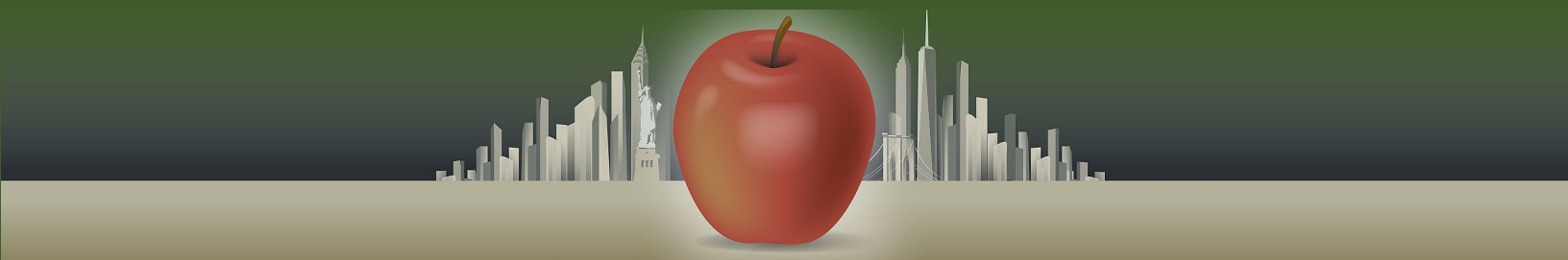
AMERICAN PSYCHIATRIC ASSOCIATION

167th Annual Meeting, New York, NY

SYLLABUS



CHANGING THE PRACTICE AND PERCEPTION OF PSYCHIATRY

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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

New York, NY
May 3-7, 2014

Published by

AMERICAN PSYCHIATRIC ASSOCIATION
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
May 2014

Scientific Program Committee
Philip R. Muskin, M.D., Chairperson, New York, NY
Cameron S. Carter, M.D., Vice-Chairperson, Sacramento, CA

Members
Iqbal Ahmed, M.D., Honolulu, HI
Barton J. Blinder, M.D., Newport Beach, CA
Josepha A. Cheong, Nashville, TN
Catherine C. Crone, M.D., Falls Church, VA
Donald C. Goff, M.D., New York, NY
Elisabeth B. Guthrie, M.D., New York, NY
Kelli J.K. Harding, M.D., New York, NY
Lucy A. Hutner, M.D., Brooklyn, NY
Laura K. Kent, M.D., New York, NY
Julio Licinio, M.D., Canberra, ACT Australia
Annette M. Matthews, M.D., Portland, OR
Michael F. Myers, M.D., Brooklyn, NY
Godfrey D. Pearlson, M.D., Bloomfield, CT
Nyapati R. Rao, M.D., East Meadow, NY
Kenneth R. Silk, M.D., Ann Arbor, MI
Linda Worley, M.D., Little Rock, AR

Consultants
Robert J. Boland, M.D., (AAP) Providence, RI
John Luo, M.D., Los Angeles, CA
Arnaldo Moreno, M.D., San Francisco, CA
Edmond H.T. Pi, M.D., Hacienda Hts, CA
Daniel S. Pine, M.D., Bethesda MD
Yvette I. Sheline, M.D., Saint Louis, MO

Corresponding Consultant
Charles S. Price, M.D., Reno, NV

Council on Medical Education and Lifelong Learning
Richard F. Summers, M.D., Chairperson, Philadelphia, PA
Deborah J. Hales, M.D., Arlington, VA

Members
Mary Jo Juneau Fitz-Gerald, M.D., (ASM), Shreveport, LA
Vishal Madaan, M.D., (ECP) Charlottesville, VA
Lisa Mellman, M.D., New York, NY
Mark H. Rapaport, M.D., Atlanta, GA
Pedro Ruiz, M.D., Miami, FL
Steve Schlozman, M.D., Boston, MA
Sandra Sexon, M.D., Augusta, GA
Marcia L. Verduin, M.D., Orlando, FL
Art C Walaszek, M.D., Madison, WI
John Q. Young, M.D., San Francisco, CA

Corresponding Members
Adrienne L. Bentman, M.D., (AADPRT), Hartford, CT
Larry R. Faulkner, M.D., (ABPN) Buffalo Grove, IL
Jon A. Lehrmann, M.D. (AAP), Milwaukee, WI
Mary S. Sciutto, M.D., New York, NY

Fellows
Kara Brown, M.D., Chicago, IL
Benjamin N. Angarita, M.D.
Alicia A. Barnes, D.O., Mays Landing, NJ
Karina Fajardo, M.D., Miami, FL
Elizabeth M. Homan, M.D., Iowa City, IA
Samantha A. Miller, M.D., Bronx, NY
Juliet J. Muzere, D.O., Atlanta, GA

CEO and MEDICAL DIRECTOR 'S OFFICE
Saul Levin, M.D., M.P.A., CEO and Medical Director
Kristin Kroeger, Chief of Allied and External Partnership

DIVISION OF EDUCATION
Deborah J. Hales, M.D., Director
Judith H. Carrier, Ph.D., Deputy Director
Kristin Moeller, Director, Department of CME
Nancy Delanoche, Associate Director, Graduate/Undergraduate Education
Miriam Epstein, CME Senior Program Manager
Trang Duong-Smith, Senior Program Manager for Online Learning
Ann Thomas, CME Program Coordinator
Katie Robinson, CME Program Coordinator
Kay Acevedo, Executive Assistant

OFFICE OF SCIENTIFIC PROGRAM S
Joy Rather, Associate Director, Conference and Online CME
Philip Pardee, Associate Director, IPS
Diane M. Runels, Assistant Director, Scientific Program Office
Lisa Walker, Manager, Conference CME Program
Lauren Anderson, Coordinator, Conference CME Program
Tiffany Burns, Coordinator, Conference CME Program

MEETING S & CONVENTIONS
Cathy L. Nash, C.M.P., Director
Vernetta V. Copeland, Associate Director
Stephanie Dumey, C.M.P., Associate Director
Jolene McNeil, Associate Director
Chantalle Hinton, Senior Meeting Planner
Diane Wesley-Butler, Executive Assistant

ACCME Accreditation Statement for Educational Activities

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 167th 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, a list of references, and a summary of each individual paper or session. We wish to express our appreciation to all of the authors and other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to Scientific Program Office staff and the APA Meetings Department.

Philip Muskin, M.D.
Cameron Carter, M.D.
Scientific Program Committee

EMBARGO: News reports or summaries of APA 2014 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of the 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.

Dear Colleagues and Guests:

Welcome to the 167th Annual Meeting of the American Psychiatric Association in New York City. *"Changing the Practice and Perception of Psychiatry*," is this year's theme. The theme resonates with several key forces impacting psychiatric medicine and mental health care: *scientific discovery*—leading to changes in our understanding of the brain, behavior, and mental disorders and our ability to treat them; and *health care reform*—which is changing the way health care and mental health care is provided and financed.

As part of the Opening Session (Sunday, 4:30–6:45p.m., Hall 3E), I am privileged to host what promises to be a fascinating conversation with Nobel laureate Eric Kandel, MD and Emmy Award Winner Alan Alda. Alan Alda, well-known as a television, stage and film actor, director and writer, has had a lifelong interest in science and hosted PBS' *Scientific American Frontiers* from 1993 to 2005 and the 2010 documentary miniseries *The Human Spark*.

I am also pleased that a very important national political leader, well-known as an advocate for mental health policy and services, will be delivering the William C. Menninger Memorial Convocation Lecture.

The fields of psychiatric medicine and mental health care are poised on the brink of transformative advances in diagnostic methods and therapeutic modalities, all featured in this meeting: the genetics and neuroscience underpinnings of schizophrenia, bipolar disorder, Alzheimer's disease, autism, addictions, and other serious conditions. For example, the Frontiers of Science lecturers will include Scott Small, M.D., whose work combines brain imaging with gene-expression technologies to study Alzheimer's disease, and B.J. Casey, Ph.D., who has pioneered novel uses of neuroimaging methodologies to examine behavioral and brain development.

The Affordable Care Act, the rise of accountable care organizations, and a renewed focus on patient-centered care, afford psychiatrists and primary care providers an unprecedented opportunity to work collaboratively to improve health. The Integrated Care track addresses the changing roles and different approaches, and provides practical skills for leadership roles within collaborative care teams. Understanding and embracing these changes is key to the future of psychiatry. Ezekiel J. Emanuel, M.D., Ph.D., a former special advisor to the Obama Administration on health policy, will offer insights on the Affordable Care Act and the future of mental health care.

Topical tracks represented in the *Guide to the Annual Meeting* highlight our featured program partner, the National Institute on Mental Health (NIMH), and our subspecialties (addiction, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine). Once again there are strong concentrations in military mental health, ethics, and DSM-5.

Additional meeting highlights include the always popular *MindGames*, APA's national Jeopardy-like competition for residents (Tuesday, 6:00p.m., Marriott Marquis); and the annual American Psychiatric Foundation Benefit at the National Historic Landmark Intrepid aircraft carrier (Saturday, 7:00–10:00p.m., *ticket required*).

Special thanks to the Scientific Program Committee, under the leadership of chair Philip R. Muskin, M.D., for its outstanding work. The meeting offers hundreds of sessions to learn the latest science, clinical advances, and promising practices from among the best in the field, along with abundant networking and social opportunities.

Sincerely,

Jeffrey Lieberman, M.D.

TABLE OF CONTENTS

MAY 03, 2014

TOP 10 MEDICAL STORIES 2013: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW

Chairs: Robert Boland, M.D., Tina Gaud, M.D.
Speaker: Monique V. Yohanan, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the key internal medicine literature from 2013 with a special focus on topics likely to be of interest to psychiatrists, especially those caring for patients with co-morbid medical conditions; 2) Emphasize literature related to cardiovascular risk factors, including lifestyle and behavioral factors which increase cardiovascular risk; 3) Recognize the likely impact of selected publications in terms of newsworthiness and potential effect on clinical practice; 4) Provide a critical appraisal of the evidence base and methodology of selected publications.

SUMMARY:

This session will provide a review of the internal medicine literature published in 2013. Emphasis will be placed on conditions likely to be of interest to psychiatrists caring for patients with co-morbid medical conditions. Cardiovascular risk factors, including lifestyle and behavioral conditions which increase risk, will be discussed. The selection of articles for review will be based on likely clinical impact, including newsworthiness and the potential that this new evidence will change clinical practice. Additionally, a critical appraisal of the evidence will be offered, including a discussion of study methodology and potential sources of bias.

AN INTRODUCTION TO SOLUTION FOCUSED THERAPY

Chair: Anne B. Lutz, M.D.
Speaker: Anne B. Lutz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the unique aspects of solution-focused therapy (SFT) and how this differs from a problem-focused perspective ; 2) Identify the core assumptions/tenets of SFT approach and solution-focused skills that assist in engaging with externally motivated patients: beginning with strengths and resources; identifying VIPs; 3) Understand how to develop a "yes set" with patients and identify and amplify positive differences (exceptions) uncovering resources with patients and utilize scaling questions when negotiating goals; 4) Remain solution-focused in follow-up sessions when working with adolescents and their families. Understand how to Maintain a solution-focused conversation when things are worse; 5) List solution-focused assessment questions and learn how to flip questions from problem-focused to solution-focused when assessing addiction.

SUMMARY:

Solution focused therapy is a competency based model that minimizes emphasis on past problems and failings, and instead focuses on client strengths and prior successes. This approach of treatment is in accordance with the positive psychology movement that emphasizes wellbeing and optimal functioning instead of pathology and etiology. Solution focused therapy focuses on the specifics of how to do this. It provides an additive dimension to the problem focused techniques taught within medicine, and psychiatry in particular, in which there is an expectation that change can only occur through the understanding and exploration of problems. This evidenced -based approach has been developed inductively based on over 30 years of sessions with clients, and has been used successfully in a variety of settings including rehabilitation centers, child protection agencies, community mental health agencies, schools, inpatient units, domestic violence and substance abuse centers and in private practice. Solution focused therapy can be conceptualized as a meta-model and when done well can be easily integrated with other effective treatment techniques. This model of therapy often results in briefer lengths of treatment and as such is an essential skill for psychiatrists and other medical mental health providers, whose services are in extremely short supply and high demand. As physicians and psychiatrists are challenged to work with fewer resources while managing and treating increasingly complex and "multi-problem" families, delving into the details of strengths and resources is invaluable. Because so much has been written about problem focused assessments, the focus of this presentation is on solution focused assessment and treatment. This presentation will teach the basic tenets of the solution focused therapy, the core skills and techniques required when practicing this model of treatment and most critically the "How To(s)" of this treatment approach.

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

Chairs: Iqbal Ahmed, M.D., Francisco Fletes, M.D.
Speakers: Robert M. McCarron, D.O., Sarah Rivelli, M.D., Jane Gagliardi, M.D., M.H.S., Samir Sheth, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. Patients with severe mental illness have increased morbidity and have shorter life spans due to various medical illnesses, including metabolic abnormalities. The workshop faculty practice both internal medicine / family 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, with a focus on general medical conditions which frequently present in the psychiatric patient population.

MAY 04, 2014

OPIOID THERAPY, PAIN, AND ADDICTION AT THE CROSSROADS

Chair: Annette Matthews, M.D.
Speaker: Steven D. Passik, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe and trace the recent history of the expansion of opioids for chronic pain and the rise of prescription opioid abuse; 2) Conduct an evaluation of the risk level of opioid therapy for a particular patient; 3) Employ a management strategy for risk tailored to the individual patient.

SUMMARY:
Opioid prescribing expanded dramatically in the past 15 years in part based on arguments that may have overstated benefits and minimized risks. However, opioid therapy is now under fire by the media, regulatory and clinical fronts and has been virtually discredited based on equally dishonest arguments overstating risks and understating benefits. This leaves new groups of patients with pain at the crossroads and on the verge of abandonment, often without a voice advocating on their behalf. Is there a way forward? Many of these patients will be seeing addiction medicine specialists for consultation who will need to help sort out: is the patient addicted; do they have adherence issues that are problematic but fall short of addiction; or were they simply the recipients of pain care that was suboptimal? Ironically, addiction medicine specialists may prove to be the best advocates for thoughtful comprehensive pain care these groups of patients have!
Dr. Passik will discuss these issues and suggest solutions to keeping opioids available and safe for those who need them.

MIND/BODY MEDICINE: THE LINK BETWEEN CLINICAL MEDICINE AND PUBLIC HEALTH
Chair: Kelli Harding, M.D.
Speaker: Gregory L. Fricchione, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review the concepts of stress and resiliency; 2) Introduce the Four Hypotheses of Mind Body Medicine; 3) Introduce brain evolution and an evolutionary neuromedicine approach to understanding resiliency enhancement; 4) Suggest that resiliency represents attachment solutions to stress of separation threats; 5) Establish the clinical and public health mission of Mind Body Medicine to promote health and prevent illness.
SUMMARY:
Four Mind Body Medicine hypotheses strongly emerge based on new science that will be reviewed. The first hypothesis is that the mind and body are a unity. The second hypothesis is that psychosocial stress gets transduced into mitochondrial oxidative stress. Every cell has to deal with psychosocial stress in this physiological way through the influence of stress response systems. The third is that cellular oxidative stress uncovers disease vulnerability. One need not manifest this vulnerability if resiliency can be enhanced buffering against psychosocial stress and by extension, cellular oxidative stress. This leads to the fourth hypothesis- a simple heuristic mind body medicine equation. If the numerator is stress and the denominator is resiliency, one's future vulnerability to illness will be approximated in the quotient. This equation provides psychosomatic medicine with an opportunity to link clinical medicine and public health through health promotion and illness prevention.

MAY 05, 2014

ADVANCES IN SLEEP DISORDERS: WHAT'S NEW UNDER THE MOON
Chairs: Kenneth R. Silk, M.D., Elliot C. Wagenheim, M.D.
Speaker: Karl Doghramji, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the salient developments in the pathophysiology and management of primary sleep disorders over the past few years; 2) Understand key clinical features of selected sleep disorders and develop a rational approach to identify these disorders in psychiatric practice; 3) Appreciate the potential impact of the management of primary sleep disorders on psychiatric complaints and conditions.
SUMMARY:
More than half of all psychiatric patients complain of disturbances of sleep and wakefulness. Sleep disorders are associated with impaired daytime function, and predict a hightened 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.

REDUCTIONS IN CORONARY HEART DISEASE MORTALITY; LESSONS FOR PSYCHIATRY
Chair: Philip R. Muskin, M.A., M.D.
Speaker: Lee Goldman, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand why coronary heart disease mortality has declined by more than 70% in the past 40 years; 2) identify how interventional procedures have often replaced medications; 3) determine what Psychiatry might learn from this experience.
SUMMARY:
Mortality rates for coronary heart disease, the leading killer in the U.S., peaked in the late 1960s and have been declining ever since. About 50% of the decline is due to risk factor reduction - about half in people who do not have coronary disease and about half in people who already have it. The remaining 50% can be attributed to improvements in treatment for acute and chronic coronary disease. All these treatments are based on an understanding of the epidemiology and pathophysiology of coronary disease, and all have been proved to be effective and cost-effective in randomized trials. By comparison, many interventions that were previously thought to be useful have been abandoned because they were not effective, usually because they treated signs and symptoms but, paradoxically, increased mortality. In the process, cardiology has become increasingly interventional, with targeted devices replacing many ineffective or less effective medications. The potential applicability of these historical and current observations to psychiatry will be discussed.

AN UPDATE ON PSYCHOPHARMACOLOGY IN THE MEDICALLY ILL

Chair: Catherine C. Crone, M.D.
Speaker: James L. Levenson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) How to modify dosage in patients with impaired hepatic or renal function; 2) Special concerns that arise in patients with a variety of acute and chronic medical disorders; 3) When to stop a psychiatric drug before elective surgery; 4) Choose an appropriate drug and route of administration for patients who are unable to take orally.

SUMMARY:

In this session, we will cover complexities that arise in prescribing psychiatric drugs in medically ill patients, including adverse medical risks, effects of organ impairment, alternate routes of administration in patients unable to take medicines orally, and use of psychotropics in the perioperative period. The content is practical and evidence-based, and includes topics like bleeding risk with SSRIs, treatment of psychosis in Parkinson disease, antidepressants for irritable bowel syndrome, lithium's renal risks, which antidepressants should not be prescribed in a woman taking tamoxifen, and the differential diagnosis of fever in a patient on an antipsychotic.

MAY 05, 2014

ADVANCES IN RESEARCH I

Chairs: Herbert Pardes, M.D., Jeffrey A. Lieberman, M.D.
Discussant: Philip S. Wang, Dr.P.H., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to 1) recognize the importance of diverse disciplines to the understanding and diagnosis and treatment of psychiatric illnesses; 2) understand and explain to others the linkage between current research in one of the areas and clinical significance; 3) conduct her/his care and treatment of patients with a much enhanced understanding of research developments and efforts going forward.

SUMMARY:

Psychiatry as a discipline embraces a wide variety of approaches. In this Presidential Symposium the focus will be to provide an update and highlights of some of those contributions to the rich field of Psychiatry. One of the remarkable aspects of the diverse scholarly arenas which relate to psychiatry is the increasing tendency for overlap. What for example are the genes that are consequential in the pathophysiology of psychiatric disorders, and how do they relate to clinical aspects of psychiatry? In looking at illnesses such as Schizophrenia and bipolar disease, what do we know about dysfunctional neurocircuits that are tied to clinical symptoms? Increasingly we are searching for specific treatments targeted at specific types of Schizophrenia or other illnesses. What's the evidence for effectiveness of psychotherapy for such illnesses? An increasing synthesizing theme is moving toward personalized medicine which will generate more closely targeted treatments to specific illnesses and hopefully improved outcomes. How does the disturbing data regarding the global and impressively large prevalence of psychiatric illness relate to treatment capacity? Who will see whom? How will we handle the needs for far greater numbers of providers and capacity for treatment of psychiatric disorders? What's the role of integrated primary care and psychiatry? And at the same time how do Genetic studies, Imaging studies, Neurobiological Circuits, Therapeutic research and Epidemiology pull together to provide the practicing Psychiatrist with increasingly effective tools to address the problems brought to them? This outstanding group of leaders from diverse fields will provide the audience with a crisp and broad understanding of the latest concepts and techniques, and the possibilities for improvement in diagnosis and therapeutics.

NO. 1

PSYCHOTHERAPY IN PSYCHIATRY

Speaker: Glen O. Gabbard, M.D.

SUMMARY:

Psychotherapy research has demonstrated that a number of psychotherapeutic approaches to major psychiatric disorders are efficacious. We now have data from randomized controlled trials showing that complex disorders like schizophrenia, major depressive disorder, borderline personality disorder, eating disorders, post-traumatic stress disorder, and anxiety disorders all are significantly improved with specific psychotherapies. We also have data suggesting that we can now begin to document the impact of psychotherapy on the brain, providing deeper understanding of the mechanisms of therapeutic action of the different therapies. However, a major paradox exists - at the moment of these breakthroughs in research and treatment, fewer psychiatrists are including psychotherapy in their practices. Suggestions for future directions are offered

NO. 2

PARADIGMS FOR THERAPEUTIC DISCOVERY

Speaker: William T. Carpenter, M.D.

SUMMARY:

The major paradigm for therapeutic discovery conceptualizes schizophrenia as a disease entity. Advances with this model have been modest. Schizophrenia conceptualized as a clinical syndrome invites deconstruction into psychopathology domains. Each domain becomes an independent target for discovery. This model has been used in developing specific forms of CBT for specific symptoms. Departing from psychopathology per se, a third model identifies impaired function for treatment development. Cognitive remediation and supported employment are examples. Two paradigms are more basic with a hypothesized relationship to psychopathology. Endophenotypes are more proximal to pathophysiology and may identify new therapeutic targets and methods for proof of concept testing. Even more basic is the RDoC initiative from NIMH where behavioral constructs tied to specific neural circuits become the basis for discovery. Resulting therapeutics are hypothesized to be relevant to aspects of psychopathology. Another approach shifts the discovery paradigm to the life course. Early in life targets involve attempts to reduce vulnerability to mental disorders with primary prevention. Later, with mental illness vulnerability established, therapeutic targets include enhanced resiliency and reduction in proximal risk factors aimed at secondary prevention of a psychotic illness. Early detection/intervention programs are based on this paradigm.

NO. 3

FMRI BASED INSIGHTS INTO COGNITION, EMOTION AND PERCEPTION IN SCHIZOPHRENIA: GUIDING THE DEVELOPMENT OF NEW THERAPIES FOR REFRACTORY SYMPTOMS.

Speaker: Cameron S. Carter, M.D.

SUMMARY:

In recent years new methods from cognitive neuroscience such as fMRI have provided new insights into the nature of the disrupted functional neural circuitry that underlies disabling clinical symptoms in schizophrenia and bipolar disorder with psychosis. Building on older ideas of executive function deficits it is increasingly understood that specific impairments in functional circuits involving the prefrontal cortex are disrupted in schizophrenia and bipolar disorder with psychosis, leading to distinct deficits in cognitive control functions that in turn lead to impaired cognition, behavioral disorganization, negative symptoms and impaired functioning. In the present talk we will review recent fMRI studies of cognitive and emotional control in schizophrenia and bipolar disorder and link alterations in functional neural circuitry to known disturbances at the cellular and local circuit level in these illnesses,. We will then discuss how these findings are guiding the development of novel therapies, including pharmacological and neurostimulation approaches to address these disabling and treatment refractory symptoms in schizophrenia and bipolar disorder.

NO. 4
PROGRESS IN THE NEUROBIOLOGY OF PSYCHIATRIC DISORDERS: TOWARD A NEW THERAPEUTICS.
Speaker: Steven E. Hyman, M.D.

SUMMARY:
Recent decades have seen refinements in the tolerability of drug treatments for psychiatric disorders but little progress toward fundamentally new mechanisms of action or improvements in efficacy. In this lecture I will explore how remarkable new tools emerging in neurobiology offer promise for a new generation of therapeutics. New tools and technologies have emerged in neurogenetics, stem cell neurobiology, and in the study of neural circuits. The important open question is how we can best put them to use in the service of patients.

ADVANCES IN RESEARCH 2
Chair: Herbert Pardes, M.D.
Discussant: Philip S. Wang, Dr.P.H., M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) recognize the importance of diverse disciplines to the understanding and diagnosis and treatment of psychiatric illnesses; 2) understand and explain to others the linkage between current research in one of the areas and clinical significance; 3) conduct her/his care and treatment of patients with a much enhanced understanding of research developments and efforts going forward.

SUMMARY:
Psychiatry as a discipline embraces a wide variety of approaches. In this Presidential Symposium the focus will be to provide an update and highlights of some of those contributions to the rich field of Psychiatry. One of the remarkable aspects of the diverse scholarly arenas which relate to psychiatry is the increasing tendency for overlap. What for example are the genes that are consequential in the pathophysiology of psychiatric disorders, and how do they relate to clinical aspects of psychiatry? In looking at illnesses such as Schizophrenia and bipolar disease, what do we know about dysfunctional neuro-circuits that are tied to clinical symptoms? Increasingly we are searching for specific treatments targeted at specific types of Schizophrenia or other illnesses. What's the evidence for effectiveness of psychotherapy for such illnesses An increasing synthesizing theme is moving toward personalized medicine which will generate more closely targeted treatments to specific illnesses and hopefully improved outcomes. How does the disturbing data regarding the global and impressively large prevalence of psychiatric illness relate to treatment capacity? Who will see whom? How will we handle the needs for far greater numbers of providers and capacity for treatment of psychiatric disorders? What's the role of integrated primary care and psychiatry? And at the same time how do Genetic studies, Imaging studies, Neurobiological Circuits, Therapeutic research and Epidemiology pull together to provide the practicing Psychiatrist with increasingly effective tools to address the problems brought to them? This outstanding group of leaders from diverse fields will provide the audience with a crisp and broad understanding of the latest concepts and techniques, and the possibilities for improvement in diagnosis and therapeutics.

NO. 1
PSYCHIATRIC SERVICES IN THE ERA OF HEALTH REFORM
Speaker: Steven Sharfstein, M.D., M.P.A.

SUMMARY:
The accessibility and quality of medical care, including psychiatric care, faces serious challenges in the early 21st century. By many outcome and availability measures, America lags behind other western countries. The implementation of the Affordable Care Act (Obamacare) is an opportunity to achieve the three goals in public health: better care (including the experience of care by patients and families), better health (public health), and lower cost. In psychiatry, we have a number of special challenges, including an acute shortage of psychiatric beds; the over-use and crowding of emergency rooms; the epidemic of the homeless mentally ill, who often spend time in jails and prisons; the related safety concerns with a focus on guns and mental illness; and the funding of essential non-medical care, such as housing and supported employment. The Affordable Care Act expands access for millions of Americans to mental health treatment at parity with general medicine. With many psychiatrists opting out of insurance reimbursement, however, extreme shortages of specialty care are likely, especially for the seriously and persistently mentally ill. Disparities continue as low-income Americans and minorities cannot afford access to opportunities for quality care and treatment compared to those who can pay out of pocket. Will a responsive service system emerge in the new era, or will we continue to be hobbled by a broken public and private non-system of care and treatment?

NO. 2
GENETICS AND GENOMICS IN PSYCHIATRY: IMPLICATIONS FOR BIOLOGY, DIAGNOSIS AND TREATMENT.
Speaker: Pamela Sklar, M.D., Ph.D.

SUMMARY:
The overall burden of suffering for psychiatric patients, their families and society are huge and, until recently, these disorders had seemingly proven refractory to the best neurobiological and genetic experimental strategies. We remain without clarity regarding key issues that could lead to improved diagnosis and treatment, however, there is now cause for optimism. In the last decade, we have moved from knowing nothing about the types of genetic loci involved, to having a substantial understanding of rare and common variants that increase disease risk across many disorders. In fact, there has been an explosion of convincing genetic evidence indicating a contribution of many DNA changes to the risk of becoming ill. These will be discussed as well as their implications for genetic testing. Unfortunately, the boundaries of current diagnostic classifications do not align with those being drawn by shared genetics. Translating genetics into biological and etiological understanding has not yet advanced, and will likely only do so when experimental methods are developed than can address the large numbers of genes and variants within them that, along with environmental and stochastic effects, result in the development of disease for a particular person. New computational methods for discovering networks of complex effects and interactions can now be used to detect the patterns of pathophysiology and to search for therapeutics using genomics driven approaches.

NO. 3

EPIDEMIOLOGY OF PSYCHIATRIC DISORDERS: IMPLICATIONS FOR THE CHANGING OF CLINICAL PRACTICE

Speaker: Myrna Weissman, Ph.D.

SUMMARY:

Since the 1908's, through large and well developed community surveys, the rates risks of psychiatric disorders across the nation has been documented. Information of the type of treatment sought as well as changing trends in care through epidemiologic and household national medical care surveys are also available. These data provide clear trends including high rates of psychiatric disorders, decreasing use of psychotherapy, increasing use of medication, and increasing treatment of psychiatric disorders in primary care by primary care physicians. The passage of the Affordable Care Act in 2010 will accelerate these trends and provide more access to care for the previously uninsured. Among them will be many individuals with high rates of psychiatric disorders because of coverage denials in the past because of pre-existing mental disorders or because of the social factors associated with lack of insurance e.g. unemployment, poverty, divorce, substance abuse, etc. These trends have clear implications for the future delivery of mental health care, the role of psychiatry in the training of primary care physicians and other mental health professionals, and the place of psychotherapy in mental health care.

NO. 4

THE INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH: RESEARCH ACROSS THE COLLABORATION SPECTRUM

Speaker: Lori Raney, M.D.

SUMMARY:

The integration of primary care and behavioral health is a rapidly evolving area of research with the Affordable Care Act containing promising mechanisms for funding these important advances. The field of psychiatry is well-positioned to play a significant role in health care reform with these new models that meet the intent of the Triple Aim: to improve outcomes, contain costs and enhance the patient experience of care. This presentation will provide a synopsis of 1) the robust evidence base for the detection and treatment of mental illness in primary care settings and 2) the emerging evidence base for addressing the mortality gap due to untreated medical conditions in patients with serious mental illnesses. Core features and guiding principles for the developing models will be reviewed and the role of the psychiatrist in these models will be described.

MAY 03, 2014

DSM-5: CASES THAT CLARIFY THE NEW NOMENCLATURE

Chair: John W. Barnhill, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To make use of illustrative cases to better understand some of the key changes in DSM-5; 2) To better understand the rationale behind some of the DSM-5 changes; 3) To develop a pragmatic approach to some of the more complex diagnoses in DSM-5.

SUMMARY:
This symposium is intended to clarify ways in which DSM-5 can be used in the creation of psychiatric diagnoses. Each presentation will conform to the following structure: a brief outline of a case, followed by the discussion of an initial differential diagnosis. Additional clinical information will then be provided, and the presenters will conclude with more definitive diagnoses. Each of the cases will refer to diagnoses that have been viewed as controversial and/or have been significantly reframed between DSM-IV and DSM-5. Specific topics will include eating disorders, the somatic symptom disorders, and body dysmorphic disorder, as well as discussion of broader changes in regards to nomenclature and organization. Throughout this symposium, the presenters will make use of illustrative cases to highlight DSM-5 changes as well as practical ways that the new diagnostic categories can be used.

NO. 1
INTRODUCTION TO THE DSM-5 CHANGES
Speaker: John W. Barnhill, M.D.

SUMMARY:
DSM-5 features changes that affect individual diagnoses, but it also includes broader changes that address the classification of disorders. The axial system is gone, for example, and the chapters have been reorganized to fit with theories about development and etiology. The introduction to this symposium will make use of several cases from which the broad DSM-5 changes will be discussed.

NO. 2
ARFID AND THE CHANGES IN THE DSM-5 EATING DISORDERS
Speaker: Janna Gordon-Elliott, M.D.

SUMMARY:
DSM-5 has introduced multiple clarifications and changes to the chapter on Feeding and Eating Disorders. This case-based presentation will review the current evidence base for these changes and focus on a disorder new to DSM-5: Avoidant-Restrictive Food Intake Disorder (ARFID).

NO. 3
CHANGES IN THE DISORDERS MARKED BY SOMATIC SYMPTOMS
Speaker: Anna L. Dickerman, M.D.

SUMMARY:
Physical symptoms marked by abnormal or maladaptive thoughts, feelings, and behaviors are described in the DSM-5 chapter on Somatic Symptom and Related Disorders. Previously described among the DSM-IV somatoform disorders, these disorders have undergone significant changes in regards to nomenclature, criteria, and suggested clinical approach. Cases will be used to clarify the history of these diagnoses with a focus on the DSM-5 criteria.

NO. 4
BODY DYSMORPHIC DISORDER AND THE DSM-5 REORGANIZATION OF THE DISORDERS OF ANXIETY
Speaker: Katharine A. Phillips, M.D.

SUMMARY:
DSM-5 features a significant reorganization of the disorders in which anxiety is prominent. In particular, there are now separate chapters for the anxiety disorders, the obsessive-compulsive and related disorders, and the trauma and stressor-related disorders. This case-based presentation will briefly discuss the evidence for this reorganization and then focus on body dysmorphic disorder and its inclusion in the chapter on obsessive-compulsive and related disorders.

MAY 04, 2014

BEHAVIORAL HEALTH IMPLICATIONS OF PARENTAL WARTIME MILITARY SERVICE FOR MILITARY CHILDREN, THEIR FAMILIES, AND THE TREATMENT COMMUNITY

Chairs: Stephen J. Cozza, M.D., Christopher Raczynski, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the relevance of ecological and developmental models for responding to the needs of military and veteran families; 2) Articulate the importance of family-focused interventions for combat-injured or ill service members and veterans; 3) Identify at least three specific effects of military-related stressors on mental health utilization among military children; 4) Describe how clinical and public health models can be melded effectively in order to bolster services available for military children and their families.

SUMMARY:
An estimated two million American military children have experienced the deployment of at least one parent at least once in the course of the nation's combat operations in Afghanistan and Iraq. This symposium will examine the impact of a parent's service on military children and families and explore prevention and intervention strategies designed to optimize adjustment and improve behavioral health outcomes. Dr. Cozza will describe the profound impact which a service member/veteran's physical and psychological injuries may have on their children and on other family members with special emphasis on parental mental health, parenting capacity, family organization and community interactions. The family's changing needs will be examined as they progress from initial notification of injury or death in a combat area to treatment, recovery and reintegration within civilian communities. Data from family studies of combat-injured war fighters will underscore the

importance of family-focused care. Dr. Millegan will report on the effects of parental deployment and frequent geographic relocations on mental health utilization among military children. His findings demonstrate significant increase in mental health service utilization (higher rates of mental health outpatient visits, ER visits and psychiatric hospitalizations) among affected children even after adjusting for demographic differences and past mental health history in child and parents. Dr. Lester will provide a research update and ecological framework for understanding the impact of parental wartime service on child and family adjustment. Her presentation will outline public health prevention and intervention approaches based on the Institute of Medicine Behavioral Health Continuum of Care principles for meeting the needs of military and veteran children and families. Specific approaches for enhancing behavioral health outcomes among military and veteran families and their children will be described and longitudinal outcome data from ongoing program implementation shared. Drs. Porter and Kudler will describe historical precedents, pressing needs and current opportunities for blending clinical and public health models in order to build "Communities of Care" for military children and their families. Their presentation will show how this culturally-competent, clinically-informed, public health approach harnesses the strengths of military families and the communities that surround them.

NO. 1

THE IMPACT OF COMBAT-RELATED INJURY AND ILLNESS ON MILITARY CHILDREN AND FAMILIES

Speaker: Stephen J. Cozza, M.D.

SUMMARY:

Approximately two million military children have seen a parent deploy into combat. While most deployments end with a parent's safe return home, more than 50,000 service members have been physically injured in combat, and even more have been diagnosed with traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD). This presentation will review the impact of service member/veteran physical and psychological injuries on children and families, describing the profound effects on parents' mental health (including military and civilian), parenting capacity, family organization, and community resources. The presentation will describe a family's changing needs as they move from the initial notification of injury or death and on to treatment, recovery and reintegration into civilian communities. Data from studies of combat-injured families will be reviewed. Clinicians will recognize the importance of family focused care when treating ill and injured combat service members and veterans.

NO. 2

THE EFFECTS OF PARENTAL DEPLOYMENT AND GEOGRAPHIC MOVES ON MENTAL HEALTH UTILIZATION OF CHILDREN OF US MILITARY PERSONNEL

Speaker: Jeffrey Millegan, M.D., M.P.H.

SUMMARY:

Children of US military parents have several circumstances unique to military service including frequent prolonged parental separation due to deployment and regular geographic moves. A population-based retrospective study was conducted on administrative data to examine the effects of these stressors on mental health utilization. Children, ages 9 to 17, of parents who had recently deployed in support of OIF/OEF were compared with children of parents who had not deployed with regard to rates of child psychiatric hospitalizations. After adjusting for demographics and past mental health history in the child and parents, children of deployed parents were 10% more likely to have a psychiatric hospitalization compared to those whose parents did not deploy. Children, ages 6 to 17, of military parents who had recently had a geographic move were compared with children who had not recently removed with regard to rates of mental health outpatient visits, ER visits and psychiatric hospitalizations. After adjusting for demographics and past mental health history in the child and parents, children, ages 6 to 11 had higher rates of mental health outpatient visits. Children, ages 12 to 17 had higher rates of mental health outpatient visits, ER visits and psychiatric hospitalizations.

NO. 3

THE IMPACT OF PARENTAL WARTIME SERVICE ON MILITARY CONNECTED CHILDREN: TRANSLATING FAMILY PREVENTION SCIENCE INTO PRACTICE

Speaker: Patricia Lester, M.D.

SUMMARY:

A decade of war has underscored the importance of understanding the impact of parental military service on military and veteran children and their families. Military children and families face multiple challenges, including extended separations, disruptions in family routines, and potentially compromised parenting related to traumatic exposure and subsequent mental health problems. This presentation: 1) Provides a research update and ecological framework for understanding the impact of these experiences on child and family adjustment; and 2) Utilizes this framework to describe public health prevention and intervention approaches based on the Institute of Medicine Behavioral Health Continuum of Care for meeting the needs of military and veteran children and families. Specific examples of embedded community and health system preventive behavioral health approaches for enhancing behavioral health outcomes in military and veteran families and their children will be described with longitudinal outcome data from ongoing program implementation.

NO. 4

BUILDING COMMUNITIES OF CARE: PUBLIC HEALTH PERSPECTIVES AND CLINICAL PRACTICES IN SUPPORT OF MILITARY CHILDREN AND THEIR FAMILIES

Speaker: Rebecca I. Porter, Ph.D.

SUMMARY:

Military children don't exist in a vacuum; rather, they are embedded in and deeply influenced by their families, neighborhoods, schools and the culture and demands of the military itself. Military children live in virtually every community across the United States yet they are often invisible within their own schools, health care programs and other social systems. In this time of fiscal constraint, all facets of society including volunteer, non-profit, and local governmental programs need to rally together to supplement existing federal programs in support of these children. This presentation will describe

historical precedents, pressing needs and current opportunities for blending clinical and public health models in order to build "Communities of Care" for military children and their families. This culturally-competent, clinically-informed, public health approach harnesses the strengths of military families and the communities that surround them.

NO. 5
BUILDING COMMUNITIES OF CARE: PUBLIC HEALTH PERSPECTIVES AND CLINICAL PRACTICES IN SUPPORT OF MILITARY CHILDREN AND THEIR FAMILIES
Speaker: Harold Kudler, M.D.

SUMMARY:
Military children don't exist in a vacuum; rather, they are embedded in and deeply influenced by their families, neighborhoods, schools and the culture and demands of the military itself. Military children live in virtually every community across the United States yet they are often invisible within their own schools, health care programs and other social systems. In this time of fiscal constraint, all facets of society including volunteer, non-profit, and local governmental programs need to rally together to supplement existing federal programs in support of these children. This presentation will describe historical precedents, pressing needs and current opportunities for blending clinical and public health models in order to build "Communities of Care" for military children and their families. This culturally-competent, clinically-informed, public health approach harnesses the strengths of military families and the communities that surround them.

MAY 05, 2014

ADVANCES IN GERIATRIC PSYCHIATRY

Chair: Sandra A. Jacobson, M.D.

Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify several psychiatric disorders occurring in elderly patients with cerebrovascular disease; 2) Describe the role of brain stimulation in mood and memory disorders in late life; 3) Diagnose ADHD in older adults; 4) Understand the role of amyloid imaging in the diagnosis of Alzheimer's disease; 5) Describe Recent Developments in the Understanding of Psychiatric and Cognitive Complications of Parkinson's Disease.

SUMMARY:
The field of geriatric psychiatry is evolving, along with other areas of medicine, into a complex and highly differentiated set of specialized domains. With a population that is not only growing older, but living longer with diseases such as Alzheimer's disease, Parkinson's disease, and vascular disease, it becomes clear that clinicians in our field will need a deep working knowledge of the various neuropsychiatric manifestations of these conditions. In this Advances session, five distinguished investigators - each a pioneer in his/her field - will discuss recent developments in research and clinical care that will have immediate relevance to geriatric psychiatry practice. Dr. Robert Robinson will talk about identification, treatment, course, and prognosis of several neuropsychiatric disorders that arise in the context of cerebrovascular disease. Dr. Sarah Lisanby will discuss the state of the science regarding the use of rTMS and magnetic seizure therapy in the geriatric population. Dr. Lenard Adler will discuss the pitfalls inherent in diagnosing ADHD in elderly adults as well as recommended treatments and their efficacy in this population. Dr. Helen Hochstetler will discuss the newly-approved modality of amyloid PET imaging in the diagnosis of Alzheimer's disease, focusing on issues of accuracy, reliability, and correlation to CSF findings. Finally, Dr. Daniel Weintraub will discuss the changing conceptualization of Parkinson's disease, in which psychiatric and cognitive manifestations are considered on a par with motor signs. Particular attention will be paid to impulse control disorders and their relationship to dopaminergic medications. In the final 30 minutes of the session, we will be privileged to welcome Dr. Dilip Jeste to reflect on the research advances presented, and to discuss the implications
for clinical practice and future investigation.

NO. 1
NEUROPSYCHIATRIC DISORDERS IN ELDERLY PATIENTS WITH CEREBROVASCULAR DISEASE
Speaker: Robert G. Robinson, M.D.

SUMMARY:
The neuropsychiatric disorders that occur in elderly patients with cerebrovascular disease range from depression and anxiety disorders to apathy, pseudobulbar affect, anosognosia, and aggression. Research conducted worldwide has yielded clinically useful information on the frequency, cause, course, treatment, and prevention of these disorders as well as their effect on recovery and mortality in stroke patients. This talk will present new data on the identification and course of several of these disorders, and will report findings from clinical trials including antidepressant trials that showed promising effects in preventing these disorders.

NO. 2
MAGNETS, MOOD, AND MEMORY: ROLES FOR RTMS AND MAGNETIC SEIZURE THERAPY IN GERIATRIC PSYCHIATRY
Speaker: Sarah H. Lisanby, M.D.

SUMMARY:
Novel therapies for depression and cognitive decline in late life are sorely needed. While ECT has unparalleled efficacy, there remains a risk of cognitive side effects, which are of particular concern in geriatric patients who may already have some degree of cognitive decline. Transcranial Magnetic Stimulation (TMS) is less invasive than ECT and has not shown a significant risk of amnesia. To the contrary, interesting work has emerged regarding the use of TMS to enhance cognitive function, albeit with protocols different from those used in depression treatment. Now there are two TMS coils FDA-approved for depression, though they have been less well studied in the geriatric population. While the antidepressant efficacy of TMS is of interest considering its relative safety, there remains a need for more potent therapies for more treatment refractory patients. Magnetic Seizure Therapy (MST) presents the attractive option of combining the noninvasiveness of magnetic stimulation with

the efficacy of seizures. The current state of the literature on magnetic approaches to effectively treat mood disorders while sparing cognition using TMS and MST will be reviewed, along with the emerging evidence for using focal neuromodulation to boost resilience to cognitive decline.

NO. 3
ADHD IN OLDER ADULTS
Speaker: Lenard A. Adler, M.D.

SUMMARY:
Adult ADHD affects 4.4% of the US adult population and is often undiagnosed. Untreated adults with ADHD have significant impairments, including higher rates of divorce/separation, underachievement academically and occupationally, substance use, cigarette smoking (with decreased quit rates) and sexually transmitted diseases. There is significant overlap of the symptoms of adult ADHD with other neurological and medical diseases that affect cognition, including traumatic brain injury, hypothyroidism, mild cognitive impairment, and side effects of cardiovascular and chemotherapeutic drugs. Diagnosing older adults with ADHD can be particularly problematic, as the diagnostic criteria require an onset of significant symptoms prior to the age of 12, necessitating a lengthy retrospective history. This presentation will review epidemiology, diagnosis, differential diagnosis, and treatment of older adults with ADHD.

NO. 4
USE OF AMYLOID IMAGING IN THE DIAGNOSIS OF ALZHEIMER'S DISEASE
Speaker: Helen M. Hochstetler, Pharm.D.

SUMMARY:
Alzheimer's disease (AD) is a progressive neurodegenerative disease that can only be definitively diagnosed by pathological findings of beta-amyloid neuritic plaques and neurofibrillary tangles on post-mortem examination. Clinical diagnosis is made years before autopsy, and can be difficult, especially at earlier disease stages and when comorbidities exist. In fact, even in the hands of geriatric specialists, autopsy and amyloid imaging data have shown that 1 in 5 patients with a clinical diagnosis of AD does not have pathological evidence of AD. Currently available diagnostic tests differ with respect to the information they provide, and may have high or low prognostic value in early versus late stage disease. This talk will briefly review AD pathology, AD diagnosis, currently available tests (blood labs, MRI, CSF analysis, FDG PET), and the use of amyloid PET imaging across AD stages. Data on accuracy and reliability of amyloid imaging will be presented, as well as correlations to CSF analyses.

NO. 5
PERSPECTIVES ON THE NEUROPSYCHIATRY OF PARKINSON'S DISEASE
Speaker: Daniel Weintraub, M.D.

SUMMARY:
Although Parkinson's disease (PD) is still considered a movement disorder and is diagnosed on that basis, the high prevalence of cognitive impairment and numerous psychiatric complications suggest that it is more accurately conceptualized as a neuro-cognitive-psychiatric disorder. In addition to the most commonly studied disorders of dementia, depression, and psychosis, other relatively common and clinically significant psychiatric complications include impulse control disorders (ICDs), anxiety symptoms, disorders of sleep and wakefulness, and apathy. The emergent focus on non-motor aspects of PD over the past quarter century is exemplified by the non-linear increase in the number of manuscripts published that are devoted to this topic, as well as quality improvement efforts that increasingly stress non-motor features. This presentation will cover recent changes in our understanding of the epidemiology, neurobiology, and management of psychiatric and cognitive complications of PD.

ADVANCES IN TREATMENTS OF PSYCHIATRIC DISORDERS

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Treat affective disorders more effectively; 2) Identify which paraphilias require treatment; 3) Recognize the role trauma plays in treatment planning.

SUMMARY:
Advances in Treatments of Psychiatric Disorders will focus on the latest "cutting edge" treatment approaches to major psychiatric disorders. Dr. David Spiegel will cover the best strategies for trauma and stressor-related disorders. Dr. Joseph Goldberg will discuss pharmacotherapy, ECT. transcranial magnetic stimulation, and the various psychotherapies in addressing mood disorders. Dr. Barbara Milrod will provide a survey of the latest treatments for DSM-5 anxiety disorders. Dr. John Gunderson will illustrate up-to-date treatments for borderline personality disorder. Finally, Dr. Richard Balon will outline the DSM 5 distinction between paraphilia and paraphilic disorders.

NO. 1
TREATMENT OF TRAUMA, STRESSOR-RELATED, AND DISSOCIATIVE DISORDERS
Speaker: David Spiegel, M.D.

SUMMARY:
There have been some important changes in the Trauma, Stressor-Related, and Dissociative Disorders Section of the DSM-5 that affect treatment as well as diagnosis. The definitions Acute and Post-traumatic Stress Disorders include a broader range of symptoms, including dysphoria, and a dissociative subtype of PTSD. Dissociative Identity Disorder has been altered to emphash:e the intrusive nature of the d'ssociative symptoms as disruptions in consciousness, includes an experience of possession as an alteration of identity,and notes that amnesia for everyday as well as traumatic events is typical. Dissociative Fugue has been included as a specifier of Dissociative Amnesia,so is no longer a separate diagnosis. Derealization has been added to Depersonalization Disorder. Effective treatment of these stressor- and trauma-related disorders involves a primary focus on psychotherapy,with adjunctive use of antidepressants, mood stabilizers, and anti-anxiety medications for symptom control and treatment of comorbid disorders such as depression and anxiety. Salient psychotherapy

includes exposure-based cognitive restructuring,along with attention to stabilization,emotion regulation,stress management, working through traumatic experiences, and consolidation of treatment gains. Treatments for the aftermath of trauma and dissociation involve integrating emotion, cognition, memory,and somatic control.

NO. 2
ADVANCES IN THE PHARMACOTHERAPY AND PSYCHOTHERAPY OF MOOD DISORDERS
Speaker: Joseph F. Goldberg, M.D.

SUMMARY:
An overview of state-if-the-art treatments for DSM-5 mood disorders is presented. Antidepressants that modulate monoamines remain cornerstones of treatment, although robust efficacy wanes after several nonresponses, regardless of antidepressant class. Current evidence favors aumentation with atypical antipsychotics (aripiprazole or quetiapine) after partial response to an antidepressant. Recent antipdepressants are dual-agonist levomilnacipran and the novel serotonin modulator/stimulator vortioxetine, while antiglutamatergic drugs (e.g. katamine, esketamine, riluzole) receive growing research interest. In bipolar depression, traditional antidepressants have never shown greater efficacy than placebo, and carry risks for mood destabilazation, nevertheless benefit some subgroups. Quetiapine, olazapine-floxetine combination and lurasidone are FDA approved for bipolar depression, with more modest or preliminary data supporting use of lamotrigine, modafinil/armodafinil, or pramipexole. The newest DSM-5 “mixed features” or “anxious distress” specifiers prompt further treatment consideeratins. ECT remains a tretent of choice for severe/”urgent” depresssion. Modified techniques for transcranial magnetic stimulation (e.g. deep TMS) may bring its antidepressant efficacy closer to ECT. Evidence-based psychotherapies for depression include cognitive, interpersonal family and group therapies, which hasten recovery, and enhance relapse prevention in conjunction with pharmacotherapy.

NO. 3
UPDATE IN CURRENT TREATMENTS FOR ANXIETY DISORDERS
Speaker: Barbara Milrod, M.D.

SUMMARY:
This talk will provide a current review of evidence-based treatments across DSM-IV-
5 Anxiety Disorders, presented in a practical way for clinicians. This section will be based on the most recent reviews that will appear in Treatments of Psychiatric Disorders. 5th Edition, Gabbard, G. (Ed), American Psychiatric Press (in press). Recommendations for Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, Social Phobia, Specific Phobias, Separation Anxiety Disorder will be reviewed. A brief overall overview will be provided.

NO. 4
TREATMENT OF BORDERLINE PERSONALITY DISORDER
Speaker: John Gunderson, M.D.

SUMMARY:
Treatment of borderline patients continues to undergo dramatic changes. Amongst these have been the shift from a psychoanalytic paradigm to multi modal treatment and from handed-down clinical wisdom to evidence-based manuals. The common characteristics of the evidence-based-treatments (EBT’s) will be described. Paralleling these changes have been changes in expectations. Treatments now should begin with expectations of steady and enduring improvement. These seemingly positive changes in our knowledge remain academic for most borderline patients. Most borderline patients continue to be feared and avoided by most clinicians. When they receive treatment for BPD it is rarely from clinicians who have been exposed to the EBT’s on their lessons. Reasons for this will be described. A model for good psychiatric care by non-BPD specialists that incorporates the lessons learned from prior EBT’s will be described. The importance of an unapologetic diagnostic disclosure and psychoeducation about BPD’s genetics and course is emphasized. Medication trials should begin cautiously by enlisting the borderline patient in evaluating the benefits. Establishing a treatment contract in which treatment is contingent upon progress will be encouraged. This approach now allows treaters to avoid many of the problems prior treatments have unwittingly evoked.

NO. 5
TREATMENT OF PARAPHILIC DISORDERS: WHAT IS NEW, WHAT WORKS, AND WHAT IS CONTROVERSIAL
Speaker: Richard Balon, M.D.

SUMMARY:
Paraphilia means love beyond the usual –“any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners” The DSM-5 differentiates between paraphilia and paraphilic disorder: the latter means paraphilia which is either distressing or acted on with usually non-consenting person or causing harm to the partner. This distinction helps in the treatment decision â€“ a paraphilia is a necessary but not sufficient condition for having a paraphilic disorder, and a paraphilia by itself does not necessarily require or justify clinical intervention (DSM-5).
Treatments used in paraphilic disorders include various forms of therapy (individual; group; cognitive-behavioral), hormonal and psychopharmacological approaches (e.g., antidepressants, antipsychotics) and their combinations. For various reasons inherent to this group of disorders, data from solid treatment studies are not available.
Some aspects of managing paraphilic disorders are controversial. Patient and society interests in treatment may differ. The threshold of treatment is not always clear. The goals and length of treatment are usually not specified (e.g., should the patient be treated after distress/behavior are gone, yet fantasies remain?; should treatment of some paraphilic disorders be lifelong?). Finally, various forms of prevention of these disorders have not been properly explored.

MAY 06, 2014

ADVANCES IN MANAGING THE SIDE EFFECTS OF PSYCHOTROPIC MEDICATIONS

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

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate and understand the basis for common side effects of antidepressants, antipsychotics, and mood stabilizers; 2) Recognize methods for anticipating the likelihood, dose relationships, and time course for the occurrence of psychotropic drug side effects; 3) Recognize, monitor, and safely treat adverse drug effects involving systemic reactions, weight gain/metabolic dysregulation, cardiovascular and neurologic/cognitive toxicities, and sexual functioning; 4) Balance treatment risks and benefits tailored to an individual patient's symptom presentation, predisposition for adverse effects, and therapeutic alliance when drug tolerability can be managed safely.

SUMMARY:
Adverse effects of psychotropic medications impede treatment adherence and can discourage both patients and clinicians from pursuing otherwise effective treatments for significant psychiatric disorders. This session will provide a practical review and update on the assessment and management of psychotropic drug side effects, focusing on medication nonadherence, drug effect sizes and number-needed-to-harm, extrapolation from clinical trials, laboratory and end-organ monitoring, pharmacogenetic and other patient-specific risk factors for drug intolerances, and differentiating benign from medically serious treatment complications. Evidence-based strategies will be discussed for monitoring and managing iatrogenic weight and metabolic dysregulation, arrhythmogenic and other cardiovascular toxicities, neurotoxicities (including iatrogenic movement disorders, cognitive problems, seizures, and systemic phenomena such as neuroleptic malignant syndrome), and sexual side effects of antidepressant, antipsychotic, and mood stabilizing drugs.

NO. 1
CORE CONSIDERATIONS IN THE EVALUATION AND MANAGEMENT OF DRUG SIDE EFFECTS
Speaker: Joseph F. Goldberg, M.D.

SUMMARY:
This presentation will provide an overview of fundamental concepts for assessing side effects and making informed risk-benefit treatment decisions. Appropriate care requires that practitioners are familiar with all intended and unintended effects of a drug. To gauge the balance between treatment risks and benefits, clinicians must consider multiple factors, including the magnitude and uniqueness of a drug effect, the severity and complexity of a given clinical presentation, availability of viable treatment alternatives, and whether appropriate "antidote" strategies exist to safely manage adverse effects. FDA drug registration trials may underestimate actual side effects if they have not been systematically evaluated, and reported drug safety and efficacy may not always be generalizable to "real world" patients. Side effect data from registration trials also provide little if any information about dosing relationships or predicting the time course to symptom emergence and resolution. Other key considerations about suspected side effects include their pharmacodynamic plausibility, individual patients' predisposing characteristics, "nocebo" effects, expectations about side effects, pharmacokinetic considerations (e.g., slow metabolizer genotypes), and populations with unique vulnerabilities (e.g., risks for antidepressant-induced mania, suicidality in youth, or antipsychotic-related mortality in elderly dementia patients), as well as medicolegal documentation and disclosure.

NO. 2
MANAGING WEIGHT GAIN AND METABOLIC RISK FROM PSYCHOTROPIC DRUGS
Speaker: John W. Newcomer, M.D.

SUMMARY:
Major mental health conditions increase risk for premature mortality primarily due to cardiovascular disease and diabetes mellitus. Modifiable cardiometabolic risk factors are common in this population, including overweight and obesity, dyslipidemia and hyperglycemia. Psychotropic medications, including antipsychotics, antidepressants and mood stabilizers, can adversely affect these risk factors, with quantification of treatment-specific risk generally focused on antipsychotics. Mechanisms by which these agents can increase risk include increases in adiposity, associated with well-characterized changes in insulin sensitivity and lipid profiles. Practice guidelines and regulatory language suggests that prescribers should monitor weight and other metabolic parameters, but evidence suggests mixed clinician performance in this area. Based on individual patient-level risk and medication-specific risk, clinicians are advised to undertake risk-benefit analyses and shared decision-making in the process of optimizing care. In addition to dietary and lifestyle modifications, limited evidence supports pharmacologic strategies that may attenuate weight, with substantial evidence supporting the use of FDA-approved treatments for dyslipidemia and diabetes when these conditions are identified. This presentation will review current knowledge about the relative risks among antipsychotics and other major psychotropic drugs for metabolic risk, along with methods to monitor and manage risk.

NO. 3
IDENTIFYING AND MANAGING CARDIAC SAFETY RISKS OF PSYCHOTROPIC DRUGS
Speaker: Carrie Ernst, M.D.

SUMMARY:
Psychiatrists increasingly must confront arrhythmogenic and other potential cardiac toxicities from a range of psychotropic medications. These include not only ventricular repolarization anomalies and conduction delays but also other (e.g., tachy/brady-) arrhythmias, orthostatic hypotension, myocarditis, cardiomyopathies, and sudden cardiac death. This presentation will review key concepts involving cardiac safety when prescribing first- and second-generation antipsychotics, lithium, tricyclics, some high-dose SSRIs, and stimulants. Strategies will be discussed for interpreting and monitoring QTc intervals, recognizing (and minimizing) risk factors for QTc prolongation, managing pressor or orthostatic effects, and choosing the safest psychotropic drugs in high-vulnerability populations such as post-MI patients or those with pre-existing QTc prolongation.

NO. 4
MANAGING NEUROTOXIC EFFECTS OF PSYCHOTROPIC DRUGS

Speaker: Claudia F. Baldassano, M.D.

SUMMARY:
Adverse neurologic effects of psychotropic drugs include motor disturbances (e.g., tremor, tardive dyskinesia, dystonias, bruxism, tics, akathisia and extrapyramidal side effects), gait abnormalities, headache, hypersensitivity reactions, oculogyric crises, cognitive dulling, and seizures, among others. Clinician must discern when focal neurologic signs reflect frank neurotoxicities (e.g., lithium overdoses) or idiosyncratic emergencies (e.g., neuroleptic malignant syndrome; aseptic meningitis) that demand urgent attention, in contrast to benign annoying adverse effects (e.g., tremor) that may nevertheless threaten treatment adherence and satisfactory outcomes. This presentation will review common neurologic adverse effects of psychotropic medications including side effect recognition and assessment, differential diagnosis, time course, risk factors, and dosing relationships. Participants will gain familiarity with clinical assessment techniques (e.g., how to assess drug-induced from illness-related cognitive complaints; how to differentiate neuroleptic malignant syndrome from serotonin syndrome) and management strategies (e.g., treatment options for tardive dyskinesia; minimizing adverse cognitive effects when treating antipsychotic-induced pseudoparkinsonism). Differences will be discussed among relative risks for adverse neurologic events across psychotropic drugs, alongside tips for choosing among treatment options in light of a given patient's' likely risks and benefits.

NO. 5
ASSESSMENT AND MANAGEMENT OF SEXUAL DYSFUNCTION WITH PSYCHIATRIC ILLNESS
Speaker: Anita H. Clayton, M.D.

SUMMARY:
Sexual functioning(SF) occurs via neuroendocrine systems through a balance in excitatory hormones, peptides, and neurotransmitters vs. inhibitory factors.Psychiatric illness and the medications used to treat them also have effects on SF through these systems, making it difficult to separate the effect of the underlying condition from an adverse effect of treatment medications.Additionally, co-morbid psychiatric(e.g. primary sexual disorders) and medical conditions and associated medication use may confound assessment.Genetic factors, too, may increase the risk of sexual dysfunction(SD) with psychotropic medications.Methodological issues such as adequate quantitative measures of sexual functioning, statistical vs. clinically-meaningful differences, and gender effects may further complicate management.As SD reduces patientsâ€™ quality of life, it is often a reason for medication non-adherence.Thus, provider-initiated, proactive, longitudinal assessment of sexual function and patient preference/satisfaction is essential.Current best-practice management strategies include switching the medication to one associated with less sexual dysfunction and adding a medication for augmentation/antidote.Less desirable strategies include dose reduction, drug holidays, and waiting for tolerance to develop.In addition, interventions for identified primary sexual disorders, and effective treatment of medical conditions and changing other medications that contribute to SD can optimize management.

MAY 07, 2014

ADVANCES IN ADDICTION PSYCHOPHARMACOLOGY

Chairs: Domenic A. Ciraulo, M.D., John A. Renner Jr., M.D.

EDUCATIONAL OBJECTIVE:
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 use disorders; 3) Participants will demonstrate knowledge of medications being developed to treat nicotine, alcohol, opioid, cannabinoid, cocaine and other stimulant use disorders.

SUMMARY:
This course will review the pharmacology of 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 use disorders. 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 use disorders and the improved treatment outcomes and reduced costs that have resulted. Yet these medications are effective for only a fraction of the treatment-seeking population. Although three new medications were approved to treat alcohol dependence [i.e., oral naltrexone, long-acting injectable naltrexone (also approved to treat opioid dependence), and acamprosate], they have not been as widely prescribed as the prevalence of the disorder would seem to justify. Medications to treat other addictive disorders, including cocaine and other stimulant use disorders and cannabis use disorder, have not been shown consistently to be superior to placebo treatment. However, research has identified some promising candidates for the treatment of cocaine use disorder, including the anticonvulsant topiramate, the analeptic modafanil, and immunologically-based treatments. In summary, there is a growing armamentarium of medications to treat addictive disorders. Further, greater understanding of the neuropharmacology and pharmacogenetics of addictive disorders promises to provide additional options and methods to target therapy for these highly prevalent, often serious, and costly disorders.

NO. 1
MEDICATIONS TO TREAT COCAINE AND OTHER STIMULANT USE DISORDERS
Speaker: Richard N. Rosenthal, M.A., M.D.

SUMMARY:
This lecture will review the pharmacology of cocaine and other stimulants and the pharmacological treatment of dependence on these drugs. While use has declined in the last few years,

cocaine is still relatively easy to obtain as demonstrated in its primacy in drug-related emergency-department visits. The use of "club drugs" which include GHB (g-hydroxybutyrate), 3,4 methylenedioxymethamphetamine (MDMA) ("ecstasy"), and ketamine, has also raised concern, particularly use among adolescents and young adults. Clinicians must also be concerned with non-club uses of the club drugs, particularly among high school and college students. This presentation will focus on the psychopharmacology and pharmacologic treatment concerns regarding cocaine and three common club drugs: GHB, MDMA, and ketamine.

NO. 2
MEDICATIONS TO TREAT ALCOHOL USE DISORDERS
Speaker: Henry R. Kranzler, M.A., 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 use disorders 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 USE DISORDERS
Speaker: 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 as well as medications that have shown promise in the laboratory. While there are limited studies that have tested pharmacologic interventions in outpatient individuals with cannabis use disorder, it is a rapidly evolving area of research. The currently available controlled trials will be reviewed along with treatment implications. Further, novel areas of investigation will be discussed.

NO. 4
MEDICATIONS TO TREAT OPIOD USE DISORDERS
Speaker: John A. Renner Jr., M.D.

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

NO. 5
MEDICATIONS TO TREAT TOBACCO USE DISORDERS
Speaker: Petros Levounis, M.D.

SUMMARY:
This lecture will review the pharmacology and pharmacologic treatment of tobacco use disorders. Food and Drug Administration approved medications include bupropion, varenicline, and the nicotine replacement therapies (patch, gum, inhaler, lozenges, and nasal spray). The contraindications and major advantages and disadvantages for each intervention will be discussed, as well as strategies for combining pharmacological interventions and the integration of motivational interviewing techniques to provide a more comprehensive treatment approach. The controversy over the reported neuropsychiatric sequelae of varenicline and bupropion, the black box warnings, and the scientific evidence supporting or refuting these claims will be critically assessed.

MAY 03, 2014

THE LONG-TERM TREATMENT FOR A PATIENT WITH HIV

Chair: Marshall Forstein, M.D.

Speakers: Francine Cournos, M.D., Lawrence M. McGlynn, M.D., Robert Kertzner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the various historical stages of the HIV epidemic and their meaning in the treatment of a long term survivor; 2) Identify the impact of changes in medical status on psychological coping; 3) Recognize the potential emotional impact on the therapist who treats multiple patients with HIV infection at various stages of illness; 4) Recognize how the medical issues affect the course of psychotherapy over time.

SUMMARY:
The HIV epidemic has had significant implications for psychiatric practice over the past 30 years. Different stages of the epidemic have both shaped and changed the medical and psychological issues that psychiatrists must incorporate into their treatment with patients infected with HIV. As a disease that initially affected people in the first several decades of life, patients infected with HIV often presented a disruption in the expected life course. As a physician who began seeing patients with AIDS in the early 1980's, the presenter will use a case that has evolved over more than twenty years to illustrate the changes in the HIV epidemic and their implications for psychotherapy. The discussion will highlight the impact of long-term survival from the pre-antiretroviral era as well as the clinical issues now facing an otherwise healthy middle-aged gay man who has developed cognitive impairment that has disrupted his life course and greatly affected the therapeutic relationship. The presenter will illustrate the changes in therapeutic style and countertransference that has both helped and hindered the treatment. Participants will be encouraged to ask questions and explore issues pertaining to their own practice in the case discussion.

MAY 04, 2014

TRANSFERENCE-FOCUSED PSYCHOTHERAPY OF A PATIENT WITH SEVERE BORDERLINE PERSONALITY DISORDER

Chair: Frank E. Yeomans, M.D., Ph.D.

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the completion of this session participants will be able to demonstrate knowledge of the role of intense intrapsychic affective conflicts in a patient's acting out behavior in the treatment of BPD; 2) At the completion of this session participants will be able to diagnose and characterize the manifestations of intense positive and negative transferences as they are enacted in the therapeutic relationship in treatment of patients with BPD; 3) At the completion of this session participants will be able to demonstrate knowledge of the sequence of interventions that promotes personality integration in the treatment of patients with BPD .

SUMMARY:
The treatment of Borderline Personality Disorder (BPD) is a challenge for psychiatrists. The APA Clinical Guidelines for BPD recommend diagnosis-specific psychotherapy as the treatment of choice, with ancillary psychopharmacology in most cases. BPD is the only condition for which the APA Guidelines recommend psychotherapy as the treatment of choice. The BPD diagnosis covers a range of clinical presentations, from the more fragile and depressed to the more aggressive. Michael Stone's research has shown that the presence of strong aggressive features is a negative prognostic factor. The case we will be discussing represents the full, long-term (6 year) treatment of a patient who began therapy with a diagnosis of BPD with significant aggressive, anti-social, paranoid and narcissistic features (a patient who met many of the criteria for the diagnosis of Malignant Narcissism, as described by Otto Kernberg). In addition, the patient, who had a history of early attachment trauma, presented initially with insecure/disorganized attachment representational states as assessed on the Adult Attachment Interview (AAI) given at the beginning of treatment. The description of the treatment will highlight working on highly affectively charged, extreme negative and positive transferences with the ultimate goal of first, helping the patient gain awareness of the split polarized idealized an persecutory aspects of her self that she tended to project and experience as external to her, and second, helping her integrate the extreme aggressive and idealized segments of her personality that fueled her destructive and self destructive symptomatology. After Dr. Yeomans' presentation of the case, Dr. Caligor will discuss underlying psychodynamic issues and Dr. Diamond will discuss issues from the point of view of attachment theory.

SUICIDE BY A PATIENT: THE PSYCHOLOGICAL IMPACT AND RESULTANT GROWTH

Chair: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize common reactions when a clinician loses a patient to suicide; 2) Identify important ways of seeking assistance for oneself; 3) Meet with grieving families and others with reason, compassion and helpfulness; 4) Record key steps of postvention examination in tertiary prevention and healing.

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 is considered an occupational hazard of treating mentally ill patients. Further, losing a patient to suicide may be one of the most difficult professional times in one's career. This case conference is an updated version of two previous APA case conferences on suicide loss in 2010 and 2013. The presenter will give several brief case presentations of patients that he has lost to suicide spanning a forty year career. He will then highlight the following issues: 1) psychological reactions to

patient suicide, including the myriad variables that characterize the physician-patient relationship; 2) self-care after losing a patient to suicide; 3) the clinician's roles and responsibilities after suicide, including outreach to survivors (family and significant others); 4) malpractice litigation after suicide (including ways to decrease the risk of liability, risk management, coping with lawsuits); and 5) postvention examination in the aftermath of suicide. Discussion with the presenter and attendees is an essential feature of this case conference (at least one third of the time will be protected). Those attending can expect to gain much new knowledge and become more comfortable with this very difficult dimension of professional life.

MAY 05, 2014

A PSYCHIATRY CONSULTATION-LIAISON CASE OF A YOUNG WOMAN WITH AN EATING DISORDER AND PSYCHOTIC DISORDER WHO REFUSED TO EAT AND DRINK FOR ONE MONTH

Chairs: Christopher Cselenyi, M.D., Ph.D., Ilana Nossel, M.D.

Speakers: Christopher Cselenyi, M.D., Ph.D., Ilana Nossel, M.D., Evelyn Attia, M.D., Steven Hoge, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify opportunities to better coordinate care for patients on medical units with severe and co-morbid medical and psychiatric conditions; 2) Recognize importance of appreciating multi-dimensional nature of psychiatric illness even when patients present with acute and life-threatening symptoms; 3) Understand ethical dimensions of treatment over objection in cases where medical and psychiatric illnesses overlap. .

SUMMARY:
We present the case of a 34-year old graduate-school-educated woman with a history of psychotic disorder and an eating disorder who refused any food or drink for one month. She was treated on a medicine service with psychiatric consultation for 29 days. During her hospital course, a token behavioral plan was attempted before the patient was eventually placed in restraints and given nutrition and antipsychotic medication by duodenal tube. The patient reported improvement in psychotic symptoms and resumed adequate oral nutrition before she was transferred back to the psychiatric inpatient unit. Expert panelists in the fields of psychotic disorders, eating disorders, and ethics will discuss the case. We encourage questions and comments from the audience as we focus on the following discussion questions:
1) Could this patient's symptoms be attributed to a diagnosis other than schizophrenia, such as bipolar disorder or borderline personality disorder?
2) What were the roles of the patient's starvation and eating disorder in the etiology of her symptoms, and how should this have informed appropriate treatment?
3) The patient was physically restrained for 7 days and given medication through injections and tube feeds; did we do all we could to respect her autonomy and legal rights.
4) We treated the patient on a medical unit where the extent of her family's involvement was greater than it would have been had she been on a psychiatric unit. Did this affect her treatment and our understanding of her illness?
5) How could her treatment on the medical ward have been better coordinated?

NEUROPSYCHIATRY CASE CONFERENCE: AUTOIMMUNE MECHANISMS OF BEHAVIOR CHANGE

Chair: Sheldon Benjamin, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be able to recognize the presentation and course of Anti-NMDA and related forms of autoimmune limbic encephalitis ; 2) Become familiar with the laboratory and neurodiagnostic evaluation of suspected limbic encephalitis; 3) Become familiar with one method for conducting neuropsychiatry case conferences.

SUMMARY:
Neuropsychiatry case conferences can be excellent vehicles to facilitate clinical neuroscience education for trainees and clinicians. The model of neuropsychiatry case conference demonstrated here includes the usual history and examination findings as well as excerpts from clinical interviews. This is followed by presentation of laboratory and neurodiagnostic findings (both imaging and neuropsychological assessment). The presentation of neurodiagnostic findings is used as an opportunity to discuss the methods used, the relevant anatomy and pathophysiology, and the meaning of any findings. Two cases of autoimmune limbic encephalitis, one in a young woman and one in a middle aged man, will be used to demonstrate the method and utility of the neuropsychiatry case conference. Since its description by Joseph Dalmau in 2007, anti-NMDA autoimmune encephalitis has been increasingly shown to be a cause of subacute behavioral change associated with seizures, movement disorders, and cognitive dysfunction. Although the condition remains relatively rare, accurate diagnosis leads directly to highly effective treatment, so psychiatrists should be familiar with the presentation, evaluation, and natural course of this syndrome. The Psychiatry Milestones, created by a committee under the auspices of the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Psychiatry and Neurology, are due to be implemented in July 2014 as part of the ACGME's Next Accreditation System. The Psychiatry Milestones include a number of milestones grouped in the new Medical Knowledge Clinical Neuroscience subcompetency. Neuropsychiatry case conferences such as this one are an ideal vehicle for achieving these newly required milestones.

PTSD, AMNESIA, OR DISSOCIATION: IS DISSOCIATION STILL ALIVE? IF SO, WHAT DO WE DO ABOUT IT?

Chair: José R. Maldonado, M.D.

Speaker: David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants should be able to recognize signs and symptoms of dissociation, as well as differential diagnosis.; 2) Participants will learn the differences (and benefits) between

hypnosis and conventional psychotherapy in the management of the psychological consequences of trauma.; 3) Participants will learn various quick and effective hypnotic techniques for the integration of dissociated memories.

SUMMARY:
Two cases of patients suffering from a dissociative disorder will be used to demonstrate how trauma leads to the use of dissociative defenses and psychopathology. We will also discuss how hypnosis may be used to help in the diagnosis and treatment of these disorders by assisting patients to access dissociated memories and achieve lasting integration:
1. A middle aged, married woman begins couples therapy, but soon after starting her husband drops out. As she continues therapy, she reveals an affair with a co-worker. During a particular session the patient reports a new dream: "I was in my childhood home, in my grandfather's room. He asked me to climb to bed, where he is sitting; then the mattress turns into quicksand." This leads to an episode of dissociation for which she is taken to the ER "behaving like a 6 year old child". During the ensuing hospitalization, conventional therapy failed to achieve integration and 6 days into the admission an expert consultation is requested.
2. A middle aged woman, happily married with 3 wonderful children, has a history of GAD and mild hypochondriacal tendencies (but these are under reasonably good control after years of psychotherapy) and was considered to "asymptomatic". After her mother's untimely death the patient begins to experience traumatic flashback and dissociative episodes leading to a request for an urgent consultation.
We will review the cases and videotape evidence of both presentations, followed by a discussion of the differential diagnosis and how to proceed with treatment. Emphasis will focus on the use of hypnosis to allow for controlled access to dissociated/repressed memories and to help patients achieve lasting integration. We will discuss the differences between conventional psychotherapy and hypnosis-facilitated therapy, particularly the benefits and risks of hypnosis.

CBT FOR TREATMENT-RESISTANT DEPRESSION

Chair: Donna Sudak, M.D.

Speakers: Yesne Alici, M.D., Jesse H. Wright, M.D., Ph.D., Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Summarize combined treatment strategies that can assist us in working with chronic and recurrent depression; 2) Demonstrate strategies used in CBT that benefit patients with chronic and recurrent depression; 3) explain how to conduct creative behavioral activation and enhance routines in patients with treatment resistant depression.

SUMMARY:
Treatment Resistant Depression frequently has a poor prognosis. Patients with Treatment Resistant Depression are significantly less likely to respond to subsequent medications, may require alternative treatments and have high levels of comorbidity. Treatment costs are significant, in direct medical costs, social and occupational impairment, Such costs incurred include lost productivity, functional decrements, decreased quality of life and relationships. Patients with Treatment Resistant Depression often have poor social adjustment/social supports, and significant psychosocial skill deficits, including lack of assertiveness and poor communication. Such deficits lead to interpersonal and occupational impairment. This case conference will detail combined treatment strategies and the use of CBT in managing Treatment Resistant Depression.

MAY 06, 2014

TREATMENT OF CHRONIC PAIN & PSYCHIATRIC COMORBIDITY: SUCCESSFUL MODELS OF INTEGRATED CARE

Chairs: Michael R. Clark, M.B.A., M.D., M.P.H., Glenn J. Treisman, M.D., Ph.D.

Speaker: Marc Fishman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe a behavioral model of the generation and maintenance of chronic pain disorders; 2) Discuss the role of psychiatric co-morbidity in chronic pain disorders; 3) Describe the contribution of the current model of palliative care to the U.S. opiate addiction epidemic.

SUMMARY:
Chronic pain is associated with suffering and disability as well as enormous costs of medical services and lost productivity, severe psychiatric and medical morbidity, global impairment in psychosocial function, and increasing use and misuse of opioid analgesics and other medications such as sedative-hypnotics which are typically only temporarily ameliorative, and have severe side effects, including addiction. We will present a case based discussion of chronic pain and the complex psychiatric co-morbidity. We will review the epidemiology and biology, the hypothesis of abnormal illness behavior, the mechanisms of classical and operant conditioning that sustain it, the phenomena of opioid-induced hyperalgesia and other medication side effects that unfortunately impede patient improvement. We will present a critique of the existing symptom focused and comfort targeted approach that uses a palliative care model, and will present an alternative model of treatment that emphasizes function rather than analgesia as the primary goal of treatment, features treatment of psychiatric morbidity, utilizes reconditioning and medications targeting neuropathic pain mechanisms, and takes a rehabilitative approach to overcoming disability. This symposium will feature a cased based interactive discussion that will cover mechanisms of chronic pain, the behavioral view of the problems associated with current treatment, the psychiatric co-morbidities that confound treatment and the intersection with addiction. An alternative rehabilitative approach to chronic pain management will be described. Most cases of chronic nonmalignant pain should be formulated through a psychiatric lens, treated by a multidisciplinary medical team with psychiatric leadership, and that chronic pain treatment is best regarded as a psychiatric discipline.

FAMILY THERAPY FOR SCHIZOPHRENIA: FROM INDIVIDUALS

TO NAMI

Chairs: S. Charles Schulz, M.D., Michael O'Sullivan, M.D.

Speakers: Michael O'Sullivan, M.D., Ken Duckworth, M.D., Richelle N. Moen, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) assess of the needs of a family with a first episode of psychosis; 2) understand and utilize NAMI; 3) plan for family therapies.

SUMMARY:
The emergence of Expressed Emotion in the 1970s was a stimulus for connecting with families in order to help patients with schizophrenia and to decrease relapse. At study centers, clinicians also integrated education sessions for parents - usually one day - which was enthusiastically received. The emergence of Hoffman's surveys about family needs led to greater demand for support with groups forming - including NAMI in 1979. Since that time there, has been a marked increase in services to families from psychoeducation, to long-term groups, to couples therapy. As First Episode Programs have emerged, clinicians noted the enormous shock to families, their isolation, and lack of knowledge about the illness. Also, many clinicians have noted that the perceived stigma leads to further isolation. Further, parents noted the substantial impact on the young siblings. With the establishment of the First Episode Programs, the family groups have received excellent feedback from parents. The families have noted very helpful information and the opportunity to meet with others in the group. Further, many participants in the Family Groups have noted how this leads them to NAMI. In this case conference, Dr. Michael O'Sullivan will present a report on the assessment and treatment of a 24-year-old single young man with significant psychotic symptoms and mood swings. In addition, there was a significant issue with alcohol abuse. The patient did respond to treatment; however, significant family issues were noted that led to family interventions. Following the case presentation, Dr. Ken Duckworth of NAMI National will describe and discuss NAMI work around the country to connect and help families. NAMI provides substantial support for parents and now siblings of patients with psychotic illnesses. Further, NAMI now also advocates for families and patients in their communities. Following Dr. Duckworth, Dr. Richelle Moen will describe and discuss the integrated treatment approach for First Episode Psychosis patients and their families. The initial focus will be on a psychoeducational skill-based model. Further, strategies to reduce Expressed Emotion will be described. This will be followed by describing the sequential team approach to the family of the young patient presented earlier in the conference. In conclusion, Family Therapy has emerged as a most valuable service to assist young people with a psychotic illness. Further, there are substantial needs of families that will be discussed in the Case Conference.

