVOLUTION OF A NEW MODEL OF PERSONALITY DISORDERS FOR DSM5

Presenter: Andrew E. Skodol, M.D.

SUMMARY:

The Personality and Personality Disorders Work Group has continued its efforts to address the many problems with DSMIV's exclusively categorical approach to personality disorders (PDs) (e.g., excessive comorbidity, within-diagnosis heterogeneity, arbitrary diagnostic thresholds, limited coverage, etc.). It is evident that the consensus in the field for some time has been that a significant change is warranted. Calls for a more dimensional approach to personality pathology have been made almost since the publication of DSMIII, and the development of a hybrid model combining aspects of categories and dimensions was suggested even before the publication of DSMIV. The current model is such a hybrid, combining two dimensional ratings – one of impairment in core functions of personality and the other of pathological personality traits – to make categorical diagnoses of six specific DSMIV PDs and a category of PD trait specified (PDTS), which captures all other PD variations. All patients with PDs, whether diagnosed as a specific type or not, can now be described with precise information about both personality functioning and pathological traits. The model reflects a balance between research evidence and clinical experience. The model has evolved in response to feedback from numerous experts, the general community of clinicians and researchers who have responded to the earlier versions, and the members of the DSM5 Task Force. The currently proposed model is much simpler than the preceding ones, requiring essentially the two assessments – of personality functioning and of a maximum of 25 traits (but only 2 to 7 for the specific types) – along with 3 other criteria very similar to their DSMIV counterparts to arrive at any PD diagnosis. Moreover, the number of specific types to be considered remains fewer than in DSMIV. Additional traits can be assessed if they capture important clinical heterogeneity, relevant to treatment or prognosis for example. Furthermore, diagnostic criteria, applicable to both clinical and research purposes, have been reinstated in the

revised DSM5 PD proposal. This presentation will review the current status of the personality disorders as proposed for DSM5, including the rationales for the changes, and available data from the APA sponsored and conducted Field Trials.

S021-5.

NEUROCOGNITIVE DISORDERS

Presenter: Ronald Petersen, M.D., Ph.D.

SUMMARY:

The work group for the diagnostic criteria for Neurocognitive Disorders (NCD) has proposed a new scheme for classifying cognitive disorders for DSM5. The basic approach involves a syndromic characterization of the disorder with subsequent assignment of presumed etiology. The initial classification of the disorders includes two levels of impairment: Mild NCD and Major NCD. Mild NCD characterizes individuals with a degree of cognitive impairment, e.g., 1 SD below expected performance using appropriate normative data if available, involving one or more cognitive domains to a degree that is not normal for age but does not meet criteria for Major NCD (dementia). This level of performance must represent a change for the person and the individuals must maintain their functional independence. These persons have been classified as having mild cognitive impairment in some classification schemes such as that for Alzheimer's disease. Major NCD is similar to the previous diagnosis of dementia and includes a more severe degree of cognitive impairment in one or more domains, typically in the 2 SD range of performance using appropriate normative data if available. These individuals are dependent upon others for their daily function and have lost independence. When the syndromic characterization of Mild or Major NCD has been made, a suitable judgment regarding the etiology is made using clinical information and testing available. For example, specific criteria for the NCD's due to Alzheimer's disease, frontotemporal degeneration, dementia with Lewy bodies, vascular cognitive impairment, Huntington disease, HIV/AIDS, traumatic brain injury or other causes will be described. Examples of the application of these proposed criteria to the field of Alzheimer's disease will be discussed. In particular, the role of neuroimaging and fluid biomarkers will be covered with respect to the new international criteria for these disorders recently published. Gaps in knowledge will be discussed and plans for updating the criteria in the future will be explored.

SYMPOSIUM 022

THE CONTRIBUTIONS OF BRAIN IMAGING TO THE STUDY OF PSYCHOSIS

Chair: Raquel E. Gur, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the application of brain imaging to the study of psychosis, 2) Demonstrate knowledge of the measures applied in the study of brain and behavior, 3) Demonstrate knowledge of the implications for diagnosis and treatment

SUMMARY:

Brain imaging is widely applied in the study of psychosis aiming to elucidate the nature and extent of brain dysfunction. Progress in the field has enabled to address fundamental questions applying diverse approaches and experimental designs. The symposium will review and discuss recent progress pertinent to the study of brain and behavior including comparative studies of schizophrenia and bipolar disorders and studies of psychosis prone individuals. Dr. Matcheri Keshavan will present neuroimaging data from the Bipolar Schizophrenia Network for Intermediate Phenotypes suggesting common and unique differences between schizophrenia and psychotic bipolar disorders. Dr. Cameron Carter will present studies on cognitive and emotional underpinnings of cognitive disorganization and negative symptoms and the alterations in neural circuitry that lead to these deficits in schizophrenia and psychosis risk states. Dr. Larry Siedman will present data showing that abnormalities are present in fMRI processing of both working memory and longer term declarative verbal memory in the psychosis prodrome. Dr. Raquel Gur will present data showing a similar pattern of neurobehavioral and neuroimaging dysfunction in psychosis prone and in individuals with schizophrenia. We will discuss implications for the classification of psychoses into schizophrenia and psychotic bipolar disorder, underlying brain circuitry, aberrations in brain development and treatment approaches.

S022-1.

THE KRAEPELINIAN SCHIZOPHRENIA-BIPOLAR DISORDER DIVIDE: WHAT DO THE NEUROIMAGING STUDIES TELL US?

Presenter: Matcheri S. Keshavan, M.D.

SUMMARY:

The classification of psychoses into schizophrenia and psychotic bipolar disorder as distinct disorders, originally proposed by Emil Kraepelin, has survived for over a century. This dichotomy, however, has been brought into question in recent years by the observations of a considerable overlap between these two disorders in phenomenology, neurobiology, treatment response and in the susceptibility

genes. In this paper, I will review the current literature on the unique vs. common features of these disorders, with specific reference to findings from neuroimaging studies. This body of knowledge will be examined in context of neuroimaging observations from our ongoing Bipolar Schizophrenia Network for Intermediate Phenotypes (BSNIP) study. Our interim data (total n= ~1000) suggest structural alterations common to these disorders that quantitatively vary across these disorders, with schizophrenia showing the most extreme changes and psychotic bipolar disorder being intermediate relative to controls. However, alterations that uniquely characterize these disorders are also seen. It is proposed that the neurobiology of psychotic spectrum disorders might not fit well with categorical distinctions, but are better represented by a dimensional continuum that may cut across traditional DSM diagnostic entities.

S022-2.

UNDERSTANDING AND TREATING IMPAIRED COGNITION AND EMOTION IN SCHIZOPHRENIA

Presenter: Cameron S. Carter, M.D.

SUMMARY:

During the onset of schizophrenia individuals with this disorder typically undergo a functional decline that is associated with the emergence of cognitive deficits and negative symptoms. Unlike the positive symptoms of psychosis these deficits do not improve with antipsychotic medications, and their negative impact of patients' functioning remains one of the most vexing challenges for clinicians. We will present results using functional neuroimaging and cognitive EEG in people with schizophrenia that seek to increase our understanding of the cognitive and emotional underpinnings of cognitive disorganization and negative symptoms and the alterations in neural circuitry that lead to these deficits. Across a series of studies of patients in the early phases of the illness, including those with subthreshold psychosis risk states, we have observed disruptions in circuits which depend upon the integrative (cognitive control) functions of the prefrontal cortex (PFC) that emerge during the transition to psychosis and remain stable during the first couple of years of the onset of schizophrenia. These alterations in neurophysiology are expressed as impairments across a range of cognitive domains (working memory, attention, language processing) as well as forms of emotional processing and are associated with symptoms of behavioral disorganization and amotivation, as well as global measures of functioning. Post mortem studies have suggested alterations in the balance between inhibitory and excitatory elements in the PFC in schizophrenia and consistent with this oscillatory activity during cognitive control is reduced in the illness. Pharmacological, neurostimulation and cognitive training approaches that may improve cognitive and emo-

tional processing and the associated disorganization and negative symptoms in schizophrenia will be discussed.

S022-3.

ALTERATIONS IN WORKING AND DECLARATIVE MEMORY CIRCUITRY IN THE PSYCHOSIS PRODROME

Presenter: Larry J. Seidman, Ph.D.

SUMMARY:

Background: Primary deficits in schizophrenia (SCZ) include working and longterm memory. It is critical to understand how the neural circuitry underlying these functions goes awry and at what point in the illness. We evaluate whether the primary brain regions implicated in memory functions (dorsolateral PFC (DLPFC), anterior cingulate gyrus (ACG), hippocampus (HIPP), parahippocampus (PARAHIPP), and parietal cortex (PAR)) that are abnormal in patients with SCZ, are present prior to psychosis onset ("prodrome") and how the neural circuits are altered as they carry out these cognitive functions. Methods: Subjects are 35 prodromal participants (PRO) and 35 healthy controls. Groups are comparable on sex, age, handedness, and ethnicity. Structural and functional MRI (fMRI) scans were acquired on a Siemens 3T magnet. Visual 2back vs 0back working memory tasks and a verbal encoding task were used in fMRI. SPM8 was used to analyze fMRI data, with a focus on the anatomically defined regions of interest (ROIs). Results: Analyses are ongoing. To this date using the first half of the sample, despite comparable performance on tasks in PRO vs. controls, significant alterations in functional activity were observed in PARHIPP and DLPFC, and PAR in response to the 2back task, while the verbal encoding task elicited alterations in PARAHIPP, DLPFC, and ACG. Conclusions: Abnormalities are present in fMRI processing of both working memory and longerterm declarative verbal memory in the psychosis prodrome, indicating preillness developmental deficits. Findings will be linked with levels of symptoms and other aspects relevant to conversion to psychosis.

S022-4.

BRAIN FUNCTION IN PSYCHOSISPRONE YOUTH AND SCHIZOPHRENIA

Presenter: Raquel E. Gur, M.D., Ph.D.

SUMMARY:

A growing body of scientific evidence suggests that severe mental illnesses are disorders of brain development that are already emerging by adolescence. The onset of psychosis is commonly preceded by diverse and nonspecific changes in

behavior and functional capacity, that can be difficult to distinguish from the common tribulations of adolescence and that occur over time periods that differ across individuals. We have applied complementary lines of research in order to examine cognitive and emotion processing in young people who also participated in a brain imaging study. A large population based study compared youths who endorsed psychotic symptoms to typically developing participants. The psychosis prone group showed impaired performance in executive and emotion processing measures, similar to those seen in individual with schizophrenia. Furthermore, structural MRI showed decrease in brain volume and fMRI indicated abnormal activation in frontotemporal brain systems related to performance on neurobehavioral probes of working memory and emotion identification. The pattern of brain dysfunction evident in psychosis prone youths is similar to that observed in people with schizophrenia and suggests that aberrations in brain development are evident before clinical presentation.

SYMPOSIUM 023

ADVANCES IN THE ASSESSMENT AND TREATMENT OF NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

SUMMARY:

By many measures, negative symptoms of schizophrenia are a major cause of functional disability in schizophrenia. Symptoms such as alogia, apathy, amotivation, avolition, flat or blunted affect, and asociality persist even when the psychotic symptoms (delusions, hallucinations, and formal thought disorder) subside with antipsychotic medications. Negative symptoms are an enduring domain of the complex psychopathology of schizophrenia and have continued to be a challenge to researchers and clinicians alike. Many believe that restoration of social and vocational functioning in schizophrenia will ultimately be linked to progress in reversing or at least ameliorating the persistent negative symptoms that afflict a majority of persons suffering from this devastating psychiatric brain disorder. However, progress is being made on several fronts and this symposium is designed to update attendees about recent advances in the recognition, measurement, and neuropharmacological approaches, (past and present) to the treatment of negative symptoms. The first presenter Dr. Nasrallah, will outline and compare the primary enduring vs. the secondary (reversible) negative symptoms and describe the various iatrogenic causes of secondary negative symptoms or those elicited by psychiatric or physical comorbid conditions. Dr. Blanchard will describe the various rating scales that have been used to measure the severity of negative symptoms including a recent NIMH sponsored project to develop a new assessment tool. Dr. William Horan will discuss the

evidence for linking negative symptoms with functional disability. Dr. Lindenmayer will then present a comprehensive overview of past and current pharmacologic interventions to treat negative symptoms. Finally, Dr. Lasser will present fresh data from a recently completed FDA study of a stimulant (Lisdexamfetamine Dimesylate Risdex amphetamine dimesylate), in the treatment of prominent negative symptoms of schizophrenia. The discussant, Dr. Buckley, will synthesize the data presented by the faculty and delineate the remaining gaps in the assessment and treatment of negative symptoms.

S023-1

ASSESSMENT TOOLS TO MEASURE NEGATIVE SYMPTOMS: CURRENT STATUS AND FUTURE PROSPECTS

Jack Blanchard Ph.D.

SUMMARY:

Negative symptoms in schizophrenia are related to functional impairment, persist over time, and respond poorly to current medications. Unfortunately, progress in the development of new treatments for the negative symptoms of schizophrenia may be impeded by limitations of available assessment instruments. Current instruments to assess negative symptoms will be briefly summarized with a focus on both the contributions as well as the limitations of these measures. Recent advances in the measurement of negative symptoms will be highlighted including the NIMH-funded Collaboration to Advance Negative Symptom Assessment in Schizophrenia (CANSAS). CANSAS is a multi-site project that is intended to develop and validate a next-generation clinical rating scale for negative symptoms using a transparent, iterative, and data-driven process. This new scale, the Clinical Assessment Interview for Negative Symptoms (CAINS), was designed to thoroughly assess all aspects of negative symptoms including both experiential (anhedonia, avolition, asociality) and expressive (blunted affect, alogia) deficits. Results from two multi-site studies of the CAINS, based on over 420 patients, will be summarized including data on inter-rater agreement and initial convergent and discriminant validity. General recommendations for the assessment negative symptoms will be highlighted and directions of future clinical research will be summarized.

S023-2

FUNCTIONAL DISABILITY ASSOCIATED WITH NEGATIVE SYMPTOMS

William Horan Ph.D.

SUMMARY:

Poor functional outcome is a hallmark of schizophrenia. Recovery-oriented treatments aim to identify key determinants of poor functioning and develop novel interventions that target them. Substantial evidence indicates that negative symptoms show reliable cross-sectional and longitudinal associations with various measures of poor functional outcome. These outcome measures commonly include indexes of work, independent living, and social functioning. This presentation will provide an overview of research documenting linkages between negative symptoms and poor outcome across prodromal, recent-onset, and chronic stages of schizophrenia. The presentation will also describe findings from two approaches that our group and others have recently used to clarify how negative symptoms contribute to poor outcome. The first seeks to identify inter-relations between specific facets of negative symptoms (expression and experience-related symptoms) and functional outcome (e.g., functional capacity versus attainment). The second uses statistical modeling techniques to evaluate how negative symptoms interact with other established predictors of outcome, including neurocognition and social cognition, to impact community functioning. Converging findings indicate that negative symptoms are an important treatment target for reducing functional disability.

S023-3

REVIEW OF PHARMACOLOGICAL STRATEGIES IN THE TREATMENT OF NEGATIVE SYMPTOMS

Jean-Pierre Lindenmayer M.D.

SUMMARY:

This presentation will review pharmacological strategies for negative symptoms in schizophrenia. Both first generation and second generation antipsychotic agents appear not to be very effective in ameliorating negative symptoms. Hence, a number of augmentation strategies have been explored using various underlying mechanisms of action. The addition of antidepressants to antipsychotic medication was found in two meta-analyses to show benefits over placebo addition. Data, however, remain too limited to make definitive statements regarding their efficacy. To remediate GABA deficits in the PFC, the use of GABA agonists with affinity for the $\alpha 2$ subunit of the receptor has been proposed, with modest results so far. Ampakines and other molecules that increase glutamate at AMPA receptors such as glycine and D-cycloserine, have shown some efficacy, but results appear inconsistent across studies. There may be a potential therapeutic role for nicotinic agonists, with limited data so far. Given the proposed role of dopamine in the PFC in

the pathogenesis of negative symptoms in schizophrenia, dopamine agonists that either directly or indirectly activate D1 or D2 receptors have been hypothesized to improve these symptoms. In particular, the role of psychostimulants has been explored some years ago, but has received less attention as patients with schizophrenia appear to be more sensitive to their psychotogenic effects. However, the risk of a psychotogenic response is determined by clinical state, dosing and concomitant antipsychotic treatment. Given that amphetamines may improve cortical hypodopaminergic states, recent treatment data in patients with stable negative symptoms will be demonstrated.

S023-4

COMBINING LISDEXAMFETAMINE DIMESYLATE WITH ANTIPSYCHOTIC MEDICATIONS FOR THE TREATMENT OF PREDOMINANT NEGATIVE SYMPTOMS OF CHRONIC SCHIZOPHRENIA

Robert Lasser M.D.

SUMMARY:

Background: Effective treatments are needed for the negative symptoms of schizophrenia (NSS), putatively associated with low mesocortical dopamine activity. While amphetamines are known to be dopamine agonists, and can theoretically improve negative symptoms, controlled trials in NSS are lacking due to concerns about possible exacerbation of psychosis. This multicenter study examined adjunctive treatment with lisdexamfetamine dimesylate (LDX), a d-amphetamine prodrug, in a cohort of adults with stable schizophrenia (≥ 2 years), predominant NSS and maintained on stable atypical antipsychotics. Methods: Consenting participants received open-label (OL) adjunctive LDX for 10 weeks, followed by 4 weeks double-blind randomized withdrawal (RW). Participants received 20 mg/d LDX for the first 2 weeks with weekly, incremental (10 mg/wk to maximum 70 mg/d) adjustments based on clinical response and tolerability. Efficacy measures included modified SANS-18 (global and attention items removed) and SANS Global items, a composite of 25 SANS items (SANS-25), PANSS total and subscales. Safety evaluations included treatment-emergent adverse events (TEAEs), vital signs, and Calgary Depression Scale for Schizophrenia (CDSS). Withdrawal criteria included $\geq 25\%$ increase in PANSS total or ≥ 2 -point increase on selected positive items at 2 consecutive visits, increase in suicidal ideations, or positive drug screen. Data are presented for 92 participants receiving OL LDX; 69 entered RW to continue LDX ($n=34$) or placebo ($n=35$). Results: At baseline, mean (SD) SANS-18 score was 60.2 (4.36). Mean change (95% confidence interval [CI]; weeks 0-10 OL) was -12.9 (-15.0, -10.8) (primary endpoint; $P<.0001$). 52.9% were SANS-18 responders ($\geq 20\%$ reduction from baseline). All SANS Global items,

SANS-25, and PANSS total scores showed significant decreases ($P < .0001$ for each). PANSS positive scores decreased slightly by mean (95% CI) of -1.0 (-1.4, -0.5). During RW, no differences between LDX and placebo in negative or positive symptoms were seen. Small mean changes in BP and pulse were noted. There was no meaningful change in CDSS throughout the trial. In OL, common TEAEs $\geq 5\%$ were headache, decreased appetite, insomnia, dizziness, dry mouth, and diarrhea. 3.3% of participants had serious TEAEs and 5.4% of participants discontinued due to TEAEs in OL phase. By SANS and PANSS negative scores, NSS significantly decreased and PANSS total score improved with OL LDX without positive symptom worsening. There was no overall symptom worsening with abrupt LDX discontinuation during placebo treatment. Conclusions: The dopamine agonist, LDX, may be safely administered to improve prominent negative symptoms in carefully selected patients with clinically stable schizophrenia. Confirmation with larger, controlled trials is needed.

S023-5

DISTINGUISHING THE PRIMARY (ENDURING) FROM THE SECONDARY (REVERSIBLE) NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Henry Nasrallah M.D.

SUMMARY:

In contrast to the positive (psychotic) symptoms of schizophrenia, which can be treated with antipsychotic medications, the negative symptoms have no available treatments yet. This has important implications for the long-term outcome of schizophrenia because the negative symptoms (along with the cognitive deficits), account for the functional disability associated with this serious psychiatric brain disorder. Negative symptoms such as impoverishment of thoughts and speech (alogia), inability to initiate action (avolition), lack of drive (amotivation) inability to express appropriated facial expressions (flat or incongruous affect), and lack of pleasure (anhedonia), collectively impair that patient's ability to carry out productive, social, or vocational activities. Discovering effective treatments to reverse or at least mitigate negative symptoms is one of the major unmet needs in schizophrenia. However, not all negative symptoms are enduring. There are several secondary negative symptoms that are treatable or preventable. The following are some of the causes of secondary negative symptoms:

1. Psychosis can exacerbate social withdrawal and reduce verbal communications, which improve when paranoia or hallucinations are suppressed with antipsychotic drugs.
2. Excessive dopamine D2 receptors (higher than 78%) with antipsychotics has been shown to cause iatrogenic Parkinsonism symptoms which includes blunted facial expression,

apathy, and anhedonia. Those secondary negative symptoms can be reversed by lowering the antipsychotic dose.

3. Depression whose symptoms include restricted affect, apathy, and anhedonia clinically resemble primary negative symptoms, is a frequent comorbidity in schizophrenia. Treating depression can reverse those secondary symptoms associated with depression.
4. Co-existing PTSD often co-occur with schizophrenia and its symptoms of withdrawal and blunting can mimic negative symptoms.
5. Obstructive sleep apnea is a frequent complication of obesity, which afflicts many patients with schizophrenia. Its symptoms of excessive daytime sleepiness, apathy, and inactivity can be misconstrued as negative symptoms. In conclusions, the assessment of negative symptoms must include a careful evaluation of the presence of secondary negative symptoms. This is important for research involving drug treatment of the primary negative symptoms.

SYMPOSIUM 024

PATIENT SUICIDE IN RESIDENCY TRAINING

Co-Chairs: Meredith A. Kelly, M.D., Joan M. Anzia, M.D.

Discussant: Edward R. Shapiro, 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 commits 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, more than 33,000 suicides occurred in the U.S in 2006. Studies estimate that 2068% 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 commits suicide. We believe this lack of discussion interferes with the use of positive coping strate-

gies 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 a brief introduction, the symposium will begin with a psychiatry resident sharing her feelings and experience after her patient committed suicide. Second, a residency training director will discuss the challenges in educating trainees about the impact of patient suicide. She will show a video for residents of a psychiatrist supervisor discussing his own experience of patient suicide. Breakout sessions led by panelists will follow, allowing for sharing of experiences with patient suicide among audience participants. Two attending psychiatrists will then share their experiences of developing a support system for other residents during their own training, and the strategies they use now as supervisors. Next, another residency training director will discuss the collaborative project of making the training video of residents and faculty discussing patient suicide shown earlier; he will present data from the pilot study of the video in use. The last presenter will be a psychiatrist and medical director/CEO of a large psychiatric institution, who will discuss the challenges and goals in helping the clinical community address and process a patient suicide. The symposium will have a second breakout session to discuss interventions to help residents deal with patient suicide in their own training programs. Finally, there will be sharing of the group discussions by reporters.

S024-1.**RESIDENT EXPERIENCE OF PATIENT SUICIDE**

Presenter: UyenKhanh QuangDang, M.D.

SUMMARY:

Following a brief introduction, the symposium will begin with my experience, as a resident physician, of having a patient who had been under my care commit suicide. I will give a brief presentation on the patient's history and hospital course, and discuss the aspects of the case that stood out to me as well as the treatment team. I will also discuss what it was like to learn of the patient's suicide and how it affected me in the shortterm as well as in the longerterm. I will finish by discussing the lessons I have drawn from this experience, which apply to working with suicidal patients in particular and how it has affected my understanding of patients' suffering in general.

S024-2.**HOW "COLLATERAL DAMAGE: THE PSYCHIATRIST'S RESPONSE TO SUICIDE" CAME ABOUT AND WHAT IT IS SUPPOSE TO PROVIDE**

Presenter: James Lomax, M.D.

SUMMARY:

Patient suicide is one of the most stressful times in the psychiatrist's professional life in addition to being a huge tragedy for the individual who completes suicide and the family and loved ones who are "survivors." Each of the psychiatrists who contributed to the development of this DVD have had the experience of a patient suicide and had to manage the experience without a great deal of preexisting support. The sense of being a failure, being deeply ashamed, and experiencing a stigmatized isolation is very prominent. Without adequate support, this can lead to enormous selfdoubt and a very unhelpful retreat from patients. The DVD consists of "clinical stories of suicide" that share information about the patient, the psychiatrist, and the "postvention stage" of suicide care. The DVD also includes a panel discussion of the professionals involved and what can be learned from suicide that may enable professional growth at a difficult point in time. After an introduction to the development of the DVD, Dr. Lomax will show the DVD and facilitate a discussion of it and observations about it in the audience. Lomax, JW: "A Proposed Curriculum on Suicide Care for Psychiatry Residency," in *Suicide and Life Threatening Behavior*, Vol. 16(1), pp. 5664, Spring, 1986. Bongar, B, Lomax, JW, Marmatz, M: "Training and Supervisory Issues in the Assessment and Management of the Suicidal Patient," in *Suicide: Guidelines for Assessment, Management & Treatment* Ed: Bruce Bongar. Oxford University Press, Inc., 1992.

S024-3.**PATIENT SUICIDE IN RESIDENCY TRAINING**

Presenter: Christina V. Mangurian, M.D.

SUMMARY:

According to the Centers for Disease Control and Prevention, more than 33,000 suicides occurred in the U.S in 2006. Studies estimate that 2068% 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 commits 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 a brief introduction, the symposium will begin with a psychiatry resident sharing her feelings and experience after her patient committed suicide. Second, a residency training director will

discuss the challenges in educating trainees about the impact of patient suicide. She will show a video for residents of a psychiatrist supervisor discussing his own experience of patient suicide. Breakout sessions led by panelists will follow, allowing for sharing of experiences with patient suicide among audience participants. Two attending psychiatrists will then share their experiences of developing a support system for other residents during their own training, and the strategies they use now as supervisors. Next, another residency training director will discuss the collaborative project of making the training video of residents and faculty discussing patient suicide shown earlier; he will present data from the pilot study of the video in use. The last presenter will be a psychiatrist and medical director/CEO of a large psychiatric institution, who will discuss the challenges and goals in helping the clinical community address and process a patient suicide. The symposium will have a second breakout session to discuss interventions to help residents deal with patient suicide in their own training programs. Finally, there will be sharing of the group discussions by reporters.

S024-4.

INSTITUTIONAL RESPONSES TO PATIENT SUICIDE: THE UCSF MODEL

Presenter: Andrew Booty, M.D.

SUMMARY:

This part of the symposium will address the way in which patient suicides are handled at UCSF, including but not limited to an annual suicide symposium as well as individual interventions after an incident takes place.

SYMPOSIUM 025

CAN MAJOR DEPRESSION BE PREVENTED? NEW INSIGHTS FROM BASIC AND CLINICAL STUDIES

Co-Chairs: Alan F. Schatzberg, M.D., Ned H. Kalin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the risk factors for depression, 2) Demonstrate knowledge of possible approaches for improving stress resilience in primate models, 3) Demonstrate knowledge of strategies for improving cognitive function

SUMMARY:

In recent years, considerable data have emerged regarding specific risk factors for depression, including early abuse and genetic variation. These observations allow for possible early diagnosis of risk as well as for interventions to

prevent the development of depression or related anxiety disorders. However, what the optimal interventions might be and when they can be applied are only now beginning to emerge. This symposium presents data from 4 different approaches to the problem. Ned Kalin presents on a large cohort of rhesus monkeys that have been assessed for relative degrees of anxiety – like behavior in response to stranger intrusion. The model has yielded a number of candidate genes that account for variation in anxious reactions to stranger intrusions. Alan schatzberg discusses data from a squirrel monkey study in which timelimited separations from mothers early in life are associated with enhanced brain development, improved cognition, and greater ability to handle stress in adult life. Ian gotlib presents data on the use of attentional bias training and realtime neurofeedback to prevent depression in young nondepressed children of mothers with a history of recurrent depressive episodes. Last, charles nemeroff discusses prevention of depression in – as well treatment approaches to – subjects with a history of early child abuse who are at increased risk for developing depression in adulthood. Emphasis in all the talks is placed on understanding how recent research could lead to improved strategies for preventing major depression.

S025-1.

USING THE NONHUMAN PRIMATE DEVELOPMENTAL MODEL OF ANXIOUS TEMPERAMENT TO CONCEPTUALIZE NEW APPROACHES TO EARLY INTERVENTIONS

Presenter: Ned H. Kalin, M.D.

SUMMARY:

Anxious temperament can be identified early in life and is a robust predictor of the later development of anxiety disorders, depression and co morbid substance abuse. We have developed a developmental model of anxious temperament in young rhesus monkeys that has allowed us to determine the influences of genetic variation on the expression of this risk phenotype and its underlying brain substrate. In addition, using transcriptome analyses we have identified alterations in gene expression that provide clues about new treatment targets. Data will be presented focusing on how this new information can be used to guide the investigation of novel treatment strategies in children who are at risk to develop anxiety and affective disorders. In recent years, considerable data have emerged regarding specific risk factors for depression, including early abuse and genetic variation. These observations allow for possible early diagnosis of risk as well as for interventions to prevent the development of depression or related anxiety disorders. However, what the optimal interventions might be and when they can be applied are only now beginning to emerge. This symposium presents data from 4 different approaches to the problem.

Ned Kalin presents on a large cohort of rhesus monkeys that have been assessed for relative degrees of anxiety like behavior in response to stranger intrusion. The model has yielded a number of candidate genes that account for variation in anxious reactions to stranger intrusions. Alan Schatzberg discusses data from a squirrel monkey study in which timelimited separations from mothers early in life are associated with enhanced brain development, improved cognition, and greater ability to handle stress in adult life. Ian Gotlib presents data on the use of cognitive training to prevent depression in nondepressed children of depressed mothers who are carriers of the short form of the serotonin transporter. Last, Charles Nemeroff discusses prevention of depression as well treatment approaches to subjects with a history of early child abuse who are at increased risk for developing depression in adulthood. Emphasis in all the talks is placed on understanding how recent research could lead to improved strategies for preventing major depression.

S025-2.

STRESS INOCULATION AND RESILIENCE IN A PRIMATE MODEL

Presenter: Alan F. Schatzberg, M.D.

SUMMARY:

Data from our group in squirrel monkeys indicate that although hippocampal volume and stress responsiveness have large heritable components, environmental factors still play crucial roles in adaptability to stress. We present data from a series of studies that have explored different rearing experiences of mother-infant dyads. In our studies we have explored the relative effects of three conditions to which mothers and infants are exposed: a control non stress group; a mild stressor group where mothers, who are rearing infants, need to forage for food; and a group where the potential stress is intermittently separating infants for a few hours per week from their mothers. We have followed the monkeys through adolescence. Monkeys exposed to intermittent separations demonstrated enhanced prefrontal development on MRI, greater performance on cognitive testing, and enhanced ability to deal with physical stress in adulthood. These data point to potential approaches in infant rearing to improve stress coping into adulthood. Clinical implications are discussed.

S025-3.

PREVENTING THE ONSET OF DEPRESSION IN HIGH-RISK CHILDREN: A NOVEL EXPERIMENTAL APPROACH

Presenter: Ian Gotlib, Ph.D.

SUMMARY:

Clinically significant depression is among the most prevalent and costly of all psychiatric disorders. In an effort to elucidate mechanisms underlying high familial risk for depression, we have been conducting a large-scale study examining psychological and neural characteristics of young never-disordered girls whose mothers have a history of recurrent depressive episodes. We estimate that approximately half of these girls will themselves develop an episode of major depression. Indeed, the results of our study indicate not only that high-risk girls are characterized by selective attention to negative stimuli, increased cortisol secretion in response to a laboratory stressor, and increased levels of reactivity in the salience network (SN) of the brain, but further, that this psychobiological reactivity is predicting onset of depression in those girls who have already developed a depressive episode. Consequently, in a new sample of high-risk children, we are testing the ability of attention bias training (ABT) and real-time neurofeedback (NFT) to delay or prevent the subsequent onset of depression. Children will receive either (ABT), in which they are trained to attend selectively to positive stimuli and to avoid attending to negative stimuli, or NFT, in which they learn to reduce activation in the SN during viewing of negative stimuli. Each form of intervention also has a matched control condition. Preliminary data are exciting: compared with children in the control conditions, children who receive veridical attentional or neurofeedback training exhibit lower levels of psychophysical and affective reactivity to a laboratory stressor following the training than they did before the training. I will discuss implications of these findings for the prevention of depression.

S025-4.

THE NEUROBIOLOGY OF CHILD ABUSE AND NEGLECT: IMPACT ON THE PATHOPHYSIOLOGY AND TREATMENT OF MOOD DISORDERS

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

SUMMARY:

We summarize the genetic, brain imaging and neurotransmitter studies that have revealed the long-term consequences of child abuse and neglect and how these changes increase vulnerability to mood disorders in adulthood. Exposure to interpersonal trauma during childhood increases the risk of certain psychiatric disorders beyond the risk associated with adult violence exposure. In particular, alterations in the hypothalamic-pituitary-adrenal (HPA) axis, a major mediator of the stress response, contribute to the long-standing effects of early life trauma. However, not all exposed individuals demonstrate altered HPA axis physiology, suggesting that genetic variations influence the psychiatric consequences of trauma exposure. Variants in the gene encoding the CRF(1) receptor interact with adverse environmental factors to

predict risk for stress-related psychiatric disorders. Studies of the CRF system have thus suggested molecular targets for new drug development, biological risk factors, and predictors of treatment response. In addition, the effect of abuse may extend beyond the immediate victim into sequent generations as a consequence of epigenetic effects transmitted directly to offspring and/or behavioral changes in affected individuals. Recognition of the biological consequences and transgenerational impact of trauma has critical importance for both treatment research and public health policy.

SYMPOSIUM 026

BIPOLAR DISORDER: STATE OF THE ART TREATMENTS

Chair: Michael Gitlin, M.D.

Discussant: Mark Frye, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Know the most current data on optimal treatment for each phase of bipolar disorder, 2) Understand the place of psychotherapy in the treatment of bipolar disorder, 3) Be aware of the subtypes of bipolar disorder that may present specific challenges

SUMMARY:

Over the last decade, more controlled studies on the treatment of bipolar disorder have emerged compared to the forty previous years. This symposium will review the state of the art treatment for bipolar disorder separated by phase and type of treatment. For acute mania, antipsychotics, lithium and valproate are all effective. Combinations of an antipsychotic with a classic mood stabilizer may provide greater efficacy. For bipolar depression, some (but not all) antipsychotics and anticonvulsants also show efficacy in treating bipolar disorder. A central controversy in bipolar depression surrounds the use of antidepressants, both as to their efficacy and their liability for precipitating hypomanic/manic episodes. Maintenance treatments are virtually mandatory and include lithium, lamotrigine and antipsychotics, both individually and in combination. The design of the maintenance treatment studies has been somewhat controversial and the core design issues will be analyzed. The different types of adjunctive psychotherapy, including family focused treatment, cognitive, behavioral, educational and interpersonal approaches, for which increasing numbers of studies have shown clear efficacy, will be discussed, highlighting both the commonalities and the differences among them. Finally, less classic presentations of bipolar disorder including mixed states and rapid cycling present specific challenges with treatment strategies and will be discussed.

S026-1.

NEW DEVELOPMENTS IN THE TREATMENT OF ACUTE MANIA: CLINICAL AND METHODOLOGICAL ISSUES

Presenter: Roger S. McIntyre, M.D.

SUMMARY:

During the past decade there has been substantial development in the development of pharmacological agents for manic/mixed states. The disparate assortment of agents available invites the need for an empirically based approach to selecting and sequencing therapies in acute mania. Results from available studies as well as conventional meta-analyses and network analyses, indicate that the overall effect size expressed as number needed to treat (NNT) is not identical across agents. Moreover, emerging evidence indicates that antipsychotic agents may offer greater effect sizes when compared to traditional mood stabilizers. Recent studies also suggest that early partial symptomatic improvement (i.e. within 48 hours of treatment exposure) may identify a subpopulation of individuals with high probability for remitting with the index therapy. Conversely, lack of early symptomatic improvement may powerfully predict individuals who are nonremitters obviating the need for exposure to inefficacious agents with adverse event hazards. The presentation herein will review new evidence indicating differential efficacy between agents in acute mania, it will also review recent analyses suggesting early symptomatic improvement has prognostic capability and as well will introduce results from recent analyses evaluating antimanic agents in individuals with the DSMV proposed phenotype of "mania with mixed features."

S026-2.

TREATMENT OPTIONS FOR ACUTE DEPRESSION IN BIPOLAR DISORDER

Presenter: Michael Bauer, M.D., Ph.D.

SUMMARY:

The burden of depression represents the most debilitating dimension for the majority of patients with bipolar disorder and dominates the longterm course of the illness. The purpose of this presentation is to review the evidence base of the available treatment options for bipolar depression assigned to two frequent clinical scenarios. The evidence is largely based on a systematic literature search. All relevant randomized controlled trials were critically evaluated. Overall, the evidence from treatment trials in bipolar depression is relatively sparse compared with the number of controlled trials in unipolar depression and as such the choice of treatment is governed by a multitude of factors.

While clinical trials provide evidence on the efficacy of a certain intervention in a specific population, they cannot necessarily determine which intervention will be optimal for a given patient in a given specific situation. They can however inform the choice of intervention and in particular prevent clinicians from choosing interventions that have been shown to be ineffective. Monitoring of potential unwanted effects and of the appropriateness of treatment can help to effectively balance benefits and risks in individual situations. However, the quality of the assessment and reporting of risks in clinical trials need to be increased to better inform treatment decisions. Scenario A: if a patient with bipolar depression is currently not being treated with a mood stabilizing agent (de novo depression), then quetiapine or alternatively olanzapine are an option, carbamazepine and lamotrigine can be considered. Antidepressants are an option for shortterm use, but whether they are administered as mono or combination treatment with mood stabilizing agents is still controversial. Most clinicians prefer to use antidepressants in combination with an antimanic substance. Scenario B: If a patient is already treated with a mood stabilizing agent (breakthrough depression) once adherence has been confirmed and the dose has been adjusted, lamotrigine is an option in patients on lithium. There is no evidence for further effects of antidepressants in cases where a patient is already receiving a mood stabilizer, however, an additional antidepressant is preferred by most clinicians.

S026-3.**MAINTENANCE TREATMENT OF BIPOLAR DISORDER**

Presenter: Michael Gitlin, M.D.

SUMMARY:

Bipolar disorder is an inherently recurrent disorder, requiring maintenance preventive treatments in the vast majority of patients. The number of effective maintenance treatments for bipolar disorder has markedly increased over the last decade with substantial evidence for second generation antipsychotics and some anticonvulsants. Despite this, the natural history of treated bipolar disorder both in studies and in naturalistically treated samples is characterized by recurrences, some of which are true breakthrough episodes while others may be associated by nonadherence. Because of this, increasing numbers of patients are appropriately treated with multiple medications as a maintenance regimen. For some medications, maintenance treatment has been demonstrated in randomized controlled trials for both monotherapy and in combination with other mood stabilizers. Lithium continues as our most well established maintenance treatment in bipolar disorder with somewhat better efficacy in preventing manias than depressions. Lamotrigine, olanzapine and quetiapine have efficacy in preventing

both manias and depressions, although lamotrigine's efficacy is more robust in preventing depressions, and olanzapine's efficacy greater in preventing manias. Aripiprazole, ziprasidone and risperidone longacting injection all prevent manias, but not depressions. Carbamazepine and oxcarbazepine have weaker data bases in support of their efficacy. Finally, adjunctive psychotherapy shows clear efficacy in preventing mood episodes, hospitalizations and days ill and should be considered for any patient with multiple breakthrough mood episodes despite adequate pharmacotherapy. Despite the number of agents with demonstrated efficacy as maintenance treatments in bipolar disorder, optimal treatment regimens are still a combination of databased therapy in combination with individualized creative treatment algorithms.

S026-4. THE TREATMENT OF COMPLEX BIPOLAR DISORDER

Presenter: Gin Malhi, M.D.

SUMMARY:

Bipolar Disorder is typically viewed as a disorder of two phases, depression and mania though in the last decade there has been an increasing appreciation of maintaining wellness and the importance of prophylaxis. In recent years it has become apparent however that this too is a simplistic view of bipolar disorder and that the illness is far more complex than ever imagined. This presentation will consider the complexities of bipolar disorder. Specifically the treatment of mixed states, rapid cycling, comorbidity with anxiety and substance misuse, and the occurrence of bipolar disorder at the extremes of ages and during pregnancy will be discussed. The presentation will culminate in presenting a schema for considering complex bipolar disorder and its management.

S026-5.**ADJUNCTIVE PSYCHOSOCIAL INTERVENTIONS FOR BIPOLAR DISORDER**

Presenter: David J. Miklowitz, Ph.D.

SUMMARY:

There is increasing evidence for the effectiveness of psychosocial interventions in conjunction with pharmacotherapy for bipolar disorder. This talk will review major trials of psychosocial therapy for the acute and maintenance phases of bipolar disorder. Currently, there is evidence for familyfocused therapy (FFT), interpersonal and social rhythm therapy (IPSRT), and cognitive behavioral therapy (CBT) in the acute stabilization of depressive episodes. In maintenance treatment, there is evidence for FFT, IPSRT, CBT, group psychoeducation, and individual psychoeducation.

The treatments vary in their effects on depressive versus manic symptoms and their relative impact on components of psychosocial functioning. Recent trials find evidence for adjunctive family interventions in children and adolescents with bipolar disorder. Several innovations have been explored in open trials: mindfulnessbased treatments, individual psychoeducation with electronic mood monitoring, and cognitive rehabilitation. A summary of common and distinctive elements of psychosocial approaches will be given, along with directions for future research.

SYMPOSIUM 027

IMPULSIVITY AND BEHAVIORAL DYSINHIBITION ACROSS PSYCHIATRIC DISORDERS: PATHOLOGICAL GAMBLING, PERSONALITY DISORDERS, SUICIDE, AND ADHD

Chair: Antonia S. New, M.D.

Discussant: Antonia S. New, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Consider the dimension of impulsivity/behavioral dysinhibition across psychiatric diagnoses, 2) To understand possible differences within the impulsivity/behavioral dysinhibition symptoms domains and to consider how this relates to associated symptoms, 3) To understand possible treatment implications of differences across the impulsive/behavioral dysinhibition spectrum, 4) To consider shared and distinguishing characteristics in impulsive aggression directed towards others and impulsive suicidal behavior, and 5) To consider the role of subjective and objective measures of impulsivity symptoms

SUMMARY:

This symposium will examine the dimension of impulsivity/behavioral dysinhibition across psychiatric diagnoses, and will explore the role of subjective and objective measures of impulsivity symptoms. It will examine possible differences within the impulsivity/behavioral dysinhibition symptom domains and how they relate to associated symptoms. Finally, it will consider possible treatment implications of differences across the impulsive/behavioral dysinhibition spectrum and consider similarities and differences across impulsive aggression directed towards others and impulsive suicidal behavior. First, Dr. Carlos Blanco will review impulsive and compulsive aspects of pathological gambling, their neurobiological underpinnings and some potential avenues for treatment. Dr. Mercedes PerezRodriguez will review the available evidence on multiple facets of impulsivity in borderline personality disorder (BPD). She will discuss selfreport measures of impulsivity including the Barratt Im-

pulsivity Scale (BIS) and the Eysenck Impulsiveness Questionnaire, and behavioral measures such as the Point Subtraction Aggression Paradigm (PSAP). She will comment on the inconsistent findings across selfreport and behavioral measures, and the finding of different levels of impairment across different facets of impulsivity in BPD. She will present the associations between genetic factors and measures of facets of impulsivity in BPD and how they relate to symptom severity. Dr. Michael McCloskey will present on the inconsistent findings regarding selfreported and behavioral measures of impulsivity in Intermittent Explosive Disorder. He will show data from different measures of behavioral impulsivity as well as selfreport scales including the Barratt Impulsivity Scale (BIS) and the UPPS (Urgency, Lack of Perseverance, Lack of Premeditation and Sensation Seeking) Impulsiveness Scale. Dr. Marianne Goodman will discuss levels of impulsivity and selfdestructive behavior in a sample of mixeddiagnosis group of veterans with high risk suicidal behavior. Finally, Dr. Jeffrey Newcorn will provide a developmental perspective, giving an overview of ADHD, its developmental trajectory into adulthood, how it presents in clinical and other settings, and focus on potential comorbidity with mood disorders, with antisocial and other personality disorders, and substance use disorders. He will describe how ADHD can be seen as a template on which some of the other adult impulsivity disorders exist, and consider treatment implications.

S027-1.

IMPULSIVE BEHAVIOR IN PATHOLOGICAL GAMBLING: A BEHAVIORAL ADDICTION

Presenter: Carlos BlancoJerez, M.D., Ph.D.

SUMMARY:

Pathological gambling (PG) is a persistent and recurrent maladaptive pattern of gambling behavior characterized by increased preoccupation with gambling activities, loss of control, and continued gambling despite problems in social or occupational functioning. It is associated with significant financial losses, legal problems and disrupted interpersonal and familial relationships. PG has been conceptualized as an obsessivecompulsive spectrum disorder, an impulse control disorder and a behavioral addiction. This presentation will summarize the evidence supporting these competing conceptualizations using data from epidemiology, clinical phenomenology, genetics, neuroimaging and treatment response. A special emphasis will be placed on examining the concepts of impulsivity and compulsivity as applied to PG, examining its neurobiological correlates and discussing the implications for future classifications (e.g., DSMV), treatment strategies and research directions.

S027-2.

SEARCHING FOR ENDOPHENOTYPES IN BPD: A FOCUS ON SELFREPORTED AND BEHAVIORAL IMPULSIVITY

Presenter: Mercedes PerezRodriguez, M.D., Ph.D.

SUMMARY:

To develop more effective treatments, it is crucial to advance our understanding of the dimensions underlying psychiatric disorders, and identify dimensions that are common across disorders, as well as those that differentiate them. In accord with the interim guidance for the study of the Research Domain Criteria (RDoC), we seek to advance in this direction by examining selfreport, behavioral and genetic data of different facets of impulsivity in borderline personality disorder (BPD). Impulsivity, which is one of the DSMIV criteria for BPD diagnosis, and poor selfregulation, including both selfinjury and impulsive aggression directed towards others, are a core characteristic of BPD. BPD is a prototypic diagnosis for impulsive aggression, which can manifest clinically in a variety of behaviors, including destruction of property, assault, domestic violence, selfinjurious and suicidal behavior, or substance abuse. I will review the findings regarding selfreported and behavioral tasks measuring impulsivity in BPD. BPD patients have been shown to have high levels of different facets of impulsivity, measured by impulsivity scales, or by behavioral tasks such as laboratoryinduced impulsive aggression. While the evidence for high selfreported impulsivity in BPD is robust, the empirical studies on impulsive behavior in BPD have yielded mixed results. I will review neuroimaging findings of the underpinnings of impulsive behavior in BPD. Brain imaging studies in BPD have shown disruption of the neural circuitry implicated in impulsive aggression, leading to the hypothesis that abnormal frontal inhibition of limbic regions may underlie BPD pathology. For example, anatomical magnetic resonance imaging (MRI) studies show volume reduction in BPD in frontal regions, including right anterior cingulate gyrus (ACG), and decreased activity in ACG in response to a serotonergic probe. A recent study showed decreased gray matter volume in right orbital frontal cortex (OFC) in BPD adolescents. A resting 18FDGPET study in BPD revealed an inverse correlation between lifetime aggression and OFC metabolism. Subsequent 18FDGPET scans conducted in a resting state confirmed hypometabolism in BPD patients in OFC and ACG. Together, these studies suggest that BPD patients have abnormal frontal modulation of limbic regions. I will review candidate genes for different facets of impulsivity and their relation to selfreported and behavioral measures of impulsivity. Candidate genes f

S027-3.

IMPULSIVITY AND INTERMITTENT EXPLOSIVE DISORDER: MAKING SENSE OF INCONSISTENT

FINDINGS

Presenter: Michael S. McCloskey, Ph.D.

SUMMARY:

Intermittent Explosive Disorder (IED) is the diagnosis used to classify individuals who engage in repeated acts of affective aggression that are disproportionate to any provocation, and not better accounted for by the effects of a substance, medical condition, or other psychological disorder. In short, IED is a disorder of affective or "impulsive" aggression, and is categorized as an impulse control disorder in the current Diagnostic and Statistical Manual. Despite this, findings on the relationship between IED and measures of impulsivity have been inconsistent with selfreport measures generally (but not always) suggesting increased impulsivity in IED, while behavioral measures of impulsivity often fail to show this relationship. The authors will examine the existent data on the relationship between impulsivity and IED, with suggestions on how the findings fit into a theory of IED as a disorder of emotional dysregulation.

S027-4.

ASSESSMENT OF PREDICTORS OF HIGHRISK MIXEDDIAGNOSIS SUICIDAL VETERANS

Presenter: Marianne S. Goodman, M.D.

SUMMARY:

Objective: The purpose of this study was to assess the predictors of high risk (HR) suicidal behavior in a group of veterans with mixed diagnostic profiles and compare them to a group of lowrisk veterans receiving mental health care. **Method:** 110 veterans receiving mental health services aged 1855 completed diagnostic interviews for Axis I and II and assessments of trauma, impulsivity, interpersonal functioning. **Results:** 86 males and 24 females participated with mean age of 40. 55% were determined to be high risk. 73% of the HR veterans had made suicide attempts and approximately one third had suicidal ideation on a daily or almost daily basis lasting 8 or more hours a day. There were no statistical differences between high and low risk suicidal risk veterans for combat exposure, alcohol use or any demographic variable (except gender). Statistical differences did exist for Axis I Major Depression (65% HR vs. 32%LR), Substance Abuse Disorder (65%HR vs. 42% LR) and Axis II Borderline Personality Disorder (78% HR vs. 13% LR). To explore what aspect of BPD symptoms contributed to highrisk status, we assessed the effect of symptom dimensions of BPD from the DIBR (affective, cognitive/psychosis, impulsive action patterns and interpersonal relations) in predicting highrisk status. After BPD diagnosis, the most powerful predictor of highrisk status was impulsivity, with

a minor contribution also of depression. Conclusions: Behavioral disinhibition in the form of suicide in highrisk suicidal veterans is associated with the borderline personality disorder diagnosis, and the only symptom component that seemed to be associated with high risk status beyond the overall diagnosis was impulsivity.

S027-5.

ADHD AND IMPULSIVITY: LONGITUDINAL COURSE, COMORBIDITY, AND IMPAIRMENTS RELATED TO PERSISTENCE INTO ADULTHOOD

Presenter: Jeffrey H. Newcorn, M.D.

SUMMARY:

Although attentiondeficit hyperactivity disorder (ADHD) had previously been considered to be a childhood disorder, it is now well know that ADHD persists over the lifespan, with a prevalence rate of 45% in adults. Moreover, ADHD is associated with a wide range of comorbid disorders in childhood, as well as heightened risk for the development of other psychiatric disorders in adulthood. Impulsivity is a core symptom of ADHD, with problems in inhibitory control seen across a broad range of behavioral and cognitive functions. Of note, many of the most serious outcomes associated with ADHD (e.g., aggression, antisocial behavior, criminality, substance abuse, personality disorders) are probably best accounted for by the persistence of impulsive behavior. This presentation will review the longitudinal course of ADHD, examine the symptomatic presentation and comorbidity associated with ADHD in adulthood, and consider possible links between ADHD and other disorders of impulsivity in adults.

SYMPOSIUM 028

FIRST ANNUAL MEMBER IN TRAINING/ EARLY CAREER PSYCHIATRIST LEADERSHIP FORUM

Co-Chairs: Joyce A. Spurgeon, M.D., Sarah Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Increase awareness of what the APA offers and how membership can enhance the practice of psychiatry in the MIT/ECP population, 2) Create opportunity for networking between MIT/ECPs and APA leaders and staff, 3) Facilitate mentorship opportunities, 4) Increase MIT/ECP participation in the APA and submissions to the Annual Meeting

SUMMARY:

Meet The Experts: The goal of this experience is to pair

MITs/ECPs with the experts in the field. This is a unique opportunity to allow the APA's younger members to interact with their area of interest in a nonthreatening environment which facilitates knowledge as well as networking. Orientation to the APA: Dr. Bernstein will lead this section. It will be an overview of the structure of the APA. Navigation of the annual meeting tips will be provided. The focus is to introduce APA members to the leadership and organizational charts that exist within our organization. Workshop Submission 101: Dr Stotland will provide participants with how to submit a workshop. This is also a time to brainstorm about topics that interest the attendees for the following year's annual meeting. Mentorship: Drs. Davis, Spurgeon, Johnson will provide the example of the Kentucky district branch's mentorship program. This will also be a way to explore mentorship opportunities that are occurring throughout the country.

S028-1.

APA'S STRUCTURE AND LEADERSHIP

Presenter: Carol A. Bernstein, M.D.

SUMMARY:

This presentation will focus on helping the participant learn more about the organization as well as give a 'face' to the APA leadership. Normally, this presentation becomes a question and answer time where the issues of district branches and individual members are addressed.

S028-2.

HOW MENTORSHIP CAN BE A POWERFUL TOOL FOR THE LOCAL DISTRICT BRANCHES

Presenter: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

The discussion will start with using the Kentucky District branch as an example, but it will expand to discuss ways to enhance mentorship within each of the district branches. It will focus on how mentorship can be a valuable tool for professional development as well as a way to enhance one's satisfaction with one's career.

S028-3.

HOW TO SUBMIT PRESENTATIONS TO THE ANNUAL MEETING

Presenter: Mary Helen Davis, M.D.

SUMMARY:

This includes tips on how to make one's presentation a

stronger application. It also reviews some of the criteria the committee uses to help choose the program for the annual meeting. There is normally a brainstorming part of this presentation that allows attendees to participate and talk about what they would like to see at their annual meeting. It is a source of networking where people can get together to work on projects for the following year's annual meeting.

SYMPOSIUM 029

PROMOTING RESILIENCE, RECOVERY, SOCIAL INCLUSION, AND BEHAVIORAL HEALTH EQUITY: A HISTORICAL AND CONTEMPORARY PROFILE OF PHILADELPHIA

Chair: Annette B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recite salient statistics concerning demographics, socioeconomic indicators and the psychiatric epidemiology of the citizens of Philadelphia, 2) Appreciate the value of programs focused on facilitating the resilience of youth living in an urban setting, 3) Discuss challenges to community mental health revolving around race relations in contemporary Philadelphia, 4) Understand how recent interactions between the mental health system and the correctional system have led to the development of a variety of jail diversion programs, and 5) List the components of the Philadelphia behavioral health system that will promote health equity among people in recovery

SUMMARY:

This symposium is the lead session of OMNA on Tour, the traveling mental health disparities program of the American Psychiatric Association Office of Minority and National Affairs. The symposium presentations provided by community leaders and scholars will provide an overview of the demographics and pertinent statistics related to the mental health and overall wellbeing of Philadelphia's residents, particularly people living in poverty and culturally diverse populations. The mental health impact of sociological phenomena in Philadelphia underlying crossracial interaction since the Civil Rights movement will be discussed. The session will also highlight how Philadelphia's public behavioral health system has responded to the needs of its citizens through its investment in the resilience of youth and the development of a comprehensive array of innovative programs to promote recovery and health equity.

S029-1.

THE COSMOPOLITAN CANOPY: RACE AND CIVILITY IN EVERYDAY LIFE IN PHILADELPHIA

Presenter: Elijah Anderson, Ph.D.

SUMMARY:

The racial incorporation process that began with the civil rights revolution of the 1960s has impacted American institutions but particularly the urban environment, which it has been reshaped in the process. Although Philadelphia remains remarkably segmented by race, African Americans and other people of color are increasingly present in now-diverse public settings which they once viewed as off limits. Under the "cosmopolitan canopy," a virtual island of civility in a sea of otherwise segregated living, urban dwellers often display their best "downtown behavior," which involves a form of social gloss. In these public spaces, most typically, diverse denizens openly express their cosmopolitan sides and manage to keep their ethnocentric sides in check, apparently getting along with others in public. This is all positive. But on occasion, racial situations arise that threaten and rend the canopy, including scenes of tension. These incidents often involve race, class, sexual preference, and gender. The most troublesome incidents are characterized by dramatic shows of acute disrespect based on difference—black people in particular often find themselves in newly diverse settings, enacting social roles in which they may not be expected, or accepted, and may face derision. On occasion, they are insulted outright—after the fact, blacks may joke with one another about the incident, calling it a "nigger moment"—a version of which can happen to a member of most any marginalized group. In these circumstances, in this instant, the color line is abruptly drawn. Unlike the old days of the American caste system, when such racial borders were understood—and generally accepted, today's color line is blurred, enduring in a different, more subtle form, but it is insidious in virtually every respect. This new color line represents a fundamental fault line of present-day race relations, especially for numerous black people who experience upward mobility. When such insulting but consequential moments occur, often in an otherwise trusted setting, the victim can feel humiliated, even traumatized. These situations get managed, and are often covered over by social gloss, by which the canopy repairs itself by putting on the face of resilience—resulting in a veneer of racial civility that maintains until the canopy is rented yet again.

S029-2.

RESILIENCE IN ACTION: A PRESENTATION BY YOUTH M.O.V.E. PHILADELPHIA

Presenter: Marc Forman, M.D.

SUMMARY:

Youth M.O.V.E Philadelphia will be the primary presenters of this program on Resilience. This group, comprised

of 1422 year old minority youth, is under the direction of Randolph Alexander, CommunityBased Development Specialist with the CommunityBased Services Development Unit of the Department of Behavioral Health and Intellectual Disability Services, (DBHIDS), City of Philadelphia. Youth M.O.V.E is a youthled advocacy group that has provided training in resilience and other types of presentations designed to reduce stigma related to behavioral health issues. Most recently, training in resilience was presented to the staff of DBHIDS, with over 560 attendees during 8 training sessions . During this APA symposium Youth M.O.V.E Philadelphia will describe their group, how it was founded, its purposes, and more specifically, how they participated in the development and implementation of the training in resilience. They will describe their own personal stories, the risk and adversities which they faced in their childhood and adolescence. They will identify those growthpromoting and protective factors which enabled them to become resilient and move forward with their lives in a productive manner. The presentation will offer a compelling demonstration of the value of lived experience, narrative medicine and personal storytelling as a means of helping us understand resilience.

S029-3.**RESILIENCE IN ACTION: A PRESENTATION BY YOUTH M.O.V.E. PHILADELPHIA**

Presenter: Randolph Alexander,

SUMMARY:

Youth M.O.V.E Philadelphia will be the primary presenters of this program on Resilience. This group, comprised of 1422 year old minority youth, is under the direction of Randolph Alexander, CommunityBased Development Specialist with the CommunityBased Services Development Unit of the Department of Behavioral Health and Intellectual disAbility Services, (DBHIDS), City of Philadelphia. Youth M.O.V.E is a youthled advocacy group that has provided training in resilience and other types of presentations designed to reduce stigma related to behavioral health issues. Most recently, training in resilience was presented to the staff of DBHIDS, with over 560 attendees during 8 training sessions . During this APA symposium Youth M.O.V.E Philadelphia will describe their group, how it was founded, its purposes, and more specifically, how they participated in the development and implementation of the training in resilience. They will describe their own personal stories, the risk and adversities which they faced in their childhood and adolescence. They will identify those growthpromoting and protective factors which enabled them to become resilient and move forward with their lives in a productive manner. The presentation will offer a compelling demonstration of the value of lived experience, narrative medicine and

personal storytelling as a means of helping us understand resilience.

S029-4.**REDUCING DISPARITIES IN ACCESS TO TREATMENT FOR JUSTICEINVOLVED INDIVIDUALS DIAGNOSED WITH SEVERE MENTAL ILLNESS**

Presenter: Jean H. Wright, Psy.D.

SUMMARY:

This presentation will alert the attendees to how Philadelphia County has addressed disparities in access to behavioral health treatment for justice involved citizens diagnosed with severe mental illness (SMI) and cooccurring disorders. The scope of this discussion will include examples of collaborative initiatives that provide returning citizens with supports geared toward helping them remain in their communities. It will also highlight how crosssystem collaboration has been a catalyst for promoting treatment, recovery, and public safety. A related area of focus will underline how disparities in access to treatment are confounded by additional issues: i.e. people of color, who have been diagnosed with SMI, and are justice involved, are arrested more often, remain in jail for longer periods, and if/when released, receive technical parole violations more readily carrying more severe penalties. Attendees will receive information on the unique challenges in Philadelphia County, and how the criminal justice system, behavioral health system, and treatment providers were able to partner successfully to meet these challenges.

S029-5.**TRANSFORMING A BEHAVIORAL HEALTH SYSTEM TO A RECOVERY AND RESILIENTORIENTED SYSTEM OF CARE: IMPROVED HEALTHCARE AND HEALTH EQUITY IN PHILADELPHIA**

Presenter: Arthur C. Evans, Ph.D.

SUMMARY:

The Philadelphia Department of Behavioral and Intellectual disAbility Services (DBHIDS) oversees a large and complex urban behavioral health system that serves over 100,000 people per year. For the past six (6) years, this agency has been engaged in an aggressive process to radically transform its system of care to focus on recovery for adults and resilience for children. The aim of DBHIDS is to improve the health and wellbeing of all citizens in Philadelphia. This presentation will first provide an overview of the system transformation efforts to achieve a recovery and resilient-oriented system of care. Four building blocks of system transformation efforts will be described, including the need

to: 1) Optimize clinical service delivery; 2) Add and integrate recovery support services; 3) Align fiscal and administrative policies and procedures with system goals; and 4) Build crosssystems partnerships and community capacity to address behavioral health problems. The presentation will then highlight the centrality of identifying and eliminating known behavioral health disparities in this system transformation approach. This approach includes the use of empirical processes to identify differential access and engagement to services among racial and ethnic minority groups, as well as strategies to improve treatment and long term clinical outcomes. Particular strategies and initiatives utilized to address identified disparities will then be described. Strategies include the development of the Healthcare Reform and Health Equity Unit at DBHIDS, the funding of specific initiatives aimed at reducing behavioral health disparities in prioritized geographic areas, and supporting a variety of locally defined communitybased initiatives. Two DBHIDS specific initiatives aimed at promoting resilience among youth and increasing access to behavioral health services among courtinvolved adults will be highlighted separately in the symposium. Thus, this symposium will demonstrate how a transformed behavioral health system will improve healthcare for everyone, while attending to the elimination of known behavioral health disparities.

SYMPOSIUM 030

MEDICATION USE FOR TREATING ALCOHOL DEPENDENCE

Co-Chairs: Raye Z. Litten, Ph.D., Fertig Joanne, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize novel targets for discovering and developing candidate compounds, 2) Determine the efficacy and safety of two new promising medications in recently completed clinical trials, 3) Determine the latest clinical finding of the extendedrelease naltrexone for the treatment of alcohol, 4) Identify the latest research strategies to develop and deliver new and more effective alcohol medications

SUMMARY:

Alcohol abuse and dependence (i.e., Alcohol Use Disorders) are among the most prevalent mental health disorders found in the world today. More than 76 million people worldwide are estimated to have diagnosable Alcohol Use Disorders. Pharmacotherapy offers promising means for treating alcohol addiction, and significant progress has been made in the past 20 years. Currently, four medications have been approved by FDA for alcohol dependence. Unfortunately, these medications do not work for everyone; as a result, active research continues to search for effective

medications to treat an even wider range of patients. In this symposium, novel molecular targets will be identified, especially as it relates to the brain stress system; efficacy and safety findings of two recent completed alcohol clinical trials of promising medications, gabapentin and quetiapine, will be presented; and new clinical findings of Vivtrol, the injectable extendedrelease naltrexone, will be updated in terms of mechanisms, efficacy, and use in realworld treatment settings. As alcohol research continues to unravel the biological mechanisms that underlie alcohol addiction, more, differently targeted medications will be available for alcoholism treatment. As a result, affected individuals and their families will be spared myriad, costly alcoholismassociated medical, psychological, social, economic, and personal problems.

S030-1.

QUETIAPINE FOR THE TREATMENT OF ALCOHOL DEPENDENCE

Presenter: Fertig Joanne, Ph.D.

SUMMARY:

Despite advances in developing medications to treat alcohol dependence, few such medications have been approved by the FDA. A typical antipsychotic medications have been widely prescribed and studied with varying results. NIAAA's Clinical Investigations Group (NCIG) conducted a double-blind, placebo controlled trial of a the atypical antipsychotic quetiapine. Two hundred twenty four alcoholdependent patients reporting very heavy drinking were recruited across five clinical sites. Patients received either quetiapine or placebo and Medical Management behavioral intervention. Patients were stratified on gender, clinical site, and reduction in drinking prior to randomization. Results of this multisite study will be discussed.

S030-2.

GABAPENTIN TREATMENT OF ALCOHOL DEPENDENCE AND ALCOHOLRELATED DISTURBANCES IN MOOD AND SLEEP

Presenter: Barbara J. Mason, Ph.D.

SUMMARY:

Protracted abstinence symptoms in alcohol dependence, e.g., craving, dysphoria and insomnia, represent a state of heightened vulnerability to drinking relapse. Such symptoms may reflect prolonged disturbances in brain stress and reward systems, e.g., GABACRF interactions in the extended amygdala. Gabapentin, approved for epilepsy and pain, is associated with enhanced GABAergic activity, possibly via an action on voltagegated calcium channels, and has

been used offlabel to treat disturbances in sleep and mood. We hypothesized that gabapentin would have efficacy for relapse prevention in alcohol dependence by acting directly on drinking behavior and/or on symptoms of protracted abstinence that may modulate drinking behavior. Gabapentin was associated with significantly greater reductions than placebo on measures of drinking quantity and frequency, as well as higher rates of complete abstinence and no heavy drinking over the 12week study. Gabapentin was also associated with significantly greater reductions in measures of craving, depression and sleep disturbance than placebo. Gabapentin may offer a new treatment for alcohol dependence that improves both drinking outcomes as well as symptoms of protracted abstinence often associated with drinking relapse, e.g., craving, dysphoria and insomnia. Positive outcomes for gabapentin lend support to the role of neuro-modulating drugs for treatment of alcohol dependence.

S030-3.

NOVEL TARGETS FROM THE DARK SIDE OF DEPENDENCE ON ALCOHOL: FOCUS ON THE BRAIN STRESS SYSTEMS CRE, DYNORPHIN, AND VASOPRESSIN

Presenter: George F. Koob, Ph.D.

SUMMARY:

Dysregulation of the brain emotional systems that mediate arousal and stress is a key component of the pathophysiology of alcoholism. Alcoholism is a chronically relapsing disorder characterized by a compulsion to seek and take drugs and manifestation of a negative emotional state when the drug is removed. Activation of brain stress systems is hypothesized to be a key element of the negative emotional state produced by dependence that drives drug seeking through negative reinforcement mechanisms. The role of brain arousal stress systems, including corticotropinreleasing factor, dynorphin, and vasopressin, will be explored in alcohol dependence with an emphasis on the neuropharmacological actions of these neurotransmitters in extrahypothalamic systems in the ventral striatum and extended amygdala. Compelling evidence indicates that the brain stress systems, a heretofore largely neglected component of dependence and addiction, play a key role in engaging the transition to dependence and maintaining dependence once initiated. A role of the brain stress systems in addiction not only provides insights into the neurobiology of the dark side of addiction but also provides novel targets for the treatment of alcoholism.

S030-4.

EXTENDEDRELEASE NALTREXONE FOR THE TREATMENT OF ALCOHOL DEPENDENCE

Presenter: David R. Gastfriend, M.D.

SUMMARY:

XRNTX (Vivitrol®) was developed with support from National Institute on Drug Abuse Grant R43DA013531 and National Institute on Alcohol Abuse and Alcoholism Grant N43AA001002. Dr. Gastfriend is a fulltime employee of Alkermes, Inc. Unlabeled/Unapproved Uses Disclosure: None Extendedrelease naltrexone (XRNTX; Vivitrol®), developed to address poor adherence in addictive disorders, is approved for alcohol and opioid dependence treatment. In alcohol dependent adults with =4day initial abstinence, XRNTX increased initial and 6month abstinence. On fMRI, XRNTX attenuated the salience of alcohol visual and olfactory cues, and post hoc analyses demonstrate efficacy even during high cueexposure holiday periods. Generally well tolerated, without adverse hepatic impact or intractable acute pain management, principal adverse effects include injection site reactions and nausea. Despite its higher cost, three retrospective claims analyses found XRNTX's total health care costs were no different or lower vs. psychosocialonly treatment or treatment with all FDAapproved oral agents, apparently because of fewer hospitalizations. XRNTX appears compatible with counseling and selfhelp; pilot data suggest that antihedonic effects are selective for alcohol consumption vs. various daily activities. While research continues, XRNTX has been found feasible in primary care, public and justice systems.

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SYMPOSIUM 031

CURRENT MODELS OF COLLABORATIVE CARE

Chair: Amy C. Brodkey, M.D.

Discussant: Jurgen Unutzer, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) List recent developments which have converged to spur increased interest in the integration of behavioral health and primary care, 2) Discuss several models of collaborative care, including coordinated care, consultation, colocation and reverse colocation, and types of integration., 3) Review potential benefits and pitfalls of collaborative care models

SUMMARY:

A number of developments in medicine, economics, and policy have converged to increase interest in the collaboration of primary care and mental health professionals in patient care. In terms of health care costs, primary care has been shown to be less expensive than specialty care, and the foremost barriers to improved care have been found to be

depression and noncompliance with treatment. In addition, most persons treated for psychiatric disorders do so in the primary care sector, and lack of access to outpatient mental health services is a major barrier to care for patients and referring physicians alike. Medical costs decrease for patients with access to behavioral health treatment. These considerations have become more important with the advent of Accountable Care Organizations, spurred by the Patient Protection and Affordable Care Act to provide efficient, high quality, coordinated care. The “medical home” movement, based on principles of provision of comprehensive primary care services in a setting that facilitates partnerships between patients and their personal physicians, has also added to interest in multispecialty collaboration. Collaborative care is an overarching term describing ongoing relationships between clinicians over time. Models include expedited referrals (coordinated care), regular consultations, and colocation of primary and behavioral health staff with varying degrees of integration of care. The roles of psychiatrists and other mental health professionals within these systems vary widely. This symposium will feature five presenters with experience with different models of collaborative care: coordination with embedded mental health providers in an academic primary care practice which is part of a medical home learning collaborative; colocation and integration of primary care and behavioral health services within a multisite federally qualified health center; colocation and collaboration in a Veterans Administration Hospital outpatient department as part of their mandated Primary Care Mental Health Integration initiative; the ‘reverse colocation’ of a primary care center within a large communitybased mental health provider; and the Washington State Mental Health Integration Program (MHIP) in which 20 psychiatrists provide systematic consultation to a large network of community health clinics. Presenters will describe and evaluate the system in which they work and present available outcome data.

S031-1.

A PILOT STUDY EMBEDDING BEHAVIORAL HEALTH PROVIDERS IN AN ACADEMIC PATIENT-CENTERED MEDICAL HOME PRACTICE

Presenter: Susan Day, M.D., M.P.H.

SUMMARY:

The Edward S. Cooper Internal Medicine Practice was one of 32 practices participating in the South East Pennsylvania Chronic Care Learning Collaborative between 2008 and 2011. ES Cooper is a teaching practice of the University of Pennsylvania, caring for approximately 12,000 patients. As part of the Collaborative, the practice pursued NCQA recognition as a patientcentered medical home (PCMH), a process which includes establishing the frequency of behav-

ioral risk factors and psychiatric/mental health disorders in the practice. Depression and anxiety were among the top 15 diagnoses, while obesity, insomnia, and tobacco use were among the top reasons for office visits. Capacity to provide services to these patients was affected by limited access to behavioral health services within the health system. To address this gap in care, a pilot project was undertaken with an outside behavioral health agency who agreed that all patients would be seen in the office, regardless of insurance, if only for triage to outside psychiatric services. Over a six month period, embedded psychologists evaluated patients referred from three general internal medicine practices. Data indicates a disproportionate rate of referral of medical assistance patients. While our initial intent was to address the issues of the nonadherent patient with medical problems, only 39% of patients who were referred had 1 or more chronic medical conditions. Lessons from the collaboration included the importance of psychiatric back up for medication management; the unexpected pent up demand for in office mental health services; medical provider interest in learning more about topics such as handling difficult patients and motivational interviewing; the high frequency of no-show visits (33%); and the specific challenges of the underinsured (only 31% of patients with insurance were able to pay their copay). Defining the population most likely to benefit from inoffice care, establishing an effective relationships between medical and behavioral health providers, assuring psychiatric back up and a sustainable business plan are essential to a successful collaboration.

S031-2.

INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTH CARE IN A MULTISITE FEDERALLY QUALIFIED HEALTH CENTER

Presenter: Amy C. Brodkey, M.D.

SUMMARY:

Federally Qualified Health Centers provide comprehensive primary and behavioral health services to all patients regardless of ability to pay or insurance status. Located in medically underserved areas, FQHCs are a critical component of the health care safety net, serving populations that are predominantly lowincome, minority, and un or underinsured or covered by public insurance programs. In 2010, FQHCs served an estimated 20 million patients, and the figure may rise to 40 million by 2015. Over 70% of FQHCs report providing some type of behavioral health services (85% onsite but only 40% at all sites), and over 90% of these report some integration of care. Components of this integration include colocation of services; communication and coordination between providers; and shared expertise, information, treatment planning and decisionmaking. Social workers are the most common mental health providers

in these settings. In 2009, FQHCs served almost a million patients (almost 5 million visits) for treatment of MH/SA disorders. Visits to psychiatrists numbered almost 900,000. A recent report highlighted the relatively low utilization of psychiatrists in these centers. Only 5% of sites are used to train psychiatric trainees. This presentation will review the evolution over 15 years of care integration in a multisite FQHC located in or adjacent to Philadelphia public housing projects. Elements of this integration have included depression screening in primary care; regular behavioral health primary care staff meetings; twoway referrals; communication via the electronic medical record and “hallway consultations”; colocation and referral to social worker, nutritionist, dental clinic, diabetes nurse, and other providers; use of a discounted onsite pharmacy; and telephone, online or inperson consultations. The addition of behavioral health consultants located within primary care in the past 5 years has made shortterm and emergency behavioral health treatment possible and has increased efficiency of referrals of appropriate patients to the behavioral health service, as well as to healthrelated groups and classes. Although limited, data from the Depression Collaborative, the Pennsylvania Chronic Care Initiative, and patient satisfaction assessments will be presented. The presenter will discuss her assessment of what works well and what doesn’t and evaluate barriers to integration and essential elements for success.

S031-3.

INTEGRATING HEALTH CARE BY REVERSE COLOCATION

Presenter: Lawrence A. Real, M.D.

SUMMARY:

Specialty behavioral health providers frequently act as de facto health homes for people with serious mental illness, who struggle to overcome multiple barriers to accessing timely and appropriate physical health care. These barriers include: stigma and the reluctance of primary care providers to engage and treat them; obstacles, figuratively and literally, to the navigation of complex healthcare systems; and difficulty establishing trusting relationships, stemming from both illness and experiential factors. “Reverse colocation”, embedding primary care within a communitybased behavioral health facilities, significantly reduces these barriers, and allows participants to extend the trust they have developed in the behavioral health staff to the primary care staff. One option for providing such services is to partner with a Federally Qualified Health Center (FQHC), who can more easily open a satellite primary care center at the specialty facility than the behavioral health provider can generate such services on its own. Such partnerships face numerous challenges to successful implementation, including those concerning fiscal viability, health informa-

tion management, and philosophies of care, e.g., wellness and recoveryoriented versus disease management. Via learning collaboratives involving multiple variations on this partnership theme, and under the auspices of agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), strategies are evolving that can provide guidance in how best to approach the partnership process, to implement maximally integrated programs, and, eventually, to achieve the ultimate goal of changing both the health behaviors and health outcomes of individuals with severe and persistent mental illness.

S031-4.

VETERANS HEALTHCARE ADMINISTRATION: PRIMARY CARE MENTAL HEALTH INTEGRATION CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM

Presenter: Patricia Allred, M.D.

SUMMARY:

The overall purpose of the VA Primary CareMental Health Integration initiative is to integrate care for Veterans’ physical and mental health conditions, improve access and quality of care across the spectrum of illness severity, and allow treatment in mental health specialty settings to focus on persons with more severe mental illnesses. The VHA initiated funding for Primary CareMental Health Integration in fiscal year 2007. The clinical goals and structural components were clarified in September 2008 with the release of the VA Uniform Mental Health Services Handbook which requires PCMHI services be available on a fulltime basis at all VHA medical centers and very large CBOC’s (Community Based Outpatient Clinics.) The programs are to use a “blended” integrated care model that includes both “colocated collaborative care” and “care management” components. The “colocated collaborative care” model involves having a behavioral health provider whose office is in close proximity of the primary care providers, immediately available for consultation with PC team, for assessment of patients, development of biopsychosocial treatment plans, initiation of treatment and monitoring response to treatment. “Care management” provides assessment and monitoring using evidencebased guidelines and structured protocols, usually by telephone. The implementation of the PCMHI Initiative has been variable across the nation, but the 2010 VA PCMHI Evaluation Survey found that 97% of VAMCs and 67% of VL CBOCs reported having PCMHI programs, including 45% of VAMCs & 27% of VL CBOCs having blended programs with colocated collaborative care and care management. The survey showed that all programs had reductions in patient experience of stigma, decrease in referrals to specialty MH for mild/moderate conditions and an increase in likelihood that mental health problems were

identified and patients would receive guideline concordant MH treatment with better psychotropic medication adherence. This presentation will discuss implementation of the program nationally and specifically at one VAMC, including roles of various behavioral health personnel, diagnoses treated, referral guidelines and treatments used, as well as current outcome data, challenges and goals.

S031-5.

MHIP: THE WASHINGTON STATE MENTAL HEALTH INTEGRATION PROGRAM

Presenter: Jurgen Unutzer, M.D., M.P.H.

SUMMARY:

The Mental Health Integration Program (MHIP; <http://integratedcarew.org>) is a statewide program of patient-centered, integrated care for safety net patients served in over 100 community health centers and 30 community health centers in the State of Washington. Patients served include adult patients on short term disability, uninsured patients, Veterans and family members of Veterans, older adults, children, and high risk mothers. Since its inception, the program has served over 23,000 patients ranging in age from 1 to 100 with a variety of behavioral health problems including depression, anxiety disorders, bipolar disorder, alcohol and substance abuse problems. More than 20 psychiatrists are serving as consultants to the program statewide, and the program is a mature example of a large-scale implementation of evidence-based collaborative care for common mental disorders. We will discuss experience with implementing this program statewide and report on clinical program outcomes. We will also discuss the role of a pay-for-performance component of the program which has been associated with substantial improvements in clinical outcomes since its initiation in 2009.

SUNDAY, MAY 6, 2012

SYMPOSIUM 032

THE FUTURE OF PSYCHIATRIC DIAGNOSIS: UPDATES ON PROPOSED DIAGNOSTIC CRITERIA FOR DSM5 (PART II)

Co-Chairs: David J. 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) Describe the most notable changes being adopted in DSM5 in the sections on Schizophrenia and Psychotic Disorders, Depressive Disorders, Bipolar Disorders, Anxiety and ObsessiveCompulsive Disorders, and Trauma and

Dissociative Disorders, 2) Explain how proposed revision are addressing gaps in the currently DSMIV nosology, 3) Discuss the ways in which the work groups intend the finalized criteria to facilitate better clinical care of patients

SUMMARY:

Members of the 13 DSM5 Work Groups are currently finalizing draft diagnostic criteria and proposed dimensional changes to disorders in preparation for the release of the revised manual in May 2013. Final proposals are being informed largely by evidence from the literature, including, where available, secondary data analyses; results from the two designs of the DSM5 Field Trials (large, medical-academic settings and routine clinical practice settings); and feedback from patients, professionals, and the general public. A threepart symposium series will provide audiences with updates on the latest status of proposed revisions to DSM's diagnostic criteria from the chairs of each of the 13 work groups. In this session (Part II), attendees will learn about draft changes among Schizophrenia and Psychotic Disorders, Depressive Disorders, Bipolar Disorders, Anxiety and ObsessiveCompulsive Disorders, and Trauma and Dissociative Disorders. Where available, select results from field trials and specific feedback received via the DSM5 Web site may be shared.

S032-1.

ANTICIPATING DSM5: THE PSYCHOSIS CHAPTER

Presenter: William T. Carpenter, M.D.

SUMMARY:

May 2012 will be the last APA Annual Meeting prior to publication of DSM5. Anticipated changes from the Schizophrenia and Other Psychoses chapter in DSMIV include: Chapter organization according to course and a spectrum concept for schizophrenia related disorders. Altering A criteria for schizophrenia to give less emphasis to Schneiderian first rank symptoms. Dropping subtypes. Reconceptualizing catatonia across DSM5. Shifting the concept of schizoaffective disorder to an illness lifetime rather than an illness episode. Adding a new paradigm based on psychopathology domains to compliment categorical diagnoses. Potentially adding a new disorder class: Attenuated Psychosis Syndrome. Field trial data will be reported as relevant to the changes under consideration.

S032-2.

PROPOSED CHANGES IN THE DSM5 SECTION ON MAJOR DEPRESSIVE DISORDERS

Presenter: Jan Fawcett, M.D.

SUMMARY:

With regard to changes in criteria we propose dropping the bereavement exclusion for the diagnosis of a Major Depressive Episode. We also are proposing to drop the D criteria for Dysthymia. With regard to proposed new diagnosis, we propose adding diagnoses of Premenstrual Dysphoric Disorder, Temper Dysregulation Disorder, Mixed Anxiety Depressive Disorder, Suicide Behavior Disorder, and NonSuicidal Self Injury. There may be some attempt to have more specific NOS subcategories. With regard to behavioral dimensions, we propose an anxiety severity scale to be estimated by the diagnosing clinician in addition to the categorical diagnosis, and a suicide concern scale with a suggested minimum review of a list of chronic and acute suicide risk factors leading to a conclusion concerning how much of the treatment plan will be focused on preventing suicide in a specific case. We propose dropping the sub category mixed state, and substituting a mixed features specifier across the spectrum of unipolar and bipolar disorder. The presentation will review these proposed changes and the basis for the Mood Disorder Workgroups recommendations.

S032-3.**UPDATES FROM THE MOOD DISORDERS WORKGROUP FOR DSM5: BIPOLAR DISORDER**

Presenter: Trisha Suppes, M.D., Ph.D.

SUMMARY:

The Mood Disorders Workgroup for the DSM5 has made a number of recommendations regarding bipolar disorder that include maintaining the duration of hypomanic episodes at 4 days, revision of bipolar NOS, emphasis on increased activity/energy, and replacing Mixed Episodes with a Mixed Features Specifier. The appropriate and best definition for the duration of symptoms used to define hypomanic episodes has been long debated with passionate proponents on all sides of the discussion. While requiring 4day duration of hypomanic symptoms to meet episode criteria has been questioned, particularly in light of the original inclusion in DSMIV with a relatively arbitrary definition of 4 days, review of the existing literature does not necessarily clarify the impact of changing the duration required for a hypomanic episode. In many of the studies to date, the focus has been on symptom count or symptom type as potential alternative approaches to defining hypomania and not on duration of symptoms. Extensive debate, discussion, and review of both published and unpublished literature contributed to the DSM5 Mood Disorder committee's recommendation that the 4day duration requirement for a diagnosis of a hypomanic episode be retained. This recommendation essentially preserves relatively unchanged

the diagnostic criteria for bipolar II disorder. In the process of these discussions and review of the literature, the committee detected a need for categories to specifically capture patients with 23 day durations of hypomania in order to study these individuals as a distinct group. Thus the committee proposed that bipolar Not Otherwise Specified include defined and codable subcategories of bipolar disorder presentations, including those individuals with shorter duration hypomania but who meet symptom count and severity criteria. Issues of shorter duration "cycling" will be discussed. In addition, the workgroup recommended that Mixed Episodes be replaced by a Mixed Features Specifier which could be added to any diagnoses when 3 nonoverlapping symptoms of depression or hypo/mania are concurrent with a fully syndromal episode of the opposite polarity. The rationale for these proposed changes will be discussed and ongoing field trials to assess the feasibility of these proposed changes reviewed. Potential modification of Criterion A for hypomania and mania will also be reviewed.

S032-4.**UPDATE ON PROPOSED DSM5 CHANGES FOR ANXIETY DISORDERS AND OBSESSIVECOMPULSIVE AND RELATED DISORDERS**

Presenter: Katharine A Phillips, M.D.

SUMMARY:

This presentation will provide an update on the most notable changes proposed for anxiety disorders and for obsessivecompulsive and related disorders in DSM5. Proposed changes are based on reviews of the literature, field trial data, secondary data analyses, surveys of experts, and input from the field. Proposed changes that will be discussed include the following: 1) Modification of diagnostic criteria, subtypes, and specifiers for individual disorders 2) Addition of hoarding disorder, skin picking disorder, and olfactory reference syndrome (most likely to the Appendix) 3) Deletion of disorders (for example, combining panic disorder with agoraphobia and panic disorder without agoraphobia into one disorder, panic disorder) 4) Name changes (social anxiety disorder, hair pulling disorder) 5) Enhancement of developmental considerations (for example, modification of separation anxiety disorder to include adults) 6) Addition of dimensional approaches – for example, adding dimensional ratings of insight/delusionality to some obsessivecompulsive and related disorders, and including anxiety and obsessions/compulsions as "crosscutting" dimensions for assessment of all patients, regardless of their diagnosis 7) Inclusion of a category/chapter of obsessive compulsive and related disorders This presentation will discuss how the proposed changes address gaps in DSMIV and are intended to facilitate better patient care.

S032-5.

PROPOSED TRAUMA AND STRESS-RELATED DISORDERS FOR DSM5*Presenter: Matthew J. Friedman, M.D., Ph.D.***SUMMARY:**

In DSM5, PTSD and related disorders will no longer be considered "Anxiety Disorders" but will be classified within a new category, "Trauma and Stress-Related Disorders". All disorders classified under this heading will have prior exposure to a traumatic/stressful event as a necessary diagnostic criterion. This will include, PTSD, Acute Stress Disorder (ASD), Adjustment Disorders (ADs), Reactive Attachment Disorder and Disinhibited Social Engagement Disorder. This presentation will focus on proposed diagnostic criteria for PTSD, ASD and ADs. The DSMIV PTSD construct is based on a fear-conditioning model. In DSM5 it is proposed that in addition to fear-based reactions, anhedonic/dysphoric and externalizing symptoms may characterize posttraumatic clinical presentations. This is consistent with the variety of symptoms routinely observed among individuals exposed to a traumatic stressor. Hence, there are four, rather than 3 symptom clusters proposed for DSM5: Criterion B Re-experiencing Symptoms; Criterion C Avoidance Symptoms; Criterion D Negative Alterations in Cognitions and Mood; and Criterion E Alterations in Arousal and Reactivity. In addition, the A1 (External Stressor) Criterion has been tightened up while the A2 (Subjective Stressor) has been eliminated. Given strong evidence that severe acute posttraumatic reactions do not necessarily include dissociative symptoms, ASD will no longer require that such symptoms be present in order to meet diagnostic criteria. Instead, the ASD diagnostic threshold will be met, if an individual exposed to a Criterion A event exhibits any eight Intrusion, Dissociative, Avoidance or Arousal symptoms. Adjustment Disorders, residual diagnoses in DSMIV, have been moved into this category and conceptualized as a stress-response syndrome. There are three significant changes to AD criteria. First, an ASD/PTSD subtype has been added to provide a diagnostic niche for individuals exposed to a criterion A event whose symptoms do not exceed the ASD or PTSD diagnostic thresholds. Second (as with major depression) the bereavement exclusion has been eliminated so that loss of a loved one can qualify as a stressful event that might precede an AD. Finally, a Bereavement-Related subtype has been proposed for DSM5. The proposed PTSD criteria have been tested in two internet surveys and in the DSM5 Field Trials. Data obtained from these sources will be presented to show how the criteria performed

SYMPOSIUM 033**CLINICAL AND ADMINISTRATIVE ASPECTS OF****THE DSM5 PERSONALITY DISORDERS***Chair: James Reich, M.D., M.P.H.**Discussant: Andrew E. Skodol, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session the participant should be able to: 1) Have increased understanding of how changes in the DSM5 personality disorders will impact the ordinary psychiatric practitioner clinically, 2) Have increased understanding of how changes in the DSM5 personality disorders will impact the ordinary psychiatric practitioner administratively, 3) Have increased understanding of how changes in the DSM personality disorders have evolved over time and how this approach differs from European approaches

SUMMARY:

Among the diagnostic categories undergoing the greatest change in the DSM5 revisions are the personality disorders. This large change will impact clinical practice in many ways. This symposium attempts to address some of these changes that clinicians will face. There will be a presentation the history leading up to the current changes and how it compares to past personality disorder criteria changes. One presenter will address the question of how we can best determine the criteria for a personality disorder (This would be by identifying validators of personality disorders.) Another will discuss how these changes will affect approaches to psychotherapy. These changes will affect the approach to comorbidity of Axis I and Axis II disorders. This will be discussed with an emphasis on how this would affect the use of personality pathology to predict outcome of Axis I disorders. A shift as large as this in diagnostic criteria will affect practicing clinicians in many administrative ways as well. An expert on psychiatric administration will talk on this aspect.

S033-1.

PERSONALITY DISORDERS: THE DSM1 TO DSM5 CROSSWALK*Presenter: Donald W. Black, M.D.***SUMMARY:**

Maladaptive personality traits have been recognized since ancient times. Hippocrates described the four temperaments that were used up to the 20th century. In 1948 the APA set to work on a single national system for classification to replace the many competing schemes. This became the DSMI published in 1952. At 132 pages, definitions were relatively simple. There were few changes in DSMII (1968). The DSMIII, spearheaded by Robert Spitzer, came out in

1980 and represented a revolutionary break with the past. The goal was to produce a scientific document that stressed reliability by introducing operational diagnostic criteria. DSMIII became a much talked about sensation. Coming in at 494 pages, DSMIII listed 265 disorders, many of them new including borderline personality disorder, and introduced the multi-axial diagnostic system. There were few changes in DSMIII-R (1987) and DSMIV (1994). DSM5 is now under development and is set to come out in 2013. A major goal is to introduce the concept of dimensionality and reduce the number of personality types. The latest developments will be discussed and placed into perspective against past categorizations of personality.

S033-2.

VALIDATORS OF PROPOSED DSM5 PERSONALITY DISORDERS

Presenter: Larry J. Siever, M.D.

SUMMARY:

A number of important changes have been proposed for the transition from DSMIV to DSM5 including reduction in the number of disorders referred to as prototypes in DSM5 as well as moving to a trait-based system. In this context, it is important to review extant validators for some of the proposed changes. Validators in the domains of genetics, neurobiology, course, and treatment outcome provide support for diagnoses of borderline and schizotypal personality disorder. Considerable data is available also for antisocial personality disorder. Other disorders suggested for inclusion in DSM5 such as obsessive compulsive personality disorder, avoidant personality disorder, and possibly narcissistic personality disorder and arguments for their inclusion revolve more around clinical utility. Studies from normal populations supporting dimensional levels of severity in psychopathologic populations invite a complementary trait-based system. While external validators cited have been more utilized for prototypical disorders rather than traits, more extensive psychometric studies have been utilized for trait-based systems. While the focus of this presentation will be on disorder-based validators, state-of-the-art issues regarding both diagnostic types and trait systems will be discussed.

S033-3.

PERSONALITY AND OUTCOME OF AXIS I DISORDERS AFTER DSM5

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

SUMMARY:

The interaction of Axis I and Axis II disorders has long been

discussed and studied. It has now been well established that personality pathology predicts poorer outcome in depressive disorders. There is also considerable evidence for this in the anxiety disorders and some for physical outcome in cardiac illness. This presentation will review what we know of this phenomena in the areas of depression, anxiety and cardiac outcome. Theoretical and clinical aspects will be discussed briefly. The discussion will then shift to how the transition to the DSM5 personality disorders may affect how we apply previous research findings.

S033-4.

DIMENSIONAL DIAGNOSTIC CLASSIFICATION OF PERSONALITY DISORDER: IMPLICATIONS FOR PSYCHOTHERAPY

Presenter: John Livesley, M.D.

SUMMARY:

The proposed incorporation of dimensions into the DSM5 classification of personality disorder raises concerns about the relevance of current therapies when treating phenomena that appear to be radically different from the traditional clinical conditions that they were developed to treat. However, it will be argued that rather than presenting a problem, dimensional classification offers new ways to conceptualize treatment and creates the opportunity to develop new treatment strategies. Although contemporary therapies were developed to treat specific disorders such as borderline personality disorder, they target specific traits such as impulsivity, emotional lability, and dependency that are the basic elements of dimensional diagnosis. Explicit adoption of dimensional classification will facilitate a structured approach to treatment by providing a systematic description of the clinical phenomena that are targets for therapeutic intervention. Dimensional diagnosis also encourages alternative ways to think about treatment. Personality traits arise from heritable mechanisms that are elaborated during development into complex cognitive-emotional structures that mediate proclivities to show specific behaviors. The heritability of traits and their repetitive consolidation during development suggest that it may be more effective to focus on promoting more adaptive ways to express traits than to attempt more radical change in trait structure. Four strategies will be discussed: 1. increasing understanding and acceptance of one's basic traits; 2. modulating the intensity and frequency of trait expression by restructuring the cognitive component; 3. promoting more adaptive expression of a given trait by changing the repertoire of behaviors associated with the trait; and 4. encouraging the identification and creation of environmental niches that are compatible with the adaptive use of the individual's salient traits.

S033-5.

UNINTENDED AND NONPSYCHIATRIC CONSEQUENCES OF A CHANGE IN DIAGNOSIS

Presenter: Kenneth R. Silk, M.D.

SUMMARY:

A revision in a specific diagnosis and/or a category of diagnoses does not merely impact the clinicians who use the diagnostic system or those patients who receive diagnoses within that category, even if there is sufficient scientific evidence to support changing the diagnosis. There are a number of ways that other systems can be impacted by the change in the diagnosis, and the effect of the change on those systems is probably greater the larger the overall change. The simplest example of this might be found in the question: If we change the diagnostic label or the diagnostic criteria for borderline personality disorder will such a change impact the stigma that currently accompanies that diagnostic label? Other systems can be impacted as well. Government systems may develop policies around a given diagnosis or diagnostic category (e.g. the diagnosis of Dangerous and Severe Personality Disorder in the UK) and allocate resources to detect and to treat those categories. What happens to those policies and resources when the category no longer exists? There are other aftereffects that involve people who have been diagnosed with the "old" personality disorder diagnosis and may have had consequences either in their place of employment or in the military that led to dismissal or disability based upon a diagnosis that either no longer exists or whose criteria has changed so dramatically that the current definition is far from the original definition upon which prior adverse decisions had been made. These and other issues raise ethical concerns that can unwittingly erupt when a person or a committee decides that a change in how we diagnosis a person or persons needs revision because the scientific evidence no longer supports it or demands revision. Thus diagnosis, particularly in the field of psychiatry, is not merely a way we categorize individuals in terms of grouping them according to psychopathological commonalities; it can have profound effects upon how various aspects of the wider society and institutions within that wider society view them, treat them, and provide policies that either support or hinder them.

SYMPOSIUM 034

A COMPREHENSIVE MODEL FOR MENTAL HEALTH TOBACCO RECOVERY IN NEW JERSEY

Chair: Jill M. Williams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand how a comprehensive and integrated

approach for addressing tobacco may be more effective for smokers with mental illness, 2) Participants will also become familiar with how the 3 main components of engaging the community, changing the treatment environment and providing clinical treatment can work together to increase the demand for tobacco treatment services and help more smokers to quit, 3) Learn how environmental strategies for addressing tobacco are necessary given that social and institutional factors outside of the person have in the past reinforced or enabled tobacco use within the overall system, 4) Participants will recognize that tobacco dependence treatments for smokers with mental illness are well suited to the behavioral health care setting given the success of treatment for other cooccurring addictions in these settings, and 5) Participants will learn about CHOICES, a successful peerdriven program for reaching unmotivated smokers in the community

SUMMARY:

Although public health interventions have resulted in decreased smoking rates in the United States general population over the last 50 years, smokers with mental illness have not benefited as greatly from these efforts. Smoking rates in individuals with a mental illness or addiction are at least double the rates of tobacco use in the general population and there is evidence that this group consumes a sizeable portion of the tobacco sold in the United States (Lasser et al 2000). Individuals with mental illness suffer many consequences of tobacco use with excessive premature death, particularly from cardiovascular disease. Despite this information, smokers with mental illness have reduced access to tobacco dependence treatment across the health care spectrum. We have developed a comprehensive model for Mental Health Tobacco Recovery in New Jersey (MHTRNJ) that has the overarching goal of improving tobacco cessation for smokers with serious mental illness (Williams et al., 2010). Important steps involve engaging patients, professionals and the community to increase understanding that addressing tobacco use is important. In addition to increasing demand for tobacco treatment services, we must educate mental health professionals in evidencebased treatments so that patients can seek help in their usual behavioral health care setting. Communitybased smoking cessation services for the general population are often too brief for smokers with mental illness. Peer services that offer hope and support to smokers are essential. Each of the policy or cessation initiatives described address the two core goals of this model: to increase demand for tobacco cessation services for mentally ill smokers and to help more smokers with mental illness to quit. Each has been pilot tested for feasibility and/or effectiveness and revised with feedback from stakeholders. In this way this implementation model has brought together academics, clinicians, administrators and mental health consumers to develop tobacco programming and policy

that has been tested in a real world environment and serves as a model for other states. This symposium will review the main components of the MHTRNJ model in order to provide the participant with an integrated approach to addressing tobacco use in a mentally ill population. REFERENCES 1. Williams JM, Zimmermann MH, Steinberg ML, Gandhi KK, Delnevo C, Steinberg MB, Foulds J. A Comprehensive Model for Mental Health Tobacco Recovery in New Jersey. Administration and Policy in Mental Health and Mental Health Services Research Sep;38(5):36883. 2. Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: A populationbased prevalence study. JAMA 2000; 284(20): 26062610.

S034-1.

A COMPREHENSIVE MODEL FOR MENTAL HEALTH TOBACCO RECOVERY IN NEW JERSEY: INTRODUCTION AND OVERVIEW OF THE MODEL

Presenter: Mia Zimmermann, M.P.H.

SUMMARY:

Although public health interventions have resulted in decreased smoking rates in the United States general population over the last 50 years, smokers with mental illness have not benefited as greatly from these efforts. Smoking rates in individuals with a mental illness or addiction are at least double the rates of tobacco use in the general population (Lasser et al., 2000). Some estimates are that two-thirds of current cigarette smokers have a past or present mental health or substance abuse disorder and there is evidence that this group consumes a sizeable portion of the tobacco sold in the United States (Lasser et al 2000). Individuals with mental illness suffer many consequences of tobacco use with 25 years of life expectancy lost with excess mortality particularly from cardiovascular disease (Miller et al., 2006). Despite this information, smokers with mental illness have reduced access to tobacco dependence treatment across the health care spectrum. We have developed a comprehensive model for Mental Health Tobacco Recovery in New Jersey (MHTRNJ) that has the overarching goal of improving tobacco cessation for smokers with serious mental illness (Williams et al., 2010). Important steps involve engaging patients, professionals and the community to increase understanding that addressing tobacco use is important. In addition to increasing demand for tobacco treatment services, we must educate mental health professionals in evidencebased treatments so that patients can seek help in their usual behavioral health care setting. Community-based smoking cessation services for the general population are often too brief for smokers with mental illness. Peer services that offer hope and support to smokers are essential. Each of the policy or cessation initiatives described address the two core goals of this model: to increase de-

mand for tobacco cessation services for mentally ill smokers and to help more smokers with mental illness to quit. Each has been pilot tested for feasibility and/or effectiveness and revised with feedback from stakeholders. In this way this implementation model has brought together academics, clinicians, administrators and mental health consumers to develop tobacco programming and policy that has been tested in a real world environment and serves as a model for other states. This session will provide the background to inform the participant of the problem and then review the main components of the MHTRNJ model in order to pro

S034-2.

INNOVATIONS IN TOBACCO DEPENDENCE EDUCATION AND INTERVENTION: THE CHOICES PROGRAM

Presenter: Patricia Dooley, M.A.

SUMMARY:

CHOICES stands for Consumers Helping Others Improve their Condition by Ending Smoking. Here we describe the unique consumer-driven perspective of the CHOICES program for addressing tobacco. Despite evidence that tobacco dependence is a major issue, changes within the mental health system have been slow to develop. CHOICES employs mental health peer counselors called Consumer Tobacco Advocates (CTAs) to deliver the vital message to smokers with mental illness that addressing tobacco is important and to motivate them to seek treatment. CTAs serve as tobacco-focused consultants to assist with linkages to treatment, advocacy, support and the provision of educational materials. Successful partnerships with consumer advocacy groups, particularly the Mental Health Association in New Jersey, have contributed to the rapid growth and success of CHOICES. The overarching goal of the CHOICES program is to increase the demand for tobacco treatment services among mental health consumers. We conducted an IRB approved outcomes study of a subset of smokers who received the individual feedback intervention. The findings of this study will be discussed during the session. The CHOICES program of peer-to-peer community outreach to help smokers with mental illness is the first of its kind. Few other programs have been developed for addressing tobacco among people with mental illness that include consumers in the planning and delivery of services. The CHOICES program exemplifies many aspects of a successful wellness and recovery initiative: It targets a group with a tremendous health care need, seeks to reduce the harm caused by tobacco in a vulnerable group, focuses its efforts in the community, which best accommodates the target population, employs peers to reduce educational or cultural barriers that may exist, and develops successful partnerships with key stakeholder groups for sustainability.

To date, mental health advocacy groups have not been vocal in demanding tobacco treatment services for smokers with mental illness. In fact these groups have traditionally taken a position to protect tobacco use in mental health treatment settings, even using legal means to stall or overturn them. Advocates can provide an important role in raising awareness about the inequities of tobacco use, its consequences and also shine a light on the lack of tobacco control funding directed towards smokers with mental illness. Advocates should demand that access to evidencebased tobacco

S034-3.

ENVIRONMENTAL CHANGES NEEDED IN THE MENTAL HEALTH SYSTEM TO SUPPORT TREATMENT EFFORTS

Presenter: Jill M. Williams, M.D.

SUMMARY:

Despite the high prevalence of tobacco use, disproportionate tobacco consumption, and excess morbidity and mortality, smokers with mental illness have reduced access to tobacco dependence treatment across the health care spectrum. We have developed a comprehensive model for Mental Health Tobacco Recovery in New Jersey (MHTRNJ) that has the overarching goal of improving tobacco cessation for smokers with serious mental illness. For years, tobacco use and the mental health system have been inextricably linked. In the MHTRNJ Model we use the term environment to include the level of the agency or larger mental health system since these social and institutional factors outside of the person likely reinforce or enable tobacco use within the overall system. Clean indoor air and smokefree workplace regulations have contributed to a reduction in smoking prevalence and increased cessation efforts of smokers in the general population and should be applied to mental health treatment and housing settings. Tobaccofree hospital initiatives have not shown an adverse effect on hospitalized psychiatric patients. A tobaccofree environment will support the cessation efforts of individuals and also effect culture change by establishing new accepted norms. Paradoxically, although tobacco treatment has traditionally not been offered in behavioral health settings, this sector of health care is wellsuited to deliver it and may offer advantages compared to primary care, if barriers can be overcome. We must educate mental health professionals in evidencebased treatments so that patients can seek help in their usual behavioral health care setting. Psychiatrists appear unprepared to treat nicotine dependence, although they report considerable interest in this area. In NJ, we have been delivering a focused continuing medical education (CME) curriculum to mental health practitioners since 2006 (Williams 2009). Results from this training will be discussed. REFERENCES
1. Williams JM, Steinberg ML, Hanos Zimmermann M,

Gandhi KK, Lucas GE, Gonsalves DA, Pearlstein I, McCabe P, Galazyn M and Salsberg E. Training Psychiatrists and Advanced Practice Nurses to Treat Tobacco Dependence. *Journal of the American Psychiatric Nurses Association* 2009; 159(1): 5058

S034-4.

CLINICAL TREATMENT APPROACHES FOR SMOKERS WITH MENTAL ILLNESS

Presenter: Jonathan Foulds, Ph.D.

SUMMARY:

Despite the high prevalence of tobacco use, disproportionate tobacco consumption, and excess morbidity and mortality, smokers with mental illness have reduced access to tobacco dependence treatment across the health care spectrum. We have developed a comprehensive model for Mental Health Tobacco Recovery in New Jersey (MHTRNJ) that has the overarching goal of improving tobacco cessation for smokers with serious mental illness. National treatment guidelines recommend that all smokers should be offered counseling and pharmacotherapy, and given that smokers with a mental illness tend to be heavier smokers, these recommendations should be followed more aggressively in this population, not less. Tobacco treatment should be integrated into mental health treatment, with every tobacco user receiving assessment, motivational interventions and a long term treatment perspective that helps them to quit. Brief tobacco dependence interventions such as telephone quitlines, which are effective in primary care and public health settings, may lack the intensity or specialization needed for this population to stop smoking. We have developed smoking cessation treatments that can be delivered within the mental health treatment center in conjunction with tobacco treatment medications. Access to pharmacotherapy can be a barrier to successful treatment since studies indicate heavy smoking and high levels of nicotine dependence in some groups of mentally ill smokers.

SYMPOSIUM 035

INTEGRATIVE PSYCHIATRY FOR TREATMENT OF MOOD AND ANXIETY DISORDERS ACROSS THE LIFE CYCLE

Chair: Helen Lavretsky, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss the scope and prevalence of complementary and alternative medicine use in the US population for treatment and prevention of mood and anxiety disorders across the life cycle, 2) Understand the scope of comple-

mentary and alternative medicine approaches in pediatric mental health in the US, 3) Understand the indications, recommended dosing, and adverse effects of the more popular and betterstudied natural remedies for psychiatric disorders, 4) Understand the role and the efficacy of hypnosis and mindfulness used in the psychotherapy of mood and anxiety disorders, and 5) Discuss the use of mindbody techniques such as yoga and Tai Chi for treatment and prevention of mood disorders in later life

SUMMARY:

The Symposium will provide indepth discussion of the complementary and alternative medicine (CAM) in the context of Integrative Psychiatry used for treatment and prevention of mood and anxiety disorders across the life cycle. The Symposium targets broad audience of clinicians, researchers and trainees at various levels of training in geriatric psychiatry. Participants will gain familiarity with the potential uses of mindfulness meditation, yoga, Tai Chi, acupuncture, massage, and natural supplements to treat depression and anxiety disorders, and will be provided with an overview of the use of CAM in pediatric, adult, and geriatric populations. The use of CAM is increasingly recognized by health-care practitioners as an important factor to consider in taking the history and formulating treatment plans even in “traditional Western” medical settings. CAM has increased in popularity in the US and worldwide over the past two decades, particularly in the area of mental health. Mood and anxiety disorders are one of the most common reason for which people seek out CAM interventions. Despite the increasing use of these alternative therapies, physicians are relatively unaware of the efficacy, dosing, and safety issues pertaining to CAM products and treatments. First, Scott Shannon will describe evidencebased CAM approaches in treating children and adolescence with mood and anxiety disorders. Second, David Mischoulon will discuss the data on the efficacy and safety of some of the more commonly used natural products and acupuncture for treating depression and bipolar disorder. Third, David Spiegel will review the phenomena of hypnosis and mindfulness and their role in the psychotherapy of mood and anxiety disorders. Fourth, Mark Rappaprot will discuss the neurobiology of massage used for treatment of anxiety and mood disorders. Lastly, Helen Lavretsky will provide an overview of CAM use for treatment and prevention of laterlife mood disorders and will present the results of her studies of Tai Chi use for treatment of depression in older adults, and the yogic meditation, Kirtan Kriya, for stress and depression in caregivers. The final panel discussion will provide an overview of the future of integrative psychiatry and applications of CAM to treatment of mood disorders across the life span.

S035-1.

THE USE OF MINDBODY INTERVENTIONS FOR TREATMENT AND PREVENTION OF LATERLIFE MOOD DISORDERS

Presenter: Helen Lavretsky, M.D.

SUMMARY:

Background: Nearly twothirds of elderly patients treated for depression fail to achieve symptomatic remission and functional recovery with firstline pharmacotherapy. New strategies are needed to improve clinical outcomes of geriatric and caregiver depression. METHODS: In the first study, we asked whether a mindbody exercise, Tai Chi Chih (TCC), added to escitalopram could augment the treatment of geriatric depression designed to achieve symptomatic remission and improvements in health functioning and cognitive performance in 112 older adults with major depression who were treated with escitalopram for approximately 4 weeks. 73 partial responders to escitalopram continued to receive escitalopram daily and were randomly assigned to 10 weeks of adjunct use of either 1) TCC for 2 hours per week or 2) health education (HE) for 2 hours per week. RESULTS: 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 those receiving escitalopram and HE. Subjects in the escitalopram and TCC condition also showed significantly greater improvements in 36Item Short Form Health Survey physical functioning and cognitive tests and a decline in the inflammatory marker, Creactive protein, compared with the control group. The second study examined the potential of daily brief yogic meditation (Kirtan Kirya) practice to improve distress and coping, mental health, cognition, and the activity of immune cell telomerase activity and nuclear factorkappa B (NF kappa B (NFkB)) in 39 stressed family dementia caregivers. The severity of distress improved in both groups; however, the meditation group showed significantly greater improvement in mental health, cognitive performance, and adaptive coping. Telomerase levels were increased by 43% in the meditation group compared to 7% in the relaxation group ($p<0.05$). Improvement in scores on measures of distress and coping and cognition correlated strongly with increases in telomerase, and decreases in nf kappaB activity in the meditation group, but not the relaxation group. In the meditation group, the standardized volume of interest (sVOI) method of analysis demonstrated significant decreases in the bilateral associative visual cortex (VC) (left $t=5.47$, $p=0.012$; right $t=3.24$, $p=0.048$) and right inferior frontal gyrus (rGFi) ($t=4.438$, $p=0.021$), while the relaxation control group did not show any significant decreases, and demo

S035-2.

NATURAL REMEDIES AND ACUPUNCTURE FOR

MOOD DISORDERS: REVIEW OF THE EVIDENCE

Presenter: David Mischoulon, M.D., Ph.D.

SUMMARY:

Complementary and Alternative Medicine (CAM) has increased in popularity in the US and worldwide over the past two decades, particularly in the area of mental health. Mood disorders are one of the most common reason for which people seek out CAM interventions. Despite the increasing use of these alternative therapies, physicians are relatively undereducated with regard to efficacy, dosing, and safety issues pertaining to CAM products and treatments. This lecture will review the efficacy and safety of some of the more commonly used natural products for treating depression, including St John's Wort, Sadenosyl methionine, and omega3 fatty acids. We will also review a few products that may be helpful in bipolar disorder, such as Nacetyl cysteine and vitamin supplements. Other CAM therapies such as acupuncture, which is also thought to help in mood disorders, will also be reviewed. Clinicians who attend this lecture will obtain a good understanding of the evidence, indications, recommended dosing, and adverse effects of the more popular and betterstudied CAM therapies for mood disorders, and will be able to advise patients who are already using or considering trying these remedies.

S035-3.**TRANCE AND TREATMENT: MINDING MOOD AND ANXIETY**

Presenter: David Spiegel, M.D.

SUMMARY:

Healing ceremonies in many cultural traditions involve inducing an alteration in mental state. Most mind/body techniques employed in the West involve inducing a change in mental state coupled with instructions to control symptoms such as pain or anxiety, or even to improve the course of a disease. Hypnosis, begun as a therapeutic discipline in the 18th Century, was the first Western conception of a psychotherapy. Hypnosis is a state of highly focused attention coupled with a suspension of peripheral awareness. This ability to attend intensely while reducing awareness of context allows one to alter the associational network linking perception and cognition. The hypnotic narrowing of the focus of attention is analogous to looking through a telephoto lens rather than a wide angle lens – one is aware of content more than context. This can also facilitate reduced awareness of unwanted stimuli, such as pain, or of problematic cognitions, such as depressive hopelessness. Such a mental state enhances openness to input from others often called suggestibility and can increase receptivity to therapeutic

instruction. Psychotherapeutic intervention using hypnosis and mindfulness in the medical setting has been underappreciated as a means of enhancing psychological control over mental and physical processes. Hypnosis is a form of highly focused attention with a reduction in peripheral awareness. It differs from ordinary consciousness in that we usually respond to images and manipulate words, while in hypnosis we often respond to words and manipulate images. This image processing ability allows us to modulate perception, as studies using eventrelated potentials, PET and fMRI imaging illustrate. This hypnotic ability to modulate perception has clear clinical application, especially in pain and anxiety control. Randomized clinical trials demonstrating the efficacy of hypnosis in reducing pain, anxiety, somatic complications, and length of the procedure during radiological interventions will be presented. Evidence regarding the utility of hypnosis to facilitate cognitive restructuring of stressrelated problems, acute and posttraumatic stress disorder, and depression will be presented. Meditation has been practiced in many forms for health and healing for thousands of years. Meditation is defined as a family of selfregulation practices that focus on training attention and awareness. A recent operational definition of mindfulness meditation (MM) emp

S035-4.**CAM: IMPLICATIONS FOR MOOD AND ANXIETY DISORDERS**

Presenter: Mark H. Rapaport, M.D.

SUMMARY:

The discussion will focus on the myriad of opportunities and problems that integration of nontraditional therapies may create both for the patient and the practitioner. These issues become infinitely more challenging to address when we take into account the dynamic nature of aging throughout the human life cycle. Our field needs to begin to address the integration of CAM approaches into the therapy for mood and anxiety disorders: (1) because our patients and their families certainly are, and (2) if we abrogate our responsibilities to thoughtfully explore and lead these efforts, others will fill the void.

S035-5.**INTEGRATIVE PSYCHIATRY FOR PEDIATRIC MOOD DISORDERS**

Presenter: Scott Shannon, M.D.

SUMMARY:

Dr. Scott Shannon will review the evidence for nonconventional approaches in treating children/adolescents with

mood disorders. First, the demographics and utilization of nonconventional approaches in pediatric mental health will be covered. Given the limited nature of the evidence for conventional treatments, the evidence base is fairly limited. The data from several lines of evidence will be reviewed. First, the material on exercise will be reviewed. Next the material on vitamin D will be explored. Following this the presentation will consider studies on the use of Saint John's wort in the pediatric population. The largest segment will explore nutritional supplements that have some evidence base in children and teen populations. This will include essential fatty acids, vitamin/mineral combinations and other supplement interventions. A quick review of less conventional psychotherapy interventions will be offered: i.e. Dialectical Behavior Therapy, EMDR, etc. Finally, the data base for such things as acupuncture and massage will be covered briefly. The talk will end with a brief exploration of research issues that limit the applicability and value of randomized controlled trials for this field.

SYMPOSIUM 036

CHARACTERIZATION AND TREATMENT OF EARLY STAGES OF SCHIZOPHRENIA

Co-Chairs: S. Charles Schulz, M.D., Matcheri S. Keshavan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the brain development pathways associated with early stage schizophrenia, 2) Demonstrate knowledge of the characteristics of those prodrome patients who are at risk for conversion to schizophrenia, 3) Demonstrate knowledge of the comprehensive program for treating youth with psychosis

SUMMARY:

It has long been known that schizophrenia has its onset in teenage and young adult years, yet in the last decade a significant amount of interest has been focused on the assessment of the prodrome to schizophrenia and to the initial stages of this psychotic illness. Research has indicated that the longer a person has psychotic symptoms without receiving treatment that the poorer the person will do both socially and functionally. Thus, both prodrome and first episode clinics are emerging around the world. It is the purpose of this symposium to present the understanding of the underpinning of brain development in relationship to the emergence of psychosis, to present the latest information on classification of the prodrome, to hear about innovative approaches to "youth psychiatry" and to review the emerging treatment programs for the early stages of the illness. The first speaker, Dr. Matcheri Keshavan will provide the neuro-

scientific background of brain development in its relationship to the stages of schizophrenia. Dr. Keshavan's work in brain imaging provides a neuroscientific underpinning for the phenomenology of morbid, prodromal, and first episode psychosis. This talk will be followed by Dr. Tyrone Cannon's description of the characteristics of people with prodromal symptoms and ways to understand who is at highest risk for "conversion" to psychotic illness. This talk will be followed by a presentation by Dr. Patrick McGorry who has originated the Youth Psychiatry Program in Melbourne, Australia – a program which has provided an outstanding model for teens and young adults around the world. Dr. McGorry's presentation will describe mechanisms for connecting with young people and providing treatments over the span of the early stages of psychotic illnesses. The final presentation will be by Dr. Charles Schulz who will discuss the pharmacologic and psychosocial approaches for the early stage schizophrenia patient. This area is of considerable controversy because of young persons' higher rates of side effects than adults with the current medications being used. In conclusion, the early stages of schizophrenia are receiving substantial attention and data is mounting regarding the positive impact of early recognition and treatment. The symposium speakers will provide the neuroscience background and the current data on treatment approaches for this important patient group.

S036-1.

ADOLESCENT BRAIN DEVELOPMENT, PREMORBID IMPAIRMENTS, AND RISK FOR SCHIZOPHRENIA

Presenter: Matcheri S. Keshavan, M.D.

SUMMARY:

Psychotic disorders, notably schizophrenia, begin in adolescence, though many precursors of these illnesses date back to early childhood. Adolescence is a critical developmental period when the brain undergoes major reorganization in the service of higher cognitive functions, affect regulation, cognitive control and adaptive stress response. Adolescence is also characterized by the emergence of unique challenges, such as independence, identity formation and the formation of peer relationships. The brain's plasticity, i.e. the ability to change itself (plasticity) also undergoes major transformation during this period. The interaction between changes in neuroplasticity and the unique stresses of adolescence lead to an increase in risk for psychotic disorders, as a result of adverse genetic and environmental influences. Data from ongoing longitudinal investigations in the Pittsburgh Risk Evaluation Program (PREP) utilizing Magnetic Resonance Imaging and spectroscopy will be presented in support of this view. A fuller understanding of such an evolution of pathology and its etiological antecedents offers critical op-

portunities for early intervention and prevention.

S036-2.

ALTERED FUNCTIONAL AND STRUCTURAL BRAIN DEVELOPMENTAL TRAJECTORIES IN YOUTH AT CLINICAL RISK FOR PSYCHOSIS

Presenter: Tyrone D. Cannon, Ph.D.

SUMMARY:

Abnormal neurodevelopmental processes during adolescence have been hypothesized to play a role in the onset of schizophrenia and related disorders. Some preliminary work in small samples of first episode and clinical high risk (CHR) patients suggests a progressive loss of gray matter, particularly in prefrontal regions, in the preonset and early stages of psychosis. Here we report on longitudinal analyses of neuroimaging data obtained on subjects participating in the North American Prodrome Longitudinal Study (NAPLS). Adolescents and young adults who met criteria for a prodromal risk syndrome, along with age and gender-matched controls, were evaluated with MRI, DTI, and fMRI at baseline assessment and again at one-year followup. BOLD signal was acquired during performance of an emotion processing task. While all groups showed a general pattern of reduced gray matter over the followup interval, CHR patients who converted to psychosis showed significantly greater rates of both localized surface contraction and gray matter density reduction in lateral and medial prefrontal, superior and middle temporal, and inferior parietal regions, compared with demographically matched healthy controls and with CHR patients who did not convert. Further, whereas in cross-sectional analyses of baseline data, controls showed increases in fractional anisotropy (FA) with age in a number of white matter tracts, overall CHR patients showed an absence of age-related increases in FA in these regions, a pattern that predicted a worsening clinical course. On the fMRI task, controls displayed decreased amygdala and increased vPFC activation with age, while patients exhibited the opposite pattern, suggesting a failure of prefrontal cortex to regulate amygdala reactivity. CHR subjects who convert to psychosis show an abnormal pattern of change in structural and functional brain parameters over time, consistent with the view that altered neurodevelopmental processes during the periadolescent period, including synaptic pruning and myelination, may play a role in the pathophysiology of psychotic disorders.

S036-3.

EARLY INTERVENTION IN PSYCHIATRY: LESSONS FROM PSYCHOSIS

Presenter: Patrick D. McGorry, M.D., Ph.D.

SUMMARY:

Mental and substance use disorders are the key health issue for emerging adults, which if persistent, may constrain, distress and disable for decades. Epidemiological data indicate that 75% of people with mental disorders have an age of onset by 24 years of age, with new onsets peaking in the early twenties. In recent years, a worldwide focus on the early stages of psychotic disorders has improved understanding of these complex disorders and their outcomes. This reform paradigm has also illustrated how a staging model may assist in interpreting biological data and refining diagnosis and treatment selection. We now have a strong evidence base supporting early intervention in psychosis including robust cost effectiveness data and growing evidence that intervention even prior to full expression of the psychosis phenotype is feasible and effective. To deliver this paradigm we need to move to a broader spectrum youth mental health model which can extend the benefits of early intervention to mood and other major mental disorders. It is clear that the critical developmental needs of emerging adults are poorly met by existing service models which are stigmatised or exclude young people in other ways. Young people need a different culture of service provision to engage with and benefit from interventions. The need for structural reform and a new research agenda is clear.

S036-4.

UPDATE ON MEDICATION APPROACHES TO EARLY-STAGE SCHIZOPHRENIA

Presenter: S. Charles Schulz, M.D.

SUMMARY:

Medications for the treatment of schizophrenia have usually been assessed for efficacy in middle-aged populations of patients who frequently have many years of exposure to antipsychotic medicine treatment. With the field of psychiatry's attention to reducing the duration of untreated psychosis (DUP), there has been greater attention paid to assessing the efficacy of antipsychotic medicine in teenagers and young adults. Results of studies with young people have shown statistically significant rating scale score reduction with antipsychotic medication. More recently, trials for adolescents have shown significant results leading to FDA approval for some second generation antipsychotics. In addition, the studies have noted the importance of dosing strategies in these patients who frequently have never received antipsychotic medication treatment. First episode studies of risperidone and olanzapine compared to haloperidol utilized doses that were lower than those used in older patients. A challenge for clinicians has emerged as data shows the sensitivity of young people to movement disorder and metabolic side effects of antipsychotics. A

recent study of neuroleptic naïve young patients demonstrated increased weight with four atypical agents at a mean of 10 weeks (Correll et al., JAMA, 2009). Beyond the data of efficacy and tolerance of second generation antipsychotics in young patients is the finding that with each relapse there is an increased length of time to restabilization. This focuses attention on the need for continuity and adherence programs. In summary, reducing DUP is a focus of helping young people; however, there are challenges clinicians face in initiating treatment.

SYMPOSIUM 037

NEUROBIOLOGICAL MECHANISMS IN BORDERLINE PERSONALITY DISORDER

Co-Chairs: Christian Schmahl, M.D., Harold W. Koenigsberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize advances in research on the neurobiology of borderline personality disorder, 2) Learn about different aspects of emotion regulation in BPD, 3) Understand mechanisms of selfinjurious behavior in BPD

SUMMARY:

In recent years, neurobiological research in the domain of Borderline Personality Disorder (BPD) has grown substantially. Advances have been made particularly in the investigation of mechanisms behind emotion dysregulation and the contribution of disturbed pain processing to the pathophysiology of the disorder, e.g. in the context of selfinjurious behavior. This symposium will comprise some of the latest research findings in these areas. Sabine Herpertz will present a study on the influence of oxytocin on facial processing showing that oxytocin has the potential to reduce the hypersensitivity towards social threat. Presenting a study on the default mode network, Ruth Lanius shows that altered connectivity of this network during painful stimulation may underlie a different appraisal of pain in BPD patients. Harold Koenigsberg presents data from a study showing that repetitive reappraisal training can reduce negative reactions to aversive pictures, associated with a decrease of medial prefrontal cortex activation. Finally, Inga Niedtfeld shows that painful stimulation leads to an improvement of prefrontal limbic inhibition, potentially mirroring the tension-reducing effect of selfinjury.

S037-1.

OXYTOCIN MODULATES THREAT HYPERSENSITIVITY IN BPD

Presenter: Sabine Herpertz, M.D.

SUMMARY:

Objectives: borderline personality disorder (bpd) patients show a hypersensitivity to experience interpersonal threat, tend to ascribe resentment to others, and consequently frequently experience anger that they may not be able to control. We were interested whether the neuropeptide oxytocin (oxo) that has been reported to enhance trust in others, e.g. By enhancing the processing of positive social stimuli and improving the capacity to effectively attend the eye region of conspecifics can modulate threat hypersensitivity in bpd. **Methods:** 35 female bpd patients and 31 female controls were included in a randomized controlled trial either receiving 27 iu intranasal oxytocin or a placebo. They were instructed to classify briefly presented fearful, angry and happy facial expressions. To examine the effect of oxytocin on gazeorienting behavior, stimuli were unpredictably shifted either downward or upward on each trial, thus manipulating whether participants initially fixated on the eye or mouth region. We assessed eyemovement data as well as functional imaging data. **Results:** eyetracking data in the placebo condition points to hypersensitivity of bpd patients to social threat in an early stage of processing as they showed highly significant longer latencies of saccades in response to angry but not to happy faces. Oxo administration normalized the latencies of saccades for angry faces and reduced the number of saccades to the eye region of angry faces in bpd. In addition, oxo enhanced the number of saccades to the mouth in response to happy faces and therefore the facial region that best reflects social approach behaviour. Functional neuroimaging data with regard to valence and gazerelated effects will be presented, as well. **Conclusions:** data suggest that oxo could have the potency to reduce hypersensitivity to social threat in bpd.

S037-2.

ALTERATIONS IN DEFAULT MODE NETWORK CONNECTIVITY DURING PAIN PROCESSING IN BPD

Presenter: Ruth A. Lanius, M.D., Ph.D.

SUMMARY:

Background: recent neuroimaging studies have associated activity in the default mode network (dmn) with self-referential and pain processing, both of which are altered in borderline personality disorder (bpd). In patients with bpd, antinociception has been linked to altered activity in brain regions involved in the cognitive and affective evaluation of pain. Findings in healthy subjects indicate that painful stimulation leads to blood oxygenation level-dependent (bold) signal decreases and changes in the functional architecture of the dmn. The objective of the present study was to connect the previously separate research areas of dmn

connectivity with the investigation of altered pain perception in bpd and explore dmn connectivity during pain processing in patients with bpd. Methods: twentyfive women with bpd and 22 agematched controls participated in this study. Psychophysical assessment and functional magnetic resonance imaging (fmri) during painful heat versus neutral temperature stimulation was carried out. Dmn connectivity as assessed via independent component analysis and psychophysiological interaction analysis. Results: compared to controls, patients with bpd showed less integration of the ventral posterior cingulate cortex and inferior frontal gyrus into the dmn. Higher bpd symptom severity and trait dissociation were associated with an attenuated signal decrease of the dmn in response to painful stimulation. During "pain" compared to "neutral", bpd patients exhibited less posterior cingulate cortex seed region connectivity with the left dorsolateral prefrontal cortex. Conclusion: patients with bpd showed significant alterations in dmn connectivity, with differences in spatial integrity and temporal characteristics. These alterations may reflect a different cognitive and affective appraisal of pain as less selfrelevant and aversive, and a deficiency in the switching between baseline and taskrelated processing. This deficiency may be related to everyday difficulties of bpd patients to regulate their emotions, focus mindfully on one task at a time, and efficiently shift their attention from one task to another.

S037-3.

TRAINING IN COGNITIVE REAPPRAISAL TO REDUCE NEGATIVE AFFECT IN BORDERLINE PERSONALITY DISORDER: BEHAVIORAL AND FMRI FINDINGS

Presenter: Harold W. Koenigsberg, M.D.

SUMMARY:

Borderline personality disorder (bpd), a disorder characterized by emotional instability, and a suicide rate of 10%, is quite difficult to treat. Recent work has shown that neural processing of emotion in bpd is aberrant. When bpd patients attempt to apply a common and highly adaptive emotion regulation strategy, cognitive reappraisalbydistancing, they do not engage the anterior cingulate and intraparietal sulci as healthy subjects do and do not downregulate amygdala activity. We examine whether this impairment in emotion regulation can be reversed by focused training. Method: 10 bpd subjects were instructed to reduce their reactions to aversive images by using a reappraisalbydistancing strategy. On each of 5 consecutive practice days, they were shown 48 different negative images. Half were preceded by an instruction to simply look and half to distance. Subjects rated emotional reactions to each image after carrying out the instruction. Bold fmri images were acquired as subjects performed the task on days 1 and 5. Results: with training,

bpd subjects significantly reduced subjective negative reactions to aversive pictures in the look condition (day 1 day 5: $t(9)=2.21, p<.05$). Training was associated with an increase in bold activity in the left caudate and a decrease in bold activity the dorsomedial prefrontal cortex (dmpfc) in both the look and distance conditions. The amount by which subjects decreased their negative reactions when distancing from day 1 to day 5 was directly correlated with the level of caudate activation on day 5 ($r = 0.585, p = 0.075$). Conclusion: bpd subjects receiving 5 days of training in reappraisalbydistancing increased their capacity to reduce negative subjective responses to aversive images, even when simply looking at the images. This was associated with an increase in caudate activation and a decrease in dmpfc activation. While this preliminary work calls for replication in a larger sample, it suggests that borderline patients may be trained to enhance their capacity to downregulate negative emotional reactions by means of cognitive reappraisal.

S037-4.

PAINMEDIATED AFFECT REGULATION IN BPD

Presenter: Inga Niedtfeld, M.A.

SUMMARY:

Disturbed affective responding and affective dysregulation are core symptoms of borderline personality disorder (BPD). At a neurobiological level, findings point to a conjunction of limbic hyperarousal and dysfunctional prefrontal regulation mechanisms. A second core symptom in BPD is selfinjurious behavior (SIB), which is known to correspond to affective dysregulation and is used by patients to escape from aversive tension or undesired emotions. To investigate the potential role of selfinflicted pain as a means of affect regulation in patients with bpd, we conducted an fMRI study with 20 patients and 23 healthy subjects using picture stimuli to induce negative (vs. Neutral) affect and thermal stimuli to induce heat pain (vs. warmth perception). Both negative and neutral pictures led to stronger activation of the amygdala, insula, and anterior cingulate cortex in patients with bpd than in healthy subjects. Amygdala activation correlated with selfreported deficits in emotion regulation. During the sensory stimulation, we found decreased amygdala and anterior cingulate cortex activation, which was independent of painfulness. Using psychophysiological interaction (PPI) analyses, we found the coupling between limbic regions and prefrontal control regions to be enhanced when patients experienced pain. The results are in line with previous findings on emotional hyperactivity in BPD. If the negative correlation between limbic and prefrontal brain areas reflects functional inhibition, this could be interpreted as an improved inhibition of limbic arousal by means of painful stimulation in BPD, supporting current theories on the function of selfinjury.

SYMPOSIUM 038

BORDERLINE PERSONALITY DISORDER AND THE MOOD DISORDERS SPECTRUM: COMORBIDITY, CONFUSION, AND CONTROVERSY

Chair: Lois W. Choi-Kain, M.D., M.Ed.

Discussant: S. Nassir Ghaemi, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the longitudinal interactions between comorbid mood disorders and borderline personality disorder, 2) Identify diagnostic, clinical, phenomenological, and biological common and distinguishing features in mood disorders and borderline personality disorder, 3) Understand current controversy between conceptualizations of bipolar spectrum disorders and comorbid borderline personality disorder with mood disorders

SUMMARY:

The clinical and empirical overlap among the diagnostic constructs of Borderline Personality Disorder (BPD), atypical depression (AD), and bipolar spectrum disorders are both significant and poorly understood. While BPD's symptomatology span the characteristic interpersonal sensitivities and mood reactivity common to atypical depression, it also involves the combination of mood lability and impulsivity common to bipolar disorders. Alternative theories of clinical misdiagnosis, complex comorbidity, and affective spectrum disorders have attempted to explain these significant overlaps. This symposium will 1) review the common and distinguishing diagnostic, clinical, phenomenological, and biological features in mood disorders and BPD; 2) describe common and differentiating clinical and empirical markers of each disorder; 3) discuss the interaction of mood disorders with BPD longitudinally; and 4) outline the current controversy regarding the relationship between these disorders. Implications for future research and practical clinical management will be discussed.

S038-1.**THE IMPORTANCE OF CONSIDERING BORDERLINE PERSONALITY DISORDER WHEN INTERPRETING STUDIES OF THE VALIDITY OF THE BIPOLAR SPECTRUM**

Presenter: Mark Zimmerman, M.D.

SUMMARY:

The nosological status of borderline personality disorder as it relates to the bipolar disorder spectrum has been con-

troversial. Studies have supported, in part, the validity of the bipolar spectrum by demonstrating that these patients, compared to patients with nonbipolar depression, are characterized by earlier age of onset of depression, recurrent depressive episodes, comorbid anxiety and substance use disorders and increased suicidality. However, all of these factors have likewise been found to distinguish depressed patients with and without borderline personality disorder. However, there are a few disorder specific validators. In this presentation I will summarize data from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project comparing the demographic and clinical characteristics of depressed patients with and without borderline personality disorder. Most of the factors used to validate the bipolar spectrum also distinguish depressed patients with and without borderline personality disorder thereby highlighting the importance of distinguishing between variables that are specific and nonspecific for validating the bipolar spectrum.