MAY 03, 2014

COURSE 1
SEX, DRUGS, AND SOCIAL MEDIA: PROFESSIONALISM AND ETHICS PUT TO THE TEST
Director: Glen O. Gabbard, M.D.
Faculty: Gabrielle Hobday, M.D., Holly Crisp-Han, M.D., Valdesha Ball, M.D., Laura Roberts, M.A., M.D., Funmilayo Rachal, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the major professionalism and ethics issues regarding the use of the electronic media; 2) Identify the major problematic boundary issues inherent in dual relationships; and 3) Recognize the "hidden" professionalism themes in the areas of gender, sexuality, race, culture and religion.
SUMMARY:
Making ethics and professionalism clinically relevant and practical has been a perennial problem in the education of psychiatrists and other mental health professionals. In this course we take some of the major clinical dilemmas encountered in practice and bring them to life with vivid clinical examples and film clips. To be sure we engage the learners, we will use the Audience Response System to pose questions that grow out of the details of the clinical problems we present. The audience can then receive instant feedback on how their responses compare to those of their colleagues. The major areas that will be covered include the problems of maintaining professional boundaries, dual relationships, intercolleaguial relationships, the complicated issues surrounding race, culture, gender, sexuality and religion in the clinical setting and the brave new world of electronic media, i.e., email, texting, social media. The course will end with an interactive dialogue with the audience based on complex clinical dilemma in the areas of professionalism and ethics.

COURSE 2
MELATONIN AND LIGHT TREATMENT OF SEASONAL AFFECTIVE DISORDER, SLEEP AND OTHER BODY CLOCK DISORDERS
Director: Alfred Lewy, M.D., Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Use the salivary dim light melatonin onset and sleep time to phase type circadian sleep and mood disorders as to whether they are phase advanced or phase delayed; 2) Treat a patient with appropriately timed bright light exposure (evening or morning) and/or low-dose melatonin administration (morning or afternoon) using the patient's phase type; and 3) Monitor treatment response using the DLMO/mid-sleep interval, targeting 6 hours.
SUMMARY:
This course will enable practitioners to advise patients on how to use melatonin and bright light to treat circadian sleep and mood disorders. There are two categories for these disorders: phase advanced and phase delayed. The prototypical patient with SAD (seasonal affective disorder, or winter depression) is phase delayed; however, some are phase advanced (Lewy et al., PNAS, March 9, 2006). Shift work maladaptation, non-seasonal major depressive disorder (Emens, Lewy et al., Psychiatry Res., Aug. 15, 2009) and ADHD can also be individually phase typed and then treated with a phase-resetting agent at the appropriate time, so as to correct the circadian misalignment component. Phase-advanced disorders are treated with evening bright light exposure and/or low-dose (0.3-0.6 mg) morning melatonin administration. Phase-delayed disorders are treated with morning bright light and/or low-dose melatonin administration 8-12 hours after waketime. High doses of melatonin (3-10 mg) can be given at bedtime to help some people sleep. The best marker for body clock time 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. The marker for body clock time is called the dim light melatonin onset (DLMO) and occurs on average at about 8 or 9 p.m.; earlier DLMOs indicate a phase advance, later DLMOs indicate a phase delay. Within a year or two, this test should become available to clinicians. In the meantime, waketime can be used a marker for body clock time. The circadian alignment between DLMO and the sleep/wake cycle is also important. The time interval between the DLMO and mid-sleep is called the phase angle difference (PAD). In SAD patients, the more PAD deviates from 6, the more severe is the depression. Therapeutically, the goal is to use bright light and/or low-dose melatonin to restore PAD to six hours, thus correcting the internal circadian misalignment between the body clock and the sleep/wake cycle. Use of the DLMO for phase typing and guiding clinically appropriate phase resetting will be discussed in detail, focusing on SAD. A jet lag treatment algorithm will be presented that takes into account the direction and number of time zones crossed, for when to avoid and when to obtain sunlight exposure at destination and when to take low-dose melatonin before and after travel. Specific examples going to and from New York and four representative time zones (Paris, New Delhi, Honolulu and Japan) will be discussed. Low-dose melatonin and sunlight advice will also be given for the extended week-ends before the transitions between Daylight Saving Time and Standard Time, as well as for combating "Monday Blues." Delayed and Advance Sleep Disorders will also be discussed. Books instructing the use of light treatment and sleep deprivation will also be reviewed, as well as the most recent research findings.

COURSE 3
EVIDENCE BASED PSYCHODYNAMIC THERAPY: A CLINICIAN'S WORKSHOP
Directors: Richard F. Summers, M.D., Jacques Barber, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Become aware of the substantial evidence base supporting psychodynamic psychotherapy; 2) Improve treatment selection by applying a contemporary framework for conceptualizing psychodynamic therapy; 3) Diagnose core psychodynamic problems and develop a psychodynamic formulation for appropriate patients; and 4) Understand how to develop an effective therapeutic alliance and employ techniques for facilitating change.
SUMMARY:
This course will build the clinician's ability to provide effective and pragmatically-focused psychodynamic therapy by reviewing the current evidence base for the treatment, presenting a contemporary and concise conceptual framework for the treatment and offering a detailed discussion of psychodynamic technique. Many video clips with class discussion about technique and a group exercise on defining the core psychodynamic

problem of a presented patient will make the course lively and participatory.
The course follows the arc of therapy by discussing the central concepts of therapeutic alliance, core psychodynamic problem, psychodynamic formulation, psychotherapy focus and strategies for change. Presentation of the relevant evidence is paired with the model and the specific techniques to bolster the clinician's confidence in the effectiveness of the method. The video clips and group discussion provide an opportunity for a nuanced discussion of technique.

COURSE 4
TREATMENT OF SCHIZOPHRENIA
Director: Phillip G. Janicak, M.D.
Faculty: Rajiv Tandon, M.D., Phillip G. Janicak, M.D., Morris Goldman, M.D., Stephen R. Marder, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the psychopathological dimensions, recent DSM-5 diagnostic criteria and neurobiological underpinnings of schizophrenia; 2) Describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics, as well as novel therapies.; 3) Better, understand the efficacy, safety and tolerability of antipsychotics when used for acute and chronic schizophrenia; and 4) Describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs.
SUMMARY:
Treatment of schizophrenia and related psychotic disorders has rapidly evolved since the re-introduction of clozapine in 1989. There are now nine additional second-generation antipsychotics in various formulations (i.e., risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, iloperidone, paliperidone, asenapine, lurasidone). The relative effectiveness of these drugs when compared with each other (e.g., CAFÉ trial in first episode psychosis), as well as with first generation antipsychotics (e.g., the CATIE and CUtLASS trials), continues to be clarified. Increasingly, strategies to improve cognition, mood and negative symptoms, as well as safety and tolerability issues, are the focus of attention. The integration of cognitive therapeutic approaches, psychosocial interventions and rehabilitation programs with medication is also critical to improving long-term outcomes (e.g., recovery). Our increased understanding of the neurobiology and psychopathology of schizophrenia will guide the development of future more effective agents for acute and maintenance strategies.

COURSE 5
ADHD IN ADULTS: FROM SCIENCE TO CLINICAL PRACTICE
Directors: Craig Surman, M.D., Paul Hammerness, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will be aware of common presentations of ADHD in adults; 2) Participants will be able to apply clinical assessment techniques to identify ADHD; 3) Participants will understand the evidence basis, and limits of that basis, for medication and non-medication therapies for ADHD in adults; and 4) Participants will be able to implement treatment plans for ADHD in adults .
SUMMARY:
Purpose: In the last decade the body of research on Attention Deficit Hyperactivity Disorder in adulthood has grown dramatically. Consumers frequently present to clinicians with the condition, but most practicing clinicians have not had formal training in its management. This course will catch participants up on the extent, including limits, of the science of ADHD, and train participants in evidence-informed approaches to identifying and managing ADHD in clinical practice.
Course Format: The faculty are practicing clinicians who have contributed to 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 published in the Journal of the American Medical Association. Up-to-date scientific findings will serve as context for practical, step-by-step training in the art of in-office clinical decision making. Attendees will participate in a virtual patient encounter, learn to identify ADHD symptoms, and practice applying medication and non-medication 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) step-by-step instruction on personalizing treatment for ADHD patients, including optimal pharmacologic and non-pharmacologic supports; 4) evidence based-cognitive behavioral therapy strategies; 5) principles for managing common complex presentations, including patients with non-attention executive function deficits, mood disorders, anxiety disorders, and substance abuse disorders
Summary: This course offers participants practical and effective techniques to appropriately diagnose and treat ADHD in adults, developed from a growing body of research.

COURSE 6
INTERPERSONAL PSYCHOTHERAPY
Director: John C. Markowitz, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand the basic rationale and techniques of interpersonal psychotherapy for depression; 2) To understand key research validating its use; and 3) To understand some of the 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 or persistence of their mood disorder, and to explore practical interpersonal options to achieve desired goals. Acute treatment helps patients to resolve a current life crisis, thereby also relieving symptoms. IPT has had impressive research success in controlled clinical trials for acute depression, prophylaxis of recurrent depression, and other disorders such as bulimia. This course, now in its 21st 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 7
MENTALIZATION BASED TREATMENT (MBT) FOR BORDERLINE PERSONALITY DISORDER (BPD): INTRODUCTION TO CLINICAL PRACTICE
Directors: Anthony Bateman, M.D., Peter Fonagy, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of the mentalizing problems of borderline personality disorder; 2) Recognise mentalizing and non-mentalizing interventions; 3) Develop and maintain a mentalizing therapeutic stance; and 4) Use some basic mentalizing techniques in everyday clinical work.
SUMMARY:
Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as their own) leading to self-awareness and other awareness. We have to be able to continue to do this in the midst of emotional states but borderline personality disorder (BPD) is characterised by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity in order to ensure 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 mentalising. The most important aspect of MBT is the therapeutic stance. Video and role plays will be used to ensure participants recognise 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 programme both at the end of treatment and at 8 year follow-up. A trial of MBT in an out-patient setting has also been completed. This shows effectiveness when applied by non-specialist practitioners. Independent replication of effectiveness of MBT has been shown in cohort studies and additional randomised controlled trials are in progress. The course will therefore provide practitioners with information about an evidence based treatment for BPD, present them with an understanding of mentalizing problems as a core component of BPD, equip them with clinical skills that promote mentalizing, and help them recognise non-mentalizing interventions.

COURSE 8
STREET DRUGS AND MENTAL DISORDERS: OVERVIEW AND TREATMENT OF DUAL DIAGNOSIS PATIENTS
Director: John W. Tsuang, M.D.
Faculty: Larissa Mooney, M.D., Timothy W. Fong, M.D., Karim Reef, D.O.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants should be able to understand the issues relating to the treatment of dual diagnosis patients; 2) Participants should know the popular street drugs and club drugs; and 3) Participants should know the available pharmacological agents for treatment of dual diagnosis patients.
SUMMARY:
According to the ECA, 50-percent of general psychiatric patients suffer from a substance abuse disorder. These patients, so-called dual diagnosis patients, are extremely difficult to treat and they are big utilizers of public health services. This course is designed to familiarize participants with diagnosis and state-of-the-art treatment for dual diagnosis patients. We will first review the different substance of abuse, including club drugs, and their psychiatric manifestations. The epidemiological data from the ECA study for dual diagnosis patients will be presented. Issues and difficulties relating to the treatment of dual diagnosis patients will be stressed. The available pharmacological agents for treatment of dual diagnosis patients and medication treatment for substance dependence will be covered. Additionally, participants will learn the harm reduction versus the abstinence model for dual diagnosis patients.

MAY 04, 2014

COURSE 9
MIGRAINE AND PSYCHIATRIC COMORBIDITIES
Director: Mia T. Minen, M.D., M.P.H.
Faculty: Mia T. Minen, M.D., M.P.H., Todd A. Smitherman, Ph.D., Gretchen E. Tietjen, M.D., Richard B. Lipton, M.D., Dawn C. Buse, Ph.D., Elizabeth Loder, M.D., M.P.H.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe a general approach to patients who presents with headache, specifically migraine; 2) List the psychiatric comorbidities associated with migraine including depression, anxiety, PTSD and abuse and be able to screen for them; and 3) Be able to formulate psychopharmacologic and non-pharmacologic treatment options available for these patients.
SUMMARY:
Current research has shown that many neurologic diseases and psychiatric diseases are related, so it would be best to encourage further integration among these two fields. To date, many psychiatrists are not comfortable assessing patients with neurologic disorders.
Migraine is a common neurologic disorder which exemplifies how a neurologic disorder has many psychiatric comorbidities. For example, research has shown an association between migraine and affective disorders, anxiety, abuse and sleep. By learning about migraine and the associated psychiatric comorbidities and by translating this knowledge into clinical practice, patient care may be improved.
Faculty will provide an update on the various comorbid psychiatric conditions of migraineurs. They will discuss how to efficiently screen these patients for the comorbidities, and they will discuss how to treat these patients using pharmacologic and non-pharmacologic strategies. The program will conclude

with case presentations led by leading headache experts in the field.

COURSE 10

DIALECTICAL BEHAVIOR THERAPY FOR PSYCHIATRISTS: USING DBT STRATEGIES IN YOUR PSYCHOTHERAPY AND PSYCHOPHARMACOLOGICAL PRACTICE

Directors: Beth S. Brodsky, Ph.D., Barbara Stanley, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use DBT interventions for outpatient management of suicidal and non-suicidal self-injurious behaviors and medication management particularly for patients with borderline personality disorder; 2) Apply basic DBT interventions in psychotherapy and psychopharmacology practice, to increase treatment retention, engagement and reduce symptoms in emotionally and behaviorally dysregulated patients; and 3) understand the skills patients learn in DBT, how to apply them and how to ''think" in a DBT framework about difficult to manage patients particularly those with BPD.

SUMMARY:

Psychiatrists, both those with primarily psychopharmacology practices and those who do psychotherapy, are faced with challenges when working with patients with BPD or emotional dysregulation in other disorders. These challenges can lead to clinician burnout and a desire to avoid treating these patients. DBT provides a framework for understanding and managing these difficult patients. DBT conceptualizes the disorder and provides interventions so that clinicians can be more effective and able to feel positively about their work with BPD patients. This course will illustrate how psychiatrists can incorporate these ways of thinking and intervening into a non-DBT clinical practice. This course will provide a hands-on review of basic DBT theory and interventions and will teach strategies, conceptualizations and interventions that can be easily incorporated into a current practice of psychiatry. The course is interactive and will provide a DBT toolkit to increase effectiveness in targeting of suicidal, non-suicidal self harm behaviors, treatment and medication adherence issues, and other symptoms of emotional and behavioral dysregulation. The course will also focus on the application of DBT to avoid the common pitfalls of working with these difficult patients, namely "splitting", anxiety- producing calls for help, overwhelming requests for time and attention, interpersonal hostility, and clinician burnout. The course will review the DBT biosocial theory of the etiology of BPD, dialectic and social learning theory, how they inform the treatment approach and can aid psychiatrists to maintain an empathic therapeutic stance, to stay engaged with and keep BPD patients engaged in treatment. Validation strategies will be taught through the use of interactive case examples and exercises. Course participants will learn DBT strategies for engaging patients in taking responsibility for their treatment and for actively working to reduce suicidal behaviors and address difficulties with medication adherence. Case vignettes and video will demonstrate the use of diary cards and behavioral analysis. The course will include a review of the four DBT skills modules, mindfulness, interpersonal effectiveness, emotion regulation and distress tolerance. One skill from each module will be taught in an interactive role play of a DBT skills group. Participants will learn specific interventions to treat self-harm behaviors on an outpatient basis. These include guidelines for close monitoring, enhanced enhanced suicide risk assessment, safety planning, and being available for between-session phone contact while setting limits and avoiding clinician burnout. DBT conceptualizations and interventions to minimize "splitting", especially within the context of a split treatment, will be taught and illustrated. There will be ample opportunity for discussion, practice, and role playing.

COURSE 11

MOOD DISORDERS IN LATER LIFE

Directors: James M. Ellison, M.D., M.P.H., Yusuf Sivrioglu, M.D.
Faculty: Joan M. Cook, Ph.D., Donald Davidoff, Ph.D., Brent Forester, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) appreciate the unique demographic, diagnostic, and clinical characteristics and needs of older adults affected by unipolar or bipolar mood disorders; 2) plan and implement an evidence-based approach to the diagnosis and somatic treatment of late life mood disorders; 3) plan and implement an evidence-based approach to the psychosocial treatment of late life mood disorders; and 4) describe and understand the complex inter-relationship between late life mood and cognitive disorders.

SUMMARY:

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

COURSE 12

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

Director: Abhilash Desai, M.D.
Faculty: George T. Grossberg, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe various genetic and non-genetic factors influencing healthy brain aging; 2) Discuss modifiable risk factors for Alzheimer's disease and related disorders; 3) Discuss protective factors for Alzheimer's disease and related disorders; and 4) Identify at least 3 simple and practical strategies to improve memory and brain function.
SUMMARY:
Research in the last few decades has greatly improved our understanding of various genetic and non-genetic factors (especially lifestyle and environment) that play a prominent role in age-associated decline in memory and other cognitive functions as well as in the pathogenesis of Alzheimer's disease and related disorders (especially vascular cognitive impairment). This course is designed for psychiatrists and allied healthcare professionals who want to enhance their knowledge about healthy brain aging and would like to provide evidence-informed prudent guidance for middle-aged and older adults to preserve and improve brain and memory function. The participants will learn about different trajectories of cognitive health in older adults. The participants will also learn about innovative community programs, web resources, and tools to promote brain and memory wellness in local communities and organizations.

COURSE 13
GOOD PSYCHIATRIC MANAGEMENT (GPM) FOR BORDERLINE PERSONALITY DISORDER (BPD): WHAT EVERY PSYCHIATRIST SHOULD KNOW
Directors: John Gunderson, M.D., Paul Links, M.D.
Faculty: Brian Palmer, M.D., M.P.H.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Explain the diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); 2) Manage the problem of recurrent suicidality and self-harm while limiting personal burden and liability; and 3) Expedite alliance-building via use of medications and homework.
SUMMARY:
The course will describe an empirically validated treatment approach, General Psychiatric management (GPM) (McMain et al., AJP, 2009). It emphasizes management strategies involving practicality, good sense, and flexibility. Listening, validation, judicious self-disclosures and admonishments create a positive relationship in which both a psychiatrists' concerns and limitations are explicit. Techniques and interventions that facilitate the patient's trust and willingness to become a proactive collaborator will be described. Guidelines for managing the common and usually most burdensome issues of managing suicidality and self-harm (e.g.intersession crises, threats as a call-for-help, excessive use of ER's or hospitals) will be reviewed. How and when psychiatrists can usefully integrate group, family, or other psychotherapies will be described.

COURSE 14
PRACTICAL ASSESSMENT AND TREATMENT OF BEHAVIOR DISTURBANCE FOR THOSE WITH MODERATE TO SEVERE DEMENTIA
Director: Maureen Nash, M.D.
Faculty: Sarah Foidel, O.T.R./L., Maria Shindler, M.S.N., R.N.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) After participating in this course, participants will have a working knowledge of how to assess and differentiate between varying types of dementia and delirium.; 2) After participating in this course, participants will be able to list common causes of delirium in the elderly and identify high risk factors, causes, and prevention strategies.; 3) After this course, participants understand the current literature and practical applications of current pharmacological and non-pharmacological interventions for people with dementia and behaviors.; 4) After participating in this course, participants will be able to discuss evidence based treatment for effective symptom management in common types of dementia.; and 5) After participating in this workshop, participants will be able to recognize and encourage use of appropriate interventions to improve quality of life in people with dementia.
SUMMARY:
Preventing and treating moderate to severe behavior disturbance in those with dementia is one of the most challenging problems in geriatric psychiatric clinical practice. The regulatory environment and concerns about the risks of treatment are in the press and on the minds of clinicians and the general public. Successful treatment requires a wholistic view of assessment, symptom interpretation and knowledge of the evidence base. This course is designed for psychiatrists, primary care providers and advanced practice nurses who desire to learn about how to assess and manage behavioral disturbances in those who have dementia. The course will thoroughly review assessment, nonpharmacological management, pharmacological strategies and discussion of quality of life issues. Management for both inpatient and outpatient situations will be covered; however, emphasis will be on the most difficult situations-typically those who are referred to Emergency Departments or are inpatients on adult or geriatric psychiatric units. The first half will be an overview of behavior disturbance and how to measure it and determining the proper diagnosis. Determining the type of dementia and detecting delirium is emphasized for proper management. There will also be a subsection reviewing delirium as it relates to behavior disturbance in those with dementia. Next there will be discussions of practical nonpharmacological interventions and in-depth discussion of the pharmacological management of behavioral disturbances in dementia. Current controversies and the regulatory enviornment in long term care will be discussed. 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 throughout and is an integral part of the learning process.

COURSE 15
SLEEP MEDICINE - A REVIEW AND UPDATE FOR PSYCHIATRISTS
Directors: Thomas D. Hurwitz, M.D., Imran S. Khawaja, M.B.B.S.
Faculty: Max Hirshkowitz, Ph.D., R. Robert Auger, M.D., Elliott Lee, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the major sleep disorders that can affect pa-

tient in their practices; 2) Determine which patients should be referred to a board certified sleep physician.; 3) Help patients with obstructive sleep apnea pursue therapy.; 4) Determine if patients experience excessive daytime sleepiness, and; 5) Facilitate use of CBT principles to treat insomnia.

SUMMARY:

This course will present an overview of basic topics in sleep medicine addressed to psychiatrists engaged in clinical practice. It will be introduced by a discussion of CNS regulation of sleep and wakefulness, and the polysomnographic features of sleep stages relevant to subsequent presentations of sleep disorders. Each presentation will begin with a clinical case vignette leading to information about evaluation, diagnosis, relevant genetics, pathophysiology, and therapy. Topics to be addressed include insomnia, restless legs syndrome, hypersomnias including narcolepsy and idiopathic hypersomnia, breathing-related sleep disorders, circadian rhythm sleep disorders, parasomnias, and a final presentation on comorbidity of selected psychiatric illnesses and sleep disorders.

COURSE 16

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

Directors: Lori Raney, M.D., Anna Ratzliff, M.D., Ph.D.
Faculty: Jurgen Unutzer, M.D., M.P.H., Lori Raney, M.D., Anna Ratzliff, M.D., Ph.D., John Kern, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Make the case for integrated behavioral health services in primary care, including the evidence for collaborative care; 2) Describe the roles for a primary care consulting psychiatrist in an integrated care team; 3) Describe rationale for providing primary care services in the mental health setting.; and 4) Discuss program structure requirements to successfully deliver primary care services in the mental health setting.

SUMMARY:

This course is designed to introduce the role of a psychiatrist functioning as part of an integrated care team. The first part of the course describes the delivery of mental health care in primary care settings and includes the evidence base and guiding principles. The second part is devoted to reviewing approaches to providing primary care in mental health settings and the emerging models in this area. The material includes a discussion of both the evidence base for this work and the practical "nuts and bolts" for care delivery. Examples in diverse locations, emphasis on team building and psychiatric leadership will be an integral part of the course. Liability concerns in these settings will also be discussed.

Four speakers including Jurgen Unutzer, MD and Anna Ratzliff, MD, PhD from the University of Washington, Department of Psychiatry, Lori Raney, MD, Chair APA Workgroup on Integrated Care and John Kern, MD, Chief Medical Officer, Regional Mental Health will present didactic material and allow ample time for questions and discussion.

COURSE 17

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

Director: José R. Maldonado, M.D.
Faculty: Yelizaveta Sher, M.D., José R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatric masquerades are medical and/or neurological conditions which present primarily with psychiatric or behavioral symptoms. The conditions included in this category range from metabolic disorders (e.g. Wilson's disease and prophyria), 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 18

ESSENTIALS OF ASSESSING AND TREATING ADHD IN ADULTS AND CHILDREN

Director: Thomas E. Brown, Ph.D.
Faculty: Anthony Rostain, M.A., M.D.

EDUCATIONAL OBJECTIVE:

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) Understand an updated model of ADHD as developmental impairment of executive functions; 3) Assess and diagnose adults or children for ADHD using appropriate instruments and methods; 4) Select appropriate medications for treatment of ADHD and comorbid disorders; and 5) Design multi-modal treatment for adults or children with ADHD.

SUMMARY:

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

ventions into a multimodal treatment plan tailored for specific adults and/or children or adolescents with ADHD.

MAY 05, 2014

COURSE 19
CAN'T WORK OR WON'T WORK? PSYCHIATRIC DISABILITY EVALUATIONS
Director: Liza Gold, M.D.

Faculty: Marilyn Price, M.D., C.M., Donna Vanderpool, J.D., M.B.A.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the relevant clinical and nonclinical factors in assessing disability; 2) More effectively treat patients who present with disability issues, including requests for documentation; 3) Recognize the differences between and requirements of various types of disability evaluations; and 4) Understand the risk management issues of providing disability evaluations both as an independent evaluator and as a treating clinician .
SUMMARY:
Faculty will review the complex relationship between psychiatric impairment and work disability in competitive employment contexts utilizing case examples and interactive discussion. Legal or administrative disability decisions may depend on psychiatric opinions and may have profound implications for an evaluee's psychological, social, financial, and employment status. Additional treatment and risk management issues arise when patients ask treating psychiatrists for disability documentation, and these will also be reviewed. Comprehensive disability evaluations should consider personal, social, economic, and workplace factors or circumstances that may influence a disability claim or status. We will present a "work capacity" model that facilitates the development of case formulations that can assist clinicians in answering some of the frequently asked questions in disability evaluations. Faculty will review and discuss the differences and requirements of the various disability evaluations, including Social Security Disability Insurance, Workers Compensation, and private insurer's long-term disability. Finally, we will discuss and review relevant ethical issues, including those that arise when psychiatrists provide disability evaluations and documentation for their own patients, HIPAA issues, legal liability in the provision of disability evaluations, and risk management of these important practical aspects of disability evaluations.

COURSE 20
EXPLORING TECHNOLOGIES IN PSYCHIATRY
Directors: Robert Kennedy, M.D., John Luo, M.D.
Faculty: Carlyle Chan, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review the various current and emerging technologies and connections that are possible in psychiatry and medicine.; 2) Evaluate the emerging technologies and how they impact clinical practice today and tomorrow.; and 3) Recognize the pros and cons of electronic physician/patient communication.
SUMMARY:
Managing information and technology has become a critical component of the practice of psychiatry and medicine. Finding ways to make technology work both as a means of communication and as a way of keeping up-to-date on current changes in the field is an important goal. The process of being connected means developing a new understanding about what technology can best facilitate the various levels of communication that are important. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system to visit a remote patient, participating in a social network about a career resource, using a smartphone or tablet to connect
via email, obtaining critical drug information at the point of care, or evaluating the impact of various treatments in healthcare management, there are many ways and reasons to connect. The movement toward digitizing healthcare information is making the numerous apps and mobile devices a great way to integrate and streamline all aspects of the medical process for enhanced care.
This course will explore many of the ways that clinicians can use technology to manage and improve their practice, 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. Clinicians increasingly rely on digital and Internet-based tools to improve the medical outcomes of the care they provide. The goal of this course is to explore the most current technologies and how they can assist the busy clinician in managing the rapidly changing world of communication and information. It will explore the evolving role of tablets and smartphones and how these leading edge technologies have changed our relationship to information and their widespread adoption by psychiatrists and healthcare professionals. It will also describe the evolution of mobile and cloud technology. A review of social media, new trends and how physicians can manage their online identity in the changing online world is critical. Other topics include teleconferencing, educational technologies and resources for lifelong learning, electronic medial 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, practice trends and technologies that will impact the profession over the next decade.

COURSE 21
THE DSM-5 CULTURAL FORMULATION INTERVIEW (CFI) ILLUSTRATED: VIDEOTAPED CASE VIGNETTES THAT SHOW THE CFI'S USE IN CULTURALLY APPROPRIATE ASSESSMENT
Director: Russell F. Lim, M.D., M.Ed.
Faculty: Francis Lu, M.D., Roberto Lewis-Fernandez, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Use the 16 questions of the cultural formulation interview to conduct a culturally appropriate assessment.; 2) Be familiar with the use of the 12 supplementary modules when appropriate such as cultural identity, explanatory models, age related issues, religion, the clinician-patient relationship, etc.; and 3) Be able to formulate a case using the DSM-5 Outline for Cultural Formulation.
SUMMARY:
DSM-5 advances the evolution of the practice of Cultural Psychiatry with the Cultural Formulation Interview (CFI). Based on the Outline for Cultural Formulation, it is a 16-question interview, with 12 supplementary modules (Explanatory Model, Level of Functioning, Psychosocial Stressors, Social Network,

Cultural Identity, Spirituality, Religion, and Moral Traditions, Coping and Help-Seeking, Patient-Clinician Relationship, Immigrants and Refugees, School-Age Children and Adolescents, Older Adults, and Caregivers) and an Informant Module. The course will highlight the most useful of the 16 questions, broken down into four sections, 1) Cultural Definition of the Problem (1-3); 2) Perceptions of Cause, Context, and Support (4-10); 3) Cultural Factors Affecting Self-Coping and Past Help Seeking (11-13); and 4) Cultural Factors Affecting Current Help Seeking (14-16). The clinician wanting to perform a culturally appropriate assessment now has sample questions to use to collect the clinical data for the OCF.

The course will introduce the DSM-5 Outline for Cultural Formulation, discuss the development of the Cultural Formulation Interview (CFI), and go through the 16 questions of the CFI, and lecture material will provide suggestions on how to elicit information for the OCF using the CFI and videotaped case vignettes will demonstrate the use of the questions to illustrate key themes to explore. There will be discussion time for the discussion of the video vignettes, and use of the supplementary modules. Participants will be able to identify and use questions from the CFI and supplementary modules to perform a culturally appropriate assessment and complete a cultural formulation on any patient.

COURSE 22

TRANSFERENCE-FOCUSED PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER: DESCRIBING, OBSERVING, AND DISCUSSING THEORY AND TECHNIQUE

Directors: Frank E. Yeomans, M.D., Ph.D., Otto F. Kernberg, M.D.
Faculty: John F. Clarkin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and appreciate the central role of an individual's internal concept of self and others in personality and in personality disorders; 2) Understand the need to appropriately structure therapy with borderline patients in order to decrease acting out and direct emotions into the treatment; and 3) Utilize interpretation to help the patient become aware of and gain mastery of aspects of the self that were previously denied and acted out.;

SUMMARY:

This course will describe and demonstrate Transference-Focused Psychotherapy (TFP), an evidence-based psychotherapy for Borderline Personality Disorder described in our 2006 book published by APPI. The course will begin by explaining an understanding of personality and personality disorders based on an individual's identity in terms of internal representations of self and others. This view is consistent with developments in the field as represented in the new conceptualization of personality disorders considered in the DSM 5. After discussing this view of personality disorders, the course will go on to describe the strategies, tactics, and techniques used in TFP to address and treat the symptoms of BPD and the underlying core sense of self. Addressing identity issues as well as symptoms helps the individual advance to fuller satisfaction of life goals in terms of work and love. The course will follow the model of and refer to our APPI book and will present video segments of demonstration sessions that we have created to accompany the new version of our treatment manual that is scheduled to be published in 2014.

COURSE 23

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

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the evidence base linking meaning factors and medication response; 2) Construct an integrated biopsychosocial treatment frame; 3) Diagnose common psychodynamics underlying pharmacologic treatment resistance; 4) Use psychodynamic interventions in pharmacotherapy to ameliorate psychodynamic contributors to medication issues; and 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 ignored, and psychiatrists have neglected some of our most potent tools for working with 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 objective-descriptive 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, medications, and outcomes, and will review psychodynamic concepts relevant to the practice of psychopharmacology. Then, exploring 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 vital 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.

COURSE 24

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

Directors: Patricia L. Gerbarg, M.D., Richard P. Brown, M.D.
Faculty: Martin A. Katzman, M.D., Fredlee A. Kaplan, M.S.W., Beth P. Abrams, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how Heart Rate Variability and, sympatho-vagal balance contribute to overall well-being and stress-resilience; 2) Discuss the vagal-GABA theory of inhibition and its potential relevance to treatment of stress, anxiety, and trauma-related

disorders; 3) Experience Coherent Breathing for stress reduction and learn how Voluntarily Regulated Breathing Practices (VRPs) can be used to reduce anxiety, insomnia, depression, and symptoms of PTSD; 4) Experience Open Focus attentional training for stress reduction, improved attention, and relief of physical and psychological distress, for clinicians and their patients; and 5) Develop a program of further learning about breath and meditative practices that are accessible and that will improve clinical outcomes in psychiatric practice.

SUMMARY:

Participants will learn the neurophysiology and clinical applications of powerful self-regulation strategies to improve their own well-being and the mental health of their patients. Through a program of non-religious practices, participants will experience Voluntarily Regulated Breathing Practices (VRBPs), including Coherent Breathing, Breath Moving, "Ha" Breath, 4-4-6-2 Breath with Movement, and healing sounds. They will also experience Open Focus attention training and meditation. Through repeated rounds of breathing and meditation with gentle movements and interactive processes, attendees will discover physical and psychological benefits of mind/body practices. How to build upon this knowledge and use it in clinical practice will be discussed.

Studies of the use of these mind-body practices in the treatment of anxiety, Generalized Anxiety Disorder, depression, post-mass disaster PTSD, chronic treatment resistant PTSD in military veterans, schizophrenia, healthcare providers, pain, and stress-related medical conditions such as Inflammatory Bowel Disease will be reviewed. The development of a program providing relief of pain and distress in children in a post-surgical pediatric unit in a hospital in El Salvador will be presented. Adaptation of mind/body programs for disaster relief will be discussed in relation to the survivors of mass trauma, including military veterans, Southeast Asian tsunami, September 11th World Trade Center attacks, the 2010 earthquake in Haiti, the Gulf Horizon oil spill, and liberated slaves in Sudan.

Cases of patients with post-traumatic stress disorder, including disconnection syndrome will be explored from the perspective of neuroscience, polyvagal theory, vagal-GABA theory of inhibition, and neuro-endocrine (HPA axis and oxytocin) response. Clinical issues, risks, benefits, timing, and patient selection, when introducing mind/body practices into treatment, will be highlighted.

This course is suitable for novices as well as experienced practitioners.

COURSE 25

AUTISM SPECTRUM DISORDERS: GENETIC RESEARCH AND TREATMENT REVIEW

Director: Alice R. Mao, M.D.

Faculty: Matthew N. Brams, M.D., James Sutcliffe, Ph.D., Stephanie Hamarman, M.D., Jennifer Yen, M.D., Julie Chilton, M.D., Oscar Bukstein, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will receive updates ongenetics, and psychopharmacology research, diagnostic procedures and educational/psychotherapeutic and behavioral interventions ; 2) This autism institute will help the clinician to integrate psychopharmacologic, behavioral and educational intereventions for individuals with ASD through the lifespan; and 3) Develop an appropriate multi-modal treatment plan encompassing emotional and educational support for the parents and caregivers, appropriate diagnosis, and clinical implications of recent research advances in ASD.

SUMMARY:

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

The purpose of this course is to provide a review of advances in genetic and behavioral/educational interventions and pharmacological interventions for children with autism. Increased awareness of the multiple domains that diagnosis and treatment can encompass will help the child and adolescent psychiatrist to develop a realistic plan for helping their patient with ASD to achieve optimum functioning and adaptive life skills.

Obstacles to achieving appropriate care because of parental denial, lack of information and limited financial resources will be identified. The importance of providing support to the parents or caretakers of children with autism in order to help them navigate through often conflicting and confusing treatment recommendations will be discussed. This autism course will review clinical translational research and then help the clinician to integrate psychopharmacologic, behavioral and educational interventions for individuals with ASD through the lifespan. Genetic research will be reviewed in order to provide hypothesis for etiology of the specific cognitive, motor, behavioral and learning deficits seen in children with autism spectrum disorders. This will be followed by practical clinical information to assist the clinician to work collaboratively with parents to develop a comprehensive treatment plan encompassing diagnostic, pharmacologic, behavioral and social interventions.

COURSE 26

TEACHING PSYCHOTHERAPY? LET HOLLYWOOD (& CABLE TV) HELP!

Directors: Steven E. Hyler, M.D., Prameet Singh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how to use selected film and TV clips as adjunctive aides to teach psychiatry residents and medical students about psychotherapy.; 2) Learn how to find an appropriate film or TV

clip to illustrate just about any aspect of the therapy process.; and 3) View scenes from multiple vantage points and consider therapeutic technique, psychopathology, diagnostic issues, controversies, as well as popular cultural issues.

SUMMARY:

The basis of psychodynamic psychotherapy begins with "Freud" the 1962 film, directed by John Huston and starring Montgomery Clift as Freud that presents an excellent starting point for teaching about the discovery of the unconscious, the development of analytic technique, the importance of dreams, the Oedipal conflict, as well as an exploration of transference and counter-transference issues. Robert Redford's 1980 film, "Ordinary People" portrays the problems faced in dealing with a traumatized, depressed and suicidal patient. Recent cable TV shows, "The Sopranos" and "In Treatment" contain a wealth of material that can be used in teaching about various aspects of therapy including: initiation of therapy, adjunctive use of medications, involvement of family members, missed sessions, payment for therapy, erotic transference and many more. The course will include brief clips of selected scenes from movie/TV and allow ample participation for discussion from the participants.

COURSE 27

EVALUATION AND TREATMENT OF SEXUAL DYSFUNCTIONS

Director: Waguih W. IsHak, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Updated for the DSM-5, this course is designed to meet the needs of psychiatrists who are interested in acquiring current knowledge about the evaluation and treatment of sexual dysfunctions in everyday psychiatric practice. The participants will acquire knowledge and skills in taking an adequate sexual history and diagnostic formulation. The epidemiology, diagnostic criteria, and treatment of different sexual dysfunctions will be presented including the impact of current psychiatric and non psychiatric medications on sexual functioning. Treatment of medication-induced sexual dysfunction (especially the management of SSRI-induced sexual dysfunction) as well as sexual dysfunction secondary to medical conditions will be presented. Treatment interventions for sexual dysfunctions will be discussed including psychotherapeutic and pharmacological treatments. Clinical application of presented material will be provided using real-world case examples brought by the presenter and participants. Methods of teaching will include lectures, clinical vignettes and group discussions.

COURSE 28

EMERGENCY PSYCHIATRY: TRIAGE, EVALUATION, AND INITIAL TREATMENT OF THE CRISIS PATIENT

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

Faculty: Jon S. Berlin, M.D., Seth Powsner, M.D., Scott L. Zeller, M.D., Leslie Zun, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the goals of emergency triage and medical assessment for the psychiatric patient; 2) Complete an emergency psychiatric evaluation; 3) Perform a comprehensive risk assessment; and 4) Manage and treat an agitated patient.

SUMMARY:

Emergency psychiatry, as a distinct practice, has existed since the mid-1950s and has grown exponentially with deinstitutionalization. Now there are many forms of services on and off of hospital campuses. Psychiatric emergencies may occur in office settings, inpatient settings, and emergency departments, as well as in the community. When they do occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes differentiating a clinical emergency from a social emergency.

This seminar can serve as a primer or as an update for psychiatrists in the evaluation and management of psychiatric emergencies. The course faculty offer decades of experience in emergency psychiatry. The participants will learn about the role of medical and psychiatric evaluations and the use of risk assessment of patients in crisis. The participants will also learn about the management of agitation as part of a psychiatric emergency. A combination of lectures and case discussion cover fundamental and pragmatic skills to identify, assess, triage, and manage a range of clinical crises.

COURSE 29

THE CLINICAL ASSESSMENT OF MALINGERED MENTAL ILLNESS

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

COURSE 30

MOTIVATIONAL INTERVIEWING FOR ROUTINE PSYCHIATRIC PRACTICE

Director: Steven Cole, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe 3 questions and 4 skills of Brief Action Planning (B.A.P.); 2) Explain how B.A.P. aligns with the "Spirit of Motivational Interviewing"; 3) Discuss the three levels and 13 separate skills of "Stepped Cate Advanced Skills for Action Planning (SAAP)" for patients with persistent unhealthy behaviors; 4) Use the 8 core competencies of BAP and 13 advanced skills of SAAP in routine psychiatric practice.; and 5) Gain skill to demonstrate/train BAP/SAAP for students, team members, and colleagues.

SUMMARY:
Motivational Interviewing (MI) is defined as a "collaborative, patient-centered form of guiding to elicit and strengthen motivation for change." There are over 15 books on MI, over 1000 publications and 200 clinical trials, 1500 trainers in 43 languages, and dozens of international, federal, state, and foundation research and dissemination grants. Four meta- analyses demonstrate effectiveness across multiple areas of behavior including substance abuse, smoking, obesity, and medication non-adherence as well as improved outcomes in physical illnesses, including mortality. MI has been shown to contribute to improved outcomes when combined with cognitive-behavioral or other psychotherapies. New data reinforces its relevance for psychiatrists: life-expectancy of patients with severe mental illness is 32 years less than age and sex-matched controls and the risk of death from cardiovascular disease is 2-3x higher in mental patients than controls. Despite this evidence and its compelling relevance, most psychiatrists have little appreciation of the principles and practice of MI. Using interactive lectures, high-definition annotated video demonstrations, and role-play, this course offers the opportunity to learn core concepts of MI and practice basic and advanced MI skills. The course introduces participants to an innovative motivational tool, "Brief Action Planning (BAP)," developed by the course director (who is a member of MINT: Motivational Interviewing Network of Trainers). Research on BAP was presented at the First International Conference on MI (2008) and the Institute of Psychiatric Services (2009). BAP has been published by the AMA, by the Patient-Centered Primary Care Collaborative, by Bates' Guide to the Physical Exam, and the Commonwealth Fund and disseminated by programs of the CDC, HRSA, the VA, the Indian Health Service, and the Robert Wood Johnson Foundation. Participants will learn how to utilize the 3 core questions and 5 associated skills of BAP in routine practice and in a manner consistent with the "Spirit of Motivational Interviewing." For those patients with persistent unhealthy behaviors, attendees will also have the opportunity to observe and practice 13 higher-order evidence-based interventions, described as "Stepped Care Advanced Skills for Action Planning" (SAAP). Though designed as an introductory course, the material will also be useful to practitioners with intermediate or advanced experience in MI (or other behavior change skills) because they will learn how to utilize BAP in routine care for improved clinical outcomes and/or for training others.

COURSE 31
UNDERSTANDING AND TREATING NARCISSISTIC PERSONALITY DISORDER (NPD) WITH AN OBJECT RELATIONS APPROACH -- TRANSFERENCE FOCUSED PSYCHOTHERAPY
Directors: Frank E. Yeomans, M.D., Ph.D., Otto F. Kernberg, M.D.
Faculty: Eve Caligor, M.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand and assess the range of narcissistic pathology ; 2) appreciate the defensive psychological function of the pathological grandiose self as the psychological structure that underlies narcissistic personality disorder; 3) utilize treatment techniques that address narcissistic resistances and help engage the patient in therapy; and 4) become familiar with treatment techniques that help patient and therapist enter into contact and work with the anxieties beneath the grandiose self.

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

MAY 06, 2014

COURSE 32
ECT PRACTICE UPDATE FOR THE GENERAL PSYCHIATRIST
Directors: Peter B. Rosenquist, M.D., Charles H. Kellner, M.D.
Faculty: Andrew Krystal, M.D., M.S., Donald Eknoyan, M.D.

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

SUMMARY:

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

COURSE 33
AN INTRODUCTION TO RADICALLY OPENâ€"DIALECTICAL BEHAVIOR THERAPY (RO-DBT) FOR DISORDERS OF OVER-CONTROL
Director: Thomas R. Lynch, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will be introduced to a new biosocial theory for overcontrol (OC) and new RO-DBT treatment strategies designed to enhance willingness for self-inquiry and flexible responding.; 2) Participants will be introduced to treatment targets oriented around five OC themes—emotion inhibition, behavioral avoidance, rigidity, aloof and distance, and envy/bitterness; 3) Participants will learn behavioral methods to up or down regulate a neuroregulatory deficit by activating an antagonistic area of the brain- e.g., ventral vagal social-safety complex (PNS-VVC); 4) Participants will be introduced to new approaches for engaging and maintaining OC client's in therapy, manage therapeutic alliance-ruptures; and 5) Participants will be introduced to new skills designed to enhance intimate relationships and vulnerable expression of emotion, learn from critical feedback, and enhance loving-kindness-forgiveness.
SUMMARY:
Self-control-inhibiting acting on urges, impulses, and desires-is highly valued in most societies, and failures in self-control characterize many of the personal and social problems afflicting modern civilization. However, too much self-control can be equally problematic. Overcontrol (OC) has been linked to social isolation, poor interpersonal functioning, hyper-perfectionism, rigidity, risk aversion, lack of emotional expression, and the development of severe and difficult-to-treat mental health problems, such as chronic depression, anorexia nervosa, and obsessive compulsive personality disorder. Based on 18 years of research, two NIMH funded randomized controlled trials with refractory depression (RCTs), one open-trial examining anorexia, a case-series study with anorexia, and an ongoing multi-center RCT in the UK (REFRAMED; funded by EME-MRC) the aim of this introductory workshop is to introduce clinicians to the theoretical foundations and new skills underlying a new adaptation of DBT for disorders of overcontrol â€"referred to as Radically Open-Dialectical Behavior Therapy(RO-DBT; treatment manual pending release; Guilford Press).

While resting on many of the core principles of standard DBT, the therapeutic strategies in RO-DBT are oftentimes fundamentally different. For example, RO-DBT contends emotional loneliness as the core problem for OC-not emotion dysregulation as in standard DBT. The biosocial theory of OC posits that heightened threat sensitivity and diminished reward sensitivity transact with early family experiences emphasizing «mistakes as intolerable» and «self-control as imperative» to result in an overcontrolled coping style that limits opportunities to learn new skills and exploit positive social reinforcers. A major component of this theory is that heightened threat sensitivity makes it more difficult for an individual with OC to enter into their neurologically based safety zone-a state associated with feeling content and socially engaged. RO-DBT posits a unique mechanism of therapeutic change by linking neuoregulatory theory and the communicative functions of emotional expression to the formation of close social bonds. This translates into novel skills focused on social-signaling and changing psychophysiological arousal-a key component differentiating RO-DBT from other treatments. New approaches designed to enhance social connectedness will be introduced-including skills designed to activate a neurobiologically-based social-safety-engagement system, signal cooperation, encourage genuine self-disclosure, break-down over-learned expressive inhibitory barriers, practice forgiveness and loving-kindness, and change unhelpful envy/bitterness using slides, handouts, video clips, and role plays.

COURSE 34
ADVANCED ASSESSMENT & TREATMENT OF ADHD
Director: Thomas E. Brown, Ph.D.
Faculty: Anthony Rostain, M.A., M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Explain implications of the new model of ADHD as developmental impairment of executive functions; 2) Describe research that supports this new new model of ADHD; 3) Utilize research based-criteria to select and fine-tune medications for ADHD, modifying as needed to address various comorbid disorders; 4) Design and monitor treatment for patients with ADHD that utilizes effectively integrated medication and psychosocial approaches; and 5) Consider strategies for effective treatment of patients with ADHD when these are complicated by other medical or psychosocial problems.
SUMMARY:
This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and have mastered basic concepts and skills for treatment of this disorder. It will discuss implications of the new model of ADHD as developmental impairment of executive function, highlighting research that supports this model and describing implications for assessment and treatment. A revised model of ADHD comorbidities will also be described. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by bipolar disorder, substance abuse, learning disorders, OCD, anxiety disorders or Autism Spectrum disorder. Discussion of case materials will illustrate ways in which ADHD can be complicated by psychiatric comorbidity and

by a diversity of interacting psychosocial factors,

COURSE 35
BUPRENORPHINE AND OFFICE-BASED TREATMENT OF OPIOID USE DISORDER
Directors: Petros Levounis, M.D., John A. Renner Jr., M.D.
Faculty: Andrew J. Saxon, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the rationale and need for opioid pharmacotherapy in the treatment of opioid use disorder and describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment; 2) Understand specific information on the legislative and regulatory history of office-based opioid pharmacotherapy; 3) Understand the pharmacological characteristics of opioids and identify common co-morbid conditions associated with opioid use disorder; 4) Understand treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain; and 5) Describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder.
SUMMARY:
Physicians who complete this course will be eligible to request a waiver to practice medication-assisted therapy with buprenorphine for the treatment of opioid use disorder.
The course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder and review:
• DSM-5 criteria for opiate use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of opiate use disorder,
• Confidentiality rules related to treatment of drug dependence, DEA requirements for recordkeeping, billing, and common office procedures,
• The epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, ADHD, and how to distinguish independent disorders from substance induced psychiatric disorders, and
• Common clinical events associated with addictive behavior.
Special treatment populations, including adolescents, geriatric patients, pregnant addicts, HIV positive patients, and chronic pain patients will be addressed and small-group case discussions will be used to reinforce learning.

COURSE 36
A PSYCHODYNAMIC APPROACH TO TREATMENT-RESISTANT MOOD DISORDERS: BREAKING THROUGH TREATMENT RESISTANCE BY FOCUSING ON COMORBID PERSONALITY DISORDERS
Director: Eric Plakun, M.D.
Faculty: Edward Shapiro, M.D., David Mintz, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe recent evidence that psychosocial factors play a role in the cause and effective treatment of treatment resistant mood disorders; 2) Explain the contribution to treatment resistance of personality disorders, including primitive defenses like splitting; 3) Define the practice of *psychodynamic psychopharmacology* and explain its role in effective treatment of treatment resistant mood disorders; 4) Utilize specific psychodynamic principles to improve outcomes in patients with treatment resistant mood disorders.
SUMMARY:
Although algorithms help psychiatrists select biological treatments for patients with treatment resistant mood disorders, the subset of patients with early adverse experiences and co-morbid personality disorders often fails to respond to medications alone. These treatments frequently become chronic crisis management, with high risk of suicide. This course describes a comprehensive approach to this subset of treatment resistant patients derived from a longitudinal study of patients in extended treatment at the Austen Riggs Center. The course offers an overview of psychoanalytic object relations theory to set the stage for understanding primitive defenses and their impact on treatment resistance. Ten psychodynamic principles extracted from study of successful treatments are presented and illustrated with case examples. These include listening beneath symptoms for therapeutic stories, putting unavailable affects into words, attending to transference-countertransference paradigms contributing to treatment resistance, and attending to the meaning of medications [an approach known as "psychodynamic psychopharmacology"]. This psychodynamic treatment approach guides interpretation in psychotherapy, but also guides adjunctive family work, helps integrate the psychopharmacologic approach and maximizes medication compliance. Ample opportunity will be offered for course participants to discuss their own cases, as well as the case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients.

COURSE 37
MINDFULNESS-BASED COGNITIVE THERAPY FOR DEPRESSION
Director: Stuart J. Eisendrath, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will learn the basic aspects of mindfulness meditation and its application to psychotherapeutic interventions for major depression; 2) Participants will learn about the theoretical and therapeutic differences between mindfulness-based cognitive therapy (MBCT) and traditional cognitive behavior therapy (CBT); 3) Participants will better understand existent research and literature supporting MBCT broadening therapeutic implications.; 4) Participants will learn about MBCT's contribution to the field of neuroscience and the understanding of depression through a brain network model; and 5) Participants will engage in experiential meditation exercises and learn how these techniques can be applied in psychotherapeutic settings.
SUMMARY:
Mindfulness-Based Cognitive Therapy (MBCT) is a relatively new form of psychotherapy that blends mindfulness meditation with elements of traditional cognitive behavioral therapy (CBT). The course will describe the initial development of MBCT as a preventive therapy against depression relapse. Several randomized controlled trials have demonstrated its effectiveness in reducing relapse with efficacy rivaling maintenance antidepressants. MBCT is appealing to patients as it promotes self-efficacy and emotion regulation. MBCT has also been extended as a therapy for active depression, particularly as an augmentation strategy for medication-resistant patients. Although its psychological mechanisms are not completely clear, MBCT appears

to reduce rumination, enhance self-compassion, decrease experiential avoidance, and increase mindfulness. In addition, because of studies demonstrating mindfulness meditation's effects on brain function, MBCT may have direct impact on neural pathways involved in depression. The course will examine the research literature supporting MBCT's broadening use and theoretical psychological and neural mechanisms.

As noted above this course will also have an experiential component, allowing participants to become directly familiar with several of the unique therapeutic features of MBCT. This interactive portion of the course will focus on meditation techniques and awareness training and their applications for helping depressed patients to gain "metacognitive awareness" and increased perspective on their thoughts, feelings and sensations.

MAY 05, 2014

PERSONALITY DISORDERS

Speaker: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) test their knowledge and in staying current regarding clinical and diagnostic aspects of personality disorders and their treatment; 2) answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from further study; 3) understand treatment strategies and evidence and relate multiple choice question based learning to their own patient care.

SUMMARY:
Personality disorders (PDs) have been identified in every edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). The PDs are moderately heritable conditions, comparably so to such disorders as major depression and schizophrenia. As is true in all of medicine, the combination of heritable risk and environmental stress can lead to the development of an illness, a formula that applies to the PDs as well as to other psychiatric disorders. The PDs generally have their onset in late adolescence or early adulthood, and it is often early life trauma or neglect that impairs the normal attachment process, thus interfering with the development of a healthy sense of self and of healthy and mutually rewarding interpersonal relationships. Personality research has increased exponentially, and new findings about personality, personality disorders, and Axis I/Axis II comorbidity have proliferated. One theme of this research has been a widely endorsed view that personality and personality disorders are best conceptualized dimensionally, rather than categorically.
In This FOCUS LIVE session an expert clinician will lead a lively multiple choice question-based discussion. Participants test their knowledge with an interactive Audience Response System, which instantly presents the audience responses as a histogram on the screen. Questions in this session will cover personality disorders and comorbidity, including diagnosis, treatment, and new developments.

POSTTRAUMATIC STRESS DISORDER

Speaker: Kerry Ressler, M.D., Ph.D.; BarbaraO. Rothbaum, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) test their knowledge and in staying current regarding clinical and diagnostic aspects of posttraumatic stress disorder (PTSD).; 2) increase their knowledge and help them identify areas where they might benefit from further study.; 3) understand treatment strategies and evidence and relate multiple choice question based learning to their general knowledge of the topic and to their own patient care .

SUMMARY:
This multiple choice question-and-answer presentation focuses on information that is important to practicing general psychiatrists, including epidemiology, screening and diagnosis of PTSD, psychotherapy and pharmacotherapeutic treatment approaches, comorbidity, Traumatic Brain Injury, and new developments in PTSD. The recent Institute of Medicine (IOM) report on PTSD estimates that as many as 520,000 service members from the conflicts in Afghanistan and Iraq, are expected to develop posttraumatic stress disorder (1). These military personnel combined with the civilian prevalence estimates of about 7%- 10% of the general population indicate that PTSD is a major public health concern. Comorbidity is the rule rather than the exception with PTSD, as the majority of individuals with PTSD have more than one comorbid disorder. It is usually the comorbid conditions that bring them to the attention of healthcare and mental healthcare professionals rather than the PTSD.
In FOCUS LIVE! sessions, expert clinicians lead lively multiple choice question-based discussions. Participants will test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen, allowing private comparison to other clinicians in the audience.

MAY 03, 2014

LEVERAGING PSYCHIATRIC EXPERTISE: INTEGRATED CARE AND HEALTH CARE REFORM

Chair: Lori Raney, M.D.

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

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

SUMMARY:
The integration of primary health and behavioral health has a robust evidence base and the dissemination and adoption of this practice has progressed rapidly. The idea that bringing together the diverse cultures of primary care and behavioral health to better treat mental illnesses in primary care and improve the health status of those with mental illnesses in public mental health settings both intrigues and excites professionals in both disciplines.
In primary care settings the development and implementation of the IMPACT and TEAMCare models have proven that collaborative care models, which introduce new members to the health care team: a consultant psychiatrist and a care manager, can improve outcomes in the treatment of mental illness, are cost effective and can reduce overall healthcare expenditures. In public mental health settings an emerging data base shows connecting our most vulnerable patients with serious mental illnesses to much needed resources in primary care can lead to effective treatment of chronic illnesses and reduce mortality associated with cardiovascular disease. Receiving these services can lead to a reduction in the 25 year mortality gap. The major stumbling blocks to the full scale dissemination of these models include the siloed funding for mental health and primary care dollars, same day billing of a primary care and behavioral health visits, carved out mental health funding, and lack of coding and reimbursement models to pay for the collaboration and consultative portions of care. Models of funding are currently being tested nation-wide, funded by innovation projects provided in the Affordable Care Act, legislated changes in state Medicaid reimburse structures, private foundations and other resources to bridge the gap to more sustainable funding is implemented. The value added to a healthcare system when psychiatric and behavioral health resources are included is well proven and healthcare teams held accountable for outcomes, cost containment and patient satisfaction (the "Triple Aim"), will seek our expertise to design systems of care to meet these goals. Psychiatrists need to be prepared for these changes to assist in well-informed and meaningful ways.
This Forum brings together a cadre of experts who have led this revolution and includes Wayne Katon, MD, a pioneer in collaboration with primary care and lead author of the TEAM-Care study, Jürgen Unützer, MD, lead author of the IMPACT study, Ben Druss, MD who tested the PCARE model and whose research involves improving the health and health status of persons with SMI, and Roger Kathol, MD, who studies funding mechanisms for collaborative care sustainability. A TED talk format will be used to focus the content and provide thought provoking questions from the presenters to encourage audience participation.

MAY 05, 2014

RACHMANINOFF AND HIS PSYCHIATRIST

Chair: Richard Kogan, M.D.

SUMMARY:
The great Russian composer/pianist Sergei Rachmaninoff (1873-1943) plunged into a severe depression after the disastrous world premiere of his First Symphony, with profound feelings of hopelessness and helplessness. After three years of complete creative paralysis, Rachmaninoff sought consultation with Dr. Nikolai Dahl, a Russian physician whose practice was devoted exclusively to the use of hypnosis in the treatment of psychiatric problems. Dr. Dahl employed a combination of psychotherapy and hypnotherapy which eventually cured Rachmaninoff of his writer's block. Rachmaninoff expressed his gratitude by dedicating his beloved Piano Concerto No. 2 to Dr. Dahl.
Concert pianist and psychiatrist Dr. Richard Kogan will perform musical examples that will illustrate the connection between the mind and music of Rachmninoff and demonstrate the transformative impact of Dr. Dahl's treatment. There will be an exploration of the course of Rachmaninoff's and Dr. Dahl's lives after they both fled Russia following the Bolshevik Revolution of 1917. There will also be an inquiry about possible medical conditions such as Marfan's syndrome and acromegaly which could account for Rachmaninoff's enormous hands.

FACING THE CHALLENGES OF TREATING PATIENTS WITH BORDERLINE PERSONALITY DISORDER: A DIALOGUE WITH THE FAMILY AND FRONTLINE CLINICIANS

Chairs: Barbara Stanley, Ph.D., Beatrice A. Tusiani, M.A., M.S.

Speakers: Beatrice A. Tusiani, M.A., M.S., Barbara Stanley, Ph.D., Kenneth R. Silk, M.D., Richard Hersh, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Effective strategies for managing medications with patients with borderline personality disorder; 2) The importance of key family members in working effectively with patients with borderline personality disorder and how to effectively engage with families; 3) Ways to communicate effectively with patients with BPD and their families about diagnostic, confidentiality, safety and treatment expectations. .

SUMMARY:
Treating patients with borderline personality disorder (BPD) is

one of the most challenging tasks clinicians face. The challenge of treating individuals with BPD is, in part, because (1) available psychotherapies and medications are only partially effective, (2) the genuine high risk nature of the disorder (e.g. suicidal behavior, impulsive risky behaviors, non-suicidal self injury, substance abuse), and (3) the difficult interpersonal nature of the disorder (i.e. stormy relationships, anger dyscontrol, emotional dysregulation, extreme sensitivity to rejection [perceived and real]) that is manifest in all relationships, including the doctor-patient relationship. It is not uncommon for patients with BPD to have angry outbursts towards their clinicians, complain to other clinicians about their psychiatrist, be noncompliant with treatment recommendations, and terminate treatment precipitously. BPD is a complex diagnosis that occurs in the context of many other diagnoses, e.g. Depression, substance abuse, eating disorders. Clinicians often focus on the other diagnoses, are often reluctant to make the BPD diagnosis and are even more reluctant to share the diagnosis with patients and family members. This forum will discuss how to work effectively with (rather than avoid or fear) patients with BPD and engage their family members as allies. The forum, shares the perspective of family members and clinicians experienced with BPD.

AASP FORUM: PREVENTION AS SOCIAL RESPONSIBILITY IN MENTAL HEALTH

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

Speakers: Carl Bell, M.D., Ruth Shim, M.D., M.P.H., Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Present the role of prevention in Psychiatry and Mental Health as important in public policy that addresses mental health disparities in diverse and vulnerable populations; 2) Identify examples of effective primary and secondary prevention in diverse and prevention in diverse and vulnerable populations; 3) Recognize the role of Psychiatry in the current debates on the role of prevention in healthcare reform.

SUMMARY:
As modern medicine progresses in the science of disease prevention, the use of vaccination, epidemiological surveillance, and risk-targeted interventions have become a greater portion of public health policy. Initial motivating factors have been prevention of widespread morbidity/ mortality (as in epidemics) and reduction of greater health costs (as in healthcare reform plans). Increasingly, health promotion and prevention are seen as important social policy to address health disparities and the impact of disabilities and adverse social outcomes in at risk populations. This year's AASP Forum will focus on prevention and its role in psychiatry and social psychiatry. Carl C. Bell, M.D., winner of the 2014 AASP Abraham Halpern Humanitarian Award for his work in advocacy and prevention, will present on his work on prevention of fetal alcohol and its adverse impact on youth, particularly their risk of entry into the child welfare and juvenile justice systems. Dilip Jeste, M.D., APA Past President, will focus on cognitive and mental health prevention with older adults. Ruth Shim, M.D., MPH will focus on early identification of depression amongst minorities. Andres J Pumariega, M.D., AASP President, will focus on mental health identification and level of care determination as secondary prevention for youth in juvenile justice. These presentations support a greater role for psychiatry in public health policy for the US if we are to [prevent mental health disparities and significant mental health risk in vulnerable populations.

WPA EDUCATION AND LEADERSHIP : OPPORTUNITIES AND CHALLENGES

Chairs: Pedro Ruiz, M.D., Dinesh Bhugra, M.D., Ph.D.

Speakers: Michelle Riba, M.D., M.S., Edgard J. Belfort, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) recognize opportunities for leadership in the WPA; 2) review of educational challenges and opportunities in working with colleagues in other countries; 3) opportunities for publications in international journals and books will be reviewed.

SUMMARY:
This forum will provide an opportunity for members of the World Psychiatric Association (WPA) leadership to discuss the opportunities and challenges in programs and projects related to education and leadership. All of the speakers hold positions on the WPA Executive Committee and will discuss various activities, needs, and future directions in which mental health professionals from throughout the world can help form and shape. Such topics as leadership training programs in the WPA; leadership opportunities for young psychiatrists; ideas for publishing in international journals and books; and mentorship and training with international colleagues are all topics that will be addressed by the speakers.

MAY 06, 2014

NEW MODELS FOR CONSULTATION-LIAISON PSYCHIATRY IN THE ERA OF HEALTH CARE REFORM: THE EMBEDDED PSYCHIATRISTS

Chairs: Philip R. Muskin, M.A., M.D., Anne Skomorowsky, M.D.

Speakers: Elena Friedman, M.D., Laura Kent, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand the principles of the â€œliaisonâ€ psychiatrist in comparison to the dedicated or embedded psychiatrist; 2) learn about the core issues that the embedded psychiatrist encounters in working with a medical team; 3) learn models for investigating the healthcare financing of an embedded psychiatrist.

SUMMARY:
The era of health care reform requires a change in consultation-liaison focus in the general hospital. A consultation-based model has predominated since the 1980's. If a patient admitted to the general hospital presents with significant psychiatric complaints, the primary team requests a consultation. It may be the case that by the time a psychiatrist has been called, the

psychiatric or behavioral situation has become emergent. Many patients who might benefit from psychiatric intervention never receive services, as their needs may not be as manifest. With health care reform, hospitals must provide the highest quality care while reigning in costs, decreasing length of stay, preventing readmissions. We have found that what was once called the "Liaison" model is most compatible with these goals. In the Liaison model, the psychiatrist is a member of the medical team-to use a military metaphor, he or she is "embedded" in the primary team. This model was weakened because the psychiatrist was unable to recoup salary expenditures through billing. Today, we recognize that while the psychiatrist provides service to the patient, she also services the team's physicians and the hospital. A philanthropist who had an interest in the psychiatric care of the medically ill initiated our program. Evaluation by the psychiatrist took place on hospital day, as opposed to the a delay of 6-7 days into the hospitalization for the traditional consultation service. More importantly, through daily walk-rounds with the medical team, the psychiatrist was able to evaluate over 1000 patients in the first two years of the program. The majority of these patients would not have seen a psychiatrist prior to the initiation of the program. Due to the program's success, the Department of Medicine analyzed the length of stay data for the program compared to similarly diagnosed patients seen historically. A decrease stay of approximately 1.3 days was found for the patients seen as part of the program. Medicine then approached hospital administration for funding to expand services and provide a similar program at another site. We present the perspectives of each psychiatrist involved in our program; each different role has brought its own challenges and found its own niche.

MAY 07, 2014

NEW TREATMENTS FOR MENTAL DISORDERS: FOCUS ON SCHIZOPHRENIA AND OCD

Chairs: Jeffrey A. Lieberman, M.D., Zafar Sharif, M.D.

Speakers: Zafar Sharif, M.D., Carolyn Rodriguez, M.D., Ph.D., Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Inform audience of novel treatments for schizophrenia and OCD ; 2) Learn about the proposed mechanisms for new treatment targets in Obsessive-Compulsive Disorder; 3) Discuss effectiveness of 30 hybrid cognitive remediation sessions compared to active control in improving cognition, and functional capacity in patients with schizophrenia or schizoaffective disorder; 4) stabalized on lurasidone.

SUMMARY:
This session will present new as yet unpublished results of studies of novel treatments for schizophrenia and OCD. Neurocognitive deficits in patients with schizophrenia are a primary determinant of poor functional outcome and generally respond poorly, if at all, to antipsychotic treatment. In fact, anticholinergic, antihistaminergic, and motor side effects of these drugs may further impair cognitive functioning. Recently there has been substantial interest in the potential for cognitive remediation in improving cognition and functional capacity in this population. Previous research has shown that efficient auditory processing is crucial for the successful encoding and retrieval of verbal information and that disturbance in these elemental processes is related to higher-order cognitive dysfunction in schizophrenia. Dr. Sharif will present a study conducted to evaluate the effectiveness of 30 hybrid cognitive remediation sessions compared to active control in improving cognition, and functional capacity in patients with schizophrenia or schizoaffective disorder who are stabilized on lurasidone. Ketamine, an nmda (n-methyl d-aspartate) receptor antagonist, has previously been shown to rapidly decrease obsessive thoughts in unmedicated adults with obsessive-compulsive disorder (ocd). The mechanism of ketamine in ocd is unknown. The authors examined the effects of ketamine versus saline infusions on gaba and glutamate+glutamine (glx) levels in the medial prefrontal cortex (mpfc) in OCD using proton magnetic resonance spectroscopy (1h mrs). In the study presented by Dr. Rodriquez unmedicated adults (n=17) with OCD received two intravenous infusions at least 1 week apart: one infusion of saline and one infusion of ketamine (0.5mg/kg), each delivered over 40 minutes while lying supine in a 3.0 t ge mr scanner. Resonances of gaba and glx were measured in the mpfc in six sequential 13-minute acquisitions before, during, and following each infusion. Baseline plasma gaba levels were collected. OCD severity was assessed at baseline and 1 week post-infusion with Yale-Brown obsessive-compulsive scale (ybocs).

INTERACTIVE SESSIONS

MAY 03, 2014

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER MENTAL HEALTH IN 2014

Chair: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

"Lesbian, Gay, Bisexual, and Transgender (LGBT) Mental Health in 2014" aims to engage the general psychiatrist in an open discussion on current mental health topics that affect LGBT communities and LGBT affirmative treatment. This interactive session will address coming out, heterosexist attitudes, the "don't ask, don't tell" mentality, legal issues, gay parenting, and sexual identity in patient-therapist relationships. We will also discuss case studies with different DSM-5 diagnoses, illuminating the impact of LGBT identity and illustrating a way of working with each presented patient. While "LGBT Mental Health in 2014" is a useful general discussion for the clinician new to treating LGBT patients, it also hopes to provide new insights for psychiatrists, residents, medical students, and other mental health clinicians who are already familiar with working with LGBT communities.

GOOD PSYCHIATRIC MANAGEMENT (GPM)

Chairs: John Gunderson, M.D., Paul Links, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) disclose the BPD diagnosis and discuss it's clinical implications; 2) manage suicidal or self-harm threats with reduced stress and without liability fears; 3) recognize how adverse interpersonal events predict self-harm, dissociation, depressive, angry, or anxious episodes, and relapse.

SUMMARY:

The authors Drs. John Gunderson and Paul Links have written a book, the Handbook of Good Case Management for Borderline Personality Disorder, that operationalizes the basic principles of effective treatment for these patients. The treatment, entitled Good Psychiatric Management (GPM), is intended to teach the basics about treatment that all professionals should know. Knowing these basics will be sufficient to help the majority of their borderline patients achieve lasting remission. GPM begins with open disclosure of the BPD diagnosis and with a psychoeducational discussion of what the diagnosis means in terms of its etiology, identifying its roughly 55% heritability, and of its expected course. Education about BPD's course includes description of the encouraging frequency and duration of remissions as well as the discouragingly common failure to achieve successful work and partnerships. These discussions facilitate the development of an alliance with patients and families by diminishing patterns of mutual blaming, by establishing a realistic optimism about the future, and by identifying an appropriate treatment approach. GPM emphasizes the patients' role in determining their success in therapy and in life. They are expected to work between sessions on the issues being discussed, and to help monitor whether progress is being made. Treaters help patients become aware of how their symptoms result from adverse interpersonal events. They focus on life outside therapy, encourage vocational initiatives, and they use medications, family interventions and groups as needed. This approach has had substantial empirical validation from a multi-site Canadian study in which it performed as well as a more intensive high quality DBT (McMain et al. AJP 2009). Most borderline patients will respond to the GPM approach with substantial life-changing improvements.

In this session the authors will discuss the clinical experiences that shaped this approach, including the common mistakes that they learned from. They will also discuss the development of the Handbook; how it began with an informal manual, and became elaborated by the addition of interactive case vignettes and videotapes. Finally, they will discuss how they are working to establish GPM as the standard model of treatment for BPD by all non-experts clinicians.

OVERLAPPING NEURONAL CIRCUITS IN ADDICTION AND OBESITY

Chair: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how drugs of abuse, food, and other natural rewards affect an organism's reward system; 2) Describe the common neural circuitry underlying addiction and obesity; 3) Appreciate the need for employing a multipronged approach in treating addiction and obesity.

SUMMARY:

Drugs and food exert their reinforcing effects in part by increasing dopamine in limbic regions, which has generated interest in understanding how drug abuse/addiction relates to obesity. Both in abuse/addiction and in obesity there is an enhanced value of one type of reinforcer (drugs and food respectively) at the expense of other reinforcers, which is a consequence of conditioned learning and resetting of reward thresholds secondary to repeated stimulation by drugs (abuse/addiction) and by large quantities of palatable food (obesity) in vulnerable individuals. In this model, exposure to the reinforcer or to conditioned-cues (processed by the memory circuit) results in overactivation of the reward and motivation circuits and inhibition of the cognitive control circuit resulting in an inability to inhibit the drive to consume the drug or food. These neuronal circuits, which are modulated by dopamine, interact with one another so that disruption in one circuit can be buffered by another, which highlights the need of multiprong approaches in the treatment of addiction and obesity.

MAY 04, 2014

RECENT ADVANCES IN ANTIDEPRESSANT TREATMENT

Chair: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand current status of new antidepressants under development; 2) Discuss development of ketamine and other glutamatergic agents; 3) Understand the importance of cogni-

tion in treatment selection.

SUMMARY:

This interactive session will focus on antidepressant treatment. First we will poll the participants informally re issues to be discussed. For example, the audience can raise clinical problems they have encountered in treating patients with major depression; ask re the presenter's views re specific treatments or combinations; queery re new developments; etc. This will be followed by a brief presentation of data from recent studies on several new antidepressants e.g., ketamine, vortioxetine, etioxetine, r-modafinil, etc. as well as a short review of new data on pharmacogenetic predictors of response. After the presentation, there will be Q and A regarding the talk and the speaker will also address as many of the issues raised in the informal polling as possible. The session is highly interactive and aims at providing participants with new information on antidepressants and to address commonly observed problems encountered in treatment.

INTEGRATED CARE MODELS: THE DEVELOPMENT OF COLLABORATIVE CARE

Chair: Wayne J. Katon, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1)Understand the gaps in quality of depression care in primary care systems; 2) Understand how comorbid depression adversely effects outcomes of chronic medical illness; 3) Understand the key components of collaborative care models.

SUMMARY:

Dr Katon will provide an interactive session describing the gaps in quality of mental health care in primary care settings as well as the prevalence of depression and adverse impact of this affective illness on chronic medical illnesses. He will describe the development and dissemination of collaborative care models and his recently developed TEAMcare model that has been shown to improve the quality of care and psychiatric and medical outcomes of patients with comorbid depression and poorly controlled diabetes and or heart disease. He will describe his current work on national studies to widely disseminate these models of care.

A NEW DSM-5 "ALTERNATIVE MODEL" FOR THE PERSONALITY DISORDERS

Chairs: John M. Oldham, M.D., Andrew Skodol, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss dimensional vs. categorical models for the personality disorders; 2) Discuss biological and genetic factors in borderline personality disorder; 3) Review patterns of treatment for borderline personality disorder; 4) Understand the Alternative Model for Personality Disorders of DSM-5.

SUMMARY:

You will learn the most recent findings about the prevalence of personality disorders, their causes, and how to identify and treat patients with these disorders. There will be special emphasis on borderline personality disorder, the personality disorder most frequently encountered in mental health treatment settings. The American Psychiatric Association practice guideline for the treatment of patients with borderline personality disorder will be described, indicating that there are effective, evidence-based treatments for patients with this challenging, disabling, and often misunderstood condition. In addition, a new Alternative Model for Personality Disorders, recently published in Section III of DSM-5, will be described.

HOW I BECAME ME

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role that psychodynamic psychiatry plays in career choices; 2) Identify crucial choice points in developing a career plan; 3) Recognize how childhood issues shape adult choices.

SUMMARY:

In this interactive session for residents, the focus will be on how I developed into the kind of psychiatrist I became. Included in the discussion will be how one keeps psychodynamic thinking alive in an era where third party payers and cultural influences want quick, reductive answers to complex clinical problems. Throughout the presentation, I will illustrate instances in my own professional career that were influential in making key choices about how I wished to spend my daily existence as a psychiatrist. I will also help the residents think about their own choices and the capacity to re-think decisions as they go forward.

GRIEF, BEREAVEMENT, AND DEPRESSION: SORTING OUT THE DIAGNOSIS AND MANAGEMENT ISSUES

Chairs: Ronald Pies, M.D., M. Katherine Shear, M.D., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the substantive differences between ordinary grief and major depressive disorder, and the reasons for eliminating the "bereavement exclusion"; 2) Describe the syndrome of "complicated grief" and a proven efficacious approach ; to treating it; 3) Describe the management and treatment strategies applicable to post-bereavement depression.

SUMMARY:

The constructs of ordinary grief, complicated grief, and depression remain sources of confusion and controversy in psychiatry. Some have argued, for example, that there is no clear line between "intense grief" and "mild major depression", and that it is virtually impossible to distinguish these two conditions early in the course of a major loss, such as bereavement (the death of a loved one). Many in the "grief community" opposed the decision, by the DSM-5 work group, to eliminate the so-called "bereavement exclusion" that guided diagnosis in the DSM-IV, and the issue remains one of considerable controversy. The status of "complicated grief" (CG) has also been a matter of debate, and the DSM-5 did not adopt a formal diagnostic category for CG; however, in section 3 of the DSM-5 (conditions for further study), "Persistent Complex Bereavement Disorder" (PCBD) is described, and has many features in common with various descriptions of CG. We will discuss these issues and their practical implications for psychiatrists, as well as discussing research findings re: treatment and management. We will emphasize that ordinary grief and major depressive disorder-though sharing some features-are distinct constructs, both diagnostically and phenomenologically (i.e., with respect to the felt experience and world-view of the patient). We will examine such concepts as "the fallacy of misplaced empathy", in relation

to the identification of "disordered" vs. "non-disordered" mood states. We will also examine the ambiguities of causality in the genesis of depressive states. Some of the research supporting the elimination of the bereavement exclusion will also be discussed. The issues of psychotherapy and medication, in relation to post-bereavement depression and complicated grief, will be addressed. We will consider and discuss brief clinical vignettes and entertain clinically-related questions from the audience.

ADVANCED GERIATRIC PSYCHOPHARMACOLOGY: FOCUS ON THE PSYCHIATRY C/L SERVICE

Chair: Sandra A. Jacobson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Distinguish delirium from catatonia, and describe treatment algorithms; 2) Describe two clinical scenarios in which antipsychotic medication would be contraindicated in a hospitalized elder; 3) Diagnose serotonin syndrome, akathisia, and respiratory dyskinesia, and describe treatment of these syndromes; 4) Recognize non-convulsive status epilepticus, and describe its diagnostic work-up and treatment; 5) Explain the principles of psychopharmacological treatment of elders with 1) hepatic impairment, and 2) renal impairment, and list several specific recommendations for their treatment.; .

SUMMARY:

The consultation/liaison service provides an excellent opportunity to showcase the skills and knowledge base of psychiatrists who represent our field to medical/surgical colleagues and the public. Clinical issues that arise at the interface of psychiatry, medicine, and surgery can prove to be complex, and usually require a multimodal approach. Psychopharmacological interventions often are indicated. This workshop will use cases taken from the presenter's personal experience on consultation/liaison services at several large teaching hospitals. Topics covered will include the differentiation of catatonia from delirium, control of psychosis in patients with Lewy body disease, rapid control of akathisia, recognition and treatment of non-convulsive status epilepticus, treatment of the tardive syndrome of respiratory dyskinesia, and specific recommendations for pharmacologic treatment of patients with hepatic and/or renal impairment. Attendance at this session will be limited, and ample time will be allowed for questions and discussion.

SEXUALITY, AGGRESSION, AND IDENTITY IN LOVE RELATIONS

Chair: Otto F. Kernberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess dominant areas of couples' conflicts, and their therapeutic implications; 2) Intervene selectively with cognitive-behavioral or psychodynamic approaches to couples' conflicts; 3) Establish an appropriate diagnostic and therapeutic frame, and priority setting of interventions.

SUMMARY:

This workshop will explore the creative and threatening aspects of conscious and unconscious developments of couples in stable love relations. The vicissitudes of their freedom or inhibition in the sexual realm, in the pursuit of daily life arrangements, and in the constriction of boundaries or conflictual value systems may combine and change in unpredictable ways over a lifetime. Concrete examples of these developments will be explored in the areas of romantic love affairs, chronic triangulations, sadomasochistic destructiveness, the spectrum of narcissistic equilibrium, and empty conventionalism.

MEET THE AUTHORS: NORMAL CHILD AND ADOLESCENT DEVELOPMENT: A PSYCHODYNAMIC PRIMER

Chairs: Karen J. Gilmore, M.D., Pamela Meersand, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and distinguish the role of dynamics, diagnosis and development in their adult patients' presentations; 2) Identify the presence of childhood modalities in current functioning and understand their links to the past; 3) Facilitate their patients' evolution of autobiographical narratives to encompass the past and its links to current choices and conflicts; 4) Restore continuity and cohesion to their patients' sense of self over time; 5) Identify the sequential mental organizations of childhood and their presence in adult fantasy life, object relations, and self-representation.

SUMMARY:

The authors discuss their book and its relevance to clinical work, not only for those who treat children and adolescents but also for adult psychiatrists. Since adult personality and psychopathology contain elements of the past, such as childhood trauma, conflicts and fantasies, familiarity with childhood mental organizations facilitates the recognition of these components and the distortions they create in the adult. Knowledge of development can serve as a guidebook to a complex city, where the old commercial district, the new waterfront, the recycling of buildings and neighborhoods for new purposes, the residues of ancient customs and landmarks, and the impact of contemporary technology are all intermingled. Clinicians with a working knowledge of development can better understand, and help each patient understand, his or her unique inner life, historical conflicts, and current symptomatology. They can better distinguish the deforming effect of childhood catastrophes, including the onset of severe psychiatric illness, when they understand the organization of the mind that withstood such events. The capacity to place patients in developmental context restores continuity and meaning to their autobiographical narratives. This in turn facilitates patients' self-reflective capacities and compassion for themselves and others.

MAY 05, 2014

INTERPERSONAL PSYCHOTHERAPY: AN UPDATE

Chair: Myrna Weissman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Update the participants on the international studies; 2) Update participants in the new adaptations; 3) Answer questions on patient care and on appropriateness of treatment for specific conditions .

SUMMARY:

Interpersonal Psychotherapy is an evidenced based treatment for depression defined in a manual, translated into 7 languages and evaluated in over 30 clinical trials. New versions for primary care have been developed and are now being adapted for patient centered care that may expand access to mental health services for diverse populations under the Affordable Health Care Act. While psychotherapy is having a decreasing role in the United States in patient use and in training there is an in-

crease in interest and use in low income countries such as Haiti, Ethiopia, Brazil, Uganda. This interactive session will describe some of the new developments. Questions from the participants will be answered following a brief presentation from one of the developers.

PSYCHIATRY ADMINISTRATION: MEETING THE CHALLENGES OF THE CHANGING HEALTH CARE ENVIRONMENT

Chairs: Ann Marie T. Sullivan, M.D., Joseph P. Merlino, M.D., M.P.A., Bruce Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the major trends in health care that are impacting systems of care and service delivery to our patients, especially the impact of health care reform.; 2) Learn strategies employed in state, municipal and private settings to meet the challenges of health care reform, especially focused in three areas: integrated care, medicare ACOs and medicaid reform.; 3) Problem solve with participants the specific issues they face in their treatment settings and systems as a result of these changes in healthcare delivery.

SUMMARY:

The session will focus on the challenges faced by psychiatric administrators in the changing world of healthcare reform, including integrated care, medicaid reform and medicare ACOs. Presenters will share their experiences and strategies in the public and private sector, focusing on medicaid redesign strategies at the state level, psychiatrists role in the ACO and the integration of medical and psychiatric care in a variety of treatment settings. Specific strategies such as the use of Lean methodology in redesigning care; the role of capitation and financial incentives and penalties in financing care; and the critical role of care coordination across systems will be discussed. Participants will be invited to present their specific challenges and problem solve in the session.

MEET THE AUTHOR: DSM-5 HANDBOOK OF DIFFERENTIAL DIAGNOSIS

Chair: Michael First, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be familiar with the six steps to differential diagnosis presented in the first chapter of the handbook; 2) Be familiar with the process of using symptom-based decision trees in order to arrive at a differential diagnosis from the "Bottom up"; 3) Be familiar with the use of differential diagnosis tables to insure that other diagnoses in the differential have been considered. .

SUMMARY:

Differential diagnosis is the bread and butter of our task as clinicians. The DSM-5 Handbook of Differential Diagnosis is designed to improve a clinician's skill in formulating a comprehensive differential diagnosis by presenting the problem from three of different complementary perspectives. The first perspective, "Differential Diagnosis Step by Step," explores the differential diagnostic issues that must be considered in each and every patient being evaluated by providing a six step diagnostic framework. The second perspective, "Differential Diagnosis by the Trees," approaches differential diagnosis from the bottom up-that is, a point of origin that begins with the patient's presenting symptom(s) such as depressed mood, delusions, and insomnia. Each of the 29 decision trees included in the Handbook indicates which DSM-5 diagnoses must be considered in the differential diagnosis of that particular symptom, and offers decision points reflecting the thinking process involved in choosing from among the possible contenders. The third perspective, "Differential Diagnosis by the Tables," approaches differential diagnosis from a later point in the diagnostic assessment process-that is, once the clinician has reached a tentative diagnosis and wants to ensure that all reasonable alternatives have received adequate consideration. This section of the Handbook contains 66 differential diagnosis tables, one for each of the most important DSM-5 disorders. The information provided in the decision trees and the differential diagnosis tables is somewhat overlapping, but each format also has its own strengths and may be more or less useful depending on the situation. The decision trees highlight the overall algorithmic rules that govern the classification of a particular symptom. Differential diagnostic tables are provided for most of the disorders in DSM-5 and indicate those disorders that share important features and thus should be considered and ruled out. They have the advantage of providing a head-to-head comparison of each disorder, highlighting both the points of similarity as well as the points of differentiation. Different clinicians will have different purposes and different methods of using this Handbook. Some individuals will be interested in a comprehensive overview of the process of making DSM-5 diagnosis and will find it rewarding to review the Handbook cover to cover. Others will use the Handbook more as a reference guide to assist in the differential diagnosis of a particular patient. In this session, the three approaches will be discussed in detail, using case material to demonstrate how each approach is utilized.

MAY 06, 2014

MATERNAL/FETAL INTERACTIONS: NEUROBEHAVIORAL DEVELOPMENT BEFORE BIRTH

Chair: Catherine Monk, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the influence of pregnant women's mood on fetal and child development; 2) Learn about the mutual biological influences between mother and fetus, including epigenetic changes in the placental related to maternal HPA axis activation; 3) Recognize the role of perinatal experiences in future risk for mental illness .

SUMMARY:

Consistent with a developmental focus on the etiology of mental disorders , mounting evidence indicates that prenatal exposure to maternal distress exerts pervasive effects on infant and child physiology, behavior, and neurobehavioral trajectories. By inference, these findings implicate in utero alterations of fetal CNS development, and suggest that evidence of the maternal influence should be identifiable during the period when it occurs. This interactive discussion will explore this emerging science of the fetal origins of future mental health, with a focus on fetal and placental data. It also will consider evidence suggesting individual differences in fetal neurobehavior may influence maternal well-being; these findings indicate that the exquisite mother-infant bi-directional communication begins before birth. Implications for the care of women in the perinatal period also will be discussed, as well as new dyadic treatments that build on this new science of maternal-perinate

relationship.

BRAIN STIMULATION TECHNIQUES

Chairs: Sarah H. Lisanby, M.D., Mustafa M. Husain, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the leading indications for the various brain stimulation techniques currently clinically available in psychiatry today; 2) Distinguish the relative risks and benefits of the different forms of brain stimulation technologies; 3) Evaluate the proper place of brain stimulation technologies in treatment algorithms; 4) Understand the mechanisms of action of the various forms of brain stimulation available today, and those on the horizon.

SUMMARY:

Brain stimulation technologies represent a paradigm shift in the field of psychiatry. With transcranial magnetic stimulation (TMS) recently FDA approved, and new deeper penetrating TMS coils now clinically available, the array of options available to clinicians has rapidly expanded. As exciting as the new developments are, the field presently lacks clear guidelines regarding how best to incorporate these powerful new tools into practice. In addition, evidence regarding dose/response relationships is beginning to emerge but remains at an early stage. Therefore it is important to provide guidance to practitioners about the differences among these technologies, and improve access to information about their relative strengths and weaknesses. This interactive session will cover the various forms of brain stimulation available today and those on the horizon (including electroconvulsive therapy, TMS, deep brain stimulation, transcranial direct current stimulation, cranial electrical stimulation, magnetic seizure therapy, and vagus nerve stimulation). Chaired by Dr. Sarah Lisanby and co-Chaired by Dr. Mustafa Husain, this session will address the audience's questions about how best to utilize these technologies, how to optimize their dosage, how to evaluate proper patient selection, and how to manage patients through the treatment course.

MEET THE AUTHOR: COGNITIVE BEHAVIOR THERAPY FOR CHILDREN AND ADOLESCENTS

Chair: Eva Szigethy, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand theory of cognitive behavioral therapy for children and adolescents with psychiatric disorders such as bipolar disorder, oppositional defiant disorder, and obsessive compulsive disorder; 2) 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 empirically tested CBT protocols. This session will showcase the book, Cognitive Behavioral Therapy for Children and Adolescents, 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 is 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. This session will give an overview of the books content with emphasis on CBT for bipolar disorder, oppositional defiant disorder and OCD and cover case examples using the text and video material. An emphasis on developmental and cultural considerations will be provided.

FUTURE OF PSYCHIATRY

Chair: Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session the participant should be able to: 1) Evaluate the information available regarding the current state of the mental health field for diagnostic interpretation and validation of early diagnosis relative to early detection and intervention for mental disorders 2) Effectively consider data supporting the coupling of team based multi-element approaches, which involve institutional, office and community settings, and the development of optimal forms of early detection and intervention 3) Discuss the current methodology for the development and broad implementation of strategies for sensitive and specific early detection and diagnostic methods, and gage the establishment of evidence for effective intervention, prevention, and lessening of morbidity for mental disorders as the research develops.

SUMMARY:

The brain is the final frontier of biomedical research. It is by far the most complex organ in the human body with over 100 billion neurons and literally trillions of synapses which are the connections between cells. The brain is the seat of all mental functions and behavior, and malfunctions in the brain form the basis of psychiatric disorders ranging from mood and psychotic disorders to Alzheimer's disease and Autism.

Because of its complexity and the fact that the brain was enclosed deep within the skull, our understanding of brain function and brain disorders has lagged behind that of other organ systems. Consequently, brain disorders which are manifest as mental and behavioral disturbances were historically shrouded in ignorance and stigma until modern research technologies and methods including genetics, molecular biology, neuroimaging and psychopharmacology were applied to their investigation. The result has been a watershed in our understanding of the pathologic basis of mental disorders and the development of scientifically based treatments.

As impressive as the advances of the past three decades have been, we can reasonably expect the rate of progress in unraveling the mysteries of the brain and mental illness to accelerate and revolutionize the way psychiatric medicine is practiced and mental health care is provided within the next decade. These changes will involve the use of laboratory assisted diagnosis, the ability to assess a person's potential to develop mental illness premorbidly and offer them the prospect of individualized treatment in the context of personalized medicine. When this comes to pass we will be able to substantially limit the morbidity and disability associated with mental illness and ultimately prevent their onset. The psychiatry departments of Columbia and Cornell with NYPH hope to establish the new standards for practice of psychiatry in the future.

MAY 03, 2014

LECTURE 1

PSYCHIATRIC GENETICS: THE REVOLUTION HAS ARRIVED

Lecture Chairs: Cameron S. Carter, M.D., Julio Licinio, M.D.
Lecturer: Steven E. Hyman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the concept of polygenic disorders; 2) Understand the obstacles to using genetics for diagnosis; 3) Understand how genetic information can contribute to therapeutics.

SUMMARY:

After years of frustration, new technologies and large global consortia have made it possible to address the complexities of psychiatric genetics at the scale it requires. For example, genotyping of approximately 40,000 schizophrenia patients and 40,000 healthy comparison subjects has yielded more than 100 loci with high levels of confidence. The genetics of bipolar disorder and autism are also proceeding effectively. This lecture will review basic principles and current findings, but will focus on the significance of emerging genetic findings for psychiatry.

LECTURE 2

ALZHEIMER'S DISEASE: GENES, DIAGNOSTICS AND THERAPEUTIC ADVANCES

Lecture Chair: Julio Licinio, M.D.
Lecturer: Steven M. Paul, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the most common forms/symptoms of Alzheimer's disease; 2) Understand how apoE alleles work and how they play a role in Alzheimer's disease; 3) Awareness of current therapeutic advances in early detection and interventions.

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 Æ4 allele increasing and the Æ2 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-Î² peptides (AÎ²) 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. Very recent work in our laboratory and others suggest an important role for microglia/bone marrow-derived macrophages in mediating the apoE-dependent clearance of AÎ² within the brain. Our data on age-dependent and apoE-dependent brain amyloid burden in animals are strikingly reminiscent of earlier postmortem neuropathologic studies and more recent PET neuroimaging data in cognitively normal humans and patients with AD carrying different apoE alleles. Very 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 the impact of genetic risk factors and 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. A critical review of recent clinical trial data for several potential disease-modifying treatments will also be presented.

LECTURE 3

FROM PSYCHIATRY TO CLINICAL NEUROSCIENCE

Lecture Chairs: Cameron S. Carter, M.D., Julio Licinio, M.D.
Lecturer: Thomas R. Insel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify 3 major innovations in our approach to mental illness; 2) Recognize the role of circuitry in the biology of mental illness; 3) Appreciate the need for a new approach to diagnosis and treatment of mental illness.

SUMMARY:

Each year more people are receiving more treatments for mental disorders yet there is no evidence of a commensurate reduction in the morbidity or mortality of any mental illness. While there are many potential reasons for this apparent disconnect between treatment and public heath impact, we must consider that our current approaches are not sufficient for the severity or complexity of mental disorders. This lecture will suggest some different approaches, including changing our diagnostic system to move beyond symptoms and changing our therapeutic strategies to move recent revolution in neuroscience. Modern neuroscience gives us new ways of addressing mental disorders as circuit disorders and suggest that successful treatments (via psychotherapies, devices, or medications) can be re-conceptualized as circuit tuning based on the inherent plasticity of the human brain. The transition to clinical neuroscience means that we will use insights about brain development and plasticity along the with new tools for mapping brain structure and function to offer our patients new opportunities for prevention, recovery, and cures.

LECTURE 4

NEUROBIOLOGY OF RETT SYNDROME AND RELATED NEUROPSYCHIATRIC DISORDERS

Lecture Chair: Julio Licinio, M.D.
Lecturer: Huda Y. Zoghbi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe neuropsychiatric phenotypes associated with MeCP2 disorders; 2) Enhance understanding of genetic contributions to psychiatric phenotypes; 3) Explain the role of various neurotransmitter systems in different neuropsychiatric phenotypes.

SUMMARY:

Rett syndrome is a progressive neuropsychiatric disorder that is characterized by apparently normal development up to 12-24 months of age followed by loss of acquired skills (e.g., language and hand use) and the development of a plethora of neurobe-

havioral abnormalities including cognitive and social deficits, motor dysfunction and
Parkinsonian features, stereotyped behaviors, anxiety and a variety of psychiatric symptoms, and autonomic dysfunction. Rett syndrome is caused by loss-of-function mutations in the X-linked gene encoding Methyl-CpG-binding protein 2 (MeCP2). Curiously, doubling MeCP2 levels also causes Rett-like phenotypes and premature lethality in males, whereas females manifest psychiatric symptoms. Mouse models either lacking or over-expressing MeCP2 reproduce the features of Rett and the MECP2 duplication syndrome, respectively. Furthermore, mouse models carrying various mutant Mecp2 alleles have demonstrated that the brain is exquisitely sensitive to the levels of MeCP2 and that the loss and gain of the protein produce inverse effects on synapse number and synaptic function. Studying the role of the protein in various neuronal subtypes is revealing that MeCP2 is critical for the normal function of all the neuronal types tested. Moreover, these studies are providing insight into the contributions of various neurons and neuronal networks to various neuropsychiatric features and physiological behaviors.

LECTURE 5
THE AFFORDABLE CARE ACT AND THE FUTURE OF MENTAL HEALTH CARE IN AMERICA
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: Ezekiel J. Emanuel, M.D., Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the how the US health care system compares in cost and quality to the rest of the world; 2) Understand the key elements of the Affordable Care Act; 3) Critically examine how the Affordable Care Act will impact the delivery of health care to improve quality and lower costs. .
SUMMARY:
The Affordable Care Act is ushering in profound changes in the US health care system with the goal of combating the pressing challenges of rising costs and inadequate quality. But there is much more work to be done, particularly in improving care delivery for patients with chronic and psychosocial illnesses. In this presentation, Dr. Ezekiel Emanuel, Vice Provost at the University of Pennsylvania and key architect of the Affordable Care Act, will describe the unique challenges we face in providing care for those who need it most and the absolute economic necessity of finding new efficiency in health care delivery. He will also discuss various ways in which the Affordable Care Act is already effecting mental health care, innovative approaches that private companies have adopted, and the imperative of future parity between mental and physical health.

LECTURE 6
PSYCHIATRIC ILLNESS, PSYCHIATRIC TREATMENT, AND PREGNANCY OUTCOMES
Lecture Chair: Linda L. M. Worley, M.D.
Lecturer: Kimberly Yonkers, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Articulate risks associated with psychiatric illness in pregnancy; 2) Counsel patients about risks and benefits of psychotropic treatment in pregnancy; 3) Identify key factors that limit inferences about the risks and benefits of psychiatric treatment in pregnancy.
SUMMARY:
The consequences and treatment of psychiatric illness in pregnancy has received considerable attention during the past few years. In particular, mood disorders and their pharmacological treatment, as well as selected anxiety disorders have been studied with regard to a variety of neonatal and maternal outcomes. Solid data about the risks of psychiatric disorders in pregnancy and about treatment for these conditions can assist patients and their clinicians in illness management decisions. However, the literature is now complex and studies do not agree as to a number of maternal and neonatal outcomes that may be associated with psychiatric illness and its treatment. This presentation will focus on mood and anxiety disorders and provide a synthesis of the recent data that addressed the risks of psychiatric illness in pregnancy as well as the risks and benefits of psychiatric treatment.

LECTURE 7
ADVANCES IN ADDICTION RESEARCH
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: Nora D. Volkow, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the utility of new imaging tools and molecular/genetic technologies for understanding the biological underpinnings of addictive disorders; 2) Demonstrate knowledge about the complex biological and environmental factors that underlie vulnerability to drug abuse and addiction ;3) Discuss clinical implications of recent advances in addiction science for the development of behavioral, pharmacological, and immunological strategies for addiction treatment and prevention.
SUMMARY:
Research on drug abuse and addiction has made remarkable strides in recent years. Unprecedented technological advances are allowing for a deeper and more detailed understanding of brain development and function at the level of synapses, cells, circuits and genes. A broadened understanding of the biological correlates of an individual's risk and consequences of drug abuse and addiction at the molecular, genetic, epigenetic, biochemical, neurobiological, cognitive, behavioral and social levels is allowing for the design and development of increasingly effective addiction treatments, including behavioral interventions to promote brain recovery as well as new medications and immunotherapies. This presentation will highlight a number of recent findings in the science of addiction and their potential for translation into clinical practice.

LECTURE 8
TIME IN TREATMENT
Lecture Chair: B. Timothy Walsh, M.D.
Lecturer: John M. Oldham, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the importance of longer-stay intensive hospital treatment for selected patients with complex, treatment-refractory conditions; 2) Recognize the value of utilizing standardized outcome measures to monitor inpatient treatment; 3) Identify the potential for large datasets to inform individual treatment planning; .
SUMMARY:

Psychiatric hospital treatment in the US is generally synonymous with acute treatment, with an average length of stay of five to seven days. For many patients this amount of time in the hospital will suffice, particularly if accompanied by intensive communication with families and referring clinicians, and by thoughtful arrangements for appropriate continuity of care. Too often, however, care is fragmented and communication is less than ideal. Patients lose their balance again, cycling back for another short stay in the hospital. For those with complex illnesses, there is just too little time to sort things out, to stabilize the family system, and to launch the right treatment. When such patients can attain the stability afforded by longer inpatient stays, they may be far better equipped to succeed on the road to recovery. Data will be presented from the Menninger Clinic, the private psychiatric teaching hospital at Baylor College of Medicine in Houston, reviewing standardized assessment measures of patient progress during and at the completion of six to eight weeks of intensive treatment. Outcome measures demonstrate that, overall, patients make substantial gains by the time of discharge. More needs to be learned, however, about how strongly patients are psychologically immunized to sustain these gains after returning home. Preliminary data will be presented of a second phase of data collection, assessing patients for up to a year after discharge. More recently, a research project has been implemented to accumulate large-scale data on all patients eligible and willing to participate. SCID-I and SCID-II diagnostic data are obtained, and blood samples are stored for targeted genomic sequencing. In addition, brain imaging studies are carried out that include fMRI, DTI, and an interactive protocol looking at reward circuitry. The "n" of participating patients is growing rapidly, and the data will be analyzed internally as well as selectively submitted to large data registries. Our hope is that these data will move us closer to evidence-based personalized medicine, enabling us to more accurately select the right treatment for the right patient.

LECTURE 10
LEADING CHANGE THROUGH EDUCATION AND MENTORSHIP
Lecture Chair: Ronald O. Rieder, M.D.
Lecturer: Carol A. Bernstein, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have a better understanding of the characteristics of leadership which promote change in a dynamic health care environment.; 2) Have a better appreciation of the pivotal role of mentorship in creating the next generation of leaders.; 3) Have improved knowledge and awareness of an educator's trajectory in achieving these goals.
SUMMARY:
The role of educational leadership as a vehicle for initiating change in the health care delivery system is frequently ignored in the literature on medical education. One of the core values of residency training in psychiatry is the capacity to develop and promote the next generation of psychiatric leaders. Moreover, dramatic shifts in the demographic characteristics of future generations highlight the need for creative approaches to education and training especially with regard to mentorship. This lecture will focus on important characteristics in educational leaders which can promote successful transitions, key factors necessary for effective mentorship of the next generation and personal reflections on potential career paths in leadership and training.

LECTURE 9
CREATING A LEARNING MENTAL HEALTHCARE SYSTEM: THE EXAMPLE OF POPULATION-BASED SUICIDE PREVENTION
Lecture Chair: Cameron S. Carter, M.D.
Lecturer: Greg E. Simon, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the principles of measurement-based mental healthcare; 2) Understand the role of population-based data in clinical practice and quality improvement; 3) Understand longitudinal relationships between suicidal ideation and suicidal behavior; .
SUMMARY:
In a true learning mental healthcare system, research and practice are completely integrated. Every patient and every clinician is fully engaged in creating and learning from practice-based evidence. Several recent developments have brought integration of practice and research within reach. Measurement-based care has spread from research to community practice. Electronic medical records organize comprehensive treatment and outcome data for large, representative populations. Advances in data science and statistical methods allow us to shift from broad questions to personalized predictions. Data from the Mental Health Research Network (an NIMH-funded consortium of researchers affiliated with large health systems) will be used to illustrate this integration of research and practice. In these health systems, routine use of the PHQ9 depression questionnaire has created a data resource of over 1 million assessments of depression and suicidal ideation for over 450,000 patients. These data are now supporting clinical tools for patients and providers; system-wide quality improvement programs, and public-domain research regarding prediction and prevention of suicidal behavior. The barriers to creating a nationwide learning mental healthcare system are more cultural than technical. They include: developing a culture of transparency and trust, resisting the tendency to privatize knowledge, and acknowledging our uncertainty about important health decisions.

MAY 04, 2014

LECTURE 11
PROMOTING MENTAL HEALTH IN THE PEOPLE'S REPUBLIC OF CHINA
Lecturer: Michael R. Phillips, M.D., M.P.H.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the historical trajectory of mental health services in China; 2) Learn about the unique demographic pattern of mental illnesses and suicide in China; 3) Appreciate the revolutionary nature of Chinaâ€™s new national mental health law.
SUMMARY:
This lecture will provide a historical overview of the changing landscape of mental health in China since liberation (1949) with an emphasis on the economic reform era, which started in 1978. Dr. Phillips, a Canadian public health psychiatrist trained in the USA who has lived and worked in China since 1985, will describe the many social, economic and political factors that

have influenced the perception and management of mental disorders through the lens of his own personal experiences. He will describe the pattern of mental illnesses in the country identified in a large epidemiological study, the dramatically changing rates of suicide, and the governments' gradual recognition of the importance of mental illnesses, as exemplified in the recent passage of China's first national mental health law.

LECTURE 12
YOUTH MENTAL HEALTH: THE CASE FOR TRANSFORMATIONAL REFORM IN MENTAL HEALTH CARE
Lecture Chair: Godfrey Pearlson, M.D.
Lecturer: Patrick D. McGorry, M.D., Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the epidemiology of mental disorders and especially that 75% of mental disorders emerge before the age of 25 years; 2) Appreciate the low levels of help-seeking and access to appropriate care in young people and the consequent missed opportunities for early intervention, functional improvement and productivity gains; 3) Become aware of international reform momentum and actual progress in building a novel low stigma system of access and care for young people with emerging mental disorders; 4) Commit to playing a personal supportive role if possible to ensure that early intervention for young people with emerging mental disorders becomes a reality.
SUMMARY:
Mental and substance use disorders are among the most important health issues facing society. They are by far the key health issue for young people in the teenage years and early twenties, and if they persist, they constrain, distress and disable for decades. Epidemiological data indicate that 75% of people suffering from an adult-type psychiatric disorder have an age of onset by 24 years of age, with the onset for most of these disorders - notably psychotic, mood, personality, eating and substance use disorders- mainly falling into a relatively discrete time band from the early teens up until the mid 20s, reaching a peak in the early twenties. 50% of young people will experience at least one period of poor mental health during the transition to adulthood. While health care at the other end of the lifespan dominates health spending and threatens to overwhelm budgets everywhere, the underspend on young people stands in stark contrast. Young people stand on the threshold of the peak productive years of life, and thus have the greatest capacity to benefit from stepwise evidence-based treatments and better health care delivery for their major issue, mental ill-health. A substantial proportion of young people are being neglected and consigned to the "NEET" scrapheap with disastrous human and economic consequences. Mental ill-health is a key risk for "NEET"status. In recent years, a worldwide focus on the early stages of schizophrenia and other psychotic disorders has improved the prospects for understanding these complex illnesses and improving their short term and longer term outcomes. This reform paradigm has also illustrated how a clinical staging model may assist in interpreting and utilising biological data and refining diagnosis and treatment selection. There are crucial lessons for research and treatment, particularly in the fields of mood, personality and substance use disorders. Furthermore, the critical developmental needs of adolescents and emerging adults are poorly met by existing conceptual approaches and service models. The pediatric-adult structure of general health care, adopted with little reflection by psychiatry, turns out to be a poor fit for mental health care since the age pattern of morbidity of the latter is the inverse of the former. Developmental considerations and youth culture demand that young people are offered a different style and content of service provision in order to engage with and benefit from interventions. The need for international structural reform and an innovative research agenda represents one of our greatest opportunities and challenges in the field of psychiatry. Fortunately this is being explored in a number of developed countries, notably Australia, Ireland, Canada, Denmark and the UK, and has the potential to spread across the world as a dynamic health reform front.

LECTURE 13
THE STRANGEST DISEASE: THE PATHETIC PAST BUT HOPEFUL FUTURE OF SCHIZOPHRENIA
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: E. Fuller Torrey, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the history of schizophrenia, including when it first appeared and increased in incidence; 2) Better recognize and understand the unusual symptoms of schizophrenia, and why it is so stigmatized by psychiatrists, neurologists, and the general public; 3) Conceptualize and support a future in which the various forms of schizophrenia will be understood as neurological syndrome, and treated as such.
SUMMARY:
Schizophrenia is a strange disease. British historian, Roy Porter noted, "Strangeness has typically been the key feature in the fractured dialogues that go on…between the 'mad' and the 'sane.' Madness is a foreign country." Schizophrenia has been widely misunderstood, poorly treated, and almost universally stigmatized. Freud spoke for many when he said: "I do not like these patient…I feel them to be so far distant from me and from everything human. A curious sort of intolerance, which surely makes me unfit to be a psychiatrist." There have always been occasional individuals with schizophrenia-like symptoms. We know that diseases such as pellagra, syphilis, and temporal lobe epilepsy can do so. But schizophrenia as we know it appeared abruptly in the 18th century, then increased markedly in the 19th century during which time an "alarming increase in insanity" was regularly noted. Strangely, in the 20th century it leveled off. Many symptoms of schizophrenia also seem strange to us, at odds with our lived experiences. These include a loss of sense of self, flattening of emotions, thinking disorders, loss of pain sensitivity, and especially anosognosia. Such symptoms impede understanding and are one reason why we have treated individuals with schizophrenia so poorly. In the 18th century, we put them in jails and prisons, then in the 19th century transferred them to hospitals for treatment. At the end of the 20th century, we then closed the hospitals and transferred the patients back to jails and prisons. Deinstitutionalization as it has been carried out has been one of the strangest and most tragic social policies in American history. It appears that we now finally have the knowledge we need to treat schizophrenia rationally and humanely. We understand the brain networks involved, and the cerebral basis for symptoms such as loss of sense of self and anosognosia. We are rapidly gaining knowl-

edge of how infectious agents and other environmental factors interact with predisposing genes to cause symptoms. And we understand that pharmacological treatment must be combined with social and rehabilitative support. All that is missing is the will to make this happen.

LECTURE 14
ADMINISTRATION ADVICE AND PITFALLS
Lecture Chair: Thomas S. Newmark, M.D.
Lecturer: Paul Fink, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand some of the difficulties of administration psychiatry; 2) Identify styles of administration; 3) To see how people respond to the boss.
SUMMARY:
Psychiatric administration is a complicated task. After chairing multiple departments and organizations I feel that someone who takes on these jobs must have a great deal of tack and willingness to work with people to create a solution to problems. There is no school to train people for psychiatric administration except the school of hard knocks. I will discuss the problems of firing psychiatrists, dealing with human nature, which tends to go in the wrong direction, and knowing what your final goal is in the project. This lecture will address the problems and difficulties a chairman of a department and a president of an organization struggle with during their tenures.

LECTURE 15
DEVELOPING A FORENSIC PRACTICE: A GUIDE FOR GENERAL PSYCHIATRISTS
Lecturer: William H. Reid, M.D., M.P.H.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Consider objectively the pros, cons, and practicalities of adding forensic work to their practices; 2) Understand many of the differences between the principles of patient care and those of forensic consultation; 3) Understand the main differences between the needs of patients and those of lawyers and courts; 4) Be aware of the primary tasks that must be mastered in order to work effectively with lawyers and courts; 5)Understand many of the important ethics issues involved in forensic practice.
SUMMARY:
There is nothing “magic” about forensic practice, but it is different from general clinical work. Clinical knowledge and skills are its foundation, but one cannot be successful â€“ or do a good job for forensic clients â€“ without understanding the lawyer’s and court’s viewpoint and the legal context in which one’s psychiatric expertise may have a role. Other elements of successful and ethical practice include the nuances of professional relationships with attorneys, critically reviewing records and other information, the differences between forensic and clinical evaluations, writing excellent forensic reports, and testifying at deposition and in court (less often than one might think). The principles of setting fees, billing & collections, office operations, and even marketing oneself are often different from those found in medical practice. Credibility and reputation are crucial to practice success.

LECTURE 16
BEING AND BECOMING AN IMG ACADEMICIAN: PERSONAL NOTES ON RESEARCH DEVELOPMENT
Lecturer: Jose Canive, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Evaluate the impact of information processing deficits in patients with psychosis; 2) Name two brain structures involved in auditory information processing; 3) Develop a positive attitude towards engaging in an academic career and will be able to identify at least three key ingredients to launch or enhance their research careers.
SUMMARY:
This presentation has three major goals: (1) To provide an overview of processing information deficits in patients with psychosis, in particular those who suffer from schizophrenia; (2) To describe research aimed at deciphering brain structures, neural circuitry and genetics underpinnings of this deficit; (3) To encourage IMGs to develop an academic career via identification of key elements that in retrospect paved the speaker’s way. The presenter will dwell on how serendipity, ambitiousness, determination, professional exposure, mentorship, optimism, research infrastructure, focus, and keeping an open mind may contribute to become an IMG academic researcher.

MAY 05, 2014

LECTURE 17
PSYCHIATRY, NEUROSCIENCE AND BEHAVIORAL HEALTH CARE: ESSENTIAL INVESTMENTS IN THE EMERGING AMERICAN HEALTH CARE MARKETPLACE
Lecture Chair: Harold Pincus, M.D.
Lecturer: Gary L. Gottlieb, M.B.A., M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the context of health care delivery in the American economy; 2) Recognize the challenge in evolution from fee for service to risk-based payment; 3) Envision the broad and deep opportunity for psychiatry to catalyze solutions and create opportunity for improved care.
SUMMARY:
The simultaneous growth of health care costs and the aging of the population threaten the American economy. Health care expenditures are crowding out other essential government services and they are impeding private sector investment and employment. In its aspiration to achieve universal coverage and introduce new payment paradigms, the Patient Protection and Affordable Care Act (ACA) seeks to catalyze changes that will drive the market from transaction based fee for service payment toward budget based risk sharing between providers and payors. Similarly, state and local governments and private payors are developing strategies to slow health care cost growth while improving health and care outcomes. These approaches seem familiar, reflecting failed efforts of the 1990s that were perceived to create barriers to access to care and drove down unit prices for services, particularly specialty and hospital care. The adverse effects of those approaches have been sustained for people with mental health and substance use disorders, where public sector service cuts, and persistent underpayment and utilization control in the private sector, have diminished access to essential high quality services. With a full

understanding of the drivers of growing total medical expense (TME) and the requirements of improved outcomes, there is great opportunity for the current wave of change to differ fundamentally from that experience. The Mental Health Parity and Equity Addiction Act of 2008 created some guardrails that protect insurance benefits for people in need of behavioral health care. Moreover, the accountability in public health outcomes and care quality demanded by the framework of the ACA and now included in many private sector contracts, magnifies the importance of behavioral health services and creates substantial financial incentives to invest in them to reduce TME. In particular, the growth of accessible psychiatric and substance use services is essential in the management of chronic diseases and conditions, which account for the vast majority of costs. This presentation will make the strong case for the opportunity for Psychiatry to help to lead the transformation of the American health care delivery system. The need for innovative solutions to ensure appropriate care and the return on potential investment in psychiatric services will be demonstrated.

LECTURE 19
THE THREE ASPECTS OF BEING HUMAN
Lecturer: C. Robert Cloninger, M.D., Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the three aspects of being human (body, thoughts, and soul); 2) Identify evidence of the evolution of human brain functions that support consciousness of the three aspects of being human: somatic, cognitive and spiritual; 3) Discuss the corresponding systems of learning and memory (behavioral conditioning, semantic learning, and self-aware learning); 4) Describe the evidence of the interdependence of three aspects of well-being (physical, mental, and spiritual); 5) Attendees will learn about the nature of the friendships of Oskar Pfister (Lutheran minister and founder of pastoral counseling), Ludwig Binswanger (existential psychiatrist), and Sigmund Freud.
SUMMARY:
Constructive dialogue between psychiatry and religion is grounded in a joint interest in providing an adequate account of human nature as a means to help people to develop in well-being. Since antiquity well-being has usually been regarded as healthy integrated functioning of a person's three aspects of being-body (soma), thoughts, and soul (psyche). As a means to well-being, biological psychiatry emphasizes the importance of the physiological processes of the brain, religion emphasizes the importance of particular beliefs and rituals, and spirituality emphasizes the value of enlarging consciousness of the unity of being through introspection and contemplation. However, empirical work on well-being and on the evolution of human brain functions shows that the physical, mental, and spiritual aspects of well-being are interdependent. When any one is neglected, obstacles to well-being are likely to persist, leading to weak and inconsistent results. In this lecture, I will contrast the divergent approaches of psychiatry, religion, and spirituality to the ternary aspects of being and well-being. Science is most effective when it pursues knowledge without reliance on authority, which requires an open-minded attitude to all three aspects of human beings. Such joint interest in all three aspects of being and well-being was an important part of the enduring friendships of Oskar Pfister, Ludwig Binswanger, and Sigmund Freud despite differences in their religious and existential beliefs. The relations among Pfister, Binswanger, and Freud show how a spirit of open-minded inquiry, mutual personal respect, and a shared ternary model of psychic structure facilitate constructive dialogue.

LECTURE 18
MEMORY AND THE AGING BRAIN
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: Eric R. Kandel, M.D.
EDUCATIONAL OBJECTIVE:
At the end of the session the participants should be able to 1) Discuss neural systems and molecular mechanisms contributing to learning and long-term memory; 2) Possess knowledge of memory system identification in the human brain and the two major forms of neural memory storage; 3) Express insights ino the molecular biology of memory storage to understand various forms of age related memory loss
SUMMARY:
In my talk I will consider the neural systems and molecular mechanisms that contribute to learning and long-term memory. I will divide my talk into two parts: First, I will consider how different memory systems were identified in the human brain and how they were shown to be involved in two major forms of neural memory storage: 1) simple memory for perceptual ad motor skills and 2) complex memory for facts and events. I will then discuss how our insights into the molecular biology of memory storage are allowing us to understand various forms of age related memory loss.
The hippocampal formation, a circuit made up of interconnected subregions, plays a vital role in memory. Each hippocampal subregion houses a population of neurons with distinct molecular expression profiles and physiological properties. This molecular and functional anatomy is thought to account in part for the differential vulnerability of hippocampal subregions to various pathogenic mechanisms.
Indeed, although both Alzheimer's disease (AD) and the normal aging process affect hippocampal-dependent memory processes, several recent studies suggest that the two disorders might be distinguished by distinct anatomical patterns of hippocampal dysfunction. Postmortem studies have suggested that the entorhinal cortex (EC) as well as the CA1 subregion and the subiculum are the hippocampal subregions that are most affected by AD, whereas the dentate gyrus (DG) and CA3 are relatively preserved. Similar patterns have been detected in vivo by high-resolution variants of functional magnetic resonance imaging (fMRI). In contrast to AD, normal aging does not cause cell death or other pathognomonic histological abnormalities. Rather, age-related memory loss is characterized by dysfunctional neurons. Results from high-resolution fMRI and cognitive studies suggest that the primary initial target of normal aging is the DG, whereas the EC is relatively preserved. Although these anatomical patterns are suggestive, no specific molecular defects underlying age-related DG dysfunction have been identified. To obtain more direct evidence that age-related memory loss is not an early form of AD, my colleagues and I sought to isolate a molecular correlate of the aging human DG and explore whether this molecule mediates age-related memory loss. We hoped that these experiments could achieve two goals. First, the results could confirm or deny the anatomical pattern associated with aging and therefore further establish

that aging and AD target the hippocampal circuit via separate mechanisms. Second, these findings could offer insight into the etiology of age-related memory loss with the potential of opening up new therapeutic avenues.

To distinguish age-related memory loss more explicitly from Alzheimer's disease (AD), we have explored its molecular underpinning in the dentate gyrus (DG), a subregion of the hippocampal formation thought to be targeted by aging. We carried out a gene expression study in human postmortem tissue harvested from both DG and entorhinal cortex (EC), a neighboring subregion unaffected by aging and known to be the site of onset of AD. Using expression in the EC for normalization, we identified 17 genes that manifested reliable age-related changes in the DG. The most significant change was an age-related decline in RbAp48, a histone-binding protein that modifies histone acetylation. To test whether the RbAp48 decline could be responsible for age-related memory loss, we turned to mice and found that, consistent with humans, RbAp48 was less abundant in the DG of old than in young mice. We next generated a transgenic mouse that expressed a dominant-negative inhibitor of RbAp48 in the adult forebrain. Inhibition of RbAp48 in young mice caused hippocampus-dependent memory deficits similar to those associated with aging, as measured by novel object recognition and Morris water maze tests. Functional magnetic resonance imaging studies showed that within the hippocampal formation, dysfunction was selectively observed in the DG, and this corresponded to a regionally selective decrease in histone acetylation. Up-regulation of RbAp48 in the DG of aged wild-type mice ameliorated age-related hippocampus-based memory loss and age-related abnormalities in histone acetylation. Together, these findings show that the DG is a hippocampal subregion targeted by aging, and identify molecular mechanisms of cognitive aging that could serve as valid targets for therapeutic intervention.

Together, our results have a number of implications. Most important, our studies provide the best evidence so far that age related memory loss is a distinct disorder that is independent of Alzheimer's disease. The specific deficiency of RbAp48 in the human hippocampal formation with age is consistent with earlier imaging studies showing age-associated patterns of hippocampal vulnerability. The validation in normal and in genetically engineered mice that RbAp48 plays a role in hippocampal-dependent memory and age-related memory loss confirms that this selective pattern occurs in people. By extension, our studies support the idea that age-related memory loss is a disorder independent of AD. Furthermore, because RbAp48 has not been implicated in previous AD studies, our findings provide further evidence that hippocampal dysfunction in AD and aging are driven by distinct pathogenic mechanisms.

Finally, our data suggest that RbAp48 mediates its effects, at least in part, through the PKA-CREB1-CBP pathway, which we have earlier identified as being important for age-related memory loss in the mouse. This molecule and the PKA-CREB1-CBP pathway are therefore valid targets for therapeutic intervention. It has already been shown that agents that enhance the PKA-CREB1 pathway ameliorate age-related hippocampal dysfunction in rodents. Our results suggest that CREB1-enhancing drugs may have similar beneficial effects in aging humans.

LECTURE 20

WHY WAS THE 2012 NOBEL PRIZE IN CHEMISTRY AWARDED FOR STUDIES OF G PROTEIN-COUPLED RECEPTORS-AND WHY SHOULD A PSYCHIATRIST CARE?

Lecture Chair: Julio Licinio, M.D.

Lecturer: Jonathan A. Javitch, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand what a GPCR is and its basic organization and structure; 2) Understand the concept of functional selectivity and its potential relevance to dopamine receptor ligands such as aripiprazole; 3) Understand the relevance of GPCR dimerization.

SUMMARY:

G protein-coupled receptors (GPCRs) constitute one of the largest families of receptors that sense signals from outside of the cell and couple this molecular recognition process to multiple signal transduction pathways and thereby modify cellular responses. GPCRs are responsible for our senses of vision, smell, and taste, and also are essential components of communication between cells. Approximately 40% of drugs target GPCRs, and such compounds are widely used within psychiatry. This lecture will provide an update on the structure, function and regulation of GPCRs, with a focus on the dopamine D2 receptor, the critical molecular target of antipsychotic drugs. The concepts of functional selectivity, a process by which a drug can exert different effects at signaling pathways downstream of the same receptor, and of receptor dimerization will be explored.

LECTURE 21

DANIEL MCNAUGHTON AND THE EVOLUTION OF THE INSANITY DEFENSE

Lecturer: J. Richard Ciccone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the centuries-long debate between total insanity and partial insanity as the criteria for a finding of not guilty by reason of insanity; 2) Describe the events leading up to McNaughton's shooting of Drummond; 3) Explain the role oflsaac Ray's A Treatise on Medical Jurisprudence of Insanity on the evolution of the Insanity Defense.

SUMMARY:

In January 1843, Daniel MeNaughton shot and killed Edward Drummond, chief of staff to the Prime Minister Robert Peel. McNaughton's trial involved some of the most famous people of the time. McNaughton defense was that he was insane. The prosecution argued that only total insanity excuses and the defense asserted that partial insanity qualifies for a finding of not guilty. Each side presented vigorous, historically-based arguments in support of their respective positions. Isaac Ray, one of the founding members of the American Psychiatric Association, played an important role in the McNaughton trial. His text A Treatise on the Medical Jurisprudence of Insanity (Boston, 1838) was quoted extensively by the defense attorney in support of partial insanity excusing. The trial resulted in the jury finding McNaughton "Not Guilty, on the ground of insanity."Public and political outrage at the jury's verdict led the House of Lords to debate the appropriate criteria to be used to determine if a defendant was not guilty by reason of insanity. The Lord Chancellor asked the fifteen judges ofthe Queen's Bench to convene and provide their guidance to Parliament's legislative efforts. After receiving the thoughts of the Queen's Bench,

Parliament passed the "McNaughton Test" for the determination of insanity. This test was quickly adopted in the United States by almost every state. Isaac Ray, in the 1853 edition of A Treatise on the Medical Jurisprudence of Insanity, commented on the "McNaughton Test," and his observations continue to influence the evolution of the insanity defense.

MAY 06, 2014

LECTURE 23
FAR FROM THE TREE: PARENTS, CHILDREN, AND THE SEARCH FOR IDENTITY
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: Andrew Solomon, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the difference between vertical and horizontal identity; 2) Identify the mental health implications of having a stigmatized identity; ; 3) Understand the fluidity of our definitions of illness and identity.
SUMMARY:
This lecture will tell the story of parents who not only to deal with their exceptional children but also find profound meaning in doing so I propose that diversity is what unites us all. I have studied families coping with deafness, dwarfism, down-syndrome, autism, schizophrenia, multiple severe disabilities, with children who are prodigies, who are conceived in rape, who become criminals, who are transgender. While each of these characteristics is potentially isolating, the experience of difference within families is universal. All parenting turns on a crucial questions: To what extent parents should accept their children for who they are and to what extent they should help them become their best selves. Whether considering prenatal screening for genetic disorders, cochlear implants for the deaf, or gender reassignment surgery for transgender people, I examine a universal struggle toward compassion and love. Many families grow closer through caring for a challenging child; most discover supportive communities of others similarly affected; some are inspired to become advocates and activists, celebrating the very conditions they once feared. Speaking from my own experience of growing up when my gayness was deemed an illness to a time when it was deemed an identity, and looking at the experience of becoming a parent as a gay person, I will examine how other families negotiate difference, and in doing so will explore themes of generosity, acceptance, and tolerance.

LECTURE 24
IMPROVING CARE FOR THE PREGNANT WOMAN AND HER NEWBORN: ADOLF MEYER'S BIOPSYCHOSOCIAL MODEL AND THE PREVENTION OF MENTAL ILLNESS
Lecturer: Robert Freedman, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the perinatal factors that affect later risk for psychiatric illness; 2) Update patients and families on current research on perinatal prevention of future mental illness; 3) Address health issues for pregnant women and their newborns for which psychiatric expertise should be part of integrated care with obstetrics, pediatrics, and family medicine.
SUMMARY:
Adolf Meyer conceived of psychopathology as the reactions of persons to environmental stressors, conditioned on their underlying biology. In the 21st century, genes have been identified as fundamental mechanisms of the biological predisposition to mental illness. Many of these genes are at their highest activity not during illness but during fetal brain development. Genetic variants associated with future serious mental illnesses, including schizophrenia, bipolar disorder, autism, and ADHD, produce abnormalities in the development of basic inhibitory and excitatory neuronal circuits. The perinatal environment is also an important determinant of early brain development. Maternal infections, dietary deficiencies, substance abuse, and anxiety and depression all contribute biological insults to the developing fetus that result in deficient brain development and risk for later mental illness. The psychopathological impact of fetal brain developmental abnormalities presents challenges for intervention: (1) the risk for later psychiatric illness is not apparent even at birth, (2) early abnormalities, either genetic or environmental, increase risk for more than one illness and thus appear to be non-specific, and (3) during the years between birth and the emergence of illness, other, more immediate factors, including brain injury, substance abuse, and psychosocial stress channel this early heightened risk into more pathologic outcomes, as Meyer first proposed. However, the 9-month period of fetal brain development is a brief critical interval for prevention of lifelong brain illness. Once this initial window of brain development has closed, there would seem to be little possibility to remedy its deficiencies. Research efforts to improve fetal brain development, particularly for fetuses who already carry genetic risk, have been initiated. Similar to interventions like folic acid to prevent spina bifida, these interventions have the potential to diminish risk for serious illness even in those who otherwise have significant genetic or environmental risk. Psychiatrists who care for the pregnant woman, by treating maternal psychiatric illness and substance abuse, play a unique role in preventing future mental illness in her child.

LECTURE 25
DEVELOPMENT OF FEAR AND ANXIETY: FROM BENCH TO BEDSIDE
Lecture Chair: Cameron S. Carter, M.D.
Lecturer: BJ Casey, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the changes in behavioral and brain development during adolescence when anxiety disorders peak; 2) Understand the environmental and genetic factors that may put an individual at increased risk for anxiety and stress related disorders; 3) Understand developmental and genetic evidence for why some individuals with anxiety may not respond to cognitive behavioral therapy.
SUMMARY:
The study of fear learning and memory has garnered significant interest in recent years for its potential role in anxiety and stress related disorders. Regulating fear is a principle component of these disorders. By studying the development of fear learning and memories, insight can be gained into not only how these systems function normally across development, but also how they may go awry in psychiatric disorders. By taking into account developmental, environmental, and genetic factors,

the hope is that insights may be gained toward finding better treatments and preventative measures for vulnerable populations.

LECTURE 26

THE PRACTICALITY OF CULTURAL PSYCHIATRY: BRIDGING THE GAP BETWEEN THEORY AND PRACTICE

Lecturer: Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the role that culture plays in psychiatric practice, from the perspective of patients and clinicians; 2) Describe a clinical approach that can be used to assess the role of culture in diagnosis and treatment planning; 3) Identify how patients' cultural interpretations impact symptom expression and treatment expectations, as well as strategies to negotiate these interpretations to enhance clinical care.

SUMMARY:

Culture affects every aspect of clinical care, both for patients and clinicians. As patients, culture impacts whether we identify our condition as mental illness, the care we seek, the symptoms we experience and present to clinicians, and our treatment expectations. As clinicians, our own personal cultures and the culture of biomedicine influence our illness classifications, what we attend to most in patients' experiences, our communication styles, the priorities and procedures that structure our work settings, and our moral stance toward care. The effects of culture are so pervasive that they easily recede to the background, assumed to be "just the way things are." They may only be revealed by jarring experiences of dissonance, such as due to cross-cultural miscommunications or instances of failed engagement, or when invoked to explain persisting health care disparities in underserved cultural groups such as US Latinos. Yet, even when we recognize that culture has a pervasive impact on clinical care, it can be challenging to incorporate this awareness into our daily practice as clinicians, researchers, educators, administrators, and policymakers. Given the time and knowledge constraints we face, how can the promise of cultural competence be made practical, teachable, fundable, and implementable? This talk describes the efforts of the awardee to bridge the gap between theoretical and practical sides of cultural psychiatry. His clinical focus includes the development of the DSM-5 Cultural Formulation Interview, a brief method for conducting cultural assessment and treatment planning with psychiatric patients from any cultural background that is feasible in routine care. Research will be presented on two projects evaluating the relevance of culture for clinical practice: one on clarifying the relationship between Latino cultural concepts of distress (e.g., "nerves") and psychiatric disorders in order to reduce misdiagnosis, and the other on a novel approach for enhancing medication adherence based on eliciting and negotiating patients' interpretations of illness and treatment. Attention will also be paid to methods for educating residents in cultural psychiatry, the process of mentoring young researchers on how to incorporate culture in psychiatric research, and the role of the cultural psychiatrist as policymaker addressing health and health care disparities.

MAY 07, 2014

LECTURE 27

PSYCHIATRY AND DEVELOPMENTAL NEUROSCIENCE: GUIDING PRINCIPLES FROM RESEARCH ON ANXIETY

Lecture Chair: Elisabeth B. Guthrie, M.D.

Lecturer: Daniel S. Pine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of basic symptomatic presentations of pediatric anxiety; 2) Demonstrate knowledge of components of the neural circuit that gives rise to anxiety; 3) Demonstrate knowledge of how understanding this circuit informs novel therapeutics.

SUMMARY:

This presentation will review research in three areas. First, the presentation briefly will review from a broad perspective major symptomatic aspects of pediatric anxiety disorders as well as aspects of their longitudinal outcome. Second, the presentation will review in slightly more detail data from available randomized controlled trials in pediatric anxiety disorder. This primarily will include discussion of data on selective serotonin reuptake inhibitors (SSRIs) and cognitive behavioral therapy in randomized controlled trials of pediatric anxiety disorders. Issues related to the safety of SSRIs also briefly will be discussed. Third, the presentation will review in greatest depth cutting-edge research in affective neuroscience, discussing the implications such research carries for future work in child psychiatry. This will include consideration of potential medication adverse effects as well as future novel therapies. In terms of novel therapies, two processes will be examined: attention and extinction. In the first area, work on attention provides novel insights for computer-based attention retraining therapies that will target sub-cortical contributors to anxiety. In the second are, work on extinction may target an underlying learning-related deficit found in pediatric anxiety disorders.

LECTURE 28

THE ASCENT OF ASIAN PSYCHIATRY GLOBALLY

Lecturer: Ira D. Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify research on the efficacy of hospital treatment; 2) Discuss strengths and weaknesses of a psychopharmacology curriculum for psychiatric residents and medical students in Asia; and 3) Provide impressions of Asian psychiatry as it is now evolving.

SUMMARY:

This presentation will review one psychiatrist's experience in doing research and teaching across Asia over the last four decades. The research was done in Japan comparing outcome of psychiatric hospitalization to outcomes in Italy and the United States. The teaching experience consisted of exchanging pedagogical techniques and content focused on a) diagnosis and treatment of schizophrenia, b) psychiatric hospital treatment, and c) family and couples therapy and intervention. The most recent focus has been on developing a model psychopharmacological curriculum for teachers of a) psychiatric residents, b) medical students and c) family medicine physicians. Results of the research and of the teaching efforts will be detailed. Country-by-country impressions will be described for Japan, Indonesia, Thailand, China, India, Morocco, Korea and the Philippines. Asian and non-Asian psychiatrists have much to learn from each other.

LECTURE 29
CIRCUIT DYNAMICS OF ADAPTIVE AND MALADAPTIVE BEHAVIOR
Lecture Chair: Jeffrey A. Lieberman, M.D.
Lecturer: Karl Deisseroth, M.D., Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand optogenetic tools; 2) Understand clarity method; 3) Understand findings on causal circuit dynamics of behavior.
SUMMARY:
Recent development of technologies (optogenetics, CLARITY, and SWIFT imaging) for probing cellular-resolution components of intact nervous systems has enabled elucidation of neural circuitry underlying adaptive and maladaptive behaviors. Here we review the principles and practice, as well as the underlying engineering, for these new technologies. One unifying theme is that control of projection-specific dynamics is well-suited for modulating behavioral patterns relevant to a broad range of psychiatric diseases. Causal structural dynamics has in this way emerged as a principle linking form and function in the brain.

LECTURE 30
POSTPARTUM PSYCHOSIS AND INFANTICIDE: PSYCHIATRIC AND LEGAL PERSPECTIVES ON MOTHERS WHO KILL
Lecturer: Margaret Spinelli, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the complicated presentation and etiology of postpartum psychosis and understand the treatment modalities and prevention strategies of this rare puerperal mental illness; 2) Evaluate and differentiate mothers with psychotic infanticidal ideation from those with ego dystonic, obsessive compulsive infanticidal ideation associated with postpartum depression; 3) Recognize the archaic nature of our insanity defense as it applies to our 21st century biopsychosocial model of psychiatry.
SUMMARY:
Postpartum psychosis is a rare and severe mood disorder with a rapid onset and florid psychotic features. It is a psychiatric emergency. Because infanticide is associated with puerperal psychosis, mothers must be separated from their infants. Whereas gonadal steroids have multiple mood modulator effects, the focus in exploring the etiology of the postpartum psychosis has been the withdrawal effect of the gonadal pregnancy hormones as triggers to CNS neurotransmitters. Furthermore childbirth is a period of risk for acute episodes of psychosis in women with bipolar disorder. Researchers have found that genetic factors also influence vulnerability to postpartum triggering of such episodes. Analysis of this homogeneous subgroup of families resulted in a genome-wide significant linkage signal on chromosome 16p13. Another area of study is the heightened immune responsiveness and altered endocrine set point in the early postpartum period. Most recent and elegant work demonstrates a robust dysregulation of the immuno-neuro-endocrine set point in postpartum psychosis, with a notable over-activation of the monocyte/macrophage arm of the immune system. The importance of this work extends to early identification, treatment and prevention of postpartum psychosis and infanticide. Despite substantial findings that support the biological determinants of postpartum psychosis, "killer mothers" may face the death penalty in the United States. Yet, most countries provide compassionate legislation with probation and mandated psychiatric treatment for mothers with mental illness who commit infanticide. The archaic nature of the United States' legislation as it applies to our 21st century biopsychosocial model of psychiatry and infanticide is discussed. The psychiatric community should promote appropriate treatment of mentally ill women who commit infanticide by fostering shared knowledge between psychiatry and the law, so that decisions about the treatment and punishment of mentally ill persons will not be left exclusively in the hands of the judicial system.

LECTURE 31
ZOOMING INTO THE HIPPOCAMPAL CIRCUIT IN SCHIZOPHRENIA AND RELATED PSYCHOTIC DISORDERS
Lecture Chair: Jeffrey A. Lieberman, M.D.,
Lecturer: Scott A. Small, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1)Learn about functional imaging variants; 2) Learn about the patterns of dysfunction in schizophrenia; 3) Learn how these patterns inform future diagnostic tools and novel therapeutic interventions.
SUMMARY:
The hippocampal formation, a circuit comprised of distinct regions, has been implicated in a growing number of disorders. It has been hypothesized that each disorder can be distinguished by a specific pattern of affected and resistant regions. Mapping a disorder's pattern of vulnerability can be used to improve its diagnosis, but more importantly it can be used to uncover pathogenic mechanisms. In this talk I will review neuroimaging studies that have applied this biomedical logic to schizophrenia and related psychotic disorders. Hypermetabolism in the CA1 region of the hippocampal circuit appears to be primary defect in the 'prodromal' stages of the disorder, which then leads to hippocampal atrophy as the disease progresses. Complimentary studies in animal models, suggest that abnormal elevations in glutamate act as the pathogenic trigger of these hippocampal defects. Together these studies suggest ways to potentially diagnose and therapeutically intervene during the prodromal stages of the disorder.

MAY 03, 2014

DSM-5: WHAT YOU NEED TO KNOW

Directors: Darrel A. Regier, M.D., M.P.H., David J. Kupfer, M.D.
Faculty: William Narrow, M.D., M.P.H., Jan Fawcett, M.D., Katharine A. Phillips, M.D., Joel E. Dimsdale, M.D., Ruth O'Hara, Ph.D., William T. Carpenter, M.D., Kenneth J. Zucker, Ph.D., Charles P. O'Brien, M.D., Ph.D., David Shaffer, M.D., Andrew Skodol, M.D., Sue Swedo, M.D., Robert J. Ursano, M.D., Ronald Petersen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

2014 PSYCHIATRY REVIEW

Directors: Arden D. Dingle, M.D., Robert Boland, M.D.
Faculty: Anthony Rostain, M.A., M.D., Richard Balon, M.D., Sandra M. DeJong, M.D., M.Sc., Mark Servis, M.D., Marcy Verduin, M.D., Vishal Madaan, M.D., Josepha A. Cheong, M.D., Joseph Layde, J.D., M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

MAY 04, 2014

UPDATE ON PEDIATRIC PSYCHOPHARMACOLOGY

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

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

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

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

MAY 05, 2014

TREATMENT OF BIPOLAR DISORDER

Directors: Terence A. Ketter, M.D., Po Wang, M.D.
Faculty: Shefali Miller, M.D., Kiki Chang, M.D., Natalie Rasgon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

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

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

SUMMARY:

Treatment of bipolar disorders is rapidly evolving. DSM-5 has raised important diagnostic issues related to bipolar disorder, including: mixed symptoms and depression accompanied by anxiety symptoms in adults, mood and behavioral problems in children and adolescents, and premenstrual dysphoria in women. Current FDA-approved treatments include mood stabilizers (lithium, divalproex, carbamazepine, and lamotrigine) and second-generation antipsychotics (olanzapine, risperidone, quetiapine, ziprasidone, aripiprazole, asenapine, and lurasidone) with robust evidence supporting their differential efficacy across illness phases, and varying adverse effect profiles. There is also currently an increasing appreciation for the need for evidence-based, personalized care. Quantitative (numerical) as opposed to qualitative (non-numerical) approaches have the potential to yield more reproducible outcomes. Number needed to treat (NNT) is a quantitative measure of potential benefit representing how many patients need to be treated to expect one more favorable outcome. Number needed to harm (NNH) is an analogously defined potential risk metric. This course includes presentations of therapeutic advances as well as NNT and NNH analyses of approved pharmacotherapies for various phases (acute mania, acute depression, and maintenance) of bipolar disorder, to facilitate assessments of not only diagnoses but also of risks and benefits of treatments in individual patients. In addition, there are presentations regarding the substantive specific differences in the treatment of bipolar disorder in children and adolescents, as well as in women. Taken together, the information in this course should facilitate clinicians' efforts to perform more accurate assessments and to translate the latest advances in research into evidence-based personalized state-of-the-art care for patients with bipolar disorder.

MAY 06, 2014

PSYCHOPHARMACOLOGY

Director: Alan F. Schatzberg, M.D.

Faculty: David Sheehan, M.B.A, M.D.; Charles DeBattista, M.D.; Terrence Ketter, M.D.; Antonio Hardan, M.D., Rona Hu, M.D.

SUMMARY:

This Masters Course in Psychopharmacology will present new material on the pharamacologic treatment of major psychiatric disorders. The course will involve presentation of data, Q&A, and case discussions.

DIAGNOSTIC INTERVIEWING USING DSM-5

Director: Abraham M. Nussbaum, M.D.

Faculty: Gary J. Gala, M.D., Bipin Subedi, M.D., Cathryn A. Galanter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the differences between DSM-IV-TR and DSM-5 and how they alter the diagnostic exam.; 2) Utilize DSM-5 to screen for and diagnose the major categories of mental illness.; 3) Develop strategies for teaching DSM-5 to trainees.; 4) Explore how DSM-5 is utilized in child/adolescent, forensic, and psychosomatic settings.; 5) Become aware of DSM-5 screening tools, rating scales, and emerging models.

SUMMARY:

In May 2013, the APA released DSM-5, the first version of the Diagnostic and Statistical Manual of Mental Disorders organized on the basis of advances in the neurosciences. In this course, we will explore how DSM-5 is altering the diagnostic interview. We will examine the structure of DSM-5, which organizes diagnoses, when possible, on the basis of the underlying dysfunction. We will review DSM-5's definition of a mental disorder, which points toward a neuroscientific definition of mental illness. For each of the main categories of mental illness, we will discuss screening tools for both general medicine and mental health settings. Presenters will show how they use DSM-5 as adult, child and adolescent, forensic, and psychosomatic psychiatrists. We will discuss how to learn DSM-5 and how to teach it to trainees. We will discuss how DSM-5 can be used in different clinical settings. We will introduce DSM-5 screening tools, symptom rating skills, and emerging models like the Cultural Formulation Interview and the hybrid dimensional-categorical personality disorder diagnostic system. This course is ideal for anyone interested in learning how to fully integrate DSM-5 into his or her practice. The course will use the best-selling Pocket Guide to the DSM-5 Diagnostic Exam as a starting point, but will also explore other ways of putting DSM-5 into practice.

MAY 03, 2014

***WHAT MAISIE KNEW*: HOW CHILDREN UNDERSTAND FAMILY CONFLICTS AND DIVORCE**

Chairs: Beth M. Belkin, M.D., Ph.D., Scott Palyo, M.D.
Speakers: Beth M. Belkin, M.D., Ph.D., Scott Palyo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will recognize the emotional impact of divorce and custody disputes on child development; 2) Attendees will appreciate that children often see much more than they understand; 3) Attendees will learn that parents may use children as pawns in custody disputes; 4) Attendees will become more familiar with the complexities, the emotional toll, and the role of parenting in divorce and custody disputes.

SUMMARY:

The 2013 film "What Maisie Knew" will be screened, followed by a discussion including one of the filmmakers as well as experts in the legal and psychological aspects of divorce. An adaptation of Henry James' 1897 novel about a messy divorce, the film is updated to contemporary New York. In both the novel and the film, the parents aren't just selfish, bad at parenting and preoccupied with their jobs--they're handsome monsters, giddily promiscuous and living ruthlessly for pleasure. (1) Maisie is a child divided by her parents in consequence of their being divorced. She was "divided in two and the portions tossed impartially to the disputants. They would take her, in rotation, for six months at a time."(2) Maisie views the actions of her parents impassively, fixing on them "just the stare she might have had for images bounding across the wall in the slide of a magic lantern...strange shadows dancing on a sheet."(2) Her parents become more involved in their post-divorce lives and new partners, using Maisie mainly as a pawn in the war they are waging against each other, "a little feathered shuttlecock they could fiercely keep flying between them."(2)In the film, Maisie lives with her parents in a beautiful Tribeca apartment. Her mother Susanna is a rock star, working on a new album, and father Beale is an English art dealer, always on his cell phone. Their vicious arguments are constant background noise in Maisie's life, and she is shown coloring in her room or playing with her toy horses as sounds of parental hatred ricochet up through the floorboards. It might as well be traffic outside for all Maisie reacts to it. Divorce is clearly inevitable with these two, but it is once they separate that the combat really begins. (3)Many children, after divorce, move into a vacuum created by parents who are overwhelmed by the changes in their lives and unable to carry on as they had before. Divorce often lead to a partial or complete collapse in an adult's ability to parent for months and sometimes years after the breakup. Caught up in rebuilding their own lives, mothers and fathers are preoccupied with a thousand and one concerns, which can blind them to the needs of their children.(4)The story of Maisie depicts a child who is a victim of two wretchedly selfish people. The film provides a view into her clear-eyed but imperfect understanding and interpretation of the mysterious world of the adults in charge of her. It can serve as a springboard for discussions about loss of innocence, the nature of resilience, and the impact of bitter custody disputes on child emotional and mental health. 1. Horne, P. (2013) WMN on Film, Telegraph Media Group Ltd. 2. James, H. (1897) WMN, London: Penguin Books. 3. Ebert, R. (2013) WMN, www.rogerebert.com/reviews. 4. Wallerstein, J., et al. (2000) The Unexpected Legacy of Divorce, New York: Hyperion.

***HOW TO SURVIVE A PLAGUE*: A STORY OF THE EARLY AIDS EPIDEMIC; THE DEVELOPMENT OF ANTIRETROVIRAL DRUGS; AND THE IMPACT THIS HAD ON OUR PATIENTS.**

Chair: Philip Bialer, M.D.
Speakers: Joseph Lux, M.D., Kenneth Ashley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the struggle to develop and approve drugs to treat HIV/AIDS; 2) Understand the devastating emotional impact of the early AIDS epidemic; 3) Identify the actions that activist groups can take to speed the process of drug development.

SUMMARY:

Since the beginning of the HIV/AIDS epidemic, more than one million people have been diagnosed with AIDS and half of them have died. Alarmingly, new HIV infections remain remarkably stable at about 50,000 per year and at the end of 2009 it was estimated that more than 1.1 million people in the U. S. are living with HIV infection. Men who have sex with men accounted for 61% of these new infections and many of these were among men of color.

Since the introduction of the first protease inhibitors in 1996 as part of multi-drug regimens to treat people with HIV/AIDS many have come to see this illness as a manageable, chronic condition rather than the "death sentence" such a diagnosis used to imply. However, the development and FDA approval of the first antiretrovirals initially was not an easy or timely process following the usual pathways. This moving documentary film is the story of how two activist groups, ACT UP and TAG (Treatment Action Group), were able to influence the pharmaceutical industry and government agencies to identify promising new drugs and move them from experimental trials to patients in record time.The panel, which will include clinicians working with this population since early in the epidemic, will discuss the impact that HIV/AIDS had upon our patients during the time preceding the availability of antiretroviral drugs and how this has evolved with current treatments.

***BLACK SWAN* - PERFECTIONISM, SELF-MUTILATION AND MADNESS**

Chairs: Alice R. Mao, M.D., Monica Grover, M.D.
Speakers: Jennifer Yen, M.D., James W. Lomax, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of the conflict between parents' vs personal goals on creating a cohesive sense of self in young adolescents; 2) Appreciate the struggles of adolescent girls as they find their sexual identity; 3) Recognize the pressures placed on competitive dancers and the consequences of the extreme perfectionism required of young ballerinas.

SUMMARY:

Background: Adolescence and young adulthood is a critical time for the formation of self-identity. One's sense of self is profoundly influenced by parental, peer and romantic attachments. For young girls, the stress of dysfunctional attachments can manifest itself in mental illness, including eating disorders, depression and anxiety. Participation in sports, including dance and gymnastics as well, frequently compounds attempts

at establishing a stable identity in the way it requires an unwavering focus on perfection and a denial of physical or emotional weakness. Black Swan (108 minutes), a full length feature film directed by Darren Aronofsky and released in 2010, portrays a young ballerina, Nina, as she struggles within the competitive world of the ballet to become the lead dancer in Swan Lake. The movie was widely screened throughout the United States, receiving four Academy Award nominations and one win for Natalie Portman as Best Actress. When Nina lands the lead as both the White and the Black Swan she must cast off her innocence and perfectionism in order to successfully perform the role of the uninhibited and seductive Black Swan. As she goes to extreme lengths to recreate herself as a ballerina, she also goes through a radical process of self-transformation, unfortunately resulting in tragic consequences. Method: A brief introduction will be made followed by a screening of the Black Swan. Each presenter will briefly discuss a major theme and explore one particular character's relationship with Nina and their effects on her transition to prima ballerina. An analysis of the consequences of transgenerational narcissism on Nina's individuation and autonomy will be given, followed by a discussion on the role of Nina's choreographer as both father figure and catalyst for sexual. We will also examine the nature of Nina's relationship with her co-ballerina, Lily. Finally, the manifestations of Nina's internal conflict through her physical self, as evidenced by self-mutilation and restrictive eating habits, will be explored. Results: Black Swan demonstrates the implications of dysfunctional parental interactions on adolescent self-identity and sexual maturity. This depiction of a young woman with a fragile sense of self, suffering from an untreated mental illness will provide stimulus for discussion regarding the contrast between clinical reality and media depiction of mental illness. Conclusions: While most parents desire to raise children to be independent and resilient, they can also be blinded by their personal desires and the need to cope with their own psychopathology. From a unique perspective, the film dramatically illustrates the role of maladaptive relationships and their negative impact on adolescent development. Audiences are given a brief window into the life of a young woman struggling with severe psychosis , allowing them to better appreciate the implications for treatment.

MAY 04, 2014

CONCUSSION IN YOUTH SPORTS: THE ROLE OF PSYCHIATRY
Chairs: David Baron, D.O., M.Ed., Marientina Gotsis, M.F.A.
Speaker: D. Andrew Baron, B.A.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List the most common psychiatric symptoms associated with concussion in athletes; 2) Discuss the role of film in educating athletes, coaches, parents, and the public about symptoms of concussion in sports; 3) Diagnose concussion in youth athletes; 4) Identify why youth athletes may not report early symptoms of concussion.
SUMMARY:
It is difficult to overestimate the importance of concussion in youth sports. Over 300,000 youth sports related concussion occur each year, and many more likely go undiagnosed. Until recently, concussion symptoms were thought to be almost exclusively neurologic: headache, dizziness, unstable gait, poor concentration, slowed reaction time. Current clinical observations have demonstrated the critical role of psychiatric symptoms in the immediate post concussive period and beyond. The emphasis on brain safety in contact sports athletes, male and female, has resulted from a number of high profile athletes who committed suicide after having suffered numerous concussions over their years of competition, and the law suits players filed against the league. The NFL settled out of court for $765 million in August, 2013. Despite the increase in public awareness, youth athletes continue to withhold information about head trauma to coaches, trainers and parents, risking serious injury. On Setember1, 2013, a 16 year old high school football player died as a result of Second Impact Syndrome related to head trauma during a game. This media seminar will be focused on a short film produced by the session Chair, on this important topic. The co Chair is a interactive media expert who works in TBI research, and has produced award winning films in TBI education, which will also be aired. The role of media as an effective educational tool for youth athletes will be a topic of discussion with the attendees. This is designed to be a highly interactive media session on the use of film to promote public mental health education.

***DON'T CHANGE THE SUBJECT:* A DOCUMENTARY FILM ABOUT SUICIDE**
Chair: Michael Blumenfield, M.D.
Speaker: Mike Stutz
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Assess how this documentary film can be used to stimulate discussion about suicide which is a subject people often don't want to discuss; 2) Suggest how grieving family members of suicide victims can be encouraged to focus on how they lived their lives rather than on why they committed suicide; 3) Identify how the creative arts, particularly dance and comedy, can be used to facilitate discussion about death and suicide .
SUMMARY:
After a brief introduction by Dr. Michael Blumenfield a 97 minute documentary film titled Don't Change the Subject will be shown. This movie was made by Michael Stutz, a filmmaker , director and producer who lost his mother to suicide when he was 12 year old. The film includes an exploration of his mother's suicide as well as interviews with various people who have contemplated ending their lives. There are also creative dance and comedy routines which deal with this subject in a meaningful way. He follows a talented choreographer who is preparing a group of young dancers to perform a piece about autopsies. The result is as dramatic as is the meaning to young performers who had to come to grips with what their dance was about. We are introduced to a successful comedian who has a team of writers help him prepare his material that daringly enough is going to be about suicide. It is about the filmmaker who is trying to figure out why is mother, who he believed loved him, would leave him by her own hand. He reads her letters, listens to tapes of her talking, looks at old film clips and ponders this issue with his older brother, aunt and step mother who married his father after his mom died. His brother never understood how she could have done this when she was in the music business and knew how important was his debut as an opera director that was happening the following week. His aunt, who is a psychiatrist, knew her sister had problems but didn't see this

coming. His stepmother only recently reveals her own special connection with suicide. While the filmmaker may not have ever completely understood why his mother ended her life, he did realize that more then how she ended her life, she should be remembered for how she lived her life which included much love and support to her children. This message alone gives the film great value. However the film accomplishes much more by confronting the stigma that people feel when discussing suicide. This documentary film has received much acclaim in the showings around the country at various colleges and to mental health groups. It also has raised some controversial questions which will be discussed in the interview with the filmmaker by Dr. Blumenfield. There also will be ample time for questions and discussion from the audience.

AFFLICTIONS: CULTURE AND MENTAL ILLNESS IN INDONESIA
Chair: Robert Lemelson, Ph.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand why on a population basis, patients diagnosed with severe mental illness experience less severe symptoms, fewer subsequent episodes and greater job retention than their western counterparts; 2) Consider the long-term care and treatment of mentally ill patients in a developing nation and to illustrate the likely reasons for their outcomes; 3) Learn how film, cinematic language, and person-centered narratives can be used to explore psychiatric issues; 4) Understand how cinema allows a much wider audience to directly and emotionally understand the complex factors that impact the lives of the mentally ill.
SUMMARY:
Afflictions: Culture and Mental Illness in Indonesia, Volume 2: Neuropsychiatric Disorders is the second half in a series of 6 ethnographic films on severe mental illness in Indonesia. The series is based on material drawn from 12 years of person-centered research by director and anthropologist Robert Lemelson. Volume 2 follows 3 individuals of different ages and backgrounds with neuropsychiatric disorders, and explores the relationship between culture, mental illness, and first-person experience. The Bird Dancer focuses on the social stigma of neuropsychiatric disorder and the human suffering it entails. Family Victim examines the bi-directional influences between an individual considered to have a disruptive or troublesome personality and his social world. Kites and Monsters follows a young Balinese from boyhood to manhood, discovering the influential and protective aspects of culture that may guide developmental neuropsychiatric processes.

SIX MILLION AND ONE
Chairs: Anna Balas, M.D., David Fisher
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants who attend this screening will gain new insight into; how to navigate the treatment of patients that are children of affected parents.; 2) Identify and analyze the difference in the responses of siblings who are dealing with their parents traumatic pasts.; 3) Discuss the transmission of trauma from generation to generation.
SUMMARY:
Four siblings in search of history and an understanding of their father's life set out on a remarkable journey in this eloquent documentary about four adult children of Holocaust survivors. The film reveals their different reactions to their father, and also features compelling interviews with American WWII veterans who liberated Gunskirchen.

MAY 05, 2014

TAKING THE BULL BY THE HORNS: ANALYZING THE MOTION PICTURE *ONE FLEW OVER THE CUCKOO'S NEST,* **WINNER OF THE TOP 5 ACADEMY AWARDS.**
Chair: Lawrence Richards, M.D.
Speakers: Roger Peele, M.D., Michael A. Schwartz, M.D., Steven Moffic, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1)Study, expand upon, and to correctly discuss the record of this motion picture's effect upon psychiatry, including why the bell is rung at the opening of the APA's other meeting, the IPS; 2)Better correlate the movie's relationships to the neuropsychiatric areas of community psychiatry, historical state hospital forensic relationships, electroconvulsive therapy, and neurosurgery. ; 3)Have some update on history and status of ECT and psychosurgery as neuropsychiatric somatic therapies, these latter now including Deep Brain Stimulation and Transcranial Magnetic Stimulation; 4)Better comprehend the doctor-patient relationship and issues of trust, private versus state facilities, and the forensic improvements like informed consent and research review committees; 5)Learn from and exchange ideas and memories with speakers having administrative, community, historical, psychoanalytic, psychosocial, and treatment expertise as well as from one another.
SUMMARY:
This movie will be used to teach some history of psychiatry, including the state hospital system, history and use of ECT, some about other forms of convulsive therapies, psychosurgery, and move on toward psychiatric wards, duration of treatment, length of stay, group therapy, therapeutic mileau, community meetings, patient government and the role of psychoanalysis and the legal status. The film is shot in and around Oregon State Hospital, and psychiatrist Dean Brooks advised about and eventually performed in the movie. Audience will be asked to share about their training days and residency experiences. The story also works well for discussions on diagnoses of the patients seen, discussion on the milieu as shown, discussions of treatments as shown, comparisons with that available today, along with observations of the staff and physical plant. The story is about a state hospital, it's staff, it's patients, a few outsiders in the community, and a new admission who has factitiously convinced the criminal justice system he has a mental illness. This film has a mixed reputation among our colleagues, and at the 2013 Media W/S about Hollywood's portrayal of psychiatrists, this film was cited as the one most destructive to psychiatry. Most importantly, this session will serve to alert, orient, and update younger psychiatrists about this film, its impact on psychiatry, and the standing of mid-20th C psychiatry. It's obviously a well made film that 'struck a chord' nationally back in the 1970s, along with winning the top five awards of the Academy of Motion Picture Arts and Sciences. The presenters believe rather than being avoidant, anxious, defensive, simply unaware, or in some cases guilt ridden, about the content of this major Oscar winning film, today's younger psychiatrists

should be aware and prepared to educate the public as well as the media "p.r.n." The old proverb for this is : take the bull by the horns.

References: 1.Max Fink, M.D. for extensive publications in re Electro-Convulsive Therapy, i.e. ECT; 2. The Film was released in 1975, and in 1976 won the following Academy Awards: Michael Douglas and Saul Zaentz for producing the Best Picture;Louise Fletcher for Best Actress; Jack Nicholson for Best Actor; Milos Forman for Best Director; Messrs. Hauben and Goldman for Best Adapted Screenplay, thereby becoming the first film in 41 years to sweep all 5 major categories. Brad Dourif playing Billy was nominated for best supporting actor, and all these won six Golden Globes. Three other Academy nominations included film editing, cinematography, and original musical score; Danny DeVito also played a patient, Mr. Martini. 3. Lawrence Richards, M.D. will handout a history of psychosurgery summarized by the dates, which includes the Nobel Prize for Medicine and Physiology in 1949. So, what went wrong?

***SIDE EFFECTS* - THE MOVIE FOLLOWED BY A PANEL DISCUSSION WITH THE PRODUCER AND WRITER, SCOTT Z. BURNS AND CO-PRODUCER, A. SASHA BARDEY, MD**

Chair: Alexander S. Bardey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of malingering and its detection in the criminal justice system; 2) Explore the use of malingering and its depiction in a feature film; 3) Explore the role of lying in our culture.

SUMMARY:

We will be screening Side Effects, a feature film released earlier this year, written and produced by Scott Z. Burns, directed by Steven Soderbergh and co-produced by A. Sasha Bardey, MD. The story uses Big Pharma as a backdrop to a story of murder, insanity, malingering and retribution. The film highlights issues of good, evil, mental illness and deception. Through an interactive discussion with the writer-producer and co-producer we hope to engage an informed audience in a discussion about malingering and deceit, its depiction in this film,in broader media and in our culture.

MAY 06, 2014

***VOICES* - DOCUMENTARY FILM ABOUT THE HUMAN AND UNTOLD STORIES OF PSYCHOSIS**

Chairs: Gary Tsai, M.D., Rachel Lapidus, M.D., M.P.H.
Speaker: Hiroshi Hara, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Better recognize and empathize with the challenges of living with psychotic illness, both for the individual and family; 2) Identify practices which may better meet the needs of their psychotic patients; 3) Recognize cultural issues which may play a role in their clinical encounters, particularly for their Asian clients.

SUMMARY:

Voices tells the real stories of three individuals from very different backgrounds, all of whom are connected by their struggles with psychotic mental illness. While distinct in many ways, their life journeys are also bound by the commonality of the human experience. In this state in which reality is bendable and at times frightening, the impact of psychosis is often misunderstood and incomprehensible to those unfamiliar with this unique experience. Subsequently, the human side of the psychotic experience is often lost. Exploring the compelling stories, struggles, successes and heartbreak of its featured individuals and their families, Voices offers a humanizing glimpse into lives and stories which are frequently confined to the shadows of society. For more information: www.VoicesDocumentary.com

UNDERSTANDING JOY: A PERSONAL STORY OF PATHOLOGICAL GAMBLING

Chair: Christopher Welsh, M.D.
Speakers: Joanna F. Franklin, M.S., Susan Hadary, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize some of the common signs and symptoms associated with Gambling Disorder; 2) Appreciate the personal toll Gambling Disorder can take on an individual's life; 3) Describe some of the similarities between Gambling Disorder and other Addictive Disorders.

SUMMARY:

Today, the medical profession, judicial system, policy makers, and the general public struggle to deal with issues related to gambling addiction, trying to understand the underlying medical basis of what is now understood to be a devastating disorder capable of transforming the lives of individuals, leading them to sacrifice their family relationships, work, moral values and every other aspect of their well-being. In this documentary, the issue of Gambling Disorder is explored through the tragic story of Joy, a woman who lost everything due to her gambling. Commentary from experts in the fields of psychiatry, neurology and law add insight to various aspects of the disorder. Members of the Maryland Center of Excellence on Problem Gambling and the movie's director will lead a discussion of the movie.

***NO KIDDING? ME TOO!* - A DOCUMENTARY BY JOE PANTOLIANO**

Chairs: Paul Summergrad, M.D., Joe Pantoliano

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the barriers to public acknowledgement of mental illness and substance use disorders; 2) Appreciate the burdens that stigma place on all those who suffer; 3) Consider opportunities to educate the public and achieve parity for mental health care.