S038-2.**PHENOTYPE, ENDOPHENOTYPE, AND GENOTYPE COMPARISONS BETWEEN BORDERLINE PERSONALITY DISORDER AND MAJOR DEPRESSIVE DISORDER**

Presenter: Marianne S. Goodman, M.D.

SUMMARY:

The relationship between Major Depressive Disorder (MDD) and Borderline Personality Disorder (BPD) has remained controversial for over twentyfive years and continues to be the topic of numerous biological, phenomenological, and longitudinal studies. This presentation reviews data from the last ten years and compares the two disorders' phenotypes, putative endophenotypes and genotypes, focusing heavily on neuroimaging findings. Review of the literature. Familiality and phenotypic differences suggest that BPD differs in important ways with respect to symptomatology, prognosis, and heritability. The neurobiological findings in both MDD and BPD are still preliminary at present, and no coherent model for either disorder can be said to have emerged. Overlapping biological processes including amygdala hyperreactivity, volume changes in subgenual anterior cingulate cortex, and deficient serotonergic function appear to underlie emotional dysregulation in both disorders. However, the disorders seem to differ in their patterns of brain region involvement, neurohormonal indices, and sleep architecture. At present, the minimal data available for putative genotypes of BPD is still emerging, nonspecific to the disorder and demonstrates significant overlap with MDD. While both disorders involve mood alterations, the affective instability in BPD is fundamentally distinct from the mood disturbance in MDD. Overlapping symptomatology

ogy between these disorders may result from an overlap in the underlying biology, but the biology that makes individuals vulnerable to each disorder is as yet only beginning to be understood.

S038-3.

ATYPICAL DEPRESSION: MOOD DISORDER, BORDERLINE PERSONALITY DISORDER, OR BOTH?

Presenter: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:

Atypical depression (AD) and borderline personality disorder (BPD) are diagnostic entities that both describe syndromes characterized by mood reactivity and longstanding interpersonal hypersensitivities to rejection and criticism. The atypicality of AD refers to its constituent symptoms that are not consistent with usual symptoms of depression, including reverse vegetative symptoms like increased appetite and hypersomnia. The atypical nature of the manifestations of depression in AD have led to questions of whether the disorder is not actually form of depression but rather either bipolar type II or borderline personality. The confusion between AD and BPD has been explained by mood disorders researchers through the concept of cyclothymic temperament, which is hypothesized to contribute to both BPD and AD. In other words, the atypical nature of this kind of depression is explained through considerations of temperament, that is a feature of personality. In contrast, BPD is a disorder highly comorbid with depression, involves depressive states which are phenomenologically distinct from major depressive episodes in the sense they are more chronic, interpersonally reactive, and unresponsive to pharmacologic interventions typically effective for MDD. Significant dysclarity and controversy about the relationship between AD and BPD exist, but limited research exist to elucidate the boundaries and overlaps between these diagnoses. This presentation will review existing research and competing theories which explain the diagnostic confusions and comorbidity between AD and BPD. Recommendations for diagnosis and treatment planning will be discussed.

S038-4.

INTERACTION OF BPD AND AFFECTIVE DISORDERS: 10YEAR FOLLOWUP

Presenter: John G. Gunderson, M.D.

SUMMARY:

This presentation derives from 10year followup data on 240 patients with Borderline Personality Disorder (BPD) in the Collaborative Longitudinal Study of Personality Disorders (CLPS). Time to remission and to relapse analyses were

done to examine the interaction of BPD with major depressive, dysthymia, and bipolar disorder. Our results show that BPD greatly extends the time to remission of MDD ($p = .0001$) and that this effect is reciprocal, i.e., MDD extends BPD's time to remission ($p = .0004$). The latter result differs from an earlier CLPS report in which MDD failed to significantly effect BPD's course (Gunderson et al. 2008). Unlike MDD, dysthymia did not have a significant effect on BPD time to remission. Time to relapse analyses indicate that BPD diminishes the length of MDD's remission ($p = .0001$), but had no significant effect on the duration of Bipolar I or II. MDD had a strongly negative effect (i.e., shortened BPD's time to relapse, $p = .0013$), but dysthymia, Bipolar I, and Bipolar II had no effect. The results suggest more interaction between BPD and MDD than between BPD and Bipolar Disorder. The nosological and treatment implications of these results will be discussed.

SYMPOSIUM 039

NEUROBEHAVIORAL AND PHARMACOLOGICAL APPROACHES TO TARGET COGNITIVE REMEDIATION IN DRUG ADDICTION

Co-Chairs: Will Aklin, Ph.D., Ivan D. Montoya, M.D., M.P.H.

Discussant: Morris D. Bell, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify proposed mechanisms that elucidate the neurophysiologic substrates underlying cognitive deficits in drug users, 2) Understand options for clinical testing of a pharmacotherapeutic intervention – alone or in combination with behavioral treatment that may moderate and/or reverse an identified cognitive deficit in a drugdependent patient population, 3) Become familiar with research on various pharmacotherapeutic and/or behavioral treatment interventions that aim to improve cognitive functioning, attenuate drug use and its consequences

SUMMARY:

Deficits in cognitive functions (e.g., attention, planning, memory, inhibition) play an important role in the vulnerability, progression, and dependence of drug addiction. Specifically, patients with cognitive limitations, including risky decisionmaking, cognitive inflexibility, and high impulsiveness often fail to complete the full course of treatment and are more likely to relapse, potentially worsening the patient's neurocognitive condition and subsequent treatment outcomes. Neurobehavioral and pharmacological studies have begun to explore therapeutic approaches that focus on the relationships between executive functions and problematic decision making that might lead to or sustain behav-

ior related to drug abuse and dependence. The proposed symposium aims to provide an overview of current studies that incorporate preliminary evidence of cognitive remediation into clinical trials with pharmacological and/or behavioral interventions to improve treatment efficacy, retention, relapse prevention, and longterm treatment outcome. Each of the proposed studies also will provide a discussion of proposed mechanisms that elucidate the neurophysiologic substrates underlying cognitive deficits in drug users.

S039-1.

COGNITIVE ENHANCEMENT AND REMEDIATION STRATEGIES TO IMPROVE SMOKING CESSATION OUTCOMES

Presenter: A. Eden Evins, M.D., M.P.H.

SUMMARY:

Deficits in cognitive functions such as attention and inhibitory control are associated with failure to attain abstinence during smoking cessation attempts among smokers with and without comorbid psychiatric illness, with lower likelihood of completing a full course of treatment and with more likely to lapse or relapse after initial abstinence. Additionally, nicotine withdrawal is associated with cognitive impairment. Therapeutic approaches that ameliorate baseline or abstinence associated cognitive impairment, either alone or combined with other effective behavioral or pharmacologic therapy, may improve treatment outcomes. Current clinical trials underway that incorporate cognitive remediation with pharmacological and/or behavioral interventions to improve treatment outcomes include a trial of the putative cognitive enhancing agent, Dcycloserine, added to cue exposure therapy, a trial of an alpha7 nicotinic agonist alone or in combination with NRT to reverse withdrawal associated cognitive impairment, an accelerated learning paradigm using RealTime fMRI neurofeedback for learned selfcontrol craving and inhibitory control, and a trial of mindfulness meditation vs cognitive behavioral therapy for enhanced inhibitory control. All studies are conducted in treatment seeking smokers attempting to quit smoking. The neurophysiology of the proposed baseline or withdrawal associated cognitive process targeted with each therapy in nicotine dependent smokers will be discussed.

S039-2.

MATCHING COGNITIVE REMEDIATION TO THE DISTINCT COGNITIVE DEFICITS ASSOCIATED WITH SUBSTANCEABUSING PRISONERS WITH PSYCHOPATHY VERSUS OTHER EXTERNALIZING DISORDERS

Presenter: Joseph P. Newman, Ph.D.

SUMMARY:

Psychopathy and other externalizing disorders involve ubiquitous deficits in selfregulation that manifest as chronic antisocial behavior and substance use disorders. Despite their similar behavior problems, the dysfunctional cognitiveemotional interactions underlying the respective selfregulation deficits of psychopaths and externalizers are substantially different. Psychopathic individuals are characterized by an attention bottleneck that causes them to be oblivious to information that would otherwise contraindicate their goaldirected behavior and initiate selfregulation. Other externalizing disorders are characterized by high emotional reactivity and cognitive control deficits that are exacerbated in affectively charged situations. Although these disorders are notoriously resistant to standard interventions, it should be possible to achieve greater therapeutic benefit using cognitive remediation strategies that specifically target their respective deficits. Cognitive remediation involves training individuals in particular cognitive skills, such as paying attention to contextual cues, applying working memory, and sustained attention. Using a 2 group by 2 treatment crossover design, we are currently evaluating the extent to which cognitive remediation may be used to modify the dysfunctional cognitiveemotional interactions associated with substance dependent prisoners with predominantly psychopathic versus externalizing traits. More specifically, we are evaluating the extent to which training attention to relevant contextual information can alter the attention bottleneck problem associated with psychopathy. Simultaneously, we are evaluating the extent to which practicing cognitive control under affectively charged conditions enhances selfregulation in prisoners with other externalizing disorder. In this presentation, we (1) review the evidence concerning the distinct deficits associated with psychopathy and other externalizing disorders, (2) describe our Affective Cognitive Control and Attention to Context training protocols and experimental design, and (3) present preliminary evidence regarding the differential efficacy of these training protocols for bringing about pre to posttreatment change in selfregulation among criminal offenders with substance dependence disorders.

S039-3.

DOPAMINE, COGNITIVE FUNCTION, AND COCAINE

Presenter: Joy Schmitz, Ph.D.

SUMMARY:

Cocaine dependence has been linked closely to deficits in the dopamine (DA) brain system. Chronic cocaine users show impairments in cognitive processes known to be associated with DA (e.g., decisionmaking, behavioral inhibition,

attentional bias). These cognitive impairments have been shown to predict higher dropout rates, less efficacious therapy, and greater likelihood of relapse. Treatment medications aimed at bolstering cognitive functions via DA modulation might decrease dropout and enhance clinical outcome. This paper will review the literature and present new evidence supporting therapeutic interventions (including DA-enhancing medications) that target remediation of cognitive-behavioral deficits in cocaine dependent patients. Emerging research that integrates neuroimaging findings with cognitive deficits and treatment outcome will be presented.

S039-4.

COGNITION AS A TARGET FOR NICOTINE DEPENDENCE TREATMENT

Presenter: Caryn Lerman, Ph.D.

SUMMARY:

Cognitive alterations are a core symptom of nicotine withdrawal and dependence. This presentation will include emerging data from a series of studies which aim to characterize objective cognitive deficits during the early nicotine withdrawal; to identify genetic and neural substrates of withdrawal-related cognitive deficits; to determine the influence of cognitive deficits on smoking relapse; and to evaluate pharmacologic and behavioral interventions to reduce cognitive deficits and boost quitting success. These data identify significant deficits in working memory during the early nicotine withdrawal period and show that smokers who carry allelic variants associated with reduced prefrontal levels of dopamine are more prone to these effects. Working memory deficits, in turn, predict relapse to smoking in treatment-seekers. Treatment with the nAChR $\alpha 4\beta 2$ partial agonist, varenicline, reverses deficits in working memory, and fMRI data point to medication effects on activation in the dorsolateral prefrontal cortex which correlate with cognitive performance. Lastly, new data from a clinical trial of cognitive training for smoking cessation will be presented, along with preliminary data on the effects of novel pharmacologic approaches for cognitive enhancement. The potential role of cognitive performance and brain activity as an early surrogate marker for response to medications for nicotine dependence will also be explored in this presentation.

SYMPOSIUM 040

INTEGRATED PSYCHIATRY PRIMARY CARE SERVICES IN HOUSTON, TEXAS

Chair: Britta Ostermeyer, M.D.

Discussant: John M. Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVE

At the conclusion of the session the participant should be able to: 1) Understand well the Community Behavioral Health Program in Houston, Texas and will be able to describe and summarize the program's goals, members, organization, and patient flow, 2) Analyze both, the elements what have worked well within the Community Behavioral Health Program as well as the barriers and problems to integrated care that have not worked well within the program as yet, 3) Understand and state the recommendations for integrated mental health primary care settings by the State of Texas as well as will understand the integrated care setting of the Healthcare for The Homeless Program, 4) Summarize at least three meaningful ideas or recommendations for integrated care settings that psychiatrists and primary care physicians can work on jointly in an integrated manner

SUMMARY:

Dr. Ostermeyer and Dr. Shah, both psychiatrists, will present a detailed overview of the Community Behavioral Health Program (CBHP) in this interactive symposium. CBHP was founded in 2004/05 and is the 2007 APA Institute of Psychiatry Gold Award Recipient for community services. It is a fully integrated mental health primary care program operating at 13 large scale primary care community medical homes, two school-based child clinics, and the Homeless Program of Harris County Hospital District (HCHD). CBHP is staffed by psychiatrists (5.3 FTE, fulltime and several parttime clinicians), residents (1.4 FTE), and social work psychotherapists (13.6 FTE) from the Menninger Department of Psychiatry, Baylor College of Medicine who work integrated with approximately 200 primary care physicians (PCP) of Baylor College of Medicine, The University of Texas Health Science Center, and HCHD. HCHD is one of the largest public health care entities in the US providing all-around ambulatory and hospital-based medical, surgical, and psychiatric services, primarily to an underserved population in Houston with a catchment area of 4 million. PCPs were provided with a variety of different educational opportunities on psychiatric topics to further their scope of primary care psychiatric interventions, primarily focused on psychopharmacology. Clinicians were satisfied with the program, improvement was detected in patients treated (as measured on the BASIS24), new psychiatric appointment waiting periods substantially decreased within HCHD in the outpatient area from 68 months previously to 48 weeks, there was an increase in community-based mental health services, and a decrease of hospital-based psychiatric EC admissions by 18%. Dr. Reed, a PCP with leadership responsibility within HCHD, will discuss his experience within CBHP, what has not worked well within CBHP as yet, and evaluate the barriers to integrated care. Dr. Buck, a PCP, who served as a consultant to the State of Texas on state-

wide guidelines for integrated mental health primary care settings, will review the recommendations for integrated care by the State of Texas and share his integrated care experiences within the Healthcare for the Homeless Program in Houston. Dr. Oldham, will review and discuss the lessons learned and how psychiatrists and primary care physicians may proceed jointly from here.

S040-1.

FOUNDATION AND OVERVIEW OF THE COMMUNITY BEHAVIORAL HEALTH PROGRAM (CBHP)

Presenter: Britta Ostermeyer, M.D.

SUMMARY:

This presentation by a CBHP psychiatrist and the CBHP Director/Founder will review with the audience the vastly underfunded mental health care situation of Harris County Hospital District (HCHD) prior to the Community Behavioral Health Program (CBHP) and how the integrated care program was initiated first by a small pilot project in 2004 and was then expanded by grant money in 2005. The presentation will provide a detailed overview of this integrated care program, its team members, locations, goals and objectives, as well as review and discuss the successful impact that this program has made within the HCHD system over the past six years.

S040-2.

THE CBHP PSYCHIATRIST: THE GOOD, THE BAD, AND HOW WE IMPROVED

Presenter: Asim Shah, M.D.

SUMMARY:

This presentation by a practicing CBHP psychiatrist and the CBHP Associate Director will review the roles of the psychiatric providers within the Community Behavioral Health Program (CBHP), review providers' patient templates and patient flow within the primary care community medical homes, and review the praise as well as the several concerns verbalized by the CBHP psychiatrists and behavioral health therapists (social work psychotherapists). While there has been much positive feedback and job satisfaction, concerns have been raised over templates, the setup of the program at the primary care facility, and/or support staff issues at the underserved primary care community medical homes of Harris County Hospital District. CBHP has made constructive changes based upon feedback by its team members over time and this presentation will review, discuss, and reflect upon the changes that have been implemented based upon lessons learned within CBHP since its foundation in 2004/05.

S040-3.

THE CBHP PRIMARY CARE PHYSICIAN: EXPERIENCES AND BARRIERS TO INTEGRATED CARE

Presenter: Brian C. Reed, M.D.

SUMMARY:

This presentation will review the Community Behavioral Health Program (CBHP) from the perspective of a primary care physician who has practiced in this program as a primary care physician since its foundation as well as an administrative physician in leadership. In addition, barriers to integrated care will be reviewed and discussed with the audience. Despite receiving behavioral health training during family medicine and internal medicine residencies and having had some additional training opportunities within CBHP, the comfort level of primary care physicians with the management of depression, anxiety, bipolar disorder, and psychosis is variable. The educational psychiatric review series focused on DSMIV and psychiatric medications introduced at the launch of the CBHP in 2005 helped to set a common standard of care for patients with mental health problems among our primary care physician group. The availability of the behavioral health therapists (social work psychotherapists) and psychiatrists within the medical homes facilitated comanagement and for some integration of the mental health issues between primary care providers and psychiatrists. The presentation will discuss some common concerns and barriers to the integrated care setting, such as time management concerns, limitations to curbside consultations, and difficulties regarding followup care arrangements for stabilized patients with psychiatric conditions. The turnover of primary care physicians within our Harris County Hospital District practice group has led to a need for additional and new educational psychiatric management updates for primary care physicians. These updates will be discussed and shared with the audience as well. Additionally, reductions in state and local funding has placed additional demands upon an already stressed system in our metropolitan area.

S040-4.

THE GUIDELINES FOR INTEGRATED CARE BY THE STATE OF TEXAS AND INTEGRATED CARE WITHIN HEALTH CARE FOR THE HOMELESS

Presenter: David Buck, M.D., M.P.H.

SUMMARY:

This presentation will review the recommendations and guidelines for integrated mental health primary care settings by the legislator in the State of Texas. These guidelines were developed by a group of professionals who met with ex-

perts in the field and who reviewed different integrated care settings. In addition, from a primary care perspective, this presentation will review the integrated care setting of the Healthcare for the Homeless Program in Houston (HHH), Texas. This program has a psychiatrist onsite for one day a week. HHH's infrastructure differs from the Community Behavioral Health Program.

SYMPOSIUM 041

THE WIDENING SCOPE OF PSYCHODYNAMIC PSYCHIATRY

Chair: Joan G. Tolchin, M.D.

Discussant: Sergio Dazzi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the use of psychodynamic therapy in the treatment of persons with chronic and severe mental illness and the role of the therapist in maintaining a long term psychodynamic therapeutic relationship in chronic mental illness; consider the use of specific techniques in long term psychodynamic treatment of patients with chronic mental illness, 2) Identify patients who can benefit from telephone psychotherapy in lieu of inperson treatment and learn to treat them using psychotherapy on the telephone; utilize the telephone as a tool to foster a positive therapeutic alliance during the initial treatment phases, and identify patients for whom regular phone contact with the therapist can aid in resolving impulsive symptoms, 3) Identify male patients who are transgendered from patients who suffer from autogynephilia and other paraphilias; recognize emotional conditions that arise during the transgender transformation as a result of hormonal and societal changes and be able to distinguish these from psychiatric disorders; assess when a maletofemale transgender individual has achieved emotional stability and adaptation to her new role, 4) Assess patients' understanding of unconscious mental process and appropriately enhance their comprehension of it during psychodynamic treatment

SUMMARY:

Psychodynamic psychiatry, in a tradition initiated by Freud, emphasizes the interplay of conscious and unconscious mental process, internal conflict, and the surviving and vital importance of early childhood experience in determining behavior.¶The session will focus on the broad and appropriate use of psychodynamic principles in a variety of clinical situations and treatment modalities. In the initial presentation, Dr. Carolyn Robinowitz will address the use of psychodynamic principles in the long term treatment of persons with chronic and severe mental illness. Dr. Joan Tolchin will

then describe how the therapist can utilize the telephone as a tool and a therapeutic aide in psychodynamic psychiatry, as well as discuss how in some clinical situations, telephone psychotherapy can be useful in lieu of inperson sessions. Dr. David Lopez will discuss how new male to female hormonal and surgical transexual techniques have brought new possibilities to those seeking such gender transformation, and how hormonal and societal adaptations can easily be confused with psychiatric pathology, and other psychodynamic and biological implications the psychiatrist must deal with. A clinical case is presented to illustrate. Dr. Matthew Tolchin will offer a clinical illustration of an effort to assess and enhance a patient's understanding of unconscious mental process, intending to encourage the use of such technique and such teaching in order to increase the symposium participants' effectiveness as psychotherapists. Dr. Sergio Dazzi will discuss and synthesize the presentations, focusing on the use and integration of psychodynamic principles in modern treatment settings.

S041-1.

DYNAMIC PSYCHOTHERAPY: TERMINABLE AND INTERMINABLE

Presenter: Carolyn B. Robinowitz, M.D.

SUMMARY:

In supervising and teaching residents about dynamic psychotherapy, the focus tends to be somewhat time limited, due to the time constraints of the residency. Emphasis is on initiating treatment and the therapeutic alliance as well as the externally defined termination at the end of one or more academic years. Yet in clinical practice, patient care tends to be much more long term, just as our colleagues in primary care provide care for their patients throughout a lifetime. Psychiatric disorders and particularly the more severe disorders tend to be chronic in their course, with remissions and exacerbations over time, more like the model of hypertension and diabetes in their course than that of infectious disease. Psychiatrists initially work with patients to address presenting problems and work to help elucidate the unconscious factors that have shaped development, behavior and symptoms; but as therapy progresses, psychodynamic treatment comes to address a wide range of life stages and change. In addition to focusing on unconscious dynamic issues, therapy will consider stressors and other events that impact patients' mental health and coping ability. Resolution of acute issues can be followed by a life time of good function, but life stages, family issues, work, medical illness and other environmental factors can disrupt resiliency and good function, and lead to new or exacerbated symptoms and distress. Treatment planning needs to address both acute care and more intermittent and recurring treatment over time. While such planning is especially needed in the

care of persons with more severe and chronic conditions, a longer term perspective is valuable in a variety of diagnoses and patient characteristics. Over the past 40 years, this presenter has worked with a number of patients who have been diagnosed with a range of psychiatric disorders and whose treatment needs have been intermittent over some three or four decades. All have been able to function in the community, outside of a hospital situation, and have been able to maintain gainful employment as well as relationships with colleagues, friends, family, and significant others. During these decades, the frequency of therapeutic visits varied; for some patients, scheduled appointments (monthly to quarterly) were most useful, while others had episodes of more frequent sessions in response to life stressors or exacerbation of symptoms interspersed with longer interruptions of treatment. As these re

S041-2.

USING THE TELEPHONE IN PSYCHODYNAMIC TREATMENTS

Presenter: Joan G. Tolchin, M.D.

SUMMARY:

The telephone is an important tool and a therapeutic aide in psychodynamic psychiatry. The therapist's availability to the patient by phone can help to foster and solidify a positive therapeutic alliance during the initial phases of treatment. Additionally, regular phone contact with patients with substance abuse and impulse behavior disorders can support positive improvement in patients' symptoms. Clinical cases illustrate these principles. Telephone psychotherapy, in lieu of inperson sessions, is discussed in detail. The presentation describes how to select appropriate patients, and how to arrange and conduct telephone psychotherapy successfully. Clinical material demonstrates these concepts.

S041-3.

MALE TO FEMALE TRANSSEXUAL: CONSIDERATIONS OF THE PSYCHODYNAMIC PSYCHOTHERAPY DURING THE TRANSGENDER TRANSFORMATION

Presenter: David L. Lopez, M.D.

SUMMARY:

The newer hormone blocking agents, hormone replacement treatments, and facial feminization and sex reassignment surgical techniques have increased the likelihood of transgender males to successfully transition to become females. This brings a new paradigm in the conceptualization of this condition and the psychodynamic and biological implications that the psychiatrist must deal with. During the trans-

formation phase of a transsexual, hormonal and societal adaptations can easily be confused with psychiatric pathology. A case of a male transsexual is presented to illustrate these clinical implications.

S041-4.

THE DOORMAN'S FRIEND: A FUNDAMENTAL THOUGHT EXPERIMENT THAT DISTINGUISHES BETWEEN UNCONSCIOUS AND CONSCIOUS MENTAL PROCESS

Presenter: Matthew A. Tolchin, M.D.

SUMMARY:

A clinical example illustrates an effort to assess and enhance a patient's understanding of unconscious mental process. A late middleaged patient had had several years of formal analysis much earlier in life, apparently competent and helpful. He had had two experiences of major depression during midlife, treated successfully with appropriate medication and psychotherapy. Because of a planned retirement he was referred while that second episode was not yet fully resolved, for evaluation, maintenance and adjustment of medication, and further psychotherapy. During the transition an impromptu thought experiment was devised, and revealed that in the course of extensive and highly productive prior analytic and therapeutic work he had developed little or no tangible grasp of the occurrence and manifest consequences of unconscious mental process. The aim of the presentation is to encourage the use of such assessment and cultivation of patients' understanding of unconscious process in order to increase the symposium participants' effectiveness as psychotherapists.

SYMPOSIUM 042

PSYCHIATRISTS WORKING WITH THE UNITED NATIONS

Chair: Vivian B. Pender, M.D.

Discussant: Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify how Psychiatrists can contribute to the international community at the United Nations, 2) Recount plans and projects by Psychiatrists at the United Nations, 3) Learn strategies to promote mental health on an international level

SUMMARY:

As a nongovernmental organization with special consultative status at the United Nations, the International Psycho-

analytical Association is in a privileged position to make psychoanalytic theories of human development and mental health visible at the UN. On issues of human rights, violence, effects of trauma and prejudice psychiatrists/psychanalysts can contribute understanding and promote international welfare. As well, international issues of psychiatric illness and treatment can be brought to the attention of the psychiatric community.

S042-1.

INTERNATIONAL PSYCHIATRY: LESSONS FROM TANZANIA

Presenter: John W. Barnhill, M.D.

SUMMARY:

Increasing numbers of students, residents, and psychiatric faculty are working internationally for relatively brief amounts of time. These experiences can be transformative for the participant and very helpful to the host community. This paper will focus on ways in which the visiting clinician can be effective and also the ways in which the experience can prove to be suboptimal for all concerned.

S042-2.

THE INTERNATIONAL PSYCHOANALYTICAL ASSOCIATION AS AN N.G.O. OF THE U.N.

Presenter: Isaac Tylim, Psy.D.

SUMMARY:

Since 1997, the IPA has had special consultative status with the United Nations. What this entitles members of the UN Committee of the IPA to is a yearly pass to attend meetings inside the UN, to be recognized when making a verbal intervention, to submit written recommendations to UN agencies, and generally promote a mental health perspective to the many resolutions that come before the UN General Assembly. Examples of the effect of the IPA's presence can be demonstrated by the cosponsorship of UN agencies to hold conferences at the UN on topics such as violence and trauma. In addition, outreach to the 193 government Missions to the UN is possible and planned for a future project.

S0423.

CHAIRING THE NGO COMMITTEE ON THE STATUS OF WOMEN

Presenter: Vivian B. Pender, M.D.

SUMMARY:

The NGO Committee on the Status of Women was estab-

lished in 1972 and today has members representing over 80 international and national NGOs in Consultative Status with the United Nations. The mandate is to foster dialogues between NGOs and Member States concerning issues that are being discussed that impact the rights and wellbeing of women and girls.

S042-4.

FIELD WORK IN A PSYCHIATRIC CLINIC IN TANZANIA

Presenter: Sargam Jain, M.D.

SUMMARY:

The difficulties of integrating models of psychiatric illness and psychiatric personnel in a medical clinic/hospital setting in Tanzania were numerous. These ranged from finding the clinic, to language for mental illness, to differential diagnosis to treatments that were available and acceptable. A consultationliaison model was used to interface with the traditional healers that were the predominant form of caregivers in the region. Some interesting findings such as the under representation of women were elucidated. Somatic illness was prevalent. Positive outcomes relied on the resources that were available such as family support and free medications.

S042-5.

A PSYCHIATRIST IN HAITI

Presenter: Madeleine Lansky, M.D.

SUMMARY:

The January 2010 earthquake in Haiti was a horrific tragedy that cost over three hundred thousand lives and at least the same number of people injured. However, the earthquake was only one of a series of traumatic events for Haiti and its peoples. Once known as the "Pearl of the Caribbean", Haiti was colonized by the French using the labor of African slaves. It boasts a tradition of a successful African revolution that led to its freedom from France, and the expansion of US lands through The Louisiana Purchase, both of which marked France's retreat from American soil. In 1804, a traumatized Haitian slave population went on to create its own nationhood. Its independence was purchased through lofty sums paid to France slave holders, leaving it an independent nation that has been focused on repayment of debt rather than implementation of the social, economic and political infrastructure needed to run a resilient and prosperous nation. This presentation will discuss the work accomplished after the recent earthquake and devastation.

S042-6.

WELLBEING FOR U.N.STAFF: A PROJECT

Presenter: Phillida Rosnick, Ph.D.

SUMMARY:

From 2006 to 2009, members of the UN Committee of the International Psychoanalytical Association along with members of Disaster Psychiatry Outreach and the UN Department of Stress Services worked biweekly to put together a manual for UN staff. UN statistics showed increased over the general population of depression, anxiety, substance abuse and completed suicides in UN staff. The proposed manual consisted of a premission screening, and a postmission debriefing. The standard at the time did not include provisions for adequate attention to mental and psychological needs of UN staff who were at times being sent to difficult regions of the world for periods of time ranging from 2 weeks to 6 months. Proposed screening would consist of a psychiatric history, a mental status exam and assessment of untreated or treated symptoms or illness. Post mission debriefing would include a history and exam to ascertain the psychological well being of the individual.

SYMPOSIUM 043**ATTACHMENT SECURITY AND ITS IMPLICATIONS FOR PSYCHIATRY**

Co-Chairs: Allison M Lee, M.D., Gary M. Rodin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the concept of attachment and attachment styles, 2) Understand the distinction between early and late attachment, 3) Understand the impact of attachment style on caregiving relationships in patients with bipolar disorder and depression, the elderly, and patients with advanced cancer

SUMMARY:

Attachment theory describes the process by which humans establish and maintain human relationships in childhood and throughout adult life. Through interactions with caregivers over time, children develop characteristic styles of relating which can be characterized as secure, anxious, avoidant, or disorganized. While initially developed to understand relationships between parents and young children, attachment styles have been shown to persist across the life span and to shape all relationships that involve felt security, including romantic ones and those with health care providers. Attachment theory can be applied to how couples regulate emotions and maintain felt security when faced with one partner's chronic illness. It can also provide a useful framework to understand how caregivers respond to suffer-

ing in their partners, how patients seek care and how they face the end of life. In this symposium, new findings will be presented on the relationship of attachment style to clinical outcomes in patients with bipolar disorder, patients with depression, geriatric patients, and patients with advanced cancer. Implications for clinical care will be discussed, including specific recommendations for clinicians.

S043-1.**THE RELATIONSHIP OF ATTACHMENT STYLE TO EXPRESSED EMOTION AND CAREGIVER BURDEN IN BIPOLAR DISORDER**

Presenter: Allison M Lee, M.D.

SUMMARY:

Objective Relationships between bipolar patients and their caregivers have been shown to have a significant impact upon patient and caregiver wellbeing, and interventions targeting these relationships have been shown to have an impact on clinical outcomes. Expressed Emotion (EE) is a characteristic of families that encompasses criticism and emotional over-involvement, and has been associated with worse outcomes in patients. Caregiver Burden is the concrete and psychological toll taken on caregivers by their caregiving activities. Attachment styles have been shown to impact caregiving relationships in other patient populations. Our goal was to determine to what extent EE and caregiver burden were associated with attachment styles in bipolar patients and their caregivers. Methods Patients with bipolar disorder and their caregivers were recruited from The Family Center for Bipolar Disorder in New York City. Upon study entry, patients and caregivers completed questionnaires assessing personality and character traits, mood symptoms, expressed emotion, burden, and other indicators. The Relationship Scales Questionnaire was used to measure attachment style, the Perceived Criticism Scale was used to measure Expressed Emotion, the Family Adaptability and Cohesion Evaluation Scale was used to measure family dynamics, and the Mood Disorder Burden Index and the Family Attitude Scale were used to assess caregiver burden. Results Less securely attached patients rated themselves ($p < .01$) and their caregivers ($p < .01$) as more critical of one another, and rated caregiver criticism as more upsetting to themselves ($p < .01$). More fearfully attached patients rated themselves as more critical of caregivers ($p < .05$) and rated their own criticism as more upsetting to caregivers (trend, $p = .09$). Patients with more preoccupied attachment rated their family as more enmeshed ($p < .05$). Dismissing attachment in caregivers was associated with less reported caregiving burden ($p < .05$). Conclusions An association was shown between attachment style and clinically relevant family characteristics in bipolar disorder. Secure attachment in bipolar patients was associated with lower EE, while

fearful and preoccupied attachment styles were associated with higher EE. Dismissing attachment in caregivers was associated with less caregiving burden. Attention to the attachment dynamics of the patient-caregiver relationship may allow a therapist to more effectively help families who are coping with the disorder.

S043-2.

ATTACHMENT PROCESSES IN OLDER ADULT CAREGIVING RELATIONSHIPS

Presenter: Joan Monin, Ph.D.

SUMMARY:

Attachment theory stipulates that the need for relationship security is one of the most fundamental of all basic needs for people of all ages, and it provides a basis for understanding complex interpersonal dynamics throughout the lifespan. Although attachment theory has stimulated an enormous body of empirical research during infancy, childhood, and early adulthood, research on late life relationships using this perspective has been relatively limited. Attachment theory is an especially useful framework for understanding how couples regulate emotions and maintain felt security when faced with one partner's chronic illness, a common occurrence in late life. Two studies will be presented showing how attachment orientation relates to one's own as well as one's partner's health and wellbeing in the caregiving context. The first is a laboratory study of 53 caregiving spouses of older adults with osteoarthritis. Results of this study revealed that attachment anxiety was associated with greater self-reported personal distress in reaction to watching a partner in pain (but not a stranger), and heightened perceptions of partner pain mediated this association. The second study was an interview study and examined the extent to which spouse and AD patient's (n=58) attachment insecurity (anxious and avoidant attachment) were associated with each partner's report of patient suffering. Overall, results indicated that when both partners were high in attachment insecurity, suffering was highest in the patient. Together these studies highlight the importance of considering attachment dynamics to understand both partner's health and wellbeing in the context of older adult caregiving relationships.

S043-3.

THE LAST ACT: IMPLICATIONS OF ATTACHMENT SECURITY WITH LIFETHREATENING DISEASE

Presenter: Gary M. Rodin, M.D.

SUMMARY:

Attachment security has important implications in early

development, in romantic relationships and near the end of life. There has been relatively little attention to this construct in the last stage of life, although attachment security is fundamental in the adjustment to threat of disability and dependency that occurs with progressive disease. We have conducted longitudinal research in patients with metastatic cancer examining the predictive role of attachment security and the extent to which it can change in this population in response to brief psychological interventions. We found that depressive symptoms in these patients were predicted by the interaction of disease-related physical distress, self-esteem, spiritual wellbeing and attachment security. While social support did not directly predict physical distress, individuals who were anxiously attached were in double jeopardy, because they also perceived less social support. Pilot data from a brief psychotherapeutic intervention referred to as CALM (Managing Cancer and Living Meaningfully) showed a reduction in death anxiety and a growth in attachment security following the intervention. Evidence suggests that attachment security predicts adjustment at the end of life, and that it may respond to psychotherapeutic interventions which are tailored to specific attachment needs.

S043-4.

DISTINCT BUT OVERLAPPING NEURAL NETWORKS SUBSERVE DEPRESSION AND INSECURE ATTACHMENT: SUBCORTICAL ACTIVITY DISTINGUISHES EARLY VERSUS LATE ATTACHMENT

Presenter: Zimri Yaseen, M.D.

SUMMARY:

Insecure attachment has been linked to depression and to outcome in psychotherapy. The neural mechanisms subserving the relationship between attachment security and depression are not well understood. We have developed a method to examine attachment-related brain activity in depression. Twenty-eight women, half depressed, viewed images of their mother, a female friend, and female strangers during fMRI scanning. The effects of depression and insecure attachment were determined with whole-brain multiple linear regression of blood-oxygen-level-dependent (BOLD) response against subjects' Beck Depression Inventory (BDI) and Adult Attachment Interview (AAI) coherence of mind scores. Interaction effects were analyzed with ANOVA. Activity associated with depression and with insecure attachment was found in the corticostriatothalamic affect regulating circuits. For early attachment (Mother-Friend contrast), depression scores correlated with activation of cortical and subcortical components of these circuits, while attachment insecurity correlated with subcortical activity in the same circuitry. Depression and attachment insecurity correlated with both cortical and subcortical activity for Mother-Stranger, and areas of overlap and of enhancing interactions

between depression and insecure attachment were found. For late attachment (FriendStranger contrast), only cortical effects were found.

S043-5.

ATTACHMENT'S RELATIONSHIP TO THE ATTITUDES, STRESS, AND BEHAVIOR OF DAUGHTERS CARING FOR A PARENT WITH DEMENTIA

Presenter: Cory K. Chen, Ph.D.

SUMMARY:

Objective Providing care to a parent with dementia is among the most stressful and difficult of caregiving relationships. In addition to the daytoday challenges of caring for an individual with dementia, caregivers must navigate the complex emotions evoked by their unique history with that parent. Attachment theory may provide insights into how caregivers navigate both the concrete tasks and the emotional strains of caring for a parent with dementia. The current study explores the ways that attachment security, as measured by both (1) explicit memories about a caregiver's relationship with attachment figures and (2) implicit knowledge of secure base caregiving narratives, is associated with the caregiver's attitudes, stress and behavior towards their parent. Methods Participants were 77 daughters of a parent with dementia. Caregivers were administered telephone interviews and questionnaires to assess the caregiver's memories of their relationship history with the parent, implicit caregiving narratives, and the caregiver's self report of their experience of stress, current conflict in the relationship with their parent, critical attitudes towards their parent and involvement in their parent's care. Results Our findings suggest that measures of attachment security that assess explicit memories of the caregiver's relationship history with attachment figures were significantly associated with stress and criticism of their parent, such that more securely attached caregivers tended to experience less stress ($p < 0.01$) and held less critical attitudes toward their parent ($p < 0.01$). In contrast, greater knowledge of secure base behavior was associated with caregiver report of less conflict ($p < 0.05$) and less involvement ($p < 0.05$) in the care of their parent. Conclusions This study suggests that attachment may represent a multifaceted construct that impacts caregiving in a variety of ways. Implications for the development of psychological interventions for caregivers of individuals with dementia will also be discussed.

MONDAY, MAY 7, 2012

SYMPOSIUM 044

THE FUTURE OF PSYCHIATRIC DIAGNOSIS: UPDATES ON PROPOSED DIAGNOSTIC CRITERIA FOR

DSM5 (PART III)

Co-Chairs: Darrel A. Regier, M.D., M.P.H., David J. Kupfer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the most notable changes being adopted in DSM5 in the sections on Somatic Symptom Disorders, Eating and Feeding Disorders, SleepWake Disorders, Sexual and Gender Identity Disorders, and Substance Use Disorders, 2) Explain how proposed revision are addressing gaps in the currently DSMIV nosology, 3) Discuss the ways in which the work groups intend the finalized criteria to facilitate better clinical care of patients

SUMMARY:

Members of the 13 DSM5 Work Groups are currently finalizing draft diagnostic criteria and proposed dimensional changes to disorders in preparation for the release of the revised manual in May 2013. Final proposals are being informed largely by evidence from the literature, including, where available, secondary data analyses; results from the two designs of the DSM5 Field Trials (large, medicalacademic settings and routine clinical practice settings); and feedback from patients, professionals, and the general public. A threepart symposium series will provide audiences with updates on the latest status of proposed revisions to DSM's diagnostic criteria from the chairs of each of the 13 work groups. In this session (Part III), attendees will learn about draft changes among Somatic Symptom Disorders, Eating and Feeding Disorders, SleepWake Disorders, Sexual and Gender Identity Disorders, and Substance Use Disorders. Where available, select results from field trials and specific feedback received via the DSM5 Web site may be shared.

S044-1.

DSM5 PROPOSALS FOR SOMATIC SYMPTOM DISORDERS

Presenter: Joel E. Dimsdale, M.D.

SUMMARY:

Somatoform disorders are commonly encountered in primary care practice. There are considerable drawbacks to the status quo criteria which limit their utility. This presentation will outline proposals for changing the ways these disorders are conceptualized in DSM V. Key changes involve deemphasizing the centrality of the medically unexplained symptoms and emphasizing instead the importance of somatic symptoms accompanied by excessive thoughts, feelings, and behaviors related to these symptoms.

S044-2.

DSM5 CLASSIFICATION OF SLEEPWAKE DISORDERS*Presenter: Charles Reynolds, M.D.***SUMMARY:**

This presentation will describe the proposed DSM5 classification of sleepwake disorders into (1) insomnia disorder, (2) hypersomnia disorder, (3) narcolepsy/hypocretin deficiency, (3) breathingrelated sleep disorders, (4) restless legs syndrome, (5) REM sleep behavior disorder, (6) parasomnia disorders, (7) circadian rhythm sleep disorders, and (8) substanceinduced sleep disorders. The goal of the DSM5 classification of sleepwake disorders is to facilitate recognition, diagnosis, management, and referral of patients with sleepwake disorders by both mental health and general medical clinicians, neither of whom is assumed to have specialty expertise in sleep medicine. This goal is important because symptoms of sleep wake disturbances (1) are prominent in most psychiatric disorders, (2) may provide opportunities for early intervention or even prevention of common mental disorders like depression and anxiety, (3) may indicate the coexistence of medical and psychiatric disorders, and (4) often warrant independent clinical attention in their own right, in addition to care for coexisting mental and medical illnesses. This presentation will also review how the proposed DSM5 sleepwake disorders classification differs from DSMIVTR: (1) DSM5 does not use language of causal attribution (e.g., “due to”) but instructs the diagnostician simply to list coexisting sleepwake, psychiatric, and medical/neurologic disorders (the rationale for this approach is to simplify the classification system, by recognizing that directions of causality are usually not clear but are frequently multidirectional, together with the fact that patients often need simultaneous and integrated attention to more than one coexisting disorder to assure optimal outcomes); (2) DSM5 integrates a developmental perspective, encompassing pediatric, adult, and geriatric clinical issues; (3) DSM5 does not use “dyssomnia not otherwise specified.” (Rather, DSM5 proposes to recognize as distinct diagnostic entities Restless Legs Syndrome and REM Sleep Behavior Disorder, previously classified in DSMIV as “Dyssomnia NOS.”); and (4) DSM5 proposes the use of dimensional measures of severity (e.g., those derived from the NIH Patient Reported Outcomes Measurement Information Systems, or PROMIS) to facilitate measurementbased care in specialty mental health and primary care settings. In summary, the DSM5 approach to sleep wake disorders classification attempts to capture clinical utility and science

S044-3.

NEUROSCIENCE AND SUBSTANCE USE DISORDERS

IN DSM5

*Presenter: Charles O Brien, M.D., Ph.D.***SUMMARY:**

As the final version of DSM5 nears publication, clinicians should be aware of the impact of DSM5 on their diagnosis and treatment of patients who may have Substance Use Disorders. The coming of health care reform in 2014 will demand that all primary care patients be evaluated for substance abuse problems and if such a problem is detected, referred for early treatment. Cost benefit studies have shown that early treatment prevents later complications and thus reduces costs to the health care system. A major change that will be noticed is the absence of two levels of diagnosis: abuse and dependence. Analysis of interview data from large studies shows that there is no evidence to support the existence of an intermediate level that was formerly called “abuse.” Evidence shows that there is a unidimensional condition now called “substance use disorder” and we no longer use the term “dependence” when we really mean “addiction.” Substance use disorder will now be mild, moderate or severe depending on the number of symptoms. Another important change is the addition of the symptom of “craving” and the deletion of the “legal problems” symptom. The threshold is still being discussed but mild will probably require just two symptoms. Craving is important because in large population interview studies, it tends to be a more severe symptom and may continue long after detoxification, thus increasing risk of relapse. It is also a symptom that is associated with dopamine release and the greater the dopamine, the more severe the craving reported by the patient. Craving is also associated with cues that activate brain reward structures in drug free former addicts. The DSM5 Substance related disorders work group appreciates the input from the field that we have received in response to showing our proposed changes on the web in 2010 and 2011. A field trial is currently underway, but even after the 2013 publication, the classification system will be a living document, subject to further changes as new scientific data are published.

S044-4.

EATING DISORDERS IN DSM5*Presenter: B. Timothy Walsh, M.D.***SUMMARY:**

In DSMIV, there are only two “officially” recognized eating disorders, Anorexia Nervosa and Bulimia Nervosa. In addition, Pica, Rumination Disorder, and Feeding Disorder of Infancy or Early Childhood are included in the section on Disorders Usually First Recognized in Infancy, Child-

hood, or Adolescence. The Eating Disorders Work Group has recommended several major changes regarding the placement and description of eating disorders in DSM5. First, it recommends that Binge Eating Disorder, a syndrome described in an Appendix in DSMIV, be formally recognized. Second, because Feeding Disorder of Infancy has received little clinical or research attention, and because a number of other presentations are not captured by current criteria, the Work Group recommends that this disorder be renamed Avoidant/Restrictive Food Intake Disorder (ARFID). ARFID would encompass problems currently captured by Feeding Disorder of Infancy or Early Childhood and also presentations including the avoidance of food because of its sensory characteristics (e.g. appearance, texture, temperature), and the restriction of food intake following an alarming experience, such as choking. Finally, the Work Group recommends that all disorders characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning problem be grouped in a section in DSM5 termed Feeding and Eating Disorders. In addition, a number modest of changes to the existing diagnostic criteria have been recommended with the goal of reducing the high frequency of use of Eating Disorder Not Otherwise Specified (EDNOS) in DSMIV. This presentation will review the current recommendations for eating disorders, their potential advantages and disadvantages, and emerging data from field testing.

S044-5.

REPORT ON THE SEXUAL AND GENDER IDENTITY DISORDERS WORKGROUP

Presenter: Kenneth J. Zucker, Ph.D.

SUMMARY:

The Sexual and Gender Identity Disorders Workgroup published in 2010 its literature reviews on the sexual dysfunctions, gender identity disorder (GID), and the paraphilias. In this presentation, I will provide an update on some of the substantive changes proposed for these diagnoses in DSM5. Based on literature reviews and analysis of existing empirical data, it was recommended that the diagnoses of hypoactive sexual desire disorder and sexual arousal disorder in women be merged into one overarching diagnosis, provisionally termed Sexual Interest/Arousal Disorder and the diagnoses of dyspareunia and vaginismus be merged into one overarching diagnosis, provisionally termed GenitoPelvic Pain Penetration Disorder. For GID, a name change to Gender Dysphoria has been proposed and secondary data analyses were used to modify the wording of the diagnostic criteria and to tighten up the threshold for the diagnosis in children and to make more precise the diagnostic criteria

for adolescents/adults. For the paraphilias, the proposed name change to Paraphilic Disorder will be discussed. I will also present the results of independent field trials conducted at several U.S. centers on over 500 patients and will discuss the implications of these findings for several of the paraphilias, including Pedophilia. I will also present the results of independent field trials for a proposed new diagnosis, Hypersexual Disorder.

SYMPOSIUM 045

SCHIZOPHRENIA AND BIPOLAR DISORDER SPECTRUM: NEW FINDINGS AND CLINICAL IMPLICATIONS

Co-Chairs: S. Charles Schulz, M.D., Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate the knowledge of the neuroscience underpinning of the schizophrenia/bipolar spectrum, 2) Demonstrate the knowledge of the genetic similarities and difference between bipolar disorder and schizophrenia, 3) Demonstrate the knowledge of the latest proposals for diagnostic strategies of psychosis.

SUMMARY:

Throughout the 20th century, the illnesses schizophrenia and bipolar disorder (manicdepressive disorder) were considered separate disorders. Clinically, it was considered important to differentiate the two illnesses for treatment and prognosis. In the realm of research aimed at finding etiology of each illness and developing specific treatments differentiating these two illnesses was considered to be crucial. In recent years, emerging data has noted both genetic and physiological similarities in these illnesses. This has led to an examination of schizophrenia, bipolar disorder and other psychotic illnesses being part of a spectrum. The purpose of this symposium is to examine the background of the spectrum theory and its implications for diagnosis and treatment. The first speaker, Dr. Carol Tamminga, will describe research on the characteristics of schizophrenia and bipolar disorder illustrating the similarities and differences of these two illnesses and its implications for better understanding them. Her session will be followed by Dr. Robert Freedman who will discuss the most recent work on the genetic underpinning of schizophrenia and bipolar disorder and their linkage to endophenotype characteristics. From there, Dr. Trisha Suppes will discuss the implications of these findings and other nosologic theories in being able to classify patients with psychotic and mood symptoms. This is currently a crucial discussion of the DSM 5. To conclude the symposium, Dr. Philip Janicak will review and discuss the

emerging data regarding the pharmacological approaches to people in the area of schizophrenia and bipolar disorder. It is well known that in recent years medications from a number of classes have been tested and utilized across these boundaries. In conclusion, the assessment of schizophrenia and bipolar disorder as being part of a spectrum is being closely examined from the vantage point of biology, nosology, and psychopharmacology. These speakers will address these points with an eye to the implications for researchers and practitioners.

S045-1.

PHENOTYPING ACROSS THE PSYCHOSIS SPECTRUM: SCHIZOPHRENIA, SCHIZOAFFECTIVE AND PSYCHOTIC BIPOLAR DISORDER

Presenter: Carol A. Tamminga, M.D.

SUMMARY:

Until now, schizophrenia and bipolar disorder have been considered independent diagnoses. However, recent evidence indicates that dimensions of behavioral illnesses may provide a more biologically oriented basis for identifying the molecular underpinnings of psychiatric disorders. Therefore, a consortium of investigators (Bipolar and Schizophrenia Network for Investigating Psychosis, BSNIP) collaborated on a deep phenotyping project across the schizophreniabipolar psychosis dimension, with the hypothesis that there exists both unique and common phenotypes and associated genotypes in these two diagnostic groups. The results show that many imaging, electrophysiological, oculomotor and cognitive phenotypes are the same in individual with schizophrenia or psychotic bipolar disorder, while some fewer phenotypes are distinct. For example, probands with schizophrenia and psychotic bipolar disorder have approximately the same distribution of grey matter loss in neocortex (prominent throughout frontal and temporal neocortex), while the schizophrenia group has a more profound loss in each region. Moreover, there is a continuous distribution of individuals with these diagnoses across a 'schizobipolar' continuum, with schizoaffective disorder filling in between the two major diagnoses. Relatives of individuals with schizophrenia and psychotic bipolar disorder show similar, if less marked changes, that do not appear to differ from each other with respect to these phenotypes. We are testing whether or not the genetic determinants of these phenotypes are also common across the diagnoses and develop models of how these diseases are similar or independent. The implications of a newly appreciated aspect of the genetics of schizophrenia—namely the proportion of spontaneous rare mutations in schizophrenia—need to be considered. It is estimated that up to 50% of the cases of sporadic schizophrenia are associated with spontaneous mutations. Distinguishing between spontane-

ous and familial cases might be complicated by spontaneous mutations occurring in the context of inherited vulnerabilities. The process of examining endophenotypes across these categories, agnostic to psychotic diagnoses, will enhance our knowledge of the biology of psychiatric diseases.

S045-2.

GENETIC PREDISPOSITION, ENDOPHENOTYPES, AND NEW TREATMENT STRATEGIES FOR SCHIZOPHRENIA AND BIPOLAR DISORDER

Presenter: Robert Freedman, M.D.

SUMMARY:

Poor sensory filtering and distractibility are prominent clinical features of most psychoses, including schizophrenia and bipolar disorder. Diminished neuronal inhibitory function is a possible physiological mechanism that underlies these symptoms. Demonstration of the neuronal dysfunction includes diminished inhibition of the cerebral evoked response to repeated stimuli, hyperactivity of many brain areas in neuroimaging studies, and inadequate tracking of target stimuli. Deficits in the expression of synthetic enzymes for the inhibitory neurotransmitter gamma aminobutyric acid (GABA) are found in both illnesses in cerebral interneurons that are normally responsible for inhibition of repeated responses. Genetic factors that regulate their development and function appear to be common between the two disorders. In addition, genetic mechanisms that regulate neuronal inhibition, including the excitation of interneurons by acetylcholine through nicotinic cholinergic receptors, a pathophysiological mechanism in schizophrenia and their inhibition by catecholamines through alpha noradrenergic receptors, a pathophysiological mechanism in bipolar disorder, present treatment possibilities for both illnesses. Treatment with nicotinic agonists and adrenergic antagonists, in addition to treatment with antipsychotics that can also engage these mechanisms, are being explored as new treatment strategies.

S045-3.

UPDATE FROM THE MOOD DISORDERS WORKGROUP FOR DSM5: BOUNDARIES OF BIPOLAR AND SCHIZOPHRENIA DISORDERS

Presenter: Trisha Suppes, M.D., Ph.D.

SUMMARY:

During the development of the proposed changes for DSM5, discussions have ranged from merging Bipolar Disorder, with psychosis with Schizophrenia and Related Disorders to eliminating Schizoaffective Disorder entirely. These suggestions were not made in a frivolous manner but

because of intriguing and developing data sets suggesting some degree of overlap between groups of symptoms we call bipolar disorder and schizophrenia. While the last few years have produced a number of studies supporting a degree of overlap in aspects of the genetics of both schizophrenia and bipolar disorders, newer studies suggest other potential areas of overlap as well. In this presentation, the discussion and science behind the current proposals will be presented. In particular, the potential nosologic difference between bipolar disorder characterized by significant psychotic symptoms versus bipolar disorder absent of psychotic symptoms will be discussed. Clinically, what are the implications of the proposed DSM5 diagnoses? Does medication response provide clues to boundaries between disorders or add to the confusing story? Is it reasonable to house a disorder with no psychotic elements and only mood and energy disturbances under the same diagnosis as one characterized by severe psychotic symptoms? These issues will be discussed in the context of the schizophrenia and bipolar disorder spectrum debate.

S045-4.

THE CONVERGENCE OF PSYCHOPHARMACOTHERAPY FOR SCHIZOPHRENIA AND BIPOLAR DISORDER

Presenter: Philip G. Janicak, M.D.

SUMMARY:

This presentation focuses on the rationale and evidence base supporting the use of agents which “cross the boundary” between schizophrenia and bipolar disorder. In this context, delineating distinct drug approaches for patients with schizophrenia or bipolar disorder is becoming increasingly more complex. A clear example is the use of antipsychotics for both disorders. While first developed for the treatment of schizophrenia, these agents were also commonly used to treat bipolar disorder years before the introduction of lithium. More recently, a series of randomized controlled trials demonstrated that second-generation antipsychotics also have mood stabilizing effects on various phases (e.g., acute manic/mixed episodes; acute depressive episodes; as maintenance therapy). As a result, several of these agents now have specific FDA-approved indications for bipolar disorder. Although “classic” mood stabilizers (e.g., lithium; valproate) have been considered as augmentation strategies with standard antipsychotics, results have been inconclusive. Presently, a number of novel strategies are being tested in proof of concept studies as potential treatments for both schizophrenia and bipolar disorder. In this context, a promising approach involves glutamatergic modulation. One example is the possible role of lamotrigine as a maintenance therapy for bipolar disorder and as an augmentation approach in patients with schizophrenia who are clozapine

nonresponders. Other overlapping strategies involve agents acting through various gabaergic mechanisms and new drug targets addressing the hypercortisolemia which may be involved in the pathophysiology and stress vulnerability seen in more severe mental conditions.

SYMPOSIUM 046

INNOVATIVE SUBSTANCE ABUSE RESEARCH FINDINGS: WHAT ARE THE BARRIERS TO IMPLEMENTATION?

Co-Chairs: Frances R. Levin, M.D., John J. Mariani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) The audience will become aware of exciting new substance abuse research findings that have direct treatment implications, 2) The audience will understand the definition of implementation science and its application to the translation of clinical discovery into application, 3) The audience will understand important principles of behavioral change from business and communications research, and their application to the translation of clinical discovery into application, 4) Consider impediments to the dissemination of these findings and strategies to overcome them

SUMMARY:

Scientific advances in genetics, functional brain imaging, and therapeutics have the potential to lead to revolutionary changes in the treatment of substance use disorders. Historically, advances in addiction science have had only limited acceptance into community treatment settings. This symposium will focus on emerging advances in addiction science and propose strategies for implementation in community settings. Speakers will discuss recent advances in addiction science including functional brain imaging, genetics and personalized medicine, and computerized treatment approaches. Past difficulties in implementation of evidence-based addiction treatments into the community will be reviewed, and proposals for transforming the standard of community care will be discussed. A panel discussion will provide an opportunity for interaction with attendees.

S046-1.

GENETICS AND PHARMACOGENETICS OF DRUG AND ALCOHOL DEPENDENCE

Presenter: Henry R. Kranzler, M.D.

SUMMARY:

Risk of addiction to drugs and alcohol is strongly influenced by genetic factors and research has begun to identify

specific gene variants that underlie that risk. Other research has focused on genetic variants that moderate the response to pharmacological treatments for addictive disorders. As these fields mature, they will substantially inform both screening for individuals at risk for substance use disorders and individualized treatment decisions for affected individuals. This presentation will provide an overview of research in the genetics and pharmacogenetics of addictive disorders and consider impediments to the widespread implementation of these technologies in medical practice.

S046-2.

THE IMPACT OF FUNCTIONAL IMAGING ON CLINICAL PRACTICE: PROMISES AND PITFALLS

Presenter: Diana Martinez, M.D.

SUMMARY:

Brain imaging with Positron Emission Tomography (PET) provides insight into the alterations in brain chemistry that accompany addiction. By measuring changes in neurotransmitter systems and how these correlate with drug-seeking behavior, a potential use for functional imaging is to develop better treatment strategies. Over the past decade, we and others have used PET imaging to investigate correlations between dopamine transmission and risk and resilience in addiction. These results have produced insights into the underlying neural mechanisms and into potential treatments for substance abuse, although these have largely been limited to cocaine addiction. Despite these advances, the findings from this body of research have not yet translated to the clinic. This is partly due to the limitations of imaging, which requires resources and expense that are not widely available. Nonetheless, insights from these imaging studies and how they could impact clinical management will be discussed.

S046-3.

COMPUTER-DELIVERED THERAPY FOR ADDICTION: STATE OF THE SCIENCE AND OPPORTUNITIES FOR EMBEDDING TECHNOLOGY-BASED THERAPEUTIC TOOLS IN SYSTEMS OF CARE

Presenter: Lisa A. Marsch, Ph.D.

SUMMARY:

Technology (computers, web, mobile devices) offers the potential to play a critical role in improving the effectiveness, cost-effectiveness and reach of efforts to assess, prevent, and treat substance misuse and other risk behavior. Using technology to deliver evidence-based interventions allows for these complex activities to be implemented with fidelity and at low cost, without increasing demands on time or training

needs of health care professionals. Technology-based therapeutic tools may function as important “clinician extenders”, which may enable more widespread dissemination of evidence-based care to broader audiences in a wide array of settings than what is possible with traditional models alone. This presentation will review the state of scientific research focused on the development and experimental evaluation of technology-based interventions targeting substance use disorders and related issues. The opportunities and challenges for integrating these technology-based interventions into an array of community-based systems of care will be addressed. Finally, the potential public health and policy implications of this work in the behavioral health care arena will be discussed.

S046-4.

CHANGING PRACTICE WITH RESEARCH: IT AIN'T JUST DISSEMINATION

Presenter: A. Thomas McLellan, Ph.D.

SUMMARY:

Drawing upon two recent translation implementation science projects involving screening and brief interventions (SBI) (one in a cancer clinic, one in a NY high school medical clinic), the talk will describe the steps necessary to translate, implement and sustain one well-studied form of evidence-based practice. Both studies were ultimately successful and both clinics are at the writing sustaining and enhancing their use of SBI but the steps needed to assure this draw heavily from business research (particularly franchise research), communications research (tailored marketing, mass customization) and social policy research. The message is that sustained application for evidence-based practices requires much more than “dissemination” efforts or even political pressure, and that there are important lessons for researchers in the business and communications fields.

SYMPOSIUM 047

INVENTING THE NECK: CONNECTING BODY, MIND, WORLD FROM THE TOP DOWN AND THE BOTTOM UP

Chair: Kenneth S. Thompson, M.D.

Discussant: David A. Pollack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the work of culture change and negotiated power shifts and the growing role of the person in their own care and the subsequent reconceptualization of services, of what we do for people and what they do for

themselves, 2) Demonstrate what happens to healthcare, to people, to ourselves and to our society when we begin to do these things, 3) Demonstrate the vitality of changing health care and the possibilities it holds

SUMMARY:

Impelled by the need for health care redesign and having the resources to do so, initiatives to connect behavioral health care and primary care are blossoming across the country. In truth, body, mind and world have never been disconnected as anyone who has been ill or cared for someone who is ill well knows. And yet, the new efforts in health care to more actively consider all three of these elements at the same time are bringing some new things into the world. Among them are a growing appreciation of how invested we providers have become in being separate; an awareness of how the consumers of our services have wanted useful services and not a mere model; and, most critically, an eyeopening appreciation of the possibilities for health that approaching people as whole people can unleash. The presentations in this symposium are by persons from across this country involved in the heart of this work. Their presentations will sketch out the work of culture change and negotiated power shifts and the growing role of the person in their own care and the subsequent reconceptualization of services, of what we do for people and what they do for themselves. They will demonstrate what happens to healthcare, to people, to ourselves and to our society when we begin to do these things. The journey we have started within the context of 21st century health care reform is profound, greater than the sum of its substantial parts and its original intentions. While the language of change at times appears pedestrian (changes in billing codes or the sharing of information), the conceptual and organizational reordering how we see and understand people and do the work of health care that is occurring is anything but mundane and has only just started. This symposium will demonstrate the vitality of this new way and the possibilities it holds. It will help illuminate the next steps forward.

S047-1.

IMPROVING BEHAVIORAL HEALTH CARE IN PRIMARY CARE: PARTNERS IN INTEGRATED CARE

Presenter: Keith Kanel, M.D.

SUMMARY:

Partners in Integrated Care is a collaborative, multistate effort to ensure that depression and unhealthy substance use are identified and addressed as part of routine primary care through a combination of two evidencebased, integrated, teamdriven models: Improving MoodPromoting Access to Collaborative Treatment (IMPACT); and Screening, Brief

Intervention, and Referral to Treatment (SBIRT). The rationale for focusing on primary care is that: 1) there is less stigma associated with accessing services; 2) people are more likely to contact their primary care doctor than any other health care professional when they start to experience new symptoms; and 3) depression and unhealthy substance use often cause, aggravate or accompany other chronic health problems that require coordination from a primary care provider. With considerable experience implementing these models in their respective communities, project partners — the Pittsburgh Regional Health Initiative, the Institute for Clinical Systems Improvement, the Wisconsin Initiative to Promote Healthy Lifestyles, the Wisconsin Collaborative for Healthcare Quality, and the Network for Regional Health care Improvement — are working together with funding from the Agency for Healthcare Research and Quality (AHRQ) to develop efficient training and implementation strategies and a marketing plan to support shared learning, inform policymaking, and engage providers. This presentation will describe the processes involved in planning and implementing the project and will describe initial results and products.

S047-2.

PSYCHOSOCIAL PEDIATRICS FOR THE NEW MILLENNIUM

Presenter: Howard King, M.D.

SUMMARY:

We recruited pediatricians and nurse practitioners to participate in an educational program. Our goal was to enhance practitioners' confidence in providing psychosocial assessment for children and families. Each month an expert discussed topics related to psychosocial pediatrics including utilizing reflective listening and empathic interviewing skills; understanding the role of family systems; the diagnosis of childhood depression, and other issues related to building a psychosocial skill base. Participants presented cases from their practice, receiving supervision from course leaders. Course participants discussed ways to help parents address the issues that arose. When parents worried their child might have a psychosocial problem, we encouraged course participants to invite a family member to return. Participants came to understand how the patient's problem came to be and how to develop a plan for management and support. The benefits pediatricians and the families with whom they work might derive by asking a family to return include: 1. Diagnosing emotional problems in children at the earliest time. 2. Focusing on the entire family and not just the child. 3. Reflecting as pediatricians, "Who is the real patient in this family?" 4. Pediatricians considering how their own issues might interfere with understanding family dynamics more clearly. 5. Improving parents' capacity as

decisionmakers as well as esteeming them as storytellers⁶. Being mindful how family secrets including mental illness, domestic violence, and the addictions are often passed from one generation to another.⁷ Finally, knowing that “half of therapy is preparation for therapy” and pediatricians should value their role helping families follow through with mental health referrals. By the end of this educational program we hope to have sufficient evidence-based data to show insurers and health systems that in the best kind of medical care, psychosocial/behavioral healthcare deserves parity and reimbursement equal to the physical healthcare we provide.

S047-3.

FOCUSING HEALTH CARE: THE CAMDEN EXPERIENCE

Presenter: Jeff Brenner, M.D.

SUMMARY:

The City of Camden is one of America's poorest cities. For the last nine years, the Camden Coalition of Healthcare Providers has been working to build a citywide coalition to improve the quality, capacity, and accessibility of healthcare services while reducing costs. Driven by a homegrown patient-level database with eight years of longitudinal hospital claims records for every city resident, the Coalition has worked methodically to redesign how healthcare is delivered and target services to the most costly and complex patients. The Coalition efforts include a combination of primary care clinical redesign, a citywide Health Information Exchange, outreach projects targeted to the highest cost patients, patient education programs, and community organizing. The Camden Coalition worked with the NJ Chamber of Commerce, NJ Hospital Association, Citizen Action, and other partners to pass a Medicaid Accountable Care Organization (ACO) bill in August 2011. The bill will permit shared savings to be captured from reductions in ER and hospital use in Medicaid and the Camden Coalition will be the first Medicaid ACO in New Jersey. The Coalition was recently featured in an article by Dr. Atul Gawande in the *New Yorker* and on PBS Frontline.

S047-4.

INTEGRATING HEALTH CARE BY CROSSING THE PROFESSIONAL LINE: PEER SUPPORT SPECIALISTS AND THE JOURNEY TO WELLNESS

Presenter: Marshall E. Lewis, M.D.

SUMMARY:

San Diego County is pursuing a vision of integrated primary and behavioral health care in which many different behavioral health programs develop partnerships with

primary care clinics, to provide virtual Patient-Centered Medical Homes where the two partnered provider organizations accept dual responsibility for their two populations, ensuring that all patients have the combination of medical and behavioral health service they require, across the full spectrum of more or less acute and/or complex clinical pictures. Based on successful experiences with peer services in the mental health and substance treatment sectors, we are now turning a focus to the role of consumers in supporting system change, providing disease management support specifically geared to the behavioral health population, and supporting individuals as they maneuver in the health system. As clients have better access to primary care homes, we believe that a consumer support dimension will particularly help clients with serious mental illness to obtain optimal health outcomes in both physical as well as behavioral health domains. It is our early experience that consumer support staff work very well with psychiatrists and the entire healthcare team. This presentation will describe the further progress San Diego has made in implementing this novel approach to integrating care.

S047-5.

PURSuing WELLNESS FROM HEAD TO TOE: A SEEKER'S PERSPECTIVE

Presenter: Lisa St. George, M.S.W.

SUMMARY:

For years people with mental health challenges have had their minds, behaviors, and thoughts addressed through psychiatry, but caring for the head often led to not caring for the body. There are two reasons for this. First, the people and doctors were first and foremost concerned with the person's mental health took on a master status. Second, access to healthcare is challenging when people go to physicians who may not be accustomed to working with them, have fear and stigma regarding patients. Across the USA, systems of health care are beginning to integrate physical and behavioral health care. There are some challenges, but the benefits are great for both people, and systems of care. The physical health care system historically understands that when health care intervention occurs, people get well. That is the expected outcome for most people who get physical health care. Traditionally, mental health systems of care did not see people as able to recover. So, people will engage in a system that has expectations of good outcomes. Additionally, our mental health systems have been flooded with people who, like me, were told they can never get better, work, or live a healthy life. Numbers of people being served kept growing, the system became overwhelmed and service providers and people suffered because of it. None of us could do the work needed for recovery when everything was overwhelmed. New science shows that people recover from mental illness.

Additionally, the use of Peer Support has created a venue for communicating HOPE to people where once there was none. This creates higher levels of wellness. Seeking integrated physical and mental healthcare will mean that we do not have to continue to be at the high risk of early death that currently exists. We can recover from head to toe.

SYMPOSIUM 048

PSYCHIATRY AND THE ROLE OF PSYCHIATRISTS AS LEADERS IN THE FIELD OF MEDICINE IN TERMS OF HEALTH POLICY AND THE CHANGES IN HEALTH CARE DELIVERY

Co-Chairs: Rahn K. Bailey, M.D., Jeremy A. Lazarus, M.D.

Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize the changing world of healthcare delivery, 2) Identify the need for new strategies, 3) Understand the future of healthcare and our place in it, 4) Formulate new strategies for delivering healthcare solutions more efficiently and widely, and 5) Realize the role of leadership within the healthcare community

SUMMARY:

The Joint Session will present an interactive discussion regarding the role of psychiatrists as leaders in the field of health policy and governance. There will be commentary on unexpected challenges faced by medical professionals in the coming years as a consequence of the healthcare reform law. The discussion will entail the implications and ramifications of the Obama Healthcare plan, the merits of going into practice singularly, or joining a group. The manner that medical reimbursement is expected to change will be addressed. The panel will discuss the path of the future APA/AMA/NMA leadership with regards to physician concerns. Further how the leadership can better represent physician concerns to the Government and private sector. Similarly The Panel will discuss the need for Preventive Psychiatry and integration of Psychiatric Screening in Primary Care and Internal Medicine, with stress upon the importance of Geriatric Medicine and Psychiatry with respect to changing dynamics in different demographics.

S048-1. THE ROLE OF PSYCHIATRISTS AS LEADERS IN HEALTHCARE

Presenter: Rahn K. Bailey, M.D.

SUMMARY:

Leadership is a key part of a physicians' professional work

regardless of specialty and setting. While the primary focus for physicians is on their professional practice. Physicians can have a direct impact on patient experience and outcomes. Among the ranks of Physicians, Psychiatrists are attuned to the needs and the undercurrents of their patients and their environments. It is part of the personality and the training of a Psychiatrist that they grasp the subtleties of coming change with natural grace. Therefore it falls upon such individuals to guide their colleagues to achieve policy objectives in Government and the Private Sector.

S0482.

THE ROLE OF PROFESSIONAL MEDICAL ASSOCIATIONS IN REPRESENTING THE INTERESTS OF PHYSICIANS TO THE GOVERNMENT AND PRIVATE SECTOR

Presenter: Jeremy A. Lazarus, M.D.

SUMMARY:

In the changing world of Healthcare Delivery, Insurance and Medicare reimbursements, physicians have always stood stronger when they have done so under the banner of organizations such as the AMA, NMA and the APA. Professional Associations depend on and represent the needs of their members. Physicians act as advocates for the needs of their patients. As such it is our duty to ensure the quality of healthcare is not compromised with changes in policy. Furthermore policy should be influenced by organizations and associations that represent large bodies of physicians to affect changes that are favorable to delivery of healthcare.

S048-3.

HEALTHCARE REFORM AND CHANGES IN HEALTHCARE DELIVERY IN THE FUTURE

Presenter: Annelle B. Primm, M.D., M.P.H.

SUMMARY:

The future of healthcare in America is in flux. There are numerous cultural issues in psychiatry and cooccurring psychiatric illness and substance abuse. Disparities in healthcare delivery systems are a stark reality of our time. In these times of change with respect to the healthcare reform and the affordability of healthcare for the average American lies a road of uncertainty for the community Medical Psychiatrists and Physicians.

SYMPOSIUM 049

USE OF TECHNOLOGY FOR RESEARCH, TREATMENT, AND EVALUATION OF ALCOHOL DEPENDENCE

Chair: Dan Falk, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge of the benefits of virtual reality technology to enhance training of health care professionals in SBI for alcohol problems, 2) Demonstrate knowledge of the prospects and drawback of webbased approaches to alcohol treatment, 3) Demonstrate knowledge of the potential for using biosensors in alcohol research and practice

SUMMARY:

Within the last decade, a multitude of novel technologies have been developed to speed the course of alcohol treatment and related research. For instance, the widespread availability of the Internet, wireless technology, and computers has made possible a number of technological advances that capture important realtime drinking-related information from patients in the field; simulate the realworld experiences of drinkers and of health practitioners who treat alcohol problems; and deliver interactive computerized versions of promising behavioral interventions. With the tremendous promise potentially afforded by these tools, research and development is rapidly evolving. More research is needed to further develop, refine, validate, and creatively implement these novel methods within alcohol clinical trials and treatment paradigms. This symposium will highlight several cuttingedge uses of technology in research, treatment and evaluation of alcohol dependence. Dr. Daniel Falk (Chair) will provide a brief overview of technology in alcohol treatment and relate its important role to NIAAA's mission. Dr. Reid Hester will provide an overview on Web-based approaches to Screening and Brief Intervention (SBI) for problem drinkers. Drs. Dale Olsen and Paul Grossberg will discuss simulation software to efficiently train health practitioners in the use of SBI. Dr. Patrick Bordnick will present his research using stateoftheart computerized virtual reality to simulate drinking environments as an adjunct to cognitive behavior therapy in the treatment of alcohol dependence. And finally, Dr. Nancy Barnett will provide an update on the use biosensors to objectively measure alcohol consumption in the context of alcohol treatment and forensic evaluation.

S049-1.

COMPUTERDELIVERED INTERVENTIONS: A STEPPED CARE APPROACH FOR PROBLEM DRINKERS

Presenter: William Campbell, M.S.

SUMMARY:

There is a great need for effective and efficient interventions for heavy drinkers, many of whom will never go to treatment. We have developed computerbased interventions to meet this need and evaluated them in randomized clinical trials. They include: the Drinker's Checkup (DCU) for older adults; the College Drinker's Checkup (CDCU) for younger adults; Moderate Drinking (MD) for less severe problem drinkers; and Overcoming Addictions for more severe drinkers and drug abusers. This presentation will: review the stepped care model and stages of change as they affect selection of interventions; briefly review these interventions and the data from randomized clinical trials that support their effectiveness; and discuss how they can be used within psychiatric treatment.

S049-2.

VIRTUAL REALITY SKILLS TRAINING FOR HEALTH CARE PROFESSIONALS IN ALCOHOL SCREENING AND BRIEF INTERVENTION

Presenter: Dale Olsen, Ph.D.

SUMMARY:

Educating health care professionals about the identification and treatment of patients who drink more than recommended limits is an ongoing challenge. An educational randomized controlled trial was conducted to test the ability of a standalone training simulation to improve the clinical skills of health care professionals in alcohol screening and intervention. The "virtual reality simulation" combined video, voice recognition, and nonbranching logic to create an interactive environment that allowed trainees to encounter complex social cues and realistic interpersonal exchanges. The simulation included 707 questions and statements and 1207 simulated patient responses. A sample of 102 health care professionals (10 physicians; 30 physician assistants or nurse practitioners; 36 medical students; 26 pharmacy, physician assistant, or nurse practitioner students) were randomly assigned to a no training group ($n = 51$) or a computerbased virtual reality intervention ($n = 51$). Professionals in both groups had similar pretest standardized patient alcohol screening skill scores: 53.2 (experimental) vs 54.4 (controls), 52.2 vs 53.7 alcohol brief intervention skills, and 42.9 vs 43.5 alcohol referral skills. After repeated practice with the simulation there were significant increases in the scores of the experimental group at 6 months after randomization compared with the control group for the screening (67.7 vs 58.1; $P < .001$) and brief intervention (58.3 vs 51.6; $P < .04$) scenarios. The technology tested in this trial is the first virtual reality simulation to demonstrate an increase in the alcohol screening and brief intervention skills of health care professionals.

S049-3.

VIRTUAL REALITY SKILLS TRAINING FOR HEALTH CARE PROFESSIONALS IN ALCOHOL SCREENING AND BRIEF INTERVENTION: PART 2

Presenter: Paul Grossberg, M.D.

SUMMARY:

Paul Grossberg, M.D. is presenting part 2 of “Virtual Reality Skills Training for Health Care Professional in Alcohol Screening and Brief Intervention.” See Dr. Dale Olsen’s abstract.

S049-4.

VIRTUAL REALITY APPLICATIONS FOR ALCOHOL AND DRUG ABUSE

Presenter: Patrick S. Bordnick, Ph.D.

SUMMARY:

Research and treatment applications using virtual reality (VR) in alcohol use disorders, based on NIAAA support, show promising results. Primarily, studies have focused on using VR based cue reactivity systems for the assessment of craving and physiological reactivity to proximal and contextual cue types. VR enhances traditional cue reactivity paradigms, by allowing access to proximal, contextual, and complex cues that have been difficult to utilize without the use of technologies such as VR. Results from cue reactivity assessment studies on alcohol, nicotine, and cannabis will be presented. Going beyond human laboratory studies, VR applications are being utilized to teach coping skills and relapse prevention strategies for alcohol and nicotine dependence. Results from nicotine cessation trials indicate that VR leads to increases in coping skills use and decreased abstinence. A novel VR based treatment for alcohol dependence is under development and will be highlighted in this presentation. Specifically, the drinking contexts/environments developed to date, rational for using VR in alcohol treatment, and potential applications for assessment and behavioral modification. Overall the use of VR in addictions treatment and research, assessment, DSMIV diagnostic training, and behavioral change applications will be discussed.

S049-5.

BIOSENSORS FOR ALCOHOL TREATMENT RESEARCH AND PRACTICE: AN UPDATE

Presenter: Nancy Barnett, Ph.D.

SUMMARY:

Biosensors are now available that provide a continuous estimate of blood alcohol concentration (BAC) based on

the concentration of alcohol in perspiration on the skin. These transdermal alcohol monitors are worn on the ankle or wrist, have sensors that sample the vapor near the skin for ethanol, and store readings for later download. These alcohol biosensors are an important methodological advancement for alcohol research and treatment, in that they provide objective, continuous data on alcohol use. This presentation will provide background on recent research using a transdermal sensor, including laboratory work, field trials, and clinical applications. Two recent investigations also will be presented. In one, 70 participants wore a sensor for up to 28 days and reported 690 drinking episodes. Controlling for body mass index, there were no gender differences in the sensor detection of reported drinking episodes, but at the level of four or fewer drinks, women’s drinking was more likely to be detected ($p < .01$) due to higher alcohol concentration readings. In the second investigation, heavy drinking participants ($N=15$) who received daily contingent reinforcers for no sensor-detected alcohol use showed a significantly lower number of days of detected drinking and a significantly longer number of consecutive days of no detected drinking than participants who received noncontingent reinforcement ($N=15$), $ps < .05$. By providing an objective measure of alcohol use, transdermal alcohol sensors can augment self-report, thereby enhancing current alcohol research and supporting new research endeavors.

SYMPOSIUM 050

GRIEF OR MAJOR DEPRESSION? THAT IS THE QUESTION

Co-Chairs: Sidney Zisook, M.D., M. Katherine Shear, M.D.

Discussant: Ronald W. Pies, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Accurately define the bereavement exclusion for the diagnosis of major depressive episode, 2) Based on the best available research data, make a diagnosis on an individual meeting symptomatic criteria for major depression that occurs within 2 months of the death of a loved one, 3) Describe key arguments for and against maintaining the bereavement exclusion in DSM5

SUMMARY:

Mr. B has been sad and tearful 100% of the time since his mother died 4 weeks previously. In addition, he is listless, cannot enjoy anything, sleeps fitfully, has lost 8 lbs, cannot concentrate or make decisions, has no energy and ruminates about his shortcomings as a son. He denies morbid feelings of worthlessness, is not suicidal and is able to go to work most days, although his productivity is down. Does

Mr. B have a major depressive episode (MDE) or is he just grieving (i.e., experiencing the 'normal' emotions associated grieving)? That question, and its answer, is the subject of this symposium. Bereavement, the death of a loved one, is one of the most stressful life events of ordinary life and is a well established and robust risk factor for the onset or persistence of MDE. Yet bereavement is the only life event that has been singled out by recent editions of the Diagnostic and Statistical manual (DSMIII, IV and TR) to negate the diagnosis of MDE. Of interest, the ICD10 does not exclude recently bereaved individual from the diagnosis of major depression. Clinicians using the DSMIV would likely diagnose Mr. B with the VCode, Bereavement, while those using ICD10 would diagnose him with a MDE. In the first instance, Mr. B would not be considered ill, probably would not be offered treatment and would have an excellent prognosis. In the second instance, he would have a psychiatric disorder, may require formal intervention and is likely to experience chronicity or recurrences. Which of these diagnostic conventions and clinical scenarios more accurately captures the best available evidence and leads to the most appropriate management and prognostic implications? This question has received great attention in the lay press, among grief and bereavement experts, and by the APA's DSM5 Mood Disorders Taskforce, which has proposed eliminating the bereavement exclusion from DSM5. This symposium will discuss the background and rationale of the bereavement exclusion for the diagnosis of MDE (Dr Alana Iglewicz), review psychiatric literature bearing on its validity and present detailed accounts of several key studies that have argued for, or against, deleting the bereavement exclusion in DSM5 (Drs Emmanuelle Corruble, Elie Karam and Ramin Mojtabai). It will include 2 formal discussions of the pertinent issues and the presentations (Drs Paula Clayton and Ronald Pies), and ample opportunity for audience Q&A. At the end of the session, not all participants will be expected to agree on Mr. B's diagnosis, but all should have more informed opinions than at the outset.

S050-1.

THE BEREAVEMENT EXCLUSION FOR THE DIAGNOSIS OF MAJOR DEPRESSION: BACKGROUND AND RATIONALE

Presenter: Alana Iglewicz, M.D.

SUMMARY:

Since the publication of DSMIII in 1980, the official position of American Psychiatry has been that recent bereavement is an exclusion criterion for the diagnosis of a major depressive episode (MDE), especially if the MDE symptoms and impairment are relatively mild. However, the empirical validity of this exclusion has not been well established. The APA's DSM5 Mood Disorders Work Group has proposed

eliminating the Bereavement exclusion (BE) from DSM5, largely on the basis of research indicating that there is little to no systematic differences between individuals who develop a major depressive episode (MDE) in response to bereavement as opposed to in response to other severe stressors, such as loss of a job or suddenly developing a catastrophic illness. This presentation reviews the background for the BE, examines arguments for and against retaining it in DSM5 and summarizes the data on which the Work Group's recommendations were based.

S050-2.

BEREAVEMENTRELATED AND NONBEREAVEMENTRELATED DEPRESSIONS: A COMPARATIVE FIELD STUDY IN LEBANON

Presenter: Elie G. Karam, M.D.

SUMMARY:

The issue of excluding Bereavement related depressive episodes from the repertoire of major depression was carefully studied in a prospective community study. Age of onset, symptomatology, dysfunction, as well as recurrence were similar in Bereavement and Nonbereavementrelated depressive episodes. Furthermore the conditional symptoms required by DSMIV of psychomotor retardation, of worthlessness and suicidality were equally prevalent in bereaved and nonbereaved episodes. Treatment seeking was predicted only by dysfunction and not by any other symptom or bereavement status. While precipitants of depressive episodes might color the content, the cardinal yardsticks of disease expression and evolution seem to be similar in both groups.

S050-3.

THE DISCRIMINANT VALIDITY OF DMSIV BEREAVEMENT EXCLUSION FOR THE DIAGNOSIS OF MAJOR DEPRESSION: RESULTS OF NATURALISTIC REALWORLD STUDIES IN FRANCE

Presenter: Emmanuelle Corruble, M.D., Ph.D.

SUMMARY:

The aim of the DSMIV Bereavement exclusion E criterion for Major Depressive Episode (MDE) is to discriminate subjects with a modest "normal" depressive syndrome, that should not be medicalized prematurely. We aimed at assessing the discriminant validity of the MDE Bereavement exclusion criterion in naturalistic realworld studies. In a first crosssectional casecontrol study of 17,988 selfreferred individuals seeking treatment for depressive symptoms in France (1), 8.5% met all MDE criteria except the bereavement exclusion. Bereavementexcluded subjects were more

severely depressed than matched MDE controls without bereavement and similar to MDE controls with bereavement. Two symptom cues, suicidal ideation and worthlessness, were more pronounced in bereavementexcluded individuals than in MDE controls. In a second 6week longitudinal study performed in another sample of 11,510 selfreferred individuals seeking treatment for depressive symptoms in France, we showed that matched subjects fulfilling the MDE A, B, C and D criteria, and differing only on the presence/absence of the E criterion based on the clinician's judgement, were not different in terms of objective cognitive impairment (2) and 6week outcome (3). Our results suggest that the Bereavement exclusion criterion has a poor discriminant validity in officebased practice of treatment seeking individuals in France. New studies are now needed to confirm these results.

S050-4.

CHARACTERISTICS AND 3YEAR COURSE OF BE-REAVEMENTRELATED DEPRESSIVE EPISODES: A LONGITUDINAL COMMUNITYBASED STUDY IN THE UNITED STATES

Presenter: Ramin Mojtabai, M.D., Ph.D.

SUMMARY:

The DSMIV criteria for major depressive episodes exclude brief episodes that are better accounted for by bereavement. However, there is a proposal to remove this exclusion from the DSM5. This study used longitudinal data from the National Epidemiologic Survey on Alcohol and Related Conditions waves 1 (N=43,093) and 2 (N=34,653) to compare the demographic and psychiatric characteristics of bereavementrelated single brief (<2 months) depressive episodes and other types of depressive episodes and the future risk of depression among these groups and participants without a history of depression at baseline. The study found that compared to participants with other types of depression, those with bereavementrelated single brief depressive episodes were more likely to have a later onset and to be black, but less likely to have had impairment in role functioning, comorbid anxiety disorders or a treatment history at baseline. Participants with bereavementrelated single brief episodes were less likely than those with bereavementunrelated single brief episodes to experience fatigue, increased sleep, feelings of worthlessness and suicidal ideations. The risk of new depressive episodes in the followup in participants with bereavementrelated single brief episodes was significantly lower than in participants with bereavementunrelated single brief episodes and other types of depression; but similar to the risk in the general population participants with no baseline history of depression. It is concluded that bereavementrelated single brief depressive episodes have distinct demographic and symptom profiles compared to other

types of depressive episodes and are not associated with increased risk of future depression. The findings support preserving the DSMIV bereavement exclusion criterion for major depressive episodes in the DSM5.

SYMPOSIUM 051

IMPACT OF PSYCHIATRIC DISORDER ON HIV MANAGEMENT

Chair: Marshall Forstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Review the myriad of mental health challenges that can accompany HIV disease, 2) Recognize the impact of HIV on the central nervous system and appreciate the diagnostic workup and treatment of cognitive motor impairment, 3) Understand the diagnostic and treatment options for a patient with HIV and a cooccurring mental health disorders

SUMMARY:

Despite the growing evidence of mental health and behavioral disorders associated with HIV disease and AIDS, these conditions are commonly overlooked and too often undertreated. Mental health conditions can have a profound influence on adherence to antiretroviral therapies, clinic attendance, quality of life, disease progression, and highrisk behaviors. Clinical experience and research also provide substantial evidence that HIV directly infects the brain soon after initial infection, which can result in organic disease expression such as central nervous system (CNS) impairment, neuropsychiatric disorders, and/or psychiatric complications including HIV1 associated dementia complex, minor neurocognitive disorder, asymptomatic neurocognitive impairment, CNS opportunistic infections, HIVassociated mania, delirium, depression, anxiety, psychosis, pain, and sleep disorders. Neurocognitive disorders associated with HIV (HAND), in particular, remain among the most common clinical disorders encountered in people infected with HIV, even in an era in which potent antiretroviral therapy is widely deployed. Such 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. Often described as "a neuropsychiatric disease with systemic manifestations" HIV's assault on the brain and behavior requires the participation of clinicians throughout the course of illness. In this symposium, faculty will present basic information in the direct care and support for the HIV patient, including discussion of CNS dysfunction; assessing and monitoring patients for the neuropsychiatric consequences of HIV; thought disorders; mood and anxiety disorders; sleep disorders and insomnia;

and pain. Six 20-minute sessions will be followed by a question and answer period and case discussions.

S051-1.

CENTRAL NERVOUS SYSTEM COMPLICATIONS

Presenter: Stephen J. Ferrando, M.D.

SUMMARY:

Although AIDS is primarily an immune system disorder, it also affects the nervous system and can lead to a wide range of severe neurological disorders causing such symptoms such as confusion and forgetfulness, behavioral changes, headaches, and/or progressive weakness. Cognitive motor impairment or damage to the peripheral nerves is also common. Such complications occur in more than 40% of patients with HIV infection. These disorders may be caused, directly or indirectly, by HIV itself or by infectious, autoimmune, or neoplastic processes secondary to immunodeficiency. Some neurologic conditions are even caused by antiretroviral drugs. Symptoms become more frequent and severe as the immune system declines and symptomatic illness and AIDS ensue. This session will provide a brief overview of the clinical manifestations, differential diagnosis, and treatment of HIV-associated neurocognitive disorders, including HIV-associated minor neurocognitive disorder and HIV-associated dementia.

S051-2.

MOOD DISORDERS AND HIV

Presenter: Lawrence McGlynn, M.D.

SUMMARY:

Mood Disorders are very common in patients with HIV and form the bulk of the psychiatric complications of HIV infection. They can occur at any time during the illness and range from mild to life threatening. In addition, mood disorders rarely occur in isolation and are often associated with other psychiatric illnesses, substance use, and of course, the underlying HIV illness. These disorders can have profound effects on partners, caretakers, family and friends. Managing mood disorders are best addressed by a comprehensive plan and adaptable to the variable and changing needs of the patient. Current treatments, which can be used individually or in combination, are often very effective. During this session participants will examine the range of mood disorders and review available treatment options.

S051-3.

PSYCHOSIS AND HIV

Presenter: Francine Cournos, M.D.

SUMMARY:

Psychosis in HIV is a generic term for any one of a number of symptomatic manifestations of thought disorders. The presence of psychosis in patients with HIV disease can contribute to difficulties in medical care, delays in diagnosis, tense relationships between health care providers and patients, and poor understanding of illness and treatment options. As with depressive syndromes, psychotic disorders may be made worse by medications, metabolic abnormalities, or HIV infection itself. During this session participants will review diagnostic options for distinguishing among thought disorders, discuss the use of antipsychotics, and examine useful tools for working with patients to successfully manage their illness.

S051-4.

HIV AND ANXIETY DISORDERS

Presenter: Mary Ann Cohen, M.D.

SUMMARY:

Anxiety is a common symptom in HIV-infected patients. When anxiety symptoms are severe or persistent, patients may have an anxiety disorder. These disorders include panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and posttraumatic stress disorder (PTSD), social phobia and other phobias, obsessive compulsive disorder (OCD), or acute stress disorder and anxiety disorder due to a general medical condition. Some of these anxiety disorders, for example OCD, will occur in people with HIV no more frequently than in the general population. Other disorders, including PTSD, can be prompted or exacerbated by the experience of HIV, especially when there is already an underlying proclivity toward the disorder. Patients with other psychiatric disorders, such as adjustment disorders, major depression, psychosis, or substance use disorders, can also present with significant anxiety. During this session participants will examine the differences among these specific disorders, understand the recurrence of anxiety symptoms during the course of HIV illness, and review treatment options.

S051-5.

SLEEP DISORDERS AND HIV

Presenter: Mary O Dowd, M.D.

SUMMARY:

Patients with HIV or AIDS are more likely to complain of sleep difficulties than are patients with other medical illnesses. However, clinicians may not always register the seriousness of disrupted sleep. It is important for medical professionals treating patients with HIV disease to take complaints of disrupted sleep seriously, since such complaints

are associated with an increased risk of depression, pain, and substance abuse. Sleep disorders are highly prevalent in the HIV seropositive population, and have been demonstrated to be a primary contributor to nonadherence to HIV retroviral regimens. More importantly, sleep has been demonstrated to be a powerful predictor of both comorbid psychiatric illnesses as well as medical comorbidities. Emerging evidence links impaired sleep quality to inflammatory cytokines that may contribute negatively to overall health status. This session will review common disorders of sleep initiation and sleep maintenance including primary insomnia, sleep disorders secondary to either HIV or other comorbid medical and psychiatric conditions, and treatments for the various sleep disorders.

S051-6.

HIV AND PAIN

Presenter: Marshall Forstein, M.D.

SUMMARY:

Pain is a very negative but common experience for patients with HIV/AIDS. People with HIV can experience pain in all parts of the body due to HIV infection and immunosuppression itself, HIV-related opportunistic infections and HIV-related cancers, antiretroviral treatment, and related symptoms such as nutritional deficiencies. It affects all parts of the body and can significantly affect quality of life. People with HIV who experience pain may not be able to earn a living, care for their families, or take part in social activities to the extent they would were they not in pain. Pain and its effect on life can also lead to emotional problems such as depression and anxiety. In almost every case, it is a treatable problem that is all too often undertreated by clinicians. Pain relief should be seen as a vital component of HIV treatment, not only to improve their standard of life but also as a means of fighting the virus itself through improved adherence to medications. During this session participants will review the origins of pain, discuss assessment strategies, and outline various treatment options.

SYMPOSIUM 052

FUNDAMENTALS OF THE PERINATAL PSYCHIATRIC CONSULTATION

Co-Chairs: Aerin M. Hyun, M.D., Ph.D., Olivia M. Joly, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Have a better understanding of how to obtain an appropriate history from a perinatal psychiatric patient, with emphasis on screening and epidemiology of mood/anxiety disorders in pregnancy and the postpartum period,

2) Be informed of effective strategies in staying up to date and current with the most recent literature on the rapidly evolving field of Women's Perinatal Mental Health, 3) Manage common acute psychiatric emergencies involving perinatal patients, 4) Understand the basics of psychotropic and psychodynamic treatments for the perinatal psychiatric patient, and 5) Compose a formulation tying together the underlying biological, psychological, social and psychodynamic aspects of the perinatal psychiatric patient

SUMMARY:

According to the Centers for Disease Control and Prevention (CDC), postpartum depression affects 10%15% of mothers within the first year after giving birth. Furthermore, recent studies suggest that up to 20% of women suffer from mood and anxiety disorders during pregnancy. Currently, knowledge regarding the risks of prenatal exposure to the psychotropic medications often called for in these illnesses is incomplete. As such, many patients discontinue or avoid psychopharmacologic treatment during pregnancy, often putting themselves at higher risk for recurrence or new onset of mood and anxiety symptoms. Given the incomplete knowledge of safety data for the use of psychotropic medications in pregnancy, women with histories of psychiatric illnesses often seek consultations regarding the use of medications in pregnancy. The current availability of clinicians with an expertise in this area is sparse, which often leaves psychiatrists facing challenges when making recommendations regarding the treatment of psychiatric illness during pregnancy. The purpose of this symposium is to provide psychiatrists with an opportunity to learn about the special considerations needed when diagnosing and treating pregnant, postpartum and lactating women with mental health concerns. By gathering leading researchers in the field of Women's Mental Health, we aim to provide an expert and comprehensive overview of the process involved in evaluating and treating such patients. Specifically, the symposium will be divided into six sections in which expert participants will speak about historytaking/screening, medication treatments, acute management, psychodynamic considerations, case formulation, and methodologies for keeping up to date with the most current literature in the field. This symposium should prove to be invaluable in educating psychiatrists about a large and rapidly growing percentage of our patient population.

S052-1.

RISK/BENEFIT DECISION MAKING AND THE PERINATAL CONSULTATION

Presenter: Margaret Spinelli, M.D.

SUMMARY:

The detection and appropriate management of psychiatric conditions among women of reproductive age before or early in pregnancy is critical. In managing psychiatric conditions during pregnancy and among women who could become pregnant, the clinician must consider and weigh the risks and benefits of discontinuing, changing or continuing psychotropic medications. Depression and anxiety disorders can be treated effectively during pregnancy with psychotherapy, medications or ECT. In recent years, antidepressant use during pregnancy has increased significantly. Women with depressive disorders who are planning a pregnancy or who could become pregnant should be informed about the potential risks of an untreated illness during pregnancy as well as the potential risks of pharmacotherapy. Decisions to discontinue, change or continue medication should be made with the patient and informed consent. Identifying healthy women at risk along with appropriate referral for social and psychological intervention during preconception visit might prevent the emergence of depressive disorders during pregnancy and the postpartum period. Currently, >20,000 women exposed to antidepressants with pregnancy outcomes are available in the literature. However, there is continuing fear of physicians prescribing and women taking these drugs during pregnancy, probably due to many of the studies reporting conflicting outcomes. This presentation offers the clinician a framework for risk benefit decision making and informed consent during the perinatal psychopharmacology consultation. Lorenzo I, Ayers B, Einarson A: Antidepressant use in pregnancy. *Expert Opin. Drug Safety* May 5, 2011 epub ahead of print Frieder A, Dunlop A, Culpepper L, Bernstein P: The clinical content of preconception care: women with psychiatric conditions. *American Journal of Obstetrics and Gynecology* Dec 2008 Supplement, S328S332

S052-2.**INFORMATION GATHERING: HOW TO STAY UP TO DATE WITH THE MOST CURRENT LITERATURE IN PERINATAL PSYCHIATRY**

Presenter: Elizabeth M. Fitelson, M.D.

SUMMARY:

There has been an explosion in recent years of studies pertaining to perinatal mental health issues, from increasing knowledge about the risks of untreated illness, to the potential effects of both standard and alternative treatments on mother and child. Unfortunately, much of the data is contradictory, of uncertain quality, or is difficult to interpret in terms of relevance for individual patient care. Nevertheless, staying up to date with the literature is vital when making clinical decisions in this population. The purpose of this portion of the symposium is to provide a framework for asking the right questions and finding relevant answers for

clinicians caring for perinatal psychiatric patients. Topics covered will include: strategies for maximizing efficiency of literature searches, guidance for reliable sources of information and its interpretation, and the basics of evaluating the quality and relevance of studies in this population.

S052-3.**ACUTE MANAGEMENT OF THE OBSTETRIC PATIENT**

Presenter: Lucy A. Hutner, M.D.

SUMMARY:

Consultationliaison psychiatry services, which provide psychiatric consultations to hospitalized medical inpatients, can potentially identify and treat acute disorders arising in the antenatal and postnatal periods. For example, identification of depression in the late pregnancy/immediate postpartum period might serve as a useful timepoint to assess, educate, and intervene with an at-risk mother and her family. In addition, acute management of obstetric inpatients carries a specific set of challenges to the consulting psychiatrist, ranging from participating in capacity decisions regarding the care of the newborn, to managing psychiatric emergencies on a wellbaby nursery floor. In this section, the current literature on acute management of the obstetric patient will be reviewed. Current data on the most common sorts of dilemmas faced by the consulting psychiatrist will be discussed. This will then be followed by a set of guidelines identifying the most common challenges to the consulting psychiatrist who manages patients on antenatal and postpartum floors. References: Rigatelli M, Galeazzi GM, Palmieri G: Consultationliaison psychiatry in obstetrics and gynecology. *J Psychosom Obstet Gynaecol*; 2002 Sep;23(3):16572. Sloan EP, Kirsh S: Characteristics of obstetrical inpatients referred to a consultationliaison psychiatry service in a tertiarylevel university hospital. *Arch Womens Ment Health*; 2008 Dec;11(56):32733.

S052-4.**MEDICATION TREATMENTS FOR THE PERINATAL PSYCHIATRIC POPULATION**

Presenter: Adrienne Einarson, R.N.

SUMMARY:

Psychiatric disorders are relatively common among women of childbearing age. Approximately 50% of pregnancies are unplanned, so a substantial number of women may inadvertently become pregnant while taking a psychotropic drug, as well as a number of women suffering from a serious mental illness who must receive pharmacological treatment. There remains a high level of anxiety regard-

ing safety among women and healthcare providers alike, most likely because of the conflicting studies that have been published in the literature and dire warnings from government organizations. These fears have recently been exacerbated by the precedent setting jury trial held in September 2009, when the parents of a boy born with a cardiovascular defect following exposure in utero, to Paxil@ were awarded \$2.5 million to be paid by GSK, the manufacturer. Despite this ruling being emotionally, rather than evidencedbased, further lawsuits are pending, with lawyers constantly recruiting women through the media, who took any SSRI in pregnancy and delivered a baby with a malformation, to participate in a class action suit against the various drug companies. Consequently, treating a psychiatric disorder during pregnancy with pharmacotherapy, is a complex decision making process, which has to be made between the pregnant woman and her health care provider following careful evaluation of the evidencebased information. The purpose of this presentation is to provide current evidencebased information regarding the safety/risk of psychotropic drug use in pregnancy and lactation. Following a systematic review of the literature, the body of evidence to date, suggests that psychotropic drugs are relatively safe to take in the perinatal period. Women and their health care providers should not be unduly concerned if she requires treatment and should not be influenced by the media or other nonevidencedbased opinions. In addition, there is no such thing as the “safest” drug to use, as optimal control of the psychiatric disorder should be maintained by treating the woman with the particular drug that is effective for her illness during pregnancy, the post partum period and thereafter.

S052-5.

PERINATAL CONSULTATION: PSYCHOTHERAPEUTIC TREATMENT OPTIONS

Presenter: Kristin Leight Wesley, M.D.

SUMMARY:

The perinatal consultation should involve consideration of psychotherapeutic treatments for women with psychiatric disorders in pregnancy and the postpartum. Many women who are pregnant or breastfeeding prefer psychological interventions to psychopharmacologic treatments, due to the potential risks involved with the latter (Sockol 2011, Chabrol 2004). In addition, psychotherapies can address the reality that pregnancy and the postpartum are times of significant psychological and psychosocial change, affecting the woman’s sense of identity, as well as her relationships and societal role. In this segment of the symposium, we will discuss some of the psychological developmental issues that occur in pregnancy and the postpartum, and what can go awry. We will also review the evidencebased psychotherapeutic options for treatment of mood and anxi-

ety disorders in pregnancy and the postpartum, including interpersonal psychotherapy (IPT) and cognitivebehavioral therapy (CBT) (Austin 2008, Bledsoe 2006, Sockol 2011, Spinelli 2003). Austin MP, Frilingos M, Lumley J, et al.: Brief antenatal cognitive behavior therapy group intervention for the prevention of postnatal depression and anxiety: a randomised controlled trial. *J Affect Disord* 2008, 105:35–44. Bledsoe, S. E., & Grote, N. K. (2006). Treating depression during pregnancy and the postpartum: A preliminary meta-analysis. *Research on Social Work Practice*, 16(2), 109–120. Chabrol, H., Teissedre, F., Armitage, J., Danel, M., & Walburg, V. (2004). Acceptability of psychotherapy and antidepressants for postnatal depression among newly delivered mothers. *Journal of Reproductive and Infant Psychology*, 22, 5–12. Cho HJ, Kwon JH, Lee JJ: Antenatal cognitivebehavioral therapy for prevention of postpartum depression: a pilot study. *Yonsei Med J* 2008, 49:553–562. Sockol LE, Epperson CN, Barber JP. A metaanalysis of treatments for perinatal depression. *Clinical Psychology Review* 2011, 31: 839849. Spinelli MG, Endicott J: Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *Am J Psychiatry* 2003, 160:555–562.

S052-6.

THE FORMULATION: PUTTING IT ALL TOGETHER

Presenter: Laura Miller, M.D.

SUMMARY:

The ultimate aim of a perinatal mental health consultation is to help pregnant and postpartum women make informed decisions about their mental health care. Given the plethora of information available, both from the consultant and from other sources, it is helpful to provide women with a conceptual framework with which to process the information. An especially useful framework is that perinatal mental health decisions involve risk/risk analyses – weighing the risks of untreated symptoms against the risks of effective interventions. In considering the risks of untreated symptoms, the formulation includes:

- Likelihood of symptom persistence, exacerbation or relapse during pregnancy and postpartum
- Risks to the woman from untreated symptoms
- Risks to the fetus or newborn from untreated symptoms
- Effects of untreated symptoms on functioning, including effects on parenting other children, on family relationships, on social networks, and on occupational functioning

In considering the risks of pharmacologic interventions, effective consultation includes:

- Explaining the range of research methodologies in language patients can understand, such that patients realize that the trustworthiness of data and conclusions is variable.
- Emphasizing the central importance of therapeutic effectiveness when choosing a medication type and dose.
- Summarizing reliable data about

potentially effective medications. • Discussing dosing strategies during pregnancy and postpartum. In reviewing nonpharmacologic interventions, it is important to assess patient motivation, treatment burden and feasibility, and to help patients find practical ways to incorporate these interventions into their lives. At the end of the consultation, it is helpful to check the patient's understanding of the material, elicit her emotional reactions to the material, ascertain her values and priorities in weighing the relative importance of different types of risk, and offer to speak with others (e.g. other health care providers, family members) if relevant.

SYMPOSIUM 053

THE BLACK COMMUNITY AND ITS LGBT MEMBERS

Chair: Billy E. Jones, M.D., M.S.

Discussant: June J. Christmas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Better understand the changing dynamics between the Black community and its LGBT members, to include the increased visibility and acceptance and gay marriage and domestic partnership. The participant will better understand the impact of these changes on how Black LGBT individuals see themselves and how they function., 2) Know the most current and up-to-date scientific knowledge of the determinants of sexual orientation, 3) Know the etiology of homophobia in the Black community, including the role of the Black church, and determine if homophobia is greater than in other ethnic groups, 4) Better understand how these dynamics, issues and positions affect the LGBT individual, and how behavioral scientists can incorporate this understanding into psychotherapy and mental health education and prevention

SUMMARY:

This Symposium will address the current and changing relationship and dynamics between the Black community and its LGBT members. There will be a review of how the increased choices that Black LGBT members now have in many parameters, i.e. religion, marriage, workplace, social life, etc affect the psychological stressors and the resultant adaptations and conditions. The symposium will also explore the often heard statement "Homophobia is greater in the Black community". Is it accurate, never been a fact or has it now changed? The symposium will present the current scientific knowledge of the etiology of sexual and gender orientation, as well as, examine the complicated and often difficult views of the Black church regarding Black LGBT members. The symposium will examine the role

of psychiatrists and other behavioral scientists in treating Black LGBT members and in addressing these issues in the wider Black community. The treatment role requires the therapist to possess up to date knowledge, have worked out his/her homophobia and be sensitive to the needs of the patient. The role in the wider Black community consist of providing mental health education and prevention.

S053-1.

BEING BLACK AND LESBIAN, GAY, BISEXUAL OR TRANSGENDERED

Presenter: Richard G. Dudley, M.D.

SUMMARY:

This paper will review how things have changed for Black lesbian, gay, bisexual and transgendered individuals as a result of a variety of factors, including, for example, the overall increased visibility, understanding and acceptance of LGBT individuals, more accepting and welcoming work place environments, changing laws regarding gay marriage and other forms of same-sex domestic partnerships, and the emergence of alternative religious communities that are more welcoming of LGBT persons. The impact of these changes on how Black LGBT individuals see themselves and how they function will be explored, as will how Black LGBT individuals manage functioning within a Black family and larger Black community that may be less understanding and less welcoming than other segments of our society.

S053-2.

THE CURRENT SCIENCE OF LGBT AND MENTAL HEALTH

Presenter: Kenneth B. Ashley, M.D.

SUMMARY:

This presentation will review the recent literature and current scientific knowledge on sexual orientation, sexual identity, and mental health. Over the years there have been many theories presented on the causes of homosexuality and transgenderism. Recently, there have been larger and more well designed studies on various aspects of the mental health issues of LGBT populations. The studies include the search for potential causes of homosexuality, disparities in the rates of mental illness among LGBT, the impact of bias on the mental health of LGBT individuals, and treatment issues for LGBT patients. The focus of this talk will be on the current scientific thinking regarding potential etiologies for homosexuality. As a result of the struggle for equal rights and scientific advances there has been significant interest in the biology of sexual orientation. These studies, as well as studies on non biologic themed theories of the causes of

sexual orientation, will be presented. The discussion will also include recent literature on rates and causes of mental illness in LGBT populations, as well treatment issues.

S053-3.

IS THERE MORE HOMOPHOBIA IN THE BLACK COMMUNITY?

Presenter: Marjorie Hill, Ph.D.

SUMMARY:

This presentation will examine homophobia in the Black community. It will focus on the negative effects and the psychological toll it causes in Black LGBT members. It will also highlight the psychological coping mechanisms and techniques that LGBT members adopt to withstand the trauma. This presentation will also discuss the often cited belief that there is more homophobia in the Black community than in other ethnic groups.

S053-4.

LGBT PERSONS AND THE BLACK CHURCH

Presenter: Kelly Douglas, Ph.D.

SUMMARY:

This presentation will address the issue of homophobia in the Black church. It will discuss how this is related to the overall reluctance to discuss sexuality in the Black Church, largely stemming from Black people's attitudes toward their own sexuality which were negatively contributed to by White racist cultural assault on Black sexuality. The presentation will discuss how homophobia/heterosexism is used to perpetuate sexual oppression. The presentation will also explore some often cited passages of the bible that are used by the Black church and others to claim that homosexuality is "a sin". There will be recommendations presented to assist in moving toward a just theology of Black sexuality.

S053-5.

THE BLACK COMMUNITY AND LGBT MEMBERS: THE ROLE FOR BEHAVIORAL SCIENTISTS

Presenter: Jerome M. Gibbs, Ph.D.

SUMMARY:

Most therapists have within their patient population people who are either lesbian, gay, bisexual or transgender. Some of these individuals will be Black. This presentation will address the knowledge base that is needed to understand the cultural issues that have affected these patients, both as a Black and as a LGBT person, and will emphasize the

effect of being a double minority. This presentation will also address the role that psychiatrists and other behavioral scientists must play in providing mental health education and prevention in the Black community regarding homophobia.

SYMPOSIUM 054

ADDRESSING THE MENTAL HEALTH NEEDS OF RETURNING SERVICE PERSONNEL AND VETERANS

Chair: Terri L. Tanielian, M.A.

Discussant: Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the nature of the postdeployment psychiatric problems affecting United States service personnel who deployed to support operations in Afghanistan and Iraq, 2) Describe the longitudinal course of PTSD, depression, and substance use among United States service personnel who served in Afghanistan and Iraq, 3) Understand the special challenges associated with differentiating psychiatric problems from probable traumatic brain injury among returning service personnel, 4) Understand the barriers to and preferences for mental health treatment among returning service personnel

SUMMARY:

Since 2001, more than 2.25 million US servicemembers have deployed to support military operations in Iraq and Afghanistan. Over the past several years, several studies have examined various aspects associated with the psychological consequences of these deployments. Few have done so in a comprehensive manner or longitudinally. This symposium will feature presentations using data from a representative sample of previously deployed servicemembers, to include active and reserve components across all military service branches. The presentations will share data from multiple studies conducted between 2007 through 2010 to examine the prevalence of postdeployment psychiatric problems, to include PTSD, depression, and substance use disorders, describe the longitudinal trajectory of these problems within the cohort, and discuss the challenges in differentiating between psychiatric symptoms and probable traumatic brain injury, as well as present data on the barriers to and preferences for mental health treatment among this newest generation of veterans. The presenters will also discuss the unique challenges in addressing mental health needs among this population due to the nature of the multiple health care systems through which they may receive care. Finally, the discussion will highlight recent changes in how the Department of Defense addressed these problems within its military health care system.

S054-1.

PREVALENCE OF PTSD AND DEPRESSION OVER TIME AMONG IRAQ AND AFGHANISTAN VETERANS*Presenter: Terry L. Schell, Ph.D.***SUMMARY:**

The presentation will document how risk for mental health problems, and the severity of psychological symptoms, accumulates with additional deployment related trauma. It will also present data on the longitudinal course of these problems following service members' return from deployment. The presentation will include data from the Invisible Wounds study that was not published in the overall report, as well as data from a subsequent RAND study of military veterans. The implications of these findings will be discussed with respect to (a) optimal deployment planning, (b) the Posttraumatic Stress vs Posttraumatic Stress Disorder distinction, and (c) differences between PTSD in military and typical civilian samples.

S054-2.

PREVALENCE AND CORRELATES OF DRINKING BEHAVIORS AMONG PREVIOUSLY DEPLOYED MILITARY AND MATCHED CIVILIAN POPULATIONS*Presenter: Rajeev Ramchand, Ph.D.***SUMMARY:**

We examined drinking behaviors (frequency of use, quantity of use, and frequency of binge drinking) and correlates of frequency of use and binge drinking in a representative sample of previously deployed personnel from the US military (n = 1887). Drinking behaviors were compared with a matched sample of adults in U.S. households (n = 17,533). Comparable patterns of alcohol consumption were reported in both samples: 70% of previously deployed personnel and 69% of US adults reported drinking alcohol in the past 30 days though, civilians drank on average more drinks on the days that they drank than did previously deployed military personnel. Regression analyses indicated that among previously deployed military personnel, deployment-related experiences (e.g., combat-related traumas) and psychological distress (e.g., symptoms associated with posttraumatic stress disorder) were associated with frequency of drinking behaviors. We discuss the implication of our findings for developing interventions to modify drinking behaviors for military personnel.

S054-3.

HEALTHCARE SEEKING AMONG PREVIOUSLY**DEPLOYED MILITARY PERSONNEL: BARRIERS TO AND PREFERENCES FOR TREATMENT***Presenter: Lisa Jaycox, Ph.D.***SUMMARY:**

Efforts to develop and make available mental health services for individuals with postdeployment PTSD and depression have been expanding over the last decade, within the DoD, the VHA and in the civilian sector. However, understanding the preferences for care among individuals with these mental health problems, as well as the barriers that exist for obtaining care, are key elements in ensuring accessibility of these services to those in need. In this presentation, we will discuss findings from a study of 1659 previously deployed Active Duty servicemembers to understand the unique issues in this group. We will compare and contrast the findings of this study to civilian studies of preferences for treatment and barriers to care. Finally, we will discuss the findings in light of the existing systems of care and offer recommendations for ways to improve access to care.

S054-4.

CAN MEASURES OF POSTCONCUSSIVE SYNDROME DISTINGUISH TRAUMATIC BRAIN INJURY FROM POSTTRAUMATIC PSYCHIATRIC PROBLEMS?*Presenter: Terri L. Tanielian, M.A.***SUMMARY:**

Postconcussive symptoms (PCS) observed after a traumatic brain injury (TBI) may be attributable to physical or psychological causes. Such symptoms are used as a screener for ongoing TBI-related morbidity in the military and VA health systems. We analyzed data from a (N = 419) subsample of individuals who indicated a probable TBI as part of a survey into postdeployment health. Although we expected improvement in PCS with increased time since injury, there was a nonsignificant trend in which PCS levels were greater among individuals for whom more time had elapsed. Both physical and psychological trauma exposure contributed similarly and independently to the prediction of current PCS. There was also an interaction, such that physical traumas were less predictive of postconcussive symptoms with greater passage of time. In spite of this evidence suggesting that PCS often have a psychological origin, individuals who experienced a probable TBI evidenced showed significantly greater overall physical impairments than those who did not. We conclude that commonly assessed postconcussive symptoms do not appear to be specific indicators of ongoing TBI-related morbidity when they are assessed months or years after the trauma. However, there is evidence of ongoing physical health problems associated with these injuries.

SYMPOSIUM 055

DYSCONNECTIVITY OF THE BRAIN IN ADDICTION AND PAIN

Co-Chairs: James M. Bjork, Ph.D., Joseph Frascella, Ph.D., M.S.

Discussant: Nora Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand how functional magnetic resonance imaging (fMRI) can assess synchronized activity between brain regions (functional connectivity) when the subject is at rest and not performing a task in order to detect brain network function, and that this is a promising new brain metric, 2) Become familiar with what regions of the brain are implicated in acute drug craving or pain perception, or in chronic addiction (such as revealed by task fMRI), 3) Realize how connectivity to and from addiction and painlinked structures is aberrant in pain and in addiction, 4) Come away with an appreciation for how treatment for addiction or pain can include a concomitant change in connectivity of addictionrelated brain regions, and 5) Come away with the concept of interregional dynamic brain connectivity as a measurable potential brain signature of addiction, or of cognitive traits conferring risk for addiction, or impaired addiction recovery

SUMMARY:

How does the brain communicate with itself? How is this awry in addiction and pain? Functional magnetic resonance imaging (fMRI) has been crucial to our understanding of brain regions and networks recruited in the service of cognitive performance both in healthy control subjects, and in subjects with psychiatric disorders. More recently, fMRI has also been used to identify brain networks—defined as brain regions showing synchronized coactivation of bloodoxygenlevel dependent (BOLD) signal over time during a “restingstate,” when the subject is not actively performing any cognitive task. Restingstate fMRI (rsfMRI) thus offers the opportunity to explore the innate, dynamic functional connectivity between brain structures of interest. Notably, psychiatric or neurological disordermediated differences in behavioral task performance (which complicate interpretation of taskfMRI activation differences) are avoided in rsfMRI. In this series of talks, the speakers will explain the foundations and concepts behind fMRIbased functional connectivity. This will segue into discussion of data on functional connectivity in ADHD as an exemplar the first psychiatric disorder to be extensively investigated using rsfMRI. Talks will then proceed to describe observed aberrations in dynamic functional brain connectivity in different

substance use disorders, including findings on how individual differences in functional brain connectivity relate to behavioral flexibility more generally. Finally, the concluding talk will address altered brain connectivity in different pain states. These talks will also include the latest data on the effects of pharmacological intervention strategies (such as the nicotine patch or analgesics). This will provide a framework for the concluding discussion session where clinical and diagnostic potential of rsfMRI will be addressed. It is intended that practitioners will leave the session aware of the significant potential for rsfMRIbased functional connectivity as a rising modality with potential for functionbased diagnosis and an in vivo marker for therapeutic monitoring.

S055-1.

REVEALING THE BRAIN'S CIRCUIT DIAGRAMS VIA RESTING STATE FUNCTIONAL CONNECTIVITY

Presenter: F. Xavier Castellano, M.D.

SUMMARY:

A large proportion of the brain's energy economy is invested in synchronized largeamplitude ultralow frequency spontaneous fluctuations. These intrinsic fluctuations are recorded during fMRI scans as brief as 5 minutes, which require no taskspecific training other than remaining still. This technique can be applied broadly across the lifespan and nearly all clinical populations. The resulting signals are stable and robust; they can be easily aggregated across scanning centers, even without prior coordination. Analyses of thousands of datasets reveal universal and individual patterns of functional connectivity that differ with age, maturation, learning, psychopathology, or psychotropics. A brief demonstration of the chief analytical methods being used will be provided with examples drawn from studies of AttentionDeficit Hyperactivity Disorder. Restingstate fMRI studies have rapidly become an important tool in the search to understand brainbehavior relationships with substantial relevance for addiction science.

S055-2.

FUNCTIONAL AND STRUCTURAL CONNECTIVITY IN CHRONIC MARIJUANA AND TOBACCO SMOKERS

Presenter: Francesca Filbey, Ph.D.

SUMMARY:

Models of substance use disorders (SUDs) such as the somatic marker hypothesis posit that the main neural dysfunction in addiction is an imbalance between the frontal executive control and subcortical / striatal reward systems

(VerdejoGarcia & Bechara, 2009). However, while these systems have been well characterized individually, the reciprocal relationship between them has yet to be determined. The few existing studies have reported disruptions in functional connectivity in substance abusers, including marijuana and tobacco smokers, such as decreased functional connectivity between striatal and prefrontal networks (FusarPoli et al., 2010) (Cole et al., 2010). However, how these disruptions in functional connectivity relate to structural metrics have yet to be determined. To date, the few studies on white matter integrity in substance abusers have been inconsistent (Jacobs et al., 2009). Using MRN's large repository of data that enables crossstudy sharing and automated data processing (Bockholt et al., 2010), we examined rsfMRI, cueexposure task fMRI, and diffusion tensor imaging (DTI) in 39 regular marijuana users, 38 regular tobacco smokers and 40 nonusing controls. Functional connectivity was determined using seed based correlation (SBC) analyses of the rsfMRI, psychophysiological interactions (PPI) of the task fMRI data and fractional anisotropy (FA) of DTI data. Similar to earlier studies, SBC results indicated less functional connectivity between striatal (i.e., nucleus accumbens, amygdala) and prefrontal networks (i.e., middle frontal gyrus) in both marijuana and tobacco smokers compared to nonusing controls. Among the substance abusers, marijuana smokers had less functional connectivity between striatal and cingulate regions compared to tobacco smokers. PPI findings showed strong intraconnectivity within the network through the synchronized activation in the ventral striatum and orbitofrontal cortex during drug cueexposure. DTI analyses showed that the marijuana users had greater white matter integrity compared to the nicotine users and the nonusing controls. Using multimodal techniques, this study describes the structural and functional mechanisms by which connectivity between brain systems are altered in marijuana and tobacco smokers. Individual differences in connectivity may be used as a marker for risk or as a diagnostic metric that could inform therapeutic outcomes in both marijuana and nicotine use disorders.

S055-3.

PHENOTYPE/GENOTYPEDEPENDENT BRAIN CIRCUIT ALTERATIONS IN NICOTINE DEPENDENCE

Presenter: Elliot Stein, Ph.D.

SUMMARY:

Despite intensive scientific investigation and public health imperatives, nicotine addiction treatment outcomes have remained modest and relatively stable over the years, even in the face of several new pharmacotherapeutic interventions. Noninvasive brain imaging has contributed important new insights into the neuroplastic adaptations that result from chronic drug intake. New experimental approaches

and neurobiological hypotheses are now needed to better capture the totality of the cognitive, affective and pharmacological complexities of the disease. Recent advances in assessing brain network dynamics through resting state functional connectivity may allow for such systemslevel assessments. Emerging evidence supports a critical role for the insula in nicotine addiction. Likewise, the anterior insula, potentially together with the anterior cingulate cortex, appears to pivotally influence the dynamics between largescale brain networks subserving internal and external state processing. We present evidence for a novel brain circuit between the anterior cingulate and ventral striatum a) whose strength is inversely proportional to nicotine addiction severity and b) interconnects with the insula, whose circuit strength is also impaired. Further, the insula appears critically involved in connectivity between both of these regions. Patients with schizophrenia, who present with one of the highest incidence of nicotine dependence, show reductions in circuit strength between these regions, both in those who smoke and those who do not. Interestingly, this circuit is under the influence of an alpha 5 nicotinic receptor subunit, once again both in patients and healthy smokers. Further, a specific white matter tract that interconnects this corticostriatal circuit is also impaired in nicotine dependence. Finally, we present evidence that nicotine withdrawal alters an amygdalainsulamedial prefrontal circuit, and whose strength can be modulated with nicotine patch and varenicline, two efficacious pharmacotherapies. Taken together, we suggest that resting state functional connectivity is an important emerging tool for identifying specific brain circuits altered during nicotine addiction and withdrawal. A better understanding of such circuit dysfunctions may be usefully applied to examine both the performanceenhancing effects of nicotine and the cognitive impairments associated with withdrawal. Functional circuits may eventually serve as sensitive treatment outcome p

S055-4.

FUNCTIONAL CONNECTIVITY OF REWARD RESPONSITIVITY AND DISINHIBITION

Presenter: Angus MacDonald III, Ph.D.

SUMMARY:

Using independent components analysis and metaanalytic techniques adapted from Laird and colleagues (2011), we have identified functional brain networks at rest that closely overlap a number of activationrelated cognitive processes derived from metaanalysis. In a sample of 27 participants measured at two time points, a large minority of these networks appeared to be reliable enough for the measurement of individual differences. This finding suggests that, in contrast to more traditional BOLD activation studies, resting connectivity may be useful for studying several individual

differences simultaneously in crosssection samples. To test this potential, we found that in a sample of 50 healthy adolescents, the less rewardseeking were participants as measured by the Behavioral Activation Scale (BAS), the stronger the relationships between ventromedial and orbitofrontal cortices. Among those with less aversion motivation as measured by the Behavioral Inhibition Scale (BIS), the stronger were the relationships between structures in the right lateralized executive control network. To evaluate whether resting state activity was related to behavioral performance on tasks relevant to addiction, we examined the extent to which 27 cocaine users differed from demographically similar controls in a network identified using an anterior cingulate cortex seed region approach. Here cocaine users showed increased functional connectivity between the ACC and dorsolateral prefrontal cortex, and furthermore the extent to which connectivity was increased correlated with choices in a delayed discounting task and performance on a reversal learning task. These findings complement a growing body of work on functional connectivity networks and their relationship to reward responsiveness and disinhibition, and raise the possibility that a growing database of neurometrically informed work will contribute to an efficient and cumulative science of connectivity.

S055-5.

FUNCTIONAL CONNECTIVITY IN PAIN AND OPIOID ANALGESIC DEPENDENCE

Presenter: David Borsook, M.D., Ph.D.

SUMMARY:

While endogenous opioids play a significant role in normal or adaptive brain function from endogenous analgesia and placebo response, the use of prescription opioids in the treatment of chronic pain or in opioid abuse/dependence may alter brain systems in a maladaptive manner. In this presentation we will explore the following two concepts: 1. Opioid effects on brain systems in health and disease 2. Opioid effects in prescription opioid abuse The concept of opioids producing maladaptive changes in brain function may relate to complex interactions within and across neural circuits. Recent imaging findings are supportive of such changes that may provide insights into mitigating these effects particularly in the field of pain medicine.

SYMPOSIUM 056

MYTHBUSTERS: UNTANGLING PSYCHIATRIC MYTHS FROM TRUTHS

Chair: Sparsha Reddy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the mechanism of action of monoamine oxidase inhibitors (MAOIs), their potential side effects, drug/food interactions, and therapeutic effects, 2) Outline the risks, benefits and limitations of antipsychotics in the treatment of delirium, 3) Use the presented evidence to guide the choice of screening labs to be included in psychiatric medical clearance, 4) Make an informed, evidence-based decision about when neuroimaging is indicated in a patient with a psychiatric presentation

SUMMARY:

During medical school, residency training and daily clinical practice, one is bombarded with a wide variety of clinical information. It is not uncommon for a “rule of thumb,” “hypothesis” or “coincidence” to ultimately evolve into “fact.” We are creatures of habit so if something has been practiced for decades, it is usually accepted as truth. Given the breadth of medicine in this day and age, it is often difficult to discern fact from fiction. Is a head computed tomography (CT) required in each patient after a first psychotic break? Is routine TSH screening a necessary part of psychiatric medical clearance? Should a patient taking MAOIs abstain from red wine? Is an antipsychotic medication a good choice for routine use in delirium? These are questions that arise on a regular basis and more often than not, the answer is usually “yes” because this is what has been taught and practiced; it is familiar and accepted. In this symposium, leading consultation liaison (CL) psychiatrists from several academic institutions will investigate these commonly misunderstood psychiatric “myths” that have become part of general practice. They will present the available evidence on these topics which are relevant not just to the CL psychiatrist but to the general psychiatric practitioner and ultimately the patient. This information may lead to improved clinical outcomes while minimizing harm to the patient from radiation exposure (by avoiding unnecessary head CTs), medication side effects (from MAOIs and antipsychotic medications), drug/food interactions (as in the case of MAOIs) and expensive medical bills (by making informed decisions about screening labs).

S056-1.

MAOI MYTHS: THINGS I LEARNED IN MEDICAL SCHOOL THAT TURNED OUT NOT TO BE QUITE TRUE

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

SUMMARY:

Monoamine oxidase inhibitors (MAOI's) are the first antidepressants. In the early 1950's, iproniazid caused euphoria and improvement of mood in patients with tuberculosis.

Animal experiments demonstrated antidepressant effects leading to the discovery that MAOI's inhibit enzymes that deaminate dopamine, norepinephrine, and serotonin. Iproniazid was the first MAOI antidepressant. Hepatotoxicity and adverse cardiovascular events resulting from unrealized interactions with certain medications and tyramine containing foods ('cheese reaction') limited the widespread use of the drug. Secondgeneration MAOI's are chemically distinct from iproniazid and are not hepatotoxic, but pharmacodynamic effects with other medications and foods remain a limitation. MAO has two forms: "A" which primarily acts on dopamine, norepinephrine and serotonin; "B" which primarily acts on phenethylamine and tyramine (in the striatum "A" is responsible for the majority of dopamine oxidative metabolism). Inhibition of MAOB in the GI tract prevents the metabolism of tyramine in food, resulting in absorption of larger than normal amounts of tyramine. Large amounts of absorbed tyramine can cause the release of substantial quantities of norepinephrine, resulting in a hypertensive crisis. Inhibition of gut/liver MAOB is unrelated to the therapeutic effects of MAOI's, which depend upon inhibition of brain MAOA. This talk will focus on the mechanism of action of MAOI's, their potential side effects, drug/food interactions, and therapeutic effects. The food/drug interactions were quite rare but limited the use of MAOI's and some of the presumed interactions were incorrect. The limited use of MAOI's has resulted in a situation where many psychiatrists have no experience in treating patients with these drugs. The talk will review the therapeutic uses of MAOI's and review the limitations in the use of MAOI's. MAOI's are an important class of medication that has fallen into disuse secondary to dietary restrictions and drug interactions. Modern diets, which are less restrictive than in the past, may lead to increased use of MAOI's. Psychiatrists need to understand how MAOI's work in order to differentiate the CNS effects that can be therapeutic (neurotransmitter) or adverse (drug interaction), from the peripheral adverse effects (food interaction). This understanding may lead to greater use of the MAOI's for patients who do not respond to or do not tolerate the SSRI and SNRI medication

S056-2.

THE MYTH OF ANTIPSYCHOTICS THAT ANTIPSYCHOTICS WORK FOR DELIRIUM: TRUE? OR JUST WISHFUL THINKING?

Presenter: Robert J. Boland, M.D.

SUMMARY:

Professor Barry Powell defines a myth as a "traditional story with collective importance." While discussing Greek Mythology, his approach is equally useful for medical myths. They begin as stories, usually interesting cases, which are

then disseminated, at first orally (supervisory discussions, rounds, case presentations and "curbside consults). The frequent retelling endows the stories with a growing authority as they advance from intriguing anecdote to accepted truth. Along the way, they become written, finding their way into textbooks and treatment protocols. As with all myths, they are neither inherently true nor false. They are, in fact, usually based in some legitimate experience but their level of acceptance outpaces any rational justification. Many examples of these phenomena can be found in medicine; this presenter describes one: the use of antipsychotics for delirium in the medical setting. Medical students are taught that antipsychotics, particularly haloperidol, are the treatment of choice for delirium, and other alternatives (for example benzodiazepines) are not only inferior, but potentially harmful. Such statements are found widely, including in author's writings. However, what is their basis? The presenter will trace a growth from case study and anecdotal evidence to acceptance into treatment protocols and then examine the evidence for and against this myth. Recommendations both for current practice and future directions of research will be suggested based on the existing data. It should be remembered that our willingness to accept myths isn't merely ignorance or naivety. It stems from our desperation to master the bewildering complexities that surround us: whether they are the cosmic riddles of the natural world or the perplexities of the agitated intensive care patient, our decisions have life and death impact. Furthermore, we must make these decisions with inadequate information. Thus we grasp at myths to guide us; but in doing so we must also critically examine them to find whether the kernels of truth they contain will help us make the right decisions. In the case of antipsychotics, we find that there is some information to enlighten us, but we must be aware of the limits of that information.

S056-3. WHICH LABS TO CHECK: FROM B12 TO THYROID

Presenter: John W. Barnhill, M.D.

SUMMARY:

With every patient contact, psychiatrists are confronted with the question of which labs to order. A host of competing factors influence the decision. Which labs are likely to contribute to good psychiatric care and which to good nonpsychiatric medical care? Which are cost effective? Which could possibly be contributory? Which are likely to yield false positives and false negatives? How do case reports, clinical "zebras," and potential malpractice lawsuits affect our practice habits? To what extent should the initial psychiatric and physical exam guide the choice of screening labs, and when should a confusing clinical picture lead to a hunting expedition? This paper will review the existing

literature on some of the most common lab tests ordered by psychiatrists. For example, in regards to the thyroid, the paper will outline whether the literature supports the practice of wholesale assessment of thyroid function. The paper will conclude with a set of guidelines for the assessment of labs that are commonly checked by psychiatrists.

S056-4.

INDICATIONS FOR NEUROIMAGING IN PSYCHIATRIC PATIENTS

Presenter: Colin J. Harrington, M.D.

SUMMARY:

Psychiatric disease, neurologic disease, and medical illnesses that affect brain function, can be associated with changes in emotion, perception, cognition, and behavior. The distinction between neuromedical illnesses with secondary psychiatric manifestations and primary psychiatric disease is important in guiding proper diagnosis and treatment. In this regard, psychiatric diagnoses are often approached as exclusionary, and arrived at only after adequate medical evaluation. The role of neuroimaging in this diagnostic process has long been debated. This presentation will focus on the use of neuroimaging in psychiatric and behavioral differential diagnosis. We will discuss neurologic and medical diagnoses that can present with psychiatric, personality, and related behavioral changes and that may be associated with brain imaging findings. Related to this, we will examine the idea and practice of neuroimaging in first episode psychosis. We will also consider those elements of a case that are more suggestive of a primary medical cause of newly presenting psychiatric symptoms and that would compel neuroimaging as part of the investigation – including unusual symptom constellation or presentation, atypical age of onset, irregular course of illness or response to treatment, and the presence of associated cognitive, neurologic, or other somatic findings. The use of, indications for, and limitations of specific neuroimaging modalities, including CT, MRI, and functional imaging will be discussed.

SYMPOSIUM 057

BEYOND DSM5: SHIFTING PARADIGMS IN SCHIZOPHRENIA

Co-Chairs: Matcheri S. Keshavan, M.D., Henry A Nasrallah, M.D.

Discussant: Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Learn about the current state of knowledge and

controversies on the epidemiological facts about schizophrenia, 2) Learn about varied clinical presentations of schizophrenia and current thinking of diagnostic criteria as is being debated and conceptualized as we move toward DSM5, 3) Learn about the current understanding of the genetic basis of schizophrenia and the latest approaches to unravel the genetic and environmental risk factors and their interactions as they related to this illness, 4) Learn about the current state of knowledge and controversies on the psychosocial and pharmacological treatments of schizophrenia, and 5) Learn about the various conceptual models of schizophrenia, and how these models can be deconstructed and reintegrated

SUMMARY:

Few would doubt the major advances in our understanding of the manifestations of schizophrenia, its causes and treatments over the recent decades. While new facts been accumulating, however, the nature of this disease entity as a disease entity remains to be defined. Not surprisingly, available treatments are still those derived by serendipity, and the need to think “outside the box” is more than ever. Fortunately, many paradigm shifts are taking place across psychiatry and neuroscience that impact on how we understand, diagnose, treat and possibly present this disease, and will be the topic of this symposium. Rajiv Tandon will review the various changes that are occurring in our view of the clinical definition of this illness, and the revisions in our thinking that may impact on the next iteration of psychiatric classification in DSM5. Dolores Malaspina will discuss changes in epidemical approaches being increasingly informed by translational research, and will illustrate this by her work on paternal age as an etiological factor in schizophrenia. Daniel Weinberger will discuss the Shifting paradigms that impact on our understanding of the genetic complexity of schizophrenia. Henry Nasrallah will discuss the sea change that has been occurring in our approaches to treatment of this illness. Carol Tamminga will outline a big picture view of the current state of the field of schizophrenia, identify the gaps in knowledge, unmet needs and potential future steps.

S057-1.

PARADIGM SHIFTS IN CLINICAL CONCEPTUALIZATION OF SCHIZOPHRENIA

Presenter: Rajiv Tandon, M.D.

SUMMARY:

Dementia praecox or schizophrenia has been considered a unique disease entity for the past century and despite changing definitions and boundaries over the past century, the construct continues to convey useful information in that

a diagnosis of schizophrenia suggests a distinctive clinical profile a characteristic longterm course with an admixture of positive, negative, and cognitive symptoms; and likelihood of benefit from antipsychotic treatment. On the other hand, the current concept of schizophrenia has serious shortcomings. First, it is not a single disease entity it has multiple etiological factors and pathophysiological mechanisms. Second, its clinical manifestations are so diverse that its extreme variability has been considered by some to be a core feature. Third, its boundaries are illdefined and not clearly demarcated from other clinical entities. Fourth, its expression varies over its longitudinal course. The principal paradigm shift in the clinical conceptualization of schizophrenia is the explanation of its heterogeneity in terms of the interplay between variations in: (a) illness dimensions and intermediate phenotypes; and (b) distinct stages of schizophrenic illness. Accordingly, several revisions have been proposed in DSM5. Modest changes are proposed in the actual criteria for schizophrenia, which include elimination of the primacy given to Schneiderian first rank symptoms. More significant changes are proposed to better describe the heterogeneity of the disorder and better characterize it in each individual patient. It is proposed that the classic subtypes be eliminated and instead, a number of specifiers and repeated dimensional measures be utilized. These include measures of positive, negative, disorganization, cognitive, mood, and motor symptoms. Demarcation of an Attenuated Psychosis Syndrome might permit safe and effective prevention whereas better delineation of schizoaffective disorder should improve diagnostic utility. Tandon R, Nasrallah HA, Keshavan MS. "Facts of Schizophrenia" 4. Clinical features and conceptualization. Schizophrenia Research 2011; 110: 123.

S057-2.**SHIFTING PARADIGMS IN THE EPIDEMIOLOGY OF SCHIZOPHRENIA**

Presenter: Dolores Malaspina, M.D.

SUMMARY:

Schizophrenia is commonly acknowledged to be a heterogeneous syndrome, and its etiology remains poorly elucidated. The challenge of etiological heterogeneity has necessitated important paradigm shifts in epidemiological approaches to the disorder. The genetic foundations of this illness are now sought to be explained by a combination of models: common genes of small effect; rare genes of large effect; and epigenetic mechanisms. Neurobiological mechanisms which mediate the effects of putative environmental factors are being uncovered and the nature of specific geneenvironment interactions are being investigated. These changes are summarized and an example is provided. In researching the heterogeneity of schizophrenia, we demonstrated significant

differences between groups of familial and sporadic patients. We were particularly surprised to see greater homogeneity in sporadic than familial cases, given the many environmental factors associated with schizophrenia. Our translational epidemiology program led to the discovery that advancing paternal age was a significant risk factor for schizophrenia. Epidemiology studies conducted as a component of "translational research" were a paradigm shift and population birth cohorts are particularly valuable in this regard. Such cohorts were initially launched to examine pregnancy and early health outcomes, but the data can also be used decades later to study psychiatric conditions. Cross-linking the information to other databases in the population permits a prospective population based study design. Translational epidemiology will also be an optimal approach for models that focus on intergenerational mechanisms of disease susceptibility; wherein a parental (or grandparental) exposure can increase an offspring's risk of illness through epigenetic pathways. The translational epidemiology approach in our work has now produced a novel neuroimaging biomarker for paternal age related schizophrenia for use in clinical studies.

S057-3.**THE SIMPLE TRUTH ABOUT THE GENETIC COMPLEXITY OF SCHIZOPHRENIA**

Presenter: Daniel Weinberger, M.D.

SUMMARY:

Over the past six years, genes putatively related to the etiology of schizophrenia and related conditions have been identified. There is considerable controversy about whether any of the genetic evidence so far is valid. This controversy resides largely in questions about the strength of statistical evidence, though it is generally agreed that the end game in gene identification of complex disorders such as mental illnesses cannot be based on statistics. The end game is a biological one, based on demonstrating that variation in a candidate gene impacts on the biology of the gene so that it biases towards expression of the biology of the illness. Ultimately, the genes tell us what schizophrenia is at a basic cellular level. This talk will address the biological clues that have emerged so far about the genetic origins of schizophrenia and some of the likely explanations for the current controversies. The current evidence converges on subtle molecular bottlenecks in diverse aspects of synaptic processing and brain development. It is premature to assume that functional variants have or will not be found, that differing alleles and haplotypes suggest failure of replication, and that pathogenic pathways will be too complex to be resolved. Allelic heterogeneity and novel RNA transcripts will likely be the rule for schizophrenia susceptibility genes and many of these transcripts appear to be especially abundant during

fetal brain development. Rare cases with the diagnosis of schizophrenia have pathogenic structural chromosomal variations. These observations converge on the conclusion that there are many pathways to schizophrenia and related phenotypes, that Interactions of variations within genes, between genes, and with the environment confound simple models of genetic association in psychiatry but show biologically lawful effects on brainrelated intermediate phenotypes. Thus, simple models of genetic association do not work. Promising new therapeutic targets will emerge from the exploration of candidate pathogenic networks.

SYMPOSIUM 058

INTEGRATING PRIMARY CARE, MENTAL HEALTH, AND PUBLIC HEALTH: EUROPEAN AND AMERICAN PERSPECTIVES

Co-Chairs: Eliot Sorel, M.D., Igor Svab, M.D., Ph.D.

Discussant: David A. Pollack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Prevalence and comorbidity of mental disorders and noncommunicable diseases, 2) New models of collaborative and integrated care and their implications for service, training, and research, 3) Health policies that are catalytic toward collaborative and integrated care

SUMMARY:

Health systems across the world remain significantly fragmented affecting access, quality and costs of the care delivered. They also are primarily individually focused, with an emphasis on secondary and tertiary prevention, with little or no primary prevention and insufficient populations' focus. Strengthening health systems is a global public health challenge for all countries: low, middle and high income. Given the high prevalence of noncommunicable diseases across the world, including mental disorders, as well as the high prevalence of comorbidity between mental disorders and other noncommunicable diseases, the integration of primary care, mental health and public health is one of the important and catalytic contributions towards diminishing health systems' fragmentation, enhancing access, quality, diminishing costs and strengthening health systems' performance. Our symposium, "Integrating primary care, mental health and public health: European & American perspectives" addresses these challenges in European and American contexts. similarities, differences, best practices and lessons learned to date, from both sides of the Atlantic, and how they may apply to emerging models of collaborative and integrated care in medical homes and accountable care organizations is presented.

S058-1.

INTEGRATING PRIMARY CARE & MENTAL HEALTH: EUROPEAN PERSPECTIVES

Presenter: Gabriel Ivbijaro, M.D.

SUMMARY:

Europe is a continent with a vast diversity of health care systems and policies. In that respect, primary care is organized very differently in different European countries. The European Union does not get involved in health policy issues of its member countries, which means that we are faced with a wide variety of situations even within the EU countries. Nevertheless, the importance of integration of primary care and mental health has been increasingly recognized by policymakers throughout the continent. This presentation will present examples of integration of primary care and mental health in different countries in Europe. A special emphasis will be given to the developments in the UK (especially London) and the developments in primary care in countries of central and Eastern Europe, which have undergone significant changes in the last 20 years. The direct costs of mental health in England are around £22.5 billion a year. This includes spending in health and social care and a variety of other agencies, but not the indirect costs of the impact on the criminal justice system and in lost employment and accounts for more than 12 per cent of the total NHS budget (London case for change 2011). A significant proportion is spent on the 8 million inhabitants of London, 12% of the total population, but mental health outcomes continue to be variable with significant levels of unemployment associated with mental ill health, poorer physical health outcomes, increased mortality and decreased levels of general satisfaction. London's mental health commissioners have recommend that the most effective way to address the science to service gap in mental health is by adopting a more integrated approach based on the pyramid of health recommended in the 2008 WHO/WONCA report and have put forward a model of care to address this. The science and evidence informing the proposed London model of care for long term mental health conditions (NHS London 2011) is described and an evaluation study from London to show how true integration can be best achieved is presented.

S058-2.

PRIMARY CARE PSYCHIATRY: THE U.K. PERSPECTIVE

Presenter: Dinesh Bhugra, M.B.B.S, Ph.D.

SUMMARY:

In the national health service there is a clear divide between primary care and secondary care across all specialties,

although some general practitioners (GPS) do have special interests and run special services for physical and psychiatric problems (e.g. diabetes clinic, antenatal services, addictions). Several studies have indicated that over onethird of patients attending their GPS have underlying or related comorbid psychiatric conditions. These vary and include common mental disorders such as anxiety, depression, phobias and various Types of psychoses, although the total numbers for the latter conditions are relatively low. In the National Health Service, since primary care physicians act as gate keepers to secondary care mental health services, such an approach has several advantages and also disadvantages as a result of which continuity of care may suffer (Goldberg and Gournay 1997, Gask et al 2010). Over the past three decades, psychiatric services have changed dramatically from asylums to community mental health services and functional teams, and this has meant that occasionally services tend to become fragmented. This means that in clinical practice the patient has to traverse a fragmented pathway into care. As has been shown, a vast majority of patients are treated in primary care (Goldberg and Huxley 1992). With the impact made by the economic downturn on the National Health Service, it has become imperative that service providers not only need to save large sums of money but also have to be innovative in developing services. One such model is possible development of primary care psychiatry, which may be a significant way forward. There are several models of good clinical practice as a result and these will be described in this presentation. Challenges related to such a move will be discussed. Policy impact on developing new services must be taken into account into any changes related to resource allocation. Furthermore, as the new NHS health and social care bill goes through the Westminster parliament, it brings with it potential challenges as over £60 billion are handed over to GPS to commission services. These challenges and changes have lessons for service providers elsewhere. Advantages of working closely with primary care physicians using true consultationliaison models mean that patients can be transferred across more easily between primary care and secondary care services. It also means that continuity of care and mutual learnin

S058-3.

MAKING COMMON CAUSE: HOW A PARTNERSHIP WITH PSYCHIATRY COULD MAKE PRIMARY HEALTH CARE COMPLETE

Presenter: Frank Degruy, M.D.

SUMMARY:

More healthcare, and more mental healthcare, is rendered in the primary care setting than anywhere else. Primary care is simply incomplete without the full incorporation of behavioral and mental healthcare into its fabric, given that

so many primary care encounters are with patients who either have a primary mental disorder or a medical problem complicated by behavioral or psychiatric factors. Moreover, even straightforward chronic disease management efforts require of primary care patients difficult changes in health behaviors. Heretofore, the behavioral dimension of primary care has been managed inadequately, even though it is well known that timely and skillful attention here improves health, and saves time and money. The barriers against integrating mental and primary healthcare are formidable, but solutions are beginning to emerge, at least in some settings. The patientcentered medical home (PCMH) is the current platform for a substantial redesign of primary care in the us, and it offers a powerful point of departure for a comprehensive, fully integrated, wholeperson care that includes mental healthcare and health behavior change. A comprehensive PCMH requires new “rules of engagement:” new rules for communication, new leadership skills and norms, new practice conventions (e.g., teambased care, nonvisit encounters, patient selfmanagement, etc.), new team members (e.g., care managers), and revised roles. Across the various implementations of such care, principles or guidelines for success and sustainability are beginning to emerge. This part of the symposium will address those aspects of primary care that most benefit from a partnership with psychiatry (e.g., patients with severe or confusing psychiatric symptoms; chronic diseases complicated by mental disorders; multiproblem, difficult patients, etc.), and will describe specific ways in which a psychiatrist can successfully operate in this setting (e.g., as a consultant to the care manager, as a consultant to the PCC, as a primary clinician engaged in joint, teambased problemsolving of difficult clinical problems). Particular attention will be given to emerging financial models that make this collaboration feasible and sustainable.

S058-4.

INTEGRATING PRIMARY CARE AND MENTAL HEALTH: SERVING UNDERSERVED POPULATIONS

Presenter: Sergio AguilarGaxiola, Ph.D., M.D.

SUMMARY:

CoMorbidity of chronic physical conditions with common mental/substance use (m/su) disorders is the norm rather than the exception. The burdens of chronic physical conditions and cooccurring m/su disorders have an enormous impact on individuals and their families especially from underserved populations. For example, people with serious M/SU illnesses are experiencing astounding rates of premature death due to cooccurring chronic disease conditions. Recent studies estimate that persons with serious mental illness can expect to live 25 fewer years than the general population. These startling premature death rates

underscore the importance of studying and gaining a better understanding of the extent and consequences of the co-occurrence of mental and physical disorders. Coordination of all these types of health care is essential to improved patient care and health outcomes, especially for chronic health conditions. Improving the quality of mental health care and general health care depends upon the effective collaboration and integration of all mental, substance use, general health care, and other human service providers to coordinate the health care of consumers and their families in a culturally and linguistically appropriate manner. This presentation will present new findings from the world mental health surveys on the co-occurrence of mental/substance use and physical morbidities. It will provide an overview of the provision of M/Su interventions in primary care settings particularly for racial and ethnic populations, outline strengths and challenges and provide recommendations. Finally, it will also present an overview of the integrated medicine/psychiatry ambulatory residency training program (impart), a best practice training model developed at UC Davis health system that combines psychiatry with family medicine or internal medicine training, with an emphasis on care of underserved populations.

SYMPOSIUM 059

CLINICAL NEUROMODULATION: WHAT EVERY CLINICIAN NEEDS TO KNOW

Chair: Sarah H. Lisanby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Define and describe the new forms of neuromodulation available in psychiatry today, 2) Identify the proper indications and position in treatment algorithms for new forms of brain stimulation, 3) Recognize the risks of neurostimulation techniques, notably the potential impact on cognition.

SUMMARY:

Clinical neuromodulation in psychiatry used to be synonymous with electroconvulsive therapy (ECT). Today, we have a broadening array of new technologies to stimulate the brain in ever more precise and increasingly less invasive ways. These new tools open great potential to advance the field of clinical therapeutics. At the same time, these developments pose challenges to clinicians as we seek to define the proper role of these new tools relative to existing treatments. These challenges include decisions concerning patient selection, dosage selection, and how best to stage treatments within algorithms of care. This symposium focuses on the current status of clinical neuromodulation, highlighting recent successes as well as the challenges facing

the future of this rapidly growing field. Experts spanning the conventional and novel electromagnetic technologies are brought together to provide the latest thinking on this exciting topic. Dr. Lisanby will lead off the symposium by providing an overview and perspective on the emerging field of clinical neuromodulation, emphasizing present realities and future promise. Next, Dr. O'Reardon will focus on the recently approved technology of transcranial magnetic stimulation (TMS), highlighting what the evidence shows regarding its proper clinical role and enumerating the boundaries of the evidence where research is still needed to inform practice. Dr. Husain will address the seizure therapies, old and new, from new developments in ECT to magnetic seizure therapy (MST). Dr. Greenberg will review the current status and research needs regarding deep brain stimulation for obsessive compulsive disorder. Finally, Dr. McClintock will examine what we know about cognitive outcomes with brain stimulation modalities, and what we can do to optimize the safety of these technologies. Emphasis will be placed on what the practicing clinician needs to know, and how best to translate these new developments into the care of real world patients.

S059-1.

CLINICAL NEUROMODULATION: PRESENT REALITIES AND FUTURE PROMISE

Presenter: Sarah H. Lisanby, M.D.

SUMMARY:

Clinicians today have at their disposal a growing number of tools to modulate brain function for the treatment of psychiatric disorders. Currently approved or cleared interventions include electroconvulsive therapy (ECT), vagus nerve stimulation (VNS), transcranial magnetic stimulation (TMS), and deep brain stimulation (DBS) for obsessive compulsive disorder. Studies are underway to help determine if more may ultimately be added to this list, such as novel forms of TMS, transcranial direct current stimulation, and DBS for depression, among others. There are also novel technologies using ultrasound and light that are in the early stages of development. Together, these tools represent a family of clinical neuromodulation approaches that offer hope when psychotherapy and/or psychopharmacology fail. While the expanding therapeutic horizon has never been more exciting, the ultimate impact of these interventions on real world outcomes hinges on a number of factors such as effect size, risk/benefit ratio, access, affordability, and therapeutic spectrum. This talk will critically assess the present reality and future promise of clinical neuromodulation. Key challenges include dosimetry, concomitant treatments, and staging of interventions relative to other available treatment options. Practical advice will be given to guide clinicians in their decisionmaking about how best to incorporate clinical

neuromodulation into their practices.

S059-2.

STATE OF THE ART OF TMS: EVIDENCE BASED PRACTICE

Presenter: John O Reardon, M.D.

SUMMARY:

Transcranial Magnetic Stimulation (TMS) received clearance by the FDA in 2008 for the treatment of major depression in patients who had failed to respond to one and only adequate antidepressant trial in the current episode. TMS treatment is a time consuming endeavor requiring attendance 5 days a week for 4 to 6 weeks (2030 sessions). Given patchy or no third payor reimbursement for the procedure it is also an expensive undertaking. Such challenging logistics mean that the patients seeking treatment with TMS are usually those of some means and a degree of treatment much greater than one failed trial (a mean of 3.4 adequate trials at our center, n=100 consecutive patients). Additionally in real world clinical practice most of TMS treatment is added on as an augmentation or adjunctive treatment to existing medication treatment. Thus there is a wide evidence gap between what happens in the clinical world post FDA approval versus the guidance furnished by the non-pragmatic clinical trials to date. As TMS has disseminated widely into practice, it is apparent that many different avenues are being explored by clinicians to optimize treatment outcomes. These include: more pulses per session (6000 versus the standard dose of 3000 pulses), energy set at 110% of motor threshold rather than 120% per FDA label, use of EEGbased F3 targeting rather than the standard 5 cm rule, augmentation by addition of slow frequency TMS at 1 Hz to the right prefrontal cortex (PFC), use of TMS offlabel in patients with bipolar illness, and a wide range of medications in combination with TMS. Such modifications are typically done on a case by case basis and thus can provide anecdotal evidence only. There is some literature that has examined TMS efficacy in combination with medications, in patients with bipolar disorder and there have been several studies and at least one metaanalysis of efficacy of 1 Hz TMS to the right PFC. Most recently the National Network of Depression Centers (NNDC) has established a webbased registry of naturalistic treatment at NNDC TMS programs. Such data as it emerges will provide further guidance on how TMS can be more optimally and safely delivered in practice.

S059-3.

STATE OF THE ART CONVULSIVE THERAPY: ECT AND MST

Presenter: Mustafa Husain, M.D.

SUMMARY:

Convulsive therapies have been shown to be an effective and safe somatic therapies for severe psychiatric illness. Over the past several decades Electroconvulsive Disorder (ECT) have been used to treat Major Depressive Disorder. In this presentation, data will be presented to show the effectiveness of ECT for Acute, Psychotic; Melancholic Depression. As well as use of ECT for rapid response. Prevention of relapse of depressive episodes, Comparing continuation – ECT (CECT) vs continuation Pharmacotherapy (CPham) will also be reviewed. In recent years there have been advances in developing innovative methods to provide seizure therapy using high strength focal Magnetic Field to induce underlying cortical neuronal stimulation leading to generalize seizure activity. This presentation will address the advantages and advancement in the development of this Magnetic Seizure Therapy (MST) for MDD. Will also present data from open label pilot study of MST in patient with MDD.

S059-4.

DBS FOR OCD: CURRENT STATUS, RESEARCH NEEDS, AND RECOMMENDATIONS

Presenter: Benjamin D. Greenberg, M.D., Ph.D.

SUMMARY:

OCD affects 1% of adults, but only a small subset are surgical candidates given strict selection criteria. Exhaustive presurgical evaluations necessarily involve intensive patient and family involvement. Data are mainly openlabel, though small studies have used shamcontrolled DBS, and in one case a sham lesion. DBS focuses on prefrontal cortexbasal gangliathalamic circuitry, mainly via implantation in the ventral anterior limb of the internal capsule and adjacent ventral striatum (VC/VS), or VS subterritories (nucleus accumbens or ventral caudate), with the subthalamic nucleus also targeted. Ablations include the anterior capsule or the dorsal anterior cingulate. Across procedures, meaningful benefit appeared in 3060%, but ablations and DBS impose different risks and burdens. Mean severity decreases from “very severe” to “moderate” illness were paralleled by functional gain. OCD symptoms primarily based in harm avoidance benefited most, although “incompleteness” OCD has also improved. Translational research mapping ventral prefrontalbasal circuitry in primates has delineated potential pathways of DBS effect. Stimulationrelated changes in behavioral phenotypes related to fear conditioning and extinction are the focus of ongoing collaborative work, in concert with our controlled multicenter trial of VC/VS DBS for intractable OCD.

S059-5.

COGNITIVE OUTCOMES WITH CLINICAL BRAIN STIMULATION

Presenter: Shawn McClintock, Ph.D.

SUMMARY:

Brain stimulation therapies encompass state-of-the-art antidepressant strategies that are able to selectively modulate different aspects of the central nervous system. These modalities include transcranial magnetic stimulation (TMS), electroconvulsive therapy (ECT), magnetic seizure therapy (MST), and deep brain stimulation (DBS). In addition to their antidepressant properties, each brain stimulation modality can affect neurocognitive function, which is mediated by the respective treatment parameters. Specifically, TMS has been found to have no adverse cognitive effects, but depending on certain parameters, may be able to enhance select neurocognitive functions. Despite conflicting data from large scale investigations and metaanalyses, ECT is associated with time limited neurocognitive adverse effects of disorientation, anterograde and retrograde amnesia. Both MST and DBS are presently in development as antidepressant therapies, and evidence suggests that they have relatively benign neurocognitive effects. Additional research is warranted to better understand the relationship between the brain stimulation therapies and neurocognitive function, clarify the risk and benefit ratio, and develop respective neurocognitive profiles. These studies should take into consideration the effects of patient characteristics, such as demographics and disease state, and selection of psychometrically sound neuropsychologic instruments. Thus, this presentation will 1) review data regarding the neurocognitive effects of brain stimulation modalities, 2) discuss optimal treatment parameters to improve the risk benefit ratio, 3) discuss relevant methodologic issues in brain stimulation neurocognitive research, and 4) provide suggestions for future research investigations.

SYMPOSIUM 060**ELECTRONIC HEALTH RECORD PRIVACY UPDATE**

Co-Chairs: Zebulon Taintor, M.D., Glenn A. Martin, M.D.

Discussant: Deborah Peel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe national policies on privacy in electronic health records, 2) Describe issues in implementing such policies in exchanges of electronic health information, 3) Describe privacy and other issues in shareware, 4) Describe privacy and social media issues in electronic health software certification, and 5) Describe trends and consequences of breaches of protected health information

SUMMARY:

This symposium will trace recent developments in privacy in electronic health records and related issues. a) National privacy policies have been elaborated by the National Health Information Policy Committee Tiger Team, co-chaired by Deven McGraw. Policies are patient-centered around the guiding principle that no one should be surprised to discover an unexpected use of one's health information. The policies have laid down general principles on the definition of HIPAA covered entities and their use of protected health information, operations of Regional Health Information Organizations (RHIOs) and Health Information Exchanges (HIEs), confidentiality laws, etc. The challenge is adapting to changing technology and increasing integration and sharing of health information. b) Actual operation of a RHIOs privacy policies will be discussed by Glenn Martin, medical director of the Interboro RHIO in New York City. He will describe how a RHIO can receive, maintain, and transmit health information, including the hazards and benefits of different methodologies, the benefits and burdens of compliance with laws and regulations. c) Shareware is noncommercial, not-for-profit computer software that offers an alternative to high-priced commercial electronic health products. Dr. Robert Koldner, developer of the VISTA system at the Veterans Administration, was the first National Coordinator for Health Information technology. He orchestrated initial certification efforts and the development of privacy standards. He will discuss how these have progressed and led to his present concern of promoting shareware. d) Steven Daviss, cochair of the Behavioral Health work group on the Certification Commission on Health Information Technology (CCHIT) will describe how the standards evolved in relation to privacy and the impact of other certifications. Author of *Shrink Rap*, he will discuss the influence of less privacy in social media. e) Breaches in protected health information were reported voluntarily and in news media, but required reporting has been in place for two years. Zebulon Taintor will describe how trends in breaches, who is least protective, sloppiness vs. criminality, prosecutions, personal losses, and consequences of breaches.

S060-1.**PRIVACY AS HEALTH IT ENABLER: ARE WE THERE YET?**

Presenter: Deven C. McGraw, J.D., M.P.H.

SUMMARY:

Health information technology (health IT) has enormous potential to improve the quality of physical and mental health care, both in terms of care provided to individuals as well as population health. But until very recently, little

progress had been made to advance widespread adoption of health IT and electronic health information exchange to improve health. Among the obstacles was lack of funding to support technology adoption; lack of interoperability among disparate record systems; and failure to effectively address the complex privacy and security issues raised by the ehealth technologies. In February 2009, Congress broke the “logjam” and enacted significant provisions supporting health IT as part of the economic stimulus legislation. The legislation dedicated significant funds to support health IT adoption through payments to individual providers and grants for health information exchange infrastructure, and strengthened privacy and security protections for health information by filling significant gaps in the privacy and security regulations under HIPAA. The first year of the adoption incentive programs began January 2011, but it is uncertain whether the potential of health IT will be fully realized by these efforts. The paper will assess the progress to date in realizing the promise of ARRA, focusing in particular on whether we have sufficient privacy and security policies (and enforcement of those policies) to build and maintain the trust of both providers and patients. The paper will address the status of federal policy initiatives and the recommendations of key federal advisory bodies, and also address possibilities for “granularity” (patients actively controlling who is told what) becoming a usual practice.

S060-2.

HEALTH INFORMATION EXCHANGES OR THE HEALTHY EXCHANGE OF INFORMATION: CAN IT BE DONE WHILE PROTECTING OUR PATIENTS' PRIVACY INTERESTS?

Presenter: Glenn A. Martin, M.D.

SUMMARY:

Over the past several years there has been an explosion in the growth of health information exchanges (HIEs) in cities and states throughout the country. While financial sustainability models are not mature, and the actual financial, safety and healthcare benefits of the exchanges have not been fully proven, HIEs are an accepted lynchpin of health care reform, medical homes, accountable care organizations, etc. These exchanges usually link information obtained from individual physicians, large group practices and hospitals, as well as pharmacy benefit managers, laboratories, imaging centers and some insurance carriers including Medicaid. Information is shared among these providers, public health authorities and eventually will be shared with the patients themselves through internet portals or personal health records. Over the last years two important developments are directly impacting psychiatrists and their patients. First there is an active push in many states, notably New York State to include those with mental illness and substance

abuse in medical homes and managed care setups. The impetus is the realization that comorbid physical and mental conditions are expensive to treat and care coordination is key to both clinical and financial success. Use of HIEs to actively support these initiatives is being promoted and supported by the state. The second significant development is the increasing breadth of information being exchanged. In the early exchanges the psychiatric visit may not appear directly, but much sensitive information could be deduced from the lists of purchased medications, ordered labs would be accessible through an HIE. As more and more discharge summaries, care notes and treatment plans are being uploaded, more sensitive information is online. Additionally this information is frequently found in free text fields, a location where computers have the greatest difficulty identifying the information as sensitive and treating with appropriate increased safeguards. This presentation will provide real life examples of the technical and legal challenges faced by a functioning RHIO and HIE in Queens, NY and how they have been met, postponed or missed. Experience gained participating in the publicprovidervendorgovernmental consortium in New York State that has grappled with these issues, including the overlapping and conflicting laws and regulations governing confidentiality of mental health and substance abuse treatment, (they are d

S060-3.

OPENSOURCE SOFTWARE AS SHARED INFRA-STRUCTURE: A NOVEL STRATEGY TO ENHANCE DATA INTEROPERABILITY WHILE IMPROVING INFORMATION PRIVACY IN EHRS AND HIES

Presenter: Robert M. Kolodner, M.D.

SUMMARY:

Healthcare IT solutions are not only important for the delivery of high quality, affordable health care, they are essential for us to achieve a Learning Health System – a goal described and promoted in the past few years by the National Academy of Science / Institute of Medicine. While being “good enough” to deliver value for current healthcare stakeholders (patients, providers, payers, etc.), especially as payment incentives shift from volume of service to health outcomes, interoperability among current health IT solutions is, at best, expensive and slow with little progress being made in information privacy and applying patient preferences on how their data is shared and used. Vendors implement their own, individual solutions for interoperability, with variable results and slow progress. Traditionally, open source software (sometimes called freeware or shareware) has been seen simply as a low cost alternative to (expensive) proprietary software solutions. Although health IT open source solutions may achieve pockets of usage among resource poor organizations and providers

when positioned as a competitor to established commercial alternatives, across the overall market, such have become just one of many products available, achieving very modest market share. An alternative approach to open source has been emerging in other industries whereby competitors join together to develop open source software solutions to shared problems that are very difficult to solve and holding back more widespread use of IT products, solutions, and services in that industry. These solutions are then voluntarily incorporated into both proprietary and open source products and solutions to enable the industry to resolve their shared problems and foster more rapid growth of the market opportunities at a significantly lower cost. This paper will describe open source health IT projects and activities that are working to make health information interoperability faster, easier, and cheaper to achieve, while providing a pathway to improve health information privacy and applying patient preferences.

S060-4.

APA 2012: BALANCING PRIVACY WITH CONVENIENCE AND UTILITY IN HEALTH NETWORKS: MERGING OF HIES, PHRS, AND SOCIAL MEDIA

Presenter: Steven R. Daviss, M.D.

SUMMARY:

Electronic health records (EHRs) are being connected to each other via health information exchanges (HIEs) that are largely statebased communication networks designed to improve the flow of health information so that providers have the most current data available when treating a patient. Other networks of health information exist, such as personal health records (PHRs) and social media health networks, such as PatientsLikeMe. HIEs are typically opted-in networks, meaning that patients are automatically in the network unless they take steps to opt-out. Fewer HIEs are opted-out networks, where one must actively opt-in to permit one's health information to flow on the network. While PHRs tend to have very limited, if any, sharing of data across recipients, social media health networks enjoy robust sharing of personal health information. All of these networks vary in how they handle sensitive health information, such as mental health, substance use, HIV status, reproductive health, domestic violence, and genetic data. The degree to which one has control over how one's health information is shared, with who, and for what purpose, also varies widely across these network types. The author reviews these different networks and describes how privacy is managed and the locus of control in each. The major themes developed are that patients are increasingly gaining control over how their information is accessed and shared, and that patients are becoming more open with the sharing of their personal health data so that they gain increased

convenience and functionality in the health care information marketplace.

S060-5.

TRENDS AND CONSEQUENCES IN BREACHES OF PROTECTED HEALTH INFORMATION

Presenter: Zebulon Taintor, M.D.

SUMMARY:

Breaches in the confidentiality of protected health information (PHI) have been mounting and are part of a national trend of poor protection of personal information that most Americans would prefer not to have disclosed. Yet more than half the population has been involved in loss of privacy for some such data. Mechanism: Health data are most frequently lost from a laptop, flash drive, or disc to which they have been transferred from a secure server. The modal event is a worker taking the device off site (usually home) to "work on it" when it is stolen or lost. Losers: The modal loser of PHI is an administrator who is working with a large data base for billing or quality (!) assurance. Third party carriers, some of whom are not described as having access to the data, nonetheless do have such access and abuse it. Data pass from HIPAA covered entities to noncovered entities and get lost along the way. Data sometimes are passed along so many links in a chain that liability is difficult to establish. Physicians and other clinicians rarely are involved in such breaches. Sloppiness vs. criminality: Most data breaches are accidents and no one, including those whose privacy has been compromised, seem to suffer no consequences. Initially victims were not informed, then not in a timely way. Required reporting and notification may show more consequences than have been tracked so far. Criminal breaches of PHI are usually for monetary gain, especially insurance fraud and medical identity theft, which have been prosecuted per se. rather than under HIPAA. Curiosity about the specifics of media worthy cases or people has motivated another class of criminal breaches, usually record snooping without monetary gain. Personal losses and other consequences of PHI breaches: Few actual losses and lawsuits citing personal damages have been reported, but the number is increasing. Consequences include loss of health insurance, inability to maintain an acceptable credit rating. The most hazardous is merging the victim's health clinical data with those of the thief (usually in worse medical shape) in the victim's electronic health record, which may result in risks treatments for conditions the victim doesn't have, such as diabetes. Prevention: Policy changes resulting from breaches and other measures will be proposed.

SYMPOSIUM 061

THE PSYCHOTHERAPY OF HOPE: BACK TO THE

FUTURE IN CELEBRATING THE 50TH ANNIVERSARY OF PERSUASION AND HEALING

Co-Chairs: Julia B. Frank, M.D., Renato D. Alarcon, M.D., M.P.H.

Discussant: Thomas N. Wise, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify common effective elements in eclectic, culturally specific and religious/spiritual approaches to treating mental disorders, 2) Connect the common features of psychotherapy to the relief of demoralization in various populations, including immigrants, specific cultural groups, and the medically ill, 3) Defend psychotherapy as a legitimate enterprise within the prevailing medical paradigm of applied evolutionary science, 4) Articulate a strong defense for continuing to teach principles of psychotherapy to trainees at all levels

SUMMARY:

This symposium explores new applications of the ideas in Jerome Frank's classic text, *Persuasion and Healing*, published 50 years ago, and staunchly defended ever since. Initially viewed as heretic, Frank proposed that all therapies succeed or fail based on common elements, rather than on mechanisms suggested by particular theories. The most effective element of any psychotherapy is a relationship between a sufferer and a socially sanctioned healer whose methods inspire hope and foster a sense of mastery. Frank further argued that the relief of demoralization, rather than the cure of disorders or the relief of target symptoms, is the fundamental purpose and effect of all psychotherapy. The papers to be presented draw upon Alarcon, R and Frank, JB *The Psychotherapy of Hope: the Legacy of Persuasion and Healing* (JHUP 2012), a volume of essays extending Frank's concepts in light of present day advances in basic and social science, as applied to a variety of people in potentially demoralizing circumstances. Joining Frank's search for universal principles underlying psychotherapy, contributors highlight the role of narrative in human evolution and survival, and the universal influence of culture on the construction of healing narratives. Evolutionarily and culturally informed principles of healing have particular relevance for relieving demoralization in persons who have been dislocated or alienated from their original cultures, and those with serious chronic medical illness, as will be discussed. Evolutionary principles also provide a framework for the psychotherapy of women who develop psychiatric disorders in relation to pregnancy. To promote psychotherapy as a crucial element of physician's professional identity, we describe a model program for teaching basic psychotherapeutic principles to medical students, psychiatry's ambassadors

into the medical settings of the future.

S061-1.

INTEGRATING EVOLUTIONARY SCIENCE AND MEANINGFUL PSYCHOTHERAPY: TREATING PERINATAL MOOD AND ANXIETY DISORDERS

Presenter: Julia B. Frank, M.D.

SUMMARY:

Jerome Frank strove to reconcile the meaningful enterprise of psychotherapy with the realities of bodily disease. *Persuasion and Healing* explored placebo effects, the impact of symbolic caregiving upon symptom expression and disease outcome. Fifty years later, evolutionary science offers new paths for integrating meaning and biology. An evolutionary perspective helps a physiciantherapist prioritize interventions and make rational choices in applying different therapeutic tools. As a concrete example, this paper examines the treatment of perinatal psychiatric disorders. Pregnancy, birth and the nurturing of offspring are obviously crucial to species survival. Treating perinatal disorders involves attending to the woman's psychological capacities for attachment, understood in relation to the hormonal changes of pregnancy and parturition. These capacities evolve in parallel with her need to reestablish homeostasis, rapidly changing relationships with others, and movement into the culturally shaped role of parent. Potential interventions include directly modifying biology (use of medication, nutritional or hormonal supplements, behavioral modification of sleep), the resolution of internal conflicts related to becoming a mother, modifying relations with partners, grandparents and peers (various forms of evidence based psychotherapy), and encouraging participation in birthrelated rituals. Organizing eclectic psychiatric intervention according to the principles of evolutionary biology provides medically trained psychotherapists with a plausible, and possibly true, theory that may give them confidence in the scientific legitimacy of their treatment and enhance their ability to be persuasive, in Frank's terms, when trying to mobilize healing forces within their patients.

S061-2.

ACCULTURATION AND DEMORALIZATION IN IMMIGRANT AMERICA

Presenter: John M. De Figueiredo, M.D., Sc.D.

SUMMARY:

Since the 1950s, psychiatrists and epidemiologists have attempted to identify the factors associated with success or difficulty in immigrants' adaptation to the American way of life. In cross sectional studies, immigrants express similar

overall levels of distress when compared with native born persons of similar age and social class. Perceived powerlessness, alienation, social class and social distance also emerge as important determinants of successful adaptation. When the perceived distance between the values of the country of origin and American values is large, acculturation becomes even more challenging. Contrary to expectation, research has found a higher prevalence of risk behaviors and adverse health outcomes among more acculturated immigrants. Jerome Frank's hypothesis that many forms of distress result from demoralization, a state of diminished hope and subjective incompetence, may explain this paradox. Subjective competence is a measure of perceived ability to fulfill one's own and others' expectations. Eurowestern cultures, the US in particular, promulgate the expectation that individual effort can overcome any obstacle. To the extent that more acculturated immigrants may hold such expectations more strongly than their less acculturated peers, they are more likely to feel subjectively incompetent (selfblaming, even helpless) when they cannot fully attain them. As Frank also noted, psychotherapy reshapes the meaning patients ascribe to experience. Effective psychotherapy with immigrants must take into account the paradoxes of acculturation and address them with compassion and respect.

S061-3.

CULTURAL CONTENTS AND DYNAMICS OF THE PSYCHOTHERAPEUTIC ENCOUNTER

Presenter: Renato D. Alarcon, M.D., M.P.H.

SUMMARY:

Patient and therapist each bring to their encounter a unique set of "cultural endowments" that include a variety of ingredients and contribute to a reciprocal influence aimed at the relief of identified psychopathologies. Such ingredients include assumptive world, meanings, history and tradition, values, language and religion, helpseeking patterns, interaction styles, strengths and weaknesses as well as individual identities. Certain research variables, including expressed emotion, social ranking and placebo responsiveness are also expressions of cultural influences, and generate a unique dynamic process whose impact requires continuous research efforts. Building on and expanding concepts elaborated in Jerome Frank's *Persuasion and Healing*, this presentation examines the cultural contents of every psychotherapy, their interactions, steps of adaptation and effects on outcome. The notion of "cultural syndromes" and the description of theoretical principles and clinical use of two types of "cultural psychotherapies" (Morita and Dichos therapies) offer specific examples of the practical applicability of these concepts.

S061-4.

EXISTENTIAL INQUIRY: BRIEF PSYCHOTHERAPY FOR COUNTERING DEMORALIZATION IN CHRONIC ILLNESS

Presenter: James L. Griffith, M.D.

SUMMARY:

Psychotherapy that counters demoralization can help build resilience against the emotional ravages of a chronic medical or psychiatric illness, whether cancer or schizophrenia. Such psychotherapy emphasizes the mobilization of hope as an effective antidote for demoralization. Pragmatically, hope can be regarded as the product of "agencythinking" (perceiving and believing that one can act effectively) and "pathwaythinking" (strategizing and planning paths towards goals). Psychotherapy thus helps activate agencythinking or pathwaythinking when either is deficient by drawing upon a patient's internal strengths, such as character or personal identity; or relational resources, such as family or friendships. Further, a patient can learn how to practice hope as something "one does" rather than "one feels." A practice is an intentional program of action that is undertaken, not for utilitarian purposes, but for how it shapes one's being as a person and how one chooses to live in relation with others. For religious patients, spiritual practices often serve this role in daily life and as such can be incorporated into a clinician's secular psychotherapy. Case illustrations show how existential inquiry, as a psychotherapeutic interviewing method, can help a demoralized patient to discern internal and relational resources that can be fashioned into practices of hope.

S061-5.

A PSYCHODYNAMIC PSYCHOTHERAPY CURRICULUM FOR MEDICAL STUDENTS

Presenter: Janis L. Cutler, M.D.

SUMMARY:

For Jerome Frank, psychoanalysis was a rich source of hypotheses to be studied using methods outside of psychoanalytic practice. This work led him to conclude that the quality of the therapeutic alliance is central to the success of all professional care, including the outcome of medical treatment. Frank's position reaffirmed the relevance of psychodynamic principles in medical education at every level. Phenomena such as unconscious conflict, transference, countertransference, and resistance contribute to challenging doctorpatient interactions. Medical students' understanding of these concepts fosters sophisticated interviewing techniques and interpersonal skills that will strengthen their ability to forge healing relationships with patients across all specialties. Active and sustained advocacy is required to ensure the place

of these principles in the current environment of medical education. We have developed a sequence of lectures and seminars that successfully conveys this material, beginning in the preclinical introduction to psychiatry course and continuing in the psychiatry clerkship and fourth year electives. The curriculum engages the students in listening, reflecting, and self-awareness, and emphasizes the practical applicability of these concepts and techniques for all physicians. We have found that a medical school psychiatric curriculum that includes psychodynamic psychotherapy engenders medical students' interest in and enthusiasm about the field of psychiatry. This presentation will describe the curriculum and the extensive student feedback that we have collected about its value and impact.

SYMPOSIUM 062

ETHICS AND MEDICAL LEADERSHIP

Co-Chairs: Michael F. Myers, M.D., Leah J. Dickstein, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss common ethical challenges for physicians in leadership positions, 2) Understand generic ethical dilemmas when considering one's role as a member of an institution or organization, 3) Acquire skills in imparting high ethical standards to tomorrow's psychiatrists

SUMMARY:

Ethical issues in medicine, particularly in leadership, have gained greatly increased visibility and acknowledgement since 2000. In all forms of the media, print, online, TV, multiple areas where lack of medical ethics is possible, have unfortunately become probable and continuing. Examples in all government agencies, pharma, medical centers and offices, work & compensation, health insurance options, education and training, malpractice issues have become part of medicine. For the past several years, as APA chair of the American Psychiatric Leadership fellowship, I have led a fellowfocused session on these issues. Each year participants have demonstrated knowledge and concerns about their future careers relating to these basic issues. We know patient care is much more complicated and effective today given new research, treatment options and ethical issues for all at all levels, from patients to practitioners, faculty, government, medical centers and payment options and requirements. We don't learn enough however about the extraordinary physicians and others involved in giving voluntary free care at the highest level by choice and their ethical behaviors. Today's speakers will discuss ethics in medical leadership related to their current medical roles and concerns.

S062-1. ETHICAL LEADERSHIP IN MEDICINE

Presenter: Leah J. Dickstein, M.D., M.A.

SUMMARY:

Ethical issues in medicine, particularly in leadership, have gained greatly increased visibility and acknowledgement since 2000. In all forms of the media, print, online, TV, multiple areas where lack of medical ethics is possible, have unfortunately become probable and continuing. Examples in all government agencies, pharma, medical centers and offices, work & compensation, health insurance options, education and training, malpractice issues have become part of medicine. For the past several years, as APA chair of the American Psychiatric Leadership fellowship, I have led a fellowfocussed session on these issues. Each year participants have demonstrated knowledge and concerns about their future careers relating to these basic issues. We know patient care is much more complicated and effective today given new research, treatment options and ethical issues for all at all levels, from patients to practitioners, faculty, government, medical centers and payment options and requirements. We don't learn enough however about the extraordinary physicians and others involved in giving voluntary free care at the highest level by choice and their ethical behaviors.

S062-2.

ETHICAL LEADERSHIP FOR THE PROFESSION OF MEDICINE

Presenter: Jeremy A. Lazarus, M.D.

SUMMARY:

The integrity of the profession of medicine sits squarely in the ethical code and guidance that professional medical organizations ascribe to and then educate their members about. Adhering to and enforcing that code also serve to support the vigor with which professional medical organizations walk the walk and not only talk the talk on their ethical code. This presentation will give a brief history of the authors sojourns through the world of ethics within both the American Psychiatric Association and the American Medical Association from both a members and leaders perspective. Some of the hurdles encountered in attempting to lead the organization to either modification of or enforcement of the code will be described. Teaching and mentoring future leaders to be involved in both ethical decision making as well as involvement in ethics committees or enforcement is another special area that has been in need of constant refreshing. The author will describe efforts to do both at the APA and at the AMA. In addition, the author will describe some of the most vexing ethical issues facing

the entire profession of medicine and some of the approaches to these. Examples of common ethical dilemmas faced by physicians including psychiatrists will be presented. The “politics” of advancing ethics within organizations will also be discussed. Finally, the author will provide some reflections on the dual role of ethics committees in educating and enforcing an ethical code and some of the barriers and complexity of this dual role.

S062-3.

WOMEN PSYCHIATRISTS IN LEADERSHIP ROLES: CHANGE AND ETHICS

Presenter: Donna M. Norris, M.D.

SUMMARY:

Women now have greater diversity of career choices in psychiatry to achieve professional success than when I began my career over 30 years ago. This change was influenced by the rigorous and focused leadership of many women psychiatrists who challenged the status quo. The author will highlight personal observations of select and significant changes to the field of ethics and practice and to organized psychiatry which were stimulated by these women leaders. There are many paths which may be helpful to enhance leadership skills. An important concept to consider is that ethical leadership is not for the risk adverse, but accepting the associated challenges may be critical to attaining any true success. Significant insights and guiding principles regarding leadership development will be reviewed.

S062-4.

ETHICAL CHALLENGES FACING CHIEF RESIDENTS

Presenter: Sherif A. Ragab, M.D.

SUMMARY:

Residency programs across the nation have depended on chief residents to fulfill administrative and liaison roles. This position has provided residents with a unique opportunity to develop their administrative, leadership, communication and conflict resolution skills. It includes functioning as a resident, an administrator, a junior faculty and serving as liaison between residents, administration and faculty. The multifaceted role of chief residents could bring about some ethical challenges. The chief residents may have privileges to know confidential information from program directors, administration, faculty and residents alike. This could include situations with an ethical obligation to share this information to resolve problems versus honoring confidentiality. Often there is a conflict to avoid siding with administration or compensating by siding with the residents' body. Another challenge for the chief residents is in work-

ing with other senior residents, as recognized by Lim et al in 2009, as the most significant challenge for most PGY4 chief residents. One of its facets is trying to balance being a peer and an authority figure at the same time. Many training programs have more than one chief resident who could have conflicting views on any decision making process. The above mentioned are examples of possible ethical challenges that chief residents could face. Other ethical challenges can evolve depending on multiple variables including interpersonal relations, group dynamics, administrative policies and particular situations that training programs could be facing at points of time among others. Reference: Russell F. Lim, M.D., Eric Schwartz, M.D., Mark Servis, M.D., Paul D. Cox, M.D., Alan Lai, M.D. and Robert E. Hales, M.D., M.B.A. The Chief Resident in Psychiatry: Roles and Responsibilities Acad Psychiatry 33:5659, January/February 2009

S062-5.

ETHICAL LEADERSHIP ISSUES FOR PROGRAM DIRECTORS IN PSYCHIATRY

Presenter: Michael F. Myers, M.D.

SUMMARY:

Much has been written about generic ethical issues for psychiatrists in leadership positions. Program directors in psychiatry serve two masters, their chair (or department or institution) and their residents. Consequently, they have a unique set of ethical dilemmas that comprise much of their daily work. In this paper the presenter will discuss some of the common ethical challenges for training directors: respecting the parameters surrounding confidentiality (for both residents and faculty); seeking clarity in knowing what and how much information is ethically sound to share with chief residents; designing and implementing appropriate and comprehensive didactics in ethics for psychiatrists; ensuring that one's residents understand the ethically appropriate dynamics with the pharmaceutical industry; supporting resident research endeavors and being vigilant with one's institutional review board (IRB); adhering to the highest ethical standards when overseeing recruitment, interviewing applicants and making tough decisions regarding acceptance in a very competitive atmosphere; acting quickly, decisively and judiciously when a faculty person has received consistently poor evaluations by trainees; identifying and seeking timely confidential evaluation of residents who are ill, disruptive, or impaired; respecting departmental and institutional policies when residents are placed on remediation, probation or dismissed; respecting boundaries around privacy when a resident loses a patient to suicide and/or is subject to medical chart audit review or litigation for malpractice; knowing how high to set specific benchmarks (clinical evaluations, intraining examinations, mock boards) for promotion to the next level of postgradu-

ate training when one's program is being evaluated by the ACGME on resident satisfaction indices and board examination pass rates upon graduation; and ensuring that all of the six competencies in medical education are understood and modeled by oneself, one's faculty and one's residents, including stateoftheart and respectful teaching of medical students and other health professionals.

SYMPOSIUM 063

DOUBLE TROUBLE: COOCCURRENCE OF ALCOHOLISM AND PSYCHIATRIC DISORDERS

Chair: Alan I. Green, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Learn to estimate the prevalence of cooccurring Alcohol Use disorders and common psychiatric disorders in clinical and general population samples, 2) Recognize the specific and potentially "unique" impact different cooccurring psychiatric disorders have on treatment, 3) Identify promising treatment approaches, 4) Specify highpriority research questions still to be addressed to better inform clinical practice

SUMMARY:

Alcohol dependent individuals have exceptionally high rates of cooccurring psychiatric disorders. For example, individuals suffering from alcohol dependence are four times more likely to have a mood disorder, three times more likely to have an anxiety disorder, and seven times more likely to have an antisocial personality disorder. Approximately half of individuals with schizophrenia or bipolar disorder suffer from an Alcohol and/or Substance Use Disorders. In addition, a significant number of alcohol dependent individuals exhibit two or more comorbidities. Although individuals with comorbid alcohol dependence and psychiatric disorders are most likely to seek treatment, they have a poorer treatment prognosis, a higher risk for treatment dropout, less support for sobriety from family and work environment, and a higher risk for suicide. This symposium will highlight the high prevalence of alcohol/psychiatric comorbidity, present stateoftheart research findings as it relates to treatment, and finish with a general discussion related to identification of knowledge gaps that are ready for future research. It will become apparent from the different presentations that each cooccurring disorder presents its own unique challenges for the treatment provider in terms of etiology, diagnosis, and treatment. The presenters in this symposium are experts in their respective areas and have conducted some of the cuttingedge research, chipping away at understanding the complexity of cooccurring disorders. The field is in its infancy and many questions remain to be

answered. Research is only beginning to address this relatively neglected area of cooccurring disorders and recognize the challenges that are present in identifying the best approach to treatment.

S063-1.

ALCOHOLISM AND ANXIETY DISORDERS

Presenter: Domenic Ciraulo, M.D.

SUMMARY:

This presentation will review recent research on the treatment of alcoholism associated with anxiety disorders. The influence of anxiety on clinical outcomes in individuals with alcohol dependence will be discussed. Recent findings from behavioral and pharmacologic treatment studies will also be reviewed (1R01 AA 01592301 and 1R01AA01372701A1).

S063-2.

DEPRESSION AND ALCOHOL USE DISORDERS

Presenter: Kathleen Brady, M.D., Ph.D.

SUMMARY:

The relationship between depressed mood, depressive disorders and alcohol use disorders is complex. Depressed mood is commonly seen in individuals with alcohol use disorders, but is often associated with acute intoxication and withdrawal and resolves with time in abstinence. In this presentation, diagnostic issues at the interface of depression and alcohol use disorders will be reviewed. The neurobiologic interface between depression and alcohol use and the implications for pharmacotherapeutic treatments will be explored. Data from recent trials exploring cognitive behavioral therapies targeting cooccurring depression and substance use disorders will be presented.

S063-3.

INTEGRATING ADDICTION TREATMENT SERVICES IN MENTAL HEALTH AND PRIMARY CARE SETTINGS: APPLICATION OF BENCHMARK MEASURES OF PROGRAM CAPABILITY

Presenter: Mark P. McGovern, Ph.D.

SUMMARY:

Over the past twenty years, considerable efforts have been focused on improving services for persons with cooccurring substance use and psychiatric disorders. Despite increased awareness and systemic investment, the data reveal that less than 10% of persons with comorbid disorders receive integrated care. These findings are from patient perspectives,

and contradict self-reports from treatment providers. Across several studies, public, private and VA provider estimates of available integrated treatments range from 50 to 84% of programs. This patient-provider disconnect may be due to a lack of precise policy, practice and workforce definitions for integrated care. Also, the contradiction may involve provider self-report bias. This paper presents data from a nationally representative sample of traditional addiction, mental health and federally qualified health center agencies (n=283). Objective data on integrated services were gathered using three standardized observational measures of program co-occurring capability. Findings reveal that the majority operate at the Addiction Only Services, Mental Health Only Services or Health Care Only Services level. However, on most benchmarks, programs are near Dual Diagnosis Capability. Precision in definitions and guidelines can focus implementation efforts to leverage integrated services into routine addiction, mental health and health care settings.

S063-4.

AN EPIDEMIOLOGICAL UPDATE ON ALCOHOL AND PSYCHIATRIC COMORBIDITY: PERSONALITY DISORDERS, LONGITUDINAL COURSE, AND METASTRUCTURE OF COMMON DISORDERS

Presenter: Deborah S. Hasin, Ph.D.

SUMMARY:

The NESARC, a national survey of 43,093 U.S. adults, has provided unprecedented information on the co-occurrence of alcohol and other psychiatric disorders comorbidity. One important area of recent research has focused on the follow-up interview three years later with 34,653 of the initial respondents. This has facilitated research on the longitudinal course of disorders. Recent findings indicate that several personality disorders, including antisocial, borderline and schizotypal personality disorder, predict poor 3-year course of alcohol dependence. The consistency of these findings with predictors of the 3-year course of other substance use disorders, major depression and anxiety disorders is reviewed. In addition, the NESARC has contributed to our understanding of the metastructure of comorbidity, including the broad underlying internalizing and externalizing domains. The position of several new disorders (personality disorders, bipolar disorder and gambling disorder) and the need for a third domain characterized by isolation and thought disorder is examined.

SYMPOSIUM 064

PSYCHIATRISTS AS ACTIVISTS: ON BEING PART OF THE SOLUTION

Chair: Annette B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) List at least three characteristics of psychiatrist activists, 2) Describe common challenges that psychiatrists change agents face in their transformative work, 3) Discuss strategies for developing more psychiatrist change agents

SUMMARY:

This symposium, a component of OMNA on Tour, is being presented to bring attention to the contributions of psychiatrists and psychoanalysts to activism and advocacy for a range of causes affecting marginalized groups: women and reproductive rights, the rights of gay, lesbian, bisexual and transgender people, urban populations living in poverty, helping family members of homicide victims, fostering the healing of school children from trauma and loss, prevention and resilience among youth, and facilitating healing and self and collective efficacy among disaster survivors. These activists have emerged from their offices and ivory towers to the front lines and the trenches to be visible, vocal, proactive, passionate and unrelenting in their drive to transform unjust and unconscionable circumstances into the humane, ethical, and mental health promoting environments. Each activist will provide a personal narrative of their evolution as an activist psychiatrist, describe their approach to visionary leadership and discuss examples of their work.

S064-1.

PSYCHIATRIC ACTIVISM AND WOMEN'S REPRODUCTIVE RIGHTS

Presenter: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

Under the radar of many psychiatrists, there is a zealous attack on women's rights and women's health in the United States. Following are a few of the many examples. The Federal Government still subsidizes abstinence-only sex education although it has proved counterproductive. The morning-after pill is misconstrued as an abortifacient, and states defund Planned Parenthood, the only source for contraception for hundreds of thousands of women. A woman who made a desperate suicide attempt while pregnant is being prosecuted in Indiana for murdering her fetus. A Texas law requires that a woman seeking an abortion be told by the physician that she is ending the life of a whole, complete, separate human being, and must hear the fetal heartbeat and see the ultrasound. In many states, and in a United States Supreme Court decision, the assertion of adverse psychiatric sequelae is the rationale for restrictive laws and practices. Papers supposedly demonstrating these

sequelae are methodologically unacceptable, and careful reviews by the American Psychological Association, the Royal College of Psychiatrists, and individual researchers address these methodological errors and conclude that there is no evidence for a significant incidence of ill effects of women's mental health. One-third of the women in the United States have an abortion some time during their lives. So abortion laws and regulations affect a great many of our patients, and scientifically inaccurate information about psychiatric sequelae is being used to make it difficult for them to obtain abortions and needlessly frightened about adverse outcomes if they do have them. The American Psychiatric Association has taken a firm position in favor of reproductive rights for several decades. Dr. Stotland has had to testify to the scientific facts, either on behalf of the APA or as an individual, in both houses of Congress and in states including Wisconsin, California, Alaska, Louisiana, and Texas, in attempts to counter the enactment and implementation of unduly restrictive legislation. She has written one book, edited another, and spoken to and on the media. This is not an easy activism nor a comfortable one, but it is a crucial one.

S064-2.**THE POLITICS OF SEXUAL SCIENCE A GAY PSYCHIATRIST'S REPORT FROM THE TRENCHES OF THE CULTURE WARS**

Presenter: Jack Drescher, M.D.

SUMMARY:

New scientific findings have evoked political responses throughout history. Galileo Galilei's scientific claim that the earth revolved around the sun challenged 17th century church doctrine. The 19th century findings of Charles Darwin were at the center of the 20th century's sensationalized Scopes Monkey Trials. Yet while most religions now accept Galileo's once-heretical findings, Darwin's theory remains a contentious issue in the contemporary social debates known as the "culture wars." However, in matters of public health today, the influence of special interests challenging scientific findings remains a cause for concern. In 2007, former Surgeon General Richard Carmona testified that political pressures to distort science impeded his office's efforts to educate the American public about stem cell research, sex education, emergency contraception, global climate change, prison mental health services, and secondhand smoke. Deliberately distorting findings for personal or political reasons can serve to undermine the entire scientific enterprise. Furthermore, research created solely to support nonscientific agendas raises the question of whether science can survive in an environment of politicization at all. This presentation provides examples of how politicized, special interest groups exploit the way the media reports stories in order to distort scientific findings. The goal is to use

the media to influence the public's perception of scientific findings in ways that will influence the development and implementation of public policies. Nowhere is this type of distortion more apparent than in efforts to change public opinions about lesbian, gay, bisexual and transgender (LGBT) civil rights. This is an arena where opponents to these rights often distort authentic research findings on sex, gender, gay parenting, etc. They also generate and publicize questionable research findings of their own, while promoting mediatrained "experts" whose opinions are often outside the mainstream of contemporary scientific thought. The presentation offers ways in which psychiatrists have, can and should get more involved, both the local and national levels, when confronted by political efforts to misrepresent scientific findings and research.

S064-3.**PSYCHIATRISTS AS LEADERS IN POST DISASTER EMOTIONAL RESILIENCY RECOVERY**

Presenter: Denese O. Shervington, M.D., M.P.H.

SUMMARY:

A disaster's forces of harm are a complex interplay of the interrelationship and interdependence of ecological factors – the individual/family context, the community context and the societal/structural context. People who experience catastrophic events show a wide range of reactions: some suffer only worries and bad memories that fade with emotional support and the passage of time; others experience long term problems. PTSD, Depression, and Substance Abuse are the most common post trauma psychiatric sequelae. Severe, lasting and pervasive psychological effects are likely when there is a high prevalence of trauma in the form of injuries, threat to life and loss of life. A global panel of experts on traumatic disaster identified principles to guide mental health care efforts shortly after a mass trauma. These elements of successful recovery emphasize promoting: 1) A sense of safety; 2) a sense of calm; 3) a sense of self – and community efficacy; 4) a sense of connectedness; and 5) a sense of hope. In the aftermath of Hurricane Katrina, due to the disproportionate negative mental health impact on poor people and people of color, the Institute of Women and Ethnic Studies, under the leadership of Dr. Denese Shervington, developed a division of community based post-disaster collective recovery and emotional resiliency. The goals are to: 1) promote individual and community wellness through knowledge and mutual support; 2) facilitate collective participation in individual and community healing; 3) build personal and collective efficacy amongst community members; and, 4) assist community members in sharing their experiences and envisioning the future. A common feature of programmatic activities is providing spaces where: community members gather to tell their stories,

learn about the impact of trauma, learn positive thinking techniques, practice selfcare, learn techniques to manage stress, and participate in culturebased activities for renewal.

S064-4.

THE RANGE OF INTERVENTIONS IN TRAUMATIZED COMMUNITIES

Presenter: Bruce Sklarew, M.D.

SUMMARY:

For nearly one hundred years, psychiatrists and psychoanalysts have addressed the transmission of trauma and the prevention of violence in troubled communities. The early pioneers were August Aichorn, Anna Freud, John Bowlby, Eric Erickson, Fritz Redl and Karl Menninger. Contemporary interventions are described in *Analysts in the Trenches: Streets, Schools, War Zones*, edited by Bruce Sklarew, Stuart W. Twemlow and Sallye Wilkinson (The Analytic Press, 2004). These interventions include working at Ground Zero, dealing with international relations, developing models for change in schools and helping rehabilitate soldier children in Africa. These community psychiatrists and psychoanalysts are applying their knowledge of the influences of unconscious processes including transference, externalization, projection and other defenses to traumatized population groups. They integrate theory with observable phenomena in considering how internal and external factors interact to influence development and adaptation. They address the emotional sequelae of violence, sexual and physical abuse, traumatic loss, learning inhibitions, scapegoating and teenage pregnancy. Dr. Sklarew has initiated two inner city projects with the Wendt Center for Loss and Healing in Washington, DC, both of which involve trauma and loss. The Schoolbased Mourning Project: A Preventive Intervention in the Cycle of Inner City Violence is a model of secondary prevention designed to help high risk, inner city elementary school children deal with multiple losses and trauma. The difficulty bearing depression, helplessness and hopelessness from these experiences often leads to antisocial acting out or premature pregnancy. This group used a range of innovative approaches developed by Dottie WardWimmer to facilitate mourning. Teachers and parents reported improvements in these children and pre and postpost testing, particularly the more culturefree DrawaPerson Test, showed very significant gains. The Recover Program at the Office of the Chief Medical Examiner in Washington, D.C. makes bereavement workers available to family members 365 days a year. We have seen over 30,000 family members over a period of ten years. Practical and emotional support provides a sense of safety and security in a Winnicottian holding environment when family members view Polaroid photographs of deceased family members.

S064-5.

DO THE RIGHT THING”

Presenter: Carl C. Bell, M.D.

SUMMARY:

As an older Black woman once told Dr. Bell: “I’d rather see a sermon than hear one.” Dr. Bell will paint a verbal picture of the work he has done as an activist. From these described experiences, participants learn the independent, visionary attitudes necessary to advocate and how to survive putting a career on the line to “do the right thing.” The reality is that it is professionally dangerous to advocate for a change in the status quo. Dr. will supply with a list of techniques necessary to balance being an activist and having a career as either a clinical, research, or administrative psychiatrist. How to use the media as a force in activism will be highlighted. Personal values and selfleadership will also be underscored as necessary in the service of advocacy. The Prince by Machiavelli “It ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old condition, and lukewarm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience with them. Thus it happens that whenever those who are hostile have the opportunity to attack, they do it like partisans, whilst the others defend lukewarmly, in such wise that the prince is endangered along with them.”

S064-6.

DEMOCRACY, VOICES AND PSYCHIATRY

Presenter: Kenneth S. Thompson, M.D.

SUMMARY:

Psychiatrists have long had an ambivalent relationship with activism. Caught between our roles as therapeutic agents and medical police, we stand to gain and lose when we align with either the forces of change or the forces of the status quo. This dilemma becomes especially acute in a democratic society where “voice” is the primary instrument of governance. Our role to help people attain a meaningful life in the context of the pull and tug of political life means that we must help people find their voice, even as we set some of the boundaries for its expression. There are clear ethical issues here, as well as leadership to be exercised. This presentation will be a meditation on psychiatrists as professionals, as activists and as advocates and the unique role we can play as

witnesses, visionaries and leaders.

SYMPOSIUM 065

TRAUMA, PTSD, AND HIV: PSYCHODYNAMIC AND EDUCATIONAL APPROACHES TO ADHERENCE IN A COMMUNITY MEDICAL SETTING – APA/AAPDP COLLABORATIVE SYMPOSIUM

Chair: Cesar A. Alfonso, M.D.

Discussant: Cesar A. Alfonso, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Apply the concepts presented in this symposium to develop psychosomatic medicine curricula for communitybased clinics, 2) Apply innovative concepts for the prevention of HIV transmission and improvement adherence to medical care and antiretroviral medication persons with HIV/AIDS, 3) Understand the psychodynamics of nonadherence in persons with PTSD and HIV/AIDS

SUMMARY:

The salience of psychoanalytic principles and psychodynamic psychotherapy is evident in every aspect of psychosomatic medicine from coping with severe and complex illness, to teaching psychiatry to trainees, to medicalpsychiatric rounds, and integrated models of health care delivery. Members of the APA and Academy of Psychosomatic Medicine AIDS Psychiatry Special Interest Group have collaborated with members of the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) to develop a symposium that applies psychodynamic concepts to AIDS psychiatry. While these concepts are relevant to all severe and complex medical illness and can reduce suffering, morbidity, and cost of care, in persons at risk for HIV or persons with HIV/AIDS, psychosomatic medicine and psychodynamic principles have public health implications and can make a difference in preventing transmission of HIV and adherence to HIV medical care and antiretroviral medication. In HIV clinics from East Harlem and the South Bronx in New York to those in Southern California, many clinicians have been baffled by the high incidence of trauma histories its association with nonadherence to risk reduction and medical care. When the Associate Director of the Pacific AIDS Education Training Center requested assistance in training HIV clinicians to work with traumatized persons with AIDS and improve adherence to care, we designed a curriculum and implemented an inservice training program with a before and after examination. The program was designed to help clinicians take a trauma history, evaluate for the presence of PTSD, and refer for appropriate psychiatric care. The curriculum, its implementation, and outcomes

will be presented along with the psychodynamics of nonadherence in persons with early childhood trauma, PTSD, and HIV. This program can be used as a model for inservice training in communitybased settings.

S065-1.

DEVELOPMENT OF A TRAUMA AND PTSD CURRICULUM TO MEET THE NEEDS OF HIV CLINICIANS AND THEIR PATIENTS

Presenter: Sharon M. Batista, M.D.

SUMMARY:

There is an extensive literature detailing the associations between early traumatic experiences, PTSD and anxiety disorders, comorbid psychiatric illness, and HIV infection (15). Symptomatic psychiatric illness is a major risk factor for HAART nonadherence in persons infected with HIV. Our team's rationale for creating this syllabus was a direct response to the needs of the Center for AIDS Research, Education and Services (Drew CARES) of Charles Drew University of Medicine and Science in Los Angeles. Drew CARES' Associate director, Phil Meyer, made contact with the AIDS Psychiatry Special Interest Group of the Academy of Psychosomatic Medicine, requesting consultation on treatment issues pertaining to survivors of trauma. While it is ideal that treatment centers serving HIV positive persons possess a wide range of comprehensive mental health services, there are many centers that cannot access a psychiatrist with expertise in treating persons with HIV and AIDS. Our intent in creating this syllabus was to provide continuing education to the mental health professionals at Drew CARES with the goal of enhancing the staff's ability to integrate the assessment of early childhood trauma and PTSD into routine historytaking, understand and interpret signs and symptoms of trauma sequelae, and diagnose PTSD. Though a curriculum could never be a substitute for psychiatric consultation and treatment, we hoped to be able to use this educational model as a means of enhancing clinical knowledge for staff at other treatment centers with similar needs and limited access to psychiatric consultation. In this symposium, we will describe the process of collaboration to develop the curriculum as well as the complexity of diagnosis of anxietyspectrum disorders and sequelae of childhood trauma in a community setting providing treatment to an HIV positive population. The emphasis here will be on integrating knowledge of comorbidities and life history of the individual patient into a biopsychosocial approach to assessment and treatment of the patient, including methods of screening specifically for PTSD.

S0652.

PSYCHODYNAMICS OF TRAUMA, PTSD, AND

NONADHERENCE TO MEDICAL CARE IN PERSONS WITH HIV AND AIDS

Presenter: Mary Ann Cohen, M.D.

SUMMARY:

The psychodynamics of nonadherence to medical care in persons who have experienced trauma are complex and multifactorial. We have described associations of childhood trauma, posttraumatic stress disorder and nonadherence with risk reduction and medical care in persons with HIV (15). Adherence to medical care in all severe and complex medical illness has significant implications for patients, families, and caregivers. Nonadherence results in pain, suffering, complications, and increased morbidity and mortality as well as frustration for caregivers. In persons with HIV and AIDS, nonadherence to risk reduction and medical care also has serious public health implications. When clinicians at an HIV clinic observed that many patients who were not adhering to care had a history of trauma, they requested help in finding a way to treat trauma and improve adherence to care. Phil Meyer, LCSW, Associate Director of the Center for AIDS Research, Education and Services (Drew CARES) of Charles Drew University of Medicine and Science in Los Angeles requested help in addressing this dilemma in adherence to HIV care. His request led me develop an inservice training program for his clinic. The program that we developed was based on the premise that childhood or later trauma leading to posttraumatic stress disorder is associated with multifactorial reasons for nonadherence. These include difficulty with trust, low self-esteem, difficulty caring for the self and body, high levels of anxiety and depression, and a sense of a foreshortened future. For HIV clinicians to help their patients adhere to care they need to understand the psychodynamics of posttraumatic stress disorder due to childhood and other trauma. In this symposium we describe how we tailored our training program to meet the needs of HIV clinicians and their patients. The training program was designed to help clinicians to take a trauma history, assess for posttraumatic stress disorder, and develop an understanding of the psychodynamics of posttraumatic stress disorder and its treatment. This symposium will familiarize participants with the training program as well as its impact on clinicians and patients.

S065-3.

OUR PATIENTS WITH TRAUMA ARE NONADHERENT TO MEDICAL CARE: AN INNOVATIVE APPROACH TO EDUCATION IN AN AIDS CLINIC

Presenter: Maria TiamsonKassab, M.D.

SUMMARY:

In this symposium, I will discuss the implementation of the threepart curriculum. This curriculum was comprised of the following: 1. Taking the trauma history and the relationship of trauma and PTSD to HIV 2. PTSD diagnosis and management 3. Case presentation and consultation I will elaborate on the different treatment modalities used in the management of PTSD with particular emphasis on HIV patients with trauma and adherence to medical care. My experience with the program participants who were all working in different HIV agencies in the metro Los Angeles area using the interactive format will also be described. The objectives of this curriculum were for the participants to understand the process of implementing an innovative approach to education of HIV clinicians, the treatment issues involved in the management of the HIV patient with trauma, and to determine the impact of this curriculum on HIV clinician practice.

S065-4.

RESULTS AND OUTCOMES OF A TRAUMA, PTSD, AND HIV TRAINING PROGRAM

Presenter: Phil Meyer, L.C.S.W.

SUMMARY:

In a recent needs assessment conducted by the Pacific AIDS Education Training Center (PAETC), the Medical Director of a large HIV Clinic serving minority patients in South Los Angeles stated that the single largest barrier to medication adherence among his patients was untreated trauma. In this same needs assessment, master's level mental health clinicians in Los Angeles identified trauma treatment as one of their top three training needs. In an effort to address this situation, the PAETC at Charles Drew University engaged Mary Ann Cohen and her colleagues to develop a curriculum focusing on HIV and PTSD. As the Associate Director of the PAETC, and the person who initiated this project, I will provide a brief background of the process that lead to the development of the curriculum, including data from the needs assessment that inspired it. Results from an electronic pre/post test integrated into the curriculum slide set will be presented, along with the outcomes of the participant evaluations.

SYMPOSIUM 066

COMPLICATED GRIEF AND DSM5: A STRESSRESPONSE SYNDROME

Co-Chairs: Naomi M. Simon, M.D., M.Sc., Charles Reynolds, M.D.

Discussant: Matthew J. Friedman, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize and address acute grief as well as early symptoms of Complicated Grief, 2) Describe current screening, assessment, and diagnostic considerations for complicated grief, 3) Explain rates of comorbidity and symptom overlap between Complicated Grief and closely related disorders (i.e. Major Depressive Disorder, Post-traumatic Stress Disorder) as well as the independence of Complicated Grief as a diagnosis, 4) Distinguish differences in the presentation and treatment response of individuals with complicated grief bereaved by suicide

SUMMARY:

This symposium will examine current thinking and relevant data supporting the inclusion of complicated grief in DSM5. Removal of the bereavement exclusion for the diagnosis of depression has been controversial due to concern that normal grief not be pathologized. By contrast, the clinical syndrome of complicated grief (CG) represents an inordinate prolongation of acute grief such that the normal response becomes chronic and debilitating. CG can be reliably identified, different from other mood and anxiety disorders, and is associated with substantial distress and impairment, including a high risk for suicidal ideation and behavior. The death of a loved one is a uniquely challenging life experience, one of the most difficult a person can face, yet most people find a way to come to terms with the loss and restore a sense of meaning and purpose in their own lives. Those who don't do so need treatment. Clinicians need to be able to understand, recognize and treat complicated grief. This symposium will present an update of key findings related to CG and its treatment, including new data from ongoing treatment studies. Topics discussed include 1) a proposal for revision of the Bereavement V Code to help clinicians recognize and support normal acute grief and prevent the development of complicated grief (Dr M Katherine Shear), 2) an overview of the rationale for including CG in DSM5 and a discussion of the impact on clinical practice (Dr Charles Reynolds), 3) a review of what we know about the differential diagnosis of complicated grief, its presentation and common comorbid diagnoses (Dr Naomi Simon), and 4) a summary of what is known about CG and suicide (Dr Sidney Zisook). Drs. Matthew Friedman, Chair of the DSM5 subworkgroup that has proposed inclusion of CG as an adjustment disorder, and Paula Clayton, Medical Director of the American Foundation for Suicide Prevention and a pioneer in bereavement research, will serve as discussants.

S066-1.

THE BEREAVEMENT VCODE AS AN AID TO PREVENTION OF COMPLICATED GRIEF

Presenter: M. Katherine Shear, M.D.

SUMMARY:

On average 59 million people die every year around the world. Loved ones left behind typically experience an acute grief response with physical as well as psychological symptoms. Attachment relationships anchor the lives of most people, and losing a loved one has profound and far-reaching effects. Attachment loss is different from other life events in that social expectations for grief are often ritualized. Though rituals vary across cultures, intense sadness and disruption of daily life activities is expected and socially sanctioned. Rituals foster a natural healing process after attachment loss and most people adjust adaptively. Although the pain and disruption of acute grief is often as intense as that seen with a mental disorder, natural healing is not typical of mental disorders, nor is ritualized social support. On the other hand, many people are confused and unsettled by acute grief and many seek professional advice. They worry about whether their grief is healthy, and seek information and advice about what to expect and what to do to heal most effectively. This kind of consultation is appropriately coded under the Bereavement V code. However, information in DSMIV V62.82 focuses only on distinguishing normal grief from depression, and this differential diagnosis is not the only problem clinicians face when consulted by a bereaved person. There is natural awkwardness talking with bereaved people whose heart's desire is reunion with a person who has died, as we are uncertain about how to be comforting. Clinicians need to know how to help. They need to understand what acute grief looks like and how best to monitor progress. This presentation provides a framework for thinking about bereavement, grief and mourning and a proposal for revising the Bereavement V code in DSM 5, including suggestions for 1) ways to explain acute grief to bereaved patients and optimize support for mourning, 2) how and when to diagnose and treat cooccurring disorders during a period of acute grief, and 3) how to monitor and alleviate symptoms that may be harbingers of complicated grief.

S066-2.

ASSESSMENT AND DIAGNOSIS OF COMPLICATED GRIEF

Presenter: Charles Reynolds, M.D.

SUMMARY:

The proposed diagnosis, Complicated Grief, (CG) refers to the prolongation, beyond six months, of the symptoms, distress, and impairment of acute grief, such that the bereaved person fails to progress towards integrated grief. About 10% of those with attachment bereavements experience CG, often in relation to a person with whom there had been a deeply positive, loving relationship. The 'complica-

tions' burdening such patients include ruminations about the circumstances or consequences of the death, avoidance of reminders of the deceased and/or compulsive proximity seeking, ineffective emotion regulation (e.g., excessive anger, guilt, anxiety, insufficient positive emotions), and disturbances in sleepwake cycle and other neurovegetative functions. Other symptoms include preoccupation with thoughts of the deceased, persistent yearning and longing for the deceased, prolonged intense sadness, and failure to reengage in activities or relationships. Suffering is immense and protracted, typically lasting for years before a decision to seek treatment. Conventional treatments for depression and anxiety have had limited impact on the suffering of most patients because such treatments do not address the complications of grief that has gotten 'off track' nor support the natural healing process. CG can be understood fundamentally as the absence of healing, the absence of a return to health and well being in the wake of bereavement. It is this clinical phenotype that is captured by the proposed diagnosis of CG. These are extraordinarily complex patients with profound illness and high levels of suicidality, whose treatment is often inadequate. Thus, recognition of complicated grief in DSM5 is important to ensure appropriate clinical care. Therefore, the goals of this presentation are (1) to discuss stateoftheart methods of screening, assessment, and diagnosis; and (2) to offer perspectives on the nosologic issues under review at DSM5 (e.g., duration of symptoms needed to qualify for diagnosis; classification as an adjustment rather than as a stress disorder). Consistent with the DSM5 emphasis on measurementbased care, this presentation will describe screening for CG (via the Brief Grief Questionnaire), measuring its intensity (via the Inventory for Complicated Grief), and diagnosing the syndrome (via proposed, published criteria being tested in a NIMHsponsored multisite randomized clinical trial).

S066-3.

COMPLICATED GRIEF: DIFFERENTIAL DIAGNOSIS AND COMORBIDITY

Presenter: Naomi M. Simon, M.D., M.Sc.

SUMMARY:

Complicated Grief (CG), variously called prolonged, traumatic or pathological grief, is a debilitating syndrome that is being considered for inclusion in the DSM nomenclature. CG has been described as an inordinate prolongation of acute grief due to complicating cognitive, behavioral, and social/environmental factors. CG symptoms include intense yearning and longing for the deceased, difficulty accepting the death, frequent intrusive thoughts of the loved one, anger and/or bitterness regarding the death, recurring pangs of painful emotions, and avoidance related to reminders of the loss. One issue that remains under debate is whether

this condition can be clearly distinguished from other stress related psychiatric conditions, such as major depression and posttraumatic stress disorder, how commonly CG coexists with mood and anxiety disorders, and its additive effects on severity and quality of life. The goals of this symposia will thus be to 1) understand the overlap and differences between symptoms of CG, depression and posttraumatic stress disorder (PTSD), 2) present data from structured clinical interviews in a treatment seeking sample with CG demonstrating rates of comorbidity and independence of CG as a diagnosis, 3) present rates and additive clinical impact of CG comorbidity in three different primary diagnostic cohorts: bipolar disorder, major depressive disorder, and anxiety disorders (including generalized anxiety disorder, panic disorder and PTSD). While definitive criteria for CG as a potential new diagnosis in DSM5 remain under active consideration, available data suggest that CG can be clearly distinguished from mood and anxiety disorders, occurs both independently and comorbidly, and that threshold CG symptoms are of clinical relevance even in the face of a primary mood or anxiety disorder, adding to impairments in function and quality of life in bereaved individuals.

S066-4.

SUICIDE LOSS SURVIVORS AND COMPLICATED GRIEF

Presenter: Sidney Zisook, M.D.

SUMMARY:

Suicide is one of the top 20 causes of death globally for all ages. It has been estimated that for every person who dies by suicide, 68 loved ones are left behind. More often than not, survivors are left to deal with a myriad of unanswered questions and painful emotions. This presentation reviews pertinent literature on the experiences of suicide survivors with the goal of answering the following vexing and important questions: 1) is the grief of suicide survivors fundamentally different and more severe than of other (nonsuicide) bereaved individuals? and 2) does a focused type of treatment developed for bereaved individuals with complicated grief apply equally well to suicide survivors? Under any circumstances, bereavement can be one of life's most painful experiences, but especially so after suicide, one of the most difficult ways for bereavement to occur. Yet, it is not clear that suicide survivors are at greater risk than other bereaved individuals for postbereavement depression or PTSD, and some, but not all, studies have found that suicide survivors may be at elevated risk for Complicated Grief (CG), a chronic and persistent condition associated with negative health and mental health outcomes. On the other hand, suicide survivors do have several relatively unique obstacles to overcome: They often feel plagued by a myriad of unanswered questions and may be painfully ostracized

from their community; they are often beset with selfblame, a sense of guilt or responsibility for the death, and feelings of rejection by the deceased; and many suicide survivors also experience social stigma and shame, not experienced to the same degree by other mourners, which might further complicate their grief response. Despite the intense and prolonged difficulties suicide survivors face, there is a paucity of empirically based treatments to offer, including for those with CG. The state of our knowledge about how, when, and with whom to intervene after a suicide is still quite primitive, suggesting a pressing need for further research in this important area. We are currently trying to respond to that need by including at least 40 suicide bereaved participants in an ongoing 4site study of antideepreants and complicated grief therapy (CGT) in bereaved individuals with CG who will receive clinical management and be randomized to also receive 1 of 4 treatments: 1) citalopram or 2) placebo medication or 3) CGT + citalopram or 4) CGT + placebo medication.

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SYMPOSIUM 067

UPDATES ON SCREENING AND TREATMENT OF THE PSYCHOLOGICAL EFFECTS OF THE WARS IN IRAQ AND AFGHANISTAN

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Discussant: Christopher H Warner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the clinical presentation of Soldiers and other service members returning from the wars in the Middle East, 2) Know newest methods of screening and treatment for those service members and their Families, 3) Understand barriers to care, both in theater and at home, and how to overcome those barriers

SUMMARY:

In the early years of the wars in Afghanistan and Iraq, unanticipated and extended deployments were extremely taxing for military families. The murders and murder/suicides at Ft Bragg in 1992 highlighted the perils of rapid return from the battlefields in Afghanistan to civilian life. The investigation at Ft Bragg and other installations revealed continuing problems with access to care, as well as the reluctance of career minded Soldiers to seek treatment. In response to those and other events, training and systems were put into place to prepare Soldiers for redeployment. One of the earlier trainings, Battlemind, was designed to help reintegrate service members and families. It recently evolved into the Comprehensive Soldier Fitness program, which is focused on enhancing resiliency. Many Soldiers are reluctant to

engage in care for numerous reasons, including worry about effects on their career. Often their families are the ones who try to get them to seek treatment. To try to reach all service members, behavioral health has added many new systems of evaluation and care. The Post Deployment Health Assessment (PDHA), which screens Soldiers on return from theater, was implemented after the first Gulf War. However Soldiers often did not admit to symptoms as they were returning home, since they just wanted to get there, as fast as possible. Beginning in 2005 the PDHA was joined by the PostDeployment Health ReAssessment, done at three to six months after return. It was designed to connect with service members after "the honeymoon was over". In order to improve access to care, the Army and other Services have dramatically increased their number of mental health providers, up about 70% between 2007 and 2010. Stigma, however, is a persistent problem, despite numerous efforts to reduce it. A tremendous amount of money has been poured into Family programs. There are specialized programs at Walter Reed and other facilities for the families of the wounded. They seek to prepare children for seeing their father or mother missing a limb, or disfigured from a blast. Another tough area has been support to families of the deceased. In the past, spouses and children had to leave their base housing and support systems relatively soon after their loved one's death. Again this has improved over time, with longer access to housing and health care. Organizations such as TAPS have been invaluable in providing support. The rising suicide rate has been a major concern for all in the Army. The combination of unit and individual risk factors include: the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. There are consistent and high profile attempts to reduce suicide with numerous trainings for service members, focusing on buddy aid and gatekeepers. However so far the efforts have only been partially successful.

S067-1.

SCREENING AND INTERVENTION

Presenter: John C. Bradley, M.D.

SUMMARY:

In the early years of the wars in Afghanistan and Iraq, unanticipated and extended deployments were extremely taxing for military families. 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. In response to those and other events, training and systems were put into place to prepare soldiers for redeployment. One of the earlier trainings, Battlemind, was designed to

help reintegrate service members and families. It evolved into the Comprehensive Soldier Fitness Program, which is focused on enhancing resiliency. To try to reach all service members, behavioral health has added many new systems of evaluation and care. The Post Deployment Health Assessment (PDHA), which screens soldiers on return from theater, was implemented after the first Gulf War. However soldiers often did not admit to symptoms as they were returning home, since they just wanted to get there, as fast as possible. Beginning in 2005 the PDHA was joined by the PostDeployment Health Reassessment, done at three to six months after return. It was designed to connect with service members after “the honeymoon was over”. In order to improve access to care, the Army and other Services have dramatically increased their number of mental health providers, up about 70% between 2007 and 2010. Stigma, however, is a persistent problem. There are specialized programs at Walter Reed and other facilities for the families of the wounded. They seek to prepare children for seeing their father or mother missing a limb, or disfigured from a blast. The rising suicide rate has been a major concern for all in the Army. The combination of unit and individual risk factors include: the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability, alcohol, and easy access to weapons. There are consistent and high profile attempts to reduce suicide with numerous trainings for service members, focusing on buddy aid and gatekeepers. However so far the efforts have only been partially successful. The prolonged effects of exposure to violence and death are not easy to change. Ongoing efforts include: The Defense Center of Excellence; the Comprehensive Behavioral Health Campaign Plan; the DoDVA Integrated Mental Health Plan; the Army and DoD Sui

S067-2.

PROVIDING PSYCHIATRIC TREATMENT IN WAR ZONES: PERSPECTIVES FROM A COMBAT STRESS CONTROL PSYCHIATRIST IN IRAQ AND AFGHANISTAN

Presenter: Jerald J. Block, M.D.

SUMMARY:

An Army Reserve psychiatrist will discuss his observations of battlefield psychiatric treatment in both Iraq (200910) and Afghanistan (201112). Meeting participants will be introduced to the role of the Combat Stress Control (CSC) units, the delivery of mental health care in war, and the differences observed between civilian and military psychiatry.

S067-3.

THE PACIFIC PSYCHOLOGICAL HEALTH TASK

FORCE: BUILDING PARTNERSHIPS TO ENHANCE PSYCHOLOGICAL HEALTH CARE IN THE PACIFIC REGION

Presenter: Carroll J. Diebold, M.D.

SUMMARY:

The Pacific Region encompasses a vast area vital to the preservation of our Nation’s security. This region has thousands of Active Duty Service Members, Reservists, National Guard, Veterans, and their dependents, many of whom are located in areas of limited healthcare infrastructure, to include psychological health services. In addition, many of these service members have deployed in support of combat operations in the Middle East. This presentation will provide an overview of the origin of the Pacific Psychological Task Force (established in 2008) to include the unique challenges of behavioral healthcare delivery in the Pacific Region via a collaborative effort via assets from the Active Component Army, Navy, and Air Force; Veterans Administration; Army National Guard and Reserve; TRICARE Contractor; Hawaii Community Health Centers; and independent behavioral healthcare organizations. Over the past four years, such collaboration has produced enhanced behavioral health screening, assessment, and treatment of service members; telehealth services to remote locations; School Mental Health Services on military installations; treatment programs available to both veterans and active duty; managed care contractor sponsored services; and continuity of treatment between the Active Component healthcare system, Veterans Administration, TRICARE contractor, and the private sector.

S067-4.

PHARMACOTHERAPY FOR PTSD

Presenter: David M. Benedek, M.D.

SUMMARY:

The APA’s Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder was published in October 2004. As with most published practice guidelines, it supported the use of pharmacologic agents—particularly SSRIs—for the treatment of PTSD(1). In response to increased attention on U.S. military veterans returning from combat in Iraq and Afghanistan, the Institute of Medicine also reviewed and summarized the evidence supporting treatment for PTSD. Their 2007 report concluded that existing evidence was sufficient only to establish the efficacy of exposurebased psychotherapies in the treatment of PTSD. However, the report included a dissenting opinion by one author about the strength of the evidence for pharmacotherapy. Recent studies bolster support

for pharmacological intervention in many circumstances, but randomized controlled trials have called into question the efficacy of SSRIs for the treatment of PTSD in combat veterans (2). Emerging evidence suggests the potential for psychotherapy to be facilitated by at least one recently identified pharmacological agent (d-cycloserine). Other recent studies and guidelines suggest that in certain patient populations new pharmacological options, such as prazosin may, in some circumstances, be more effective than other widely prescribed medications indicated for PTSD. Increased understanding of the neuromolecular basis for the stress response points to the possibility that new agents with other mechanisms of action may also be helpful, but efficacy has been established in clinical trials. References (1) American Psychiatric Association: Practice Guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *Am J Psychiatry* 2004; 161 (11 suppl): 131 (2)Benedek DM, Friedman MJ, Zatzick D, and Ursano RJ. Guideline Watch: Practice Guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder, *Focus*, 2009 Vol. VII, No. 2, 20413.

S067-5.

BUILDING COMMUNITY DEPLOYMENT MENTAL HEALTH COMPETENCE AND CAPACITY THROUGH DOD/VA/STATE AND COMMUNITY PARTNERSHIPS

Presenter: Harold Kudler, M.D.

SUMMARY:

Although many may assume that deployment-related mental health issues faced by Service Members/Veterans and their families would be reliably identified and dealt with within the Department of Defense (DoD)/Department of Veterans Affairs (VA) continuum of care, national data demonstrates that, ten years after the start of America's military operations in Afghanistan (Operation Enduring Freedom/OEF) and Iraq (Operation Iraqi Freedom/OIF), only half of all OEF/OIF veterans eligible for VA care have presented to VA. Of note, over half of these have at least one working mental health diagnosis. Even among those Veterans who have presented to VA, an estimated 50% seek part of their care in the community. This means that up to 75% of all OEF/OIF Veterans (and virtually all of their family members) are seeking help for deployment-related mental health care needs within the community. The question is: Are community providers and systems prepared to effectively screen, engage, assess and treat deployment-related mental health problems? This presentation will describe DoD/VA/State and Community partnerships designed to improve access to care and quality of care for Military/Veteran populations and their families. It will offer best practice models and findings from a recent Community Provider Question-

naire focused on what community providers (mental health and primary care) believe that they already know about this population, their level of confidence in working with these patients, and their learning needs and preferences. This presentation and the discussion which follows will consider next steps in engaging, training and coordinating the efforts of community providers with those of DoD and VA to optimize deployment mental health efforts in these and future operations.

S067-6.

PSYCHOLOGICAL EFFECTS OF THE LONG WAR STRATEGIES FOR MITIGATION

Presenter: Elspeth C. Ritchie, M.D., M.P.H.

SUMMARY:

Ten years of war and repeated deployments have led to both physical and psychological wounds. This talk will discuss both old and new challenges, including suicide, Post-Traumatic Stress Disorder, traumatic brain injury, and pain management. While an array of behavioral health services has long been available to address the strain on our soldiers and families, these services are clearly strained. There are numerous initiatives to provide outreach, education and training, including Combat and Operational Stress Control, Operational Stress Control and Readiness (OSCAR), RESPECTMIL, the Defense Center of Excellence (DCoE) and the National Intrepid Center of Excellence. Chaplains, Military One Source, and Army Community Service also offer support. There are also multiple new intervention strategies, which have met with mixed success. These include increased mental health screening, case management, policies to improve pain management and decrease polypharmacy, increased cooperation between the VA and the DoD, and telemedicine. Nonetheless the suicide rate remains high and violence related to combat challenges us all. Civilian providers are essential to taking care of soldiers and veterans. There continue to be major challenges that will face our service members, their families and the nation.

SYMPOSIUM 068

INTEGRATED TREATMENT OF EATING DISORDERS: WHAT TO ASK AND WHAT TO DO

Chair: Joanna E. Steinglass, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Assess and diagnose eating disorders, including anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified, 2) Incorporate current research findings about eating behavior into a psychiatric assessment, 3)

Describe evidence based treatments for eating disorders and novel approaches, 4) incorporate cultural factors into the assessment and treatment of eating disorders

SUMMARY:

Mental health professionals commonly encounter patients with eating disorders. Eating disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder affect approximately 5% of the general population, with higher rates seen among clinical samples. The complexity and high degree of risk associated with eating disorders leave many clinicians uncomfortable with the clinical management of these patients. This symposium will focus on the evaluation and management of patients with eating disorders. Using research findings, the speakers will describe assessment and treatment techniques likely to improve care. Dr. Evelyn Attia will discuss the evaluation process, including how to engage the patient in treatment decisions; Dr. Laurel Mayer will extend the discussion of clinical assessment, presenting results from eating behavior studies that predict clinical outcome; Dr. Joanna Steinglass will review evidencebased treatments for eating disorders, including novel approaches such as an adapted exposure therapy/response prevention intervention for anorexia nervosa; Dr. Kathleen Pike will discuss the prevalence and expression of eating disorders from a global perspective and will explore cultural influences that impact risk and presentation.

S068-1.

WHEN A PATIENT IS IN YOUR OFFICE: INITIAL ASSESSMENT AND MANAGEMENT OF EATING DISORDERS

Presenter: Evelyn Attia, M.D.

SUMMARY:

Eating Disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder, present with behavioral and physiological disturbances that can be medically serious, even lifethreatening. Patients with eating disorders may be reluctant to discuss some or all of their symptoms with clinicians, and may not present for help for their eating disorder until years after illness onset. Also, as eating disorders often cooccur with other psychiatric illnesses such as depression and anxiety disorders, proper identification of eating disorders may be challenging. This presentation will review methods for the evaluation and diagnosis of eating disorders including a discussion of severity assessment. Procedures around initial management and triage will be presented. An overview of behavioral management of eating disorders across various integrated levels of care will be described.

S0682.EATING IN EATING DISORDERS: WHAT IS IMPORTANT?

Presenter: Laurel Mayer, M.D.

SUMMARY:

Anorexia Nervosa (AN) is a psychiatric illness characterized by low weight, intense fear of gaining weight, and fear of fat. As core symptoms of this illness, these fears lead to significant dietary restriction and weight loss. Eating behavior paradigms have consistently demonstrated that patients with eating disorders can engage in pathological eating behavior in the laboratory setting. Eating behavior studies can thus be used successfully to investigate clinical assumptions. This presentation will review the recent findings on eating behavior and its role in illness maintenance and the prediction of relapse in AN, and identify potential targets for treatment intervention.

S068-3.

CBT AND BEYOND: NEW TREATMENTS FOR EATING DISORDERS

Presenter: Joanna E. Steinglass, M.D.

SUMMARY:

Treatment of eating disorders, across diagnoses, emphasizes engaging patients in both developing healthy eating patterns and grappling with overconcern with shape and weight. Specifics of treatment differ between disorders, due to different findings in clinical trials. In the treatment of bulimia nervosa (BN), cognitive behavior therapy (CBT) has significant evidencebased support. Basic principles of CBT for BN that can be integrated into clinical management will be described. Additional psychotherapy and psychopharmacologic management strategies with empiric support will be present. In treatment of anorexia nervosa (AN), behavioral therapy is instrumental in the acute treatment. The evidence for CBT will be presented, along with the incorporation of motivational techniques necessary in the engagement of individuals with AN. Current treatments for AN are often disappointing. Promising findings come from two new approaches: an adaptation of CBT using exposure and response prevention, and olanzapine for the acute treatment of AN.

S068-4.

LOST IN TRANSLATION: INTEGRATING CULTURE IN EATING DISORDERS

Presenter: Kathleen M. Pike, Ph.D.

SUMMARY:

Eating disorders were once thought to reside only among women within the middle and upper middle classes of western cultures. However, as the field has evolved and as clinical research on eating disorders expands around the globe, it is evident that no gender, social group, culture or socioeconomic class has a monopoly on eating disorders. It is nonetheless the case that important sociocultural factors contribute to the rise of eating disorders, with different rates of risk and important variants in expression of eating disorders reported in different cultural contexts. This talk will describe the distribution of eating disorders around the globe and explore the ways in which culture impacts both the incidence and expression of eating disorders. In this context, I will discuss different cultural groups within the United States, with particular focus on eating disorders among certain minority groups, including Native Americans, black Americans and Hispanic Americans. By highlighting patterns that have been described in communities as diverse as Fiji, Japan, Hong Kong and Curacao, I will highlight the role of culture in the emergence and expression of eating disorders and ways in which culture impacts both access to treatment and treatment delivery.

SYMPOSIUM 069

INTEGRATED APPROACHES TO THE CARE OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Co-Chairs: Andrew E. Skodol, M.D., Harold W. Koenigsberg, M.D.

Discussant: Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand key phenomenology of borderline personality disorder from both biological and psychological perspectives, 2) Recognize the prognostic importance of diagnosing comorbid borderline personality disorder in patients with Axis I disorders, 3) Appreciate the appropriate roles of psychotherapy and pharmacotherapy in the treatment of borderline personality disorder, 4) Learn a model for the successful collaboration between different providers of treatment of patients with borderline personality disorder, and 5) Understand how recent research on the course and treatment of borderline personality disorder suggest prescriptive indications for patient-treatment matching

SUMMARY:

Complex mental disorders are challenging to understand, to diagnose, and to treat. Consequently, myriad theories of etiology, hypothesized pathophysiological mechanisms, and practical approaches to the clinical care of patients with

these disorders have emerged over time and compete today for a clinician's interest and loyalty. Few disorders have engendered as much recent debate and controversy about their nature and treatment as has borderline personality disorder (BPD), about which the clinical and research literature has exponentially increased since its introduction as an official personality disorder category in DSM-III. While competing approaches engender healthy advances in knowledge, at the same time, debates can become ideological and foster rigidity in thinking and practice, which might impede progress toward better care of borderline patients. In this symposium, diverse perspectives on the nature, assessment, and treatment of BPD will be discussed with the goal of providing an integrated approach to understanding, diagnosis, and care. Topics will include 1) neural and interpersonal mechanisms of emotional regulation in BPD; 2) the impact of BPD on the clinical course of multiple Axis I disorders and the implications for comprehensive assessment and diagnosis; 3) appropriate uses of psychotherapy and psychopharmacology in the treatment of BPD as represented by the APA's Practice Guidelines for BPD; 4) a model for the successful collaboration between multiple different providers of care in the treatment of BPD; and 5) recent evidence to support prescriptive indications for patient-treatment matching and evidence-based guidelines for integrated care. The goal is to inform clinicians that competing theories and treatment approaches can each have clinical utility, and rather than adopting a narrow or singular perspective, an integrative approach is more likely to result in better understanding and clinical care.

S069-1.

AFFECTIVE INSTABILITY: TOWARD AN INTEGRATION OF NEUROSCIENCE AND PSYCHOLOGICAL PERSPECTIVES

Presenter: Harold W. Koenigsberg, M.D.

SUMMARY:

Affective instability, a hallmark feature of borderline personality disorder (BPD), is associated with the intense affect storms, interpersonal reactivity, impulsivity, identity disturbance and suicidality which characterize BPD. Phenomenologically, affective instability in BPD has a number of components: 1) hyperreactivity to evocative psychosocial cues, 2) increased intensity of affective response, 3) slow return to affective baseline, and 4) rapid shifts from one affective state to another. Understanding the mechanisms underlying borderline affective instability is central to understanding BPD and to developing new treatment strategies. Affective experience bridges neurobiological and psychological domains. Recent neuroimaging work has demonstrated anomalous patterns of neural activity as borderline patients process and attempt to regulate emotion and when they

engage in emotionally charged 2person interactive tasks. BPD patients show increased amygdala, fusiform and occipital activity when viewing faces and emotional social scenes. They appear to show neural sensitization rather than habituation to repeated emotional stimuli and to inadequately engage the anterior cingulate and intraparietal sulci when attempting voluntary cognitive emotion regulation. In addition to employing singleperson cognitive strategies, emotion can be regulated by means of social interactions. Borderline patients may engage in particular stereotyped interpersonal patterns in attempts to control their emotional states. Unfortunately, these patterns often have maladaptive consequences. The emotional experience of BPD patients is shaped by a complex interplay between underlying neural processing and socialcognitive mechanisms. Interpersonal interactions begin to shape emotion regulatory strategies in the infantcaregiver relationship and continue to have a formative influence throughout childhood into adolescence and adulthood. These effects map into corresponding alterations in neural emotion processing networks. Conversely, functional properties of the emotional networks in the brain will influence patterns of relating to the caregiver and significant others in the course of development. Thus, aberrant underlying emotional networks may predispose to the development of maladaptive relationship patterns and self and otherrepresentations. This presentation will review neural and interpersonal mechanisms of emotion regulation in BPD to begin to develop integrative model

S069-2.

BPD ADVERSELY AFFECTS THE COURSE OF AXIS I DISORDERS: AN INTEGRATED PERSPECTIVE ON ASSESSMENT AND PROGNOSIS

Presenter: Andrew E. Skodol, M.D.

SUMMARY:

Borderline and other personality disorders have been diagnosed on a separate axis from all other mental disorders (except mental retardation) since DSMIII. Although the rationale for Axis II has changed over successive editions of the DSM, most recently in DSMIV the rationale is to ensure “that consideration will be given to the possible presence of Personality Disorders...that might otherwise be overlooked when attention is directed to the usually more florid Axis I disorders.” How often clinicians assess patients for and diagnose personality disorders in routine practice, as opposed to listing “diagnosis deferred,” is not clear. But, if clinicians are expected to diagnose comorbid personality disorders in a patient with another type of mental disorder, they would be more motivated to do so if they understood that the effort had clinical utility. One way in which a diagnosis has been said to possess utility is if it provides “nontrivial information about prognosis and treatment outcome,” i.e., “infor-

mation about the likelihood of future recovery, relapse, (and) deterioration...” In this presentation, data from two largescale longitudinal studies – one from a clinical population and one from the general community – will be presented on the adverse effects of comorbid borderline personality disorder (BPD) on the course of major depressive disorder (MDD), alcohol and drug use disorders, and several different anxiety disorders over time. The studies are the Collaborative Longitudinal Personality Disorders Study (CLPS) and the National Epidemiological Study of Alcohol and Related Conditions (NESARC). In the CLPS, BPD slowed time to recovery from MDD and hastened time to relapse over 6 years of followup. BPD also increased the likelihood of new onsets of alcohol and drug use disorders and of relapse of OCD and new onsets of GAD and panic disorder with agoraphobia over seven years. In the NESARC, BPD was a robust predictor of persistence of MDD over three years, with the effects of demographics, Axis I comorbidity, other personality disorders, family and treatment history, and other risk factors for persistence statistically controlled. Similarly, BPD was significantly associated with the persistence of alcohol, cannabis, nicotine, and other drug use disorders in the NESARC followup. Finally in the NESARC, BPD was associated with new onsets of GAD, panic disorder, social phobia, and specific phobia, and with persistence of panic disorder and social phobias.

S069-3.

APA PRACTICE GUIDELINES FOR BPD: INTEGRATING PSYCHOTHERAPY AND PSYCHOPHARMACOLOGICAL MANAGEMENT

Presenter: John M. Oldham, M.D., M.S.

SUMMARY:

Borderline personality disorder (BPD) is a psychiatric disorder that has its onset early in life, leads to highrisk and lifethreatening behavior, involves extreme emotional distress and dysregulation, and often cooccurs with other major mental disorders. The course of the illness can be stormy, with repeated hospitalization and with significant impairment in functioning. Until relatively recently, treatment efforts were symptomtargeted, uneven, and unsystematic, with disappointing results. With the development of dialectical behavior therapy (DBT) and the publication of randomized controlled trials (RCTs) demonstrating the effectiveness of this treatment for patients with BPD, a new era of interest and research in this disorder evolved. Another form of psychotherapy, mentalizationbased therapy (MBT), was also shown in RCTs to produce substantial improvement in patients with BPD, gains that persisted for years after treatment completion. In 2001, an evidence-based Practice Guideline for the Treatment of Patients with Borderline Personality Disorder was published by the

American Psychiatric Association, recommending psychotherapy as the primary, or core, treatment for this condition, along with adjunctive, symptomtargeted pharmacotherapy. In ensuing years, RCTs have been published demonstrating the effectiveness of a number of other treatment approaches, including schemabased therapy, transferencefocused therapy (TFP), cognitive behavioral therapy (CBT), generalized psychiatric management (GPM), and systems training for emotional predictability and problem solving (STEPPS). In addition, although the core evidencebased treatment remains psychotherapy, recent studies suggest that medications (e.g., mood stabilizers, secondgeneration antipsychotics) can provide substantial symptom relief. No longer is BPD an illness shrouded by pessimism and a sense of hopelessness; instead, it is a condition for which there are many effective treatments. These advances in the treatment of BPD will be reviewed in this presentation.

S069-4.

COLLABORATIVE TREATMENT OF PATIENTS WITH BPD

Presenter: Kenneth R. Silk, M.D.

SUMMARY:

Patients with borderline personality disorder tend to view the world in extremes and tend to categorize people into good and bad. Further, patients with borderline personality disorder often are treated by more than one mental health provider. Many of the treatments that have been found to be effective in this patient group involve multiple modalities, particularly individual as well as group therapy, and usually these different therapeutic formats are not provided by the same person. If one adds to the mix an additional provider who is prescribing medications for the patient, then one can appreciate how complicated the situation can become and how disagreements, misunderstandings, and differing approaches to the patient can confound the treatment, especially in a patient population where clarity, consistency, structure, and validation are important elements to its success. Without good collaboration between the various people providing care to these patients, then that propensity of the patient to consider people at the extreme ends of the good/bad continuum can be exacerbated. It would appear that the wisest approach would be to have a formalized understanding as to how the various providers will collaborate among themselves to provide a coherent and integrated approach to the patient. While treatments such as Dialectical Behavior Therapy have aspects of the treatment (such as the consultation group) that will facilitate this collaboration and integration, in the real world because people work in private offices, in different health care systems, and with complicated busy schedules, the ability to confer, collaborate and integrate treatment is not an easy task. This presentation

will present a series of suggested considerations that should be arranged and established prior to seeing these patients that might provide an opportunity to provide a smoother and more coherent integrated approach to these patients. Mutual respect among the various providers as well as clarity as to who is to deal with particular crises and other aspects of the treatment not only can help prevent confusion and disagreement among the various providers, but also can provide the direction and structure that are very important to the patient and to treatment success. Kenneth R Silk, MD University of Michigan Health System Ann Arbor, MI 481092700 Schlesinger A, Silk KR: Collaborative treatment. In Oldham JM, Skodol AE, Bender DS (Eds). *The American Psychiatric Publis*

S069-5.

RECENT EMPIRICAL FINDINGS ON BPD AND THEIR IMPLICATIONS FOR INTEGRATED CARE

Presenter: Kenneth N. Levy, Ph.D.

SUMMARY:

Borderline personality disorder (BPD) is a highly prevalent, chronic and debilitating disorder characterized by emotional lability, impulsivity, interpersonal dysfunction, angry outburst, and suicidality. Recent studies suggest that BPD is more prevalent than schizophrenia, bipolar disorder, and autism combined. Historically, BPD has been thought to be difficult to treat with patients frequently not adhering to treatment recommendations, using services chaotically, and repeatedly dropping out of treatment. Many clinicians are intimidated by the prospect treating BPD patients and are pessimistic about the outcome of treatment. Therapists treating patients with BPD have displayed high levels of burnout and have been known to be prone to enactments and even engagement in iatrogenic behaviors. However, in recent years there has been a burgeoning empirical literature on the treatment of BPD. Beginning with Linehan's seminal randomized controlled trial (RCT) of Dialectical Behavior Therapy, there are now a range of treatments – deriving from both the cognitivebehavioral and psychodynamic traditions – that have shown efficacy in RCTs and are now available to clinicians. The results of these efficacy studies suggest important evidencebased principles. First, BPD is a treatable disorder. Second, because BPD is chronic, it requires longerterm treatments (all efficacious approaches conceptualize treatment as a multiyear process). Third, therapists have a range of options across a number of orientations available to them and it is premature to foreclose on any one of the available options that have been tested. Although there have been few direct comparisons, enough data now exists from RCTs and metaanalyses to suggest that no one approach is superior to another. Despite these findings, only about half the patients in treatment respond re-

ardless of treatment. Additionally, although many patients have shown symptomatic improvement and diagnostic remission, they still experienced significant social and functional impairment. Thus, a significant portion of individuals receiving an efficacious treatment are not improving, and these individuals might be better served in different treatments. Additionally, having different treatment options is important because – given the heterogeneity of BPD – it is unlikely that any one treatment will be useful for all patients. Epidemiological, experimental, metaanalytic, and treatment studies will be reviewed in or

TUESDAY, MAY 8, 2012

SYMPOSIUM 070

THE ROLE OF PSYCHIATRISTS IN THE PREVENTION OF VIOLENCE AT THE LEVEL OF NATIONS, COMMUNITIES, AND INDIVIDUALS

Co-Chairs: Sue Bailey, M.D., John M. Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) To look at the evidence of how mental health individuals, in particular psychiatrists, can play their full part in the prevention of violence as part of their involvement in public health, where without mental health there can be no public health, 2) To increase the knowledge of attendees about the impact at the level of countries, local communities and individuals of violence. The session will drill down from knowledge at a universal level to knowledge within individual countries, down to a specific project looking at how psychiatrists can work with all agencies to prevent the evolution of violence in young people in an urban city, 3) The session is aimed to stimulate the interest of psychiatrists in how they can play their part within their own local communities, to assist in the reduction of violence and the consequences this has on individuals

SUMMARY:

Violence and abuse has widespread and ongoing impacts on individual and population mental health and wellbeing, through both personal experience and fear of violence and abuse. A serial number of WHO reports have provided clear evidence of these negative impacts and their contributions, maintaining social and economic inequalities to people and communities throughout their life course. Large scale longitudinal studies show that early exposure to abuse can impact across a life course. Much violence exerts a hidden and unrecognised influence on health, wellbeing, and socioeconomic inequalities. More publicly visible forms of violence, such as youth violence, are widely reported and can create a disproportionate level of fear in the wider commu-

nity, that can reduce social interaction, trust and cohesion. The studies of the effects of violence and abuse report a myriad of negative impacts, including poor school achievement, increased antisocial behavior and health risktaking, poor mental health and wellbeing, short and long term adverse health outcomes, negative social impacts, worsening inequalities and discrimination, and a perpetuation of cycle of violence. More recently there has been an increasing interest in the impact of dating and sexual violence, and the impact of intimate partner and sexual violence, particularly sexual violence as it may occur within a gang culture. This well-established economic impact of violence and abuse is evident across various countries of the world. We have a clear understanding of the risk factors of violence, and how violence and inequalities are linked. Given we know the risk factors perpetrating violence and the association between mental disorder and risk of violence, the aim of this symposium will be to look at the impact of violence from a global and national perspective. It will drill down into how psychiatrists should properly play their part in the prevention of violence in local communities, working in innovative projects with other agencies, including the voluntary sector. And further, how such projects can be delivered in the diverse circumstances in which individuals live across the world, in the context of often limited workforce and financial resources.

S070-1.

VIOLENCE AND SCHIZOPHRENIA: THERAPEUTIC VARIATIONS AND DIFFERENT SOCIETAL INFLUENCES RESULT IN VARIABLE EXPRESSION BETWEEN THE U.S. AND OTHER COUNTRIES

Presenter: Peter F. Buckley, M.D.

SUMMARY:

The treatment of patients with schizophrenia who are aggressive is particularly challenging. Our capacity for accurate prediction of violent behavior itself a daunting task juxtaposes our responsibilities for societal risk alongside our responsibility to provide care for the patient who is/ could become violent. Additionally, there is the specter of local media exposure that more often than not misinforms the public about the relationship between violence and schizophrenia. Additionally, risk factors for violence among patients with schizophrenia are variably expressed and therapeutic options differ depending upon the configuration of regional services, prevailing treatment practices, and correctional influences. As an example, the issues of forced medication, hospitalization, and treatment with schizophrenia individuals is highly controversial and varies across countries. In England, lack of mental capacity – often itself accompanied by aggressive behavior – is a common reason for involuntary detention and it often also influences sub-

sequent hospital care. In Italy, the communitybased model has a high tolerance for disturbed behaviors and involuntary admissions account for only 13% of the total inpatient admissions (which are low anyway). In the U.S., violent behavior is one precipitant for involuntary hospitalization and potentially also forced medication treatment, although there is wide variation across states. This presentation will address the management of violence and schizophrenia in the USA and contrast this with other countries in order to tease out the interplay of societal tolerance, stigma, and clinical decision making in moderating the expression of violence among patients with schizophrenia in our communities.

S070-2.

PUBLIC MENTAL HEALTH AND VIOLENCE: LINKS, CHALLENGES, AND SOLUTIONS

Presenter: Dinesh Bhugra, M.B.B.S, Ph.D.

SUMMARY:

Exposure to violence directly and indirectly in its many guises can lead to some psychiatric disorders. Exposure to traumatic violent events can act as significant life events. On the other hand, many psychiatric disorders themselves can produce increased rates of violence to the self and to others. Violence can work at various levels and also has many forms, from simple aggressive stances to fullblown physical attacks. The challenges for psychiatrists in understanding violence and managing it at a broad community and public mental health level and at clinical level are many. From banning of guns to managing psychiatric disorders adequately can involve many strategies. Thus psychiatrists can play a role in public mental health and clinical matters. Violence towards the self also raises significant issues. Sexual violence, violence towards other vulnerable groups such as children, elderly or lesbian, gay and transgender individuals can add to violence levels. Gender roles, cultural factors, alcohol and substance abuse and personality factors all need to be considered in any assessment or intervention and in our understanding and management of acts of violence. Public health can provide a structure to our understanding of as well enabling clinicians to manage psychiatric patients who may be vulnerable to violence or are prone to acts of violence. There is considerable evidence in the literature to indicate that early interventions in childhood especially those presenting with conduct disorders directly or through parenting skills and family education can lead to a reduction in developing personality disorders. Public health interventions in this context show evidence that managing childhood disorders can improve the quality of life and reduce the risk of developing adult psychiatric disorders. Managing violent acts of selfharm and harm to others need a different set of clinical and strategic skills. Early interventions and adequate treatments and intervention can reduce

rates of violent attacks. Public mental health has become much more visible in the uk and can be used in other settings provided adequate resources are made available for this purpose.

S070-3.

BUILDING AN ALLIANCE FOR A SAFER FUTURE: A PUBLIC HEALTH APPROACH TO ADDRESSING VIOLENCE AND REDUCING HEALTH INEQUALITIES IN SCOTTISH SOCIETY

Presenter: Denise Coia, M.D.

SUMMARY:

Scotland has an unenviable international reputation as a violent country. A World Health organisation report on violence and health highlighted homicide rates in young men between 10 and 29 as 5.3 per 100,000. The equivalent rate in England and Wales is 1 per 100,000. On this very limited measure Scotland is one of the most violent countries in Western Europe. Violence has become “normalised” in certain communities. Typically, those with high levels of deprivation and different values and norms of what is, and what is not acceptable and tolerable. The cost to Scotland of violence and the inequalities that underlie it go beyond reputation and traditional costs (cost to Police services and the wider criminal justice system) which are considerable but the impact is much wider particularly in relation to health. Our health inequalities continue to get wider in Scotland. The death rate from assault in our most deprived communities is nearly 4 times the Scottish average and 10 times that of least deprived communities. This confirms that in relation to violence and its impact on your health, where you live matters. The Scottish Government has responded to the problem by using a public health model to understand and respond to violence. In April 2006 the Violence Reduction Unit was established as a national centre of expertise in Scotland. Other initiatives have followed based on the model of the unit. They are backed by a range of specific national strategies (early years, youth justice, alcohol and drugs, domestic abuse) and implementation programmes focusing on prevention models. This presentation describes the impact of these national policies and local interventions in Scotland and highlights the continuing effect alcohol and drug misuse has on our young people and its relationship with violence in Scotland. It also highlights the shared learning that has taken place across similar European programmes and describes the role of psychiatrists in developing national policy and implementing public health prevention initiatives to reduce violence.

S070-4.

VIOLENCE AND MENTAL ILLNESS: PUTTING THE-

ORY INTO PRACTICE IN A LOCAL COMMUNITY

Presenter: Sue Bailey, M.D.

SUMMARY:

This paper will take what is known from the international and national literature, and look at a worked example in practice, at how services in one locality, in a major UK city, have come together to deliver a coordinated strategy and implementation of initiatives to both prevent the development of violence in young people in a local community, and also to reduce the risk factors to mental illness. It will describe how mainstream mental health services are working together with nongovernmental organizations, and how this plays out in a large urban conurbation, where there is a wide diversity of ethnic groups and where additionally there are high numbers of asylum seekers. The paper will show how from a pathway of early identification of those at risk from mental illness from the stage of antenatal clinics, right through to later interventions for those adolescents with emerging evidence of serious mental illness or personality disorder, and are offered a multiagency intervention, including those who have committed violent offences and are detained in secure adolescent psychiatric provision.

SYMPOSIUM 071**UPDATES ON REPRODUCTIVE ISSUES IN WOMEN'S MENTAL HEALTH**

Chair: Gisele Apter, M.D., Ph.D.

Discussant: Carol Nadelson, M.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) Be updated on pharmacological treatment of the pregnant and lactating woman, 3) Address and manage women's mental health issues in diverse situations meeting specifically gender-oriented needs during the reproductive cycle

SUMMARY:

Reproductive issues on women's mental health are still in dire need of being recognized, addressed, managed and treated. Women have been main frontline caregivers and constantly subjected to violence over the centuries. Even if progress is on its way, description of world situations and how they may specifically be addressed still need to be established. Choice of reproduction is still questioned, even when scientific data show that improved access to contraception and abortion jointly enhance both maternal and infant health. Maintained and even heightened fecundity

levels in developed countries are positively correlated with open and affordable access to contraception and abortion. The myth of bliss in motherhood persists, persistently undermining its link to psychopathology and psychiatric disorders. How to address and treat major mood and anxiety disorders during the peripartum, with appropriate programs, inclusive of psychotherapeutic and pharmacological approaches needs to be regularly discussed, and informed. Risks and benefits of treating psychiatric disorders during pregnancy and the postpartum are constantly in need of being reassessed and tailored to meet individual requirement. When infertility issues eventually appear, specific management of women should also be available. This symposium will focus on all these different aspects of psychiatric issues related to reproduction. Review of the literature, methodological issues and therapeutic management of all situations will take place. We will give specific attention to how gender and social policy have implications for promoting women's mental health. A general comprehensive discussion encompassing reproductive women's mental health issues will complete our presentations.

S071-1.**VIOLENCE AGAINST WOMEN AND PROMOTING MENTAL HEALTH**

Presenter: Helen E. Herrman, M.D., M.B.

SUMMARY:

The connections between mental health and a healthy life make the improvement of women's mental health a necessity for good health and community development. In countries of all types poor mental health is associated with violence, social disadvantage, human rights abuses and poor health and productivity, as well as heightened risk of mental illnesses. Conversely, 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. This presentation will consider findings from a study of women in primary health care, and published reports on mental health promotion, women's mental health, and violence prevention, to highlight the evidence for effective public health actions. It will highlight the need for practical collaborations between health and nonhealth sectors in reducing women's exposure to violence and promoting mental health and psychosocial wellbeing.

S071-2.**ABORTION TRAUMA: DECONSTRUCTING THE MYTH**

Presenter: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

Careful analyses continue to reveal that induced abortion is not a significant, independent cause of psychiatric illness. The decision to terminate a pregnancy often occurs in the context, or as a result of, psychosocial stress factors that include or raise the risk of psychiatric disorders. Studies ignoring these factors and concluding that there is a causal relationship continue to frighten our patients and mislead our policy makers. This presentation lays out the scientific evidence and the tools for analyzing it.

S071-3.

EMOTIONAL ASPECTS OF ASSISTED REPRODUCTIVE TECHNOLOGY

Presenter: Malkah T. Notman, M.D.

SUMMARY:

The use of assisted reproductive technology has increased enormously enabling couples with infertility or genetic or other illnesses to have babies. These techniques also can make possible unusual genetic combinations and definitions of motherhood, fatherhood and families. The techniques, stresses, and emotional issues raised will be described and discussed.

S071-4.

DECISION MAKING REGARDING PSYCHOPHARMACOLOGY IN PREGNANCY AND POSTPARTUM

Presenter: 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. These women often seek consultation about how to minimize their risks. Women who are still on medication must decide whether to continue this treatment or discontinue medication. They fear that medication may cause a miscarriage or harm the fetus, however, almost 70% of women who discontinue medication have a relapse during pregnancy. The postpartum period is the time in women's lives when they are most likely to develop a psychiatric disorder or require a psychiatric admission. Women must deal with decisions about whether to stop breastfeeding in order to take medication, cope with depression or anxiety until they are finished breastfeeding or take medication at the same time they are nursing. Multiple publications claiming problems to the baby if the mother takes medication add to the dilemma about how to choose an effective

tive 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.

S071-5.

THERAPEUTIC MANAGEMENT, PSYCHOTROPIC MEDICATION AND THE POSTPARTUM

Presenter: Gisele Apter, M.D., Ph.D.

SUMMARY:

Psychotropic prescription during the postpartum necessitates a benefit/risk assessment taking into account mother, infant and the parent/infant relationship. The peripartum is a period during which the patient, the woman is preoccupied with motherhood whether or not she is able to directly care for her infant. Therefore guidelines and rules of psychotropic prescription need to take into account this unique situation. Whenever the patient's wishes are available, whether she wishes to breastfeed or not, needs to be taken into account. Most psychotropic medications, except Lithium are compatible with breastfeeding. Advantages and inconvenience of breastfeeding for the mother (lack of sleep for example), the infant and the mother/infant relationship need to be explicated, taking state-of-the-art knowledge on later development of infant and maternal health into account. Necessity of not discontinuing treatment when medication is an essential part of psychiatric care must be explained. The risk of relapse needs to be assessed by physicians, and understood by patients and this, not only for the woman, but also as regards her maternal capacity. Most women are worried that medication will harm the developing infant, but neglect the fact that they need to be able to care for themselves in order to cope with the stress linked to the care of a newborn. How informed decisions can be made will be described through clinical data, using updated guidelines of safety of medication and current knowledge on psychotropic medication, infant development, and the mother/infant relationship.

SYMPOSIUM 072

THE CHANGING FACE OF TERRORISM

Chair: Jerrold M. Post, M.D.

Discussant: John O. Beahrs, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the generational transmission of hatred, including the increasing emphasis on socialization

and recruitment of women and children to participate in terrorist violence, 2) Understand the manner in which the new communications technology contributes to the shaping of terrorist identities and to the spread of violent ideology, 3) Understand implications for counterterrorism, including deradicalization and social interventions with vulnerable populations to promote resilience and decrease vulnerability

SUMMARY:

The communications technology revolution and the death of Osama bin Laden have profoundly changed the face of terrorism. This symposium first considers the manner in which the cultural context shapes emerging identities of youthful terrorists. The crucial role of mothers of jihadists in shaping the identities of their offspring is first reviewed by a Muslim woman who is a political psychologist and then by an Israeli woman who is a forensic psychologist. The relationship between traumatized populations and vulnerability to being socialized to extremist violence will then be considered. A paper focusing on the phenomenon of “lone wolves” who have been radicalized on line and form a virtual community of hatred will be presented. The radicalization online, which has contributed to the generation of terrorists among Islamic youth abroad and in the United States, is a strategic program of Muslim extremist leaders which is very difficult to counter. Some of the daunting implications for counterterrorism are then considered. A systematic program of deradicalization is being developed to counter this development be presented. Finally, the requirement for measures to enhance resilience, drawing on vulnerable Somali émigrés in the Minneapolis area, will consider the importance of social interventions to reduce vulnerability to extremist radicalization.

S072-1.

MOTHERS OF THE MUJAHIDEEN: WHY THEY KILL

Presenter: Farhana Qazi, M.A.

SUMMARY:

Militant mothers of Islam are motivated by a message of resistance, rebellion and revenge. They are mothers of a larger network who raise their children to be devout, dedicated and determined Muslims who learn to fight for a cause, a faith and a people in need. They are mothers hoping to alter the status quo with their ability to recruit and reinforce the principles of violent jihad, stressing the use of violent action for justice a narrative that guides their behavior. However, not all mothers of conflict pursue violence. In certain conflicts, Muslim women advocate nonviolent protest and address social and political ills with banners of peace and prosperity. Slogans of hate for the enemy do not necessar-

ily translate into violence or support for suicide terrorism. Violent or not, protests led by mothers of the mujahideen stirs the masses. Mothers have the ability to communicate to a larger audience; they are the messengers of conflict. These women espouse the age-old mantra that “Islam is the solution”, a slogan cited by violent Islamist groups worldwide. From the hills of Kashmir (in both India and Pakistan) to the cities of Iraq, women of two distinct regions are destined for change. This article examines how women in two conflicts are propagators of jihad, violent or nonviolent, and ways in which women sustain the struggle led by men. It highlights ways in which women support their men-husbands, brothers, cousins, fathers and more importantly, sons on the path to glory with jihad as their *tour du force*.

S072-2.

THE SMARTER BOMB: WOMEN AND CHILDREN IN PALESTINIAN TERRORISM

Presenter: Anat Berko, Ph.D.

SUMMARY:

Recent years have seen the increasing involvement of women in global terrorism, and Palestinian women have taken an active part in the militant national struggle. Access to the Internet, satellite broadcasts, and cellular phones has weakened Muslim patriarchal authority, and the eye of Big Brother is no longer as sharply focused on Muslim women as it was formerly. The daughter of the house has left her sheltered life and mounted the stage of international terrorism. No longer covered by veil and floorlength, shapeless dress, her scantily clothed body is exposed to the world as she proceeds to the site of a terrorist attack, after which her intimate organs are left strewn on the ground. The escalating involvement of women in terrorism not only emphasizes the intensity of the conflict between Islam and the West in general, and between Israelis and Palestinians in particular, but it also goads men into action. However, women’s participation in terrorism and the fact that it brings them into frequent contact with men has rent the fabric of religiously oriented Muslim society. The consequence is that although the use of women for terrorist purposes is effective and makes headlines, their “contribution” to the Palestinian terrorist campaign is fundamentally unacceptable and goes unrecognized. They are regarded as “wanton” and “bad,” and are often sexually abused by the men around them. The terrorist activities of women have shattered the patriarchal family structure and changed traditional Muslim society from within. Interviews were conducted over many years with women suicide bombers who for whatever reason did not carry out their missions, with other security prisoners, with terrorists who sent women out on terrorist missions, with young men who took part in attacks, with political leaders (including Hamas members of the Palestinian Legis-

lative Council), clerics, and many others. What results is an understanding of the inner workings of the minds of those whose aim is to mass murder the citizens of the State of Israel. The meeting with women and children who planned to be suicide bombers is important to the battle being waged against the tidal wave of the global jihad, which attacks both the West and the moderate Arab states. Meeting with terrorists face to face forces us to think outside the box about finding different ways to cope with this kind of terrorism. The question is raised whether female suicide bombers are in fact the heralds of a Palestinian femini

S072-3.

TRAUMA AND VULNERABILITY TO EXTREMIST VIOLENCE

Presenter: Schuyler W. Henderson, M.D., M.P.H.

SUMMARY:

In communities where violent radicalization emerges, psychological trauma is often present on a large scale. Many forms of psychological trauma have been described, such as direct vs. indirect; past vs. current; high vs. low intensity; childhood vs. adult; and individual, familial, and community directed traumas. Although few believe there is any simple, linear association between trauma and violent radicalization, their coexistence must be addressed. Surprisingly, possible relationships have been neither empirically investigated nor well developed conceptually. This presentation develops a set of hypotheses about potential relationships between trauma and violent radicalization on individual, family, and community levels, and considers the implications of these relationships for psychiatric and psychosocial interventions, policy planning, and further empirical investigation.

S072-4.

LONE WOLVES, RADICALIZATION ONLINE, AND THE VIRTUAL COMMUNITY OF HATRED

Presenter: Jerrold M. Post, M.D.

SUMMARY:

The author's studies of the generational provenance of terrorism indicate that dissidence to loyalty, where youth are rebelling against the generation of their parents who were loyal to the regime, represent the generational dynamics of social revolutionary terrorism. This dynamic also characterizes a group of alienated, isolated Islamic youth radicalized online, so-called "lone wolves," exemplified by Major Nidal Hasan, a military psychiatrist who was the perpetrator of the Fort Hood massacre; Umar Farouk Abdulmutallab, the "underwear bomber"; and Faisal Shahzad, "the Times

Square bomber". They seem to have turned against their secular cosmopolitan fathers and found the rhetoric of Anwar alAwlaki, "the bin Laden of the internet" and other radicalizers, attractive, giving them a sense of belonging to the virtual community of hatred. AlAwlaki's rhetoric features three themes: 1. The Muslims are victims; 2. They (the West and Israel) are responsible; 3. This justifies and calls for violence against the victimizers to rectify this collective injustice. Recruitment of "lone wolves" is a dangerous and growing phenomenon, which is a serious dilemma for counterterrorism.

S072-5.

WALKING AWAY: THE DISENGAGEMENT AND DERADICALIZATION OF TERRORISTS

Presenter: John G. Horgan, Ph.D.

SUMMARY:

In recent years, research on terrorism has begun to focus on the distinct but related processes of disengagement and deradicalization. Having focused efforts primarily on understanding how and why someone becomes involved in terrorism, a growing body of analysts and practitioners have begun to ask how and why people walk away from terrorism. In this presentation, John Horgan, director of Penn State University's International Center for the Study of Terrorism will describe the bases of these processes, and will draw lessons learned from practitioner efforts worldwide to effectively deradicalize those involved in terrorist activity. Horgan will illustrate his arguments with excerpts from interviews he has conducted with 29 former terrorists from organizations that range from the IRA to Al Qaeda. Horgan will conclude with the delivery of a research agenda required to develop an empirically derived approach to risk assessment of terrorist offenders.

S072-6.

PREVENTING TERRORIST RECRUITMENT THROUGH PROMOTING FAMILY AND COMMUNITY RESILIENCE IN MUSLIM DIASPORAS

Presenter: Stevan Weine, M.D.