SUMMARY:

Becoming public about mental health or substance use conditions requires courage, commitment and support. The stigma surrounding these illnesses makes such public disclosure even more difficult. This empowering documentary sheds light on what nearly 100 million Americans suffer in isolation. It does so through candid, often humorous discussions with seven people from all walks of life, all affected differently by mental illness, including a brain surgeon with bipolar disorder, and three high school students managing bipolar disorder and clinical depression. Each frankly discusses the struggle before they were diagnosed, including attempts at self-medication and other destructive behavior, as well as the hope and encouragement they discover when managing their own recovery and realizing they are not alone. The result is an inspiring vision of a

society where those impacted by mental illness are surprised to find millions of others like themselves. After the film is presented Joe Pantoliano the director and Emmy Award-winning actor, will join APA President-elect in a conversation about mental health, stigma, recovery and what we need to do together to achieve the right care for all persons who suffer with these important brain disorders.

MAY 07, 2014

***VALENTINE ROAD:* A FILM ABOUT A TEEN MURDER**
Chair: Richard R. Pleak, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Illustrate complex issues of teen murder; 2) Appreciate issues of violence on the basis of gender identity; 3) Understand hatred against others developing in youth .
SUMMARY:
Valentine Road is a wrenching, powerful 2013 film exploring the true story of the in-school murder of a 15 year-old boy by the 14 year-old male classmate he asks to be his valentine. The film explores the complex issues of extreme victimization based on homophobia and transphobia, adolescent hatred and white supremacism, as well as forensic issues of trying adolescents as adults. The 90-minute film, shot over several years with interviews with family and jurors, will be screened with a discussion following. The filmmaker will be invited to attend the discussion.

THE KING OF KONG: VIDEO GAMING AS RECREATION, PROFESSION, AND ADDICTION
Chairs: Petros Levounis, M.D., Tauheed Zaman, M.D.
Speakers: Mona Thapa, M.D., Nedson Campbell, M.D., Mandrill Taylor, M.D., M.P.H.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Assess individuals with video gaming problems; recognize diverse clinical presentations; and diagnose video gaming addiction.; 2) Treat video gaming compulsive behaviors using Cognitive-Behavior Therapy (CBT) and Motivational Interviewing (MI).; 3) Identify common elements shared by video gaming addiction, other behavioral addictions, and substance use disorders.
SUMMARY:
The King of Kong: A Fistful of Quarters (2007, 79 minutes) is a documentary that follows diehard video game enthusiasts as they compete to break Guinness World Records playing the classic video game "Donkey Kong." What seems to start as a youthful, playful, and essentially harmless sport, develops into a fiercely competitive sport, and perhaps a bona fide behavioral addiction. Do the players in the film suffer from a medical condition or are they exhibiting an exaggerated form of everyday social and personal ailments? Are they professional athletes, of sorts, or are they just having fun? Recently, both the American Psychiatric Association and the American Society of Addiction Medicine have accepted behavioral addictions under the umbrella of more traditional addictions, namely the substance use disorders. However, there are several behaviors that have significant compulsive traits but for which we have not quite made up our minds whether we should classify them as addictions or not. Are there such things as sun-tanning, exercise, or video gaming addictions? What about food addiction, work addiction, or love addiction? Looking at all these behaviors as potential addictions seems sometimes serious, sometimes silly, and almost always arbitrary. The spectrum of illness that encompasses the behavioral addictions feels like a slippery slope that starts with discrete and legitimate medical conditions and tumbles all the way down to capricious (and occasionally fraudulent) medicalization of everyday life. Given this context, we will discuss "The King of Kong" as a detailed case study to examine the cultural and scientific contexts of video gaming, the difficulties of defining compulsive behaviors, and the clinical approach to the assessment and management of video gaming addiction. We will discuss the psychodynamic underpinnings of the relationships vividly depicted in the film, and broaden these to an understanding of the conflicts and experiences common to many other types of addiction. Finally, we will develop a bio-psycho-social formulation based on our case study, discuss a potential treatment plan, and provide resources to clinicians who treat patients with such disorders in their everyday psychiatric practice. The workshop is open to all psychiatrists who would like to study the assessment and management of video gaming addiction and its similarities to other addictions, but is particularly targeted towards members in training and early career psychiatrists.

MAY 03, 2014

CREATIVE APPLICATIONS OF PSYCHODYNAMICS
Chairs: Cesar A. Alfonso, M.D., Mary Ann Cohen, M.D.
Discussant: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the psychodynamics of creativity and clinical applications in the care of creative individuals; 2) Apply the psychodynamics of attachment theory and early childhood trauma to the care of young parents and their infants as well as children, adolescents, and adults; 3) Identify psychodynamic aspects of developmental milestones, richness of experiences and challenges of late life in order to adequately conduct psychotherapy with older adults and caregivers; 4) Understand how to integrate psychodynamic principles in the care of survivors of torture; 5) Learn creative ways to teach psychodynamics to psychiatric residents throughout their training experiences in a variety of treatment settings.

SUMMARY:
Applying psychodynamic psychotherapy principles is a challenging endeavor but can be effectively accomplished using different methods in a variety of settings. Experienced clinicians in academic leadership positions will illustrate how to integrate creatively psychodynamic principles in psychiatric practice. The first presenter, Dr. Clarice Kestenbaum, a Past President of The American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) and of the American Academy of Child and Adolescent Psychiatry, will explore the effects of early childhood trauma on physical and psychological functioning in adult life. The second presenter, Dr. Richard Brockman, Associate Professor of Psychiatry at Columbia University Medical Center, psychoanalyst and successful playwright, will take up the challenge of treatment impasses with patients who engage in repetitive negative patterns of behavior. After presenting a review of the neurobiology of the repetition compulsion he will explore the neurobiology of a new idea and free choice. The third presenter, Dr. Asher Aladjem, Clinical Professor of Psychiatry at NYU, will share his experience caring for people who have experienced severe trauma, transcontinental displacement, and political persecution based on his experience as one of the founders and chief psychiatrist for the NYU/Bellevue Program for Survivors of Torture. Psychodynamic approaches to treatment can provide a safe haven for the survivor of torture and a means to heal. The fourth presenter, Dr. Douglas Ingram, a Past President of the AAPDP and Clinical Professor of Psychiatry at New York Medical College, will describe applications of psychodynamic principles in the treatment of spousal caregivers. The description of psychodynamic therapy for individuals with anxiety and depression consequent to the burden of caregiving provides an approach to their successful treatment. The fifth presenter, Dr. Joanna Chambers, Director of Residency Training at Indiana University, will challenge the conventional curricula and practice of teaching psychodynamic principles to residents by presenting a new pedagogic paradigm that integrates neurosciences and psychological theory. She will describe a model that includes teaching a thorough understanding of the neurobiology of a patientÊ¼s presentation, their psychology from various analytic and other psychotherapeutic schools of thought, the various social factors that impacts each of these, and most importantly the integration of all three areas. The symposium discussant will be Dr. Dilip V. Jeste, a master clinician, APA Immediate Past President, Estelle and Edgar Levi Chair in Aging, Director of the Sam and Rose Stein Institute for Research on Aging at UCSD. There will be ample time for audience questions and discussion. This symposium is sponsored by the American Academy of Psychoanalysis and Dynamic Psychiatry, an allied organization of the APA.

NO. 1
EARLY CHILDHOOD TRAUMA MAY RESULT IN ADULT PSYCHOPATHOLOGY: CAN PSYCHODYNAMIC THERAPY WITH YOUNG CHILDREN CHANGE THE OUTCOME?
Speaker: Clarice J. Kestenbaum, M.D.

SUMMARY:
Early childhood trauma is an overwhelming life stressor with profound effects on physical and psychological functioning. How much stress is necessary to produce a trauma in any given individual? An individual's coping mechanisms and resilience and the presence or absence of support systems determines the outcome.
Several illustrative vignettes describe adult psychopathology such as anxiety, phobic avoidance, and depression when traumatic events in childhood were not dealt with. In contrast, the author presents three clinical examples where creative play therapy, story-telling, and doll play helped young children work through their traumatic experience. A 20-year follow-up with successful outcomes offers anecdotal evidence of therapeutic efficacy.

NO. 2
THE NEUROBIOLOGY OF A NEW IDEA - PSYCHOTHERAPEUTIC IMPLICATIONS
Speaker: Richard M. Brockman, M.D.

SUMMARY:
A vignette describes a patient who is 'stuck' stuck in repetitive patterns of thinking/behavior/choice. The clinical example will demonstrate a patient who repetitively makes choices that leave her more or less with the same unsatisfactory result, in more or less the same unsatisfactory place. Even when she is convinced that she has chosen a new path, she finds herself where she began. The underlying neurobiology of this "repetition compulsion"? will be explored. Data and hypotheses will serve to explain why and how someone might always be led to make the same ˜bad" choice. The opposite will then be explored: the neurobiology of a new idea, that is to say the neurobiology of a free choice. We conclude with the practical applications of these neurobiological concepts in the clinical setting.

NO. 3
PSYCHODYNAMICALLY-INFORMED TREATMENT OF SURVIVORS OF TORTURE
Speaker: Asher Aladjem, M.D.

SUMMARY:
A recent study of 55,000 Holocaust survivors indicated that survivors live longer than non-survivors. The implications of this

study in the context of working with survivors of torture will be explored and clarified in terms of "carrying the message," finding new meaning in life, and the drive to live longer.
Caring for survivors of torture requires an understanding that the experience of torture is a life-altering one. Helping to seek ways to find a tolerable place for torture that does not diminish or trivialize the trauma can allow the survivor to live with his or her experience and find new meaning in life. Psychodynamic approaches to treatment can provide a safe haven for the survivor of torture and a means to heal.
This presentation is based on the multidisciplinary work done in the clinics of the NYU/Bellevue Program for Survivors of Torture.

NO. 4
PSYCHODYNAMIC PSYCHOTHERAPY WITH SPOUSAL CAREGIVERS
Speaker: Douglas H. Ingram, M.D.

SUMMARY:
Clinical vignettes will serve to illustrate the applications of psychodynamic principles in the treatment of spousal caregivers. The description of psychodynamic therapy of patients with anxiety and depression consequent to the burden of caregiving provides an approach to their successful treatment. Psychotherapeutic sessions conducted once or twice weekly incorporate supportive, limit-setting, confrontational, and dialogic elements within a psychodynamic clinical matrix. The slow yet progressive dementias of the ill spouse impose a burden on the so-called well spouse that often requires ongoing support best accomplished from the perspective of a psychodynamic orientation. Adjunctive medication is often beneficial. Transference and countertransference factors figure significantly in the ongoing treatment of spousal caregivers.

NO. 5
TEACHING PSYCHODYNAMICS IN 2014
Speaker: Joanna E. Chambers, M.D.

SUMMARY:
Psychiatry as a field is evolving. In the last century, our field has moved from an emphasis on the psychoanalytic to an emphasis on the biological aspects of mental illness. As neither the psychotherapies of our day nor the pharmacological and genetic research has yet to explain or treat all mental anguish, we need to integrate the neurosciences with the psychology. To date, these two areas of psychiatry have been studied and taught as separate entities. I will present an educational model for teaching our residents in an integrated fashion, including the theories of neuroscience, DSM diagnosis, psychopharmacology, and psychological perspectives. The goal of this model includes teaching a thorough understanding of the neurobiology of a patientâ€™s presentation, their psychology from various analytic and other psychotherapeutic schools of thought, the various social factors that impacts each of these, and most importantly the integration of all three areas.

HOT TOPICS IN FORENSIC PSYCHIATRY
Chair: Debra Pinals, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe common elements of malpractice and risk management considerations in psychiatric practice related to firearm inquiries and antisocial personality disorders; 2) Describe clinical and legal framework related to the Family and Medical Leave Act and the Americans with Disabilities Act; 3) Describe phenomenological aspects of mass murder from a forensic psychiatric perspective.

SUMMARY:
Forensic Psychiatry is a field that is diverse and exciting. General practitioners in psychiatry frequently encounter issues and cases that raise a number of clinical, legal, policy, and ethical questions that dovetail forensic practice. The American Academy of Psychiatry and the Law (AAPL) provides a resource for education on an array of topics related to this field. In this symposium, leading educators of AAPL will present a sampling of six topics that are of interest to general practitioners. Topics that will be covered include an overview of risk management and psychiatric malpractice case considerations, psychiatric approaches to addressing patient access to and usage of firearms and recent legislation that impacts these discussions with patients. As another angle on risk assessment, this symposium will provide an overview of assessing and treating antisocial personality disorder and patients with psychopathic personality traits. Participants will also learn about the detection of malingered memory deficits to help address this vexing issue that arises in clinical practice. Additional presentations will cover psychiatric evaluations related to the Family and Medical Leave Act and the Americans with Disabilities Act. Finally, the presentation will include an overview of current knowledge related to mass murder, and how this type of occurrence can be understood from a forensic psychiatric perspective. Through these topical presentations, this symposium aims to reflect a broad range of topics that bring legal and psychiatric issues together. The symposium will be structured to allow participants to ask questions of leaders in the field of forensic psychiatry to enhance overall knowledge.

NO. 1
FIREARM INQUIRIES: WHEN, WHETHER AND WHAT TO ASK
Speaker: Debra Pinals, M.D.

SUMMARY:
Recent media presentations have focused on firearm access by persons with mental illness. Many questions have been raised along legal and clinical domains relevant to firearms for persons who present in clinical contexts. With this increased focus, there is an evolving landscape that psychiatrists continue to navigate when patients present with issues related to firearms. As part of general psychiatric practice, risk assessment for violence and suicide is an important aspect of treatment and often includes questions related to firearm usage and access to weapons. That said, most psychiatrists have not received formal training on how to conduct these inquiries and what to do with responses provided. In this portion of the symposium, a general overview of recent statutory developments related to firearms and mental illness will be covered, along with some general guiding principles about how to incorporate questions into risk assessments and considerations for actions that may come about related to responses provided by patients.

NO. 2
PSYCHIATRIC MALPRACTICE: CONSIDERATIONS FOR RISK MANAGEMENT
Speaker: Debra Pinals, M.D.

SUMMARY:
Malpractice litigation in psychiatry can include any number of claims, including cases involving suicide or violence, allegations of negligent discharge from psychiatric hospitals or failure to obtain informed consent related to medication side effects, to name a few. In each case, the plaintiff must prove certain elements, and often expert testimony, or at least expert review of the facts is utilized to help convey whether there was a deviation from the standard of care. Psychiatrists must practice with good clinical judgment and not be stymied by overwhelming concerns of litigation. That said, understanding how malpractice cases unfold, the four "D" s of negligence, and the role of the expert in psychiatric cases can help de-mystify civil tort litigation and can help practitioners understand and develop steps to mitigate risks of future litigation. This overview will utilize actual examples and provide a basic foundation for practitioners interested in learning more about the nuances of malpractice cases seen in clinical psychiatry.

NO. 3
TREATMENT OF ASPD AND PSYCHOPATHY: HOPEFUL OR HOPELESS?
Speaker: Charles Scott, M.D.

SUMMARY:
Individuals with Antisocial Personality Disorder and psychopathy pose a significant risk to society, both in terms of their violation of the rights of others and in the financial costs to address these violations. This presentation reviews important distinctions between ASDP and psychopathy. The Hare Psychopathy Checklist-Revised (PCL-R) will be reviewed with a discussion of its relevance in assessing a patient's risk of future violence. A review of pharmacological and psychological treatment approaches designed to "treat" ASPD are highlighted. Research that examines treatment outcome of intense programs designed for "Dangerous and Severe Personality Disorder" patients will be highlighted.

NO. 4
EVALUATING AMNESIA: A GUIDE TO REMEMBER
Speaker: Charles Scott, M.D.
SUMMARY:
Amnesia claims are common in both civil and criminal litigation. However, structured assessment approaches are often absent or lacking in assessments of claimed amnesia. Long-term memory systems important to assess include both declarative and nondeclarative systems. Four key types of memory subtypes include semantic, episodic, procedural, and priming memories. This presentation will provide an overview of how memories develop and how memories may become contaminated over time. Specific interview and psychological testing methods to assess claimed memory loss will be emphasized. Particular attention will be given to the assessment of malingered amnesia to include such evaluation strategies known as the "floor effect" forced-choice memory paradigms, and atypical response patterns.

NO. 5
PREVENTING CHRONIC PSYCHIATRIC DISABILITY: THE FAMILY MEDICAL LEAVE ACT AND THE AMERICANS WITH DISABILITIES ACT IN CLINICAL PRACTICE
Speaker: Liza Gold, M.D.

SUMMARY:
Patients with acute or recurrent psychiatric disorders often develop functional impairments. These may progress to disability issues, which have implications for patients' financial, social, and occupational future. Clinicians can assist their patients in avoiding the development of a chronic disability status by supporting functioning while treating illness. The option of limited work leave and gradual transition back to work with reasonable accommodations can help prevent the development of chronic disability or stressful job loss while giving patients more time to stabilize their psychiatric symptoms. To assist patients in maximizing their occupational functioning and minimizing the impact of psychiatric symptoms on job performance, clinicians should be able to educate and advise their patients about utilizing FMLA leave and ADA's reasonable accommodations. Knowledgeable clinicians can help guide their patients back to occupational functioning and assist patients in protecting their jobs and often their confidentiality in the workplace as well. To do so, psychiatrists need to understand the provisions of the FMLA and the ADA, the role of the psychiatrist when patients choose to utilize these federally protected options, and the benefits and drawbacks associated with them.

NO. 6
MASS MURDER IN AMERICA
Speaker: Phillip Resnick, M.D.

SUMMARY:
The public and the media often turn to psychiatry to try to make sense of a mass murder such as the Newtown, Connecticut school shooting. This presentation will explain the motives, targets, and psychological make up of lone terrorists. Myths about mass murderers will be debunked. For example, they don't "snap," and the incidence of mass murder is not increasing. Mass murderers are often violent true believers who see themselves as warriors on a mission to vanquish a hated enemy. Examples of their enemies include the government, technology, abortionists, and minorities. Domestic terrorists feel elevated above other men. They do not doubt the rightness of their ideology. Most often they do not know their victims. They are not out for money or personal gain, other than the notoriety of their acts. They tend to have few friends, and were quiet and withdrawn as children. The isolation they have felt in their lives is replaced by a strong sense of belonging to their ideological cause itself. They are not psychopaths, because psychopaths are not willing to risk death for a cause other than their own personal gain. Case examples to illustrate the mentality of mass murderers will include the Theodore, Kaczynski, the Unabomber, Timothy McVeigh, the Oklahoma City bomber, and Eric Randolph, the Atlanta, Georgia Olympics bomber.

CHANGING THE PRACTICE OF PSYCHIATRY: EUROPEAN VERSUS U.S. PERSPECTIVES
Chair: Mario Maj, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the main European and US perspectives about ongoing and expected developments in psychiatric diagnosis; 2) Recognize the main European and US perspectives about ongoing and expected developments in psychotherapies; 3) Recognize the main European and US perspectives about ongoing and expected developments in psychiatric services.

SUMMARY:
There is nowadays, at the international level, a climate of growing dissatisfaction and skepticism about the validity of psychiatric diagnoses, the effectiveness of psychiatric treatments, and the organization of psychiatric services. Some differences are emerging in both the scientific and the lay literature between European and US perspectives about how to overcome this crisis. As far as psychiatric diagnosis is concerned, the main emphasis in Europe is being on the limitations of the operational approach and the need for a revival of psychopathology, while in the US the stress is being laid on the need for a diagnostic system which better reflects recent neuroscience advances. In the area of psychotherapies, the role of evidence-based interventions such as cognitive-behavioral therapy and psychoeducation in the management of major mental disorders such as schizophrenia and mood disorders seems to be differently appreciated in Europe vs. the US. Regarding psychiatric services, the shift from hospital-based to community-based mental health care seems to be more extensively endorsed and implemented in Europe, while some drawbacks of the community-based approach, such as trans-institutionalization and de-professionalization of care, seem to be more widely acknowledged in the US. This symposium aims to summarize and discuss these different views, focusing on what European and US researchers and clinicians may learn from the respective experiences and on possible areas of consensus about desirable future developments.

NO. 1
EUROPEAN PERSPECTIVES ABOUT ONGOING AND EXPECTED DEVELOPMENTS IN PSYCHIATRIC DIAGNOSIS
Speaker: Josef Parnas, M.D., Ph.D.

SUMMARY:
More than 30 years after launching the DSM-III, psychiatry and psychiatric classification again seem to confront a crisis, recently made audible by a chorus of critical voices in the face of the release of DSM-5 and preparations of the ICD-11. Some of the “unintended” consequences of the DSM-III/ICD-10 “operational revolution” comprise arbitrariness of the diagnostic thresholds, their inadequacy for detection of psychosis, the issues of co-morbidity (atomization of psychopathological syndromes), inadequacy of structured interviews, dehumanization (mechanization) of psychiatric practice, persisting unreliability of clinical diagnoses, perception of psychiatric academia as being irrelevant for clinical concerns, and, significantly, a disappointment of the neo-Kraepelinian promise of “carving nature at its joints.” Most importantly, “operational” criteria are, in fact, not “operational” in any theoretically significant sense, but rather involve an oversimplification of descriptive psychopathology to a lay level and a strong aversion towards adopting an adequate theoretical framework for psychiatry. Some ongoing responses to these challenges are outlined: dimensional and symptom-based approaches (e.g., to psychosis), suspension of phenotype-related, nosological concerns (Ã la RDoC), revival of prototypical models, and revival of “continental” phenomenology (systematic study of experience, expression, and existence) coupled with interdisciplinary research approach.

NO. 2
U.S. PERSPECTIVES ON PSYCHIATRIC DIAGNOSIS: PAST AND FUTURE
Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:
This presentation reviews US perspectives on psychiatric diagnosis from the pre-DSM-III era into the post-DSM-III era. Changes in diagnostic thinking in the 1970s and earlier compared to post-DSM-III categories are examined. Basic assumptions of current American nosology based on DSM-III viewpoints on etiology, relevance of symptoms versus course, biology, and treatments are reviewed. Those assumptions are critiqued and their strengths and limitations are discussed. Possible future avenues for psychiatric diagnosis in US psychiatry are then formulated, including continuation of the DSM-5 system versus alternatives like the NIMH Research Domain Criteria approach or a new clinical research agenda like the original Research Diagnostic Criteria.

NO. 3
PSYCHOTHERAPY IN EUROPE AND THE ECONOMY: A PRIORITY FOR EARLY AND EFFECTIVE INTERVENTION IN YOUTH?
Speaker: David Fowler, M.B.B.S.

SUMMARY:
The current position of psychotherapy in mental health services is shaped by the economic climate. However, this provides an opportunity as well as a challenge. To justify its position in mental health services, psychological therapies have to show themselves to be efficient, effective and cost effective. This paper firstly provides a brief overview of some of the most promising areas for psychological intervention research across the ages, including developments in low intensity novel computer based interventions for common mental health problems; psychological interventions for psychosis which are now recognized as effective and developments in bipolar disorder as well as in old age and dementia. However, perhaps the most exciting and priority area for psychological intervention development is early intervention in youth mental health. It is beyond doubt that in the economic climate the sharpest point of the axe has fallen on young people with high rates of unemployment and disadvantage. Unfortunately also we know that it is exactly at this age in life where many severe mental health problems evolve, but it is also where service structures are weakest. The paper reviews developing work in early intervention and emergent severe mental health problems, highlighting recent trials and ongoing trials.

NO. 4
U.S. PERSPECTIVES ON THE PRACTICE OF PSYCHOTHERAPY: PRESENT AND FUTURE
Speaker: Michael E. Thase, M.D.

SUMMARY:
For several decades the role of psychotherapy in the treatment of mood, anxiety and psychotic disorders has decreased, due in part to the shift of some portion of treatment to primary care settings and to what might arguably be called an overemphasis on pharmacotherapy. Meta-analyses conducted over the past decade indicate that the specific effects of pharmacotherapy - as reflected by drug vs. placebo differences - are smaller than generally appreciated and that nonspecific elements of treatment account for a larger proportion of benefit than the specific effect of pharmacotherapy. At the same time, meta-analyses have shown that the combination of focused psychotherapy and pharmacotherapy significantly improves the outcomes compared to pharmacotherapy alone for most mental disorders. There is also meta-analytic evidence that the specific elements of psychotherapy are less important than nonspecific ones. It is thus time to improve access to psychotherapy for individuals with mild-moderate nonpsychotic mental disorders as an alternative to pharmacotherapy and to ensure that competently administered psychotherapies are available for those who do not adequately benefit from pharmacotherapy alone. There is a need for training of mental health professionals in evidence-based psychotherapy and for efforts to incorporate lower-cost methods of delivering psychotherapy via Internet and related applications.

NO. 5
EUROPEAN PERSPECTIVES ABOUT ONGOING AND EXPECTED DEVELOPMENTS IN PSYCHIATRIC SERVICES
Speaker: Wulf Rössler, M.D., M.Sc.

SUMMARY:
Any attempt to describe public mental health care in Europe faces the problem of defining Europe and of dealing with the diversity of its health systems. Europe is not identical with the European Union and comprises a huge variety in the economic and social conditions. Thus, it is useful to pinpoint four prototypical clusters concerning mental health care in Europe. One cluster focuses on the UK, where the closure of large asylums has largely been accomplished and a system of community care in the National Health System has been established. The second cluster concentrates on Italy beginning in the 1970s with radical changes in the provision of mental health care. Italy has been in this regard a controversially discussed reform model worldwide. The third cluster describes continental Europe with France and the German-speaking countries. Psychiatric reforms in France were based on a strict sector model, while the German-speaking countries reformed primarily their inpatient system of large state mental hospitals. And the final cluster describes the former East European countries, which quite late have started to reform their mental health care system. During the last decade the European Union has tried to adapt mental health care to collective standards, which will be described.

NO. 6
U.S. PERSPECTIVES ABOUT ONGOING AND EXPECTED DEVELOPMENTS IN PSYCHIATRIC SERVICES
Speaker: Robert E. Drake, Ph.D.

SUMMARY:
The US has at least 51 mental health care systems because each state and the District of Columbia administer separate systems. Nevertheless, the dominance of Medicaid funding for public mental health programs, the widespread use of new medications, the recent economic recession, and the Affordable Care Act have induced similar changes in these systems. Deinstitutionalization occurred in the US during the 1970s and 1980s, with varying development of community-based systems. Erosion in state funding for community mental health programs has occurred over the past decade in virtually every state. People with serious mental illnesses now get more medications and fewer psychosocial services in every state. Losses of low-income housing and other social services have also adversely affected people with serious mental disorders, resulting in high rates of homelessness and incarceration in some states. The Affordable Care Act will extend health insurance and parity of mental health care to a significant portion of the heretofore uninsured, although some states may opt out. Other significant changes underway include integrating the mental health care and general medical care systems and greater use of behavioral health technologies of many types.

HOT TOPICS IN GERIATRIC PSYCHIATRY
Chair: David C. Steffens, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe 3 late life diseases that impact the elderly; 2) Identify 2 biological factors related to late life depression; 3) Describe the demographical trends for older adults with schizophrenia in the next decade; 4) List 3 new agents for the imaging and treatment of early dementia.

SUMMARY:
This session provides an overview of major topics in the field of geriatric psychiatry. Specifically, the presenters will discuss 1) late life depression with cognitive impairment; 2) schizophrenia In later life: and 3) dementia. Participants will be provided an update on best practices as well as a discussion of recent research in these areas that will impact future interventions.

NO. 1
DEMENTIA DIAGNOSIS AND TREATMENT: OLD AND NEW UNMET NEEDS
Speaker: Melinda S. Lantz, M.D.

SUMMARY:
The diagnosis and treatment of Dementia and Neurocognitive disorders has progressed rapidly in areas such as development of biomarkers, neuroimaging agents and considerations for early recognition of mild neurocognitive impairment. Increased awareness of the need for cognitive screening and testing has led to even greater demand for interventions, in an area with limited options. Clinical trials of humanized monoclonal amyloid beta antibodies have been intriguing but frustrating due to limited efficacy. Issues of cost effective treatments remain elusive and the need for daily care of patients with dementia is an ongoing public health issue. Family caregivers continue to provide the majority of care given to patients with dementia with issues of stress, burden and economic instability continuing to increase. The need for home-based behavioral interventions,

ongoing caregiver education and support and clinically relevant respite care services remains high. This session will highlight the new approaches to early assessment and interventions for dementia while addressing our ongoing needs for a system of chronic dementia care.

NO. 2
DEPRESSION, COGNITIVE IMPAIRMENT AND COGNITIVE DECLINE IN LATE LIFE DEPRESSION
Speaker: David C. Steffens, M.D.

SUMMARY:
There is substantial epidemiological evidence linking depression with later development of dementia. In this presentation, this evidence will be briefly reviewed and used as a springboard to discuss more recent clinical/translational research in late life depression, cognitive impairment and cognitive decline.

NO. 3
SCHIZOPHRENIA IN LATER LIFE: NEW PERSPECTIVES ON TREATMENT, RESEARCH, AND POLICY
Speaker: Carl Cohen, M.D.

SUMMARY:
There is a looming crisis in the care of older adults with schizophrenia. The number of older adults with schizophrenia (defined as age 55 and over) is expected to double over the next decade. By 2025, older adults will comprise one-fourth of the population with schizophrenia. This growth will place enormous strains on a care system that has been structured to treat younger people. Recent work supports the emergence of a paradigmatic shift that has implications with respect to how we conceptualize research, policy, and clinical care for this aging population. The paradigm includes several elements that will be discussed in this presentation: (1) There is an increasingly more nuanced approach to outcome; e.g., symptoms and global parameters are only weakly associated with each other and that each measure needs to be examined and treated separately.(2) In general, outcome for most measures are more favorable than had been believed during much of the 20th century. (3) Contrary to earlier conceptualizations, schizophrenia in later life is not a state of quiescence with little change in symptoms or outcome. (4) Course and outcome of schizophrenia in later life can viewed within the psychiatry recovery model and the life course perspective of gerontology.

MAY 04, 2014

PHARMACOLOGIC TREATMENT DILEMMAS IN ADDICTION
Chairs: Steven L. Batki, M.D., Jeffrey DeVido, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the risks and benefits of agonist, partial agonist, and antagonist pharmacotherapies in the treatment of opioid use disorders; 2) Identify the risks and benefits of the different pharmacotherapies for the treatment of alcohol use disorders; 3) Identify the risks and benefits of stimulant and nonstimulant pharmacotherapies in the treatment of ADD/ADHD in individuals with substance use disorders.

SUMMARY:
Nine percent of the adult U.S. population uses illegal drugs, with fully a quarter of the population acknowledging binge drinking as defined by the CDC, 5 or more drinks on one occasion. The addicted patient presents numerous dilemmas to the treating psychiatrist, not least of which is the proper selection of the safest and most efficacious pharmacologic treatments for the main forms of substance use and for some of the co-occurring psychiatric disorders that accompany substance use. This symposium will address the pharmacologic treatment of the addicted patient, focusing on four challenging issues: insomnia, Attention Deficit Disorder (ADD), and the choice of pharmacologic approaches to opioid addiction and alcohol dependence. The attendee will come away with a basic knowledge of state-of-the-art approaches to these situations, which are no less difficult for their frequency. Regarding insomnia and substance use disorders, a growing body of literature provides preliminary evidence regarding which medications may have efficacy or not. When ADD symptoms occur in the presence of an SUD, clinicians must balance the risks of possible misuse with the benefits that stimulant medication may provide. The prescription of opiate agonist/partial agonists and antagonists also hinges on balancing enormous benefits with potential harms and requires examination of the limited data on direct comparison of the efficacy of the different medications. Similarly, the evolving list of medications available for alcohol use disorder require that the clinician have a firm grasp of the risks, benefits, and latest data from clinical trials. This symposium will inform clinicians on the evidence-base for pharmacotherapy choices in these four difficult addiction clinical domains.

NO. 1
TREATING INSOMNIA IN PATIENTS WITH SUBSTANCE USE DISORDERS
Speaker: Kirk J. Brower, M.D.

SUMMARY:
Insomnia is common, persistent and associated with relapse and suicidality in patients with substance use disorders. Due to its multifactorial etiology including substance-related and other underlying factors, clinical assessment of insomnia is crucial before selecting among the best treatment options. Contributing factors include premorbid insomnia (in up to half of cases with alcohol use disorders); co-occurring medical, psychiatric, and sleep disorders; prescribed medications; environmental factors, and inadequate sleep hygiene. Underlying disturbances in sleep regulatory mechanisms (sleep drive homeostasis and circadian rhythm physiology) and genetic influences also contribute. A practical approach to assessment will be discussed, including when polysomnography is indicated. Treatment options include behavioral therapy alone or in combination with pharmacotherapy. Traditional sleeping medications with abuse potential can be avoided in the overwhelming majority of cases, particularly since they are not well-studied in patients with substance use disorders. Preliminary evidence for efficacy will be presented regarding cognitive-behavioral therapy for insomnia and select medications (e.g., trazodone & gabapentin). Important outcomes include both improvement in sleep and prevention of relapse to substance use. Finally, practice points are highlighted, making use of the best available evidence while providing general principles when gaps in our knowledge

exist.

NO. 2
PHARMACOLOGIC TREATMENT OF ADHD IN SUDS
Speaker: Frances R. Levin, M.D.

SUMMARY:
Attention deficit/hyperactivity disorder (ADHD) is the most common psychiatric disorder in children and adolescents. Adults with ADHD are at increased risk for co-occurring substance use disorders. Adults with substance use disorders and co-occurring ADHD, as well as other psychiatric disorders, are overrepresented in clinical populations, and are typically are among the most challenging patients to treat. The most commonly used medication treatments for ADHD are psychostimulants, and the use of these medications in patients with substance use disorders is complex. Common diagnostic and clinical management issues in treating adults with co-occurring ADHD and substance use disorders will be discussed, with special attention focused on the complicated issues that arise when prescribing controlled substance (stimulants) to adults with substance use disorders.

NO. 3
MEDICATIONS FOR OPIOID USE DISORDERS: PRACTICAL CONSIDERATIONS IN SELECTING OPIOID AGONIST AND ANTAGONIST THERAPIES
Speaker: Hilary Connery, M.D., Ph.D.

SUMMARY:
The prevalence of opioid use disorders (OUD) has increased 10-fold over the past decade and both heroin use and illicit prescription opioid analgesic use has increased dramatically among youth cohorts, leading to a national epidemic of opioid-related overdose deaths. The prevention of morbidity and mortality due to OUD is a public health imperative, and evidence-based medication therapies for OUD have been demonstrated across studies and regional cohorts to consistently double the rates of opioid abstinence achieved in treatment for OUD, while medical detoxification alone results in rapid relapse (> 80% in most studies). There are currently three types of pharmacologic stabilization and maintenance therapies targeting central mu-opioid receptors: 1) full agonist stabilization/maintenance with methadone, 2) partial agonist stabilization/maintenance with buprenorphine, and 3) antagonist stabilization/maintenance with extended-release naltrexone . These medical therapies will be reviewed with consideration of mode of effectiveness, comparative risks and benefits of each medication, patient-specific considerations to guide treatment choice, and risk management strategies to incorporate into office-based practice.

NO. 4
ALCOHOL PHARMACOTHERAPY: WHAT IS THE FIRST LINE MEDICATION?
Speaker: Kathleen Brady, M.D., Ph.D.

SUMMARY:
During the past 20 years, great strides have been made in understanding the neurobiology of alcohol dependence. This increased understanding has led to the investigation of new therapeutic targets for the development of potential pharmacotherapeutic agents and several agents have received FDA approval for relapse prevention in alcohol dependence. In this presentation, new data on optimal use of naltrexone, alone and in combination with other agents, will be presented. The use of agents targeting glutamatergic systems, including topiramate, will be reviewed. Evidence supporting the involvement of endocannabinoids, Substance P, oxytocin, CRH and other stress system peptides in the pathophysiology of alcohol dependence and potential for therapeutic development in these areas will be discussed. Finally new findings in the pharmacotherapy of co-occurring psychiatric disorders and alcohol dependence will be covered.

MISSED OPPORTUNITIES IN PSYCHIATRIC PRACTICE
Chair: Mark Olfson, M.D., M.P.H.
Discussant: Mark Olfson, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify four evidence-based psychiatric practices that have been substantially underutilized in community practice; 2) Describe the patient population who is most likely to benefit from the practice; 3) Identify at least two barriers to increasing access and use of the practice and two promising strategies for overcoming these barriers.

SUMMARY:
Despite substantial progress over the past several years in developing evidence-based psychiatric treatments for some of the most common serious psychiatric disorders, the delivery of these treatments in community practice remains uneven. This symposium features presentations from leading experts in four key underused evidence-based psychiatric treatments: exposure and response/ritual prevention for obsessive-compulsive disorder (Dr. Helen Blair Simpson), interpersonal psychotherapy for depression (Dr. John C Markowitz), long-acting injectable antipsychotic medications for schizophrenia (Dr. Christopher U. Correll), and clozapine for treatment-resistant schizophrenia (Dr. Scott Stroup). Each presentation will review the evidence for the effectiveness of the respective treatment, its underuse, common barriers to access of the evidence-based treatment, and suggested solutions for addressing these barriers. A discussion will be held of common and unique features of each treatment and patient population and the challenges and opportunities they pose for narrowing the gap between clinical research and everyday practice.

NO. 1
DISSEMINATING COGNITIVE-BEHAVIORAL THERAPY FOR OCD: RATIONALE
Speaker: Helen B. Simpson, M.D., Ph.D.

SUMMARY:
Cognitive-behavioral therapy consisting of exposure and response/ritual prevention (ERP) is an evidence-based treatment for obsessive-compulsive disorder (OCD). As monotherapy, ERP is as effective as serotonin reuptake inhibitors (SRIs), the only medications approved by the Food and Drug Administration for OCD. Since SRIs typically lead to partial response, ERP is also used an as augmentation strategy, and it has recently been

shown to be more efficacious than medication strategies like the addition of antipsychotic medication. However, many OCD patients do not receive ERP. This talk will review the evidence supporting the use of ERP in OCD, outline the barriers OCD patients face in accessing this treatment, and describe strategies that have been developed to address this important gap in care delivery.

NO. 2
INTERPERSONAL PSYCHOTHERAPY (IPT): AN UNDERUSED RESOURCE
Speaker: John C. Markowitz, M.D.

SUMMARY:
Interpersonal psychotherapy (IPT), developed by Klerman, Weissman, and colleagues in the 1970's, has an excellent research track record as a treatment for mood and eating disorders; some evidence suggests it may benefit patients with anxiety disorders as well. Unlike cognitive behavioral therapy, however, IPT has never been widely disseminated. Although IPT is one of the leading empirically-validated psychotherapies, included in numerous treatment guidelines as a first line therapy, the ACGME has not mandated its teaching, and only a minority of psychiatric residency programs and psychology graduate programs provide training in IPT. Despite high levels of acceptance by therapists and patients, IPT remains an underused resource. This presentation will document the problem and present potential solutions for the dissemination of IPT.

NO. 3
LONG-ACTING INJECTABLE ANTIPSYCHOTICS: UTILIZATION, EVIDENCE
Speaker: Christoph U. Correll, M.D.

SUMMARY:
Maintenance treatment and relapse prevention are the most prevalent and, arguably, the most important treatment phases in the management of schizophrenia. Management options include monotherapy with oral antipsychotics, adjunctive pharmacologic and non-pharmacologic treatments, long-acting injectable antipsychotics (LAIs), and implantable antipsychotics. Since non-adherence is highly prevalent in schizophrenia and since non-adherence is closely linked with relapses, hospitalizations, decreased functioning and, possibly, disease progression, the use of LAIs has long been proposed as an important treatment strategy for the maintenance management of schizophrenia. However, compared to known non-adherence rates and despite increasing options, LAI utilization has remained low in general and much lower in the US than in many other countries. This presentation will review the evidence base regarding the utility of LAIs and their place in the treatment algorithm in the management of schizophrenia. Three sets of meta-analytic evidence for the effectiveness of LAIs versus oral antipsychotics will be reviewed: 1) randomized controlled trials, mirror image studies and cohort studies. The effect of trial design, patient populations and comparators will be critically discussed. Finally, patient and prescriber reasons for and against this treatment option, as well as barriers to the appropriate and earlier use of LAIs will be examined.

NO. 4
UNDERUSE OF CLOZAPINE AND AN INITIATIVE TO ADDRESS THIS IN NEW YORK
Speaker: Thomas S. Stroup, M.D., M.P.H.

SUMMARY:
Antipsychotic medications are largely ineffective for approximately 30% of patients with schizophrenia who are considered treatment resistant." Clozapine is the only antipsychotic approved for treatment-resistant schizophrenia, but it is rarely used. A retrospective study using U.S. Medicaid claims data from 45 states was conducted among 326,119 individuals with a schizophrenia-spectrum disorder (ICD-9 code 295.X) who initiated one or more antipsychotic treatment episodes between January 2002 and December 2005. Clozapine accounted for 2.5% of starts of antipsychotic medication among patients in the overall sample and for 5.5% of starts among patients with treatment resistance. Treatment resistance and living in a county with historically high rates of clozapine use were among the strongest predictors of clozapine use. Efforts to address irregular access to clozapine are needed to improve recovery opportunities for people with schizophrenia. New York State initiated a multi-faceted Best Practices Initiative-Clozapine" in 2011 to ensure that clozapine would be considered in appropriate situations. The New York State Office of Mental Health supported creation of a Clozapine Manual, a telephone consultation service for clinicians, personal calls from state medical leadership with clinical leaders, and on-line educational modules for providers and for consumers who were considering clozapine.

EPIDEMIOLOGY AND TREATMENT OF PATIENTS WITH COMORBID PSYCHIATRIC AND MEDICAL ILLNESS
Chairs: Wayne J. Katon, M.D.,

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Enhance understanding of the epidemiology of comorbid depression and other psychiatric illnesses in patients with chronic medical illness; 2) Understand the adverse impact of comorbid psychiatric disorders on self care and outcomes of chronic medical illness; 3) Understand the collaborative care models that have improved outcomes of patients with comorbid psychiatric and medical illness.

SUMMARY:
Over the last decade research has shown that patients with comorbid psychiatric illness and chronic medical illness die from 10 to 20 years earlier than patients with chronic medical illnesses alone. This symposium will describe the prevalence of depression and other comorbid psychiatric illnesses in patients with chronic medical illness as well as the prevalence of chronic medical illnesses in patients with severe mental illness. The symposium will describe models of care that have been developed and tested in randomized trials to improve outcomes of these patients. Dr Wayne Katon will describe his research on models to improve medical and psychiatric outcomes of patients with comorbid depression and poorly controlled diabetes and hypertension. Dr Michael Sharpe will describe models of care his team has developed that have been shown to improve depression and functional outcomes in patients with comorbid depression and cancer. Dr Jeff Huffman will describe the

adverse impact of depression in patients with heart disease and models of care that have been developed to improve depression outcomes in these patients. Dr Lydia Chwastiak will describe the poor quality of medical care and adverse medical outcomes of patients with severe mental illness, and several promising models that integrate medical care into community mental health care that have been shown to improve medical outcomes of these patients.

NO. 1
DEPRESSION AND DIABETES: A POTENTIAL LETHAL COMBINATION
Speaker: Wayne J. Katon, M.D.

SUMMARY:
Major depression occurs in up to 20% of patients with type 2 diabetes and has been found to be associated with higher symptom burden, greater functional impairment and less adherence to self-care of this illness. Prospective studies have found that comorbid depression in patients with diabetes is a risk factor for microvascular and macrovascular complications, dementia and mortality. Comorbid depression also increase risk of serious hypoglycemic episodes requiring emergency visits or hospitalization, intensive care unit admission and ambulatory care sensitive hospitalizations all of which markedly increase medical costs.

Several randomized trials of collaborative depression care in patients with diabetes and depression have shown this model of care improves depressive and functional outcomes, reduces cost but does not improve self-care (ie glycemic control). A recent trial of multicondition collaborative care (the TEAM-care trial) for patients with comorbid depression and poorly controlled diabetes and or heart disease (HBA1c of at least 8.5%, SBP>140, LDL>130) found that this intervention improved depression, HbA1c, SBP and LDL disease control and reduced costs.

NO. 2
EPIDEMIOLOGY AND TREATMENT OF PATIENTS WITH COMORBID PSYCHIATRIC AND MEDICAL ILLNESS: AN ACADEMY OF PSYCHOSOMATIC MEDICINE SYMPOSIUM
Speaker: Jeff Huffman, M.D., Ph.D.

SUMMARY:
Depression in cardiac patients is common, underrecognized, and deadly. Major depression is present in 15% of patients with cardiac patients, a rate substantially higher than in the general population, and the vast majority of these patients have their depression go unrecognized and untreated. Depression has been associated with the development of cardiovascular illness, independent of traditional risk factors. Furthermore, among patients with existing cardiac disease, depression has been independently linked to recurrent cardiac events, rehospitalizations, and cardiac mortality. Fortunately, antidepressants (especially SSRIs) and psychotherapeutic interventions have been found to be safe and effective for depressed patients with heart disease. More recently, collaborative care and related integrated care models have been used to deliver these depression treatments to patients with cardiovascular disease. Such models appear to be feasible, well-accepted, and highly effective in reducing depressive symptoms in this population, with promising effects on medical outcomes. In this symposium, Dr. Huffman will review the prevalence and risk factors for depression in patients with heart disease, discuss specific treatments for depressed cardiac patients, and describe the evidence regarding integrated care models in this vulnerable population.

NO. 3
CHRONIC MEDICAL ILLNESS AND SEVERE MENTAL ILLNESS
Speaker: Lydia Chwastiak, M.D., M.P.H.

SUMMARY:
When compared to the general population, individuals with serious mental illness, such as bipolar disorder or schizophrenia, have significantly higher rates of chronic medical conditions, contributing to 8-10 years of premature mortality. Multiple factors contribute to excess medical morbidity and mortality among this vulnerable population. Poor health behaviors are common: approximately two-thirds of patients with schizophrenia or bipolar disorder smoke cigarettes. Treatment with second- generation antipsychotic medications is associated with adverse metabolic outcomes, such as new-onset diabetes and poor diabetes disease control. Poor quality of medical care for diabetes and cardiovascular disease has been observed, and is associated with increased risks of disease complications and preventable hospitalizations. Individuals living with serious mental illness are also disproportionately represented among other vulnerable groups, including chronically homeless and incarcerated individuals, adding another level of complexity to the management of their medical illness. In this symposium, Dr. Chwastiak will summarize new areas of knowledge about these health disparities, and describe innovative approaches to improve medical care for patients with schizophrenia and other serious mental illnesses.

MAY 05, 2014

CHILD AND ADOLESCENT PSYCHIATRY: THE NEXT DECADE
Chair: Paramjit T. Joshi, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss AACAP's Back to Project Future project, its findings, goals, and implementation; 2) Identify the impact of the Affordable Care Act on psychiatric practice and patients; 3) Learn about the new diagnostic criteria and category for Pediatric Bipolar Disorder and the rationale for Disruptive Mood Dysregulation Disorder in the DSM-5.; .

SUMMARY:
This symposium discusses the landscape for child and adolescent psychiatry and highlights opportunities and challenges for the field. The American Academy of Child and Adolescent Psychiatry (AACAP) recently underwent a strategic planning process that sets a roadmap for the future of the subspecialty over the next ten years. This program reviews the major findings of this project, while also specifically discussing the major changes that are likely to impact the field as a result of the Affordable Care Act. In addition, speakers discuss the two most significant changes in diagnostic criteria from DSM-5 for child and adolescent psychiatry, autism spectrum disorder and bipo-

lar disorder. Many changes are ahead for the field. Participate in this program to learn how AACAP plans to address these changes and ensure that child and adolescent psychiatrists have a role in collaborative care models to ensure better care and outcomes for our patients.

NO. 1
AFFORDABLE CARE ACT AND COLLABORATIVE CARE
Speaker: Gregory K. Fritz, M.D.

SUMMARY:
The passage of the Affordable Care Act (ACA) and the implementation of mental health parity together promise a dramatic change in the provision of mental health services. While the ultimate impact will depend on the details of the laws' execution, many elements of the ACA point to improved access and quality of care for patients. That much care will be provided in multidisciplinary homes that include mental health professionals and be reimbursed in a system other than fee-for-service means both an opportunity and a challenge for psychiatrists. Substantial training will be required for both medical and mental health professionals, and creative co-location and care delivery (e.g. telepsychiatry) pilot projects will be essential to determine the best approaches in the new healthcare system. Child psychiatrists are noted to be in especially short supply and the need to expand and incentivize such training has been explicitly recognized in the ACA provisions. Effective advocacy is required to ensure that as the details are rolled out, the tantalizing promise of stepping away from the mind/body dichotomy and reintegrating psychiatry and medicine is actually achieved.

NO. 2
DSM-5: BIPOLAR DISORDER
Speaker: Paramjit T. Joshi, M.D.
SUMMARY:
Research over the last decade has informed some of the changes in the diagnostic classification of Mood Disorders in the DSM-5. There is much disagreement in the definition of the phenotypic presentation – "narrow phenotype and the broad phenotype". Many of the youngsters in the latter criteria do not meet the stringent criteria for a manic episode by way of duration and clustering of symptoms. DSM-5 has introduced a new diagnostic category: disruptive mood dysregulation disorder (DMDD), within the Mood Disorders section of the manual. The new criteria are based on a decade of research on severe mood dysregulation, and may help clinicians better differentiate children with these symptoms from those with bipolar disorder or oppositional defiant disorder.

NO. 3
DSM-5 AUSTISM SPECTRUM DISORDERS
Speaker: Bennett L. Leventhal, M.D.

SUMMARY:
While autism has been a described clinical phenomenon for centuries, attempts at careful phenotyping began with the seminal work of Leo Kanner. With the advent of standard screening and diagnostic instruments, as well as evolving epidemiologic research, the phenotypic heterogeneity of autism is becoming clearer. And, while possibly less than perfect, DSM-5 attempts to capture this phenotype in the new diagnostic category, Autism Spectrum Disorder (ASD). With only two principle phenotypic elements (social communication deficits and restrictive/repetitive behaviors), ASD no longer contains sub-types and yet fully represents the dimensionality of this complex clinical syndrome. DSM-5 offers a fresh clinical perspective on a complex syndrome. This presentation will examine the changes in from DSM-IV to DSM-5 and consider the implications of these changes for practice and policy.

NO. 4
LOOKING FORWARD TO BACK TO PROJECT FUTURE AND CHANGE
Speaker: Martin J. Drell, M.D.

SUMMARY:
Dr. Drell's presentation focuses on a two-year strategic planning process for the American Academy of Child and Adolescent Psychiatry (AACAP) that was one of his Presidential Initiatives (2011-2013). The initiative was based on the reality that our field, like all of medicine, will be greatly impacted by the continuation of healthcare reform under the Affordable Care Act, as well as inevitable changes brought on by changing demographics, economic realities, and new research discoveries. Based on a similar planning processed called Project Future, published in 1983, the initiative is entitled Back to Project Future (BPF). The charge to the BPF Taskforce was to attempt to predict what child and adolescent psychiatrists will be doing in 2023, and what AACAP needs to do to prepare the field. The process, which involved a steering committee led by James Macintyre, MD, support from three major BPF subcommittees (Service/Clinical Practice, Training and Workforce, and Research), and input from distinguished consultants, Academy committees and members, and several outside organizations led to a roadmap for the Academy's journey over the next decade. Dr. Drell will go over the history of the original Project Future and Back to Project Future and summarize the major points in the report, as well as AACAPs initial responses to it.

SUICIDAL BEHAVIOR IN MAJOR DEPRESSION AND BIPOLAR DISORDER: CLINICAL AND NEUROBIOLOGICAL FACTORS
Chairs: Maria A. Oquendo, M.D., Antoni Benabarre, M.D., Ph.D.
Discussant: Maria A. Oquendo, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify clinical factors associated with risk for suicidal behavior; 2) Identify neurobiological correlates associated with suicidal behavior; 3) Identify similarities and differences between risk factors for suicidal behavior in unipolar and bipolar mood disorders.

SUMMARY:
There are about 1 million suicides a year and between 25 and 50 suicide attempts for each suicide death worldwide. Suicidal behavior is most commonly associated with depressive and bipolar disorders, yet clearly the bulk of individuals with these conditions do not attempt suicide or die by their own hand. Several clinical and neurobiological markers have been linked to the presence of suicidal behavior in the context of mood disorders. For example, individuals who report childhood trauma are at high risk for suicidal behavior and the temperamental,

neurobiological, and clinical endophenotypes that mediate risk are just beginning to be elucidated. This presidential symposium will cover genetic, epigenetic, early environmental, temperamental, neurocognitive and clinical contributors to suicidal behavior .

NO. 1
COURSE OF ILLNESS AND INCIDENCE OF SUICIDE ATTEMPTS IN UNIPOLAR AND BIPOLAR MOOD DISORDERS
Speaker: Erkki T. Isometsa, M.D., Ph.D.

SUMMARY:
One half of all suicides are by subjects who suffer from major mood disorders. Preventing suicides among them is thus central for suicide prevention. Temporal variations in illness-related risk states and time spent in them are likely important determinants of cumulative overall risk for suicidal acts. However, longitudinal studies combining life-chart methodology with timing of attempts are scarce. The author led longitudinal studies of depression (Vantaa Depression Study) and bipolar I and II disorder (Jorvi Bipolar Study), investigating the incidence of suicide attempts over time across variable mood states. Incidence rates of suicide attempts were found 5-, 25- and 65-fold in subthreshold depression, major depressive episodes, and bipolar mixed states, respectively. Population attributable fractions of time spent in the high-risk states were found very high. A similar analysis was conducted in a five-year study of depression in primary care (Vantaa Primary Care Depression Study) with convergent findings. Thus, duration of high-risk states seems a central determinant of overall risk. Hopelessness, childhood abuse, poor social support, concurrent substance use, cluster B personality disorders and presence of impulsive-aggressive traits also markedly increase risk of suicidal acts during mood episodes. Nevertheless, diminishing the time spent in high-risk phases appears crucial for prevention.

NO. 2
GENETICS OF SUICIDAL BEHAVIOUR IN BIPOLAR DISORDER: AN UPDATE
Speaker: Antoni Benabarre, M.D., Ph.D.

SUMMARY:
Rates of suicidal behaviour (SB) in bipolar patients are amongst the highest in psychiatric illnesses. Although literature is teeming with results from studies focused on analyzing the impact of different sociodemographic, clinical and genetic variables on SB, it is still hardly difficult to clinicians to identify suicidal patients. Therefore, the identification of new biological markers of SB is a matter of concern since it would optimize the management of this serious complication. Up to date, genes linked to the serotonergic system, the HPA axis and genes encoding some neurotrophic factors have been the most analyzed concerning bipolar disorder (BD). However, less is known about the potential impact of variability at genes linked to the mechanisms of action of Lithium. This mood stabilizer, which is one of the mainstays of BD treatment, has been claimed to present certain antisuicidal properties. In this regard, recently, a study has highlighted the potential relevance of genetic variability at two pathways involved in the mechanism of action of lithium (the phosphoinositol and the Wnt/Î²-catenine pathways) in the emergence of SB in bipolar population. More specifically, the authors found that the presence of AA genotype of the rs669838-IMPA2 and GG genotype of the rs4853694-INPP1 gene convey risk for SB in BD. They also observed that T-allele carriers of the rs1732170-GSK3b gene and A-allele carriers of the rs11921360-GSK3b gene had higher risk for attempting suicide.

NO. 3
NEUROIMAGING AND THE PREVENTION OF SUICIDAL BEHAVIOR
Speaker: J. John Mann, M.D.

SUMMARY:
Neuroimaging studies of suicidal behavior have their origins in postmortem studies of suicides that mapped neuroreceptor systems and first showed that abnormalities of the serotonin system associated with suicide as a cause of death were confined to brainstem serotonin nuclei and their projections to ventral prefrontal cortex and anterior cingulate cortex. These brain areas are involved in willed action and decision-making and as such are highly relevant for the diathesis or predisposition for suicidal behavior. This presentation will focus on what we have learned from in vivo imaging studies of suicide attempters and aspects of the diathesis for suicidal behavior that include decision-making, impulsive-aggressive traits and cognitive regulation of mood. Some of the studies employ functional MRI or structural white matter tract measures to map circuits and connectivity, other studies are neurotransmitter-specific and employ PET and SPECT. A brain circuit coupling dorsal lateral prefrontal cortex, amygdala, anterior cingulate and ventral prefrontal cortex has been identified. Suicide prevention approaches such as cognitive therapy and medications appear to target this circuitry and may modify it as part of a process that reduces the predisposition to suicidal behavior. This presentation will describe the progress made in brain imaging of suicidal patients and provide perspective on whether it may one day become part of clinical practice.

NO. 4
SOCIAL PAIN AT THE CORE OF THE SUICIDAL PROCESS
Speaker: Philippe Courtet, M.D., Ph.D.

SUMMARY:
With one million deaths worldwide, suicide is a major health problem. New hypothesis to better understand this complex phenomenon are needed because efficient therapeutic strategies are still lacking. The stress-vulnerability model is largely admitted to understand suicidal act; i.e. only predisposed subjects, under stress condition, will attempt suicide. Unbearable pain, particularly psychological pain, is a frequent theme of suicide notes. Subjects with a higher propensity for mental suffering may be at greater risk of suicidal act. In most cases, suicide attempters have reported psychosocial stress leading to a social devaluation or a feeling of exclusion. Dysfunctional social cognitions could be involved in suicidal behavior through two pathways because it produces pain and increases sensitivity to some social events. Brain imaging is a helpful tool to better understand in vivo the neuroanatomical basis of suicidal vulnerability and its link with social as well as psychological pain. Neuroimaging studies mainly showed the involvement of prefrontal and cingulate cortices in both psychological pain and

suicidal vulnerability. In addition, there is increased evidence of an overlap between psychological/social pain and physical pain. By stressing that pain is core to suicidal behaviour, we may provide new avenues for improving the comprehension of physiopathology (i.e. opioid system) and treatment of suicidal behaviour (i.e. pain becoming a therapeutic target).

NO. 5
NEW MONITORING STRATEGIES FOR SUICIDE RISK: A FOCUS ON DISRUPTIONS IN CIRCADIAN RHYTHMS
Speaker: Enrique Baca-Garcia, M.D., Ph.D.

SUMMARY:
Despite recent advances in the neurobiology of suicidal behaviors and mood disorders, clinical assessment of suicide risk relies solely on clinical interviews and self-reported scales. Identifying biomarkers for mood disorders and suicide is crucial for expanding pathophysiological and etiological theories, developing novel treatments and improving early diagnosis and prognosis. The search for biomarkers and endophenotypes of suicidal behavior is particularly challenging since suicide is a highly complex behavior, likely mediated by a genetic diathesis interacting with environmental and psychosocial risk factors and epigenetic mechanisms. There is growing evidence of an association between sleep disorders, circadian rhythms and suicidal behaviors. Recent advances in monitoring systems have allowed to perform noninvasive, objective and quantitative measures of motor activity and circadian rhythms using wrist-worn actigraphic devices. Using these monitoring devices, it has been shown that daily-motility rhythms are strongly associated with suicidal ideation in depressed subjects. Objective biomarkers of suicide-risk such as a specific circadian rhythm biosignature correlated with suicidal ideation could have a key role in the assessment of suicide risk stratification in clinical settings, particularly when patients are unwilling or unable to disclose suicidal ideation to clinicians. Furthermore, actigraphic devices could be used to monitor symptom improvement and response to t

No. 6
SOCIAL COGNITIVE NEUROSCIENCE

Chair: Cameron S. Carter, M.D.

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to:
1) Understand how a modern, cognitive neuroscience based understanding of mechanisms underlying emotional regulation and dysregulation can inform the development and validation of psychodynamic treatment approaches
2) Appreciate the role of functional neuroimaging in elucidating mechanisms of emotion regulation and learning and their relationship to clinical symptoms.
3) Understand the clinical impact of alternative cognitive and behavioral techniques in regulating emotions along with the neural mechanisms that underlying these effects.

SUMMARY:
At the turn of the last century, psychoanalysts theorized about the role of unconscious mechanisms in shaping thoughts and behaviors. Towards the end of the last century, cognitive neuroscientists began using neuroimaging and other techniques to map the neural mechanisms underlying emotions in order to better understand human thought and behavior. Progress in this area has been rapid and exciting, and holds promise for guiding treatments for a number of mental disorders. This symposium will highlight findings from neuroscience research on emotion regulation and learning and the mechanisms of change, both neural and psychological, associated with cognitive and behavioral interventions. These new advances can also inform psychodynamic theory and therapies, and this will be highlighted during the session.

MAY 06, 2014

SCHIZOPHRENIA: A COLLABORATIVE APPROACH TOWARDS EFFECTIVE IMPLEMENTATION OF STRATEGIES TO PROMOTE A NEW CARE MODEL FOCUSED ON RECOVERY

Chair: W. Wolfgang Fleischhacker, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize that, with suitable care and support, people with schizophrenia can achieve some degree of recovery, with a reduction in the impact of schizophrenia on everyday life and improved symptoms; 2) Identify practical strategies that patients have used successfully to help manage their symptoms and integrate with society and the workplace; 3) Focus on the potential for recovery as the first consideration in treatment decisions for people with schizophrenia, as well as reducing symptoms, and apply lessons learned to clinical practice; 4) Recognize the central role of self-help and advocacy groups in recovery-oriented care; 5) Understand the importance of early diagnosis and treatment in changing the outlook of recovery, and recognize the need for reorganization of healthcare services and changes in policy to improve care.

SUMMARY:
Schizophrenia is a potentially disabling and severe mental disorder that imposes a substantial burden on individuals and society. Care and outcomes for people with schizophrenia have improved in recent years, but many people still do not live fulfilled lives. Views regarding the outcome of the illness have been evolving, and a growing movement emphasizes a vision of recovery, with a shared hope and expectation of living a productive and satisfying life with mental illness. With appropriate care and support, people can recover, with an improvement in their symptoms and a reduction in the impact of schizophrenia on everyday life. But what do we mean by recovery? This symposium will focus on the significance of 'recovery' to different audiences, and how each group can play its part in promoting recovery. It is often defined clinically by the absence of symptoms and achievement of normal functioning. By contrast, patients may view recovery as a process of adaptation to mental illness: resilience and empowerment can promote personal growth, leading to a fulfilled and meaningful life in the community. Peer-led interventions play a central role in recovery, by supporting those affected by mental illness, campaigning against discrimination, and much more. The potential for recovery should be the first consideration in treatment decisions,

so that clinicians and patients focus on optimal outcomes from treatment, as well as reducing symptoms. 1) Stephen Marder will share a clinical perspective and discuss recent qualitative studies of individuals who are functioning at a high level and living successfully with schizophrenia. 2) Lisa Halpern will describe what recovery means for people with schizophrenia, highlighting the importance of hope, empowerment, personal growth and use of inner strengths to help them reach full potential and achieve their aims. 3) Ken Duckworth will discuss the impact of recovery for families and carers, and how advocacy and self-help groups can help by supporting those directly affected by schizophrenia and presenting current views of recovery to a wide audience. 4) Jeffrey Lieberman will highlight the importance of early detection, intervention and sustained engagement with treatment in enhancing recovery. A new care model that fosters recovery and prevents disability will be discussed, focusing on the consequent need for reorganization of mental health care services and reimbursement schemes. Wolfgang Fleischhacker will take the role of discussant, presenting the European perspective on the topics covered. The symposium will conclude with a discussion of how to create a better future for all and how to remove barriers to recovery. Presentations at the symposium will be linked to an ongoing initiative led by an international, multidisciplinary team. The symposium will reinforce the theme of the report from this group: Schizophrenia: time to commit to policy change.

NO. 1

LESSONS LEARNED FROM INDIVIDUALS LIVING SUCCESSFULLY WITH SCHIZOPHRENIA

Speaker: Stephen R. Marder, M.D.

SUMMARY:

Stephen Marder, MD, Amy N Cohen, PhD, Alison Hamilton, PhD, Elyn Saks, JD, Shirley Glynn, PhD, Doug Hollan, PhD, John Brekke, PhD. Many people with persistent schizophrenia symptoms achieve good educational, vocational and social outcomes. We used qualitative research methods to study individuals with very good outcomes to improve our understanding of the methods they use to manage symptoms. 20 patients with DSM IV schizophrenia (confirmed by the SCID) who met criteria for high vocational functioning were evaluated using person-centered interviews, a method that follows a person's train of thought to avoid interviewer bias.

Most individuals were unmarried and some had doctoral, masters and bachelor degrees. Several strategies for managing symptoms were reported, including avoiding overstimulation, managing physical health, taking medication regularly and engaging in spiritual activities. Individuals described strategies for managing delusional thoughts and hallucinations. The results support the ability of people with schizophrenia to move toward recovery even when they are burdened by persistent psychopathology.

NO. 2

WHAT DOES RECOVERY MEAN TO PEOPLE WITH SCHIZOPHRENIA?

Speaker: Lisa Halpern, M.P.P.

SUMMARY:

Recovery is about hope and empowerment - the belief that things will get better and working to achieve that. It is about finding an inner strength to co-exist with schizophrenia and to reach one's full potential. Recovery is highly individual and variable in scope. It is an ongoing, fluid process through which one becomes able to mitigate effects of symptoms. It is hard work that requires accepting steps back while moving toward the desired goals that might include abstract concepts such as achieving happiness, or concrete ones like staying out of the hospital.

Recovery means regaining things that were lost: cognitive skills, personality, friendships, schooling, a job, self-sufficiency and a renewed zest for life. A person may develop new purpose as they grow beyond the impact of the psychiatric diagnosis. A person is "in recovery" when they have recognized that, along with help from professionals, there are many things they can do to speed the return to a better quality of life.

NO. 3

HOW DOES A FOCUS ON RECOVERY CHANGE THE OUTLOOK FOR FAMILIES AND CAREERS OF PEOPLE WITH SCHIZOPHRENIA?

Speaker: Ken Duckworth, M.D.

SUMMARY:

Despite improvements in attitudes, many people with schizophrenia still face social isolation, prejudice and discrimination, making it difficult for them to live a productive life in society. The illness also imposes a heavy toll on families and friends, who bear much of the day-to-day burden of care. People who are affected by schizophrenia, both patients and those who care for them, can offer powerful and eloquent insights into the condition. As a result, peer-led interventions have an important place in recovery-oriented schizophrenia care and can substantially improve wellbeing and quality of life of those affected. We will discuss what recovery means for families and carers of individuals with schizophrenia and the role of advocacy and self-help groups. They can help by providing support and information for those directly affected by the condition, tackling discrimination and presenting current views of recovery to a wide audience.

NO. 4

A NEW CARE MODEL FOR SCHIZOPHRENIA: REDEFINING HEALTH POLICY

Speaker: Jeffrey A. Lieberman, M.D.

SUMMARY:

Historically, schizophrenia has been associated with poor outcomes and little prospect of recovery. However, recent advances in medication and psychosocial treatments, together with success stories from patients who live fulfilled and productive lives, have begun to change the perspectives and expectations of the public and of clinicians. The outlook is now more positive than ever before, and there is considerable scope to limit the morbidity associated with schizophrenia. A new care model that fosters recovery and prevents disability will be discussed; this model emphasizes the importance of early detection, intervention and sustained engagement with treatment. This presentation will highlight the need for reorganization of mental health care services and reimbursement schemes, as well as for the development and implementation of strategies to address

the stigma associated with schizophrenia.

IMPLEMENTING FIRST EPISODE PSYCHOSIS (FEP) SERVICES IN THE U.S.

Chair: Robert Heinssen, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify, understand, and discuss factors that facilitate or impede effective engagement of FEP clients and family members in recovery-oriented care; 2) Identify, understand, and discuss medication treatment approaches recommended for first episode psychosis and how these differ from guidelines for multi-episode schizophrenia; 3) Identify, understand, and discuss core principles of individual therapy and family psychoeducation for FEP; 4) Identify, understand, and discuss aspects of supported education and supported employment interventions that positively impact FEP clients' academic and work functioning; 5) Identify, understand, and discuss the key features of team-based care for FEP, including strategies for optimizing the effectiveness of the team in addressing the client's recovery goals.

SUMMARY:

It is estimated that approximately 100,000 adolescents and young adults in the United States experience a first episode of psychosis (FEP) every year. The early phase of psychotic illness is widely viewed as a critical opportunity for indicated prevention, and a chance to alter the downward trajectory and poor outcomes associated with serious mental disorders such as schizophrenia. An abundance of data accumulated over the past two decades supports the value of early intervention; compared to traditional treatment approaches, coordinated specialized services provided early in the course of illness are an effective means for improving clinical and functional outcomes among youth at risk for serious mental illness. Research conducted in Australia, Europe, Canada, and the United States has tested the benefit of coordinated specialty care for FEP that combines lose-dose antipsychotic pharmacotherapy with psychological and rehabilitative interventions to reinforce coping and resilience, improve school, work, and social functioning, and enhance quality of life. Early psychosis identification and intervention programs have been implemented in several nations, but this approach has not been widely adopted in the United States. In this symposium we present new information relevant to the opportunities and challenges of implementing FEP specialty care programs in U.S. community treatment settings, including (1) factors that facilitate or impede effective engagement of FEP clients and family members in recovery-oriented care; (2) FEP prescription practices from a nationwide sample of "real world" community clinics, and possible areas for improvement; (3) the core principles of individual therapy and family psychoeducation for persons who have recently experienced a first psychotic episode; (4) methods for adapting supported employment interventions to meet the needs of adolescent/young adult clients; and (5) strategies for creating first episode treatment teams, conducting outreach to reduce the duration of untreated psychosis, and delivering ongoing training to maintain providers' skills. Findings will be summarized in the form of guidance to health care decision makers interested in implementing early intervention services in the near future.

NO. 1

ENGAGEMENT IN FEP CARE: CLIENT AND FAMILY MEMBER PERSPECTIVES

Speaker: Alicia Lucksted, Ph.D.

SUMMARY:

The experiences of clients and their family members as they encounter First Episode Psychosis (FEP) services are crucial for their engagement, service use, and recovery. For those new to dealing with psychotic symptoms, the related life disruptions, and new to using mental health services, such experiences shape not only their involvement with a single program but color their impressions of mental health care broadly. This presentation will summarize and give specific examples of diverse factors affecting client and family member engagement with the Recovery After an Initial Schizophrenia Episode (RAISE) Connection Programs in Maryland and New York. Methods: 32 clients and 18 family members participated in semi-structured interviews that explored client and family engagement factors regarding Connection Program team services. Audio-recorded interviews were transcribed and coded for engagement using qualitative research methods. Results: Interviewees discussed 15 factors that worked well to promote engagement (e.g., highly personalized, responsive, and flexible interventions) and 21 factors that diminished client and family engagement. The implications of findings for program implementation, refinement of FEP operations, and sustainability of quality services will be discussed.

NO. 2

STAGE-SPECIFIC PHARMACOTHERAPY FOR FEP

Speaker: Delbert Robinson, M.D.

SUMMARY:

Better treatment of the initial psychotic episode offers the promise of better long-term outcomes. We examined current US medication community treatment for first episode psychosis to identify possible areas for improvement. Method: Study entry prescription data was obtained from 404 first episode patients in the RAISE-ETP study who were recruited from 34 community treatment centers in 21 states. Results: 39.4% of the 404 might have benefited from changes in their psychotropic prescriptions. Of these 159 subjects, 8.8% were prescribed recommended antipsychotics at higher than recommended doses, 32.1% were prescribed olanzapine (often at high doses), 23.3% more than one antipsychotic, 36.5% an antipsychotic but also an antidepressant without a clear indication, 10.1% psychotropic medications without an antipsychotic and 1.2% stimulants. There were regional, sex, age and insurance effects on medications selected for prescription. Diagnostic categories had little effect on prescribing patterns; no substantial racial or ethnic differences were found in multivariate models. Conclusions: Policy makers should consider not only patient factors but also service delivery factors in efforts to improve first episode prescription practices. Tools such the RAISE-ETP COMPASS medication decision support system for first episode treatment and focused clinician education may also be useful for these efforts.

NO. 3
PSYCHOTHERAPEUTIC APPROACHES FOR FEP PATIENTS AND RELATIVES
Speaker: Kim Mueser, Ph.D.

SUMMARY:
The core principles of individual therapy and family psychoeducation for persons who have recently experienced a first episode of psychosis will be reviewed, including the evidence-base supporting those principles. Examples of individual therapy and family psychoeducation programs will be given to illustate some of the guiding principles. Practical challenges to providing individual and family interventions will be discussed, as well as solutions to these challenges.

NO. 4
SUPPORTED EMPLOYMENT AND EDUCATION FOR FEP
Speaker: Keith Nuechterlein, Ph.D.

SUMMARY:
Return to school or work is often a key goal of individuals who have recently had a first psychotic episode. Supported employment and education have the potential to greatly increase the proportion of first episode psychosis (FEP) patients who return to competitive work or school. The most fully-documented form, Individual Placement and Support (IPS), involves integration of an IPS specialist with the clinical team to facilitate assertive outreach, rapid individualized search for schooling or employment, and ongoing vocational support. After initial naturalistic research in the U.K. had suggested the promise of IPS for FEP, two randomized controlled trials clearly demonstrated its impact. A 6-month trial in Melbourne found that 85% of FEP patients could return to work or school, compared to 29% treated as usual. A larger 18-month randomized controlled trial at UCLA added the Workplace Fundamentals Module (WFM) to reinforce retention of effects. IPS-WFM was compared to identical clinical treatment but with conventional separate vocational rehabilitation. Within 6 months, 83% of FEP patients in IPS-WFM returned to work or school, compared to 41% in conventional vocational rehabilitation. Significant differential effects were sustained over 18 months. Early supported education/employment can dramatically increase school and job recovery in FEP.

NO. 5
IMPLEMENTING FEP PROGRAMS IN STATE MENTAL HEALTH SYSTEMS
Speaker: Lisa B. Dixon, M.D., M.P.H.

SUMMARY:
A new conceptualization of schizophrenia and related psychotic disorders has led to a new care model developed for patients with first-episode psychosis (FEP) that fosters recovery and prevents disability. The RAISE Connection Program uses shared decision-making to assist FEP clients and families in managing their illness through the use of evidence-based therapeutic interventions including medication, supported employment and education, skills training, and family support and education. Methods: Sixty five FEP individuals, ages 15-35, were recruited from community sites in Baltimore and New York City. An independent research team conducted assessments of symptoms and functioning at baseline and every six months for two years. Results: Rates of perceived shared decision making and engagement in treatment exceeded 90%. Occupational and social functioning improved significantly over time (Ps < .001); rates of work, school participation, and remission doubled over the study period. Summary: Findings led to the implementation of early psychosis services in New York State and Maryland. Lessons learned from the Connection Program may inform expansion of FEP services in other states, including the challenges of creating first episode teams, conducting outreach to reduce the duration of untreated psychosis, delivering training to maintain providers' skills, monitoring outcomes, and financing services.

DEVELOPING A NATIONAL NEUROSCIENCE CURRICULUM â€“ PLANNING FOR THE FUTURE OF PSYCHIATRY
Chairs: Adrienne L. Bentman, M.D., Richard F. Summers, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the value of incorporating a neuroscience framework into the clinical practice of psychiatry; 2) Describe various resources and approaches for teaching and learning neuroscience; 3) Develop learning activities to integrate neuroscience into psychiatry in a way that is both accessible and engaging.

SUMMARY:
Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Yet most psychiatrists have relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of access to neuroscience teaching faculty. In addition, neuroscience has generally not been taught in a way that is engaging and accessible. The focus of this session will be on strategies to teach and learn neuroscience in order to incorporate a modern neuroscience perspective into clinical care and bring the bench to the bedside. There will be ample opportunity for audience participation and discussion.

NO. 1
INCORPORATING A NEUROSCIENCE FRAMEWORK INTO THE CLINICAL PRACTICE OF PSYCHIATRY
Speaker: Adrienne L. Bentman, M.D.

SUMMARY:
Much of neuroscience education has remained lecture-based without employing active, adult learning principles. It is also frequently taught in a way that seems devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the import of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience is poised to assume in psychiatry, we continue to under-represent this essential perspective in our work. In this overview, we will describe our efforts to bridge this gap.

NO. 2
WHY YOU SHOULD CARE: THE CLINICAL RELEVANCE OF NEU-

ROSCIENCE IN 21ST CENTURY PSYCHIATRY
Speaker: David Ross, M.D.

SUMMARY:
The ability to remember new material is proportional to its perceived importance: to this end, we will describe methods to embed neuroscience content into case conferences so as to demonstrate its direct relevance to the patients that we treat. In addition to including a neuroscience framework in case formulations, we will describe how cutting edge topics in translational neuroscience could change the way we treat patients in the future. We will also discuss the use of popular news and media coverage as an opportunity to review and appraise modern neuroscience literature and develop skills to serve as ambassadors of psychiatry and neuroscience with the lay public.

NO. 3
THINKING OUTSIDE THE BOX: NOVEL AND CREATIVE WAYS TO TEACH AND LEARN NEUROSCIENCE
Speaker: Michael Travis, M.D.

SUMMARY:
Historical approaches to education viewed students as passive, “empty vessels”, waiting to be filled. In recent years, a vast body of literature on adult learning has debunked this paradigm. In this session we describe novel and creative methods to teach and learn neuroscience built on principles of adult learning. We will describe various approaches to teaching neuroscience through technology, on-line resources, and â€œflipped classroomâ€ exercises. Participants will gain exposure to a series of active, experiential learning, exercises focused on consolidating foundational knowledge in neuroscience.

NO. 4
DEVELOPING A NATIONAL NEUROSCIENCE CURRICULUM
Speaker: Melissa Arbuckle, M.D., Ph.D.

SUMMARY:
This presentation will describe the National Neuroscience Curriculum Initiative we have developed in collaboration with the Education Committee of the American Psychiatric Association (APA) and the American Association of Directors of Psychiatry Residency Training (AADPRT). The overarching aim of this initiative is to create, pilot, and disseminate a model curriculum that will train psychiatrists to integrate a modern neuroscience perspective into their clinical work. Our goal is to identify ways to engage psychiatrists in learning and teaching neuroscience from the perspective of a trainee, an educator, a neuroscience expert, or an independent practitioner just trying to keep up with the field. Within this session we will review our efforts to date to (1) identify and develop a core set of foundational, teaching resources in neuroscience; (2) develop accessible templates that elaborate content and process for experiential learning exercises; (3) provide direct training to stakeholders for how to effectively implement teaching materials; (4) bring together diverse groups of clinician educators and neuroscientists in regionally based learning collaboratives and (5) engage participants from diverse training programs in an ongoing process to pilot, refine, and develop new teaching activities.

COLLABORATIVE CARE: NEW OPPORTUNITIES FOR PSYCHIATRISTS
Chair: Jurgen Unutzer, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Make the case for integrating behavioral health and the rest of health care services; 2) Explain the role of a psychiatric consultant in evidence-based collaborative care programs; 3) Review the evidence-base for collaborative care for depression and other common mental disorders.

SUMMARY:
Integrated behavioral health care programs create rewarding opportunities for psychiatrists to work closely with other health care providers to achieve the “Triple Aim” of Health Care Reform: to improve the patient care experience, improve the health of populations, and reduce the cost of health care. Collaborative Care (CC) is an evidence-based, systematic approach to Integrated Care in which primary care and mental health providers work closely together to deliver effective treatment for depression and other common mental disorders to defined populations of patients in primary care and other medical settings. This symposium will explore the history of collaborative care, the research evidence-base for collaborative care, examples of large scale implementations of collaborative care, application of collaborative care to improve the medical care of those with severe mental illness, and experiences of a collaborative care consultant.

NO. 1
THE HISTORY, DEVELOPMENT, AND EVOLUTION OF COLLABORATIVE CARE MODELS
Speaker: Wayne J. Katon, M.D.
SUMMARY:
In the 1980s extensive literature documented the high prevalence of depression in primary care and major gaps in accurate diagnosis and provision of evidence based treatments. At the same time medical researchers were also documenting gaps in quality of care of other medical illness such as diabetes and hypertension. Ed Wagner began writing about these gaps in chronic illness care and developed the chronic illness model in the early 1990s. Collaborative depression care models were one of the first models developed that used many components of the Wagner model and the first trials of collaborative depression care were published in the mid-1990s. Since then approximately 79 trials have documented the effectiveness of these models to improve outcomes of patients with anxiety and depression. Moreover recent trials have developed multicondition collaborative care approaches to treat depression and poorly controlled medical illness or multiple psychiatric illnesses.

NO. 2
IMPLEMENTING EVIDENCE-BASED COLLABORATIVE CARE PROGRAMS IN REAL WORLD HEALTH CARE SETTINGS.
Speaker: Jurgen Unutzer, M.D., M.P.H.

SUMMARY:
With the overwhelming research evidence for collaborative care for depression and other common mental disorders, the attention has recently turned to the implementation of evidence-based collaborative care programs in diverse health

care settings. We will explore challenges related to 'translating' the research evidence base into large scale implementation of such evidence-based programs and present several examples of successful implementations and lessons learned.

NO. 3
CAN COLLABORATIVE CARE IMPROVE CARDIOVASCULAR OUTCOMES AMONG PATIENTS WITH SERIOUS MENTAL ILLNESS?
Speaker: Lydia Chwastiak, M.D., M.P.H.