SUMMARY:

President Obama has stated that strong and resilient individuals, families, and communities are the best defense against terrorist ideologies. Over the past ten years there has been an explosion of interest in resilience in the clinical, community, and family sciences concerning a broad range of adversities. What does this new knowledge of resilience tell us about deterring terrorism? How can we counter violent extremism through community level approaches? State-

ments from U.S. policymakers say it can be done through a focus on enhancing resilience. Is this just rhetoric or is it a prescription for new policies and programs? Resilience, as defined by community psychologists, refers to a process of multisystemic adaptive capacities leading to improved outcomes after a disturbance or adversity. Family therapists conceptualize resilience in terms of family processes that lie in multiple domains of family life that help families and their members to cope with adversities, including family belief systems, family organization, and family communication. The concept of resilience applied to violent extremism leads to a focus on protective resources that could mitigate against existing risk exposures. Building community and family protective resources to counter violent extremism in Muslim diasporas should be approached like a public health strategy with a multilevel, multidimensional, contextual strategy aimed at enhancing these protective resources. The case of the SomaliAmerican community in Minnesota is an example where resilience-focused community-based approaches are needed. Our current community-based ethnographic research project is focused on better understanding these processes so that they may inform the development of terrorism prevention initiatives. We have found that there are individual, family, and community processes that mitigate whether or not a young person is radicalized and recruited. These processes are familiar to prevention researchers who address a range of public health and social adversities, such as child maltreatment, HIV prevention, and violence prevention. Preventive interventions have been able to lessen youth's negative actions through effectively enhancing protective resources at multiple levels. This is certainly good news, but challenging because it calls for a shift from traditional ways of countering and studying terrorism. This shift requires: 1) moving away from a heavy focus on risk factors to an equal focus

SYMPOSIUM 073

COMPLEMENTARY AND ALTERNATIVE MEDICINE RELEVANT TO PSYCHIATRY

Chair: Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Know the range of CAM relevant to psychiatrists today, 2) Understand the relevance for CAM in the treatment of pain and PTSD, 3) Learn about the use of canines in medicine and psychiatry, to include helping service members with mobility, pain and PTSD

SUMMARY:

This symposia will cover a range of both established and new complementary and alternative (CAM) therapies.

Both the Defense Center of Excellence and the National Intrepid Center of Excellence are researching best practices. Medical acupuncture is increasingly being used by military psychiatrists. A combined use of different forms of CAM is being increasingly used. The Army has been using canines increasingly in Army medicine, including service dogs for wounded service members and animal assisted therapy dogs in theater. The use of animals specifically for PTSD will be explored further.

S073-1.

COMPLEMENTARY AND ALTERNATIVE MEDICINE: INTEGRATIVE HEALTH CARE FOR PSYCHIATRY AND NEUROLOGY

Presenter: Nisha N. Money, M.D.

SUMMARY:

The latest techniques and innovative approaches to treat neuropsychological disorders will be discussed.

S073-2.

MEDICAL ACUPUNCTURE'S NEW POTENTIAL IN PSYCHOLOGICAL HEALTH

Presenter: Joseph M. Helms, M.D.

SUMMARY:

The tradition of acupuncture has long included needle patterns to calm and center the psyche. Recent specific neuro-anatomical protocols have shown great promise in military medicine to calm symptoms of acute battlefield stress and pain, and assist in resolving psychological and physical problems associated with PTSD and TBI.

S073-3.

TREATING PAIN AND PTSD WITH ACUPUNCTURE

Presenter: Robert L. Koffman, M.D., M.P.H.

SUMMARY:

Military providers are increasingly using acupuncture and other forms of complementary and alternative medicine for both pain and PTSD. Last year this author travelled to Afghanistan and did battlefield acupuncture. There is research being done on acupuncture and other forms of CAM at the National Intrepid Center of Excellence. This talk will highlight some of the various uses of acupuncture and cover basic techniques.

S073-4.

THE THERAPEUTIC USE OF ANIMALS IN MEDI-

CINE AND PSYCHIATRY

Presenter: Elspeth C. Ritchie, M.D., M.P.H.

SUMMARY:

The HumanAnimal Bond is clearly powerful, although not well understood. Service dogs and other animals have been extremely helpful for people with a wide range of disabilities. Many different types of animals have been shown to reduce physiological arousal. Now there is increased interest in using canines with a variety of psychiatric disorders, including PTSD. This paper will present some of the anecdotal and more emerging use of canines in Soldiers, other service members and veterans with PTSD.

SYMPOSIUM 074**RESEARCH ADVANCES IN PSYCHIATRIC PHARMACOGENOMICS**

Chair: David A. Mrazek, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Appreciate the progress that has been made in the use of genome wide association studies to define the drug response of patients with bipolar disorder, 2) Appreciate the progress that has been made in the use of genome wide association studies to define the drug response of patients with schizophrenia, 3) Appreciate the progress that has been made in the use of genome wide association studies to define the drug response of patients with attention deficit disorder, 4) Appreciate the progress that has been made in the use of genome wide association studies to define the drug response of patients with major depressive disorder

SUMMARY:

The focus of this symposium will be on the presentation of new research that is providing the evidential basis for the translation of research finding to clinical practice. The presenters will focus on four primary classes of psychotropic medications.

S074-1.**PERSONALIZED TREATMENT OF BIPOLAR DISORDER: ADVANCES IN THE PHARMACOGENETICS OF LITHIUM RESPONSE**

Presenter: John R. Kelsoe, M.D.

SUMMARY:

Current treatment of bipolar disorder frequently involves a lengthy trial and error process of serial mood stabilizer tri-

als until an optimal regimen is identified. Patients display a range in responses to drugs that suggest underlying genetic differences. Pharmacogenomics promises the identification of specific gene variants that influence this variability that may ultimately be used for predictive tests to aid physicians in medication choice. Lithium response in particular displays features suggesting that good responders may have a genetically distinct form of illness. A variety of clinical features are related to good lithium response such as elated mania, good interepisode recovery, family history of bipolar disorder, family history of lithium response and others. We have conducted a retrospective study of lithium response in 288 bipolar subjects in which we examined 50 candidate genes. Two genes in particular, a phosphodiesterase, PDE11A, and a neurotrophin receptor, NTRK2, showed evidence of association. Association to the NTRK2 gene was subsequently replicated in an independent sample of 77 subjects prospectively assessed using a relapse prevention design. Association to these genes was seen primarily in bipolar subjects who displayed two clinical features associated with response: strong family history and elated mania. These data are consistent with the idea that these genes predispose to a lithium responsive form of bipolar disorder that is genetically distinct. A new large international multisite prospective pharmacogenetic trial of lithium and valproate, the Pharmacogenomics of Bipolar Disorder Study, will also be described.

S074-2.**PROGRESS TOWARD USE OF PHARMACOGENETIC INFORMATION TO AVOID ANTIPSYCHOTIC-INDUCED TARDIVE DYSKINESIA AND WEIGHT GAIN**

Presenter: James L. Kennedy, M.D.

SUMMARY:

INTRODUCTION: The older typical antipsychotics have a tendency to induce tardive dyskinesia (TD) at rates up to 30 %, while the newer atypicals often induce severe weight gain that can lead to serious metabolic syndrome. As shown in the CATIE trial, the typical antipsychotic perphenazine had similar efficacy to the newer atypicals. Thus in terms of efficacy, the physician can choose relatively equally between typical and atypical antipsychotics, but faces a dilemma in writing a prescription: Shall I risk TD or metabolic syndrome in this particular patient? If a genetic test is able to provide even a modest amount of useful information in terms of risk for one of these side effects versus the other, there is a good opportunity to reduce suffering in the patient and reduce health care costs. **METHODS:** Three independent samples of antipsychotic-treated patients were examined for genetic factors involved in TD or weight gain. We examined genetic markers from the biological systems involved in antipsychotic action, including dopa-

mine, and serotonin systems. The samples consisted of 240 schizophrenia patients chronically treated with traditional neuroleptics who were assessed for TD using the Abnormal Involuntary Movement Scale (AIMS), and who then were started on a prospective clozapine trial, lasting 6 months or more. During treatment they were monitored for weight gain at 3 months and 6 months. TD was further assessed via AIMS scores in a second sample of N=100 patients who were seen in a TD clinical consultation service. A third sample of psychosis patients (N=80) from Germany, who underwent treatment as usual in an academic clinic, were assessed for weight gain. RESULTS: For TD, our data suggest involvement of a haplotype of DRD3 promoter markers ($p = 0.01$ with TD diagnosis; $p = 0.008$ with quantitative AIMS score). We have typed markers in the DRD2 gene that have not previously been tested in TD, and also find significant association ($p = 0.03$). Weight gain is associated with the melanocortin4 receptor at two different locations in the gene and replicated in the German sample. Other associations with weight gain include the synaptic associated protein25, and neuropeptide Y genes. Algorithms to combine these markers into predictive combinations are underway. CONCLUSIONS: Other work has indicated usefulness of hepatic enzyme genes (CYP450) in avoiding antipsychotic-induced side effects. Those genetic variants, in combination with the genes for pha

S074-3.

PHARMACOGENOMICS IN THE SEARCH FOR NEW ADHD TREATMENT TARGETS

Presenter: James T. McCracken, M.D.

SUMMARY:

While current ADHD medical interventions possess solid efficacy and safety, nearly 40% of children and adolescents with ADHD do not respond to standard treatments. Furthermore, adherence to ADHD therapies is relatively poor, given that as many as 50% of newly treated patients drop their treatment within the first 12 months or less, presumably influenced in part by side effect burden. Pharmacogenomics has been introduced as one research strategy with which to better understand the large interindividual variability in treatment response and tolerability. This presentation will introduce the unmet treatment needs of ADHD and review most recent findings from the application of pharmacogenomic research strategies to this treatment challenge. Results suggest that individual genetic background does play a significant role in moderating treatment response. Similarly, common adverse events associated with stimulant treatment also appear to be significantly moderated by common genetic variation. While gene variants in several monoaminergic genes moderate these differences, evidence is also emerging that genes underlying absorption,

metabolism, and distribution may be important as well. A model of how genetic information may be applied to clinical decision making will be proposed.

S074-4.

INCREASING THE PRECISION OF THE PHARMACOGENOMIC PREDICTION OF ANTIDEPRESSANT RESPONSE

Presenter: David A. Mrazek, M.D.

SUMMARY:

For the past eight years, the use of pharmacogenomic testing to guide antidepressant treatment has evolved. The initial focus was primarily on establishing the metabolic capacities of patients with the goal of avoiding adverse effects. Subsequently, key “target” genes have begun to be evaluated to increase the accuracy of the estimate of the probability of response. While the translation of research findings to clinical practice has been relatively slow, there has been a rapid accumulation of new research findings which link specific biomarkers to antidepressant treatment response. Two specific areas of this new research will be highlighted. The first area of research is the use of genomewide association analyses (GWA) to identify potential additional predictor gene variance for both improved efficacy and safety. These independent GWA analyses of SSRI responses have been completed and larger GWA analyses are underway. The second area of research will be the use of metabolic profiles to provide a complimentary strategy for medication response prediction. Specific new associations will be reviewed and additional necessary research configurations will be discussed. Finally, the development of an International SSRI Pharmacogenomic Consortium will be reviewed.

SYMPOSIUM 075

DEVELOPMENTS IN FORENSIC PSYCHIATRY IN THE UNITED STATES AND FRANCE: VIVE LA DIFFERENCE!

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand controversies about forensic psychiatry in the United States and France, 2) Understand new developments about forensic psychiatry in the United States and France., 3) Better understand the differences about forensic psychiatry in the United States and France

SUMMARY:

The French Psychiatric Association and the American

Psychiatric Association have held joint symposia for over two decades on the subject of differences in approaches to psychiatric issues. This year's symposium is entitled Developments in Forensic Psychiatry in the United States and France Vive La Difference! Dr John Talbott (US) will chair the symposium and introduce the session. Dr Francois Petitjean (FR) will cochair the session and lead the discussion. Dr. Francois Petitjean (FR) will begin by summarizing the newly enacted law in France on the forensic assessment and processing of the mentally ill undergoing commitment and the results after nine months. He will be followed by Dr Carl Malmquist (US) 22:20 A new law for psychiatric treatment in France.who will provide an American forensic psychiatrist's views on the french law. Then Dr Raphael Gourevitch (FR) will present data on involuntary psychiatric hospitalizations prior to the June 2011 law and Dr Richard Bonnie (US) will discuss involuntary psychiatric hospitalizations in the United States. Finally Dr Marc Antoine Crocq (FR) will speak about what is known about compulsory community treatment in France and Dr Jeffrey Janofsky (US) will speak on the administrative and clinical service burden of such a law in the United States. There will then be ample time for questions and answers.

S075-1.**A NEW LAW FOR PSYCHIATRIC TREATMENT IN FRANCE: FIRST IMPRESSIONS AFTER NINE MONTHS**

Presenter: Francois C. Petitjean, M.D.

SUMMARY:

The Act of July 5, 2011 on the rights and the protection of individuals under psychiatric care and the modalities of their care reforms the 1990 law which regulated involuntary admission until then. The new Act stipulates that the care constraint can be carried out at the hospital but also as an outpatient in a specialized center or in the community. Two main types of involuntary treatment remain: psychiatric care at the request of a third party and psychiatric care decided by the representative of the State. Involuntary treatment begins with a period of observation lasting 72 hours maximum. This observation is necessarily an hospitalization period, with a complete physical examination and two successive certificates established by two different psychiatrists psychiatrist confirming the necessity of involuntary treatment; At the end of the 72 hours, the patient can either maintain an hospitalization or benefit from an involuntary community treatment. When an hospitalization is decided, a judge must interview the patient within 15 days after admission, and then every 6 months if necessary, and decide whether involuntary hospitalization is appropriate. This control raises tensions, judges wishing to organize hearings in court, psychiatrists preferring they take place in hospital,

mostly because of the resources in personnel necessary to accompany patients to court. This new act introduces three main changes: community involuntary treatment, 72 hours observation period, systematic judge hearing. Authors will discuss the main consequences of these changes introduced since August, 1 , 2011.

S075-2.**OUTLIER COMMITMENT GROUPS**

Presenter: Carl P. Malmquist, M.D.

SUMMARY:

Special commitment problems arise with two outlier groups: minors with mental disorders, and the commitment processes employed in some states with sexual offenders and their special statutes. These will be discussed and contrasted with the situation existing in France.

S075-3.**DATA ON INVOLUNTARY PSYCHIATRIC HOSPITALIZATIONS IN FRANCE PRIOR TO THE JULY 2011 LAW**

Presenter: Raphael Gourevitch, M.D., Ph.D.

SUMMARY:

Since as far back as 1838, there has been a Law in France governing compulsory admissions to psychiatric hospitals for the mentally ill. The June 1990 revision made the letter of the law slightly more complicated but did not substantially modify its spirit: basically it took satisfyingly into account clinical pragmatism, defence of individual rights and requirements of public order when appropriate. After a short background history, we will present here the main principles of the 1990 Law, then some facts and figures illustrating how it was applied by mental health services in real life practice. Its undeniable limitations and weaknesses recently resulted in the controversial July 2011 Law. New objectives and procedures introduced by this latter revision will be presented elsewhere in the symposium.

S075-4.**MENTAL HEALTH LAW REFORM IN THE UNITED STATES**

Presenter: Richard J. Bonnie, J.D.

SUMMARY:

This presentation will review the 25year controversy regarding mandatory outpatient treatment (MOT) of civilly committed patients in the United States, describe current

practice in states with available information, and comment on efforts to reduce the use of coercion in mental health care.

S075-5.

WHAT DO WE KNOW ABOUT COMPULSORY COMMUNITY TREATMENT?

Presenter: Marc Antoine Crocq, M.D.

SUMMARY:

The new law on compulsory psychiatric treatment, which took effect in France on August 1, 2011, includes a new provision allowing compulsory community treatment (CCT). Thus, compulsory treatment is no longer automatically associated with hospitalization. This innovation was opposed by critics and it almost failed to pass a Senate committee. In practice, CCT can be started only after a treatment program has been agreed upon with the patient during a preliminary hospital stay of at least 72 hours. An embryo of CCT existed in the previous French law on compulsory psychiatric treatment (1990). Then, the patient could be tentatively discharged from compulsory hospitalization with a trial furlough; he remained under the hospital's responsibility and could be readmitted swiftly if necessary. However, this was only meant as a short-term arrangement before definitive discharge. The new law does not define in detail how CCT will be enacted in practice; this should be clarified by future decrees. CCT will be probably be carried by the public psychiatric care system, which consists of geographical sectors equipped with coordinated inpatient and outpatient facilities. Collaboration with the emergency services and police will have to be formalized. A peculiarity of the French system is that decisions concerning the patients involve not only physicians and judges, but also the prefect – the State's representative in each department. International studies conclude that the evidence for the effectiveness of CCT is equivocal. Obviously, a key ingredient of success is the development of a relationship with the patient that can go beyond coercion and reach some level of trust.

S075-6.

COMPARE AND CONTRAST THE NEW FRENCH CIVIL COMMITMENT LAW WITH CIVIL COMMITMENT PRACTICES IN THE UNITED STATES

Presenter: Jeffrey Janofsky, M.D.

SUMMARY:

In the United States in colonial times there were no public facilities for psychiatric care of the poor. Indigent mentally ill were sent to poor houses. The violent mentally ill were jailed. By the 18th and early 19th century an informal sys-

tem developed. Families and physicians decided whether a person should be hospitalized based on the need for treatment. The only way to challenge admission was by a writ of habeas corpus. By the late 19th and 20th centuries state laws cycled between criminalization of commitment procedures based on dangerousness to self or others, and an emphasis on *parens patriae* or the need for treatment. In 1971 only 9 states limited civil commitment to persons who were dangerous. Fortyone states allowed involuntary treatment based on the need for treatment only. This began to change in 1972 after Wisconsin's *Lessard v. Schmidt* decision, a class action suit including all persons held involuntarily under Wisconsin's commitment statute. The Court found that patients could only be civilly committed if there was: an extreme likelihood of dangerousness based on recent overt act attempt or threat; beyond a reasonable doubt standard of proof; least restrictive alternative; and multiple procedural safeguards. Furthermore in 1975 the U.S. Supreme Court decided *O'Connor v. Donaldson*. The Court held that: A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement... In short, a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends. By 1980 all states required some sort of danger to self or others or gravely disabled standard for involuntary admission. Definitions of dangerousness vary widely: mere danger to self or others vs. imminent danger to self or others vs. substantial likelihood that the patient will cause serious physical harm to himself or others in the near future with a recent overt act of dangerous behavior. The need for treatment standard appeared to have been abolished. However, in practice, many trial level or administrative courts interpret a patient's inability to care for themselves safely in the community without treatment as danger to self.

SYMPOSIUM 076

GENETIC AND EPIGENETIC FACTORS IN SUICIDAL BEHAVIOR: EFFECTS OF EARLY AND LATE ENVIRONMENTAL STRESSORS

Co-Chairs: Maria A. Oquendo, M.D., Enrique BacaGarcia, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Participants will be able to identify early childhood experiences that may increase risk for suicidal behavior, 2) Participants will be able to identify epigenetic factors as relevant to suicidal behavior, 3) Participants will be able to identify temperamental factors that increase risk for suicidal behavior

SUMMARY:

The effects of early childhood trauma, especially abuse, are far-reaching. Individuals who report childhood trauma are at high risk for suicidal behavior but the neurobiological, temperamental and clinical endophenotypes that lead to such an effect are just beginning to be elucidated. This symposium will cover genetic, epigenetic, temperamental, neurocognitive and clinical contributors to suicidal behavior and their connection to childhood abuse. The role of current stressors will be discussed as well.

S076-1. DEVELOPMENTAL VULNERABILITY TO SUICIDAL BEHAVIOR

Presenter: Philippe Courtet, M.D., Ph.D.

SUMMARY:

The study of the vulnerability to suicidal behavior should improve our understanding of the pathophysiology of this complex phenomenon and provide new tools for early detection or treatment. There is increasing evidence for the involvement of both genetic and environmental factors in the risk of suicidal behaviour. Our studies examine the influence of genetic and prenatal factors, both on their own and through additive effects on different characteristics of suicidal behaviour (e.g. Violence, age at onset, number of suicide attempts, decision making). We will present very recent data suggesting that: 1) Prematurity is associated with an increased risk of violent suicide attempts and a younger age at first suicide attempt. Importantly, we found an additive effect for prematurity, childhood abuse, and temperamental traits on age at first suicide attempt. 2) Childhood abuse interacts with genes to influence temperamental traits related to suicidal behaviour. 3) Childhood abuse interacts with stress related genes to influence decisionmaking, a potential neuroanatomical endophenotype of suicidal behaviour. 4) For the first time, the in vivo association between severity and type of childhood maltreatment and increased methylation of a stressrelated gene (NR3C1) These data illustrate the current conceptualization of these issues that may inform further studies on the vulnerability to suicidal behaviour. Indeed, this data supports a neurodevelopmental hypothesis of suicidal behaviour wherein specific combinations of early deleterious environment and genes confer suicidal risk, which should be detectable early, prior to the manifestation of suicidal behaviour.

S076-2.**THE ROLE OF LIFE EVENTS IN PRECIPITATING SUICIDE ATTEMPTS AND COMPLETED SUICIDE**

Presenter: Mercedes P. Rodriguez, M.D., Ph.D.

SUMMARY:

Despite prevention efforts, suicide causes one million deaths per year, 30,000 in the United States alone. The fact that suicide attempt rates in the United States have been stable over the past decade and rates of completed suicide have slightly increased suggests that suicide prevention and treatment strategies are not working, raising questions about current views regarding risk factors for suicidal behavior. The role of stressful life events in precipitating suicide attempts is unclear, with several studies finding that stressful life events predict suicide attempts whereas others find no evidence supporting this fact. Surprisingly few prospective studies have examined the relationship between life events and suicide attempts or completed suicide. Moreover, whether suicide attempters and completers represent the same population evaluated at different points along a progression towards suicide death, overlapping populations, or completely different populations, remains an unresolved problem. I will present data from studies: 1) examining life events and other risk factors in suicide attempters; 2) comparing life events and other risk factors in suicide attempters and suicide completers; and 3) prospectively examining the role of life events and other risk factors on completed suicide. I will conclude by explaining possible ways to use these novel tools in suicide prevention from a clinical standpoint.

S076-3.**EPIGENETIC REGULATION OF GENES INVOLVED IN STRESS RESPONSE BY EARLYLIFE ADVERSITY: IMPLICATIONS ON SUICIDE RISK**

Presenter: Gustavo Turecki, M.D., Ph.D.

SUMMARY:

While most individuals who display suicidal behavior do not have a history of earlylife adversity, a significant minority does. Recent animal and human data have suggested that earlylife adversity leads to epigenetic regulation of genes involved in stressresponse systems. In this presentation, I will discuss the clinical implications of these findings, and particularly, I will focus on recent research data suggesting that earlylife adversity increases risk of suicide by influencing the development of stable emotional, behavioral and cognitive phenotypes that are likely to result from the epigenetic regulation of the hypothalamicpituitaryadrenal axis and other systems involved in the stress response.

S076-4.**A PROSPECTIVE STUDY OF THE ROLE OF LIFE EVENTS IN PRECIPITATING SUICIDAL BEHAVIOR**

Presenter: Maria A. Oquendo, M.D.

SUMMARY:

Suicidal behavior is often conceptualized as a response to overwhelming stress. We studied depressed patients (n=430) were followed for two years postdischarge while receiving naturalistic treatment in the community. Participants were assessed prospectively for mood symptomatology, occurrence of life events and recurrence of MDE. While MDE recurrence increased the risk nearly fivefold, life events did not appear to precipitate suicidal behavior. Even in the context of an MDE, life events had no effect. Among baseline characteristics, sex and one of two baseline pessimism factors predicted suicide attempts. Although the role of stressful life events in precipitating suicidal acts requires further study, these data undermine clinical lore positing a relationship between life events and suicidal acts. These findings parallel recent reports for mood disorders suggesting that “reasons” for depression, which make the occurrence of symptoms “understandable” may not in fact be the causes of depression. Of note, and perhaps in contrast, recurrent MDE is a strong predictor of suicide attempts. That a treatable risk factor such as depression so solidly predicts suicide attempts is cause for hope. Interventions to minimize MDE recurrence should be a priority in suicide prevention efforts.

SYMPOSIUM 077

MORAL TREATMENT TO RECOVERY: THE IVY LEAGUE HOSPITALS LOOK AT CONTEMPORARY ETHICAL ISSUES IN PSYCHIATRY

Chair: Virginia L. Susman, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand how the precepts of moral treatment have influenced current personcentered values and practices, 2) Discuss the medicolegal and ethical tensions involving public disclosure of personal health information, 3) Identify ethical conflicts between providing patient satisfaction and optimal treatment and between ensuring safety and fostering autonomy

SUMMARY:

The Ivy League Consortium began over one hundred years ago and is comprised of some of the nation's oldest free standing asylums. Our modernized facilities remain among the most highly regarded psychiatric hospitals. The Consortium also continues to serve as the standard bearer for the Enlightenment era therapy known as Moral Treatment, a therapy that revolutionized psychiatric care two hundred years ago and which counts among its philosophic and intellectual descendants the profession of occupational

therapy, the therapeutic community movement and the Recovery movement. The core values and principles of Moral Treatment include respect for the dignity of every person and commitment to providing noncoercive care while fostering a sense of meaning through active engagement and occupation. Looking at contemporary ethical challenges through the lens of these principles, this symposium will include presentations from almost all of our member institutions. We will begin with an historic overview of the distinct British and French approaches to Moral Treatment and will conclude with a comparison between the benevolent paternalism of early asylumbased Moral Treatment and the individualistic, selfdeterminism of current Recoveryinspired community treatment models. Papers discussing the ethical aspects of contemporary issues surrounding confidentiality, the enthusiasm for customer satisfaction that has become an important business aspect of healthcare, and the tensions between providing safety while ensuring personal choice and freedom should give rise to thoughtful discussion and debate.

S077-1.

A HISTORIC OVERVIEW OF THE INCEPTION OF MORAL TREATMENT

Presenter: David S. Roby, M.D.

SUMMARY:

While mental illness has always been a part of the human condition, for millennia its management included only social isolation, confinement, physical neglect, restraint, mockery and scorn. In the late middle ages, several institutions around the world made efforts to change and improve the quality of care. A brief review of some of the innovative institutions in Europe and America between 1400 and 1800 will be presented. While these early efforts did reflect a more humanistic, compassionate form of treatment for the mentally ill, it was not until the late 1700's when more pervasive and revolutionary reform began. Philippe Pinel was a French physician who devoted 35 years of his professional life to improving the treatment of psychiatric patients. He became famous for removing the shackles from patients, many of whom had been institutionalized for years, some had even committed murder. His professional development and decision to pursue psychiatry will be reviewed. His contributions include improving living conditions at the Bicetre, and subsequently the Salpêtrière. He advocated systematic observation and records which presaged the psychiatric case history. He also proposed changes in diagnostic nosology. Ultimately he attempted to correlate clinical with anatomic findings. William Tuke was a British Quaker who left school at the age of 14 to work in the family tea business. He experienced a personal loss with the untimely death of his first wife. After this, he committed himself to

increased involvement in his Quaker meeting and its reforms. In 1791, Hannah Mills, a young Quaker woman became acutely ill and showed a mental status change. She was admitted to the York Asylum where she was isolated and fellow Quakers could not visit her. She died soon thereafter at the age of 24. Her tragic death led Tuke to vow to create an alternative institution, and in 1796 the York Retreat opened. In 1813, Samuel Tuke published a detailed description of the York Retreat including the principles of moral treatment. Interested clinicians from America and Europe visited, and several created similar institutions modelled after the retreat. Thomas Scattergood, a Quaker minister from Philadelphia visited the Retreat in 1799 and advocated that a similar hospital be built. This proposal came to fruition with Friends Hospital which opened in 1817 to accommodate those unfortunate persons deprived of the use of their reason. Despite coming to their work from

S077-2.

CONFIDENTIALITY OF MENTAL HEALTH RECORDS AFTER DEATH

Presenter: Patricia R. Recupero, M.D., J.D.

SUMMARY:

In recent years, the voluntary disclosure of many public figures' struggles with psychiatric illness have helped reduce stigma surrounding mental health treatment but have also sparked increasing public curiosity about private details of their struggles. This talk will identify major legal and ethical considerations involved in responding to requests for access to deceased patients' mental health records. The presenters will provide an historical overview of changing attitudes, from the 18th Century practice of allowing members of the public to view psychiatric patients as a form of spectacle or entertainment, to the rise of moral treatment and modern psychiatric ethics today, including nonmaleficence and patient autonomy. The presentation will review relevant historical cases, such as the publication of the poet Anne Sexton's therapy tapes and the Vincent Foster case. Relevant ethical and legal concerns, such as HIPAA, liability for breach of confidentiality, case law, familial right to disclose information, and therapist/patient privilege will be discussed. The presenters will also review a contemporary case, in which an academic researcher sought to gain access to the private psychiatric records of an historical figure who was allegedly treated at Butler Hospital in Providence, RI, prior to her death.

S077-3.

DISTINCTIVE COMPETENCIES

Presenter: Frederick W. Engstrom, M.D.

SUMMARY:

The Moral Treatment movement defined how it would treat patients: with humanity, respect, dignity, and with minimal coercion. Today, psychiatrists need to define better what they do. Our inability to define our work has led to confusion in three important areas: patients are not given a way to know whether or not they are receiving a high quality of care (Come to us!!! Trust me!!! I am very good!!!); generic payment schedules do not recognize differences in quality of care (one price fits all); and a medical health system that treats behavioral health as a mysterious appendage. Psychiatrists, inpatient psychiatric units, and other entities can and should better define themselves; the concept of 'distinctive competencies' can help in that regard. For example, an inpatient unit could define. • Distinctive Competencies: e.g., "We treat adults who need inpatient hospitalization. We are especially equipped to work with those with coexisting medical and psychiatric problems, and those who are highly psychotic." Myriad competencies could be addressed: eating disorders, aggression, personality disorders, PTSD, substance abuse or dependence, chronic illness, cooccurring disorders, etc. • Which patients are (and are not) treated on the unit • The programming, treatments, philosophy, structure, and other aspects that address those patients and are consistent with the competencies noted above • The training and competencies of the staff, and hiring decisions – both present and future. Distinctive Competencies address several issues: • Patients know what they are getting • Staff members know the treatment philosophy and areas of expertise • Managers can schedule specific trainings for staff to address competencies • Appropriate clinicians will be hired – with the right training and focus • Marketing Department will be able to better define the "Brand" who you are and what you stand for. • Admitting clinicians will know which patients are most appropriate for which treatment units or programs • The administrators will more effectively negotiate with payors because they can define what services are provided. The payors will understand what they are getting for their money and for what services they are being billed. • Medical clinicians will better understand their psychiatric colleagues, thereby improving coordination of care.

S077-4.

SAFE AND SATISFIED PATIENTS, CIRCA 2012

Presenter: Philip J. Wilner, M.D.

SUMMARY:

Psychiatric inpatient care has evolved significantly since the birth of the asylum movement in the late 18th century. The modern psychiatric hospital, shaped by advances in psychopharmacology, deinstitutionalization, managed care and most recently costcontainment pressures remains the

center of acute care, staff training and student education. In the last decade, prompted by the influential Institute of Medicine Reports *To Err is Human* (1999) and *Crossing the Quality Chasm* (2001), significant gaps in patient safety were recognized and the need for increased patient engagement was identified. Pressure has increased to achieve high scores on safety indicators and patient satisfaction metrics. Of great concern, in some institutions these priorities have trumped emphasis on diagnostic specificity, evidencebased practices and adherence to clinical pathways, dimensions that also are critical to high quality patient care. This presentation will trace the evolution of inpatient psychiatric practice with emphasis on the contemporary challenges faced by clinicians to integrate a large array of priorities. Some of these priorities are well intended efforts to implement a more patientcentered, recovery focused approach. Others are regulatory mandates designed to standardize practice in an effort to assure safety and quality at the highest levels. Still others are driven by academic advances in health care and psychiatry in particular. Balancing these priorities has had unintended as well as intended consequences for the practice of psychiatry. What are the tradeoffs faced by psychiatrists in the shift in role from clinician to caregiver and in the shift in focus from dignity to privacy, from creativity to conformity and perhaps most significantly, from a model that stressed physician leadership to one guided by shared governance principles? What ethical questions are raised when decisionmaking is guided by a patient/consumer's selfperception and interest rather than scientific findings and clinician experience? What impact will these changes have on the future psychiatric workforce?

S077-5.

SUPERINTENDENT OF THE ASYLUM TO RECOVERY COACH: THE PSYCHIATRIST'S ROLE

Presenter: Virginia L. Susman, M.D.

SUMMARY:

When asylums first adopted Moral Treatment, consultant physicians with no role beyond ministering to patients' bodily needs were hired. However, by the mid 1800's, physiciansuperintendents became the norm in asylums on both sides of the Atlantic. Believing that psychiatric illness was caused by chaotic, crowded urban life, treatment involved creating systematic orderliness in carefully designed asylums located in pastoral settings. Asylums were headed by male physicians and female matrons simulating parents in well run, harmonious homes. Patients, seen as childlike in their need for structure and predictability, were encouraged in more and less subtle ways to conduct themselves in a socially appropriate manner. Proper behavior on the part of the childpatient was rewarded with increased freedom and access to the parentified physiannurse dyad. Although

asylum care faded away with the advent of oversized and overcrowded facilities, this model of benign paternalism and the belief that it was fundamentally healing, did not. Inherent to this naïve model of care were powerful values that have endured and which underlie many more sophisticated forms of treatment. The French physician, Pinel, recognized that patients' premorbid lifestyle and aspirations shaped both their symptoms and their response to treatment. According to the tenets of their faith, the Quakers in York saw a spark of divinity worthy of respectful treatment in even the most disturbed patients. Appreciation of the uniqueness of the individual and of a universal right to humane, noncoercive care are as central to today's psychiatric ethics as they were to the beliefs and motivations of these pioneers of Moral Treatment. While the core values have endured, the psychiatrist's role has undergone change and challenge. After the asylum era, the psychiatrist became more of a scientist, an expert whose experience and knowledge commanded respect and compliance. For another fifty years the psychiatrist's authoritative role was reinforced by enthusiasm for the dramatic effects of medication on individual and public mental health. In recent years, a general erosion of confidence in leaders and experts has occurred. A positive shift toward more egalitarian partnering between physicians and patients has arisen in parallel to this broader societal change. The Recovery movement champions autonomy and the rights of individuals, and deemphasizes a disease model in favor of embracing personal efficacy

SYMPOSIUM 078

PERSONALIZED MEDICINE: AN UPDATE

Chair: Markus Heilig, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Attendees will learn to determine how genetic variation influences medication response in the treatment of alcohol addiction, 2) Attendees will learn to identify the different genetic variants and how they interact to enhance treatment outcome, 3) Attendees will learn the cuttingedge research approaches that will lead to further advancement in personalized medicine

SUMMARY:

Personalized medicine is likely to have a prominent role in healthcare over the next several decades. Even today pharmacogenomic testing is being conducted to evaluate the safety of various medications for the treatment of numerous medical disorders, including cancer, bipolar disorder, epilepsy, depression, and hypertension. In the treatment of alcoholism, it is clear that no single treatment is effective for every individual. A more efficient approach is to personal-

ize the treatment of each individual patients' demographic characteristics; physiological/biochemical indicators; genome/transcriptome/epigenetic characteristics; cultural indices; and behavioral experience. These individual profiles eventually could be lined to different components of alcohol addiction (e.g., reward, negative affect, and craving). Although the application of pharmacogenomics to the treatment of Alcohol Use Disorders has only just begun, it represents a fruitful area of research for the next decade. In this symposium, several promising genetic variants have been identified that have implications for personalized medicine. These include the A118G variant of the muopioid receptor gene, a variant that influences the response to naltrexone; two polymorphic variants at the regulatory region and the 3'untranslated region of the serotonin transport gene (5HTT) and genetic variants at the serotonin 5HT3AB genes, variants that alter the responsiveness to ondansetron; and a polymorphic variant of the 5HTT gene that regulates responsiveness to sertraline in a subpopulation of alcohol dependent patients. Research that focuses on matching patients to specific treatments during the next decade will be a high priority. It also carries some of the greatest challenges. Nonetheless, the progress made thus far in the field of pharmacogenomics and pharmacogenetics is encouraging and will, most likely, play a prominent role in developing newer and safer medications for Alcohol Use Disorders

S078-1.

THE ROLE OF PHARMACOGENETICS IN TREATING ALCOHOL DEPENDENCE WITH ONDANSETRON

Presenter: Bankole A. Johnson, M.D., Ph.D.

SUMMARY:

Pharmacogenetic treatments are important in advancing a personalized medicine approach to treating alcohol dependence because they can optimize therapeutic response and limit interindividual variability. The serotonin (5HT) transporter (5HTT) gates approximately 60% of neuronal 5HT function. Specific genetic variants of the 5HTT gene have been associated with the prediction of alcohol craving and with major differences in 5HT expression; hence, they could be an important target for clinical treatment. We aimed to demonstrate that ondansetron is an efficacious pharmacogenetic treatment for alcohol dependence. Two hundred eightythree alcoholdependent individuals were randomized by genotype in the 5'regulatory region of the 5HTT gene (LL/LS/SS) in a controlled, doubleblind clinical trial. Additional genotyping was performed for another functional single nucleotide polymorphism (SNP), rs1042173 (T/G) in the 3'untranslated region of the 5HTT gene, and for rs1150226 (A/G) and rs17614942 (A/C) in the HTR3A and HTR3B genes, respectively. The HTR3A and HTR3B genetic variants were included in the analyses because

ondansetron targets primarily 5HT3AB receptor complexes on postsynaptic neurons. Subjects were given ondansetron, a specific 5HT3 antagonist (4 µg/kg twice daily), or placebo for 11 weeks, plus weekly standardized cognitive behavioral therapy. Differences in genetic variation predicted the increased abstinence and reduced drinking severity that were seen following ondansetron treatment. This new knowledge on the epistatic effects of the 5HTT, HTR3A, and HTR3B genes on ondansetron treatment response among alcohol-dependent individuals could pave the way toward pharmacogenetic treatment of alcoholdependent individuals with ondansetron.

S078-2.

SSRIS: WIDELY PRESCRIBED MEDICATIONS THAT MAY ADVERSELY AFFECT A SUBGROUP OF ALCOHOLICS

Presenter: Henry R. Kranzler, M.D.

SUMMARY:

Selective serotonin reuptake inhibitors (SSRIs) are a key component in the treatment of major depression and anxiety disorders. SSRIs are often prescribed to alcoholics to ameliorate the depressive and anxiety symptoms that they commonly experience. Over the past 15 years, evidence has emerged that earlyonset/high vulnerability alcoholics may drink more when treated with an SSRI than with placebo. In contrast, SSRIs reduce drinking relative to placebo in lateonset/low vulnerability alcoholics. Although a number of studies have shown such a differential effect, the form of the interaction of ageofonset group by medication group has varied. This effect could differ as a function of a polymorphism in SLC6A4, the gene encoding the serotonin transporter, which appears to moderate some of the effects of SSRIs. We conducted a placebocontrolled trial of sertraline in a sample of 134 nondepressed alcoholics who were differentiated by their age of onset of alcohol dependence. Patients were genotyped for the triallelic 5HTTLPR polymorphism (which yields two alleles: S' or L') in SLC6A4. Results showed that the moderating effect of age of onset on the response to sertraline was conditional on genotype. Although there were no main or interaction effects among S' allele carriers, in L' homozygotes, the effects of medication group varied by age of onset ($P = 0.002$). Whereas lateonset alcoholics reported fewer drinking and heavy drinking days when treated with sertraline ($P = 0.011$), earlyonset alcoholics had fewer drinking and heavy drinking days when treated with placebo ($P < 0.001$). On the basis of these findings and the existing literature, in the absence of major depression, SSRIs should probably be prescribed only to lateonset alcoholics.

S078-3.

ALCOHOL DEPENDENCE AND PERSONALIZED MEDICINE: LEVERAGING NEUROBIOLOGICAL PHENOTYPES TO UNCOVER GENETIC PREDICTORS

Presenter: Kent Hutchinson, M.D.

SUMMARY:

The etiology of alcohol dependence is related to changes in the neuronal systems involved in the anticipation of reward and executive control. Current treatments target these same systems. Genetic and epigenetic variations that are associated with individual differences in these mechanisms may be important in terms of predicting the effects of current treatments and treatments in development. We recently developed an approach that leverages neurobiological phenotypes to link changes at the molecular level (e.g., genetic and epigenetic variation), to changes in neuronal function, and ultimately to changes in clinical outcomes. In a recent study, an exploratory genome wide analysis identified 302 SNPs that were associated with large clusters of brain activation as well as focal activation of the dorsal striatum after exposure to alcohol cues. An aggregate genetic risk (AGR) score reflecting the combined influence of these SNPs demonstrated a similar association with BOLD response after exposure to alcohol cues and loss of control over drinking in an independent sample. In a third independent genome wide dataset from a large community sample, the correlation between the AGR score and alcohol abuse was significant. Results from these genetic analyses, as well as epigenetic analyses and implications for personalized medicine, will be discussed during the presentation.

S078-4.

FUNCTIONAL POLYMORPHISM OF THE MU OPIOID RECEPTOR GENE (OPRM1) INFLUENCES REINFORCEMENT LEARNING IN HUMANS

Presenter: Elliot Stein, Ph.D.

SUMMARY:

Previous reports on the functional effects (i.e., gain or loss of function), and phenotypic outcomes (e.g., changes in addiction vulnerability and stress response) of a commonly occurring functional single nucleotide polymorphism (SNP) of the muopioid receptor (OPRM1 A118G) have been inconsistent. To further investigate this, we examined the effect of this polymorphism on implicit reward learning. Probabilistic signal detection task was used to determine whether this polymorphism impacts response bias to monetary reward in 63 healthy adult subjects: 51 AA homozygotes and 12 G allele carriers. OPRM1 AA homozygotes exhibited typical responding to the rewarded response that

is, their bias to the rewarded stimulus increased over time. However, OPRM1 G allele carriers exhibited a decline in response to the rewarded stimulus compared to the AA homozygotes. These results extend previous reports on the heritability of performance on this task by implicating a specific polymorphism. Through comparison with other studies using this task, a possible mechanism exists by which the OPRM1 polymorphism may confer reduced response to natural reward through a dopaminemediated decrease during positive reinforcement learning.

SYMPOSIUM 079

AMERICAN PSYCHIATRY AND HUMAN RIGHTS IN THE 21ST CENTURY: SERVICES TO SPECIAL POPULATIONS

Chair: Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the relevance of human rights concepts and UN conventions to the psychiatric and mental health needs of special populations, 2) Recognize the human rights implications of mental health disparities, xenophobia towards immigrants, and lack of appropriate services to women and children, 3) Recognize the role that psychiatry can play in advocacy for the needs of these special populations and the leverage that UN conventions can provide in this advocacy

SUMMARY:

Background: The focus of American Psychiatry for many years was on the human rights abuses by other nations and on how special populations in other nations (dissidents, refugees and displaced persons, torture victims) and the impact of their experiences on their mental health. Though such focus is legitimate, American psychiatry has rarely turned inward to examine the human rights record of our specialty and our health system as it relates to our own populations with special needs. This is particularly true as these relate to the various UN conventions that outline human rights across various domains and populations. Many of these conventions relate to issues that are directly relevant to disparities in care and the rights of vulnerable and minority populations. Objective: In this symposium (second of a two part series), the application of human rights principles to various aspects of mental health issues and psychiatric care to special populations in the U.S. will be examined. Methods: The presenters will focus on the relevance of mental health issues and access to care and human rights for ethnic/ racial underserved populations, women and children, immigrants and refugees within the current climate in the U.S., and people in the criminal jus-

tice system. Conclusions: An important mission for social psychiatry is addressing these human rights issues within the United States as they relate to populations with special needs.

S079-1.

HUMAN RIGHTS AND RACIAL/ETHNIC DISPARITIES

Presenter: Andres J. Pumariega, M.D.

SUMMARY:

Minority populations face a number of barriers to effective mental health care. These include population barriers (socioeconomic disparities, stigma, poor health education, lack of documentation), provider factors (deficits in cross-cultural knowledge and skills and attitudinal sensitivity), and systemic factors (services location and organization, lack of culturally competent services, etc.). These barriers result in increased mental health disparities among these populations. Latinos are the least likely of all groups to access specialty care (5.0%), even though Latinos and African-American children have the highest rates of need (10.5%). These disparities have resulted in the overrepresentation of minorities, both youth and adults, in other service sectors such as special education, child welfare and adult welfare, and criminal and juvenile justice. These issues are particularly acute among young children and among Latino youth (4). Hispanic families underutilize mental health services due to language and cultural barriers, while Asians-Americans experience shame around mental illness (5). Stigma is a major barrier to seeking mental health services in general, and cultural beliefs play a large role in the perpetuation of stigma. The fear of doublestigmatization (being culturally different as well as “crazy”) also presents major barriers for diverse families and youth to accessing services. This presentation will review the status of mental health disparities amongst underserved populations in the United States through the perspective of human rights, particularly as defined by the UN conventions on human rights, on the rights of the child, and on immigrant and refugees. Though the United States has embarked on some national level initiatives to address racial/ethnic disparities, these fall short of the needs involved and have yet to be integrated into efforts around health care reform and standards for Medicaid and Medicare. Reference: Alegria, M., Vallas, M., & Pumariega, A.J. Racial and ethnic disparities in pediatric mental health. *Child and Adolescent Psychiatric Clinics of North America*. 19 (4): 759774, 2010.

S079-2.

HUMAN RIGHTS AND MENTAL HEALTH OF WOMEN

Presenter: Beverly J. Fauman, M.D.

SUMMARY:

In 1973, in the decision *Roe v. Wade*, the Supreme Court ruled that a woman had the right to the private decision to terminate her pregnancy. Prior to that landmark decision, it commonly fell to psychiatrists to state that a pregnant woman would be at risk for suicide if forced to carry an unwanted pregnancy to term. Many of us recognized that this unevenly gave educated middle and upperclass women an option not readily available to less sophisticated women; it also put us in the position of having the power to grant an abortion “to save the life of the mother.” While we recognized that this was often deceptive (I am sure that most of the women for whom I wrote such letters were not and would not become suicidal) it demonstrates the lengths to which we would go to protect women from political and religious control over their bodies. This presentation will explore what impact social forces have had on women’s mental health, and how women have responded in recent decades. It will also discuss these issues in the context of human rights for women and the relevant UN conventions. For *Her Own Good: Two centuries of the experts’ advice to women*, Ehrenreich B and English D, Anchor Books, 2005

S079-3.

HUMAN RIGHTS AND SERVICES TO SPECIAL POPULATIONS: CHILDREN AND YOUTH

Presenter: Consuelo C. Cagande, M.D.

SUMMARY:

One of the most important international documents recognizing the human rights of children is the UNICEF’s Convention on the Rights of the Child Treaty. As of November 2005, 192 countries ratified the convention. Although, the U.S. played a major role and signed the convention, they have yet to ratify it, along with the other only country who has not ratified it, Somalia (1). On September 2000, the Surgeon General’s Conference on Children’s Mental Health (CMH): Developing a National Action Agenda was held. It’s goals fostered on the promotion of public awareness of children’s mental health issues, reducing the stigma, develop and implement prevention and treatment services in the field of CMH, improve assessment and recognition of mental health needs in children, eliminate racial/ethnic and SES disparities in access to MH care services, improve access to MH care services, train frontline providers and educate MH care providers and monitor the access to and coordination of quality of MH care services (2). Eleven years later the U.S. may have accomplished a few of these goals but we still lack services for children who have less to no access to mental health care, i.e. juvenile justice system, learning/

intellectually disabled, compounded by many factors, i.e. low socioeconomic status, inappropriate or lack of resource distribution. REFERENCES: (1) http://www.unicef.org/crc/index_30229.html (2) <http://www.surgeongeneral.gov/topics/cmh/childreport.html> (3) Pumariega, A.J. Children and Adolescents. In: Ruiz, P. & Primm, A. (Editors) Disparities in Psychiatric Care: Clinical and Cross Cultural Perspectives. Philadelphia: Lippincott Williams & Wilkins, In Press, Chapter 12, pp. 117126, 2009.

S079-4.

ADDRESSING HEALTH DISPARITIES IN IMMIGRANT AND REFUGEE CHILDREN IN THE UNITED STATES

Presenter: Eugenio M. Rothe, M.D.

SUMMARY:

Refugees are oftentimes very resilient and resourceful, despite the many difficulties that they face. In spite of this, experiences of persecution, violence, war, killing or torture as well as the subsequent losses suffered by these children and adolescents increase the risk of psychological distress and psychiatric disorders. PTSD symptoms have been found in children exposed to persecution, war and organized violence in many parts of the world. Even though there has been significant research involving the diagnosis and treatment of PTSD in young refugees, there still is a lack of accurate data on other mental health issues affecting this population and there is very limited information in their helpseeking and service utilization. Traditional Western mental health services and treatment approaches have not been historically effective with immigrants and refugees. They often underutilize traditional mental health services as a result of numerous internal and external barriers. These include the stigma associated with mental illness and treatment in their cultures and countries of origin (usually stronger than that seen in Western nations), a lack of clinicians who speak the languages and understand the cultures of refugees, low priority for obtaining mental health services among more pressing human needs (food, shelter, employment, etc.), and lack of finances or insurance coverage to pay for services. This presentation will discuss how the principles of culturally competent mental health services and community-based systems of care are most applicable to the development and delivery of effective mental health services to this particular population. Howard, M., & Hodes, M. (2000). Psychopathology, adversity, and service utilization of young refugees. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(3), 368–377. Rothe E. M., Pumariega A. J. (in press) The Mental Health of Immigrants and Refugee Children. In: U. Segal & D. Elliott (Eds) *Refugees Worldwide: Mental Health*, Vol 3.

SYMPOSIUM 080

UPDATE ON HIV AND AIDS PSYCHIATRY

Chair: Mary Ann Cohen, M.D.

Discussant: Mary Ann Cohen, 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, 3) Recognize and treat the psychiatric manifestations of HIV and AIDS and address the complexities of psychiatric diagnosis and psychopharmacology of HIV care, 4) Understand the role of the psychiatrist in decreasing risk behaviors, and 5) Understand how to decrease stigma of HIV

SUMMARY:

This symposium is designed to provide an update in AIDS psychiatry for psychosomatic medicine psychiatrists, general psychiatrists, and mental health clinicians. AIDS is a severe and complex multimorbid medical illness with a profound impact on patients, families, and caregivers. Understanding the 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 and affected with HIV. 1. Introduction and Discussion Mary Ann Cohen, MD a. Epidemiology b. History of AIDS Psychiatry c. Stigma d. AIDS as paradigm of psychosomatic medicine 2. HIV through the Life Cycle Suad Kapetanovic, MD and Adriana Carvalho MD a. Childhood and adolescence including transitioning b. Adulthood including pregnancy and reproductive aspects of HIV c. Older adulthood 3. Psychiatric Disorders Jordi Blanch, MD a. Cognitive disorders delirium and dementia b. Mood disorders c. Psychotic disorders d. Substance use disorders e. Anxiety disorders including PTSD 4. Psychiatric Treatments – Joseph Lux, MD and Kelly Cozza, MD a. Psychotherapeutic approaches to care (1) Settings and models of care (2) Networking, crisis intervention, psychodynamic psychotherapy, couple and family therapy, and other treatments b. Psychopharmacologic approaches to care (1) Psychiatric side effects of antiretrovirals (2) Psychotropic medications (3) Pharmacokinetics and pharmacodynamics 5. Multimorbid Medical Illness nonHIV and HIVrelated – Joseph Lux, MD a. HIVrelated b. NonHIVrelated c. Unique symptoms d. Potential for severe medical and disfiguring antiretroviral side effects 6. Palliative and End of Life Care Harold Goforth, MD a. Biopsychosocial approach to palliative care (1) Medical symptoms of pain, dyspnea, insomnia, nausea, vomiting, diarrhea, blindness, paralysis,

paresis, weakness, cachexia, pruritus, disfigurement from both illnesses and their treatments (2) Psychologic symptoms of depression, anxiety, confusion, psychosis, existential anxiety, death anxiety, bereavement, delirium, dementia (3) Social and spiritual concerns and needs including finding meaning, demoralization, loss of job, key roles, family, friends, partners b. Coping with alienation, social isolation, stigma c. Alleviation of suffering throughout the course of illness including the end of life

S080-1.

HIV THROUGH THE LIFE CYCLE: CHILDHOOD, ADOLESCENCE, AND REPRODUCTIVE HEALTH

Presenter: Suad Kapetanovic, M.D.

SUMMARY:

The objective of this presentation is to place mental health and psychiatric aspects of HIV care in the context of patient age, development and clinical milestones salient to HIV care. As HIVinfected persons move through the life with this now chronic illness, the nature of vulnerability of their mental health evolves. Concerns about impact of in utero exposure of developing brain to maternal HIV, immune dysregulation, antiretroviral medications and/or substances of abuse are followed by assessing the child's readiness for and psychosocial complications of diagnostic disclosure. With adolescence come concerns about risky health behaviors, such as nonadherence, unsafe sex or substance abuse which are soon to be followed by need to address reproductive health decisionmaking. The clinical manifestations and functional impact of psychiatric symptoms in HIVinfected individuals can be expected to evolve along the same continuum. This is a timely topic for both consultliaison psychiatrists and for those psychiatrists treating HIVinfected patients of all age groups in their practices, as the cohort of perinatally HIVinfected youth is entering the third decade of life.

S080-2.

HIV THROUGH THE LIFE CYCLE: AGING OF HIV POPULATION

Presenter: Adriana Carvalhal, M.D., Ph.D.

SUMMARY:

By 2015 more than half of all people living with HIV in the United States will be older than 50. With an aging HIV-infected population, and suggestions that HIV itself may cause conditions normally associated with aging, there is a pressing need for more research in this field. Patients infected with HIV lose brain functional abilities 15 to 20 years prematurely probably because of either HIV infection

itself or the treatments used to control it. Blood flow in the brains of HIV patients is reduced to levels normally seen in much older subjects. HIV can penetrate the brain causing varying degrees of cognitive deficits. Though the introduction of cART has decreased the incidence of HIVassociated dementia, many people living with HIV continue to experience cognitive deficits. Because of the increased survival of persons living with HIV, the prevalence of HIV associated neurocognitive impairment continues to increase. Cognitive deficits in persons with HIV have been shown to diminish quality of life and interfere with individuals' abilities to carry out daily tasks.

S080-3.

UPDATE ON HIV AND AIDS PSYCHIATRY PSYCHOPHARMACOLOGIC APPROACHES TO CARE

Presenter: Kelly L. Cozza, M.D.

SUMMARY:

Psychopharmacologic approaches to care. (1) Overview of Pharmacology and Drug Interaction Principles (2) Psychotropic medications and HIV (3) Overview of Antiretrovirals

S0804.

PSYCHIATRIC DISORDERS

Presenter: Jordi Blanch, Ph.D.

SUMMARY:

The prevalence of neuropsychiatric disorders in HIVinfected patients is high, and they are associated to a poorer outcome of the infection. However, they are often underdiagnosed and undertreated. Cognitive disorders, mood disorders, psychotic disorders, substance use disorders and anxiety are more prevalent in these patients than in the general population. Three forms of HIVassociated neurocognitive disorders were classified in three clinical forms according to the severity of the symptoms: asymptomatic neurocognitive impairment, mild neurocognitive disorder, and HIVassociated dementia. Depression in HIV+ patients could be difficult to differentiate from a "natural" reaction to HIV diagnosis. Second, many symptoms of depression can be confounded with physical symptoms of the HIV disease. And finally, some medications given to these patients can also produce depressive symptoms. Manic and psychotic symptoms could be the first presentation of the infection. A medical and neuropsychiatric evaluation and the use of lab tests and imaging are required to discard central nervous organic diseases due to HIV or due to immunosuppression. Substance use disorders increase the risk of getting HIV, but they are also associated to a poorer outcome of the illness due to a poorer antiretroviral adherence, the risk of modi-

fyng the pharmacokinetics of antiretrovirals, impairing cognition, and increasing the risk of reinfection. Anxiety symptoms could be confounded with physical symptoms and, on the other hand, anxiety disorders may increase fatigue and physical limitations and produce sleep problems.

S080-5.

MULTIMORBID MEDICAL ILLNESS: NONHIV AND HIVRELATED

Presenter: Joseph Z. Lux, M.D.

SUMMARY:

Infection with HIV and progression to AIDS is associated with a number of systemic medical complications and illnesses. These complications may include endocrine, metabolic, cardiovascular, dermatologic, gastrointestinal, ophthalmologic, oncologic, renal, and GI disorders. These disorders may be associated with HIV infection, or alternatively complications related to treatment with antiretroviral medications. Multimorbid medical illness in HIVinfected individuals will be discussed in this symposium. HIV infection is also commonly associated with Hepatitis C coinfection and a knowledge of this comorbidity and the emerging treatments for Hepatitis C will also be discussed in this symposium.

S080-6.

UPDATE ON HIV AND AIDS PSYCHIATRY: PALLIATIVE AND END OF LIFE CARE

Presenter: Harold W. Goforth, M.D.

SUMMARY:

This portion of the symposium will focus upon the goals of hospice and how they may be applied to HIV care at the end of life. Diagnostic criteria for HIV/AIDS and eligibility criteria for hospice will be reviewed, and special treatment considerations at the end of life will be discussed. At the conclusion of this portion of the presentation, audience members will better understand HIV/AIDS, pertinent symptoms and challenges related to end of life care, and appropriate hospice referral and selection.

SYMPOSIUM 081

IMPROVING QUALITY OF CARE FOR PATIENTS WITH PSYCHIATRIC ILLNESS: COMBINING AND INTEGRATING PSYCHOPHARMACOLOGICAL, INDIVIDUAL, AND FAMILY THERAPY

Co-Chairs: Alison M. Heru, M.D., Ira Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Have knowledge of the evidence for the efficacy of a combined, integrated treatment, 2) Understand general principles that can be applied regarding the sequence of interventions for specific disorders, 3) Know how to assess the needs of the patient as well as the family members/significant others

SUMMARY:

Individual therapy, family therapy and pharmacotherapy are wellaccepted evidencebased treatment interventions. Each of these treatments is indicated for axis I and II disorders and for problems of living. There has been little thought and limited research in how clinicians can integrate, combine and sequence these treatments and how to decide on which treatments to offer for a particular individual and their family / significant others. For many reasons, historical as well as financial, the central issue is that combined / integrated care is often not provided even when indicated. This symposium demonstrates how to combine these three modalities to improve patient care. We provide guidelines for effective intervention, based on a comprehensive assessment. For many decades, a biopsychosocial approach to patient care has meant a comprehensive assessment of the patient and their family environment but it has lacked guidelines for effective intervention. Clinical decisionmaking with the patient and the family involves a discussion of the biopsychosocial components that contribute to the illness, followed by a discussion of treatment options. The expectations that accompany each treatment modality must be discussed and the expected changes for each specific modality must be provided to the patient and family. Three expert clinicians will outline their model including a) its basic components, b) its methods, c) its evidence base with d) a special focus on indications/contraindications and how to combine 2 or 3 of these modalities. Each presenter will review their approach to one clinical case. The panel will then discuss the sequencing of treatments and the pros and cons of integrated care. The clinical case example will be distributed at the beginning of the symposium and referenced throughout each presentation. Cases will also be accepted from the audience for discussion in the last hour.

S081-1.

COMBINING PHARMACOTHERAPY WITH OTHER MODALITIES

Presenter: Alan F. Schatzberg, M.D.

SUMMARY:

Psychopharmacology has become a major approach in the treatment of patients with psychiatric disorders. The discipline has evolved from its humble beginnings with a limited

number of classes of agents with a relatively narrow range of mechanisms of action to now include a host of classes and agents many with disparate effects. This development demands considerable knowledge of the basic biology of the disorder as well as the specific pharmacology of specific agents. The development of the field however is not the only development in psychiatric treatment. Rather, there have been parallel developments in the psychotherapies as well as in devices such that the practitioner needs to be able to incorporate advances in all of them to most optimally help his or her patient. As a model of other areas in psychiatry, recent developments in psychopharmacology and stimulatory device treatment of major depression will be reviewed in conjunction with data from studies on the biology of early abuse and cognitive deficits in depression with an eye toward understanding how these various approaches can be integrated optimally to treating particular patients. Early child abuse is associated with an increased risk for developing increased responsiveness to stress as well as major depression in adulthood and this risk interacts with specific genetic vulnerability. These patients may respond to medication but do best when medications are combined with psychotherapy. An illustrative case will be presented. Optimally effective treatment outcomes will require sophisticated application of knowledge of biology, pharmacology and psychotherapy and training and education need to incorporate such approaches.

S081-2.**COMBINING INDIVIDUAL THERAPY WITH OTHER MODALITIES**

Presenter: Glen O. Gabbard, M.D.

SUMMARY:

In the practice of general psychiatry, one inevitably combines medication and psychotherapy techniques. However, this combination is undertheorized in our literature. In this presentation the practice of combining individual therapy strategies and pharmacotherapy will be systematically considered from the standpoint of enhancement of outcome, adherence, meanings of medication, and different modes of therapeutic action. The presentation will also address the practical matter of sequencing of the two modalities overall and within sessions.

S081-3.**FAMILY INTERVENTION BY PSYCHIATRISTS AS A ROUTINE COMPONENT OF PATIENT CARE**

Presenter: Gabor I. Keitner, M.D.

SUMMARY:

Illnesses onset and evolve in a social context and impact on friends and relatives of the ill person. The ways in which the patient's significant others, in turn, deal with the illness influences its course and outcome. It is necessary, therefore, to involve the families of patients in the assessment and treatment process. Family interventions can be stand alone treatments or adjunctive to pharmacotherapy and psychotherapy. A number of different family assessment and family therapy models have been tested for use in many different illnesses. In general, family interventions have been found to be useful in the management of many chronic medical conditions as well as in major depression, bipolar disorder, anxiety disorders, schizophrenia and substance abuse. Most psychiatrists are not comfortable with or skilled in working with families in spite of the evidence for its usefulness. This presentation will outline ways in which psychiatrists can systematically involve the families of patients in their assessment and treatment and ways to combine and integrate family interventions with pharmacotherapy and psychotherapy.

SYMPOSIUM 082**INTEGRATED CARE AND THE FUTURE OF PSYCHIATRY: TEACHING PSYCHIATRY RESIDENTS AND FELLOWS TO WORK AT THE INTERFACE OF MENTAL HEALTH AND PRIMARY CARE**

Co-Chairs: Deborah S. Cowley, M.D., Robert M. McCarron, D.O.

Discussant: Barry S. Solomon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss the role of the psychiatrist as a consultant, primary medical provider, or supervisor of populationbased mental health care in primary care settings, 2) Discuss the skills required of psychiatrists in primary care settings and how to teach residents and fellows these skills, 3) Discuss opportunities and challenges in establishing clinical rotations and educational experiences to teach trainees skills in primary care psychiatry, 4) Discuss the role of the psychiatrist of the future in integrated care settings, such as medical homes and accountable care organizations, and how to prepare trainees for this role

SUMMARY:

Over 20% of children and adults in the U.S. have a diagnosable mental disorder and most of these individuals first present to their primary care providers for routine care. Those with mental disorders have significant medical comorbidity, decreased life expectancy, and generate higher health care costs than those without psychiatric disorders.

Common barriers faced by primary care providers in caring for these patients include lack of access to traditional behavioral health services, lack of time, inadequate training, and 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 psychiatry residents and fellows. At Cambridge Health Alliance, psychiatry residents and psychosomatic medicine fellows provide consultation in several multiethnic primary care and specialty medical clinics. At Johns Hopkins, child psychiatry fellows are colocated 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, and a collaborative care model for treating depression has been implemented in some sites. At the University of Washington, psychiatry residents learn to provide psychiatric consultation in primary care clinics, and skills in population-based care, supervising other mental health providers. Educators from these programs will discuss opportunities, challenges, and rotation goals; unique skills that psychiatrists need in order to provide integrated care and how to teach them; and how integration relates to health care reform models such as medical homes and accountable care organizations.

S082-1.

TRAINING CHALLENGES FOR RESIDENTS IN PSYCHOSOMATIC MEDICINE POSED BY NEW MODELS OF HEALTH CARE DELIVERY: INTEGRATED CARE AND THE “MEDICAL HOME”

Presenter: Marshall Forstein, M.D.

SUMMARY:

Cambridge Health Alliance has had elements of integrated mental health care in ambulatory medical clinics for several years. Integration has taken on more prominence as the organization is reorganized itself along the lines of medical homes and prepares to become an Accountable Care Organization. In this context training in internal medicine,

family practice and psychiatry has been challenged to adapt to the changing landscape and prepare residents for such work in the future. Currently, all adult psychiatry residents work (for six months one half day a week) in one of our community medical centers. Since many of our patients are of diverse ethnic and racial backgrounds, residents and psychosomatic fellows learn how to use interpreters to evaluate and treat patients who speak a language other than their own. Residents and fellows see patients referred by the primary care physicians and determine whether the patient needs brief therapy, medications, ongoing treatment, or even in acute situations, hospitalization. Attending psychiatrists are available during the time the resident is in the primary care clinic. Psychiatry trainees learn how to assess and provide a written consultation, providing formal and case based guidance to primary care providers about mental health care that can be administered by the primary care provider, such as starting antidepressants, etc. Complicated comorbidities and serious mental illness are often referred to a psychiatric clinic. Trainees and attendings meet with primary care docs in teams and discuss complex cases and comorbid psychiatric/medical conditions. Integrating psychiatry into the primary care clinics poses challenges that are both structural (space, administrative support, etc) and conceptual: primary care providers must learn how to use psychiatry as consultants and as part of the ongoing team of providers. Psychiatry trainees must learn how to “fit in” to their limited schedule the unending number of patients needing both assessment and ongoing care. They must also learn to be very flexible in assessment and treatment, challenging more traditional ways of thinking about treatment. Primary care and psychiatry attendings are often faced with teaching a model of care that they were not taught. This presentation will describe some of the efforts within the department of psychiatry to meet these new demands.

S082-2.

TRAINING CHALLENGES FOR RESIDENTS AND FELLOWS IN PSYCHOSOMATIC MEDICINE POSED BY NEW MODELS OF HEALTH CARE DELIVERY: INTEGRATED CARE AND THE “MEDICAL HOME”

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

SUMMARY:

Cambridge Health Alliance has had elements of integrated mental health care in ambulatory medical clinics for several years. Integration has taken on more prominence as the organization is reorganized itself along the lines of medical homes and prepares to become an Accountable Care Organization. In this context training in internal medicine, family practice and psychiatry has been challenged to adapt to the changing landscape and prepare residents for such work in the future. Currently, all adult psychiatry residents

work (for six months one half day a week) in one of our community medical centers. Since many of our patients are of diverse ethnic and racial backgrounds, residents and psychosomatic fellows learn how to use interpreters to evaluate and treat patients who speak a language other than their own. Residents and fellows see patients referred by the primary care physicians and determine whether the patient needs brief therapy, medications, ongoing treatment, or even in acute situations, hospitalization. Attending psychiatrists are available during the time the resident is in the primary care clinic. Psychiatry trainees learn how to assess and provide a written consultation, providing formal and case based guidance to primary care providers about mental health care that can be administered by the primary care provider, such as starting antidepressants, etc. Complicated comorbidities and serious mental illness are often referred to a psychiatric clinic. Trainees and attendings meet with primary care docs in teams and discuss complex cases and comorbid psychiatric/medical conditions. Integrating psychiatry into the primary care clinics poses challenges that are both structural (space, administrative support, etc.) and conceptual: primary care providers must learn how to use psychiatry as consultants and as part of the ongoing team of providers. Psychiatry trainees must learn how to “fit in” to their limited schedule the unending number of patients needing both assessment and ongoing care. They must also learn to be very flexible in assessment and treatment, challenging more traditional ways of thinking about treatment. Primary care and psychiatry attendings are often faced with teaching a model of care that they were not taught. This presentation will describe some of the efforts within the department of psychiatry to meet these new demands.

S082-3.

MENTAL HEALTH INTEGRATION IN A PEDIATRIC PRIMARY CARE CLINIC: PROVIDING CARE AND CROSSTRAINING PEDIATRIC AND CHILD PSYCHIATRY RESIDENTS

Presenter: Emily Frosch, M.D.

SUMMARY:

More than 20% of children and adolescents in the United States have a diagnosable behavioral or mental health problem, but only 20% of those receive adequate treatment. Primary care clinicians play a critical role in not only identifying but also often treating and managing such conditions. Awareness of, training in, and comfort with mental health problems, however, remains variable across pediatric primary care providers. In an effort to address this important patient care issue, a number of academic medical centers have successfully implemented models of integrated behavioral and mental health services within primary care

residency training practices. This presentation will focus on one such model at a large, urban academic center. The Harriet Lane Clinic (HLC) at the Johns Hopkins Children's Center serves as the medical home for 8,500 infants, children and adolescents in the surrounding East Baltimore community. The patient population is primarily African American and low income, with nearly 90% eligible for public insurance through Medicaid. Many patients and families experience major social and financial challenges associated with living in poverty, including issues of substance use, homelessness, unemployment, and mental health problems. In an effort to provide comprehensive care, the clinic has become a “onestop shop” with an integrated array of onsite multidisciplinary services, including but not limited to onsite mental health consultation, nutrition and lactation consultation, legal services, and dental services. The HLC serves as the main primary care and adolescent medicine training site for the Johns Hopkins Pediatric Residency Program and over 60 residents have their continuity clinic experience in the HLC. We have developed a mental health consultation model and a core mental health rotation which engages residents as experiential learners working side-by-side with mental health professionals in a variety of settings. The goals of this rotation include demystifying the referral process, building interdisciplinary relationships, enhancing awareness of resources, and increasing both comfort with and confidence in identifying, managing, and referring mental health issues. Pediatric Residents each rotate to the Hopkins Children's Mental Health Center and other mental health settings (inpatient and outpatient programs) and Child Psychiatry Residents rotate to the HLC to be available for direct consultation. The rotation ha

S082-4.

IMPACT OF INTEGRATED PSYCHIATRY PRIMARY MEDICAL CARE TRAINING ON RESIDENT COMFORT WITH GENERAL MEDICAL CONCERNS IN PATIENTS WITH MENTAL DISORDERS

Presenter: Kristen Snyder, 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. This is an elective rotation during which the resident is responsible for delivering all ongoing primary medical and psychiatric care for the patients in their panels. Patients must have at least one chronic psychiatric disorder and may have multiple medical diagnoses, frequently including chronic conditions such as hypertension, hyperlipidemia, diabetes, COPD and various pain disorders. The clinic takes place for one half day per week

in Portland VA primary care clinics, where the residents typically work side by side with OHSU medicine residents. Psychiatry and medical faculty provide onsite supervision and the psychiatry residents review literature and didactic materials with faculty on common medical and psychiatric topics relevant to the patient population served. The residents also have the opportunity to accompany home health providers on routine visits to their patients. Psychiatry residents enter the PPMC program typically during their second, third or fourth postgraduate years and remain in the program for a minimum of one year. The PPMC program generally has been selected by residents voicing a desire to retain their identity as physicians. 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 evaluation and 4) increasing comfort and familiarity with integrated care concepts. The program has demonstrated clinical outcomes comparable to that of standard care and high satisfaction in patient participants. Further, data supports achievement of the rotation goals in graduates from PPMC. However, we have not seen increased rates of performing medical screening or providing treatment of medical issues in graduates from the program in their subsequent clinical settings and continue to explore whether trends towards development of medical home models will increase participation of residents trained in integrated care in such settings.

S082-5.

INTEGRATED CARE AND THE FUTURE OF PSYCHIATRY: EDUCATING PSYCHIATRISTS TO WORK AT THE INTERFACE OF MENTAL HEALTH AND PRIMARY CARE

Presenter: Jaesu Han, M.D.

SUMMARY:

University of California, Davis has developed several clinical teaching sites that work to coordinate primary care and psychiatry. During this symposium Dr Han and McCarron will describe their experience setting up and managing the teaching sites. Two university sites consist of primary care residents working with combined trained faculty (Family Medicine and Internal Medicine / Psychiatry) to provide psychiatric consultation in the primary care setting. As psychiatry rotations are not residency requirements in either family medicine or internal medicine residency, this consultative experience in a primary care setting is fairly unique. In a county primary care site, combined trained faculty supervise psychiatry residents during an outpatient medicine rotation that replaces the more typical but less clinically relevant inpatient medicine experience utilized

by most psychiatry residency training programs. Senior psychiatry residents also provide psychiatric consultation in the county primary care setting. Finally, a collaborative care model for treatment depression has been implemented at both university and county sites.

S082-6.

USING AN ELECTIVE ROTATION IN AN INTEGRATED CARE PROGRAM TO FOSTER DEVELOPMENT OF RESIDENT PSYCHIATRIST CONSULTING SKILLS

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

SUMMARY:

The Mental Health Integration Program (MHIP) is a Washington statewide, evidence and outcomebased model of collaborative stepped care to treat common mental disorders in primary care settings. A University of Washington resident elective rotation provides the opportunity for a resident to work closely with a MHIP consulting psychiatrist and participate in weekly phone consultation with a behavioral health specialist located in a primary care clinic. Residents are responsible for developing formulations and treatment plans for patients to be implemented in a primary care setting. Additionally, residents have the opportunity to participate in clinic visits to primary care sites to provide inperson consultation and primary care provider education. Rotation goals include: to be able to define the key components of an integrated mental health program, to be familiar with the evidencebased literature about integrated mental health programs, to be able to describe the different roles and providers in an integrated mental health program and the ways they support clients, to have developed comfort using screening questionnaires to aid in diagnosis and treatment of common mental health disorders, to be familiar with the evidencebased literature about providing mental health care in a primary care setting, to have developed an educational talk to deliver to a primary care team, to become more skilled in caseload consultation with behavioral health specialists and to be able to demonstrate that they actively participated in and provided psychiatric consultation in an integrated care team.

SYMPOSIUM 083

ASSESSMENT OF SUBSTANCE USE DISORDER PATIENT OUTCOMES BASED ON LONGITUDINAL REGISTRY/EMR DATA

Chair: Petra Jacobs, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify gaps in knowledge and practice regard-

ing mental health illnesses, including psychiatric and SUD comorbidity, drug related mortality risk among patients receiving opioid prescription for pain and patients with opioid addiction, 2) Discuss the importance of collecting and analyzing clinical data to address these gaps and improve patient outcomes and provide examples from US and internationally, 3) Discuss how the use of large clinical databases, registries and EMR can improve the identification and treatment of highrisk psychiatric and SUD patient populations

SUMMARY:

Registries are observational studies used to collect uniform data to evaluate outcomes in a population defined by a disease, condition, or exposure. Specifically, a registry can describe the natural history of disease, provide baseline and temporal trends in treated and untreated patients, elucidate rare/unknown adverse events in real world clinical practice, observe relationships between disease state, practice patterns, and outcomes, and describe longterm effectiveness of treatments. Dr. Donald Stablein will present methodologies used to assess Registry data and provide examples of research findings that inform clinical practice in the United States.

S083-1.

OVERVIEW OF METHODOLOGIES USED TO ASSESS LARGE REGISTRY DATABASES

Presenter: Donald Stablein, Ph.D.

SUMMARY:

Registries are observational studies used to collect uniform data to evaluate outcomes in a population defined by a disease, condition, or exposure. Specifically, a registry can describe the natural history of disease, provide baseline and temporal trends in treated and untreated patients, elucidate rare/unknown adverse events in real world clinical practice, observe relationships between disease state, practice patterns, and outcomes, and describe longterm effectiveness of treatments. Dr. Donald Stablein will present methodologies used to assess registry data and provide examples of research findings that inform clinical practice in the United States.

S083-2.

SUBSTANCE USE DISORDERS AND COMORBID PSYCHIATRIC DISORDERS AMONG YOUNG PSYCHIATRIC PATIENTS: FINDINGS FROM A LARGE ELECTRONIC HEALTH RECORDS DATABASE

Presenter: LiTzy Wu, D.Sc., M.A.

SUMMARY:

This study examined the prevalence of substance use disorders (SUDs) among psychiatric patients aged 217 years in an electronic health records database (N=11,457) and determined patterns of comorbid diagnoses among patients with a SUD to inform emerging comparative effectiveness research (CER) efforts. DSMIV diagnoses of all inpatients and outpatients at a large universitybased hospital and its associated psychiatric clinics were systematically captured between 2000 and 2010: SUD, anxiety (AD), mood (MD), conduct (CD), attention deficit/hyperactivity (ADHD), personality (PD), adjustment, eating, impulsecontrol, psychotic, learning, mental retardation, and relational disorders. The prevalence of SUD in the 212year age group (n=6210) was 1.6% and increased to 25% in the 1317year age group (n=5247). Cannabis diagnosis was the most prevalent SUD, accounting for more than 80% of all SUD cases. Among patients with a SUD (n=1423), children aged 212 years (95%) and females (75100%) showed high rates of comorbidities; blacks were more likely than whites to be diagnosed with CD, impulsecontrol, and psychotic diagnoses, while whites had elevated odds of having AD, ADHD, MD, PD, relational, and eating diagnoses. Patients with a SUD used more inpatient treatment than patients without a SUD (43% vs. 21%); children, females, and blacks had elevated odds of inpatient psychiatric treatment. Collectively, results add clinical evidence on treatment needs and diagnostic patterns for understudied diagnoses.

S083-3.

PRESENTATION OF EUROPEAN AND AUSTRALIAN COHORTS THAT ASSESS THE RISK AND ASSOCIATED INFLUENCES ON MORTALITY DURING AND AFTER OPIOID TREATMENTS

Presenter: Matt Hickman, M.S.C., Ph.D.

SUMMARY:

We present findings from International Cohorts (UK, Italy, Australia) show that: drug related mortality risk is high among opioid and injecting drug users; the risk of mortality is reduced during a specialist drug treatments (especially opiate substitution treatment (OST)); but there are temporary increases in mortality risk both at treatment initiation and cessation. In Western Europe and Australia, opiate users' mortality risk can be 12% annually: >10 times higher than the general population. Overdose due to respiratory depression contributes 5080% death prior to long term cessation of injection/opiate use. Death rates during OST are 2 to 5fold lower than the mortality risk out of treatment. In the Australian cohort, the risk of mortality was higher on treatment initiation (45 times) than treatment cessation (~3 times) compared to the risk of death during the rest

of the treatment episode. Deaths in the first few weeks of treatment may be due to overdose induced by a precipitate increase in prescribed dose and/or patients concurrently taking heroin or illegal supplies of opiates with their substitution treatment, as well as an increased risk of suicide and other injury. In Italy and the UK, the overdose and allcause mortality rates were 810 fold higher in the month following treatment, compared to the mortality rates after the first month of treatment. There was no evidence of a marked difference in the mortality rates after treatment in those prescribed methadone or buprenorphine, but some suggestion that overdose deaths in the first two weeks may be lower in those initiated on buprenorphine rather than methadone. Natural history studies in UK illustrate the persistence of addiction and high probability of relapse following periods of abstinence, as well as improved survival in patients exposed to prolonged drug treatment. These findings raise several important issues for clinicians and policymakers. First, increasing treatment duration as well as scaling up treatment delivery may be critical to achieving a reduction in drug related deaths in the population. E.G. in the UK a fivefold scale up of OST, though associated with a reduction in methadone related deaths per daily dose after the introduction of supervised consumption, did not lead to any observed reduction in the overall number of opiate related deaths.

S083-4.

PRESENTATION OF EMR SYSTEM IN ITALY AND OUTCOME STUDIES USING ITS DATA

Presenter: Roberto Mollica, M.D.

SUMMARY:

National EMR used in Italy is a tool that allow to record information on patients regarding several aspects related to treatment for addiction: personal data (sociodemographic), used drugs, type of treatment(s) delivered and activities and therapies provided within it (like medication), serologic status for HIV, HBV and HCV, presence of comorbid diseases other than addiction. Adding some simple further information like urine probes results collected during treatments it is possible make an evaluation of outcome. In this study will be presented results from 18.000 patients undergoing methadone or buprenorphine treatment in Italy. Moreover, it will be showed how intraoperability among different systems can allow to achieve clinical and scientific output using basic and standard administrative data.

S083-5.

USING NATIONAL VA PATIENT DATABASES AND REGISTRIES TO EVALUATE CARE AND OUTCOMES FOR PATIENTS WITH MENTAL AND SUBSTANCE

USE DISORDERS

Presenter: Frederic Blow, Ph.D.

SUMMARY:

The US Department of Veterans Affairs Veterans Health Administration (VHA) operates the largest healthcare system nationally, providing care to over 5.5 millions veterans annually. The VHA has a comprehensive clinical EMR that is abstracted and rolled up nationally in databases that include diagnostic, utilization, pharmacy, and other clinical data. Several national longitudinal registries of individuals with psychiatric illnesses have been constructed and are used for evaluation by the VHA's National Serious Mental Illness Treatment Resource and Evaluation Center (SMITREC) since 1998. These include the National Psychosis Registry, the National Registry for Depression, and a national database on completed suicides. This presentation will discuss the use of these national databases and registries for monitoring care and outcomes of individuals with comorbid substance use disorders and other mental health conditions.

SYMPOSIUM 084

MENTALIZING: CURRENT CORE CONCEPTS

Chair: Howard E. Book, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Operationally define mentalization, 2) List three ways in which mentalizing improves clinical care, 3) Describe the benefits of mentalizing in psych/med education

SUMMARY:

“Mentalizing” as a psychodynamic concept and cognitive capacity, has become a major focus in understanding how individuals maintain robust relationships in their daytoday social encounters, at work and at play, with family, friends, and even strangers. For those of us in the mental health field, mentalizing has emerged as a key focus in understanding, addressing, and enhancing weaknesses in intra and interpersonal functioning that exist across clinical syndromes. This symposium offers attendees an opportunity to deepen their core knowledge of what “mentalizing” is, and its relationship to “empathy;” the significance mentalizing has for delivering good clinical care in psychiatry; the importance of mentalizing in teaching medical students and residents; and how and what the therapist says and does during psychotherapy to enhance the patient's capacity to mentalize. Each presentation is clinically grounded, and offers case vignettes to illustrate the concepts discussed. The question and answer period following each presentation,

and at the end of the overall symposium, gives attendees an opportunity to comment on, and ask questions about, the information presented.

S084-1.

MENTALIZING: CURRENT KEY CONSTRUCTS

Presenter: Howard E. Book, M.D.

SUMMARY:

Mentalizing is a core intra and interpersonal skill that promotes adaptive social functioning in human beings. Relative deficiencies in this capacity cut through most psychiatric diagnoses, and specific psychotherapeutic interventions, offer patients the opportunity to enhance or develop this skill. Illustrated by clinical vignettes, this presentation offers an updated operationalized and psychodynamic definition of mentalizing, and its intrapersonal and interpersonal relevance in predicting, and therefore influencing one's own, and others' behaviour. It then describes prementalizing thinking modes ("teleological" and "equivalence/pretend" modes) as well as complex mentalizing capacities. This presentation then moves to compare, contrast, and relate "mentalizing" to "empathizing," another core social skill with which it is often confused. Using case vignettes, this paper underlines particular differences in the therapist's use of his/her mentalizing and empathizing capacities in offering psychotherapeutic interventions to the patient.

S084-2.

HOW MENTALIZATION CONTRIBUTES TO GOOD PSYCHIATRIC MANAGEMENT

Presenter: John G. Gunderson, M.D.

SUMMARY:

Enhanced capacity for mentalizing is likely central to all effective psychotherapies. In good psychiatric management, expanding the patient's capacity to mentalize often takes the forms of: (1) Helping patients develop a life narrative in which they see themselves as active and accountable participants, rather than passive or blaming subjects; (2) Facilitating patients' consideration of how they effect the therapist's feelings and behaviours, by extension, how their behavior impacts others in their life; (3) Aiding patients in recognizing that how they see themselves may be quite different than how others view them; (4) Using role modeling to illustrate the importance of curiosity, patience, and tolerance of "not knowing" in deeply understanding themselves and others; and, (5) Prescribing medications with the patient as an active collaborator in assessing the value that particular drug has for them. This presentation will use case vignettes to illustrate these concepts and interventions, with the goal

of demonstrating how mentalization contributes to good psychiatric management.

S084-3.

A ROLE FOR MENTALIZING IN PSYCHIATRIC AND MEDICAL EDUCATION

Presenter: Jon J. Hunter, M.D.

SUMMARY:

Mentalizing has proven to be a helpful concept for understanding and treating patients psychotherapeutically. The premise of this paper is that many of the concepts inherent to mentalizing (and attachment theory more generally) can focus and deepen training in psychiatry and medicine, by first impacting on how the instructor relates to the student, and secondly, on how the student relates to the patient. In particular it emphasizes that students are individuals, engaged in the developmental acquisition of capacity. As such, they will benefit from teaching that recognizes their individuality, and that provides a 'secure base' via the presence of the instructor that will optimize safe exploration of concepts, thus maximizing knowledge transfer. This is achieved by the teacher effectively and accurately mentalizing about the student, as well as modeling mentalizing about the patient, so that the student can both experience being mentalized, and observe clinical mentalizing by the teacher. The ultimate goal is to increase the student's capacity to mentalize about their patients. Approached this way, a teacher can help a student appreciate the way they contribute to interactions, and enable them to participate in the relationship with the patient in a manner that optimizes alliance, and diminishes countertransference reactions. The insight provided typically occurs with better boundary maintenance and less intrusion than can occur in some supervisory relationships that blend into a pseudo-therapy for the student. In particular, this approach has been a productive 'shortcut' in the education of medical students going into fields other than psychiatry. These students wish for increased understanding and expertise in understanding doctor-patient relationships, but do not find that a medical-based curriculum about DSM diagnoses advantages them in this regard, nor do they have the time or interest to delve into deeper psychodynamic training. We encourage them to wonder about and explore what is in a patient's mind during the clinical encounter, especially about them as doctors who are nevertheless strangers approaching at a time of illness and anxiety. Adding to this a reflection on how they are experiencing the patient within their own mind further adds to their capacity to appreciate the patient's unique circumstances, and work more closely on shared goals with them. Therefore, mentalizing contributes to medical training, both as content (a subject

S084-4.

GENERIC MENTALIZATIONBASED INTERVENTIONS: HOW TO FOSTER A MENTALIZING STANCE IN YOUR PATIENTS*Presenter: Patrick Luyten, Ph.D.***SUMMARY:**

Mentalizing, the ability to understand ourselves and others in terms of mental states, is a fundamental capacity that allows us to navigate our social world. Although mentalizationbased interventions were initially developed in the context of the treatment of patients with severe impairments in mentalizing, such as patients with Borderline Personality Disorder, the scope of mentalizationbased treatments has considerably broadened, and now includes treatments for patients suffering from eating and anxiety disorders, depression, drug addiction, and antisocial personality disorder. In addition, several intervention programs for at-risk mothers and adolescents are currently being evaluated. Despite their differences, all these interventions are rooted in the same therapeutic stance and incorporate similar mentalizing techniques. Moreover, to the extent that all forms of psychopathology involve impairments in mentalizing, a focus on mentalizing is likely to increase the effects of therapeutic interventions, regardless of the specific kind of intervention that is offered. In this presentation, I will outline the basic therapeutic stance as well as basic and advanced techniques that promote mentalization based on a multidimensional understanding of mentalizing. This will include a discussion of the typical sequence of interventions in mentalizingbased treatments, starting from the identification of a break in mentalizing. This will also involve a discussion of how to recognize and address nonmentalizing modes (i.e., psychic equivalence, teleological and pretend mode). Finally, more advanced mentalizationbased interventions will be outlined. Examples and clinical vignettes are used to illustrate these techniques and interventions.

SYMPOSIUM 085**PSYCHOSOCIAL TREATMENTS FOR PEDIATRIC BIPOLAR DISORDER: IMPROVING THE PROGNOSIS BEYOND MEDICATIONS***Chair: Darryl C. Smith, M.D., M.P.H.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session the participant should be able to: 1) Understand the limitations of pharmacological treatment in bipolar disorder, 2) Identify similarities and differences between the typical presentation of bipolar disorder in children and the classic adult presentation, 3) Recognize which symptoms and risk factors are helpful in

recognizing bipolar disorder and which may be red herrings, 4) Use assessment procedures to aid in differential diagnosis and measuring response to treatment, and 5) Describe different psychosocial modalities in the treatment of bipolar disorder and understand the potential impact of their integration into bipolar treatment

SUMMARY:

Bipolar spectrum disorders are estimated to affect up to 8.3% of the population (1). BPD is the 6th leading of cause disability in the US (2). Suicide rates are estimated at 10 to 20 times the general population in the US (3). Both patients and their families can suffer academically, socially, emotional, and occupationally. (4). Symptoms of bipolar disorder can be seen in up to 60% of adults before the age of 20 (5). This is a prime point to intervene to improve the lifetime prognosis. Early treatments for BPD focused primarily on psychopharmacological modalities. Although there has been overall success with treatment with lithium, second-generation antipsychotics, and anticonvulsants, the treatment response rates are still only roughly 50% (6, 7). More recent studies have shown some utility for the integration of psychosocial methods into treatment plans to improve the overall prognosis (8). Drawing upon audience participation, as well as a widely representative speaking panel, this symposium will address 1) challenges in the diagnosis of pediatric bipolar 2) identification of risk factors for the guidance of treatment planning 3) the possible overall impact of psychosocial treatments on bipolar disorder, 4) psychoeducational treatment, 5) familyfocused therapy, 6) interpersonal therapy and 7) cognitive behavioral therapy. The intended audience is clinicians interested in treatment alternatives in bipolar disorder. Child and adolescent psychiatry/psychology practitioners will participate in the discussion. This symposium is chaired by a current APA Child Fellow. Literature References 1. Merikangas KR, Akiskal HS, Angst J, et al. Lifetime and 12month prevalence of bipolar spectrum disorder in the National Comorbidity Survey replication. *Arch Gen Psychiatry*. May; 2007 64(5): 543–552. [PubMed: 17485606] 2. Murray, C.; Lopez, A. *The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Disease, Injuries, and Risk Factors in 1990 and Projected to 2020*. Cambridge, MA: Harvard University Press; 1996. 3. Baldessarini RJ, Tondo L, Hennen J. Lithium treatment and suicide risk in major affective disorders: update and new findings. *J Clin Psychiatry*. 2003; 64(Suppl 5):44–52. [PubMed: 12720484] 4. Egeland JA, Hostetter AM, Pauls DL, Sussex JN. Prodromal symptoms before onset of manicdepressive disorder suggested by first hospital admission histories. *J Am Acad Child Adolesc Psychiatry*. Oct; 2000 39(10):1245–1252. 5. Lewinsohn PM, Klein DN, Seeley JR. Bipolar disorders in a community sample of older adolescents: prevalence, phenomenology, comorbidity, and course. *J Am Acad Child Adolesc Psychiatry*. Apr; 1995

34(4):454–463. 6. Loranger AW, Levine PM. Age at onset of bipolar affective illness. *Arch Gen Psychiatry*. Nov; 1978 35(11):1345–1348. 7. Biederman J, Joshi G, Mick E, et al. A prospective openlabel trial of lamotrigine monotherapy in children and adolescents with bipolar disorder. *CNS Neurosci*

S085-1.

ANYTHING BESIDES MEDICATION? AN OVERVIEW OF ALTERNATIVES TO PHARMACOTHERAPY IN THE TREATMENT OF PEDIATRIC BIPOLAR DISORDER

Presenter: Darryl C. Smith, M.D., M.P.H.

SUMMARY:

Bipolar disorder in children and adolescents is both difficult to diagnose and treat. Symptoms of bipolar disorder can be seen in up to 60% of adults before the age of 20 (1). Unfortunately, medications have only lead to modest improvements in remission rates (2). In order to narrow this nearly 50% gap, psychosocial treatments offer alternatives to standard pharmacotherapy that may result in an even greater prognosis. Unlike psychopharmacological trials, many randomized trials have not been conducted. This presentation will help the audience understand the utility of such interventions. It will begin with a discussion of the current limitations to the treatment of pediatric bipolar disorder. The following psychosocial treatments and associated major recent study findings will then be discussed: 1) cognitivebehavioral therapy 2) dialectical behavioral therapy 4) familyfocused therapy 5) psychoeducational and 6) interpersonal social rhythm therapy. The second half of Dr. Smith's presentation will focus on ways of improving existing treatment and overcoming existing gaps and barriers based on the current state of medical treatment. Core principles of integrated assessment prior to treatment planning and research gaps and directions for future research will conclude the discussion. References 1) Egeland JA, Hostetter AM, Pauls DL, Sussex JN. Prodromal symptoms before onset of manicdepressive disorder suggested by first hospital admission histories. *J Am Acad Child Adolesc Psychiatry*. Oct; 2000 39(10):1245–1252. 2) Loranger AW, Levine PM. Age at onset of bipolar affective illness. *Arch Gen Psychiatry*. Nov; 1978 35(11):1345–1348.

S085-2.

THE ASSESSMENT OF CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER

Presenter: Eric A. Youngstrom, Ph.D.

SUMMARY:

The overarching goal of this article is to examine the cur-

rent best evidence for assessing bipolar disorder (BPD) in children and adolescents and provide a comprehensive, evidencebased approach to diagnosis. Evidence based assessment strategies are organized around the “3 Ps” of clinical assessment: Predict important criteria or developmental trajectories, Prescribe a change in treatment choice, and inform Process of treating the youth and his/her family. The review characterizes BPD in youthsspecifically addressing bipolar diagnoses and clinical subtypes; it then provides an actuarial approach to assessment using prevalence of disorder, risk factors, and questionnaires; discusses treatment thresholds; and identifies practical measures of process and outcomes. The clinical tools and risk factors selected for inclusion in this review represent the best empirical evidence in the literature. By the end of the article, clinicians will have a framework and set of clinically useful tools with which to effectively make evidencebased decisions regarding the diagnosis of BPD in children and adolescents.

S085-3.

FUNCTIONAL IMPAIRMENT, STRESS, AND PSYCHOSOCIAL INTERVENTION IN BIPOLAR DISORDER

Presenter: David J. Miklowitz, Ph.D.

SUMMARY:

The longitudinal course of bipolar disorder (BD) is highly impairing. This article reviews recent research on functional impairment in the course of BD, the roles of social and intrafamilial stress in relapse and recovery, and the role of adjunctive psychosocial interventions in reducing risk and enhancing functioning. Comparative findings in adult and childhood BD are highlighted. Life events and familyexpressed emotion have emerged as significant predictors of the course of BD. Studies of social information processing suggest that impairments in the recognition of facial emotions may characterize both adult and earlyonset bipolar patients. Newly developed psychosocial interventions, particularly those that focus on family and social relationships, are associated with more rapid recovery from episodes and better psychosocial functioning. Familybased psychoeducational approaches are promising as early interventions for children with BD or children at risk of developing the disorder. For adults, interpersonal therapy, mindfulnessbased strategies, and cognitive remediation may offer promise in enhancing functioning.

S085-4.

A CHILD AND FAMILYFOCUSED CBT FOR PEDIATRIC BIPOLAR DISORDER: DEVELOPMENT AND PRELIMINARY RESULTS

Presenter: Sally Weinstein, Ph.D.

SUMMARY:

OBJECTIVE: To describe child and family-focused cognitive-behavioral therapy (CFFCBT), a new developmentally sensitive psychosocial intervention for pediatric bipolar disorder (PBD) that is intended for use along with medication. CFFCBT integrates principles of family-focused therapy with those of CBT. The theoretical framework is based on (1) the specific problems of children and families coping with bipolar disorder, (2) a biological theory of excessive reactivity, and (3) the role of environmental stressors in outcome. CFFCBT actively engages parents and children over 12-hour-long sessions. **METHOD:** An exploratory investigation was conducted to determine the feasibility of CFFCBT. Participants included 34 patients with PBD (mean age 11.33 years, SD = 3.06) who were treated with CFFCBT plus medication in a specialty clinic. Treatment integrity, adherence, and parent satisfaction were assessed. Symptom severity and functioning were evaluated before and after treatment using the severity scales of the Clinical Global Impression Scales for Bipolar Disorder (CGIBP) and the Children's Global Assessment Scale (CGAS) respectively. **RESULTS:** On completion of therapy, patients with PBD showed significant reductions in severity scores on all CGIBP scales and significantly higher CGAS scores compared to pretreatment results. High levels of treatment integrity, adherence, and satisfaction were achieved. **CONCLUSIONS:** CFFCBT has a strong theoretical and conceptual foundation and represents a promising approach to the treatment of PBD. Preliminary results support the potential feasibility of the intervention.

SYMPOSIUM 086

PSYCHIATRY AND CANCER UPDATE

Co-Chairs: Michelle B. Riba, M.D., M.S., Luigi Grassi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify many of the major issues in psychooncology, 2) Review aspects of spirituality and psychooncology, 3) Discuss some of the major clinical issues in child and adolescent psychooncology, 4) Recognize several of the major communication barriers and challenges for clinicians in psychooncology, and 5) Understand delirium and its management in psychooncology

SUMMARY:

This symposium will feature some of the key leaders in psychooncology providing clinical and research updates. Psychooncology requires integrated, coordinated care. The very experienced psychiatrists on this panel will discuss their work in a number of important areas of clinical

psychooncology care children and adolescents with cancer (Dr. Margaret Stuber); the role of spirituality and research findings (Dr. David Kissane); management of delirium in patients with cancer (Dr. William Breitbart); how to communicate with patients and families (Dr. Walter Baile); variables that may predict survivorship in patients with cancer in group psychotherapy (Dr. David Spiegel). Dr. Luigi Grassi, an international psychooncologist, will cochair this important symposium. This symposium will provide participants the opportunity to hear from leaders in this field, ask questions, and hear about case examples that emphasize some important clinical points.

S086-1.

CIRCADIAN CORTISOL AS A PREDICTOR OF RESPONSE TO PSYCHOTHERAPY FOR DEPRESSION AND PTSD AMONG BREAST CANCER SURVIVORS

Presenter: David Spiegel, M.D.

SUMMARY:

Background; HPA dysregulation is associated with advancing breast cancer and is related to disease-related stress. Women with metastatic breast cancer have flatter than normal diurnal cortisol patterns,¹ and the degree of loss of daily variation in cortisol predicts earlier mortality with breast cancer, independent of other known risk factors for subsequent mortality.² Similar relationships have been found in other cancers,³ linked to depressive symptoms.⁴ We also have evidence that worsening depression predicts shorter survival with breast cancer, independent of other known risk factors.⁵ PTSD is also associated with abnormalities in cortisol, notably generally low and easily suppressed levels with loss of normal circadian rhythmicity.^{6,8} Such HPA dysregulation is also associated with disruption of sleep and other circadian rhythms. Nighttime shift work and exposure to light at night increase breast cancer risk. We examined the link between loss of normal diurnal cortisol rhythm and response to group psychotherapy for depressive and anxiety symptoms among women with metastatic breast cancer. **Methods**The sample was comprised of 125 women with metastatic breast cancer enrolled in a randomized group psychotherapy trial of Supportive/Expressive Group Psychotherapy (SEGT). All participants (N=125) received educational materials and completed the Center for Epidemiologic Studies–Depression Scale (CESD), and the Impact of Event Scale (IES), at baseline (before randomization) and at 4, 8, and 12 months. The treatment group received 1 year of SEGT (N=64), which was not offered to the control group (N=61). Salivary cortisol was measured on three consecutive days at waking, noon, 5 and 9 PM, and slopes (logtransformed rate of change) were computed. **Results**We found that steeper diurnal cortisol at baseline predicted better subsequent improvement in depression

(N=89, beta = 5.0, p = .0079). This relationship was largely driven by response to group treatment (change by condition interaction, N=53; beta 7.26, p= .05; r=.36, p=.0085). Those with steeper diurnal cortisol in the treatment group of our randomized group therapy intervention trial showed greater declines in CESD depression scores over the ensuing year. We also found that steeper (more normal) diurnal cortisol at baseline predicted better subsequent improvement in Impact of Event Scale scores over the ensuing year in the treatment group (N=51, r=.36, p=.001) but not in the control group (N=34, r=.2

S086-2.

SPIRITUAL AND RELIGIOUS COPING WITH CANCER

Presenter: David W. Kissane, M.D.

SUMMARY:

Within a typology of existential distress, many of the challenges that arise and are prominent in cancer care lie within the realms of spirituality and religious approaches to coping with stress. Knowledge of the world's major religions is crucial for the clinician to understand these issues, routinely make use of a spiritual assessment and integrate appropriate responses into a comprehensive and personcentered management plan. Studies of prayer, the power of placebo, the use of rituals, role of meditation, the 12step program, development of narrative and meaningbased psychotherapies and integrative medicine are important themes. Clinicians must be adept at recognizing when spirituality is interfering with appropriate anticancer care and wise about role confusion and professional boundaries in delivering psychooncology care. Apt use of spirituallyinformed psychotherapy enhances coping and adaptation towards the endoflife.

S086-3.

UPDATE ON PEDIATRIC PSYCHOONCOLOGY

Presenter: Margaret L. Stuber, M.D.

SUMMARY:

Pediatric oncology has had significant success in survival over the past 20 years. However, recent longitudinal studies of survivors have demonstrated that there is a significant longterm impact of the cancer treatment on health, social functioning, and emotional state. Adult survivors of childhood malignancy are less likely to be married, have completed college, be employed, or make more than \$20,000 a year than their siblings. They are also more likely to report clinical levels of emotional distress emotional functional impairment than their siblings or population norms. Symptoms consistent with PTSD are more than four times more

likely in longterm cancer survivors than their siblings. However, survivors also report benefits from the cancer experience. This talk with discuss the predictors and correlates of these findings from the Childhood Cancer Survivors Study and the implications for psychooncology.

S086-4.

HOW TO COMMUNICATE WITH PATIENTS AND FAMILIES

Presenter: Walter F. Baile, M.D.

SUMMARY:

Effective communication with cancer patients comprises a number of skills especially those pertinent to understanding the "subtext" behind emotional responses to bad news such as "does this mean I'm going to die?". Recently, training in these difficult conversations has relied more on interactive methods such as workshops with actors and other forms of simulation. In this presentation we introduce the novel use of sociodrama to teach oncology faculty and staff to communicate more effectively around end of life situations. We illustrate the concepts of role reversal and doubling and discuss how they were applied in dealing with an angry reaction by a family who were told there was no further chemotherapy for their young son. We illustrate how in brief workshops learners can be introduced to these skills, practice and evaluate workshop content.

S086-5.

TREATMENT OF DELIRIUM IN CANCER PATIENTS

Presenter: William Breitbart, M.D.

SUMMARY:

Dr Breitbart will provide an overview of the current evidence based management of delirium in cancer patients. Diagnostic assessment and delirium phenomenology will be described and common diagnostic tools will be described. Nonpharmacologic strategies for managing delirium will be described and the evidence for their utility will be presented. The date of the current literature on controlled trials of typical and atypical antipsychotics will be discussed and evidencebased treatment recommendations will be made. Delirium prevention studies will be discussed. Trials of other agents will be presented. Adverse effects and safety of atypicals for use in treating Delirium will be discussed.

SYMPOSIUM 087

CONTROVERSIES IN AUTISM SPECTRUM DISORDER: SEPARATING FACTS FROM MYTHS

Chair: Shafali S. Jeste, M.D.

Discussant: James T. McCracken, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Define the diagnostic criteria for autism spectrum disorders (ASD) and appreciate the heterogeneity in the clinical presentation, 2) Identify the primary psychiatric and neurological comorbidities found in ASD and the evidencebased treatments for these comorbid conditions, 3) Understand the epidemiology of ASD, the challenges in quantifying prevalence, and the possible etiologies for increase in incidence over the past several years, 4) Gain familiarity with the genes associated with ASD, the methods used to identify them, and the pathways by which certain genetic mutations may contribute to pathogenesis, and 5) Recognize early behavioral markers of ASD in infants at highrisk as well as biomarkers associated with these early behavioral deficits

SUMMARY:

Autism spectrum disorders (ASD) are a heterogeneous group of neurodevelopmental disorders characterized by deficits in social interaction and language, as well the presence of repetitive behaviors and restricted interests. Over the past few years, the field of ASD research has exploded, with rapid changes in our understanding of the phenotype, incidence, causes, and early diagnosis. The goal of this symposium is to separate fact from fiction in the major controversies in the field, such as the role of vaccines, rising prevalence, genetic causes, and early risk markers. The first lecture, by child neurologist Dr. Jeste, will focus on diagnosis and clinical phenotype, with emphasis on the neurological and psychiatric comorbidities that can cause significant functional impairment. She also will review the new DSM5 diagnostic criteria being proposed and the debate surrounding some of the changes. This talk will be followed by a presentation by Dr. Leventhal, a psychiatrist who has published timely work on the epidemiology of ASD internationally. He will discuss the epidemiology of ASD and the possible causes for increase in incidence over the past decade. He will also present very recent data from an epidemiological study performed in Korea. Next, neurogeneticist Dr. Geschwind will provide a comprehensive and timely review about the genetics of ASD. He will clarify the definitions of the various terms used to define the types of genetic variants associated with ASD and review the most current information about the known causative genes and the novel methods being used to isolate these mutations. Finally, Dr. Nelson, a leading developmental cognitive neuroscientist, will present exciting data from studies on infants at highrisk for ASD, based on having an older sibling with ASD, and he will present the current understanding of the earliest behavioral and biological markers of ASD in infants as young as

6 months of age. These talks will be followed by a summary and synthesis by Dr. McCracken, a child psychiatrist who specializes in ASD treatment.

S087-1.

CLINICAL CONSIDERATIONS IN ASD: WHAT ARE THE IMPLICATIONS OF THE CHANGES IN DIAGNOSTIC CRITERIA?

Presenter: Shafali S. Jeste, M.D.

SUMMARY:

Our understanding of the clinical presentation of autism has improved over the past several years, with a growing appreciation for the tremendous heterogeneity of this spectrum of disorders. I will present the plans for the new, evidencebased diagnostic criteria in DSM5, many of which have caused controversy. I also will review our current knowledge about the clinical factors that most influence prognosis and specific treatment goals. Finally, I will present recent data from our work on the neurological comorbidities in autism, with focus on the motor deficits. In the process, I will address certain myths about causation, diagnosis and prognosis.

S087-2.

EPIDEMIOLOGY OF ASD: WHY THE RISE IN PREVALENCE?

Presenter: Bennett L. Leventhal, M.D.

SUMMARY:

Reports on the prevalence of autism and Autism Spectrum Disorder (ASD) have suggested a progressively prevalence estimates over the past 40 years or more. More recent work has suggested multiple reasons for these finding, including broadened diagnostic criteria and increased awareness. This presentation will review these issues while also examining more recent prevalence studies and their impact on our understanding of ASD epidemiology and the implications of these findings for research and clinical practice.

S087-3.

GENETICS OF ASD: IS IT ALL IN THE GENES?

Presenter: Daniel Geschwind, M.D.

SUMMARY:

Since autism is not caused by one gene, but many genes and is itself a clinically diverse condition, the genetic contribution to autism is complex, and there are likely to be many causes, leading to a reformulation of the syndrome of

autism, as the “autisms.” We have focused on methods to reduce its heterogeneity by studying simple components of autism such as language or social cognition, or even physical features such as head size or gender. We have also worked with other groups to identify rare mutations that when added together appear to account for a significant fraction of autism’s genetic risk. We are working to understand how specific genetic risk factors affect brain structure and function to better understand how autism occurs and hence how we might better treat it. This talk will provide cutting edge information about the state of the field of autism genetics and will address the question, “Is it all in the genes?”

S087-4.

EARLY SIGNS AND BIOMARKERS OF ASD: HOW EARLY CAN WE DETECT THE DISORDER?

Presenter: Charles Nelson, Ph.D.

SUMMARY:

It is generally accepted that children on the autism spectrum who receive early intervention generally do better than those who enter intervention programs later in life. However, early intervention is predicated on early identification, and currently, most children are not diagnosed with an ASD until age 3. In this talk I will describe the preliminary results from an ongoing, longitudinal study focused on infants at risk for developing an ASD: specifically, those with at least one older sibling with autism. The focus of my remarks will be on the use of electrophysiological and metabolic tools (EEG, ERP, and fNIRS) to identify infants at risk for developing autism within the first months of life.

SYMPOSIUM 088

RAPID URBANIZATION: IMPACT ON MENTAL HEALTH

Chair: Jitendra Kumar Trivedi, M.D., M.R.C.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss and be aware regarding the impact on Mental Health by rapid urbanization in Western and Central Asia., 2) Discussing the impact on Mental Health by Rapid urbanization in Southern Asia. There shall be deliberation and discussion on the situation of Mental Health in these countries as a result of rapid urbanization., 3) Discuss the impact of Mental Health by Rapid urbanization in Eastern Asia., 4) Discuss and be aware regarding the Impact on Mental Health by Rapid urbanization in Australasia and the South Pacific.

SUMMARY:

Globalization defined as ‘crossing borders’, is not a new phenomenon. In fact people have moved around the world, probably since time immemorial, and one need to look no further than the Bible for confirmation that many of the reasons for these movements were the same then, millennia ago, as they are today: economic, to seek a better way of life and a higher standard of living (economic migrants); fleeing conflict and persecution (asylumseekers); and to conquer and colonise(Trivedi, J.K.,2002). Urbanization in developing countries involves changes in social support and life events which have been shown to affect mental health; mainly depression and anxiety, particularly among women from low income group. Although depressive and anxiety disorders have a high prevalence and account for a large proportion of visits to primary health services there is little international health research in this field. The determinants, extent and outcome of the association between urbanization and mental health requires multidisciplinary research by social scientists, social psychiatrists and public health professionals(Trivedi, J.K., Himanshu Sareen & Mohan Dhyani, 2008). An appreciation of different conceptual models and associated methods is required before effective research can begin. A wellintentioned willingness to share the knowledge and educational courses developed in the West should not become a patronizing attempt to impose the findings and practices of industrialized countries on those working in very different situations. Part of the solution might be to use to the full the knowledge and experience of mental health professionals who are part of the immigrant community and to remove some of the barriers to their professional integration. Other issues such as the avoidance of environmental determinism; the separation of macrosocial and microsocial variables; the weakness of urban/rural comparisons of mental health; the role of rural to urban migration; the debates about crosscultural psychiatry; and the policyrelevance of research, all need consideration in the development of research into this rapidly emerging, but relatively neglected problem. The consequent rural-tourban migration brings with it a series of problems and expectations. Blue et al (1995) have elegantly demonstrated increased rates of common mental disorders in the urban slums of India, Brazil and Chile. This increase is related to social factors – poor housing and its related infrastructure and economic problems(Wame, K. & Mckenzie,2008). The loss of social support resulting from migration to urban areas brings its own problems. Another danger of globalization worth bearing in mind is the drive to homogenization that derives from the culture of consumerism (Moreiras, 1998). Clinicians must also be aware of the relocation of languages in cultures as a result of globalization (Mignolo, 1998). The links between languages and the boundaries of humanity have shaped the ideas o

S088-1.**IMPACT ON MENTAL HEALTH BY RAPID URBANIZATION IN WESTERN AND CENTRAL ASIA**

Presenter: Mohit Ahmad, M.D.

SUMMARY:

Countries of the West Asia and Middle East at the same time have many similarities and diversities. According to WHO, on the average they spend 45% of their GDP on health out of which, between 12% goes to mental health, most of which still for the old mental institutions.

Starting the decade of 1980s, a new movement to modernize psychiatry and mental health started. The main strategy of this movement which, was supported by WHO was integration of mental health in the general health and Primary Health Care systems. Integration compensated for shortages in human and other resources and decreased the stigma. Today, examples of such programs exist in many countries like Bahrain, Iran, Jordan, Pakistan, Saudi Arabia and Oman. In Lebanon involving private sector general practitioners is being taken seriously. These are probably movements that will lead the way towards the future of psychiatry in this region. More recently, efforts are being made to develop basic mental health structure in countries in complex emergencies. Mental health programs in natural disasters were developed after recent earthquakes in Iran and Pakistan. In Afghanistan, Iraq and Palestine also mental health programs to address the mental health problems have developed. The paper reviews the existing literature and try to provide a clearer picture of the achievements and also challenges by mental health realities, systems and structure including the roles of public, private and insurance sectors in this increasingly important part of the world Ahmad Mohit, M.D., DABPN Professor (Rtrd), Tehran University of Medical Sciences President Elect, Iranian Psychiatric Association Chairman, Section of Literature and Psychiatry, WPA. 13, 15th Street, Gandhi Street Tehran, 1517894511 Iran mohitahmad@gmail.com +9821 88778687 (Office), +98912 1329699

S088-2.**IMPACT ON MENTAL HEALTH BY RAPID URBANIZATION IN SOUTHERN ASIA**

Presenter: Jitendra Kumar Trivedi, M.D., M.R.C.

SUMMARY:

Urbanization is a continuous process. It has been started since the beginning of human civilization. The process of urbanization has been accelerated in the last century. Rapid increase in urban population as a proportion of total population is resulting in rapid urbanization of the world. A

majority of world population is residing in urban areas. The growth rate is more in urban area as compared to the rural areas. As per the current census (2011) of India, the population growth rate in India is 17.64% (overall). In the urban areas, the growth rate is 31.80% and in the rural areas, it is 12.18%. This shift of paradigm has drawn the attention of demographers, sociologists, scientists and politicians alike. Urbanization has great impact on the society. It affects the life style, economy, health, culture and many more important social parameters. Though it is driving the economies of most of the nations of the world, a serious concern regarding the impact of urbanization on mental health is warranted. Urbanization exposes the individual to a more stress and affects mental health. The range of disorders and deviancies associated with urbanization is enormous and includes psychoses, depression, stress related disorders, sociopathy, substance abuse, alcoholism, crime, delinquency, vandalism, family disintegration, and alienation. Urban population is heavily influenced by changing cultural dynamics leading to particular psychiatric problems like depression, alcoholism and delinquency. Urbanization affects the mental wellbeing of all age groups and both genders. Rapid urbanization adds to the economic burden of family, indirectly affecting the mental health. South Asia, being world's most heavily populated region is mainly consists of the developing countries. These countries by virtue of their developing economies and a significant proportion of population still living below poverty line are particularly vulnerable and tend to have a higher burden of diseases with an already compromised primary health care delivery system. Urbanization is rapid in this heavily populated region giving impact on the mental health. The focus is to analyze the impact of rapid urbanization on mental health in south Asia.

S088-3.**IMPACT ON MENTAL HEALTH BY RAPID URBANIZATION IN EASTERN ASIA**

Presenter: Harishchandra Gambheera, M.D.

SUMMARY:

East Asian countries include Peoples the Republic of China, the Republic of China Japan North Korea, South Korea, and Mongolia. More than 1.5 billion (22%) of world Population live in geographic East Asia, about twice Europe's population. The East Asian region is now experiencing a rapid increase in urban populations with the socio economic changes in urbanization. The Urbanization is referred as physical growth of urban areas as a result of global change. Urbanization is also defined by the United Nations as movement of people from rural to urban areas with population growth equating to urban migration Most of the countries in East Asia either have undergone or undergoing rapid urbanization altering the dynamics of society at large, fam-

ily in particular. Urbanization also brings about changes in social support and life events which have been shown to affect mental health to a very great extent. Higher incidence of depression and anxiety disorders has been shown to occur in urbanization of developing countries. Such changes in disease patterns affect the entire gamut of population especially the vulnerable sections: elderly, children, and women. Changes in socioeconomic and cultural factors in urbanization make significant alterations in aetiological factors of mental illnesses and changes in the social support system affecting the prognosis and outcome. Thus making changes in incidence and prevalence pattern of mental illnesses with the cultural changes occur in urbanization. The diversification and segregation of individuals, results in social pathologies including drug abuse criminal activity, suicide, homicide, or mental illness. However the effects of urbanization on incidence and prevalence of mental illnesses and their management and longterm prognosis have not been studied in East Asian region to a greater depth. Such epidemiological researches may be necessary to come to a definite conclusion on such detail.

S088-4.

IMPACT ON MENTAL HEALTH BY RAPID URBANIZATION IN AUSTRALASIA AND THE SOUTH PACIFIC

Presenter: Mohan Isaac, M.D., D.P.M.

SUMMARY:

The region where Australia, New Zealand and more than a dozen other independent nations and small island territories are located in the Pacific is referred to as 'Oceania' by the United Nations Statistics Division. The population living in this region of the world in 2011 is estimated to be around 36 million. All but 11 million out of this population live in Australia and New Zealand. The population of Oceania is just around 0.5% of the total global population of about 6.9 billion. Oceania is one of the most sparsely populated regions in the world. The population density in the countries of Oceania varies greatly throughout the region. Nauru which is the world's smallest republic has a high population density of 1267 people per square mile. Australia and New Zealand are the most urbanized countries in the region. 85 and 80 percent of the population respectively in these two countries live in cities. Australian cities such as Melbourne, Sydney, Perth and Adelaide and the New Zealand city of Auckland are 5 of the top 10 most livable cities in the world in 2011 according to The Economist. Other than Australia and New Zealand, most countries in Oceania have a single major city which generally serves as the country's capital as well as the major port. In all countries in the region, extensive urbanization has been steadily taking place due to a variety of reasons. Except from Australia and New Zealand,

there is very little data which is easily available on mental health related issues such as prevalence of various psychiatric disorders across the country, organization of mental health services and their effectiveness, availability and training of mental health care personnel. There is hardly any systematic research on the impact on mental health due to urbanization. However, information from a variety of secondary sources throws light on rapid urbanization related effects on health and mental health. The presentation will critically discuss the impact on mental health due to urbanization in Oceania.

SYMPOSIUM 089

RACIAL/ETHNIC MINORITY POPULATIONS AND THE SOCIAL DETERMINANTS OF MENTAL HEALTH

Chair: Ruth S. Shim, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Address the challenges and unique mental health needs of specific race/ethnicity groups, 2) Recognize the social determinants of mental health that contribute to Native American, African American, Hispanic/Latino, and Asian American populations, 3) Understand the impact of culture on mental health and mental disorders, 4) Develop strategies for improving mental health care for specific racial/ethnic populations

SUMMARY:

The Social Determinants of Health have been examined and well documented in recent years; however, there continues to be limited research on the impact of Social Determinants on Mental Health. This symposium will examine the impact of various social determinants of mental health on four unique racial/ethnic populations in the United States. There are 565 native sovereign nations within the borders of the United States. Native Americans who reside on reservation land are not subject to state or local jurisdiction but are under their own tribal jurisdiction. There is a dearth of tribally operated inpatient hospitals for the mentally ill which presents a major barrier in seeking involuntary hospitalization for those Native American persons who are danger to themselves or others. One native sovereign nation in Arizona has developed a mental health code and intergovernmental agreement to assist their community members in securing mental health care. Latino immigrants have compromised access to and utilization of health care services, by virtue of being foreignborn. In addition, the physical and mental health status of Latinos deteriorates once they immigrate to the US. Lack of access to health care and health information may contribute to this decline

in health status. Additional barriers to mental health care access include: immigration status, lack of health insurance, low socioeconomic status, low English proficiency, and perceived discrimination. Mental health disparities in care are often seen when comparing African Americans to white populations; however, methodological limitations often make it difficult to determine the true role of neighborhood and environmental factors like poverty, unemployment, nutrition, discrimination, and chronic stress. The impact of these factors on the overall mental health within the African American population is an important issue that needs more thoughtful examination. Portrayed as the “model minority” because of their relatively high educational, occupational, and economic attainments, Asian Americans are also exposed to a number of mental health risk factors. Recent immigrants from Asia grapple with acculturation stressors of language barriers, migratory grief, social isolation, limited social support, and declined social status. Those who do come to the attention of mental health professionals tend to exhibit more severe and chronic symptoms in comparison with nonAsians. Understanding both the particular risk factors Asian Americans experience as well as the barriers to mental health care they face are critical to developing successful mental health treatments for Asian Americans. This symposium aims to discuss the role of psychiatrists in the ongoing management and treatment of these populations by highlighting strategies to improve access to and quality of mental health treatment among these populations, and by discussing new strategies to promote mental health within these communities.

S089-1.

DEVELOPMENT OF THE “BARRIERS TO HEALTH AND MENTAL HEALTH CARE ACCESS QUESTIONNAIRE” FOR USE AMONG IMMIGRANT LATINO WOMEN

Presenter: Kaney K. F. Fedovskiy, M.D., M.P.H.

SUMMARY:

To conduct focus groups addressing perceived barriers to health and mental health care access among Latina immigrants. To develop a questionnaire of barriers to health and mental health care access, based on focus group data. To pilot the developed barriers to health and mental health care access questionnaire and assess relevance for its use in future studies. Upon approval of our research protocol from the Emory School of Medicine Institutional Review Board and the Grady Research Oversight Committee, immigrant Latino women were recruited to participate in a focus group addressing their perceived barriers to health and mental health care access. Eight focus groups of four to six women were conducted by a female, bilingual/bicultural moderator, at the Latin American Association, a wellknown, local,

nonprofit organization that offers a range of services to Latinos. The focus group findings informed the development of the “Barriers to Health and Mental Health Care Access Questionnaire.” Once developed, the questionnaire was piloted with Latina participants (ages 18 to 64) seeking care at a Spanishspeaking, primary care clinic within Grady Health Systems, a large urban, public sector hospital. The focus groups discussed several mutable barriers to health and mental health care access, including the cost of health care, lack of health information, lack of health insurance, communication difficulties (Language barriers with health care providers and/or interpreter unavailability), immigration/recent arrival status, work and schedule conflicts, lack of childcare, and stigma. Focus group findings and literature review resulted in the development of questionnaire items within nine question domains. The subsequent questionnaire study showed that, even among a clinic sample of immigrant Latino women, many of the same barriers to health and mental health care access experienced by the focus group participants existed. This study characterized many barriers to health and mental health care access perceived by local Latina immigrants, for the purpose of developing a questionnaire to be used among local immigrant Latino women. The questionnaire demonstrates relevance for use among local immigrant Latinas and may be useful in future studies. While there are many qualitative studies looking at barriers to care, there are few studies that attempt to quantify perceived barriers. There are no known validated measures to assess barriers to health and mental health care.

S089-2.

SECURING CIVIL COMMITMENT BETWEEN SOVEREIGN NATIONS

Presenter: Monica TaylorDesir, M.D., M.P.H.

SUMMARY:

There are 565 native sovereign nations within the United States. These nations have a federal trust relationship with the United States government which requires the United States government to provide medical treatment to all Native Americans living within the United States. Even though there are government funds available the resources for mental health care for Native Americans are severely limited. This paper reviews the struggle of Native American Communities to strike a balance between health services, the legal system and public health needs. The history of psychiatric hospitals is briefly reviewed along with civil commitment and case law that have highlighted the unique relationship that Native Americans have with the United States government along with the social determinants that affect the mental health of Native American Communities. In conclusion a review of tribal models for civil commitment and a successful civil commitment model of a southwestern

Native American Community is delineated.

S089-3.

RACIAL/ETHNIC MINORITY POPULATIONS AND THE SOCIAL DETERMINANTS OF MENTAL HEALTH

Presenter: NhiHa T. Trinh, M.D.

SUMMARY:

The social determinants of health have been examined and well documented in recent years; however, there continues to be limited research on the impact of social determinants on mental health. This symposium will examine the impact of various social determinants of mental health on four unique racial/ethnic populations in the United States. There are 565 native sovereign nations within the borders of the United States. Native Americans who reside on reservation land are not subject to state or local jurisdiction but are under their own tribal jurisdiction. There is a dearth of tribally operated inpatient hospitals for the mentally ill which presents a major barrier in seeking involuntary hospitalization for those Native American persons who are danger to themselves or others. One native sovereign nation in Arizona has developed a mental health code and intergovernmental agreement to assist their community members in securing mental health care. Latino immigrants have compromised access to and utilization of health care services, by virtue of being foreignborn. In addition, the physical and mental health status of Latinos deteriorates once they immigrate to the US. Lack of access to health care and health information may contribute to this decline in health status. Additional barriers to mental health care access include: immigration status, lack of health insurance, low socioeconomic status, low English proficiency, and perceived discrimination. Mental health disparities in care are often seen when comparing African Americans to white populations; however, methodological limitations often make it difficult to determine the true role of neighborhood and environmental factors like poverty, unemployment, nutrition, discrimination, and chronic stress. The impact of these factors on the overall mental health within the African American population is an important issue that needs more thoughtful examination. Portrayed as the “model minority” because of their relatively high educational, occupational, and economic attainments, Asian Americans are also exposed to a number of mental health risk factors. Recent immigrants from Asia grapple with acculturation stressors of language barriers, migratory grief, social isolation, limited social support, and declined social status. Those who do come to the attention of mental health professionals tend to exhibit more severe and chronic symptoms in comparison with nonAsians.

S089-4.

RACIAL/ETHNIC DISPARITIES, SOCIAL SUPPORT, AND DEPRESSION: EXAMINING A SOCIAL DETERMINANT OF MENTAL HEALTH

Presenter: Ruth S. Shim, M.D., M.P.H.

SUMMARY:

We examined the risk of depression as it relates to social support among individuals from African American, Caribbean black, and nonHispanic white backgrounds. 6,082 individuals participated in the National Survey of American Life (NSAL), a nationally representative, psychiatric epidemiological, cross-sectional survey of household populations designed to explore racial and ethnic differences in mental disorders. NSAL survey questions were used as a proxy for social support. Logistic regression analysis was used to examine the correlates between having DSMIV diagnosis of major depressive disorder in the past year, demographic variables, and social support. African American race/ethnicity was associated with decreased odds of depression when compared to nonHispanic whites, even when controlling for social support variables and demographics (OR = 0.51, 95% CI = 0.430.60). There was a threefold increase in risk of depression among individuals who reported feeling “Not Very Close At All” with family members compared to those who reported feeling “Very Close” to family (OR = 3.35, 95% CI = 1.816.19). These findings reinforce previous research documenting the important relationship between social support and depression, and perhaps should lead us to reexamine the individualistic models of treatment that are most evaluated in United States. The lack of evidence-based data on support groups, peer counseling, family therapy, or other social support interventions may reflect a majorityculture bias toward individualism, which belies the extensive body of research on social support deficits as a major risk factor for depression.

SYMPOSIUM 090

ASSISTED OUTPATIENT TREATMENT FOR PERSONS WITH SEVERE MENTAL ILLNESS: THE DATA AND THE CONTROVERSY

Chair: Marvin S. Swartz, M.D.

Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss the existing empirical data on the effectiveness of assisted outpatient treatment, 2) Discuss the controversies about the use of assisted outpatient treatment, 3) Review new data on the costs and benefits of assisted

outpatient treatment

SUMMARY:

In 1999, joining 41 other states with involuntary outpatient commitment statutes, the New York State legislature enacted Kendra's Law, establishing a provision for assisted outpatient treatment (AOT) for persons with mental illness at risk of relapse due to failure to adhere to recommended treatment. The goal of AOT is to improve outcomes for persons with mental illness who have difficulty engaging in mental health services, which they need to prevent their conditions from deteriorating to the point of relapse and hospitalization. While most states had previously established identical legal criteria for involuntary inpatient and outpatient commitment, Kendra's Law became one of a small number of newer statutes that attempted to prevent relapse by setting a lower clinical threshold for involuntary outpatient commitment. Despite these supposed benign intentions, in New York and other states, AOT has become a flashpoint for controversy, especially among certain consumer advocacy and civil liberties groups. The 2005 reauthorization of Kendra's Law included a provision that the New York State Office of Mental Health conduct an independent evaluation of the effectiveness of AOT and report findings to the NY State Legislature. Researchers from Duke University in collaboration with Policy Research Associates, the MacArthur Research Network on Mandated Community Treatment and the New York State Office of Mental Health recently completed that evaluation. This symposium will review the existing empirical data about the effectiveness of AOT in the United States with a particular focus on the recently legislatively mandated evaluation of Kendra's Law in New York State. The controversy about and legal challenges to the use of AOT will also be critically discussed. In addition, new findings from an evaluation of the cost and benefits of AOT in New York State will be presented and discussed. Finally these new studies of AOT will be discussed in the broader context of the use of legal tools or mandates to attempt to improve treatment adherence.

S090-1.

IS ASSISTED OUTPATIENT TREATMENT EFFECTIVE?

Presenter: Marvin S. Swartz, M.D.

SUMMARY:

Assisted outpatient treatment (AOT) is a civil court procedure whereby a judge can order a noncompliant, person with mental illness to comply with needed treatment. Over forty states and the District of Columbia have explicit AOT statutes, although it is used erratically, even within states. Most states set the threshold for AOT identically to those

for inpatient commitment. Evidence of AOT's effectiveness from noncontrolled studies is difficult to interpret, most notably due to lack of comparable committed and noncommitted groups, difficulty in comparing treatment across comparison groups and selection effects. Selection effects, where patients are selected by clinicians and the court for a predicted good outcome under AOT, make it particularly difficult to interpret noncontrolled studies, although they generally report beneficial outcomes for these selected patients. In the first experimental study, conducted in North Carolina, patients ordered to AOT had fewer readmissions to the hospital, spent fewer days in the hospital and had a number of other improved outcomes if they received AOT for 6 months or more. However a similar study of a pilot statute at New York City's Bellevue Hospital found such no benefit. In 1999, the New York State legislature enacted Kendra's Law, establishing a provision for AOT for persons with mental illness at risk of relapse. AOT includes a wide array of courtordered enhanced outpatient services including intensive case management. In support of AOT, NY also appropriated considerable new funding to provide these enhanced services. Researchers from Duke University in collaboration with Policy Research Associates, the MacArthur Research Network on Mandated Community Treatment and the New York State Office of Mental Health recently completed a legislatively mandated evaluation of New York's AOT program and found that it reduced psychiatric hospitalizations, hospital lengths of stay, improved receipt of intensive case management services and medication adherence—among a number of positive outcomes. This presentation will critically review findings from this evaluation.

S090-2.

UNPACKING THE CONTROVERSY ABOUT ASSISTED OUTPATIENT TREATMENT

Presenter: Jeffrey W. Swanson, Ph.D.

SUMMARY:

Assisted outpatient treatment (AOT) remains one of the most controversial mental health legal and policy issues, regardless of empirical findings about its effectiveness or lack thereof. Strong AOT supporters see it as an avenue to needed treatment in the community for people with serious mental illness and a less restrictive alternative to involuntary hospitalization; vocal opponents see it as an instrument of social control and an unwarranted deprivation of individual liberty. Advocates as well as opponents of AOT sometimes selectively use data about AOT's benefits and drawbacks in "straw man" arguments to debunk the opposing position, and thus advance their own strongly held views about autonomy vs. paternalism in mental health treatment. Many opponents of AOT believe that it may serve as a barrier to improving services, because policymakers will seize

upon AOT as a “cheap fix” to remedy a paucity of community-based services in underfunded public mental health systems. However, data to date suggests that AOT, if it is effective, can only be so when more intensive services are provided, obviating use of AOT as an inexpensive remedy. Opponents of AOT in New York State have raised additional concerns about racial bias in assigning AOT to minority populations, although these claims largely rest on whether AOT is seen as a loss of liberty or use of a less restrictive alternative to hospitalization. Analysis of New York AOT data probably represent the strongest data to date on the effectiveness of AOT. These findings suggest that AOT can reduce adverse outcomes, but does not suggest that AOT is inherently effective across diverse treatment settings. Nor does it rule out that alternative treatment strategies might be equally effective. This presentation will examine the nature of the controversies around AOT, how it fits in the broader framework of public health law and how concerns about racial bias in AOT can be both conceptually and empirically examined.

S090-3.

REVIEWING NEW DATA ON THE COST AND BENEFITS OF ASSISTED OUTPATIENT TREATMENT

Presenter: Richard A. Van Dorn, Ph.D.

SUMMARY:

This session will present findings on comprehensive costs of the New York State assisted outpatient treatment (AOT) program over the period from 1999 to 2007. We collected mental health services and criminal justice system costs for a sample of approximately 2,000 individuals from several sources. First, we reviewed and extracted all available budgetary and service information from public programs involved in providing services, directly or indirectly, in support of the county AOT programs. Similarly, we obtained mental health administrative program costs by reviewing budgetary information and by interviewing county AOT Program Directors. We also gathered data on arrests, jail, and prison stays for all individuals who have been on AOT. Medicaid claims were our primary source for estimates of health care costs. We first conducted a descriptive analysis comparing the mean total perpatient monthly cost of services billed to Medicaid for patients in each group since 1999. Using the claims data we compared patterns of service utilization, including monthly number of billed outpatient service encounters in various categories (e.g., intensive case management, individual psychotherapy, medication management, etc.), hospitalizations, inpatient bed days, and pharmacy costs for psychotropic and other prescribed medications. We also incorporated criminal justice costs including arrests and days incarcerated each month. We estimated total AOT costs, and extrapolated any findings of

cost savings over time. We also provide a test of the statistical significance of any differences. Comprehensive estimates of costs and outcomes for AOT care can provide crucial information to help public policy makers decide i.e., by balancing the costs and potential benefits and drawbacks of these programs whether AOT is warranted from a fiscal and ethical perspective. The study also provides policyrelevant information regarding the resources and safeguards that are necessary to put in place in order to achieve potential beneficial outcomes under AOT. These results will be generalizable broadly to other jurisdictions and mental health systems that resemble the diverse counties in New York State where the study was conducted.

SYMPOSIUM 091

CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

Chair: Herbert D. Kleber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) List the advantages and disadvantages of various medications and behavioral interventions for the drugs discussed, 2) Understand the key issues in treating pain in substance dependent patients, 3) Be familiar with the various approaches in the clinical development of new pharmacotherapies to treat substance dependence

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 officebased 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.

S091-1.

CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE

Presenter: Adam Bisaga, M.D.

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult and no commonly accepted pharmacotherapies. While cocaine produces acute enhancement of the dopaminergic neurotransmission, 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. The biological mechanism underlying this effect as well as practical and safety concerns involved in prescribing psychostimulant medications to cocaine abusers will be discussed. Other pharmacological strategies appear to have potential as abstinence-maintenance treatments, including medications that enhance GABAergic neurotransmission such as topiramate, tiagabine, and baclofen. Strategies to prevent cocaine from entering the brain are also being developed, and results with a “cocaine vaccine” are promising. As the cognitive impairments interfere with response to behavioral treatment, using cognitive enhancers may be a useful strategy in some patients. A combination of pharmacological interventions (possibly more than one medication) and behavioral interventions will likely be required for patients to achieve and maintain abstinence.

S091-2.**CHOOSING TREATMENT FOR CANNABIS DEPENDENCE**

Presenter: Frances R. Levin, M.D.

SUMMARY:

Cannabis is the most commonly used illicit drug in the United States. For some users, underlying psychopathology might increase the risk of substance abuse, whereas in others, longitudinal data suggest that marijuana use may increase the risk of depression and severe mental illness. Both instances have treatment implications. Moreover, it is now well-recognized that heavy chronic cannabis use can lead to a characteristic withdrawal syndrome upon discontinuation of use. Such withdrawal symptoms may hinder a patient's ability to reduce or cease his/her use. Although there have been several large clinical trials that suggest that various psychotherapeutic treatment approaches are efficacious, no one type of psychotherapy has been found to be superior. However, combined behavioral strategies may show the most promise. There are a limited number of controlled laboratory and treatment trials that have assessed the efficacy of pharmacologic interventions. At present, agonist therapies have shown the most promise (e.g., dronabinol (oral THC)), as well as combined pharmacotherapies (such as dronabinol and lofexidine). For cannabis-dependent patients with psychiatric comorbidity, pharmacologic interventions have produced mixed results. An overall review of this literature and its treatment implications will be discussed.

S091-3.**COMBINING MEDICATIONS AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE ABUSE**

Presenter: Edward V. Nunes, M.D.

SUMMARY:

Several types of psychosocial-behavioral interventions, including cognitive behavioral skillbuilding approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12Step facilitation), have been studied for use either alone or in combination with medications for treatment of substance abuse. Such interventions have served as means by which to help patients to achieve abstinence by encouraging lifestyle change and promoting medication compliance. An overview of these models and a brief review of findings in treatment outcome research will be provided. The potential for combining behavioral and pharmacologic approaches will be discussed. In addition, new insights from brain imaging research that inform the neurobiology underlying response to behavioral treatment will be discussed, along with implications for the design of new treatments.

S091-4.**TREATMENT OF CHRONIC PAIN AND OPIOID DEPENDENCE: ROLE FOR OPIOID AGONISTS AND ANTAGONISTS**

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

SUMMARY:

Prescription opioid abuse has reached epidemic proportions in the U.S. in the past ten years, with rapidly escalating rates of both opioid misuse and treatment admissions for problems related to opioid abuse. While it is essential to maintain therapeutic access to opioids for legitimate analgesic use, clinicians also face the significant challenge of minimizing the potential for opioid abuse and diversion. Addiction in pain patients is often more subtle and difficult to identify than in illicit substance users. Strategies for assessing which patients are at increased risk for opioid abuse in a pain management setting will be reviewed. Screening and risk stratification, use of 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 and abuse-resistant formulations, as well as the risks and benefits of long-acting opioids such as methadone as well as the partial mu agonist buprenorphine. The role for opioid antagonist maintenance with long-acting naltrexone (Vivitrol) in cases of opioid abuse

and hyperalgesia will also be examined. The advantages and disadvantages of various effective pharmacologic choices for the treatment of opioid dependence in chronic pain patients will be summarized. Future research directions to be considered include potential targets for medication therapy aimed at minimizing adverse consequences of opioid analgesic therapy in patients at risk for opioid addiction.

S091-5.

DETECTING AND MANAGING SEDATIVEHYPNOTIC AND PRESCRIPTION STIMULANT ABUSE

Presenter: John J. Mariani, M.D.

SUMMARY:

Sedativehypnotics and stimulants are widely prescribed classes of psychotropic agents, particularly by psychiatrists. Despite the development of new agents and novel drug delivery systems, concerns about abuse liability and the behavioral safety of sedativehypnotics and prescription stimulants still remain. While these medications are effective treatments for psychiatric disorders, specifically sedativehypnotic agents for anxiety disorders and stimulants for attentiondeficit/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 sedativehypnotic and stimulants in the presence of cooccurring substance use disorders. These issues include recognizing the clinical signs and symptoms associated with abuse of sedativehypnotic or stimulant medications and clinical strategies to manage these patients.

SYMPOSIUM 092

UPDATE ON BODY DYSMORPHIC DISORDER

Co-Chairs: Katharine A Phillips, M.D., Jamie Feusner, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Attendees will be able to identify key clinical features of BDD as well as abnormalities in visual, emotional, and information processing, 2) Attendees will be able to assess and diagnose BDD, 3) Attendees will be knowledgeable about effective treatments for BDD, as well as those that are ineffective

SUMMARY:

Body dysmorphic disorder (BDD) – a distressing or impair-

ing preoccupation with imagined or slight defects in physical appearance – is a common and severe disorder. BDD is associated with high rates of suicidality and markedly poor psychosocial functioning, yet it often goes unrecognized and is often ineffectively treated in clinical settings. This symposium will present data (including new findings) that will increase understanding of BDD, help clinicians recognize BDD, and enable clinicians to more effectively treat these often difficulttotreat patients. Presentations will focus on the following: 1) Dr. Phillips will present data on BDD's clinical features, how to recognize and diagnose BDD, and proposed changes for DSM5; 2) Dr. Feusner will present data on abnormal visual information processing and abnormal emotional processing in BDD, and the treatment relevance of these findings; 3) Dr. Hollander will discuss pharmacologic approaches to treating BDD; 4) Dr. Wilhelm will discuss CBT strategies for BDD, including recent neurocognitive research that is relevant to CBT treatment of BDD; and 5) Dr. Sarwer will discuss cosmetic treatment (e.g., surgery, dermatologic treatment) for BDD, which many patients receive but which appears to be ineffective. Dr. Simpson will discuss the presentations and their relevance to patient care. There will also be time for audience questions.

S092-1.

BODY DYSMORPHIC DISORDER: CLINICAL FEATURES, ASSESSMENT, AND PROPOSED CHANGES FOR DSM5

Presenter: Katharine A Phillips, M.D.

SUMMARY:

BDD is a common and severe disorder that often goes unrecognized in clinical settings. This presentation will present data on BDD's clinical features, which include obsessional preoccupation with perceived appearance flaws that may involve any body area (most commonly, skin, hair, or nose) and compulsive behaviors, such as comparing one's appearance with that of other people, mirror checking, camouflaging the perceived flaws, excessive grooming, skin picking, reassurance seeking, and compulsive tanning. Most patients have poor or absent insight (i.e., delusional beliefs) regarding the perceived flaws. BDD is associated with substantial morbidity, including high rates and levels of social and academic/occupational impairment, being housebound, psychiatric hospitalization, and suicidality. This presentation will review key clinical features of BDD and will also discuss recent findings, including data on age at onset, insight, and suicidality. Clues to the presence of BDD, and approaches to assessing and diagnosing BDD, will be discussed. This presentation will also discuss changes proposed for DSM5, including changes to BDD's diagnostic criteria, specifiers, and location in the manual.

S092-2.

ABNORMALITIES OF VISUAL AND EMOTIONAL PROCESSING IN BODY DYSMORPHIC DISORDER*Presenter: Jamie Feusner, M.D.***SUMMARY:**

An important clinical phenotype in body dysmorphic disorder (BDD) may be perceptual distortions for appearance. Individuals with BDD perceive certain appearance features as defective and ugly, which may be due to a propensity to focus on details at the expense of configural elements. Neuropsychological studies suggest that individuals with BDD demonstrate abnormalities performing visuospatial tasks and processing faces. More recently, evidence has also accrued from functional magnetic resonance (fMRI) studies demonstrating aberrant patterns of visual processing of ownfaces, others' faces, and even inanimate objects. These studies suggest that individuals with BDD have abnormalities in configural and holistic visual processing. This may be associated with impaired ability to contextualize visual details of faces and their environment properly into a whole percept. In addition, there is preliminary evidence of aberrant emotional processing, with abnormally low limbic responses to emotional stimuli. This talk will review these findings as well as relevant results from structural neuroimaging (tractography and network analyses) and psychophysical studies. We will also briefly discuss possibilities as to how these findings may be utilized in therapeutic settings to better understand patients' symptomatology, communicate to patients about abnormal brain processes to help improve insight, and to develop and test new treatment strategies.

S092-3.

NEUROPSYCHOPHARMACOLOGY OF BODY DYSMORPHIC DISORDER*Presenter: Eric Hollander, M.D.***SUMMARY:**

This presentation will describe current pharmacological treatment approaches for body dysmorphic disorder (BDD) in both adults and children. Controlled trials and pilot studies with SSRI's, atypical antipsychotics, and other agents will be presented. The impact of medication on associated symptoms such as depression, social anxiety, and suicidal thoughts/urges will be highlighted. FDA warnings and guidelines that influence treatment selection will be discussed. These findings will be compared to standard and novel treatments of related conditions, and the relationship between body dysmorphic disorder and other obsessive-compulsive spectrum disorders will be described. Finally, treatment findings will be discussed in light of the putative

neurocognitive endophenotype of body dysmorphic disorder, and the associated brain circuitry and neurotransmitter systems, which mediate this endophenotype. This presentation will enhance the skill set of clinicians in treating adults and children with body dysmorphic disorder, and provide for a better understanding of the role of pharmacological treatments in the overall care of BDD patients.

S092-4.

INFORMATION PROCESSING BIASES AND COGNITIVE BEHAVIOR TREATMENT OF BODY DYSMORPHIC DISORDER*Presenter: Sabine Wilhelm, Ph.D.***SUMMARY:**

Body Dysmorphic Disorder (BDD) is a severe body image disorder characterized by a preoccupation with an imagined or slight defect in appearance. In this talk, geared towards both clinicians and researchers, I will first focus on experimental work examining cognitive and neuropsychological factors that likely contribute to the development and maintenance of BDD. Thereafter I will describe the role of these factors in cognitive behavioral models of BDD. I will then provide an overview of a new modular cognitive behavioral therapy (Wilhelm, Phillips, and Steketee, in press) aimed at modifying these factors as well as other BDD symptoms. Because BDD differs in important ways from other disorders, cognitive behavioral therapy must be tailored specifically to BDD's unique symptoms. Outcome data from our recent waitlist controlled trial on modular CBT for BDD will also be presented.

S092-5.

BODY DYSMORPHIC DISORDER AND COSMETIC SURGERY*Presenter: David Sarwer, Ph.D.***SUMMARY:**

In 2010, more than 13 million Americans underwent cosmetic surgery or a minimally invasive cosmetic treatment to improve their appearance. Over the past several decades, a now large literature has investigated the psychosocial characteristics of these patients and the psychological changes that they experience postoperatively. While the vast majority appear to be psychologically appropriate for surgery, between 515% suffer with BDD. Conversely, a majority of patients with BDD seek and receive cosmetic treatment (e.g., surgical, dermatologic, dental) for their BDD symptoms. Almost all patients with BDD experience no change or a worsening in their BDD symptoms following cosmetic treatment. Thus, many believe that the condition contrain-

dicates cosmetic surgery. This presentation will discuss data on cosmetic procedures – in particular, cosmetic surgery – in patients with BDD. Approaches that clinicians can consider when their BDD patients desire cosmetic surgery will also be discussed.

SYMPOSIUM 093

THERE IS NO SUCH THING AS A “MED CHECK”

Chair: Jeffrey Geller, M.D., M.P.H.

Discussant: Jeffrey Geller, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the apparent, current limitations on psychiatrists prescribing medications for patients in outpatient settings and learn ways to make the “medication visit” much more than that, 2) Be able to make a short appointment consistently meaningful and therapeutic for patients, 3) Understand that effective appointments can be achieved in a variety of situations

SUMMARY:

For hundreds, if not thousands of years, the clinical needs of the person consulting the healer drove most aspects of the encounter between the two. In the twentyfirst century, the setting and the payor drive the encounter, with a palpable disregard for the individual patient’s needs and the psychiatrist’s match of services to needs. No matter what direction health reform takes, there is virtually no chance that we will return to the era when the doctorpatient relationship was a relationship between two parties, unencumbered by all manner of third parties. Nor is there any likelihood that this relationship will be an hour session with medication and psychotherapy intermingled. Rather, what we have now are patients seen in organized settings where the psychiatrist is expected to do a “medication visit” at the rate of 3,4,6 or even 8 per hour (double booking for no shows). In this session we will assist participants in transforming the “med visit” into much more. It is quite possible for a 15 minute appointment to be consistently meaningful and therapeutic for a patient. Dr Mistler will describe “shared decision making”, a concept that is fundamental to recovery and to transforming short patient encounters from simple prescription writing to therapeutic encounters. We have examples from three psychiatrists who work in community sites across the USA as to their experiences in practicing psychiatry in this manner.

S093-1.

AN OVERVIEW OF SHARED DECISION MAKING

Presenter: Lisa A. Mistler, M.D., M.S.

SUMMARY:

Following the general health care system, the public mental health system in the United States has been shifting from a paternalistic model of care toward a more collaborative model. This movement was driven in part by a growing realization that providers and consumers often have different views regarding goals, risks and benefits of treatment. While the traditional service system focuses primarily on symptom reduction and client stability, consumers desire to move beyond symptom management in order to live, work, learn, and participate fully in their communities. This has set the stage for changing how mental health treatment decisions are made. Few treatment decisions involve a clear best choice; the typical decision involves tradeoffs among multiple partially effective interventions with different risks. This is particularly true for mental health medication treatment decisions. This fundamental dilemma gives rise to the paradigm of shared decision making (SDM), which we will describe in more detail during this symposium. SDM includes several essential elements: patient knowledge; explicit provider encouragement of the patient’s involvement; time; patient preferences and values; patient and provider knowledge of choices; and appreciation of the patient’s responsibility and right to have an active role in treatment decisions. A model SDM system would provide clients and providers with access to correct, clear and concise information that is easily retrieved and updated, as well as the resources necessary to discuss relevant options without significantly draining provider resources. In addition, an SDM system must include legislation that eliminates outdated informed consent rules and replaces them with liability protection language that recognizes the priority of autonomy and the responsibilities of provider and client as a partnership of equals. Providers would no longer have to guess regarding their legal liability and they could improve the health outcomes of their patients by enabling them to be more invested in their treatment choice. Ultimately, when a provider and client collaborate in the treatment decision, they are prioritizing patient autonomy over beneficence. In instances of disagreement after discussion, the client’s preference should determine the treatment, since the client has to live with the decision and its implications. By protecting patient autonomy and acknowledging the importance of provider opinion and analysis, SDM provides the

S093-2.

FROM CALIFORNIA: CHALLENGES AND PARADOXES

Presenter: Bernadette M. Grosjean, M.D.

SUMMARY:

In 2004, California's voters passed Proposition 63 (Mental Health Services Act) to improve the delivery of mental health services to the community. As a result, Full Service Partnership (FSP) programs were implemented. Patients referred to FSP are adults diagnosed with severe mental illness who require intensive delivery of services in the community. The majority are homeless and high utilizers of state and county services: emergency rooms, inpatient units and jails. In order to be enrolled in the program, our "clients" need at least a severe diagnosis on the Axis 1, most often schizophrenia or bipolar disorder. Most of them also present several comorbidities such as addiction and personality disorders. Although these multiple diagnoses almost always imply the need for medication management, the erratic journey of these patients through multiple, fragmented, 15minute "Med Check" systems demonstrates how inefficient a "philosophy of (managed) care" can be. We at FSP have seen that relatively brief periods of "continuity of care" with "eyetoeye", wideranging and "long enough" encounters with their psychiatrist succeed in solid improvements for a population identified as "impossible to treat". This says a lot about the limits of the "Med Check" approach. Simultaneously, it reminds us of the almost shocking power of a real, flexible and comprehensive interhuman encounter. What is no big news for veteran practitioners and generations of healers is today confirmed by neurosciences: relationship is an essential part of the healing process. Concurrently, contemporary, poorly conceived "Med Check" constraints may seriously impede the full deployment of the therapeutic process. An additional concern is that the evolution of the practice of psychiatry, with an emphasis on the quickfix and the myths of miraculous pills has taken over the training of young physicians who no longer learn about "everything else" (than medication). The question is: will governmental politics, health administrators and academic players realize the relative ineffectiveness of the "Med Check" system before it undermines the art of psychiatry and empties it of its essence, to the detriment of our patients.

S093-3.

GROUP MEETINGS IN BEHAVIORAL HEALTH THAT INCLUDE PRESCRIBING AND DISCUSSING MEDICATION AS PART OF THE TREATMENT/RECOVERY PLAN

Presenter: Benjamin Crocker, M.D.

SUMMARY:

Group process has long been a fundamental aspect of psychiatric treatment. Springing from the crisis of war and attempts to bring psychotherapy to large numbers of hospitalized patients, groups were a major part of the community mental health response to deinstitutionalization and remain a mainstay of acute psychiatric treatment in IOP and partial

hospital settings. This presentation will address the use of groups in ongoing outpatient services that include the prescribing of medication. Groups provide flexibility of scheduling, efficiency of staffing time, "productivity" in fee for service payor systems, but more importantly provide an ongoing social context to treatment that can endure beyond staffing changes and offer the experience of social support that can be generalized in community recovery experiences. Groups can also be an effective way of linking evidence based psychotherapy and psychoeducational treatment to medication treatment across the diagnostic spectrum. We will also discuss the potential use of group BH interventions in the integration of behavioral health and primary care, where group medical visits are part of the Medical Home model.

S093-4.

ONLY IN NEW YORK: TURNING IT INTO 15 MINUTES OF FAME

Presenter: Hunter L. McQuiston, M.D.

SUMMARY:

As in most states, psychiatric service delivery in New York is undergoing change toward valuing brief, focused, clinical encounters. How public sector behavioral healthcare systems adapt to this takes on additional local community texture, modified by such factors as population characteristics, individual service needs, and clinical setting. Utilizing personal experience, as well as information gleaned from individual providers, the presenter will discuss how psychiatrists in a New York City outpatient and community-based delivery system are adapting to increased pressure for "productivity" while optimizing the ability to help a person pursue his or her recovery goals. This will be examined in the context of shifts in public policy, mode of reimbursement, regulatory requirements, and local fiscal demands that may affect high quality service.

SYMPOSIUM 094

RECLAIMING THE ROLE OF MOTHERHOOD FOR WOMEN WITH SERIOUS MENTAL ILLNESS

Chair: Nikole S. BendersHadi, M.D.

Discussant: Nada L. Stotland, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the prevalence and demographics of mothers at a New York state psychiatric hospital, along with reported contact with children and acknowledgment of motherhood role among treatment providers, 2) Define

“parenting capability” in mothers with mental illness, understand evidencebased ways to assess parenting capability, and learn how to present assessment findings in adversarial contexts, 3) Discuss recent research on the development of peer supports to expand parenting opportunities for mothers in marginal social circumstances

SUMMARY:

The importance of the experience of motherhood for women with mental illness is often overlooked. This symposium will address this forgotten role by examining the prevalence and demographics of mothers at one large state psychiatric hospital, by defining “parenting capabilities” and understanding how mothers with mental illness can have these capabilities assessed in evidencebased ways, as well as by exploring parenting goals and the development of peer supports for mothers with experiences of homelessness. The identification and support of mothers with serious mental illness from both clinical and research perspectives can go a long way towards reducing the stigma associated with parenting among the mentally ill, and will hopefully encourage clinicians and policymakers to acknowledge this role as important to mental health consumers.

S094-1.

MOTHERS WITH SERIOUS MENTAL ILLNESS IN A STATE PSYCHIATRIC HOSPITAL SETTING

Presenter: Nikole S. BendersHadi, M.D.

SUMMARY:

The role of motherhood among women with serious mental illness is often forgotten. This portion of the symposium will discuss a recent study which examined the prevalence of motherhood among women with serious mental illness at a large New York state psychiatric hospital. We will explore the demographics of SMI mothers at this facility, as well as their reported involvement in the lives of their children. Additionally, the identification and acknowledgement of motherhood status by treatment providers at this facility will be discussed.

S094-2.

ASSESSING PARENTING CAPABILITY IN MOTHERS WITH MENTAL ILLNESS

Presenter: Laura Miller, M.D.

SUMMARY:

Clinicians are sometimes called upon to render opinions about whether mothers with psychiatric disorders are capable of parenting their children. This portion of the

symposium is designed to address the following questions: 1. What is “parenting capability”? 2. What are evidencebased ways to assess and predict parenting capability? 3. How can parenting assessment findings be presented in adversarial contexts while preserving scientific and clinical integrity? We will: 1. Review the influence of attachment, insight, internal representations of the child and social support on parenting in women with psychiatric disorders. 2. Examine tools that have been validated for use in parenting assessment, and a multidisciplinary team approach to integrating these tools into a comprehensive evaluation. 3. Discuss how such evaluations can inform parenting rehabilitation interventions and child welfare decisions. 4. Describe strategies for maintaining integrity while presenting parenting assessment finding in adversarial contexts.

S094-3.

EXPLORING HOW PEER SUPPORT CAN EXPAND PARENTING OPPORTUNITIES FOR WOMEN WITH SERIOUS MENTAL HEALTH DIAGNOSES IN MARGINAL SOCIAL CIRCUMSTANCES: PART 1

Presenter: Mary Jane Alexander, Ph.D., Jacki McKinney, M.S.W.

SUMMARY:

Although women with serious mental health diagnoses become parents at roughly the same rates as women without, there is little information about how they navigate complex parenting trajectories, and perhaps for this reason, there are few services available to support them as parents. If recovery goes beyond repairing women’s capacity to supporting them in the doings and beings they value, then an empirical basis for customizing the evidence base to fit specific life contours is essential. With this in mind, this portion of the symposium will examine the parenting goals of women with experiences of homelessness and cooccurring disorders. Using a Capabilities framework and a Community Based Participatory Research approach, a multi stakeholder team developed a study of mothers with serious mental illness in supported housing who lived with or apart from their children. The goal was to identify how realistically women’s capabilities or practical opportunities to achieve valued roles could be expanded. In depth interviews with mothers, housing staff, child caregivers and policy makers were conducted in order to understand the value of parenting, the mothers’ real opportunities for and barriers to parenting, and their actual participation in parenting. The second part of this presentation presents the perspective of lived experience on the work of the above study, which aimed to identify strategies for engaging these mothers in peer support, and the key dimensions of peer support for parenting in marginal social circumstances. Experienced peer advocates took the lead in studying how parents who

experienced homelessness and cooccurring disorders could develop their own supports for the lives they value. In this presentation, Ms. McKinney will present this peer perspective, focusing on women's struggles to parent in difficult conditions. She will talk about principles for working with peers to develop their own supports for parenting in marginal social circumstances. She will describe how a peer parenting support curriculum can enhance recovery, family wellbeing and housing stability.

SYMPOSIUM 095

GERIATRIC BIPOLAR DISORDER: PHARMACOTHERAPY OF LATELIFE BIPOLAR MANIA

Chair: Robert C. Young, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the limitations in the existing evidence base regarding tolerability and benefits lithium compared to valproate in geriatric bipolar patients, 2) Be familiar with the design of, and preliminary findings from the geriatric bipolar disorder study, 3) Discuss sample characteristics including cognitive performance and medical comorbidity

SUMMARY:

Objectives: This symposium will present initial findings from GERIBD, an NIMH-sponsored multicenter study of acute treatment of manic and hypomanic states in elders with bipolar I disorder. **Methods:** We will outline the rationale and features of a first doubleblind, randomized controlled trial comparing two mood stabilizers in bipolar manic or hypomanic elders. In patients treated with lithium or valproate under double blind conditions, we will compare tolerability and antimanic response. We will describe cognitive performance and medical comorbidity in the sample. **Results:** Despite the importance of safe and effective management of bipolar disorder in late life, there is a limited evidence base on which to base practice. Lithium and valproate are both frequently used in bipolar elders, and open studies have found that they can be beneficial and adequately tolerated. The study selection criteria were intended to generate a sample which would likely benefit from these agents. The design emphasizes initial monotherapy, and dosing to target blood levels, while allowing lower levels if needed due to side effects. Assessment methods were selected with attention to the age group and minimization of subject burden. We will compare the tolerability of lithium and valproate, and we will contrast the antimanic response to the two agents. Based on preliminary analyses, we will also examine relationships between cognitive performance and vascular comorbidity. **Conclusions:** The study is intended to generate findings that can directly inform clinical

practice by assessing tolerability and documenting benefit at tolerated blood levels of lithium or valproate.

S095-1.

GERIATRIC BIPOLAR DISORDER: OVERVIEW OF RATIONALE AND STUDY DESIGN

Presenter: John L. Beyer, M.D.

SUMMARY:

Objectives: This presentation will outline the rationale and features of an NIMH-sponsored acute treatment study of late-life mania (GERIBD). **Methods:** We will summarize the limited available literature regarding the current management of bipolar manic states in late life. We will then review choices made in the selection of GERIBD study medications, sample selection criteria, overall design, and assessment methods. **Results:** Despite the importance of safe and effective management of bipolar disorder in late life, there is limited evidence on best clinical practices in this vulnerable population. GERIBD is multicenter randomized clinical trial that addresses the safety and benefits of lithium and valproate in late life Bipolar I manic, mixed and hypomanic states. The selection of study drug interventions (lithium and valproate) was based on review of current mood stabilizer use in elders with bipolar disorder. The study selection criteria were intended to generate a sample that could benefit from such treatment and reflected clinical practice. The study design emphasized initial monotherapy with dose adjustment based on targeted blood levels and tolerability. Assessment methods were selected with attention to the age group and minimization of subject burden. **Conclusions:** The GERIBD study is intended to generate findings that can directly inform clinical practice in this population by assessing the tolerability of these widely used agents, and their efficacy at tolerated blood levels. **Learning objectives:** 1. Participants will be able to review the current treatment practices for the treatment of late life mania 2. Participants will be able to discuss the design and interventions of the GERIBD study.

S095-2.

TOLERABILITY OF LITHIUM AND VALPROATE IN GERIBD PARTICIPANTS

Presenter: Robert C. Young, M.D.

SUMMARY:

Objectives: In this symposium we will compare the tolerability of lithium or valproate in GeriBD participants treated under doubleblind conditions. **Methods:** Participants had Bipolar I mania or hypomania. They were not demented, they did not have unstable medical conditions, and they

did not have a history of intolerance of lithium or valproate. They were randomized under double blind conditions to be treated with lithium or valproate. Blood levels were monitored and the target levels were 0.800.99 mEq/l or 8099 mg/L. If required due to side effects, levels could be adjusted to as low as 0.40 mEq/l or 40 mg/L. Participants were closely monitored, and tolerability was formally assessed at days 4, 9, 15, 21 and then weekly during nine weeks of treatment with several measures including vital signs, the UKU Side Effects Scale, laboratory tests, and EKGs. In addition, clinically significant and serious adverse events (SAEs) were systematically documented. Results: The overall dropout rates, rates of dropout attributed to adverse effects, SAEs, and incidence of specific adverse events will be compared in participants randomized to lithium or valproate. Conclusions: These are findings from the first randomized controlled trial comparing the tolerability of these mood stabilizers in older patients with bipolar mania or hypomania.

S095-3.
ANTIMANIC EFFECTS OF LITHIUM AND VALPROATE FOR THE TREATMENT OF LATELIFE MANIA AND HYPOMANIA: RANDOMIZED CONTROLLED TRIAL, GERIATRIC BIPOLAR DISORDER

Presenter: Laszlo Gyulai, M.D.

SUMMARY:

Objective: Evidence from controlled medications trials for late life mania and hypomania has been missing on which rational treatment decisions can be based. To fill this gap we present results of double blind randomized comparison of benefits of lithium or valproate in late life mania and hypomania from the GERIBD multicenter study. **Methods:** Participants were aged 60 years or older with Bipolar I disorder who did not have dementia, unstable medical conditions or a history of treatment resistance to lithium or valproate. They were randomized to be treated with lithium or valproate with doses titrated gradually to achieve target blood levels of 0.800.99 mEq/l or 8099 mg/l respectively. If insufficient improvement was observed after three weeks of treatment, risperidone was added openly to lithium or valproate. Participants were closely monitored and outcomes were assessed at days 4, 9, 15, 21 and then weekly during nine weeks of treatment with structured scales including the Young Mania Rating Scale (YMRS) and the Clinical Global Impression scale. **Results:** We compare symptom change (i.e., reduction in YMRS score), global improvement, and need for risperidone augmentation in participants randomized to lithium or valproate. **Conclusions:** This first randomized controlled trial comparing the benefits of two mood stabilizers in older patients with bipolar I mania or hypomania generates findings that have direct clinical relevance. **Learning objectives:** 1. Attendees will have a greater understanding

of the benefits of lithium and anticonvulsant mood stabilizing medication in the treatment of bipolar disorder in older adults. 2. Participants will gain familiarity with research study designs that can be generalizable to realworld, complex populations with bipolar disorder

S095-4.
COGNITIVE FUNCTION AND MEDICAL COMORBIDITY IN ELDERS WITH BIPOLAR DISORDER PARTICIPATING IN GERIBD

Presenter: Ariel Gildengers, M.D.

SUMMARY:

This presentation will focus on the cognitive variability and medical comorbidity in geriatric bipolar patients participating in a randomized controlled trial of lithium or valproate treatment. We will explore the relationship of cognitive function to medical comorbidity and lifetime history of bipolar disorder. Patients were all 60 years and older with Bipolar I experiencing manic, hypomanic, or mixed episodes. Patients did not have preexisting history of dementia. They were assessed at baseline and termination with the MMSE and Dementia Rating Scale. Medical comorbidity was assessed with the Cumulative Illness Rating Scale Geriatric. Preliminary analysis identified that increased vascular disease was related to lower memory performance. Later age of illness onset was related to greater vascular burden. Individual differences in cognitive function and medical comorbidity are meaningful dimensions of heterogeneity in this sample of bipolar elders with BD I, experiencing manic, hypomanic or mixed episodes. We will examine effects of both cognitive impairment and medical burden on treatment outcome.

SYMPOSIUM 096
CONTROVERSIES IN THE UNDER VERSUS OVER DIAGNOSIS OF BIPOLAR DISORDER

Chair: Joseph F. Goldberg, M.D., M.S.

Discussant: Frederick K. Goodwin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize ways in which current DSMIV criteria may contribute both to the falsenegative and falsepositive detection of cases of bipolar disorder, 2) Differentiate the construct of affective instability from the core elements that comprise the diagnosis of bipolar disorder, 3) Identify sources of divergence between clinician and patientrated screening assessments for bipolar disorder among patients with comorbid mood and substance use disorders, 4) Un-

derstand features of bipolarity that warrant consideration during the evaluation of patients seeking treatment for major depression

SUMMARY:

Recent years have witnessed a dramatic increase in communitybased diagnoses of bipolar disorder and expansion of the construct of the “bipolar spectrum.” While an important literature has arisen regarding its historical underdiagnosis and underrecognition relative mainly to unipolar depression less attention has been paid to its differential diagnosis, and the need for rigor in discriminating its nonpathognomonic features (particularly mood instability and impulsivity) from other psychiatric disorders. This symposium will present an overview of controversies regarding the under versus overdiagnosis of bipolar disorder, reviewing recent largescale epidemiologic screening studies and focusing on the concepts of subthreshold symptoms of mania/hypomania and duration criteria, alongside the relevance of affective instability, points of contrast with borderline personality disorder and other psychiatric conditions that mimic bipolar illness, treatment ramifications, and the utility of selfreport versus clinicianrated diagnostic assessments. Merits and weaknesses for proposed expansion of the bipolar construct in DSMV will be discussed, along with recommendations for clinical assessment, management, and future research directions.

S096-1.

DIAGNOSTIC ERROR IN BIPOLAR DISORDER: THE INHERENT LIMITS OF CRITERIABASED DIAGNOSES AND ITS IMPACT ON OVERDIAGNOSIS AND UNDERDIAGNOSES

Presenter: Mark Zimmerman, M.D.

SUMMARY:

DSMIV is a categorical system that provides descriptive diagnostic criteria for psychiatric syndromes. These syndrome descriptions are imperfect representations of underlying disease entities; thus, the criteria could be conceptualized as a type of test for the pathophysiologicallydefined illnesses. Accordingly, as with any other diagnostic test, diagnoses based on DSMIV criteria produce some false positive and some false negative results. That is, some patients who meet the criteria will not have the illness (i.e., false positives), and some who do not meet the criteria because their symptoms fall below the DSMIV diagnostic threshold will have the illness and incorrectly not receive the diagnosis (i.e., false negatives). In this context, I consider the controversy over whether the diagnostic threshold for bipolar disorder should be lowered, and the impact of diagnostic threshold on overdiagnosis and underdiagnosis rates.

S096-2.

WHY AFFECTIVE INSTABILITY IS DIFFERENT FROM BIPOLARITY

Presenter: Joel Paris, M.D.

SUMMARY:

Affective instability (AI) describes emotional dysregulation leading to “rollercoaster” mood swings driven by environmental stressors. While research into this phenomenon is still in its early stages, there is little evidence to support the assumption that it is a form of bipolar disorder. AI does not share biological markers or genetic patterns with bipolarity, has a different course, and does not respond in any consistent way to mood stabilizers. On the contrary, AI is a characteristic symptom of personality disorders, most particularly the borderline category. Recognition of AI as a distinct phenomenon allows for the prescription of the most effective treatment, which currently consists of specialized treatment for personality disorder symptoms. Many epidemiological studies on “bipolar spectrum” symptoms have failed to make this distinction, lumping together true hypomania and AI. This has led to the misdiagnosis of patients with bipolar disorder, resulting in unnecessary and ineffective pharmacological interventions. A similar level of confusion has afflicted child psychiatrists who treat putative bipolarity in prepubertal children. This error is part of a larger tendency to reduce complex psychopathological phenomena to symptoms of mood disorder.

S096-3.

CLINICIAN VERSUS PATIENTRATED MDQ SCREENING FOR BIPOLAR DISORDER AT HOSPITALIZATION: SOURCES OF DISCORDANCE

Presenter: Joseph F. Goldberg, M.D., M.S.

SUMMARY:

The Mood Disorders Questionnaire (MDQ) was developed as a selfreport screen for possible bipolar I diagnoses, although its validity has not been well established in patients with comorbid or complex psychopathology or suspected nonbipolar I mood disorders. Notably, studies of its discriminant properties have thus far yielded little information on its positive and negative predictive value in complex patients, or shed light on reasons for falsepositive ratings. This presentation will present new data on implementation of the MDQ in a large group of dualdiagnosis inpatients with mood and substance use disorders, examining total and itemwise concordance/discordance observed in patient selfratings versus facetoface MDQ item reviews by clinician interview at the time of hospitalization. Only modest correlations were observed between patient and clinician ratings,

with significantly higher total scores rated by patients than clinicians. Divergent clinician/patient ratings were most common for items assessing irritability, racing thoughts, and distractibility. Clinician interviews clarified that most false-positive item ratings by patients occurred because symptoms could not be differentiated from intoxication effects, while false-positive self-ratings for items involving distractibility and increased energy most often had other (nonbipolar, nonsubstance-related) psychiatric etiologies. Self-report screening of mania symptoms is not a reliable proxy for direct interviews in patients with mood and active substance abuse symptoms.

S096-4.

INDICES OF BIPOLAR DISORDER IN 5,635 PATIENTS SEEKING TREATMENT FOR A MAJOR DEPRESSIVE EPISODE

Presenter: Charles Bowden, M.D.

SUMMARY:

Objective: We aimed to evaluate the characteristics of patients presenting with a current major depressive episode who were assigned a diagnosis of bipolar disorder using three different diagnostic algorithms. **Methods:** The BRIDGE study, was conducted in eighteen countries in Europe, Asia and North Africa. Community and hospital based psychiatrists administered semistructured diagnostic, illness course and family history assessments to a consecutive series of adults seeking treatment for a major depressive episode (DSMIV criteria). The participating psychiatrists also completed a questionnaire on patients' clinical features which enabled a diagnosis of bipolar disorder by three different algorithms (DSMIVTR, modified DSMIV, eliminating durational and exclusionary criteria, and Bipolarity Specifier criteria, which incorporate illness course assessments and family history of hypomania/mania). Patients also completed a screening instrument for bipolar disorders, the Hypomania Checklist 32 items. **Results:** Intercurrent symptoms of affective lability, mixed states plus mood lability, history of illness age of onset of illness <30yrs, ? 2 mood episodes and family history of hypomania/mania were all significantly associated with bipolarity. Application of Bipolarity Specifier criteria developed by Angst and associates indicated that 47% met Bipolar Specifier criteria, compared with 16% per DSMIVTR criteria. Rates of bipolar diagnosis based on the three criteria applied were notably similar across major geographic, cultural and religious regions. Women with first episode postpartum (FEPP) depression had higher rates of bipolar disorders, with more hypo/mania in first degree relatives. Psychotic symptoms, atypical features, mixed depression, younger age at onset, high number of prior episodes, episodes of short duration, hypomania/mania on antidepressants, seasonality of

mood episodes and mood episodes with free intervals were significantly more frequent in FEPP depressives. Current exclusion criteria in DSMIV (hypomania due to the use of antidepressants or of other substances, or to other medical conditions) excluded patients with bipolar depression and should not be retained. Whereas bipolar II patients had significantly greater comorbidity for all subgroups of anxiety disorders; significant anxiety disorder comorbidity in bipolar I patients was limited to social phobia and OCD.

SYMPOSIUM 097

AMERICAN PSYCHIATRY AND HUMAN RIGHTS IN THE 21ST CENTURY: THE CLINICAL PROCESS

Co-Chairs: Andres J. Pumariega, M.D., R. Rao Gogineni, M.D.

Discussant: William Ulwelling, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the relevance of human rights concepts and UN conventions to the practice of psychiatry, 2) Recognize the human rights implications of stigma and consumer issues affecting psychiatric patients, 3) Recognize the human rights implications of managed care, health care reform, and access to evidencebased practices and prevention, 4) Recognize the role that psychiatry can play in advocacy around these issues and the leverage that UN conventions can provide in this advocacy

SUMMARY:

Background: The focus of American Psychiatry for many years was on the human rights abuses by other nations that involved the misuse of psychiatric practice, particularly in the former Soviet block and other totalitarian regimes. Though such focus is legitimate, American psychiatry has rarely turned inward to examine the human rights record of our specialty and our health system. This is particularly true as these relate to the various UN conventions that outline human rights across various domains and populations. Many of these conventions relate to issues that are directly relevant to access to care and the rights of affected individuals with mental illness. **Objective:** In this symposium (first of a two part series), the application of human rights principles to various aspects of psychiatric practice in the U.S. will be examined. **Methods:** The presenters will focus on the relevance of various UN conventions on human rights to psychiatric practice in the U.S., the human rights of U.S. mental health consumers and how these relate to the advocacy and recovery movements, the relevance of human rights concepts to managed care implementation and health care reform, and the human rights aspects of denial of evi-

dencebased interventions.

S097-1.

HUMAN RIGHTS AND MENTAL HEALTH CONSUMERS

Presenter: Charles W. Huffine, M.D.

SUMMARY:

The UN convention on people with disabilities and the UN convention on Human Rights cited the right to access to health care, and consequently mental health care, as critical human rights. Stigma related to mental illness not only serves as a barrier against such rights, but also violates the nondiscrimination aspects of both these UN conventions, as well as the Americans for Disabilities Act in the US. The US consumer and family advocacy movements have focused on attainment of these rights in alliance with organized psychiatry in recent years, but have rarely invoked the UN conventions in this advocacy, instead invoking US laws. This presentation looks at the mental health consumer movement through the lens of human rights movements, including the aspect of the consumer movement that seeks to address rights abuses within treatment facilities. It includes the presenter's own experience with consumer youth movements and how these have mobilized youth to seek more extensive human rights and services as well as humane treatment in residential treatment facilities. Organized psychiatry can take a more active role in advocacy using these conventions as cornerstones for advocacy and taking an international perspective on where US mental health consumers and their families stand in comparison to their brethren abroad and measured against what are essentially international aspirational standards.

S097-2.

HUMAN RIGHTS AND MANAGED CARE

Presenter: Steven Moffic, M.D.

SUMMARY:

By all accounts, the most important document for human rights is the 1948 UN Declaration of Human Rights, which attempted to prevent any atrocities similar to those of World War II. These atrocities included torture, unsound medical experimentation, concentration camps, and mass killings of those deemed undesirable to the German government. As documented by the psychiatrist Robert Jay Lifton, many physicians participated in these atrocities. The most relevant article for mental health in the declaration is Article 25: "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care . . ." It may seem

obvious that the USA has had mixed success in meeting that right. Paradoxically, the only part of our population that has a right to such medical care is the prison population, but even here the adequacy varies greatly state by state. In the general population, there are large numbers of inadequately insured and uninsured people, as well as large numbers of homeless. The managed care system of delivering health-care, in particular, has also had mixed success in addressing this human right. With its emphasis on cost savings for the businesses and government providing insurance coverage, it has enabled insurance coverage to not be even further reduced or eliminated. However, a quest for profits first, using authorization and other management strategies, has elicited questions of inadequate or poor care. One proposed solution would be the establishment of a notforprofit, managed, singlepayor system for the USA, but currently healthcare reform is just increasing the opportunities for the forprofit managed care companies. References: Moffic HS: *The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare*. JosseyBass, 1997. Schoenholz J: *The Managed Care Industry*. CreateSpace, 2011.

S097-3.

HUMAN RIGHTS AND ACCESS TO PREVENTIVE SERVICES

Presenter: Carl C. Bell, M.D.

SUMMARY:

This maintenance of life involves both intervention and prevention; a physician's neglect in applying their knowledge and ability to preclude a symptom or disease process is accepted as unethical and, in some cases, illegal. Ethicists have argued that access to adequate medical care for diseases should be a right (ie, an inherent, human allowance) and not a privilege (ie, an earned and/ or allocated allowance or advantage), and preventing the onset or progression of disease is a timehonored anchor of this profession. New research suggests that psychosocial technologies can be equally efficacious and effective in preventing mental disorders, substance abuse, and problem behaviors in children, adolescents, and young adults. Further, considering affect dysregulation is conducive to risky behaviors resulting in poor physical and mental health, there is robust scientific evidence supporting biotechnical and psychosocial interventions that increase affect regulation. Accordingly, to not provide prevention interventions that would strengthen "affect regulation" (ie, the ability to implement behaviors that manage the expression of emotions, hence preventing risky behaviors) is unethical and a violation of human rights. Scientific evidence undoubtedly shows there are effective prevention interventions to help youth develop the emotional and social intelligence (eg, optimal affect regulation) needed to curb untoward and preventable behaviors and

circumstances. From preconception to adolescence, there are prevention interventions that have been empirically supported to prevent behaviors during these times and beyond. This presentation reviews the evidence around these preventive interventions, the barriers (fiscal, ideological, and bureaucratic) to their systematic implementation, and how the advocacy around their needed implementation can be made not only in terms of effectiveness and cost savings but also denial of human rights. Reference: McBride, D, & Bell, C. Is Denial of EvidenceBased Prevention a Violation of Human Rights?. *Journal of the National Medical Association*, 2011;103: 618619.

S097-4.

HEALTH SYSTEM REFORM AND HUMAN RIGHTS

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

SUMMARY:

Health system reform seems to be primarily motivated by the increasing and unsustainable high cost of health care in this country. Underlying all the contention and debate about the scope and shape of health system reform is the basic ethical issue of the right to care and treatment in the 21st century in the U.S. Our country is unique among modern Western democracies in having so many people (currently 55 million) without insurance. There are many more Americans who are underinsured, especially when it comes to care for mental and substance use disorders. The parity law of 2008, which establishes the right of individuals to the same coverage for mental health and substance use treatment as for other medical conditions and their treatments, established a baseline for care for individuals with health insurance. But, those without insurance are out of luck. Health reform passed in 2010 (The Affordable Care Act) expands coverage to more than 33 million Americans who don't have insurance by mandating this coverage, or individuals and small businesses will have to pay penalties. This seems to be mostly motivated by trying to fix the broken health care marketplace and "bend the cost curve," but it has a major human rights issue related to the right to health care. This presentation will review the ethical and human rights issues in health care with a special emphasis on access to care for mental and substance use disorders.

SYMPOSIUM 098

COMPREHENSIVE HIV NEUROPSYCHIATRY UPDATE

Chair: Karl Goodkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should

be able to: 1) Understand current medical and treatment approaches for the HIV/AIDS patient, 2) Understand the diagnostic and treatment approaches to neuropsychiatric and psychiatric symptoms in people with HIV/AIDS, 3) Understand the pathophysiology of HIV associated neurocognitive impairment and disorder, 4) Describe psychopharmacological treatment for neurocognitive impairment and disorder as well as other psychiatric illnesses occurring in HIV/AIDS, and 5) Recognize that there are drug interactions between HIV medications and psychiatric medications

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 uptodate 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.

S098-1.

HIV/AIDS MEDICAL UPDATE

Presenter: Steven Douglas, M.D.

SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIVinfected 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 HIVinfected persons, however, is becoming increasingly complex. Research shows that HIV positive people on antiHIV medications who are virally suppressed to undetectable levels are much less likely to transmit the virus during sex. Beginning antiHIV 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

neuro inflammation early in the disease progress. While antiretroviral regimens have fewer side effects, adherence to treatment is as crucial as ever to maintain a nondetectable viral load and to maximize immune reconstitution and must be durable for many years. This session will provide the most up to date epidemiological information, guidelines for antiretroviral therapy, and considerations for patients with a history of drug use, hepatitis C virus coinfection, and mental illness. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.

S098-2.

NEUROPSYCHIATRIC OVERVIEW

Presenter: Marshall Forstein, M.D.

SUMMARY:

Since the beginning of the epidemic over 28 years ago, the role of the psychiatrist has been critical in the management of HIV/AIDS. The prevalence of HIV among people with severe mental illness is estimated to be approximately ten times that in the US general population, and even higher among people with comorbid substance use disorders. Psychiatric conditions may reduce adherence to HIV treatments and increase the likelihood of high risk sexual and drug use behaviors. Depressive disorders are nearly twice as common in HIV positive subjects compared to matched controls and may be associated with HIV disease progression. Psychiatrists must consider the potential direct effects of HIV on the central nervous system, the peripheral nervous system, and on other organ systems when assessing neuropsychiatric and psychiatric complaints. In addition, persons with HIV are often on multiple medications that may have psychiatric side effects or may induce complex drugdrug interactions. Approximately 12% of people with HIV have a concurrent diagnosis of drug dependence, further complicating assessment and treatment. This presentation will review (1) the epidemiology of mental health disorders in HIV; (2) the differential diagnosis and evaluation of neuropsychiatric and psychiatric symptoms in the context of HIV; (3) the general psychopharmacologic and psychotherapeutic treatment approaches to neurocognitive, mood, anxiety, and psychotic disorders in HIV; and (4) the potential role of the neuropsychiatrist and psychiatrist in HIV prevention and as a member of an integrated, multidisciplinary approach to HIV medical care.

S098-3.

NEUROCOGNITIVE DECLINE

Presenter: Karl Goodkin, M.D., Ph.D.

SUMMARY:

Although HIV1 associated dementia and minor neurocognitive disorder have declined in incidence, HIV1 associated neurocognitive impairment continues to be a frequent and clinically important focus in the highly active antiretroviral therapy (HAART) era. This change is consistent with neuropathological changes noted in which the encephalopathy has actually become more common, although less severe than in the preHAART era. The clinical manifestations of the HIV1 associated neurocognitive disorders themselves have changed, with chronic inactive and fluctuating forms of the dementia, for example, becoming more common. Longterm 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 (HAD) and minor cognitivemotor disorder (MCMD) [now referred to as mild neurocognitive disorder (MND)], and asymptomatic neurocognitive impairment has been added as a condition to be diagnosed. 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. The HIV associated neurocognitive disorders (HAND) conditions remain diagnoses of exclusion. Documented, effective therapies for these treatment targets remain largely constrained to the CNS penetrating antiretroviral regimens and the psycho stimulants. The recently FDA approved antiretroviral drugs in the classes of CCR5 antagonists and integrate inhibitors deserve study for the treatment of HAND, along with antiretroviral adjuvant pharmacotherapy's specific to the CNS.

S098-4.

PSYCHOPHARMACOLOGY

Presenter: Stephen J. Ferrando, M.D.

SUMMARY:

The current psychopharmacology for HIV/AIDS recognizes particular drug interactions between HIV medications and psychiatric drugs. Antiretroviral therapy, known as ART, is the drug regimen which needs to be taken every day for viral suppression and control of the disease. Anti HIV medications are metabolized in the liver known as the cytochrome p450 system. ART can compete with psychiatric medications in the liver, block or slow down these pathway (inhibit) or increase the activity or enhance the pathway (induce). ART is metabolized by the cytochrome 3A4 and the 2D6 pathways which are the same ones used by many psychiatric drugs. An overview of the clinically significant interactions will be offered. Clinicians will be introduced to medication interaction tables that are free, reliable, easy to use and readily available by the internet. Clinicians will also appreciate the potential dangers of certain medications

such as trazodone due to drugdrug interactions as well as other prescribed and over the counter medications. Recreational drugs (including “club” drugs) and their interactions will be discussed as well. Some HIV medications which are the backbone of treatment such as efavirenz [Sustiva] can worsen symptoms for individuals with major depression or posttraumatic stress disorder. This can lead to nonadherence to the medications. Pharmacologic strategies will be discussed. Both individuals taking ART as well as individuals with HIV who do not yet require ART can have increased sensitivity to medications which are commonly used in psychiatry. These include lithium, valproate, antidepressants and antipsychotics. These will be discussed. Recognition of the stage of HIV/AIDS of the individual can be helpful in making medication determinations and this will be described as well.

SYMPOSIUM 099

UPDATED APPLICATIONS OF EXPERT PSYCHIATRIC TESTIMONY IN CRIMINAL JUSTICE

Co-Chairs: Clarence Watson, M.D., J.D., Kenneth J. Weiss, M.D.

Discussant: Clarence Watson, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe legal issues related to developmental disorders, parasomnias, traumatic brain injury, neuroimaging, and child and adolescent disorders in the criminal justice setting, 2) Recognize how deficits in social cognition, especially empathy, related to Autism Spectrum Disorder (ASD) can impact the view of criminal culpability in an individual with ASD facing criminal charges, 3) Describe how neuropsychological testing and neuroimaging studies allow the clinician to inform the court in criminal cases and the limitations on the admissibility of such evidence in the courtroom, 4) Describe the legal issues that arise in evaluating parasomnia related violence and the challenges facing the clinician in testifying in court about sleep related violence, and 5) Describe the challenges in performing forensic assessments in the criminal juvenile justice system where experts are asked to assist courts in deciding whether a juvenile offender can be safely maintained in the community given risk and protective factors associated with delinquent behavior

SUMMARY:

The purpose of this symposium is to update clinicians on various psychiatric issues that experts may be asked to address during involvement criminal justice cases. The panel will discuss the legal issues related to developmental

disorders, parasomnias, traumatic brain injury, neuroimaging, and child and adolescent disorders in the setting of criminal justice. The deficits in social cognition, especially empathy, related to Autism Spectrum Disorder (ASD) will be discussed and placed into the context of criminal responsibility. Approaches to the question of whether a deficit in social cognition prevents an individual with ASD from forming criminal intent will also be discussed. Next, the panel will cover how neuropsychological testing, structural brain imaging and functional brain imaging allow the clinician to inform the court on the brain structure and function of forensic examinees suffering traumatic brain injury. The panel will also address efforts to use functional neuroimaging studies in the courtroom to help elucidate mental states that bear on questions of criminal responsibility, competency, and deception. Questions regarding the reliability of inferring mental states and abilities from brain images, and concerns that brain images may have a unique power to be more prejudicial than probative in the courtroom will be addressed. The panel will discuss the medicallegal issues that arise in evaluating parasomnia related violence and the challenges facing the clinician in explaining to a judge and jury the counterintuitive idea of engaging in directed violence during sleep. These challenges weigh heavily in jury determinations of criminal responsibility in parasomnia criminal cases. Lastly, the panel will discuss the role of the clinical expert in the criminal juvenile justice system. Experts are often called upon to provide assessments to help the courts to decide if a juvenile offender can be safely maintained in the community and they do so by performing a thorough forensic assessment, obtaining history from multiple sources of collateral, performing a complete review of court documents and finally by assessing risk and protective factors that are associated with delinquent behavior, including multiple issues related to the youths family and environment. The panel will discuss the challenges in performing those assessments.

S099-1.

INTRODUCTION OF SPEAKERS AND OVERVIEW OF PRESENTATIONS

Presenter: Clarence Watson, M.D., J.D.

SUMMARY:

The purpose of this symposium is to update clinicians on various psychiatric issues that experts may be asked to address during involvement in criminal justice cases. The panel will discuss the legal issues related to developmental disorders, parasomnias, traumatic brain injury, neuroimaging, and child and adolescent disorders in the setting of criminal justice. The deficits in social cognition, especially empathy, related to Autism Spectrum Disorder (ASD) will be discussed and placed into the context of criminal re-

sponsibility. Approaches to the question of whether a deficit in social cognition prevents an individual with ASD from forming criminal intent will also be discussed. Next, the panel will cover how neuropsychological testing, structural brain imaging and functional brain imaging allow the clinician to inform the court on the brain structure and function of forensic examinees suffering traumatic brain injury. The panel will also address efforts to use functional neuroimaging studies in the courtroom to help elucidate mental states that bear on questions of criminal responsibility, competency, and deception. Questions regarding the reliability of inferring mental states and abilities from brain images, and concerns that brain images may have a unique power to be more prejudicial than probative in the courtroom will be addressed. The panel will discuss the medicallegal issues that arise in evaluating parasomnia related violence and the challenges facing the clinician in explaining to a judge and jury the counterintuitive idea of engaging in directed violence during sleep. These challenges weigh heavily in jury determinations of criminal responsibility in parasomnia criminal cases. Lastly, the panel will discuss the role of the clinical expert in the criminal juvenile justice system. Experts are often called upon to provide assessments to help the courts to decide if a juvenile offender can be safely maintained in the community and they do so by performing a thorough forensic assessment, obtaining history from multiple sources of collateral, performing a complete review of court documents and finally by assessing risk and protective factors that are associated with delinquent behavior, including multiple issues related to the youths family and environment. The panel will discuss the challenges in performing those assessments.

S099-2.

AUTISM SPECTRUM DISORDER: APPLICATIONS OF PSYCHIATRIC TESTIMONY IN CRIMINAL CASES

Presenter: Kenneth J. Weiss, M.D.

SUMMARY:

Autism Spectrum Disorder (ASD) has received a great deal of attention, both from mental health professionals and the popular media. The core clinical problem appears to be a deficit in social cognition, especially empathy. This deficit, while not necessarily associated with criminal behavior, may lead to awkward social relations; and in some instances, to accusations of inappropriate or even criminal behavior. For example, lack of modulation of interpersonal distance and inability to foresee the consequences could lead to the appearance of a sexual boundary violation. The question for the forensic psychiatrist would be whether the deficit in social cognition prevented the individual with ASD from forming criminal intent. Short of a defense, a jury may want to know about the social cognition deficit in

determining whether the prosecution has met its burden of proof. Recent case law from the New Jersey Supreme Court suggests that expert testimony should be admissible whenever relevant; that is, not restricted to a formal psychiatric defense. The presenter will ascribe how testimony can be fashioned, using knowledge of ASD, medical literature, and relevant case law. This will fill knowledge gaps of practitioners who wish to participate in criminal cases in which the diagnosis of ASD does not fall squarely within the local insanity defense.=

S0993.

LEGAL RELEVANCE OF BRAIN FUNCTION: ADMISSIBILITY OF NUCLEAR IMAGING FOLLOWING TRAUMATIC BRAIN INJURY

Presenter: Susan E. Rushing, M.D., J.D.

SUMMARY:

Neuropsychological testing, structural brain imaging and functional brain imaging allow the forensic practitioner to inform the court on the brain structure and function of forensic examinees. Mirroring their use in clinical medical practice, neuropsychological testing and structural imaging in the form of computerized tomography (CT) and structural magnetic resonance imaging (MRI) have achieved largescale acceptance in court. However, functional imaging has faced more admissibility challenges. While functional imaging is becoming an increasingly important tool in assessing neuropsychiatric sequelae, I surmise that evidentiary challenges are largely related to the phase of trial at which the evidence is offered.

S099-4.

ADMISSIBILITY OF FUNCTIONAL NEUROIMAGING EVIDENCE IN US COURTS

Presenter: Octavio Choi, M.D., Ph.D.

SUMMARY:

Functional neuroimaging studies are increasingly being proposed for use in the courtroom to help elucidate mental states that bear on questions of mens rea, competency, and deception. However, both federal and state courts have been resistant to admitting functional neuroimaging evidence in trials, due to a variety of factors. This presentation will review the current state of admissibility of functional neuroimaging evidence, and the evolving judicial standards by which such evidence is allowed or rejected. Particular attention will be paid to questions regarding the reliability of inferring mental states and abilities from brain images, and concerns that brain images may have a unique power to be more prejudicial than probative for juries.

S099-5.

VIOLENT PARASOMNIAS AND THEIR FORENSIC ISSUES*Presenter: Elena T. Del Busto, M.D.***SUMMARY:**

Although once thought to be mutually exclusive, sleep and violence are not. Studies have shown that sleep violence, arising mostly from parasomnias most notably sleepwalking, occurs in 2% of the adult population. These violent acts are thought to occur during disruptions of sleep causing a dissociation between the sleeping mind and sleeping body. Although the exact mechanism which leads to sleep violence is not fully understood, a proposed theory attributes violent acts during sleep to hypoactivity and/or dysfunction of the prefrontal cortex areas coupled with the activation of pathways involved in complex emotional and motor behaviors. This presentation will review epidemiology, diagnostic criteria and treatment options of parasomnias most associated with violence including sleepwalking, sleep terrors, REM behavior disorder. We will illustrate medical-legal issues that arise in evaluating parasomnia related sleep violence as well as the difficulties an expert witness faces when explaining a counterintuitive idea such as committing a violent act during sleep to a jury. Additionally we will also discuss the proposed guidelines used to assist in forensic issues dealing with mens rea and diminished capacity.

S099-6.

THE ROLE OF THE EXPERT IN CRIMINAL JUVENILE JUSTICE*Presenter: Nicole A. Foubister, M.D.***SUMMARY:**

The juvenile justice system has seen widely disparate views in the management of youth offenders. Prior to the 19th, children were treated as little adults and subject to the same criminal sanctions as their adult counterparts. As childhood became increasingly known as a distinct and separate period of development, the courts began to take on *parens patriae*, that is a more paternal and rehabilitative role. At that time, the court system utilized a medical model that was centered on thorough assessments, treatment and even prevention, however this model did not come without its shortcoming as it was ultimately decided that children were being deprived of their due process rights. In *re Gault* (1967) Judge Fortas ruled that delinquent offenders were to be afforded the same due process rights as an adult charged with a crime with the exception of a jury trial. The courts continue to struggle in their views on managing juvenile delinquents, with the pendulum swinging wildly between

attempting to decriminalize offenders and act as a benevolent and loving parent versus waiving juvenile cases to the adult court system with the accompanying adult penalties. Child and adolescent psychiatrists working in the juvenile justice system lay witness to these various changes over time. The role of the clinical expert in the criminal juvenile justice system is dissimilar to the role of an expert in the adult court system. Expert testimony does not occur in the court, but rather via a report submitted to the judge. Child and adolescent forensic psychiatrists are often called upon to assist with issues regarding disposition (sentencing) of the youth offender. That is, once a child has been adjudicated (convicted), the courts struggle with determining the appropriate level of supervision and services to provide for the youth. Experts are often called upon to provide assessments to help the courts to decide if a juvenile offender can be safely maintained in the community and they do so by performing a thorough forensic assessment, obtaining history from multiple sources of collateral, performing a complete review of court documents and finally by assessing risk and protective factors that are associated with delinquent behavior, including multiple issues related to the youths family and environment. Utilizing the most up to date literature and clinical case examples, we will examine the role of a child and adolescent forensic psychiatrist in the criminal juvenile justice system.

SYMPOSIUM 100**SOMATIC SYMPTOM DISORDERS: TREATMENTS THAT WORK***Co-Chairs: Jeffrey P. Staab, M.D., M.S., Arthur J. Barsky, M.D.***EDUCATIONAL OBJECTIVE:**

At the conclusion of the session the participant should be able to: 1) Understand that patients with hypochondriasis, conversion, and other somatoform disorders may be managed quite successfully, 2) Utilize evidencebased psychotherapy, medications, and physical therapy to treat somatic symptom disorders, 3) Appreciate the fruitful role that psychiatrists may play in evaluating and treating patients with somatic symptom disorders

SUMMARY:

Background: The somatoform disorders have an image of unmanageability. These conditions date to psychiatry's earliest days, but research into successful and practical treatment interventions has woefully lagged work on other disorders. Fortunately, recent investigations provide reasons for optimism. Empirically validated concepts related to somatic symptom disorders, such as body vigilance and health anxiety, have emerged to augment historical con-

structs. Coupled with that are new data on psychotherapeutic, psychopharmacologic, and nonpsychiatric management strategies for conversion, hypochondriasis, and other somatoform disorders. These developments offer realistic methods for achieving positive outcomes in a group of patients that are considered by many clinicians to have a very negative prognosis. Objectives: This symposium will provide attendees with up-to-date information about successful, evidence-based therapeutic strategies for somatic symptom disorders. Examples will include office-based interventions and treatments offered at dedicated, tertiary care programs. Methods: A panel of experts from the US, Canada, and Europe will present research data on successful treatments for conversion, hypochondriasis, and somatization. Presentations will encompass psychodynamic, cognitive, and mindfulness psychotherapies, medication, and physical therapy. Didactic talks will provide evidence from a placebo-controlled trial of fluoxetine and CBT for hypochondriasis, a metaanalysis of short-term psychodynamic psychotherapy (STPP) for somatization, a case-controlled study of intensive physical and occupational therapy for functional movement (conversion) disorders, and a specialized group therapy program for somatoform syndromes. Video clips will illustrate patients' experiences in their own words. The symposium will conclude with an audience discussion of psychiatrists' roles in managing somatic symptom disorders in the early 21st century.

S100-1.

TREATMENT OF HYPOCHONDRIASIS: CBT, SSRI, OR BOTH? RESULTS FROM AN NIMH-FUNDED RANDOMIZED STUDY

Presenter: Brian A. Fallon, M.D., M.P.H.

SUMMARY:

Prior research has demonstrated efficacy for CBT and for SSRI therapy among patients with DSM-IV hypochondriasis. It remains unknown whether psychotherapy is more or less effective than pharmacotherapy and whether combined therapy renders greater or quicker improvement than either therapy alone. The extent to which other clinical markers may affect outcome (e.g., duration, childhood trauma, medical and psychiatric comorbidity) also remains unclear. This NIH randomized, double-masked study of DSM-IV hypochondriasis compared six months of CBT versus fluoxetine versus placebo versus the combined therapy with CBT+fluoxetine. 195 individuals recruited from the surrounding community were enrolled in this clinical trial conducted by research teams at Columbia University/NYS Psychiatric Institute in New York and Harvard University (Brigham Women's Hospital) in Boston. As the enrollment and treatment of study subjects in this five-year study are now complete, we will present the study results, hoping

to answer the critical questions above as well as provide a detailed description of the different treatment approaches.

S100-2.

SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY FOR SOMATIC SYMPTOM DISORDERS: STATE OF EVIDENCE AND VIDEOTAPE ILLUSTRATION

Presenter: Allan A. Abbass, M.D.

SUMMARY:

Short-term Psychodynamic Psychotherapies have been subjected to approximately 26 clinical studies showing large and persistent mean effects over a this set of variable quality, variable method studies. Somatic symptoms affecting each bodily system have been studied. Conditions with well-defined pathophysiology such as Crohn's disease, Peptic Ulcer Disease, Coronary Artery Disease, Emphysema and Rheumatoid Arthritis were treated in some of these studies. Emotion-focused STPP treatments outperformed insight-based models. Several studies show evidence for cost-effectiveness, including medical service use reduction. In this brief presentation Allan Abbass will overview this state of evidence including a new large cost-effectiveness study and results of applying STPP in the Emergency Department for Medically Unexplained Symptoms. A brief video clip will illustrate the assessment and treatment effects of a variant of STPP, called Intensive Short-term Dynamic Psychotherapy, in a patient with conversion disorder.

S100-3.

FUNCTIONAL MOVEMENT DISORDERS: SUCCESSFUL TREATMENT WITH A REHABILITATION PROTOCOL

Presenter: Jeff Thompson, M.D.

SUMMARY:

Functional ("psychogenic") gait and other movement disorders (aka conversion disorders) have proven very difficult to treat. This presentation will report on a historical cohort study of 60 consecutive participants in a one-week intensive motor reprogramming rehabilitation program and 60 matched controls receiving usual care. Patients going through the protocol are seen by a neurologist, psychologist/psychiatrist and physiatrist who each deliver a consistent mechanistic explanation of the movement disorder, avoiding implication of a psychogenic cause while still addressing psychopathology that is identified. The treatment uses a twice-daily PT and OT behavioral shaping approach to "reconnect the motor program" replacing the aberrant movements with normal movement patterns. Physician-rated outcomes after the one-week treatment program

documented 73.5% were markedly improved, nearly normal or in remission, similar to the patient ratings (68.8%). Long-term treatment outcomes (patient rated; median followup, 25 months) revealed 60.4% were markedly improved or almost completely normal/in remission, compared to 21.9% of controls ($p < 0.001$).

S100-4.

GROUP THERAPY TREATMENT OF FUNCTIONAL SOMATIC SYNDROMES AND SOMATOFORM DISORDERS USING CBT, MINDFULNESS, AND ACT IN A SPECIALIZED SETTING

Presenter: Per C. Fink,

SUMMARY:

Patients suffering from physical complaints not attributable to verifiable, conventionally defined diseases receive different diagnostic labels such as fibromyalgia, CFS, IBS and somatoform diagnoses. Today, only a minority of these patients receive evidence-based treatment. In this paper, we present a specialized multidisciplinary psychosomatic university hospital service for patients with such conditions, combined under the new unifying diagnostic label of Bodily distress syndrome (BDS). CBT and Mindfulness treatment in groups have been tested in RCTs, and we are presently conducting RCTs of ACT both for BDS and Health anxiety. The unifying approach of BDS is well received by both patients and referring physicians; only few patients discontinue the treatment. The results of the first RCT indicate positive effect on patient outcome. The organization of care and the rationale behind and differences between the treatment modalities will be presented as well as their pros and cons

S100-5.

SOMATOFORM DISORDERS: PATIENTS' PERSPECTIVES

Presenter: Maria Harmandayan, M.D.

SUMMARY:

Somatoform disorders are a group of illnesses characterized by bodily symptoms and signs that are distressing to patients, but cannot be fully explained by identifiable medical illnesses. These disorders are troubling to both patients and their medical professionals. Patients become frustrated with fruitless medical evaluations and may be bewildered or angry if psychological factors are raised as a possible cause of their complaints. Physicians and other clinicians struggle to communicate concepts of mind-body interactions in a way that is meaningful and able to promote patients' recovery. This presentation will illustrate, through video, successful

approaches to the diagnosis and treatment of somatoform disorders. In case vignettes, three patients will recount the hardships that they encountered in their search for proper diagnosis and treatment. More importantly, they will describe the language and models of illness that allowed them to understand their symptoms and embrace highly successful treatment strategies.

SYMPOSIUM 101

OBESITY AND BIPOLAR DISORDER: PHENOMENOLOGICAL IMPLICATIONS, COMMON NEUROBIOLOGICAL SUBSTRATES, AND THE EFFECT OF BARIATRIC SURGERY

Chair: Roger McIntyre, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Discuss the role of early childhood adversity on the propensity to excess weight in bipolar disorder, 2) To discuss the role of excess weight on cognitive function in bipolar disorder., 3) Review the effect of excess weight on the clinical presentation, course, and outcome of bipolar disorder, 4) To present data pertaining to the effect of bariatric surgery on the outcome (metabolic, psychiatric) in adults with bipolar disorder

SUMMARY:

During the past decade, epidemiological and clinical studies have amply documented the differential association of bipolar disorder (BD) with overweight/obesity/abdominal obesity/metabolic syndrome. Earlier conceptualizations that excess weight was simply a consequence of adverse health behaviours and iatrogenic artifact, have been supplanted by a more comprehensive multivariate model. The association between BD and obesity is a bidirectional relationship wherein these discrete phenotypes have overlapping pathophysiology and common antecedents. For example, early childhood trauma is identified as a nonspecific vulnerability factor to mental disorders (including BD), as well as disparate chronic medical disorders (e.g., obesity). In addition, preliminary evidence suggests that excess weight in BD contributes to cognitive dysfunction; cognitive dysfunction causes and maintains psychosocial impairment in the bipolar population. Results from phenomenological studies indicate that overweight/obesity is highly associated with a more complex illness presentation (e.g., rapid cycling), earlier age at onset, lower rate of recovery, and decreased response to psychotropic agents. It is also noted that excess weight in BD is associated with a greater vulnerability to depression, and suicidality. Taken together, the hazards posed by obesity provide impetus to prioritizing weight management and homeostatic food consumption in all individu-

als with BD. Furthermore, the extensive neurobiological overlap provides the basis for hypothesizing that a shared neurobiology exists between both phenotypes, providing new insight to the pathophysiology of both conditions, and possibly providing a framework for novel treatment approaches. Bariatric surgery has grown significantly in popularity in the general population, and is increasingly carried out in individuals with mood disorders. Relatively few studies have reported on the effect of bariatric surgery on psychiatric outcomes in the mood disorder population, notably BD. This symposium will review new data pertaining to the relationship of early life trauma and obesity in BD; the effect of excess weight on cognitive function in BD; the rate of eating disorders and the effect of excess weight on phenomenology, course, and outcome in BD; and the results of a recently completed NIMH study evaluating the effect of bariatric surgery on the course, outcome, as well as service utilization in BD.

S101-1.

OBESITY IN BIPOLAR DISORDER: THE CAUSATIVE EFFECTS OF TRAUMA AND CONSEQUENCES TO COGNITION

Presenter: Roger McIntyre, M.D.

SUMMARY:

Bipolar Disorder (BD) is differentially associated with overweight/obesity/metabolic syndrome. Efforts to parse factors mediating/moderating excess weight in bipolar individuals have emphasized behavioural effects, iatrogenic consequences, psychobiology (e.g., inflammation, neuroendocrine changes), as well as insufficient access to primary, preventative, integrated and timely health care. Results from epidemiological and clinical studies in nonpsychiatric populations have emphasized the role of trauma on propensity to age inappropriate weight gain, obesity, and components of the metabolic syndrome. A separate body of literature in the general population, supported by preclinical evidence, has emphasized the association between overweight/obesity and cognitive dysfunction/dementing disorders. This presentation will briefly review factors subserving excess weight in the bipolar population, with an emphasis on new data from the International Mood Disorders Collaborative Program (University of Toronto/Cleveland Clinic) describing the significant role of childhood sexual/physical abuse as a common antecedent to BD and obesity. New data will also be presented describing the hazardous effect of excess weight on cognitive function in individuals with BD. The implications for clinical practice and research vistas will also be discussed.

S101-2.

BIPOLAR DISORDER AND OBESITY: THE CONTRIBUTION OF EATING DISORDERS

Presenter: Susan McElroy, M.D.

SUMMARY:

Growing research has shown a relationship between bipolar disorder and both obesity and eating disorders (EDs). However, despite extensive research linking obesity with EDs, very few studies have explored the relationship of EDs with obesity in bipolar disorder. In this talk, data on the prevalence and correlates of EDs in 875 patients with bipolar disorder from the Stanley Foundation Bipolar Treatment Network, showing that binge eating disorder (BED), the most common ED in the general population and the ED most strongly associated with obesity, is the most common ED in patients with BP. The relationship of ED comorbidity, including ED diagnostic subtype, with body mass index (BMI) and body weight status in bipolar patients will be presented. It will be shown that bipolar patients with a lifetime history of any ED (BED, bulimia nervosa, or anorexia nervosa combined) are significantly heavier than those without a lifetime ED, and that BED is associated with more severe obesity as compared with the other EDs. The talk will be concluded by presenting data on the pharmacotherapy of BED, including a soon-to-be completed randomized, placebo-controlled study of lisdexamfetamine in BED.

S101-3.

BARIATRIC SURGERY AND PSYCHIATRIC UTILIZATION AMONG PATIENTS WITH BIPOLAR DISORDER

Presenter: Ameena T. Ahmed, M.D., M.P.H.

SUMMARY:

Background: People with bipolar disorder (BD) are at increase risk of obesity and obesity-associated complications, including diabetes, cardiovascular disease, and premature cardiovascular death. Bariatric surgery is the most effective treatment for morbid obesity, yet some bariatric surgery programs delay or deny surgery for patients with a BD diagnosis, despite lack of any evidence that bariatric surgery affects psychiatric course or surgical outcome. Methods: We tested the hypothesis that bariatric surgery affects psychiatric course among 6182 morbidly obese BD patients, among whom 158 had bariatric surgery during 2006-2009. We compared rates of inpatient psychiatric hospitalization and outpatient mental health clinic utilization during one year before and up to 4 years after bariatric surgery. As comparison, we calculated rates of inpatient psychiatric hospitalization and outpatient mental health clinic utilization among nonsurgery patients. Results: During the period 2006-2009,

nonsurgery BD patients had inpatient utilization between 10.514.0 hospitalizations/ 100 personyears. BD patients who underwent surgery had 0.7 hospitalizations/ 100 person-years during the 12 months prior to surgery and at most 9.3 hospitalizations/ 100 personyears during up to 4 years follow up after surgery. Outpatient utilization among non-surgery patients averaged 744 clinic visits/ 100 personyears; among surgery patients, outpatient mental health utilization was 548 clinic visits/ 100 personyears during the year prior to surgery and increased linearly to 812 clinic visits/ 100 personyears by year 4 after surgery. Conclusions: Bariatric surgery does not lead to higher inpatient or outpatient mental health utilization than usual care, among morbidly obese BD patients. There is no support for the hypothesis that bariatric surgery adversely affects psychiatric course, among a large cohort of eligible patients.

SYMPOSIUM 102

PSYCHIATRY IN DERADICALIZING VIOLENT EXTREMISTS

Chair: Zebulon Taintor, M.D.

Discussant: John G. Horgan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe findings from studies on the development of violent extremism, 2) Describe how psychological test data and other findings contributed to the development and success of a model deradicalization program in the Swat Valley in Pakistan, 3) Describe the importance of a functioning civil society to embrace the peaceful expression of all points of view and to be responsive and effective in responding to them, 4) Describe the development and exporting of a deradicalization curriculum

SUMMARY:

Psychiatry has a legitimate role in political activities when harm is caused to self or others, reality testing is impaired or there are other forms of impairment. Free speech is not an issue, nor any nonviolent form of expression or action unless there is a consensus on impairment. This symposium will examine general issues in the development of violent extremism in democratic settings where other forms of political expression are available and preferable, using the 2009 Taliban takeover of the Swat valley in Pakistan and the subsequent capture and deradicalization of violent extremists as an example: a) Development, fostering and prevention of violent extremism: Zebulon Taintor will review findings to date. Hundreds of studies have examined family and individual psychodynamics and other factors. There are common cognitive styles: tunnel vision, moral rational-

izing, transforming those with whom one disagrees into the Enemy, etc. b) Sabaoon: Feriha Peracha will describe how the development of this residential school for the youth captured from the Taliban, all of whom had non culture-bound psychological testing on intake. Test results and sentiments contributed to the rehabilitation program, which has discharged more than 100 youths back to the community and their families (some of which had given them up to the terrorists). Sabaoon was the first of the institutions developed by the Pakistani Army to be turned over to civil society. It has served as a model for comparable efforts in Pakistan. A key component in the curriculum has been a view of Islam that allows peace and love as well as the symbolic and abstract thinking in which they have been shown to have major deficits, so crucial that terrorists assassinated key faculty in this area. As with any residential treatment, community follow up and outreach are keys to maintaining improvement and prevention. c) Civil society: Without a functioning social and political system, extremist views are understandable and may be the only path to progress. Civil society roles will be contrasted on three levels: Swat by Zebunisa Jilani, granddaughter of the last Wali; Pakistan by Farrokh Captain, leading industrialist and philanthropist; America by Zebulon Taintor. d) Developing and exporting a common curriculum: Sara Savage of Cambridge University will demonstrate a psychological curriculum for deradicalization and prevention developed in the United Kingdom and now being adapted for other countries.

S102-1.

PSYCHOLOGICAL FACTORS IN VIOLENT EXTREMISM

Presenter: Zebulon Taintor, M.D.

SUMMARY:

Family and individual psychodynamics have been considered by Freud and others. Some studies point to the importance of violent extremists have been abused as children. While a high rate of having been abused has been shown in some studies, it is difficult to show that the rate is higher than in the general population in that place and time. However, there seems to be a common pathway in the development of extremist attitudes and the choice of violent means: Depression/boredom/other feelings: psychodynamically angry feelings often can be seen as anger directed inward. Boredom, seeking thrills, a desire to make a difference, wanting to take risks, etc., all are feelings and personality characteristics that have been studied extensively. Developing convictions: Frightened people look for support. The dilemmas of anxiety are resolved by specifying the threat. The family, the clan, the tribe can provide structure and unity. Groups can specify the threat as coming from another group and turn their anxiety into fear, then anger, then ac-

tion. Diffuse anger resolves into a conviction to do something. Intolerance of ambiguity: This personality variable has emerged as one of the most important in dealing with anxiety and developing convictions. Coping with Ambiguity: The stress of anxiety can lead to distorted thinking. Beck suggested how terrorists' thinking can become distorted on the path to their extreme convictions: a) overgeneralization: complaints about specific individuals are merged and individual opponents become the Enemy group; b) dichotomous thinking in which groups are seen as all good or all bad; c) tunnel vision in focusing everything on destruction of the target. Bandura pointed out that the cognitive restructuring has to include morality. People with strong convictions generally are influenced by strong convictions, despite most religions opposing violence.. Identity/Search for meaning: Terrorists develop ideas that give meaning to their lives, strong and sometimes extreme convictions. By rationalizing their morality or paying no attention to it, they can choose to act violently.

S102-2.

PSYCHIATRY IN DERADICALIZING VIOLENT EXTREMISTS : AN ANALYSIS OF THE SABOON REHABILITATION PROJECT

Presenter: Feriha N. Peracha, Ph.D., M.Sc.

SUMMARY:

Following the counter insurgency in Swat (Pakistan), 200 young boys apprehended from the camps of the militants were inducted in a rehabilitation project called Sabaoon (Pusto: "first ray of sunlight") The results of the assessments point to factors that predate the period of engagement with militant groups and others, that are determined at family and the most immediate community level: Poverty Academic problems (falling out of mainstream education) Lack of authority figure (fathers working out of Swat, either in Pakistan or abroad) Large sibships with lack of direction and/or Intervention Conduct Disorder, behavioral issues, impulsivity, aggression and hostility Medical concerns/ neurological deficits. Sabaoon provides a comprehensive rehabilitation and deradicalization program with modules focusing on mainstream education, corrective religious education, psychosocial intervention, vocational training (electrician course, refrigeration and air conditioner repair course, agricultural course), extracurricular activities (Computer courses, sports: cricket, football, volleyball, badminton, table tennis) and reestablishing bonds with the family and community. The program is run by an NGO while the security for the facility is provided by the Pakistan Army. Initially, each of the inductee's report their narrative. That is, their background information (age, residential location, family size, birth order, academic level) as well as information pertaining to their family environment and

peer group. After creating a level of rapport, the inductee is asked to report on his mode of involvement and experience with militancy. Focus is maintained on providing the young adolescent with a safe environment in which he is not to be punished for his misconduct, but rather is reinforced for sharing his experience and showing acceptance. Any negative emotion (guilt/remorse) that results is termed as social responsibility on part of the individual, thus enabling him and encouraging him to incorporate positive changes within himself. After the initial narrative, detailed psychological assessments follow (neuropsychological and projective). These provide a baseline for each child. This is then used for subsequent sessions, along with narratives obtained from the child's family (upon family visits to Sabaoon) and through Community Visits (in which the social workers interact with the community elders, local army command, relatives of the family as well as neighbours). Individuals

S102-3.

INTEGRATIVE RURAL DEVELOPMENT PROGRAM BY SWAT RELIEF INITIATIVE

Presenter: Zebunisa A. Jilani,

SUMMARY:

Civil society in Swat is becoming progressively more dysfunctional. The present value system promotes corruption, propagates religious misconceptions, and lacks dignity of labor. This collapse of civil society has led to ineffective governance. Additionally, a lack of community oversight of government allows officials to disregard their duty to their constituents. Dissatisfaction with the lack of social services has created an opportunity for the Taliban to convince the population that their ideology is the only solution. It is imperative that the population be made aware of alternatives that will bring positive change in their societies. In addition to spurring development, this awareness will make the population less vulnerable to extremist takeovers. Swat Relief Initiative (SRI), with technical support from Human Development Foundation (HDF), has begun a pilot test of an Integrative Rural Development Program (IRDP). This holistic approach empowers local citizens to lead development efforts for their communities. A key feature of the IRDP is that it takes into account the needs of each specific community. More than anyone else, the local beneficiaries are aware of the kinds of development they need, and also are the most motivated to bring about change. SRI provides assistance in the creation of a local village development organization. They are encouraged to follow HDF's model, which has succeeded in other regions of the country. In this model, each neighborhood elects members of the general body, which in turn elects the officers of the organization. Committees are formed from members of the general body. Initially four committees are formed to improve education,

the economy, healthcare and the environment. The newly formed organization in the pilot village has adopted the following goals and methods to bring about change in their community. SRI will aid in the implementation of these goals. EDUCATION Create parentteacher associations, which will make parents more involved in their children's education, and will give teachers an opportunity to respond to the needs of their community. Work with government to establish a girls' middle school, as girls in the village have no opportunity for education beyond 5th grade. Implement credible teacher training programs Provide scholarships to needy students Implement a citizenship and ethics curriculum that will encourage volunteerism.

S102-4.

BUILDING THE CAPACITY OF CIVIL SOCIETY OF PAKISTAN TO WORK ON COUNTERRADICALIZATION AND DERADICALIZATION PROGRAMS

Presenter: Farrokh K. Captain, M.B.A.

SUMMARY:

Building the Capacity of Civil Society of Pakistan to work on CounterRadicalization and Deeadicalization Programs. Most experts agree that there is no single path that can be taken that can overcome the problem of radicalization of society. It has to be a mix of military, social, political, legal, educational and economic programs. These programs have to be customized to the local social and cultural norms. Experts are also unanimous on the role that the civil society can play in this direction. Unfortunately the civil society in Pakistan is not very organized. The problem is further compounded by a weak economy; weak government; weak democracy and political system; weak energy and other infrastructure systems; frequent natural disasters; regional conflicts, secession movements, corruption; nepotism; incompetence, lack of meritocracy; lack of education; lack of basic health care; ethnic, religious, lingual and regional divides, etc. Therefore, in Pakistan the mobilization and capacity building of the civil society also has to be done. However, due to the dire situation this can't be done in a sequential fashion and has to be done in parallel to getting the civil society to work on the counterradicalization (creating an environment and having programs that deter people from becoming radicalized) and deradicalization (creating an environment and having programs that induce the radicals to shun their violent ways and thoughts) programs. Thus, in addition to the normal programs for counterradicalization and deradicalization such as: • Work on mitigating the basic economic, social and political drivers of radicalization. Especially starting vocational programs, jobs and micro finance and entrepreneurship programs. • Counter the radicals messages especially the distorted version of Islam that is being preached and changing the

curriculum that emphasizes Jihad. Islamic scholars who are well respected by even the radicals are to be identified and their messages correcting the misconception that have to be publicised • Training programs for thprayers leaders and madrasah teachers • Civil society to be on the lookout for signs that may create inducement for individuals towards radicalization • While experts like psychiatrist and army and the civilian administrations take steps for eradicalization process the Civil society can play a role in ensuring that the deradicalized don't go back to their old ways. • Civil society can help in prevention of

S102-5.

PREVENTING RADICALIZATION TO EXTREMIST VIOLENCE THROUGH RAISING INTEGRATIVE COMPLEXITY

Presenter: Sara Savage, Ph.D.

SUMMARY:

The paper summarises our findings on the effectiveness of an intervention entitled Being Muslim Being British designed to prevent violent radicalisation in UK young Muslims, funded by the European Commission and the UK's Home Office. The material and activities were designed in order to stimulate open debate and reflection on key issues for young people made salient by the London bombings of 2005. Our approach to developing the course was informed by the view that extremism (Liht & Savage, 2007) is a form of value monism that allows people to sacrifice all concerns in order to attain a dominant desired value. The single value underpins the selective radical subset of the mainline religious tradition, in effect, losing the original complexity of the religious tradition. In order to sustain value monism in radical ideologies, people will develop defensive ways of thinking in order to protect them from becoming ambivalent about the sole importance of the dominant value. Thus, our intervention was designed to foster greater complexity, particularly in the domain of values. Operationalising Peter Suedfeld and colleagues' (2003, 2005) concept of Integrative Complexity, we expose our participants to the multiplicity of value priorities that influential Muslims embody (through filmed interviews) on 'hot topics' in order in order to foster the first facet of integrative complexity (IC): differentiation – the ability to perceive multiple viewpoints and to find some validity in them. To foster second dimension of integrative complexity, (IC) integration (the ability to find linkages between and an overarching framework for the differentiated array), we created group activities that allowed participants to experiment taking different positions along value continuums along different dimensions; from monist value poles to the value plural centre and to explore the consequences and ethical implications of value positions. Through this process, we have observed, both a more

complex way of thinking and less defensiveness is achieved. Seven pilot courses around the UK (16 contact hours; 80 participants) were pre and post tested. In order to test the effectiveness of our intervention, we advanced 2 hypotheses:

1. As a result of the intervention, participants will think in more complex ways about social issues underlined by conflicting values (measured by IC coding). 2.

As a result of the intervention, participants will care about a greater amount of values when dealing

WEDNESDAY, MAY 9, 2012

SYMPOSIUM 103

NEW TECHNOLOGY TO TREAT POSTTRAUMATIC STRESS DISORDER

Chair: Robert McLay, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the treatment needs of military populations suffering from Post Traumatic Stress Disorder, 2) Be aware of emerging technologies used to treat PTSD, including Virtual Reality, Stellate Ganglia Block, Computerized Therapy, and Trans Magnetic Stimulation, 3) Understand the difficulties and limitations in assessing technologies to treat PTSD

SUMMARY:

Post Traumatic Stress Disorder (PTSD) is an anxiety disorder that, once chronic, can be resistant to both medication and psychotherapy interventions. The ongoing wars in Iraq and Afghanistan have brought forth a wave of new cases of PTSD, but also focused attention and funding on the condition. In particular, military funding sources have been interested in new technologies that have the potential to produce more rapid and effective means of treatment. Performing clinical trials in military populations has, however, proven challenging. This symposium will describe four new technologies that have been proposed to treat PTSD: Virtual Reality Exposure Therapy, Stellate Ganglia Block, Trans Magnetic Stimulation, and Attention Retraining as, at home, computerized therapy. Speakers will discuss the development of the technologies to treat PTSD, and the results of randomized clinical trials of their use. Also discussed will be special considerations for designing trials in military populations, and administrative and practical considerations in conducting such trials.

S103-1.

VIRTUAL REALITY GOES TO WAR: A BRIEF REVIEW OF THE FUTURE OF MILITARY BEHAVIORAL HEALTHCARE

Presenter: Albert Rizzo, Ph.D.

SUMMARY:

War is perhaps one of the most challenging situations that a human being can experience. The physical, emotional, cognitive and psychological demands of a combat environment place enormous stress on even the best-prepared military personnel. Numerous reports indicate that the incidence of posttraumatic stress disorder (PTSD) in returning OEF/OIF military personnel is creating a significant healthcare challenge. This situation has served to motivate research on how to better develop and disseminate evidence-based treatments for PTSD and other psychosocial conditions. In this regard, Virtual Reality delivered exposure therapy for PTSD is currently being used with initial reports of positive outcomes. This presentation will detail how virtual reality applications are being designed and implemented across various points in the military deployment cycle to prevent, identify and treat combat-related PTSD in OIF/OEF Service Members and Veterans. We will also present recent work being done with artificially intelligent virtual humans that serve in the role as "Virtual Patients" for clinical training of healthcare providers in both military and civilian settings and as online healthcare guides for breaking down barriers to care. The projects in these areas that will be presented have been developed at the University of Southern California Institute for Creative Technologies, a U.S. Army University Affiliated Research Center, and will provide a diverse overview of how virtual reality is being used to deliver exposure therapy, assess PTSD and cognitive function, provide stress resilience training prior to deployment and its use in breaking down barriers to care. Time permitting, hands-on demonstrations of some of these applications will be available to conference participants.

S103-2.

STELLATE GANGLION BLOCK FOR THE TREATMENT OF PTSD

Presenter: Anita H. Hickey, M.D.

SUMMARY:

Approximately one third of patients with chronic PTSD do not respond to current pharmacologic and psychological evidence-based therapies for PTSD. The stellate Ganglion Block has been used since 1920 to treat sympathetically maintained pain of the head, neck and upper extremity. As with PTSD, Complex Regional Pain Syndrome, the syndrome most frequently treated with the Stellate Ganglion Block, is associated with hyperarousal and generalized increases in activity of the Sympathetic Nervous System. Recently published case reports suggest that significant reduction in symptoms and medication use for prolonged

periods of time have been observed following one or more Stellate Ganglion Blocks in patients with both combat and non combat related PTSD resistant to other treatments . The discussion will focus on the risks versus benefit and the evidence and hypothetical mechanisms supporting the utilization of this procedure/technology for treatment of chronic PTSD resistant to other treatments.

S103-3.

ATTENTION RETRAINING AS AN ADJUNCTIVE TREATMENT FOR POSTTRAUMATIC STRESS DISORDER

Presenter: Laurretta Ziajko, M.D.

SUMMARY:

Patients with PTSD preferentially attend to threatening stimuli in their environments. This selective attention is thought to help maintain avoidance and hypervigilance symptoms in PTSD. Dr. Amir designed a computer program to train patients with combatrelated PTSD to preferentially attend to nonthreatening stimuli in the form of neutral words when presented with both neutral words and combatrelated words. This presentation will review the treatment and its efficacy in symptom reduction in both inpatient and outpatient treatment settings.

S103-4.

TRANSCRANIAL MAGNETIC STIMULATION FOR POSTTRAUMATIC STRESS DISORDER

Presenter: Donald Hurst, M.D.

SUMMARY:

Repetitive Transcranial Magnetic Stimulation (rTMS) has been demonstrated as an effective treatment for PTSD. rTMS is a noninvasive technique used to directly stimulate cortical neurons. A magnet induces an electrical current in the cortex, causing a depolarization of neurons, thereby activating neural circuits and inducing changes in cortical monoamines, but without causing convulsions or cognitive impairment. rTMS has been studied both as a diagnostic and therapeutic tool in neuropsychiatry for more than 30 years, and repetitive rTMS has been investigated extensively as a therapeutic option in major depression. This presentation will focus on: 1) Evidence for the effectiveness of rTMS in the treatment of PTSD 2) Possible mechanisms of action 3) Future research

SYMPOSIUM 104

GENETICS OF PSYCHIATRIC DISEASE: CURRENT PROGRESS AND FUTURE GOALS

Chair: Pamela Sklar, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify new genetic causes of schizophrenia, bipolar disorder and autism, 2) Understand the concept of genetic complexity of psychiatric disease, 3) Be aware of the changes in nosology that are likely to emerge from genetics

SUMMARY:

Genetics of psychiatric disorders has been an important area of study for the last 100 years. Along the way many important concepts have emerged from detailed investigations of families and twins, including increasingly precise estimates of the heritable components to risk for these disorders in the population, but not for individual patients. There has been an explosion of genetic information from many sources over the last 10 years such as the human genome project and other largescale genetic mapping projects. This genetic information explosion has been accompanied by extensive improvements in technologies for determining an individual's unique set of DNA variants, as well as most recently the ability to easily generate an individual's entire DNA sequence. Over the last quarter century, a number of technologies for finding specific genes and DNA variants within them that increase risk have been tried including candidate gene strategies and familybased linkage analyses, and most recently microarray based scans for association testing genomewide and genomewide DNA sequencing. While linkage and candidate gene approaches have not produced universally agreed on positive results, recent genomewide microarray and sequencing studies have. This session will review the current understanding of genetics that have emerged from a wide variety of these studies. In order to make progress, multiple large consortia have been formed so that sample sizes can be increased into ranges required for consistent and strong statistical results to be obtained. Results of these studies will be discussed in the individual talks. Specifically, the role of rare copy number variation in psychiatric disease will be covered, the progress in rare variant exploration via sequencing, genomewide association studies, polygenicity and phenotypic overlap between categorical disease diagnoses will all be highlighted. Novel loci and pathways are being discovered that are being explored by neuroscientists in a number of novel ways. Finally, we expect that there will be a continuing explosion of information and new loci for neuroscientists to investigate in the future, that may lead to novel treatment strategies for our patients and their families.

S104-1.

OVERLAPPING GENETIC VULNERABILITIES IN SCHIZOPHRENIA AND BIPOLAR DISORDER

Presenter: Pamela Sklar, M.D., Ph.D.

SUMMARY:

Bipolar disorder and schizophrenia are severe psychiatric disorders, each of which affects over 1% of the population. Family, twin and adoption studies consistently show that the strongest predictor for disease development lies in a family genetic vulnerability. While the only readily available human brain tissue comes from postmortem samples and is subject to numerous, difficult-to-control artifacts, several neural systems have been implicated, but without being able to determine whether the effects are primary or secondary. Genetic studies that investigate the genome as a whole can uncover causal relationships between genes and diseases and a series of recent genetic studies point to a very complex genetic landscape. This landscape will be discussed including observations regarding the extent to which rare specific copy number deletions and duplications have been associated with disease, common variants implicated in large-scale consortia studies, and progress in next generation sequencing of exomes and whole genomes. The spectrum of genetic risk factors compellingly associated with schizophrenia and bipolar disorder is growing at an exponential pace with solid molecular evidence for shared risk factors. Biological pathways are beginning to emerge and application of systems biological approaches will push this forward. Implications for our current and future diagnostic nosology will be also discussed.

S104-2.

GLUTAMATE SIGNALING ABNORMALITIES IN AUTISM AND IN INTELLECTUAL DISABILITY

Presenter: Joseph Buxbaum, Ph.D.

SUMMARY:

Autism spectrum disorders (asds) are characterized by deficits in social communication and by repetitive behaviors and/or restricted interests. Numerous rare genetic variants of major effect have been identified in asds. To understand how such etiological heterogeneity translates into common neurobiological pathways, we used gene enrichment and pathway analyses. We made use of a manually collated list of genes where mutations have been shown to be associated with high risk for asd. These genes include those that are well known (e.g., *nrxn3*, *nrxn4*, *shank2*, *shank3*, *fmr1*, *ube3a*, *mecp2*) and many other less common genes. To extend the findings to an additional neurodevelopmental disorder related genetically to asd, we also made use of a curated list of almost 200 genes where mutations lead to intellectual disability (id). We then used unbiased enrichment analyses, making use of data from large-scale proteomic studies, to determine whether there was evidence for

enrichment of asd genes in synaptic and subsynaptic compartments. We did similar analyses with gene expression data from postmortem samples, focusing on genes showing differential expression in asd. As a further step we took advantage of emerging whole exome sequencing data in asd to determine whether there was an enrichment of de novo variation in synaptic and subsynaptic compartments. We observed strong enrichment of asd genes in the murine or human synaptic proteome ($1.43 \times 10^7 < p < 1.81 \times 10^4$). Remarkably, much of this enrichment could be traced to just two subsynaptic proteomes, that of the nmda receptor complex (*nrc*) and that of the ampa receptor complex (*arc*). In contrast, the metabotropic glutamate receptor pathway, previously hypothesized to be broadly implicated in asd based on fragile x syndrome, did not show such enrichment. Differentially expressed genes from postmortem brain tissue showed a similarly strong enrichment for glutamate receptor signaling genes. For example, genes showing reduced expression in asd with highly enriched for genes coding for proteins in the postsynaptic density ($p = 9.3 \times 10^{11}$). In validation experiments we found that these pathways were also enriched for genes mutated in intellectual disability (id). As we had two independent datasets (one for asd and one for id) we were able to assess whether using existing protein-protein interaction (ppi) databases we were able to identify known neurodevelopmental genes.

S104-3.

PROGRESS IN ADHD GENETICS

Presenter: Benjamin Neale, Ph.D.

SUMMARY:

The importance of genetics in adhd has been well established by family and twin studies showing a high heritability of approximately 75%. To date, genome-wide linkage studies have been equivocal and genome-wide association scans (gwas) have not found genome-wide significant associations. The most comprehensive attempt at identifying the genetic basis of adhd from genome-wide association was the recent meta-analysis of the psychiatric gwas consortium analyzing a combined sample size of 2,064 trios, 896 cases and 2,455 controls. No finding achieved genome-wide significance demonstrating that common dna variants for adhd must, individually, have very small effects. In contrast to the search for common variants, molecular genetic studies have identified a role of rare copy number variants (cnvs) in adhd. Some of these cnvs have been previously identified as risk loci for other psychiatric illnesses such as autism and schizophrenia. While the evidence for the cnvs is compelling, these events are challenging to interpret biologically. Nevertheless, they provide the first molecularly derived risk factors for this common psychiatric illness and further strengthen the case that specific genetic risk factors may

play a large role in the development of disease for some individuals. Efforts to document the role of common and rare variants are still being conducted in an attempt to further elucidate the biological basis of this disease with an aim to improve treatment and outcome for patients.

S104-4.

MAJOR DEPRESSION: AN EMERGING STORY

Presenter: Patrick Sullivan, M.D.

SUMMARY:

Major depressive disorder, is a prevalent, pervasive and debilitating disorder. Morbidity from and mortality from suicide remain high despite effective antidepressants. Family and twin studies emphasize that heritability, particularly for early age of onset and recurrent depression implying a utility of genetic studies for identifying novel, underlying causes of the disorder. Large scale genomewide association studies have been completed without identifying clear genomewide significant results. However, notable results have been obtained for several loci and in particular there is support for loci identified in bipolar disorder that will be discussed. In conclusion, sample sizes remain modest in comparison to other psychiatric disorders studies. Initial results suggest that larger cohorts will need to be studied.

SYMPOSIUM 105

EVIDENCE BASED INTEGRATIVE THERAPIES FOR PSYCHIATRIC DISORDERS

Chair: Katherine Falk, M.D.

Discussant: Scott Shannon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the definition and aim of Integrative Psychiatry and how it can be incorporated into responsible, evidencebased practice alongside use of conventional mainstream interventions, 2) Understand what makes Integrative Psychiatry different from conventional psychiatry, 3) Learn about a variety of integrative treatments of specific psychiatric conditions such as bipolar disorder, sexual dysfunction, PTSD, mood disorders, somatization disorders, stress, 4) Know what lab tests to order that will reveal the metabolic and nutritional deficiencies, and how to interpret and use these lab tests

SUMMARY:

“Evidence Based Integrative Therapies for Psychiatric Disorders,” is submitted by The Task Force on Integrative Psychiatry, New York County District Branch of the APA.

This symposium will focus on clinically relevant topics in Integrative Psychiatry and will present several different approaches to Integrative Psychiatry, all from a perspective of evidencebased medicine and psychiatric care. Despite the many accomplishments of modern medicine, we are increasingly aware that many of the best treatments in conventional psychiatry are only moderately effective and poorly tolerated. While psychotropic medications can be lifesaving, they are not fully effective. Fifty percent of all patients with depression treated with antidepressants will require a change in their medication because they have not had an adequate response. In addition, they also have significant side effects, making patient compliance very difficult. Patients spend billions of dollars annually on alternative and complementary medicine (CAM) treatments, despite the fact that most of these treatments are not covered by insurance. David Eisenberg's survey in the 1990's reported in JAMA, revealed that there were 628 million visits to alternative healthcare practitioners, 243 million more than visits to all primary care MDs. More recent documentation shows increased use of CAM among patients specifically for the treatment of psychiatric disorders. In addition, CAM remedies for sexual dysfunction continue to proliferate. Substantial evidencebased research and literature exists on the effectiveness of CAM therapies for a variety of medical and psychiatric conditions. This symposium will educate psychiatrists and other health care professionals on the importance of an integrative approach and some of these available treatment options. The following topics will be covered: laboratory testing as part of a comprehensive evaluation of psychiatric patients to identify nutritional and biochemical deficiencies; mindbody techniques and lifestyle change in the treatment of stress; integrative approach to the treatment of sexual dysfunction; food and mood, the effect of diet and nutrition on cytokines, mood and brain function; and new approaches to the treatment of complex trauma and PTSD.

S105-1.

AN INTEGRATIVE APPROACH TO THE EVALUATION AND TREATMENT OF SEXUAL DYSFUNCTION

Presenter: Barbara Bartlik, M.D.

SUMMARY:

Sexual Dysfunction (SD) is a very common problem caused by diverse physical, psychological, lifestyle and medicationrelated factors. While not a medical emergency, SD can cause deep and lasting distress, and may be linked to medical and psychiatric problems as well as poor health habits. When men and women seek treatment for SD, clinicians should evaluate medical, psychiatric and sexual history, as well as medications, health practices, and many hormonal

and nutritional factors. Many medications can cause SD: selective serotonin reuptake inhibitors (SSRIs) can cause sexual dysfunction via inhibition of cholinergic activity and nitric oxide (NO) synthetase, reduction of dopaminergic activity, and increased release of prolactin. Pharmacologic contraception (PC) can cause sexual and mood problems, as well as elevations in SHBG, which may persist well after the medication is discontinued. Other adverse effects of PCs include weight gain, headache, stroke, blood clots, myocardial infarction, problems with glucose regulation, lipid disorders, reduced resistance to infections and reduction in natural killer cell activity. Pharmacologic contraception, whether oral, transdermal or intravaginal, can impair sexual function and cause chronic inflammation and vulvar pain. Decreased libido, female-initiated sexual activity, frequency of intercourse and arousal have been reported with PCs. PCs also contribute to mental depression, perhaps, by diminishing B12 and folate levels, important factors in methylation. Methylation is vital to DNA transcription, toxin elimination, neurotransmitter formation and the production of hormones, enzymes and antibodies. Patients with genetic methylation defects may, perhaps, be at increased risk for PC side effects. The presentation will describe how to test for MTHFR genetic defects and for levels of vitamins, minerals and other micronutrients, as well as what to do when abnormalities are detected. Little acknowledged, micronutrient deficiencies magnesium, zinc, iron, vitamin D, B vitamins, omega3 fatty acids, amino acid precursors to neurotransmitters, and many others may contribute to SD. Further, chronic consumption of foods with poor nutritional quality or that disagree with the individual, and exposure to environmental toxins, may also negatively impact sexual function. While counseling and psychotherapy also may be warranted, supplementing for hormonal (testosterone, DHEA, thyroid) and micronutrient deficiencies will benefit

S105-2.

STRESS MANAGEMENT AND MINDBODY APPROACHES TO MENTAL HEALTH PROBLEMS

Presenter: Sarah Williams, M.D.

SUMMARY:

Increasingly, the problems that plague our patients are due to the effects of stress, to difficulty regulating affect, and to the inability to cope with traumatic, depression and anxiety-provoking situations and stimuli. Therefore, as psychiatrists, we need to have tools we can provide our patients to help them deal with these stresses and difficulties more adaptively. Fortunately, these tools exist, and can be learned by us and taught to our patients. In this part of the workshop we will review the evidence for the effectiveness of stress management and mindbody approaches for the enhancement of emotional wellbeing and alleviating mental health

problems; review the most evidence-based, clinically useful, stressmanagement strategies including Cognitive Behavioral methods, relaxation and breath work, and meditation, with an emphasis on current mindfulness-based methods; and look at the evidence base, and clinical applications of Yoga, the prototypical, and increasingly popular, mindbody approach to maintaining mental and physical health.

S105-3.

MOOD AND COGNITION CAN BE DERAILED BY COMMONPLACE FOODS

Presenter: Richard M. Carlton, M.D.

SUMMARY:

Commonplace foods can provoke acute suffering in patients with Major Depressive Disorder, schizophrenia, or ADHD. The most common trigger foods are chocolate, dairy, and wheat (and, for ADHD: synthetic additives). Symptoms often remit on removing the offending food, and recur on reintroduction. The mechanisms appear to be based on (1) inflammatory cytokines reaching and disrupting the brain; and/or (2) activation of brain opiate receptors by chocolate and/or by opioidlike fractions of cow's milk protein (casomorphins) and of wheat protein (gluten exorphins).

S105-4.

DEPRESSION AND ANXIETY IN THE PREGNANT AND POSTPARTUM PATIENT: BEYOND MEDICATION

Presenter: Kelly Brogan, M.D.

SUMMARY:

Dr. Brogan will discuss a comprehensive assessment of the reproductive age woman with consideration of "modifiable risk factors" such as genetic polymorphisms, thyroid health, and diet with a focus on evidence-based non-medication interventions such as folate, vitamin D, SAME, PUFAs, cranial electrical stimulation, light box therapy, and meditation.

S105-5. EMOTIONAL FREEDOM TECHNIQUE

Presenter: Anthony J. Tranguch, M.D., Ph.D.

SUMMARY:

The Emotional Freedom Technique (EFT) is a novel approach (1) to reducing symptoms of anxiety (24), PTSD (59), phobias (1011), cravings (2), depression (2, 5), and psychosomatic conditions (2, 1213). It combines elements of exposure, cognitive restructuring, waking hypnosis, and physical relaxation while tapping or massaging a sequence of acupressure points and simultaneously repeating a few

simple phrases aloud. Although the mechanism of action is unknown, a growing body of evidence is beginning to support this easy-to-learn technique, which can often yield faster and more robust results than standard CBT approaches. In fact, a recent controlled comparison study (7) has shown EFT to be as effective as the evidence-based treatment Eye Movement Desensitization and Reprocessing (EMDR) for the treatment of PTSD. In this workshop, participants will be able to: a) describe the theory behind EFT and Energy Psychology approaches; b) identify at least 3 conditions for which EFT can be used; and c) perform the basic EFT protocol to alleviate a variety of psychological conditions.

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SYMPOSIUM 106

NEUROENDOCRINE AND GENE-ENVIRONMENT INTERACTION IN PSYCHIATRIC DISORDERS: CURRENT CONCEPTS

Co-Chairs: Amresh Shrivastava, M.D., Charles B. Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Role of neuroendocrine in psychopathology of psychiatric disorders, 2) Newer environmental risk factors and genetic polymorphism, 3) Neurobiology and gene-environment interaction, 4) Research issues in Psychoneuroendocrinology of psychiatric disorders.

SUMMARY:

Neuroendocrine and gene-environment interaction in psychiatric disorders: current concepts” Amresh Shrivastava, MD The psychiatric disorders are etiologically complex involving both heritable and nonheritable factors. Recent research has indicated that environmental factors, including psychosocial factors, play an important role in manifestation of symptoms. The gap between understanding of those who develop psychiatric illness and those who do not amongst the subgroup of genetic as well as clinical high risk candidates is partly explained by role of environmental factors. These, social, psychological, ecological and cultural factors possibly determine the modulation of biological factors at the level of gene expression and neuroendocrinal systems. Advances in genetics is indicating how nonspecific some genes are for psychiatric disorders, e.g. having associations in common for schizophrenia, bipolar disorder and autism. Earlier stages of psychiatric disorders may be multivalent and that early detection, coupled with a clearer understanding of the environmental factors, may allow prevention. The role of environmental factors also possibly explains ‘social determinants of health and disease’. Environmental factors can act upon the genome to bring about epigenetic changes in gene expression involved in the etiology of these disorders. E.g. Altered functioning of serotonergic, noradrenergic system and HPA axis systems may stem from both genetic and developmental causes. Adversity in early life has developmental consequences on these systems that persist into adulthood. Genetic differences may also contribute to alterations in functioning of neurobiological systems. Moreover, the interaction of early life experiences of adversity and genetic vulnerability is increasingly thought to play a role, including via epigenetic mechanisms. Research advances have shown encouraging results to explain these complex interaction e.g. Psychosis-associated environmental exposures, particularly at key developmental stages, may result in long-lasting epigenetic alterations that impact on the neurobiological processes involved in pathology. We are at the exciting stage where it is feasible to start investigating molecular modifications to explore gene-environment interaction. This symposium we present some the recent data related to these issues

S106-1.

IDENTIFICATION OF GENETIC POLYMORPHISMS THAT MEDIATE THE INCREASED VULNERABILITY TO MOOD AND ANXIETY DISORDERS AFTER EXPOSURE TO CHILD ABUSE AND NEGLECT

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

SUMMARY:

It is now well established that the likelihood to develop

syndromal mood and anxiety disorders is determined by both heritable and environmental factors. Twin studies have clearly documented very significant genetic contributions for major depression, bipolar disorder and several anxiety disorders, including posttraumatic stress disorder (PTSD). In spite of the overwhelming evidence for a paramount role for genetics in the diathesis for these major psychiatric disorders, attempts to identify the “depression gene”, “bipolar gene” or “PTSD gene” have been unsuccessful. It is now clear that no such single gene is responsible for such disease vulnerability, similar to other findings in complex medical disorders, such as diabetes. What has emerged is the importance of multiple genes which together interact with environmental factors, such as child abuse and neglect in a classic gene X environment interaction to increase or decrease disease vulnerability. This presentation will summarize recent findings from our group and others concerning genetic polymorphism that mediate child abuse/neglect associated vulnerability to major depression, PTSD and treatment response. These include the CRF1 receptor, CRF binding protein, BDNF, Oxytocin, 5HT3 receptor, PAC1 receptors and FKBP5. The implications of these findings for personalized medicine in psychiatry will be described.

S106-2.

HPA AXIS ACTIVITY, GENETIC VARIATION, AND PSYCHOSIS IN MAJOR DEPRESSION

Presenter: Alan F. Schatzberg, M.D.

SUMMARY:

Background: Psychotic major depression has a prevalence of approximately 0.4%. It is characterized by cognitive disturbances in attention, executive function, and verbal and visual memory in addition to delusions (often guilty, somatic, or nihilistic) or auditory hallucinations. Patients with the disorder often demonstrate elevated activity of the hypothalamic pituitary adrenal (HPA) axis in comparison to nondelusional depressives and healthy controls. We have explored the relationship of elevated cortisol activity to cognitive deficits and now also report on a series of potential differences in allelic variation in genes that contribute to HPA Axis regulation. **Methods:** Approximately, 150 subjects with major depression with or without psychotic features healthy controls have been studied for overnight cortisol, cognition, and structural and functional brain imaging. Specific findings will be presented that point to differentiation among the groups on these measures. In addition we have explored allelic variation in the major genes that help regulate the HPA Axis including the glucocorticoid receptor (GR), mineralocorticoid receptor (MR), the FKBP5 co-chaperone to GR, corticotropin releasing hormone (CRH) as well as its type 1 and 2 receptors. We have also explored variations in the D2 receptor gene that appear to have vari-

ants involving GR responsive elements. Results: Data point to significant group differences in HPA Axis activity, cognitive performance, amygdala volume, and fMRI performance on working and verbal memory among the groups. Allelic variations in relationship to HPA overactivity will be reported on as well.

S106-3.

REGIONSPECIFIC ALTERATIONS IN THE CORTICOTROPIN RELEASING FACTOR (CRF) IN THE POSTMORTEM BRAIN OF SUICIDE VICTIMS

Presenter: Ghanshyam N. Pandey, Ph.D.

SUMMARY:

Abnormalities of hypothalamic-pituitary-adrenal (HPA) axis in depression and suicide are among the most consistent findings in biological psychiatry. However, the specific molecular mechanism associated with HPA axis abnormality in the brain of depressed or suicidal subjects is not clear. It is believed that abnormal HPA axis is caused by increased levels of CRF in the brain and decreased levels of corticoid receptors in the brain of depressed or suicide subjects. We examined if alterations in protein and mRNA expression of CRF are associated with teenage suicide and have therefore determined the protein and gene expression of CRF, CRF receptors (CRFR1 and CRFR2), and CRF binding protein (CRFBP) in the prefrontal cortex (PFC), hippocampus and amygdala of teenage suicide victims and teenage normal control subjects. The postmortem brain samples were obtained from the Maryland Brain Collection at the Maryland Psychiatric Research Center, Baltimore, MD, USA. Samples were obtained from 24 teenage suicide victims and 24 normal teenage control subjects. Psychological autopsy was performed and the subjects were diagnosed according to the Schedule for Clinical Interviews for DSMIV (SCID). The brain samples were stored at 80°C till assayed. Protein expression was determined using Western blot and gene expression (mRNA) was determined using realtime RT-polymerase chain reaction (qPCR) technique. We observed that the protein and gene expression of the CRF was significantly increased in the prefrontal cortex (Brodmann area 9; BA9) and in amygdala, but not in the hippocampus or subiculum, of teenage suicide victims compared with normal control subjects. The protein and gene expression of CRFR1 was significantly decreased in the PFC and amygdala, but not in the hippocampus, of suicide victims. However, the protein or gene expression of CRFR2 was not significantly changed in any of the brain areas. Another mechanism by which CRF is inactivated in the brain is by binding to a protein known CRFBP. We found that the protein and mRNA expression of CRFBP was significantly decreased in PFC and amygdala of suicide victims compared with controls. These results thus indicate that suicidal behavior is associated with

increased CRF and decreased inhibitory protein CRFBP in certain specific areas of the brain of suicide victims compared with controls. This increase in CRF may also cause a decrease in specific CRF receptors, and thus CRF may be an appropriate target

S106-4.

NEUROENDOCRINES IN FIRST EPISODE SCHIZOPHRENIA

Presenter: Amresh Shrivastava, M.D.

SUMMARY:

Environmental factors are acknowledged as key determinants of development of schizophrenia. Studies suggest that the altered expression of genes and proteins involved in numerous neurodevelopmental, metabolic and neurotransmitter pathways can result from inadequate amounts of modulators, transporters and, synthesizers. Advances in the prenatal period in the genesis of schizophrenia suggest that environmental factors and HPA axis may establish a vulnerability to the disease. Further, the onset of psychotic disorders may be associated with a higher rate of stress and change to the hippocampus. Thyroid hormone is a possible link between genes and environment. Its dysfunction has been observed during antipsychotic treatment, malignant neuroleptic syndrome treatment resistance, and chronic schizophrenia. It is regulated by the Hypothalamic Pituitary Adrenal gland (HPA) axis, which is an associated endocrinal abnormality in psychosis. Molecular and genetic studies suggest that the thyroid hormone receptor is necessary in mediating developmental effects of thyroid hormone. It is a plausible neuromodulator that can bridge genes and environment. Thyroid hormones also regulate the expression of many neurotransmitters, their synthesizing enzymes, and receptors. This study examined the status of the thyroid hormone in an early psychosis cohort in which we studied thyroid hormone levels in a cohort of early psychosis patients using a cross-sectional design. In a cohort of 60 patients, 43 (71.6%) were hypothyroid (mean TSH = 5.2 mU/L). However, TSH levels did not significantly correlate with the PANSS total scores or the duration of illness. The level of TSH did however show a positive correlation with the negative symptoms scale of the PANSS ($p < 0.03$). A significant positive correlation with negative symptoms indicates that a hypothyroid state may be a symptom that concomitantly explains the coexistence of depressive and negative symptoms in some patients. This likely has implications for psychiatric management in both the short and long term. 1. Associate Professor of Psychiatry, The University of western Ontario, London, Ontario, Canada & associate Scientist, Lawson health research Institute, London, Ontario, Canada

S106-5.

THE LINK BETWEEN STRESS AND DEPRESSION AT THE NEUROBIOLOGICAL AND COGNITIVE INTER-FACE

Presenter: Gustavo E. Tafet, M.D., Ph.D.

SUMMARY:

The role of chronic stress in the origin and development of depression has long been demonstrated. In this regard, it plays a critical role at the psychological level, where it has been demonstrated the effect of chronic stress in the development of a cognitive vulnerability which predisposes to develop depressive symptoms. Regarding the psychoneuroendocrinological point of view, chronic stress produces dysregulation of the HPA axis, with the resulting increase in 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 chronic 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 the preventive, at the psychopharmacological and the psychotherapeutic levels.

SYMPOSIUM 107

ADOLESCENT ONSET BORDERLINE PERSONALITY DISORDER: UPDATES ON ETIOLOGY, PHENOMENOLOGY, AND TREATMENT UTILIZATION

Chair: Marianne Goodman, M.D.

Discussant: Carla Sharp, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Recognize Borderline Personality Disorder (BPD) in adolescents and understand potential etiologic factors, 2) Become aware of the extent of suicidal behavior and mental health service utilization patterns of such individuals, 3) Better understand how these topics impact the clinical care of adolescents diagnosed with borderline personality disorder

SUMMARY:

Borderline personality disorder (BPD), one of the most crippling and frequently lethal of all psychiatric illnesses, can present in adolescence. For at least a subset of individu-

als, BPD symptoms can persist into adulthood, with adverse longterm outcomes. Very recent data suggests that adolescent BPD symptomatology is associated with impaired functioning in multiple adult domains including role and social function, and lower academic and occupational attainment. Such data conflict with the current clinical bias of waiting until adulthood to diagnosis BPD and instead argue for improving our ability to recognize, accurately diagnose, and treat the disorder in adolescence. This symposium will present recent findings on etiology, phenomenology, and treatment. Dr. Andrew Chanen will begin the symposium with results from a study of preadolescent temperament and its relationship to adolescentonset BPD. Dr. Erin Hazlett will address possible neurobiological underpinnings of adolescent BPD with neuroimaging data on the cingulate. Dr. Mary Zanarini will present data on childhood adversity in two samples of inpatients with BPD: one with an adolescentonset of BPD and another with an adultonset BPD. Dr. Shirley Yen will discuss predictors of suicide attempts in an adolescent sample with strong BPD traits followed prospectively for six months. Dr. Marianne Goodman will review aspects of treatment utilization of hospitalized adolescents with BPD and compare them to another sample of inpatients with adultonset BPD. Lastly, our discussant Dr. Carla Sharp, an expert in adolescent BPD psychopathology, will discuss the clinical implications of these findings

S107-1.

THE ROLE OF TEMPERAMENT AND MALTREATMENT IN THE EMERGENCE OF BORDERLINE AND ANTISOCIAL PERSONALITY PATHOLOGY DURING EARLY ADOLESCENCE

Presenter: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:

Objective: A prospective, longitudinal design was utilized to examine the role of temperament and maltreatment in predicting the emergence of borderline (BPD) and antisocial (ASPD) personality disorder symptoms during adolescence. **Method:** 245 children aged between 11 and 13 years were recruited from primary schools in Melbourne, Australia. Participants completed temperament, maltreatment, BPD and ASPD symptom measures. Approximately two years later, 206 participants were reassessed for BPD and ASPD symptoms. **Results:** Childhood neglect is associated with an increase in ASPD symptoms for children with low Effortful Control, while abuse is associated with an increase in BPD symptoms for children with low Affiliation. While it was observed that high levels of abuse had a strong main effect upon BPD symptoms, Negative Affectivity moderated this effect. Adolescents who experienced high levels of parental abuse showed increases in symptoms irrespective of their levels of Negative Affectivity, where for those experiencing

low parental abuse Negative Affectivity showed a positive relationship with increases in symptoms. **Conclusions:** The current study contributes much needed prospective, longitudinal information on the early development of symptoms of BPD and ASPD, and supports importance of both temperamental and environmental factors in predicting the emergence of these mental health problems early in life.

S107-2.

NEUROIMAGING FINDINGS IN ADOLESCENTONSET BORDERLINE PERSONALITY DISORDER

Presenter: Erin A. Hazlett, Ph.D.

SUMMARY:

Borderline personality disorder (BPD) is a serious mental illness characterized by emotional dysregulation, impulsivity, and impaired interpersonal relationships. Our prior work has shown that both adults and adolescents with BPD have reduced volume of gray matter in the anterior cingulate, a region involved in aspects of attention, emotional regulation, and the integration of cognitive and emotional processes, among other functions. We have also recently shown that adolescents with BPD have increased white matter volume in posterior cingulum regions. In this study, using diffusion tensor imaging (DTI), we examined fractional anisotropy (FA), a measure of white matter fiber integrity in 13 healthy control (HC) adolescents and 11 age and gender-matched adolescents with BPD and comorbid major depressive disorder (MDD). We hypothesized based on prior work showing these same BPD/MDD adolescents have greater-than-normal white matter volume that they would show white matter fiber tract abnormalities measured with FA. We acquired 3T DTI in all participants and examined FA in the gray and white matter underlying five anteriortoposterior cingulate regions (Brodmann area (BA) 25, 24, 31, 23, and 29) in each hemisphere using previously published methods and a multivariate analysis of variance approach. Compared with the HCs, the BPD/MDD group had significantly higher FA in the white matter averaged across all cingulum BAs and both hemispheres but normal FA in cingulate gray matter (Diagnostic group x Matter type interaction, $p=0.01$, Wilks). These preliminary results suggest that adolescents with BPD/MDD have myelination and/or axonal abnormalities in the cingulum. These preliminary data suggest a possible mechanism underlying the emotional dysregulation observed in adolescents with BPD/MDD. Future studies will need to address the specificity of these findings to BPD.

S107-3.

CHILDHOOD ADVERSITY ASSOCIATED WITH ADOLESCENTONSET AND ADULTONSET BPD

Presenter: Mary C. Zanarini, Ed.D.

SUMMARY:

The first purpose of this study was to determine the prevalence of childhood adversity reported by inpatients with adolescentonset borderline personality disorder (BPD). The second purpose was to compare these prevalence rates to those reported by a separate sample of inpatients with adultonset BPD. 111 hospitalized girls and boys aged 13-17 who met both Revised Diagnostic Interview for Borderlines (DIBR) and DSM criteria for BPD were interviewed concerning childhood adversity. The same semistructured interview, which has proven psychometric properties, was administered to 224 adults aged 18 or older who met also DIBR and DSM criteria for BPD. All four forms of abuse studied were reported by a significantly higher percentage of patients with adultonset BPD than patients with adolescentonset BPD. All seven forms of neglect studied were also reported by a significantly higher percentage of patients with adultonset BPD than patients with adolescentonset BPD. The following rates were found for the four forms of abuse studied: verbal (75% versus 41%), emotional (72% versus 26%), physical (58% versus 26%), and sexual (58% versus 20%). The following rates were found for the seven forms of neglect studied: physical neglect (25% versus 13%), emotional withdrawal (54% versus 40%), inconsistent treatment (54% versus 28%), denial of feelings (72% versus 6%), failure to protect (56% versus 21%), lack of a real relationship (68% versus 30%), and parentification of patient (64% versus 35%). Taken together, the results of this study suggest that childhood adversity is common among adolescents diagnosed with BPD. They also suggest that childhood adversity seems to be less strongly associated than the development of adolescentonset BPD than adultonset BPD.

S107-4.

PROSPECTIVE PREDICTORS OF ADOLESCENT SUICIDALITY: A SIXMONTH POSTHOSPITALIZATION FOLLOWUP

Presenter: Shirley Yen, Ph.D.

SUMMARY:

We examined prospective predictors of suicide events, defined as suicide attempts or emergency interventions to reduce suicide risk, in 104 adolescents admitted to an inpatient psychiatric unit for suicidal behaviors and followed naturalistically for six months. Structured diagnostic interviews and self-report instruments were administered to adolescent and parent to assess demographic variables, suicide risk, psychiatric disorders, and affective and behavioral constructs. Baseline variables were used to predict suicide events (attempts, emergency intervention) at

6month followup. Most demographic variables, past history of suicide attempts, and axis I disorders at baseline did not significantly predict suicide event during followup. Baseline variables that significantly predicted a suicide event during followup were black race, high suicidal ideation in the past month, posttraumatic stress disorder, borderline personality disorder, low scores on positive affectivity, and high scores on aggression. Posthoc analyses identified childhood sexual abuse as a significant predictor as well. When these variables were subjected to multivariate Cox regression analyses, only black race, childhood sexual abuse, low positive affect intensity, and high aggression scores remained significant. Taken together, these results suggest that the prediction of suicide attempts in adolescents with BPD or strong borderline features is multifactorial in nature.

S107-5.

TREATMENT HISTORIES REPORTED BY INPATIENTS WITH ADOLESCENTONSET AND ADULTONSET BORDERLINE PERSONALITY DISORDER

Presenter: Marianne S. Goodman, M.D.

SUMMARY:

The first purpose of this study was to assess the psychiatric treatment histories reported by inpatients with adolescentonset borderline personality disorder (BPD). The second purpose was to compare these treatment histories to those reported by a separate sample of inpatients with adultonset BPD. 111 hospitalized girls and boys aged 13-17 who met both Revised Diagnostic Interview for Borderlines (DIBR) and DSM criteria for BPD were interviewed concerning their histories of psychiatric treatment. The same semistructured interview, which has proven psychometric properties, was administered to 224 adults aged 18 or older who met also DIBR and DSM criteria for BPD. Borderline adolescents and adults had basically the same lifetime rate of individual psychotherapy (95% versus 96%). However, they were significantly more likely than those with adultonset BPD to have a history of taking standing medications (93% versus 84%) and to have had prior psychiatric hospitalizations (98% versus 72%). The lifetime number of individual therapies did not differ significantly by study group (mean=3.8). However, those with adolescentonset BPD had taken a significantly lower total lifetime number of psychotropic medications (mean=3.4 versus 5.6) and had a significantly lower number of prior hospitalizations (mean=3.2 versus 6.4) than those with adultonset BPD. Those with adolescentonset BPD were significantly younger when they first entered individual psychotherapy (mean=12 versus 19), started taking standing medications (mean=13 versus 23), and were first hospitalized for psychiatric reasons (mean = 15 versus 24). Taken together, the results of this study suggest that adolescentonset BPD is associated with high

lifetime rates of outpatient and inpatient treatment. They also suggest that it is associated with treatment histories as complex as adultonset BPD.

S107-6.

CHILDHOOD ADVERSITY ASSOCIATED WITH ADOLESCENTONSET AND ADULTONSET BPD

Presenter: Mary C. Zanarini, Ed.D.

SUMMARY:

The first purpose of this study was to determine the prevalence of childhood adversity reported by inpatients with adolescentonset borderline personality disorder (BPD). The second purpose was to compare these prevalence rates to those reported by a separate sample of inpatients with adultonset BPD. 111 hospitalized girls and boys aged 13-17 who met both Revised Diagnostic Interview for Borderlines (DIBR) and DSM criteria for BPD were interviewed concerning childhood adversity. The same semistructured interview, which has proven psychometric properties, was administered to 224 adults aged 18 or older who met also DIBR and DSM criteria for BPD. All four forms of abuse studied were reported by a significantly higher percentage of patients with adultonset BPD than patients with adolescentonset BPD. All seven forms of neglect studied were also reported by a significantly higher percentage of patients with adultonset BPD than patients with adolescentonset BPD. The following rates were found for the four forms of abuse studied: verbal (75% versus 41%), emotional (72% versus 26%), physical (58% versus 26%), and sexual (58% versus 20%). The following rates were found for the seven forms of neglect studied: physical neglect (25% versus 13%), emotional withdrawal (54% versus 40%), inconsistent treatment (54% versus 28%), denial of feelings (72% versus 6%), failure to protect (56% versus 21%), lack of a real relationship (68% versus 30%), and parentification of patient (64% versus 35%). Taken together, the results of this study suggest that childhood adversity is common among adolescents diagnosed with BPD. They also suggest that childhood adversity seems to be less strongly associated than the development of adolescentonset BPD than adultonset BPD.

SYMPOSIUM 108

SUCCESS STORIES IN TELEPSYCHIATRY: MEDICAL SETTING CONSULTATION, TRANSCULTURAL “STORE AND FORWARD”, CLINICAL TRIALS RESEARCH, AND MILITARY APPLICATIONS

Co-Chairs: Sonya Lazarevic, M.D., M.S.W., Steven E. Hyler, M.D.

Discussant: Steven E. Hyler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Appreciate innovative use of telepsychiatry in medical settings, the military and clinical research, 2) Identify areas of practice for which telepsychiatry can provide solutions, 3) Understand models of telepsychiatry

SUMMARY:

Over the last decade, telepsychiatry has migrated from primarily government usage to its inclusion into academia, remote clinics, research and private practices. This symposium will review several success stories, where implementation of telepsychiatry via videoteleconferencing (VTC) has been utilized as a solution to address clinical and research gaps in psychiatry. First, the fundamentals of consult psychiatry in the medical setting will be presented. Second, the novel use of asynchronous “store and forward” telepsychiatry in transcultural settings will be presented. Third, clinical research applications of VTC will be analyzed, and its effectiveness in comparison with face-to-face interventions reviewed. Fourth, telepsychiatry has recently been found to be a valued method of ensuring continued mental health care during the systematic restructuring of military hospitals like Walter Reed Army Medical Center. The symposium will conclude with a review of several additional applications of telepsychiatry, and focus on technological advances, treatment guidelines, legal, documentation, reimbursement and security issues.

S108-1.

TELEPSYCHIATRY TO MEDICAL SETTINGS: MODELS AND GUIDELINES FOR PRIMARY CARE CLINICS AND EMERGENCY ROOMS

Presenter: Donald M. Hilty, M.D.

SUMMARY:

New models of psychiatric intervention are needed to improve the accessibility of mental health care in the primary care setting, particularly in rural areas of the United States. Some models of service delivery have been successful in suburban and urban settings, but they do not always apply to rural settings. Ehealth innovations like videoconferencing, telephone, secure messaging (email), and the Internet are increasingly being used to provide consultation/liaison service to primary care. In addition, more telepsychiatry to emergency rooms is occurring, which is complex due to the acuity of patients and triage of patients, including assessments of dangerousness. Models that have been researched and guidelines that have been published will be discussed to help attendees do good clinical care and avoid pitfalls.

S108-2.

CROSSCULTURAL PSYCHIATRY MADE SIMPLE: ASYNCHRONOUS TELEPSYCHIATRY AS A DISRUPTIVE INNOVATION

Presenter: Peter Yellowlees, M.D.

SUMMARY:

The objective of this study is to examine the feasibility and diagnostic reliability of asynchronous telepsychiatry (ATP) consultations in Spanish. The feasibility of asynchronous telepsychiatry has previously been established with English language speaking patients and providers. In this study, 24 Spanish speaking patients were assessed in Spanish via ATP by a bilingual clinician. All ATP consultations were then examined by two separate Spanish speaking psychiatrists, before being translated into English and then reexamined by two English speaking psychiatrists. Acceptable levels of agreement were found for major diagnostic groupings among the Spanish and English speaking psychiatrists. Kappa values ranged from .52 (83% agreement) upwards. It is concluded that ATP consultations in Spanish, and from Spanish to English are feasible and diagnostically reliable. The nature of the ATP process allows rapid translations to occur and this approach to medical assessment could be useful across national boundaries and in numerous ethnic groups. Cross language ATP may also offer significant benefits over the use of realtime interpreting services, a clear example of a disruptive innovation in the field of medicine.

S108-3.

THE USE OF TELEPSYCHIATRY IN CLINICAL TRIALS

Presenter: Janet B Williams, D.S.W.

SUMMARY:

The rate of failed trials in psychiatry is unacceptably high. This may be due in part to rating variability in multisite multicountry trials, and to incentives that often result in the inclusion of inappropriate subjects. The use of independent blinded centralized raters is one strategy for reducing variability across raters and minimizing conditions that can lead to baseline score inflation and expectation bias. This strategy, made feasible by the technology of telepsychiatry, has proven effective in multiple trials across therapeutic areas. To date, over 80,000 scale administrations have been scheduled and completed using centralized raters to conduct interviews by teleconferencing or videoconferencing. Data will be presented on operational aspects of this approach, including its equivalence to faceto face interviews and effectiveness in detecting signal and reducing placebo response in CNS clinical trials.

S108-4.

TELEPSYCHIATRY IN A MILITARY SETTING AND THE IMPACT OF BRAC

Presenter: Keith Penska, M.D.

SUMMARY:

Service members, retirees and military dependents regularly utilize military mental health services. Telepsychiatry is a proven way to increase access of care. The military has a well developed and innovative telepsychiatry program which uses apps, smart phones and mobile teleconferencing units to connect remotely located personnel to mental health services. The implementation of BRAC (Base Realignment and Closure) has launched the largest medical restructuring undertaken in the military health system. This presentation will explore the unique challenges psychiatrists face in providing continued access to care during BRAC, and how telepsychiatry has become an alternative option.

S108-5

RECENT ADVANCES IN TELEPSYCHIATRY

Presenter: Sonya Lazarevic, M.D., M.S.W.