SUMMARY:
Individuals with serious mental illness (such as schizophrenia or bipolar disorder) are a health disparities population, with an average life expectancy which is 8-10 years shorter than that of the general population. Most of this premature mortality is due to cardiovascular disease; and the control of chronic medical conditions which are cardiovascular risk factors (hypertension, hyperlipidemia and diabetes) can be particularly challenging for these patients. Among patients with diabetes, those with comorbid serious mental illness have higher rates of diabetes complications, preventable hospitalizations and diabetes-specific mortality. In this symposium, Dr. Chwastiak will review studies of interventions which improve cardiovascular risk factors among patients with serious mental illness, and describe an innovative community mental health center-based collaborative care approach to the management of diabetes and schizophrenia.

NO. 4
TALES FROM THE INTEGRATED SIDE: WHAT IS IT REALLY LIKE TO WORK AS A PRIMARY CARE CONSULTING PSYCHIATRIST?
Speaker: Anna Ratzliff, M.D., Ph.D.

SUMMARY:
There is now a strong evidence-base for Collaborative Care and other structured approaches to providing mental health care in primary care settings. However, few psychiatrists have experience training or working in this type of practice. Dr. Ratzliff will discuss her 'real world' experience working as a both a co-located psychiatrist in a primary care clinic and as a consulting psychiatrist with in a state-wide implementation of Collaborative Care the Mental Health Integration Program. Joys, challenges and lessons learned from this work will be reviewed.

MAY 03, 2014

DEMENTIA AND DELIRIUM
Moderators: Amber C. May, M.D., Priya Krishnasamy

-1
NEUROPATHOGENESIS OF DELIRIUM: A REVIEW OF CURRENT ETIOLOGICAL THEORIES AND COMMON PATHWAYS
Speaker: José R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the leading theories regarding the pathophysiology of delirium;2) Appreciate the complementary nature of the various theories currently believed to explain the phenomena of delirium;3) Appreciate how multiple theories and pathways are likely to act together to cause the biochemical abnormalities we know as delirium.

SUMMARY:
Delirium is a neurobehavioral syndrome caused by dysregulation of neuronal activity secondary to systemic disturbances. Over time, a number of theories have been proposed in an attempt to explain the processes leading to the development of delirium. Most of these theories are complementary, rather than competing. This paper represents a review of published literature and summarizes the top seven proposed theories and their interrelation. The hypotheses included in this literature review include the: “Neuroinflammatory”, ’’Neuronal Aging”, “Oxidative Stress”, “Neurotransmitter Deficiency”, “Neuroendocrine”, “Diurnal Dysregulation”, and “Network Disconnectivity” hypotheses. A review of the available literature suggests that many of the factors or mechanisms included in these theories lead to a final common pathway associated with alterations in neurotransmitter synthesis and availability which mediates the behavioral and cognitive changes observed in delirium. In general, the most commonly described neurotransmitter changes associated with delirium are deficiencies in acetylcholine availability (êch), melatonin (êMEL); excess in dopamine (éDA), norepinephrine (éNE), and/or glutamate (éGLU) release; and variable alterations (e.g., both a decreased and increased activity) in serotonin (êé5HT); histamine (êéH1&2), and/or gamma-amino butyric acid (êéGABA). These alterations in neurotransmitter synthesis appear to provide a relatively satisfactory explanation of the complex behavioral and cognitive changes observed in delirium. At the end, it is likely that none of these theories by themselves explain the phenomena of delirium, but rather it is more likely that two or more of these, if not all, act together to cause the biochemical abnormalities we know as delirium. It is unlikely that we will find a single path to the development of delirium, more likely, the syndrome of delirium represents the common end product of one or various interdependent neurochemical pathway derangements.

-2
EFFICACY AND TOLERABILITY OF RISPERIDONE, YOKUKAN-SAN AND FLUVOXAMINE FOR THE TREATMENT OF BPSD: A BLINDED, RANDOMIZED TRIAL
Speaker: Satoshi Nishino, Ph.D.
Co-Author(s): Mika Teranishi, M.D., Ph.D., Masatake Kurita, M.D., Ph.D., Kenji Takeyoshi, M.D., Yukio Numata, M.D., Tadahiro Sato, M.D., Ph.D., Amane Tateno, M.D., Ph.D. and Yoshiro Okubo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize that yokukansan or flvoxamine was more generally well tolerated compared with risperidone in BPSD patients;2) Know according to risperidone, yokukansan or fluvoxamine were equally effective in the treatment of BPSD, we think that yokukansan or flvoxamine is more recommended compared with antipsychotic drugs.;3) Understand may not recommend to atypical antipsychotics such as risperidone for BPSD, because its drugs should be considered treating a careful treatment of risks and benefits for elderly subject.

SUMMARY:
The descriptive term behavioral and psychological symptoms of dementia (BPSD) is used to cover a range of non-cognitive disturbances including anxiety, depression, irritability, aggression, agitation, eating disorders and inappropriate social or sexual behaviors. BPSD are seen in about 90% of patients with dementia. We aimed to compare these features (efficacy and tolerability) of risperidone, yokukansan and fluvoxamine used for BPSD in elderly patients with dementia. Ninety inpatients with dementia according to DSM-â…£criteria were investigated in Sato Hospital, Koutokukai. We conducted an 8-week, rater-blinded, randomized trial, administering flexibly-dosed risperidone, yokukansan or fluvoxamine. Primary outcome measures were Neuropsychiatric Inventory in Nursing Home Version (NPI-NH) total score and its items. Secondary outcomes measures were cognitive function measured by Mini-Mental State Examination (MMSE), and daily life function measured by Functional Independence Measure (FIM). Neurological side effects were measured by the Drug Induced Extra-Pyramidal Symptoms Scale (DIEPSS). At the end of the study, we had analyzed 76 patients (92.7%). Mean NPI-NH total score decreased in all three drug groups, with no significant between-group differences. MMSE and FIM scores did not change significantly. DIEPSS scores did not change in the yokukansan and fluvoxamine groups, but increased significantly in the risperidone group. Risperidone, yokukansan and fluvoxamine were equally effective in the treatment of BPSD in elderly patients. However, yokukansan or fluvoxamine for BPSD showed a more favorable profile in tolerability compared with risperidone. This trial is registered at UMIN Clinical Trials Registry (identifier: UMIN000006146).

-3
IMMIGRATION, DURATION OF RESIDENCE, AND DEMENTIA KNOWLEDGE IN CHINESE AMERICAN IMMIGRANTS
Speaker: Benjamin K. P. Woo, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the relationship between immigration, duration of residence, and dementia knowledge among Chinese American immigrants;2) Understand the need for culturally sensitive and effective interventions to increase dementia health knowledge among Chinese American immigrants;3) Become aware of innovative approaches to teach dementia mental health to Chinese American immigrants.

SUMMARY:
Introduction: Early detection of dementia can lead to quality care for patients and their caregivers. For Chinese American immigrants, however, there exists language and cultural barriers which hinder this population from obtaining appropriate mental health knowledge and care. The current study examined the association between dementia knowledge with immigration and duration of residence (DOR) in the US. Methods: The study was conducted in two phases. The first part examined differences in dementia knowledge in a demographically matched sample of Chinese-speaking elderly residing in the US and Hong Kong (n = 50 each). In the second part, 151 Chinese American immigrants in Los Angeles aged 40-64 answered a self-administered, 11-item survey assessing knowledge of dementia symptoms, treatment, cause, and prognosis. These subjects were divided into 2 subgroups based on duration of residence (DOR) in the US in order to compare dementia knowledge differences. Results: In the first part, compared to elderly residing in Hong Kong, Chinese American elderly were statistically less likely knowledgeable about dementia (mean [SD] 5.53 [1.76] vs. 6.27 [1.46], t=2.29, df=98, P=0.02). In the second part, DOR did not greatly impact the understanding of dementia between respondents with <20-year versus ≥20-year DOR. Both groups exhibited deficiencies in recognizing the symptoms of dementia. Chinese American immigrants with a <20-year DOR were less likely (P=0.04) to understand that dementia shortens life expectancy after onset, compared to those with a longer DOR. Conclusions: These findings show that immigration to the US may result in less dementia knowledge for Chinese elderly. Yet, DOR did not greatly impact dementia literacy. For Chinese American immigrants with a <20-year duration of residence, educators should focus on developing culturally sensitive, innovative educational materials on dementia prognosis.

GERIATRIC PSYCHIATRY
Moderators: Derya I. Akbiyik, M.D., Priya Krishnasamy

-1
OLFACTORY IDENTIFICATION DEFICITS PREDICT RESPONSE TO CHOLINESTERASE INHIBITORS IN PATIENTS WITH MILD COGNITIVE IMPAIRMENT
Speaker: Davangere P. Devanand, M.D.
Co-Author(s): Gregory H. Pelton, M.D.
Howard Andrews, Ph.D.
Bruce Levin, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the utility of olfactory identification deficits in patients with mild cognitive impairment in predicting conversion to Alzheimer's disease;2) Identify the magnitude and likely time course of treatment response to cholinesterase inhibitors in mild cognitive impairment and Alzheimer's disease;3) Understand the potential utility and mechanisms for olfactory identification deficits predicting response to cholinesterase inhibitors in mild cognitive impairment and Alzheimer's disease

SUMMARY:
Background: Odor identification deficits occur early in the course of Alzheimer's disease (AD) and strongly predict the transition from mild cognitive impairment (MCI) to a clinical diagnosis of AD. The olfactory bulb and tract are among the earliest brain structures to show the neuropathological features of AD, and these olfactory regions are rich in acetylcholine. Cholinesterase inhibitors show efficacy to a small degree in AD. We examined whether baseline odor identification deficits would predict cognitive improvement during treatment with cholinesterase inhibitors during follow-up. Methods: 148 patients with MCI were recruited and followed at 6-month intervals for up to 9 years. Baseline olfactory testing was conducted with the 40-item, multiple-choice format, University of Pennsylvania Smell Identification Test (UPSIT). During follow-up, patients received open treatment with cholinesterase inhibitors. The outcome measure was the change in episodic verbal memory performance on the 12-item, 6-trial Selective Reminding Test (SRT) from the visit that a cholinesterase inhibitor was initiated to the visit that occurred 12 months later. Results: Donepezil was the main cholinesterase inhibitor prescribed. Lower baseline UPSIT scores were associated with increase in SRT total recall over 12 months in MCI patients who received a cholinesterase inhibitor (n=24, r=0.52, p=0.009). Lower baseline UPSIT scores were also associated with increase in SRT total recall in the subset that received cholinesterase inhibitors and later were diagnosed with AD (n=16, r=0.51, p=0.04). In regression analyses on the increase in SRT total recall over 12 months, low baseline UPSIT but not baseline SRT total recall predicted improvement in SRT total recall over 12 months of cholinesterase inhibitor treatment. Age, sex and education were not significant covariates in all of these analyses. Discussion: No clinical predictor or biomarker has been shown consistently to predict response to cholinesterase inhibitors. Odor identification deficits predicted long-term improvement with cholinesterase inhibitor treatment. Cholinesterase inhibitors are prescribed widely in patients with AD and a large proportion of patients with MCI also receive this class of medication. Accurate prediction of who should receive cholinesterase inhibitor treatment improves potential benefit while decreasing the risk of side effects without needless drug exposure in patients without AD brain pathology. The study findings show that odor identification testing, which is inexpensive and easy to administer, needs to be developed further as a predictor of cognitive improvement with cholinesterase inhibitor treatment, to personalize selection for treatment that may delay clinical conversion to AD, and to select/stratify patients in treatment trials. This strategy can guide treatment by clinicians and have immediate public health impact in these widely prevalent conditions, MCI and AD.

-2
CLOZAPINE IN A GERIATRIC POPULATION: INDICATION FOR USE AND EFFICACY VERSUS SAFETY PROFILE
Speaker: Kasia Gustaw Rothenberg, M.D., Ph.D.
Co-Author(s): Chris Kenedi MD, Gary Cheung MD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize efficacy of Clozapine treatment in the geriatric population;2) Identify the methods to effectively monitor side effects of Clozapine;3) Identify the need and methods of safety monitoring in pharmacotherapy in geriatric population

SUMMARY:
Objective Clozapine has been described as the "gold standard"

therapy for treatment-resistant schizophrenia, causing fewer extra pyramidal side-effects than when first generation antipsychotics are used. It has also proved beneficial in treatment-resistant agitation in patients with dementia. Clozapine pharmacotherapy is reported to be of the low fatality rate has been attributed to clinical monitoring systems. It can lead however to potentially fatal agranulocytosis or myocarditis/cardiomyopathy as well as to a myriad of less severe side effects. The difficulty in monitoring the treatment may be a reason the medication in underutilized in geriatric population despite potential benefits. Aim: The aim of this study was to analyze efficacy and safety profile of Clozapine use in a cohort of stable patients under the care of geriatric mental health service in Auckland, NZ. Method: the cohort consisted of 26 geriatric multi-ethnic patients treated with Clozapine. MAPS questioner was used to monitor side effects. Results: The medication was utilized predominantly for psychotic spectrum of diseases follow by mood and cognitive disorders. Lower doses of Clozapine (Mean dose+ 100mg) seemed to be effective in elderly Patient. Hyper-salivation, constipation and falls seemed to be the most common side effects observed in this population. Proper monitoring allowed however allowed appropriate medical intervention with improvement. Conclusion: Clozapine is useful and effective medication for elderly population if appropriate monitoring of side effects in implemented.

-3

EXECUTIVE FUNCTIONING COMPLAINTS AND ESCITALOPRAM TREATMENT RESPONSE IN LATE-LIFE DEPRESSION

Speaker: Kevin J. Manning, Ph.D.
Co-Author(s): George S. Alexopoulos, M.D., Samprit Banerjee, Ph.D., Sarah Shizuko Morimoto, Psy.D., Joanna K. Seirup, Genevieve Yuen, M.D., Ph.D., Theodora Kanellopoulos, Ph.D., & Faith Gunning-Dixon, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the value of older adults' subjective executive functioning complaints in predicting antidepressant treatment response;2) Identify the aspects of executive functioning that are selectively associated with late-life depression;3) Identify the pros and cons of using subjective assessment methods with patients.

SUMMARY:

Objectives: Executive dysfunction is often present in late-life depression. This study investigated the association between subjective report of executive dysfunction and response to antidepressant treatment in late life depression. Methods: 100 older adults with late life depression (58 with executive functioning complaints and 42 without executive functioning complaints) completed a 12-week trial of escitalopram. Treatment response over 12 weeks, as measured by repeated Hamilton Depression Rating Scales, was compared for adults with and without executive complaints using mixed-effects modeling. Results: Mixed effects analysis revealed a significant group by time interaction, $F(1, 523.34) = 6.00$, $p = .01$. Depressed older adults who reported executive functioning complaints at baseline demonstrated a slower response to escitalopram treatment than those without executive functioning complaints. Conclusion: Self-report of executive functioning difficulties may be a useful prognostic indicator for subsequent speed of response to antidepressant medication.

USE THE WEB FOR EDUCATION AND CLINICAL SUPPORT

Moderators: Derya I. Akbiyik, M.D., Kasey Riquelm

-1

IMPLEMENTATION OF WEB-BASED CLINICAL DECISION SUPPORT IN EMERGENCY DEPARTMENTS

Speaker: Molly Finnerty, M.D.
Co-Author(s): Edith Kealey, M.S.W., Emily Leckman-Westin, Ph.D., Kate M. Sherman, M.S.W., Erica Van De Wal, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the diverse information needs of emergency room staff, and how claims-based electronic client data can meet those needs;2) Identify essential tasks in health information technology (HIT) implementation, key factors associated with success, and the role of the learning collaborative in implementation support;3) Understand how claims-based data support clinical practice;4) Recognize the impact of physician involvement on how HIT is used.

SUMMARY:

Background: Staff in Emergency Departments (EDs) are called upon to make critical treatment decisions requiring rapid access to accurate information. PSYCKES is a web-based clinical decision support tool that provides up to five years of Medicaid claims data across treatment settings. These data are provided in user-friendly reports that allow busy physicians to quickly review integrated views of medical and mental health services, including medications, inpatient and outpatient services, and laboratory services. Methods: NYS conducted a voluntary statewide learning collaborative in 2012-2013 to support PSYCKES implementation in 19 EDs. Each participating ED was required to submit an action plan for reaching implementation milestones; to report monthly on progress towards milestones; and to participate in monthly calls. Site visits and key informant interviews at high-performing EDs explored factors associated with successful implementation. Results: 11 participating EDs reported that PSYCKES had been integrated into routine operations. Key factors associated with successful implementation include engagement of a project champion, collaboration with staff across professional disciplines, and integration with existing hospital systems. Challenges included staff training, competing priorities, and coordination across multiple departments. Information from the decision support system was used in initial assessment, medication reconciliation, treatment decisions, care coordination, and discharge planning. Discussion: Psychiatrists were able to access and integrate information from PSYCKES into their clinical practice. Practices developed and tested in this collaborative could inform future HIT implementation efforts. Defining the contributions of physicians may suggest new professional roles in an environment of increasing HIT utilization.

-2

A PSYCHIATRIST-LED, HIT-SUPPORTED, MULTI-HOSPITAL LEARNING COLLABORATIVE TO REDUCE CARDIOMETABOLIC

RISK IN ANTIPSYCHOTIC PRESCRIBING

Speaker: Edith Kealey, M.S.S.W.
Co-Author(s): Kate M. Sherman, M.S.W., Emily Leckman-Westin, Ph.D., Riti Pritam, M.S., Alison Burke, J.D., M.S.W. and Molly T. Finnerty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand key goals and activities of the learning collaborative model, and how these promote rapid adoption of best practices;2) Identify strategies used by participating clinics to reduce cardiometabolic risk among patients prescribed antipsychotic medications;3) Understand the multi-dimensional role of physicians in developing , leading, and implementing the Learning Collaborative;4) Recognize the impact of the Learning Collaborative on prescribing practices.

SUMMARY:

Background: People with mental illness are 3 times more likely to have metabolic syndrome, in part due to iatrogenic effects of antipsychotic medications. The New York State Office of Mental Health and the Greater New York Hospital Association sponsored a 2011-12 statewide behavioral health quality improvement collaborative in hospitals, focused on improving prescribing practices for individuals with cardiometabolic conditions. Psychiatrists played key roles on the Collaborative Steering Committee, championed the project at participating hospitals, and drove change in prescribing practices at the patient level. Methods: 32 outpatient mental health programs at 18 hospitals participated in the collaborative. Participating hospitals had access to PSYCKES, a web-based clinical decision support tool that includes over 50 quality measures calculated from administrative data and provides up to five years of Medicaid treatment history on patients meeting criteria for quality concerns. Cardiometabolic risk was defined as treatment with an antipsychotic with higher metabolic impact among those patients with an existing cardiometabolic condition (e.g. diabetes) who were on any antipsychotic. Key project activities included reviewing the medication regimens of all clients with the quality concern; changing the regimen if indicated, and/or documenting the rationale for continuing the regimen; and tracking progress over time. The collaborative conducted training activities and provided technical assistance and on-site consultation. Programs reported monthly on project activities and completed initial and final surveys to report on QI practices and strategies and feedback on the collaborative. Medicaid data analysis tracked change in the cardiometabolic risk indicator. Results: Analysis of state Medicaid data shows an average annual percent change (AAPC) of -19.4% (95% CI: -23.9, -14.5) in the cardiometabolic risk quality indicator among participating hospitals, compared to an AAPC of -3.5 (95% CI: -5.4, -1.6) among non-participants. Greater impact was observed in decreases of new starts of higher-risk antipsychotics for patients without evidence of a psychotic disorder. Conclusion: This psychiatrist-led quality improvement collaborative significantly reduced prescribing of antipsychotics with higher impact on cardiometabolic risk among patients with existing cardiometabolic conditions.

-3

SOCIAL ANXIETY DISORDER AND TECHNOLOGY-BASED COMMUNICATION

Speaker: Michael Van Ameringen, M.D.
Co-Author(s): Beth Patterson, BScN, BEd, MSc candidate
William Simpson, BSc, PhD candidate
Jasmine Turna, BSc

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To become aware of the increasing use of the internet and technology for social purposes in individuals with Social Anxiety Disorder;2) To understand the potential impact of internet/technology-modalities of communication on the social functioning of individuals with Social Anxiety Disorder;3) To assess the feasibility of using internet/technology-based treatments for Social Anxiety Disorder.

SUMMARY:

Background: Literature examining the effects of increased internet use/technology on social behavior is emerging with equivocal results of risk vs. benefits. Social Anxiety Disorder(SAD) is an anxiety disorder which has a profound impact on communication; individuals with SAD have also been found to be high users of the internet. The impact of internet use on the social functioning of individuals with SAD was examined in an internet survey.
Method: In September 2012, a survey was posted on the website of a Canadian anxiety research centre asking respondents about the reasons for and time spent on the internet during their leisure time. The survey asked about online friendships, social media participation and preferred communication style. Participants also completed a validated, self report screening tool for anxiety and depression, measures of functional impairment and symptom severity.
Results: Of the 500 respondents who completed the survey, most met criteria for at least one clinical diagnosis(83%) and 58% had SAD. The sample was compared by SAD diagnosis: Social Anxiety Disorder(SAD) vs. No Social Anxiety(NoSAD) vs. Controls(no current disorder). NoSADs spent significantly greater amounts of time than SADs($p<.05$) interacting with others face to face(FTF) per day. SADs reported higher rates of anxiety/discomfort during FTF interactions than NoSADs and Controls($p<.001$). SADs felt significantly less close to their friends than controls or NoSADs($p<.05$). SADs were also significantly more likely to send a text message to avoid FTF or telephone contact than those in the Control or NoSAD groups($p<.05$), SADs were significantly more likely to use computer-based communication to avoid FTF than controls ($p<.05$) . The SAD group was examined by symptom severity(severe SAD = SPIN > 40). Severe SADs(vs. moderate) were more likely to: send a text message to avoid FTF or telephone interactions($p=.007$); report the internet has facilitated avoidance of seeking help for their anxiety($p=.021$); feel less close to people they communicate with FTF($p=.005$); feel more anxious($p<.001$) and less comfortable($p=.002$) communicating FTF. Severe SADs had significantly higher scores on SDS, YBOCS, GAD-7, PDSS-SR, PHQ-9, and had a greater number of comorbid disorders(3.7 ± 1.5 vs. 2.9 ± 1.4, $p<.001$) than moderate SADs. The sample was also compared by frequency of internet use. High users(> 3-4 hours of leisure time/day) reported significantly higher numbers of online friends, and felt significantly closer to their online friends than people with low internet use ($p<.001$). High internet users were also

more likely to report a decrease in the quality of their offline friendships(p=.03) and higher rates of severe SAD(p=.02). Conclusions: SAD was associated with high internet use during leisure time. Given the high use of the internet by individuals with SAD for social interaction, technology based treatments may improve access to treatment and improve social functioning.

TECHNOLOGY AND PSYCHIATRIC TREATMENT

Moderators: Derya I. Akbiyik, M.D., Kasey Riquelm

-1

PSYCHIATRIST USE OF PATIENT-REPORTED OUTCOMES: UPTAKE AND CHALLENGES IN IMPLEMENTING A WEB-BASED PATIENT-REPORTED OUTCOMES APPLICATION

Speaker: Elizabeth Austin, M.P.H.
Co-Author(s): Molly Finnerty, M.D., Elizabeth Austin, M.P.H., Edith Kealey, M.S.W., Abbey Hoffman, M.S., Laura Bartkowiak, M.P.H., Emily Leckman-Westin, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review common challenges faced by psychiatrists in shifting to a patient reported outcomes-based model of care;2) Understand critical factors necessary to support psychiatrists in their uptake and use of patient reported outcomes tools;3) Identify effective strategies to support psychiatrists and broader clinical teams in integrating patient reported outcomes into treatment planning and service delivery in the outpatient setting.

SUMMARY:
Background: Patient reported outcomes (PROs) are increasingly valued as a model for driving more effective treatment decisions and outcomes. MyPSYCKES is an innovative web-based application developed by the New York State Office of Mental Health (NYSOMH) that facilitates the regular use of patient reported outcomes and shared decision-making in the outpatient setting. Specifically, clients use MyPSYCKES to report on their symptoms and status before each medication appointment, generating a PROs-based report that they review with their psychiatrist and develop a shared decision about next steps based on the PROs identified. Methods: NYSOMH implemented MyPSYCKES in twelve outpatient Medicaid mental health clinics throughout New York State. The team reviewed application usage statistics to assess patterns of use and uptake by clients and psychiatrists. The team then analyzed qualitative data gathered while providing implementation support (Learning Collaborative calls, site visits, Helpdesk technical assistance) to identify discrepancies and challenges in program use across sites. Results: Among the six clinics that have launched to date, there are 1,482 clients using the MyPSYCKES program. 65% of these clients have completed a profile that tailors the application to their individual wellness activities, crisis signs, and overarching treatment goals. 48% have used the application at least once to generate a PROs-based report on their symptoms and goals. Of the 1,891 reports that have been generated to date, 732 (41%) have an accompanying shared decision documented from the psychiatrist who reviewed that report with the client. Qualitative analyses of the implementation experiences at the six clinics elucidate that psychiatrists 1) find value in tools that facilitate systematic patient reported outcomes, 2) are often challenged in managing the amount of information patients report when using a PROs tool, 3) need more support from the clinic at large to fully integrate a PROs tool into their workflow, and 4) lack routine processes to translate PROs into their clinical decision-making processes with clients. Discussion: The NYSOMH experience with MyPSYCKES demonstrates early evidence that psychiatrists value patient reported outcomes, but still struggle to integrate PROs into treatment planning in effective ways. More systematic supports are needed to help psychiatrists use PROs, particularly in ways that allows patient reported outcomes to inform treatment decisions. The NYSOMH team will discuss adaptations made to the MyPSYCKES application based on psychiatrist feedback to improve its functionality, as well as implementation strategies used to further support psychiatrists in using patient reported outcomes in treatment.

-2

A RANDOMISED CONTROLLED TRIAL TO EVALUATE THE EFFECTIVENESS OF TELEPHONE-BASED INTERPERSONAL PSYCHOTHERAPY FOR THE TREATMENT OF POSTPARTUM DEPRESSION

Speaker: Cindy-Lee Dennis, Ph.D.
Co-Author(s): Sophie Grigoriadis, M.D., Ph.D., Ellen Hodnett, R.N., Ph.D., Melissa Jovellanos, M.Sc., Alexander Kiss, Ph.D., Paula Ravitz, M.D., Lori Ross, Ph.D., John Zupancic, M.D., Sc.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the importance of treating postpartum depression;2) Identify the advantages of providing telephone-based treatment ;3) Identify principles of a randomized controlled trial design

SUMMARY:
Substantial data indicate potential health consequences of untreated postpartum depression (PPD) for the mother, infant, and family. Studies have evaluated interpersonal psychotherapy (IPT) as a treatment for PPD; however, the results are questionable due to significant methodological limitations. IPT is consistent with a comprehensive review of maternal treatment preferences, which suggests mothers favour 'talking therapy' as a form of PPD treatment. Unfortunately, IPT is not widely available, especially in rural and remote areas. To improve access to care, telepsychiatry has been introduced and includes the provision of therapy via telephone. The purpose of this randomized controlled trial was to evaluate the effect of telephone-based IPT on the treatment of PPD. Healthcare providers from across Canada referred mothers 12 on the Edinburgh Postnatal Depression Scale to the trial coordinator. Self-referrals were also accepted. Mothers with major depression, as diagnosed using the Structured Clinical Interview-DSM-IV, were randomized to either the control group (usual care) or intervention group (usual care plus 12 telephone-based IPT sessions provided by nurses). Diverse study outcomes at 12, 24, and 36 weeks post-randomization will be presented. Results from this trial will: (1) develop the body of knowledge concerning the effectiveness of telephone-based IPT to treat PPD; (2) advance our understanding of training nurses to deliver IPT; and (3) provide an economic evaluation of an IPT intervention.

-3

A COMPARISON BETWEEN ONLINE AND LIVE MULTIFAMILY PSYCHOEDUCATION PROGRAMS FOR CHILDREN WITH MOOD AND ANXIETY DISORDERS

Speaker: Sarosh Khalid-Khan, M.D.
Co-Author(s): Nazanin Alavi, M.D. , Elaine Choi, BSc, Gbolahan Odejayi, M.D., Archana Patel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know the role of Multifamily psychoeducation group programs (MFPGs) in reducing levels of expressed emotion in the family climate for adolescent with mood disorder;2) Understand barriers to taking part in psychoeducation group programs (MFPGs);3) Identify advantages of offering online Multifamily psychoeducation group programs (MFPGs)

SUMMARY:
Introduction: Multifamily psychoeducation group programs (MFPGs) have been shown to be effective in reducing levels of expressed emotion in the family climate for adults with mood disorders; this reduction has been associated with improved outcome. However, the effectiveness of MFPGs has not been investigated to the same extent with children with mood and anxiety disorders. Additionally, children with anxiety disorders may be reluctant to participate in live group sessions; offering psychoeducation sessions through e-mail may be an effective method of delivering this service to these families. Methods: The families of children (12 years old or younger) who were referred with a mood or anxiety disorder to the Division of Child & Adolescent Psychiatry at Queen's University were given the opportunity to choose in an on-line or live psychoeducation program while they are on the wait list to see a psychiatrist. All parents were assessed before and after the program using the Expressed Emotion Adjective Checklist, Understanding of Mood Disorders Questionnaire, and Understanding of Anxiety Disorders Questionnaire, while the children were assessed using the Children's Depression Inventory and Multidimensional Anxiety Scale for Children. During the six sessions, participants were provided with topic-specific information, suggestions on improving skills and strategies, interactive activities and worksheets. Results: In both groups, participants' knowledge of mood and anxiety disorders increased. Some of the participants' in both groups did not need further treatment and were improved after receiving the sessions. Both modalities were equally effective in delivering the psychoeduction sessions. Conclusions: Psychoeducation programs for the family either live or online are an effective way to increase knowledge, provide resources and support, and build on skills, thus giving individuals more control and confidence when dealing with a mood or anxiety disorder. Addressing the whole family is especially important when helping children with psychological disorders. This is an effective intervention that should be made accessible to a wide range of patients.

-4

INTERNET-DELIVERED COGNITIVE BEHAVIOR THERAPY FOR BODY DYSMORPHIC DISORDER: A PILOT STUDY

Speaker: Jesper Enander, M.Sc.
Co-Author(s): Volen Z. Ivanov, M.sc., Erik M. Andersson, M.sc., Paul Lichtenstein, Ph.D., Brjánn Ljótsson, Ph.D., David Mataix-Cols, Ph.D., Christian Rück, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have an basic understanding of how Internet cognitive behavior therapy (iCBT) can be used to treat patients with body dysmorphic disorder (BDD);2) Identify which patients are suited for iCBT;3) Have an basic understanding of how treatment progress can be monitored via the Internet.

SUMMARY:
Background: Body dysmorphic disorder (BDD) is a debilitating psychiatric condition characterized by an excessive preoccupation with slight or imagined defect(s) in one's psychical appearance, that leads to clinically significant distress and/or impairment in social and/or occupational functioning. Epidemiological studies have reported a point prevalence of 0.7 % to 2.2 % in the general population, with about an equal proportion among men and women. Because of the poor insight it is not uncommon for people with BDD to seek, and receive, cosmetic treatments (e.g. dermatological, surgical, or dental). However, such treatments very rarely improve symptoms. A treatment that is showing promise is cognitive behavior therapy (CBT). A novel way to deliver CBT is via the Internet. Internet-based CBT (iCBT) has been shown to be effective in the treatment of various diagnoses (e.g. social anxiety disorder, depression, irritable bowel syndrome, and OCD) with similar effect sizes as "face-to-face" treatment but more cost effective and less time consuming for the therapist. To date, no trials have been published on the effectiveness of iCBT for BDD. Aim: To test the feasibility of a novel and protocol-based CBT treatment for BDD administered via the Internet. Methods: A pilot study with within-group design combined with repeated measurements. Analysis of primary (Body Dysmorphic Disorder Modification of the Y-BOCS; BDD-YBOCS) and secondary outcome measures between baseline and post treatment in order to determine if the treatment significantly reduces symptoms associated with BDD. Results: Currently 23 patient is treated with iCBT. The treatment ends in November 2013 and preliminary results are promising. Final results from the study will be presented at the annual meeting. Significance: Development of a novel treatment delivered via the Internet could substantially increase accessibility. Furthermore, people with BDD can be reluctant to seek mental health care, partly due to the conviction that the perceived physical defect is real, and the belief that a cosmetic procedure will "fix" it. In other words, people with BDD don't usually see themselves as "psychiatric" patients and it can take some time before they finally end up at a psychiatric clinic where they can receive a treatment that actually works (e.g., SRI or CBT). iCBT has the potential to be perceived as less "psychiatric" in the sense that it is flexible and time efficient â€“ the patient does not have to come to a clinic once a week, and the treatment can be done at home at times that are convenient for the patient. Thus, iCBT could have the potential to narrow down the gap that it takes for a BDD patient to seek help from the mental health care system.

MAY 04, 2014

MOOD DISORDERS: COMPLIANCE, METABOLIC SYNDROME, AND INSULIN

Moderators: Vivek Singh, M.D., Sri Venkata Uppalapati, M.D.

-1

IS METABOLIC SYNDROME ASSOCIATED WITH SEVERITY OF ILLNESS AND OUTCOMES AMONG INPATIENTS WITH MOOD DISORDERS?

Speaker: John W. Goethe, M.D.
Co-Author(s): Jeff Wisniowski, M.P.H, B.S.; Bonnie L. Szarek, R.N.; Stephen Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the associations of MetS with readmission rates, LOS, and GAF in patients with mood disorders;2) Compare and contrast in patients with MDD vs. BPD, the associations of MetS with readmission rates, LOS, and GAF;3) Discuss the implications of readmission within 1 vs. 3 vs. 6 vs. 12 months of index inpatient discharge.

SUMMARY:

Objective: Recent studies indicate that metabolic syndrome (MetS) is common in patients with mood disorders and may be associated with high severity and poor psychiatric and medical outcomes. The study aims were to determine if (1) MetS (or any MetS criterion) was associated with severity/outcome and (2) any of these associations differed by type of mood disorder. Methods: MetS was defined using Adult Treatment Panel III criteria (ATP). MetS measures were obtained in 7154 consecutively discharged inpatients (4/08-3/12) with a clinical diagnosis of MDD, bipolar disorder (all BP and BP-1 only), or depressive disorder NOS (D-NOS). For each diagnostic subgroup logistic regressions examined associations between MetS and each MetS criterion separately and each of several indicators of illness severity and outcome: GAF at admission and discharge, LOS, readmission (RA) within 1, 3, 6, 12 months of index discharge. Results: The study sample was patients age 18-74 (mean=39.8±14.1) and was 55% female, 63% White, 23% Latino, 11% Black, 60% MDD, 27% BP-1, 13% D-NOS. Risk of RA within 1, 3, 6, 12 months was increased in BP patients meeting ≥1 of the 5 MetS criteria (ORs=1.94, 1.95, 1.89, 1.53); in the BP-1 subsample this RA risk was even greater (0Rs=2.54, 3.16, 2.79, 1.56). In BP-1, RA risk at 1 month was additionally associated with BMI ≥30 (OR=1.72). Increased RA risk in MDD was only associated with the HDL criterion and only at 1 month (OR=1.43). Increased RA risk in D-NOS was only associated with meeting the waist circumference criterion (at 1, 3, 6, 12 months, OR=3.63, 2.53, 2.06, 1.86). LOS > 8 days (highest quartile) was most likely in those with FBS ≥ 100 in both BP and MDD (ORs=1.53, 1.48) and in those with hypertension in both BP and D-NOS (ORs=1.46, 1.37). Discharge GAF ≤ 42 (lowest quartile) was more likely in patients with hypertension for both MDD (OR=1.26) and D-NOS (OR=2.14) and patients with a diabetes diagnosis in BP (OR=1.59) and BP-1 (OR=1.72). An association with meeting full criteria for MetS was only found in BP with a discharge GAF ≤ 42 (OR=1.44). There were no other significant associations between MetS and either LOS or GAF. Discussion: These results may not apply to all mood disorder patients; this sample was limited to patients at one site who were hospitalized at study entry. Also, while RA is an important measure of outcome, it can reflect issues not examined here, such as treatment adherence and access to care. Nonetheless, these findings suggest that MetS in mood disorder patients is associated with poor outcome and that these vary by type of mood disorder and outcome measures used. Further research is needed, including studies that examine factors that may be common to both MetS and mood disorders.

-2

COMORBID INSULIN RESISTANCE AND TYPE II DIABETES PREDICT CHRONIC COURSE OF BIPOLAR ILLNESS AND POOR RESPONSE TO LITHIUM

Speaker: Cynthia V. Calkin, M.D.
Co-Author(s): Martin Alda, M.D., Julie Garnham R.N.B.N., Tomas Hajek, M.D., Ph.D, Claire O'Donovan, M.D., Martina Ruzickova, M.D., Ph.D., Claire Slaney, R.N., Rudolf Uher, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role of insulin resistance in bipolar patients refractory to treatment;2) Recognize the possible effect of insulin resistance on the course of bipolar illness;3) Recognize the association between insulin resistance and response to lithium in bipolar disorder.

SUMMARY:

Objectives: Patients with bipolar disorder (BD) have up to three times increased risk of type II diabetes (T2D). The relationship between insulin resistance (IR, a precursor to T2D) and BD has not been thoroughly studied. We do not know what impact IR/T2D may have on the course of bipolar illness; whether treating IR/T2D can improve mood symptom control, decrease level of disability, or ameliorate bipolar treatment response and/or outcome. Further, T2D is frequently occult in BD. In a previous study we found that patients achieving complete remission of symptoms on lithium had significantly lower body mass index (in the healthy range), compared to those in the obese range, who had no clinical response to lithium. As obesity increases risk for IR, conceivably, IR/ T2D may also affect the quality of remission in BD; they may be risk factors for refractory illness and responsible for residual symptoms, increasing morbidity and mortality. This study aims to examine the association between of abnormal glucose metabolism and course and outcome in BD, including response to lithium treatment. We hypothesize that patients with co-morbid IR/T2D will have a more refractory form of BD than those without IR/T2D, as well as poorer response to lithium.
Methods Patients for this study have been recruited from the Maritime Bipolar Registry and Mood Disorders Specialty Program. The diagnosis of T2D was determined according to two measures of fasting plasma glucose (FPG) and 2-hour oral glucose tolerance test, if still equivocal. Fasting serum insulin and FPG were used in the Homeostatic Model Assessment-IR equation to quantify insulin resistance in those with normal FPG. The National Institute of Mental Health-Life Cart Method (NIMH-LCM) is used to document clinical course and treatment history. The Retrospective Criteria of Long-Term Treatment Response in Research Subjects with Bipolar Disorder Scale has been used as a measure of treatment response.
Results A total of 156 patients have been included in the study with diagnoses of BD I and II and an age range of 19-77 years. Of these patients, 121 have completed blood testing, showing that only 46.3% of all patients were euglycemic, 32.2% had IR

and 21.5% had T2D. Using logistic regression, we found that 50% of bipolar patients with IR or T2D had a chronic clinical course, compared to those who were insulin resistant (27.3%. OR = 3.07, p=0.007). More bipolar patients with T2D and IR had a complete lack of response to lithium compared to euglycemic patients (36.8% and 36.7%, versus 3.2%, respectively (OR = 8.40, p<0.0001).
Conclusions Our results showed that more than half of bipolar patients have some abnormality in glucose metabolism. Co-morbid IR and T2D strongly predict a chronic clinical course (versus episodic), and poorer response to lithium.

-3

CLINICAL PHARMACISTS' INTERVENTIONS INCREASE ADHERENCE TO ANTIDEPRESSANT TREATMENT IN THE COMMUNITY.

Speaker: Yoram Barak, M.D., M.H.A.
Co-Author(s): Yuval Ben-Amnon, M.D., Shmuel Klang Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Utilize clinical pharmacists to increase adherence of depressed patients; 2) Recognize common obstacles to antidepressant treatment adherence;3) Identify depressed patients in the community in need of support for long-term treatment.

SUMMARY:
Background: The treatment goal of major depressive disorder (MDD) is achieving and maintaining remission. There are many obstacles in the path to reach this goal, one of the major obstacles being poor adherence to medication regime. Clinical pharmacists (CPs) are accessible to primary care patients and are in a unique position to help improve adherence. Several studies have demonstrated mixed results for CPs interventions to increase adherence amongst MDD patients. Aim: To compare the effectiveness of pharmacist intervention with standard care, for patients with MDD. Method: An exploratory controlled trial undertaken in 17 general community pharmacies with clinical pharmacists in Israel. Participants were patients suffering from MDD prescribed escitalopram by their general practitioner. Within a one-year period 173 patients were enrolled and 96 (55%) completed six months of antidepressant treatment. CPs initiated pharmacist medication review at enrollment followed by face-to-face pharmacist adherence support throughout the study period. No blinding was Results: The primary outcome measure was adherence to antidepressant treatment at 6 months. At one month adherence rates were 71% in the pharmacist arm and at 6 months rates were 55% versus published norms of 42% (p=0.004). There were no differences between sites in adherence rates. CPs participating in this study reported higher levels of confidence in supporting MDD patients at the end of the study. Conclusions: This is the first trial of pharmacist adherence support in Israel, and demonstrates benefits for patients in the community suffering from MDD.

-4

CHRONIC VERSUS INTERMITTENT BIPOLAR DEPRESSION IN STEP-BD PATIENTS

Speaker: Joseph F. Goldberg, M.D.
Co-Author(s): Roy H. Perlis, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the prevalence of chronic/persistent (versus intermittent) depression in STEP-BD bipolar disorder patients over a 1-year prospective follow-up; 2) Describe clinical characteristics that differentiate chronic from nonchronic bipolar depression;3) Evaluate relative risk for suicidal behavior in patients with chronic versus intermittent patterns of bipolar depression

SUMMARY:
Chronic versus Intermittent Bipolar Depression in STEP-BD Patients Although depression is widely recognized as the predominant mood state in bipolar disorder patients, little is known about the extent to which it presents as a persistent versus intermittent phenomenon. Inasmuch as changes in polarity to and from depression are hallmark differentiators of bipolar and unipolar disorders, we sought to compare clinical features among bipolar patients based on patterns of their depressive symptom duration uninterrupted by achieving euthymia. Subjects were 788 bipolar I or II enrollees in the NIMH Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) with complete quarterly depression symptom ratings during at least one year of follow-up. Affective symptoms were monitored by quarterly assessments using the Montgomery Asberg Depression Rating Scale (MADRS) and other standardized measures. Results indicated that 147 subjects (18.7%) had MADRS scores >10 at baseline and consistently across all quarterly assessments for 1 year. Chronic/persistently depressed patients were more likely to be male (50.3% of chronic versus 38.9% of non-chronic; p=0.01)), had more lifetime suicide attempts (40.6% of chronic versus 38.9% of nonchronic; p=.05), more often had a comorbid Axis I anxiety disorder (56.5% of chronic versus 30.6% of nonchronic), had more past-year days depressed (p<.0001) and days irritable (p<.0007), and less often had a history of psychosis (32.6% of chronic versus 42.4% of nonchronic; p=.003). The findings indicate that chronic (rather than intermittent) depression arises in a substantial minority of bipolar patients and may be distinguished by a number of clinical features, notably, greater anxiety comorbidity and risk for suicidal behavior.

SUICIDE AND NON-SUICIDAL SELF-INJURY

Moderators: Priya Krishnasamy, Francis Shin

-1

PREDICTORS FOR SUICIDAL IDEATION IN AN EPIDEMIOLOGIC CATCHMENT AREA IN MONTREAL, CANADA: A LONGITUDINAL STUDY

Speaker: Venkat Bhat, M.D.
Co-Author(s): Venkat Bhat. M.D., Aihua Liua, Ph.D., Jean Caron, Ph.D., Gustavo Turecki, M.D, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate that the Epidemiologic Catchment Area in Montreal study was longitudinal and had an extensive list of variables looking at suicidal ideation during last 12 months;2) Know that the proximal risk factors for SI include particular forms of stress, not seeking/receiving help for mental health problems and depression/mania;3) Appreciate that the distal

rick factors include immigration, stigma, social stigma, and lack of social support.

SUMMARY:
Objectives: The Montreal Epidemiological Catchment Area Study (ECA) is a longitudinal project currently underway at the Douglas Institute. Longitudinal studies give a better measure of causality and allow for the exploration of predictors, mediators and moderators. This study aims to identify predictors for incidence of suicidal ideation during the last 12 months. Methods: The ECA study under the form of a community survey includes a randomly selected sample of 2434 individuals between 15 and 65 years of age (T1); 1822 agreed to be re- interviewed two years later (T2). Mental disorders which included suicidal ideation (SI) were identified with the Canadian Community Health Survey (CCHS 1.2) version of the Composite International Diagnostic Interview. The ECA study includes a comprehensive battery of questionnaires which collects an extensive list of variables associated with mental illness. Systematic logistic regression with appropriate model selection was used to identify variables at time T1 which could serve as predictors of having had suicidal ideation during the last year at time T2.
Results: Among the 1822 subjects at T2, 1742 subjects had no SI (95.61%) and 80 subjects had SI (4.39%) during the last year. Subjects with SI during the last 12 months had significantly higher comorbidity (mood, mania, agoraphobia, alcohol dependence), higher past month psychological distress, lower education and were more likely to be single. The following variables at T1 served as predictors of SI at time T2: Immigration status, poor physical health, social stigma, and absence of social support; history of the following during the last year- particular forms of stress (cutting ties with children, job loss or work related problems, and physical abuse), not seeking help for mental health problems, not receiving help for mental health problems, and history of depression or mania. Conclusion: The study had an extensive list of variables. The proximal risk factors for SI include particular forms of stress, not seeking/receiving help for mental health problems and depression/mania. The distal rick factors include immigration, stigma, social stigma, and lack of social support. Other proximal and distal variables such as coping skills, substance use and impulsivity were not significant predictors. The predictors of incidence and remission will give a better understanding of risk factors in the suicide risk continuum, allow development of effective prevention programs and help to improve mental health services.

-2

NON-SUICIDAL SELF-INJURY IN DSM-5: SHOULD THE PROPOSED CRITERIA BE BROADENED TO INCLUDE OTHER METHODS OF SELF-HARM?

Speaker: James Bolton, M.D.
Co-Author(s): Hayley Chartrand M.A., Huntae Kim M.D., Minoo Mahmoudi M.D., Jitender Sareen M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the prevalence and correlates of non-suicidal self-injury among patients in the emergency department; 2) Recognize that people who deliberately harm themselves by overdosing are similar on most measures to those harming themselves by cutting;3) Recognize the DSM-V criteria for the newly proposed diagnosis of Non-Suicidal Self-Injury.

SUMMARY:
Objective: Non-suicidal self-injury (NSSI) is a Section III diagnosis in the new DSM-V. Criteria state that self-harm must include "damage to the surface of his or her body," and therefore other forms of self-harm cannot be considered as NSSI. This study sought to compare people with non-suicidal self-harm by cutting with those who overdosed on medication without intention to die, across a broad range of measures including sociodemographics, mental disorders, and future self-harm presentations. Method: The sample included consecutive adult presentations over 3 years (January 1 2009 to Dec. 31 2011) to psychiatric services at the two tertiary care hospitals in Winnipeg, Canada (n=5,607). 259 presentations (4.6%) were categorized as self-harm behavior without suicidal intent based on the Columbia Classification Algorithm for Suicide Assessment (C-CASA). Chart reviews were conducted to extract method of self-harm, sociodemographic information, mental disorder diagnoses, and previous suicidal behavior. Future self-harm presentations within 6 months were tracked at the two hospitals. Logistic regression compared the 2 groups of interest (cutting vs. overdose) across the measures listed above.
Results: 187 charts were reviewed. 90 people presented with overdose (48%) and 40 (21%) presented with cutting during the study period. No sex differences were observed. High rates of Cluster B personality traits or disorders were observed in both the overdose and cutting groups (38% and 51%, respectively), but were not statistically different [odds ratio (OR)=1.70, 95% confidence interval (CI) 0.80-3.64]. Both groups showed similar high rates of childhood abuse (48% and 46%), aggression and impulsivity (62% and 66%), and previous psychiatric treatment (60% and 68%). Equal rates of representation to the emergency department within 6 months occurred for both groups (13%), and only 1 within each group was for self-harm without intention to die.
Conclusions: Overdosing was a common method of self-harm without intention to die in this emergency department sample. They were similar to people that self-harmed by cutting on almost all demographic and diagnostic measures, suggesting that the method of self-harm was not a distinguishing feature in these presentations. Further study in other populations is required and may help inform the criteria for this newly proposed disorder.

-3

CORRELATES OF NON-SUICIDAL SELF-INJURY VERSUS SUICIDE ATTEMPTS AMONG TERTIARY-CARE EMERGENCY ROOM PATIENTS IN MANITOBA

Speaker: Hayley Chartrand, M.A.
Co-Author(s): Joanna Bhaskaran, B.Sc. (Hons.), James M. Bolton, M.D., Laurence Y. Katz, M.D., Jitender Sareen, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand that a number of correlates of non-suicidal self-injury and suicide attempts are similar;2) Recognize that the majority of individuals with non-suicidal self-injury presented only once to emergency services over 30 months;3) Appreciate that individuals with non-suicidal self-injury are more likely to experience early life adversity and psychiatric comorbidity

compared to those with no suicidal thoughts or behavior.

SUMMARY:
Objective: With the recent release of DSM-5, the distinction between non-suicidal self-injury (NSSI) and suicide attempts is highlighted in the section of conditions for further study. Diagnostic criteria are laid out for both NSSI and suicidal behavior disorder as separate and distinct disorders. This study examined the prevalence and correlates of NSSI in emergency settings and compared them to suicide attempts.
Methods: Data came from a sample of physician-assessed, consecutively-referred adults to psychiatric services in emergency departments of two Manitoba tertiary-care hospitals between January 1, 2009 and June 30, 2011 (N=5,336). Presentations of NSSI were compared to suicide attempts as well as no suicidal behavior across a broad range of demographic and diagnostic correlates.
Results: Of the 5,336 presentations, 230 (4.3%) were NSSI, 749 (14.0%) were suicide attempts, and 2380 (44.6%) featured no suicidal thoughts or behavior. Compared to presentations without suicidal behavior, NSSI was more highly associated with female sex, childhood abuse, anxiety disorders, depression, aggression and impulsivity, age under 45, and substance abuse. Comparing NSSI and suicide attempts, no differences were observed on sex, age, history of child abuse, or presence of anxiety or substance use disorders. However, suicide attempts had a higher likelihood of recent life stressor [Odds Ratio (OR)=1.44; 95% Confidence Interval (CI)=1.05-1.99], active suicidal ideation (OR=8.84; 95% CI=5.26-14.85), depression (OR=3.05; 95% CI=2.23-4.17), previous psychiatric care or suicide attempts (OR=1.89; 95% CI=1.36-2.64), and single marital status (OR=1.63; 95% CI=1.20-2.22). 80.7% of individuals with NSSI presented only once to emergency services over the 30-month study period. Of those who presented multiple times, only 18.2% re-presented with NSSI.
Conclusions: NSSI is associated with early life adversity and psychiatric comorbidity. The majority present only once to emergency services and deliberate self-harm presentations seemed to change over time. Future studies should continue to clarify whether NSSI and suicide attempts have distinct risk profiles.

-4

IDENTIFYING GAPS IN SUICIDE PREVENTION STRATEGIES IN LOWER AND MIDDLE INCOME COUNTRIES (LMICS)

Speaker: Rahel Eynan, Ph.D.
Co-Author(s): Rahel Eynan Ph.D., Paul S. Links M.D., FRCPC., Ravi Shah, M.D., Shubhangi Parkar M.D., Ph.D. , TSS Rao M.D., Kranti Kadam M.D., Chetali Dhuri M.D., K Kishor M.D., Amresh Shrivastava M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review current suicide prevention strategies;2) Identify gaps in existing suicide prevention services and supports;3) Examine suicide prevention competencies training for health care professionals;4) Discuss recommendations for strategic, coordinated suicide prevention training services.

SUMMARY:
Suicide is one of the leading causes of premature death worldwide and claims the lives of approximately one million individuals annually. Low and middle income countries (LMICs) are disproportionally affected by the burden of suicide with approximately 85% of all suicides occurring in these countries, particularly in China and India. This reflects both the large population and the relatively high prevalence of suicide in these countries. To put this in perspective, the number of suicides in India alone is equivalent to the total number of suicides in the four European countries with the highest number of suicides. Yet, suicide and its prevention have received relatively less attention in India and other LMICs than it has in Europe and North America. Mental health and suicide prevention services and supports generally lag behind general health care services. The goal of our study was to identify gaps and barriers in suicide prevention strategies. In addition to environmental scans which examined existing data, we used a mixed methods approach of collecting data. The quantitative data was collected with a closed-ended survey and qualitative data was garnered from focus group interviews and consultations with key informants. Our findings indicate that provision of appropriate suicide prevention services are often hindered by systemic barriers: the low allocation of funds for mental health in the national health budgets, stigmatization, lack of infrastructure and availability of services, lack of trained mental health care professionals, a lack of competencies and expertise in GPs, and the social determinants of suicide (e.g. gender, age, poverty, culture, religious sanctions, rapid urbanization, globalization). While there are some suicide prevention initiatives, the efforts are largely uncoordinated, under-resourced, and mostly unevaluated.

BORDERLINE PERSONALITY DISORDER: 16 YEARS OF THE MSAD STUDY

Moderators: Kenneth R. Silk, M.D., Laurentiu Dumitrescu

-1

RATES OF RECURRENCE OF BORDERLINE SYMPTOMS AFTER SUSTAINED SYMPTOMATIC REMISSION

Speaker: Mary Zanarini, Ed.D.
Co-Author(s): Frances R. Frankenburg, M.D., Garrett M. Fitzmaurice, Sc.D., D. Bradford Reich, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize that the acute symptoms of BPD tend to have relatively low rates of recurrence after a sustained period of remission;2) Recognize that rates of recurrence for the temperamental symptoms of BPD are substantially higher;3) Recognize the need for the development of treatments that focus on the temperamental symptoms of BPD.

SUMMARY:
Objective: The main objective of this study was to assess the rate of recurrence of 24 symptoms of borderline personality disorder (BPD) after sustained remissions of these symptoms.
Method: 290 patients meeting rigorous criteria for BPD were interviewed concerning their borderline psychopathology at baseline and every two years over 16 years of prospective follow-up.
Results: Rates of recurrence of the 12 acute symptoms of BPD (e.g., self-mutilation, suicide efforts) were substantially

lower than the rates of recurrence of the 12 temperamental symptoms of BPD (e.g., chronic feelings of anger, intolerance of aloneness). After eight years of remission, we found a median recurrence rate of 23% for the acute symptoms of BPD and a median recurrence rate of 55% for the temperamental symptoms of BPD. Conclusions: Taken together, the results of this study suggest that the acute symptoms of BPD tend to have more stable remissions than the temperamental symptoms of BPD.

-2

PRN (AS-NEEDED) PSYCHOTROPIC MEDICATION USE IN BORDERLINE PATIENTS AND OTHER PERSONALITY-DISORDERED COMPARISON SUBJECTS: A 16-YEAR FOLLOW-UP STUDY

Speaker: Eduardo Martinho Jr., M.D.

Co-Author(s): Frances R. Frankenburg, M.D.; Garrett M. Fitzmaurice, Sc.D.; Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the magnitude and the determinants of PRN (as needed) psychotropic medication use in the course of borderline personality disorder and other personality disorders;2) Understand the long term-relationship of PRN psychotropic medication use to recovery status in borderline patients;3) Define principles and effective strategies for prescribing PRN psychotropic medication to borderline patients.

SUMMARY:

The use of PRN (as-needed) psychotropic medication in borderline patients has not been well characterized. This study had three purposes: (i) to describe the prevalence of PRN psychotropic medication use among borderline patients and other personality-disordered comparison subjects over 16 years of prospective follow-up; (ii) to examine the rates reported by ever-recovered and never-recovered borderline patients; and (iii) to examine the reasons for taking PRN medication reported by these patients. Overall, the prevalence of PRN psychotropic medication use was initially approximately 3 times higher among borderline patients than other personality-disordered comparison subjects, with a significant one-third decline in the use of PRN medication reported by borderline patients over time. In analyses restricted to borderline patients, never-recovered borderline patients were about twice as likely to use PRN medication than ever-recovered borderline patients over time. In terms of reasons for use, the rates of PRN medication use to decrease agitation for both diagnostic groups declined significantly over time, although they remained significantly higher among borderline patients. Likewise, never-recovered borderline patients reported higher use of PRN medication to decrease agitation than ever-recovered borderline patients over time. The results of this study indicate that PRN psychotropic medication is widely used for the treatment of borderline patients, particularly those who have not achieved a recovery in both the symptomatic and psychosocial realms. They also suggest that borderline patients use proportionally more PRN medication to decrease agitation than other personality comparison subjects, with lower proportional use of PRN to reduce agitation found among recovered borderline patients.

-3

PREVALENCE AND COURSE OF SEXUAL RELATIONSHIP DIFFICULTIES IN RECOVERED AND NON-RECOVERED PATIENTS WITH BORDERLINE PERSONALITY DISORDER OVER 16 YEARS

Speaker: Esen Karan, M.Sc.

Co-Author(s): Garrett M. Fitzmaurice, Sc.D., Frances R. Frankenburg, M.D., Isabella J. M. Niesten, M.Sc., Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that the prevalence of sexual relationship difficulties (i.e., avoidance of sex and being symptomatic after sex) declines significantly over 16 years of prospective follow-up;2) Recognize that these sexual difficulties are significantly more common over time among non-recovered than recovered borderline patients;3) Recognize that remissions are very high for both groups, while recurrences (of avoidance of sex) and new onsets (of both types of difficulty) are more common among non-recovered borderline patients.

SUMMARY:

Although borderline patients experience a wide range of sexual problems, there is less evidence documenting their sexual relationship difficulties. This study had two aims. The first aim was to examine the prevalence of sexual relationship difficulties (i.e., avoidance of sex and becoming symptomatic after sex) over 16 years of prospective follow-up among recovered and non-recovered patients with borderline personality disorder (BPD). The second was to determine time-to-remission, recurrence, and new-onset of these sexual relationship difficulties. The sexual relationship difficulties of 290 patients meeting both DIB- R and DSM-III-R criteria for BPD were assessed at baseline using the Abuse History Interview and reassessed every two years over eight waves of prospective follow-up. The prevalence of sexual relationship difficulties declined significantly over time for both groups of patients, while remaining significantly more common among non-recovered borderline patients. By 16-year follow-up over 95% of each group of patients achieved remission for both sexual relationship difficulties. Recurrences of avoidance of sex were more common in non-recovered patients. In addition, non-recovered patients had higher rates of new-onsets of each type of sexual relationship difficulty. Although sexual relationship difficulties are more common among non-recovered BPD patients, they are not chronic for either group of patients.

-4

IMPULSIVE ACTIONS REPORTED BY BORDERLINE PATIENTS AND AXIS II COMPARISON SUBJECTS: A 16-YEAR PROSPECTIVE FOLLOW-UP STUDY

Speaker: Michelle Wedig, Ph.D.

Co-Author(s): Garrett Fitzmaurice, Sc.D.; Frances R. Frankenburg. M.D; D. Bradford Reich, M.D.; Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the prevalence of impulsive actions in borderline personality disorder and those with other personality disorders;2) Understand the differences in impulsive behaviors in those with borderline personality disorder and other personality disorders;3) Understand the differences in impulsive

behaviors between males and females in those with borderline personality disorder;4) Understand the predictors of the frequency of impulsivity in borderline personality disorder.

SUMMARY:

The first goal was to examine the difference in impulsive behaviors between those with borderline personality disorder (BPD) and those with other personality disorders (OPD) over 16 years of prospective follow-up. Second, we examined gender differences in impulsive behaviors in those with BPD. Third, we examined predictors of impulsive actions in those with BPD. Two-hundred ninety inpatients meeting criteria for BPD and 72 inpatients meeting criteria for another personality disorder were assessed during their index admission. These subjects were reassessed every two years. Most impulsive behaviors were significantly more common in those with BPD. Most of these behaviors declined significantly over time for those in both groups. Men with BPD were more likely than women to engage in most impulsive behaviors. Further, agreeableness, conscientiousness and a family history of substance abuse were the best predictors of impulsivity in those with BPD over time.

PERSONALITY AND PERSONALITY DISORDERS

Moderators: Vivek Singh, M.D., Stephanie Peglow

-1

AN FMRI STUDY OF AFFECTIVE INTERFERENCE WITH COGNITIVE FUNCTION IN BORDERLINE PERSONALITY DISORDER

Speaker: Paul H. Soloff, M.D.
Co-Author(s): R. White, BS, P.J. Pruitt, BS, V. Diwadkar, PhD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the disruptive effects of negative emotion on cognitive functions such as response inhibition, conflict resolution and episodic memory recall in borderline personality disorder;2) Relate functional abnormalities in neural processing of cognitive tasks to structural and/or metabolic abnormalities in specific brain networks ;3) Appreciate the clinical importance of affective interference with cognitive controls in the presentation of affective lability, impulsive-aggression and self-injurious behavior in BPD.

SUMMARY:

Introduction: Affective instability, impulsive-aggression, and self-injury in BPD may be mediated by loss of cognitive inhibition in the presence of intense negative emotion. Although structural and metabolic brain abnormalities have been implicated in this process, the neural effects of emotion on cognitive brain networks remain unclear. Using three novel fMRI protocols, we studied affective interference with cognitive function, specifically targeting brain regions reported to be aberrant in BPD. Method: Female subjects, aged 18-45 yrs., were recruited from clinic and community sources, assessed for Axis I and II disorders by structured interviews, and for BPD on the DIB-R. Exclusion criteria included all psychotic, bipolar, and substance dependence diagnoses. Controls had no current or lifetime DSM-IV disorders. All subjects were physically healthy, drug and alcohol-free for at least one week, with a negative drug screen and pregnancy test prior to the scan. fMRI data were collected at the UPMC Imaging Center on the 3.0T Semens Trio system. Data were analyzed using SPM8. Three behavioral paradigms were presented: Go No-Go (targeting the orbitofrontal cortex (OFC/PFC)), X-CPT (targeting the anterior cingulate (ACC)), and an episodic memory task (targeting hippocampus (HIP) and amygdala (AMY)). Each task incorporated negative, positive and neutral stimuli from the Ekman Faces, or the International Affective Pictures Series. Contrasts included: Neg. > Pos., Neg. > Neutral, and Pos. > Neutral. Results: 23 BPD subjects (mean age 25 yrs.), were compared to 15 controls (mean age, 29 yrs). Comparing Neg. > Pos. faces in the affective Go No-Go task, BPD subjects had decreased activation relative to controls in the middle-inferior (mid-inf) OFC (lt.), (and increased activation in sup. parietal cortex (rt), basal ganglia (rt), HIP (rt), AMY (lt), and a separate area of mid-inf OFC (lt.)). In the affective X-CPT task, comparing Neg. > Pos. faces, BPD subjects had increased activation in the ACC (rt), (also in sup. parietal cortex (lt.), mid-inf OFC (lt) and HIP (lt.) compared to controls). During memory encoding of Neg. > Pos. pictures, BPD subjects had diminished activation compared to controls in HIP, (also in ACC (lt.), sup. parietal cortex (lt.), and dorsal PFC (lt.)). During memory retrieval, diminished activation in BPD subjects was seen in HIP(lt.) (also in ACC (lt), and dorsal PFC (lt.)).Conclusion: Each of the affective paradigms successfully engaged brain regions associated with specific cognitive tasks and previously reported as structurally or metabolically aberrant in BPD. Negative affective interference with these tasks was associated with functional abnormalities in related cognitive brain networks in BPD compared to control subjects. The borderline patient's dysregulated emotion and impulse control may be mediated by the effects of negative emotion on vulnerable brain networks. (Supported by NIMH Grant MH048463).

-2

A RANDOMIZED CONTROLLED TRIAL OF EXTENDED-RELEASE QUETIAPINE IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: Donald Black, M.D.
Co-Author(s): S. Charles Schulz, M.D., Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose borderline personality disorder;2) Understand the treatment options for borderline personality disorder;3) Describe the results of a randomized trial in which quetiapine was used to treat borderline personality disorder

SUMMARY:

The efficacy and tolerability of low and moderate doses of an extended-release form of quetiapine fumarate (quetiapine XR) was examined in the treatment of adults with borderline personality disorder (BPD). A randomized, double-blind, placebo-controlled, dose comparison trial was conducted at three outpatient treatment centers from January 2010 to March 2013. Ninety-five persons with DSM-IV BPD were randomly assigned to quetiapine XR 150 mg/day (n=33), quetiapine XR 300 mg/day (n=33), or placebo (n=29). Scores on the clinician-rated Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD) were analyzed by using a linear mixed-effects model. The groups were well matched on demographic and clinical variables. Estimated regression coefficients showed that

the group receiving quetiapine XR 150 mg/day had significant improvement on the clinician-rated ZAN-BPD compared to the placebo group. Time to response (a ≥50% reduction in the total ZAN-BPD score) was also significantly shorter for patients receiving quetiapine XR (150 or 300 mg/day) than those receiving placebo. A total of 79% of the subjects receiving quetiapine XR were rated as "responders" compared to 62% of those who received placebo. Treatment-emergent adverse events included sedation, change In appetite, and dry mouth. The overall completion rate for the 8-week double-blind treatment phase was 63% (55% for quetiapine XR 150 mg, 58% for quetiapine XR 300 mg, and 79% for placebo). Subjects assigned to quetiapine XR had a significant reduction in the severity of symptoms of BPD compared to those receiving placebo. Quetiapine XR 150 mg/day is effective and well tolerated in the treatment of BPD.

-3

THE RELATIONSHIP BETWEEN FUNCTIONAL IMPAIRMENT AND BORDERLINE PERSONALITY DISORDER

Speaker: Frances Frankenburg, M.D.
Co-Author(s): Mary C. Zanarini, Ed.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that vocational and social impairment is common among borderline patients;2) Recognize that this impairment is more severe than among axis II comparison subjects;3) Recognize that a rehabilitation model of treatment may be useful for borderline patients with substantial functional impairment.

SUMMARY:

Objective: The purpose of this study was to compare the functioning and well-being of borderline patients and axis II comparison subjects. Method: The SF-36, a self-report measure of functioning with well-developed psychometric properties, was administered to 208 borderline patients and 52 axis II comparison subjects participating in the 18 year follow-up wave of the McLean Study of Adult Development (MSAD), a prospective study of the longitudinal course of borderline personality disorder (BPD). Results: Using preliminary data from this still incomplete follow-up wave, borderline patients reported significantly lower scores on all eight subscales of the SF-36, indicating greater impairment in the following areas: physical functioning, physical role limitations, bodily pain, general health perceptions, vitality, social functioning, emotional role limitations, and emotional well-being. Conclusions: Limitations in functioning caused by physical and emotional problems are common among borderline patients and distinguishing for the disorder.

-4

IMPACT OF CHILDHOOD MALTREATMENT ON NORMAL ADULT PERSONALITY TRAITS IN THE GENERAL POPULATION

Speaker: Michael P. Hengartner, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the impact of childhood maltreatment on adult personality; 2) Discriminate between different forms of childhood maltreatment and their distinct effects;3) Integrate those findings within a higher-order structure of normal and pathological personality;4) Consider those findings in clinical practice with respect to diagnosis, prognosis and intervention in maltreated patients

SUMMARY:

Objective: Childhood maltreatment is a major public health and social-welfare problem, causing extreme personal distress and societal burden. In the literature the association between childhood maltreatment and personality disorders is well documented. However, almost nothing is known about the impact of childhood maltreatment on normal personality functioning.
Method: We assessed normal traits from the five-factor model of personality and childhood maltreatment in 1500 subjects aged 21-40 from a general population-based community sample from Zurich, Switzerland, using data from the Zurich Programme for Sustainable Development of Mental Health Services.
Results: In bivariate analyses emotional abuse was most pervasively related to personality, showing significant detrimental effects on neuroticism, extraversion, openness, conscientiousness, and agreeableness. Neuroticism was significantly related to emotional abuse and neglect, physical abuse and neglect, and sexual abuse. Emotional abuse affected neuroticism in men more profoundly than in women, although the effect size was very small. Adjusting multivariately for the covariance between childhood maltreatment variables, high neuroticism was mainly related to emotional abuse (Î²=0.193), low extraversion to emotional neglect (Î²=â€“0.259), high openness to emotional abuse (Î²=0.175), low conscientiousness to emotional abuse (Î²=â€“0.110), and low agreeableness to emotional neglect (Î²=â€“0.153). The proportion of total variance explained was highest in neuroticism (8.5%), followed by conscientiousness (6.3%), extraversion (5.0%), agreeableness (4.1%), and openness (1.9%). Except for openness (small effect size) the proportion of variance explained represented small-to-medium effect sizes.
Conclusion: In addition to the well-documented associations with severe personality pathology, childhood maltreatment similarly impacts normal personality traits. Neuroticism may be the predominantly affected trait and emotional abuse and neglect the strongest maltreatment risk factors. Integrated within a common higher-order structure of normal and pathological personality the predominantly affected dimension would be negative affectivity, followed by disinhibition, detachment, and antagonism. Those findings have important clinical implications.

CHILD AND ADOLESCENT PSYCHIATRY

Moderators: Francisco Fletes, M.D., Sri Venkata Uppalapati, M.D.

-1

SUICIDE ATTEMPTS IN PRIVATE SCHOOL ADOLESCENTS

Speakers: Rosemary C. Baggish, M.Ed., M.P.H., Peter H. Wells, Ph.D.
Co-Author(s): John B. Goethe, M.D., Peter H. Wells, Ph.D., Stephen B. Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be

able to: 1) Identify the prevalence of suicide attempts among private school students;2) Recognize factors that contribute to suicide attempts ;3) Recognize factors that are associated with the prevention of suicide attempts;4) Identify areas worthy of further scientific exploration

SUMMARY:

Objective: To determine the prevalence of suicide attempts (SA) among adolescent private school students and identify variables associated with SA. Method: 8407 students in 18 private schools completed the Independent School Health Check survey (ISHC) during the 2012-2013 school year. This self-report tool has 108 items about behaviors/feelings related to academics, school experiences, and social and home life and includes 30 questions from the Centers for Disease Control's Youth Risk Behavior Surveillance System (YRBSS), which primarily focuses on public school students. Data were analyzed using chi-square and logistic regression methods.
Results: The sample was approximately half female, predominately white (63%) (Asian [17%], black [7%] and Hispanic [5%]) and was geographically over represented by students in the Northeast (47%, with 19% in the Mid-Atlantic, 19% the Southeast, 11% the Midwest, and 4% the West). SA were associated with negative self-ratings in three areas: mood, social support, and risk behaviors. For example, elevated risk of SA was associated with "sad or hopeless feelings" (odds ratio [OR]=15.68, 95% confidence interval=11.49-21.38); being bullied (3.61, 2.77-4.71); and smoking >10 days in the past month (12.94, 7.19-23.28). Conversely, variables such as having "minimal anxious feelings" (0.16, 0.11-0.22), an adult expresses interest in her/him (0.22, 0.16-0.30), a "sense of belonging at school" (0.21, 0.16-0.28), and not drinking alcohol and not smoking (0.54, 0.41-0.70) were associated with reduced risk of SA. For some of the variables that were associated with SA the ORs varied by student characteristics. For example, the OR for SA associated with being bullied was two-fold greater for students in grades ≤10 (20.91, 8.95-48.88) versus grades >10 (9.14, 3.91-21.37), and this association among white students (15.76, 5.62-44.21) was 64% greater than among non-whites (9.61, 4.69-19.73). A regression model showed that self-cutting/injuring remained a strong predictor of SA (7.05, 3.61-13.76) after controlling for demographics and risky behaviors/experiences, including problem drinking (5.3% of students) (2.43, 1.16-5.11) and having sad or hopeless feelings (17.9%) (4.73, 2.30-9.72).
Conclusion: The prevalence of SA was one-third that reported in YRBSS, but the risk factors identified were similar in the two populations (J.A. Epstein and A. Spirito, 2010). This study is the first large-scale assessment of suicide risk to focus on students in private schools, and it adds to the literature on at-risk adolescents. It also examines variables not covered in the YRBSS, identifying additional areas of potential importance (e.g., roles of academic pressure and grades, sleep, parental engagement, sexual orientation), and supports the need for continued research.

-2

HOARDING DISORDER IN ADOLESCENCE: PHENOMENOLOGY AND CLINICAL CORRELATES

Speaker: Volen Z. Ivanov, M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify clinically significant hoarding symptoms in children and adolescents;2) Assess hoarding symptoms in adolescents;3) Diagnose or rule out Hoarding disorder in adolescents

SUMMARY:

Background: Hoarding disorder (HD) is a common psychiatric disorder affecting 2-6% of the population. Although mainly considered to be a problem of old age, adult retrospective reports and recent epidemiological findings suggest that hoarding symptoms debut already in adolescence. The phenomenology and clinical correlates of hoarding in young people are however largely unknown. Objective: To investigate the phenomenology and clinical correlates of hoarding symptoms in adolescents. Methods: Adolescents throughout Sweden who at age 15 screened positive for Hoarding disorder in a large epidemiological study were contacted and offered an in-depth assessment of their hoarding symptoms and psychiatrical comorbidity. Study participants meeting some of the criteria for Hoarding Disorder (n=15) were defined as hoarding subjects and compared to age matched controls who met none of the disorder criteria (n=17). We investigated the level of hoarding symptoms, what types of objects adolescents saved and acquired, the extent of clutter in their homes, their reasons for saving and acquiring, the degree of parental intervention and the presence of comorbid psychopathology.
Results: Subjects in the hoarding group endorsed more hoarding criteria, higher hoarding symptom load as well as hoarding related cognitions compared to the non-hoarding group. Hoarding participants also had higher levels of ADHD symptoms and more comorbid diagnoses. However no differences between the groups emerged in terms of autistic symptoms. None of the participants met the Hoarding disorder criterion for clutter. Reasons for saving objects among the hoarding subjects were similar to those common among adults, i.e. emotional attachment and instrumental value. Data collection is ongoing. Conclusion: These findings are consistent with prior studies suggesting that hoarding symptoms originate already in adolescence. The results also suggest that the clinical presentation of hoarding in adolescents is similar to the one seen in adult samples with the exception of levels of clutter, which are comparatively low among adolescents. The study findings have implications for early identification and prevention of hoarding disorder.

-3

NEURONAL PRUNING IN ADOLESCENCE: DO MEMES PLAY A ROLE?

Speaker: Hoyle Leigh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the phenomenon of neuronal pruning in adolescence and young adulthood;2) Understand the role of learning and memory in the mechanism of neuronal pruning;3) Recognize the role of memes and culture in determining the outcome of neuronal pruning;4) Formulate ways in which education may play a role in affecting the pruning process and enhance mental health

SUMMARY:

The purpose of this presentation is to address the question, "Do memes play a role in the pruning of neurons in adolescence?" The major mechanism for generating diversity of neuronal connections beyond genetic determination is the activity-dependent stabilization and selective elimination of the initially overproduced synapse. We are born with approximately 100 billion neurons and half of them die by pruning beginning at puberty and thought to be completed during early adolescence (Huttenlocher, 1979). The biological mechanism through which axonal pruning occurs still remains unclear but pruning has been associated with guidance molecules in mice. Guidance molecules serve to control axon pathfinding through repulsion, and also initiate pruning of exuberant synaptic connections. There is evidence that, in humans, pruning continues beyond adolescence and throughout the third decade of life before stabilizing at the adult level. Such a long phase of developmental reorganization of cortical neuronal circuitry, which is associated with learning, may have implications for understanding the effect of environmental impact on the development of human cognitive and emotional capacities as well as the human-specific neuropsychiatric disorders.(Petanjek et al., 2011). How does learning then actually determine which neurons survive and which do not? Neuronal pruning occurs as small-scale axon terminal arbor pruning. Axons extend short axon terminal arbors toward neurons within a target area. Certain terminal arbors are pruned by competition. The selection of the pruned terminal arbors follow the "use it or lose it" principle seen in synaptic plasticity. This means synapses that are frequently used have strong connections while the rarely used synapses are eliminated (Vanderhaeghen, 2010). What, then, determines the "use it or lose it" principle in adolescence and young adulthood? There is a massive infusion and processing of information in the form of memes or portable memory from the environment (culture) during this period and this may play a crucial role in determining the specific neurons to survive or be pruned. Information introduced from the cultural environment is incorporated in the brain as memory - i.e., as new neural synaptic connections with long-term potentiation (Kandel, 2006). Neural memes thus formed develop synaptic connections with pre-existing memes, which may either reinforce or attenuate each other (Leigh, 2010). Such reinforced neural connections (memes) are likely to survive while others may be actively pruned. Thus, the Darwinian natural selection of neural clusters proposed by Edelman (Edelman, 1987) occurs as memes. Abstract thinking developing in adolescence (Piaget, 1973) may represent the brain's acquiring the ability to categorize memes and thus allow categorical memetic pruning. It may be possible to identify and modify the neural memes that are involved in such categorical neuronal pruning.

-4

DO PARENTS' AND TEACHERS' ASSESSMENTS OF ADHD SYMPTOMATOLOGY VARY BASED ON THEIR GENDER AND THE GENDER OF THE CHILD?

Speaker: Venkat Bhat, M.D.
Co-Author(s): Venkat Bhat, M.D. Natalie Grizenko, M.D., Sarojini Sengupta, Ph.D., Ridha Joober, M.D. Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate that for parent evaluations, boys are given worse restless impulsive scores at baseline, but no gender differences are seen with treatment;2) Know that for baseline teacher evaluations, boys are given worse RI scores while female teachers give total scores overall;3) Appreciate that, with treatment, male children show bigger changes, female teachers notice bigger changes overall, and females teachers also appear to notice bigger changes in female children.

SUMMARY:

Objectives: The male-to-female ratio for clinic-referred ADHD children is 10 to 1, and that of children in the community at large is 3 to 1. It is thought that gender differences in the phenotypic expression of ADHD are behind the underreferral of girls. The Conners Global Index-Teachers (CGI-T) is a questionnaire given to teachers to document symptoms in the classroom setting. Similarly, the Global Index-Parents (CGI-P) is a questionnaire given to parents to document symptoms in the home setting. The aim of this study is to assess whether the gender of the teacher or parent completing the CGI-T or CGI-P influences the score as a function of the student's gender. Methods: This study was part of a larger randomized, double-blind, placebo-controlled trial of MPH versus placebo over a 2-week period, and diagnosis of ADHD was based on DSM-IV. The CGI-T was given to teachers of these children with ADHD, and they were asked to complete it based on the student's behaviour in the classroom, both before and after administration of medication (MPH versus placebo). Similarly, parents filled out the CGI-P at home both before and after administration of medication (MPH versus placebo). Finally, raw total and factor scores are converted to normalized T-scores, with a score of 65 or higher considered to be clinically significant
Results: 1. CGI-P: a) Parents give a worse score for boys at baseline but only for restless-impulsive (RI) and total score (TS), but not for emotional lability (EL); b) No difference between gender of parents for baseline assessments; c) Boys and girls show similar changes with MPH; d) Parents of both gender see similar changes in MPH and no differences between boys and girls in treatment response. 2. CGI- T: a) Teachers give a worse score for boys at baseline but only for RI; b) Compared to male teachers, female teachers give 4 points more at baseline for TS; c) With RI scores for MPH, teachers see a 5 point change in boys as compared to girls for RI. Further, female teachers see a bigger change as compared to male teachers-10 vs 5 points; d) With EL scores for MPH, male children show a greater change-10 vs 5 points, no overall differences are seen between gender of teachers, and an interaction is seen between teacher's and child's gender; e) With TS for MPH, differences by gender of child, gender of teacher and an interaction trend towards significance was noted. Conclusion: Higher RI scores for males drive differences in baseline ratings by parents. However, parents irrespective of their gender, see equal changes with treatment for boys and girls. On baseline teacher evaluations, RI scores are worse for boys but teachers give worse TS. With MPH treatment, male children show bigger changes, female teachers notice bigger changes overall, and females teachers also appear to notice bigger changes in female children

OPIOID AND INHALENT ABUSE

Moderators: Amber C. May, M.D., Jerome Taylor

-1

ABSTINENCE FROM DRUGS OF ABUSE IN COMMUNITY-BASED MEMBERS OF NARCOTICS ANONYMOUS

Speaker: Marc Galanter, M.D.
Co-Author(s): Helen Dermatis, Ph.D., Stephen Post, Ph.D., Courtney Santucci, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about demography and drugs used in NA;2) Learn about the psychology of NA membership;3) Refer patients to NA

SUMMARY:

Objective: Narcotics Anonymous is an abstinence-based fellowship with over 58,000 meetings worldwide. There has, however, been little research reported on its members. This study was designed to clarify the nature of the recovery process in abstinent, long-term members of NA. Method: We conducted a survey at 10 NA group meetings in three different states, with cooperation of the NA World Service Office. A 51-item self-administered questionnaire, addressing key aspects of addiction and recovery, was anonymously completed by 527 respondents. Results: Respondents were 72% male, mean age 39, 62% White, with principal drug problems cocaine/crack, 32%; heroin, 26%; other opiates, 12%; crystal methamphetamine, 12%, alcohol, 9%; marijuana, 7%, stimulants, 2%. Eighty-six percent had prior substance abuse treatment. On average they had first encountered NA at age 27, and had been abstinent an average of 6.1 years previously; and 49% had served as sponsors. Ninety-three percent designated themselves as spiritual, and only 31% as religious; 84% reported a spiritual awakening, and 49% reported no alcohol or drug craving in the previous week. In multiple linear regression analyses, NA program member affiliativeness and beliefs, spiritual awakening, and sponsor service explained 24% of the variance in craving. When depression was entered into the analysis, 38% of the variance in craving was accounted for. Conclusions: NA represents a cost-free option for support of long-term abstinence from diverse drugs of abuse for addicts of different backgrounds. It is likely that lower craving is associated with the affiliative attitudes among members, NA-related beliefs, and acquiring a spiritual orientation. Significance: Drug addiction is, for most who suffer it, a lifelong illness. Despite this, the ongoing availability of resources to support abstinence is essential. Professional treatment, in this regard, is not feasible either economically or through available manpower resources. An understanding of this mutual help fellowship for addicted people is therefore important for clinicians who treat addicted patients.