SUMMARY:

This presentation will focus on several common applications of telepsychiatry and will guide the participant through the APA and ATA practice guidelines. Barriers to increased use of telepsychiatry include legal, reimbursement, training and security issues. New, lower cost, hardware and software and start up telepsychiatry websites and businesses are popping up with increased frequency. Innovative US, Canadian and Australian programs shaping telepsychiatry, will be reviewed.

SYMPOSIUM 109

EVIDENCEBASED CLINICAL CARE OF CHALLENGING PATIENTS: AN UPDATE FROM EMERGENCY PSYCHIATRY

Co-Chairs: Scott A. Simpson, M.D., M.P.H., Jagoda Pasic, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand current trends and new evidence-based practices in emergency psychiatry, including for the treatment of patients with agitation, substance abuse, personality disorders, and high healthcare utilization, 2) Learn new techniques for treating emergent and challenging patients, including approaches with brief psychotherapy, 3) Appreciate the limitations of and opportunities for research in the emergency psychiatry setting, 4) Apply principles and

practices of the psychiatric emergency service, including of high utilizer case management, in the care of challenging patients

SUMMARY:

This symposium introduces new clinical practices and academic research in emergency psychiatry through a focus on common, challenging patient care issues: substance abuse, agitation and aggression, personality disorders and anxiety, and high healthcare utilization. Speakers will discuss not only the state of germane literature but also present new evidence deepening our understanding and effecting the delivery of emergent psychiatric care. Practical, evidencebased clinical tips learned from the psychiatric emergency service will be contextualized for providers' application across inpatient and outpatient settings. As psychiatric clinicians face limited community resources, fewer inpatient beds, and rising acuity outside the hospital, the evolving lessons from emergency psychiatry pose benefit for all patients regardless of where they are treated.

S109-1. HIGH UTILIZER CASE MANAGEMENT FOCUSES RESOURCES AND DECREASES COSTS

Presenter: Jagoda Pasic, M.D., Ph.D.

SUMMARY:

Roughly, four percent of emergency room patients comprise 23 percent of all visits (Pasic 2005). High utilizers of psychiatric emergency care are characterized by severe, chronic illness with intense comorbidity: psychiatric illness, substance dependence, homelessness, poor social support, and ongoing legal issues coexist at high rates (McNiel 2005). Such synergistic pathology can quickly overwhelm and frustrate providers, and traditional approaches to care may fail to ameliorate these patients' heavy healthcare use (Althaus 2011). We will review the literature on this topic and present original data from our high utilizer case management program for high utilizing patients at a major urban county hospital. Since 2008, our emergency department-based program has assertively built relationships with high utilizing patients around a philosophy of compassionate, patientdirected care; provision of concrete resources; and coordination with a network of community providers. In one year (2010), case management for 65 selected patients decreased inpatient hospitalizations by 47%, outpatient visits by 63%, and decreased hospital charges over \$900,000. Moreover, this decrease in service use persists beyond the termination of enrollment in our program. Principles and practices underlying our approach to these challenging patients as well as constraints of high utilizer case management are discussed.

S109-2.

RECONSIDERING ILLICIT DRUG TESTING IN EMERGENCY PSYCHIATRY

Presenter: David S. Kroll, M.D.

SUMMARY:

Despite illicit drugs' prevalence and ability to mimic psychiatric pathology, compulsory toxicology screening in the emergency department is of unclear benefit in guiding treatment decisions and patient disposition. (Eisen 2004, Schiller 2000) National guidelines generally advise against routine screenings, (Lukens 2006) yet often routine screenings are requested or required by psychiatric facilities that screen patients from the emergency room. The limitations of commonly used drug screening protocols and the constant arrival of new illicit substances into the marketplace contribute to this uncertainty. This presentation reviews the research underlying guidelines on substance testing and presents original data examining how drug screening factors into psychiatric evaluation and management in the emergency setting. The value of research from the emergency setting extends to outpatient and community psychiatric practices as well.

S109-3.

WEATHERING THE STORM: PSYCHOTHERAPY IN THE EMERGENCY SETTING

Presenter: Anna McDowell, M.D.

SUMMARY:

Patients seeking emergency services are in crisis, whether mental, physical, or social. Patients in crisis are struggling to tolerate distress, confront addictive patterns, and mobilize defenses; emergency providers can feel equally challenged to treat patients including those with anxiety, substance use disorders, and recurrent suicidality. We will provide a concise summary of current literature on psychotherapeutic interventions in the psychiatric emergency setting and introduce specific techniques – from dialectical behavioral therapy, motivational interviewing, and psychodynamic psychotherapy – suitable for brief, emergent treatment. Safe and immediately effective, brief psychotherapy can help providers establish rapport with patients; ameliorate patients' acute distress; and increase the likelihood of patients accessing further outpatient psychiatric care. Awareness of psychotherapeutic principles, such as countertransference, also benefits providers who care for challenging patients.

S109-4.

RESTRAINT AND SECLUSION: MINIMIZING USE, MAXIMIZING SAFETY, AND PREDICTING NEED

Presenter: Scott A. Simpson, M.D., M.P.H.

SUMMARY:

Though often accepted as necessary to prevent patients from injuring themselves or others, the use of physical restraints and seclusion pose clinical, ethical, and practical challenges to psychiatrists. This lecture reviews the clinical ethics, practice, and research as well as our original investigation on the use of physical restraints on psychiatric patients. Before and since the APA's unanimous proposition in 1844 purported the application of "personal restraint" to be in the "true interests of the insane," psychiatrists have struggled over the ethics and application of this most invasive of psychiatric procedures (Barton 1987); now, reduction of such measures remains a priority among professional and governmental associations, driven in part by growing awareness of the adverse effects of restraints – including orthopedic injury, posttraumatic stress disorder, and death (Cleary 2010, Mohr 2003). Minimizing restraint use requires a focus of limited resources on those patients most vulnerable to requiring restraint. But identifying patients at risk for restraint has proven difficult – prior efforts at predicting restraint and seclusion use have been mixed and largely focused on inpatient populations. We describe our efforts to address limitations in prior research and initial findings in predicting restraint and seclusion use in a psychiatric emergency service. Implications for the management of agitated and aggressive patients in the outpatient, community, and inpatient settings will be addressed.

SYMPOSIUM 110

TRICHOTILLOMANIA: UPDATES ON PHENOMENOLOGY, NEUROBIOLOGY, AND TREATMENTS ACROSS THE LIFESPAN

Chair: Melissa H. Rooney, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the phenomenology, epidemiology, symptoms and diagnosis of trichotillomania and recognize common comorbidities and manifestations of impairment, 2) Describe the psychopharmacologic and behavioral treatment modalities of trichotillomania in children and adults, and understand the evidence behind these approaches, 3) Gain insight into advances in research and the likely classification of trichotillomania in DSM5, with an emphasis on implications for patient care

SUMMARY:

Trichotillomania (TTM) is a psychiatric condition characterized by the recurrent avulsion of hair resulting in noticeable hair loss and causing significant distress or impairment

in social, occupational or other areas of functioning (APA). It is classified in the DSMIV TR as an impulse control disorder not otherwise specified and estimated lifetime prevalence lies between 0.6 and 3.4%, with a peak age of onset of 13 years. (Chamberlain). The disorder is associated with significant physical and psychological comorbidities and is often underdiagnosed by clinicians (Duke). This symposium seeks to provide adult and child and adolescent psychiatrists with a framework to appropriately recognize and treat TTM in patients, with an emphasis on evidence-based behavioral and psychopharmacologic treatments. A panel of experts in TTM will present on facets of the etiology, assessment, and on research advances, with ample time for discussion with audience members. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision Washington, DC: American Psychiatric Association. 2010. Chamberlain SR. Lifting the veil on trichotillomania. *Am J Psychiatry*. 2007 Apr;164(4):56874. Duke DC. Trichotillomania: A Current Review. *Clin Psychol Rev*. 2010 Mar;30(2):18193.

S110-1.

AN OVERVIEW OF TRICHOTILLOMANIA: PHENOMENOLOGY, EPIDEMIOLOGY, COMORBIDITIES, AND IMPAIRMENT

Presenter: Douglas W. Woods, Ph.D.

SUMMARY:

Trichotillomania, or chronic hair pulling resulting in hair loss, is a poorly understood disorder. The current talk will review the literature on the disorders phenomenology, including discussion about the various styles of pulling that may result in differential treatment needs. In addition, the latest data on prevalence estimates will be reviewed along with the most recent data on the prevalence of cooccurring disorders in affected samples. Finally, the paper will review the data from both clinical samples and online surveys of community trichotillomania samples with respect to various aspects of impairment and their relationship with TTM severity.

S110-2.

NEUROBIOLOGY, COGNITION, AND PSYCHOPHARMACOLOGIC TREATMENT OF TRICHOTILLOMANIA

Presenter: Jon E. Grant, M.D., J.D.

SUMMARY:

The aim of this talk is to provide an overview of the current state of knowledge regarding the neurobiology, cognition and pharmacological treatment of trichotillomania. The

talk explores the neurobiological underpinnings of trichotillomania as identified using neuroimaging, neurocognitive assessment, and animal models. The talk will examine dysregulation of neural circuitry involved in affect regulation, motor habit generation, and inhibitory control. In addition, the talk will discuss the strengths and weaknesses of the pharmacological studies that have been performed in trichotillomania and explore how subtyping individuals with this behavior may be useful in providing more effective pharmacological treatment.

S110-3. TREATMENTS FOR TRICHOTILLOMANIA ACROSS THE DEVELOPMENTAL SPECTRUM: AN EMPIRICAL UPDATE

Presenter: Martin E. Franklin, Ph.D.

SUMMARY:

The extant literature on treatments for TTM will be summarized, with particular attention to recent findings regarding cognitive behavioral interventions for children and adolescents, combined treatment with behavioral and pharmacology in adults, and recent treatment development efforts to augment standard behavioral interventions for adults with TTM with procedures designed to address negative affect more generally speaking. Recommendations for future efficacy and effectiveness studies will be provided.

S110-4.

PHARMACOLOGICAL TREATMENTS FOR PEDIATRIC TRICHOTILLOMANIA

Presenter: Michael H. Bloch, M.D.

SUMMARY:

Trichotillomania (TTM) has an estimated lifetime prevalence of 13%. Although TTM typically has a childhood onset, it has been rather sparsely studied in children. Children with TTM can experience significant impairment due to peer teasing, avoidance of activities (such as swimming and socializing), difficulty concentrating on school work and medical complications due to pulling behaviors. Metaanalysis of randomized trials in adults with TTM has demonstrated that SSRI, the most commonly prescribed treatment for TTM has no efficacy in treating hairpulling. A recently published placebocontrolled trial has demonstrated the potential efficacy of the atypical antipsychotic, olanzapine in the treatment of TTM. Another randomized, placebocontrolled trial in adults with TTM has also demonstrated the efficacy of N-acetylcysteine (NAC), a glutamate modulating agent in the treatment of adults with TTM. Adults given NAC showed significant improvements in their trichotillomania symptoms compared to placebo on the Massachusetts General Hospital – Hairpulling Scale. Fifty-six percent

of adults with TTM treated with NAC were treatment responders compared to just 16% on placebo. No randomized controlled trials of pharmacological interventions have been completed for This presentation will examine the evidence behind different pharmacological treatments in TTM and reveal the results of a randomized, placebocontrolled trial of N-acetylcysteine in children with TTM.

S110-5.

ADVANCES IN RESEARCH AND UPDATES FOR DSM5

Presenter: Eric Hollander, M.D.

SUMMARY:

This presentation will focus both on recent research in trichotillomania as well as its classification in the DSMV. Trichotillomania was classified in DSMIV TR as one of the five impulse control disorders (alongside pyromania, pathological gambling, intermittent explosive disorder, and kleptomania). In DSMV it will be listed as an Obsessive-Compulsive Spectrum Disorder (alongside obsessive-compulsive disorder previously an anxiety disorder; and body dysmorphic disorder previously a somatoform disorder). Trichotillomania may also be considered a pathological grooming disorder (alongside with nailbiting and skinpicking). Impulse control disorders may also be considered behavioral addictions, since they share many characteristics with drug addictions, including impulsive choice and similar reward circuitry. In DSMV, only pathological gambling will be classified as a behavioral addiction. This presentation will also describe trichotillomania as a pure impulse control disorder, and describe its brain circuitry, endophenotype, neurocognitive profile, and neurotransmitter function. The endophenotype of trichotillomania will then be contrasted with similar measures in the putative obsessive-compulsive spectrum disorders of OCD and obsessive-compulsive personality disorder, and the behavioral addiction pathological gambling.

SYMPOSIUM 111

ADOLESCENT SUBSTANCE USE DISORDERS: CLINICAL UPDATES AND NEW DEVELOPMENTS IN TREATMENT

Co-Chairs: Christopher J. Hammond, M.D., Oscar G. Bukstein, M.D., M.P.H.

Discussant: Geetha Subramaniam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the different pharmacologic and

behavioral treatment options and the new research developments in treatment for adolescents with substance use disorders (SUDs) and for adolescents with comorbid SUDs and other DSMIV axis I disorders (dual diagnosis patients), 2) Describe phenomenological features of adolescent SUDs and the different riskfactors and variables that contribute to positive and negative outcomes in adolescents with SUDs, 3) Integrate this knowledge into a clinically applicable and evidence based approach

SUMMARY:

Adolescent substance use disorders (SUDs) represent a largescale public health problem contributing in large part to the increase in morbidity and mortality observed in this age range (Hopfer & Riggs 2007). In 2001, 1.1 million adolescents met criteria for substance abuse treatment, and yet fewer than 100,000 received treatment (McLellan & Meyers 2004). In this population, comorbidity with other psychiatric disorders (defined as dual diagnosis) is more common than not, and is associated with more severe substance abuse and poorer health outcomes (Hopfer & Riggs 2007; Grella et al. 2001). Standard of care pharmacologic and behavioral treatments are both fragmented and limited, but multiple trials are currently underway to investigate this unique and difficult to treat population. In this symposium, we provide clinical updates and new data from four different adolescent SUD treatment studies currently underway. Dr. Jack Cornelius and Dr. Paula Riggs will discuss pharmacologic intervention trials and standard of care treatment in dual diagnosis adolescent populations. Dr. Kevin Gray will discuss treatment studies of adolescents with cannabis dependence and a doubleblind placebo controlled pilot study using NAcetylcysteine. Dr. Aaron Hogue, from the Center for Addiction and Substance Abuse (CASA), will discuss a medication integration program pilot study for integrating behavioral and pharmacologic treatments for adolescents with attention deficit/hyperactivity disorder (ADHD) and SUDs. The discussant, Dr. Geetha Subramaniam, from the National Institute of Drug Abuse (NIDA), will tie the studies together and will discuss current and future NIDA initiatives for adolescent SUDs. Presentations will be followed by a panel discussion and a question and answer session. References Hopfer, C. & Riggs, P. (2007). Substance Use Disorders. In A. Martin & F.R. Volkmar (Eds.) *Lewis's Child and Adolescent Psychiatry A Comprehensive Textbook*. Philadelphia, PA: Lippincott Williams & Wilkins, 616624. McLellan A.T. & Meyers, K. (2004). Contemporary addiction treatment: a review of systems problems for adults and adolescents. *Biol Psychiatry*, 56, 764770. Grella, C. E., Hser, Y. L., Joshi, V., & RoundsBryant, J. L. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. *Journal of Nervous and Mental Disease*, 189, 384–392.

S111-1.

PHARMACOTHERAPY OF COMORBID YOUTH

Presenter: Jack R. Cornelius, M.D., M.P.H.

SUMMARY:

Background/Objective: We recently conducted a first doubleblind, placebocontrolled trial of fluoxetine (20 mg) in adolescents with comorbid major depressive disorder and an alcohol use disorder. Method: All subjects in that 12week study also received cognitive behavioral therapy (CBT) and motivational enhancement therapy (MET). Results: 50 subjects signed informed consent, and all 50 completed the study. No subject complained of serious side effects, and none was discontinued from medications because of side effects. A significant improvement (decrease) was noted in depressive symptoms (BDI and SIGH), level of drinking (TLFB), and days of intoxication (ACQ) in both the fluoxetine group and the placebo group. However, no significant differences were noted between the fluoxetine group and the placebo group on any outcome variable. Conclusions: These findings suggest that fluoxetine is safe and well tolerated in this population. However, no evidence for efficacy was found for fluoxetine for treating either the depressive symptoms or the excessive drinking of our comorbid adolescent population. The CBT/MET therapy may have been helpful for treating those symptoms (Cornelius et al, 2009). An overview of two of our other recent pharmacotherapy studies involving comorbid subjects will also be briefly presented, including a placebocontrolled trial of fluoxetine in MDD/cannabis use disorder subjects (Cornelius et al., 2010) and a very recent unpublished pilot study involving the promising nonSSRI antidepressant medication mirtazapine in comorbid subjects.

S111-2.

NACETYLCYSTEINE AS A TREATMENT FOR CANNABISDEPENDENT ADOLESCENTS: RESULTS FROM A DOUBLEBLIND RANDOMIZED CONTROLLED TRIAL

Presenter: Kevin M. Gray, M.D.

SUMMARY:

Adolescent cannabis users are particularly prone to adverse consequence of use and progression to dependence. Despite recent advances in adolescenttargeted psychosocial treatments, effect sizes remain small to modest. A potential avenue for improving outcomes is the use of pharmacotherapy to augment psychosocial interventions. A small number of medication treatments have been explored in adult cannabis users, but results have generally been discouraging. Preclinical research indicates that Nacetylcysteine (NAC),

via glutamate modulation in the nucleus accumbens, holds potential promise as a substance dependence pharmacotherapy. NAC holds particular appeal, as it is inexpensive, is available over-the-counter, and possesses an established safety/tolerability record in adults and children. To investigate whether NAC may be efficacious as a cannabis cessation treatment, we randomized treatment seeking cannabis dependent adolescents (age 15.21, N=116) to receive a double blind eightweek course of NAC (1200 mg twice daily) or placebo, each added to a contingency management intervention. The primary outcome was likelihood of negative weekly urine cannabinoid tests. Results indicated that NAC was well tolerated, with a minimal adverse event profile. NAC participants were more than twice as likely as placebo participants to submit negative urine cannabinoid tests (Odds Ratio = 2.3, $p < 0.05$). These findings support NAC as a potential pharmacotherapy to complement psychosocial treatment for adolescent cannabis dependence. Future studies are needed to replicate these findings and explore the efficacy of NAC across a variety of treatment contexts. NIDA (R01DA026777, K23DA020482). Correspondence: graykm@mus.edu

S111-3.

DEVELOPING A MEDICATION INTEGRATION PROTOCOL FOR TREATMENT OF COOCCURRING ADHD AND SUD IN ADOLESCENTS

Presenter: Aaron Hogue, Ph.D.

SUMMARY:

The goal of this presentation will be to describe the rationale and design of a brief protocol designed to systematically integrate pharmacological interventions for Attention-Deficit/Hyperactivity Disorder (ADHD) into behavioral treatment services for adolescent substance users with comorbid ADHD. ADHD is a prevalent cooccurring condition for adolescent substance use (ASU) that can significantly impede successful ASU treatment. Recent evidence indicates that stimulant medications for adolescent ADHD are effective in reducing ADHD symptoms among general clinic populations; moreover, new controlled research on comorbid ASU/ADHD suggests that ADHD medication is welltolerated, not prone to misuse, and promotes clinical gains when integrated with manualized behavioral intervention. Unfortunately, in real world settings ADHD is vastly underdiagnosed, undertreated, and poorly monitored among ASU clients. Moreover, ADHD medication acceptance and compliance is particularly difficult to achieve in highrisk adolescent populations. Structured clinical procedures for integrating ADHD medication interventions into routine behavioral services for ASU clients are urgently needed to help comorbid adolescents achieve durable clinical gains for both conditions. To meet the urgent need for

combined interventions for ADHD/ASU clients, we will design and test a protocol designed to promote integration of ADHD medication into ASU treatment services: Medication Integration Protocol (MIP). MIP will contain five intervention tasks deemed essential for integrating pharmacological interventions into outpatient behavioral treatment for youth: Task 1: Standardized psychiatric and computerbased assessment of ADHD symptoms and executive functioning; Task 2: Clinical feedback and psychoeducation on adolescent's ADHD and executive functioning profile; Task 3: Familybased relational reframing of adolescent symptoms and overlap with cooccurring problems; Task 4: Family decisionmaking about initiating an ADHD medication regimen; Task 5: Ongoing integration of medication management and familybased behavioral services. MIP will be integrated into existing familybased services at one partnering clinical site and treated by site family therapists who will be newly trained and monitored in MIP. The partnering clinic provides family therapy as the routine standard of care for outpatient behavioral health and offers onsite child psychiatry services. This treatment development project will

S111-4.

CLINICAL AND TREATMENT IMPLICATIONS OF ADVANCES IN ADOLESCENT ADDICTION RESEARCH

Presenter: Paula D. Riggs, M.D., M.A.

SUMMARY:

Dr. Riggs will present research advances in our understanding of the impact of marijuana and other substance of abuse on adolescent brain development as well as other research that informs why adolescents appear to be more vulnerable to addiction and the emergence of psychiatric disorders compared to adults. She will also present an overview of the most effective existing treatment interventions for adolescents with substance use disorders and identify the limitations of current treatments including the lack of integrated treatment for cooccurring psychiatric disorders, which is the rule rather than the exception. The second half of Dr. Riggs' presentation will focus on ways of improving existing treatment and overcoming existing gaps and barriers based on the current state of the science including: (1) derive core principles of integrated assessment and treatment of cooccurring psychiatric and substance use disorders in adolescents and young adults; (2) presentation of an evidencebased integrated treatment model; (3) increasing schoolbased mental health and substance treatment programs for earlier intervention and to address barriers to treatment access and health disparities for disadvantaged youth; (4) identifying research gaps and directions for future research.

SYMPOSIUM 112

DSM5 PERSONALITY DISORDERS OVER THE OCEAN: EUROPEAN PERSPECTIVES ON TREATMENT AND MENTAL HEALTH CARE

Co-Chairs: Simone Kool, M.D., Ph.D., Theo Ingenhoven, M.D., Ph.D.

Discussant: R. Michael Bagby, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Know the similarities and differences between North American and European evidencebased guidelines on personality disorders, 2) Know the stateofheart in European guidelines for personality disorders concerning psychotherapy, pharmacotherapy, comorbidity, suicidality and long term psychiatric care, 3) Understand the impact of the proposed DSM5 section of personality disorders on the development of stateofheart treatment guidelines and algorithms

SUMMARY:

The introduction of the DSM5 model for personality disorders (PDs) will have a major impact on European mental health practice. In this symposium these consequences will be viewed in the light of a stateofheart overview of European guidelines for PDs. From a clinical perspective, the introduction of the hybrid DSM5 model for PDs into current European diagnostic assessment procedures can be straightforward since West European countries already have a tradition in the use of multi conceptual diagnostic models for personality pathology, which foster assessment procedures with dimensional outcome measures. However, the economic recession and the financial cut back in the mental health sector in European countries nowadays have a major impact on clinical practice since there are less resources available for thorough diagnostic assessments in patients with PDs, as well as for psychotherapeutic treatments. In this symposium a series of presentations concerning PDs and personality pathology will be presented from various perspectives, each of them covering a major topic in current European guidelines for the diagnosis and treatment of PDs. Overviews will be given of the stateofheart in the fields of psychiatric management, psychotherapy, pharmacotherapy, treatment of comorbid disorders, life threatening suicidal behavior and longterm psychiatric care. The presenters will point at the similarities and differences between North American and European evidencebased guidelines, and at the consequences of the introduction of the DSM5 model of PDs in Europe in the light of the economic recession.

S112-1.**GROUP PSYCHOTHERAPY AS PREFERRED TREATMENT FOR PERSONALITY DISORDERS: THE DUTCH SITUATION**

Presenter: Konstant Gielen, M.D.

SUMMARY:

The new DSM5 section personality disorders entails a novel way of diagnosing personality disorders in terms of pathology of the self and problems with interpersonal relations. Thus psychotherapy for personality disorders would preferably focus on the individual in his interactions with others. Clinical psychotherapy in the Netherlands has a long tradition in which not only psychotherapy but also nonverbal therapies like art, movement and social therapy play a pivotal role in learning to adapt better to social situations and to mentalize affect. Sociotherapists work with the experiences of patients in the inpatient setting and in living together on a ward or in a house. This integrative approach is also widely used in other countries, such as the UK, Belgium and Scandinavia. Often the inpatient treatment is limited to 9 months, and is followed by a daytreatment program of 23 days a week. Other modalities of daytreatment also exist. This presentation will give a scope of the Dutch situation of inpatient and daytreatment psychotherapy for personality disorders. We will focus on different treatment backgrounds, such as the mentalization based treatment, schema therapy and psychoanalytical psychotherapy. Furthermore, we will describe from daily practice the challenges offered to the staff and teams in working with severe personality disorders and necessary prerequisites. Recent cut backs on the mental health funds have led to a critical appraisal of the effectiveness of the treatment modalities. Data from a multicenter study will be presented concerning patients who received outpatient, daytreatment and inpatient group psychotherapy.

S112-2.**PERSONALITY DISORDERS AND COMORBIDITY: DIAGNOSTIC AND CLINICAL ISSUES AND THE NEED FOR INTEGRATED CARE**

Presenter: Simone Kool, M.D., Ph.D.

SUMMARY:

Comorbidity of personality disorders (PDs) with other psychiatric diseases is seen frequently in clinical practice. For example, in literature, comorbidity of PDs with affective disorders is diagnosed in about 60% of the patients. Especially in patients with borderline PD, high frequencies of comorbidity up to 80% have been found. This fact has important implications for both diagnosis and treatment of both types of disorders. In this presentation, the diagnostic conse-

quences of comorbidity of PDs with other Axis I disorders and particularly with affective disorders will be put forward in the light of the DSM5 proposal for PDs. Also, the clinical implications will be presented, especially the need for integrated treatment such as combinations of an evidence based psychotherapy modality and pharmacotherapy according to recent guidelines.

S112-3.

EUROPEAN PHARMACOTHERAPY ALGORITHMS IN SEVERE PERSONALITY DISORDERS

Presenter: Theo Ingenhoven, M.D., Ph.D.

SUMMARY:

In this presentation DSM5 consequences will be discussed for pharmacotherapy algorithms for patients with severe PDs. Based on a dimensional and symptomtargeted approach, a systematic review of placebo controlled randomized clinical trials will be presented on the efficacy of antipsychotics, antidepressants and mood stabilizers on subsequent symptomatic outcome domains. Diverging evidencebased European pharmacotherapy guidelines for PDs will be discussed. Recent metaanalyses favor further development of stateofheart pharmacotherapy algorithms and treatment guidelines. International collaboration can bridge the gap we still face from both sides of the ocean.

S112-4.

THE MANAGEMENT OF PERSISTENT SUICIDAL BEHAVIOR IN PERSONALITY DISORDERS

Presenter: Johannes B. van Luijn, M.S.C.

SUMMARY:

The new Dutch Multidisciplinary Guideline for the Treatment of Suicidal Behavior stresses the importance of focusing on suicidal behavior in personality disorders and other psychiatric disorders. Suicidal behavior is a feature of (B) PD both in DSM IV and 5. All major therapies for PD use a kind of contract to help the patients to achieve control over their selfdestructive behavior and safeguard their treatment. They succeed with most patients. This presentation describes the principles of management when suicidality persists and is a chronic threat. Contrary to acute suicidal behavior, the therapist attitude toward chronic suicidality should be patience instead of action. The principles can be described in eight "C's": commitment, containment, contract, contextual understanding, countertransference, collaboration, comprehensiveness and concern for acute episodes. The principles will be discussed with examples from clinical practice.

S112-5.

PSYCHIATRIC MANAGEMENT FOR PERSONALITY DISORDERS THE FRAME OF TREATING PERSONALITY DISORDERS

Presenter: Adrianus J. A. Kaasenbrood, M.D., Ph.D.

SUMMARY:

American and European studies have shown the effectiveness of psychotherapy in the treatment of personality disorders. As a result many patients benefit from these treatments, leading to a better quality of life with fewer symptoms and complaints. However, in a recent study in The Netherlands only 20% of patients with personality disorder who seek help in general mental health care receive such an evidence based psychotherapy. Partly this will be the result of a lack of implementation of these evidence based psychotherapies in mental health organizations. Moreover, the idea that the evidence based psychotherapies will cover all domains of care that are necessary in a program for personality disorders is premature. In this contribution, an overview of the necessary care other than psychotherapy will be presented. In principal this care is focusing on preparing patients with a personality disorder to participate in psychotherapy. For another part it focuses on social psychiatric treatment of patients who don't manage to get into psychotherapy or who have dropped out. For still another part adequate care consists of basic interventions fitting every patient in a program for personality disorders, like to diagnose the disorder, psychoeducation, indication for treatment, treatment evaluation et cetera. This contribution not only gives a conceptual frame for this part of mental health care (called "Psychiatric Management") but also discusses what is needed to implement this kind of psychiatric management.

SYMPOSIUM 113

PSYCHONEUROIMMUNOLOGY: INTEGRATION AND PRACTICAL APPLICATION OF AN EMERGING FIELD IN MEDICINE

Chair: Sirid Kellermann, Ph.D., M.B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify potential underlying causes of commonly seen neuropsychiatric conditions, 2) Integrate biomarker assessments to complement conventional evaluations, 3) Comprehensively evaluate and treat complex psychiatric disorders using clinical psychoneuroimmunology

SUMMARY:

The convergence of the fields of psychiatry, neurology, immunology, and endocrinology, is one of the most exciting and rapidly advancing areas of medical science. This emerging field reflects an evolution in how we think about human health and disease by considering patient physiology not as a collection of isolated systems, but rather as a single, interconnected supersystem. With this expanded and interdisciplinary perspective, clinicians are empowered to better address today's most challenging health concerns. The communication between the nervous, endocrine and immune systems has been well established by decades of research. For example, inflammation increases certain cytokines that induce enzymatic activity which leads to decreased serotonin availability. Conversely, antidepressant medications have been shown to decrease proinflammatory cytokines. In another example, the transition into menopause is characterized by a significant decline in the production of estrogen and progesterone, but is also often associated with symptoms tied to nervous system function: depression, anxiety, fatigue, irritability, memory loss, and sleep disturbances. These symptoms can be attributed to the interactions between the monoamine transmitters and GABA with the steroid sex hormones. In this way, the hormonal decreases associated with menopause often exacerbate existing neurotransmitter imbalances. Understanding these intimate neuroendocrine relationships is accompanied by a growing appreciation that clinical biomarkers such as cytokines, neurotransmitters, and hormones can be used to assess imbalances in these interactions. An integrated, comprehensive model that combines conventional psychiatric evaluations with biomarker assessments can help better target therapeutic interventions, thus increasing the likelihood of successful clinical outcomes. This symposium will explore the emerging paradigm of psychoneuroimmunology, with the objective of empowering attendees with the knowledge and tools to more comprehensively treat complex psychiatric disorders. The science behind biomarker assessments for psychiatric conditions will be highlighted; followed by a series of case reviews and clinical anecdotes from clinicians well versed in clinical psychoneuroimmunology.

S113-1.

PNEI AND NEUROIMMUNE CONNECTIONS

Presenter: Sirid Kellermann, Ph.D., M.B.A.

SUMMARY:

The communication between the nervous, endocrine and immune systems has implications for many disease states. The connection between inflammation and psychiatric conditions has become well established through decades of research. A clear understanding of this connection empowers clinicians with adjunctive and alternative treatments when patients respond unexpectedly to historically proven

therapies. A growing appreciation of the crosstalk between the nervous and immune systems has shown that both systems are dependent upon the health of the other; therefore a thorough assessment of nervous system function should not ignore the possibility of inflammation-driven neuropsychiatric symptoms. Identifying the potential underlying causes of psychiatric complaints allows for a more targeted plan of intervention.

S113-2.

NEUROENDO CONNECTIONS AND BIOMARKER VALIDITY

Presenter: Kelly Olson, Ph.D.

SUMMARY:

The communication between the nervous, endocrine and immune systems has implications for many disease states. The connection between the nervous and endocrine system has become a key point of intervention for conditions previously thought of as "endocrine" in nature. This is shown clinically through the increased use of psychotropic medications for menopausal and cyclic complaints. A clear understanding of how hormonal fluctuations impact nervous system function and neurotransmitter synthesis and stores empowers the clinician to more effectively target interventions in a multisystem approach for increased efficacy. The interplay between the nervous, endocrine and immune systems can be assessed using biomarkers such as neurotransmitters, hormones and cytokines. Understanding how these biomarkers are measured in various biological fluids; and the clinical relevance of the measurements is an essential part of learning to effectively using biomarker assessments for psychiatric conditions.

S113-3.

HOW TREATMENT FOR A VARIETY OF CLINICAL CONDITIONS HAS BEEN ENHANCED BY BIOMARKER ASSESSMENTS

Presenter: Dana E. Shaw, M.D.

SUMMARY:

Integrating biomarker assessments alongside conventional assessments provides for a more comprehensive picture of the underlying causes of many common psychiatric complaints. Through clinical anecdotes and literature review, the audience will learn how biomarker assessments have enhanced and targeted the treatment for a variety of clinical conditions; from ADD to depression to addiction.

S113-4.

CLINICAL APPLICATIONS

Presenter: Elizabeth Stuller, M.D.

SUMMARY:

Understanding 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 therapy. Identifying the impact of an intervention on all three integrated systems allows for a greater understanding of why an individual may respond poorly to one treatment, yet positively to another with a similar mechanism.

SYMPOSIUM 114**NEW INSIGHTS IN TREATING DEPRESSED WORKERS: FOCUS ON EARLY IDENTIFICATION AND INTERVENTION**

Chair: Raymond W Lam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify strategies for reducing the negative impact of depression in the workplace, 2) Describe how Employee Assistance Programs function within workplace settings, 3) Describe the benefits of antidepressants and cognitive behaviour therapy on work productivity, 4) Discuss the strengths and limitations of telephonedelivered psychotherapy

SUMMARY:

Major depression carries a huge economic toll on both individuals and society. Occupational functioning is particularly affected by the symptoms of depression and there is increasing attention on the impact of major depression in the workplace. Given its high prevalence, early identification of major depression in workplace settings and early interventions will likely be needed to optimize functioning outcomes. Employerfunded initiatives such as Employee Assistance Programs (EAPs) can play a major role in identifying and managing work stress and depressive symptoms in employees and their families. Novel applications of evidencebased psychotherapies, such as those administered by telephone and computer, may allow greater access to treatment and greater convenience for workers as they won't have to leave work for therapy appointments. This symposium, sponsored by the Canadian Network for Mood and Anxiety Treatments (www.CANMAT.org) will present new

and emerging data on the prevalence and burden of major depression on working people, the role of EAPs in depression recognition and care, and the use of antidepressants and telephonedelivered psychotherapy in depressed workers. Results will be highlighted from the WORKER Study, a randomized controlled trial of the benefits of escitalopram and telephonedelivered cognitive behaviour therapy (CBT) on productivity outcomes in working patients with major depressive disorder.

S114-1.**EPIDEMIOLOGY OF DEPRESSION AND WORK IMPAIRMENT**

Presenter: Scott Patten, M.D., Ph.D.

SUMMARY:

Major depression is now generally regarded as the leading single cause of disability in Canada. The impact of this condition is due both to its high prevalence and its deleterious effects on functioning. The peak prevalence of major depression occurs in age ranges critical for preparatory education and establishment of career paths. However, the prevalence of major depression remains high throughout the most productive years of occupational life. As the Western economies evolve towards cognitively demanding and serviceoriented industries, the impact of major depression is likely to be further magnified. Most people with major depression continue to work, but their productivity is substantially impaired while doing so (presenteeism). Major depression is also associated with workplace absenteeism. Longitudinal studies confirm that major depression strongly predicts transition out of the working population, especially in young to middleaged adults. Much of the literature concerned with workplace mental health has emphasized workrelated causes of depression such as effortreward, demandcontrol, and worklife imbalance. Such models provide a framework for developing and evaluating preventive activities. However, clinical management remains the most important avenue for reducing the impact of this condition. Innovative approaches capable of improving access to mental health care, reducing the duration of major depressive episodes and reducing the frequency of recurrence are urgently needed.

S114-2.**THE IMPACT OF DEPRESSION ON CLIENT FUNCTIONAL OUTCOMES IN AN EMPLOYEE ASSISTANCE PROGRAM**

Presenter: Debra Wolinsky, M.Ed.

SUMMARY:

Employee and Family Assistance Programs (EAPs) offer confidential, short-term counselling services for employees with personal problems that affect their work performance, whether or not those problems originate in the workplace. Although depression, anxiety and stress are often presenting complaints, there is little research on the impact of depression on outcomes with EAP intervention. In this study, we sought to determine the effects of depression on functional outcomes within an EAP setting. Anonymized data were obtained from the Client Records of over 10,000 consecutive, self-referred clients served by PPC Canada (www.ca.ppcworldwide.com), an EAP providing service to over 350 organizations across Canada. Assessment measures included the self-rated Personal Health Questionnaire (PHQ9), measures of work stress and impairment, and the clinician-rated Global Assessment of Functioning (GAF) scale. We found that a large proportion of clients (37%) were experiencing clinically significant depression, and that these clients had more problems with work impairment and job satisfaction, and lower overall functioning, than clients without depression. EAP intervention resulted in improvement in functioning in all clients, although clients with depression still had lower functioning at closing relative to those without depression. Since EAPs may be the “first line of defense” for working people with MDD, they should be considered important components for service delivery of early depression treatment. Objectives At the end of the presentation, participants will be able to: Describe how Employee Assistance Programs function within workplace settings. Describe the prevalence and characteristics of clinically important depression in a cohort of clients attending an EAP. Describe the effects of EAP intervention on functional outcomes in clients with depression.

S114-3.**WORK PRODUCTIVITY GAINS WITH TREATMENT OF DEPRESSION: BENEFITS OF PHARMACOTHERAPY AND PSYCHOTHERAPY**

Presenter: Raymond W Lam, M.D.

SUMMARY:

It is widely recognized that major depressive disorder (MDD) is associated with significant impairment in occupational functioning, particularly with “presenteeism”, or reduced productivity when working while still depressed. However, there is little research on the effects of treatment on work productivity. We recently conducted a systematic review of clinical trials in depression that included a work productivity outcome measure and found only a handful of studies. One problem for the field is that current methods make it difficult for working people to leave work to participate in clinical trials, in part because of the intensive procedures and the frequency and long duration of study

visits. In this presentation, we describe a novel methodology that minimizes the frequency and duration of study visits to allow busy working people to participate in a clinical trial. The WORKER Study is a 12-week randomized controlled trial of escitalopram plus cognitive-behaviour therapy (CBT) in working patients with MDD. All patients are treated with 1020 mg of escitalopram and then randomized to 8 sessions of a validated brief CBT program administered by trained therapists over the telephone, or to adherence reminder telephone calls. Outcomes included depression rating scales administered by blind raters over the telephone, and productivity questionnaires completed over a secure web site. We have completed recruitment for the study (N=105) and will present symptom and productivity outcome data to determine the differential effects of combined antidepressant medication and telephone-administered CBT compared to medication alone.

S114-4.**ACCEPTABILITY OF TELEPHONE-DELIVERED COGNITIVE-BEHAVIOURAL THERAPY FOR MAJOR DEPRESSION IN THE WORKER STUDY**

Presenter: Sagar V. Parikh, M.D.

SUMMARY:

Cognitive Behaviour Therapy (CBT) and antidepressants are first-line treatments for major depression, with some recent meta-analyses suggesting combination approaches as the most effective. However, providing CBT presents significant cost and access barriers. To explore the merits and feasibility of telephone CBT, we conducted the WORKER Study, a 12-week randomized control treatment of escitalopram plus CBT in working patients with major depressive disorder, followed by a 12-week open observation period. All patients are treated with 10 to 20 mg of escitalopram and then randomized to eight sessions of a validated brief CBT program administered by trained therapists over the telephone, or to adherence reminder telephone calls. We have completed recruitment of 105 subjects for the study, with the final participant due to finish the study by the summer of 2011. We will provide rates of completion and satisfaction with telephone CBT. Based on a preliminary data analysis, about 75% of CBT subjects completed the telephone CBT and over 80% reported significant satisfaction with phone delivery of psychotherapy.

SYMPOSIUM 115**RECENT DEVELOPMENTS IN CROSSCULTURAL, ETHNIC, AND ETHNOPSYCHOPHARMACOLOGICAL ASPECTS OF MOOD DISORDERS A GLOBAL PERSPECTIVE**

Co-Chairs: Shamsah B. Sonawalla, M.D., Albert Yeung, M.D., Sc.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Appreciate that culture and ethnicity significantly influence the manifestation and response to treatment in mood disorder, 2) Understand the principles and clinical application of ethnopsychopharmacology, 3) Recognize crosscultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders, 4) Obtain a global perspective on management of mood disorders

SUMMARY:

This symposium will discuss recent developments in cross-cultural, ethnic and ethnopsychopharmacological aspects of mood disorders, and attempt to provide a global perspective on some of these issues. The past two decades have seen a rapidly growing interest in crosscultural psychiatry. Much of this is due to the increasing migration of the world's population across countries, especially into the United States. It is more important today than ever before for a clinician to understand illness in a cultural context. Culture has a major influence on symptom expression, helpseeking behavior, attitudes towards treatment, treatment expectations and response, therapeutic compliance, family involvement, and the 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 drugdrug interactions and metabolism, adverse events, compliance, and response to treatment. He will also discuss various approaches to improving clinical compliance and outcomes and the role of genetic screening for poor and slow metabolizers. Dr. Albert Yeung will present the impact of cultural beliefs on the treatment of Chinese Americans with mood disorders and discuss possible solutions to improve pharmacological treatment of 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 AsianIndian population, both in an Indian and a global setting. He will review the impact of migration and socioeconomic changes on manifestation of mood disorders in this population, and suggest psychopharmacological and psychotherapeutic modifications for treatment. Dr. Paolo Cassano will discuss challenges faced by clinicians working with the Hispanic population, and review approaches to treatment of mood disorders in the Hispanic 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 presentation and treatment of mood disorders in women globally, with a focus on premenstrual, postpartum and perimenopausal depression. She will discuss gender roles across cultures, the role of family, community and social support systems and their impact on depression, with suggested strategies for management.

S115-1.

ETHNOPSYCHOPHARMACOLOGY UPDATE

Presenter: David C. 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 nonbiological 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 intragroup differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are one of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9/2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. This lecture will also review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders. The role of genetic screening for poor and slow metabolizers will be discussed.

S115-2.

CULTURALLY SENSITIVE COLLABORATIVE TREATMENT (CSCT) OF DEPRESSED CHINESE AMERICANS IN PRIMARY CARE

Presenter: Albert Yeung, M.D., Sc.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, Canadian Eskimos, Japanese, and Southeast Asians, equivalent concepts of depressive disorders are not found (Marsella et al., 1985). Studies exploring illness beliefs among depressed Chinese Americans with low degrees 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 underrecognition and undertreatment of MDD among Chinese Americans. Culturally Sensitive Collaborative Treatment (CSCT) was developed to improve recognition of depression and the acceptability and adherence to treatment of MDD. It includes systematic depression screening in primary care and culturally sensitive psychiatric interview. The outcomes of implementing the CSCT in a primary care clinic will be discussed.

S115-3.

DEPRESSIVE DISORDERS IN THE ASIAN INDIAN POPULATION: EFFECTS OF CULTURE, GLOBALIZATION AND ETHNOPSYCHOPHARMACOLOGY

Presenter: Rajesh M. Parikh, M.D.

SUMMARY:

The Asian Indian community is among the fastest growing ethnic groups in the United States, and comprises 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, which often influence expression of depression and response to treatment. Mental illness is often viewed as an embarrassment or stigma and mood disorders are underdiagnosed and undertreated. Family involvement is substantial in all stages of treatment, including interactions with the treating physician and compliance with treatment. Cultural sensitivity is of paramount importance during interactions with patients and their families; this helps assess cultural influences on the illness and facilitate treatment acceptability and compliance, particularly with antidepressant medications. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements and adverse event profiles for antidepressant medications in this population. The influence of globalization and suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in India and the U.S. will be discussed.

S115-4.

MAJOR DEPRESSIVE DISORDER WITH ATYPICAL PSYCHOTIC SYMPTOMS IN LATINOS

Presenter: Paolo Cassano, M.D., Ph.D.

SUMMARY:

Atypical psychotic symptoms are prevalent in Latinos and have been referred to with different terms (i.e. putative psychotic symptoms, nonpsychotic hallucinations, idioms of distress), given the uncertainty around their nature and clinical implications. In US Latinos, the lifetime prevalence of atypical psychotic symptoms is 9.5%. In clinical settings, the cross-sectional prevalence of atypical psychotic symptoms ranges from 22% to 46%, and is even higher among Latino veterans. Among Latinos with Major Depressive Disorder (MDD), up to 27% experienced current psychotic symptoms. Atypical psychotic symptoms are associated with higher medical and psychiatric comorbidity, greater suicidality, functional impairment and utilization of services. Despite the prevalence and significance of atypical psychotic symptoms in Latinos and their association with MDD, there is no consensus on treatment strategies. Clinicians treating depressed Latinos are often confronted with the clinical dilemma of whether antidepressants should be augmented with an antipsychotic. We will review the epidemiology, clinical features, and significance, as well as the treatment strategies, for atypical psychotic symptoms, with a particular focus on their presentation in MDD. The relationship of atypical psychotic symptoms with other culture-specific syndromes in Latinos will also be reviewed.

S115-5.

DEPRESSION IN WOMEN: A CULTURAL PERSPECTIVE

Presenter: Shamsah B. Sonawalla, M.D.

SUMMARY:

This presentation will discuss possible cultural factors contributing to gender difference in the prevalence of depression, review depression across a woman's reproductive life cycle, and highlight some cultural differences in this area. Women are two to three times more likely to suffer from depression than men. Some possible explanations for this difference include biological factors such as hormonal factors, and social and cultural factors. For instance, in some cultures, women are more prone to 'self-silencing' and 'learned helplessness,' contributing to depression. Up to 80% of women experience premenstrual symptoms, and the experience of premenstrual symptoms varies across cultures. Some researchers have discussed the 'medicalization of PMS' and low-calorie diets (which reduce the amount of tryptophan

essential for the production of serotonin) as contributing factors in PMS. Up to 15% of women experience postpartum depression. Researchers have found a relationship between postpartum depression and factors such as a cultural preference for a male child, lack of partner support, lack of social organization of postpartum events and a lack of social recognition of the role transition for the new mother. Menopause is a normal transition in a woman's life; however, every woman's experience with menopause is unique and is influenced by several factors, including culture. Up to 80% of women in western societies suffer from physical and psychological difficulties at menopause. Interestingly, women in some nonwestern cultures appear to be significantly less affected by menopausal ills, e.g., Rajput women in India, who report minimal or no 'symptoms' of menopause. Studies suggest that women experience greater levels of stress, depression and anxiety when seeking treatment for infertility, which is traditionally viewed as a woman's problem, even if a male factor is responsible for the couple's infertility. Findings from a study on couples undergoing in vitro fertilization in India will be discussed. The importance of understanding the cultural context in harnessing cultural factors and a holistic approach in the treatment of women with mood disorders will be discussed.

SYMPOSIUM 116

SEVERE MOOD DYSREGULATION, BIPOLAR, AND ATTENTIONDEFICIT/HYPERACTIVITY SYMPTOMS IN CHILDHOOD: SYMPTOM OVERLAP AND DIAGNOSTIC CONFUSION

Chair: Steven P. Cuffe, M.D.

Discussant: Robert R. Althoff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the symptom overlap and differential diagnostic complexity of mood and ADHD symptoms in children, including narrow versus broadphenotype bipolar symptoms, 2) Discuss the presentation, differential diagnosis and treatment of ADHD and severe mood symptoms in very young children, 3) Discuss the epidemiology and evolution of mood and ADHD symptoms over childhood and adolescence, 4) Understand the current research on the physiological differences between children with severe mood dysregulation and narrowphenotype bipolar disorder

SUMMARY:

AttentionDeficit/Hyperactivity Disorder is the most common mental disorder of childhood and causes significant longterm morbidity. The core symptoms of ADHD are inattention, impulsivity and hyperactivity, combined with

the common comorbid symptoms of irritability and behavior problems (oppositional defiant disorder and conduct disorder). These symptom clusters overlap with children who have bipolar disorder and severe mood dysregulation. The overlap of symptoms makes the nosology problematic, and can lead to significant confusion for clinicians. This symposium seeks to clarify the diagnostic issues, and to present clinicians with information on which to base their diagnostic assessments of these children. The first talk is by Jean Thomas, M.D., who presents on diagnostic issues in very young children. The lack of diagnostic specificity and associated diagnostic confusion are the primary challenges in differentiating disruptive disorders across the age spectrum. That is, disruptive behaviors, "like a fever of unknown origin," are nonspecific symptoms of distress identified in many childhood disorders, including: Attentiondeficit/Hyperactivity Disorder and associated executive function difficulties; anxiety and mood disorders, including bipolar disorder and severe mood dysregulation; and parentchild relationship disorder. This presentation highlights new research that demonstrates how comorbid diagnoses help achieve specificity and guide treatment in young children. The second talk by Steven P. Cuffe, M.D. presents data from a communitybased, longitudinal epidemiological study of children followed from age 512 through 1318. The prevalence of ADHD, bipolar disorder, and severe behavioral problems is presented, including the prevalence of specific bipolar symptoms such as grandiosity and decreased need for sleep. The prevalence of DSMIV TR bipolar disorder is extremely low in this sample. The evolution of these symptoms/diagnoses over the course of 8 years is presented. In the final talk, Brendan Rich, Ph.D presents data concerning the debate regarding the nosological boundaries of pediatric bipolar disorder (PBD) and its relationship to severe mood dysregulation (SMD), i.e. chronic irritability, overreactivity to negative emotional stimuli, and hyperarousal, without mood episodes and euphoria. Clarifying the differentiation of these disorders may be best achieved using neurocognitive tasks that measure core deficits (e.g. the processing of emotional stimuli, irritability and frustration tolerance), along with neuroimaging techniques including functional magnetic resonance imaging (fMRI) and magnetoencephalography. Data presented will support the contention that that PBD and SMD differ in their clinical characteristics and pathophysiology. Following the three talks, Robert Althoff, M.D., Ph.D., will discuss the presentations and relate them to his work studying mood dysregulated children.

S116-1.

EARLY DISRUPTIVE DISORDERS: COMORBIDITY GUIDES DIAGNOSTIC AND TREATMENT SPECIFICITY

Presenter: Jean M. Thomas, M.D.

SUMMARY:

The lack of diagnostic specificity and associated diagnostic confusion are the primary challenges in differentiating disruptive disorders across the age spectrum. That is, disruptive behaviors, “like a fever of unknown origin,” are non-specific symptoms of distress identified in many childhood disorders, including: Attentiondeficit/Hyperactivity Disorder and associated executive function difficulties; anxiety and mood disorders, including bipolar disorder and severe mood dysregulation; and parentchild relationship disorder. This presentation highlights new research that demonstrates how comorbid diagnoses help achieve specificity and guide treatment in young children. The historic cutpoint between disruptive behavior disorders (externalizing symptoms), and anxiety/depressive disorders (internalizing symptoms) delineates two separate groups of disorders in the DSMIV, DSMIIIR and DSMIII. Comorbid externalizing and internalizing symptoms in adolescents were first documented in 198687. Similarly, disruptive behavior disorders comorbid with anxiety/depressive disorders have been repeatedly documented in schoolage children and adolescents. These same two comorbid diagnoses were more recently documented in toddlers and preschool children (Thomas & Guskin., 2001), (Luby et al., 2002), and others. Thomas and Guskin (2001) also document that, in young children (aged 18 to 47 months), disruptive behavior disorders were commonly diagnosed with one of three comorbid diagnoses: 1) neurodevelopmental differences (cognitive, speechlanguage, motor), 2) posttraumatic stress disorder, or 3) affective (anxiety/depressive disorders). Among these three copresenting disorders, the most frequent comorbid diagnosis was affective disorder. Furthermore, among these three copresenting disorders, parentchild relationship disorder was most commonly associated with affective disorders New research shows that toddlers (24 to 42 months) who present with a chief concern of impairing disruptive behavior can be delineated into two comorbid diagnostic groups. These two groups, Disruptive/Neurodevelopmental Disorders and Disruptive/NonNeurodevelopmental Disorders (affective disorders) define two comorbid diagnostic patterns that guide diagnostic and treatment specificity. The ratio of toddlers in these two comorbid groups was 2 to 1, respectively. That is, approximately twothirds of the disruptive toddlers had comorbid neurodevelopmental differences and onet

S116-2.**EPIDEMIOLOGY AND EVOLUTION OF ADHD AND BIPOLAR SYMPTOMS: A COMMUNITYBASED STUDY**

Presenter: Steven P. Cuffe, M.D.

SUMMARY:

Background: The number of children diagnosed with bipolar disorder has increased dramatically over the past 10 years. This led to concern in the media and disagreement among mental health professionals about broadening the definition of bipolar disorder to include children with severe mood and behavioral outbursts despite failing to meet DSMIV criteria. Proponents of this approach believe that bipolar disorder in children presents with this symptom pattern. Detractors say that although these children have serious problems, there is no evidence they will develop bipolar disorder as adolescents or adults. This paper presents data from a communitybased, longitudinal, epidemiological study of elementary school aged children and explores symptoms of mania among the sample over time. **Method:** Children from a large, single school district in South Carolina were screened with the Vanderbilt ADHD Diagnostic Teacher Rating Scale. Parents of high screens and a gender frequencymatched sample of low screen children were invited for a diagnostic interview with the Diagnostic Interview Schedule for ChildrenIV. Wave 1 was completed in 2004; wave 2 was completed 34 years later followed by waves 3, 4 and 5 at one year intervals. Statistical weights were calculated to account for the complex sampling design, which, when applied to the data, allow for unbiased estimates of diagnoses and symptoms among children in the school district. All weighted estimates (percentages) are presented alongside raw numbers. The children were followed for up to 8 years. Symptoms of ADHD, bipolar disorder, depression and behavior problems were assessed. Four waves of data are presented here; the 5th wave is currently in process and will be available at the time of the presentation. **Results:** The prevalence of ADHD at wave 1 was 8.5% (N=480). One child met criteria for bipolar disorder in wave 2, and 1 additional child met criteria in wave 4; criteria for bipolar disorder was not met at either baseline or wave 3 for any children (overall prevalence 0.3%). Symptoms of mania were significantly higher in the ADHD group; however the endorsed symptoms overlapped with ADHD (more talkative, increased goal directed activity) and significantly decreased over time. The number of children reported to have at least one criterion B symptom was 11 (N=480), 2 (N=291), 2 (N=278), and 1(248) in waves 1 through 4, respectively. At wave 1, only one child had grandiosity and 0 had decreased ne

S116-3.**DIFFERENTIATING PEDIATRIC BIPOLAR DISORDER AND SEVERE MOOD DYSREGULATION USING NEUROCOGNITIVE DATA**

Presenter: Brendan A. Rich, Ph.D.

SUMMARY:

Pediatric bipolar disorder (PBD) is one of the most debili-

tating childhood psychopathologies. Although epidemiological data suggest PBD is relatively rare, studies in the last decade find a fortyfold increase in community settings. This raises concerns regarding the extent to which PBD is being overdiagnosed. The diagnostic boundaries of PBD continue to be debated. Of particular concern is the relationship between PBD (i.e. narrow phenotype) and severe mood dysregulation (SMD), characterized by chronic irritability, overreactivity to negative emotional stimuli, and hyperarousal (i.e. broad phenotype). It is possible that the rising prevalence rates of PBD reflect the diagnosis of BD in youths who present with extreme affective and behavioral lability, i.e. symptoms central to the SMD classification. Clarifying the nosological relationship between PBD and SMD has significant implications for the conceptualization of these disorders and identification of their optimal treatment. In this talk we present results of a series of studies that begin to differentiate the pathophysiology of PBD and SMD. Research targets core deficits of these childhood psychopathologies, including processing positive and negative emotional stimuli, face emotion understanding, irritability, and frustration tolerance. We present cognitive, behavioral, functional magnetic resonance imaging (fMRI), and magnetoencephalography (MEG) data. Results find that although there are certainly clinical and behavioral similarities, the neural mechanisms mediating core symptomatology appear to differ between these classifications. Of particular interest, we find distinct patterns of activation in PBD vs. SMD youth in limbic and prefrontal regions that are critical to the processing of emotional stimuli and regulating behavioral responses, including irritability. Regions that differentiate PBD and SMD include the anterior cingulate cortex (ACC), insula, and medial and superior frontal gyri. Results provide information regarding the neural mechanisms of these disorders and indicate distinctions between the pathophysiology of PBD and SMD.

SYMPOSIUM 117

HOW TO SUCCEED IN PSYCHIATRY: AN INTERNATIONAL EARLY CAREER PSYCHIATRIST PERSPECTIVE

Co-Chairs: Julian Beezhold, M.D., Sarah Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Have a broad overview of issues affecting residents and early career psychiatrists including future challenges for the profession, wellbeing of psychiatrists, priority setting early in one's career and the complexity of medical error, poor performance and its consequences and prevention, 2) Identify some of the issues that link early career psychiatrists practising in different settings internationally, 3) Implement some practical steps to enhance their future

career satisfaction and success

SUMMARY:

This wideranging symposium for Early Career Psychiatrists (ECP) and those with an interest in Psychiatric Education brings together international expertise in Early Career Psychiatrist issues. The session aims to highlight and provide time for discussion around some of the most important topics that affect ECPs. This will be achieved using research findings and the extensive experience of the presenters. The presenters bring a wealth of experience in ECP issues both in the USA and in Europe and beyond that will be shared with participants. The presentations will focus on wellbeing, leadership, setting priorities, future directions and agendas in psychiatry and how to deal with medical error and its consequences. International comparative wellbeing research on psychiatry residents in nearly 30 countries will be presented and the implications discussed, will the common themes and concerns highlighted. Setting priorities successfully is a key ingredient for ECP success practical guidance will be discussed. Medical error, misconduct, complaints and litigation are part of the context in which ECPs practice. A broad overview of these will be used to suggest and debate some of the implications for working practice. Strategies for minimizing the occurrence and the personal and economic cost of medical error will be reviewed. Finally there will be a discussion regarding a future agenda for ECPs. This will draw on experience from ECP and Resident organizations internationally as well as from the American Psychiatric Association, the European Psychiatric Association and the World Psychiatric Association.

S117-1.

TOWARDS A NEW AGENDA FOR EARLY CAREER PSYCHIATRISTS

Presenter: Andrea Fiorillo, Ph.D.

SUMMARY:

Psychiatry as a discipline is going to face significant changes in the upcoming twenty years. Although these changes can be particularly stimulating and challenging from both intellectual and scientific viewpoint, the new generations of psychiatrists might not be properly prepared to face such changes. Seven key areas could be identified, which might require a substantial restructuring the paradigms on which psychiatry has posed its foundations in the past century and are listed hereafter: 1) the need to rediscover functional psychopathology; 2) the integration of pharmacotherapy with evidencebased psychosocial interventions; 3) the further integration of psychiatry within medicine; 4) the changes in mental health care settings; 5) the rise of new psychiatric syndromes and diagnoses; 6) the need to combat stigma

towards psychiatry in the media; 7) the role of psychiatry within society. Within this cultural and social scenario, a new identity of modern psychiatrists is emerging. The re-examination of a working agenda must not be a transversal evaluation of principles or practices, but it should become an integral and continuing part of work in the field of mental health, at the practice, research and education levels. We believe that a cogent reconsideration of these aspects is now urgently needed from mental health professionals, if psychiatry is to survive and be useful in the promotion of health and mental health in the future.

S117-2.

MENTAL HEALTH AND WELLBEING OF EARLY CAREER PSYCHIATRISTS

Presenter: Nikolina Jovanovic, M.D., Ph.D.

SUMMARY:

Longstanding evidence suggests that those who choose medicine for a career are at greater risk for both mental and physical health problems. Mental health professionals seem to be at increased risk for developing certain mental health problems, particularly burnout syndrome and depression, which may lead to drug abuse and suicide. Since younger age and poor professional experience may significantly contribute to development of these problems, early stage of psychiatrists' career seems to be the most critical part of their professional life. Being aware of this problem and its impact on service provision, an important initiative came from European trainees and young psychiatrists to comprehensively study this problem and offer possible solutions. That is how the Burnout International Study (BoSS) was created, aiming to search for risk factors that may endanger and/or protect mental health of psychiatric trainees. The study started in 2008 and 35 countries from all over the world have joined to participate. Our data suggests that European psychiatric trainees suffer from moderate level of burnout and that approximately 5% meet criteria for major depression. Even more serious are results that approximately 1% attempted suicide, while number of those with serious suicidal ideation goes up to 20% in some countries. Should this data worry us? Should we do something about it? The aim of this presentation is to discuss these problems and suggest solutions.

S117-3.

SETTING PRIORITIES FOR YOUNG CAREER PSYCHIATRISTS

Presenter: Joshua Blum, M.D.

SUMMARY:

Achieving a fulfilling career and personal life are goals desired by many but are unlikely to happen by chance. At the very least, one's chances are significantly increased with self knowledge and a vision of what one wants and finds meaningful. In defining goals for a job search, for example, it is important to consider the terms of the ideal job, as well as all aspects that surround it, such as its location, pay, and distance from home. One should also consider the aspects of home life that are important and how a compromise between work and nonwork can be achieved. Because mental health can be an emotionally exhausting profession, taking care of oneself in a holistic fashion is important not only for quality of life but for professional longevity. Lastly, even health can not be enjoyed if one does not have adequate time to do so, thus setting priorities entails effective time management and the ability to assertively refuse or triage requests and other demands on your time.

S117-4.

MEDICAL ERROR, COMPLAINTS AND LITIGATION

Presenter: Julian Beezhold, M.D.

SUMMARY:

Early Career Psychiatrists face many challenges along the path to a rewarding and successful career. Lessons from the past, from research and from the experience of others may be helpful in avoiding some of the consequences that follow when things go wrong. This paper presents an overview of medical error, malpractice and misconduct; and the consequences of these including complaints and litigation. It draws on experience and data from across medicine, but with a special focus on psychiatry. Human beings, including psychiatrists are inherently fallible. Yet we have to work in a system that demands perfection and is often punitive in its response to mistakes. Psychiatrists are also exposed to the risk of multiple jeopardy – a single error can result in separate investigation and sanctions from a multitude of different bodies. Successfully navigating one's way through these complex interrelated systems is a constant challenge for all Early Career Psychiatrists (and others!); whilst potentially the consequences of failure can be careerending with profound professional and personal impact. This paper examines the different but related topics of error, malpractice and misconduct by defining each one and presenting some data on incidence and cost. It goes on to provide data regarding the outcomes thereof in the form of complaints and litigation. Finally, there is a discussion on the whole way in which medical error is approached. This uses data from the airline industry and road safety, as well as from other specialties within medicine such as anaesthetics. An evidence based approach is suggested that may contribute towards minimizing the incidence and adverse effect of errors in one's personal practice.

WEDNESDAY, MAY 9, 2012

SYMPOSIUM 118

SPIRITUALLY INTEGRATED CLINICAL PSYCHIATRIC PRACTICE AND PSYCHOTHERAPY

Co-Chairs: Peter J. Verhagen, M.D., John Petzet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Explore arguments for integrating spirituality into treatment based on shared worldview, existential need, moral distress, coping and human flourishing, 2) Make use of his or her own professional background to conceptualize the religious and spiritual resources of patients which produce positive health outcomes, 3) Develop clinical reasoning to understand the person's frame of reference and to analyze the clinical relevance of religious, spiritual or anomalous experiences, 4) Develop a more open and professional stance to engaging patients on religious, spiritual and/or anomalous experiences

SUMMARY:

Although tensions between psychiatry and religion persist, interest continues to grow in the place of spirituality in mental health, clinical psychiatric practice, and by extension psychotherapy. Emerging questions include: How are psychiatrists to differentiate spiritual experiences from psychotic, dissociative and other psychopathological symptoms? Should spirituality inform the goals of treatment? Should clinicians provide spiritual care? Is it possible for clinicians to agree on a model for integrating spiritual and psychological approaches? How do these tensions look from an Islamic perspective? Based on clinical vignettes the contributors will offer four different perspectives on these questions: a psychoanalytic, a group analytic, a spiritually integrated treatment and a clinical psychiatric perspective. Participants in this session will consider whether whole person psychiatry provides a framework that can effectively accommodate other approaches (e.g. cognitive behavioral, psychodynamic, group therapeutic), and address boundary and ethical challenges.

S118-1.

ANALYZING THE CLINICAL SIGNIFICANCE OF SPIRITUAL/ANOMALOUS EXPERIENCES IN THE CLINICAL SETTING

Presenter: Alexander MoreiraAlmeida, M.D., Ph.D.

SUMMARY:

Introduction: Spiritual experiences may be confused with

psychotic and dissociative symptoms, presenting a challenge to differential diagnosis. On the other hand, psychotic patients frequently present symptomatology with religious/spiritual content. Objective: To present and discuss criteria for the differential diagnosis between spiritual/anomalous experiences and mental disorders and to show their application in clinical practice. Method: Three types of cases of patients who report spiritual experiences in the clinical setting will be presented: a) individuals with no mental disorder presenting spiritual experiences that resemble psychotic symptoms; b) patients with mental disorders whose symptoms have religious/spiritual content; c) patients with mental disorders who also have spiritual experiences resembling psychotic symptoms. Discussion will center on the clinical application of several guidelines for making the differential diagnosis between spiritual/anomalous experiences and mental disorders, and their limitations. Results: There is strong evidence that psychotic and anomalous experiences are frequent in the general population and that most of them are not related to psychotic disorders. Frequently, spiritual experiences involve nonpathological dissociative and psychotic experiences that are often related to indicators of good mental health. Some features suggest the nonpathological nature of a spiritual experience. They include: short duration, not having an unwilling character, lack of suffering, lack of social or functional impairment, compatibility with some religious tradition and recognition by others, absence of psychiatric comorbidities, control over the experience, capacity to perceive its unusual/anomalous character, and personal growth with the experience. Conclusions: It is crucial for cultural competence to understand the person's religious and spiritual frame of reference and to analyze the clinical relevance of spiritual/anomalous experiences that may resemble dissociative and psychotic symptoms. References: Lomax JW, Kripal JJ, Pargament KI. Perspectives on "sacred moments" in psychotherapy. *Am J Psychiatry.* 2011;168(1):128. Lukoff D, Lu F, Turner R. Toward a more culturally sensitive DSMIV: psychoreligious and psychospiritual problems. *J Nerv Ment Dis.* 1992;180(11):67382 MoreiraAlmeida A, Cardena E. Differential diagnosis between nonpathological psychotic and spiritual experiences and mental disorders: a co

S118-2.

ISLAMIC RELIGIOUS EXPERIENCES AND CONCEPTS IN CLINICAL PSYCHIATRIC PRACTICE
WALID SARHAN F.R.C.PSYCH.

Presenter: Walid Y. Sarhan, M.D.

SUMMARY:

Introduction: Islam is not merely a religion but a complete system of life, which is integrated in the culture and life of Muslims; consequently the concepts and religious experi-

ences are intermingled with the daily behaviors in health and sickness, in daily psychiatric practice it is important to know these concepts and experiences in order to reach the right diagnosis and psychotherapeutic approach. Method: Three cases will be presented. The first is related to guidance prayer and the Sophie school of Islam, with Generalized Anxiety Disorder and Major Depressive episode management. The second case is related to the evil eye and the black magic which interfered with the right diagnosis, a case which explores the roles of jugglers, religious scholars and spells. The third case presents the role of Jinn in Muslim patients, and how resistance to therapy can be due to certain beliefs about Jinn. Results: Understanding Islamic religion was of great importance in helping these three patients, and failing to understand it would have been an obstacle to helping them. Conclusion: The presentation of the three cases from daily busy psychiatric practice in Amman–Jordan, an Arab Muslim country shows clearly the need for mental health professionals to take into consideration the religious and spiritual background of the patient in diagnosis and management. Professionals need to know true Islamic teachings and whether or not they correspond to prevailing practices. If a professional cannot ethically treat a patient because of religious complexity, he should refer the patient to another professional, or at least seek the help of a religious scholar. References 1. Stein, M. (2011), Faith and the practicing analyst. *Journal of Analytical Psychology*, 56: 397–406. doi: 10.1111/j.14685922.2011.01916.x. 2. Magic, jinn and envy 19982011 islamweb.net. 3. Somayya Abdullah Islamic Counseling & Psychotherapy Trends in Theory Development, Zeriislam.com nukqëndrondomosdoshmërisht pas çdotekstitëautorëve – Copyright © ZeriIslam 20052009. 4. Alean AlKrenawi and John R. Graham Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings: February 2000 –national association of social workersNASW. 5. Peter J. Verhagen, Herman M. van Praag, Juan J. LópezIbor Jr., John L. Cox and Driss Moussaoui Religion and psychiatry: beyond boundaries Book World psychiatric association 2010. 6. Mawan A. Dwairy: counseling and psychotherapy with Arabs and Muslims. Publ

S118-3.

USING PSYCHOANALYTIC PERSPECTIVES TO HELP PATIENTS BENEFIT FROM SPIRITUAL AND RELIGIOUS RESOURCES

Presenter: James Lomax, M.D.

SUMMARY:

Introduction Medical health professionals often avoid discussions about religious and spiritual matters with patients because their professional formation has not helped them to connect what they have learned as professionals with

their patients' "clinical stories" about religious and spiritual experiences. This presentation provides three examples from clinical practice to illustrate how a background in psychiatry and psychoanalysis allows a practitioner to make use of such material in order to promote growth and produce healing. Method Three cases will be presented. The first case involves an experience which is emotional and evokes a religious "cognition" that is with the intellectual and educational background of the patient, but involves a "conclusion" that he is reluctant to accept. The second case is an illustration of spirituality as an attachment phenomena in which the patient's experience of an "anomalous event" is nurtured by the therapist because of its capacity to reflect spiritual connection as healthy attachmentseeking (and not psychopathology) even though the experience, itself, is anomalous and would be considered by some individuals as paranormal and by others as a possible sign of psychopathology. The third case also relates to spirituality as an attachment phenomena, but also adds the role of "sacred objects" as what William Meissner referred to as "creative illusion formation." Results The reputed clinical stories involved incremental growth and healing which can occur when a mental health professional makes use of his or her own professional background to conceptualize the religious and spiritual resources of patients which produce positive health outcomes. Conclusion These cases illustrate the way in which respectful dialogue and exchanges between mental health professionals utilizing a psychoanalytic orientation and religious and spiritual professionals (whether from pastoral or theological backgrounds) may produce powerful synergisms to improve health outcomes of patients and better interdisciplinary dialogue. References: 1. Lomax JW, Kripal JJ, and Pargament KI (2011): "Perspectives on 'Sacred Moments' in Psychotherapy." A Clinical Case Conference in *Am J Psychiatry* 168:1. 2. LoboPrabhu S and Lomax, James W. Lomax, M.D. (2010): "The Role of Spirituality in Medical School and Psychiatry Residency Education." In *Int. J. Appl. Psychoanal. Studies* 7(2):180192. 3. Meissner WW (1984): Chapter 7

S118-4.

SPIRITUALLY INTEGRATED PSYCHOTHERAPY

Presenter: John Peteet, M.D.

SUMMARY:

Introduction Tensions between psychiatry and religion persist, but interest continues to grow in the place of spirituality in mental health, and in psychotherapy. Clinicians lack clear conceptual and practical guidelines for approaching patients' spiritual concerns. Methods Four potential approaches to spiritual concerns in psychotherapy are to: (1) acknowledge the problem, but limit discussion to its medical/psychological dimension; (2) clarify the spiritual

as well as the psychological aspects of the problem, suggesting resources for dealing with the former, and considering working with an outside resource; (3) address the problem using the patient's own philosophy of life; and (4) address the problem using a shared perspective on life. Casespecific factors relevant to choosing an approach include clinical, therapistrelated, boundary, transference/countertransference and ethical considerations. More general considerations include: Should spirituality inform the goals of treatment? Should clinicians provide spiritual care? Is it possible for clinicians to agree on a model for integrating spiritual and psychological approaches? Results Participants will explore arguments for integrating spirituality into treatment based on shared worldview (Bergin), existential need (Griffith), moral distress (forgiveness promoting, 12 Step), coping (Pargament), and human flourishing (Cloninger), and the application of a spiritually integrated approach to a clinical case. Conclusion Whole person psychiatry provides a framework that can both accommodate other approaches (e.g. psychodynamic, and cognitive behavioral), and address the boundary and ethical issues involved. References Peteet JR. Approaching spiritual issues in psychotherapy: a conceptual framework. *J Psychotherapy Pract Res* 1994;3:237245 Peteet JR. Depression and the Soul. A Guide to Spiritually Integrated Treatment. New York, Routledge. 2010

S118-5.

USING GROUP ANALYTIC PERSPECTIVES TO HELP PATIENTS DISCOVER SPIRITUAL RELATIONSHIPS

Presenter: Peter J. Verhagen, M.D.

SUMMARY:

Introduction Integrating spirituality and religion into mental health care, psychiatry and psychotherapy is still controversial. The role of spirituality in group psychotherapy was until recently virtually ignored. Method Group psychotherapy/group analysis use important frameworks with which we can learn to "see" what is happening on a spiritual level. Although religious, spiritual or anomalous experiences happen to individuals, these belong to and are members of a larger transpersonal network, which a group is equipped to study. Cases will be presented in order to explain the concept of the so-called "invisible group". Another helpful tool will be introduced also: individuals and communities tend to perceive their spiritual relationships as analogous to the various human relationships with which they are familiar. This notion provides an important aid for understanding the structure of different basic forms of spirituality. Looking at spirituality in that way we can discover inherent opportunities for therapeutic progress. The cases will also illustrate this recognizable aspect of spirituality. Results Participants will recognize the importance of the two tools presented

and illustrated and gain some understanding of the dynamics of spirituality in group psychotherapy. This might stimulate psychiatrists and psychotherapists to develop a more open professional stance when engaging patients on religious, spiritual and/or anomalous experiences. Conclusion Without an adequate framework we can keep spiritual experiences to ourselves, try to share them with others who may share with us their similar experiences, or we push them to the back of our minds. However, if the experience is important it is urgent to find a frame of reference for dealing with it. Group psychotherapy/group analysis offer such a framework. In general, studies clearly indicate that outcomes can be enhanced by integrating spiritual/religious elements into therapy, and that this can be done by religious and nonreligious therapists alike. The growing appreciation for the clinical importance of religion/spirituality in psychiatry and psychotherapy requires continued examination and research. Careful and thoughtful clinical case description is of utmost importance to stimulate this trend. References Hefti R. (2011). Integrating religion and spirituality into mental health care, psychiatry and psychotherapy. *Religions*; doi: 10.3390/rel20x000x. Schermer, VL (2006). *Spiritu*

SYMPOSIUM 119

TRANSLATIONAL RESEARCH ON MOOD DISORDERS: A PRIMER FOR THE CLINICIAN

Co-Chairs: Jair C. Soares, M.D., Julio Licinio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand emerging findings related to brain abnormalities involved in major depression, 2) Understand emerging findings related to genes involved in treatment response in major depression., 3) Understand emerging findings related to brain abnormalities involved in pediatric bipolar disorder, 4) Understand emerging findings related to brain and neurocognitive abnormalities in bipolar disorder with a focus on frontolimbic brain changes, and 5) Understand emerging findings related to oxidative stress and neuronal resilience as mechanisms involved in mood disorders

SUMMARY:

Mood disorders are increasingly being recognized as brain diseases. Translational research conducted over the past decade has started to shed light on specific mechanisms involved. This research cuts across the age spectrum with findings suggestive that abnormalities in frontolimbic brain regions are already identifiable early in illness course, including in children and adolescents who develop these conditions. This symposium will include leading clinician scientists working on mood disorders research who will

review emerging findings in their respective areas. We will discuss findings on major depression and bipolar disorder, with a focus on neuroimaging, neurocognitive and genetics research. We will also discuss a model that proposes that oxidative stress and abnormalities in neuronal resilience are key mechanisms involved in causation of brain abnormalities that have been identified in these illnesses.

S119-1.

DECONSTRUCTING MOOD AND ANXIETY DISORDERS: TOWARDS A BRAIN CIRCUITRY IMAGING CLASSIFICATION

Presenter: Yvette I. Sheline, M.D.

SUMMARY:

Background: An important NIMH objective is the creation of dimensional approaches to psychiatric diagnosis. Findings from neuroimaging studies that focus on disruptions in important brain circuits across individuals with both unipolar major depression and PTSD will be presented to probe the question of crosscutting neural system impairments. In studies of both depression and PTSD, disturbances of affect, cognitive control and emotional regulation have been found, however the extent to which there may be common disturbances in brain circuitry is not known. Methods: 75 individuals with PTSD, MDD and controls were studied using emotional conflict paradigms during fMRI neuroimaging sessions. In addition resting state BOLD data were acquired. All participants underwent assessment of depressive and anxiety symptoms and ascertainment of stress measures. Results: In resting state data both depressed and PTSD participants had increased connectivity of three networks to the same hub, the bilateral dorsal medial prefrontal cortex region, an area we term the dorsal nexus. In addition both depressed and controls had decreased connectivity of the amygdala with the anterior cingulate cortex. Further, in conflict paradigms there were a number of important similarities as well as differences in patterns of activation. Preliminary studies contrasting antidepressant and cognitive behavioral therapy effects on neurocircuitry will be presented. Conclusions: Similar patterns of dysfunction in brain activation and in disrupted patterns of connectivity may help to explain similarities in symptoms that are shared in these disorders. In particular both depression and PTSD may result in decreased ability to focus on cognitive tasks, rumination, excessive selffocus, increased vigilance and emotional, visceral and autonomic dysregulation.

S119-2.

GENETICS OF BIPOLAR AND UNIPOLAR DISORDERS

Presenter: Wade H Berrettini, M.D., Ph.D.

SUMMARY:

This presentation reviews some aspects of the genetic risks for bipolar disorders (BPD) and recurrent unipolar disorders (RUP). The inherited susceptibilities for BP and RUP are explained by dozens to hundreds of common alleles of small effect and by an untold number of rare alleles of both small and large effect, regions are reviewed, including some which may be shared with schizophrenia. These results suggest that nosology must be changed to reflect the genetic origins of the multiple disorders which are collectively described by the terms, BPD and RUP. The genome wide association study (GWAS) results for BPD implicate common alleles of small effect in several genes, including ankyrin 3 (ANK3), an Ltype calcium channel subunit (CACNA1c), spectrin repeat containing, nuclear envelope 1 (SYNE1), and Oz/tenm homolog 4 (ODZ4), among others. There is evidence that susceptibility to schizophrenia may be mediated by some ANK3 and CACNA1c alleles, suggesting that nosology must be reconsidered. The RUP GWAS results have been characterized by smaller sample sizes, but alleles in the piccolo (PCLO) gene have been implicated in both RUP and BPD phenotypes.

S119-3.

THE NEUROBIOLOGY OF CHILDREN AND ADOLESCENTS WITH AND AT RISK FOR DEVELOPING BIPOLAR DISORDER

Presenter: Melissa DelBello, M.D.

SUMMARY:

Objective: To examine findings from recent neuroimaging studies of adolescents with and at high risk for developing bipolar disorder (BP) in order to identify neural substrates underlying adolescent BP as well as neural markers of illness development and treatment response. Methods: We will review structural and functional magnetic resonance imaging (sMRI and fMRI) and MR spectroscopy (MRS) studies of adolescents with and at familial risk for BP and compare findings with those reported in BP adults. Results: BP adolescents exhibit structural and functional abnormalities in the striatum, amygdala, and ventral prefrontal regions. Specifically, in contrast to BP adults, BP adolescents have smaller amygdala volumes. Additionally, alterations in ventral prefrontal cortical development and in prefrontal-amygdala connections are present in BP adolescents. MRS studies reveal abnormalities in markers of neuronal integrity and membrane metabolism in the cerebellum and prefrontal cortex of adolescents at risk for BP. Findings from studies also suggest that medications may minimize these abnormalities. Conclusion: Structural, functional and neu-

rochemical abnormalities in the ventral lateral prefrontal cortex, amygdala, striatum, and cerebellar vermis are present in BP adolescents and may represent neurobiological predictors of illness development and treatment response.

S119-4.

NEUROIMAGING AND NEUROCOGNITIVE FINDINGS IN BIPOLAR DISORDER

Presenter: Jair C. Soares, M.D.

SUMMARY:

This presentation will focus on results of recent neuroimaging and neurocognitive studies with adult bipolar disorder patients that indicate key abnormalities in frontolimbic brain regions. These emerging findings are likely to be key pathophysiology mechanisms involved in the disorder.

S119-5.

MITOCHONDRIA AND ENERGY METABOLISM IN MOOD DISORDERS AND THEIR TREATMENT

Presenter: L. Trevor Young, M.D., Ph.D.

SUMMARY:

Changes in energy are a core feature of mood disorders with increased energy and goal directed activity in mania and anergia and psychomotor retardation in depression. Molecular and genetic approaches have now identified that fundamental components of the cellular energy system, particularly the mitochondria, may be central to the pathophysiology of bipolar disorder and its treatment. In this presentation, the literature which supports alterations in mitochondrial will be reviewed examining findings from postmortem brain, peripheral blood cells and in relevant animal studies. In particular, the pattern of decreased function of part of the electron transport chain, complex I, will be explored which leads to increased oxidative stress and free radicals which can damage cellular DNA and protein and ultimately lead to cell death. More recent findings suggest that oxidative damage may be particularly marked to synaptic proteins which might help to understand the changes in monoaminergic systems, like dopamine, which are known to be important in mania and depression. Not only have mitochondrial changes been found in bipolar disorder but this is an area of active research in autism and also movement disorders. Several treatments which enhance the brain antioxidant system are under intensive study and there are already some positive studies on the efficacy of these agents as mood stabilizers. The presentation should help to enhance participant's understanding of the current research in the biological causes of mood disorders and also identify potential novel treatment approaches.

SYMPOSIUM 120

PSYCHOSOMATIC MEDICINE: TOPICS ACROSS THE ADULT LIFESPAN

Chair: Susan HattersFriedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Identify key psychosomatic medicine issues in patients across the adult life span, 2) List critical treatment considerations in treatment of pregnant and postpartum women with mental illness, 3) Integrate key cardiac issues in a clinical psychiatric practice, 4) Explain diagnostic and treatment considerations in delirium

SUMMARY:

Presenters will review basic concepts in CL Psychiatry as well as presenting advanced concepts and updates regarding four critical topics within adult psychosomatic medicine, specifically Perinatal Psychiatry, PsychoOncology, Cardiac, and Delirium. Dr. Friedman will discuss guiding principles in the treatment of mental illness in women during pregnancy and the postpartum period. Dr. Schuermeyer will then review the impact of psychiatric comorbidities of anxiety and depression in patients undergoing cancer treatment. Dr. Jain will discuss recent developments at the intersection of cardiology and psychiatry. Dr. Lackamp will discuss the often difficult diagnosis of delirium and treatment paradigms. The CL psychiatrist has an important role throughout many different hospital departments, throughout the adult life cycle, and practice in these four areas will be reviewed in detail.

S120-1.

PRINCIPLES OF PERINATAL PSYCHIATRY AND NOVEL TREATMENT OPTIONS

Presenter: Susan HattersFriedman, M.D.

SUMMARY:

The objectives include: to discuss guiding principles of treatment of mental disorders in pregnancy and the postpartum period, review recent findings, and describe novel treatment programs for these disorders, in which rational patients may refuse medications. Major principles of diagnosis and treatment within perinatal psychiatry will be reviewed. Novel therapies and programs will be discussed based on literature and recent work. The treatment of mental illness during pregnancy and the postpartum period requires careful consideration of risks and benefits of treatment modalities, along with understanding of potentially significant risks of untreated mental illness. General

guidelines for treatment will be discussed and illustrative cases presented. Specific diagnoses, including depression in pregnancy and the postpartum, bipolar disorder and postpartum psychosis, schizophrenia, and anxiety disorders will be discussed. Psychotherapy is an important component of treatment, especially in consideration of the desire to expose the fetus or breastfed infant to the lowest effective medication dose. Alternate therapies such as light therapy and music therapy will also be discussed. An innovative psychosomatic program in the Neonatal Intensive Care Unit will be described, which allows for significant liaison, and sheds further light on problems encountered by these mothers. Perinatal mental health treatment modalities fall within the purview of the CL psychiatrist. The overarching principals of risk/benefit decision making, violence/suicide risk management, and appropriate utilization of psychotherapy remain critical. At the conclusion of this session, the participant should be able to: discuss treatment options for various mental illnesses in pregnancy and the postpartum; and explain diagnostic clues in complicated perinatal psychiatric disorders.

S120-2.

INTEGRATED CARE WITHIN PSYCHOONCOLOGY

Presenter: Isabel N. Schuermeyer, M.D.

SUMMARY:

The field of PsychoOncology has had significant growth since its development. It has been established that cancer patients have higher rates of depression and anxiety. If left untreated, there is a clear impact to their quality of life and cancer course. These patients that also suffer from depression have less pain tolerance, longer hospital stays and worse adherence to their cancer treatment compared to nondepressed cancer patients. Various interventions have been studied to treat depression and anxiety in this population and there is good evidence of effective treatments. Unfortunately, without integrated care, these patients are often under treated. The barriers to treatment can include patient reluctance to seek treatment, lack of screening for depression and lack of knowledge regarding management of cooccurring mental illness. Further, clinicians need to be cautious regarding the potential for drug/drug interactions in choosing antidepressants. With the improvement in cancer treatments, patients are living longer and cancer has become a chronic illness. The psychiatric illnesses found in cancer survivors have been an area of recent research, which emphasis on the posttraumatic stress found in this population. Integrated care is essential in screening, diagnosis and treatment for these patients, as it is believed that this posttraumatic stress will be a more common phenomenon as more patients survive cancer. In addition, there is concern that this could prevent patients from adhering to follow up

recommendations. During this portion of the symposium, the diagnosis and treatment of depression and anxiety in cancer patients will be reviewed, including the potential for drug/drug interactions where clinicians need to be more cautious in medication choices. Integrated care models that have been used in cancer care will also be discussed.

S120-3.

GETTING TO THE HEART OF THE MATTER

Presenter: Abhishek Jain, M.D.

SUMMARY:

To summarize recent studies, current findings, and ongoing research involving cardiovascular issues as they relate to day-to-day psychiatric care. We will review the latest literature at the intersection of cardiology and psychiatry, including important topics such as QTC prolongation, cardiac risk factors, cardiac monitoring guidelines, and treatments considerations in psychiatric patients. We will discuss the practical incorporation of these issues in a psychiatric practice. The overlap between psychiatric treatment and cardiac issues has raised concerns, questions, and confusion, especially over the recent years. Synthesizing the most up-to-date information, applying the data to clinical vignettes, and welcoming audience input provides a practical framework for approaching the challenging cardiology/psychiatry interaction. Reviewing the complicated relationship between cardiac and psychiatric issues will help clinicians deliver evidence-based care, provide a framework to educate our nonpsychiatrist colleagues, and inform patients. The participant should be able to: 1) discuss the latest literature overlapping cardiac and psychiatric issues, and 2) have a framework to incorporate the latest literature into clinical practice.

S120-4.

DELIRIUM IN THE GENERAL MEDICAL HOSPITAL: RECOGNITION, EVALUATION, AND TREATMENT

Presenter: Jeanne M. Lackamp, M.D.

SUMMARY:

Delirium (alternatively described as “encephalopathy” or “acute mental status changes”) is one of the most common causes of psychiatric consultations in both academic and community inpatient settings. An important but often overlooked diagnosis, delirium represents an urgent medical/psychiatric challenge which requires swift intervention. Delirium can impact a patient’s immediate health status and complications, length of hospital stay, and long-term morbidity/mortality. Causes of delirium are numerous, but typically include infections, metabolic derangements, medi-

cation effects (particularly with regard to polypharmacy and drugdrug interactions), and withdrawal phenomena. This portion of the symposium will focus on delirium recognition and evaluation, as well as current practice guidelines regarding use of medications in treating delirious patients.

SYMPOSIUM 121

ALZHEIMER'S DISEASE AND OTHER DEMENTIAS: HOPE THROUGH THE NEW RESEARCH

Co-Chairs: Ruby C CastillaPuentes, M.D., D.P.H., Allitia DiBernardo, M.D.

Discussant: Alejandra L. Leon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) To recognize the importance of an early and accurate diagnosis to improve prognosis and treatment outcomes in patients with AD and other dementias, 2) To evaluate the new approaches in the treatment of neuropsychiatric symptoms of dementia, 3) To understand the new neurophysiologic findings in patients with AD, 4) To review the challenges in the diagnostic of dementia and pseudodementia, and 5) To evaluate epidemiological data comparing AD with other types of dementia (e.g. vascular dementia)

SUMMARY:

Potential causes of dementia are too numerous. Improving early diagnosis of AD and other types of dementia is important not only for patients and families, but also for researchers who seek to better understand the causes of dementia and find ways to reverse or halt them at early stages. Improved diagnosis can also reduce the risk that people will receive inappropriate treatments. Research in the last 20 years has led to a greatly improved understanding of what dementia is, who gets it, and how it develops and affects the brain. This new research hope to improve the lives of people affected by the dementias and may eventually lead to ways of preventing or curing these disorders. While the search for diseasemodifying therapies continues, the speed and accuracy of diagnosis at the foundation of patientcentred care is of equal importance. Earlier and more accurate diagnosis, detecting disease progression and the pursuit of optimal therapeutic management are key areas where solutions are being pursued. To effectively address complex pathology of AD and other dementias, new multimodal approaches are increasingly tested in preclinical and clinical settings. The symposium offers an overview of current development in this promising therapeutic field. Approaches to the datadriven development of treatments across the AD continuum will be presented. The emerging evidence on AD biomarkers and the evolving clinical criteria will be

discussed.

S121-1.

APATHY IN THE DEMENTED PATIENT: IDENTIFICATION AND MANAGEMENT

Presenter: Bernardo Ng, M.D.

SUMMARY:

BACKGROUND: Apathy is a common but not exclusive neuropsychiatric manifestation of dementia. It is associated with reduced functional level, decreased response to treatment, poor illness outcome, caregiver distress/frustration, and chronicity. It is as well, unfortunately under recognized and undertreated in the demented patient. **METHODOLOGY:** For this symposium published evidence in pathophysiology, identification and management of apathy was reviewed. Also, clinical evidence of treatment response to management of dementia patients with apathy at our center was reviewed. **RESULTS:** Although existing evidence is not scientifically robust, there are numerous publications in the subject First; there is supportive evidence of the hypothesis that apathy is the behavioral manifestation of a frontal subcortical circuit syndrome. Second, the clinical manifestations of the apathy, can be operationally defined as affective (lacking in emotions), behavioral (inactive, chores abandoned), or cognitive (no interest in the activities of others). Fourth, there are both pharmacological and nonpharmacological measures to manage apathy. A review of a case series of patients treated at our geriatric center will be presented. **DISCUSSION:** Apathy is usually related to changes in affect, behavior, and cognition. It is associated with behaviors that have previously been shown to affect patient safety, independence, and quality of life; with concomitant impact in the caregiver. Clinicians dedicated to the care of dementia patients, have to keep in mind that based on the limited published evidence, it is hard to generalize the findings, and therefore need to be creative in 1) early identification of apathy in older patients and particularly in those with cognitive deficit and dementia, 2) apply treatment initiatives available in the literature, and 3) when the patient is not responding adequately be open to other treatment options. Roth RM, Flashman LA, McAllister TW. Apathy and its treatment. *Curr Treat Options Neurol.* 2007 Sep;9(5):36370. van Reekum R, Stuss DT, Ostrander L. Apathy: why care? *J Neuropsychiatry Clin Neurosci.* 2005 Winter;17(1):719.

S121-2.

NOVEL COMPOSITE ENDPOINTS FOR IMPROVED SENSITIVITY IN MILD COGNITIVE IMPAIRMENT (MCI) TRIALS

Presenter: Allitia DiBernardo, M.D.

SUMMARY:

Background: Scientific advances in understanding the characteristics of the normal aging process the factors that contribute to optimal aging, and the pathological conditions that occur with increasing age, such as dementia, have resulted in a medical initiative towards the therapeutic interventions. Objective: One of the challenges for clinical investigators is to clearly distinguish between benign forms of cognitive dysfunction associated with increasing age and cognitive decline associated with incipient dementing disease (known as mild cognitive impairment (MCI)) and is hypothetically an important treatment target in order to delay progression to dementia. The amnesic subtype of MCI is of particular interest because these individuals most likely progress to Alzheimer's disease (AD). Methods: Currently hypothesised therapeutic approaches in MCI are mainly based on AD treatment strategies. Long term secondary prevention randomised clinical trials have been completed in amnesic MCI populations, encompassing agents with various mechanisms of action. Results: The design of clinical trials in MCI is influenced by study objectives and definition of primary end points: time to clinical diagnosis of dementia, and AD in particular, or symptom progression. Design of future clinical trials in MCI should be further developed particularly as regards the selection of more homogeneous samples at entry, optimal treatment duration, and multidimensional and reliable outcomes. Conclusion: Novel composite endpoints for improved sensitivity in MCI trials will be discussed in this presentation.

S121-3.**IS IT DEMENTIA OR DEPRESSION? ALZHEIMER'S DISEASE VERSUS DEPRESSIVE PSEUDODEMENTIA**

Presenter: Jose L. Ayuso, M.D., Ph.D.

SUMMARY:

Early Alzheimer's disease (AD) and depressive Pseudodementia share many symptoms, so it can be difficult to distinguish between the two disorders. Estimates suggest that between 2% and 32% of older individuals who experience cognitive problems actually have pseudodementia. However, this number may not be completely accurate, because it is often difficult to distinguish between depression and dementia in older adults. A thorough clinical interview can reveal important clues about the proper diagnosis. Although pseudodementia is reversible, treating it can be as complex as treating AD, requiring a flexible approach and multiple treatment modalities (e.g., medication, psychotherapy, or a combination of both). Both medications and psychotherapy techniques may require several weeks before providing a noticeable decrease in symptoms. Recent findings indicating that depression is a risk factor for AD have

raised the possibility that depression treatment may lead to prevention of cognitive decline and dementia. This presentation will review the clinical picture of both conditions and summarize the available evidence regarding the association between depression and AD dementia. Specific recommendations also are made regarding studies needed to advance research in this area.

S121-4.**IS DEPRESSION DIFFERENT AMONG PATIENTS WITH ALZHEIMER'S DISEASE AND VASCULAR DEMENTIA?**

Presenter: Ruby C CastillaPuentes, M.D., D.P.H.

SUMMARY:

Background: Alzheimer's disease (AD) and vascular dementia (VaD), are entities which together account for approximately 80% of dementias. Limited information exists on the potential differences in the subtype of depression between both conditions. Objective: To compare the subtypes of depression between patients with VaD and AD. Methods: Using the Integrated Healthcare Information Services (IHCIS) database, analysis was conducted on 3,672 patients 60 years or older with dementia identified from January 1st to December 31, 2001. Dementia subgroups (VaD and AD) and depression were defined using ICD9 criteria. Demographics variables and types of depression in the year of followup were compared between patients with AD and VaD. Results: Included were 725 patients with VaD and 2,947 patients with AD. Overall the VaD group (44.14%), exhibited significantly higher prevalence of depressive disorders, compared with the the AD group (18.53%; $\chi^2=210.321$; $p<0.0001$). Similarly patients with VaD, exhibited significant higher prevalence in the following subtypes of depression: Major depressive disorder recurrent episode (13.8% vs 5.0%, $\chi^2=68.9$, $df=1$, $p<0.0001$); Dysthymic disorder (3.8% vs 1.9%, $\chi^2=8.6$, $df=1$, $p=0.003$); Adjustment disorder, depressive (1.8% vs 0.7%, $\chi^2=4.8$, $df=1$, $p=0.028$); and Depressive disorder, not otherwise specified (22.6% vs 12.2%, $\chi^2=45.9$, $df=1$, $p<0.0001$). The prevalence of the depression coded as Depressive Psychosis (using ICD9 criteria), had the lowest prevalence and did not differ between the two groups (less than 1% in both groups; $\chi^2=0.07$, $df=1$, $p=0.93$). Conclusions: These results confirm that compared with AD, patients with VaD have greater prevalence of depression. Subtypes of depression, MDD, depressive disorder, NOS, dysthymia and adjustment disorder with depressive features are also more frequent in VaD. This study highlights the need to refine diagnostic of depression in dementia patients. Rigorous assessment of psychiatric symptoms in VaD and AD should be part of good clinical practice.

S121-5.

MANAGEMENT OF BEHAVIORAL SYMPTOMS IN ELDERLY PEOPLE WITH OR WITHOUT DEMENTIA

Presenter: Carlos A. LeonAndrade, M.D.

SUMMARY:

Objective: To review treatment of behavioural symptoms in Elderly population with and without dementia. **Methods:** Review of bibliography of recent review papers and original articles. **Results:** This review discusses alternatives to drugs, indications for appropriate use of drugs, frequently encountered side effects of drugs, and considerations for those with neuroleptic sensitivity. An approach that employs a combination of environmental, and pharmacologic interventions to address disruptive behaviour in Elderly people with and without dementia. **Conclusion:** Optimal treatment of behavioural disturbances in patients with or without dementia involves nonpharmacologic approaches and using medications with demonstrated efficacy. Pharmacologic treatment should target only those symptoms or behaviours that respond to medication. This approach minimizes excessive medication use and reduces adverse outcomes.

SYMPOSIUM 122

THE COST AND QUALITY OF CARE PROVIDED TO VETERANS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Chair: Katherine E. Watkins, M.D.

Discussant: Harold A. Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the quality of care provided to veterans with mental health disorders, 2) Describe the quality of care provided to veterans with substance use disorders, 3) Describe variations in care provided to veterans with mental health and substance use disorders

SUMMARY:

Objective: This symposium will describe the results of a 4 year externally conducted evaluation of the mental health and substance abuse treatment services provided by Veterans Administration (VA) in terms of patient characteristics, costs, quality and variations in care. **Method:** We conducted a comprehensive, national evaluation of VA services provided to veterans who received care for any of the five following diagnoses: schizophrenia, bipolar disorder, post traumatic stress disorder, major depressive disorder, and substance use disorder. We used administrative data to understand characteristics and costs for all veterans who received services in 2007 for at least one of the five diagno-

ses (N=836,699). We used medical record data to evaluate the quality of care for a stratified random sample of 7,069 veterans by applying 50 performance measures. Finally, we conducted a national telephone survey of 6,190 veterans to assess perceptions of care. **Findings:** The number of veterans with any of the 5 conditions, and the costs per veteran, increased from FY2004 to FY2008. The quality of care reflected in the performance measures varied considerably across measures and by veteran characteristics. **Conclusions:** Veterans with mental and substance use disorders account for a larger proportion of healthcare utilization and costs than their representation among all veterans receiving VA health care. The proportion of veterans receiving recommended care ranges widely and varies by geographic location and patient characteristics. Areas for quality improvement will be highlighted. **Funding:** U.S. Department of Veterans Affairs

S122-1.

THE QUALITY OF CARE PROVIDED TO VETERANS WITH SUBSTANCE USE DISORDERS

Presenter: Katherine E. Watkins, M.D.

SUMMARY:

Context Substance use disorders are highly prevalent in veterans, and improving their quality of care is a national priority. Prior studies of quality are limited in scope and approach. **Objective** To report on the quality of substance use care provided by the Veterans Administration (VA) to all veterans with substance use disorders. **Design** Analyses of VA administrative and medical record data. **Setting** All VA facilities. **Patients** All veterans (N=344,866) who received services in 2007 for treatment for a substance use disorder, and a stratified random sample of 2,144 veterans whose medical records were reviewed. **Results** The proportion of veterans receiving recommended care varied widely, from a high of 82% for proportion assessed for suicide ideation, to a low of 16% for pharmacotherapy for alcohol dependence. In general, individuals with substance use disorders were more likely to receive recommended care compared to individuals without substance use disorders. **Conclusions** Increased efforts are needed to improve the efficiency and quality of care for veterans with substance use disorders.

S122-2.

THE QUALITY AND COSTS OF CARE PROVIDED TO VETERANS WITH MENTAL HEALTH DISORDERS

Presenter: Carrie M. Farmer, Ph.D.

SUMMARY:

Background: Mental health disorders are highly prevalent

in veterans, and improving their quality of care is a national priority. Prior studies of quality are limited in scope and approach. This presentation will report the quality and cost of mental health care provided by the Veterans Health Administration (VHA) to all veterans with schizophrenia, bipolar I disorder, post traumatic stress disorder (PTSD), and major depressive disorder (MDD). Design: We used administrative data to understand characteristics and costs for all veterans who received services in 2007 for schizophrenia, bipolar I disorder, PTSD, major depressive disorder, or substance use disorder (N=836,699), and used medical record and administrative data to evaluate the quality of care for a stratified random sample of 7,069 veterans by applying 50 performance measures. This presentation will focus on findings related to schizophrenia, bipolar I disorder, PTSD, and MDD. Results: The number of veterans with any of the 4 mental health disorders, and the costs per veteran, increased from FY2004 to FY2008. In FY2008, these veterans represented approximately 3.8% of all living veterans, but 16.5% of veterans who used the VA, and consumed 34.4% of VA health care spending. The quality of care reflected in the performance measures varied considerably across measures. For example, while 82% of veterans were assessed for suicidal ideation, only 23% of veterans receiving psychotherapy were assessed for response to treatment. Rates of receipt of evidencebased treatments were also mixed: among those in psychotherapy, 30% received cognitive behavioral therapy, while less than onethird of veterans identified with schizophrenia or bipolar disorder received continuous maintenance treatment with antipsychotics or mood stabilizers. Conclusions: Veterans with mental health disorders account for a larger proportion of healthcare utilization and costs than their representation among all veterans receiving VA health care. The proportion of veterans receiving recommended care ranges widely. Areas for quality improvement will be highlighted.

S122-3.

VARIATIONS IN QUALITY OF VHA CARE FOR MENTALLY ILL VETERANS

Presenter: Marcela HorvitzLennon, M.D., M.P.H.

SUMMARY:

Objective: To report on regional and other variations in the quality of mental and substanceuse care provided by the Veterans Administration (VA) to all veterans with schizophrenia, bipolar I disorder, stress disorder, major depression, and substanceuse disorders. Method: Data sources were administrative data for all veterans (N=836,699) who received services in 2007 for treatment of at least one of the five diagnoses, a stratified random sample of 7,069 veterans whose medical records were reviewed, and survey data from a national telephone survey of 6,190 veterans. Outcome

measures were performance measures reflecting receipt of recommended processes of care. We assessed variations by geographic region (Veterans Integrated Service Networks: VISNs), age and sex. We used generalized linear mixed models to compare rates across VISNs. Findings: Although no VISN consistently performed above or below the network average, we observed variations across VISNs. Indicators with the largest variation by VISN were housing and employment assessment (26 percentage points), Intensive Case Management (21 percentage points) and 7day followup after inpatient hospitalization (23 percentage points). We also found variations by veteran demographic characteristics. Conclusions: The quality of VA mental health care varies across several domains. Further investigation to understand the sources of observed variations is warranted. Funding: U.S. Department of Veterans Affairs

SYMPOSIUM 123

POLICE ENCOUNTERS WITH INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES

Chair: Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Describe the key characteristics of the Crisis Intervention Team program, 2) Summarize recent research findings on use of force directed toward individuals with serious mental illnesses, 3) List three favorable outcomes associated with perceived procedural justice in police encounters, 4) Describe five clinical features of the excited delirium syndrome

SUMMARY:

This session will provide psychiatrists with an overview of recent research and developments pertaining to the all-toofrequent interactions between law enforcement officers and individuals with serious mental illnesses. Police officers are often first responders to emergency calls involving mental health crises, and at least 10% of all police contacts involve persons with mental illnesses (with officers providing up to onethird of emergency mental health referrals). Thus, police officers often serve as de facto mental health professionals making decisions about referral to mental health services v. arrest v. other discretionary decisions. In doing so, officers are gatekeepers to both the justice and psychiatric systems. Despite this psychiatrictriage role, officers receive very little training on mental illnesses; in fact, they want more training and find the topic very important to their work. To improve officers' responses to individuals with serious mental illnesses, the Crisis Intervention Team (CIT) program was developed in 1988 in Memphis. This program equips police officers with knowledge, attitudes,

and skills to enhance responses to people with serious mental illnesses. CIT gives select officers 40 hours of specialized training provided by police trainers, local mental health professionals, family advocates, and consumers. Officers are then specialized, firstline responders for calls involving persons in crisis. CIT also supports partnerships between psychiatric emergency services and police departments, encouraging treatment rather than jail when appropriate. A primary goal of CIT is increased safety for all involved in the encounter. The limited evidence to date suggests that this policebased program may result in less use of force and presumably fewer injuries. Recent research findings on use of force in encounters with persons with mental illnesses will also be presented. While use of force is considered an undesired outcome of police encounters, perceived procedural justice, on the other hand, is a favorable outcome. Perceived procedural justice (PPJ) in mental health courts appears to be related to lower criminal recidivism and more positive emotional reactions, and PPJ in involuntary commitments may minimize perceptions of coercion. In police encounters, individuals with mental illnesses that experience greater PPJ report more cooperation in the encounter and with the law since the encounter. Another key topic pertaining to police encounters with individuals with mental illnesses and/or substance use disorders is an increasingly recognized syndrome of extreme agitation. Specifically, the excited delirium syndrome, which is widely recognized in many police jurisdictions, and in the emergency medicine field, will be described as it may characterize some police encounters with persons with serious mental illnesses and/or stimulant intoxication.

S123-1.

THE CRISIS INTERVENTION TEAM MODEL

Presenter: Beth Broussard, M.P.H.

SUMMARY:

The widely disseminated Memphis model of the Crisis Intervention Team (CIT) program, which strives to improve officer and patient safety, enhance access to mental health services, and promote treatment instead of incarceration when appropriate, thereby improving health outcomes, has quickly become an internationally recognized prebooking jail diversion model. This presentation will give an overview of the CIT program by examining its 40hour training component for officers and summarizing its core elements. The presentation will also review preliminary research on officer, subject, and communitylevel effects of CIT, which provide preliminary support for this important collaboration between law enforcement, mental health, and advocacy.

S123-2.

USE OF FORCE IN POLICE INTERACTIONS WITH CONSUMERS

Presenter: Michael T. Compton, M.D., M.P.H.

SUMMARY:

Background: Few studies have examined police officers' use of force toward individuals with schizophrenia, despite the widely disseminated Crisis Intervention Team (CIT) model of partnership between mental health and law enforcement that seeks to reduce use of force and enhance safety of officers and individuals with mental illnesses. This study tested the hypotheses that CITtrained officers would select a lower level of force, identify nonphysical actions as more effective, and perceive physical force as less effective in an escalating psychiatric crisis, compared with non-CITtrained officers. Methods: Police officers (n=135)—48 CIT trained and 87 non-CIT trained— completed a survey containing 3 scenariobased vignettes depicting an escalating situation involving a subject with psychosis. Data were analyzed using repeatedmeasures analyses of variance. Results: Officers escalated their preferred actions across the scenarios. A significant scenario by group interaction indicated that CITtrained officers chose less escalation (ie, opting for less force at the third scenario) than nonCITtrained officers. Officers reported decreasing perceived effectiveness of nonphysical action across the 3 scenarios. A significant scenario by group interaction indicated that CITtrained officers reported a lesser decline in perceived effectiveness of nonphysical actions at the third scenario. CITtrained officers consistently endorsed lower perceived effectiveness of physical force. Conclusions: Efforts are needed to reduce use of force toward individuals with psychotic disorders. These findings suggest that CIT may be an effective approach. In addition to clinical and programmatic implications, such findings demonstrate a role for clinicians, advocates, and schizophrenia researchers in promoting social justice through partnerships with diverse social sectors.

S123-3.

PERCEIVED PROCEDURAL JUSTICE, EMOTIONAL EXPERIENCE AND COOPERATION/RESISTANCE IN ENCOUNTERS BETWEEN POLICE AND PERSONS WITH MENTAL ILLNESSES

Presenter: Amy C. Watson, Ph.D.

SUMMARY:

There is growing attention to the frequency with which police officers respond to situations involving persons with mental illness and efforts to improve their ability to safely and effectively deescalate resolve encounters. Despite its obvious value to developing strategies to improve police re-

sponse, there has been scant attention to the experiences of persons with mental illnesses in these encounters. The procedural justice framework provides a lens through which we can gain a better understanding of how persons with mental illnesses experience police behaviors and how this shapes cooperation and resistance in the immediate encounter and over time. In this paper, we describe findings from a study that focused on the experiences of persons with mental illness, specifically examining the role of perceptions of procedural justice on emotional experience and cooperation/resistance. Implications for models of police response will be discussed.

S123-4.

THE EXCITED DELIRIUM SYNDROME

Presenter: James Roberts, M.D.

SUMMARY:

Uncontrollable and violent aggressive behavior can be caused by a number of medical or psychiatric conditions or can be drug induced. This has been termed by law enforcement and emergency medical personnel “the excited delirium syndrome,” and it can challenge law enforcement officials, and medical personnel. Individuals with this condition are at grave personal risk from many spheres, and they also pose a danger to those attempting to help them. A potential outcome of unrecognized and incorrectly treated excited delirium can be a sudden and unexpected death, often with charges of police brutality or physician incompetence. It often affects otherwise healthy young adults and is poorly understood by the lay public and law enforcement personnel.

SYMPOSIUM 124

SAVING DISTRESSED MARRIAGES: PSYCHIATRIC AND PSYCHOLOGICAL APPROACHES TO IMPROVING COUPLES' RELATIONSHIPS

Chair: Scott D. Haltzman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) identify and name the seven common stages (and typical time course) of marriage: passion, realization, rebellion, cooperation, reunion, explosion, and completion, 2) Be aware of cognitive tools (modifying expectations, differentiating individual goals from couple's goals, appreciating communication differences) to help married individuals form better strategies for improving marriage., 3) Be able to understand and teach behavioral strategies including reflective and empathic listening skills to help couples improve marital quality and prevent divorce, 4) Recognize ways in

which individual therapy can be employed as a means to help teach cognitive approaches and problems solving skills

SUMMARY:

50 years ago, divorce rates in the US skyrocketed from 17 percent to about 50 percent. Studies show that, contrary to expectations, people do not become happier when they divorce (unless they are in abusive marriages). Moreover, epidemiological studies show that when people divorce, they have greater risk for depression and other health issues, and their children are at higher risk for mental health issues. Psychiatrists can and should access marital quality (even of individual patients) in the office, and be able to recognize potential marital problems. They can teach the seven stages of marriage (Passion, Realization, Rebellion, Cooperation, Reunion, Explosion and Completion). Psychiatrist can help teach individuals how to take proactive role in improving marital quality and preventing divorce. Therapists can instruct couples in strategies to improve marital quality, such as reflective and empathic listening, soft startups, conflict management, and repair, thus staving off divorce, reducing risks of domestic violence and improving quality of life for patients, spouses and children .

S124-1.

SAVING DISTRESSED MARRIAGES

Presenter: Rita DeMaria, Ph.D.

SUMMARY:

Psychologists have long employed individual and social stage models to facilitate treatment; by understanding developmental levels, clinicians can better conceptualize the behavior they observe and design treatment approaches to manage pathology. Research into long term committed relationships demonstrates that marriage, too, has specific and predictable stages. The presentation will detail the 7 stages of marriage and typical problems that emerge based on key tasks for various stages and provide an assessment process for clinicians. The 7 stages identified in this model are Passion, Realization, Rebellion, Cooperation, Reunion, Explosion, and Completion. Each stage has a set of missions and key developmental task. In healthy marriages, completion of these tasks leads to improved communication, passion, and friendship, and fosters good will to address interpersonal conflicts. However, poorly functioning couples often have impairment in task completion, leading to marital distress and (often) dissolution. Clinicians can assess the marriage utilizing questionnaires designed to help couples identify their stage the specific relationship skills needed for resolving current conflicts and well as identifying crucial missed tasks. Distressed couples have typically not mastered the developmental tasks as their marriages progress and benefit

from identifying the knowledge and skills that will help them address their relationship challenges. The 7 Stages of Marriages of model helps couples identify the stages and missions to strengthen commitment, communication, and passion.

S124-2.

CONJOINT FOCUS, INDIVIDUAL APPROACH

Presenter: Brendan Greer, M.D., M.B.A.

SUMMARY:

The role of individual therapy in conjoint and familycentered work can be vital. One fairly common model has been for one member of a couple in therapy to be seen individually, as well, for either a specific diagnosis or for work which cannot happen in the conjoint sessions. In these settings, the individual's therapist has generally been seen almost as adjunct to the conjoint therapy process. The individual's therapist, however, can also serve as a member of what amounts to a therapeutic 'team' formed early in work focused on relationship issues. In such an approach, there is an active and conscious interplay between the conjoint and individual therapies. More and more, therapy focused on the individual and her or his relational history, dynamic, and behavior is also becoming validated and useful, whether in the context of conjoint therapy or strictly for an individual. In all of these models, the role of a therapist who is experienced in the multiple modes of individual treatment (including the treatment of Axis I and Axis II disorders) and also thinks and treats systemically is becoming more clearly defined. This role will be delineated and put in context of other relational therapeutic approaches, and an argument for increased training in this approach will be developed.

S124-3.

CAN LOVE BE TAUGHT? COGNITIVE AND BEHAVIORAL APPROACHES TO IMPROVING MARITAL RELATIONSHIPS

Presenter: Scott D. Haltzman, M.D.

SUMMARY:

The majority Americans state that they marry for love. Moreover, "romantic love" is a nearly universal phenomenon; in 85 percent of cultures, at least some people report "in love" feelings at some time in their lives. Cultural influences and social expectations often lead individuals to believe that a strong love feeling is sufficient for continued marital success. The data do not support such a belief. Research suggests that certain behavioral patterns, such as applying wellhoned listening skills and refraining from

negativistic interactions can improve the chances of successful marriages and contented spouses. This lecture will focus on how psychiatrists and therapists can clarify realistic expectations for married couples, and help individuals or couples apply behavioral strategies to improve the quality of their marriage. It will specifically address studies implying the success of "Federally Recognized" marriage education programs (such as PAIR and PREP) and also examine the results of the largest ever multisite study ("Building Strong Families") which suggested that marriage education Programs do NOT work.

SYMPOSIUM 125

LONGTERM TREATMENT AND OUTCOME OF OBSESSIVE COMPULSIVE DISORDER

Chair: Jane Eisen, M.D.

Discussant: Wayne Goodman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Understand the role of medication usage and the impact of medication discontinuation in the long term course of OCD, 2) Understand the role of cognitive behavioral therapy in the long term treatment of OCD, 3) Understand predictors of longterm improvement, remission and relapse in OCD, 4) Understand the impact of intensive residential treatment in OCD

SUMMARY:

Both pharmacotherapy and cognitive behavioral therapy have been shown to be effective in the shortterm treatment of Obsessive Compulsive Disorder. However, there is surprisingly little empirical longterm data to guide clinicians treating this frequently chronic disorder. For example, a number of studies have shown significantly higher rates of relapse following SSRI discontinuation, but only one of these studies followed subjects past 1 year. Presenting data from both U.S. and International samples across a range of clinical settings, this symposium will address the latest findings on the longterm course and treatment of OCD. Information regarding the effect of medication discontinuation over 5 years of followup, as well as the longterm durability of exposure and response prevention (ERP) will be presented. To further guide clinicians, we will present data regarding clinical features that have been shown to influence longterm treatment adherence and the likelihood of improving from OCD and staying well. Finally, we will address the role of intensive residential treatment for individuals with a chronic and severe course.

S125-1.

PATTERNS OF REMISSION AND RELAPSE IN THE FIVEYEAR COURSE OF OCD

Presenter: Christina L. Boisseau, Ph.D.

SUMMARY:

Despite the increased recognition of the public health significance of OCD over the past two decades, surprisingly little is known about the longterm course and prognosis of the disorder. This presentation will examine rates of remission and relapse as well as predictors of remission and relapse in a group of 200 participants with primary OCD over 5 years. Over a third (40%) of the participants had a remission. Severity of OCD, duration of OCD illness at intake, and primary obsessions regarding overresponsibility were significant predictors of remission. Hoarding decreased the likelihood of remission and only 2 in 21 participants with primary hoarding achieved remission. Approximately twothirds (65%) of the participants who remitted subsequently relapsed. Significant predictors of relapse were poor insight, and the presence of Obsessive Compulsive Personality Disorder. Furthermore, those participants who had a partial remission were more likely to relapse compared to those who had a full remission. The presentation will address the importance of focusing on the content of the primary obsessional concerns, the need to achieve full remission, and other clinical features such as insight and comorbid OCPD as critically important targets for assessment and treatment of OCD.

S125-2.**THE IMPACT OF DEPRESSION ON THE TREATMENT OF OBSESSIVE COMPULSIVE DISORDER: RESULTS FROM A FIVEYEAR FOLLOWUP**

Presenter: Patricia van Oppen, Ph.D.

SUMMARY:

Obsessive compulsive disorder (OCD) is usually not present as a single diagnosis, and major depression is one of the most frequent comorbidities. However, it is unclear whether depressive symptoms are predictive of treatment response, and debate remains whether they should be targeted in the treatment of comorbid patients. The current presentation will discuss the predictive value of depression and OCD symptoms in the long term outcome of OCD treatment. In this study, relations between OCD and depressive symptoms were systematically investigated in a group of OCD patients who received behavior or cognitive therapy either alone or in combination with fluvoxamine. This presentation will examine the long term effect of depressive symptoms on OCD symptoms in the treatment of OCD.

S125-3.**IMPACT OF SSRI DISCONTINUATION**

Presenter: Jon E. Grant, M.D., J.D.

SUMMARY:

Although data support the use of serotonin reuptake inhibitors (SRIs) in the treatment of obsessive compulsive disorder (OCD), little is known about how long a patient needs medication or how OCD responds once medication is discontinued. This presentation will discuss data from a fiveyear prospective study on pharmacotherapy discontinuation during the course of OCD. The presentation will examine how many subjects receive an adequate trial of an SSRI, what their response is to discontinuing medication, and how they respond if medication is restarted. The presentation will examine whether clinicians are overtreating many OCD patients and whether medications should be discontinued at some time point.

S125-4.**IMPACT AND OUTCOMES OF INTENSIVE RESIDENTIAL TREATMENT FOR OBSESSIVECOMPULSIVE DISORDER**

Presenter: S. Evelyn Stewart, M.D.

SUMMARY:

Objectives: Obsessive-compulsive disorder (OCD) is a treatable condition with empirically proven approaches, including cognitivebehavior therapy and serotonergic medications. However, response and remission rates are suboptimal. Intensive residential treatment (IRT) is a management approach for those with severe, treatmentresistant OCD. This study series aimed: 1) to establish effectiveness of and outcome predictors for IRT; 2) to examine longterm outcomes following IRT; and 3) to examine IRT augmentation with the glutamatergic agent, memantine. Method: Subjects admitted to the Massachusetts General Hospital/McLean OCD Institute (OCIDI) were included in each study (N's = 44 to 476). Admission, monthly and discharge (or lastobservationcarriedforward) measures of OCD, depression and psychosocial functioning were collected, in addition to measures at 1, 3 and 6 months postdischarge. Clinically significant response was defined by a 25% reduction in Yale-Brown Obsessive Compulsive severity (YBOCS) scores. IRT responder and nonresponder group characteristics were compared. Multiple regression analysis then modeled relationships between final OCD severity and outcome predictor variables, accounting for multicollinearity and potential outliers. The memantine augmentation trial included 22 IRT subjects receiving memantine and 22 controls, matched based on outcome predictors. Results: In the effectiveness and outcome predictor studies, YBOCS scores decreased

by 30.1%, from 26.6 (SD 6.1) to 18.6 (SD 7.2) ($p < 0.001$). Psychosocial functioning, depression severity scores and selfreport global functioning ratings also indicated significant improvement. Treatment responders comprised 59.3% of the outcome predictor sample. Decreased OCD severity ($p < 0.001$), female gender ($p = 0.003$) and better psychosocial functioning ($p = 0.003$) predicted less severe OCD at discharge (adjusted $R^2 = 0.28$). For the long-term outcome samples, OCD severity did not significantly change between discharge and one (17.4, SD 6.5), three (16.5, SD 7.4) or six month (16.2, SD 7.3) followup points ($p > 0.24$), and significant improvement from initial admission was maintained ($p < 0.001$). In the memantine augmentation trial, mean YBOCS score decreases were 7.2 (SD 6.4) among cases and 4.6 (SD 5.9) controls, reflecting clinical improvement among cases (27% decrease) but not controls (16.5% decrease). PGI ratings reflected worsening in none of the cases and in 28.6% ($N=2$) of controls

S125-5.

LONGTERM OUTCOME FROM COGNITIVE BEHAVIORAL THERAPY FOR OBSESSIVECOMPULSIVE DISORDER

Presenter: Helen Simpson, M.D., Ph.D.

SUMMARY:

Cognitive behavioral therapy consisting of exposure and response prevention (EX/RP) is a highly effective treatment for obsessive compulsive disorder (OCD). In large randomized controlled trials, EX/RP has been shown to be effective acutely both as monotherapy and as a method to augment partial response to serotonin reuptake inhibitors (SRIs). However, the longterm efficacy of EX/RP has been less studied. This presentation will review the available literature on the durability of EX/RP and present data from two randomized controlled trials conducted by the authors. The first study followed patients who responded acutely to 12 weeks of EX/RP, SRIs, or their combination for another 12 weeks after treatment discontinuation. Those receiving EX/RP either with or without the SRI clomipramine had a lower rate of relapse and a longer time to relapse than those who responded acutely to clomipramine alone. The second study followed patients on SRIs who responded to the addition of 8 weeks of EX/RP treatment for up to 12 months after acute treatment. Patients remained on their SRIs and received monthly EX/RP maintenance sessions for the first 6 months and were followed naturalistically for another 6 months. The majority of patients maintained their gains over the 12 months of followup. Factors that predict good longterm outcome from EX/RP treatment will be discussed.

SATURDAY, MAY 5, 2012

WORKSHOPS

WORKSHOP 001

UPDATE ON PARASOMNIAS: A REVIEW FOR PSYCHIATRIC PRACTICE

CoChair(s): Dimitri D Markov, M.D., Marina Goldman, M.D.

Presenter(s): Karl Doghramji, M.D., Dimitri D Markov, M.D., Abigail Kay, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Participants will be able to describe clinical features of various parasomnias, 2) Participants will be able to distinguish among the various parasomnias based on history and the sleep state during which they occur, 3) Participants will be able to understand the etiologic factors associated with parasomnias

SUMMARY:

Parasomnias, defined as undesirable behavioral, physiological or experiential events that accompany sleep, are common in the general population. As a rule they occur more frequently in children than in adults with the exception of REM sleep behavior disorder (RBD), which is more common in men over 50. No longer considered to be invariably a sign of psychopathology, parasomnias are currently understood as clinical phenomena that arise as brain transitions between REM sleep, nonREM sleep, and wakefulness. This paper presents a clinical approach to diagnosing and treating parasomnias in the general population and in psychiatric patients. Faculty will also discuss challenges of treating sleep disorders in patients with substance use disorders.

WORKSHOP 002

MANAGEMENT STRATEGIES FOR ANTISOCIAL PERSONALITY DISORDERS

Chair: Donald W. Black, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Prevalence, risk factors, and outcome of ASPD and clinical management strategies, 2) Use of STEPPS program in BPD offenders with ASPD traits in correctional settings, 3) Use of the "SplitSecond Decision" Program in young, incarcerated offenders

SUMMARY:

Participants who attend this workshop will learn about Antisocial Personality Disorder (ASPD) and two new management strategies currently used in offenders. ASPD will be reviewed and its epidemiology, risk factors, and outcome described. Proposed changes for DSM5 will be reviewed, as well as overall clinical management strategies. The STEPPS program, originally developed as a cognitive/behavioral, skillstraining group treatment program for people with borderline personality disorder, has been used in both male and female offenders in a variety of correctional settings, and treatment groups have included offenders with ASPD traits in addition to meeting the required criteria for BPD. Its use in these populations and outcome data will be discussed. The "SplitSecond Decision" program in youthful offenders has been shown to decrease aggression and disciplinary infractions in incarcerated youth (ages 14-21) in a Connecticut prison. The main focus of this treatment is on awareness of the buildup of arousal leading to aggression or disruption; peer culture evolves from valuing fighting to encouraging selfcontrol for one's own benefit. While the use of these programs is being described in offenders for this workshop, they may be readily transported to community settings for individuals with ASPD traits (e.g., residential treatment, substance use programs, day treatment, etc.).

WORKSHOP 003

REEFER MADNESS? THE ROLE OF PSYCHIATRY IN THE EVOLUTION OF MARIJUANA AS A MEDICAL TREATMENT

Chair: Christopher A. Milburn, M.D., M.S.

Presenter(s): Kenneth M. Certa, M.D., Robert L. Dupont, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the reasons behind the rise of the use of marijuana as a medical treatment, 2) Describe regulations behind the use of marijuana as they vary from state to state, 3) List the proposed benefits of marijuana as a medical treatment, 4) Describe the pitfalls of the current status of marijuana regulation and distribution

SUMMARY:

The legalization of marijuana for medicinal use is becoming increasingly common throughout the United States. Currently sixteen states plus the District of Columbia have legalized the use and cultivation of marijuana for a variety of medical conditions ranging from symptomatic relief of nausea and vomiting to the treatment of inflammatory bowel conditions, migraines, fibromyalgia and multiple sclerosis. However, despite the potential use of marijuana for amelio-

ration of symptoms, there is literature correlating the use of marijuana with the development of psychotic syndromes including schizophrenia. A recent systematic review by Moore et al. showed a positive correlation between cannabis use and the development of lasting psychotic illness. Despite this, population studies, including a study by Frisher et al., have found no increase in rates of schizophrenia, despite increasing marijuana use in the United Kingdom. Yet other studies examining the issue of legalization of marijuana from a risk reduction perspective have noted that marijuana use shows a paradoxical decline with legalization. Currently, the laws in the states which have legalized marijuana have little ability to regulate the purity of marijuana or THC content. Further, in general, the physician acts merely as a gatekeeper to allow a patient to receive the medication from a dispensary or to cultivate their own marijuana. This workshop will outline the current state of marijuana legalization in the United States as well as the potential advantages and disadvantages of legalization. The available outcome data on psychiatric morbidity resulting from marijuana legalization within the United States and other parts of the world will be discussed, as will the current evidence linking the use of marijuana with the development of psychiatric illness. The role of the physician in prescribing medical marijuana will be reviewed as will the role of psychiatry in influencing policy and advising our medical colleagues. Workshop participants from areas with widespread legal use, as well as those from states where use remains illegal, will compare experiences with emergent symptoms, symptom relief, and other important sequelae of the legalization movement.

WORKSHOP 004

PREVENTION OF MENTAL HEALTH SEQUELAE: EVIDENCEBASED PRACTICES IN PROTECTION, PREVENTION, AND INTERVENTION IN AFRICANAMERICAN POPULATION

APA Caucus of Black Psychiatrists

Chair: Napoleon B. Higgins, M.D.

Presenter(s): Carl C. Bell, M.D., William B Lawson, M.D., Ph.D., Kenneth S. Thompson, M.D., Rahn K. Bailey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify stressors that are unique to the AfricanAmerican community that lead to poor mental health outcomes, 2) Understand early detection of mental illness in communities and develop strategies for early intervention including physicianpatient relationship, and local community and national interventions, 3) Participants should be able to identify, develop and implement preventive strategies for their independent practice of psychiatry in order

to decrease the burden of mental illness for patients and their families, 4) Discuss topics regarding subpopulations including child protective and juvenile services, community violence, trauma and disaster, and pharmacologic and suicide prevention

SUMMARY:

The purpose of this workshop is to discuss strategies to prevent mental illness using evidencebased practices. So often the target of mental health services is tertiary treatment and reactionary to the morbidity and early mortality of mental illness. This is costly when mental disease has already burdened the mind of individuals and caused unrest and discord within the family and community. AfricanAmericans are a unique subgroup of the American population due to their history and culture. Within the AfricanAmerican community there are higher rates of poverty, community violence, racism, and poor family constructs. AfricanAmericans are highly dependent on governmental health care services and are largely affected by political decisions and policy changes. By taking a closer look at this group we hope this information can be extrapolated to other groups within the mental health community, and the American populous as a whole. Discussion on previously implemented community programs will inform mental health professions of how they may implement these methods in their own individual practice. Prevention requires change within local areas and on a national level. Developing infrastructure, coordinating the public in local communities, and pushing for national policy changes are detrimental for transformation in the delivery of mental health care. This workshop will present evidencebased practices and services which have revealed programs that work in preventing mental illness and have given early intervention to prevent further morbidity and mortality.

WORKSHOP 005

WORKSHOP ON INTEGRATION OF PRIMARY CARE, PREVENTIVE SERVICES, AND ASSERTIVE COMMUNITY TREATMENT TEAMS

CoChair(s): Erik R. Vanderlip, M.D., Nancy Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Critically appraise the Role of Assertive Community Treatment Teams in the physical health promotion of their clients, 2) Review the use of tools such as disease registries to improve adherence to recommended screening guidelines for cardiovascular disease risk factors, 3) Understand the concept of the PersonCentered Medical Home, and appreciate its relevance to the Assertive Community Treatment model, 4) Apply focused quality improvement

processes to Assertive Community Treatment teams targeted at advancing physical health indices, and 5) Understand basic health screening recommendations for clients suffering with severe and persistent mental illness

SUMMARY:

Assertive Community Treatment (ACT) offers an unprecedented array of services in a multidisciplinary teambased format to persons suffering from severe, chronic and debilitating mental illness (SPMI). ACT is one of few evidence-based models of healthcare delivery within mental health, and is being implemented in a number of new states as a standard of care for persons with SPMI. With the passage of the Affordable Care Act, renewed enthusiasm has been placed towards personcentered care, and the notion of the PersonCentered Medical Home (PCMH) as a foundation of advancements in health service delivery. Integral to this is a focus on teambased care and healthbehavior change. Additionally, persons with SPMI have significantly shorter lifeexpectancies due primarily to cardiovascular disease (CVD). Modifiable risk factors for CVD are poorly screened for and/or treated within the SPMI population. Because of its unique structure, ACT has many functions similar to a PCMH for persons with SPMI. Many ACT teams anecdotally manage multiple physical health comorbidities amongst their clients. In the summer of 2011, a national survey of ACT teams was distributed assessing the current state of primary care integration, with specific attention towards the role of ACT teams in the diagnosis, screening, management and referral of physical health amongst their clients. Additionally, the survey assessed the degree to which ACT teams were already functioning as PCMH's according to wellpublished guidelines within the primary care realm. Presenters will review the results of their survey and highlight avenues for further services research and targets of quality improvement programs for ACT teams. Presenters will also share the results of an ongoing quality improvement exercise utilizing a disease registry and clinical reminders to improve adherence to recommended preventive health screening guidelines on a Universitybased Iowa ACT team.

WORKSHOP 006

A HISTORICAL OVERVIEW OF THE INCEPTION OF MORAL TREATMENT IN PSYCHIATRY

APA/The Scattergood Foundation

Chair: David S. Roby, M.D.

Presenter(s): David S. Roby, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Review prevailing attitudes and treatment of

mental illness between 1400 and 1770, 2) Brief overview of selected innovative psychiatric institutions between 1400 and 1770, 3) Compare and contrast the careers and reforms introduced by Philippe Pinel and William Tuke.

SUMMARY:

While mental illness has existed since antiquity, the norm of treatment for millennia has been social isolation, confinement, physical neglect, restraint, mockery and scorn. Beginning in the late middle ages, several institutions around the world strived to improve the quality of care. There will be a brief review of some of the innovative institutions in Europe and America between 1400 and 1800. While these efforts do reflect a more humanistic, compassionate treatment of the mentally ill, more pervasive and revolutionary reform would occur in the late 1700's. Philippe Pinel was a physician who would devote 35 years of his professional life to improving treatment of mental patients. He would become famous for his removing shackles from patients, many of whom had been institutionalized for years, and some had even committed murder. His professional development and decision to pursue psychiatry will be reviewed. His contributions include improving the living conditions at the Bicetre, and subsequently the Salpêtrière. He advocated systematic observation and records presaging the psychiatric case history. He proposed changes in diagnostic nosology, and ultimately correlation between clinical and neuroanatomic findings. William Tuke was a British Quaker who dropped out of school at the age of 14 to work in the family tea business. He experienced a personal loss with the untimely death of his first wife. After this, he committed himself to increased involvement in his Quaker meeting and its reforms. He was a cofounder of the Ackworth school. Following the tragic death of a young Quaker woman, Hannah Mills in 1791 at the public facility, the York Asylum, Tuke vowed to create an alternative, the York Retreat which opened in 1796. William Tuke's grandson Samuel Tuke published a detailed account of the York Retreat in 1813. This included an articulation of the principles of "moral therapy." Interested clinicians from Europe and America visited the Retreat and credited it as the inspiration for their own institutions which would open over the next 60 years. For example, Thomas Scattergood, a Quaker minister from Philadelphia visited the York Retreat in 1799, and on returning to America would advocate for the creation of a similar institution in Philadelphia. This proposal came to fruition with Friends Hospital which opened in 1817 to care for those unfortunate persons deprived of the use of their reason. Moreover, moral therapy in psychiatry had a stuttering beginning with isolated reforms around the world. Some of these remained in existence for many years, but the principles surrounding them were not widely disseminated or adopted. In contrast, both Pinel and Tuke were to have a widespread dramatic impact on treatment of patients with mental illness. While

their training was quite diverse, ultimately they would adopt a similar approach to many aspects of treatment.

WORKSHOP 007

TRAINING FOR THE FUTURE: ADDRESSING COMMUNITY PSYCHIATRY WORKFORCE SHORTAGES AND HEALTH CARE REFORM THROUGH RESIDENT TRAINING IN PUBLIC PSYCHIATRY

CoChair(s): Matthew D. Erlich, M.D., Sharat G. Parameswaran, M.D.

Presenter(s): Jules Ranz, M.D., Fumi Mitsuishi, M.D., M.S., Michael Yao, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Address the growing need for psychiatrists in community mental health settings due to increased access from the 2011 Affordable Care Act to concurrent public psychiatry workforce shortages, 2) Understand the variability of residency training in public psychiatry and community mental health care in the U.S. as demonstrated by a national survey and workshop presentations, 3) Formulate a potential framework to address this workforce shortage and need for expansion of the public mental health system by addressing psychiatry residency training requirements

SUMMARY:

Currently, there is a growing shortage of mental health professionals in the community mental health care setting (CMHC). Workforce shortages continue to expand in the public mental health system and are projected to triple over the next 15 years due to the increased inclusion of behavioral health services under the Affordable Care Act and other health care reforms. The current number of psychiatric patients that have services delivered in CMHCs is approaching 1 million, and there is enhanced demand for able and efficacious psychiatric providers in the community setting. The training of psychiatry residents in public and community psychiatry is essential; however, current ACGME requirements to meet these demands are limited in scope: (1) Community psychiatry clinical experiences without specific requirements regarding duration or location; (2) Systemsbased practice requirements which include elements important to familiarizing residents with public psychiatry training but lack specific methods by which this is to be achieved within a residency curriculum; and (3) Explicit medical knowledge (i.e. didactics) without requirements for public or community psychiatry or consistency in delivering this information. Psychiatry residency training programs approach these ambiguities in differing ways. Clinical rotations occur in public settings; however it is unclear if

this is due to service requirements for the medical center or local community and/or opportunities to train residents in clinical care in public settings. Formalized didactics oriented to public settings are variable with respect to public setting (community clinic vs. publicly funded inpatient hospital vs. forensic unit), class year, structured public psychiatry curriculum vs. electives, and postdoctoral (or fasttracking) opportunities into a Public Psychiatry Fellowship. This workshop will better elucidate the variability of community/public psychiatry opportunities to U.S. psychiatry residents. Data from a survey of public psychiatry curricula in residency programs across the U.S. will be presented which will review curricular variations, attitudes towards preparedness for service in the public sector, and expectations for 21st century community psychiatry demands. Residents from programs in New York, California, and Oregon will present varying perspectives on public psychiatry training at their respective institutions, with emphasis placed upon a novel structured personcentered systemsbased care assessment in CMHC, electives in public psychiatry fellowship training during PGY4 year (“fasttrack”), and curricular modifications of CMHC into resident outpatient training. An interactive discussion with the audience will follow whereby the goal will be to propose a potential framework to address this training gap, workforce shortage, and need for expansion of the public mental health system.

WORKSHOP 008

HELPING PATIENTS WHO DRINK TOO MUCH: USING THE NIAAA CLINICIAN’S GUIDE

U.S. National Institute on Alcohol Abuse and Alcoholism

Chair: Mark L. Willenbring, M.D.

Presenter(s): Mark L. Willenbring, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Screen for at-risk and dependent drinking, 2) Diagnose alcohol dependence; 3) Conduct brief motivational counseling for at-risk drinking.

SUMMARY:

Heavy drinking and alcohol dependence are common among psychiatric patients, yet few psychiatrists receive the training necessary to effectively manage them. Although standard practice is to refer patients with severe alcohol dependence to a rehab program, most patients will decline or will not have access, or will relapse after a period of abstinence. Fortunately, most patients who drink too much will respond to relatively brief nonintensive outpatient psychiatric management. In this workshop, participants will be introduced to the National Institute on Alcohol Abuse

and Alcoholism's (NIAAA) *Helping Patients Who Drink Too Much: A Clinician's Guide*, an evidencebased guide for nonaddiction specialists. They will develop skills in screening for alcohol problems using a singlequestion, diagnosing and staging alcohol dependence, brief motivational counseling, and treatment of alcohol dependence with medication and brief behavioral support. In addition, chronic care management for patients with severe recurrent dependence will be discussed. Also covered in this workshop will be a new online resource devoted to the Guide and related professional support materials, including downloadable forms, publications, and training resources (www.niaaa.nih.gov/guide). NIAAA has fulfilled requests for many thousands of copies to individual practitioners as well as treatment centers, health maintenance organizations, state and community health programs, medical societies, and schools of medicine, nursing, and social work.

WORKSHOP 009

THE ETHICS OF PATIENT-TARGETED GOOGLING

APA/The Scattergood Foundation

Chair: David Brendel, M.D., Ph.D.

Presenter(s): David Brendel, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify pros and cons of searching online for information about patients, 2) Understand ethical dilemmas around patient targeted googling, 3) Establish a framework for decision making with respect to patient targeted googling.

SUMMARY:

With ongoing advances in internet search technology, psychiatrists today must grapple with the question of whether to search for information about patients online. Respect for patient privacy must be balanced against the importance of obtaining relevant and clinically useful information about patients, which may be easily found on publicly accessible websites. This session will describe the ethics of "patient-targeted googling" and present a pragmatic model for the psychiatrist who is weighing the pros and cons of searching online for patient information.

WORKSHOP 010

HEALTH CARE REFORM AND PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS: WHAT TO TEACH, HOW TO TEACH, WHERE TO TEACH

CoChair(s): Hoyle Leigh, M.D., Jon Streltzer, M.D.

Presenter(s): Beena Nair, M.D., Seth Powsner, M.D., Don R. Lipsitt, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss the implications of health care reform act for teaching psychiatry to primary care physicians, 2) Discuss models for effective teaching of psychiatry to primary care physicians, 3) List important concepts and skills to teach, and discuss the advantages and disadvantages of different methods and venues of teaching primary care physicians.

SUMMARY:

With the enactment of the health care reform bill, there will be an increase in the number of patients seeking primary care, and an urgent need to train primary care physicians in how to recognize, diagnose, treat or refer patients with psychiatric symptoms. This is a golden opportunity for consultation liaison psychiatrists to participate in improving healthcare by teaching psychiatry to primary care physicians. This workshop will explore, with active audience participation, what is effective in teaching psychiatry to primary care physicians. Each panelist will address the issues of what to teach, how to teach, and the teaching venues. The moderator of this workshop (HL) will emphasize the concept of epigenesis as a bridge between genes, experience, and environment, and the seminar format in the medical school as effective venues. Dr. Lipsitt will discuss the perceived needs, barriers and practice of primary care physicians in caring for patients diagnosed with somatoform disorder. Dr. Nair will present her experience in teaching women's mental health to primary care physicians. Dr. Powsner will discuss and demonstrate innovative multimedia teaching techniques in the emergency room setting for the teaching of psychiatry. Dr. Streltzer will present his experiences and ideas in teaching primary care physicians about chronic pain and discuss the use of new practice guidelines on opiate use. Presentations will be limited to about 60 minutes with 30 minutes for discussion with the audience. The discussion is expected to stimulate consultation liaison psychiatrists and psychiatric educators to generate ideas that will lead to the development of more effective and efficient teaching models.

WORKSHOP 011

ELECTRONIC HEALTH RECORDS (EHR): WHAT TO LOOK FOR WHEN SELECTING AN EHR FOR YOUR PRACTICE

The APA Committee on Electronic Health Records

CoChair(s): Steven R. Daviss, M.D., Robert M. Plovnick,

M.D., M.S.

Presenter(s): Edward Pontius, M.D., Lori Simon, M.D., Zebulon Taintor, M.D., Roger Duda, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Explain the purpose of certification of EHRs, 2) Describe three methods of assessing EHR usability, 3) Enumerate five different types of functionality to look for when selecting an EHR for a psychiatric practice, 4) List the steps involved in EHR implementation, and 5) Describe the different ways that Health Information Exchanges deal with sensitive health information

SUMMARY:

As momentum for the increased use of electronic health records in Medicine continues to build, psychiatrists are learning more of the risks, benefits, and challenges of using EHRs in the delivery of health care and the communication of health information among providers. More choices regarding EHR certification have added some confusion to the market about which certifications are desirable when deciding on an EHR. The necessary features of an EHR that is to be used in psychiatric practice include some that are harder to find in EHRs designed for primary care. This functionality of a specific EHR must also be balanced with its ease of use. Once an EHR is selected, there are a number of steps to take in its successful implementation. While states are at different levels of developing their health information exchanges (HIEs), making the decision to connect to an HIE involves risks and benefits to psychiatrists and their patients. Understanding how the HIE handles sensitive health information is an important task in managing these risks.

WORKSHOP 012

ADDRESSING ADDICTION AMONG WOMEN: A USA PERSPECTIVE

Chair: Pedro Ruiz, M.D.

Presenter(s): Annelie B. Primm, M.D., M.P.H., Michelle Primeau, M.D., Patricia Junquera, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Learn about current trends of substance use among women in the USA, 2) Focus on solutions to barriers visàvis treatment and recovery, 3) Advance effective prevention efforts for this disadvantaged woman who reside in the USA

SUMMARY:

According to The 2008 National Survey on Drug Use and Health, and estimated of 42.9 % of women 12 years and older have reported using an illicit drug at some point in their life. Additionally, women 12 years and older have reported a rate about 12% of illicit drug use during the last year; also, 6.3 % of these women reported using illicit drugs in the last month. Although the rate of substance dependence among men 12 years and older is nearly twice as high as women (11.5% vs. 6.4%) the rate of substance dependence or abuse was much higher and young women during the period of 1217 years old than men (8.2% vs. 7.0%). Along these lines, the Center for Disease Control in 2007 noted that approximately 34.5% of high school women students have used marijuana during their lifetime. Additionally, the rate of inhalant abuse among high school students increased from 11.4% in 2003 to 13.5% in 2005 and to 14.3% in 2007. Within this context, in this workshop, we plan to examine the current challenges that women, especially young women, are exposed to in the United States, visàvis becoming addicts. In this regard, we have to underline the major challenges that exist in the United States when women addicts attempt to achieve recovery, as well as maintain themselves in recovery. In this workshop, we will also address the barriers that women face when entering into treatment and or sustaining recovery. It is also our objective to call attention to problems that women prone to addiction have to face when residing in the United States. Finally, we will also review the appropriate models and types of interventions that have proven to be effective in this overlooked and underserved addicted population. REFERENCES:

- HernandezAvila CA, Rounsville BJ, Krazler HR: Opioidcannabis and alcohol dependent women show more rapid progression to substance abuse treatment. *Drug and Alcohol Dependence*, 74:265272,2004.
- Ruiz P, Strain E (eds): *Substance abuse: A Comprehensive Textbook*, Fifth Edition. Philadelphia, Pennsylvania, Lippincott Williams & Wilkins,2011.
- Substance use among young mothers, National Survey on Drug Use and Health. NSDUH Report, March 2010.

WORKSHOP 013

EVIDENCEBASED INTEGRATIVE TREATMENTS FOR ANXIETY, DEPRESSION, AND TRAUMA IN MASS DISASTERS

APA Caucus on Alternative and Complimentary Medicine

CoChair(s): Helen Lavretsky, M.D., M.S., Patricia L. Gerbarg, M.D.

Presenter(s): Richard P. Brown, M.D., Patricia L. Gerbarg, M.D., Helen Lavretsky, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify complementary treatments, including herbs, nutrients, and mindbody practices for which there is sufficient evidence of safety and efficacy for use in clinical practice, 2) Understand the mechanisms of action, risks, and benefits of those complementary treatments, 3) Obtain therapeutic tools to pursue further information and updates on treatments he or she will consider using in practice

SUMMARY:

Participants will learn how to integrate complementary treatments with standard treatments in psychiatry practice. The course focuses on research and clinical applications of complementary treatments for which there is sufficient evidence of safety and efficacy. The authors have selected those treatments that are the most useful for clinicians to integrate into their practices from the following categories: herbs, adaptogens, nutrients, hormones, and mindbody practices. Evidence for efficacy and clinical practice guidelines for integrative Dr. Brown and Dr. Gerbarg will review of the research evidence, clinical uses, risks, and benefits of St. John's Wort, Sadenosylmethionine, Rhodiola rosea, Omega3 Fatty Acids, valerian, and passionflower for treatment of mood disorders. Integrative treatments for anxiety disorders, such as GAD, PTSD, Veteran and Massdisasters PTSD, will include: BreathBodyMind practices such as QiGong, Yoga, Coherent Breathing, Breath Moving, Breath Cycling, and Open Focus meditation; herbs including valerian, lemon balm, passion flower; and cranioelectrotherapy stimulator devices. Examples of the discussion of these applied techniques will include the review of research on yoga A. Neurophysiological Model for the effects of yoga breathing on the autonomic nervous system, heart rate variability, limbic system, thalamus, insula and cerebral cortex; B. Effects of yoga breathing on stress response, emotion, mental state, physical state. C. Clinical uses of yoga breathing, including risks and benefits in the treatment of stress, insomnia, depression, anxiety, posttraumatic stress disorder, veteran PTSD, mass disasters, aggression. D. Clinical studies of multimodal yoga breath programs for Mass Disasters (e.g., Southeast Asian Tsunami Survivors; September 11th World Trade Center Terrorist Attacks; Survivors of war, genocide and slavery in Sudan; 2010 Gulf Oil Spill in Mississippi; Yoga breathing as an adjunct to psychotherapy) Participants will have an introduction to the experience breath techniques that rapidly relieve stress and anxiety. Dr. Brown will lead the group in a short set of gentle, introductory Qigong movements with breathing called the Four Golden Wheels by Master Robert Peng. This will be followed by Breath-BodyMind practices including Coherent Breathing (paced breathing at 56 breaths per minute), Breath Moving, and a brief relaxation/meditation. These practices are currently

being used to relieve symptoms of stress, anxiety, and PTSD in survivors of mass disasters discussed in the preceding lecture.

WORKSHOP 014**PSYCHIATRIST'S RESPONSE TO YOUNG ADULT PATIENTS WHO HAVE HAD INAPPROPRIATE OR ABUSIVE CARE IN RESIDENTIAL TREATMENT AS ADOLESCENTS**

Chair: Charles W. Huffine, M.D.

Presenter(s): Rebecca K. Tangen, M.S.W., Shawn Muth,

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate of the risks for youth and families of certain for profit residential treatment programs for adolescents, 2) Understand the lack of standards for regulation of clinical care for teens in the for profit residential treatment industry, 3) Appreciation the phenomenon of compounding trauma and its consequences on youth who have suffered inappropriate care in residential treatment and are not believed by family, therapists or psychiatrists

SUMMARY:

Problems with for profit residential care for troubled youth have been well documented by the House Education and Labor Committee through a thorough investigation by the General Accountability Office (GAO) and several advocacy groups such as the Alliance for Safe, Therapeutic and Appropriate Residential Treatment (A START) and the Community Alliance For the Ethical Treatment of Youth (CAFETY). At hearings in October of 2007 and April of 2008 inadequate regulation, nonprofessional staff, use of hard labor, forced silenced and shunning, humiliation, forced wilderness activities with inadequate attention to medical problems, and extreme punishments such as beatings, being kept in dog cages and in stress positions were found to be common. Parent sponsored early AM kidnapping of youth with threat of force has been said to be the most traumatic event for many youth forced into such programs. Traumatized youth with a lingering sense of betrayal by their parents are in need of understanding and appropriate trauma focused treatment. Parents too experience being duped by the claims on websites that say they have the only answer to every conceivable behavioral problem of youth. Only recently have organizations of survivors, parents and concerned professionals begun to address these problems. Differences between public system and nonprofit contract residential programs and forprofits will be discussed in terms of regulation and quality of care. The appropriate role in the spectrum of care for residential programs will

be addressed vis a vis the needs of adolescents for increasing doses of autonomy and some acceptable risk taking. Psychiatrists who work with youth and young adults need to understand the variability in residential care. They need reliable ways to evaluate the veracity of claims of their patients regarding inappropriate or abusive care. Our colleagues need to honor the claims of youth as they share with us their maltreatment. Many youth bear the secrets of abusive care. There are parents who mortgaged their homes to pay for such treatment and are loath to admit their money was taken from them leaving their child with worse problems. Entering such a family as a therapist takes skills, compassion, and an ability to understand varying perspectives. This program aims to inform psychiatrists about the risks of residential treatment, how to evaluate specific programs, treatment sophistication and ethics, and when and how to warn parents as they contemplate sending their troubled youth away. This program will share ways to approach youth who have been harmed by bad programs, find peer supports, intervene in the youth's trauma based difficulties and address daunting family difficulties stemming from varying perspectives of the care the young person received.

WORKSHOP 015

COMPUTERASSISTED COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

CoChair(s): Jesse H. Wright, M.D., Ph.D., Michael E Thase, M.D.

Presenter(s): Gregory K. Brown, Ph.D., Joyce A. Spurgeon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe methods for computer-assisted cognitive-behavior therapy (CCBT) for depression, 2) Evaluate evidence for the efficacy and clinical utility of CCBT for depression, 3) Identify ways of integrating computer-assisted psychotherapy into clinical practice

SUMMARY:

This workshop is intended for clinicians who may be interested in using computer-assisted cognitive-behavior therapy (CCBT) of depression as an adjunct to clinical practice. To help clinicians better understand the potential of CCBT for enhancing clinical practice, a brief overview of the findings of a recent surge in research on CCBT will be presented. Next, the key features of three programs that have been tested in multiple investigations (Good Days Ahead, Beating the Blues, and Mood Gym) will be illustrated to show examples of computer tools for CBT that are being used in clinical practice or in self-help applications. Finally, methods

will be outlined for successful incorporation of CCBT into multifaceted plans for treatment of depression. Workshop participants will discuss: (1) indications for using computer tools in clinical practice; (2) integration of computer and human components of therapy; (3) the importance of clinician supervision and support of CCBT in treatment outcome; and (4) economic and managed care considerations. The presentation will include short didactic segments, demonstrations of internet-delivered multimedia computer programs, and discussion of issues in the implementation of CCBT.

WORKSHOP 016

2012 REVISION OF THE SCHIZOPHRENIA PSYCHOPHARMACOLOGY ALGORITHM FROM THE HARVARD SOUTH SHORE PSYCHIATRY PROGRAM

Chair: David N. Osser, M.D.

Presenter(s): Mohsen Jalali Roudsari, M.D., Theo Manschreck, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Give trials of antipsychotic medications for patients with schizophrenia that are adequate and informed by the evidence base, 2) Use medications for schizophrenia in an efficient manner leading to the best outcome in the shortest time, 3) Select augmentation strategies for clozapine that have evidence of effectiveness

SUMMARY:

This workshop focuses on the latest update of the algorithm for schizophrenia from the Psychopharmacology Algorithm Project at the Harvard South Shore Program. A literature review was conducted focusing on new data since the last published versions (1999/2001). The firstline treatment is with any second-generation antipsychotic except olanzapine or clozapine. Trials should be for 46 weeks, although in some settings they could be shorter, since most improvement with acute treatment with antipsychotics occurs within the first two weeks. If the trial of the first antipsychotic cannot be completed due to intolerance, try another firstline option until one is tolerated and given an adequate trial. There should be evidence of bioavailability indicated by side effects and/or blood level. If there is an unsatisfactory response to this adequate trial, try a second monotherapy. If there is another unsatisfactory response after an adequate trial, and at least one of the first two trials was with risperidone, olanzapine, or a first-generation antipsychotic (FGA), then clozapine is recommended for the third trial. Otherwise, a third trial prior to clozapine should occur, using one of these three options. If there is

an unsatisfactory response to monotherapy with clozapine (with dose adjusted with plasma levels), consider augmenting clozapine with risperidone, lamotrigine, or ECT. If these are unsuccessful, evidence is very limited. Possible options are memantine or omega3 fatty acid added to clozapine, a switch from clozapine to another antipsychotic not yet tried (e.g. aripiprazole), or trying a combination of an FGA with mirtazapine or celecoxib. Finally, combinations of antipsychotics not including clozapine may be considered. In this workshop, the three authors will present aspects of the algorithm. One speaker will briefly demonstrate how the recommendations can be accessed from our website using smart phones. Ample time will be provided for attendees to respond and interact with the presenters.

WORKSHOP 017

PROMOTING EMOTIONAL AND PHYSICAL SAFETY DURING RESIDENCY: BEING PREPARED FOR LIFE THREATENING EMERGENCIES

CoChair(s): Curtis A. McKnight, M.D., David P. Kasick, M.D.

Presenter(s): Julie Niedermier, M.D., Julie Teater, M.D., Curtis A. McKnight, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify and close gaps in their safety knowledge, 2) Use the practical information provided about safety issues in the workplace to elevate the quality of their patient care, 3) Describe the resident safety curriculum currently in place at an academic medical center.

SUMMARY:

Purpose: The purpose of this workshop is to assist psychiatry residents in developing competency at 1) identifying clinical situations posing safety risks to residents and patients and; 2) using practical measures to promote safety awareness in the workplace and maintain safe, effective patient care. Additionally, resident safety initiatives undertaken in an academic medical center will be described. **Content:** There have been disturbing trends about violence occurring in the health care setting. Yet, despite national accreditation and regulatory initiatives to improve patient safety and address resident work hour concerns, relatively little attention has been devoted to preparing residents for violence in the workplace. This is especially important in psychiatry residencies, as trainees are likely to encounter unpredictable and potentially violent patients or novel situations, over the course of their training. **Methodology:** Resident feedback suggests varying personal experiences and levels of comfort with potentially dangerous situations. In addition, a review of national trends in health care insti-

tutional violence as well as violent acts directed at psychiatrists or other mental health care workers was conducted. In response, a safety curriculum has been developed at an academic psychiatry residency program. It includes efforts to educate residents about awareness, preparedness and anticipation of violence; debriefing about experiences; and participation in formal Crisis Prevention Institute training. **Results:** Data from a large metropolitan academic center illustrate that there has been an incremental increase in episodes of violence in the hospital setting as well as increase in number of injuries to others, including care providers. Residents surveyed before and after participating in a safety curriculum report improved awareness and understanding of strategies for responding to crisis situations. **Importance:** This presentation highlights a mechanism for and the importance of psychiatry residents having fundamental knowledge about the dangers of workplace violence as well as practical strategies to guide clinical practice. This course is intended to raise residents' safety awareness by reviewing current literature, involving participants in discussion about this important aspect of practice, and providing them with introductory approaches to managing difficult situations.

WORKSHOP 018

CLINICAL WISDOM IN PSYCHOTHERAPY: A PHILOSOPHICAL AND QUALITATIVE REPORT

APA/The Scattergood Foundation

Chair: Arthur Caplan, Ph.D.

Presenter(s): Dominic Sisti, Ph.D., Arthur Caplan, Ph.D., Cynthia BaumBaicker, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Examine the philosophical dimensions of the concept of clinical wisdom in the context of psychotherapy, 2) Offer empirical evidence supporting the concept of clinical wisdom as a multidimensional and pragmatic construct, 3) Describe the need for pedagogical methods that help to inculcate clinical wisdom among trainees.

SUMMARY:

To precisely define wisdom has been an ongoing task of philosophers for millennia. Investigations into the psychological dimensions of wisdom have revealed several features that make exemplary persons 'wise'. In this workshop, we build on scholarship in both psychology and medical ethics by providing an account of clinical wisdom in the context of psychotherapy. With the support of qualitative data, we argue that the concept of clinical wisdom in mental health care shares several of the key ethical dimensions offered by standard models of clinical wisdom in biomedical ethics

and serves as a useful, albeit overlooked, reference point for a broader development of virtue based medical ethics. We propose that the features of clinical wisdom are pragmatic skills that include but are not limited to an awareness of balance, the acceptance of paradox and a particular clinical manner that maintains a deep regard for the other. We offer several suggestions for refining training programs and redoubling efforts to provide longterm mentorship opportunities for trainees in clinical mental health care in order to cultivate clinical wisdom.

WORKSHOP 019

DON'T YOU WANT TO BE A REAL DOCTOR? OVERCOMING CAREER DEVELOPMENT CHALLENGES FACED BY ASIAN AMERICANS IN PSYCHIATRY

APA Caucus of Asian American Psychiatrists

CoChair(s): Sharat G. Parameswaran, M.D., Paul Yeung, M.D., M.P.H.

Presenter(s): Ye B. Du, M.D., M.P.H., Esther E. Oh, M.D., Russell F. Lim, M.D., Francis Lu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe challenges for Asian American medical students in choosing psychiatry as a specialty, such as the stigma of mental illness, and the lack of family support, role models, and mentors, 2) Identify challenges for Asian American residents in training in psychiatry, including limited exposure to cultural psychiatry or supervision sensitive to the Asian American experience, 3) Identify means to overcome barriers for Asian American trainees through understanding the experience of those who have traversed the “bamboo ceiling” and their role as mentors and role models, 4) Understand how the challenges faced by Asian Americans entering psychiatry can serve as strengths in providing culturally sensitive psychiatric care and overcoming barriers to treatment

SUMMARY:

Despite the fact that over 27% of psychiatrists in US psychiatry residency programs are Asian, the challenges faced by Asian Americans entering into, and training in, psychiatry remains underexplored. Asian Americans considering psychiatry as a career are often confronted with the stigma of mental illness and mental health treatment in Asian communities, and are often faced with overcoming the devaluation of psychiatry as a career choice by their families and peers. In addition, Asian American medical students are faced with the lack of Asian American role models who have been able to successfully traverse the “bamboo ceiling” and who are invested in serving as mentors. Asian

American residents can find themselves questioning the validity of their unique identity as Asian Americans in residency programs lacking education about the impact of Asian culture on psychiatric presentation, assessment, and treatment. They also face a dearth of adequate training about issues faced by Asian American psychiatry trainees, such as unique transference/countertransference patterns or working with minority populations. This workshop seeks to explore the experience of Asian Americans in their choice to pursue training in psychiatry, and the obstacles that they face in this career trajectory. Asian American residents will discuss their experience in facing stigma in choosing a career in psychiatry, and the challenges they face as Asian Americans furthering their careers in the field. The workshop will also present the experience of senior Asian American psychiatrists with a focus on the ways to become mentors and role models to Asian American medical students, residents and early career psychiatrists. The workshop will seek to create a discussion amongst participants about the Asian American training experience and the means to best overcome the challenges faced by Asian Americans in psychiatry, including means to improve training in cultural psychiatry and improve mentorship for Asian Americans. It will also seek to foster discussion about how the challenges faced by Asian Americans entering a career in psychiatry can serve as an asset in providing culturally sensitive care to patients and in tackling barriers associated with stigma and access to care.

WORKSHOP 020

UNDERSTANDING GENETICS: IT'S NOT JUST MENDELIAN ANYMORE

Chair: Michele T. Pato, M.D.

Presenter(s): Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Develop a better understanding of the vocabulary of genetics, and 2) Identify the difference between risk and cause as defined genetically.

SUMMARY:

Most psychiatrists have a basic understanding of genetics and certainly grapple with the notion of nature versus nurture. For the last 20 years, we have been told that genetics would provide a new window into the causes of mental illness and that it would lead to a new class of targeted treatments. Though much has been published over the last two decades, only recently are we beginning to achieve results that stand the test of time and are truly replicable. At the risk, of once again, creating unrealizable expectations, these

new findings are both proof of the merit of the approach and testament to the true complexity of the syndromes that we treat every day. This workshop will provide a better understanding of what we have learned to date as a field and some essential tools for understanding the discoveries that will continue to be made in the future.

WORKSHOP 021

CHILDREN OF PSYCHIATRISTS

CoChair(s): Michelle B. Riba, M.D., M.S., Leah J. Dickstein, M.D., M.A.

Presenter(s): Eve Stotland, Esq., Helen R Valenstein, B.A., Jeremy Glick, None, Hannah Glick, None

EDUCATIONAL OBJECTIVES:

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, and 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 parent-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 022

PROMOTING IMPROVED INTEGRATION: THE ROLE OF COLLABORATIVE HEALTH CARE IN TODAY'S SOCIETY

Chair: Peter S Martin, M.D., M.P.H.

Presenter(s): Margaret Balfour, M.D., Ph.D., Marilyn Griffin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be

able to: 1) Describe the current system of health care and how this leads to difficulties in integrating primary care with mental health needs, 2) Identify different models of integrative health care, 3) Explore the concept of the medical home and discuss how it can be incorporated into the mental health realm, 4) Distinguish between the integrative models when applied to adult compared to pediatric populations, and 5) Discuss several different payment models to finance integrated health care programs

SUMMARY:

The current system of health care provides many challenges to the integration of general medical and mental health concerns. With time pressures, increasing levels of paperwork, complicated schedules, and the everexpanding perplexity of health care, it can be challenging for practitioners to provide the ideal level of care that many would desire. Changes on a systemic level are required to bring about optimal care while minimizing increased demands placed on practitioners. This workshop will examine various models that have been devised to improve the collaboration of general medical and mental health care. It will begin with a brief discussion of the current system of health care and how this can lead to marked challenges with integrating care. A brief review of different models that have been devised and researched will be examined, showing how specific models may be useful for certain patient populations. The role of the medical home model will specifically be explored to highlight how this may act as an overall framework for various collaborative approaches. Next, integrated models for adult populations will be discussed, focusing on a program developed at West Virginia University highlighting the successes and challenges that come with improving overall health care. From there, exploration of how these models can be applied to children and adolescent populations will be emphasized. Lastly, there will be an overview of payment models that have been successfully utilized to finance integrated health care. The workshop will conclude with an interactive discussion on the individual providers' experiences with collaborative care models.

WORKSHOP 023

RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chair: Eric M. Plakun, M.D.

Presenter(s): Jane G. Tillman, Ph.D.

EDUCATIONAL OBJECTIVES:

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 medicolegal 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 psychiatrist-hose 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 nonpsychiatric 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 024

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM I

CoChair(s): Margaret Haglund, M.D., Rosalyn Womack, D.O.

Presenter(s): Erica P. Kass, M.D., Sonya L. Martin, M.D., M.A., Alison D. Hermann, M.D., Meredith A. Kelly, M.D., Jason E Cheng, M.D.

EDUCATIONAL OBJECTIVES:

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:

This is Part I in a twopart workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most Chief Residents report having satisfying, positive experiences, with the majority saying they would choose to perform the role again. However, studies have also found that Chief Residents tend to be uncertain of their specific responsibilities, hypothesized to be largely due to lack of training for the role and unclear expectations from program leadership. The purpose of this workshop is to provide a forum to discuss these issues and to provide education in the nature of the role of a Chief Residency. In the workshop, we will have presentations from outgoing Chief Residents at several programs across the country. Additionally we will have discussion in both large group and small group formats with incoming Chief Residents from a variety of psychiatry residencies nationwide. 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. Since the majority of past Chief Residents report that their experience as Chiefs inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry. Literature Reference #1 Lim RF, Schwartz E, Servis M, Cox PD, Lai A, Hales RE. The chief resident in psychiatry: roles and responsibilities. *Academic Psychiatry* 2009; 33 (1): 569. Literature Reference #2 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. *Academic Psychiatry* 2007; 31:277280 Literature Reference #3 Warner CH et al: Current perspectives on chief residents in psychiatry. *Academic Psychiatry* 2007; 31:270276

WORKSHOP 025

JOINING THE RANKS OF MILITARY PSYCHIATRY AS A CIVILIAN CONTRACTOR: LESSONS LEARNED

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Presenter(s): Christopher S. Nelson, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know how to integrate into a military mental health department as a civilian contractor, 2) Understand and avoid potential pitfalls inherent in working for the military, 3) Learn how to work effectively with military service members and command **SUMMARY:** The DoD has dramatically increased the number of mental health providers in the last few years. They have hired hundreds of contract

civilian providers, many with no military experience. That has proven to be a mixed blessing from the viewpoint of their customers, the military service members. This workshop will focus on lessons learned from the point of view of an experienced psychiatrist who now works as a civilian contractor at Camp LeJeune. The Public Health Service has also provided many providers to DoD facilities and the lessons learned will be relevant to Public Health Service providers as well.

SUNDAY, MAY 6, 2012

WORKSHOP 026

PAIN IN THE NURSING HOME: A MENTAL HEALTH CONCERN

CoChair(s): Mara Aronson, M.S., R.N., Amita R. Patel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize behavioral and emotional disturbances as possible indications of physical pain, 2) Describe the importance of and difficulties in determining pain in patients with cognitive impairment, 3) By the end of this presentation, participants will be able to guide staff in utilization of pain assessment tools for the cognitively intact and for the cognitively impaired patients, 4) By the end of this presentation, participants will be able to discuss pharmacological management of pain and its limitations, and 5) Describe nonpharmacologic strategies to reduce pain and distress

SUMMARY:

For years, healthcare professionals have been taught that “pain is what the patient says it is” and certainly any pain assessment should begin by eliciting the patient’s report of comfort or pain. Estimates of the prevalence of pain among nursing home residents vary but are as high as 80%. Unfortunately, dementia and other barriers to communication are similarly prevalent among these patients. Often, discomfort and pain are manifested as agitation, aggression, and other behavioral problems. Although conditions that can cause pain become more common with advancing age, pain itself is not a normal part of aging. Whether admitted for short term therapies or long term care, the majority of residents of skilled nursing facilities have conditions associated with pain. Just as in other practice settings, patients in nursing facilities often have no pain management plan or they are undertreated. Mental health professionals are often asked to evaluate patients with problematic behaviors and who have unrecognized pain. Because there is a tremendous variety of pain etiologies, pain type, and clinical presentation among patients, the challenges of assessing and addressing pain in this population are significant but not insurmountable.

Mental health professionals can assume an important role in guiding the interdisciplinary team to recognize, assess, treat, and monitor pain. This seminar will discuss strategies to improve staff clinicians’ recognition and management of pain in nursing home patients. Included in the discussion will be cognitive, communication, and cultural barriers to pain assessment, assessment tools, staff learning needs, assessment tools, and common misconceptions about the management of pain.

WORKSHOP 027

THE INTERNET AS A WEAPON: LEGAL, EDUCATIONAL, AND PSYCHIATRIC PERSPECTIVES ON CYBERBULLYING

Chair: Patricia R. Recupero, M.D., J.D.

Presenter(s): Patricia R. Recupero, M.D., J.D., Laura B. Whiteley, M.D., Anne T. Ryan, Ed.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the psychological aspects of cyberbullying for targets and perpetrators, 2) Describe the implications of cyberbullying in schools, 3) Describe the legal and ethical challenges that may arise when seeking to remedy the problem.

SUMMARY:

In recent years, the phenomenon of cyberbullying has gained widespread recognition as one of the most challenging problems faced by students and their families, physicians and mental health clinicians, educators and school administrators, and legal professionals such as criminal prosecutors and legislators. As technology and the law continue to evolve, it will be important for psychiatrists to understand the problem of cyberbullying from multiple perspectives and in multiple contexts. Dr. Whiteley will address the developmental and psychological issues associated with bullying and cyberbullying, which can lead to long-term mental health and psychosocial consequences for both targets and perpetrators. Dr. Ryan will discuss the disruptive impact that cyberbullying can have on the safety and culture of a school. She will describe system-oriented efforts to address the problem. Dr. Recupero will introduce ethical dilemmas raised by the legal system’s responses to cyberbullying. She will analyze the dynamic tension between the protection of the target and the constitutional rights of the alleged perpetrator. Using several case examples, this workshop will help participants to develop a deeper understanding of the problem and its implications for psychiatry.

WORKSHOP 028

CBASP, AN EVIDENCEBASED PSYCHOTHERAPY

FOR THE TREATMENT OF THE CHRONICALLY DEPRESSED PATIENT

Chair: Sherif A. Ragab, M.D.

Presenter(s): Eric Levander, M.D., M.P.H., Rhea Holler, Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Differentiate chronic depression from acute/episodic major depression, 2) Learn to recognize several CBASP techniques: Situational Analysis, the Significant Other History Procedure that leads to the Interpersonal Discrimination Exercise, and Contingent Personal Responsibility, 3) Learn why CBASP adds Disciplined Personal Involvement to the traditional “neutral” therapist role

SUMMARY:

As recent evidence from STARD demonstrates, medically treating both acute and chronic depression to remission remains a difficult task for the psychiatrist. Chronic depressive illness such as dysthymic disorder or major depression with a current episode lasting longer than two years often is treatment refractory to both medication and standard psychotherapy. Relapses are common amongst remitters. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was developed specifically to treat the chronically depressed adult. Results from the largest psychotherapy and medication trial ever conducted of 681 participants demonstrated CBASP was as effective as medication alone and in combination with medication management produced significant improvements in symptom relief. Yet few clinicians are familiar with this novel psychotherapy. The principal techniques of CBASP include situation analysis (SA) in addition to two types of disciplined personal involvement by the therapist. Situation analysis teaches chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Disciplined therapist personal involvement, a taboo from the infancy of psychotherapy, targets problematic interpersonal behaviors through the use of the Interpersonal Discrimination Exercise (IDE) and contingent personal responsibility (CPR). The IDE is a personal involvement methodology used by the CBASP therapist to heal earlier developmental trauma while CPR employs disciplined personal involvement in a contingent manner to modify pathological interpersonal behavior. These techniques, SA, IDE, and CPR, will be reviewed during this workshop. With few effective evidence based psychotherapies used to treat chronic depressive illness, this workshop is designed to give an overview of CBASP.

WORKSHOP 029**THE ABC'S OF APPLIED BEHAVIORAL ANALYSIS (ABA) FOR AUTISM AND OTHER EDUCATIONAL INTERVENTIONS**

Chair: Alice R. Mao, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) To help psychiatrists to understand the major educational and behavioral interventions used to promote learning and relationship formation used for children with autism spectrum disorders, 2) To help psychiatrists to understand and describe the basic principles of ABA so that they can help parents and caregivers understand the importance of early intervention with ABA, 3) Attendees will be able to describe the essential elements of ABA Floortime and TEACCH interventions to better help their patients understand the need for early interventions and advocate for appropriate services.

SUMMARY:

Objective: to provide psychiatrists with information regarding the educational and behavioral interventions most commonly utilized in the treatment of autism spectrum disorders (ASD). 2. to describe the theoretical basis and empirical evidence supporting interventions such as applied behavioral analysis (aba), dir/floortime and teach so that physicians will be able to make appropriate treatment plan recommendations for children and adolescents with autism. Methods: using a lecture and video format, presenters will: 1) offer clinical examples and research findings to illustrate treatment intervention; and 2) use video vignettes to demonstrate a sample of autism interventions and techniques. Results: presentation content will include: 1) discussion of the specific educational and behavioral challenges common in autistic children; 2) identification and demonstration of basic principles and techniques of programs and their effectiveness. Conclusions: finding successful interventions for children with autism and related disorders can be a daunting task. Some of the most common and proven interventions are those based on aba (applied behavior analysis), relationship building skills, life skills and communication skills (speech therapy and assisted communication). Parents depend upon psychiatrists for advice and support in choosing interventions and advocating for services. Therefore, a familiarity with autism treatment interventions is essential for providing support and guidance to families and caregivers of children with autism.

WORKSHOP 030**DO COGNITIVE PSYCHOLOGY AND NEUROSCIENCE HAVE ANYTHING TO TEACH US ABOUT MORALITY?**

Chair: Carl I. Cohen, M.D.

Presenter(s): Amjad Hindi, M.D., John L. Kubie, Ph.D., Ramotse Saunders, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Develop a working understanding of “nativist” and “empiricist” perspectives in Developmental Psychology, including defining terms such as “core knowledge”, and “qualitative change”, 2) Develop a working understanding of neuroscientific approaches to eliciting answers about complex human behaviors, 3) Define and develop a working understanding of “environment” in the context of human development, and 4) Develop a working understanding of the complexity and biases involved in assigning normative labels

SUMMARY:

There have been increasingly more academic and lay publications about how certain forms of morality may be universal, innate human characteristics. These include elements such as empathy and care, fairness, loyalty, respect and authority, and sanctity. Data derived from studies of infants, primates, and anthropology have been used to justify this position. Moreover, this perspective has implications with respect to psychiatric theory and practice, and is being employed in debates regarding broader social and political policies. This workshop will discuss the validity of this perspective using presenters from neuroscience, neuropsychiatry, cognitive psychology, and social psychiatry. We will first discuss the basis for the “nativism” versus “empiricism” debate. The former views cognitive abilities as hard-wired into the brain and the latter views the brain as having inborn capabilities for learning from the environment but does not contain content such as innate beliefs. We will then address the following topics: Are there qualitative differences between how infants, children and adults think or is there a continuum? What roles do language and brain development have with respect to these transformations? What is the appropriate view of environment and should it include internal effects on gene expression in the developing fetus? What roles do language and culturally biased conceptual formulations play in the assumptions underlying these analyses? What are the limitations of evolutionary psychology methods? The workshop will encourage all the participants to engage in the discussion regarding these questions, especially as it relates to psychiatric issues about what constitutes “normal” human behavior. References: 1. Spelke ES, Kinzler KD. Core Knowledge. *Developmental Science*. 2007;10(1): 8996 2. Kagan J. In Defense of Qualitative Changes in Development. *Child Development*. 2008;79(6): 160624 3. Quinn QC. In Defense of Core Competencies, Qualitative Change, and Continuity. *Child Development*.

2008;79(6): 163338 4. Kagan J. Defending Qualitative Change: The View From Dynamical Systems Theory. *Child Development*. 2008;79(6): 163947 5. Spencer J, Blumberg M, McMurray B et al. Short arms and talking eggs: Why we should no longer abide the native empiricist debate. *Child Dev Perspect*. 2009;3(2): 7987 6. Spelke ES, Kinzler KD. Innateness, Learning, and Rationality *Child Dev Perspect*. 2009;3(2): 9698 7. Tomasello M. *Why We Cooperate*. Cambridge, MA: Boston Review, MIT Press; 2009

WORKSHOP 031

INCARCERATION OF BLACK FEMALES: CASUALTIES AND COLLATERAL DAMAGE FROM “THE WAR ON DRUGS” AND OTHER NONVIOLENT OFFENCES

APA Caucus of Black Psychiatrists

CoChair(s): Napoleon B. Higgins, M.D., Stephen A. McLeod-Bryant, M.D.

Presenter(s): Monique L. Upton, M.D., Aikiesha Shelby, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Examine the acute increase and mass arrest of drug crimes which have targeted AfricanAmerican women over the past decade, 2) Participants will be able to evaluate evidencebased intervention and diversion programs for women that are effective in keeping families together, 3) Discuss the social impact of family relationships and communities when women are taken out of the home and incarcerated, 4) Participants will understand the racial divide in rates of incarceration and the sequelae of how this has damaged AfricanAmerican communities becoming a public epidemic and health concern

SUMMARY:

There has been a rapid increase in the arrest and incarceration of AfricanAmerican women over the past 15 years. Incarceration of women causes unique issues within communities and families due to disruption of the home. In 70% of AfricanAmerican homes the mother is the sole and only provider. This presentation will take a close look at the balance of cost on the American public to incarcerate nonviolent offenders including the court cost, legal fees, and social services provided for the children and families. Much of this has occurred since the national attention to the “War on Drugs.” The fact that AfricanAmerican communities have lower drug use rates and higher incarceration statistics than most other communities, begs the question, “Why this disturbing trend is occurring”? According to the Bureau of Justice Statistics, black women are being incarcerated at a rate of twice that of Hispanic women and 5 times the rate

white women. Most of these crimes are nonviolent offenses. While the incarceration numbers of men are higher than women, women are being incarcerated at a higher rate than men and male incarceration rates are slowing. Jim Crow laws and “separate but equal” has been abolished, it is clear that incarceration is becoming the second most public detriment to blacks in America, only second to enslavement. By the end of this discussion participants should be able to understand the public epidemic of black female incarceration and the dire implications it has on the black community.

WORKSHOP 032

PSYCHIATRIST WORKFORCE SHORTAGE: CHALLENGES AND SOLUTIONS

CoChair(s): Alan Q. Radke, M.D., M.P.H., Joseph J. Parks, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the severe deficit in available psychiatrists now and in the future, 2) Quantify the psychiatrists’ supply and demand dilemma, 3) Review and evaluate potential training, recruitment, retention options and succession planning, 4) Analyze psychiatrists’ roles and interfaces in collaborative models, and 5) Identify mechanisms and infrastructure needed to expand psychiatrists’ involvement in health care reform

SUMMARY:

According to a University of North Carolina (UNC) 2008 study commissioned by Health Resources and Services Administration (HRSA) the United States have a significant shortage of mental health professionals, especially “prescribers”. The current supply of psychiatrists is at least 30,000 short of what is needed. The projected demand for all physicians continues to rise outstripping the projected increase in physicians. For psychiatry, the anticipated demand has risen dramatically. The number of people seeking psychiatric services has increased because of the growing and aging population, mental health parity and antistigma efforts. The number of psychiatric problems has increased because of the economic downturn and the psychological toll of two wars. Other factors increasing the demand for psychiatrists are direct marketing of psychiatric medications to the public and an increase in the number of black box warnings causing primary care clinicians to be reluctant to prescribe psychotropics. This is occurring at the same time that the projected supply of psychiatrists is flat. Psychiatrists are not increasing in number because retirements are outnumbering those entering the workforce through training. Currently 55% of psychiatrists are older than age

55. In a recent projection using a similar methodology to the UNC study, the deficit has increased to 45,000. Current national shortages in mental health professionals specifically psychiatrists will continue to exacerbate. All projections estimate the gap between unmet need and supply will widen substantially over the next 20 years. Traditional workforce strategies alone will do little to mitigate this projected gap. Recruitment and retention strategies must be directed at maintaining the current supply while determining how to use that supply most effectively and efficiently. The shortage of psychiatrists has been identified as a problem at the national level, and in most states. This problem is likely to intensify if current trends in recruitment, retention, training and utilization of psychiatrists continue. NASMHPD Medical Directors Council convened an expert panel to develop a Monograph (also referred to as Technical Paper) on the steadily growing shortage of Psychiatrist workforce necessary to maintain the current level of public mental health system operations. Technical paper covers contributing factors, impact on delivery system operations, and a range of feasible interventions. This monograph will be presented to multiple groups of both policy makers and clinician administrators nationally. No similar comprehensive analysis and resource for change is currently available.

WORKSHOP 033

QUALITY IMPROVEMENT: WHAT IT MEANS FOR PSYCHIATRISTS

Chair: Claudia L. Reardon, M.D. Presenter(s): Robert M. Plovnick, M.D., M.S., Art Walaszek, M.D., John M. Oldham, M.D., M.S., Jerry L. Halverson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe how principles of quality improvement (QI) are likely to influence psychiatric practice, including reimbursement, 2) Explain the requirements involving QI that psychiatrists will need to meet in order to maintain certification and licensure, 3) Recognize the essential elements in teaching QI to psychiatry trainees, 4) List the steps involved in a QI project in realworld clinical psychiatric practice

SUMMARY:

Quality improvement (QI) in medicine involves a formal approach to the analysis of performance and systematic efforts to improve it. Psychiatry has lagged behind other specialties in quality improvement initiatives, in part because psychiatrists view their specialty as an art and not just a science and because they view their care as less amenable to outcomes measures. However, there are a number of reasons why psychiatrists should take the QI movement

seriously, and this workshop utilizes a number of experts in the field to explain these myriad reasons. The Accreditation Council for Graduate Medical Education is increasingly mandating that residency programs provide education in QI to their trainees in order to maintain program accreditation. Dr. Claudia Reardon, Associate Residency Training Director in the University of Wisconsin Department of Psychiatry, has developed one of the first known longitudinal QI curricula for U.S. psychiatry residents and will share essential elements in developing such a curriculum. Dr. Art Walaszek, Vice Chair for Education in the Department of Psychiatry at the University of Wisconsin and Director of Continuing Medical Education for the Wisconsin Psychiatric Association, will explain how the American Board of Psychiatry and Neurology's Maintenance of Certification Program contains a requirement for "Performance in Practice", in which ABPN diplomates will be required to participate in QI projects. Likewise, he will discuss the inevitability that maintenance of licensure will also require physician participation in QI activities. Dr. John Oldham, APA President and Past Chair of the APA Council on Quality Care, will provide an overview of the health care policy aspects of QI in psychiatry, including how reimbursement will increasingly depend on quality indicators. Dr. Jerry Halverson, a psychiatrist-administrator at a large psychiatric hospital who has received extensive national training in QI, will conclude by sharing practical wisdom for incorporating QI into clinical practice. We will finish with plenty of time for audience discussion with a panel consisting of the above speakers and facilitated by Dr. Robert Plovnick, Director of the APA's Department of Quality Improvement and Psychiatric Services.

WORKSHOP 034

BETTER INTEGRATION OF INTERNATIONAL MEDICAL GRADUATES IN PSYCHIATRY BY UNDERSTANDING THEIR

JOURNEY THROUGH APPLICATION, RESIDENCY AND BEYOND

CoChair(s): Lama Bazzi, M.D., Renata Sanders, M.D.

Presenter(s): Lada Alexeenko, M.D., Suprit Parida, M.D., Michael Reinhardt, M.D., Lama Bazzi, M.D., Shaneel Shah, M.B.B.S., Renata Sanders, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the expectations of IMGs applying to residency in the United States, and gain an appreciation for the thought process guiding the choice of programs, 2) Realize obstacles faced by IMGs during the interview trail including financial burden, limited interviews due to visa status and even discrimination, and decisions concerning

prematch offers, 3) Gain an appreciation for the different practical aspects IMGs face in contending with the US health care system, as well as acculturation difficulties

SUMMARY:

International Medical Graduates (IMGs) account for half the applicants to the national residency matching program (NRMP) and comprise about 25% of physicians practicing in the United States. Moreover, IMGs provide care for many ethnic minorities, and work in areas underserved by primary care physicians. Still, the process IMGs go through in applying for residency positions, from the decision to leave their home countries to their acculturation into the US medical system have gone largely unaddressed. In this Workshop, organized and presented by the psychiatry residents of SUNY Downstate Medical Center we aim to describe this journey through the eyes of IMGs. Encouraged by the editors of *Academic Psychiatry*, we organized three groups to examine our classmates' perceptions of their decisions to apply in the US, their experiences on the interview trail, and their experiences after arriving in the US. We collected our data using three anonymous electronic semistructured surveys. Respondents' data were analyzed qualitatively, and recurring themes were identified. On average, the response rate was 69%. The recurring themes in the application process survey were: Significant academic/professional achievements before applying to residency Expectations of better quality of life and psychiatric care in the USA Motivation to apply to US residency because of an idealized view of life, residency and psychiatric practice in the USA Facing discrimination for being an IMG during the application process; contentment with their achievements and quality of life despite disappointment with the reality of psychiatric practice in the US. The most common themes in the interview trail survey were: Applying to many programs for fear of not matching despite extraordinary financial burden Travel expenses that often meant daylong bus rides and sleeping in stations and airports Anxiety during the first interviews including occasional xenophobic interviews Having visa status influence where one could apply Life stresses after getting into a residency program, addressed on the third survey, were commonly depicted and included financial burden, visa issues, acculturation, and adaptation to the practical aspects of US health care and education system. Considering the number of foreign physicians training in the US, we believe that exposing faculty, fellow residents and training program leaders to IMG experiences is very valuable. The responses obtained are clearly not fully generalizable, but we believe they successfully highlight issues that reflect many IMGs' experiences. We hope that this workshop will serve as a venue where prospective and current IMG residents can discuss their experiences with program directors and faculty members, increasing social support and facilitating acculturation. We hope our discus-

sion, moderated by Dr. Goldfinger, our department chair, will be interactive and contribute to an amelioration of systemic issues.

WORKSHOP 035

PSYCHIATRY ON THE FOREFRONT: INCREASING ACCESS TO CARE IN THE DISASTER SETTING

CoChair(s): Catherine S. May, M.D., Elspeth C. Ritchie, M.D., M.P.H.

Presenter(s): David M. Benedek, M.D., Brooke Parish, M.D., Catherine S. May, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand how placing psychiatrists in primary care clinics in the postdisaster period increases access to psychiatric care, 2) Identify the most common medical conditions in postdisaster patient populations, 3) Demonstrate awareness of best medical practices in diagnosing and treating these conditions, 4) Be encouraged to volunteer their services in the disaster setting

SUMMARY:

Historically, psychiatrists providing services in the disaster setting were assigned to Mental Health Teams which functioned separately from Medical Response Teams. Physical and administrative separation meant patients presenting to medical clinics in the postdisaster setting did not have immediate access to psychiatric care. In the wake of each new disaster, there is clear need for immediate mental health services. Psychiatrists are increasingly deployed as part of an integrated disaster response teams and work closely with medical colleagues to provide care to patients with medical and psychiatric comorbidities. Often psychiatrists will be called upon to deliver direct medical care. In order to function effectively in an integrated setting, it is essential that psychiatrists are familiar with the most common medical issues in disaster settings such as basic wound care, musculoskeletal injuries, common infections, and chronic illnesses. This workshop will provide psychiatrists with an overview of the diagnosis and treatment of the most common medical issues and encourage discussion of how the successful integration of psychiatry and primary care can improve access to psychiatric services. Participants will be encouraged to report their experiences with integrated care.

WORKSHOP 036

MILD TRAUMATIC BRAIN INJURY: ASSESSMENT AND INITIAL MANAGEMENT WITH NEUROPHARMACOLOGY

Chair: David Fitzgerald, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Learn about the classification system for mild and moderate/severe TBI and the strengths and weakness of this system, 2) Learn about postconcussive syndrome, timing and typical symptoms, 3) Learn about pharmacologic treatment of postconcussive symptoms

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 military and civilian areas is discussed. Recent imaging data using conventional anatomical imaging and diffusion weighted imaging after mild TBI are presented to provide better insight as to mechanisms of damage. Current therapeutic approaches are also discussed.

WORKSHOP 037

MINDFULNESS FOR THE NEXT GENERATION: THE KORU PROGRAM FOR TEACHING MINDFULNESS AND MEDITATION TO UNIVERSITY STUDENTS AND OTHER EMERGING ADULTS

CoChair(s): Hollister B. Rogers, M.D., Margaret Maytan, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define mindfulness and have a basic understanding of the benefits of a mindfulness practice to individuals in the developmental stage of emerging adulthood (ages 18-25), 2) Understand the pressures faced by emerging adults and the ways in which a mindfulness and meditation practice can help them manage their stress, 3) Identify general teaching strategies that are effective for teaching mindfulness and meditation to the emerging adult demographic, 4) Recognize and use the mindfulnessbased stress management skills that are part of the Koru Program for teaching mindfulness and stress management to emerging adults, and 5) Begin to develop his or her own program for teaching mindfulness and meditation to emerging adults

SUMMARY:

Drs. Rogers and Maytan will introduce the theoretical and practical aspects of the Koru Program, that they have developed at Duke University to teach mindfulness and meditation to emerging adults, the developmental stage that encompasses ages 18-25. The Koru Program is specifically designed to capture the interest of emerging adults and motivate them to develop the life enhancing skills of mindfulness and meditation. In this interactive workshop, the presenters will review the unique features of emerging adulthood and explain why mindfulness is a particularly good fit for individuals in transition to full adulthood. They will then describe general teaching methods that work well for this age group, and review the structure of each of the four classes that make up the Koru Program. The presenters will lead participants through some of the mindbody skills and guided meditations used in the Koru Program. Finally, the authors will lead a question and answer session to develop further the participants understanding of effective strategies for teaching mindfulness and meditation to emerging adults.

WORKSHOP 038

A RESIDENT LEADER'S TOOL KIT

American Psychiatric Leadership Fellowship Program

Chair: Sarah M. Fayad, M.D.

Presenter(s): John O Lusins, M.D., M.S., Margaret W. Leung, M.D., M.P.H., Colin E Stewart, M.D., Kristina Zdanys, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) The participant should be able to identify ways in which they can be involved with APA on a local, state and national level., 2) The participant should be able to understand how to be involved in patient advocacy. They will be able to effectively lobby for their patients with their Senators and Representatives and identify how to write a letter to the editor that addresses such issues., 3) The participant will be able to identify what to do when confronted with an ethical dilemma and how to report an Ethics complaint.

SUMMARY:

The American Psychiatric Leadership Fellowship provides resident physicians with the opportunity to improve their skills in leadership and patient advocacy. Residents do not often receive instruction on how to get involved with the APA on a local, state or national level. Such knowledge is valuable and can be a turning point in the careers of those in training and provide them with leadership opportunities. Residents are also confronted throughout their training with various ethical dilemmas and many lack the training to appropriately handle such situations. Gaining skills in

the management of ethical dilemmas provides residents with yet another important leadership skill. In the face of multiple budget cuts, patient advocacy is becoming increasingly important. Resident physicians need to gain skills to learn how to appropriately lobby for and advocate for their patients. Educating residents about each of these issues can provide them with many tools that are necessary in the development of their leadership skills.

WORKSHOP 039

INTEGRATING PSYCHOTHERAPY AND PSYCHOPHARMACOLOGY: THE PSYCHIATRIST'S ROLE IN THE DIAGNOSIS AND TREATMENT OF SEXUAL DYSFUNCTION

Chair: Eugene F. Simopoulos, M.D.

Presenter(s): Michael Irwig, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify common causes of erectile dysfunction, and the most prevalent sexual disorders in the psychiatric population, 2) Perform a basic laboratory assessment in the diagnosis of erectile dysfunction, and gain understanding in the interpretation of results, 3) Understand the role and efficacy of psychotherapy in the treatment of sexual dysfunction, 4) Gain facility in formulating a biopsychosocial explanation of a patient's sexual dysfunction, and 5) Review basic prescribing strategies in medical management of erectile dysfunction

SUMMARY:

Erectile dysfunction (ED), defined as the inability to achieve or maintain an erection sufficient for satisfactory sexual performance, is the most common sexual problem in men. It arises when there is disruption of the complex interplay between vascular, neurologic, hormonal and psychologic factors necessary for normal erectile function. It may have a significant effect on self-esteem and overall quality of life, interpersonal and intimate relationships, and even portend undetected cardiovascular disease. Risk factors for development of erectile dysfunction include advancing age, tobacco use, a history of pelvic irradiation or surgery, and antipsychotic use. Treatment guidelines exist and continue to evolve for optimal management of these patients. In this review, we provide an up-to-date assessment of diagnostic and treatment strategies for erectile dysfunction. A primary focus on ED will be maintained, though other sexual disorders that psychiatrists treat are briefly discussed. Additionally, special attention will be given to the unique role of therapy in treating the cognitive underpinnings of poor sexual performance, including diminished self-esteem, lack

of confidence, and perceived failures in the male role.

WORKSHOP 040

CHILD ABUSE IN CHILDREN FROM AFROCARIBBEAN, ASIAN AND HISPANIC HOUSEHOLDS: WHAT IT LOOKS LIKE AND HOW TO APPROACH IT

Chair: Jared Kiddoe, M.D., M.A.

Presenter(s): Caroline Fisher, M.D., Ph.D., Jared Kiddoe, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the ways in which child abuse differs across various cultures, 2) Describe different techniques for assessing child abuse across different cultures, 3) Discuss a plan of action

SUMMARY:

Child abuse is a rampant and growing problem in the United States. The statistics are as troubling as they are staggering. In the U.S. a report of child abuse is made every ten seconds. The estimated annual cost of child abuse and neglect exceeds \$100 billion, yearly. Each year over 1700 children die in the US as a result of child maltreatment and over 80% of these deaths are of children under the age of four. Child abuse also does not discriminate by socioeconomic classes African American and Hispanic children comprise over twenty percent of child maltreatment victims respectively, White children comprise over forty percent of victims. However, many of the paradigms psychiatrists and other mental health professionals use to assess for child abuse among varying populations are often not culturally sensitive which can result in both a lack of detection of possible abuse and cause possible offense to the patients they are trying to serve. Immigrant cultures can present unique challenges depending on the level of acculturation that families have achieved making assessments that more difficult. This workshop will aid psychiatrists and other mental healthcare professionals improve their cultural sensitivity when approaching potential abuse situations in diverse immigrant populations. The workshop will involve the use of realistic clinical vignettes presented by Drs. Kiddoe, Fontes and KimGoh to help workshop participants discuss the various clinical implications of crosscultural abuse assessments of children. Lectures will also provide practical tips for avoiding cultural misinterpretations and assist in crafting well thought out and probing questions. Participants will also be asked to discuss their opinions and experiences approaching this issue in their own practices. Making use of both audience participation and a panel of experts within

the realm of minority child abuse the workshop will address these issues 1) how the symptoms of child abuse vary across Asian, Hispanic and AfroCaribbean immigrant cultures, 2) how the techniques for detecting child abuse varies across these cultures, 3) How residency training programs can improve training for the detection of child abuse.

WORKSHOP 041

PREVENTION OF HARM FROM STALKING

CoChair(s): Gail E. Robinson, M.D., Karen M. Abrams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the practical and psychological impact of stalking on individuals and healthcare professionals, 2) advise patients and healthcare professionals about how to protect themselves from being stalked, 3) Advise patients and healthcare professionals about how to cope with being stalked.

SUMMARY:

Victims of stalking may experience anxiety, depression, guilt, helplessness and symptoms of posttraumatic stress disorder. They may also be subjected to vandalism and personal violence. In the general public, most stalking victims are women who are stalked by former intimates. Healthcare workers are vulnerable to being victims of stalking by their patients, most often from stalkers who are intimacy seeking, resentful or incompetent. Healthcare workers regularly see lonely or mentally unstable individuals who may misconstrue sympathy and attention as romantic interest. Therapists may be vulnerable as a result of erotic transference. Healthcare workers are often unaware of this risk and do not know how to recognize early warning signs or institute safety measures to minimize the risk of being stalked. Threat management for individual victims of stalking requires a comprehensive approach including education, supportive psychotherapy and a discussion of practical measures. Education to victims about the nature of stalking, including common emotional reactions helps to validate victims' feelings, reduce selfdoubt, and mobilize them to find ways to protect themselves. Therapists can advise and empower victims to take control of their lives and reduce their risk through documentation, collection evidence and institution of a variety of personal safety precautions. This presentation will cover both psychotherapeutic and practical approaches to individual victims that will help decrease their personal risk, as well as warning signs and suggestions for management of stalkers in the healthcare setting.

WORKSHOP 042

MANAGEMENT OF PATIENTS WITH ALCOHOL

AND COOCCURRING DISORDERS: PROBLEMS AND SOLUTIONS*U.S. National Institute on Alcohol Abuse and Alcoholism**Chair: Geetanjali Chander, M.D., M.P.H.**Presenter(s): Geetanjali Chander, M.D., Sarah Book, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Understand the impact of alcohol use disorders on clinical outcomes in patients with cooccurring mental health disorders, with special emphasis on: (1) women with cooccurring alcohol use disorders, HIV/AIDS, depression, and anxiety, and (2) individuals with cooccurring social anxiety and AUDs, 2) Screen for and diagnose cooccurring alcohol use disorders in individuals with mental health disorders, 3) Improve the approach to treatment of patients with cooccurring alcohol use disorders and mental health disorders

SUMMARY:

Alcohol and other mental health and somatic disorders frequently cooccur, and affected patients usually require a significantly greater commitment of treatment resources while experiencing significantly worse clinical outcomes. Among the wide variety of individuals with alcohol and cooccurring disorders, women with cooccurring HIV, alcohol use, and mental health disorders, and individuals with cooccurring alcohol use disorders and social anxiety disorder are populations of growing public health importance. This workshop will include an overview of the current research on HIVinfected women with cooccurring alcohol misuse and other mental health disorders, with special emphasis on cooccurring anxiety and depression. Specific topics will include the role of screening, the impact of these concurrent disorders on treatment outcomes, and researchbased recommendations for an integrated approach to the management of “triply diagnosed” HIVinfected women with cooccurring mental health and alcohol use disorders. The second presentation will highlight findings from the past decade of research on individuals with cooccurring social anxiety disorder, also known as social phobia, and alcohol use disorders, a population known to be particularly resistant to treatment. Among other topics, the speaker will share new insights on the phenomenon of use of alcohol to cope with anxietyprovoking social situations, and best approaches to helping socially anxious people participate successfully in groupbased treatments. The overarching goal of the workshop is to provide participants with practical recommendations for helping patients with these historically complex and hardtotreat disorders to improve their quality of life, with special emphasis on the use of interdisci-

plinary teams (e.g., comprising psychiatrists, psychologists, internists, social workers, etc.) to provide optimal patient care.

WORKSHOP 043**WRITING FOR THE LAY PUBLIC: POINTERS FROM A PSYCHIATRIST WRITER, INVESTIGATIVE JOURNALIST, AND THE TRAINEE PERSPECTIVE***CoChair(s): Serina R. Deen, M.D., M.P.H., David J Hellerstein, M.D.**Presenter(s): Serina R. Deen, M.D., M.P.H., David J Hellerstein, M.D., Stephen M. Fried***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Recognize the importance of training physicians in writing responsibly for the lay public, 2) Identify pitfalls in translating scientific studies for the lay public, 3) Explain three main types of nonfiction pieces psychiatrists can write for the lay public.

SUMMARY:

As psychiatrists, we learn how to communicate oneonone with patients. However there is also a valid and important role for psychiatrists to communicate with larger audiences to disseminate information; a role for which psychiatrists are generally not welltrained. All psychiatrists should be trained to some degree on how to communicate with the public, with a specific few specializing in this work. This workshop will provide advice about how psychiatrists can effectively interact with the media (e.g. issues about confidentiality, accuracy of information, and selfdisclosure). Different formats for communication, including medical journalism, opinion/editorial pieces, and narrative writing will be discussed. Case examples from written media will be used to illustrate pitfalls in the translation of psychiatric knowledge to the public. Each of the speakers will present for 15 minutes on their experience. There will be a 15 minute breakout session in the middle of the workshop when participants will be given a new study result and asked to identify the types of pieces they could write based on the study, potential places they could publish the pieces, and the needs of each publication. This will be followed by a 30 minute question and answer session. The workshop is based on a collaborative effort between a psychiatry resident, supervising psychiatristwriter, and investigative journalist in developing a residency writing elective to learn how to use written media to communicate with different audiences about important issues in psychiatry.

WORKSHOP 044

HOW DOES SHE DO IT ALL? BALANCING FAMILY, LIFE, AND CAREER

CoChair(s): Silvia W. Olarte, M.D., Leah J. Dickstein, M.D., M.A.

Presenter(s): Eva Szigethy, M.D., Ph.D., Silvia W. Olarte, M.D., Toi B. Harris, M.D., Alice R. Mao, M.D.

EDUCATIONAL OBJECTIVES:

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, 2) Discuss the current literature related to worklifebalance for women physicians, 3) Delineate unique stressors that female physicians encounter related to their vocation, 4) Discuss possible strategies to enhance professional performance

SUMMARY:

Over the last thirty years, the percentage 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 physician workforce 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. 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. Those women psychiatrists that could combine family life, intimate relationships, and academic involvement where the most satisfied. The price they reportedly paid was decreased availability for personal time. While times have changed and sharing of roles inside and outside of the home are more common, anecdotal experience among current residents and early career psychiatrists still resonates with the results obtained during the 1995 survey. This workshop will address some of the innovative solutions currently implemented by the younger generation of women psychiatrists and will discuss the existing problems stemming from the stress of balancing personal life, family and career. 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/aboutama/ourpeople/membergroupssections/womenphysicianscongress/statistics/history/table1physiciansgenderexcludesstudents.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):3214

WORKSHOP 045**GROUP SCHEMA THERAPY FOR BORDERLINE PERSONALITY DISORDER**

Chair: Heather M. Fretwell, M.D.

Presenter(s): Neele Reiss, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand and utilize the concepts of schemas and modes as they pertain to schema therapy in the treatment of personality disorders, 2) Utilize modespecific techniques to cognitively, experientially, and behaviorally treat maladaptive coping modes, and 3) Adapt techniques for use in both individual therapy and group therapy for a variety of personality disorders

SUMMARY:

Borderline Personality Disorder (BPD) has long been viewed as severe and difficult to treat. Most psychotherapeutic approaches have focused on BPD's life threatening symptoms. Other symptoms such as dysphoria or emptiness result in a decrease of general functioning and a low quality of life. Schema Therapy (ST; Young, Klosko & Weishaar, 2003) has been developed to especially address the whole array of BPD symptoms. Several studies have shown the effectiveness of ST in the individual setting (GiesenBloo et al., 2006). A recent development in ST is Group ST (GST) for patients with BPD (Farrell et al., 2009). For GST a therapist-cotherapist model has been developed to address both, the needs of the group as a whole and the need of an individual patient in the group. Key components of ST such as limited reparenting and imagery work are adapted to the group setting. In this workshop the mode model will be explained. GST specific strategies to work with dysfunctional modes will be presented and subsequently practiced by role play. The adaptation of key components to the group setting will be demonstrated. Adaptations for personality disorders other than BPD will be discussed.

WORKSHOP 046**WHEN PHYSICIANS DIE BY SUICIDE: WHAT CAN WE LEARN FROM THEIR LOVED ONES?**

Chair: Michael F. Myers, M.D.

Presenter(s): Margaret R. Watanabe, M.D., Ph.D., Dan Bree, M.S., Anna H. Rosen, M.D., Carla Fine, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Become familiar with how suicide affects the loved ones of physicians, 2) Know what bereaved family members can teach us about factors that may contribute to physician suicide, and 3) Learn how we can help grieving family members when they consult us.

SUMMARY:

It is estimated that 300,400 physicians, and an unknown number of medical students, die by suicide each year in the United States. We have increasing research on this tragic subject, especially the role of individual factors (burnout, depression, substance use, medical illness, perfectionism, extreme loss) and systemic factors (overwork, lawsuits, medical licensing and hospital privileging disclosures) but most families of medical students and physicians have been excluded from these studies. In this workshop, four family members ('survivors') will enlighten us with their observations and recommendations. Dr. Margaret "Peggy" Watanabe, an obstetriciangynecologist, lost her husband, Dr. August "Gus" Watanabe, in 2009. She will discuss how being in the business of saving lives can lead to feelings of personal failure when a family member dies. She will also discuss how difficult it can be for high achieving individuals to see that depression is not a sign of weakness or failure and how this impedes their seeking help. Dan Bree, a New York based TV producer and writer, lost his father, Dr. Robert Bree, to suicide in 2010. He will talk about how the culture of the medical community exacerbates and augments the problem of physician depression. He will also talk about new physician wellness initiatives which seek to address this problem. 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 provider. Carla Fine, a writer, lost her husband Dr. Harry Reiss, in 1989. She will discuss the impact that suicide has on families, friends, and colleagues, and talk about the silence and stigma surrounding death by suicide, especially in the medical community. Audience members are invited to engage with the speakers in their quest to reduce suicide in medical students and physicians.

WORKSHOP 047

EVALUATION AND TREATMENT OF THE COMPLEX

EATING DISORDERED PATIENT

CoChair(s): Susan Ice, M.D., Alican Dalkilic, M.D., M.P.H.

Presenter(s): David Hahn, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the most commonly occurring cooccurring conditions, both medical and psychiatric, and understand their relationship to the eating disorder, 2) Appreciate the complexity of the treatment approach to eating disorders based on the medical, nutritional, and psychological complexity of their presentations, 3) Understand how evidence based treatments can be incorporated into the treatment of complex eating disordered patients, 4) Understand the implications of pharmacotherapy of the complex eating disordered patient, and 5) Appreciate the contribution that chronicity makes to complexity and how to manage it.

SUMMARY:

Eating disorders, which have increased in incidence, prevalence, and diversity, remain complex biopsychosocial illnesses whose assessment and treatment require broadbased and expert evaluation and treatment, usually implicating a diversified treatment team. Difficult to study and difficult to delineate clearly in the treatment (versus research) setting, eating disorders demand a rational approach that combines empiricism and clinical experience. Eating disorders are multiply determined pathological states that result in significant morbidity and mortality. Causality is less important in the acute treatment setting than the presentation and progression of the eating disorder, including the presence of comorbid mental and physical illness. The evaluation of the whole individual – including commonly occurring medical and psychiatric illness, as well as the physical/nutritional impact of the eating disorder, the psychological state of the patient – including and most importantly motivation, and the social context, including family and peer relationships, are all important aspects of a full assessment. This assessment then leads to prioritization of and determination of place of treatment. Diabetes, seizure disorders, and cooccurring traumatic reactions, substance abuse and dependence, mood disorders, and personality disorders are among the increasingly common other conditions that complicate treatment of the eating disorder. One logical approach to this complexity requires an ability to choose among and integrate a variety of psychological (motivational, interpersonal, family based, cognitive behavioral, dialectic behavioral, and experiential among them), behavioral, and biological treatments, and providers of treatment, as well as treatment settings. In addition, the importance of coordinated and seamless care is extreme in dealing with these usually highly ambivalent patients for whom a

trusting treatment relationship is primary. The treatment of one problem often exacerbates another problem, physiological and/or psychological, making choice and timing of interventions critical to successful outcome. The ability to move up and down a continuum of care and to provide an adequate variety of treatment options is important in providing the support required for the natural ebb and flow of the recovery process, particularly poignant in the complex patient. Return to full function and improved quality of life are ultimate goals for all.

WORKSHOP 048

THE ART OF NARRATIVE PSYCHIATRY: INTEGRATING THE VALUES AND STRATEGIES OF NARRATIVE PSYCHOTHERAPY WITH PSYCHIATRIC PRACTICE

Chair: SuEllen Hamkins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand how to integrate innovative, strengths-based healing practices of narrative psychotherapy into one's practice of psychotherapy and psychopharmacology, 2) Understand how to therapeutically uncover and develop stories of resiliency in an initial psychiatric consultation while simultaneously gathering a thorough history, 3) Begin to apply narrative reauthoring practices in psychotherapy and medication consultations to externalize and deconstruct problems, discover and develop hidden sources of strength and skill, and promote positive identity development, 4) Understand how to therapeutically collaborate with patients in determining what medication and other biological resources have to offer in light of the values and preferences of the patient

SUMMARY:

Narrative psychiatry is an innovative approach that combines the respectful values and healing practices of narrative psychotherapy with the tools of psychiatry. Through detailed exploration of clinical interviews, this workshop will deepen participants' understanding of the theory and practice of narrative psychiatry and offers the opportunity to develop practical skills that can be easily integrated into one's existing practice. Narrative psychiatry is a strengths-based practice that relishes discovering and developing untold but inspiring stories of resiliency and skill in facing challenges. Rather than seeking the source of a problem, narrative psychiatry seeks the source of a person's strength, then expands that ability through reauthoring conversations that deconstruct problemsaturated discourses and contribute to positive identity development. Applicable to the practice of both psychotherapy and psychopharmacology,

narrative psychiatry examines what medication and other biological resources have to offer in light of the values and preferences of the person seeking consultation, authorizing the patient as the arbiter of what is helpful and what is not. Narrative psychiatry is energizing and uplifting to patients and to psychiatrists practicing it.

WORKSHOP 049

CPT CODING AND DOCUMENTATION UPDATE

APA Committee on RBRVS, Codes and Reimbursement

Chair: Ronald M. Burd, M.D. Presenter(s): Joseph M Schwartz, M.D., Junji Takeshita, M.D., Edward Gordon, M.D., L. Mark Russakoff, M.D., Sarah E. Parsons, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Be knowledgeable about current Medicare and CPT coding changes, 2) Uptodate on Medicare reimbursement concerns, 3) Have their individual questions about coding, documentation and reimbursement addressed.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding and current issues associated with documentation guidelines. This year's workshop will focus on 1) updating participants as to current issues related to CPT coding 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.

WORKSHOP 050

A TERRIBLE MELANCHOLY: DEPRESSION IN THE LEGAL PROFESSION

Chair: Lawson R. Wulsin, M.D.

Presenter(s): Daniel T. Lukasik, Esq., Lawson R. Wulsin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Raise awareness in the psychiatric community about the prevalence of depression in the legal profession, 2) Explore the reasons why those in the legal profession suffer from depression rate twice that of the general population, and 3) Offer specific solutions to treating those who

suffer with depression in the legal profession.

SUMMARY:

Clinical Depression is a large problem in the legal profession. Studies indicate that approximately 20 percent, or 200,000, of this nation's 1 million lawyers, struggle with the disease. Other studies show that as much as 40 percent of this country's 150,000 law students experience clinical depression at some point during their three years at law school. Many lawyers, those in the general public, and treating mental health providers, are unaware of the high rates of depression in the profession, the causes, or effective ways to address it. There are few tools available to law school educators, legal organizations and mental health providers to address this issue. For these reasons, an original documentary, "A Terrible Melancholy: Depression in the Legal Profession," was made in 2010. Dan Lukasik, a lawyer from Buffalo, New York, is the film's Executive Producer. Mr. Lukasik is also the creator of the first national website in this country designed to address lawyer depression, Lawyerswithdepression.com. The site has been featured in *The New York Times*, *The Wall Street Journal*, *The National Law Journal* and many other national and international publications. He has written widely on the subject and spoken around the country to educate others about this problem. In addition to the website which he began four years ago, Mr. Lukasik started a blog two years ago about his experiences dealing with stress, anxiety and depression while practicing law and started a support group for lawyers with depression which meets twice per week. The documentary features four lawyers, one judge and a lawyer whose best friend committed suicide while in law school. In addition, the film features Joshua Wolf Shenk, author of the bestselling book, "Lincoln's Melancholy: How Depression Fueled a Presidency," David Dunner, M.D., Professor Emeritus and psychiatrist at the University at Washington in Seattle, Andrew Benjamin, J.D., Ph.D., professor of psychology at the University at Washington who has studied law student and lawyer depression and James Shiffner, Ph.D., a psychologist and facilitator of a depression support group for lawyers. Mr. Lukasik will talk about how he was diagnosed with depression, his experiences with medication and therapy, and his recovery. Dr Wulsin will discuss the role of psychiatrists in promoting depression awareness within the legal profession and facilitating access to prevention and treatment services.

WORKSHOP 051

PSYCHIATRIC FACTORS IN BARIATRIC SURGERY: ASSESSMENT AND BEYOND

Chair: Sanjeev Sockalingam, M.D.

Presenter(s): Stephanie Cassin, Ph.D., Sanjeev Sockalingam, M.D., Raed Hawa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe an approach to psychosocial risk assessment of surgical candidates for bariatric surgery based upon current research data, 2) Recognize common neuropsychiatric complications secondary to nutritional deficiencies emerging postbariatric surgery, and 3) Identify the evidence on psychosocial interventions, including a novel telephone CBT intervention, on improving bariatric surgery outcomes

SUMMARY:

With the obesity epidemic reaching epic proportions in North America, weight loss treatments are in increasing demand. Bariatric surgery is a treatment alternative for morbid obesity and its popularity has resulted in over 200 000 surgeries being performed in the United States. Psychiatric comorbidity is the rule rather than the exception in bariatric surgery candidates. Assessment of "psychiatric readiness" is instrumental to the preoperative phase of bariatric surgery. The following workshop will explore recent advances on psychiatric risk stratification for bariatric surgery. Psychiatric exclusion criteria and evidence for weight loss surgery in patients with severe mental illness will be explored. The presenter will draw on research from their multisite bariatric centre, which performs over 500 surgeries per year and utilizes an integrated psychosocial team offering pre and postsurgery followup for up to 5 years. Psychosocial complications and outcomes postbariatric surgery will be reviewed. We will use cases to reinforce an approach to psychiatric assessment prior to bariatric surgery and determining suitability for this procedure. We will also review common nutritional deficiencies associated with various weight loss surgery procedures. Neuropsychiatric manifestations of key nutritional deficiencies postbariatric surgery will be discussed and reinforced with cases highlighting the role of psychiatrists in managing these deficiencies. Treatment of neuropsychiatric sequelae postbariatric surgery will be reviewed. Finally, we will review the evidence for psychosocial interventions on postsurgery weight loss and psychosocial outcomes. A discussion of a novel telephone cognitive behavioral therapy intervention and its evidence will be reviewed. During the workshop, participants will roleplay a single session from this CBT intervention. Psychiatric resources for bariatric surgery mental health professional will be provided.

WORKSHOP 052

PUBLIC LAW 111148 (THE PATIENT PROTECTION AND AFFORDABLE CARE ACT) IS DEEPLY FLAWED AND SHOULD BE REPEALED: VIEWS FROM THE LEFT AND THE RIGHT

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

Presenter(s): Leslie H. Gise, M.D., Mark J. Schiller, M.D., John J. Wernert, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the challenges of implementing the Affordable Care Act for all Americans and especially those with mental disorders, 2) Appreciate the pros and cons of a single payer solution as an alternative to the Affordable Care Act, and 3) Appreciate the pros and cons of more market-driven alternatives to the Affordable Care Act

SUMMARY:

In 2010, President Barack Obama signed into law a 2000+page Act that promises to transform the U.S. health care system. Its most notable features include barring insurance companies from denying coverage based on preexisting conditions and dropping coverage because of illness. It also expands insurance coverage to millions of uninsured Americans through an expansion of Medicaid as well as mandating coverage for individuals and small businesses. For individuals with mental illness and substance use disorders, this Act, in combination with the 2008 Mental Health Parity Law, substantially expands comprehensive, nondiscriminatory coverage for treatment. Many believe, however, despite these laudable goals, that the law is deeply flawed and should be repealed. It is extremely complex and will not bend the cost curve for health care and, therefore, is unsustainable. For individuals with mental or substance use disorders, expanding basic medical coverage may be at the expense of benefits that fall outside of the scope of what is typically covered by private insurance. Medicaid, today, covers a broader range of mental health and substance use services, including partial hospitalization, psychosocial rehabilitation, case management, and assertive community treatment. In an effort to contain costs, these benefits are not likely to be covered as Medicaid expands to those who are currently uninsured. This workshop will explore views from the Left who advocate a public, single payer, “Medicare for all” approach and from the Right who advocate a private insurance, individualchoice, competitive model that allows the market to allocate resources and contain costs.

WORKSHOP 053

PSYCHOTHERAPY UPDATE FOR THE PRACTICING PSYCHIATRIST

Chair: Priyanthy Weerasekera, M.D., M.Ed.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify and recommend specific evidencebased psychotherapies for patients with psychiatric disorders, 2)

Pay attention to important alliance building skills in delivering psychotherapies, and 3) Identify important individual variables when considering different psychotherapies for patients with psychiatric disorders

SUMMARY:

The last few decades have witnessed significant advances in psychotherapy research. This research has demonstrated that there are evidencebased 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 evidencebased therapies studied to date, cognitivebehavioural, 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 doubleblind 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 054

BEDLAM REVISITED: SOCIETY, PSYCHIATRY, AND SEVERELY MENTALLY ILL INDIVIDUALS

Chair: Ken Rosenberg, M.D.

Presenter(s): Fuller Torrey, M.D., John A. Talbott, M.D., Ken Rosenberg, M.D., Jeffrey Lieberman, M.D., Paul J Fink, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Trace the history of the plight of the SMI, and 2) Offer current and effective solutions

SUMMARY:

Currently, the largest mental institution in the United States is the LA County Jail, with New York City’s Riker’s

Island and Illinois' Cook County Jail in second and third place. Currently, a significant percentage of the SMI, once warehoused in asylums, are homeless and housed in jails. Throughout our history, American psychiatric experts have been calling attention to the problems, offering solutions, and advocating integrative care and health policy reform for our neediest patients. This workshop will trace the history of the plight of the SMI, offer current and effective solutions, and propose a positive role for American psychiatry. The workshop will begin with a five-minute video from psychiatrist and Peabody and Emmy Award winning filmmaker Kenneth Paul Rosenberg, MD. Dr. Rosenberg will briefly present previously unscreened footage shot for a documentary that he is producing on the SMI in collaboration with HBO. Paul Fink, MD, former President of the American Psychiatric Association and a preeminent proponent of destigmatization, will Chair the event. John Talbott, MD, author of "The Death of the Asylum" and editor of the American Psychiatric Press Textbook of Psychiatry and the Textbook of Administrative Psychiatry, will trace the history of the SMI from institutionalization, through deinstitutionalization, to homelessness and incarceration. Fuller Torrey, MD, founder of the Treatment Advocacy Center, will discuss the current situation in the American jails and will discuss assisted outpatient treatment programs and the importance of professional and public advocacy. Jeffrey Lieberman, MD, Chairman of Psychiatry at Columbia University Medical Center and coeditor of the Textbook of Schizophrenia, will offer closing remarks about the scientific advances in understanding severe mental illness and will offer national policy recommendations for treatment and research.

WORKSHOP 055

THE SIGMA ENIGMA: THE ROLE OF SIGMA RECEPTORS IN THE CURRENT PRACTICE OF PSYCHOPHARMACOLOGY

Chair: Damir Huremovic, M.D., M.P.P.

Presenter(s): Sadaf Ahmed, M.D., Madhavi Nagalla, M.D., Guitelle St. Victor, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Become familiar with the current state of knowledge about the little-known role of sigma receptors in neurobehavioral processes, 2) Understand how and in what fashion presently available and widely used psychotropics affect sigma receptors, and 3) Incorporate sigmaergic properties of psychotropics into their psychopharmacological formulations and approaches to treatment of various psychiatric conditions.

SUMMARY:

Once thought to be a subtype of opioid receptors, sigma receptors have recently been redefined and elevated to the level of 'receptor chaperones'. While our theoretical understanding of the role of sigma receptors remains very limited, in our daily practice of psychiatry we routinely prescribe well-known psychotropics which possess significant, but largely disregarded, sigmaergic and antisigmaergic properties. The goal of this workshop is to educate the participants about the class of sigma receptors and its possible roles in pathophysiology of neuropsychiatric conditions and to help them start taking sigmaergic properties into account when selecting psychotropic medications for a variety of indications. Sigma-1 receptors are assumed to serve as a regulator of ATP production and bioenergetics within the cell. In the endoplasmic reticulum they play a key role in Ca²⁺ signaling and cell survival, and have been shown to regulate a number of neurotransmitter systems in the brain. Furthermore, sigma-1 receptor agonists have been implicated in the enhancement of neuroplasticity and cognitive functioning. As such, sigma receptors are currently being revisited as potential mediators in psychosis, mood and anxiety disorders (OCD), as well as in dementia and delirium. Biological research is focused on discovering the exact downstream cascade of sigma receptor activation resulting in a potential improvement in neuronal metabolism and in cognitive improvement, as well as on receptor density changes suspected or discovered in various conditions (e.g. Alzheimer's dementia). While credible evidence is still pending, the practice of clinical psychiatry abounds with use of psychotropics with significant sigmaergic (e.g. donepezil, fluvoxamine) or antisigmaergic properties (e.g. haloperidol, sertraline). It is quite conceivable that some of the therapeutic benefits as well as side effects can be ascribed to sigmaergic properties of these medications. Until the role of sigma receptors is better understood, it is helpful to summarize the current state of knowledge and explore possible strategies for research and for optimization of pharmacological treatment of various neuropsychiatric disorders based on sigma effects of medications that are already being used. A discussion will be generated to gauge the current awareness of the possible role of sigma receptors in neuropsychiatry and encourage further exploration and research in this direction.

WORKSHOP 056

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM II

CoChair(s): Margaret Haglund, M.D., Alison D. Hermann, M.D.

Presenter(s): Erica P. Kass, M.D., Sonya L. Martin, M.D., M.A., Meredith A. Kelly, M.D., Jason E. Cheng, M.D.

EDUCATIONAL OBJECTIVES:

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:

This is Part II in a twopart workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences. In a recent study, most Chief Residents report having satisfying, positive experiences, with the majority saying they would choose to perform the role again. However, studies have also found that Chief Residents tend to be uncertain of their specific responsibilities, hypothesized to be largely due to lack of training for the role and unclear expectations from program leadership. The purpose of this workshop is to provide a forum to discuss these issues and to provide education in the nature of the role of a Chief Residency. In the workshop, we will have presentations from outgoing Chief Residents at several programs across the country. Additionally we will have discussion in both large group and small group formats with incoming Chief Residents from a variety of psychiatry residencies nationwide. 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. Since the majority of past Chief Residents report that their experience as Chiefs inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry. Literature Reference #1 Lim RF, Schwartz E, Servis M, Cox PD, Lai A, Hales RE. The chief resident in psychiatry: roles and responsibilities. *Academic Psychiatry* 2009; 33 (1): 569. Literature Reference #2 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. *Academic Psychiatry* 2007; 31:277280 Literature Reference #3 Warner CH et al: Current perspectives on chief residents in psychiatry. *Academic Psychiatry* 2007; 31:270276

WORKSHOP 057**EVALUATION AND MANAGEMENT OF PATIENTS WITH EXCESSIVE DAYTIME SLEEPINESS IN PSYCHIATRIC PRACTICE**

CoChair(s): Dimitri D Markov, M.D., Marina Goldman, M.D.

Presenter(s): Karl Doghramji, M.D., Dimitri D Markov, M.D., Abigail Kay, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) The participant should be able to list primary sleep disorders associated with excessive daytime sleepiness, 2) The participant should be able to understand the pathophysiology of narcolepsy and other hypersomnias., and 3) The participant should be able to understand how hypersomnias are diagnosed and treated.

SUMMARY:

In recent years, there has been a great expansion of knowledge about sleep disorders. This knowledge, however, has not been fully implemented into clinical practice. Many psychiatrists can recognize common sleep disorders. However, more needs to be done to educate psychiatrists about diagnosing and treating sleep disorders that are associated with excessive daytime sleepiness. By addressing excessive daytime sleepiness of patients, psychiatrist can improve the physical and psychological health and quality of life of their patients. Faculty will offer a practical framework to approach patients with excessive daytime sleepiness. We will discuss pathophysiology, clinical features, and management of primary sleep disorders associated with excessive daytime sleepiness. Faculty will also discuss challenges of addressing sleep disorders in patients with substance use disorders. This highly interactive workshop will offer a practical framework to approach sleepy patients.

WORKSHOP 058**LEGAL, RISK, AND ETHICAL CONSIDERATIONS IN THE AGE OF TECHNOLOGY AND ONLINE SOCIAL NETWORKING**

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

Presenter(s): Claire Zilber, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate patient confidentiality issues which can occur with online social networking, 2) Understand boundary issues which can occur with online social networking, 3) Recognize the psychiatrist's duty of professionalism when engaging in online social networking, 4) Understand general standard of care issues, limitations on use of telemedicine, and safety and security issues, and 5) Explore risk management and liability exposures pertaining to confidentiality, boundary issues, duties of professionalism and general standard of care issues as they apply to online social networking

SUMMARY:

While confidentiality is an ethical, legal and treatment requirement, the methods of communication used in the modern world have moved the boundaries to places far different from those envisioned by the developers of psychiatry. The speed of electronic media including use of social networking sites such as Facebook, Skype and YouTube, as well as use of emails and cell phones have expanded the ways of communication. Additionally, these forms of communication have increased the possibilities for breaching patient confidentiality and also have ethical and professional implications. Emphasis will be placed on the ethical, legal and professional issues presented by the use of these forms of communication. This program will examine the problems presented by modern connectivity and provide recommendations to limit or avoid the legal ramifications brought about by these changes.

WORKSHOP 059**HOW GIRLS, MOTHERS, AND MOTHERDAUGHTER RELATIONSHIPS CAN THRIVE THROUGH ADOLESCENCE: UPDATES FROM THE MOTHERDAUGHTER PROJECT**

Chair: SuEllen Hamkins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand factors that The MotherDaughter Project identified as key in helping mothers and daughters thrive despite the challenges that girls face growing up and that mothers face in raising daughters in today's world, 2) Describe how mothers and daughters can sustain close, caring relationships through adolescence by focusing on the development of both greater autonomy and greater capacity for connection, 3) Understand why girls today are dealing with challenges such as poor body image, precocious sexuality, unhealthy relationships, selfinjury and suicidality at younger ages, and what new strategies can help them thrive despite these threats, and 4) Facilitate a motherdaughter group that promotes the wellbeing of mothers, daughters, and motherdaughter relationships

SUMMARY:

How can girls make it through adolescence strong, confident and whole? How can mothers and daughters sustain positive and loving relationships through adolescence? And how can mothers get the support they need to do the tough work of mothering in today's world? Beginning over a decade ago, a group of women including psychiatrists, family therapists and community activists created the MotherDaughter Project to address these questions. Through

the examination and deconstruction of popular and professional motherdaughter discourses and through the creation and implementation of novel approaches to adolescent development, we discovered ways to help mothers, girls and motherdaughter relationships thrive through adolescence. One secret we discovered is that teen girls miss their mothers and want to stay close but they are also looking to wider culture to see what maturity looks like. Offering girls the opportunity to address the hot topics of growing up like friendship, body image, puberty and sexuality by connecting with another girl and her mother or a group of mothers and daughters meets girls' needs for having fun with peers while also staying connected with their mothers and learning from their wisdom. Likewise, connecting women with other mothers offers the chance to share challenges and expertise on growing up female. This workshop presents the latest ideas and strategies of The MotherDaughter Project, which participants can use professionally and personally as a resource that promotes healthy, confident girls, thriving mothers, and healthy, loving motherdaughter relationships through adolescence and beyond.

WORKSHOP 060**WHAT PSYCHIATRISTS NEED TO KNOW ABOUT PAIN MANAGEMENT**

APA Council on Addiction Psychiatry

Chair: John A. Renner, M.D.

Presenter(s): John A. Renner, M.D., David Borsook, M.D., Ph.D., Igor Elman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss the basic neurobiology of pain and cooccurring psychiatric disorders, including addiction, 2) Describe the practical aspects of the psychological management and pharmacotherapy of patients with chronic pain and cooccurring psychiatric disorders, and 3) Understand the management of patients with pain and cooccurring disorders

SUMMARY:

The care of patients with chronic pain is becoming a more prominent part of medical practice, and psychiatrists are increasingly asked to help manage problems associated with pain and cooccurring psychiatric disorders, including addiction. This workshop will review some of the basic neurobiology of pain, particularly as it overlaps with the neurocircuitry of psychiatry disorders (Dr. Borsook). Attention will be focused on the practical aspects of the psychological management and pharmacotherapy of patients with chronic pain and depression, schizophrenia, PTSD (Dr. Elman) and

addiction (Dr. Wasan). Participants will be encouraged to present case examples to engage faculty input in the resolution of clinical problems.

WORKSHOP 061

ETHICS AND DIAGNOSIS: THE MEDICALIZATION OF PREDICAMENTS

APA/The Scattergood Foundation

Chair: Marc Forman, M.D.

Presenter(s): Dominic Sisti, Ph.D., Marc Forman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Examine the ethical and philosophical dimensions of psychiatric diagnoses, 2) Ask whether a diagnosis even if medically legitimate is always helpful for the individual patient, and 3) Use a case study to illustrate the conflict between ethics norms and diagnostic criteria in certain circumstances

SUMMARY:

Multiple and complex bioethical considerations are present within the field of child and adolescent mental health. Confidentiality of patient records and communications, informed consent for medication and other treatment, and due process related to involuntary commitment are some of the more obvious concerns. But before ethical problems emerge in treatment, a central task of psychiatry—the diagnosis of mental disorder—presents as an ethically fraught activity. In this presentation we examine, through the use of a case vignette and philosophical commentary, ethical considerations, which are particularly relevant in our work with poor, innercity children and families. We will focus our analysis on ethical considerations related to the diagnosis of conduct disorder: is this diagnosis a true or valid explanation of the meaning of this child's problematic behavior? Does he have a psychiatric disorder or is he a victim of a social disorder? Or both? Does this diagnosis fail to consider the total life of the child and the tragic predicament he and his mother face: poverty, illiteracy, crime and insecurity? Is his "aberrant" behavior a response to those factors? Could such a holistic contextual appraisal invite nonmedical, and possibly more efficacious, interventions in this case? Ultimately, a key ethical question we must address relates to the fundamental bioethical principle of beneficence: have we helped the patient by diagnosing him with conduct disorder or would he be better off without such a diagnosis?

MONDAY, MAY 7, 2012

WORKSHOP 062

POSTMORTEM APPROACHES TO PSYCHIATRIC NEUROPATHOLOGY: LOGISTICAL, LEGAL, AND NEUROPATHOLOGICAL ISSUES

Chair: Karley Y. Little, M.D.

Presenter(s): Peter M. Thompson, M.D., M.S., Rosalind Roberts, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Audience members will understand and interpret new findings in this area more clearly, 2) Audience members will be motivated to collaborate in future post mortem studies, and 3) Audience members may be motivated to initiate post mortem research themselves.

SUMMARY:

There continues to be a strong need for more information about human brain function in psychiatric disorders. In vivo imaging techniques allow realtime clinical correlations, but have limited resolution, lack the ability to evaluate multiple molecular targets, are expensive, and often cannot be repeated because of radiation exposure risks. Myriad animal models exist, but their validity is often uncertain. All areas of medicine increasingly rely on pathological evaluation of tissue specimens from individual patients, but studies of human brain tissue from psychiatric patients, even after death, is relatively uncommon. This workshop is intended to inform the audience about a variety of methods used to collect human post mortem brain samples (subjects identified before or after their deaths, hospital versus medical examiner morgues, etc.), the state of our current scientific knowledge, and likely future directions. Three experienced directors of psychiatric brain collections will describe their approaches to the logistical, legal, and pathological issues involved. They will review the information that has been determined in human post mortem samples about schizophrenia (Dr Roberts), bipolar illness (Dr Thompson), and cocaine dependence (Dr Little). The opportunities for further development of this approach, in conjunction with other approaches, will be discussed. At the end of the presentations, a twenty minute period will be reserved for questions and comments.

WORKSHOP 063

WASTE IN PSYCHIATRY: AN OVERVIEW OF THE PROBLEM AND SOME SUGGESTED SOLUTIONS

Chair: Sunil D. Khushalani, M.D.

Presenter(s): Steven S. Sharfstein, M.D., M.P.A., Robert P. Roca, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define waste and understand the context and importance of focusing on this issue in the field of psychiatry, 2) Classify types of waste at the level of the individual practitioner and at the level of the system in which they practice, 3) Discuss the use of Lean methodological principles and tools to eliminate waste in their practices and the system in which they practice

SUMMARY:

It has been pointed out that there is widespread waste in the U. S. health care system. According to an Institute of Medicine (IOM) Report, *Crossing the Quality Chasm*, the US spends 50% more on health care than any other Western nation, without evidence of a reliable level of quality in return. We are currently spending 1718% of our GDP on health care, and health care costs keep rising at a rate that is unsustainable. We need to utilize all our available resources prudently as we strive to meet the standards put forth in the IOM report; according to the report, health care should be safe, effective, patientcentered, timely, efficient and equitable. In order to be efficient, we must first learn to recognize waste and then systematically employ waste reduction strategies across our system. The report also cautions that withholding services or trying to control costs through restrictions is a destructive shortterm approach. What is needed is a better understanding of the nature of waste itself. Three sources of waste have been described administrative, operational and clinical we will provide examples of each. Lean Methodology, which is derived from the Toyota Production System, offers a very thoughtprovoking and comprehensive paradigm for understanding the nature of waste. This methodology continuously strives to increase the value of the services provided to each “customer” (e.g., patient) by systematically and meticulously rooting out waste from every process. A core tenet of this methodology is that a quality problem underlies each instance of waste. Participants in this workshop will be introduced to the eight types of waste recognized by Lean experts and will be engaged in identifying examples of each kind of waste in medicine in general and psychiatry in particular. We will also share examples of waste we have identified and tools we have used to eliminate waste in the Sheppard Pratt Health System as we embarked upon our effort to use Lean methodology to improve our processes of care. We will then examine and discuss examples offered by the participants.

WORKSHOP 064

TRUE INTEGRATED CARE: THE ROLE OF COMBINED TRAINING IN FAMILYMEDICINE PSYCHIATRY AND INTERNAL MEDICINE PSYCHIATRY IN THE ERA OF INTEGRATION

CoChair(s): Erik R. Vanderlip, M.D., Alison C. Lynch, M.D.

Presenter(s): Robert M. McCarron, D.O., Lawson R. Wulsin, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define the history of combined training programs in Internal Medicine and Psychiatry and Family Medicine and Psychiatry, and challenges facing current programs, 2) Evaluate the benefits of combined training on individual patient levels, and larger system levels of care vs. the perceived cost of combined training, and 3) Critically appraise the role of combined training within the context of greater mental health and primary care integration.

SUMMARY:

The new APA President has boldly labeled the decade of 2010 to 2020 the era of collaboration between physical health/primary care and mental health. As more patients are enrolled in expanding coverage programs, it has become increasingly clear that psychiatrists will be working with primary care clinicians to expand their reach and effectiveness for the benefit of the population. Additionally, persons suffering from chronic and severely disabling mental illness frequently have poor preventive health care. For the last three decades, combined postgraduate training programs in internalmedicine psychiatry and familymedicine psychiatry have been created to bridge this gap. In addition to offering progressive training, combined graduates are experts in integrating medicine and psychiatry, and offer new models for psychiatric practice in integrated care settings. This includes pioneering psychiatrists’ functionality in a) the patient centered medical home, b) collaborative care, c) accountable care organizations. It also includes training tailored to “borderland” settings, such as pain centers, comprehensive heart centers, HIV clinics, substance abuse centers, sleep centers, and medpsych units. In spite of an everincreasing demand for their skill set and expertise upon completion, competition for spaces in programs fluctuates dramatically and numerous programs have closed or are in the process of closing. A moratorium on the creation of new combined programs by the American Board of Psychiatry and Neurology, due to concerns over the lack of a formal ACGME accreditation process for combination training, has contributed to the uncertain future of combined training. This workshop will feature a brief overview of the history of combined training programs in internal medicine/psychiatry and family medicine/psychiatry, and then will include commentary from program directors for IMpsych and FPpsych programs with audience participation to discuss the role of combined programs in the era of integration.

WORKSHOP 065

FACTORS AFFECTING PROVISION OF PSYCHOTHERAPY BY AMERICAN AND CANADIAN PSYCHIATRISTS

CoChair(s): Joyce C. West, Ph.D., M.P.P., John C. Perry, M.D., M.P.H.

Presenter(s): Allan A. Abbass, M.D., John C. Perry, M.D., M.P.H., Eric M. Plakun, M.D., Joyce C. West, Ph.D., M.P.P.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand current patterns of psychotherapy provided by psychiatrists in routine practice settings in the US and Canada, 2) Understand trends in psychiatric practice, including combined pharmacologic and psychotherapy treatment, patients' goals for treatment, and psychiatrists' satisfaction with various aspects of their practices, 3) Describe potential implications and responses to the decline of provision of psychotherapy by psychiatrists in the US and Canada

SUMMARY:

Although psychotherapy is a core aspect of psychiatric training and practice, recent data indicate a decline in the provision of psychotherapy by psychiatrists, with a concomitant move toward increased provision of pharmacotherapy (West et al., 2003; Mojtabai & Olfson, 2008). This decline has been anecdotally attributed to issues of service demand and payment. There is little data about barriers to the practice of psychotherapy, or about the effect of these changes on patient and therapist goals for treatment or psychiatrists' satisfaction with their practices. The American Psychiatric Institute for Research and Education (APIRE), the APA Committee on Psychotherapy by Psychiatrists (COPP) and members of the Canadian Psychiatric Association designed a joint 36item email survey as a "Study of Psychiatrists' Practices and Barriers to Psychiatric Treatment," conducted in both countries simultaneously. The electronic survey was emailed to three thousand randomly selected APA members with email addresses, excluding medical students and residents, while the Canadian version was emailed to all Canadian psychiatrists and residents who had given CPA permission to contact by email. After excluding those with undeliverable email addresses (N=109), 14% (N=407) of surveyed US psychiatrists responded; 97% of the respondents (N=394) reported currently treating psychiatric patients. In Canada 431 (24%) practitioners responded, of whom 91% currently treated patients. In their last typical work week, US respondents provided psychotherapy to 55% of patients, while Canadian respondents provided psychotherapy to 67%. Provision of psychotherapy combined with pharmacotherapy was six times more common than psychotherapy alone. The survey found many parallels between

practices and barriers to treatment in both nations, with some noteworthy differences. While psychiatrists in the US and Canada report providing psychotherapy for most patients (usually combined with medications), a large proportion of patients are not currently receiving psychotherapy from their psychiatrist. Although most psychiatrists would be interested in providing psychotherapy to their patients, they face a number of financial, administrative and other workforce barriers, which will be described. After presentation of survey results concerning factors affecting [1] provision of psychotherapy by psychiatrists, [2] choice of goals for treatment, and [3] practitioner satisfaction, the majority of the workshop time will focus on interactive discussion of the problem and potential responses to the decline of provision of psychotherapy by psychiatrists in both countries.

WORKSHOP 066

ADDRESSING MENTAL HEALTH CARE DISPARITIES THROUGH INTERDISCIPLINARY TRAINING IN INTEGRATED HEALTH CARE, CULTURAL COMPETENCE, AND FAMILY SYSTEMS

Chair: Octavio N. Martinez, M.D., M.P.H.

Presenter(s): Cindy Carlson, Ph.D., Patricia Keith, Ph.D., Jane RippergerSuhler, M.D., Prerna Arora, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Will gain knowledge in how the integrated health care model addresses mental health disparities, 2) Identify three recommended components of interdisciplinary training, 3) List three barriers and three solutions to implementing integrated health care training, 4) Understand the role and function of an independent evaluator as it relates to implementing a training program, and 5) Discuss overcoming barriers and challenges to interdisciplinary training

SUMMARY:

Significant barriers to effective mental health treatment exist across the nation. The current mental health workforce is not representative of the nation's demographics and this disparity will continue to worsen based on projections. Workforce limitations include a lack of racial and cultural diversity, inadequate cultural and linguistic competence, and uneven geographic distribution. According to HRSA, as of June 2010, there are now 3,483 Mental Health Professional Shortage areas impacting approximately 84 million individuals. Structural barriers include legislative restrictions, guild-oriented training, and service delivery challenges that reduce access to mental and behavioral health services, especially for racial and ethnic minorities. One proposed solution to structural and workforce barriers has been inte-

grated health care. This workshop describes a HRSA-funded program, the Integrated Health Care Services for Underserved Children and Families Program, which focuses on improving the training of future mental health providers (child psychiatrists and psychologists) to engage in interdisciplinary and integrated health care treatment of underserved populations in order to improve quality of care, access to care, consumer satisfaction, and health outcomes. The program focuses on training in the provision of evidenced-based, family-centered, and culturally sensitive mental and behavioral health services to underserved children and families. This workshop will inform psychiatrists and related professionals about the development, implementation, application, and evaluation outcomes of the program. Workshop goals include helping participants to recognize how models of integrated health care can represent solutions to mental health care disparities, discuss the process of interdisciplinary training including recommended components and strategies for overcoming potential challenges, and describe how to effectively use an independent evaluator to measure training program outcomes. Workshop participants will be encouraged to interact with the workshop faculty to share their own experiences and to apply knowledge to their own settings.

WORKSHOP 067

TRANSFORMATIONAL LEADERSHIP TO IMPROVE MENTAL HEALTH CARE DELIVERY IN MINORITY AND UNDERSERVED POPULATIONS

American Psychiatric Leadership Fellowship Program

CoChair(s): Tanya R. Anderson, M.D., Napoleon B. Higgins, M.D.

Presenter(s): Serena Y. Volpp, M.D., M.P.H., Tatiana Falcone, M.D., Daniel L. Dickerson, D.O., M.P.H., Brigitte Bailey, M.D., Toi B. Harris, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define Transformational Leadership, 2) Delineate key concepts of Transformational Leadership and how it applies to public psychiatry and mental health disparities, 3) Identify common barriers that Transformational Leaders in public psychiatry encounter, and 4) Describe evidence-based strategies employed to provide cultural competence education and training to community mental health stakeholders

SUMMARY:

Our nation's healthcare system is rapidly changing. The field of Medicine needs leaders in all specialties who are willing and able to forge into this new venture with open minds that are willing to creative and explore new ways of

being in order to make the necessary transformation in our health care delivery systems. The APA has invested in the development of a group of midcareer psychiatrists whose vision is to represent mental health and our consumers in the development of this transformed healthcare system. These leaders will define and describe what it means to be a transformational leader and describe the program the APA has developed to foster and grow this leadership among its membership. Key concepts of being engaged in transformational leadership will be defined and discussed. These key concepts are leadership, cultural competence, community engagement, enhancing access and training needs. The presenters will give examples of how the tools and opportunities provided by the APA Transformational Leadership in Public Policy Program has influenced their current work. Additionally, the leaders will discuss how the skills have been used to support the improvement of the mental health system in the US Virgin Islands. This information will lead to a robust audience of the psychiatrist's role in the development of this evolving healthcare system so that we as a specialty can ensure that comprehensive mental health services are included as the field of healthcare evolves.

WORKSHOP 068

TRANSITION TO PRACTICE AND TRANSITIONS IN PRACTICE: A WORKSHOP FOR MEMBERS IN TRAINING (MITS) AND EARLY CAREER PSYCHIATRISTS (ECPS)

Chair: Chetana Kulkarni, M.D.

Presenter(s): Anna Skiandos, D.O., Joyce A. Spurgeon, M.D., Michael M. Takamura, M.D., Brenda Jensen, M.D., Deepika Sabnis, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) To discuss the issues and challenges that face trainees as they transition into independent practice, 2) To discuss transitions that may occur in the early years of practice, including career and life transitions, and 3) To allow audience members an opportunity to interact with Early Career Psychiatrists in a variety of practice types and locations.

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. Panel members will include individuals in varied areas and types of practice, including Public Psychiatry, Emergency Psychiatry, Private Practice, Academic Psychiatry and the VA.

WORKSHOP 069

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

CoChair(s): Larry R. Faulkner, M.D., Beth Ann Brooks, M.D., M.S.

Presenter(s): Robert J. Ronis, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

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, and 3) Describe the ABPN's requirements for certification in the psychiatry subspecialties and in the multidisciplinary 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 interdisciplinary subspecialties of clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine. Application procedures, including training and licensure requirements, will be outlined, and the requirements for the assessment of clinical skills during residency training in psychiatry and in child and adolescent psychiatry will be delineated. 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 examination results. A substantial amount of time will be available for the panelists to respond to queries from the audience.

WORKSHOP 070

DSM5 AND THE PRISONS

CoChair(s): Rodrigo A. Munoz, M.D., Amanda Ruiz, M.D.

Presenter(s): Marcia K. Goin, M.D., Harold I. Eist, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Present evidence that the treatment of psychiatric patients behind bars is inefficient, expensive, and probably wasteful, 2) Discuss mental health courts and other strategies to treat rather than punish the mentally ill, and 3) Propose new ideas to defend the rights of the nonviolent mentally ill submitted to long periods or incarceration

SUMMARY:

Detention and correctional facilities are an excellent place to examine the DSM categories. Personality disorders, particularly the groups related to antisocial, borderline, and histrionic behaviors are very common behind bars. They are also common in nearly all major psychiatric disorders, including psychoses and bipolar disorder, as well as dual diagnoses and aging persons with dementia. Countless publications ridicule the enormous sums of money spent in corrections without documented or reproducible results. Prisons are an excellent place to examine the DSM categories. Personality disorders, specially the group related to antisocial personality in men and borderline-histrionic in women are very common behind bars, but also almost all other psychiatric disorders, including psychoses and dementias. Much money is spent in the custody of terminal prisoners in hospice programs and in the psychiatric care of people who may not have good reasons to stay in prison. This workshop addresses alternatives to imprisonment as they are currently developed in California and other states. Can psychiatrists lead in a reform movement that challenges the current state of affairs?

WORKSHOP 071

WOMEN IN PSYCHIATRY: PREGNANCY AND PARENTHOOD

Chair: Delaney Smith, M.D.

Presenter(s): Susan HattersFriedman, M.D., Cathleen A. Cerny, M.D., Delaney Smith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the impact of a pregnant psychiatrist on transference and countertransference issues, 2) Have a better appreciation of the safety issues specific to the pregnant psychiatrist as well as an overview of methods to keep one's self and one's family safe, and 3) Appreciate the impact of returning to work following the birth of a child on patient-psychiatrist dynamics as well as common struggles with balancing work and family life

SUMMARY:

The number of women in medicine has been rapidly increasing in the last several decades. American Medical Association figures place the percentage of women practicing medicine growing from 7.6% in 1970 to 27.8% in 2006. In the 200405 school year, women represented 49.5% of the medical school matriculants. The percentage of female psychiatrists has likewise been on the rise. While only 34% of practicing psychiatrists in 2006 were women, of those in a psychiatric residency program, 54.3% were women. Although the number of women in the field continues to increase, the specific challenges of balancing motherhood with a psychiatric career have not been gaining the attention they should. The length of training to become a psychiatrist means that many women are becoming pregnant while at the same time trying to complete rigorous residencies or establish their careers. Issues of boundaries become increasingly complicated when a psychiatrist is visibly pregnant. While typically trained to avoid discussing personal matters, such as family life, with patients the pregnant psychiatrist is frequent left on her own to try to decide the best way to handle informing her case load of her situation and impending maternity leave; not to mention dealing with some of the nuances of psychiatric care such as malodorous, sexually preoccupied, or intrusive patients. Another significant issue for pregnant psychiatrists is that of safety. This is particularly true when dealing with severely mentally ill individuals or those in a forensic setting. Many women have spent years trying to prove they are just as “tough” as their male counterparts and may find it difficult to make necessary adjustments in their interactions with patients. Finally, while many medical schools and residencies have begun to emphasize physician wellness, there is still a lack of training in the issues of balancing work life and motherhood. Trying to care for the emotional needs of others while attending to one’s own pregnancy can be challenging. Once the baby has arrived these issues do not become easier as the psychiatrist may struggle with guilt about leaving the baby while continuing to work to help others and trying to “do it all” while not taking sufficient care of herself. This workshop seeks to educate and support female psychiatrists through lecture and small group discussions about personal experiences with the transference, countertransference and safety issues of pregnancy and parenthood during psychiatric training and practice.

WORKSHOP 072**UPDATE ON SCREENING AND BRIEF INTERVENTION (SBI): WHAT WE KNOW AND DON’T KNOW ABOUT SBI**

U.S. National Institute on Alcohol Abuse and Alcoholism

Chair: Richard Saitz, M.D.

Presenter(s): Emily Williams, Ph.D., Mark L. Willenbring, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate the knowledge of the family of approaches that make up SBI, 2) Demonstrate the knowledge of the evidence base for SBI in a range of settings, 3) Demonstrate the knowledge of when not to rely on SBI in clinical practice.

SUMMARY:

Considerable progress has been made in developing a knowledge base for the integration of alcohol and other drug treatment in the context of primary medical care. Most notably, research has demonstrated the efficacy, effectiveness, and costeffectiveness of screening and brief intervention for problem drinkers in a range of primary care settings—emergency rooms (Bernstein et al., 2009); trauma centers (Gentilello, 2007); officebased, private practice (Ockene, Wheeler & Adams, 1997); clinics and managed care settings (Fleming & Graham, 2001). This evidence base has served as the platform for a national, multisite demonstration program in the United States (SBIRT; Babor et al. 2007). The potential public health impact of these initiatives is enormous. Despite the growing evidence base for primary carebased interventions for alcohol and other drug abuse, a number of questions remain: What settings and populations is the evidence for SBI less than convincing? How has SBI been implemented in real world practice settings? And, how can SBI be integrated into routine psychiatric practice? Three prominent clinical researchers will discuss these issues and seek to stimulate a lively audience discussion about the role of SBI in psychiatric care.

WORKSHOP 073**INTEGRATIVE GROUP THERAPY FOR ADULT PATIENTS WITH ADHD: HOW CAN WE MAKE IT EFFECTIVE?**

Chair: Alina Marin, M.D., Ph.D.

Presenter(s): Elaine Senis, M.S.W., Giselle Roddy, R.N., Susan Buchanan, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Review evidencebased treatments in adult ADHD, 2) Better understand the impact of the psychosocial interventions on the outcomes of adult patients with ADHD, and 3) Improve their ability to integrate different treatment approaches for adults diagnosed with ADHD and comorbid conditions in daytoday practice.

SUMMARY:

ADHD has been recognised and scientifically validated as a substantial clinical entity in adults. Most of these patients struggle with overwhelming problems in most areas of their lives. Both the diagnosis and the treatment are more difficult for adults than for children because of the lifetime impact of the disease and the complex comorbidity. Previous research supports the effectiveness of combining medication and psychosocial approaches for better outcomes. Some of the adults with ADHD are ambivalent about the pharmacologic treatment which may have significant side effects and sometimes fails to solve the effects of carrying forward lifetime symptoms. Integrative multimodal therapeutic approaches are expected to assist in addressing the multifaceted impact of the ADHD symptoms on the person's overall social and professional functioning. For adult patients diagnosed with ADHD the interplay between their inner world and the environment is profoundly affected by their executive functioning limitations. Work in groups can provide for these patients mutual support and encouragement, as well as the exchange of information and education. In group settings adult ADHD patients can better benefit from integrated psychotherapeutic approaches because they join in reflecting upon new therapeutic experiences. For patients with ADHD, the therapy in groups may be conducted by integrating multimodal approaches centered on their functional difficulties. This conceptualization fosters a systemic and unitary perspective on therapy and at the same time enhances the motivation for participation. Specific psychosocial treatment modalities already proven to be effective for selected adult patients with ADHD are Cognitive Behavioral Therapy and Mindfulness. Integrating these structured, previously manualized approaches into a multimodal intervention is expected to be more effective for unselected patients in real life and lead to better long term functional outcomes for adult patients with ADHD. This highly interactive workshop will bring into discussion the results of an integrative multimodal group therapy with adult patients with ADHD, as well as the clinical experience of the presenters during ten treatment sessions offered to the patients. Specific elements of this structured intervention will be demonstrated and the participants will be invited to comment on the particular modalities applied by the presenters in their work.

WORKSHOP 074**VIRGINS, VIXENS AND VAMPIRES: THE ART OF EDVARD MUNCH**

CoChair(s): Linda F. Pessar, M.D., Mariann W. Smith, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be

able to: 1) Review the major psychological events in Edvard Munch's life and their thematic elaborations in his art, 2) Discuss Munch's representations of women, and the psychological origins of these depictions, 3) Consider whether Munch's return to his family during the second half of his life represented a psychological resolution or regression

SUMMARY:

Edvard Munch (1863-1944), the Norwegian expressionist artist best known for *The Scream*, explored his own psychological history and preoccupations in his works. "Two of the most terrible enemies of mankind I inherited, the legacy of tuberculosis and insanity. Disease, madness and death were the black angels around my cradle...anxiety...sorrow... death...fear...followed me." This workshop, conducted by a psychiatrist and an art museum education curator, will review and encourage discussion about the important events in Munch's life, their depiction in his art, the thematic elaborations of these events in his other works, and Munch's own reflections in diaries and letters. The workshop will consider, as well, how Munch utilized and deviated from the artistic conventions of his time. Edvard Munch was the second of five children born into a close knit and deeply religious family. When he was five, his mother died of tuberculosis. Munch created representations of this time throughout the next 40 years. He and his sister Sophie became each other's primary support. She died when she was 15 and he 14. Munch created portraits of Sophie as a sick child and of her with him during his entire life. For Munch, Sophie was ever present, and their relationship existed in a state of timelessness. These and other deaths and losses aroused intense affective responses to intimacy, including anxiety, depression, fear and anger, especially toward women. He entered into doomed and destructive relationships and conveyed his attraction, fear and rage by portraying women as vixens, betrayers, vampires and murderesses. At age 45 Munch entered a sanatorium for treatment of depression and alcoholism where he created *Alpha and Omega*, a portfolio of drawings with text that startlingly and dramatically retells the story of Adam and Eve. Munch found this work cathartic and wrote, "...a strange calm came over me when I was working on this series...all malice let go of me." When Munch left the clinic he moved to a town nearby his family, renounced relationships with women, and lived quietly for the remaining half of his life. His dominant artistic style changed as well, reflecting less turmoil, but also less emotional vitality. In addition to interactive discussions about the life and art of Edvard Munch, the workshop will address related topics including the relationship between creativity and mood disorder, the elaboration of artists' lives in their art, and artists addressing psychological conflicts through their work.

WORKSHOP 075

PSYCHIATRISTS AND PHARMA: HOW SHOULD THEY INTERACT?*APA/The Scattergood Foundation**Chair: Paul S. Appelbaum, M.D.**Presenter(s): Paul S. Appelbaum, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Identify the issues that have arisen from psychiatrists' relationships with the pharmaceutical industry, 2) To review the recommendations of the World Psychiatric Association on dealing with these relationships, 3) To assist attendees in developing their own approaches to interactions with industry

SUMMARY:

Controversy continues over the extent to which psychiatrists' relationships with pharmaceutical companies and their representatives may compromise psychiatrists in their roles as clinicians, educators and researchers. In 2011, the World Psychiatric Association adopted a set of recommendations (which Dr. Appelbaum helped to draft) for interactions with the pharmaceutical industry by psychiatrists and their organizations. The guidelines address interactions affecting patient care, education, and research, along with issues specific to professional associations. Among the specific topics addressed are: access to clinicians by pharmaceutical representatives; receipt of meals, gifts, and samples; development of formularies; disclosure and management of researchers' and institutions' relationships with industry; control over reporting of research findings; involvement in industryfunded presentations as speaker or attendee; and education on relationships with industry. Using the WPA recommendations as a starting point, the workshop will focus on exploring the ethical principles that should underlie such relationships and how they might be applied in practice. After a brief introduction to the concerns that motivated the guidelines and the process by which they were drafted, each recommendation will be presented and then opened to the audience for discussion. The questions to be raised will include: what motivates this recommendation; how reasonable is it; what are the positive and negative consequences of the approach recommended and are there alternative approaches that might be more desirable? The focus will be on helping participants identify approaches to these issues in their own professional lives.

WORKSHOP 076**MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS VERSUS PSYCHIATRIC DISORDERS MIMICKING MEDICAL CONDITIONS DIAG-****NOSTIC AND TREATMENT CHALLENGES***APA Council on Psychosomatic Medicine and Geriatric Psychiatry**CoChair(s): Catherine C. Crone, M.D., Lorenzo Norris, M.D.**Presenter(s): Kathryn Walseman, M.D., Melissa Maitland, M.D., Sahana K. D Silva, M.D., M.S., Jason B. Williams, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of the session the participant should be able to: 1) Have greater awareness of the frequency by which comorbid medical and psychiatric conditions coexist and result in misleading clinical presentations, 2) Have greater knowledge about the various medical causes of psychiatric disorders/presentations including diagnosis and treatment considerations, 3) Have greater knowledge about somatoform disorders and how psychiatric disorders can present as primary medical conditions. This includes knowledge about diagnosis, treatment approach, and collaboration with medical providers.

SUMMARY:

During the course of residency training, significant efforts are made to instruct residents about the recognition and treatment of primary psychiatric disorders such as major depression, bipolar disorder, posttraumatic 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, dementia, 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 "treatmentresistant" psychiatric disorders or, of greater concern, actually worsen when given psychotropic medications. An additional area of clinical knowledge that would benefit residents is the recognition and management of psychiatric disorders that mimic medical conditions. Limited exposure to psychosomatic medicine during residency 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 workups are negative yet patients persist in their requests for medical/surgical inter-

vention. The following workshop aims to provide residents with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatoform disorders (medical mimics) in a casebased format with opportunities for questions and discussion with residents, fellows, and attending physicians with experience and/or expertise in psychosomatic medicine patient populations.

WORKSHOP 077

THE DIFFERENT FACES OF GLOBAL MENTAL HEALTH: CURRENT INITIATIVES, FUTURE DIRECTIONS

American Association of Community Psychiatrists

CoChair(s): Sosunmolu O Shoyinka, M.D., Mandy Garber, M.D., M.P.H.

Presenter(s): Craig L. Katz, M.D., Clare Pain, M.D., Robert Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Participants should possess a working knowledge of what Global Mental Health work entails, 2) Participants will have the opportunity to network with individuals currently carrying out projects in this area, 3) Participants will be stimulated to think creatively about ways to get involved in and possibly develop careers in Global Mental Health

SUMMARY:

The past few years have brought an increasing awareness of role of mental health in general overall health, leading to the coinage of the term “no health without mental health”. The growing trend towards globalization in recent years has led to an explosion of interest in Global Mental Health among mental health professionals, particularly among trainees and early career psychiatrists. This interest has been fueled by publications such the popular Lancet series on Global Mental Health, and workshops, including the 2010 NIMH – sponsored Research Careers in Global Mental workshop. Despite this burgeoning interest, the term “Global Mental Health” remains vague and difficult to define. Does it refer to the development of systems for the improved delivery of mental health services in different parts of the world? Does it refer to understanding and adapting effective indigenous treatments, or to manpower development, or to research, or to cross national/international collaborations? What and where the opportunities to get involved are, particularly while in training or early in one’s career when other concerns may predominate remain tricky questions. This workshop, titled: The Different Faces of Global Mental Health, grapples with these questions. By convening a panel of experts currently working in this area,

using varying approaches to Global Mental Health, we aim to show the complexity of the issues involved, and to offer a menu of options to stimulate thinking in this area.

WORKSHOP 078

ADVOCATING FOR YOUR PATIENTS IN AN ERA OF HEALTH CARE REFORM

APA Council on Advocacy and Government Relations

Chair: Jerry L. Halverson, M.D.

Presenter(s): Nicholas M. Meyers, Robert P Cabaj, M.D., Ara Anspikian, M.D., Jerry L. Halverson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Create achievable advocacy goals, 2) Identify a successful advocacy plan, 3) identify peer advocacy groups that may enhance your own advocacy efforts, 4) Identify the APA’s national advocacy goals, and 5) Create a successful advocacy plan.

SUMMARY:

The main thrust behind this workshop is to give members 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 Meyer. 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. Mr. Meyers will discuss the APA’s national advocacy goals and how the APA works to achieve them. Dr. Cabaj will 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 079

THE METRICS OF SUICIDE

Chair: M. Justin Coffey, M.D.

Presenter(s): Brian K. Ahmedani, Ph.D., M.S.W., C. Edward Coffey, M.D., M. Justin Coffey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be

able to: 1) Describe the Perfect Depression Care initiative's strategies and successes for eliminating suicide in its patient population, 2) Understand various approaches to measuring suicide and other rare events data depending the purpose for which those data are being used, and 3) Describe how comparative statelevel suicide data inform quality improvement efforts at the local health system level

SUMMARY

In 2001 Henry Ford Health System's division of Behavioral Health Services set out to eliminate suicide among all patients with depression in its HMO network. This audacious goal was a key lever in a broader aim: to achieve breakthrough improvement in quality and safety by completely redesigning depression care delivery using the Six Aims and Ten New Rules put forth in the Institute of Medicine (IOM) report *Crossing the Quality Chasm*. To communicate this bold vision, the team named the initiative Perfect Depression Care. Today, Henry Ford can report a dramatic and sustained reduction in suicide that is unprecedented in the clinical and quality improvement literature. Part of the story of Henry Ford's pursuit of perfection is the lessons learned about measuring suicide. In this symposium, team leaders from Henry Ford Health System's Perfect Depression Care team will share these lessons, along with exciting comparative data from the State of Michigan death index that shed light on the initiative's success.

WORKSHOP 080

HIGHYIELD COGNITIVE BEHAVIOR THERAPY FOR BRIEF SESSIONS

Chair: Donna M. Sudak, M.D.

Presenter(s): Donna M. Sudak, M.D., David A. Casey, M.D., Judith S. Beck, Ph.D., Jesse H. Wright, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

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, and 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 "50minute hour." Yet, traditional psychotherapy training emphasizes fulllength 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 inter-

ventions 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.

WORKSHOP 081

ANTIPSYCHOTICS IN THE MEDICALLY ILL

Chair: Vishal Madaan, M.D.

Presenter(s): Venkata B. Kolli, M.B.B.S, Durga Bestha, M.B.B.S, Jayakrishna S. Madabushi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the implications of medical illnesses on metabolism and adverse effects of antipsychotic medication, 2) Understand the important drug interactions in patients with comorbid medical conditions, and 3) Make appropriate antipsychotic choices in patients with physical health comorbidity

SUMMARY:

The utility of antipsychotics has expanded from their use in psychotic disorders to delirium, mood disorders and impulse control disorders to name a few. However, psychiatric patients have higher association with smoking, substance use and lack of exercise. Furthermore, the effects of psychotropic medications, especially metabolic effects, contribute significantly in this population. All antipsychotics are metabolised to a variable degree by the liver while some have partial renal excretion, thereby having implications for dosing and tolerability in hepatic and renal conditions. With significant co morbidity with smoking and metabolic syndrome, individuals with schizophrenia are also at an increased preexisting cardiac risk. Cardiac toxicity of antipsychotic medications, especially the risk of arrhythmias and sudden cardiac death, calls for a careful choice of neuroleptic medication in patients with preexisting cardiac conditions. Antipsychotics, when administered with benzodiazepines, are known to exacerbate respiratory depression; as a result, caution and adequate monitoring are required with impaired pulmonary function. Most antipsychotics reduce the seizure threshold; hyponatremia associated with neuroleptics has been implicated in worsening the risk. In addition, there are important interactions between antiepileptic drugs and antipsychotic agents. Antipsychotics are commonly used in delirium and their anticholinergic effects are known to play an important adversarial role. In addition, choosing an appropriate antipsychotic medication in movement disorders and dementias is a challenging task.

In the first part of this interactive workshop, speakers will briefly review relevant pharmacokinetics and pharmacodynamics of neuroleptic medications, which will constitute the basis to an understanding of the effects of antipsychotics in the medically ill. In the second part, the speakers will review the literature focusing on neuroleptic use in hepatic and renal impairments, and in those with high cardiac risk and preexisting cardiac conditions. In the next part of workshop, we will discuss making appropriate antipsychotic choices in patients with co morbid pulmonary and endocrine disorders. We will continue the discussion on choosing safe and effective antipsychotic medication in delirium, dementias, epilepsy and movement disorders. This workshop will allow the audience an opportunity to have a lively discussion and share their experiences on the topic, with the group. Reference: 1. Short DD, Hawley JM, McCarthy MF. Management of schizophrenia with medical disorders: cardiovascular, pulmonary, and gastrointestinal. *Psychiatr Clin North Am.* 2009 Dec;32(4):75973. 2. Muench J, Hamer AM. Adverse effects of antipsychotic medications. *Am Fam Physician.* 2010 Mar 1;81(5):61722. 3. Farooq S, Sherin A. Interventions for psychotic symptoms concomitant with epilepsy. *Cochrane Database Syst Rev.* 2008 Oct 8;(4):CD006118.

WORKSHOP 082

APPLYING RECOVERY AND TRAUMAINFORMED CARE PRINCIPLES TO AN INPATIENT PSYCHIATRIC SETTING

APA/The Scattergood Foundation

Chair: Gina Fusco, M.D.

Presenter(s): Gina Fusco, M.D., Cindy Takacs, M.D., Mark Combs, M.D., Joseph Garbely, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recovery and traumainformed care (TIC) principles applied to clinical programming with an adult inpatient population, 2) Integrating best practices of Recovery and TIC principles across disciplines in an inpatient psychiatric setting, 3) Working through barriers and obstacles to implementation of hospitalwide clinical programming changes

SUMMARY:

Friends Hospital, a private 192 bed psychiatric inpatient hospital in Philadelphia, has recently implemented a recovery-oriented traumainformed clinical model integrating best practice standards, and comprehensive assessment strategies. The programming changes involved a comprehensive assessment of consumer and constituent needs, identification of best practice standards utilizing trauma informed

care and recovery principles, and designing a multidisciplinary holistic approach that is both effective and practical. This workshop will identify recovery and trauma informed care principles specific to inpatient psychiatric treatment, and will review the application of these tenants to a multidisciplinary team. Specific trainings, strategies, and practice standards are identified. Inherent challenges with organizational change within a large institutional setting can affect the implementation schedule and process. Recommendations in the successful implementation and dissemination of practice standards are reviewed, and means of ongoing monitoring of the effectiveness of programming is discussed.

WORKSHOP 083

“MAYBE YOU SHOULD SEE SOMEONE...”: THE CHALLENGES OF REFERRING RESIDENT COLLEAGUES TO MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

CoChair(s): Marra Ackerman, M.D., Margaret Haglund, M.D.