-2

DENIAL OF URINALYSIS-CONFIRMED OPIOID USE IN A PRESCRIPTION OPIOID DEPENDENCE TREATMENT STUDY: PREVALENCE, CHARACTERISTICS, AND PATTERNS

Speaker: Margaret L. Griffin, Ph.D.
Co-Author(s): E. Yvette Hilario, B.S., Katherine A. McDermott, B.A., Roger D. Weiss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the purposes of urine screening in drug abuse research studies;2) Understand the role of self-reports in drug abuse research studies;3) Understand the characteristics of those who deny urinalysis-confirmed drug use.

SUMMARY:

The majority of addiction research relies on self-reports of substance use to measure outcome. In spite of the dramatic increase in prescription opioid abuse and dependence in recent years, validity of self-reports has not been examined in a population dependent on prescription opioids. The current study examines the prevalence of denial of urinalysis-confirmed opioid use, patient characteristics associated with denying use, and patterns of denying use during treatment. Opioid use self-reports were compared with urinalysis results for 360 patients enrolled in a 12-week buprenorphine-naloxone treatment trial for prescription opioid dependence. Since opioid outcome assessment included the last 4 weeks of treatment, this analysis focuses on the first 8 weeks of treatment. Most patients (71%, n=256) used opioids at some point during the first 8 weeks of treatment: 26% used in only one of the 8 weeks, 30% used in 2-3 of the weeks, and 44% used in 4-8 weeks. The analysis is limited to these patients, since the others had no opportunity to deny urinalysis-confirmed opioid use. While only 6% of all reports involved denial of opioid use in the presence of a positive urine screen, 43% of patients denied opioid use at some point, with most (78%) denying use only once. Most patients who denied opioid use reported it at other times (89/109, 82%). Patients who denied using opioids (n=109) were compared with those who reported all instances of use (n=147): multivariate logistic regression analysis showed no differences in sociodemographic variables, as well as in substance use and other clinical history. Successful opioid outcome and treatment condition were not associated with denying use. In summary, denial of urinalysis-confirmed opioid use is quite common among patients in treatment for prescription opioid dependence, although most patients who occasionally deny opioid use do report it at other times. Efforts to differentiate between patients who denied use and those who consistently reported use show that these patients are similar in sociodemographic characteristics and in substance use and other clinical history.

-3

DRAW-A-PERSON TEST IN INHALANT ABUSERS VERSUS NORMAL: A COMPARATIVE STUDY, SIGNIFICANCE OF INTERPRETATION IN CLINICAL PRACTICE

Speaker: Sanjeev Prasad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use Draw a person test identifies neurotic and psychotic features much earlier in inhalant abusers. Onset of psychotic features is much earlier in inhalant abusers than in normal population.;2) Once identified Draw a person test conducted on inhalant abusers reveals psychotic features much before they are clinically obvious. Thus treatment can be initiated early. ;3) Can Draw a person test be used for defining prognosis and if so could it also help decide the rehabilitation type for those who are suffering from brain involvement.

SUMMARY:

Draw a person test was administered to a total of 100 children aged between 10 to 15 yrs of age. Out of these 50 were

school going children and 50 were patients admitted for treatment of inhalant abuse comprising a mixture of school dropouts,vagabonds and street children. These were analysed. A consistent pattern was seen in the inhalant abuse subjects which was classified into neurotic,psychotic and organic brain damage.(pictures). There was also a correlation between the length of inhalant abuse and the quality of a person drawn. School children on the other hand showed pictures which reflected normal range of development,IQ, and neurotic features in only a few. The results were further evaluated.

PSYCHIATRY AND THE MILITARY

Moderators: Amber C. May, M.D., Gayla Rees

-1

LONG-TERM MENTAL HEALTH AND FUNCTIONING OUTCOMES OF MILITARY SEXUAL TRAUMA IN VIETNAM ERA FEMALE VETERANS

Speaker: Kathy M. Magruder, M.P.H., Ph.D.
Co-Author(s): Amy Kilbourne, Ph.D., Han Kang, Ph.D., Rachel Kimerling, Ph.D., Tracey Serpi, Ph.D., Susan Frayne, M.D., Joan Furey, M.S.N., Avron Spiro, Ph.D., Yasmin Cypel, Ph.D., Matthew Reinhard, Ph.D., Joseph Collins, Ph.D.,

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the prevalence of military sexual trauma in women Vietnam Era veterans;2) Describe risk factors, including prior trauma, military service location (Vietnam, near Vietnam, continental United States), and occupation (nurse, non-nurse);3) Describe long-term mental health and functioning outcomes for women with military sexual trauma.

SUMMARY:
While studies of Vietnam War veterans have highlighted the ill effects of combat on health and mental health for men, they have done little to increase our understanding of how women veterans fared as a result of serving in combat zones. Only with veterans of recent wars has there been attention to the unique stressors, such as military sexual trauma, that military women are likely to experience. Although 265,000 women served during the Vietnam Era, the sexual traumas of these women and their long-term outcomes have been largely undocumented. This epidemiologic study interviewed 4645 women who served in Vietnam, near Vietnam, or in the US using the CIDI for psychiatric diagnoses and questionnaires for health and functioning. In this presentation we will discuss the prevalence of military sexual trauma and the relationship with current health and mental health problems.

-2

SYNTHETIC CANNABINOID AGONISTS AND AN ACTIVE DUTY MILITARY RESIDENTIAL SUBSTANCE ABUSE PROGRAM

Speaker: George Loeffler, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate how synthetic cannabinoid agonist use impacted symptom presentation and treatment response at an active duty military residential substance abuse treatment program;2) Understand what demographic and historical variables, including aspects of military history such as combat exposure, correlated with use of synthetic cannabinoid agonists;3) Appreciate future areas of research related to synthetic cannabinoid agonist use.

SUMMARY:
Synthetic cannabinoid agonists, commonly known as “spice”, are a class of designer drugs that have emerged in recent years. We describe a retrospective case-control study performed in an active duty military substance abuse treatment facility. All subjects admitted to this program completed specialized urine testing for synthetic cannabinoid agonists at time of admission. We compared subjects with positive urine tests to those with negative tests for factors including demographics, psychometric scores at admission and discharge, treatment completion and military history. (Study is currently being completed, results expected by Fall-Winter 2013).

-3

TRAUMA AND ABUSE HISTORIES AMONG MALE VETERANS WITH PTSD AND CO-OCCURRING SUBSTANCE USE DISORDERS

Speaker: Andrew Teer, B.A.
Co-Author(s): Sudie E. Back, PhD., Frank M. Beylotte, M.S., Julianne C. Hellmuth, PhD., Therese K. Killeen, PhD., APRN, BC

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize that a prevalence of lifetime abuse in male Veterans exists just as it does for female Veterans; 2) Determine how the correlates of a history of victimization yield a more severe clinical presentation in Veterans with comorbid PTSD and SUD.;3) Identify those Veterans with a history of abuse to target treatment plans and increase treatment efficacy for Veterans with PTSD and substance use disorders.

SUMMARY:
Background: This study aimed to investigate the prevalence of lifetime abuse in male Veterans, and examine psychiatric and clinically relevant correlates of abuse. Literature exists on female Veterans with histories of abuse, but little research to date has examined male Veterans’ abuse histories. Methods: Subjects were 71 male Veterans (mean age = 37.9) participating in a larger study on the concurrent psychosocial treatment of PTSD and substance use disorders. The majority of Veterans (78%) were from recent conflicts in Iraq and Afghanistan. At a baseline visit before therapy was initiated, Veterans were administered the Mini International Neuropsychiatric Interview, Addiction Severity Index, Timeline Follow Back, Beck Depression Inventory, PTSD Checklist, Combat Exposure Scale, Clinician Administered PTSD Scale and Life Events Checklist. Results: Veterans reported exposure to an average of 9.9 different categories of trauma, with the most common being warzone trauma (97%), fire/explosion (86%), and transportation accident (83%). Over half (55%) reportedly perpetrated injury or death. The majority (78%) reported being physically assaulted and 27% reported being victims of physical or sexual abuse. Males with, as compared with those without, abuse histories evidenced significantly poorer mental health, averaging more days in the past month with mental health issues (25 vs. 14 days, p=.002, d=.98); more comorbid lifetime (3.93 vs.

2.69) and current (2.86 vs. 1.92) diagnoses in addition to PTSD (p=.006, d=1.0 and p = .034, d=.67); higher Beck depression scores (32.8 vs. 24.3, p=.016, d=.74); more suicidal ideation (p=.003, d=.87) and a trend toward more lifetime suicide attempts (p=.06, d=.52). In addition, males with abuse histories reported experiencing significantly more categories of traumatic experiences (12 vs. 9.2, p=.002, d=.95). Interestingly, males with, as compared with those without, abuse histories reportedly used substances a lower percentage of days in the past two months (.46 vs. .67, p=.041, d=.64) and consumed fewer standard drinks per day (4.26 vs. 7.15, p=.033, d=.57). Discussion: The findings demonstrate high rates of exposure to trauma among male Veterans, and a more severe clinical presentation associated with abuse histories. This information is clinically relevant and may be useful to help target treatment plans and increase treatment efficacy for Veterans with PTSD and substance use disorders. Acknowledgements: This project was supported by NIDA grant RO1 DA030143(SEB)

-4

CYTOKINE PRODUCTION AS A MARKER OF STRESS SENSITIZATION IN HIGH COMBAT EXPOSED SOLDIERS

Speaker: Geert E. Smid, M.D., Ph.D.
Co-Author(s): Mirjam van Zuiden, Ph.D., Elbert Geuze, Ph.D., Annemieke Kavelaars, Ph.D., Cobi J. Heijnen, Ph.D., Eric Vermetten, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role of stressful life events in worsening of PTSD symptoms in high combat exposed individuals during the first years following deployment;2) Describe alterations in the immune function associated with stress sensitization;3) Integrate psychoimmunological and epidemiological perspectives on prevention and treatment of PTSD in soldiers and veterans.

SUMMARY:

Objective: We recently reported that high combat exposed soldiers, but not low combat exposed soldiers, respond with linear increases in PTSD symptoms to post-deployment stressful life events (SLE), consistent with stress sensitization following deployment [1]. We hypothesized that altered immune function, measured as in vitro capacity of leukocytes to produce cytokines upon stimulation, would underlie this observed stress sensitization. Methods: We assessed cytokine production at 6 months, SLE at 1 year, and PTSD symptoms up to 2 years in a cohort of Dutch soldiers returned from deployment to Afghanistan (N=814). Latent growth and multigroup models were applied. Results: Only in high combat exposed soldiers, higher T-cell chemokine production was associated with increases in PTSD symptoms, and cytokine-SLE interaction effects on changes in PTSD symptoms were found. Conclusion: These results suggest that mitogen-induced cytokine and chemokine production constitute markers of stress sensitization in recently deployed, high combat exposed soldiers. Efforts to prevent and treat progression of posttraumatic distress following return from deployment may aim at early identification of individuals at risk, averting foreseeable stressors as well as reducing stress sensitization.[1] Smid, G. E., Kleber, R. J., Rademaker, A. R., Van Zuiden, M., & Vermetten, E. (2013). The role of stress sensitization in progression of posttraumatic distress following deployment. Social Psychiatry and Psychiatric Epidemiology (29 May 2013), 1-12. doi:10.1007/s00127-013-0709-8

NEUROMODULATION

Moderators: Francisco Fletes, M.D., Duncan Cheng

-1

TMS: EXPANDING THE SCOPE OF TMS: NEW DISORDERS, NEW BRAIN TARGETS, INTEGRATION WITH NEUROIMAGING/EEG, BETTER PATIENT SELECTION

Speaker: Alan Z. Manevitz, M.D.
Co-Author(s): James P. Halper, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand efficacy and safety of TMS for psychiatric disorders other than Major Depressive Disorder (with one failed treatment), e.g. Refractory MDD, OCD, Bipolar Depression and Schizophrenia;2) Understand the utilization of TMS with machine settings (electromagnetic parameters) coil settings other than those mandated by FDA: indications, safety and efficacy;3) Understand the indications for, advantages and disadvantages of combining TMS with pharmacotherapy and/ or psychotherapy. How TMS fits into the Biopsychosocial model of psychiatry;4) Understand the essential components of documentation: Indications for TMS, the course of the treatment session, performance of treatment center and assessment of overall patient outcome;5) Understand the mechanism of TMS(esp. neuroplasticity) integration of TMS with neuro imaging /EEG, to choose treatment site. Forays into Neurology: Stroke, Movement Disorders, Epilepsy, Autism & more

SUMMARY:

This workshop will emphasize how TMS is being used beyond the FDA guidelines which currently restricts 1) its use to only a narrow subset of patients for whom it may be useful namely Unipolar MDD patients who have failed to respond to one and only one antidepressant treatment and/or have been unable to tolerate them 2) electromagnetic parameters (machine settings) and brain targets that may be chosen. However TMS has been sucessfully used for a variety of psychiatric disorders other than MDD. including refractory MDD, Depressive disorders other than unipolar MDD, anxiety disorders OCD, and Schizophrenia in both clinical and research settings .Similarly neurologic disorders Brain injuries including Stroke (with Aphasia) , Movement Disorders, Seizure Disorders and Autism. As might be expected diverse machine settings and brain targets have been chosen for different disorders. With respect to psychiatric disorders, TMS integration with psychotherapy and psychopharmacology as well as the potential of and approaches to Maintainence therapy willl be discussed. The potential of Neuroimaging and EEG prior to and after TMS to predict patient response (and hence chose appropriate patients) , choice of brain region to be targeted and electromagnetic parameters to be used will be discussed . Clinical pearls will also be provided .The central role of Plasticity in the understanding of the mechanism of TMS will be discussed All of the faculty are world renowned experienced TMS clinicians who have made important clinical and theoretical contributions and will provide clinical examples and questions to encourage audience discus-

sion. Audience discussion of how TMS is changing the practice and perception of psychiatry will be encouraged with emphasis on how Psychiatrists must adhere to Biopsychosocial model of Psychiatry to prevent our field from being swallowed up by Neuropsychiatry or Neurology

-2

MAINTENANCE RTMS TREATMENT FOR RESISTANT DEPRESSED PATIENTS: A ONE YEAR DOUBLE-BLIND STUDY

Speaker: Rene Benadhira, M.D.
Co-Author(s): Noomen Bouaziz, M.D., Sonia Braha, Ph.D., Clemence Isaac., D.Januel, M.D., Ph.D., Virginie Moulier, Ph.D., Palmyre Schenin-King Andrianisaina.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Better know the interest of rTMS in the treatment of depressed-patients;2) Improve the patient care of depressed-patient who not respond to classical treatment;3) Learn novel outcomes in the field of rTMS for treatment-resistant depression

SUMMARY:
Background: Major depressive disorder (MDD) is a severe and highly prevalence disease with potentially life threatening illness and high level of morbidity and mortality. Traditional pharmacological strategies are not always sufficiently effective and side effects are not rare and may be the cause of discontinuation, particularly in the long-term treatment. In this context, brain stimulation techniques could be an alternative strategy to pharmacological treatment and among these techniques, rTMS could have the better profile of efficiency and tolerability. However, if clinical data are now well documented for acute treatment-resistant depression (TRD), they are still rare for relapses prevention of TRD. In this communication, we present the preliminary results of a one-year double blind randomized controlled study of maintenance rTMS treatment for TRD patients. Method: The study involved 55 TRD patients in a single site trial which consisted of two phases: an acute phase (phase I) in which all the participants received active high-frequency stimulation during 4 blocks of five consecutive working days (Monday to Friday) in an open-label design and a maintenance phase (phase II) in which responders (> 49% HDRS-17 reduction from baseline) at the end of the phase I were randomized in two arms with sham or active high-frequency rTMS maintenance treatment for the eleven following months. The rhythm of rTMS sessions in this maintenance phase was gradually reduced as follows: 3 sessions per week for 2 weeks, 2 session per week for the 2 following weeks, 1 session per week the third (M3) and fourth month (M4) and then 1 session every fortnight the last eight months (M5 to M12). Results: of 55 patients in the acute trials, 28 accepted to be included in the phase II and 13 were responders. Delta HDRS score show a significantly difference for M1-M4 (p=.003), M1-M5 (p=.004) and M1-M6 (p=.043) between the active and the placebo group. There were no serious adverse events during the trial, in particular any cognitive impairment. Conclusion: rTMS could be a novel strategy to prevent relapse in TRD patients who respond to an acute rTMS treatment and 1 session per week may be able to prevent relapses. These results need to be confirmed in a larger sample.

-3

A RANDOMIZED, DOUBLE-BLIND, SHAM-CONTROLLED CLINICAL TRIAL OF RTMS FOR GENERALIZED ANXIETY DISORDER

Speaker: Gretchen Diefenbach, Ph.D.
Co-Author(s): Michal Assaf, M.D., Laura B. Bragdon, M.A., John W. Goethe, M.D., Christopher J. Hyatt, Ph.D., David F. Tolin, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe response rates for rTMS and sham among patients with generalized anxiety disorder;2) Describe remission rates for rTMS and sham among patients with generalized anxiety disorder;3) Describe the percentage of improvement in worry symptoms in patients with generalized anxiety disorder following rTMS in comparison with sham.

SUMMARY:
Objective. Generalized anxiety disorder (GAD) is a common, impairing anxiety disorder. Nearly one third to one half of GAD patients do not respond to conventional therapies. Repetitive transcranial magnetic stimulation (rTMS) may be an effective alternative treatment. One open trial (n = 10) of rTMS for GAD demonstrated an 80% remission rate (Bystriskty et al., 2008). The aim of the current study was to determine the efficacy of rTMS for GAD compared to sham rTMS. Methods. The sample was 13 adult outpatients (69% women, mean age 45.08) with GAD randomly assigned to active (n = 5) or sham (n = 8) rTMS. Treatment was administered using the FDA-Cleared Neuronetics NeuroStar TMS Therapy System and entailed 5 sessions/week for 6 weeks of right side, low frequency stimulation (1 Hz for 15 minutes, 900 total pulses, 90% of passive motor threshold) at the dorsolateral prefrontal cortex (located using structural neuronavigation). Sham was delivered using a sham coil. Outcome measures included the Hamilton Anxiety Rating Scale (HARS, response defined as ≥ 50% improvement, remission defined as score â‰¤ 8) and the Penn State Worry Questionnaire (PSWQ).
Results. One participant withdrew (sham) and one was excluded due to deviation from the treatment schedule (active). Pre to posttreatment effect sizes (Cohen's d) for all measures at all timepoints were uniformly large for active rTMS (range d = 1.83 to 3.30) and ranged from small (d = 0.15) to large (d = 1.84) for sham. There were over twice as many HARS responders in the active condition (posttreatment n = 3, 75% active; n = 1, 33% sham; 3 month follow-up n = 3, 75% active, n = 0, 0% sham). HARS remission rates were 25% (n = 1) for active and 17% (n = 1) for sham at posttreatment and 75% (n = 3) for active and 0% (n = 0) for sham at 3 month follow-up. Participants receiving active rTMS reported larger percent improvements in worry on the PSWQ (26% at posttreatment, 31% at 3 month follow-up) than did the sham group (3% at posttreatment, 8% at 3 month follow-up). This group difference was statistically significant at posttreatment [t (4) = 3.06, p < .05] and approached statistical significance at the 3 month follow-up [t (7) = 2.13, p = .05]. Two participants are still awaiting follow-up assessment.
Conclusions. This is the first randomized-controlled trial to explore the efficacy of rTMS for GAD. Results showed large pre-to-post treatment effect sizes in anxiety and worry for active rTMS compared to more variable treatment effects for sham. The strongest treatment effects were observed on the

PSWQ, which demonstrated statistically significant superior results for active versus sham rTMS at posttreatment. These results, although preliminary and from an as yet small sample, are encouraging and speak to the importance of research using rTMS for GAD.

-4

TRANSCRANIAL MAGNETIC STIMULATION FOR DEPRESSION ALSO IMPROVES ANXIETY SYMPTOMS: A META-ANALYSIS OF RANDOMIZED-CONTROLLED TRIALS

Speaker: Bethany M. Wootton, Ph.D.
Co-Author(s): Laura B. Bragdon, M.A., Gretchen J. Diefenbach, Ph.D., John W. Goethe, M.D., David F. Tolin, Ph.D.,

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the efficacy of TMS for anxiety symptoms in individuals with depression;2) Describe the efficacy of TMS compared with sham treatment for anxiety symptoms in individuals with depression;3) Describe the strong placebo response to TMS of anxiety symptoms in individuals with depression.

SUMMARY:
Objective: Meta-analyses of randomized controlled trials (RCTs) have demonstrated a moderate antidepressant treatment effect for transcranial magnetic stimulation (TMS) targeting the Dorsolateral Prefrontal Cortex (DLPFC). Symptoms of anxiety are common in individuals with depression, and are associated with higher levels of distress, functional impairment and suicidality. However, to date, no meta-analyses have reported on the TMS treatment effect for anxiety symptoms in individuals with depression. Thus, the aim of the current study was to use a meta-analytic approach to test whether TMS is superior to sham in treating anxiety symptoms among patients with depression.
Methods: Potential articles of interest were identified through searches of the Scopus, Medline and PsycINFO databases through June 2013 using the search terms (Transcranial Magnetic Stimulation or TMS or rTMS and controlled trial or sham or RCT, and depression or depressive disorder or MDD). Relevant studies also were identified through references of originally identified articles and published reviews (including previous meta-analyses). This literature search identified 634 articles. To be included in the analysis studies must: 1) be a RCT; 2) compare active TMS with sham ; 3) target depressive symptoms as primary 4) target the DLPFC; 5) use the Hamilton Depression Rating Scale (HDRS) as an outcome measure; 6) be published in English and 7) target a human, adult sample. Sixty-four articles met all inclusion criteria. Authors were contacted to provide pre- and post-treatment means and standard deviations of the anxiety/somatization subscale of the HDRS. Data from 11 studies were obtained.
Results: Six-hundred and seventy patients were enrolled in the studies used in the meta-analysis. Of these 369 received active TMS and 301 received sham. Data was analyzed using Comprehensive Meta-Analysis V2.2. Pre- to post-treatment within group pooled effect sizes were large for active TMS (d = 1.15, 95% confidence interval (CI) 0.82-1.48) and sham (d = 0.79, 95% CI 0.51-1.08). Additionally, there was a significant moderate between group difference between the TMS and sham conditions on the anxiety/somatization factor scores at post-treatment (d = 0.41, 95% CI 0.21-0.61).
Conclusions: Results suggest that TMS improves symptoms of anxiety among patients with depression. This is an important finding given the high prevalence of “anxious depression” and the need to identify novel treatments to address this potentially treatment refractory depression subtype. Results also suggest that anxiety symptoms have a large placebo response to TMS. This finding is consistent with other studies in the literature. Despite a large placebo response, end point scores for patients receiving active TMS were significantly lower than those for sham, suggesting a superior treatment effect for active TMS.

MAY 05, 2014

ASSESSMENT, DIAGNOSIS AND TREATMENT PLANNING

Moderators: Edward T. Lewis, Alexander Heisler

-1

THE BRIEF MULTIDIMENSIONAL ASSESSMENT SCALE (BMAS): A MENTAL HEALTH CHECK UP

Speaker: Gabor I. Keitner, M.D.
Co-Author(s): Abigail K Mansfield Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be aware of a brief assessment tool that provides helpful information on a patient’s current status on multiple life dimensions;2) Quickly gather information on a patient’s perception of their quality of life,symptom severity, functioning and satisfaction with relationships;3) Monitor change over time on multiple domains in a patient’s life

SUMMARY:
There is increasing interest in using quantifiable measures to assess the clinical status of patients at every health encounter and over the course of an illness. Most available scales are either too long, focus on a narrow range of symptoms or on specific diagnostic groups.The BMAS is a four question scale (completed in less than 1 minute) that assesses a patient’s perception of their 1)quality of life,2)severity of symptoms,3) ability to execute tasks,4) interpersonal relationships. 200 consecutive psychiatric outpatients filled out the BMAS and the Outcome Questionnaire 45 (OQ45) as part of their routine care each time they came for an appointment. Internal consistency of the BMAS using Cronbach’s alpha was .75 for the 4 scales. Test retest reliability ranged from .45 for symptoms (which fluctuate) to .79 for quality of life.Congruent and convergent validity was analyzed using Peasrson product moment correlations between BMAS and OQ45 scales. All correlations with BMAS items and OQ45 scales were significant. The BMAS demonstrated acceptable reliability and validity for such a brief measure and was well accepted by patients who appreciated its brevity.

-2

SHOULD STRUCTURED DIAGNOSTIC INTERVIEW AND STANDARDIZED RATING SCALES BE USED IN ROUTINE CLINICAL PRACTICE?

Speaker: Keming Gao, M.D., Ph.D.

Co-Author(s): Keming Gao, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn the feasibility of using structured diagnostic instrument and standardized self-reported rating scales in routine clinical practice;2) Understand the prevalence and patterns of comorbidity in major depressive disorder and bipolar disorder;3) Learn the correlation between the number of comorbidity and baseline severity, and suicide ideation;4) Understand the sensitivity and specificity of using QIDS-SR-16 total score to predict the number of Axis I comorbidity

SUMMARY:
Objective: Co-occurrence of psychiatric disorders is the role rather than exception. Structured diagnostic interview, which can cover the majority of psychiatric disorders based on DSM-IV or ICD-10, have been used in clinical and epidemiological studies. Meanwhile, standardized rating scales have been used to measure the symptom severity of different psychiatric domains, such as depression and anxiety. However, their roles in routine clinical practice remain unclear. This report will present the findings using structured diagnostic interview and standardized rating scales in a group of patients seeking routine clinical care.
Methods: All patients in the Mood & Anxiety Clinic of the Mood Disorders Program at the University Hospitals Case Medical Center fill out self-reported questionnaire/scales including Quick Inventory of Depression Symptomatology-Self-Report-16 items (QIDS-SR-16), Zung's Anxiety Rating Scale, Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q), Iowa Fatigue Scale, and Frequency, Intensity and Impairment of Side Effects before a face-to-face diagnostic interview is conducted. After a traditional diagnostic interview, patients are interviewed with the Mini International Neuropsychiatric Interview Systematic-Treatment-Enhancement- Program for Bipolar Disorder version 5.0.0. Data from first 300 patients were used to study the prevalence of Axis I comorbidity in mood disorders, patterns of comorbidities, and the relationship between the number of comorbidities and baseline severity.
Results: With the exception of 2 patients refusing to complete the questionnaires, all other patients completed at least QIDS-SR-16 and Zung's before the face-to-face interview. Of 113 patients with major depressive disorder (MDD) and 166 with bipolar disorder (BPD), the prevalence of any current anxiety disorder (AD), substance use disorder (SUD), and attention deficit hyperactivity disorder(ADHD) was 76% versus 74%, 14% versus 29%, and 8% versus 21% respectively. The most common patterns of current comorbidity were MDD+AD (58.4%) for MDD, and BPD+AD (39.8%) and BPD+AD+SUD (11.4%) for BPD. More than 80% patients with MDD or BPD had ≥1 current comorbid disorder. About 20% patients with BPD and 10% with MDD had ≥ 4 other disorders. The number of comorbidities was positively associated with baseline severity and suicidal ideation in both MDD and BPD. A QIDS-SR-16 of 10 had a positive predictive value of ≥ 90% in predicting â‰¥1 comorbidity in MDD and BPD.
Conclusion: Structured diagnostic instrument like MINI is feasible and useful in clinical practice. Standardized rating scales can be used to help clinicians to diagnose and manage comorbidities. Structured diagnostic instrument and standardized rating scales should be a part of routine clinical practice.

-3
INCORPORATING PET SCAN DATA INTO PSYCHOANALYTIC THEORY, USING NETWORK THEORY IN ORDER TO DEVISE A TREATMENT STRATEGY FOR PSYCHIATRIC ILLNESS
Speaker: Alan L. Summers, M.D., M.Eng., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Develop treatment strategies utilizing PET scan data incorporated into a psychoanalytic framework, using Systems Theory;2) Advance Systems Theory as a unique tool in the analysis and treatment of multifaceted psychiatric disease states;3) Advance a new tool in the treatment of multifaceted disease states.

SUMMARY:
Psychiatry of the future may evolve to incorporate Systems Theory (ST) in the diagnosis and treatment of disease entities (ST is used extensively in sciences such as engineering and physics to describe the behavior of systems that are internally controlled by a feedback processes). Systems models and subsequent treatment strategies were devised for individuals suffering from opiate addiction with concomitant panic disorder, intermittent explosive disorder, depression, and PTSD. Our hypothetical model began with the observation of PET scan data of individuals suffering from PTSD. The scans revealed hyper metabolic foci in both prefrontal lobe and hippocampus. These foci suggested a linkage to abnormalities in behavior and cognition. I.e., (1) abnormalities in impulse control were associated with the focus in the prefrontal lobe and (2) abnormalities in memory function were associated with focus in the hippocampus. This conjecture, was then incorporated into psychoanalytic theory. The subsequent Systems model resulted in a successful treatment strategy utilizing CBT in a group therapy setting.

-4
BECK DEPRESSION INVENTORY AND SUAS-SELF RATING AS PREDICTORS OF SUICIDAL BEHAVIOR IN FEMALE BORDERLINE PERSONALITY DISORDER PATIENTS
Speaker: Antonia Puljic, M.D.
Co-Author(s): Silić Ante, M.D., Ph.D., Ostojić Draženka, M.D., Ph.D., Marcinko Darko, M.D., Ph.D., Jukić‡ Vlado M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize risk factors for suicidal behavior in patients with personality disorders;2) Identify level of risk for suicidal behavior in patients with personality disorders;3) Use SUAS for prevention strategy regarding suicidal behavior in patients with personality disorders.

SUMMARY:
Introduction: This study was designed to investigate validity of Beck Depression Inventory and The Suicide Assessment Scale-self-rating as possible predictors of suicidal behavior in Borderline Personality Disorder in sample of female Croatian patients.
Hypothesis: We hypothesized that results on specific items of scales would be associated with suicidal behavior.
Methods: We included 30 female Borderline Personality Disor-

der inpatients diagnosed according to DSM-IV TR criteria. We examined the relationship between DSM-IV TR criteria met, results on Beck Depression Inventory and SUAS-S and the presence or absence of a previous suicide attempt.
Normality of distribution of results by each item in Beck Depression Inventory and SUAS-S was checked through Kolmogorov Smirnov's test. To establish difference in mean values between groups according to the presence or absence of a previous suicide attempt we used Mann-Whitney's test.
Results: Subjects with previous suicide attempts did not show statistically significant difference on any Beck's scale item from subjects without previous suicide attempts.
Subjects with previous suicide attempts show statistically significant difference on items 2 (anger and irritability), 8 (tension), 11 (impulsivity), 16 (optimism), 18 (suicidal thoughts) and 20 (suicidal plans) items of SUAS scale with higher results for items 8, 11, 18 and 20 and lower values for item 16 when compared to subjects without previous suicide attempts.
Conclusion In our sample Beck Depression Inventory is not a good predictor of suicidal behavior of female Borderline Personality Disorder patients.
On the other hand, in our sample, some items in SUAS-S (2, 8, 11, 16, 18 and 20) can predict suicidal behavior with statistical significance.
Discussion: Borderline Personality Disorder is often complicated with suicidal behavior. We have important role in preventing such behavior by understanding risk factors and by assessing the level of risk. This relatively simple assessment tool can find use in every day clinical practice. We need further research and larger sample to clarify our results.

PHARMACOLOGIC TREATMENT OF DEPRESSION

Moderators: Iqbal Ahmed, M.D., John Daula

-1
THE LONG-TERM EFFECT OF DEPRESSION WITH ANTIDEPRESSANT ALONE VERSUS ANTIDEPRESSANT AND CBT
Speaker: John Naliyath, M.D.
Co-Author(s): Eric D. Peselow, M.D

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Evaluate the differential efficacy of antidepressant alone VS antidepressant +CBT in the long term treatment of depression ;2) Understand long term effect of CBT alone on depression;3) Understand long term effect of antidepressants alone on depression

SUMMARY:
The utility of cognitive-behavioral therapy in the treatment of acute depression has been well established. It is frequently employed with antidepressant acutely to yield greatest efficacy. While it is frequently stated that the technique of CBT learning during acute treatment are enduring there is little data suggesting this is true. We studied 327 patients over a 13 year period in a community clinic who responded to one of four selective serotonin Reuptake inhibitor (SSRI's) with a 50% reduction in Montgomery Asberg Score after 12 weeks of treatment. SSRI's used were fluoxetine, citalopram, paroxetine, and sertraline. The patients were all followed on the medication to which they responded until they either relapsed, dropped out, or terminated well (were well as of September 1, 2005 the endpoint of the study). Overall 110 patients acutely received CBT in addition to SSRI and 217 did not. Following acute response 35 of the 110 patients who received CBT acutely elected to continue CBT additive to the medication and 75 did not. Overall the group that continued CBT remained well for 49.60 months as opposed to 34.77 months for those who did not continue CBT vs 30.78 months for those who only received drug alone. Pairwise comparisons using the scheffe show that long term CBT results in significantly more months being stable than either acute CBT (p=.039) or drug alone (p=0.58). Interestingly the 75 patients who received CBT acutely but not for maintenance did not remain well longer than 217 patients who did not receive CBT acutely (34.77 vs 30.78 p=0.58). In Conclusions, CBT additive to medication during acute treatment was not enduring long-term. However maintenance CBT additive to SSRI's was effective in preventing relapse.

-2
THE EFFICACY OF SSRI'S IN THE LONG-TERM TREATMENT OF DEPRESSION
Speaker: Aleksandr Zverinskiy, M.D., M.H.A.
Co-Author(s): Eric D Peselow, MD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Evaluate the efficacy of Selective serotonin re-uptake inhibitors in the long term treatment of depression.;2) Recognize specific variables which predict success of long term treatment.;3) Identify which if any Selective serotonin re-uptake inhibitor is superior in long term treatment of depression.

SUMMARY:
Background: Unipolar major depression is a chronic, co morbid and impairing mental disorder with high lifetime prevalence. Although acute efficacy of antidepressant treatment is well established, the relative prophylactic efficacy of the antidepressant is yet to be fully determined. Studies in naturalistic setting are important in evaluating treatment outcome with antidepressants, since controlled clinical trials include only a minority of patient present in clinical practice. This study was conducted to determine the prophylactic effectiveness of 4 different types of commonly used never generation antidepressants (fluoxetine, escitalopram, sertraline and paroxetine) in unipolar major depressive disorder with long term follow up, and to identify predictors of outcome.
Methods: A 9 year follow up study was conducted among three eighty seven patients greater or equal to 18 years treated at the outpatient clinic. Patient met DSM IV criteria for major depression episodes. Outcome was assessed by the presence of recurrent episode of depression during the prophylaxis therapy with antidepressants. Predictor variables were: presence of previous depressive episodes, co morbid psychiatric conditions, including personality disorders and co- treatment with psychotherapy during prophylaxis.
Results: During an average follow up period of 34.46 months, 23.49 percent of patient remained episode free and 76.51 percent of patients had a relapse of depressive episode during the duration of the prophylaxis with antidepressants. Interestingly, escitalopram and fluoxetine had the highest prophylactic

efficacy (36% and 33.33% of the patients remained symptom free, respectively) , while paroxitine and sertaline showed poor efficacy in prevention of depressive episode (12.8% and 21.3% of patients remained symptom free, respectively). Neither presence of co-morbid psychiatric conditions nor history of previous depressive episode was predictive of the outcome of prophylaxis. However, co-treatment with psychotherapy dramatically increased prophylactic efficacy of antidepressant treatment, 41.17% of patients undergoing psychotherapy remained episode free as compared to 18.09% percent of patients who received only pharmacological treatment during the prophylaxis period (P<0.05).
Discussion: The results of the study with its long observation period indicate that escitalopram and fluoxetine appear to have prophylaxis efficacy in the treatment of unipolar depression in a naturalistic setting. A positive response to prophylaxis was associated with co-treatment with psychotherapy. Taken together these preliminary data may help in the future definition of the range of clinical utility of these widely used antidepressants in the treatment and prophylaxis of unipolar depressive disorder.

-3

MONOTHERAPY VERSUS POLYTHERAPY IN THE LONG-TERM OUTCOME OF BIPOLAR ILLNESS

Speaker: Nida Khan, M.B.B.S.
Co-Author(s): DR ERIC PESLOW MBBS

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session ,the participant should be able to evalaute the efficacy of monotherapy vs polytherapy in the treatment of bipolar illness;2) To identify subsyndromal mood symptoms and other characteristics as predictors of the outcome;3) Age, sex and age of onset as the predictors of the outcome.

SUMMARY:
INTRODUCTION:Bipolar disorder a severe and debilitating mental illness, poses a serious burden to patients and thier families quality of life.The purpose of this study was to investigate the course and 10 year naturalistic outcome of a sample after being euthymic for atleast six months on a treatment regimen. Additionally we attempted to identify the subsyndromal mood symptoms and other characterstics as predictors of outcome.
Methods:Data on 367 pts from the foundation of depression/manic depression were analyzed at two specific points -july1,1989 and august 1,1994.Pts who were included in this analysis all met Feighner criteria for primary affective disorder and RDC as well as DSM-111 criteria for recurrent bipolar illness.To be included in the study ,pts had to be evaluated by the psychistrist and rated as having euthymic mood for 6 months on their regimen.Once stable on their treatment regimen(single medicaiton n=167 or combination n=200)for 6 consecutive months the pts were then followed until one or two possible outcomes :termination well or failure.
Results:Using a survior analysis comparing the two samples (one drug vs combination)no significant differences between the two samples were were noted(p>.37).The overall probability of remaining stable for the entire group of 367 pts at 1 year,2 years ,3 years,4 years and 5 years was 94.1%,85.6%,73.8%,64.1%and 58.9% respectively.There was no difference in survival rates between males and females(z=-.347 p>.7).There was a significant correlation between length of time stable and average manic number of depressive symptoms in the prophylactivc period (r=-.148 p<.004)There was also a statistically significant correlation between length of time stable and average number of manic symptoms in the prophylactic period(r= -.148 p<.209 p<.001).There was no correaltion between length of time stable and age (r=-.011 p<.8)or age of onset (r=-.071 p<.18)
Conclusion:these findings suggest the existence of poor outcome in pts with subsyndromal manic/hypomanic or depressive symptoms.Patients after 6 months on a medication regimen (with one or more drugs) have a probablity of remaining table over the course of ten years of 42.59% regardless of sex, age ,and age of onset.

-4

THE LONG TERM CLINICAL OUTCOME OF POSTTRAUMATIC STRESS DISORDER AND MAJOR DEPRESSIVE DISORDER WITH AND WITHOUT ELECTROCONVULSIVE THERAPY

Speaker: Naser Ahmadi, M.D., Ph.D.
Co-Author(s): Lori Moss. MD
Nutan Vaidya. MD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Comparison the rate of all-cause mortality rate in PTSD & MDD with ECT vs without PTSD & MDD;2) Comparison the rate of all-cause mortality rate in PTSD & MDD without ECT vs without PTSD & MDD;3) Comparison the rate of all-cause mortality rate in PTSD & MDD with ECT vs PTSD & MDD without ECT

SUMMARY:
Background: Posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) are frequently co-exist. Electroconvulsive therapy (ECT) is the most effective treatment for refractory major depressive disorder. This study investigated the long term clinical outcome of Post-traumatic Stress Disorder and Major Depressive Disorder with and without Electroconvulsive Therapy.
Methods: This retrospective nested matched case control study is inclusive of 22164 subjects (3485 with MDD & PTSD (92 with ECT and 3393 without ECT) and 18679 without MDD & PTSD) with median follow up of 8 years. The relative risk of all-cause mortality across MDD & PTSD with and without ECT therapy as compared against those without MDD & PTSD were measured using multivariable Cox regression analyses. Medical information was obtained from electronic medical records.
Results: During the median of 8 year of follow up, the death rate was 8% (1495/18679) in subjects without PTSD & MDD, 9.7% (9/92) in subjects with PTSD & MDD who received ECT and 18% (612/3393) in subjects with PTSD and MDD who didn't receive ECT (p<0.05). Cox regression survival analyses revealed that relative risk of all-cause mortality is not significantly and statistically different in MDD & PTSD who received ECT as compared to matched cohort without PTSD & MDD (relative risk: 1.37, 95%CI 0.14 - 11.95, P=0.81). In contrast, the relative risk of all-cause mortality was 115% higher in PTSD & MDD without ECT treatment as compared to matched cohort without MDD & PTSD (relative risl: 2.15, 95%CI 1.96-2.35, P=0.001). Finally, the relative risk of all-cause mortality was 85% higher in PTSD &

MDD without ECT treatment as compared to MDD & PTSD with ECT treatment (relative risk: 1.85, 95%CI 1.69 - 2.01, P=0.001). Conclusion: 1) The all-cause mortality rate of PTSD & MDD with ECT is not statistically different than individuals without PTSD & MDD, 2) A significant increase in the risk of all-cause mortality in PTSD & MDD without ECT treatment is noted, and 3) ECT treatment is associated with reduced risk of all-cause mortality in MDD & PTSD.

TOPICS IN MOOD DISORDERS

Moderators: Elias Shaya, M.D., Brian J. Holoyda, M.D., M.P.H.

-1

PREVALENCE RATES FOR DEPRESSION BY INDUSTRY: A CLAIMS DATABASE ANALYSIS

Speaker: Lawson Wulsin, M.D.

Co-Author(s): Toni Alterman, PhD, Timothy Bushnell, PhD, Jia Li, MS, Rui Shen

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize the findings of several major studies of rates of depression in US industries;2) Summarize the range of prevalence rates among the highest rate industries in this study;3) Identify five high rate industries and the common factors that may contribute to these high rates of depression

SUMMARY:

Purpose: To estimate and interpret differences in depression prevalence rates among industries, using a large, group medical claims database.

Methods: Depression cases were identified by ICD-9 diagnosis code in a population of 214,413 individuals employed during 2002-2005 by employers based in western Pennsylvania. Data were provided by Highmark, Inc. (Pittsburgh and Camp Hill, PA). Rates were adjusted for age, gender, and employee share of health care costs. National industry measures of psychological distress, work stress, and physical activity at work were also compiled from other data sources.

Results: Rates for clinical depression in 55 industries ranged from 6.9-16.2%, (population rate = 10.45%). Industries with the highest rates tended to be those which, on the national level, require frequent or difficult interactions with the public or clients, have high levels of stress, and low levels of physical activity.

Conclusions: Additional research is needed to help identify industries with relatively high rates of depression in other regions and on the national level, and to determine whether these differences are due in part to specific work stress exposures and physical inactivity at work.

-2

SELF-REPORT TOOL FOR RECOGNIZING MANIA (STORM): A NEW SCALE FOR AIDING IN THE DIAGNOSIS OF BIPOLAR DISORDER

Speaker: Karen S. Blackman, M.D.

Co-Author(s): Amy J Odom, D.O., Marissa A. Miller D.O., Megha Tewari, M.D., David Weismantel, M.D., Brittany Williamson, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to recognize the problem of diagnosis of bipolar disorder, especially in primary care offices. ;2) At the conclusion of this session, the participant should be able to identify cases of possible bipolar disorder with the use of the new SToRM tool. ;3) At the conclusion of this session, the participant should be able recognize the importance of the clinical interview in avoiding the risk of over-diagnosis with this self-report diagnostic tool.

SUMMARY:

Objective- Bipolar disorder is a disabling disease that it is difficult to diagnose. Primary care physicians share in the burden of diagnosing and caring for significant mental illness, including bipolar disorder, but they lack an adequate screening and diagnostic tool that can fit into use in a primary care practice. Modeling after the Patient Health Questionnaire-9 (PHQ-9), we created the Self-report Tool for Recognizing Mania (SToRM) to aid primary care physicians in the screening and diagnosis of bipolar disorder. Methods- A 13-question tool was created and distributed to returning patients over an 11-month time period at the psychiatric clinic of a university health center. Each completed questionnaire was scored as positive or negative and then compared to the preexisting psychiatric diagnosis for that respondent, as shown on the problem list of the respondent's electronic medical record. Results- A total of 102 subjects completed and returned their questionnaires. Twenty-eight surveys were scored as positive for bipolar disorder while 25 subjects carried this diagnosis on their problem list, giving a sensitivity of 72% and a specificity of 87% (CI at 95%). When alternative scoring was used, sensitivity increased to 96% with only a slight decrease in specificity to 84%. Conclusions- In this pilot study, we find that the SToRM shows potential in the pursuit of a highly reliable, self-report tool which would help primary care providers screen and diagnose bipolar disorder. As such, the SToRM deserves further study.

-3

WAS MARY TODD LINCOLN BIPOLAR?

Speaker: David Casey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn the case history of Mary Todd Lincoln;2) Identify the elements of bipolar disorder as defined in DSM5 that are present in Mary Todd Lincoln's case;3) Recognize how the concept of a culture bound disorder may be applied to changes in a given culture over time

SUMMARY:

Mary Todd Lincoln, wife of President Abraham Lincoln, suffered from severe depressive episodes during and after her time in the White House. In addition to the assassination of the President, she suffered the death of a child as well as family members who were involved in the Civil War. As a member of a prominent Southern slave-holding family, she was the object of much scrutiny and criticism by the press and public during the War. Her personal behavior including financial management of the White House and her spiritualism also became public

issues. Following the War, her public crusade for a government pension kept her in the public eye. During this period, she developed an apparent psychotic episode which eventuated in her psychiatric commitment at the behest of her son Robert Lincoln, leading to their estrangement. In recent years a number of authors have addressed these episodes, particularly in regard to the question of her diagnosis. Many have viewed her as having bipolar disorder, while others have viewed her history through the prisms of feminism and skepticism of psychiatry and its diagnostic norms. In this presentation, her case history will be reviewed and these controversies discussed. The concept of culture bound syndromes, usually applied to disparate but contemporaneous cultures, will be used to examine the evolution of our own culture, over time, and the attendant issues in using current diagnostic approaches to historical figures.

PSYCHOPHARMACOLOGY

Moderators: Vivek Singh, M.D., Josepha Iluonakhamhe, M.D.

-1

PROSPECTIVE, RANDOMIZED, OPEN ULTRA LONG-TERM TREATMENT OF PANIC DISORDER WITH CLONAZEPAM, PAROXETINE, OR THEIR COMBINATION

Speaker: Antonio E. Nardi, M.D., Ph.D.
Co-Author(s): Rafael C. Freire, M.D., Ph.D., Sergio Machado, Ph.D., Adriana C. Silva, Ph.D., Marina D. Mochcovitch, M.D., M.Sc., Roman Amrein, M.D., Marcio Versiani, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the main clinical and therapeutic features of acute - 8 weeks - treatment of panic disorder with clonazepam or paroxetine in a group of 120 patients;2) Recognize the main clinical and therapeutic characteristics of long term - 3 year-period - treatment of panic disorder with clonazepam, paroxetine, or their combination;3) Describe a two-month schedule for tapering out clonazepam, paroxetine, or their combination with their clinical and therapeutic peculiarities;4) Identify the main clinical and therapeutic data of a six year follow-up. The recurrent panic attacks, the agoraphobic behavior, the returning to medication and their response;5) Acknowledge that panic disorder is a chronic recurrent condition and even after a three-year efficacious treatment with a safe tapering out schedule.

SUMMARY:
OBJECTIVE. To describe the clinical and therapeutic features of 120 panic disorder (PD) patients treated with clonazepam, paroxetine, or clonazepam + paroxetine and their follow-up for 6 years after the treatment.
METHOD: A prospective open study randomized 120 PD patients to 2 mg/day clonazepam or 40 mg/day paroxetine. Poor responders were switched after 8 weeks to combined treatment with ~2 mg/day clonazepam + ~40 mg/day paroxetine. A four-month schedule for tapering out all treatments was performed after 3 years. Efficacy, safety, and cumulative relapse and remission were studied over the following 6 years, using panic attack (PA) count per month, clinical global impression-severity (CGI-S) score, and Hamilton anxiety scale (HAMA) score. During this period assessments were done every three-month using the same instruments.
RESULTS: 94 patients completed 3 years treatment and underwent tapered drug withdrawal. After two months of tapering, 80% of clonazepam patients were drug-free, versus 55% on paroxetine; after six months, these figures had increased to 89% and 64%, respectively, versus only 44% for those on combination therapy. PA/month, CGI S, and HAMA worsened slightly and adverse events increased during the withdrawal period compared to the treatment period. Assessments were annual in 66 patients and performed at 5 or 6 years in the remaining 28 patients. In annually studied patients cumulative relapses rate were 41%, 77%, and 94% at years 1, 4, and 6. Same-drug relapse therapy was successful in most cases. 90% of these patients remained in remission (partial: 54%, full: 36%); 73% were PA free, 91% had a GCI-S score of 1, and 39% HAMA scores of 5-10; 33% needed drug treatment in each follow up year (11%: clonazepam 1 or 2 mg/day, 21%: paroxetine 20, 30 or 40 mg/day). Both treatments displayed similarly high efficacy, but clonazepam was better tolerated. Results in patients studied at the end of follow-up only were similar, but somewhat less favorable: 88% were in remission, 72% were PA-free, 62% had a CGI-S score of 1 and 30% a HAMA of 5-10, with 39% needing PD treatment.
CONCLUSION: PD is a chronic disorder, with many patients relapsing despite being asymptomatic after 3 years treatment. However, response to retreatment was always efficacious. Paroxetine and clonazepam were associated with similar long-term prognoses but clonazepam was better tolerated.

-2

THERAPEUTIC DRUG MONITORING OF ANTIPSYCHOTICS. WHEN SHOULD WE SAMPLE?

Speaker: Vidya Perera, Ph.D.
Co-Author(s): Gary Mo, B.Sc, Ph.D; Michael J. Dolton, B.Pharm (hons); Vaughan J. Carr, M.B.B.S, M.D.; Junzhe Xu, M.D.; Alan Forrest, Pharm.D

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the optimal blood sampling time points which reflect exposure to antipsychotic medicines;2) Evaluate the usefulness of trough concentrations in therapeutic drug monitoring;3) Recommend sampling strategies for therapeutic drug monitoring of antipscyhotics in clinical practice

SUMMARY:
Background: Antipsychotic medicines display wide variability in response. Pharmacometric approaches have been suggested as a method to individualize dosing regimens however the precision of this method is dependent on the sampling time points. The aim of this study was to determine the optimal sampling time-points and windows to determine clinical pharmacokinetic (PK) parameters (AUC, CL) of atypical antipsychotic drugs. Methods: This study utilised previous population PK parameters of the antipsychotic medicines aripiprazole, clozapine, olanzapine, quetiapine and risperidone. D-Optimality was utilised to identify the most important time-points which predicted the pharmacokinetic parameters identified in the population model when the drug was at steady state (SS). Monte Carlo Simulation (MCS) was used to simulate 1000 patients with variability in PK parameters and obtain concentration

time-points. Forward stepwise regression analysis was used to determine the most predictive time-points of the area under the curve for each drug at SS. Standard two stage population approach (STS) with MAP-Bayesian estimation was utilised to compare the AUC0-tau obtained between the optimal sampling and linear regression time-points. Coefficient of variation (CV%) and pearson's correlation coefficient were utilised to compare the various sampling strategies for each of the drugs. Results: Three optimal sampling time points were identified for each antipsychotic medicine. For aripiprazole, clozapine, olanzapine, quetiapine and ziprasidone the CV% of the apparent clearance using the optimal sampling strategies was 19.5, 12.6, 10.3, 17.1 and 10.7, respectively; Using the MCS and linear regression approach to predict AUC0-tau, the recommended sampling strategies included four samples (aripiprazole) (CV% and r2) (22.9 and 0.80), three samples (clozapine) (7.0 and 0.97), three samples (olanzapine) (7.7 and 0.95), four samples (quetiapine) (6.3 and 0.93) and three samples (ziprasidone) (6.6 and 0.97). Aside from clozapine, trough concentrations performed modestly when predicting AUC0-tau. The STS approach demonstrated excellent correlations and accuracy in the estimation of AUC0-tau. Discussion: The results of this analysis provide important sampling information for therapeutic drug monitoring and clinical studies investigating pharmacokinetics of antipsychotic medicines. Furthermore, the results demonstrate the trough concentrations are not appropriate estimates of exposure for many antipsychotic medicines

-3

N-ACETYLCYSTEINE IN THE TREATMENT OF GROOMING DISORDERS

Speaker: Gustavo Jesus, Ph.D.
Co-Author(s): Silva-Netto, Regina, M.D.; Vila-Nova, Vanessa, M.D.; Tavares, Hermano, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the benefit of using N-acetylcysteine in psychiatry, namely in the treatment of grooming disorders;2) Identify grooming disorders as frequent comorbid manifestations of other impulse control disorders;3) Notice that the improvement of symptoms of grooming disorders may be directly correlated with

SUMMARY:

Introduction: N-acetylcystein (NAC) is a precursor to the amino acid cysteine, which participates in antioxidant mechanisms through glutathione production and plays a role as a modulator of the glutamatergic system of neurotransmission. Thus, NAC may exert therapeutic effect in psychiatric disorders.
Objectives: Review the potential therapeutic effects of NAC in psychiatry, with main focus on grooming disorders, namely skin-picking disorder (SPD) and trichotillomania, with report of a case series.
Methods: Review of literature collected under key-words "n-acetylcysteine; psychiatric", "skin-picking disorder", "trichotillomania". Report of a series of six cases of patients with grooming disorders (SPD or trichotillomania) treated with NAC.
Results: All six patients were being treated were treated for a grooming disorder as comorbidity to a multi-impulse control disorder or an affective disorder. In combination with previously given pharmacological agents, they were administered NAC in dosages from 1200 to 1800 mg/day. All patients had great improvement of skin-picking or hair pulling behaviours resistant to other treatments. It was also observed that worsening of symptoms occurred after stopping the NAC and restarting the drug led to new remission of symptoms.
Discussion: Studies suggest that modulation of glutamatergic neurotransmission may decrease compulsive behaviors such as skin-picking, by influencing the reward reinforcement pathway. NAC may be used to achieve this modulation. The fact that in the case series stopping/re-starting the NAC corresponded respectively to worsening/improvement of symptoms, suggests a direct relation between treatment with NAC and remission of grooming disorders.
Conclusion: SPD and trichotillomania are prevalent but insufficiently studied conditions and randomized controlled studies are needed to ascertain the potential benefits of NAC for patients with these disorders, although preliminary results show a potential benefit of the usage of NAC in such disorders.

-4

VALPROIC ACID AS AN ADJUNCT TREATMENT FOR HYPERACTIVE DELIRIUM: POSTULATED MECHANISMS OF DELIRIOLYTIC ACTION AND CASE SERIES

Speaker: Yelizaveta Sher, M.D.
Co-Author(s): Ann Catherine Miller, M.D., Sermsak Lolak, M.D., Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe postulated deliriolytic mechanisms of action of valproic acid (VPA);2) Identify side effect profile of VPA and carefully choose patients with delirium appropriate for treatment with VPA;3) Know most recent evidence behind the use of VPA in treatment of delirium

SUMMARY:

Background: Delirium is the most often encountered psychiatric diagnosis in the general hospital, with incidence up to 85% in the intensive care unit (ICU) setting and significant effects on morbidity and mortality. Antipsychotics are considered first-line pharmacological treatment, but they are not FDA approved and can have significant limitations, including QTc prolongation leading to abnormal heart rhythms, extrapyramidal side effects, and paradoxical exacerbation of agitation. Valproic acid (VPA) is a potential adjunct or alternative treatment. It has significant effects on neurotransmitter systems (e.g. dopamine, glutamate, gamma-amino butyric acid, and acetylcholine), kynurenine pathway, neuro-inflammation and oxidative stress, all implicated in the pathophysiology of delirium. These effects could be mediated through VPA's effect on transcription, including inhibition of histone deacytelase (HDAC). Yet, data on the use of this agent in delirium is limited.
Objective: The goal of this presentation is to discuss rationale behind the use of VPA in delirium and to describe a case series of 16 episodes of hyperactive delirium treated with VPA as an adjunct medication.
Methods/Results: We identified 15 patients with 16 episodes of delirium, diagnosed according to DSM-IV criteria and treated with adjunct VPA by consultation-liaison psychiatrist from 8/1/2011 through 8/31/2012. All patients had hyperactive or

mixed delirium, according to the Liptzin criteria. Thirteen patients had resolution of their delirium and all patients had their agitation subside with the addition of VPA to their regimen. There were no adverse outcomes directly ascribed to VPA. Conclusions: VPA has multiple effects implicated in pathophysiology of delirium. When carefully chosen, VPA can be an effective and well-tolerated treatment option. Further studies are needed.

FORENSIC ISSUES IN PSYCHIATRY

Moderators: Britta Ostermeyer, M.D., Gayla Rees

-1

HOMICIDE AND ZOLPIDEM: WHAT DO WE KNOW AND HOW DO WE KNOW IT?

Speaker: Cheryl Paradis, Psy.D.
Co-Author(s): Lawrence A. Siegel, M.D., Stuart B. Kleinman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of current clinical guidelines in the prescription of zolpidem;2) Recognize the rare, adverse neuropsychiatric reactions associated with zolpidem use;3) Identify clinical and psychopharmacological factors associated with increased risk of adverse zolpidem reactions;4) Become better able to distinguish genuine zolpidem associated amnesia from malingering ;5) Consider a zopidem adverse reaction in the differential diagnosis when evaluating zolpidem treated individuals who engage in uncharacteristic violence accompanied by psychosis or delirium

SUMMARY:
Zolpidem is generally a safe short-term treatment of insomnia. Reported adverse neuropsychiatric reactions to zolpidem include nocturnal eating, somnambulism, agitation, hallucinations, sensory distortions, delirium, and amnesia. Studies have identified four clinical factors which may particularly support the occurrence of zolpidem-associated psychotic or delirious reactions. These factors include: the concomitant use of a SSRI, female gender, advanced age, and zolpidem doses of 10 mg. or higher. This presentation includes a review of the literature on adverse zolpidem reactions and a presentation of two forensic cases, one of a 45 year-old man, the other of a 63 year-old woman. In both individuals concomitant zolpidem and paroxetine use was associated with uncharacteristic, complex acts of violence. In these two cases, the evaluees violently killed a spouse and reported being totally or partially amnesiatic. Both had concomitantly taken 10 mg. or more of zolpidem and paroxetine, and possessed previously suggested risk factors for developing zolpidem-associated adverse reactions. In both individuals, the homicides occurred early in the course of their treatment with zolpidem. The authors concluded that both evaluees lacked substantial capacity to appreciate the wrongfulness of their conduct at the time they killed their spouses.

-2

ZOOPHILIA AND THE LAW: LEGAL RESPONSE TO A RARE PARAPHILIA

Speaker: Brian J. Holoyda, M.D., M.P.H.
Co-Author(s): William J. Newman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Summarize recent research findings on individuals who engage in human-animal sexual behaviors;2) Review the legal status of human-animal sexual contact in the United States;3) Evaluate the forensic implications of statutory and case law pertaining to bestiality.

SUMMARY:
Though societies' responses to bestiality have varied internationally, the response in the United States has typically involved condemnation and prosecution. Currently, there are thirty-one states with statutes prohibiting human-animal sexual contact. Despite the prevalence of anti-bestiality legislation, there is limited case law in the United States. Most commonly, bestiality arises in legal cases involving sexually violent predator (SVP) civil commitments. Identifying offenders who commit acts of bestiality is important since these individuals may be at an increased risk of committing a variety of other sexual and nonsexual violent acts against humans. Due to different laws between states, however, commonly used forensic risk assessment tools for sexual recidivism can yield different scores for individuals charged with or convicted of bestiality offenses. Forensic evaluators should consider this factor when conducting risk assessments. State legislatures should also consider modernizing their bestiality statutes to accord with current terminology and objectives for such laws.

SMOKING AND GAMBLING

Moderators: Vivek Singh, M.D., Francis Shin

-1

VARENICLINE EFFECTS ON SMOKING, COGNITION, AND PSYCHIATRIC SYMPTOMS IN SCHIZOPHRENIA

Speaker: Robert C. Smith, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1Discuss the efficacy of varenicline as a treatment for cigarette smoking in patients with schizophrenia;2) Assess whether varenicline has risks of increasing psychiatric symptoms, depression or suicide risk in patients with schizophrenia;3) Discuss the biological rationale which makes nicotinic agonists candidates for drugs which may improve cognition in schizophrenia.

SUMMARY:
Introduction: Schizophrenics have a high rate of smoking and cognitive deficits which may be related to a decreased number or responsiveness of nicotinic receptors in their brains. Varenicline is a partial nicotinic agonist which is effective as an anti-smoking drug in normals, although concerns have been raised about potential psychiatric side-effects. Nicotinic agonists or partial agonists have been proposed as potential treatments for cognitive deficits in schizophrenia. We conducted a double-blind placebo controlled study to evaluate effects of varenicline on measures of smoking, cognition, psychiatric symptoms, and side-effects in schizophrenic patients who were cigarette

smokers.
Methods: 87 patients with diagnosis of schizophrenia or schizoaffective disorder at 4 sties (2 US, 1 Israel, and 1 China) participated in a double-blind placebo-controlled study in which they received varenicline (2 mg/day) or matched placebo for 8 weeks, with some sites extending selected measures to 12 weeks. All subjects received brief weekly structured behavioral counseling sessions on smoking cessation. Smoking was evaluated with objective measures of breathalyzer CO, and serum nicotine and cotinine, and self-report measures of cigarettes smoked and a smoking urges scale. Cognition was measured by MATRICS cognitive battery. Psychiatric symptoms were evaluated with PANSS, SANS, and Calgary Depression scales.
Results: Varenicline significantly decreased objective measures of smoking, and responses on a smoking urges scale, more than placebo. However, only 22-24% of varenicline subjects had measures indicating they had quit smoking by 8 weeks. Varenicline did not improve either overall MATRICS Composite scores or summary scores on Cognitive Domain.. Placebo patients improved significantly more than varenicline patients on Reasoning and Problem Solving domain. Varenicline patients tended to improve more on Trial Making Test Part A. There were no significant differences between varenicline and placebo on total scores on PANSS, SANS, or Calgary Depression Scale. There was no increase in any measure of psychiatric symptoms with varenicline, and varenicline patients showed trends for decrease in symptoms scores on several measures. Varenicline patients showed a significantly greater decrease in PANSS Depression Factor sub-score than placebo patients, and had a greater decrease in SANS Avolition sub-score. Varenicline patients did not show greater side-effects than placebo treated patients at any time point.
Conclusions: Varenicline was a safe and effective drug for decreasing cigarette smoking in schizophrenic patients. It was not a cognitive enhancer on the MATRICS battery measure. It did not increase any psychiatric symptoms and may decrease some components of depression or negative symptoms in schizophrenic patients.

-2

RESPONSE INHIBITION AND SUSTAIN ATTENTION IN HEAVY SMOKERS VERSUS NON-SMOKERS: A CROSS-SECTIONAL STUDY

Speaker: Pinhas Dannon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize that repeated nicotine administration induces neeuroadaptations associated with abnormal dopaminergic activity. And, these neuronal changes may contribute to impaired inhibitory control and attention deficit; 2) Learn that long term use of nicotine has been associated with poorer performance on a variety of neurocognitive tests; 3) Understand why it remains unclear whether smokers perform worse than non-smokers on tests that involve attention and control of impulsivity.

SUMMARY:
Background: Repeated nicotine administration induces neuroadaptations associated with abnormal dopaminergic activity. These neuronal changes may contribute to impaired inhibitory control and attention deficit. Long term use of nicotine has been associated with poorer performance on a variety of neurocognitive tests. However, it remains unclear whether smokers perform worse than non-smokers on tests that involve attention and control of impulsivity. The present study examined response inhibition and sustained attention capacities in a large sample of smokers (N=114) and non-smokers (N=68).
Methods: Continuous Performance Test (CPT) and go/no-go computerized tasks were used as a measure of response-inhibition ability and sustain attention. Three-way repeated measures analysis of covariance was used with response time, variability of response time, number of commission errors (inappropriate responses to no-go stimuli) and number of omission errors (missed go stimuli) as dependent measures; Main effects were: group (smokers and controls), condition (CPT and go/no-go), and block (in each condition); Gender, education, and age were used as covariates.
Results and Conclusions: Smokers, as compared to the control group, made more errors of commission in the go/no-go task, reflecting impaired inhibition ability. However, we found no significant differences between the groups in our measure of sustained attention. Impaired response inhibition was found to co-occur with heavy smoking and therefore may be a potential target for the development of more effective cessation programs.

-3

CHARACTERISTICS OF PATHOLOGICAL GAMBLERS WITH SUICIDE ATTEMPTS IN A REGIONAL REPRESENTATIVE SAMPLE OF ADULTS

Speaker: Ernesto JoséVerdura Vizcaíno, M.Psy.
Co-Author(s): E. Baca-Garcia, M.D., Ph.D.; A.Lains, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Examine the characteristics of pathological gamblers who committed suicide attempts; 2) Determine the features that are associated with higher suicide risk between pathological gamblers; 3) Consider the characteristics of pathological gamblers with suicide attempts and the different subtypes of pathological gamblers.

SUMMARY:
The objective of this study was to examine the characteristics of pathological gamblers who commited suicide attempts and determine the features that are associated with a higher suicide risk between pathological gamblers (PGs).
Methods: We use a regional representative sample of suicide attempts in Madrid (Spain). A subgroup of 23 pathological gamblers treated in Emergency service of a Public Hospital (after a suicide attempt) were selected.
Results: PGs who commited suicide attempts used to be males (69,9%), with children (69,6%), current smokers (82,6%), with low educational level (59,1%), without familiar history of suicidal behavior (82,6%). They usually have the diagnosis of major depression lifetime (84,2%), bipolar disorder lifetime (42,9%), alcohol-drug abuse lifetime (54,5%), cannabis abuse/dependence (26,1%), cocaine abuse/dependence (39,1%) and opiate abuse/dependence (21,7%).
Conclusion: PGs who commited suicide attempts used to be males with low educational level. They usually have the diagnosis of a mood disorder and alcohol-drug abuse/dependence

during their life. These characteristics are important to consider for preventing policies of suicide between PGs.

COMORBIDITY WITH ALCOHOL ABUSE

Moderators: Edward T. Lewis, Brian J. Holoyda, M.D., M.P.H.

-1

A LONGITUDINAL ANALYSIS: THE ODDS RATIO OF MANIC EPISODE SYMPTOMS BETWEEN INDIVIDUALS WITH ALCOHOL USE DISORDERS AND WITHOUT ALCOHOL USE DISORDERS

Speaker: Shaocheng Wang, M.D., Ph.D.
Co-Author(s): Brion S. Maher, Ph.D. , Associate Professor of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the high risk individuals of alcohol use disorders among bipolar I disorder population; 2)Have the basic knowledge of National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Survey;3) Have the basic knowledge of longitudinal analysis to deal with the nationwide database from NESARC.

SUMMARY:
Objective: To quantify the longitudinal association between alcohol use disorders (AUDs, including alcohol abuse and alcohol dependence) and manic episode symptoms defined by Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) manic episode symptoms, age, gender and race/ethnics among bipolar I disorder population in United States.
Study Design: A prospective longitudinal observational study of alcohol use, alcohol use disorders, and their physical and psychiatric disabilities in National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) Wave 1 (2001-2002) and Wave 2 (2004-2005).
Methods: Those with lifetime bipolar I disorder diagnosis in the NESARC Wave 2 survey were extracted from the whole NESARC database. Descriptive statistics including proportions were used to describe the study population in the NESARC Wave 1. Logistic regression models were used to estimate the odds of alcohol use disorders at any time since the Wave 1 interview till the Wave 2 interview. Manic episode symptoms in the year prior to the Wave 1 interview were predictors. Having alcohol use disorder diagnoses after the Wave 1 interview was the outcome. This logistic regression was adjusted by gender, age and race/ethnicity.
Results: Among the 1,852 subjects, roughly 61.8% were female. Mean age was 38.9 years old; minimal is 18 years old and maximum is 88 years old in the most recent interview. 56.1%, 21.3%, 17.6% and 5.0% were white people, black people, Hispanic people, and others(Asian and native American), respectively. In the Wave 2 survey, the prevalence of alcohol use disorders was 53.5 percent; the prevalence increased from 48.0 percent by the Wave 1 survey. Male were significant associated to alcohol use disorders at any time since the Wave 1 interview, after age, race/ethnic were adjusted. (OR = 2.01, 95% CI = 1.45-2.80, p <0.001) In our longitudinal analysis, the DSM-IV manic episode criteria related to elated mood symptoms and irritable mood symptoms are both significant associated with alcohol use disorders at any time since the Wave 1 interview. Compared to those without elated mood symptoms; the bipolar I disorder participants with elated mood symptoms in the Wave 1 were less likely to have alcohol use disorders since the Wave 1 survey, after gender, age, and race/ethnic were adjusted. (OR = 0.56, 95% CI = 0.37-0.82, p =0.004) Compared to those without irritable mood symptoms; the bipolar I disorder participants with irritable mood symptoms in the Wave 1 were less likely to have alcohol use disorders since the Wave 1 interview, after gender, age, and race/ethnic were adjusted. (OR = 0.50, 95% CI = 0.32-0.80, p =0.004)
Conclusions: Significant association exists between alcohol use disorders and previous manic episode with identified symptoms. Interventions for alcohol use disorders would be best targeted to males with bipolar I disorder diagnosed without elated mood symptoms and without irritable mood symptoms.

-2

INTEGRATED EXPOSURE THERAPY IN PTSD/ADDICTION PATIENTS IS ASSOCIATED WITH A SHIFT FROM FRONTAL-STRIATAL TO TEMPORAL-PARIETAL REGULATION

Speaker: Sudie E. Back, Ph.D.
Co-Author(s): Drew Teer, B.S., Frank Beylotte, M.S., Kathleen T. Brady, M.D., Ph.D., and Colleen Hanlon, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Increase knowledge of integrated cognitive behavioral treatments for PTSD and substance use disorders;2) Identify the neural bases involved in PTSD ;3) Learn about how prolonged exposure therapy alters neural circuitry

SUMMARY:
Background: Post-traumatic stress disorder (PTSD) and substance use disorders (SUDs) are chronic and debilitating conditions which frequently co-occur and are both associated with alterations in limbic circuit regulation in the brain. While integrated, cognitive-behavioral therapies employing prolonged exposure techniques are effective for many PTSD/SUD patients (Back et al., 2012; Mills et al., 2012), the neural basis for this positive treatment response remains unclear. This pilot study aimed to examine the effect of prolonged exposure therapy on the neural response to a personalized trauma script. Methods: Subjects were six Veterans (mean age = 40.3; 5 males, 1 female) participating in a larger randomized clinical trial on the integrated treatment of Veterans with PTSD and SUDs using prolonged exposure. Continuous arterial spin labeling (ASL) data were acquired from a 3T MRI scanner on 2 occasions (pre-treatment and post-treatment) while the patients were exposed to a 6-minute audio recording of their index trauma script blocks (2, 3 minute blocks) or their own neutral script. Results: Pre-treatment exposure to the trauma-cue revealed significant perfusion of limbic circuitry, including the caudate, anterior insula and medial/orbital prefrontal cortex (p<.005). Of the four individuals that completed the treatment post-treatment exposure to the same trauma-cue revealed less activity in limbic regions and significantly elevated activity in sensory, self-awareness areas, including the thalamus, posterior insula and parietal/precuneus (p<.005). Discussion: These preliminary findings suggest that exposure therapy leads to a shift from heightened limbic tone to emergent sensory control over the

neural response to the index trauma. The findings may enhance understanding of PTSD and SUDs and identify potential treatment targets. Recruitment is ongoing and the final data set will be presented. Acknowledgements: This project was supported by NIDA grant RO1 DA030143 (SEB), NIH/NCRR grant UL1RR029882 and NIH/NCAT grant UL1TR000062.

-3

PHYSICAL AND MENTAL HEALTH AND SOCIAL FUNCTIONING IN OLDER ALCOHOL-DEPENDENT INPATIENTS: THE ROLE OF AGE OF ONSET

Speaker: Rob M. Kok, M.D., Ph.D.
Co-Author(s): Peter Blanken, Ph.D., Jolanda Hermes, R.N., Nicolien Kist, M.Sc., Julia F. van den Berg, Ph.D., Wim van den Brink, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant is aware of the importance of diagnosing alcoholism in the elderly.;2) At the conclusion of this session, the participant has a better understanding of the differences between early, late and very-late onset alcoholism.;3) At the conclusion of this session, the participant has a better understanding of the severe physical, mental and social consequences of late- and very-late onset alcoholism.

SUMMARY:
Background: Alcohol dependence is a severe and often chronic condition with a strong impact on physical and mental health and (social) functioning, in particular for older patients. Age of onset is an important criterion to distinguish subgroups of alcohol-dependent patients. The aim of this study is to determine whether older alcohol-dependent inpatients with early, late and very late onset of alcohol dependence differ in physical and mental health and social functioning.
Methods: In a specialized inpatient detoxification ward for older patients in The Hague, The Netherlands, the Addiction Severity Index was administered to 157 alcohol-dependent patients aged 50 and over (38% women, mean age 62.7 ± 6.5). Univariate and multivariate analyses were conducted to examine the association between early (age < 25), late (25-44) or and very late (≥45) age of onset and indicators of physical and mental health and social functioning.
Results: Older alcohol-dependent patients had substantial physical, mental and social problems, which were largely independent of the age of onset of alcohol dependence. However, patients with early onset alcohol dependence had more chronic somatic complaints and more suicidal thoughts than patients with late onset alcohol dependence. The very late onset group did not significantly differ from the other two groups in any of the variables under study.
Conclusions: Despite previous studies showing more favorable outcomes for the (very) late onset compared to the early onset alcohol-dependent group, their (comorbid) mental health and social problems should not be underestimated.

MARIJUANA AND PSYCHOSIS

Moderators: Gayla Rees, Jerome Taylor

-1

CANNABIS-RELATED PROBLEMS IN PEOPLE WITH SCHIZOPHRENIA

Speaker: David Gorelick, M.D., Ph.D.
Co-Author(s): Douglas L. Boggs, Pharm.D., M.S., Fang Liu, M.S., Jared A. Linthicum, M.S., Hailey E. Turner, M.S., Deanna L. Kelly, Pharm.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the major cannabis-related problems experienced by people with schizophrenia; and 2) Understand the risk factors for cannabis-related problems in people with schizophrenia

SUMMARY:
Objective: Cannabis use is common among people with schizophrenia and is associated with adverse effects on the clinical course. Less is known about its effects on daily life. This study addressed this knowledge gap by evaluating the lifetime history of cannabis-related problems in a convenience sample of people with schizophrenia, with the aim of identifying risk factors for such problems. Method: People in treatment for schizophrenia or schizoaffective disorder (DSM-IV criteria), > 18 years old, > 6th grade English reading level, history of cannabis use, and > 1 attempt to quit cannabis use gave written informed consent and completed the 176-item, semi-structured Marijuana Quit Questionnaire. Results: 158 people provided usable data, with a mean (SD) age of 41.7 (10.9) years (range 21.3-63.7), 74.7% male, 35.4%% white, 56.3% African-American, 11.7 (2.3) years of education. 41.3% reported lifetime cannabis use > 1000 times; mean (SD) age of first regular (at least weekly) use was 17.0 (4.8) years. Common cannabis-related problems included psychological—93% (impaired memory—77%, depression—61%, hallucinations—53%), interpersonal—76% (with family members—76%, with friends—59%), physical health—69% (cough-60%, headache—53%, trouble sleeping—43%), missing important obligations (school, work, doctor's appointment)—72%, physical injury to self (19%) or others (10%), risky behavior—65%, and problems with police—55%. 63% of participants talked with someone about their cannabis-related problem, chiefly a counselor (67%), friend (61%), or family member living with them (58%). 18% reported inpatient and 25% outpatient treatment for a cannabis use disorder or cannabis-related problem. Greater lifetime use was significantly associated with greater likelihood of inpatient or outpatient treatment, risky behavior, and morning use. There were few significant differences associated with gender, race, or education level. Men were significantly more likely than women to engage in risky behavior and have others express concern over their cannabis use. Age at first regular use was significantly associated with interpersonal and psychological problems.
Conclusions: People with schizophrenia have a high prevalence of cannabis-related problems in daily life, which they talk about with counselors, family, and friends. Prompt attention to these problems, and help with cessation of cannabis use, are likely to be clinically beneficial.
Acknowledgment: Supported by the Intramural Research Program, NIH, National Institute on Drug Abuse and NIDA Residential Research Support Services Contract HHSN271200599091CADB.

Co-authors: Douglas L. Boggs, Pharm.D., Deanna L. Kelly, Pharm.D., Fang Liu, M.S., Jared A. Linthicum, M.S., Hailey E. Turner, M.S.

Literature references:

Foti DJ, Kotov R, Guey LT, Bromet EJ. *Cannabis use and the course of schizophrenia: 10-year follow-up after first hospitalization*. American Journal of Psychiatry 2010;167:987-993.

Volkow ND. *Substance use disorders in schizophrenia: clinical implications of comorbidity.* Schizophrenia Bulletin 2009;35:469-472.

-2

MARIJUANA USE IN ADOLESCENCE IS ASSOCIATED WITH AN EARLIER AGE AT ONSET OF PSYCHOSIS

Speaker: Michael T. Compton, M.D., M.P.H.

Co-Author(s): Mary E. Kelley, Ph.D., Beth Broussard, M.P.H., Sarah L. Cristofaro, M.P.H., Stephanie Johnson, M.S., Claire Ramsay Wan, M.P.H., Joseph Cubells, M.D., Ph.D., Nadine J. Kaslow, Ph.D., Elaine F. Walker, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss evidence to date that links premorbid, adolescent marijuana use to risk of schizophrenia and other psychotic disorders, and to the age at onset of those disorders.;2) Understand the findings from a study designed specifically to examine the association between premorbid, adolescent marijuana use and age at onset of psychotic disorders.;3) Recognize the importance of these findings from the perspectives of mental health clinicians, researchers, and policymakers.

SUMMARY:

A number of epidemiological studies have suggested that marijuana use in adolescence is an independent risk factor for the later development of a psychotic disorder; as such, premorbid, adolescent marijuana use is thought to be a component cause of schizophrenia and other psychotic disorders. Furthermore, several studies have indicated that premorbid marijuana use may be associated with an earlier age at onset among those who develop a psychotic disorder. Age at onset is a crucial early-course feature as an earlier age at onset is associated with poorer clinical and functional outcomes. The other known predictors of age at onset are not modifiable (e.g., family history of psychosis, gender). We conducted a National Institute of Mental Health (NIMH)-funded study designed specifically to determine the ways in which premorbid, adolescent marijuana use influences a number of early-course features. Here, we show how early marijuana use is associated with age at onset, and discuss implications for clinicians, researchers, and policymakers.

-3

MARIJUANA SMOKERS AT CLINICAL HIGH-RISK FOR PSYCHOSIS EXHIBIT AN INCREASED PSYCHOTIC-LIKE RESPONSE TO SMOKED MARIJUANA

Speaker: Nehal P. Vadhan, Ph.D.