Presenter(s): Rachel Caravella, M.D., Alison D. Hermann, M.D., Richard F. Summers, M.D., Scott J. Goldsmith, M.D., Laura K. Kent, M.D., Jeffrey A. Selzer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the role of psychiatric residents and the boundaries that need to be considered when speaking to colleagues about their mental health, 2) Understand resources available to colleagues and how to access them, and 3) Understand the confidentiality and licensing implications of referring a fellow house staff member for mental health or substance abuse treatment.

SUMMARY:

Mental illness and substance abuse cause significant morbidity and mortality among resident physicians with estimated prevalence rates as high as or higher than in the general population. Depressive symptoms have been reported to affect as many as 1530% of residents (Tyssen, 2002; Broquet, 2004; Goebert, 2009), and substance abuse or dependence is identified in 715% of housestaff (Broquet, 2004). While the prevalence of suicide among resident physicians is not well documented, a recent multisite study identified suicidal ideation in 5.7% of all medical students and residents, and in 68.5% of trainees with major depression (Goebert, 2009). Despite the high prevalence and significant negative consequences of mental illness and substance use, as many as twothirds of affected residents do not seek treatment (Tyssen, 2002). Cited barriers to seek-

ing treatment include the perceived stigma of mental illness and substance abuse, concerns about confidentiality and impact on training status, and implications for licensing and future employment (Tyssen, 2002; Dunn, 2009). Trainees in psychiatry are in a unique position among residents and are not uncommonly approached by colleagues seeking advice about depression, anxiety and substance use disorders. In this workshop, we will foster a discussion of the ethical and practical challenges surrounding identifying and counseling colleagues with mental health concerns. In addition, we aim to raise awareness about resident mental health and the barriers that lead residents to delay or avoid seeking care for psychiatric symptoms. Finally, this workshop aims to highlight models of care and resources available in some training programs, address issues of confidentiality, and articulate career-related consequences of utilizing psychiatric care during residency training. References: 1. Broquet KE and Rockey PH. (2004). Teaching residents and program directors about physician impairment. *Academic Psychiatry*, 28: 221-225. 2. Center C, David M & Detre T et al. (2003). Confronting depression and suicide in physicians. *JAMA*, 289 (23): 316-3166. 3. Dunn LB, Green Hammond KA, & Roberts LW. (2009). Delaying care, avoiding stigma: Residents' attitudes toward obtaining personal health care. *Academic Medicine*, 84: 242-250. 4. Goebert D, Thompson D, & Takeshita J et al. (2009). Depressive symptoms in medical students and residents: A multischool study. *Academic Medicine*, 84: 236 - 241. 5. Reynold CF & Clayton PJ. (2009). Out of the silence: Confronting depression in medical students and residents. *Academic Medicine*, 84: 159-160. 6. Tyssen R and Vaglum P. (2002). Mental health problems among young doctors: An updated review of prospective studies. *Harvard Review of Psychiatry*, 10: 154-65.

WORKSHOP 084

TREATMENT OF PTSD AND DEPRESSION IN DOD: TAKING LESSONS LEARNED FROM THE TRENCHES INTO YOUR PRACTICE AND THE COMMUNITY

Chair: Paul S. Hammer, M.D.

Presenter(s): Paul S. Hammer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Attendees will distinguish among empirically supported treatments to address combat-related PTSD, 2) Attendees will understand how clinical support tools can be applied to enhance the delivery of PTSD and Depression care, and 3) Attendees will understand the connection between Clinical Practice Guidelines and corresponding support tools

SUMMARY:

This session will review the state of the art screening, diagnosis, psychotherapy, and pharmacotherapy interventions for PTSD and Depression. The latest research and the presenters' experience with in the military will be translated for applications and relevance to the community. Consistency with existing CPG will be emphasized, as they provide recommendations to the field based on the current scientific literature and address a range of topics, including screening, assessment, treatment, and medication management. Clinical Support Tools, developed to assist providers with the implementation of the CPGs, will be demonstrated via clinical case vignettes.

WORKSHOP 085

BULLYING: PREVENTION AND INTERVENTION: AN OVERVIEW

AAOL

Chair: David L. Scasta, M.D.

Presenter(s): Louis J. Kraus, M.D., Cheryl D. Wills, M.D., Gregory A. Miller, M.D., M.B.A., Gregory A. Miller, M.D., M.B.A., David L. Scasta, M.D., Debra Pinals, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Formulate a working definition of bullying, 2) Articulate an understanding of the scope of bullying among children and adolescents in the US, 3) Be familiar with the use of computers in "cyber bullying" of children and adolescents in the US, 4) Be familiar with the unique demands of managing bullying of sexual minority children and adolescents in the US, and 5) Have an understanding of preventive, family, and system interventions to diminish bullying.

SUMMARY:

In recent years, there has been sustained attention nationwide to the problem of bullying among children and adolescents. Suicide has been an unfortunate outcome in some cases where bullying has gone unchecked by systems not sensitized to the problem and methods of prevention. The systemic problem is amplified by the fact that there is disagreement on what constitutes bullying, and the fact that the legal approaches from state to state are inconsistent. Psychiatrists' skills in working with children, families, and educational systems, are particularly important as a component of the national dialogue that looks for preventive and interventional strategies that might minimize adverse outcomes from the phenomenon of bullying. Drawing upon evidence based perspectives from the fields of child and adolescent psychiatry, family psychiatry, LGBT psy-

chiatry (lesbian, gay, bisexual, and transgendered), and forensic psychiatry, five Assembly representatives of allied psychiatric organizations of the APA will present some of the current thinking and data about bullying as a followup workshop from the prior annual meeting.

WORKSHOP 086

DISCHARGED TO SHELTER: THE THEORY AND PRACTICE OF HOMELESS PSYCHIATRY

Chair: Dillon Euler, M.D.

Presenter(s): Hina Tasleem, M.B.B.S, Joanna Fried, M.D., Anuj Gupta, M.D., Van Yu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the barriers homeless individuals struggling with mental illness face in accessing psychiatric care in traditional institutional settings, 2) Describe how the delivery of psychiatric care onsite in nontraditional settings addresses this care gap, 3) Apply the practice of Homeless Psychiatry across different housing and service sites and with various subgroups of the homeless population, 4) Conceptualize strategies to deliver integrated, evidencebased, recoveryoriented care to homeless individuals in various communities with different resources.

SUMMARY:

Homelessness disproportionately strikes people with severe mental illness, who comprise about one third of the single adult homeless population. Homeless individuals do not access traditional avenues of psychiatric care and often seek care in emergency departments and inpatient units, settings which often cannot address their housing and entitlements needs or their typically chronic psychiatric or medical problems. Treatment plans are limited and often fail upon the “discharge to shelter,” creating an inadequate pattern of care demoralizing to the patient and clinician alike. As homelessness has grown over the past three decades, expanding psychiatric practice into settings where homeless people congregate—to meet them “where they are”—has redressed these barriers and attitudes, and created a new field of “Homeless Psychiatry.” Since its founding in 1986, The Project for Psychiatric Outreach to the Homeless (PPOH), a New York Citybased organization and APA Psychiatric Services Silver Achievement Award recipient, has developed this onsite care delivery model by extending it to a range of settings with varying resources, incorporating integrated, evidencebased practices into it, and building a training program around it. This workshop is intended both for clinicians who want to confront homelessness in their work, and for administrators looking to establish effective

care delivery systems for homeless individuals in their communities. PPOH psychiatrists will discuss various aspects of Homeless Psychiatry, interspersing case vignettes and video testimonials from homeless individuals speaking about their experiences with psychiatry and PPOH. Dr. Dillon Euler will introduce the connection between homelessness, mental illness, and psychiatry; Dr. Van Yu will detail the gap between the medical and psychiatric care needs of homeless individuals and disproportionate access and utilization to such care; Dr. Joanna Fried will discuss the advantages and challenges of providing psychiatric care in street outreach teams, soup kitchens, shelters, and residences; Dr. Anuj Gupta will illuminate the journey homeless individuals take from hospitalization through various stages of homelessness; Dr. Hina Tasleem will relate her contrast her residency training through PPOH with that of a city CPEP and inpatient unit and explore several innovations currently being undertaken at PPOH to optimize psychiatric care.

WORKSHOP 087

SUCCESSFUL CAREER PLANNING FOR WOMEN

APA Womens Caucus

CoChair(s): Gail E. Robinson, M.D., Carol Nadelson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand how to look, evaluate and apply for a new position or academic promotion, 2) Demonstrate communication techniques important in advancing a woman’s career, 3) Find a suitable career mentor, and 4) Construct a plan for selfpromotion.

SUMMARY:

Purpose: To inform women about important aspects of developing successful careers **Methods:** Lecture, PowerPoint, interactive discussion **Results:** Women often have problems knowing how to develop their careers. They may ignore the benefit of having a mentor or not know how to find an appropriate one. They may not know how to evaluate a job possibility by considering such issues as: how it fits into their family and career goals; whether the pros outweigh the cons; and the potential for career advancement. When an offer of a position is made they need negotiating skills; as well as determining what financial compensation is reasonable, they need to evaluate other perks or tradeoffs. There are effective ways of accepting and refusing an offer. Once in a situation, they need to use effective communication tools and know how to make sure their accomplishments are being noticed. **Conclusion:** Women can learn techniques for finding appropriate mentors, seeking out and appropriately negotiating for a position. Once in a position, learning how

to effectively communicate and self-promote can increase their chances of having a successful career.

WORKSHOP 088

PSYCHIATRY IN THE COURTS: HOT ISSUES

APA Committee on Judicial Action

Chair: Paul S. Appelbaum, M.D.

Presenter(s): Paul S. Appelbaum, M.D., Jeffrey Janofsky, M.D., Robert Weinstock, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the issues associated with the treatment of pretrial prisoners in correctional facilities and their restoration to competence to stand trial, 2) Recognize the ways in which prison overcrowding can block the provision of adequate mental health treatment, and 3) Discuss the problems that can arise when clinicians' duties to third parties are expanded to cover their treatment decisions.

SUMMARY:

The Committee on Judicial Action reviews ongoing court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues 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) *U.S. vs. Loughner* – The attorneys defending Jared Loughner, the man accused of killing 6 people, including a federal judge, in Tucson and wounded 13 other people, including a member of Congress, have challenged the government's right to treat him with antipsychotic medication to reduce his dangerousness to self and others, without court approval. APA filed an amicus brief in this ongoing case with the US Court of Appeals for the 9th Circuit to provide the court with information about schizophrenia, antipsychotic medication, and the urgent situations that can arise in correctional settings; 2) *Plata v. Brown* In its last term, the US Supreme Court issued an opinion upholding the order of a lower court requiring California to reduce the population of its prisons. Plaintiffs had pointed to the overcrowded conditions of the state's prisons as a crucial impediment to the provision of effective psychiatric and general medical treatment. APA filed a brief supporting the lower court opinion and providing background information about the conditions necessary for adequate treatment; 3) *BR v. West* – The Utah Psychiatric Association coauthored a brief in this case before the Utah Supreme Court, which grew out of a case in which a patient

murdered his wife. The surviving children sued the treating health professionals, alleging that the clinicians' negligent treatment had led to the murder and asserting a duty on the part of clinicians not to allow their negligent acts to injure third parties. The amicus brief filed by the UPA addresses the issue of thirdparty liability and the potential negative impact on medical treatment, including psychiatric treatment, of recognizing a broad duty. 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.

WORKSHOP 089

THE MENTAL HEALTH PARITY ACT: MAKING IT WORK FOR YOU AND YOUR PATIENTS

Chair: Paul H. Wick, M.D.

Presenter(s): Henry Harbin, M.D., Claudia L. Reardon, M.D., Anita S. Everett, M.D., Barry B. Perlman, M.D., Julie A. Clements, J.D., Irvin Muszynski

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the Parity Act and its implementation, 2) Understand how to apply strategies to achieve parity, and 3) Understand where to locate resources to aid in problem resolution with parity issues.

SUMMARY:

Mental Health Parity Act: Making It Work for You and Your Patients. The passage of the Mental Health Parity and Addictions Equity Act of 2008 (Parity Act) ranks as one of the most important pieces of legislation in recent years for psychiatrists and their patients. While the Parity Act is law, the interpretation and implementation of the act is ongoing. The Parity Act generally requires that any health plan that offers mental health and/or substance abuse benefit coverage must provide coverage with no greater financial requirements or treatment limitations than medical/surgical benefits. The so called NonQuantitative Treatment Limitations are of particular interest and include in part: medical management, preauthorization, formulary design, step therapy, out of network benefits, coding for services and how reimbursement is determined. Even though the Parity Act is law, there remain areas lacking in clear federal guidelines for their implementation. This has resulted in disagreement between mental health advocates (e.g., the APA) and insurers as to what constitutes violation of the law. The APA is vigorously assisting members and state associations in responding to lapses by insurers in implementing the Parity Act. Importantly, breeches of compliance with the law are

occurring not only with commercial insurers, but also with states, which oversee Medicaid managed care plans. A panel of participants from the Council on Healthcare Systems & Financing, Council on Advocacy & Government Relations, Council on Communications, the APA Assembly, and the APA Board of Trustees, all representing the APA Board of Trustees Work Group on Health Reform and Parity, will summarize important aspects of the Parity Act and its implementation, using examples and scenarios of strategies which members may use to challenge lapses in application of parity. Ample opportunity for active audience interaction with the panel will be provided. At the conclusion of the workshop, a participant should be able to understand the Parity Act and its implementation, how to apply strategies to achieve parity and where to locate resources to aide in problem resolution with parity issues. Literature References: Brauser D. Many insurers still trying to skirt mental health parity law. Medscape Medical News. 10 August 2011. <http://www.medscape.com/viewarticle/747852>. Accessed 6 September 2011. Dodds TJ, et al. Who is paying the price? Loss of health insurance coverage early in psychosis. *Psychiatr Serv* 2011; 62: 87881.

WORKSHOP 090

COLLABORATING FOR CHANGE: TRAINING FAMILIES TO BECOME CLINICAL ALLIES SO AS TO IMPROVE BPD TREATMENT OUTCOMES

Chair: Valerie Porr, M.A.

Presenter(s): Valerie Porr, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Teaching evidence based methods (DBT (validation) and MBT), 2) Recognizing misinterpretations, emotional dysregulations and neurobiological underpinnings of BPD, and 3) Developing compassionate understanding of the BPD family experience.

SUMMARY:

Borderline Personality Disorder is present in 5.9% of community based samples, has a 10% suicide rate .and a 70% rate of therapy dropout. After remission, many have severe functional impairments (only 25% are employed full time, 40% receive disability). With the closing of mental hospitals, the high costs of private treatment, and the paucity of availability of evidence based trained BPD professionals, family members by default are left to cope with characteristic BPD behaviors such as impulsivity, selfdestructive and suicidal acts, rapid mood changes and inter personal difficulties, without understanding BPD symptoms, neurobiology of the disorder or any training in effective methods such as how

to be supportive, reduce stress or cope effectively. Clinicians have the unique opportunity to help BPD patients by training family members to become allies, therapeutic parents or partners, modeling and reinforcing effective behavior—preventing and managing escalations through awareness of environmental stress or sand triggers and fostering relationship repair. Research on other mental disorders demonstrates informed families can be treatment adjuncts, improving outcomes. Family awareness of how to cope with suicidal ideation can decrease hospitalizations and prevent suicide attempts/completions. Families can motivate participation in evidence based therapy such as dialectic behavior therapy (DBT), transference focused therapy (TFP) and metallization (MBT). The workshop will present components from the TARA National Association For Personality Disorder Method of family psychoeducation, developed over 15 years of teaching BPD families, utilizing role plays, incorporating DBT, TFP and MBT, and enabling family members to “customize the environment to make it less stressful for the person with BPD”(Gunderson). TARA data indicates that over 80% of family workshop participants are collegeeducated professionals. The TARA method is therefore based on a collegelevel understanding of the neurobiological underpinnings of BPD including latest research on connectivity and systems in dysregulation and the hypersensitivity, hypervigilance, aversive BPD feelings, particularly shame, and cognitive misperceptions characteristic of BPD. Relative’s anger dissipates as they learn to cultivate compassion through nonjudgmental reframing and acceptance of those with BPD as doing the best they can without malicious intent.

WORKSHOP 091

USING A CHECKLIST TO CHARACTERIZE AND IMPACT ANTIPSYCHOTIC PRESCRIBING PATTERNS: DATA FROM AND IMPLICATIONS OF THE NEW YORK STATE OFFICE OF MENTAL HEALTH SHAPEMED PROJECT

CoChair(s): Sharat G. Parameswaran, M.D., Matthew D. Erlich, M.D.

Presenter(s): Gregory A. Miller, M.D., M.B.A., Lloyd I. Sederer, M.D., Cassis Henry, M.D., Thomas S. Stroup, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the underlying factors that serve as the impetus for developing the New York State Office of Mental Health’s novel antipsychotic medication prescribing checklist (SHAPEMEDs), 2) Assess how a centralized electronic checklist can be used to generate a unique clinical database specific to antipsychotic medication prescribing, 3) Un-

derstand the process of implementing the New York State Office of Mental Health's novel antipsychotic medication prescribing checklist (SHAPEMEDs) as a new best practice, 4) Evaluate the results of a checklist-driven clinical database to help understand current practices of antipsychotic medication prescribing in a statewide public mental health care system, and 5) Learn how a checklist-driven clinical database develops and informs behavioral health care policy and improves current practice in the care of people with serious mental illness.

SUMMARY:

In many areas of industry, checklists are used as a powerful tool to manage complexities. Despite increasing recognition of their importance, checklists remain underutilized in behavioral health even as they have been shown to enhance safety and practice in other areas of medicine. The complexity of behavioral health treatment is particularly notable with the use of antipsychotic medications, and includes weighing their benefits against multiple risks and potential side effects. The New York State Office of Mental Health's (OMH) SHAPEMEDs checklist was created through a public-academic partnership in recognition of the complexities inherent to the prescribing and monitoring of antipsychotic medications and the need to improve evidence-based prescribing. The intention of SHAPEMEDs is to guide clinicians in addressing pertinent issues intrinsic to antipsychotic prescribing, including polypharmacy, cardiometabolic side effects, health concerns in the recipient population, adherence, patient preference, and expense. The SHAPEMEDs electronic checklist was constructed to serve dual functions: to guide clinicians with a clinical decision-making tool that incorporates evidence-based principles and to generate a unique clinical database capable of characterizing antipsychotic prescribing practices in a public mental health system. SHAPEMEDs was implemented in June/July 2011 across the New York State OMH system, and has included strategies including establishing local champions and holding informal learning collaboratives. Data will be presented at this APA workshop regarding the implementation and uptake of SHAPEMEDs across New York State. In addition, statewide data will be presented from the clinical database generated by SHAPEMEDs, including antipsychotic prescribing patterns (e.g., use of individual medications, polypharmacy patterns), diagnoses and targeted symptoms associated with prescriptions, and associated side effects such as metabolic risk factors. As part of the SHAPEMEDs implementation plan, this collected data will be provided to medical directors in the New York State OMH system as well as OMH policymakers. The workshop will seek to stimulate discussion about the use of checklists in behavioral health care, including implementation of checklists in public mental health systems. The workshop will also include discussion of the policy implications of the generated

data set, including its potential to guide program directors to implement local strategies focused on improving clinical practices and to further inform statewide changes in policy.

WORKSHOP 092

PRESCRIBING PSYCHOTROPIC MEDICATION FOR GERIATRIC PATIENTS: PEARLS AND PITFALLS

APA Council on Psychosomatic Medicine and Geriatric Psychiatry

CoChair(s): Helen H. Kyomen, M.D., M.S., James M. Ellison, M.D., M.P.H.

Presenter(s): Helen H. Kyomen, M.D., M.S., Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVES:

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, 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, 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, and obtaining informed consent.

TUESDAY, MAY 8, 2012

WORKSHOP 093

TREATING BEHAVIORAL DISTURBANCES IN DEMENTIA IN THE ERA OF BLACKBOX WARNINGS

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

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define behavioral and psychological symptoms of dementia (BPSD), 2) Discuss the epidemiology and neurobiology of BPSD, 3) Describe the evaluation of BPSD, 4) Enumerate the evidencebased treatments for BPSD, and 5) Clarify the current controversies in the treatments for BPSD.

SUMMARY:

Behavioral and Psychological Symptoms of Dementia (BPSD) are a heterogeneous group of noncognitive symptoms and behaviors that occur commonly in patients with dementia. They are increasingly being recognized as a major risk factor for caregiver burden, institutionalization, greater impairment in activities of daily living (ADLs), more rapid cognitive decline, and a poorer quality of life. BPSD contribute significantly to the direct and indirect costs of caring for patients with dementia even after adjusting for the severity of cognitive impairment and other comorbidities. Research indicates that these symptoms develop due to a complex interplay between the biological, psychological and social factors involved in the disease process. Current data shows modest efficacy for some commonly use psychotropic medications in the treatment of these behaviors, but their use has generated controversy due to increasing recognition of their side effect profile. In this review, we discuss the epidemiology, neurobiology, diagnosis and the evidence based treatments for this important group of behaviors.

WORKSHOP 094

BUILDING RESILIENCE: RESPONDING TO COLLEGE STUDENT MENTAL HEALTH NEEDS

Chair: Doris M Iarovici, M.D.

Presenter(s): Victor I Schwartz, M.D., Hollister B. Rogers, M.D., Leah J. Dickstein, M.D., M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify barriers for college students in seeking mental health care. 2) Identify effective treatment strategies for both psychopathology and developmental concerns in the emerging adult population., and 3) Recognize crisis situations among college students, and identify ways to decrease risk of suicide.

SUMMARY:

Mental health problems among university students have increased in both incidence and severity in the past decade. In

addition to high profile tragedies, such as the Virginia Tech massacre and clusters of suicides at universities including MIT and Cornell, there are increases in student anxiety, depression, substance abuse, eating disorders, and overall distress. In 2010, college freshmen reported the lowest levels of emotional health in 25 years. The use of psychiatric medications among collegeaged students has tripled—from 9% in 1994 to 26% in 2008. Although some of this may be entirely clinically justified, new studies which question the efficacy of antidepressants in mild to moderate depression and evidence that students increasingly divert and abuse stimulants on campus suggest it's time to reexamine treatment models and consider whether there are additional creative new approaches to help build resilience in this population. There's significant variability in mental health resources available to students across the US, and in general, access to psychiatric care remains inadequate. This workshop will present several approaches to the current challenges facing clinicians working with college students. From a developmental perspective, which is essential in working with emerging adults, we will address ways to help build resilience within university students. We will present new findings on stigma and service utilization, and consider how to decrease barriers which may keep some students from seeking care. We will also review clinical approaches to dealing with students in crisis, including suicidal students. And we will consider evidencebased complementary treatments, such as mindfulness meditation, which can be incorporated both into treatment regimens for students with psychopathology, and into developmental programming for students facing developmental concerns.

WORKSHOP 095

PRIMARY CARE BEHAVIORAL HEALTH INTEGRATION: ROLES OF THE KEY TEAM MEMBERS

Chair: Lori Raney, M.D.

Presenter(s): Lori Raney, M.D., Benjamin Miller, Psy.D., Frank Degruy, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the needs in primary care for timely psychiatric consultation and the existing models of care that can provide this, 2) Describe the functions of the consultant psychiatrist in the collaborative care setting and the oversight responsibilities for the population served, 3) Understand the functions of other behavioral health providers in the primary care setting and how they interact with the consultant psychiatrist and primary care provider

SUMMARY:

Primary Care Behavioral Health Integration (PCBH) is an emerging research supported model for identification and treatment of previously undiagnosed and/or undertreated mental illness in primary care settings and unrecognized chronic health conditions in mental health clinics. Psychiatrists have had few training opportunities in this area even though they are valuable and highly sought after members of the PCBH care team. The knowledge gap is significant and is hampering psychiatrists joining these teams in wellinformed and meaningful ways. Health care reform has introduced an additional set of challenges for the field of psychiatry. To meet this workforce need, we will need new models to ensure the knowledge and skills psychiatrists bring to the health care reform table are utilized in innovative ways. One solution is the PCBH model, which introduces a population based approach to meet the mental health needs of the larger community through the use of care teams. The traditional PCBH care team includes the Primary Care Provider (PCP), the Behavioral Health Provider (BHP) and the Psychiatric Provider all working together to provide the Patient with comprehensive care at the point of contact in the primary care setting. This workshop will go beyond the traditional overview of PCBH and provide an indepth exploration of the roles of each of the core team members and their working relationships to each other. The 3 speakers are representative of the makeup of this team and will share their perspectives on the functions and training needs of each discipline. Dr. deGruy, a family practice physician and Chair of the Department of Family Medicine at UC Denver, is a national leader in collaborative care. Dr. Miller is a national expert on integrated care and has taught courses on the role of the BHP. Dr. Raney works as a team consultant psychiatrist in rural Colorado, chairs the APA Workgroup on Integrated Care and has helped develop a curriculum for educating psychiatrists in primary care collaboration. A strong PCBH integrated care team requires a psychiatrist that is knowledgeable about not only their role on the team but also the workings of the integrated system of care. This workshop strives to address the significant knowledge gap that currently exists for psychiatrists who desire to work in this developing subspecialty area.

WORKSHOP 096

MEDIMEDI: A GHOST STORY

Chair: Rodrigo A. Munoz, M.D.

Presenter(s): Brian Crowley, M.D., Harold I. Eist, M.D., Roger Peele, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Evaluate the current problems facing clinical psychiatrists contracting with Medicare, 2) Handle challenges

in dealing with intermediaries and dealing with their rules, and 3) Make decisions about contracting with Medicare.

SUMMARY:

The chronically disabled poor have been attracting notice because some planers, economists and gurus blame them for some of the Medicare and Medicaid woes. These people, the “medimedi’s”, supposedly have dual coverage and more adequate support than the nonchronic and nonindigent. The reality is very different. In California, for example, the state denies the Medicaid payment for outpatient psychiatric services, and the Medicare payment is lower than Medicaid, so that the double coverage is actually a sentence to diminished or noaccess to health care. Given that severe and chronic psychiatric conditions often lead to poverty, a substantial proportion of the medimedi’s require psychiatric care, at a time when a substantial number of psychiatrists face the need of abandoning Medicare contracts in order to continue to serve others in their communities. The proponents present their reaction to alternative proposals, including direct (notcontracted) services, affiliation with clinics, and accountable medical homes.

WORKSHOP 097

INCARCERATION OF BLACK MALES: THE EFFECTS OF UNTREATED BIPOLAR, ADHD, AND SUBSTANCE ABUSE DISORDERS

APA Caucus of Black Psychiatrists

CoChair(s): Napoleon B. Higgins, M.D., Ericka L. Goodwin, M.D.

Presenter(s): Napoleon B. Higgins, M.D., Rahn K. Bailey, M.D., Otis Anderson, M.D., Timothy Benson, M.D., Johnny Williamson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss racial disparities in diagnosis, treatment options, and research in multicultural populations related to Bipolar Disorder, ADHD and Substance Abuse Disorders, 2) Participants should be able to understand the differences in the rates of incarceration of black males in comparison to males of other ethnic backgrounds, and how governmental policies helped promote these disparities, 3) Identify how impulse control and behavior disorders are inappropriately treated in the legal and criminal justice systems

SUMMARY:

ADHD, Bipolar Disorder and Substance Abuse Disorders are neurobehavioral disorders that are characterized by impulsivity, poor decision making, anger, inattention and odd

behavior. This presentation will discuss evidencebased practices and interventions in decreasing black male incarceration rates. The alarming rate of incarcerated mentally ill AfricanAmerican males goes largely ignored and inadequately researched; which leads to inappropriate treatment of black males via the legal system. This has a major impact on AfricanAmerican communities, as well as their families. Mandatory prison sentences and “The War on Drugs” for people with drug offences have forced substance abusers into incarceration without provisions for substance abuse treatment. There are unique differences in metabolism among various cultural populations that impact the differential effects of psychotropic medications. Many jails and prisons have replaced psychiatric hospitals and house many persons with the severest forms of mental illness. Participants will be able to identify how black males with comorbid mental illness and substance abuse are receiving inappropriate care in incarcerated settings. There is currently limited focused study on the specific effects of psychiatric medications in AfricanAmericans. This talk will focus on basic psychopharmacology and drug classes in the treatment of bipolar disorder and ADHD in AfricanAmerican men.

WORKSHOP 098

COGNITIVE BEHAVIORAL STRATEGIES FOR WEIGHT LOSS

Chair: Sarah Johnson, M.D.

Presenter(s): Joyce A. Spurgeon, M.D., Casia Horseman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand factors contributing to the obesity epidemic, 2) Explain risks and benefits of commonly used weight loss strategies to the psychiatric patient population, 3) Integrate cognitive behavioral techniques to promote adherence to weight loss regimens.

SUMMARY:

We live in a society obsessed with food and weight loss and this obsession often permeates the psychiatric patient population. It is important to understand the obesity epidemic and common strategies that individuals may use to combat it in order to provide comprehensive psychiatric care. This presentation will review factors contributing to the obesity epidemic and highlight commonly used weight loss strategies. Interactive case presentations will illustrate how cognitive behavioral techniques can be integrated into practice to promote adherence to these regimens and promote success in the psychiatric population.

WORKSHOP 099

BRIEF PSYCHOTHERAPEUTIC STRATEGIES TO ENHANCE PSYCHOPHARMACOLOGICAL TREATMENTS

CoChair(s): R. Rao Gogineni, M.D., Amit Gupta, M.D.

Presenter(s): Donna M. Sudak, M.D.

EDUCATIONAL OBJECTIVES:

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) Enhance assessment of compliance and adherence by making use of measurement tools, 3) Address poor adherence to medications by making use of brief cognitivebehavioral, Psychodynamic psychoeducational, family interventions, and 4) Learn strategies to enhance understanding and techniques of trainees and clinicians to make use of psychotherapy strategies to improve adherence

SUMMARY:

Many studies in adult and pediatric psychiatric disorders have shown medication compliance rates of 20-70%: noncompliance of antidepressants 40%,schizophrenics 74%,Upto 50 % in Bipolar,50% in ADHD. Medication noncompliance leads to recurrence of symptoms and re-hospitalizations. Poor understanding and misconceptions about illness and medications, neurocognitive impairments, therapeutic alliance, family, cultural, psychodynamics and comorbidity contribute to this. Psychoeducation is essential, but often insufficient to enhance compliance to medications. Cognitive skill training and cognitivebehavioral interventions focusing on patients' beliefs and attitudes about illness and medications are very useful in enhancing medication compliance. Psychodynamic aspects of resistance (denial of illness or pathological investment in symptom maintenance), or transference (medication as a threat to counterdependent stance in life), projective identification, countertransference often impacts compliance. Family interventions and selfhelp groups are very helpful. Recognition, assessment and management of nonadherence to psychopharmacological interventions are essential skills for psychiatrists, residents and physician extenders. Will present Case based learning and small group discussion encouraging active participation by attendees in addition to presentation of EBM in this area. Psychoeducation, enhancing strategies to improve doctorpatient treatment alliance, effective use of CBT techniques, and teaching trainees and allied professionals to enhance medication adherence will be highlighted. References: Velligan D,Weiden P; Interventions to improve adherence to antipsychotic medications; Psychiatric Times, August 2006, Vol xx111,No9 2) Glen O. Gabbard; Dynamic Pharmacotherapy in Psychodynamic Psychiatry, Washington D.C.: American Psychiatric Press

Inc., 2003, 134143. 3) David L. Mintz; Teaching the prescriber's role: The Psychology of Psychopharmacology: Academic Psychiatry, 2005, 29, 187194 4) Sudak D; Combining CBT and Medication: An Evidence Based Approach, John Wiley and Sons, 2011; 5) Foster, Sheehan, Johns; Promoting treatment adherence in patients with Bipolar Disorder, Current Psychiatry, Vol 10, No 7, pp 4552

WORKSHOP 100

BOOTCAMP FOR BURNOUT: STRATEGIES TO PROMOTE RESILIENCE AND WELLNESS FOR PSYCHIATRISTS

Association of Women Psychiatrists

CoChair(s): Eva Szigethy, M.D., Ph.D., Patricia I. Ordorica, M.D.

Presenter(s): Eva Szigethy, M.D., Ph.D., Stacy S. Drury, M.D., Ph.D., Christina T. Khan, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Define burnout in physicians and the data to support this construct at all levels of career development (medical school, residency, and practice), 2) Understand how physicians can use social networking techniques and social support resources from family, friends, colleagues, and the community, 3) Know how to utilize various stress management techniques to prevent burnout including time management, relaxation, mindfulness techniques and life enhancement.

SUMMARY:

Burnout is a syndrome characterized by depersonalization, emotional exhaustion, and a sense of low personal accomplishment that leads to decreased effectiveness at work. This phenomenon has been increasingly recognized among medical students, residents and physicians in practice and has been shown to negatively impact career satisfaction and patient safety. Up to 76% of residents have been shown to meet criteria for burnout and those respondents believe they provided suboptimal patient care. The rates of burnout among physicians in practice range from 25-60% with 37-47% of academic faculty, and 55-67% of private practice practitioners meeting established criteria for burnout. Increased stress and burnout also lead to health consequences in both the emotional and physical realms. In addition, it can lead to decreased work productivity, lower quality of life, and social isolation. The data regarding the negative impact of burnout are alarming and suggests the need for effective interventions to promote resilience and wellness among physicians and physicians in training. The goals of this workshop are to address burnout among physicians at

every level of career development and discuss and demonstrate methods to reduce burnout and promote resilience and wellness. Specific stress management interventions to be covered will be social networking strategies, time management, relaxation, and mindfulness techniques, and life enhancement.

WORKSHOP 101

UPDATE ON MOVEMENT DISORDERS: CLINICAL FEATURES AND DIAGNOSIS

Chair: Vasant P. Dhopesh, M.D.

Presenter(s): Stanley N. Caroff, M.D., James F. Morley, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe common movement disorders observed in psychiatric practice, 2) Explain differences in presentation between neurological and psychogenic movement disorders, and 3) Discuss the differential diagnosis of neuropsychiatric syndromes underlying commonly observed movement disorders.

SUMMARY:

Movement disorders remain an important component of neurological, drug-induced and psychiatric disorders commonly encountered in clinical practice. Positive treatment outcomes depend upon the early recognition and diagnosis of syndromes underlying movement disorders. To enhance awareness of this topic, this workshop will present a review of the clinical phenomenology of movement disorders. First, a brief overview of the history and changing patterns of movement disorders among psychiatric patients will be presented by Dr. Caroff. Then, extensive and illustrative videos of diverse movement disorders will be shown and informal discussion of the disorders depicted in the videos will be led by Dr. Morley and Dr. Dhopesh. Active participation and questioning by the audience will be encouraged and expected. Apart from its importance for clinical practice, this review also will be valuable and worthwhile for psychiatrists preparing for the boards, recertification or MOC exams. 1. Hallett M. Classification and treatment of tremor. *JAMA*, 1991;266:1115-1117 2. Caroff SN, Hurford I, Lybrand J, Campbell EC. Movement disorders induced by antipsychotic drugs: implications of the CATIE Schizophrenia Trial. *Neurol Clin* 2011;29:127-148.

WORKSHOP 102

A TALE OF TWO SPECIALITIES: THE INTEGRATION OF ONCOLOGY AND PSYCHIATRY

CoChair(s): Sarah E. Parsons, D.O., Mary Helen Davis, M.D.

Presenter(s): Julie A. Chilton, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Implement optimal psychopharmacology to the cancer patient, 2) Facilitate optimal psychotherapy to the cancer patient, and 3) Appreciate the process of creating and sustaining an integrated model of care for cancer patients with psychiatric needs.

SUMMARY:

A diagnosis of cancer can create distress for patients and families; they may experience anxious or depressive symptoms in response to a new diagnosis or recurrence. In addition to treatment related stressors, patients face the overwhelming challenge of managing other responsibilities which may include work, family, and other health related concerns. The presence of an integrated behavioral oncology program offers a unique opportunity to quickly address the needs of patients and families, while decreasing the burden of additional medical appointments and fragmented patient care. The collaboration between oncology and psychiatric providers improves health care delivery to cancer patients and their families. Addressing the psychiatric needs of cancer patients involves specialized psychotherapy and psychopharmacology. The appropriate use of psychotropic medication in this population will be thoroughly explored; the use of antidepressants, anxiolytics, and mood stabilizers in different cancer populations will be discussed. Dignity therapy and legacy building will be specifically discussed as effective therapeutic modalities. Three models of integrated psychooncology will be presented. Aspects of program development, distress screening in the cancer population, working in a multidisciplinary setting, and success of these programs will be explored.

WORKSHOP 103

ROLE OF GENDER AND CULTURE IN PROFESSIONAL PSYCHIATRY

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

Presenter(s): Vijayalakshmi Appareddy, M.D., Rashi Aggarwal, M.D., Toi B. Harris, M.D., Joan M. Anzia, M.D.

EDUCATIONAL OBJECTIVES:

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 culture and gender on professional success in psychiatry, and 3) Discuss potential solutions to challenges faced by women

psychiatrists 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. It also has better time requirements than many other fields. 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 – the 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. 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 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 female psychiatrists in academia. We will also discuss the roles culture and ethnicity play in the lives of professional women. We will present some personal experiences of female faculty from diverse cultural backgrounds. The audience will have an opportunity to engage in a discussion based on their own experiences. We will offer potential solutions that 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 will help them and the field of psychiatry in general.

WORKSHOP 104

A PRIMER ON PSYCHOTHERAPY IN THE MEDICALLY ILL

Chair: Sanjeev Sockalingam, M.D.

Presenter(s): Susan E. Abbey, M.D., Sanjeev Sockalingam, M.D., Raed Hawa, M.D., Adrienne Tan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe common psychotherapeutic approaches in the medically ill, 2) List the indications and contraindications for each modality in specific medically ill patient populations, and 3) Demonstrate an approach to bringing key components of each psychotherapeutic modality to the “bedside” of medically ill patients.

SUMMARY:

Psychotherapy is a key treatment modality for patients adapting to medical illness and yet many psychiatrists have received little training in this setting. Patients often require assistance with understanding their medical illness, navigating role transitions, managing maladaptive thoughts, coping with distress, and facing their mortality. It is important to tailor each psychotherapy modality to the unique challenges facing each patient. Using case vignettes, this workshop will highlight the use of 4 psychotherapeutic modalities in medically ill patients. The 4 modalities include psychoeducation groups, interpersonal psychotherapy, cognitivebehavioral therapy and mindfulnessbased stress reduction. The workshop will briefly review key tenets of each modality but will focus primarily on practical components that can be applied to clinical scenarios in an integrative manner. The workshops will provide participants with an opportunity to reflect on their clinical practice and potential counterreactions and countertransference in these settings. Learning will be enhanced through various teaching techniques such as didactic teaching, case scenarios and guided selfreflection. Resources for providing or enhancing psychotherapeutic interventions in the medically ill will be discussed and provided. The intended outcome of this session is to build on participants’ foundation in psychotherapy and provide evidencebased skills to integrate psychotherapy more readily in medically ill patients.

WORKSHOP 105

THE COBBLER’S CHILDREN: DEALING WITH MENTAL ILLNESS IN OUR OWN FAMILIES

Chair: Julia Frank, M.D.

Presenter(s): Mitchell J. M. Cohen, M.D., Kathryn McIntyre, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Articulate the practical and emotional concerns of trying to help a family member with a psychiatric dis-

order, 2) Recognize that many psychiatrists have similar experiences, and 3) Network, if desired, with colleagues with experience in this area

SUMMARY:

This workshop, a repeat of well attended sessions at the Annual Meetings of 2010 and 2008, provides a forum for mental health professionals to share their experience of trying to help close family members who develop serious psychiatric problems. In a series of round robin interviews, the three panelists will each reflect on the experience of recognizing a problem, seeking help, establishing appropriate boundaries with those who take care of the troubled person, and dealing with the anxiety and sense of loss that comes when someone we love is seriously ill. Throughout, audience members will have the opportunity to ask questions and share their own experience, seeking or giving guidance to their peers as they see fit.

WORKSHOP 106

EXTENDED TREATMENT FOR ALCOHOL USE DISORDERS: AN UPDATE

U.S. National Institute on Alcohol Abuse and Alcoholism

Chair: James R. McKay, Ph.D.

Presenter(s): James R. McKay, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand rationale for considering the application of extended treatments for AUD, 2) Have a working knowledge of the major approaches to extended treatments for AUD, and 3) Apply the major elements of extended treatments in psychiatric practice

SUMMARY:

More than 10% of the U.S. population meets DSMIV criteria for substance use disorders, according to recent estimates. Although effective interventions have been identified for substance abuse, a significant percentage of patients respond poorly to them. This variability in patient response highlights the need for adaptive models of care—that is, tailored interventions based on treatment algorithms that specify treatment modifications triggered by the patient’s initial response and changes in symptoms. In addition, because relapse is common, addiction interventions should extend beyond the acute phase of care and address functioning over time. Continuing care solidifies and sustains recovery by helping the patient develop and maintain recoveryoriented behaviors and sources of support. This workshop will provide a comprehensive review of

the latest research on both standard approaches to continuing care and newer adaptive models that emphasize: more flexible protocols; less treatment burden and greater convenience for patients; more attention to patient preference with regard to components of care; use of settings other than traditional specialty care programs; greater reliance on communication technology; greater emphasis on the role of selfcare in a disease management approach.

WORKSHOP 107

RESOLVING ETHICAL CHALLENGES AND PROMOTING MENTAL HEALTH RECOVERY

APA/The Scattergood Foundation

Chair: Phyllis Solomon, Ph.D.

Presenter(s): Jonathan Lukens, M.D., Phyllis Solomon, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate knowledge about the history of recovery and understand what recovery is in the current context, 2) Recognize the ethical challenges to implementing recovery oriented services, 3) Identify intervention strategies for implementing recovery oriented services.

SUMMARY:

The president's new freedom commission has endorsed recovery as a model for mental health system transformation. With its emphasis on promoting autonomy, client choice and self-directed care, recovery is consistent with trends in medical ethics. This workshop argues that recovery represents a significant step forward in our understanding of mental health services, but raises important ethical issues regarding competence and safety. The presenters will discuss how utilizing interventions such as person center planning, psychiatric advance directives and shared decisionmaking can help to resolve these ethical challenges and promote client autonomy and recovery.

WORKSHOP 108

GREAT PERFORMANCES: MALINGERING IN FICTION

Chair: Sherif Soliman, M.D.

Presenter(s): Susan HattersFriedman, M.D., Sara G. West, M.D., Cathleen A. Cerny, M.D., Sherif Soliman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Learn about the ways in which malingered men-

tal illness is portrayed in the popular media and the manner in which these popular portrayals are generated, 2) Explore the potential implications of fictional portrayals of malingering on the practice of forensic psychiatry, 3) Explore the potential implications of fictional portrayals of malingering on public perception of psychiatry and on public policy regarding the use of psychiatric evidence in civil and criminal proceedings.

SUMMARY:

From hit drama, *The Sopranos*, to the recent sitcom *Hot in Cleveland*, feigning mental illness has been portrayed as a way to avoid criminal responsibility. Building on the well-received AV session that this group gave last year, "From Dr. Kreilzer to Hannibal Lecter: Forensic Psychiatrists in Fiction," this presentation will describe how malingered mental illness is portrayed in the popular media. The authors will use film clips to illustrate the types of malingered symptoms portrayed, the forensic situations portrayed, and whether or not the malingering is ultimately detected. Special guest Alan Oxman, Sundance Film Festival award-winning filmmaker, will discuss how filmmakers approach portraying feigned mental illness. Mr. Oxman received his MFA from the American Film Institute and is a clinical social worker working with children in NYC. He will draw upon his unique experience to illustrate how malingered mental illness is portrayed. In the final portion, the significance of fictional portrayals of malingering to the practice of forensic psychiatry will be discussed. Specifically, we will discuss whether these portrayals increase skepticism about the insanity defense and other mental health claims. We will compare portrayals of malingering with jury perceptions of the insanity defense and briefly discuss public policy implications.

WORKSHOP 109

STRENGTHENING RESILIENCE AND DEVELOPING POSTTRAUMATIC GROWTH IN CHILDREN, ADULTS, AND COMMUNITIES FOLLOWING DISASTERS

Chair: Howard J. Osofsky, M.D., Ph.D.

Presenter(s): Joy D. Osofsky, Ph.D., Michelle B. Moore, Psy.D., M.Ed., Rebecca Shahmoon Shanok, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Participants will have knowledge of expectable mental health symptoms following disasters, as well as steps to aid in recovery and mental health service delivery, 2) Participants will learn about ways to support resilience and develop approaches and services that promote resilience

and posttraumatic growth after disasters, and 3) Participants will gain knowledge about the importance of building community resilience by supporting both children and adults following disasters and will learn the necessary steps to engage a community in recovery efforts postdisaster.

SUMMARY:

Following disasters, children of all ages are traumatized by displacement and separation from families and friends caused by mandatory evacuation, loss of homes and possessions, and often, loss of community. How children and adults respond after such catastrophic events depends on many factors including their direct exposure and experience with the disaster, previous trauma and loss history, developmental level of the child, and, perhaps most important, amount of support that is available from family, school and community. Resilience building is a necessary and pivotal part of recovery postdisaster. Psychiatrists are frequently among the first clinicians to see survivors of disaster when mental health problems can become overwhelming. With the unfortunate events that have occurred nationwide recently including the Gulf Oil Spill, Hurricane Irene, tornados in Joplin, Missouri, wildfires in Texas, building resilience in individuals and in communities is crucial to ensure recovery and posttraumatic growth. With disasters becoming common occurrences, strategies to build resilience should become an important addition to psychiatrists' and other mental health professionals clinical approaches to support recovery. At the conclusion of this workshop, participants will have learned how to identify expectable mental health symptoms following disasters and also the importance of building resilience and supporting growth in children, adults and communities. Qualitative and quantitative data will be presented to highlight the effects of a Youth Leadership Program that was developed in St. Bernard Parish adjacent to New Orleans following Hurricane Katrina which encourages individuals as well as the entire community to focus on building resilience. Participants will be asked to provide feedback and reactions to audiovisual clips regarding students' participation in the Youth Leadership Program as well as clinicians' reactions to alternative strategies to resilience building in individuals and communities.

WORKSHOP 110

ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

Ethics Committee

Chair: Burton V. Reifler, M.D.

Presenter(s): Elissa P. Benedek, M.D., Harriet Stern, M.D., William Arroyo, M.D., Wade Myers, M.D., Mark S. Komrad, M.D.

EDUCATIONAL OBJECTIVES:

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, and 3) Identify boundary issues and conflicts of interest

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 111

TMS BEYOND THE FDA LABEL: CONSENSUS GUIDELINES FOR BEST CLINICAL PRACTICE

Chair: Irving Reti, M.B.B.S

Presenter(s): Linda L. Carpenter, M.D., Irving Reti, M.B.B.S, Shirlene M. Sampson, M.D., M.S., Johnny O Reardon, M.D., Sarah H. Lisanby, M.D., Mustafa Husain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Gain an improved understanding of the efficacy and safety of TMS in the clinical setting, 2) Become familiar with efficacy and safety data for patients whose clinical features are not fully consistent with the FDA approved indication, including high treatment resistance, bipolar disorder or primary diagnosis other than MDD, and for special patient populations such as adolescents and pregnant women, and 3) Review data regarding the TMS treatment with "offlabel" dosage parameters, including total number pulses, frequency of the stimulus, alternative targeting methods, and coil laterality.

SUMMARY:

In October 2008, transcranial magnetic stimulation (TMS) was approved by the FDA for treating patients with major depressive disorder who had failed one and only one adequate trial of an antidepressant treatment in the current major depressive episode. Since FDA approval, there has been a rapid and wide dissemination of TMS into clinical practice

in the US with over 200 centers providing the treatment. However, it is likely that a substantial proportion of TMS treatment is provided offlabel to patients who seek help from TMS when other options have failed and have a higher degree of treatment resistance than specified in the FDA approval label. That is because the treatment is timeconsuming and expensive with coverage by insurance carriers being uncommon. In addition to TMS patient selection often being offlabel, practitioners are increasingly utilizing offlabel dosing strategies in an attempt to improve efficacy for their patients. For example, the FDA label is for delivery of 3000 pulses per session to the left prefrontal cortex, however the approved TMS device is capable of delivering 5000 pulses per session which is being adopted by some TMS practices. In addition, stimulation of the right prefrontal cortex with low frequency pulses is sometimes effectively employed to also treat depression. Accordingly, it is timely that clinical guidelines be developed to inform the appropriate and safe use of this powerful brain stimulation technology in the setting of the clinic. The National Network of Depression Centers, a network of 21 academic medical centers with large mood disorder programs, convened a Task Group on TMS, which has created a set of consensus guidelines to address this gap in the literature, and to provide practical information for practitioners to inform their clinical application of TMS to patients with depression. They extend the previous safety guidelines which focused on TMS primarily in research settings and which were developed before the FDA approval for treating depression with TMS. The consensus guidelines are evidencebased being informed as far as possible by the now extensive database of TMS research. The aim of the workshop is to inform and educate both referring doctors and clinicians presently administering TMS about issues related to TMS clinical practice, with a special focus on patient and dose selection that are beyond the FDA label. Panelists are all members of the NNDC TMS Task Group and coauthors of the TMS consensus guidelines and will provide brief presentations about patient and dose selection and the data supporting the guideline recommendations and best clinical practice. Although we expect patient and dose selection will be the major themes, other issues that may arise include evaluation of patient progress, safety and informed consent which will be addressed by our panelists. We expect the workshop to engage clinicians and foster questions and audience participation.

WORKSHOP 112

SMALL, MEDIUM, OR LARGE? A PANEL DISCUSSION WITH PSYCHIATRISTS FROM THREE COLLEGE CAMPUSES

CoChair(s): Farah Munir, D.O., Susan Kimmel, M.D.

Presenter(s): Farah Munir, D.O., Susan Kimmel, M.D., Mi-

chelle Fulk, D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Demonstrate awareness of how the cultural and demographic differences between students in three different college and university settings may impact the delivery and utilization of psychiatric services in these different environments, 2) Describe several different approaches to suicide prevention, crisis intervention, and the promotion of safety on college campuses, 3) Contrast the degree of collaboration and integration between medical and mental health services offered by psychiatric faculty in three different collegiate settings: a large, downtown university, a midsized, private suburban university, and a small, semirural liberal arts college, 4) Highlight some of the unique mental health concerns reported by different subpopulations (conservatory, graduate level, international, disabled students, etc.) of college age patients with the use of clinical case vignettes

SUMMARY:

A recent survey of incoming college freshman (Pryor et al., 2010) found that students perception of their emotional health is at an alltime low. Today's freshmen report feeling overwhelmed and face increased financial obstacles. At the same time the expectation for utilization of mental health services is high; more students than ever expect to seek personal counseling for their concerns (Pryor et al, 2010). In order to meet the growing demand for access to high-quality psychiatric services on college campuses, many schools partner with faculty and trainees from affiliated medical schools and residency programs. In this workshop, we contrast the experiences of faculty and trainees from one academic psychiatry program in three different undergraduate clinical settings: Cleveland State University a large, urban university, Case Western Reserve University midsized, private research institution in a metropolitan area and Oberlin College a small private liberal arts college in a semirural setting. This interactive panel discussion will highlight some of the unique clinical challenges faced in treating various subpopulations: older and nontraditional students, Bisexual, Gay, Lesbian and Transgendered students, international students, and students with various types of disabilities. Clinical case vignettes will be presented to foster discussion and awareness of some of the cultural issues which may impact a clinician's ability to work effectively with different patient populations. The workshop will also offer opportunities to explore the similarities and differences in clinical service delivery, administrative support services and degree of integration between primary care and behavioral health services at each of the three colleges and universities.

WORKSHOP 113

ASSESSMENT OF SUICIDAL BEHAVIOR IN CHILDREN AND ADOLESCENTS

CoChair(s): Magdalena Romanowicz, M.D., Timothy Lineberry, M.D.

Presenter(s): Magdalena Romanowicz, M.D., Kathryn M. Schak, M.D., Sandra Rackley, M.D., Stephen O Connor, Ph.D., Timothy Lineberry, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe epidemiology of suicidal behavior in children and adolescents in the U.S., 2) Critically review evidencebasis of suicide risk assessment tools in children and adolescents, and 3) Describe key areas of risk and clinical strategies to address.

SUMMARY:

Format: Workshop with individual presentations with question and answer session and use of case examples to address clinical relevance and strategies. Background: Suicide is the third leading cause of death among young people. From 2000-2007, tenthousand ninehundred fifteen children and adolescents up to the age of 18 died by suicide in the United States. Psychiatric hospitalization rates for children and adolescents for suicidal crises has increased substantially in the past decade and is a common clinical problem. Despite the obvious tragedy of suicide and the high frequency of suicidal behavior in children and adolescents, there is limited clinically applicable research and evidence based practice recommendations to draw on for clinical management. Workshop: In this workshop, Dr. Magdalena Romanowicz will describe results of a systematic review of the suicide research literature and provide background on challenges associated with research in suicidal behavior in children and adolescents. Dr. Kate Schak will review identified risk factors for both suicide and suicidal behavior in children and adolescents and their clinical utility, or lack thereof, in clinical practice. Dr. Stephen O'Connor will describe results of research in the use of the Suicide Status Form – II (Jobes et al) in a large clinical practice and implications in assessment of girls vs. boys and diagnostic issues related in use of a clinical assessment tool. Dr. Sandy Rackley will describe challenges associated with developing a more evidence based clinical practice and identify strategies to be able to make clinical practice change to enhance evidence based practice in this population. Dr. Timothy Lineberry will address performance of suicide risk assessment and commonalities and differences between assessment of adults vs. children and adolescents and identify areas of future need in research on suicide risk assessment in children and adolescents. Dr. Lineberry will also address current perspectives with black box warning for antidepressants. The

authors will utilize clinical examples to demonstrate clinical relevance and demonstrate strategies.

WORKSHOP 114**PSYCHIATRISTS AND THE NEW MEDIA: GAINING CONTROL OF OUR SPECIALTY'S PUBLIC IMAGE**

Chair: Steven R. Daviss, M.D.

Presenter(s): Annette Hanson, M.D., Daniel J. Carlat, M.D., Hsiung C. Robert, M.D., Steven Balt, M.D., M.S., Dinah Miller, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe five characteristics that differ between old media and new media, and how these affect potentially affect patient perception of psychiatry, 2) List pros and cons of direct participation of psychiatrists in the new media, 3) Describe the style of interaction across the following social media types: Blogs, forums, podcasts, Facebook, Twitter, Google+, LinkedIn, and YouTube

SUMMARY:

Psychiatrists have long been challenged to get a fair shake in mainstream “old media”, such as film, TV, and print. Stereotypes and caricatures of psychiatrists have predominated in these media, with sensationalist portrayals gaining the most attention. As a result, those who have never had contact with a psychiatrist have opinions of us formed largely out of these skewed impressions. “New media,” carried on the internet and composed of blogs and podcasts, tweets and Facebook updates, YouTube videos and other social media content, carry the promise of psychiatrists having greater control over the opinions formed of us. Social media is more personal and more empowering, requiring only an internet connection to broadcast one's ideas to the global village. With this new power comes more opportunities for successfully portraying what the practice of psychiatry is all about, yet also more hazards for us to get it wrong.

WORKSHOP 115**FROM UTILIZATION ANALYSIS TO QUALITY MANAGEMENT IN MENTAL HEALTH CARE RESEARCH**

Chair: Wolfgang Gaebel, M.D.

Presenter(s): Povl MunkJørgensen, M.D., Harold A. Pincus, M.D., Wolfgang Gaebel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss the use of quality indicators in mental

healthcare systems analyses, 2) Estimate the role that care trajectory analyses can play in mental healthcare research, 3) Assess the contribution of mental healthcare research for improving outcomes of mental healthcare based on epidemiological and utilization analyses.

SUMMARY:

Some of the important prerequisites to improve mental healthcare services on a systems level are epidemiological assessments of the frequency of the different mental disorders in a population, studies about the utilization of mental healthcare services using routine data, trajectories of people affected by mental disorders through the mental healthcare systems, and correlations of such factors with outcome parameters. To compare and evaluate such data, outcome indicators for mental disorders are of prime importance. Several studies in different countries are addressing these issues and the main aim of this symposium is to give an overview of currently used mental healthcare research methods, essential results of recent studies, and how the findings from these studies can be translated into optimized mental healthcare services by using quality indicators.

WORKSHOP 116

LOST IN TRANSLATION: TAKING CULTURAL SENSITIVITY FROM THEORY TO THE BEDSIDE

APA Council on Medical Education and Lifelong Learning

CoChair(s): Puja Chadha, M.D., Jason E Cheng, M.D.

Presenter(s): Elena F GarciaAracena, M.D., Ye B. Du, M.D., M.P.H., Esther E. Oh, M.D., Denise Chang, M.D., Ankur Bindal, M.D., M.P.H., Alric D. Hawkins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the need for training on sociocultural issues in psychiatry residency training programs, 2) Describe novel residentdriven cultural psychiatry training formats, 3) Identify the barriers to implementing cultural psychiatry curricula and ways to overcome them, and 4) Generate ideas and plans on how to improve the cultural psychiatry curriculum at one's home institution.

SUMMARY:

ACGME and ABPN require cultural competencies for psychiatrists. (1, 2) However, ethnic minority patients still have less access to and receive lower quality of psychiatric treatment. (3) To help guide psychiatry residency training programs on providing cultural psychiatry training, AADPRT in March 2010 awarded a Model Curriculum Award in cultural psychiatry to both NYU and UC Davis. (4, 5)

While these curricula can serve as models, implementation must adapt to the unique characteristics of each residency training program, which remains a challenge. Interviews of instructors in cultural psychiatry revealed a general recommendation of having residents act as key resources in developing cultural psychiatry curricula (6). This workshop presents four novel residentdriven efforts to implement cultural humility in residency psychiatry training. It will begin with an introduction to the importance of strong cultural curricula, including presentation of some recent data on both patients' and providers' views of cultural competence in care. Next, presenters will describe their programs and curricular work. They will present on a case conference series, a cultural residency training track, the revision of an existing curriculum, and cases to illustrate the DSMIV Outline for Cultural Formulation. The projects include the novel use of multimedia in education. Key elements of implementation applied to each project include: institutional buyin, logistical considerations, curriculum and learner assessment, and sustainability. Discussion will allow participants to brainstorm ideas for improving cultural psychiatry curricula at their home programs. References: 1. ACGME Program Requirements for Graduate Medical Education in Psychiatry http://www.acgme.org/acWebsite/downloads/RRC_progReq/400_psychiatry_07012007_u04122008.pdf, last accessed September 10, 2011. 2. American Board of Psychiatry & Neurology. Psychiatry and Neurology Core Competencies Version 4.1. http://www.abpn.com/downloads/core_comp_outlines/core_psych_neuro_v4.1.pdf, accessed September 9, 2009 3. Smedley BD, Stith AY, Nelson AR: Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. National Academy Press, 2002. <http://www.nap.edu/catalog/10260.html> 4. NYU model curriculum http://aadprt.org/secure/documents/model_curricula/cultural_psych_nyu_10.pdf, last accessed September 10, 2011. 5. Davis curriculum http://aadprt.org/secure/documents/model_curricula/Cultural_Competence_Curriculum.pdf, last accessed September 10, 2011.

WORKSHOP 117

MALPRACTICE DEFENSE: STRATEGIES FOR SUCCESS

CoChair(s): Abe M. Rychik, J.D., Eugene L. Lowenkopf, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the process of a medical malpractice suit; 2) Participate more effectively within the legal system, and 3) Know the relevant legal issues and standards and how to effectively respond to accusations in a Court of Law

SUMMARY:

In every malpractice lawsuit there are a number of critical junctures at which time the physician and the attorney can positively or negatively affect the outcome of the suit, regardless of the merits of the case. This workshop presents one case from the viewpoint of the defendant psychiatrist and defendant's attorney, with emphasis on the decisions and actions to be taken, which in this case contributed to a defense verdict. The workshop presents the general legal framework and discusses the issues that arise. It offers concrete recommendations for a successful litigation outcome. This workshop examines the following issues: A. What constitutes malpractice? B. The record as evidence. C. The pleadings. D. Venue (State or Federal) considerations. E. Reporting requirements and insurance policy concerns. F. Role of insurer via the lawyer and defendant. G. Statute of limitations and continuous treatment doctrine. H. The discovery process (depositions, interrogatories, fact and expert documents). I. Plaintiff and defendant strategies. J. The Trial. K. Post Trial activity and Appeal. L. Issues of licensure and the National Practitioner's Data Bank. In summary, this workshop will provide the audience with basic knowledge and recommendations on how to most effectively proceed in a malpractice litigation.

WORKSHOP 118

LEARNING TO PRACTICE WHAT WE PREACH: TRANSLATING NEUROCOGNITIVE AND SOCIAL PSYCHOLOGICAL STUDIES OF RACISM AND SEX- ISM INTO OUR EVERYDAY PRACTICE

Chair: Annelle B. Primm, M.D., M.P.H.

Presenter(s): Donald H. Williams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Will become familiar with grace as a social construct to justify enslavement of persons of recent African descent, 2) Become familiar with the use of terror, torture, and stress mechanisms to maintain dominant/subordinate relationships between "white" and "black" populations, 3) Become familiar with preconscious and subconscious mechanisms of victimization, 4) Gain experience in consciously applying these mechanisms of victimization to a case study as well as to their own personal experiences, and 5) Explore applying their learning to their daily psychiatric and professional activities.

SUMMARY:

This presentation will briefly review the recent literature on neural cognitive and social psychological studies of racism and sexism. Chester Pierce's work on the relationship between stress, racism, sexism, terrorism and torture will be

addressed as well as his concept of "micro aggressions". Sue's further elaboration on the construct of microaggression will also be discussed. The concepts of "stereotype threat" (C. Steele), stereotypic themes that reinforce racist and sexist speaking beliefs and behaviors, and implicit association tests will also be noted. A case study (episode from the "The Help") will be analyzed by the audience using the above formulations of micro aggressions and stereotypic thinking. The remainder of the session will address how this new learning can be applied to daily psychiatric and professional activities.

WORKSHOP 119

ABPN AND APA PERSPECTIVES ON MAINTENANCE OF CERTIFICATION

Chair: Larry R. Faulkner, M.D.

Presenter(s): Robert J. Ronis, M.D., M.P.H., Beth Ann Brooks, M.D., M.S., Deborah J. Hales, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the ABPN's maintenance of certification rationale and requirements, 2) Describe the APA's programs and products that have been developed for meeting those requirements, and 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 them will be presented. The computerized multiple-choice examinations will be described, as will examination results. Related issues such as maintenance of licensure will also be discussed. Representatives of the APA will outline the programs and services the organization has developed to meet the needs of psychiatrists participating in MOC.

WORKSHOP 120

DEVELOPING A CAREER IN CHILD AND ADOLESCENT PSYCHIATRY

Chair: Ara Anspikian, M.D.

Presenter(s): Marcy J. Forgey, M.D., M.P.H., Eric R. Williams, M.D., William Arroyo, M.D., Ledro Justice, M.D., Sheryl Kataoka, M.D.

EDUCATIONAL OBJECTIVES:

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 100,000 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 121

COGNITIVE THERAPY FOR PSYCHOSIS IN PRACTICE BY PSYCHIATRISTS: BASIC TECHNIQUES

CoChair(s): Shanaya Rathod, M.D., David G. Kingdon, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand which of their patients with schizophrenia may benefit from cognitive therapy, 2) Incorporate evidencebased elements of cognitive therapy into their work with patients with schizophrenia, 3) Understand the role of cultural adaptation in therapy.

SUMMARY:

Cognitive Behaviour therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by metaanalyses and twenty two published Randomized controlled trials. Unfortunately, few training schemes exist and consequently trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully (Turkington & Kingdon, 2000). They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes, cultural issues and ways of thinking can be adapted. Specific work on voices, visions, delusions, thought disorder and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community and inpatient settings. CBT complements medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, videointerviews and allow plenty of opportunity for discussion.

WORKSHOP 122

CANNABINOID AND OPIOID SYSTEMS IN INTEGRATED TREATMENT FOR PAIN AND SUBSTANCE ABUSE (PART ONE)

Chair: Lawrence K. Richards, M.D.

Presenter(s): Jahan Marcu, Herbert D. Kleber, M.D., Amanda Reiman, Ph.D., M.S.W.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know more about the chemicals called Cannabinoids, some of which are in the Cannabis sativa plant, some endogenously made in the mammalian body, and many now made synthetically, 2) Know some of the history of cannabinoids and the discovery and operations of the Endocannabinoid System in the mammalian body, know more about and appreciate more the CNS and its various subsystems, and have increased knowledge of various relationships within Substance Abuse, 3) Know more about the opioid system and how there are new observations about that and the relationships with the cannabinoid system, and 4) Have participated in discussions about the above and have a wider and more dynamic view of substances, substance abuse, and treatment of same.

SUMMARY:

Since 1964 at least there has been a slow but steady increase of research regarding cannabinoids, the chemicals found in or resembling in activity those found in the Cannabis sativa plant. Over the years experimentation and synthesis has resulted in at least 15 synthetic cpds being developed. The AMA has changed its position regarding the scheduling of "medicinal cannabis," but the DEA holds fast. The amount of research is approaching vast despite this, but most of this is of laboratory and in vitro and exvivo nature; in vivo is lagging way behind, and will continue to do so until the DEA changes. None the less, a collaboration by PPacher of NIH's NIAAA and RMechoulam of Hebrew U's Inst. of Drug Research in Jerusalem has yielded a terrific new 2011 paper entitled "Is Lipid Signaling Through Cannabinoid 2 Receptors Part of a Protective Signaling System?" It contains a major contribution to new thought as well as serving as a great summary of much of the more modern research. (286 references, published in Progress in Lipid Research, 50 (2011)193211.) Some of that will be discussed by Lawrence Richards, M.D.,dlfapa in his role as a discussant; further discussion of the more clinical nature will be given by Herbert Kleber, M.D., dlfapa. [new p'g'ph] The new clinical presentation material comes from Amanda Reiman Ph.D. and her Canadian collaborator, Mr. Philippe Lucas, M.A., from a 4 site research follow up to her preceding work in Berkeley, CA. Mr. Jahan Marcu will deliver some highly related but new information based upon the science of molecular level anatomy research that will form much of the basis of his soon to be Ph.D. thesis for Temple U., in Philadelphia, PA. All of the above will connect with this apparent overlap between capabilities of these two systems within the mammalian body. [new p'g'ph]Following the highly attended 2010 N. Orleans W/shop on Medicinal Cannabis, there was the 2011 APA Meeting symposium on Cannabinoid Medicine in Honolulu which had over 100 attendees on the last day of that mtg. It is easily expected the membership will appreciate this session as much, and that they will see how the new

builds upon the preceding.

WORKSHOP 123

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL: HOW TO BE INVOLVED

Chair: Sarah M. Fayad, M.D.

Presenter(s): Joseph Cerimele, M.D., Robert Freedman, M.D., Monifa Seawell, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) By the end of the workshop, participants should be able to identify the purpose of the Residents' Journal., 2) Participants should be able to identify ways to be involved in the Residents' Journal, such as authoring manuscripts, peer review and guest editing., 3) Participants will be able to 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 residents, fellows and medical students involved in the writing and editing process. The Residents' Journal continues to make changes on an annual basis in an attempt to provide residents with additional scholarly activities. This workshop will provide participants with knowledge about the Residents' Journal and demonstrates ways in which one can be involved and further strengthen their academic writing, peer review and even editing skills.

WORKSHOP 124

BATH SALTS: NOT INTENDED FOR HUMAN CONSUMPTION, SERIOUSLY!

CoChair(s): Annette M. Matthews, M.D., Neisha A. D. Souza, M.D.

Presenter(s): Annette M. Matthews, M.D., Neisha A. D. Souza, M.D., Daniel S. Towns, D.O., Jennifer Creedon, M.D., Andrea J. Moore, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the chemistry of bath salts, where they come from, and how they are used recreationally, 2) Identify some of the common presentations of acute bath salt intoxication and ways to safely clinically manage these, 3) Compare the course of the epidemic of bath salts that of other stimulants of abuse such as cocaine and metham-

phetamine, and 4) Reflect on the possible long term consequences of bath salt use and what we as a profession can do about them.

SUMMARY:

The snorting, shooting, and smoking of synthetic stimulants labeled as “bath salts” and also labeled “not for human consumption” has become an epidemic fueled by the easy accessibility of the drugs from the internet or local head shops, and the lack of an easily performed drug screen for bath salts. They are marketed as “legal stimulants” and are particularly popular with those who might be required to have urine drug monitoring for some reason, such as those on probation, parole, in substance abuse treatment, needing housing eligibility, or working in sensitive positions that require drug monitoring. All the members of our panel have treated patients admitted to an inpatient psychiatric unit for intoxication with bath salts. We will describe one such case, the challenges of the acute management. We will discuss the risks and benefits of various medications for acute intoxication and the long term consequences of bath salt use. We will close with some discussion of how treatment methods that have been successful in treating other types of stimulant abuse like contingency management and the MATRIX model may or may not be generalizable to this new class of drugs.

WORKSHOP 125

INTEGRATING PSYCHIATRIC AND GENERAL MEDICAL CARE: MILITARY AND CIVILIAN MODELS

APA Lifers

CoChair(s): Sheila Hafter Gray, M.D., Stephen C. Scheiber, M.D.

Presenter(s): Valerie J. Buyse, M.D., Scott Williams, M.D., Marcia K. Goin, M.D., Ph.D., Charles C. Engel, M.D., M.P.H., Dennis Sarmiento, M.D., Robert W. Johnson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Evaluate models for integrating mental health and general medical care and select one that is appropriate for their system, 2) Use new communication technology to foster and facilitate clinical and educational collaboration in existing and potential multidisciplinary networks, and 3) Develop an integrated health care delivery system that meets the needs of patients in their community

SUMMARY:

Experience and research findings continually confirm that integrated health care is not only clinically optimal but also

cost-efficient; yet well into the 21st century the care available to patients is, with few exceptions, fragmented. It is often inaccessible, and tends to be more expensive than coordinated definitive care. We shall present several efforts, some well developed and some nascent, to address these concerns; and we shall challenge participants to envision an integrated health care system suitable for the environment in which they practice. The military solved the need for coordinated medical and psychiatric care by developing a cadre of psychiatrist-internists who may serve as the sole specialist in remote outposts where they consult with general medical officers and corpsmen, lead treatment teams, and directly manage cases with cooccurring medical and psychiatric complaints. Sarmiento’s narrative will describe how he works in a deployed situation. In tertiary settings, these specialists do sophisticated comprehensive assessments of cases, such as Williams’ patient who presented with multiple physical complaints, neurological deficits and psychiatric symptoms. Also, since 2007 the US Army has implemented a collaborative primary care program, RESPECTMil, in over 70 primary care clinics and with over 1.2 million visits worldwide. Engel will briefly delineate this model, present associated mental health outcomes, and plans for the Army’s Patient Centered Medical Homes. Care in the civilian sector has devolved from the integrated treatment of the 20th century to one in which an individual may be treated by several clinicians who rarely communicate with each other. Johnson and Buyse will describe an innovative cloud-based network that brings together primary care physicians and psychiatrists who are separated in space but share common interests – and patients. They will report on what working in this electronic community taught them about the natural consultation and referral networks that exist in the county, and point to ways these might be modified to work more effectively for both mental health and primary care clinicians, to provide consultation and coordination of care, and to deal with outlier patients – those prone to treatment nonadherence or superutilization of health care services. Goin will open the discussion, during which participants will be invited to share their questions and ideas about how they might implement integrated health care in their particular communities. Disclaimer: The opinions or assertions contained in these presentations are the private views of the speakers and are not to be construed as official or as reflecting the views or policies of the Department of Defense or any of its affiliated organizations.

WORKSHOP 126

LEARNING TO TREAT PATIENTS WITH SELF-HARM BEHAVIORS: TWO MODELS FOR TEACHING DBT TO PSYCHIATRY RESIDENTS

CoChair(s): Beth S. Brodsky, M.D., Ph.D., Deborah Cabaniss, M.D.

Presenter(s): Camille A. LaCroix, M.D., Barbara H. Stanley, Ph.D., Emily Gastelum, M.D., Aerin M. Hyun, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Learn about two models that incorporate DBT training for patients with selfharm behavior into a psychiatry residency program, 2) Think about the advantages and challenges of including DBT training in a residency program, and 3) Think together about different ways that they could incorporate DBT training into their home training programs

SUMMARY:

Psychiatry residencies have incorporated CBT into their core curriculum, and are increasing their emphasis on Evidence Based Treatments (EBT), but many have not yet included the most empirically proven CBTbased therapy for the treatment of selfharm behaviors, Dialectical Behavior Therapy (DBT), into their training programs. To address this gap, this workshop will familiarize participants with two models for teaching DBT to psychiatry residents, address the advantages and challenges of including DBT training in a residency program, and encourage participants to think about how to incorporate these models into their home training programs. The first model is based on an abbreviated 6month DBT clinical training course developed by Camille LaCroix when she served as Assistant Director of Residency Training at the University of Washington/Idaho Advanced Clinician Psychiatry Track at the Boise VAMC. The second is a comprehensive 12month clinical and research curriculum created by Beth Brodsky and Barbara Stanley at Columbia University. Deborah Cabaniss, Director of Psychotherapy Training at Columbia University, and Beth Brodsky will cochair and facilitate the workshop. Camille LaCroix, Beth Brodsky and Barbara Stanley will present the two model programs. Aerin Hyun, Columbia Women's Mental Health Fellow, and Emily Davies Gastelum, Fellow in Psychosomatic Medicine at Columbia, both recent graduates of the Columbia Psychiatry Residency, will present their experiences as residents taking the Columbia DBT course. Small groups will be moderated by the six presenters who will consult with the educators and supervisors in the groups to develop an outline for how they might implement this type of course.

WORKSHOP 127

PSYCHOTHERAPEUTIC STRATEGIES FOR COUNTERING STIGMA: WHAT SOCIAL NEUROSCIENCE CAN TEACH US

Chair: James L. Griffith, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Articulate findings from social psychology and social neuroscience research that are relevant to addressing stigma in psychiatric practice, 2) Conduct a systematic clinical assessment of stigmatizing beliefs and practices, 3) Articulate guidelines for conducting a clinical interview with a patient who stigmatizes psychiatrists, 4) Formulate a psychotherapeutic strategy for countering internalized stigma of mental illness when it hinders the progress of treatment.

SUMMARY:

Psychiatrists regularly confront clinical consequences of stigma, prejudice, and discrimination, more so than other physicians. Psychiatrists face stigma in public policies that distribute healthcare resources, in colleagues' and the public's negative perceptions of psychiatry, and in patients' attitudes towards psychiatric diagnoses and treatment. Internalized stigma of mental illness is a major reason why some psychiatrically ill patients deny illness or refuse treatment. Due to stigma, certain patients are so disdainful of psychiatrists that they refuse clinical consultations. Stigmatization, prejudice, and discrimination are largely explained by sociobiological group processes, rather than individual psychological factors. Most psychiatrists, however, receive little training about the social psychology of stigma and its pragmatic implications for clinical practice. This workshop will review major research findings about stigma from social psychology and social neuroscience research in their relevance for clinical practice. Participants will learn: (1) how to assess stigmatizing beliefs and behaviors in clinical encounters; (2) interview methods for patients who stigmatize psychiatrists; (3) how to intervene psychotherapeutically when a patient's internalized processes of selfstigmatization obstruct treatment.

WORKSHOP 128

OVERCOMING 'RESISTANCE' IN TREATMENT RESISTANT SCHIZOPHRENIA

Chair: Vishal Madaan, M.D.

Presenter(s): Durga Bestha, M.B.B.S, Thomas Cyriac, M.D., Jayakrishna S. Madabushi, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the magnitude of treatment resistant schizophrenia and the clinical and neurobiological factors related to the diagnosis, 2) Comprehend the pharmacological interventions to overcome the resistance, and 3) Understand the appropriate psychosocial interventions to manage

treatment resistant schizophrenia

SUMMARY:

Schizophrenia is a chronic relapsing and disabling condition, which is one of the most difficult psychiatric disorders to treat. A variety of studies suggest that majority of the patients with schizophrenia do not respond optimally to antipsychotic medication, with the prevalence of non-remission or treatment resistance ranging from 30% to 60%. Treatment resistance is commonly characterized by a continuation of persistent and residual symptoms, and/or suboptimal improvement in psychosocial functioning and quality of life despite receiving adequate trials with antipsychotic medication. Several studies shown that moderate to significant improvement is seen only 30% in schizophrenia. Treatment with clozapine continues to remain the main stay for treatment for this challenging group. However, for a considerable number of these patients, clozapine may not be an option owing to compliance issues, intolerance or resistance. Even in patients who accept and tolerant to clozapine, only 30%50% experience clinically significant improvement. These clozapine nonresponders are commonly described as ultraresistant cases. Use of clozapine is also limited by its potential to cause agranulocytosis. Recent genetic research on clozapineinduced agranulocytosis and HLA factors has generated much interest in the field. Despite extensive research on treatment resistant schizophrenia, there is no consensus in the diagnostic criteria, concept of neurobiological factors and treatment strategies for treatment resistant schizophrenia. In the first part of this interactive workshop, the speakers will discuss the concept, magnitude, clinical and neurobiological factors related to treatment resistant schizophrenia. In the second part, speakers will lead a discussion on pharmacological strategies to overcome treatment resistance. Issues involved in the treatment with clozapine, both from inpatient and outpatient standpoints will be discussed. This will be followed by a discussion on other strategies in patients not responding to clozapine alone, and those not tolerating the medication alone. Recent genetic research on prediction of agranulocytosis with clozapine will be discussed. Speakers will review evidencebased literature on augmentation and combination strategies for use with clozapine. A brief discussion will be conducted on role of novel agents like NMDA agonists Dalanine & Dcycloserine, COX2 inhibitors and anticholinesterase inhibitors. ECT and rTMS for treating resistant cases may also be used. Furthermore, we will discuss the role of psychosocial interventions like compliance, psychoeducation and cognitive behavior therapy for this challenging condition. The workshop will be conducted with a discussion on common problems encountered in overcoming this treatment resistance with the active participation by the audience. 1) Meghan E Mcilwain: Pharmacotherapy for treatmentresistant schizophrenia 2) Neilsen et al, Optimiz-

ing Clozapine treatment: Acta Psychiatr

WEDNESDAY, MAY 9, 2012

WORKSHOP 129

BLOGS AND TWEETS, TEXTING AND FRIENDING: TEACHING ABOUT PROFESSIONALISM AND THE INTERNET

Chair: Sandra M. DeJong, M.D.

Presenter(s): Sheldon Benjamin, M.D., Robert J. Boland, M.D., Anthony L. Rostain, M.D., M.A., Joan M. Anzia, M.D., James Lomax, M.D., Nadyah J. John, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Outline current clinical, ethical, legal and professionalism issues in the use of the internet in psychiatry, 2) Access new educational resources and suggested curriculum on this topic available on the ADPRT website and distributed at the workshop, 3) Teach medical students, residents and colleagues about professionalism and the internet using handson, interactive methods modeled in this workshop and easily integrated into existing curricula, and 4) Apply underlying principles of ethics and professionalism to the complex problems that the use of the internet in psychiatry raises.

SUMMARY:

The use of internet technology such as blogs, social networking sites (e.g. Facebook), email, and searches engines among psychiatric professionals and their patients is skyrocketing; however, few standards exist regarding its use, and concerning behaviors regarding Internet use are increasingly in evidence: In a survey of US medical schools (JAMA, 2009), 60% of schools reported incidents of students posting unprofessional online content. A recent survey of psychiatric training directors and residents found that 91% of respondents had posted personal content on the Web, but about 80% reported being unaware of having received any policies or instruction about this issue. Such evidence suggests that psychiatric residents, educators and administrators need guidelines and education about the potential professional pitfalls of Internet use, including possible clinical, ethical and legal ramifications. The AADPRT Taskforce on Professionalism and the Internet has developed a curriculum based on 36 vignettes with annotated references and other resources. T After a brief overview of some of the data and potential problems in use of the Internet in psychiatry, this presentation will focus on how to teach about professionalism and the internet in a dynamic, interactive fashion. Participants will be introduced to new resources available on the AADPRT website and

will have the hands-on experience of trying out some of the various educational approaches (e.g. vignettes, role plays) in small groups. Rather than advising against using internet resources, the curriculum suggests incorporating thoughtful discussion about potential issues raised by use of these resources into psychiatric training. We will conclude with a large group discussion and some recommendations.

WORKSHOP 130

“DON’T LABEL ME!” WORKING WITH THE SEXUAL MINORITY ADOLESCENT AND THEIR FAMILIES

CoChair(s): Cecil R. Webster, M.D., Pedro M. Bustamante, M.D.

Presenter(s): Ayesha Mian, M.D., John A. Sargent, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate developmental issues of a sexual minority identity, 2) Explore the interface of developing an ethnic, cultural, and sexual identity, and 3) Apply a culturally and developmentally sensitive approach in working with sexual minority adolescents and their families.

SUMMARY:

Youth are redefining human sexuality. A prominent sexuality researcher based at Cornell University, Ritch Savin-Williams, PhD, writes in his book, *The New Gay Teenager*, about an evolution in the way adolescents express their sexuality and notes that modern youth are no longer “embarrassed by gayness, [and] don’t consider it deviant.” He writes that they are increasingly aware and expressive of same sex desires or interests independent of sexual identity and identifies a “gap between what is being achieved in the real world of contemporary teenagers and what is acknowledged by...scholars, ...health professionals,... and parents.” As such, sexual minority youth and adolescent sexuality remain poorly understood or too often ignored aspects of adolescent mental health. Clinging to a traditional dichotomous view of sexuality has limited the practitioner’s ability to develop an accurate understanding of the adolescent’s sexuality, particularly for nonheterosexual youth. Most practitioners are aware of the potential adversities of a sexual minority status including stigma, verbal harassment, physical violence, and associated psychological distress that may lead to increased risk of suicide, substance abuse, anxiety, and depressive disorders. Unfortunately, the literature available on how to guide families through this critical period in a culturally competent way is sparse. This is especially true when considering the interface of sexuality and ethnoracial culture. Through this clinical workshop we hope to outline how modern youth are describing their

sexuality, develop a meaningful approach toward taking a sexual history, explore the impact of sexual minority status on adolescent development, and understand the interface of ethnoracial culture, sexuality, and family dynamics so that we can be better able to help sexual minority youth and their families. References: Savin-Williams, R.C. *The New Gay Teenager*. Cambridge, MA: Harvard University Press, 2005. Bouris A, Guilamo-Ramos V, et al. A Systematic Review of Parental Influences on the Health and Wellbeing of Lesbian, Gay, and Bisexual Youth: Time for a New Public Health Research Agenda. *Journal of Primary Prevention*, 2010; 31: 273309.

WORKSHOP 131

BIOMARKERS AND ALCOHOL USE DISORDERS: APPLICATIONS IN CLINICAL PRACTICE

U.S. National Institute on Alcohol Abuse and Alcoholism

Chair: Raymond F. Anton, M.D.

Presenter(s): Raymond F. Anton, M.D., Gregory Skipper, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Learn the potential uses of alcohol biomarkers in applied settings, 2) Identify the most promising alcohol biomarkers to screen and monitor individuals who suffer from problematic drinking, 3) Determine the strengths and weaknesses of the alcohol biomarkers and how they can be used in different applied settings, and 4) Attendees will learn to determine future research directions in developing more accurate biomarkers.

SUMMARY:

During the past decade, advances have been made in the identification, development, and application of alcohol biomarkers. This is important because of the unique functions that alcohol biomarkers can serve in various applied settings. These including identifying problem drinking in medical settings, serving as objective measures of treatment outcome, and monitoring abstinence in high-risk individuals (e.g., actively drinking pregnant women, persons previously convicted of alcohol-related offenses) and situations (e.g., medical, transportation, other occupations that affect public wellbeing). To carry out these functions, biomarkers must display several features including validity, reliability, adequacy of temporal window of assessment, reasonable cost, and transportability. Several new, promising biomarkers including various alcohol metabolites and alcohol biosensors, are being explored in human studies. This workshop will explore various biomarkers including percent carbohydrate-deficient transferrin (%CDT), the only FDA approved

alcohol biomarker, ethyl glucuronide (EtG), and phosphatidyl ethanol (PEth). Strengths and weaknesses of each biomarker will be discussed as well as strategies for using alcohol biomarkers in multiple applied settings. Also, advances in the technology have been made in developing new alcohol sensors that have the potential not only to measure quantitatively the amount of drinking but also to determine when drinking occurred. Moreover, recent advances in highthroughput technologies for genomics, proteomics, and metabolomics offer unique opportunities to discover novel biomarkers. Development of more accurate biomarkers will allow clinicians to better identify and monitor individuals who suffer from problematic drinking.

WORKSHOP 132

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART I OF 2)

(For Residents Only)

CoChair(s): Brian A. Palmer, M.D., M.P.H., John G. Gunderson, M.D.

Presenter(s): Kenneth R. Silk, M.D., John M. Oldham, M.D., M.S., Perry D. Hoffman, Ph.D., James Hall

EDUCATIONAL OBJECTIVES:

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. Those workshops, which were for residents only, as are these workshops, were very successful. Even though part II was held at a different time from the Part I, attendance was even greater for the Part II. We thus are submitting two workshops here in the same manner in which we submitted the 2010 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 presented over consecutive days). 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.

WORKSHOP 133

ROLES FOR PSYCHIATRISTS IN INTEGRATED CARE

American Association of Community Psychiatrists

Chair: David A. Pollack, M.D.

Presenter(s): Lori Raney, M.D., David A. Pollack, M.D., Erik R. Vanderlip, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the various direct and indirect clinical roles, as well as the planning, teaching, and oversight functions, that psychiatrists should perform in effective integrated systems of care, 2) Recognize and be motivated to learn and perform the specific consultative roles that psychiatrists should perform in effective integrated systems of care, 3) Familiar with appropriate preventive health screening and treatment interventions for comorbid general medical conditions that psychiatrists can provide or oversee for patients with severe and persistent mental illnesses.

SUMMARY:

Health care in the US is rapidly changing, especially with regard to how care is delivered. Providers, patients, and payers need to adapt to the changing healthcare environment to maximize their effectiveness and to avoid being made irrelevant by system transformation, particularly the specialized interface between primary care (PC) and behav-

ioral health (BH). It is abundantly clear that delivery system redesign is essential to improve the health of the population, to improve patient experiences with the delivery of health care services, and to reduce per capita costs for such services. Current systems are generally inadequately organized or staffed to meet these goals. The prevalence and burden of mental health conditions, their frequent comorbidity and confounding interdependent relationships with other health conditions and treatments, and the need for coordination of care for persons with such complex and multifactorial presentations are key components of the BHPC interface. It is important to emphasize that psychiatrists are critical to this interface because of their biopsychosocial expertise, their chronic illness management focus, their understanding of and utility in modifying human behavior, and their leadership skills. The lack of sufficient numbers of providers and inadequate organization of services in PC settings are key contributory factors in this system inadequacy. Beyond expanding the number of PC providers and improving services with the intention of expanding the PC safety net, the relationship of BH and PC on an interpersonal and system-based level must be considered. This workshop is intended to address the ways that psychiatrists should be trained, organized, oriented, utilized, deployed, supported, and monitored in integrated systems of care. The range of roles in which psychiatrists can engage include teambased direct clinical assessment and care, consultation with a wide range of providers, training, policy development, quality improvement, research and evaluation, system implementation, and leadership within such teams or broader systems of care.

WORKSHOP 134

ANYTIME, ANYWHERE: HOW WEBBASED EHRs ARE CHANGING PSYCHIATRIC PRACTICES

Chair: Vatsal Thakkar, M.D.

Presenter(s): Robert Rowley, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Distinguish between the webbased EHR, locally installed EHRs in practice offices, and enterprise EHR systems used by hospitals and other organizations, 2) Illustrate EHR templates for everyday recordkeeping in private and clinical practices, 3) Discuss meaningful use and how to keep \$44,000 in incentives for private practices and clinics, 4) Explain connectivity and sharing patient information between healthcare providers, clinics, and hospitals, and 5) Use HIPAA compliant, best practices to engage patients in their care.

SUMMARY:

With charting, scheduling, eprescribing, lab integrations, data portability, and a Personal Health Record (PHR) for patients, the free or lowcost, Webbased, HIPAA compliant Electronic Health Record (EHR) delivers on the promise of health IT innovation for officebased, solo practice psychiatrists, as well as those working in community clinics and in rural settings. This presentation breaks down resistance to adopting the EHR by giving psychiatrists the facts about workable alternatives to costly inoffice installations, with their maintenance, training, downtime, and customization obstacles. In addition, psychiatrists can qualify and keep \$44,000 in Meaningful Use incentives for his/her practice or clinic, rather write ongoing checks to maintain, train on, and update inoffice systems. The Webbased EHR is available ondemand at home, on the road, and in the hospital. Certain kinds of information about your patients and their therapies, i.e., prescriptions, side effects, and drug interactions; emergency and followup care with primary care physicians are demonstrated using templates that work the way that an individual psychiatrist or practice prefers to record and view its patients' records. The two presenters, a psychiatrist in private and academic practice and a primary care physician, share their firsthand experience with Webbased EHRs AND PHRs. Connectivity between healthcare providers that's already happening, HIPAA compliance, and encouraging patient engagement through the PHR are discussed.

WORKSHOP 135

THE FUTURE OF PSYCHIATRY: THE RECOVERY MODEL AND SEVERE MENTAL ILLNESS

APA Council on Advocacy and Government Relations

Chair: Robert P Cabaj, M.D.

Presenter(s): Gary Tsai, M.D., Elena F GarciaAracena, M.D., Michelle Durham, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Examine the traditional and recovery models of mental health service delivery from a historical, clinical, and systemsbased perspective, 2) Examine the challenges of providing care for individuals diagnosed with chronic and severe mental illnesses, and 3) Learn how the recovery movement can be shaped to better address the unique challenges of caring for the severely mentally ill

SUMMARY:

Since its birth from the consumer advocacy movement of the late 1980s, the recovery model has garnered increasing attention and is now widely accepted as the contemporary, guiding principle of mental health systems around

the world. In the United States, there has been a shift away from the traditional evidencebased approach the “medical model” and toward the concept of recovery, which has been a major focus of, and impetus for, the current reform of both mental health policy and practice. The patientcentered themes of recovery, which include selfdetermination, hope, social connectedness, collaboration, and empowerment, resonate with consumers and mental health providers alike. Despite this increasing support, mental health providers have also raised concerns about the recovery approach, in particular its impact on the treatment of the minority of patients who are severely mentally ill (SMI). Although the SMI only comprise 46% of the mentally ill population, this group still amounts to a substantial 8 million affected Americans. Given that approximately 40% of the SMI lack insight into their illness and often decline to engage in care as a result, this vulnerable population poses unique challenges for the mental health community. The implications of the ongoing movement toward more patientcentered care necessitates an understanding of how the recovery approach impacts the full spectrum of mental disorders, including those who are decisionallycompromised as a result of the severity of their mental illness. Although elements of the medical and recovery paradigms seem contradictory, there are also commonalities that make possible various hybrid models which incorporate the strengths of both approaches. Rather than a onesizefitsall approach toward the provision of mental health services, the special challenges posed by SMI clients who lack insight may call for a more integrated and flexible framework of service delivery which shifts paradigms depending on where SMI clients are on their individual paths to recovery. Workshop attendees will gain a better understanding of the recovery model of mental health service delivery from a historical, clinical, and systemsbased perspective. The practical and systemic challenges of providing care for individuals with SMI will be examined, with particular focus on how the recovery paradigm impacts this vulnerable and uniquely challenging population. The traditional medical model will also be discussed, along with exploration of how the recovery and traditional paradigms can coexist in a framework of service delivery that better addresses the needs of the seriously mentally ill.

WORKSHOP 136

THE CHALLENGES AND REWARDS OF BUILDING RESILIENCY IN MINORITY AND UNDERREPRESENTED PSYCHIATRY TRAINEES

APA/SAMHSA Minority Fellows

CoChair(s): Ashley K. Miller, M.D., Kimberly Gordon, M.D.

Presenter(s): Ye B. Du, M.D., M.P.H., Rupinder K. Legha, M.D., Shana Gage, M.D., Trimaime M. Brinkley, M.D., Keith Hermanstynne, M.D., M.P.H., Ifeanyi Izediuno, M.B.B.S

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) To help psychiatry trainees, but particularly minority and underrepresented psychiatry interns, residents, and fellows find ways to sustain and maintain resiliency throughout their post graduate education, 2) Participants will better understand how the cultures of medicine and psychiatry might interact for individual trainees, and 3) Participants will gain more information towards developing research related to specific minority groups and their experiences in postgraduate psychiatry education.

SUMMARY:

Trainees arriving into the field of medicine and psychiatry are filled with a myriad of expectations, experiences, and cultural backgrounds. Students must not meet all of the required recommendations of classes, exams, grades, and board scores, they must also meet the challenges that their choices could bring for their families and indeed their very own lives. Medical students face a significant amount of stress with recent studies showing that about 10% have serious thoughts of dropping out.¹ These stressors only continue after students finish medical school and start residency. After minority and women medical students reach the level of psychiatry interns, residents, and fellows, they might experience the challenges of medicine and psychiatry cultural expectations of what defines an effective psychiatrist and more so even, a “leader”.² Additionally, some retrospective studies among specific cultural groups show that residency for these individuals can be an isolative experience filled with different levels of expectation for them in comparison to their colleagues as well as overt and covert discrimination,³ Furthermore, some studies show that being from an entirely different culture might be protective for psychiatry trainees and could help to prevent burnout and one could conclude to sustain resiliency. 1. Dyrbye, Liselotte N. et al. “Burnout and Serious Thoughts of Dropping Out of Medical School: A MultiIntuition Study.” *Academic Medicine* 85 (2010): 94102. 2. Bickel J. “Gender stereotypes and misconceptions: unresolved issues in physicians’ professional development.” *Journal of American Medical Association* 277 (1997):1405–1407. 3. Liebschutz, Jane M. “In the minority: black physicians in residency and their experiences. *Journal of the National Medical Association*. 89 (2006): 14411448. 4. Woodside, Jack et al. “Observations of Burnout in Family Medicine and Psychiatry Residents.” *Academic Psychiatry* 32 (2008): 1319.

WORKSHOP 137

WHEN IS MARIJUANA USE EGOSYNTONIC?

Chair: Thomas E. Brouette, M.D.

Presenter(s): Ryan Hashem, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Appreciate the interaction of schizophrenia and cannabis use/dependence on the patient's clinical course, 2) Consider how to engage a patient who believes their pharmacological intervention is as sound as your, 3) Formulate several approaches to motivating a patient to reconsider the relationship between their emotional state, their substance use and their illness.

SUMMARY:

Marijuana is a drug that has long been associated with exacerbating psychotic symptoms and hampering recovery from mental illness. Yet despite these findings, multiple studies have found that marijuana use is significantly more common among individuals with schizophrenia than the general population. Cannabis use likely not only hastens the course of schizophrenia but that mental illness also makes the patient even more vulnerable to the emotional and economic impact of substance use. Psychiatrists are often treating patients with two active diagnoses, schizophrenia and cannabis abuse/dependence and these are often individuals who perceive themselves as having neither, much less one exacerbating the other. To engage, motivate and care for a patient with these two diagnoses require integrating elements of psychopharmacology, motivational interviewing and rehabilitation skills in order to ensure the best outcome. In this workshop, audience members are encouraged to join the presenters (an attending psychiatrist and a resident) in sharing their experiences caring for these patients and discussing approaches to some of the clinical challenges which arise.

WORKSHOP 138

DYNAMIC THERAPY WITH SELFDESTRUCTIVE INDIVIDUALS WITH BPD: AN ALLIANCE BASED INTERVENTION FOR SUICIDE

Chair: Eric M. Plakun, M.D.

Presenter(s): Donald E. Rosen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand convergence among approaches to treating selfdestructive patients from DBT and dynamic perspectives, 2) Enumerate principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of selfdestructive borderline patients, 3) Implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients, 4) List countertransference

problems in work with these patients

SUMMARY:

Psychotherapy with selfdestructive 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 selfdestructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and selfdestructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from nonlethal selfdestructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) nonpunitively interpret the patient's aggression in considering ending the therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the selfdestructive behavior, and (9) provide an opportunity for repair. These principles are compared to Linehan's DBT and Kernberg's Transference Focused Psychotherapy (TFP). DBT and TFP arrive at a similar clinical approach to work with suicidal patients despite markedly different theoretical starting points. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

WORKSHOP 139

2011 RESIDENT SUPERVISION REGULATIONS: ARE TRAINEES HAMSTRUNG OR HELPED?

Chair: Mitchell J. M. Cohen, M.D.

Presenter(s): Sheldon Benjamin, M.D., Marika I. Wrzosek, M.D., Leah J. Dickstein, M.D., M.A., Robert Rohrbaugh, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Present new supervision regulations and place them in the historical context of major issues, tensions, figures, and forces in medical education, 2) Provide residents' and educators' perspectives on implementing the new

supervision regulations, 3) Identify potential positive and negative outcomes of new regulations on patient care and training, 4) Facilitate participant discussion of experiences and strategies for adopting new supervision regulations and suggestions for their refinement.

SUMMARY:

This workshop was developed by the Medical Education Committee of the Group for the Advancement of Psychiatry (GAP). In the workshop we will examine potential benefits and problems with the more prescriptive 2011 ACGME supervision regulations as interpreted by the Psychiatry Residency Review Committee for application to training programs. Workshop faculty will place the new supervision regulations in a historical context of the shaping ideas of William Osler and Abraham Flexner on medical training and enduring training dilemmas such as tensions between independence and oversight, passive vs. active learning, and classroom vs. bedside approaches. Presentations on historical forces and issues in medical education will also serve as background for presentations of implementation and impact of the new regulations by two residency program directors and by the resident member and Ginsberg Fellow serving on the GAP Committee. All presentations are intended to prepare attendees for an interactive discussion of issues raised by the more stringent supervision regulations now in effect, experiences with their implementation, areas for clarification or refinement, and sharing of viewpoints.

WORKSHOP 140

ARMY PSYCHIATRISTS IN THE COMBAT ZONE: PERSONAL EXPERIENCES AND REFLECTIONS

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Presenter(s): Jerald J. Block, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Know what the signs and symptoms of the psychological effects of war, 2) Understand what the role of a psychiatrist is on a Combat Stress Control team, and 3) Learn how to work with local community providers to continue a safety net after return home.

SUMMARY:

Nearly 10 years have elapsed since 9/11/2001. In that time Service Members have fought in long protracted conflicts in Iraq and Afghanistan. The reactions to the prolonged conflict include a range of reactions, such as PTSD and substance abuse, but also growth and resilience. Physical injuries, including traumatic brain injury, have added to the toll.

This workshop will focus on: 1) recognizing the reactions of Soldiers and other service members; 2) learning what it is like to work as a psychiatrist in a combat zone; 3) treating common disorders such as PTSD, depression, and substance abuse; and 4) working with local community resources to continue a safety net, even after the service member leaves the military. This first author will have recently returned from serving in Afghanistan; the second author has served in Iraq, Cuba, Somalia and Korea.

WORKSHOP 141

BARRIERS TO SEEKING TREATMENT AMONG GERIATRIC MINORITY POPULATIONS WITH MENTAL ILLNESS: EXAMINING CULTURAL VIEWS CONTRIBUTING TO DISPARITIES

APA/SAMHSA Minority Fellows

CoChair(s): Deina Nemiary, M.D., M.P.H., Kimberly Gordon, M.D.

Presenter(s): Ranjan Avasthi, M.D., Steven Starks, M.D., D. Anton Bland, M.D., Nicole A. Zuber, M.D., Dorly Nerval, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Discuss barriers to seeking treatment for culturally diverse older minority populations with mental illness, 2) Understand the application of the DSMIV TR outline for cultural formulation, 3) Apply an overall cultural assessment to address barriers and improve access to care

SUMMARY:

Significant attention has been aimed at reducing the gap between the mental health needs and utilization of services among ethnically and culturally diverse individuals. Unmet needs for mental health treatment was found greatest in underserved groups, including the elderly. In spite of the greater need of geriatric patients, older adults underutilize mental health services (Hatfield, 1999; Qualls et al., 2002; Robb et al., 2002; Conner et al., 2010). To help reduce this gap; leaders both in the United States and Canada recently raised commissions to provide proposals for improving the mental health systems universally and specifically for underserved populations (Mackenzie et al., 2008). Depression has been identified as the most prevalent psychiatric diagnosis among the elderly (Conner et al., 2011). Depression among older adults is a major public health concern leading to increased disability and mortality. The President's New Freedom Commission on Mental Health highlighted this concern. Furthermore, it is reported that one in four older adults has a clinically significant mental disorder and by the year 2030, the numbers of elderly Americans with

mental illness is expected to surpass fifteen million (USDHHS, 2001). Ethnic and racial minority older adults are less likely than their Caucasian counterparts to seek specialty mental health treatment (Ruiz, Primm, 2010). This is in part related to a myriad of biopsychosocial, sociocultural and environmental factors that contribute to different barriers (i.e., health insurance coverage problems, cultural beliefs about mental illness, and poor access to culturally competent providers) to their helpseeking for treatment (Conner et al., 2010). Stigma is one of the most significant issues which include constructs of personal shame, embarrassment about mental illness, lack of knowledge of various risks and symptoms of mental illness, and pervasive cultural norms that may limit their interest in seeking care. This has been acknowledged as a particular concern among older adults (Conner et al., 2010; Segal et al., 2004) and minorities (Ojeda and Bergstresser, 2008). Alternatively, among some African Americans, they tend to cope with mental illness through informal support networks (family, friends, church leaders) (Ward et al., 2010). At the conclusion of this workshop mental health providers should be familiar with the DSMIV cultural formulation. In addition, they should be more cognizant of the cultural barriers that prevent their patients from seeking treatment.

WORKSHOP 142

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

CoChair(s): Brian A. Palmer, M.D., M.P.H., John G. Gundersen, M.D.

Presenter(s): Kenneth R. Silk, M.D., John M. Oldham, M.D., M.S., Perry D. Hoffman, Ph.D., James Hall,

EDUCATIONAL OBJECTIVES:

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. Those workshops, which were for residents only, as are these workshops, were very successful. Even though part II was held at a different time from the Part I, attendance was even greater for the Part II (over 100). We thus are submitting two workshops here in the same manner in which we submitted the 2010 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 presented over consecutive days). 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.

WORKSHOP 143

INTEGRATING CARE: BUILDING A PARTNERSHIP WITH PUBLIC HEALTH, PRIMARY CARE, AND THE COMMUNITY TO PREVENT SUICIDE

Chair: Alex N. Sabo, M.D.

Presenter(s): Brenda A. Bahnson, M.S.W., Iqbal Rizwan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the use of a PHQ2 and a PHQ9 to screen patients for depression and suicide risk, 2) Understand the use of Fawcett's imminent risk criteria and Schneidman's cube as additional tools to assess suicide risk, 3) Will know the percentage of medically ill patients admitted to a community hospital who suffer from moderate to severe depression and who have suicidal ideation, 4) Use the

workshop as a foundation, list 3 barriers to access and 3 opportunities for implementing suicide prevention measures in their own communities, and 5) Participants will identify which aspect of this particular project is of most interest and / or utility to them in their work.

SUMMARY:

The presenters will describe a Department of Public Health funded project to promote gatekeeper training and pilot a depression care manager in a rural county of Massachusetts with an elevated suicide rate. Various aspects of the project may be of special interest to workshop participants. These include: the development of a 4-year curriculum for medical students, psychiatric residents and crisis clinicians for skill development in suicide risk assessment; a systematic depression screening process for medically ill patients in a community hospital; a pilot of a depression care management process for followup of high risk patients in primary care; the development of training DVDs of patients who have made serious suicide attempts; an alliance made with mothers who have lost children to suicide and who are now working with the American Foundation for Suicide Prevention to promote suicide prevention; programs for educating nurses, corrections officers, police officers, emergency first responders, clergy, primary care physicians, home health care providers. The presenters will give an overview of the project and describe lessons learned, and they will invite workshop participants to share their own experiences and to ask questions about the aspects of the project that are of most interest to them.

WORKSHOP 144

MULTIDISCIPLINARY PERSPECTIVES ON CARE OF THE ELDERLY PATIENT IN A GENERAL ADULT INPATIENT PSYCHIATRY UNIT

(For APA Members Only)

Chair: David C. Belmonte, M.D., M.S.

Presenter(s): Jolene R. Bostwick, Pharm.D., Cathy Demars, O.T., Gloria Patterson, M.S.W., Ilze S. Hallman, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize geriatric presentations of psychiatric diagnoses and the potential confound of cognitive impairment, 2) Understand how physiological changes and medical comorbidities complicate care and impact treatment decisions, 3) Be aware of special safety concerns when working with the older patient, 4) Become familiar with developmentally relevant programming pertinent to the older adult, and 5) Broaden their view of the geriatric patient from the perspectives of multiple disciplines.

SUMMARY:

According to the Administration on Aging, by 2030 19% of the U.S. population is expected to be 65 years old and older, projected to be as many as 72.1 million individuals compared to 12.9% of the population in 2009. With this demographic shift, general adult psychiatric units will likely face a proportional increase in the number of older patients admitted for treatment of various psychiatric conditions. Factors inherent to the elderly patient and the inpatient milieu raise particular challenges that need to be addressed. The purpose of this workshop is to focus on providing inpatient psychiatric care to the geriatric patient from a multidisciplinary perspective. A panel consisting of a geriatric psychiatrist, nurse, pharmacist, social worker, and an occupational therapist will share their experiences working with older patients at the University of Michigan adult inpatient psychiatry unit. The panel will explore issues pertinent to the geriatric patient and how they are addressed at this institution, utilizing case vignettes to engage workshop participants and promote an active exchange of ideas that will serve as a foundation for establishing a standard of care for treating geriatric patients in the general adult inpatient setting. By the end of the workshop, attendees will: 1) recognize geriatric presentations of psychiatric diagnoses and the potential confound of cognitive impairment; 2) understand how physiological changes and medical comorbidities complicate care and impact treatment decisions; 3) be aware of special safety concerns when working with the older patient; 4) become familiar with developmentally relevant programming pertinent to the older adult; and 5) broaden their view of the geriatric patient from the perspectives of multiple disciplines. The importance for learning to work with the elderly patient is mounting as the population ages. General adult psychiatric units must be prepared with specialized protocols, policies, and programming to accommodate the needs of older patients, since most areas do not have a geriatricspecific psychiatric unit. This workshop will benefit mental health care providers across multiple disciplines, with the ultimate aim of providing relevant and integrated care to the older adult requiring inpatient psychiatric hospitalization.

WORKSHOP 145

HOW TO BE AN ETHICAL PSYCHIATRIST: LESSONS NOT LEARNED FROM THE MOVIES

Chair: Mark S. Komrad, M.D.

Presenter(s): Mark S. Komrad, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Consider the role that movies have in educat-

ing the public about who psychiatrists are and what we do, 2) Review research findings on the effect of movies on the expectations of patients, prospective patients, and even psychiatrists themselves about appropriate ethical behavior of treating psychiatrists, 3) Appreciate common stereotypes, archetypes and generalizations made about psychiatrists and psychiatric treatment in TV and movie portrayals, 4) View numerous movies clips that represent some common lessons inherently portrayed in movies about psychiatrist behaviors in sessions, and to critique the ethics of those examples.

SUMMARY:

If one were to learn about the ethics of psychiatric treatment strictly from Hollywood movies (the only teaching resource for most of the public), what conclusions would be drawn? The depictions of psychiatric treatment and psychiatrists in contemporary blockbuster movies and TV series, is largely at variance with everyday clinical reality. This is particularly true of the portrayals of ethical conduct on the part of treaters. Movies are rife with boundary violations, exploitation, dualrelationships, 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, what research has shown about how movies affect public opinion about mental health treatment, 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!

WORKSHOP 146

COGNITIVE BEHAVIOR THERAPY FOR PERSONALITY DISORDERS

Chair: Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVES:

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) Enhance medication adherence, and 5) Describe and implement advanced cognitive and behavioral techniques

SUMMARY:

A number of studies have demonstrated 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.

WORKSHOP 147

REAL WORLD IMPLEMENTATION OF INTEGRATED CARE PROGRAMS: FOUR PERSPECTIVES

CoChair(s): Anna Ratzliff, M.D., Ph.D., Jurgen Unutzer, M.D., M.P.H.

Presenter(s): Michael Lancaster, M.D., Michael A. Trangle, M.D., Charles C. Engel, M.D., M.P.H., Anna Ratzliff, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe the common challenges and solutions to system wide integrated care programs, 2) Discuss the outcomes from four system wide initiatives for integrated care, 3) Consider adaptations of a model of integrated care into their own practice settings.

SUMMARY:

In this workshop, participants will hear four perspectives of taking the concept of integrated care proven in the research world into real world practice. There will be an opportunity for small group discussion of the challenges and solutions to implementing an integrated care program after the four presentations. The Mental Health Integration Program (MHIP) is a Washington statewide, evidence and outcomebased model of collaborative stepped care to treat common mental disorders. Since the start of the program in January of 2008, MHIP has served over 20,000 patients and provided psychiatric consultations to 13,000 patients ages 1100. Ongoing evaluation has shown substantial improvements in coordinated care and mental health outcomes. North Carolina Community Care Network (www.communitycarenc.org) is comprised of 14 networks covering the state with 1400 practices and 4000 primary care providers providing services to over 1 million Medicaid consumers. This program began in 2010 to support the improvement of behavioral health integration into primary care through colocation, training and education in best practice models of care (SBIRT, use of PHQ9, depression guidelines), and complex case sup-

port. The NCCCN program continues to show cost savings and has consistently demonstrated bending the curve on spending for Medicaid in North Carolina. DIAMOND (Depression Improvement Across Minnesota Offering a New Direction) is a statewide collaborative care treatment model for depression in primary care. This evidence based model was launched in March 2008 and is now available through 74 primary care clinics in Minnesota involves 417 primary care FTEs and more than 8,000 patients. It was created by a collaborative of medical groups, health plans, patients, corporations, and the state department of human services and embeds an innovative bundled payment model in a fee for service environment. Results consistently show significant ongoing engagement of patients, and very good response/remission rates. Since 2007 the US Army has implemented a collaborative primary care program called “RESPECTMil” in over 70 primary care clinics and over 1.2 million visits worldwide. Dr. Engel will briefly describe the model of care, associated mental health outcomes, and plans for use within Patient Centered Medical Homes.

WORKSHOP 148

TRANSGENDER MENTAL HEALTH CARE: TEACHING CULTURAL COMPETENCY

Chair: Christopher Daley, M.D.

Presenter(s): Susan Rankin, Ph.D., Willy Wilkinson, M.P.H., Paul M. Elizondo,

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand and appropriately use identity-affirming terms and pronouns utilized by the transgender community, 2) Describe the basic concepts of the gender spectrum, parameters that define the gender spectrum, and elicit information from transgender clients to discern their identity therein, 3) Appreciate ways for their organizations to help transgender people overcome commonly encountered barriers to healthcare by implementing the trans-friendly approach, 4) Understand common issues arising when teaching transgender cultural competency

SUMMARY:

Workshop Objective: The aim of this workshop is to teach participants how create an open environment and approach clients who identify as members of the transgender community to improve quality of care. **Workshop Description:** The transgender community is composed of a diverse group of individuals who identify in many ways, a few examples of which include transsexual, bigender, thirdgender, and genderqueer. Members of the community commonly transcend society’s binary and widelyassumed definitions of

gender roles, and rather identify within a spectrum of gender expression. A large deficit of knowledge of the gender spectrum exists outside of the transgender community. This is a large part of the reason why transgender people remain a marginalized group with frequent barriers to healthcare access. Members of this group require and have the same right to thorough healthcare as do all other members of our society. However, delivering effective healthcare is contingent on creating a nonjudgmental environment for clients to express their concerns and needs related to their mental and physical wellbeing. Most formal, healthcare degree conferring education, does not yet substantially address the ways to properly treat and address members of the transgender community to accomplish this environment. This workshop seeks to help clinicians better serve the transgender community by increasing cultural competency. As many of us work in clinical educator roles, it is also increasingly important for us to be knowledgeable about diverse communities so that we can better meet the needs of our trainees, students and peers. Participants will be asked to share experiences and knowledge in small groups. These interactive discussions will aim to encourage participants to address specific, or particularly difficult incidents in which learner prejudice, learner ignorance, and learner fear of making mistakes resulted in suboptimal healthcare delivery to transgender persons. The key goal of our discussions will be to relate these experiences to implications for effective, transgender clientcentered care. Participants will also learn about panel members experiences in teaching transgender cultural competence, and be offered assistance in creating curriculum at their own institutions.

WORKSHOP 149

POLYAMORY, AN EMERGING PRESENTING ISSUE/ RELATIONSHIP ORIENTATION: WHAT DO I NEED TO KNOW FROM RESEARCHERS AND A CLINICAL SPECIALIST TO IMPROVE CARE?

Chair: Bill Slaughter, M.D., M.A.

Presenter(s): Richard A. Sprott, Ph.D., Bill Slaughter, M.D., M.A., Elisabeth Sheff, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Describe what polyamory is, begin developing a clinical approach to improved care of patients with this orientation, and have an overview of current clinicallyapplicable research, 2) Give an overview of research findings on polyamory, including known prevalence, psychological adjustment of individuals with this minority relationship orientation, relationship longevity, etc., 3) Describe longitudinal research findings on polyamory and parent/child/family relations.

SUMMARY:

“Polyamory” has been emerging over recent decades as an umbrella term for nonmonogamous consenting relationships, in contrast to monogamy, the main current global relationship orientation. It is also in contrast to polygamy and related relationship types, which can be nonconsenting and involve marriage, which polyamory need not. As a minority relationship orientation with growing incidence of clinical presentation, it is important for each psychiatrist to develop an understanding of current research and the variety of situations which treaters can be asked to help with. This information is meant to help psychiatrists begin to develop a personal clinical approach to treating such individuals. Individuals of this minority relationship orientation present to psychiatrists for a range of issues. This includes requests for direct assistance with complex relationship issues (related to couples and family therapy). Often, though, relationship issues are peripheral, with patients primarily wanting straightforward individual medication and/or talk therapy with an adequately trained treater who does not need basic education from the patient about this relationship orientation. Patients report lack of follow through with uninformed/negatively judgmental psychiatrists. Presenter 1 gives psychiatrists beginning information allowing them to be current with this emerging relationship orientation: basic descriptions of polyamorous relationships, typical presenting scenarios, clinical trajectories and brief vignettes. Presenter 2 gives an overview of research questions and data known currently. Specific questions include: How many people are not sexually exclusive in their primary relationships? The available data—giving a range of numbers in varying populations is explained and reviewed, from the US and other countries. Are people in polyamorous relationships different in adjustment? Or different in relationship satisfaction? The presenter goes over data in general showing no difference in these areas. Presenter 3 describes 15 years of longitudinal research with polyamorous individuals and families with children. This presentation will discuss the impacts of polyamory on practitioners’ lives, relationships, and families. Specifically, the presentation will detail the research methods utilized in the study, discuss the advantages and disadvantages respondents reported, and detail the attitudes and experiences of children growing up in polyamorous families.

WORKSHOP 150**JIM CROW REVISITED: MENTAL ILLNESS, SUBSTANCE USE, AND DISPARITIES FROM THE CRADLE TO THE PRISON INDUSTRIAL COMPLEX**

CoChair(s): Annette B. Primm, M.D., M.P.H., Fred C. Osher, M.D.

Presenter(s): Cassandra F. Newkirk, M.D., Arthur L. Burnett

Sr., J.D., John A. Sargent, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the level of overrepresentation of people of color and people with mental illness and substance use disorders in the criminal justice system, 2) Appreciate how the War on Drugs and other policies have contributed to the surge in imprisonment in recent decades and its disparate and devastating impact on the African American and Hispanic community, 3) Discuss the interplay between the prison industrial complex, racism, poverty, and unmet need for mental health and substance use disorder treatment, 4) Understand the cradle to prison pipeline and what steps are being taken in communities around the country to stop this trend and invest in the mental health and educational success of children of color living in poverty

SUMMARY:

This workshop, a component of the OMNA on Tour program, will focus on racial disparities in the adult correctional system and the juvenile justice system, particularly in relation to social determinants and unmet need for mental health and substance use disorder services in diverse and underserved populations. Racism, poverty, ineffective educational systems, aggressive policing in distressed communities, lack of access to mental health and substance abuse services, lack of jail diversion programs, and failed social policies such as the War on Drugs, the Rockefeller Law, Stop and Frisk, Mandatory Minimum Sentencing, have contributed to the gross overrepresentation of people of color in the criminal justice system. This complex and destructive set of forces are outlined in the recently published book, *The New Jim Crow*, by attorney, Michelle Alexander. While affected communities have suffered, the prison industrial complex has prospered, benefiting greatly from the surge in imprisonment of predominantly black and brown people in recent decades. Using third grade reading levels as an indicator, prison planners gauge the need for the building of prisons sparking concern among advocates for children such as the Children’s Defense Fund, about the cradle to prison pipeline. The panel of workshop presenters who are national leaders in criminal justice, behavioral health, children’s mental health, public policy and prison mental health will discuss these vexing issues and offer recommendations for change.

WORKSHOP 151**THE INVISIBLE SPECTRUM: THE UNSPOKEN STRUGGLES OF A WOMAN PSYCHIATRIST AS A “SPECIAL” MOM**

CoChair(s): Meena Ramani, M.D., Jack Levine, M.B.A.

Presenter(s): Vikram Dhillon, M.D., Smita Bhatt, M.D., Raisa Yagudayeva, B.S., Begum Firdous, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize professional parent's reactions to the diagnosis of Autism Spectrum Disorder, 2) Identify the unique struggles of a woman psychiatrist as a "special" mom, 3) Understand the Physician parent as a caregiver and seeker of services for their special needs child, 4) Explore avenues leading to successful home and career balance

SUMMARY:

Creating harmony and balance in the family system is a unique feat for the woman professional. Historically, the mother's role in the family unit has centered around the nurturing and raising of children. Today, the number of women entering the workplace has grown at a blistering pace, fostering a powerful transformation in the family core. This family core is further remodeled when a family member is diagnosed with a chronic mental illness. Existing literature proves that family functioning is severely altered when a child is diagnosed with an Autistic Spectrum Disorder. The cognitive, language and social impairments in conjunction with level of commitment required to address Autism takes a toll on the entire family, especially on the working mother. More recent studies have focused specifically on the parent coping strategies, effects on maternal health and positive indicators of success. Unlike other fields of Medicine, Psychiatry requires the use of self as the primary diagnostic and therapeutic tool. This process could be emotionally draining which potentially leads to vicarious traumatization. It is imperative for the psychiatrist to regroup and rejuvenate for maintenance of self in order for continued success in both the home environment and the workforce. Moreover, the specific demands caring for an autistic child creates the unspoken struggles. Currently, very little has been studied on the dual role as a woman psychiatrist and parent caregiver. This workshop will highlight the intricacies of the caregiver life of the psychiatrist, including the impact of stereotyping and stigmatization revolving around the mental illness. There will be an added focus to discuss Autism and its unparallel demands. Included will be a review of measures that help create and maintain healthy psychological wellbeing leading to positive effects for family units. This workshop will use multimedia presentation and incorporate personal accounts of professional moms, ultimately inviting the audience to an interactive discussion.

WORKSHOP 152

INTEGRATED PHYSICAL AND MENTAL CONDI-

TION CASE MANAGEMENT

Chair: Roger G. Kathol, M.D.

Presenter(s): Cheri Lattimer, B.S.N., Lori Raney, M.D., Roger G. Kathol, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) To understand the importance of health complexity and use of care management as a valueadded supplement to standard psychiatric care, 2) To understand complexitybased integrated case management (ICM) training, its components, and the application of its principles in psychiatric patients, 3) To step through the introduction of ICMlike procedures while developing integrated psychiatric programs

SUMMARY:

Psychiatric comorbidity in general medical patients is associated with resistance to physical health treatment, illness persistence, functional impairment, disability, and high health care service use. An important component of care for comorbid patients seen in the medical setting, therefore, is the effective application of outcome changing mental health and substance use disorder care with escalation of treatment when improvement is not occurring. Virtually all studies demonstrating clinical and cost outcome change in general medical patients with complexity introduced by concurrent physical and mental conditions utilize the services of care managers to support treatment recommendations, assist with adherence, and reverse barriers to improvement. This symposium will describe integrated case management, the only comprehensive and systematic care management program capable of providing concurrent assistance with general medical and psychiatric conditions through a single case manager trained in crossdisciplinary management techniques. The symposia will: Summarize the Case Management Society of America's (CMSA's) complexitybased interdisciplinary ICM training program and its software use Describe ICM application in patients with health complexity as a systematic and comprehensive means of assisting with treatment adherence, care transitions, coordination of interdisciplinary service delivery, and social/health system barriers to improvement. Explore the application of complex patient identification techniques and ICM procedures use comorbid patients, including those with serious and persistent mental illness, in an integrated care delivery setting.

WORKSHOP 153

INTERGENERATIONAL DIFFERENCES IN SELF-IDENTIFICATION AMONG PSYCHIATRISTS FROM

**MINORITY AND UNDERREPRESENTED GROUPS:
IMPLICATIONS FOR APA**

APA Council on Minority Mental Health and Health Disparities

Chair: Tanishia Choice, M.D.

Presenter(s): Kimberly Gordon, M.D., Nicole M. King, M.D., Ashley K. Miller, M.D., Tanishia Choice, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the differences in selfidentification between younger and older psychiatrists from minority and underrepresented (MUR) groups, 2) Understand the differences among younger and older psychiatrists in perceived value of membership in professional associations and components that represent MUR groups, 3) Understand the advantages and disadvantages of exclusive vs. nonexclusive MUR professional associations and components in facilitating the expression of selfidentity for younger and older psychiatrists of MUR groups

SUMMARY:

In its 1999 position statement on diversity, the American Psychiatric Association (APA) noted its commitment to fostering diversity within the APA and the field of psychiatry in general. One way in which the APA fosters diversity is through development of components within the APA, such as Council on Minority Mental Health and Health Disparities and seven minority and underrepresented (MUR) group Caucuses. Five of these Caucuses allow an APA member to join multiple Caucuses and two permit only exclusive Caucus membership. These components specifically address the concerns of the APA's MUR members. Even with these efforts, the percentage of APA members belonging to MUR groups has marginally increased for most groups since the year 2000. Recent research suggests that today's youth develop a sense of cultural and ethnic identity in a different manner than previous generations (Charmaraman and Grossman, 2010). Youth will often identify with multiple ethnic, minority and underrepresented groups, and this can be fluid overtime. Young psychiatrists may identify with groups both outside of and within the current MUR Caucuses. This changing process of selfidentity may necessitate different strategies to allow younger psychiatrists to express their identity and engage in membership in professional organizations. Citation: Charmaraman, L. Grossman, J. Importance of race and ethnicity: An exploration of Asian, Black, Latino, and Multiracial Adolescent Identity. *Cultural Diversity and Ethnic Minority Psychology*. 16(2):144151. 2010.

WORKSHOP 154**PSYCHIATRIC COMORBIDITIES IN PATIENTS
WITH EPILEPSY ACROSS THE LIFESPAN**

CoChair(s): Tatiana Falcone, M.D., George E. Tesar, M.D.

Presenter(s): Tatiana Falcone, M.D., George E. Tesar, M.D., Lara Jehi, M.D., Marcy Forgey, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify some psychiatric comorbidities that patients with epilepsy face, 2) Recognize the importance of treating psychiatric comorbidities in patients with epilepsy so we can improve their quality of life, 3) Identify the psychosocial problems that patients with epilepsy face and the role of the psychiatrist helping them resolve some of these issues

SUMMARY:

Despite continued progress in the treatment of epilepsy, the psychosocial outcome in adults is reported as poor, even in patients who reach seizurefreedom. The purpose of this workshop is to discuss the value of increased screening for mental health problems during the epilepsy appointments; how educating the patients, the parents, the peers and community about mental health problems in epilepsy is a successful intervention and how this affects the quality of life of these patient. Also we will discuss how to empower families and patients to access mental health services for patients with epilepsy, while improving the triage system to help decrease the waiting time between when the problem is identified and when the patients actually receive treatment. The risk of untreated mental health problems in patients with epilepsy is probably contributing to the risk of suicide in these patients. Some studies have reported that the comorbidity of depression in epileptic patients goes severely under recognized and undertreated. This is a major barrier encounter by epileptic children and adults. In an effort to improve quality of life of patients treated at Cleveland Clinic, the Knowledge Program[©] was developed. This Program systematically analyzed our patient medical information to improve care and outcomes. This initiative allows us to consistently measure each patient's illness severity over time and assess the efficacy of our treatment protocols. The Knowledge Program is a system which allows patients to record a self- assessment directly into their EMR (Electronic Medical Record). During the workshop Dr. Tesar will discuss data gathered through the knowledge project on more than 2000 patients with epilepsy, also the different scales used to measure severity of mental health, psychosocial and other medical issues will be discussed. Dr. Jehi will discuss the impact of all the different variables on quality of life

and Epilepsy outcomes. Dr. Falcone will discuss the results of the Impact of Childhood Neurologic Disability scale in 2200 pediatric epilepsy patients, how other comorbidities such as inattention can impact the quality of life in youth with epilepsy. Dr. Forgey will discuss her experience as a pediatric CL psychiatrist evaluating children with nonepileptic seizures.

WORKSHOP 155

HANDS UP: PSYCHIATRISTS IN THE CROSSFIRE OF THE GUN DEBATE IN AMERICA

APA Council on Psychiatry and Law

Chair: Patricia R. Recupero, M.D., J.D.

Presenter(s): Marilyn Price, M.D., Debra Pinals, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Able to describe and able to discuss the principles of dealing with the clinical management of gun possession by patients, 2) Able to describe and able to discuss the working of the Firearm Registry and the process for restoration of gun rights, 3) Able to describe and able to discuss the recent attempts to prohibit physicians from discussion gun ownership with patients.

SUMMARY:

Gun violence and suicide by firearm is an increasing concern to legislatures, courts, and the psychiatric profession. The Virginia Tech tragedy prompted a overhaul of mental health law in Virginia. The federal government has responded to incidents of gun violence by attempting to control possession of guns by those who have been treated for mental illness. Patients may be prevented from owning guns in certain states and the federal registry attempts to register all such persons. The law also provides an opportunity for the restoration of gun ownership. Some states such as Florida have attempted to make it a crime for a physician to inquire about gun ownership. This workshop will explore the issues to be considered in clinical practice with regard to guns, the role of the psychiatrist in dealing with restoration of gun ownership and the legal consequences of the proposed “gag laws” on the practicing psychiatrist. We will also discuss APA Resource and Position Statements related to these issues. Murtagh, L., Miller, M. Censorship of the Patient-Physician Relationship –A New Florida Law, 306 JAMA 1131 (2011) Jacobs, JB, Jones, J: Keeping Firearms out of the Hands of the Dangerously Mentally Ill, 47 Criminal Law Bulletin 388 (2011), electronic copy at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1871163.

WORKSHOP 156

WHAT I WISH I KNEW WHEN THE DISASTER STRUCK

APA Committee on Psychiatric Dimensions of Disasters

Chair: Amelia K. Villagomez, M.D.

Presenter(s): Catherine S. May, M.D., Joseph C. Napoli, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify how to respond to the mental health needs of their local community during times of disaster, 2) Cite ways to prepare for the mental health needs of an international community during times of disasters both in the immediate aftermath of the disaster as well as in the longterm restorations, 3) List various training opportunities and resources for disaster preparedness, 4) Enumerate the 8 actions of psychological First Aid

SUMMARY:

Psychiatrists are increasingly playing a role in disaster response. For example, “more than 700 psychiatrists responded to the 9/11 attacks alone.” (1) For psychiatrists to volunteer and use their skill sets effectively, preparation is required prior to a disaster. Such preparation includes learning the basic hierarchy of the disaster response system, affiliating with an established group or agency, acquiring knowledge about the different roles of disaster response organizations, and training in intervention strategies. Although there is no universally accepted standard for mental health disaster early intervention, an evidenceinformed approach called Psychological First Aid is gaining recognition as an essential tool. The eight actions of Psychological First Aid are contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping, and linkage with collaborative services. (2) There are similarities and differences between what one needs to know for international versus local disasters. During their presentations, the faculty will share their experiences responding to an international earthquake and local community disasters as they describe what psychiatrists, other physicians, and other mental health professionals should know before they respond to a disaster. 1. Stoddard FJ, Pandya A, Katz C: Disaster Psychiatry: Readiness, Evaluation and Treatment. Arlington, Virginia: American Psychiatric Publishing, Inc., 2011. 2. Psychological First Aid: Field Operations Guide, 2nd Edition. National Child Traumatic Stress Network, 2006. Available at: http://www.nctsn.org/sites/default/files/pfa/english/1psyfirstaid_final_complete_manual.pdf. Accessed September 11, 2011.

WORKSHOP 157

RESEARCH LITERACY IN PSYCHIATRY

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

Presenter(s): Diana E. Clarke, Ph.D., M.Sc., William E. Narrow, M.D., M.P.H., S. Janet Kuramoto, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Understand the basic concepts and study designs in psychiatric research, 2) Understand the basic statistical methods used in psychiatric research, 3) Know what it means to critically appraise the scientific literature, 4) Know why it is important to be able to critically appraise the scientific literature, and 5) Know how to critically appraise the scientific literature

SUMMARY:

The goal of the “Research Literacy in Psychiatry” workshop is to educate students and clinicians on basic concepts and research designs in psychiatric research and how to appraise the scientific literature in a critical, thorough, and systematic manner. By better understanding the research concepts and study designs used in the literature they consult, students and clinicians can better stay abreast of changes in the field, identify gaps in the literature, and in a practical sense, make clinical decisions based on the best possible evaluation of the available scientific evidence.

WORKSHOP 158**INDIVIDUAL AND COMMUNITY RECOVERY AND TRANSFORMATION THROUGH PUBLIC ART: THE PORCH LIGHT INITIATIVE, A MIXED METHODS COMPARATIVE OUTCOME TRIAL**

APA/The Scattergood Foundation

Chair: Jacob K. Tebes, Ph.D.

Presenter(s): Samantha Matlin, Ph.D., Jane Golden, B.A., M.F.A., Jacob K. Tebes, Ph.D., Arthur C. Evans, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Identify the components of the recovery perspective as it pertains to individuals with an addiction or mental illness, 2) Describe how public art, and in particular, mural making can be used to engage and promote recovery; and,, 3) Describe the impacts of public arts participation through mural making on individuallevel and communitylevel outcomes.

SUMMARY:

Since 1984, the City of Philadelphia Mural Arts Program has sought to transform distressed and vulnerable neighborhoods through communitybased public art. With more than 3,000 public murals throughout the city, Philadelphia is home to the largest public arts initiative of its kind in the world. This work has been carried out in collaboration with hundreds of partner organizations and thousands of individuals. Despite numerous positive testimonials from participants and community stakeholders, the specific impact of public arts participation on individual and community outcomes remains unknown. A recent initiative that involves an innovative collaboration among the Philadelphia Murals Arts Program, the Philadelphia Department of Behavioral Health & Intellectual disAbility Services (DBH/IDS), almost a dozen community agencies, and the Yale University School of Medicine examines whether and how mural making as public art positively impacts individual outcomes among persons in recovery from serious mental illness or addiction and revitalizes distressed city neighborhoods. The initiative consists of a multilevel, mixed methods comparative outcome trial known as The Porch Light Initiative. Funding partners for The Porch Light Initiative include: the City of Philadelphia Department of Behavioral Health & Intellectual disAbility Services, The Robert Wood Johnson Foundation, The Thomas Scattergood Behavioral Health Foundation, the William Penn Foundation, the Independence Foundation, the Claneil Foundation, The Philadelphia Foundation, and The Patricia Kind Family Foundation. After a brief overview of the project by the session chair and Principal Investigator of the project’s research component, this workshop will feature presentations by individuals who have specific leadership responsibilities for the project.

WORKSHOP 159**DECISION MAKING STRATEGIES IN APPLIED ETHICS OF BEHAVIORAL HEALTHCARE**

APA/The Scattergood Foundation

Chair: Marna Barrett, Ph.D.

Presenter(s): Marna Barrett, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participant should be able to: 1) Recognize current issues in behavioral ethics and understand how such issues create dilemmas, 2) Identify four specific models or frameworks for ethical decision-making, 3) Apply a practicebased model for ethical decisionmaking to a clinical case.

SUMMARY:

Confidentiality, informed consent, involuntary treatment,

and professional boundaries are but a few of the ethical issues confronting psychologists and psychiatrists. Although there are guidelines for ethical behavior, most ethics codes are aspirational in nature and provide little concrete help when professional duties come into conflict and a choice between two or more undesirable options is demanded. The purpose of this workshop is to explore ethical dilemmas unique to mental health, address inherent ambiguities, and present decisionmaking 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 ethical decisionmaking will be reviewed and a practice-based model for ethical decisionmaking will be applied to a clinical case.