Co-Author(s): Gill Bedi, D.Psych.; Cheryl M. Corcoran, M.D.; Margaret Haney, Ph.D.; Jeffrey G. Lieberman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand differences and similarities in the acute subjective and physiological response to smoked marijuana between prodromal and psychiatrically-healthy marijuana smokers;2) Understand the methodology of administering smoked marijuana to human participants under controlled laboratory conditions;3) Provide psychoeducation to prodromal patients about how their response to marijuana may differ from their psychiatrically-healthy peers

SUMMARY:

Aims: Marijuana (MJ) use is thought to be psychotogenic in individuals who are at-risk for psychosis, yet no study has examined the direct effects of MJ in at-risk individuals. The purpose of this novel study was to examine the acute subjective and physiological effects of smoked MJ in MJ users at clinical high-risk for psychosis (CHR) compared to healthy MJ-using controls, under controlled laboratory conditions. We hypothesized that the CHR group would exhibit increased psychotic-like effects of the drug, relative to the controls. Methods: Six CHR MJ users, as ascertained by formal criteria, and 6 control MJ users participated in this 3-session outpatient study. The groups were similar in demographic characteristics (overall mean age=23.8; SD=3.3) and MJ use patterns (overall mean weekly occasions =3.9; SD=1.8); MJ use was confirmed by urine toxicology. In each session, volunteers completed a battery of subjective measures at baseline and repeatedly after smoking half of a single MJ cigarette using a standardized procedure. MJ cigarettes were provided by the National Institute on Drug Abuse, and administration order (0.0, 2.0, or 5.5% Δ9 -THC) was randomized and double-blind. In this initial analysis, only data from the 5.5% (active) and 0.0% (placebo) MJ sessions were analyzed. Results: Following active MJ the CHR group exhibited greater ratings of paranoia ($p<0.05$), slowed time perception ($p<0.05$), anxiety ($p=0.06$) and a negative MJ effect ($p=0.06$), relative to placebo, whereas the control group did not. Following active MJ the control group exhibited greater ratings of a positive MJ effect ($p<0.05$) and MJ liking ($p<0.05$), relative to placebo, whereas the CHR group did not. Both groups exhibited Δ9 -THC - dependent increases ($p<0.05$) in heart rate, and ratings of intoxication («high») and MJ strength. All drug effects returned to baseline by the end of each session, and no serious adverse effects of study participation occurred. Conclusions: Consistent with our hypotheses, the CHR group exhibited temporary increases in select psychiatric and perceptual states, which may be consistent with a psychotogenic role for MJ use in individuals who are in the prodromal phase of psychosis. Further research is needed to examine the motivations for MJ use in the CHR population despite its apparently aversive effects.

Support: Brain and Behavior Research Foundation 2009 Young Investigator Award (NPV), R01s DA19239 and DA09236 (MH), R21 MH086125 (CMC), and CUMC Irving Scholars Awards (CMC & NPV)

MAY 06, 2014

STIGMA AND FIRST EPISODE OF PSYCHOSIS

Moderators: Nitin Gupta, M.D., Brian J. Holoyda, M.D., M.P.H.

-1

RELATIONSHIP BETWEEN IMPACT OF STIGMA AND BURDEN IN RELATIVES TO PERSONS WITH SCHIZOPHRENIA: RESULTS FROM THE COAST STUDY

Speaker: Katarina Allerby, M.Sc., R.N.
Co-Author(s): Cecilia Brain, M.D., Tom Burns, M.D., Erik Joas, M.Sc., Patrick Quinlan, M.Sc., Birgitta Sameby, R.N., B.A., Margda Waern, M.D., PhD*

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Increase their knowledge of associated stigma in relatives of persons with schizophrenia who receive treatment in setting where intense case management is often applied;2) Increase their understanding of the relationship between associated stigma and the overall burden experienced by relatives;3) Discuss factors that might help to explain the relatively low degree of burden experienced by relatives in this study;4) Recognize the need for research on interventions to help relatives cope with associated stigma.

SUMMARY:
This study aims to investigate the impact of stigma on family burden in a Scandinavian setting where intense case management is often applied. Patients who took part in the COAST adherence study were asked to identify a relative who might be willing to respond to a postal questionnaire. Of the 111 potential relatives 75 agreed to participate and 65 gave sufficient data for inclusion in this study. Relatives' experiences of stigmatization were examined using the Inventory of Stigmatizing Experiences (ISE). The Burden Inventory for Relatives to persons with Psychotic disturbance (BIRP) was used to describe the experience of burden. Experiences of stigmatization were reported by 35,5% of the relatives. One fifth reported anticipated stigma (avoidance of situations that might elicit stigma). 20% acknowledged frequent distress in accordance with BIRP. In a univariate ordinal regression model higher levels of stigma were associated with higher burden. After adjusting for patient age, gender, PANSS score and GAF (function) in a multivariate ordinal logistic regression model, two of the ISE items remained significant and these were related to quality of life (both personal and for the entire family). Relationships were found between relatives' burden and stigma impact on both a personal and family level. However, relatives' experiences of stigma and burden were less prevalent than in previous studies. This might in part reflect the fact that most of the patients attended care settings involving intense case management. Although there is a relation between associated stigma and burden it remains to be tested whether interventions aimed at reducing family members' experiences of stigma may also impact on caregiver burden.

-2

DRUG ATTITUDE AND OTHER PREDICTORS OF MEDICATION ADHERENCE IN SCHIZOPHRENIA: TWELVE MONTHS OF ELECTRONIC MONITORING (MEMSÂ®) IN THE SWEDISH COAST STUDY

Speaker: Cecilia Brain, M.D.
Co-Author(s): Katarina Allerby, R.N., Tom Burns, M.D., Jonas Eberhard, M.D., PhD, Erik Joas, MSc., Ulla Karilampi, PhD, Eva LindstrÃ¶m, M.D., PhD, Patrick Quinlan, MSc., Birgitta Sameby, R.N., Margda Waern, M.D., PhD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and identify predictors of non-adherence in schizophrenia as a basis for evidence based treatments and improved patient outcomes;2) Assess risk factors of non-adherence in schizophrenia by using established tools, methods and rating scales and critically interpret the results of the available adherence measures used;3) Understand the importance of involving both the patient and their extended social network to improve adherence;4) Discuss psychosocial treatment approaches in community based psychiatry in order to promote medication adherence.

SUMMARY:
The aim was to investigate clinical predictors of adherence to antipsychotics. Medication use was electronically monitored with a Medication Event Monitoring System (MEMS®) for 12 months in 112 outpatients with schizophrenia and schizophrenia-like psychosis according to DSM-IV. Symptom burden, insight, psychosocial function (PSP) and side effects were rated at baseline. A comprehensive neuropsychological test battery was administered and a global composite score was calculated. The Drug Attitude Inventory (DAI-10) was filled in. A slightly modified DAI-10 version for informants was distributed as a postal questionnaire. Non-adherence (MEMSÂ® adherence â‰¤ 0.80) was observed in 27%. In univariate regression models low scores on DAI-10 and DAI-10 informant, higher positive symptom burden, poor function, psychiatric side effects and lack of insight predicted non-adherence. No association was observed with global cognitive function. In multivariate regression models, low patient-rated DAI-10 and PSP scores emerged as predictors of non-adherence. A ROC analysis showed that DAI-10 had a moderate ability to correctly identify non-adherent patients (AUC = 0.73, $p < .001$). At the most "optimal" cut-off of 4, one third of the adherent would falsely be identified as non-adherent. A somewhat larger AUC (0.78, $p < .001$) was observed when the ROC procedure was applied to the final regression model including DAI-10 and PSP. For the subgroup with informant data, the AUC for the DAI-10 informant version was 0.68 ($p = .021$). Non-adherence cannot be properly predicted in the clinical setting on the basis of these instruments alone. The DAI-10 informant questionnaire needs further testing.

-3

PATHWAYS TO CARE AMONG YOUNG PEOPLE WITH FIRST-EPISODE PSYCHOSIS

Speaker: Beth Broussard, C.H.E.S., M.P.H.
Co-Author(s): Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define pathways to care, duration of untreated psychosis, help-seeking delay, and referral delay;2) Understand the findings from a study of pathways to care among first-episode psychosis patients;3) Recognize the importance of these findings from the perspectives of mental health clinicians, researchers, and policymakers.

SUMMARY:

Understanding pathways to care, or the various contacts made during the period of time from the onset of illness to the first initiation of treatment, is critical to the goal of enhancing early recognition and treatment of psychotic disorders. However, little is known about pathways to care among patients with first-episode psychosis in the United States. We examined pathways to care, including all contacts for help from the onset of prodromal symptoms until first hospital admission, in 175 urban patients, who were predominantly low-income, socially disadvantaged, and African American. We also ascertained the frequency of contact with primary care providers and police officers during the pathway. Primary care providers were the first professional contact in only 3.3% of contacts, while law enforcement accounted for 9.8%. The duration of untreated psychosis differed by the type of first professional contact. Furthermore, one of the two components of the duration of untreated psychosis, "referral delay" (but not the other, "help-seeking delay") differed by the first professional contact. Specifically, those first encountering law enforcement had the shortest referral delay and those first contacting an outpatient mental health professional had the longest. The last contact (directly preceding hospital admission) was with a primary care provider in only 3.7% and with law enforcement in 7.4%. The number of professional contacts during the pathway to care ranged from one to seven (mean=1.82, standard deviation=1.26). These findings indicate that pathways to care in this population are highly variable, and that law enforcement plays a more prominent role during the pathway in this sample than do primary care providers. Such investigations may provide insights into service enhancements that can promote early detection and intervention, thereby reducing the duration of untreated psychosis and ultimately improving illness outcomes.

BIOLOGICAL PSYCHIATRY

Moderators: Iqbal Ahmed, M.D., Elizabeth Guinto

-1

HPA AXIS GENES INTERACT WITH CHILDHOOD TRAUMA TO INCREASE THE RISK OF ATTEMPTING SUICIDE

Speaker: Alec Roy, M.D.
Co-Author(s): Mary-Anne Enoch , M.D.,David Goldman,M.D.,Vincenzo DeLuca , M.D., Colin Hodgkinson PhD.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review that childhood tauma is a risk factor for suicidal behavior;2) Review that genetic factors are associated with suicidal behavior;3) Review that HPA axis genes interact with childhood trauma to increase the risk of suicidal behavior

SUMMARY:
Background: Childhood trauma is associated with hypothalamic-pituitary-adrenal (HPA) axis dysregulation. Both factors increase risk for suicidal behavior. Corticotropin releasing hormone (CRH) is a key regulator of the HPA axis through the CRHR1 receptor. The actions of CRH are moderated by a high-affinity binding protein (CRHBP). We hypothesized that CRHBP and CRHR1 variation and the interaction with childhood trauma might influence suicidal behavior. Moreover, there might be an additive effect with FKPB5, another HPA axis gene previously associated with suicidal behavior in this dataset.
Methods: African Americans: 398 patients with substance dependence (90% men, 120 suicide attempters) and 432 non-substance dependent individuals (40 % men, 21 suicide attempters). Cross-sectional study with DSM-IV lifetime diagnoses (SCID). Haplotype-tagging SNPs were genotyped across CRHBP (8), CRHR1 (9) and for completeness, CRH (4) and CRHR2 (11). FKBP5 genotypes were available. The Childhood Trauma Questionnaire (CTQ) was administered. Of the 830 genotyped participants, a total of 474 (112 suicide attempters) completed the CTQ.
Results: Three distal CRHBP SNPs rs7728378, rs10474485, and rs1500 showed a significant interaction with CTQ score to predict suicide attempt. There was an additive effect with FKBP5: in the group exposed to high trauma, the prevalence of suicide attempt was 0.49 in carriers of the FKBP5 rs3800373 major homozygote, 0.40 in carriers of the CRHBP rs7728378 major homozygote and 0.58 in carriers of both major homozygotes. There were significant main effects for one CRHBP and one CRHR1 SNP, both unique to African ancestry.
Discussion: CRHBP may predispose, independently and additively, to suicidal behavior in individuals who have experienced childhood trauma.

-2

JEALOUSY ENDOPHENOTYPE, DOPAMINE AND BRAIN CIRCUITS

Speaker: Donatella Marazziti, M.D.
Co-Author(s): Stefano Baroni, Dr. Biol. Sci; Michele Poletti, Psychologist; Liliana Dell'Osso, MD; Ubaldo Bonuccelli, MD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss recent empirical findings on delusional jealousy in neurodegenerative diseases;2) Propose a core neural network and cognitive processes at the basis of delusional jealousy;3) Promote a discussion if jealousy itself should be considered a symptom endophenotype across distinct nosological categories;4) Suggest how normal jealousy may become delusional and fuel aggressive behaviours

SUMMARY:
Jealousy is a complex emotion characterized by the perception of a threat of loss of something that the person values, particularly in reference to a relationship with a loved one, which includes affective, cognitive, and behavioral components. Neural systems and cognitive processes underlying jealousy are relatively unclear, and only a few neuroimaging studies have investigated them. The authors discuss recent empirical findings on delusional jealousy, which is the most severe form of this feeling, in neurodegenerative diseases. After reviewing empirical findings on neurological and psychiatric disorders with delusional jealousy, and after considering its high prevalence in patients with Parkinson's disease under dopamine agonist treatment, we propose a core neural network and core cognitive processes at the basis of (delusional) jealousy, characterizing this symptom as possible endophenotype. In any case, empirical investigation of the neural bases of jealousy is just beginning, and further studies are strongly needed to elucidate the biological roots of this complex emotion

-3

CHEMICAL BIOTYPES OF DEPRESSION AND INDIVIDUALIZED NUTRIENT THERAPY

Speaker: William J. Walsh, Ph.D.
Co-Author(s): Robert A. deVito, M.D., William J. Walsh, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the laboratory tests and medical history factors that can identify the specific chemical biotype and the most promising medication approach for a patient diagnosed with depression;2) Recognize the role of epigenetic gene regulation in neurotransmitter reuptake processes;3) Recognize individualized nutrient therapies for each biotype that can be used as an adjunct to medication or counseling.

SUMMARY:

Depression is an umbrella term used to describe a collection of disorders with quite different symptoms, traits, and neurotransmission abnormalities. Evaluation of 2,800 patients diagnosed with clinical depression has resulted in a database of approximately 300,000 blood and urine chemistry levels and 200,000 medical history factors. Five major depression biotypes representing about 95% of our patient population were identified. Undermethylation was the largest chemical biotype (38%) with most patients reporting depression, anxiety, OCD tendencies, perfectionism, and a positive response to SSRI antidepressants. Undermethylation of chromatin has been associated with excessive gene expression of SERT and increased serotonin reuptake. Folate deficiency was the next largest biotype (20%), with most patients reporting high anxiety, sleep problems, food and chemical sensitivities, intolerance to SSRIs, and benefits from folate therapy or benzodiazapines. About 17% of depressives exhibited elevated serum copper as the primary imbalance. Most (95%) of the high-copper depressives were females, and a high incidence of post-partum depression, estrogen intolerance, tinnitus, and skin sensitivity was reported. About 15% of our depressive population exhibited pyrrole disorder as the primary chemical abnormality. Most pyrrole patients reported extreme mood swings, fears, anger explosions, poor short-term memory, partial improvements from SSRIs, and benefits from zinc and B-6. The smallest depression phenotype (5%) involved overloads of lead, mercury, or other toxic metals. Laboratory testing, individualized nutrient therapies, and outcome results for this large depression population will be described.

-4

RATE OF PATIENT READMISSION FOLLOWING PSYCHIATRIC HOSPITALIZATION FOR MAJOR DEPRESSIVE DISORDER CORRELATED WITH INNATE CYP2D6 FUNCTION

Speaker: Richard L. Seip, Ph.D.
Co-Author(s): John W. Goethe, M.D., Gualberto Ruano, M.D., Ph.D., Harold I. Schwartz, M.D., Richard L. Seip, Ph.D., Bonnie Szarek, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the prevalence and significance of CYP2D6 drug metabolism deficiencies;2) Assess the utility of CYP2D6 Metabolic Reserve in characterizing and individualâ€™s metabolic phenotype;3) Utilize CYP2D6 MR to improve psychotropic management.

SUMMARY:

Objective: Well-characterized sequence alterations in the CYP2D6 gene occur with significant frequency in psychiatric populations. Many psychotropic medications are known substrates for metabolism by the CYP2D6 isoenzyme encoded by the CYP2D6 gene. Priorly, we had shown that length of psychiatric hospitalization was longer, dyslipidemic side effects more pronounced, and psychotropic utilization more intricate in patients with sub-functional CYP2D6 status (APA annual meetings 2010, 2011, 2013). We hypothesized that innate CYP2D6 functional status was also related to hospital re-admission following psychiatric hospitalization for major depressive disorder (MDD).
Methods: We examined a cohort of 149 psychiatric patients with MDD admitted for hospitalization and subsequently discharged from the Hartford Hospital Institute of Living with ICD9 codes 296.20, 296.22, 296.23, 296.24, 296.25, 296.30, 296.31, 296.32, 296.33, 296.34. After the hospitalization, patients were followed for hospital readmission 30 days post discharge. CYP2D6 functional status was determined in each patient by genotyping 19 CYP2D6 alleles and quantified according to the Metabolic Reserve (MR) Index. MR is based on the combinatorial genotypes of null, deficient, functional, and rapid alleles for each patient, ranging for CYP2D6 from a low of 0 (2 null alleles) to a high of 3.0 (gene duplication or 2 rapid alleles). We grouped patients into categories of Sub-functional (CYP2D6 MR ≤1.5, N = 66 patients, 44%), Functional (CYP2D6 MR of 2.0 to 2.5, N = 70, 47%), or Supra-functional (CYP2D6 MR Index = 3.0, N = 13, 9%) metabolizer status and tested for differences in psychiatric hospital readmission 30 days after discharge across these 3 categories using the chi square test.
Results: The number of patients re-admitted 30 days after discharge was 8, for a readmission rate of 5.4% (8/149). If proportional to the cohort, the sub-functional, functional, and supra-functional categories would have had 3.5, 3.8, and 0.7 patients. Instead, the categories had 4, 2, and 2 patients, respectively. The readmission rate was 5.9% (4/66) for patients with sub-functional metabolizer status, 2.9% (2/70) for patients with Functional metabolizer status, and 15.4% (2/13) for patients with supra-functional metabolizer status (trend for between group difference, $p<0.17$). Those readmitted within 30 days had a significantly higher rate of hospitalization within the past year (7/8, 88% vs. 69/140, 49%, $p<0.036$) and trended to prescription of a greater number of antidepressants (3.1 Â± 1.5 vs. 2.2 ± 1.9, $p<0.09$).
Conclusion: Innate CYP2D6 functional status, among other factors, may affect 30 day readmission rate after psychiatric hospitalization in MDD patients. Research to investigate this possibility in a larger cohort is ongoing at our center and will be described. Pharmacogenetics is not only a tool for improved psychiatric patient care, but also for optimization of resource utilization in hospitals.

PRIMARY CARE AND PHARMACOLOGIC TREATMENT FOR CHRONIC PSYCHIATRIC PATIENTS

Moderators: Nitin Gupta, M.D., Sri Venkata Uppalapati, M.D.

-1

TREATING PSYCHOTIC PATIENTS WITH AGONIST OPIOID

THERAPY AND ATYPICAL ANTIPSYCHOTICS
Speaker: Maria Chiara Pieri, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Improve the assessment of patients;2) Improve patient care;3) Improve monitoring and follow-up patient with addiction and psychiatrics disorders;4) Value outcome of patients;5) Improve compliance in treatment of patient

SUMMARY:
The aim of the study is
To evaluate the efficacy of olanzapine in patients maintaining methadone;
2. To explore time-course variation of craving and weight at baseline and every 2 months for the first 6 months and then every 6 months until the end of the study (30th months).
3. To compare symptoms severity between patients on methadone and patients on buprenorphine
Patients were enrolled from the East Out-patient Addiction Unit (SER.T) of Bologna, Italy. All signed a written informed consent. 32 received methadone and 13 buprenorphine. 36 were included into three treatment subgroups At baseline and follow-up sessions the following rating scales were administered: The Minnesota Multiphasic Personality Inventory-2 (MMPI-2), The Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II), Bech-Rafaelsen Mania and Melancholia Scales (BRMAS, BRMES; Bech et al. 1988) covering severity of manic and depressive symptoms respectively. The VAS (Visual Analogic Scale) to quantify craving for drugs
Statical result A significant difference was found among the 3 subgroups in Baseline, Supplementary and Content Scale. The frequency of personality disorders at baseline was 72.2%. At the end of study, significantly reduced BRMES and BRMAS scores were found in all subgroups, particularly in the "olanzapine+methadone" subgroup.
Total and partial at BRMES and BRMAS scores did not significantly change during the follow-up period (6th-30th month), even if the curve displays a downward trend. VAS total scores were significantly lower both at 6th and 30th month
None of the three treatments induced a significant weight gain both after 6 months (at this time session we observed better results. The association of methadone to olanzapine even in presence of subthreshold psychiatric symptoms improve treatment adherence in substance abusers

-2
USE OF ANTIPSYCHOTICS AND ACCESS TO GUIDELINE-BASED SERVICES FOR YOUTH ON ANTIPSYCHOTICS
Speaker: Emily Leckman-Westin, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand current recommendations for the use of antipsychotics for youth;2) Appreciate the prevalence of potential overuse of antipsychotics and the prevalence of appropriate service use patterns for youth on antipsychotics relative to guideline-based care;3) Recognize the characteristics of youth with increased risk for potential overuse of antipsychotics, or low access to appropriate services for those on an antipsychotic.

SUMMARY:
Concerns around antipsychotic use in youth have gained national attention as reflected in introduction of new federal mandates for monitoring, proposed development of antipsychotic focused quality measures under CHIPRA, and recent articles in the lay press. In the current study we examine patterns of use of antipsychotics and access to appropriate services for youth receiving antipsychotics in the Medicaid program relative to current clinical practice guidelines. Methods. All youth (0-21 years of age) from 11 states in the Medicaid Analytic Extract (MAX) files were used to examine 4 measures of antipsychotic utilization and 6 measures of appropriate service use for youth on antipsychotics. MAX files provide data on beneficiary characteristics such as age, sex, and race/ethnicity, eligibility, dual (Medicaid-Medicare) eligibility, urbanicity, managed care participation, diagnoses, prescription and service utilization and expenditure summaries for the calendar year 2008. Results. Overall, use of antipsychotics among children under age 6 was extremely low (0.15%). Six percent (6.6%) of youth on antipsychotics had evidence of polypharmacy; 10.7% experienced a higher than recommended dose; and 53.7% of youth on an antipsychotic had no evidence of a primary diagnosis consistent with an antipsychotic indication. Among new starts of an antipsychotic, less than half (42.9%) had a psychosocial service prior to the start and 5.4% had had both glucose and lipid baseline screening. Finally 70.1% had evidence of a follow-up visit with a prescriber within 30 days of the new start. Among those with evidence of ongoing antipsychotic use, ongoing follow-up visits for every 90 days on an antipsychotic was 86.4% while 64.5% had evidence of one or more psychosocial visit in the past year. Metabolic monitoring rates were low, with 18.1% of the population receiving both the glucose and the lipid screening in the past year. Prevalence of measures varied by state and by youth characteristics. Conclusions: Measures of use of antipsychotic medications among youth, and access to appropriate services for youth receiving antipsychotics suggest opportunities for improving quality of care.

-3
CHALLENGES IN INTEGRATING MEDICAL CARE INTO A COMMUNITY MENTAL HEALTH CENTER
Speaker: Ludmila De Faria, M.D.
Co-Author(s): Sue Conger, LCSW

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Highlight improved outcomes for patients included in the program;2) Explore opportunities for further growth and implementation of fully integrated care to the remaining area served;3) Describe efforts and obstacles encountered in integrating care in a Community Mental Health Center

SUMMARY:
Psychiatric patients diagnosed with severe and persistent mental illness (SPMI) are known to have increased morbidity and mortality, with decreased life expectancy. Contributing factors include premature cardiovascular disease and metabolic syndrome. Risk factors associated with the development of chronic medical problems include smoking, self-neglect, unhealthy lifestyles and medication side-effects. On the other

hand, SPMI patients are more likely to see a doctor for mental health conditions rather than for physical conditions. Barriers to seeking care in a medical setting include difficult access and communication between primary care and mental health providers. In an effort to integrate the medical care of this population, our large Community Mental Health Center partnered with a local primary care FQHC to offer onsite medical care. BAWIC (Bond-Apalachee Wellness Integration Clinic) was started in 2011 as part of the PBHCI (Primary and Behavioral Health Care Integration) SAMHSA effort. Data collected shows that 326 clients were enrolled in the program since its implementation. There was improvement in all health indicators monitored. Our data is consistent with literature reports that mental health setting can be a viable and effective "medical home" for SPMI clients. Because of the initial success, there is an effort to develop a sustainable integrated program that can be expanded to provide similar services to all 8 counties served by our community mental health center. Barriers identified include financial sustainability, facilities and structural issues, lack of common electronic medical records and staffing.

INPATIENT PSYCHIATRY

Moderators: Jerome Taylor, Duncan Cheng

-1

ANHEDONIA PREDICTS POST-HOSPITAL COMMUNITY TENURE IN TREATMENT-RESISTANT SCHIZOPHRENIA

Speaker: Vassilios Latoussakis, M.D.
Co-Author(s): Adam Savitz, M.D., Ph.D., Marcie Katz, LCSW, Donna Anthony, M.D., Ph.D., Christopher F. Murphy, Ph.D

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) identify risk factors for re-hospitalization in schizophrenia;2) Recognize common rating instruments for assessing cognition and symptomatology in schizophrenia;3) Appreciate the potential role of hedonic tone in schizophrenia decompensations

SUMMARY:

Introduction:
Stable community tenure after a psychiatric hospitalization in schizophrenia patients is a discrete functional outcome with personal as well as public health significance. Except for substance use and medication non-compliance, predictors of stable community tenure among the severely and persistently mentally ill patients with schizophrenia are poorly understood. This study focused on psychopathological predictors of such tenure.
Hypothesis: We hypothesized that in treatment-resistant schizophrenia patients discharged from a long-stay inpatient social learning program, less negative symptoms (but not positive symptoms) and better cognition would predict stable community tenure.
Methods: 78 subjects (ages 21-65) with schizophrenia or schizoaffective disorder were longitudinally followed post-discharge from an inpatient social learning program.
Symptoms and cognitive function were assessed at discharge with the Brief Psychiatric Rating Scale (BPRS), Scale for the Assessment of Negative Symptoms (SANS), and the California verbal learning test (CVLT). Community tenure was assessed 6- and 12- months post-discharge.
Separate logistic regressions were used on each set of clinical subscales (SANS and BPRS) to test if these variables predicted community survival at 1 year. Significant omnibus tests were followed with univariate tests.
Results: At 6- and 12-monthspost-discharge, 51 and 40 patients were still in the community respectively with the remainder hospitalized, eloped from the residence, or lost to follow-up. Of the SANS subscales, only the anhedonia-asociality subscale predicted group membership (survivor/non survivor) at one year, Chi Square (1, N = 77) = 7.5, p = .006. None of the BPRS subscales nor any of the CVLT measures predicted community tenure.
Conclusions: A specific aspect of negative symptomatology at discharge, the ability to experience interest or pleasure as well as being involved in social relationships of various kinds, predicted "survival" in the community at 12 months in chronic, treatment-resistant patients with schizophrenia.
Discussion: Existing literature connects negative symptoms with various functional outcomes in schizophrenia. The present finding suggests that, in severely and persistently mentally ill patients, the inability to experience or anticipate pleasure as well as poor involvement in various social relationships is related to unstable community tenure. Further work may focus on: 1) how those deficits relate to more proximal causes of re-hospitalization such as substance use, medication or treatment non-compliance and 2) on the role of psychopharmacological or psychosocial rehab work on optimizing hedonic potential and social skills.

-2

INPATIENT STAY, LENGTH OF STAY, AND USE OF TELE-PSYCHIATRY IN A CRISES UNIT: PRELIMINARY FINDINGS

Speaker: Mohammed H. Daher, M.D.
Co-Author(s): Alicia Barnes, DO, Adaure Akanwa, Andre Pumariega, MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the association between telepsychiatry and length of stay;2) Recognize the usefulness of tele psychiatry;3) Recognize the impact of telepsychiatry on the impact of utilization services.

SUMMARY:

Background: Telepsychiatry is a recognized means of providing access to psychiatric services for underserved areas. However, data on services utilization variables, such as comparative admission rates and length of stay (LOS) between telepsychiatry and face-to-face (FTF) services, are non-existent. We wanted to evaluate the impact of telepsychiatry on these variables and thus performed this study.
Hypothesis: We tested the hypothesis that there is a difference in admission rates and LOS for patients evaluated by telepsychiatry in comparison to FTF.
Setting: Crises unit and associated short-term inpatient psychiatric unit located in Southern New Jersey
Methods: We chose a two-tailed T-test because of the uncertainty of whether the use of telepsychiatry increased or decreases LOS.

The experimental group (n=200) is composed of patients evaluated through telepsychiatry physicians. The control group (n=541) is composed of patients evaluated by FTF services by the same physician. The primary outcome variable is LOS. Two-tailed T-test and Chi Square test were used to determine statistical significance between the groups. Secondary outcomes include admission rates and one-month readmission rate.
Results: Patients evaluated by telepsychiatry had significantly lower LOS compared to FTF (6.01 days; n=82) vs. 5.06 days (n=81), t = -2.24, df=158, p=0.027). Percent of admissions were significantly higher for telepsychiatry than FTF (Chi square= 57.84, p = 2.836E-14). (See Table 1 for full results.) T-test also demonstrated showed significant differences in LOS for white race, patients living in private residence, and involuntary status. A higher readmission rate 30 days after initial crises visit for telepsychiatry was found (chi square= 0.67, p= 0.41). There was no difference in LOS for age, gender, black and Latino races, diagnosis, group home and homelessness, medical comorbidity, substance use, and type of insurance
Discussion: Our hypothesis that there were significant differences between evaluating patients by telepsychiatry vs. FTF in a crises unit was supported. This difference could be explained by the fact that the telepsychiatrist spent shorter time in evaluating patients, depend more on screeners and nurse evaluations and thus may practice more defense medicine. The telepsychiatrist thus admit less severely ill patients compared to FTF, so as a result telepsych patients have a shorter LOS. Physicians are evaluating more of the cases that are “on the fence” by FTF, thus explaining the lower admission rate by FTF.
Limitations: Data was not normalized. The study was not randomized. nurses and screeners sometimes selected which patients were “good” for telepsychiatry and which were “good” for FTF.
Conclusion: Evaluating patients by telepsychiatry in a crises unit has an association with shorter length of stay compared to patients evaluated FTF; but, conversely, a significantly higher rate of admissions.

-3

RESILIENCE AND PSYCHOPATHOLOGY: A POSSIBLE DETERMINANT OF HOSPITALIZATION

Speaker: Amresh K. Shrivastava, M.D.
Co-Author(s): Amresh Srivastava, MD, DMP.MRCPsych.FRCPC, Robbie Campbell RFCPC.,Cheryl Frock. Ph.D., Megan Johnston Ph.D., Coralee Belmont, MA, Larry Stitt, M.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand association of resilience and stress in adult psychiatric disorders;2) Understand how resilience is related with determinants of hospitalization;3) Understand what changes are required in clinical practices based upon significance of resilience in psychopathology of psychiatric disorders

SUMMARY:
Resilience has two important aspects of individual’s response to trauma. Firstly, it is a dynamic process enabling an individual to successfully adapt to severe adversities. Secondly, it is an individual’s capacity to change swiftly to newer adaptation after experiencing adverse situations. However it is important to understand that resilience is not merely characterised by absence of psychopathology. It is a positive trait of an individual,Resilience is a positive psychological traits which has a neurobiological mechanism associated with abnormality in neurochemistry, neuronal connectivity, epigenetics and neuroimaging. It enables one to adapt to environmental challenges, overcome adversity and protects against psychopathology. We hypothesize that resilience is involved in relapse and hospitalization. In this prospective, cross sectional, cohort study done at the RMHC St Thomas, we examined the level of resilience amongst hospitalized patients for clinical and endocrinal correlates. The study showed that demographic and clinical characteristics were comparable for patients with single and repeated hospitalization. In our sample the level of resilience had positive correlation with stressful situation (HRSS; r =0.405, p=.036) and life events in previous one year (r=0.406, p=.017) possibly due to severe psychopathology. There was a negative correlation with suicidality (SISMAP, r=-0.424, p=.12; CD-RISK <60 vs. > 60, SISMAP score (35.1 vs. 22.8 p=.004) Resilience had inverse relationship with hospitalization, psychopathology and suicidality. A direct correlation with testosterone and cholesterol levels and a negative correlation with thyroid suggests an interrelationship between suicide, depression and resilience. Amongst single (N=12) and repeatedly (N=22) admitted patients there was neither any difference in level of resilience (CD RISK-Total 49.1 Vs.51.7 p=.657, CD-RISK >40, 10 Vs.17 p >.999; CD-RISK >60, 3 Vs. 5 p >.999) nor any correlation with hospitalization on any parameter of study except for a negative correlation with life events in past one year (r=-0.357, p=.038). There was a trend to suggest presence of a critical window or â€“ cut-off point suggesting limitation in effectiveness of resilience in severe mental disorders. We conclude that overall, resilience has a positive effect of individual’s mental health, suicidality and psychopathology. Low resilience is possibly an attribute of hospitalized patients. Results from a larger sample will be more helpful. References (1) Jeste DV, Palmer BW. A call for a new positive psychiatry of ageing. Br J Psychiatry. 2013 Feb; 202:81-3. (2) Rutter M. Resilience as a dynamic concept. Dev Psychopathol. 2012 May; 24(2): 335-44. (3) O’Hara R, Marcus P, Thompson WK, Flouncy J, Vahia I, Lin X, Hallmayer J, Depp C, Jeste DV. 5-HTTLPR short allele, resilience, and successful aging in older adults. Am J Geriatr Psychiatry. 2012 May; 20(5):452-6.

COGNITION IN SCHIZOPHRENIA

Moderators: Elias Shaya, M.D., Narissa Etwaroo

-1

WHAT CAN NEUROLOGICAL SOFT SIGNS TELL US ABOUT FIRST-EPISODE PSYCHOSIS?

Speaker: Yazeed S. Alolayan, M.B.B.S.
Co-Author(s): Sean D. Cleary, Ph.D., Claire Ramsay Wan, M.P.H., Michael T. Compton, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify at least five neurological soft signs commonly observed in patients with schizophrenia, as measured by the Neurological Evaluation Scale;2) Understand the subscales of the Neurological Evaluation Scale derived using factor analytic techniques;3) Recognize the relation of neurological soft signs

to potential subtypes of schizophrenia and other psychotic disorders.

SUMMARY:
Neurological soft signs are subtle abnormalities in sensory integration, motor coordination, and sequencing of motor tasks, which do not localize a specific lesion in the nervous system. Neurological soft signs have been studied extensively in chronic schizophrenia, and to a lesser extent in first-episode psychosis. We measured neurological soft signs with the most commonly used instrument, the Neurological Evaluation Scale in a large sample of patients with first-episode psychosis (n=230). To derive the ideal subscales within this sample, we conducted an exploratory factor analysis on a randomly drawn subsample (n=100) and then a confirmatory factor analysis on the other subsample (n=130). We then used cluster analysis to determine how patients clustered with regard to the derived Neurological Evaluation Scale subscales. Using canonical correlation analysis, clusters were examined in terms of demographics (e.g., age, gender, education), other background variables (e.g., handedness, premorbid functioning), clinical characteristics (e.g., family history, age at onset of psychosis, mode of onset of psychosis, length of index hospitalization, medication dosage), symptom profiles (e.g., positive and negative symptoms) and neurocognition (e.g., premorbid intelligence and a variety of neurocognitive domains). Findings on this trait marker are informative with regard to subtyping first-episode psychosis, which is of importance to refining nosology.

-2
NEUROCOGNITION IN PSYCHOSIS
Speaker: Raquel E. Gur, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Examine neurocognitive deficits in schizophrenia;2) Evaluate neurocognitive functioning in youths with psychotic symptoms;3) Relate neurocognition to clinical status

SUMMARY:
Cognitive deficits are evident in individuals with psychotic disorders. In schizophrenia, the impairment is associated with poor functional outcome. Furthermore, psychosis-prone youths also show impaired performance before symptoms meet diagnostic criteria. This presentation will first highlight the literature where diverse measures of neurocognitive domains have been applied with consistent findings implicating fronto-temporal dysfunction. Against this background, data will be presented on the application of a computerized neurocognitive battery that examines accuracy and response time on tests that evaluate executive (abstraction and mental flexibility, attention, working memory), memory (verbal, facial, spatial), cognition (language, non-verbal reasoning, spatial processing) and social cognition (emotion identification, emotion differentiation and age discrimination) domains. Individuals with schizophrenia are impaired in accuracy and response time in multiple domains compared to those endorsing sub-threshold psychotic symptoms.

-3
SET-SHIFTING DIFFICULTIES IN VIOLENT PATIENTS WITH SCHIZOPHRENIA ARE RELATED TO PSYCHOPATHY AND IMPULSIVITY.
Speaker: Menahem I. Krakowski, M.D., Ph.D.
Co-Author(s): Pal Czobor, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify personality and cognitive risk factors for violent behavior in patients with schizophrenia;2) Understand better the interactions which exist between specific cognitive impairments and traits, such as impulsivity and psychopathy, resulting in violent behavior;3) Understand the direct and indirect role that psychopathy and impulsivity play in the emergence of violent behavior in schizophrenia.

SUMMARY:
Background: Violence in schizophrenia has been associated with deficits in executive functioning including deficits in task switching.
Methods: We used a task-switching paradigm (TS) to investigate set shifting ability in violent (VS, N=25) and non-violent (NV; N=22) patients with schizophrenia and healthy controls (HC; N=22). Psychopathy was evaluated with the Psychopathy Checklist (PCL-SV), impulsivity with the Barratt Impulsiveness Scale (BIS-11), while visual memory was assessed with the Wechlser Figural Memory test.
Results: PCL-SV total score was higher in the VS's than in the HCs and in the NV's (F=19.9;df=2,67, p<.001). Visual memory was poorer in the NV's than in the other two groups (F=7.8;df=2, 67, p<.001). On the TS paradigm, VS's and NV's evidenced more impairments than HC's when incongruent stimuli were presented (F=9.6, df=2,67 p<.001). There were no differences between the VS's and the NV's, but the correlates of these deficits were different in the two groups. In VS's, the total number of errors on incongruent trials was related (Spearman rho) to the BIS-11 Total score (r= .52, N=25, p<.01) and to the PCL-SV Total score (r=.54, N=25, p<.01). These relationships were absent in the NV's. In NV's, the total number of errors on incongruent stimuli was related to visual memory deficits (r=-.53,N=22, p=.01).
Conclusion: Set shifting difficulties with incongruent stimuli reflect distinct abnormalities in VS's and NV's. In VS's they are part of an underlying cognitive-personality deficit; in NV's they are associated with visual memory impairment.

PRIMARY CARE: INTEGRATING PREGNANCY AND EATING DISORDER TREATMENT

Moderators: Kasey Riquelm, Stephanie Peglow

-1
WHAT HAPPENS TO MENTAL HEALTH TREATMENT DURING PREGNANCY? WOMEN'S EXPERIENCE WITH PROVIDERS
Speaker: Linda Weinreb, M.D.
Co-Author(s): Nancy Byatt, DO, MBA, Department of Psychiatry and Obstetrics & Gynocology, University of Massachusetts Medical School, Tiffany A. Moore Simas, MD, MPH, Department of Obstetrics & Gynocology, University of Massachusetts Medical School

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the prevalence and impact of depression during pregnancy and in the postpartum period including its adverse effect on pregnancy, birth, and infant outcomes ;2) Understand what is known about pregnant womenâ€™s participation in mental health treatment and their experiences when interacting with treatment providers;3) Describe how womenâ€™s experiences interacting with mental health and primary care treatment providers during pregnancy may impact clinical practice and patients outcomes

SUMMARY:

Objective: Despite the availability of effective treatment options, most pregnant women with depression do not get treatment. Anecdotal reports raise concern that providers may drop women from care entirely. This exploratory study aims to: (1) elucidate experiences of women receiving depression medication at the point they learned of their pregnancy; (2) explore whether pregnant women were given opportunities to discuss risks/benefits of medications with prescribing providers or were referred for other treatments; and, (3) identify gaps in clinical care among pregnant women who may need psychopharmacological depression treatment.
Methods: We conducted a descriptive exploratory study with a convenience sample of English-speaking pregnant women aged 18-45. A structured interview was completed with 25 pregnant women who screened positive for depression (Edinburgh Postnatal Depression Scale ≥ 10) and received medication for depression when becoming pregnant or tried to get mental health care during pregnancy. Descriptive analyses were conducted.
Results: Of 219 women invited to participate, 110 (50%) consented to EPDS screening. Forty-one percent (n=46) had EPDS scores ≥ 10. Twenty-five of 46 women (54%) indicated receiving treatment with depression medication from a mental health or primary care provider (PCP) when they learned of their pregnancy (n=17) or tried to obtain mental health treatment during pregnancy (n=8). Of the subset of 17 women, 100% had a history of depression prior to being screened yet 35% were not receiving depression treatment. While 94% of women told their prescribing provider of their pregnancy, 36% reported that they had no opportunity to discuss benefits and risks of continuing medication and 42% were not given a chance to continue medication.
Conclusion: Despite the negative impact of treated depression during pregnancy, some providers may be reluctant to treat pregnant women with depression. Our study suggests that some women: (1) are dropped from depression care upon after telling their providers they are pregnant; (2) may not discuss the risks and benefits of using psychotropic medications during pregnancy; and, (3) do not get linked with ongoing mental health care when providers are reluctant to continue mental health care.

-2

SCREENING FOR PTSD IN PRENATAL CARE IN HIGH-RISK POPULATIONS: IMPORTANCE IN IDENTIFICATION AND SERVICE PROVISION TO PROMOTE HEALTHY PREGNANCY OUTCOMES

Speaker: Linda Weinreb, M.D.
Co-Author(s): Carole Upshur, EdD, Department of Family Medicine and Community Health, University of Massachusetts Medical School; Melodie Wenz-Gross, Ph.D., Department of Family Medicine and Community Health and Department of Psychiatry, University of Massachusetts Medical School; Jennifer Jo Averill Moffitt, CNM, Family Health Center of Worcester

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the association of PTSD to poorer pregnancy outcomes;2) Describe a feasible PTSD screening process in prenatal care settings;3) Describe implications of study findings for psychiatric practice and linkage with obstetrical care settings

SUMMARY:

Background: PTSD during pregnancy has been linked to drug and alcohol use, smoking, poor prenatal care and excessive weight gain, preterm birth, low birth weight, ectopic pregnancy and other problems. Women with a history of abuse are at risk for parenting problems and increased barriers to breastfeeding. For those who have experienced sexual abuse, obstetric procedures and pregnancy may trigger PTSD symptoms and avoidance of prenatal care. Despite these issues, screening and treatment for trauma-related stress symptoms in this population within obstetrical care settings is rare, and there is little data on prevalence.
Method: Two prenatal care programs located within community health centers participated in a pilot study to test the feasibility and effectiveness of screening for PTSD using the PC-PTSD, a four question screen with a yes/no response format that asks about symptoms without asking about specific traumas. Those who answer “yes” to at least two of the four questions are considered to have clinical or sub-threshold symptoms of PTSD.
Results: 621 pregnant women (7% Asian, 23% Black, 51% Hispanic, 15% White, and 3% other) were screened across two sites between 9/14/12 and 8/31/13 (screening will continue and updated figures will be reported). Of these 109 (19%) screened-in. Breakdowns by race/ethnicity and numbers of trauma symptoms will be reported.
Conclusions: Given the risk of PTSD for pregnancy outcomes, and the prevalence in ethnically and economically diverse community health center prenatal settings, a simple tool to screen for PTSD, along with referrals to appropriate psychiatric services and enhanced communication between psychiatry and obstetric providers, may greatly improve prenatal and postpartum health.

-3

A NOVEL INTEGRATED JOINT OBSTETRICS AND PSYCHIATRIC CLINIC IN A NORTH EAST LONDON TEACHING HOSPITAL

Speaker: Olivia Protti, M.D.
Co-Author(s): Livia Martucci, M.D., PhD, Farida Bano, M.D., Mary Brennan, registered Midwife

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognise the importance of early detection of mental illness in pregnancy to improve the quality of patients care. A novel interspecialty service provides effective treatment for high risk patients;2) All pregnant women in the UK are screened for mental illness at initial maternity booking. Early detection integrates with the joint psychiatric-obstetric clinic according to the risk pathways;3) We aim to describe our joint

treatment and management of mentally ill patients and the improvement in maternal, neonatal and psychiatric outcomes for the high risk psychiatric population;4) To demonstrate the efficacy of this treatment model, patient satisfaction surveys, obstetricians, psychiatrists, general practictioners and midwives feedback surveys will also be presented.

SUMMARY:

A novel integrated joint Obstetrics and Psychiatric clinic in a North East London teaching hospital

Background: Psychiatric disorders were identified as the leading cause of indirect maternal death in the confidential enquiry into maternal and child health in the UK (CMACE). CMACE recommends that specialist Perinatal Psychiatric teams should be available to every maternity network to assist in the management of women who are at risk of becoming ill and to those who already are currently unwell.
As per the CMACE and NICE recommendations, high risk patients were identified early and were followed up appropriately in the dedicated joint Obstetric and Psychiatric Perinatal mental health clinic (PNMH) clinic. These patients had a clear management plan which included system of close supervision after delivery.
Objectives: The aim of this presentation is to describe a new model of joining the antenatal obstetric clinic with a specialist perinatal psychiatric clinic, and a holistic pathway of care for women at high risk of acute psychiatric deterioration in pregnancy and in the puerperium.
Methods: Data was collected from E3/RIO (online clinical records) and the review of case notes.
Between March 2011 and October 2012, a total of 115 patients with diagnoses of psychotic depression, puerperal psychosis, bipolar affective disorder, schizophrenia /schizoaffective disorder, severe eating disorder or personality disorder and severe OCD were identified either at booking or during the antenatal period and were referred to the joint clinic.
Results: The presentation will include improved obstetrics, neonatal and psychiatric outcomes of pregnant women with severe mental illness (SMI) who attended the joint clinic, compared to the outcomes prior to the establishment of the joint PNMH clinic.
Patient satisfaction surveys, Consultant Obstetrician, psychiatrist , trainees, General Practictioners and Midwives feedback surveys will also be discussed.
Conclusion: This holistic pathway of care for pregnant women with a history of mental illness improves the outcomes for both mother and infant, as well as patients' experience and engagement.

-4

TREATMENT OF BINGE EATING DISORDER IN ETHNICALLY DIVERSE OBESE PATIENTS IN PRIMARY CARE

Speaker: Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize effective cognitive-behavioral and pharmacologic treatments for binge eating disorder in obese persons;2) Understand treatment outcomes achieved with self-help cognitive-behavioral and pharmacologic treatments delivered in primary care settings to obese patients with binge eating disorder;3) Apply these findings to the evaluation, treatment, and research of obese patients with binge eating disorder

SUMMARY:

Objective: The objective was to determine whether treatments with demonstrated efficacy for binge eating disorder (BED) in specialist treatment centers can be delivered effectively in primary care settings to ethnically/racially diverse obese patients. Two randomized controlled clinical trials (RCT) were performed in primary care settings. The first RCT compared the effectiveness of a self-help version of cognitive behavioral therapy (shCBT) and an anti-obesity medication (sibutramine), alone and in combination for BED. The second RCT compared the effectiveness of shCBT to usual care (UC).
Method: In the first RCT, 104 obese patients with BED (73% female, 55% non-white) were randomly assigned to one of four 16-week treatments (balanced 2-by-2 factorial design): sibutramine (N=26), placebo (N=27), shCBT-plus-sibutramine (N=26), or shCBT-plus-placebo (N=25). Medications were provided double-blind. Independent assessments were performed throughout treatment, post-treatment and at 6- and 12-month follow-ups. In the second RCT, 48 obese patients with BED were randomly assigned to either shCBT (N=24) or UC (N=24) for four months and independent assessments were performed monthly and at post-treatment.
Results: For the first RCT, mixed-models analyses (intent-to-treat using all available data) revealed significant time ($p<0.001$) and sibutramine-by-time interaction ($p=0.0009$) effects for percent BMI loss, with sibutramine ($p<0.001$) but not placebo ($p=0.98$) associated with significant change over time. Percent BMI loss differed significantly between sibutramine and placebo by third month of treatment and at post-treatment, but no longer significant once the double-blind medication was discontinued at 6- and 12-month follow-ups. For binge-eating, mixed-models analyses revealed significant time ($p<0.001$) and shCBT-by-time interaction effects ($p=0.05$); shCBT had significantly lower binge-eating at 6-month ($p=0.04$) but the four treatments did not differ significantly at any other time point. In the second RCT, binge-eating remission rates did not differ significantly between shCBT (25%) and UC (8%). Mixed models revealed significant decreases for both conditions but that shCBT and UC did not differ in binge-eating frequency or on associated eating psychopathology levels.
Conclusions: Findings from the first RCT suggest that pure self-help CBT and sibutramine did not show effectiveness relative to placebo for treating obese patients with BED in primary care. The second RCT found that pure-self CBT did not show effectiveness relative to usual care in generalist settings. Collectively, the findings suggest that future studies tested guided self-help methods for delivering CBT and that obesity medications may need to be maintained longer.

INTEGRATING PSYCHIATRIC ILLNESS TREATMENT INTO PRIMARY CARE

Moderators: Britta Ostermeyer, M.D., Narissa Etwaroo

-1

DEPRESSION PREDICTS USE OF URGENT CARE IN PATIENTS WITH LONG TERM PHYSICAL ILLNESS

Speaker: Elspeth Guthrie, M.D.
Co-Author(s): Chris Dickens, Carolyn Chew-Graham, Amy Blakemore, Barbara Tomenson, Cara Afzal

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Determine what factors are independently associated with use of urgent care in a primary care population with chronic physical illness;2) Determine whether depression is an independent predictor of use of urgent care in a primary care population with chronic physical illness;3) Determine what severity of depression is associated with future use of urgent care in a primary care population with chronic physical illness.

SUMMARY:
We undertook a longitudinal, prospective study based in primary care in the UK. 1860 patients were recruited from primary care records who had a diagnosis of one of the following 4 long term conditions: diabetes, ischaemic heart disease, COPD and asthma. Patients completed a questionnaire about physical and mental health, including, soico-demographics, the Hospital Anxiety and Depression Scale (HADS), physical co-morbidty and life stressors. 80% gave permission for their medical records to be checked and data about emergency hospital admissions was recorded for the year prior to completion of the questionnaire and the year following.
Out of the baseline cohort of 1411 patients, whose GP notes were reviewed, 216 (15.3%) had had an emergency admission in the year prior to completing the questionnaire. During the prospective follow-up period of 12 months, out of 1398 GP records that were assessed, 234 (16.7%) patients had at least one emergency admission to hospital. Univariate analyses showed that having an emergency admission in the year prior to completion of the questionnaire and the year following was associated with the following: female gender; age; having no partner; poor education; not working due to ill health; stomach or bowel problems; having a threatening life experience; living closer to an emergency department; having more severe disease and having more long term conditions; and having a HADS score of 8 or more.
The logistic regression model for having an emergency hospital admission in the prospective study year following completion of the questionnaire included the following variables:having no partner OR 1.53 95% CI(1.06 to 2.19); having ischaemic heart disease OR 1.59 95% CI (1.04 to 2.44); having a threatening life experience (OR 1.15 (1.03 to 1.28); having an emergency admission to hospital in the year prior to ression model for having an emergency hospital admission in the prospective study year folowing completion of the questionnaire included the following variables:having no partner OR 1.53 95% CI(1.06 to 2.19); having ischaemic heart disease OR 1.59 95% CI (1.04 to 2.44); having a threatening life experience (OR 1.15 (1.03 to 1.28); having an emergency admission to hospital in the year prior to completing the questionnaire OR 3.51 95% CI (2.05 to 6.00)and a HADS depression score or 8 or more OR 1.61 95% CI (1.07 to 2.43) .
When the HADS scores were divided into quintiles, worsening depression scores were associated with an increased risk of an emergency hospital admission, with a baseline score of 11 or more on the HADS depression scale more than doubling the risk of requiring an emergency hospittal admisson in the prospective year, after adjusting for all relevant co-variates OR 2.33 95%CI (1.09 to 4.96).
This is the first UK primary care study to show that depression is independently associated with future use of urgent care in patients with chronic physical disease.

-2
DEPRESSION AND CHRONIC DISEASES: IT IS TIME FOR A SYNERGISTIC MENTAL HEALTH AND PRIMARY CARE APPROACH
Speaker: Boris Voinov, M.D.
Co-Author(s): William D. Richie, MD, DFAPA; Rahn K. Bailey, MD, DFAPA;
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the growing significance of depression as a global leading cause of years lost to disability and its role as a major independent risk factor in many chronic illnesses.;2) Recognize the distinct effects of depression on morbidity and mortality in cancer, diabetes, heart disease, and stroke;3) Identify behavioral factors and plausible biological mechanisms (psychoneuroimmunology of depression).

SUMMARY:
Objective: To identify the growing significance of depression as a global leading cause of years lost to disability and its role as a major independent risk factor in many chronic illnesses. The distinct effects of depression on morbidity and mortality in cancer, diabetes, heart disease, and stroke are investigated, including behavioral factors and plausible biological mechanisms (psychoneuroimmunology of depression).
Data Sources: PubMed articles in English were searched from 1992 to 2012 (20-year span) using the following search criteria: psychoneuroimmunology of depression, immune-mediated inflammation, depression treatment recommendations, depression screening, years lost to disability, underserved populations and depression, chronic illnesses and depression, and selective serotonin reuptake inhibitors and immune system.
Data Synthesis: Evidence of the robust bidirectional relationship between depression and individual chronic diseases is presented and discussed. A brief overview of currently recommended psychotherapeutic and psychopharmacologic treatment approaches in regard to depression in chronic diseases is provided.
Results: Discordance between mental health and primary care within the US public health system is a systematic problem that must be addressed. This situation leads to a potentially high hidden prevalence of underdiagnosed and undertreated depression, especially in the underserved populations.
Conclusion: Measures must be implemented across the communities of mental health and primary care practitioners in order to achieve a synergistic approach to depression.

-3
WHY ARE YOU HERE AGAIN? CONCORDANCE BETWEEN CONSUMERS AND PSYCHIATRISTS ABOUT THE PRIMARY CONCERN IN PSYCHIATRIC CONSULTATIONS
Speaker: Kelsey A. Bonfils, B.S.
Co-Author(s): Kelsey A. Bonfils, B. S., Heidi M. Hedrick, M.S., Sadaaki Fukui, Ph.D., Erin L. Adams, B. A., Michelle P. Salyers, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify common primary concerns brought to psychiatric consultations by consumers and how these differ from provider reports for the same visits;2) Understand levels of concordance between consumer and providers on the primary concern in a visit;3) Recognize the relationships between trust, consumer levels of autonomy, and consumer/provider concordance.

SUMMARY:
Background: Shared decision-making, where consumers and providers work collaboratively to address treatment needs, is a burgeoning area of research in psychiatry. At the most basic level, providers need to understand consumers' primary concerns during a consultation visit. If the main concern is not understood, further shared decision-making may be hindered and rapport may be damaged. We examined primary concerns reported separately by providers and by consumers for the same visit to investigate how often providers and consumers agreed on the primary concern (concordance) and predictors of that concordance. Methods: Data was obtained during baseline interviews in a study of CommonGround, an intervention designed to increase shared decision-making. Participants were recruited from two outpatient clinics and two Assertive Community Treatment (ACT) teams in an urban community mental health center (N = 164 participants, with 1 of 4 providers). Participants had a mean age of 44.1 (SD=10.4) and most were African American (54.8%) and male (56.9%). After a psychiatric visit, consumers and providers were independently asked to report the primary concern of the visit. We matched provider- and consumer-reported concerns and rated them for level of agreement (none, partial, full). We also qualitatively examined and categorized the reported concerns. We utilized ordered logistic regression to examine how consumer characteristics, preferences about decision-making and information-seeking, and perceptions of the consumer-provider relationship predicted provider-consumer concordance, controlling for effects of clinic (i.e., outpatient vs. ACT). Results: Coder-rated consumer/provider concordance most often indicated no agreement (N = 82; 50.0%), with only 20.1% (N = 33) of responses indicating full agreement between consumer and provider. Preliminary results indicate that for consumers in the ACT clinic, odds of being in a lower agreement category increased by about 2.5 times over consumers in the outpatient clinic (p=.01). With clinic accounted for in the model, autonomy preferences were also predictive. When preference for decision-making autonomy increased by one unit, odds of being in a lower agreement category increased by about 1.7 times (p=.01). Similarly, when preference for information-seeking autonomy increased by one unit, odds of being in a lower agreement category increased by about 1.9 times (p=.06). Conclusions: Consumers' primary concerns are getting lost or being miscommunicated during psychiatric consultations, particularly on ACT teams. Greater consumer preference for autonomy in both decision-making and information-seeking predicted less concordance for the primary concern. This may indicate a communication breakdown between autonomous consumers and providers. Further work is needed to develop a common language between consumers and providers to ensure that consumer goals for psychiatric visits are acknowledged and achieved.

-4
THE STANFORD INTEGRATED PSYCHOSOCIAL ASSESSMENT FOR TRANSPLANTATION (SIPAT): A PROSPECTIVE STUDY OF MEDICAL AND PSYCHOSOCIAL OUTCOMES.
Speaker: JosÃ© R. Maldonado, M.D.
Co-Author(s): Jose R Maldonado, MD, Yelizaveta Sher, MD, Sermsak Lolak, MD, Heavenly Swendsen, MS, Danica Skibola, MD, Eric Neri, BS, Evonne David, LCSW, Catherine Sullivan, MD, Kimberly Standridge, MS.

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

SUMMARY:
Background: Available data suggest that in addition to established medical listing criteria, psychosocial and behavioral issues may significantly contribute to post-transplant outcomes. To improve the pre-transplant psychosocial evaluation process we developed a new assessment tool: the Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT).
Methods: We conducted a systematized review of our transplant-patient dedicated database and our institution's electronic medical records to identify every patient who received solid-organ transplants during the period of 6/1/2008 through 7/31/2011 at Stanford University Medical Center. All patients had been assessed with the SIPAT pre-transplantation and were closely followed by our transplant multidisciplinary team post-transplantation. We then reviewed and compared prospectively accumulated psychosocial and medical outcomes at the one year of
follow-up. The primary outcome were organ failure and mortality; secondary outcomes included occurrence and number of rejection episodes, occurrence and number of medical rehospitalization, occurrence and number of infection rates, new psychiatric complications or decompensation of pre-existing psychiatric diagnosis, new or recurrent substance abuse, presence of non-adherence, and failure of support system.
Results: Two hundred and seventeen (n=217) subjects were identified and included in the analysis. The average SIPAT score was 12.9 (SD 8.65) with range of 0 - 42. The average age at the time of transplantation was 51.9 (SD 13.4) years with the range of 20 - 80 years of age. Although there was no significant difference in the primary outcome (i.e., organ failure, mortality), due to low occurrence, the data clearly demonstrated that a higher SIPAT score was significantly correlated with the probability of poor medical and psychosocial outcomes. The SIPAT scores predicted various post-transplant medical complications, such as organ rejection episodes (p=.02), medical hospitalizations (e.g., transplant related complications) (p<.0001), and infection rates (p=.02). Similarly, SIPAT scores also predicted the occurrence of various post-transplant psychosocial complications, such as

psychiatric decompensation (p<.005), presence of non-adherence (p=.09), and failure of support system (p=0.02). When all psychosocial and medical outcomes were combined and logistic regression analysis was performed on these two pooled outcomes, it was also found that higher SIPAT scores increase the probability of an occurrence of undesirable medical outcomes (p=0.04) and negative psychosocial outcomes (p=0.03).
Conclusions: SIPAT is a comprehensive screening tool designed to assist in the psychosocial assessment of organ transplant candidates, while standardizing the evaluation process and helping identify subjects who are at risk for negative outcomes after transplantation; which may help predict psychosocial, as well as medical outcomes, after the transplantation.

PARTICULAR AND RARELY DISCUSSED TREATMENTS IN PSYCHIATRY

Moderators: Elias Shaya, M.D., Jerome Taylor

-1

MAGNESIUM AND ITS ROLE IN THE TREATMENT OF PATIENTS WITH PSYCHIATRIC ILLNESS

Speaker: Barbara D. Bartlik, M.D.
Co-Author(s): Vanessa K. Bijlani, M.D., Katerina Kryvinska, B.A., Luis G. Valdez, B.S., Liudmila Y. Kapterkina, A.S., Sarah Alvi, B.A., M.S.,Edward Tabasky, B.S., Elizabeth Goodman, B.A., Denisa Music, Eleanor Trilling, B.F.A., Robert Penrod, B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, participants will understand the importance of magnesium for the relief of psychiatric symptoms and the side effects of medication;2) Recognize the signs and symptoms of magnesium deficiency;3) Learn about the various options for administering magnesium (eg, glycinate, taurate, sulfate, citrate), both oral and topical, and how to minimize common side effects, such as diarrhea and nausea;4) Be familiar with ways to augment psychotherapeutic and psychopharmacologic approaches to treatment with the use of magnesium and other nutritional supplements;5) Be able to accurately measure magnesium levels in their patients.

SUMMARY:
Magnesium (Mg) is an essential nutrient involved in over 300 enzymatic reactions in the human body. It is necessary for the manufacture of ATP, relaxation of blood vessels, regulation of blood sugar, cardiac muscle function, bone maintenance, bowel motility, and brain physiology. An estimated 80% of Americans are deficient in Mg and most are unaware of it. Due to modern farming, food processing, and water treatment methods, most Americans ingest only two thirds of the RDA for Mg. Proper testing for Mg deficiency with erythrocyte Mg levels is not routine in medical practice, so most cases of deficiency go undetected and lead to various medical and psychiatric ailments.
Mg is important in regulating serum calcium and the influx of potassium in muscle cells. Mg deficiency can cause fatigue, dysphagia, insomnia, constipation, mitral valve prolapse, cardiac arrhythmias, tinnitus, seizures, fasciculations, numbness, tingling, hypertension, insulin resistance, tooth decay, osteoporosis, asthma, infections, nervousness, panic attacks, anxiety, depression, restlessness, irritability, photophobia, sensitivity to noise, carbohydrate and salt cravings and muscle weakness, soreness, and cramps. In addition, many common medications have been associated with Mg deficiency including proton pump inhibitors and diuretics.
Mg deficiency is associated with neuropsychiatric conditions including ADHD, anxiety, autism and schizophrenia. Unmedicated schizophrenic patients have lower erythrocyte Mg levels than controls, and it has been proposed that certain antipsychotic medications work by raising erythrocyte Mg levels.
The Ca:Mg ratio has been shown to be elevated in depressed patients.
Mg also positively affects the stress response by altering the hypothalamic-pituitary-adrenal axis. Individuals under chronic stress present with low Mg reserves. Mg interacts with the NMDA receptor, preventing its stimulation and inhibiting the influx of glutamate and calcium, thereby preventing neuronal cell damage.
Mg has a calming effect on the brain. Epsom salt baths (MgSO4) are an age-old treatment for tension and other maladies. Supplementation with Mg is inexpensive and over-the-counter. It is safe to administer as long as renal function is not impaired. Signs of Mg toxicity are diarrhea, tiredness, sedation, muscle weakness, and low blood pressure.
Mg is essential to the healthy functioning mind as well, as the entire body. Because of its many benefits, it would be useful to incorporate Mg supplementation and laboratory evaluation into routine psychiatric practice. Scientific research and clinical vignettes from the presenter's practice will be discussed.

-2

RESOLUTION OF VISUAL CONVERSION DISORDER AFTER A SINGLE SESSION OF GUIDED IMAGERY RELAXATION WITH HYPNOTIC SUGGESTION: A POSSIBLE FIRST-LINE TREATMENT

Speaker: David Sheski, M.D.
Co-Author(s): Elena Ortiz-Portillo, M.D.; Saba Syed, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Become familiar with the technique of guided imagery relaxation;2) Recognize cases of conversion disorder that may respond to guided imagery relaxation with hypnotic suggestion;3) Discuss the use of guided imagery relaxation as a first-line treatment.

SUMMARY:
Conversion Disorder can be a very challenging to diagnose and treat. Typically, it requires both an extensive workup to rule out neurophysiologic pathology and long term psychotropic management with psychotherapy. Patients are characteristically unaware of the psychological conflict that is manifesting as a physical symptom and are often resistant when this is suggested as a possible etiology. When the medical team is ultimately unable to identity an organic etiology for the patient's symptoms, friction and discontent can be created between the patient and the medical team. Anxiety can surround the diagnosis as well, particularly when it may come time to discharge a patient who functionally is still unable to walk or see. We report a case of a middle-aged Latino female who presented with medically unexplained complete bilateral visual loss after having an emotional conversation with her daughter. The blindness was functionally cured on the day three of the hospitaliza-

tion after a single session of guided imagery relaxation with a component of hypnotic suggestion. We discuss the psychodynamic and psychosocial features of the case that we believe contributed to the patient's dramatic response to treatment. As traditional psychotropic and psychotherapeutic approaches can take a great deal of time to be effective, we propose that this technique should be considered as a first line treatment, as it is low-cost, is low-risk, but can potentially be of high benefit, reducing what could otherwise be lengthy hospitalizations and recovery periods.

-3

HOW IS PSYCHOTHERAPY PRACTICED IN PUERTO RICO? A PILOT STUDY OF THE PROVIDER PERSPECTIVE

Speaker: Alejandro L. Acevedo, M.D.
Co-Author(s): Luis Franco M.D.; Nestor Galarza M.D.; Lesbia Hernandez Pharm. D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Determine how psychotherapy is being practiced by psychiatrists in Puerto Rico;2) Determine the feasibility of larger study to study the practice of psychotherapy by mental health professionals in Puerto Rico.;3) Investigate the type, length, and frequency of psychotherapeutic interactions in psychiatric practices in Puerto Rico.

SUMMARY:
Introduction: The American Psychiatric Association recommends both psychotherapy and medications as first line treatments for mood disorders. In Puerto Rico there are two accredited psychiatric residency programs and three psychology doctoral programs. However, there is no information on the provider perspective on how psychotherapy is being practiced. Hypothesis: The pilot study had the objectives of describing how psychotherapy is practiced in Puerto Rico in order to determine the feasibility of larger study to study the practice of psychotherapy by mental health professionals in the Island. Methods: We designed, and pre-tested a questionnaire with 10 residents and 2 psychology doctoral students at the Ponce School of Medicine Psychiatry and Psychology Programs after obtaining an "exempt" classification by the School's IRB. The local psychiatric and psychological associations were approached to obtain the electronic directory of their members. A convenience sample of 210 psychiatrists with available electronic addresses was invited to participate in the online survey which utilized "Survey Monkey' between April and June 2013. The data was synthesized and analyzed utilizing the Excel program. Results: Sixty psychiatrists (28.6%) agreed to participate in the study. Forty two (70%) reported to provide some form of psychotherapy to 41% or more of their patients. The most commonly utilized forms of psychotherapy were Supportive Psychotherapy (92.86%), Cognitive-Behavioral Therapy (71.43%), Brief Psychotherapy (58.93%), Psychodynamic Psychotherapy (44.64%), and Interpersonal (10.72%). Twenty one psychiatrists (35%) provided these services to specific patients on a monthly basis, 14 (23%) provided it every two weeks, 6 (10%) provided it once a week, and 9 (15%) provided it two or more times a week. Twenty six participants (43.3%) provided an average of 45 minutes and 21 (35%) an average of 16-31 minutes of psychotherapy per session. A correlation analysis of the data showed no significant difference in terms of the amount or types of psychotherapy provided between participants aged less than 45 years of age and those 45 years of age. Conclusions: There is wide variability in terms of how psychotherapy is being practicticed by the respondents. Funds are needed to obtain the electronic addresses of mental health professionals in Puerto Rico in order to further study the practice of psychotherapy from the provider perspective. Discussion: This study provides us with an initial glimpse into a controversial topic that is understudied.

MAY 07, 2014

EDUCATION, TRAINING, AND ACADEMIC DEMANDS IN PSYCHIATRY

Moderators: Edward T. Lewis, Narissa Etwaroo

-1

CHANGE IN MEDICAL STUDENT PERCEPTIONS OF PSYCHIATRY FOLLOWING PARTICIPATION IN AN INNOVATIVE CLERKSHIP

Speaker: Lisa J. Merlo, Ph.D.
Co-Author(s): Erica Frank, M.D., M.P.H., Robert Averbuch, M.D., Mark S. Gold, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify areas in which medical student perceptions of psychiatric patients change after participating in a required clerkship;2) List components of psychiatry education that are rated as most beneficial to medical student training;3) Describe ways that medical student perceptions of Psychiatry improve after completion of educational opportunities in Psychiatry;4) Recognize the importance of education regarding addiction during the required medical student clerkship in Psychiatry.

SUMMARY:
Mental illness stigma is a barrier to psychiatric care for patients, and may also prevent medical students from pursuing the field of Psychiatry. The Psychiatry clerkship at UF College of Medicine provides exposure to a variety of treatment settings (acute inpatient, chronic inpatient, residential, outpatient, consultation-liaison service, emergency department, community) and populations (child/adolescent psychiatry, college student mental health, adult psychiatry, homeless interventions, addiction treatment).
Third-year medical students completing a 6-week clerkship in Psychiatry (4 weeks) and Addiction Medicine (2 weeks) were surveyed regarding their perceptions toward Psychiatry and psychiatric patients on their first day of the clerkship, as well as the final day. Of the 139 respondents, 67 (48.2%) were male, 66 (47.5%) were female, and 6 (4.3%) chose not to disclose their sex. Most students were between 24-27 years-old. No other demographic data were collected in order to protect student anonymity.
Students rated inpatient and consultation-liaison services as most effective for education. Attendance at a 12-step meeting was also highly rated. Post-clerkship, more than twice as many students reported interest in pursuing Psychiatry or Addiction Medicine for their medical specialty. Repeated measures t-tests

demonstrated that, during the clerkship, students increased their confidence talking to patients about psychiatric symptoms (t= 16.9, p< .001), alcohol use (t= 9.3, p<.001), and other substance use (t= 10.5, p< .001). They reported being more likely to: address patients' concerns about a psychiatric disorder diagnosis (t= 7.1 p< .001), act as the primary treatment provider for a patient's psychiatric disorder (t= 5.7, p< .001), refer patients to a psychiatrist, psychologist, or other mental health specialist (t= 2.3, p< .03), and follow-up on referrals (t= 2.6, p< .02). Students also reported decreased stigma toward psychiatric patients. For example, they noted less anxiety around psychiatric patients (t= -8.7, p< .001), greater ease of identifying psychiatric symptoms (t= 8.8, p< .001), and more optimism about patients' chances for recovery (t= 2.2, p< .04). Students reported being less irritated by patients with psychosis (t= 2.8, p= .007) or cocaine dependence (t= 4.1, p< .001) at the end of the clerkship, and noted increased satisfaction working with patients suffering from depression/suicidality (t= 2.3, p< .03), psychosis, (t= 1.7, p< .09), and cocaine dependence (t= 3.2, p= .002).
Participation in an innovative clerkship can have significant positive impact on medical students' perceptions of patients with psychiatric disorders and the practice of Psychiatry. Such training may help to minimize barriers to treatment access by helping to develop competent, compassionate physicians who are in a better position to manage patients with psychiatric disorders, and may increase the appeal of Psychiatry among physicians in training.

-2

PRESSURE TO PUBLISH SCIENTIFIC ARTICLES AMONG DUTCH MEDICAL PROFESSORS: DETERMINE THE RISK FACTORS

Speaker: Joeri Tijdink, M.D.
Co-Author(s): Prof. Dr. Yvo M. Smulders, M.D. Ph.D.; Dr. A. Vergouwen, M.D. Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) have psychiatrists'knowledge on publication process and pressure;2) Have knowledge of publication pressure and validity of scientific results;3) Have knowlegde of determinants of publication pressure

SUMMARY:
Background: Publication of scientific research papers is important for professionals working in academic medical centres. Quantitative measures of scientific output determine status and prestige, and serve to rank universities as well as individuals. The pressure to generate maximum scientific output is high, and quantitative aspects may tend to dominate over qualitative ones. How this pressure influences professionals' perception of science and their personal well-being is unknown.
Methods and Findings: We performed an online survey inviting all medical professors (n=1206) of the 8 academic medical centres in The Netherlands to participate. They were asked to fill out 2 questionnaires; a validated Publication Pressure Questionnaire and the Maslach Burnout Inventory.
In total, 437 professors completed the questionnaires. among them, 54% judge that publication pressure 'has become excessive', 39% believe that publication pressure 'affects the credibility of medical research' and 26% judge that publication pressure has a 'sickening effect on medical science'. The burn out questionnaire indicates that 24% of medical professors has signs of burn out. The number of years of professorship was significantly related with experiencing less publication pressure. Significant and strong associations between burn out symptoms and the level of perceived publication pressure were found. The main limitation is the possibility of response bias.
Conclusion: A substantial proportion of medical professors believe that publication pressure has become excessive, and have a cynical view on the validity of medical science. These perceptions are statistically correlated to burn out symptoms. Further research should address the effects of publication pressure in more detail and identify alternative ways to stimulate the quality of medical science

-3

CONTINUING EDUCATION TO GO: CAPACITY BUILDING IN PSYCHOTHERAPIES FOR FRONT-LINE MENTAL HEALTH WORKERS IN UNDERSERVICED COMMUNITIES

Speaker: Paula Ravitz, M.D.
Co-Author(s): Robert G Cooke, M.D., Carolynne Cooper, M.S.W., Mark Fefergrad M.D., Andrea Lawson Ph.D., Bhadra Lokuge, B.Sc., Nancy McNaughton, Ph.D., Scott Mitchell, B.A., Scott Reeves, Ph.D., Wayne Skinner, M.S.W., John Teshima, M.D., Ari Zaretsky, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know the results of an educational outreach study of capacity building in evidence-supported psychotherapy techniques for front-line mental health workers in underserviced communities;2) Recognize elements of teaching processes and formats that can faciliate clinical practice behaviour changes;3) Know an approach to potentially mitigate disparities in access to mental health care that integrates psychotherapies.

SUMMARY:
Objective: To address gaps between need and access, and between treatment guideines that include evidence-supported psychotherapies and their implementation, capacity building of front-line clinicians is needed. Methods: A learning needs assessment was conducted with front-line mental health workers in 7 underserviced communities following which work-based CE materials were developed, implemented and evaluated. The materials included videotaped captioned simulations, lesson plans and practice reminders in CBT, IPT, Motivational Interviewing and DBT. Two sequential courses were subjected to a mixed methods evaluation with 93 front-line workers. Repeated ANOVA assessments of pre-post- educational intervention changes in knowledge and counselling self-efficacy, and focus groups were conducted. Results: Pre-post knowledge changes (P < 0.001,) and counselling self-efficacy improvements in participants in the first course offered (P = 0.001), were found; with many less dropouts in peer-led, small-group learning than in a self-directed format. Qualitative analysis found improved confidence, morale, self-reported practice changes and comfort in working with difficult patients. Conclusion: Work-based, multimodal, peer-led, interactive methods are feasible, acceptable and can facilitate knowledge translation of psychotherapeutic techniques. This may provide a model that can

be applied in other settings to build capacity of mental health clinicians with the potential to improve access by patients in need of care.

POST-TRAUMATIC STRESS DISORDER

-1

RELATION OF SLEEP DISTURBANCES WITH CORONARY ATHEROSCLEROSIS IN POSTTRAUMATIC STRESS DISORDER

Speaker: Naser Ahmadi, M.D., Ph.D.
Co-Author(s): Ramin Ebrahimi. MD; Fereshteh Hajsadeghi. MD; Maja Mircic. MD; Edwin Simon. MD; Nutan Vaidya. MD; Rachel Yehuda. MD

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Investigate the relation of presence and severity of obstructive sleep apnea and presence of atherosclerosis in PTSD;2) Investigate the relation of presence and severity of atherosclerosis and REM sleep disorder in PTSD;3) Investigate the rate of presence of atherosclerosis, obstructive sleep apnea and REM sleep disorder in subjects with and without PTSD

SUMMARY:
Background: We previously reported a relation of posttraumatic stress disorder (PTSD) with subclinical atherosclerosis. PTSD sleep disturbances (i.e. nightmares and insomnia) are hallmark of PTSD symptoms and are directly involved in PTSD-relevant emotion and memory processes. This study investigated the relation of sleep disturbances measured by polysomnography with coronary atherosclerosis measured by coronary artery calcium (CAC) in PTSD.
Methods: Five hundred fifty five veterans without known CAD (58±11 years of age, 86% men) underwent CAC scanning and overnight polysomnography for clinical indications and their psychological health status (PTSD vs. non-PTSD) was evaluated. Conditional logistic regression was employed to assess the relation of apnea hypopnea indices, non-rapid (NREM) and rapid (REM) eye movement sleep phases with PTSD.
Results: Rapid eye movement (REM) REM apnea hypoapnea indices (AHI)(45.8±9.6 vs. 34.7±10.2, p=0.001) and total AHI (29.2±7.9 vs. 22.4±8.6, p=0.001) as well as CAC (256±113 vs. 75±30, p=0.001) were significantly higher in PTSD as compared to No-PTSD subjects. Regression analyses revealed a significant linkage between CAC>0 and PTSD and between sleep apnea and PTSD which was proportionally increased with the severity of sleep apnea from relative risk of 2.42 in CAC>0 & AHI 5-15/hr to 31.6 in CAC>0 & AHI 15-30/hr to 5.45 in CAC>0 & AHI >30/hr (P<0.01). After adjustment for risk factors, relative risk (RR) of CAC>0 and AHI>5 was 1.70 (95%CI 1.35 - 2.13, p=0.001) in PTSD subjects as compared to those without PTSD. REM sleep duration was significantly less with PTSD especially in those with CAC>0(figure). The relative risk of CAC>0 and decreased REM was 2.46 (95%Ci 1.92 - 3.26, p=0.001) in PTSD as compared to No-PTSD subjects.
Conclusion: There is: 1) a significant association between presence/severity of AHI and presence of CAC with PTSD, and 2) significant linkage between decrease in REM and presence of CAC with PTSD independent of age, gender, and conventional risk factors.

-2

UNMET NEEDS AND POSTTRAUMATIC GROWTH AFTER TERRORISM: OKLAHOMA CITY DIRECTLY-EXPOSED SURVIVORS 18 YEARS LATER, PRELIMINARY RESULTS

Speaker: Phebe M. Tucker, M.D.
Co-Author(s): Sheryll-Brown, MP; Tracy-Wendling, MP; Pascal-Nitiema, MSC, MPH; Betty Pfefferbaum, M.D., J.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Compare direct terrorism survivors' mental and physical health and health care utilization patterns with non-exposed controls;2) Identify survivors' lasting PTSD and depression symptoms;3) Explore posttraumatic growth and positive coping strategies used by survivors in 18 years after direct exposure to terrorism

SUMMARY:
Direct exposure to terrorism can have short-term and lasting health and mental health sequelae, and may also lead to post-traumatic growth and positive coping skills. An ongoing telephone survey explored self-reported health and mental health, patterns of health care utilization, PTSD and depression symptoms, and post-traumatic growth and coping skills in 140 direct survivors of the Oklahoma City bombing compared to demographically matched controls 18 years after the terrorist event. Survivors were recruited from an original Oklahoma State Department of Health bombing registry of adult direct survivors (approximately 80% injured), of whom 494 agreed in 1995 to participate in research. Rating scales included Health Status Questionnaire, Hopkins Symptom Checklist, PTSD Screen (Breslau), and Posttraumatic Growth Inventory.
Survivors (median age 59 years) and controls reported similar overall health and mental health care utilization. Among major medical diseases, survivors exceeded controls only for COPD (17.6% vs. 9.1%) and cancer (15.2% vs. 10.6%). Worsened hearing after the bombing was reported in 64% of survivors and persisted in 58%. Among emotional symptoms reported extremely often or quite a bit in the past week, survivors exceeded controls for feeling blue (23.2% vs. 13.6%), excessive worrying (35.2% vs. 24.2%), low energy (29.6% vs. 19.7%), self-blame (19.2% vs. 9.1%), loss of interest (12.8% vs. 4.5%), and sudden fear (20% vs. 12.1%). In the past year, survivors reported more relationship problems (35.2% vs. 22.7%) and distressing bombing memories (29.6% vs. 6%). In the past month, survivors reported persistent PTSD symptoms of avoidance (28.8%), loss of interest (25.6%), isolation feelings (32.8%), sleep difficulties (53.2%), and jumpiness (52.4%). Life satisfaction (agree and strongly agree) were reported in fewer survivors than controls (56.1% vs. 64.1%)
Despite lingering emotional distress associated with terrorism, survivors reported positive growth in a moderate to very great degree in areas of changing life priorities (62.9%), better understanding spiritual matters (57.2%), better handling difficulties (63.5%), feeling stronger (56.2%), and learning that people are wonderful (62.6%).
Our results show that although terrorism survivors' long-term health and mental health care utilization pattern do not exceed that of controls, some health conditions, symptoms of depression and PTSD and general life satisfaction are worse. These findings suggest that there remain some unmet health and

mental health needs in survivors; it is unknown whether avoidance of care, lack of access to services, and/or health/mental health problems' resistance to treatment account for these persisting problems. Nonetheless, positive posttraumatic growth and coping appear to be strengths survivors have developed over the years to adjust to intense exposure to terrorism.

-3

RESIDENTIAL PTSD TREATMENT: RESULTS FROM A SYSTEMATIC REVIEW AND META-ANALYSIS

Speaker: George Loeffler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate results of a systematic review and meta-analysis of residential PTSD treatment;2) Understand what patient variables, studied to date, and how they predict response to residential PTSD treatment;3) Appreciate difficulties in the study of this treatment modality.

SUMMARY:

This session will describe the first systematic review and meta-analysis done, to date, of residential PTSD treatment. This will include discussion of prior work, methods and key findings. (At the time of submission systematic review is done and meta-analysis is being completed).

A secondary review of patient variables that predicted treatment response will be included. A subset of studies, drawn from the above systemic review, were identified that addressed patient variables that correlated with treatment response. These variables were divided into 6 categories: demographics, military history, disability compensation, type of trauma, substance comorbidity, other psychiatric comorbidity, symptom severity, and other factors assessed via psychometric testing.

-4

INTERPERSONAL VIOLENCE IN THE UNITED ARAB EMIRATES: RESULTS FROM AL-AIN TRAUMA REGISTRY

Speaker: Ossama T. Osman, M.D.

Co-Author(s): Alaa K. Abbas 2, Hani O. Eid, M.D., Mohamed O. Salem, M.D., Fikri Abu-Zidan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the phemomenon of interpersonal violence in the United Arab Emirates;2) Know the socio-demographic and clinical characteristics of interpersonal violence in the Arab Culture;3) Identify the mental health services needed in support of victims of interpersonal violence

SUMMARY:

An estimated 520 000 people were killed in 2001 as a result of interpersonal violence (IV) worldwide, a rate of 8.8 per 100 000 population. The cost of IV in the United States reaches up to 3.3% of the gross domestic product. In order to explore this phenomenon, we studied the socio-demographic and clinical characteristics of seventy six (76) patients with intentional injury, a subset from Al-Ain trauma registry data which were collected prospectively and represented all IV trauma patients who were admitted to Al-Ain Hospital over 3 years. Analysis of the results revealed an estimated annual injury hospitalization of IV in Al-Ain city of 6.8/100 000 population. Nearly 50% (n= 35) were in the age group of (30-44 years). Only 17.1% (n=13) were injured in the context of domestic violence. Most were males 86.8% (n=66), and half (50%) were married. More than half 56% (n=43) were from the Indian subcontinent. Almost 50% (n=44) arrived to the hospital by private cars, 21 % (n=16) arrived by police cars and 19% (n=14) by ambulance. About 56% (n=43) had head, face and neck injuries. Half of the patients (n=38) were injured in the street. More than 80% had blunt trauma, and only 19% (n=3) had bullet injuries. The mean (SD) hospital stay was 8 (14) days. The median ISS score for the patients was 2 (Range 1-25). Almost all patients were admitted to the general ward 97% (n= 74) while less than 3% (n=2) were admitted to the ICU with no reported deaths. In conclusion, the majority of patients in this study had minor body injuries. Nevertheless; the psychological impact may be major. This highlights the need to develop suitable mental health services in support of victims of interpersonal violence.

EATING DISORDERS

Moderators: Nitin Gupta, M.D., Stephanie Peglow

-1

ANXIETY DISORDERS CO-OCCURRING WITH BINGE-EATING DISORDER: ASSOCIATIONS WITH OTHER PSYCHIATRIC COMORBIDITIES AND WITH EATING DISORDER PSYCHOPATHOLOGY

Speaker: Daniel F. Becker, M.D.

Co-Author(s): Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that anxiety disorders commonly co-occur with binge-eating disorder;2) Identify the correlates of this co-occurrence pattern with respect to eating disorder psychopathology, psychological functioning, and axis I psychiatric comorbidity;3) Identify the significance of current versus past anxiety disorder co-occurrence with respect to these associations;4) Understand the potential implications of these relationships for subtyping binge-eating disorder;5) Apply these findings to the evaluation and treatment of patients with binge-eating disorder.

SUMMARY:

Objective: Binge-eating disorder (BED) is associated with elevated rates of co-occurring anxiety disorders. However, the significance of this diagnostic comorbidity is ambiguous--as is the significance of the timing of anxiety disorder co-occurrence. In this study, we compared eating disorder psychopathology, psychological functioning, and overall psychiatric comorbidity in three subgroups of patients with BED: those who currently have an anxiety disorder, those who do not currently have an anxiety disorder but who have had one previously, and those without a history of anxiety disorder. Method: Subjects were a consecutive series of 797 treatment-seeking patients (74% women, 26% men) who met DSM-IV research criteria for BED. All were assessed reliably with semistructured interviews in order to evaluate current and lifetime DSM-IV axis I psychiatric disorders (Structured Clinical Interview for DSM-IV Axis I Disorders â€“ Patient Edition) and eating disorder psychopathology

(Eating Disorder Examination). Additional self-report instruments evaluated psychological functioning. Results: In this study group, 208 (26%) subjects had a current diagnosis of anxiety disorder, 101 (13%) did not currently have an anxiety disorder but had had one previously, and 488 (61%) had never had an anxiety disorder. These groups did not differ with respect to body mass index or binge eating frequency. They did differ significantly with respect to eating disorder attitudes; specifically, the group with current anxiety disorder had higher levels of concern about weight than the group without a history of anxiety disorder ($p < .001$)--and had higher levels of concern about shape than both other groups ($p < .001$). The group with current anxiety disorder also showed higher levels of negative affect than the group with past anxiety disorder--and both of these groups had higher levels than the group without anxiety disorder ($p < .001$). Few differences were observed with respect to the developmental progression of eating disorder behaviors; however, compared to the other two groups, onset of dieting began significantly earlier in those with past anxiety disorder ($p < .05$). Finally, some differences were noted with respect to psychiatric comorbidity, with both anxiety disorder groups showing elevated lifetime rates of major depressive disorder compared to the group without anxiety disorder ($p < .001$). Conclusions: Anxiety disorders occur frequently among patients with BED. We found that both current and past anxiety disorder are associated with higher levels of negative affect and elevated rates of major depressive disorder. We also found that current anxiety disorder, but not past anxiety disorder, is associated with elevated concerns about weight and shape--and that past anxiety disorder is associated with earlier onset of dieting. These findings suggest approaches to subtyping BED patients based on psychiatric comorbidity, and may have implications for treatment.

-2

BEHAVIORAL AND FUNCTIONAL MORBIDITIES AMONG PATIENTS WITH OBESITY REFERRED FOR BARIATRIC SURGERY IN THE UNITED ARAB EMIRATES

Speaker: Ossama T. Osman, M.D.
Co-Author(s): Essam Emam, M.D., Fadwa Babikir, Msc, Fawaz Torab, M.D., Tawfik Zoubeidi, PhD.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the prevalence of anxiety and depression in the bariatric surgery outpatient morbidly obese population;2) Identify medical conditions that are commonly comorbid with obesity;3) Specify recommendations for future follow up research in the Bariatric population

SUMMARY:

Introduction: There is a significant prevalence of morbid obesity among the population in the United Arab Emirates (BMI>40kg/m2). This has been accompanied by a growth in bariatric surgery with Psychiatric assessment being part of the routine preoperative work up. We have combined the clinical assessment of patients with a research program to identify baseline psychological characteristics such as symptoms of anxiety and depression that may potentially interfere or complicate the surgical procedure. Furthermore, we have assessed how patients perceive the effect of their obesity on several domains of functioning.
Methods: All patients who seek bariatric surgery at Tawam Hospital completed a behavioral/ psychosocial evaluation and were interviewed by a psychiatrist. Eighty consecutive patients (F=69, M=19) were recruited and signed the IRB approved informed consent. The evaluation is conducted to screen for symptoms of anxiety and depression using Hospital Anxiety and Depression Scale (HAD). To assess the degree of perceived disability on four dimensions of functioning we used the Sheehan Disability Scale (SDS).
Statistical methods used Pearson Correlation to study correlation between scales and quantitative variables, while frequencies were determined for categorical variables. For comparing the age of onset of obesity with the disability scores on SDS, we used Kruskalâ€"Wallis one-way analysis of variance due to lack of normality of SDS scores.
Results: The reported frequency of significant symptoms on the HAD were 26% for anxiety and 14.7% for depression. The average mean disability scores on the SDS were 21.3%. The frequency of disabilities on each of the 4 dimensions of functioning were 28.7, 35, 36.3, 36.3 consecutively.
Higher Depression scores are associated with marked disability scores on the dimensions of Social life, Family/home responsibilities and Religious duties (0.60, 0.38, 0.29 consecutively) but not on work/school functioning. Meantime, higher anxiety scores were associated with higher disability on social life, and family/home responsibilities (0.39 and 0.3 consecutively) but not on work/school or religious duties.
There were significant correlations between the onset of obesity and the higher scores on the last three dimensions of functioning on the SDS. Recent adult age of onset for obesity was significantly correlated with high SDS scores on the dimensions of Social ($P<0.014$), family life/home responsibilities ($P<0.006$), and religious duties ($P=0.004$).
Conclusion: To our knowledge, this is the first study of the prevalence of anxiety and depressive symptoms among bariatric patients in the UAE. Our study found that significant symptoms of anxiety and depression are common among bariatric patients with morbid obesity. The results are consistent with the rates reported for prevalence of anxiety and Depression in this population in western cultures and in general population studies among Emiratis in the UAE.

-3

THE CULTURAL ORIGINS OF ANOREXIA: A CASE REPORT

Speaker: Michele Mattia, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of a close co-operation between the therapist, the psychiatt and the nutritionist;2) Have capacitiy to identify the priority given within the family system and the therapeutic team so as to prevent the risk of disconfirmation and of refusal;3) Recognize the importance of recognising the most subtle psychopathologic symptoms and the differences among them.

SUMMARY:

The excessive worries of being overweight is frequent in many societies. The culture is contemporarily both inside and outside the mind. On the basis of these socio-cultural factors anorexia

is considered as a specific syndrome which is correlated to the Western culture and mainly found within the European and American society. According to Katzman and Lee in the transition societies of the more agricultural and rural civilisations to the more industrial and therefore western ones, the youngsters could develop eating disorders of anorexic type not only as an imitation of the socio-cultural ideals of the western beauty, but also as a reaction to a situation of high inter-family emotionality which is typical of the transitional families between the patriarchal model to the modern one. Anna's anorexia sprouted during adolescence, a time when parents start specifying their wishes, needs, orientations and expectations more clearly. The infra-generational conflict is particularly strong in the relationship with daughters, as parents seem to be more demanding with them. As soon as it was possible to go to another level of therapy, we managed to enter the cultural framework of meanings which allowed to access the distorted family myths revolving around the constant desire to return to the home country. Anna suffered from a restrictive anorexia with a strong reduction of the food-intake and fasting periods, as well as continuous physical exercise. In fact one of Anna's characteristics was anguish and obsessive anxiety towards food and in particular the presence of a strong body dysmorphic disorder (BDD) related to food intake. To Anna though, the origin of her anorexia was tied to her obsessive thoughts, to her depressed state of mind and, particularly, to the ever present family prospect that one day they would magically return to their home country. One of the cultural characteristics of tthe family's structure was to channel all affective and love-related communications through food. Anorexia took the form of a sovereign freedom within a family system that held her captive, a family inhibited and regressed the evolution of the integrating Ego and therefore free from cultural expectations of a migrant family. The family was hence undergoing an internal crisis and Anna, as a second generation migrant, represented the potentials and also the risks brought about by the migration process. The anorexic behaviour therefore served as a means to keep the family united and to allow each member to tolerate the distance from their home country, the heimweh, and above all to continue living this migration as just a period of life that is suspended. Resolving this conflict finally allowed Anna to get out of the clash between the two cultures. She was finally able to undertake her own journey to maturity and differentiation while also distancing herself from the trap of anorexia which so far had only halted her cultural, social and emotive evolution.

-4

EXAMINING THE PSYCHOSOCIAL BARRIERS TO ACCESSING BODY-CONTOURING SURGERY AFTER BARIATRIC SURGERY: A QUALITATIVE STUDY

Speaker: Carrol Zhou, M.S.
Co-Author(s): Ebaa Alozairi MD, Arash Azin Honours B.sc, SMS; Raed Hawa, MD,; Allan Okrainec, MD, MHPE; Sanjeev Sockalingham, MD,; Carrol Zhou Honours B.sc, SMS

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify barriers other than cost that prevents people from accessing body contouring surgery post-bariatric surgery. ;2) Explore need for change in health care system to integrate different services together to better serve the bariatric population ;3) Understand the psychosocial environment and determinants of health that influence patients' access to healthcare resources.

SUMMARY:

Introduction: Excess skin folds are a common complication after bariatric surgery. Although many post-bariatric patients desire body contouring surgery (BCS) to correct this complication, few actually go through with the procedure. Our study aimed to explore all potential barriers to accessing BCS experienced by bariatric surgery patients in a Canadian setting.
Methods: Semi-structured interviews were conducted with patients who have received bariatric surgery but no BCS (BS group), and patients who have received both bariatric surgery and subsequent BCS (BS/BCS group). Interviews consisted of open-ended questions that explored barriers to BCS. Five interviews per study group (10 total interviews for the study) were needed to achieve saturation of themes using grounded theory analysis.
Results: Nine out of 10 interviewees reported having significant excess skin folds and all 9 of these patients reported a desire for BCS. The most frequently reported barrier was cost (n=9), which was also rated as the most important. Patients identified 10 additional barriers preventing access from BCS that were classified into two categories: patient barriers and healthcare system barriers. Patient barriers consisted of individual barriers, emotional barriers and social barriers, which included stigma related to receiving plastic surgery and opposition from friends and family members. Healthcare system barriers consisted of lack of information provided on the procedure, the prolonged wait-time for BCS, and an overall lack of advocacy of patients by healthcare professionals.
Conclusion: Despite the potential benefit of and strong desire for BCS for excess skin folds post-bariatric surgery, our study highlighted several barriers beyond cost that influence patient access to this surgical procedure. We provide preliminary evidence for re-visiting current coverage criteria and pursuing the integration of BCS services within bariatric surgery centres.

TOPICS OF INTEREST RARELY PRESENTED

Moderators: Narissa Etwaroo, Elias Shaya, M.D.

-1

PSYCHIATRIC PATIENTSâ€™ SELF-ASSESSMENT OF BODY WEIGHT IS ASSOCIATED WITH RISK OF METABOLIC SYNDROME

Speaker: Stephen Woolley, D.Sc.
Co-Author(s): John W. Goethe, M.D., Kate Terrell

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss associations between perception of weight and the risk of metabolic syndrome;2) Discuss the association between differences in patient versus interviewer assessments of patient weight and the risk of metabolic syndrome;3) Discuss differences in health behaviors associated with patient versus interviewer assessments of patient weight;4) Discuss evidence that patient perceptions about their weight might influence health behaviors and metabolic syndrome

SUMMARY:
Objective: To determine if psychiatric patients' self-rating of weight vs. interviewer assessment is associated with metabolic syndrome (MetS) and health behaviors.
Method: Adult patients (n=188) treated with second generation antipsychotics (SGAs) in psychiatric settings were recruited in 2005-2010. Patients were interviewed about lifestyles (e.g., physical activity, drinking, smoking), activities of daily living, medications, family weight and health history, and self-ratings of their silhouettes (Stunkard drawings); MetS, using the ATP-III definition (Grundy, 2005), was identified by blood and physical measurements of glucose (GLU), triglycerides (TRI), high-density lipoproteins (HDL), blood pressure (BP), and waist circumference (WC). Physical activity was categorized by duration and intensity. Data were analyzed using stratified and logistic regression methods.
Results: Patients (ages 18-58) were 56% male and 51% white, 29% Hispanic/Latino and 19% black. Diagnoses included major depression (37%), schizophrenia (25%), schizoaffective (18%), bipolar (13%), and substance abuse (42%). The proportions of the sample exceeding the cutoffs for each MetS criterion were 38% for GLU, 45% for TRI, 45% for HDL, 40% for BP and 64% for WC. Nearly half (48%) satisfied the criteria for MetS. Average BMI was in the "obese" category (BMIâ‰¥30); over 50% rated themselves "heavy." One-third reported drinking alcohol regularly, half smoked, 40% had little/no physical activity, and 14-31% needed help with â‰¥1 activity of daily living. Patients who rated themselves "thinner" than interviewers' ratings were more likely to have MetS (2.5, 1.3-4.8) and to exceed the cutoffs for GLU (1.9, 1.0-3.6), TRI (1.7, 0.9-3.3), HDL (2.0, 1.0-3.8), BP (1.3, 0.7-2.6) and WC (2.3, 1.1-4.9); they were also more likely to be in the bottom vs. top quartile of physical activity (OR=1.6). The top quartile of physical activity was associated with a 50% reduction in the odds of MetS (OR=0.5, 95% confidence interval 0.6-<1.0), and with 13-32% reductions in risk of exceeding cutoffs for GLU, TRI, HDL, BP and WC (marginally non-significant). MetS was not associated with alcohol or tobacco use.
Conclusions: Patients who rated themselves thinner than the interviewer rating had elevated risk of MetS and were less physically active; lifestyle variables were associated with having MetS. Patient self-assessments may reflect perceptions and lifestyle decisions that increase risk of MetS. The sample size was not adequate to control for some factors of interest, e.g., dietary components, but the findings suggest that SGA-treated patients' perceptions of their bodies may affect behaviors and risk of MetS. A larger prospective study is warranted.

-2

ON RELIGIOUS AND PSYCHIATRIC ATHEISM: THE SUCCESS OF EPICURUS, THE FAILURE OF THOMAS SZASZ

Speaker: Michael Fontaine, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand why the psychiatric ideas of Thomas Szasz have gained no public traction;2) Indicate why the psychiatric ideas of Thomas Szasz have probably gained a great deal of private traction, and how clinicians should deal with them;3) Understand what Szasz' ideas have in common with atheism

SUMMARY:
In 271 BC the Greek philosopher Epicurus (340-271 BC) died. The scientific-materialist and theologically atheist philosophy that he had preached, Epicureanism, continued to flourish and grow in his school ("The Garden") in Athens. It soon spread throughout the Roman Empire, especially among the upper classes. When Christianity replaced Rome as Europe's dominant power, it faded away, but the Renaissance rediscovery of the Epicurean poetry of Lucretius (c. 99-c.55 BC) gave a massive impetus to the Enlightenment. The doctrine subsequently aided the replacement of religious (Christian) values with secular (atheist) ones in Western society.
In September 2012 the Hungarian-American psychiatrist Thomas Szasz (1920-2012) died. His death was met with a brief obituary in the New York Times, but little more. The psychiatrically atheist philosophy that he had preached for over half a century has never flourished. Though he suggested and advocated many, he cannot be credited with implementing any psychiatric, social, political, or legal reforms, save perhaps deinstitutionalization. His philosophy, and especially his chief claim that mental illness is not a medical disease, has not spread throughout the world; rather, it is psychiatry that has flourished and grown worldwide, and has spread throughout all classes in the West.
Both Szasz and Epicurus preached freedom. Epicurus sought to free men from the fear of death. Szasz sought to free men from coercive psychiatry. Why was Epicureanism so successful, while Szaszianism is such a failure?
This paper offers a comparative study of Epicureanism and Szaszianism and points out many unnoticed similarities in the two philosophies. It concludes that Szaszianism was a two-pronged approach whose aims were quite different from each other. Epicurus sought to abolish men's private fear of (unhappy) life after death. Like him, Szasz attacked the private belief that mental illness has a psychochemical or physiological, rather than social, origin. Unlike Epicurus, who advocated complete withdrawal from political life (and made no effort to combat institutionalized religion), Szasz was highly political, and made every effort to combat institutional psychiatry. It is easy to see that public Szaszianism has been a failure - and deservedly so, many would say. But because we cannot, as a rule, tell how many atheists there are in the pews of a church-whether they are theological or psychiatric atheists, and whether the pews are in church or worldwide-it is far from clear now, in 2013, just how far private Szaszianism has spread, and whether it will simply fade away or someday enjoy a revival.

-3

PSYCHIATRIC MORBIDITY AMONG RURAL AND SLUM FEMALE POPULATION: A STUDY CONDUCTED IN BANGLADESH

Speaker: Jhunu S. Nahar, M.B.B.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Find out the prevalence of psychiatric disorders among the study population.;2) Compare the disorders among the rural and slum female population.;3) Find out the influence of existing socio-demographic factors on psychiatric disorders.

SUMMARY:
Method: This is a community based study, which is also

cross sectional and descriptive in nature. The sample for the main study constituted 366 randomly selected respondents (206 from rural and 104 from slum). A two-staged screening procedure was carried in the study. First, the total population was studied by screening test â€“ Self Reporting Questionnaire (SRQ) to divide the sample into 'screen positive' and 'screen negative' subjects. In the second stage, full assessment of a mixture of all 'screen positive' and 25% 'screen negative' was carried out by structured clinical interview for diagnosis (SCID- NP). Later SCID filled by the respondents was assessed by consultant psychiatrists by using DSMIV in order to put exact clinical diagnosis. Data collection of rural area was done in village Bahadurpur of Sharsha Upazilla, Jessore, Bangladesh. This is a quiet village and there is limited facilities for communication, water supply electricity etc. Effects of urbanization may be seen but not obvious. It has got 647 households with 2000 voters (total population approximately 3500). Data collection of slum area was done in Ward no. 47 of Dhaka City Corporation. The place located near Rayer Bazar, Dhaka. It has got approximately 800 to 900 households (slum rooms) with approximate population 4000 to 4500. A questionnaire for the study was also developed in order to obtain socio-demographic data and other important variables. Stress was scored according to Presumptive Stressful Life Events Scale (PSLE). The total duration of the study was from July 2010 to June 2011 Results: Higher prevalence was found among rural sample (22.8%) than slum (10.90%) population. Regarding pattern of psychiatric disorders among rural population, Depressive Disorders (46.7%), Somatoform Disorder (18.3%), and Generalized Anxiety Disorder (16.7%) showed higher prevalence rate. Among slum respondents PTSD (54.5%), Depressive Disorders (45.5%), Generalized Anxiety Disorders and Substance Misuse (18.1%) showed higher prevalence rate.

Mean stress score was also higher among rural (90.6 ± 17) respondents than slum (46.5±12.1) ones. . Poverty, loss of crops & household animals, multiple marriages of their husbands, dowry demands, child rearing etc. were the main stress factors for rural women

Conclusion: Due attention should be given to the female population especially in rural areas regarding diagnosis and treatment of mental disorders.

References: 1. Nahar JS, Morshed NM, Qusar MMAS, Khanam M, Salam MA. Psychiatric Morbidity Among Rural And Urban Population- A Comparative Study. Bangladesh Journal of Psychiatry, December 2005 19(2): 19-27

MAY 03, 2014

SEMINAR 1
HOW TO GIVE MORE EFFECTIVE LECTURES: PUNCH, PASSION, AND POLISH
Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn teaching techniques to hold audience attention; 2) Learn how to involve the audience; and 3) Learn how to improve skills in using audio visual aids.

SUMMARY:
This course will provide practical advice on how to make a psychiatric presentation with punch, passion, and polish. Instruction will be given on planning a scientific paper presentation, a lecture, and a half day course. The course leader will cover the selection of a title through to the choice of closing remarks. Teaching techniques to hold the audience's attention include the use of humor, anecdotes, and vivid images. Participants will be taught to involve the audience by breaking them into pairs to solve problems by applying recently acquired knowledge.

Participants will be told that they should never (1) read while lecturing; (2) display their esoteric vocabulary; or (3) rush through their talk, no matter what the time constraints. Tips will be given for making traditional word slides and innovative picture slides. Pitfalls of Powerpoint will be illustrated. Advice will be given on the effective use of videotape vignettes. A videotape will be used to illustrate common errors made by lecturers. The course will also cover preparation of handouts. Finally, participants will be strongly encouraged to make a three minute presentation with or without slides and receive feedback from workshop participants. Participants should plan to bring Powerpoint slides on a flash drive.

SEMINAR 2
COGNITIVE-BEHAVIOR THERAPY FOR SEVERE MENTAL ILLNESS
Director: Jesse H. Wright, M.D., Ph.D.
Faculty: Douglas Turkington, M.D., Michael E. Thase, M.D., David Kingdon, D.M.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe key modifications of CBT for treatment of severe mental disorders; 2) Detail CBT methods for hallucinations and delusions; 3) Describe CBT methods for severe and treatment resistant depression; and 4) Detail CBT methods for bipolar disorder.

SUMMARY:
In recent years, cognitive-behavior therapy (CBT) methods have been developed to meet the special needs of patients with chronic and severe psychiatric symptoms. This seminar presents these newer CBT applications for the treatment of persons with chronic or treatment resistant depression, schizophrenia, and bipolar disorder. Cognitive-behavioral conceptualizations and specific treatment procedures are described for these patient groups.

Several modifications of standard CBT techniques are suggested for the treatment of severe or persistent mental illnesses. Participants in this seminar 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. Participants will have the opportunity to discuss application of CBT for their own patients.

SEMINAR 3
SEXUAL COMPULSIVITY AND ADDICTION WITH DRS. PAT CARNES AND KEN ROSENBERG
Directors: Ken Rosenberg, M.D., Patrick Carnes, Ph.D.
Faculty: Patrick Carnes, Ph.D., Ken Rosenberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the diagnostic categories of sexual disturbances; 2) Become familiar with the common terminologies and treatments particular to sexual addiction and compulsivity; and 3) Be able to use their pre-existing skill set as psychiatrists to initiate treatment for sexual addictions and make appropriate recommendations.

SUMMARY:
Patrick Carnes, PhD, Executive Director, Gentle Path Healing program at Pine Grove Behavioral Health and Editor-in-Chief of the Journal of Sexual Addiction and Compulsivity and Kenneth Paul Rosenberg, MD, Associate Clinical Professor of Psychiatry at the Weill Cornell Medical College and Contributing Editor of the Journal of Sex and Marital Therapy, and Founder and Director of Upper East Health Behavioral Medicine will introduce psychiatrists to the diagnosis, evaluation and treatment of sexual compulsivity and addiction. The concepts of Hypersexuality and Sex Addiction are the result of clinical experience, research and current theories which put greater emphasis on the reward, control and memory systems responsible for addictions. In the coming years, 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 diagnoses related to sexual compulsivity and addiction. To understand the evolution and research of the Sexual Addiction Screening Test-Revised (SAST-R) To utilize the SAST-R in a clinical setting. To describe the PATHOS, a sexual addiction screening test being developed for physician use. To introduce the Sexual Dependency Inventory Revised (SDI-R) To describe gender differences and co-occurring patterns of sexual aversion. To provide overview of Cybersex and Internet pornography. To provide overview of sex addiction treatment. To describe evidenced-based data about recovery. To introduce the concept of task-centered therapy. To specify the research and conceptual foundations of a task centered approach to therapy. To understand task one including performables and therapist competencies. Review the theoretical neurobiology

SEMINAR 4
MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN
Directors: Shaila Misri, M.D., Deirdre Ryan, M.B.
Faculty: Shari I. Lusskin, M.D., Tricia Bowering, M.D.

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

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

MAY 04, 2014

SEMINAR 5
HIT (HALLUCINATION-FOCUSED INTEGRATIVE THERAPY): PREFERRED FOR ACOUSTIC VERBAL HALLUCINATIONS?
Directors: Jack J.A. Jenner, M.D., Ph.D., Bert L.B. Luteijn, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have knowledge about possibilities and pitfalls of integrating treatment interventions with different therapeutical backgrounds for patients with acoustic verbal hallucinations; 2) Have an impression of HIT methodology, its implementation, and its results for patients with acoustic verbal hallucinations; 3) Have been introduced in specialist motivational strategies developed for this patient population; and 4) To Assess auditory vocal hallucinations, usage of the Auditory Vocal Hallucination Rating Scale.

SUMMARY:
Prevalence of hallucinations is quite high in dissociative disorder (80%), schizophrenia (70%), psychotic depression, PTSD, and borderline personality disorder (all about 30%). Effectiveness of anti-psychotic medication is limited due to non-compliance (30-70%) and ineffectiveness when taken (20%). Hence, persistence of hallucinations is rather high.
HIT has been specifically developed for the treatment of auditory vocal hallucinations (AVH). The therapy is multi-modular consisting of: motivational strategies, two-realities approach, medication, coping training, CBT, psycho-education and rehabilitation. The framework is made of directive problem-oriented family treatment, and out-reach service.
Its effectiveness has been scientifically tested, and was found significantly more effective than TAU on burden; PANSS-scores on hallucination (NNT=2); depression, anxiety, disorganized thinking, and general psychopathology (NNT=3-5); quality of life; and social disabilities (NNT=7). Results remained at follow-up. Other significant aspects are: Low drop-out rate (9%), high satisfaction (>80% satisfied), lower costs than TAU, positive changes in relatives 'attitudes towards the patient. HIT has been positively evaluated in the current Dutch National Schizophrenia Treatment Guideline and recommended and an treatment option for persistent acoustic verbal hallucinations. Hallucination assessment, HIT treatment programme, and skills training in modules are pivotal in the workshop.

SEMINAR 6
NEUROANATOMY OF EMOTIONS
Director: Ricardo Vela, M.D.

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

SUMMARY:
Psychiatry has been revolutionized by the development of brain imaging research, which has expanded our understanding of mental illness. This explosion of neuroscientific knowledge will continue to advance. In April 2013, President Obama called for a major initiative for advancing innovative neurotechnologies for brain research. NIMH has launched the new Research Domain Criteria that conceptualizes mental disorders as disorders of brain circuits that can be identified with the tools of clinical neuroscience. Psychiatrists need to access fundamental knowledge about brain neuroanatomy and neurocircuitry that will allow them to understand emerging neuroscientific findings that will be incorporated into the practice of psychiatry.

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

schizophrenia will be discussed in the context of limbic neuroanatomical structures.

SEMINAR 7
RISK ASSESSMENT FOR VIOLENCE
Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the relative risk of violence in schizophrenia, bipolar disorder, and substance abuse.; 2) Specify four components of dangerousness.; 3) Indicate three factors that increase the likelihood that violent command hallucinations will be obeyed.; 4) Identify the magnitude of the violence risk due to paranoid delusions.

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

SEMINAR 8
BARRIERS TO ADULT SEXUAL LOVE: A NEW CONCEPTUAL AND CLINICAL APPROACH
Director: Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To introduce a vocabulary of love to the understanding of its impediments; 2) To create new perspectives on the forces that prevent relationship formation and deteriorate the ability to sustain love over time; 3) To facilitate professional dialogue that address the impediments to lovability and loving another; 4) Consider infidelity and sexual addiciton from a love perspective ; 5) To offer an answer to the question, What is love?.

SUMMARY:
The mental health professions have avoided discussing love, its impediments, and the relationship between love problems and the pathogenesis of DSM categories. This course presents a three-part compendium of love's impediments: problems that prevent relationship formation; patterns that detract from a partner's lovability; internal processes that interfere with sustaining love. It describes five dimensions of adult sexual love: pleasure, interest, sexual desire, devotion, and optimism. Each of these fluctuate predictably and unpredictably in their intensities as individuals evolve through the life cycle. The archetypal pathologies of love--including love/lust splits; infidelity; sexual excess-- will be reviewed as well as the processes that lead to the gradual disappointing discovery of partners' character traits, capacities, limitations and values. The course seeks to increase the dialogue about the role of love in creating various forms of suffering--anxiety, depression, sexual dysfunction, addictions--between psychiatrists and patients and to illuminate how these concepts can help patients to realize what the underlying here and now struggles of their lives are about. The course is designed to assist psychotherapists understand and improve their work whether or not they also employ pharmacotherapy.

MAY 05, 2014

SEMINAR 10
NARRATIVE HYPNOSIS WITH SPECIAL REFERENCE TO PAIN
Directors: Lewis Mehl-Madrona, M.D., Ph.D., Barbara Mainguy, M.A., M.F.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will be able to connect the 'default mode' to the neurology of narrative and recognize narrative as the neurological template for information storage and retrieval in the brain.; 2) Participants will be able to link hypnosis and narrative, and propose at least 3 ways in which narrative can be used to stimulate a change in perception. ; 3) Participants will be able to discuss the critical importance of structured language in communication with patients about pain management.

SUMMARY:
Hypnosis research has accelerated in recent years as the technique is becoming more acknowledged as a reliable and valid assistant in the treatment of chronic pain. Basic hypnosis is a structured conversation where language is used to facilitate absorption (deeply focused attention) and, through that, shift the person's perception about an experience. Pain is a central, not a peripheral phenomenon, and a feeling of agency towards one's recovery lowers pain. Through hypnosis it is possible to address the cognitive component of pain. Narrative hypnosis takes advantage of the brain's natural proclivity for story and the importance of personal narratives as what Hirsh, et al. (2013) call "The highest level of cognitive integration,"(p.216). Virtual Reality has shown promise as a way to reliably deliver clinical hypnosis, showing particular relief in studies with burn patients. This seminar provides the most recent research and applications of hypnosis for pain, and discusses, demonstrates and allows practice in the use of hypnosis for pain. We will also review the neuroscience that can explain how hypnosis may work, including brain circuitry related to attention, absorption, narrative, and how these interact with the circuitry used for processing pain. Participants should leave the course proficient in some basic techniques of hypnosis, or, for those more advanced in their practice, able to add several new practices not previously used.

Hirsh, J. , Mar. R., Peterson, J. (2013). Personal narratives as the highest level of cognitive integration. Behavioural and Brain Sciences, (36)181-253

SEMINAR 11
RESEARCH LITERACY IN PSYCHIATRY: HOW TO CRITICALLY AP-

PRAISE THE SCIENTIFIC LITERATURE
Director: Diana E. Clarke, Ph.D.
Faculty: William Narrow, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To understand the basic study designs, concepts, and statistics used in psychiatric research.; 2) To identify why it is important to the individual psychiatrist to be able to understand scientific literature and interpret study concepts, design and statistics.; 3) To discuss and critically appraise the scientific literature.; 4) To identify the gaps in literature in a practical sense, to have greater access to evidence-based care and informed clinical decisions.

SUMMARY:
The overall goal of the research literacy in psychiatry seminar is to educate students on what it means to critically appraise the scientific literature. Throughout the seminar, participants will be introduced to the basic concepts, study designs, and statistics in psychiatric research that will enable them to read and understand the scientific literature and appreciate the importance of being able to critically appraise the literature. Time will be allotted for participants to read a scientific article for discussion. The seminar then will utilize a "journal club"-style interactive format in which methodological and statistical issues will be introduced and discussed on a section-by-section basis as they pertain to the scientific article. After the introduction of methodological and statistical issues related to each section, participants will be given 5-10 minutes to read that respective section of the article. Participants then will discuss the article, view it with a critical eye, and analyze and apply concepts learned. In summary, participants will learn how to appraise the scientific literature in a critical, thorough, and systematic manner. Not only will this course help attendees stay abreast of changes in the field and identify gaps in the literature; in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions.

SEMINAR 12
THE PSYCHIATRIST AS EXPERT WITNESS
Director: Phillip Resnick, M.D.

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

SUMMARY:
Trial procedure and rules of evidence governing fact and expert witnesses will be reviewed briefly. The fallacy of the impartial expert witness will be discussed. Participants will learn that the adversary process seeks justice, sometimes at the expense of truth. The faculty will discuss pre-trial conferences and depositions. Participants will learn to cope with cross-examiners who attack credentials, witness bias, adequacy of examination, and the validity of the expert's reasoning. Issues of power and control in the witness cross-examiner relationship will be explored. Participants will learn how to answer questions about fees, pre-trial conferences, and questions from textbooks. The use of jargon, humor, and sarcasm will be covered.

Different styles of testimony and cross-examination techniques will be illustrated by 11 videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of suggestions for witnesses in depositions, 15 trick questions by attorneys, and over 50 suggestions for attorneys cross-examining psychiatrists.

SEMINAR 13
CPT CODING AND DOCUMENTATION UPDATE
Director: Ronald Burd, M.D.

Faculty: Jeremy S. Musher, M.D., Allan A. Anderson, M.D., David Nace, M.D., Chester Schmidt, M.D., Tracy Gordy, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) understand and appropriately use psychiatric evaluation CPT codes, therapeutic procedure CPT codes, and evaluation and management CPT codes.; 2) document the provision of services denoted by the above sets of codes.; 3) have a better understanding of the CPT code development process.

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 "Psychiatry." 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.

SEMINAR 9
INTRODUCTION TO DAVANLOO'S INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY WITH HIGHLY RESISTANT PATIENTS
Director: Alan R. Beeber, M.D.

Faculty: Gary J. Gala, M.D.
EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) identify the psychodynamic forces underlying human psychopathology in a broad range of patients.; 2) identify and diagnose the manifestations of Major Resistance in the psychotherapeutic process.; 3) identify and describe the main elements of Davanloo's technique.; 4) acquire an understanding of the crucial elements of the process of working through. ; 5)

apply many aspects of the presentation to his/her own clinical practice.

SUMMARY:

Many practitioners and theorists have sought to shorten the course of psychotherapy, typically by selecting patients for high motivation/ low resistance and by narrowing the scope of the therapy to a circumscribed problem or focus. Since the 1960's Davanloo has developed his technique of short-term psychotherapy to apply to a widening patient base of more complex patients who are highly resistant. Through audio-visually record case series he has perfected his technique of accessing the unconscious psycopathological dynamic forces underlying a broad range of disturbances. These patient's include those with anxiety and panic disorders; mild to moderate depression and chronic depressive syndromes; psychosomatic and somatization disorders (such as migraine headache, irritable bowel, non-cardiac chest pain); and complex characterologic and interpersonal difficulties; all who are highly resistant. There is now a substantial evidence base for short-term dynamic psychotherapy (many studies of which include ISTDP) and approximately 25 published outcome studies of ISTDP showing its efficacy.

In this course Davanloo's metapsychology of the unconscious will be elucidated and put in historical perspective. The development of his theory and technique, based on his clinical research involving A/V recorded case series, will be reviewed. The spectrum of patients suitable for DISTDP will be described and the psychodiagnostic process will be explicated. The "Central Dynamic Sequence" for what Davanloo termed "the Total Removal of Resistance" will be presented. The process of what patients have called "unlocking the unconscious" or "breakthrough into the unconscious" will be described. Actual audio-visually recorded sessions with patients will be presented to demonstrate each of these issues. An initial session with a highly resistant patient with complex symptom disturbances and syntonic character difficulties will be shown to highlight the diagnostic process and the process of removal of the major resistance. Access to the core psychopathologic dynamic forces will be demonstrated. Additional A/V recorded sessions of other patients will be shown to demonstrate the process of working through.

The course will include a balance of didactic presentation; audio-visually recorded actual sessions with patients; and participant discussion, questions and answers, and feedback.

SEMINAR 14

PRIMARY CARE SKILLS FOR PSYCHIATRISTS

Directors: Lori Raney, M.D., Erik Vanderlip, M.D.
Faculty: Martha Ward, M.D., Jaesu Han, M.D., Robert M. McCarron, D.O., Lydia Chwastiak, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss useful lifestyle modifications; 2) Understand the current state of the art in treating diabetes, hypertension, dyslipidemias, smoking cessation and obesity; 3) Develop skills in understanding the use of treatment algorithms for chronic illnesses; 4) Explore the use of a primary care consultant to assist in treatment of patients if prescribing desired; 5) Discuss the rationale for psychiatrist prescribing with emphasis on liability and scope of practice concerns.

SUMMARY:

The excess mortality in persons with Serious and Persistent Mental Illnesses leading to a 25 year reduction in life expectancy is a well-known problem facing psychiatrists nationwide. Attempts to develop models that improve the overall health and health status have proven to be expensive, difficult to fund and await the results of pilot projects that are underway. Many psychiatrists find themselves screening for cardiovascular risk factors (hypertension, diabetes, dyslipidemias, tobacco use and obesity) with continued inability to find adequate primary care resources for referral. In addition, some psychiatrists who have in-house primary care resources are finding themselves in positions where they are supervising primary care providers treating these problems. This leads them to a need to update their knowledge in treating the most common chronic illnesses leading to excess mortality to competently monitor progress that often includes state and local reporting on specific measures.
This Course aims to provide updated information for psychiatrists on the diagnosis and treatment of Diabetes, Hypertension, Dyslipidemias, Smoking Cessation and Obesity, using both didactic and case presentations. Algorithms for evidence-based treatment will be included. Ideally, physicians dual-boarded in both psychiatry and medicine will teach these modules to enhance the sense of the instructors understanding the predicament many psychiatrists are currently facing. Discussion time will include examining options for provision of care including psychiatrists providing some limited treatment of these disorders in their clinics with appropriate backup and support.

SEMINAR 15

THE PREVENTION OF VIOLENCE AND OF THE USE OF SECLUSION AND RESTRAINTS VIA TRAUMA-INFORMED CARE

Director: Sylvia Atdjian, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the range of traumatic adaptations and trauma-spectrum disorders; 2) Understand the neurobiology of trauma; and 3) Implement trauma-informed practices.

SUMMARY:

Trauma histories are quite prevalent among those receiving mental health services. Creating safe spaces for trauma survivors is imperative for their healing. It is also important for staff members to feel safe at work. Often violence in treatment settings leads to the use of seclusion and/or restraints which are re-traumatizing for individuals in treatment and staff members. This course will describe how trauma bears on symptom formation and behavioral manifestations including violence and will review the neurobiological substrates of trauma. The principles of trauma-informed care will be described and how trauma-informed care leads to the prevention of violence and the prevention of re-traumatizing practices such as the use of seclusion and restraints. A video clip will show trauma survivors describing their experiences before, during and after their admission to a program that was trauma-informed. The course will conclude with strategies for implementing trauma-

informed practices in various settings.

MAY 06, 2014

SEMINAR 16
THE EXPERT WITNESS IN PSYCHIATRIC MALPRACTICE CASES
Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify practical pitfalls of being an expert witness in psychiatric malpractice cases; 2) Write better malpractice opinion reports; and 3) Be a more effective expert witness in discovery 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 hindsight and confirmation 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 the plaintiff's experts. In preparing for expert witness depositions, participants will be advised about what to remove from their file, the importance of not volunteering anything, and that nothing is "off the record." Handouts will include suggestions for discovery depositions. Each participant will write an opinion about an actual inpatient suicide malpractice case. Participants will then defend their opinions in mock cross-examination.

MAY 03, 2014

THE PERINATAL PSYCHIATRIC CONSULTATION

Chair: Lucy Hutner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize elements specific to the perinatal psychiatry consultation; 2) Receive updated information on psychopharmacologic approaches to psychiatric disorders in the perinatal period; 3) Learn about nonpharmacologic approaches to psychiatric disorders in the perinatal period; 4) Recognize dilemmas and limitations in the evidence base regarding psychotropic medications in the perinatal period; 5) Learn how specialists in perinatal psychiatry approach a real-life, risk-risk decision making process with their patients.

SUMMARY:
Psychiatrists often face substantial treatment dilemmas when addressing psychiatric disorders in the perinatal period. Clinicians must take into account both the risks of exposure to treatment and the risks of untreated mental illness. But they must also have an understanding of the limitations of the current evidence, which is based on retrospective analyses. Last, clinicians need to have a comprehensive understanding of both pharmacologic and nonpharmacologic approaches to treatment in the perinatal period.
This symposium will provide an up-to-date overview of the process of the perinatal psychiatric consultation. Discussants will provide a comprehensive summary of evidence-based medication treatments for depressive and other mood disorders, as well as less well characterized medication options, such as stimulants. Discussants will also discuss nonpharmacologic treatment options that are widely used. Discussants will also provide an overview of aspects of the perinatal consultation and discuss methods of reviewing current evidence in perinatal mental health.

NO. 1
PSYCHOPHARMACOLOGIC APPROACHES: ANTIDEPRESSANTS AND MOOD STABILIZERS
Speaker: Christina L. Wichman, D.O.

SUMMARY:
This section of the symposium will focus on the use of antidepressants and mood stabilizers in the perinatal period. Risks of exposure to these medications will be discussed in detail, including a longitudinal view through the different trimesters of pregnancy as well as lactation. Risks of untreated maternal mental illness will also be discussed. Through this section, the evidence that has contributed to this body of knowledge will be presented and examined in detail. Approaches to minimize exposure to psychotropic medications will also be presented.

NO. 2
OVERVIEW OF ASPECTS OF THE PERINATAL PSYCHIATRIC CONSULTATION
Speaker: Elizabeth Fitelson, M.D.

SUMMARY:
Perinatal mood disorders can present substantial psychiatric risks to both the pregnant woman and the fetus. Perinatal pychiatrists must take into account both the risks of exposure to treatment and the risks of untreated mental illness. They must also have an understanding of the limitations of the current evidence. Established guidelines exist to guide complex decision-making, but treatment ultimately may need to be individualized for each patient. This section of the symposium will provide strategies for reviewing current evidence in perinatal mental health, will demonstrate examples of decision-making with patients, and will illustrate the most important aspects of the perinatal mental health consultation process.

NO. 3
PSYCHOPHARMACOLOGIC APPROACHES TO PSYCHIATRIC DISORDERS IN THE PERINATAL PERIOD
Speaker: Lucy Hutner, M.D.

SUMMARY:
The use of psychotropic medications in the perinatal period presents a treatment dilemma, where clinicians must use a risk-risk analysis to balance the risks of exposure against the risk of untreated maternal mental illness. While certain drug categories (such as antidepressants) have fairly well-described risks, the risk profile of other medication categories (such as stimulants) is less well characterized. This can lead to confusion regarding how to counsel patients appropriately regarding risks of exposure to some medications in the perinatal period. This section of the symposium will comprehensively describe potential risks of exposure to less well characterized medication categories, such as stimulants, benzodiazepines/anxiolytics, and antipsychotic medication. At the end of this presentation, attendees will have a more comprehensive understanding of the known and the unknown risks of several broad categories of psychotropic medications and learn to counsel patients regarding their use.

NO. 4
TREATING THE DEPRESSED PREGNANT WOMAN: THE STATE OF RESEARCH
Speaker: Margaret Spinelli, M.D.

SUMMARY:
Background: Ethical constraints prevent pregnant women from entering placebo-controlled trials. Most research on medications for depressed pregnant women is retrospective, relying on databases, teratology services, birth registries, or population records. Emphasis is typically placed on those with positive findings, while negative findings may be disregarded. These results may then be publicized in the media or used in litigation. Therefore clinicians need to be

able to comprehensively evaluate the methodology of the study to guide treatment decisions.
Method: In order to assist the patient in making an informed decision, the clinician must be knowledgeable about the risks of using medications compared to the risk of the illness to the mother and fetus. Currently, the medical literature contains studies of more than 20,000 outcomes for women exposed to antidepressants during pregnancy. Limitations of present birth defects research are described.
Results: Clinicians must be cognizant of the implications of treating the depressed pregnant woman with medication, the need to evaluate existing research data, and the ability to convey data to the patient.
Conclusion: Limitations on the availability of placebo controlled randomized treatment trials in pregnant women often discourage clinicians from providing appropriate treatment with medications. The implications of no treatment are discussed. The use of evidence-based informed consent is imperative when treating these women.

NO. 5
PERINATAL CONSULTATION: PSYCHOTHERAPEUTIC TREATMENT OPTIONS
Speaker: Kristin L. Wesley, M.D.

SUMMARY:
The perinatal consultation should involve consideration of psychotherapeutic treatments for women with psychiatric disorders in the perinatal period. 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 the perinatal period can be a time 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. We will also review the evidence-based psychotherapeutic options for treatment of mood and anxiety disorders in pregnancy and the postpartum, the including interpersonal psychotherapy (IPT) and cognitive-behavioral therapy (CBT) (Austin 2008, Bledsoe 2006, Sockol 2011, Spinelli 2003).

IS THERE A WAR ON WOMEN? REPRODUCTIVE ISSUES IN WOMEN'S MENTAL HEALTH TODAY

Chairs: Gisèle Apter, M.D., Ph.D., Helen Herrman, M.B.B.S., M.D.

Discussant: Carol C. 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) Address and manage women's mental health issues in diverse situations meeting specifically gender oriented needs during the reproductive cycle;3) Be updated on management of pregnant and lactating women's mental health issues integrating maternal, infant and mother-infant relationship well-being.

SUMMARY:
Reproductive issues on women's mental health are alternately denied, dismissed, minimized, and therefore mismanaged and mistreated. The last decades had seen progress that seems to be regularly damaged by undermining reproductive rights , the constant distortion of scientific data, and sociological and cultural bias. Current knowledge based on research and independent studies on women's mental health needs to be acknowledged in order to focus on how to face today's and tomorrow's health issues for women and their families. . We will start by describing the current issues faced by women in the world . Exposure to trauma is commonly linked to negative mental health. History of trauma and abuse of women are common around the globe. Women who have been sexually assaulted have to deal with myths and beliefs that tend to blame the victim. Women's reproductive rights, specifically free access to safe abortion are under attack under the false pretense that women will be at risk of an "abortion trauma syndrome" that does not exist in any textbook or study. At the same time infertility and Assisted Reproductive Techniques are linked to a rise in anxiety and mood reactions that are brushed aside if pregnancy occurs. Adequate screening, assessment and management of mental health disorders during the peripartum is still in dire need of major public health investment. How to reach out to women during pregnancy and the immediate postpartum, tailoring care with appropriate psychopharmacology and psychotherapeutic techniques in a way that encompasses both maternal and infant well-being still needs to be implemented. Recent published data shows that programs can be organized when policies are changed.A historical legal overview of decisions affecting women's reproductive health will be provided. A general comprehensive discussion encompassing reproductive women's mental health issues will complete our presentation.

NO. 1
CURRENT RAPE CULTURE: BLAME THE VICTIM
Speaker: Gail E. Robinson, M.D.

SUMMARY:
In North America a woman is sexually assaulted every six minutes. Sadly, we seem to be in a culture of blame the victim. A UK Judge gave a suspended sentence to a 41 yr old man because his 13 year old victim was "predatory and egging you on". Two republican politicians were publicly excoriated for referring to "legitimate "rapes and stating that a women's body will not allow her to get pregnant if she is being raped. However, myths about rape are common. Many people believe: nice women don't get raped; women "ask" to be raped by their dress or actions; most rapes are committed by strangers on the street at night; women make many false rape reports; and, if women don't report right

away, are not hysterical or have not been injured, they have not really been raped. All of these beliefs are untrue. The psychological effects of the rape will depend on the individual, her past experiences, time of life, coping styles and positive or negative reactions of others. Victims of rape may experience chronic PTSD, alteration of their life course, depression, shame and guilt, and sexual difficulties. Therapists must be able to offer support without taking over control. However, victims may have a positive outcome if they shift from shame and guilt to anger, restore their sense of control and refuse to remain a victim.

NO. 2
EMOTIONAL ISSUES IN INFERTILITY AND ASSISTED REPRODUCTIVE TECHNOLOGY
Speaker: Malkah T. Notman, M.D.

SUMMARY:
Infertility is as major stress for couples with special problems for women who have been held responsible for it in the past, Assisted reproductive technology has been an important resource for resolving infertility problems and for a number of other difficulties such as carriers of genetic abnormalities, people treated with radiation for malignancies, gay and lesbian couples wishing to have children. As it has become more prominent questions about how and when and whether to tell children have also become prominent. In the context of emerging data about genetic factors in illness and mental illness these concerns become even greater. These issues will be described and discussed.

NO. 3
THE MYTH OF ABORTION TRAUMA
Speaker: Nada L. Stotland, M.D., M.P.H.

SUMMARY:
Approximately one women in three in the United States, and significant percentages in other countries, will have an abortion in their lifetimes, and there is evidence that pre-existing psychiatric symptoms may increase the risk of unintended and unwanted pregnancy. The notion that abortion causes psychiatric illness, while not supported by valid empirical data, has been increasingly used as a rationale for legislation and court decisions limiting access to abortion services. Therefore it is imperative that all mental health professionals be aware of the serious methodological errors in the anti-abortion literature and the well-supported conclusion that abortion is not a significant cause of mental illness, both of which will be covered in this presentation

NO. 4
WOMEN'S REPRODUCTIVE HEALTH AND THE LAW
Speaker: Andrew Beck, J.D.

SUMMARY:
The histories of women's reproductive health, women's mental health, and the law have been closely intertwined not only for decades, but for centuries. The last several years have seen a proliferation of state and national laws and subsequent court decisions affecting pregnancy and abortion. In the United States, these laws--over one thousand proposed in 2012 alone--have overwhelmingly been aimed at decreasing access to abortion services, while some countries in Europe and South America have liberalized their laws. The supposed negative psychological effects of abortion have been used as arguments to support restrictions. The negative psychological effects of those restrictions, on the other hand, have been ignored. This session will cover the history and current realities of laws and court decisions affecting women's reproductive health.

NO. 5
PREGNANCY AND THE PERIPARTUM: RECOGNIZE, REACH OUT, AND MANAGE
Speaker: Gisèle Apter, M.D., Ph.D.

SUMMARY:
Pregnancy is still unjustly considered a blessed time, free of psychiatric disorders, even if there is now strong evidence that childbirth and motherhood are in fact, major stressors putting women and families to test. Even more so, past history of trauma and current adaptation to infant and environmental characteristics frequently add further to women's burdens. Thus, more often than it should, mental disorders during this period is underestimated, not assessed, therefore not diagnosed, and consequently go untreated. Treatments during pregnancy are an important issue because of their consequences, not only for women's health, but also for fetus and future infants' development. Indeed, chemotherapeutic treatments cannot always be avoided during pregnancy. The analysis of a French insurance data base of pregnant women (87,213 women) will describe prescription of psychotropic drugs during pregnancy according to gestation period and discuss them as prevention or treatment strategies. Since recent controversial research have been presented insisting on adverse risk to infant of diverse maternal medication, we will examine methodological issues and benefit/risk evaluation of mother, infant and mother-infant relationship in order to provide the best available tailored care for our patients. How to reach out to patients during the peripartum will be described through examples of programs and policies in an international setting.

BASIC CONCEPTS IN ADMINISTRATIVE PSYCHIATRY

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

Discussant: John E. Wilkaitis, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn techniques for creating an organizational culture that represents quality values, manage risk and promote accountability; 2) Understand the need for fiscal planning and budget management; 3) Learn ways to trans-

late quality services into external perceptions and initiatives that build a strong positive organization; 4) Learn to manage multiple disciplines in a cohesive fashion while growing as managers.

SUMMARY:
This is the first seminar of its kind providing an overview of the theories, principles, concepts and budgetary requirements relevant to administrative psychiatry. This seminar is broad in scope, basic in outline and covers areas of 1) psychiatric care fiscal management; 2) law and ethics; 3) professional and career issues relevant to psychiatric administrators and 4)patient safety.
1) Dr. Hatti will educate the audience on Finance & Accounting in Psychiatric Practice. He will be covering topics like Macro & Micro Economics, Budgets, Financing, Reading Financial Reports & Break Even Calculations. Directors of Community mental health centers and those who own their own practices will find this section very useful in fiscal management.
2) Dr.Reid's section will cover common clinical and clinical-administrative risk and liability issues for mental health agencies, public and private clinics and institutions, and clinicians who hold administrative positions in them. As a forensic psychiatrist with substantial experience in the field, Dr.Reid who is not an attorney, will not give "legal advice." Specific examples will be provided, as well as ample time for questions and comments.
3) Dr. Herman will discuss 'Managing Up'. Most people consider leadership in terms of managing, motivating and inspiring direct reports. However, managing up may be the most important leadership "soft skill" essential for success in an organizational setting. This presentation will discuss the concept of managing up as a distinct leadership skill set that can be acquired, and will provide a personal account of the use of executive coaching to improve a direct line reporting relationship.
4) Dr. Jayaram has served as Physician Advisor for over 2 decades in psychiatry. She will discuss patient safety in 3 areas: strategic planning and leadership initiatives;developing a culture of safety, and setting multidisciplinary performance improvement goals. She will provide examples of systems changes that affect patient care and outcomes.
This session is not expected to be exhaustive in administrative theory or human resources management. The highlights of a clinical leader's everyday practice will be the scope of the session.

NO. 1
FISCAL MANAGEMENT
Speaker: Shivkumar Hatti, M.B., M.B.A., M.D.

SUMMARY:
I will be discussing Financial Management & Accounting. This presentation describes Micro & Macro Financing, Financial statements, Budgeting & Prifitability Calculations.

NO. 2
MANAGING UP, A UNIQUE LEADERSHIP SKILL SET
Speaker: Barry K. Herman, M.D.

SUMMARY:
Most people consider leadership in terms of managing, motivating and inspiring direct reports. However, managing up may be the most important leadership "soft skill" essential for success in an organizational setting. This presentation will discuss the concept of managing up as a distinct leadership skill set that can be acquired, and will provide a personal account of the use of executive coaching to improve a direct line reporting relationship.

NO. 3
FORENSIC ISSUES FOR PSYCHIATRIC ADMINISTRATORS
Speaker: William H. Reid, M.D., M.P.H.

SUMMARY:
Dr. Reid, a forensic psychiatrist, will summarize issues and recommended procedures related to mental health organizations and the civil and criminal law, including individual and organization liability and risk management. Elements addressed will include, but not be limited to, basic U.S. jurisprudence as it applies to health care organizations and institutions, legal expectations of clinical administrators, respondeat superior (the organization's responsibility for acts of its staff), credentialing, common sources of liability risk (and their management), and common causes of action in lawsuits and complaints.

NO. 4
UNDERSTANDING PATIENT SAFETY IN PSYCHIATRIC CARE
Speaker: Geetha Jayaram, M.B.A., M.D.

SUMMARY:
Patient safety is a highly desirable goal in health care settings. In psychiatric care, its conceptualization, application and methodology are poorly understood or researched. Administrators and leaders of institutions nevertheless are required to set safety targets, implement directives of 3rd party regulators, and integrate them annually into daily practice.
Dr. Jayaram will guide the audience on real life applications of safety practices, creating a culture of safety and on capturing data to evaluate outcomes.
She will choose a few areas critical to psychiatry to discuss and encourage participant discussion on applications particular to their health care settings.

MENTALIZING IN MENTAL HEALTH PRACTICE: TIME FOR INTEGRATION

Chairs: Anthony Bateman, M.D., Robin Kissell

Discussant: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be

able to: 1) Consider the mechanism of change in treatment of borderline personality disorder; 2) Identify key mentalizing components of therapy process; 3) Recognize how to integrate mentalizing techniques with other therapeutic methods. .

SUMMARY:
Many different therapies are effective in the treatment of borderline personality disorder. Yet little is known about the process of change. It has been suggested that the driver for change in treatment of BPD is an increased ability in mentalization – the ability to self reflect and to consider the states of mind of others to understand meaning and motivation of oneself and others. Yet it is possible that any improvement in mentalizing is not sufficient for change. It is known that patients with BPD do not improve adequately over time in social and vocational functioning following treatment of any kind. This has led clinicians to be appropriately concerned that treatments are currently inadequate. As a consequence they have begun to consider new paradigms and develop treatments combining techniques from a range of evidence-based therapies.
This symposium will first discuss the possible mechanism of change in treatments for borderline personality disorder suggesting that a change mentalizing is essential but not sufficient for change and secondly outline how mentalizing is being used as a core component of multi-model treatment. The very breadth of mentalizing and its developmental origins imply that a range of treatment methods are likely to facilitate and stimulate mentalizing process. Plain old therapy uses mentalizing and attachment process as a focus for treatment and considers these as generic components of all therapies. Without mentalizing the attachment processes the relationship with the therapist cannot progress making other interventions ineffective. In the treatment of adolescents, mentalizing is used as a unifying process to ensure integration of a team who may otherwise deliver a range of treatments without cohesion. It is suggested that integrating mentalizing interventions with other techniques is not simply a question of using a bit of this and a bit of that but more a question of the clinician altering his stance at key moments in treatment. Clinical illustrations will be used through out this symposium and some empirical evidence given to suggest that integrating mentalizing with other techniques has an underlying rationale and may lead to more effective treatment for borderline personality disorder.

NO. 1
A SINGLE MECHANISM OF CHANGE IN BORDERLINE PERSONALITY DISORDER
Speaker: Peter Fonagy, Ph.D.

SUMMARY:
There are seven or eight therapies that could claim to be evidence-based in the treatment of borderline personality disorder (BPD). Are there seven or eight different mechanisms that could account for an individual with BPD losing their symptoms? We have previously suggested that an increased capacity for mentalization could be seen as driving the change process in a range of therapies. Whilst there is some evidence emerging that is consistent with this presumption, our current view is that mentalization is a necessary but not a sufficient condition for therapeutic change. Whilst we accept that there are modality-specific mechanisms which provide the structure around which a change process can occur, we now see the driver of recovery as rooted in the quality of the relationship between the patient and their social environment. Improvement rests on alterations in the epistemic quality of the communication between patient and therapist that ultimately generalises to the social environment, where the locus of recovery in BPD resides.

NO. 2
MENTALIZING IN PLAIN OLD THERAPY
Speaker: Jon G. Allen, Ph.D.

SUMMARY:
In a field dominated academically by a multitude of specialized, evidence-based treatments, we also need a solid scientific foundation to guide what many of us generalists actually provide: plain old ("talk") therapy. Attachment theory, now enriched by research on mentalizing, provides that foundation. This presentation highlights trauma in attachment relationships, which substantially undermines the development of mentalizing. The sheer complexity of developmental psychopathology associated with such trauma calls for a flexible, generalist approach to psychotherapy, with a focus on mentalizing in attachment relationships as its organizing principle.

NO. 3
THERAPEUTIC INTEGRATION AROUND A MENTALIZING FOCUS
Speaker: Elizabeth W. Newlin, M.D.

SUMMARY:
The design and implementation of an integrated psychotherapeutic inpatient program for adolescents with complex psychiatric disorders is presented. The rationale, process, and results of integrating mentalization-based treatment (MBT) with other mentalizing-supportive methodologies is outlined.
MBT provides a coherent theoretical framework within which to understand patients and has well defined clinical objectives. MBT's ultimate aim is to restore an inherent capacity, mentalizing, and targeted use of other methodologies supportive of such capacity can be used alongside MBT without losing the coherence of the treatment model. MBT unifies the treatment team's approach with a well defined therapeutic stance and model for individual, group, and family therapy. The mentalizing capacity of adolescents is further supported by mindfulness-training and selected skills-training in acceptance and commitment therapy (ACT), compassion-focused therapy (CFT), dialectical behavioral therapy (DBT), and cognitive-behavioral therapy (CBT).

NO. 4

MENTALIZING THROUGH THE LENS OF SCHEMA-BASED CBT THEORIES OF PSYCHOPATHOLOGY

Speaker: Carla Sharp, Ph.D.

SUMMARY:

Mentalizing refers to the natural human capacity to interpret the behavior of others within a mentalistic framework—that is, an individual's ability to ascribe desires, feelings, thoughts, and beliefs to others and to employ this ability to interpret, anticipate, and influence others' behavior. Fonagy and colleagues' mentalization-based developmental model of psychopathology (Fonagy, 1989; Fonagy & Luyten, 2009; Sharp & Fonagy, 2008) posits that a vulnerability in mentalizing underlies the development of various forms of psychopathology and that as the child's attachment relationships have an important role to play in the acquisition of mentalizing abilities, disruptions of early attachment experiences can derail social-cognitive development, thereby leading to psychopathology. While this theory naturally fits with its psychodynamic roots, a careful evaluation of this model exposes its overlap with schema-based CBT theories of psychopathology. In this talk, this overlap will be discussed with associated empirical evidence. In addition, the clinical implications of this overlap will be discussed by showing how CBT enhances mentalizing and vice versa.

NO. 5

BPD IN THE AGE OF EVIDENCE-BASED TREATMENTS (EBT): FROM MODALITY-TETHERED CLINICIANS TO PATIENT-TARGETED CLINICAL INTEGRATION

Speaker: Brandon Unruh, M.D.

SUMMARY:

Some clinicians who attend EBT trainings become devotees and go on to develop themselves as an "adherent" practitioner of a particular model within a treatment setting containing appropriate resources and commitment. However, this opportunity is only available to a relatively limited few, as building an adherent EBT clinical program requires the investment of large sums of money, time for the training of a team, ongoing supervision by experts, and intense clinical coordination. Other clinicians emerge from EBT trainings committed to using the principles and techniques but unable or unwilling to implement the EBT in a manner adherent to the empirically validated treatment structure. Some clinicians familiar with multiple EBTs implement components of multiple EBTs in an integrated fashion rather than select haphazardly from separate grab-bags of techniques, but this approach has not been studied. In this symposium, we propose a set of initial principles to be used to integrate basic strategies from MBT with other EBTs into a coherent treatment approach marked by informed stance-shifting, rather than impractical adherence-mongering, in response to different clinical problems at different time points in treatment. Vignettes will be presented illustrating the application of these informed stance shifts within individual sessions and across treatment course.

NO. 6

BPD IN THE AGE OF EVIDENCE-BASED TREATMENTS (EBT): FROM MODALITY-TETHERED CLINICIANS TO PATIENT-TARGETED CLINICAL INTEGRATION

Speaker: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:

Some clinicians who attend EBT trainings become devotees and go on to develop themselves as an "adherent" practitioner of a particular model within a treatment setting containing appropriate resources and commitment. However, this opportunity is only available to a relatively limited few, as building an adherent EBT clinical program requires the investment of large sums of money, time for the training of a team, ongoing supervision by experts, and intense clinical coordination. Other clinicians emerge from EBT trainings committed to using the principles and techniques but unable or unwilling to implement the EBT in a manner adherent to the empirically validated treatment structure. Some clinicians familiar with multiple EBTs implement components of multiple EBTs in an integrated fashion rather than select haphazardly from separate grab-bags of techniques, but this approach has not been studied. In this symposium, we propose a set of initial principles to be used to integrate basic strategies from MBT with other EBTs into a coherent treatment approach marked by informed stance-shifting, rather than impractical adherence-mongering, in response to different clinical problems at different time points in treatment. Vignettes will be presented illustrating the application of these informed stance shifts within individual sessions and across treatment course.

PERINATAL EFFECTS OF SUBSTANCE USE DISORDERS

Chair: Priya Gopalan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand nuances of identifying and managing substance use disorders during the perinatal period; 2) Describe the impact of alcohol and other drugs (e.g., cannabis, cocaine, nicotine, opioids) on the fetus; 3) Apply management principles for alcohol and benzodiazepine intoxication and withdrawal states to the pregnant mother; 4) Gain knowledge in opioid maintenance treatments used in pregnancy, the rationale behind their use, fetal effects of methadone and buprenorphine, and impacts on maternal and neonatal outcomes; 5) Discuss treatment strategies for improving outcomes in co-occurring psychiatric and substance use disorders, with consideration of treatment during pregnancy.

SUMMARY:

Despite the decades-long surge in clinical research devoted to perinatal psychiatry, confident provision of mental health care to pregnant mothers continues to challenge even the most seasoned clinicians. The deleterious maternal-fetal im-

pacts of perinatal affective, anxiety, and psychotic disorders are magnified in the setting of concomitant substance use. With 5% or more of pregnant patients reporting illicit drug use, stronger efforts are needed to educate clinicians about identifying and managing substance use disorders during pregnancy.

This symposium will serve as a practical guide to the management of perinatal addiction, intoxication and withdrawal states, and psychiatric comorbidities of substance use. The first portion of the symposium will be devoted to effects of illicit drugs and alcohol on mother and child, with a specific focus on opioid maintenance therapies during pregnancy. Next, speakers will review approaches to identifying alcohol and benzodiazepine withdrawal in the pregnant patient, with recommended guidelines for management. Finally, comorbid substance use and psychiatric care (i.e., "dual diagnosis" treatment) will be reviewed, with special focus on common psychiatric syndromes diagnosed in pregnancy and the postpartum period. The speakers will utilize an interactive, case-based approach to encourage audience participation and critical thinking.

NO. 1
FETAL EFFECTS OF SUBSTANCES OF ABUSE
Speaker: Jody Glance, M.D.

SUMMARY:
Women are more likely to stop using alcohol, nicotine and illicit substances during pregnancy than at any other time. Thus, it is imperative that health professionals screen for and address substance use disorders in their pregnant patients and refer to appropriate treatment. While many deleterious effects of substance use during pregnancy are well known, such as the Fetal Alcohol Syndrome, others are less pronounced and may not be apparent until later in life, as seen in childhood sleep problems associated with in-utero nicotine exposure. Negative outcomes associated with substance use during pregnancy will be discussed, along with treatment options.

NO. 2
METHADONE AND BUPRENORPHINE IN PREGNANCY
Speaker: Shannon Allen, M.D.

SUMMARY:
Opioid use during pregnancy is common and appears to be increasing as the United States faces rising misuse of prescription analgesics. Adverse outcomes are significantly increased with both illicit and prescription opioid use during pregnancy. Throughout the last few decades, methadone maintenance has been established as the gold standard for treatment of opioid dependence during pregnancy, and SAMHSA and the American College of Obstetrics and Gynecology have recently begun to support the use of buprenorphine maintenance for pregnant opioid dependent women. Opioid substitution therapies will be discussed, with a focus on management principles and potential risks and benefits for maternal, obstetrical, and fetal outcomes.

NO. 3
ALCOHOL/BENZODIAZEPINE INTOXICATION AND WITHDRAWAL STATES: OVERVIEW AND PERINATAL MANAGEMENT
Speaker: Pierre Azzam, M.D.

SUMMARY:
During pregnancy, the management of alcohol or benzodiazepine intoxication and withdrawal can prove especially challenging. Because limited data are available to guide robust evidence-based approaches to GABAergic detoxification in pregnancy, clinicians must consider the potential risks and benefits of symptom-triggered benzodiazepine therapy, front-loading approaches, and scheduled benzodiazepine tapers in the management of withdrawal states. With a focus on practical aspects of treatment and harm reduction, guidelines for management of intoxication and withdrawal syndromes will be discussed in detail.

NO. 4
DUAL DIAGNOSIS AND PREGNANCY: SPECIAL CONSIDERATIONS
Speaker: Priya Gopalan, M.D.

SUMMARY:
Mood disorders occur in the perinatal period at rates as high as 15%. Additionally, mood disorders are a common comorbidity for patients with substance use disorders, and the management of pregnant women with "dual diagnoses" poses the clinician with unique challenges. This portion of the symposium will provide a brief overview to management of mood disorders in pregnancy and highlight challenges in patients with substance use disorders.

GOLDMINE OR MINEFIELD: NAVIGATING THE SPECTRUM OF SEXUAL FEELINGS AND BEHAVIORS IN OLDER ADULTS

Chair: Sarah N. Mourra, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Effectively identify the unique characteristics of sexual transference in older adults, and appreciate it as an important clinical tool in the therapeutic relationship; 2) Identify and understand the role that cultural biases and ageism play in clinician reactions to expression of sexual feelings in older adults; 3) Understand the biological and psychosocial factors which impact sexuality in aging. They will be able to exercise comfort in addressing this with patients; 4) Appreciate ethical implications of sex in the nursing home and effectively weigh the role that cognition plays in decision making capacity; 5) Effectively recognize inappropriate sexual behaviors in dementia, and will be able to diagnose and treat this in an evidence based manner.

SUMMARY:
It is estimated that the number of adults age 65 and older in

the U.S. will grow to more than 72 million by 2030, with 14-20 percent of the elderly population expected to carry mental health or substance use diagnoses, such as depressive disorders and dementia-related behavioral and psychiatric symptoms. As indicated in the Institute of Medicine's 2012 report "The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands," the rate of specialized providers entering the workforce is dwarfed by the pace at which this population is growing.

Increasingly, the mental health care for older adults will fall with non-geriatric psychiatrists and other providers who may be unaccustomed to the special needs of this population. Recognition, management and understanding of the broad range of sexual feelings and behaviors in older adults is a key component to providing humane, appropriate and evidence based care. This presentation seeks to address any gaps in knowledge with a range of presentations that cover the many manifestations of sexual feelings and behavior in older adults.

Presentations will include education on the unique characteristics of sexual transference in older adults in the therapeutic setting, as well as barriers to recognizing and managing this appropriately. Strategies for conceptualization, containment and management will be discussed. Normal sexuality in older adults will be covered, with an emphasis on expected biological and psychosocial changes in aging that influence older adult sexual activity and health.

The symposium will transition into inappropriate sexual behaviors in dementia and hypersexuality. Evidence based techniques for assessment as well as behavioral and pharmacologic treatments will be presented.

Finally, the ethical aspects of consent in sexual encounters will be covered. For older adults living in Residential Care Facilities the issue of choosing a sexual partner or falling in love is complex. The notion of sexuality in the elderly creates problems for families and care givers about the appropriateness of these encounters and the resulting relationships. The ethics of sex in older adults and role that cognition plays in decision making capacity will be examined.

Participants are expected to gain an understanding of the full range of sexual feelings and behaviors in older adults in both inpatient and outpatient settings, and gain tools for understanding, assessing and managing these issues in this special population.

NO. 1
UNDERSTANDING AND MANAGING EROTIC TRANSFERENCE IN OLDER ADULTS
Speaker: Sarah N. Mourra, M.D.

SUMMARY:
Sexual attraction and longings in therapeutic relationships often prove to be complex and demand a sophisticated perspective to arrive at a useful formulation and constructive intervention. This issue is further complicated by issues of aging, loss and medical comorbidity that arise in elderly populations. This presentation will cover the topic of erotic transference in the elderly. It will discuss the reasons that these issues may emerge in the clinical encounter, ranging from psychodynamic content to organic brain disease. It will aim to educate clinicians and physicians who practice in the home based setting about the particular way in which this practice environment influences sexual feelings and behavior around the treating team. It will also cover relevant issues of ageism and cultural factors that influence the approach of clinicians to sexual feelings and behavior in the elderly.

NO. 2
SEXUALITY AND AGING: THE NEW NORMAL
Speaker: Kirsten Wilkins, M.D.

SUMMARY:
Despite common misconceptions, the majority of older adults are engaged in sexual activity and regard sex as an important part of life. As individuals are living longer, healthier lives, there is interest in maintaining sexual health throughout the latter decades. Indeed, many studies have shown that people remain sexually active into their seventh and eigth decade. Various aspects of aging can, however, impact one's ability to participate in and enjoy sexual activity. A general overview of the biological and psychosocial factors which impact sexuality in aging will be provided.

NO. 3
INAPPROPRIATE SEXUAL BEHAVIORS IN DEMENTIA -- AN EVIDENCE BASED REVIEW
Speaker: Rajesh R. Tampi, M.D.

SUMMARY:
Dementias are the most common type of neurodegenerative disorder. Behavioral disturbances are seen in more than 80% of patients with dementias. Although sexually inappropriate behaviors are not as common as some of the other symptoms of dementia, they can cause immense distress to all those who are affected by them. There are no randomized controlled trials for the treatment of these behaviors, but current data suggests efficacy for some commonly used treatment modalities. In this part of the symposium, we will systematically discuss various aspects of these behaviors and their available treatments

NO. 4
PASSION AND SENTIMENT: ISSUES WITH CONSENT IN SENESCENCE
Speaker: Louis Trevisan, M.D., M.Ed.

SUMMARY:
The ethical aspects of consent in sexual encounters among older adults involve many different issues. For the elderly living in Residential Care Facilities the issue of choosing a sexual partner or falling in love is complex. The notion of sexuality in the elderly creates problems for families and care givers about the appropriateness of these encounters and the resulting relationships. This section will examine the ethics of sex in the nursing home and valence that cog-

nition plays in decision making capacity.

TAKING AIM AT A LOADED ISSUE: GUNS, MENTAL ILLNESS, AND RISK ASSESSMENT

Chair: Abhishek Jain, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the general evolution of gun legislation; 2) 2) Summarize how mental health issues are incorporated in gun laws; 3) Assess any potential roles of the mental health field in formulating gun policies; 4) Integrate violence risk assessment, firearm screening, and gun laws pertaining to mental health into clinical practice; 5) Identify future directions for research and public health.

SUMMARY:
In the wake of recent mass shootings, the gun-control and gun-rights debate has been propelled into the national spotlight. Following the December 14, 2012 tragedy in Newtown, Connecticut, President Barack Obama outlined 23 executive actions, including clarifying that physicians are not prohibited from asking patients about gun possession or reporting threats of violence to law enforcement authorities, a commitment to finalizing mental health parity regulations, and launching a national dialogue on mental health (www.whitehouse.gov). Thus, mental health issues have taken a central role in the gun debate. Over the years, studies have corroborated a positive association between firearm ownership and suicide and homicide (Traylor et al, 2010). Today, federal and state laws have provisions prohibiting certain categories of persons with mental illness from purchasing or possessing firearms (Price and Norris, 2010). This has raised broad issues, such as whether or not to target, and how to define, the mentally ill in gun legislation, and specific issues, such as whether or not to routinely evaluate firearm possession and firearm safety in clinical encounters. In general, mental health professionals may benefit from basic education on firearms, firearm safety, and screening questions. A survey revealed that 55% of psychiatry residency training directors routinely screened patients regarding gun ownership (Price et al, 2010). Although psychiatrist bring a unique perspective to the issue of gun violence, the profession is reminded that there are multiple considerations besides mental illness, such as societal factors and criminal motivation, that are involved with violence.
This symposium will provide a broad overview of federal, state, and local gun legislation and regulations; a review of laws restricting gun ownership by the mentally ill; a discussion of the public policy and ethical implications of incorporating mental health issues in gun control; an analysis of including gun screening as a component of routine clinical practice; and the practical clinical application of assessing firearm safety and risk. A particular emphasis will be placed on audience participation and gaining hands-on experience with firearm screening, types of firearms, and general risk assessment instruments.

NO. 1
FEDERAL, STATE, AND LOCAL GUN LEGISLATION
Speaker: Abhishek Jain, M.D.

SUMMARY:
This section will provide a broad overview of federal, state, and local gun legislation and regulations and a review of laws restricting gun ownership by the mentally ill.

NO. 2
MENTAL ILLNESS, GUNS, AND PUBLIC POLICY
Speaker: Ryan C.W. Hall, M.D.

SUMMARY:
This portion of the symposium will highlight the political and legal concerns when the mental health field gets involved in the discussions regarding violence and gun control. Potential solutions to and perils of championing laws, which can place psychiatrists and patients at a risk for stigma, decreased access to care, and liability, will be summarized. A review of existing legislation, such as New York State's Secure Ammunition and Firearms Security (SAFE) Act, Patient Protection and Affordable Care Act (PPACA) - which has largely unknown provisions related to the protection of the Second Amendment, and laws that have questionable wording, such as Florida's 2013 Senate Bill 1484, will be included.

NO. 3
ETHICS OF PSYCHIATRIC INVOLVEMENT AND FUTURE DIRECTIONS FOR RESEARCH
Speaker: Susan Hatters-Friedman, M.D.

SUMMARY:
This segment will build on the political and legal hurdles and discuss the specific ethical and clinical challenges of the mental health field's involvement in the gun control debate. A key portion will be looking ahead to potential solutions and future directions for research.

NO. 4
FIREARM SCREENING AND RISK ASSESSMENT IN CLINICAL PRACTICE
Speaker: Renee Sorrentino, M.D.

SUMMARY:
The focus of this section is risk assessment in both clinical and forensic cases. The role of the psychiatrist in the determination of gun ownership and management will be reviewed in the context of state law and APA professional guidelines.

NARCISSISTIC PERSONALITY DISORDER: DSM-5 AND BEYOND

Chair: Elsa F. Ronningstam, Ph.D.

Discussants: Diana Diamond, Ph.D., Kenneth N. Levy, M.A.,

Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify diagnostic dimensions and traits for narcissistic personality disorder as outlined in DSM 5 Section III; 2) Know the empirically identified characteristics of pathological narcissistic functioning with regards to cognition, affect, empathy and interpersonal behavior; 3) Identify treatment implications and strategies based on a dimensional approach to pathological narcissism and narcissistic personality functioning.

SUMMARY:
The hybrid categorical dimensional model for diagnosing NPD in DSM 5 Section III opens new avenues for clinical and empirical studies of identification and individual functioning. This symposium will focus on several new aspects of pathological narcissism and NPD that significantly can broaden our understanding and treatment approaches.
Dr. Bender will summarize the proposal for NPD in the DSM-5 Section III and the procedure for assessing core elements of personality functioning and pathological personality traits. The validity of NPD as a distinct personality disorder will also be addressed.
Dr. Wright will discuss empirical methodology for evaluating and refining the DSM-5 hybrid model, and integrate individual differences related to cognition, affect, and behavior that reflect self/interpersonal impairment. Results from a 100-day daily diary study collected from a sample of patients diagnosed with personality disorders will be presented.
Dr. Baskin-Sommers will review research on empathy in NPD that suggest deficient emotional empathy and dysfunctional rather than deficient cognitive empathy, and compare with empathy-based findings for related personality syndromes (BPD and psychopathy).
Dr. Caligor will discuss pathological narcissism and NPD within the framework of object relations theory and transference-focused psychotherapy. Descriptive features, spectrum of severity and comparison to BPD will be included with implications for treatment.
Dr. Ronningstam will outline an exploratory and collaborative approach to alliance building and treatment that adjust to NPD patients' ability for self-reflection and motivation to address both internal experiences and interpersonal and vocational functioning with special focus on improving emotion regulation, and sense of agency and self-direction.

NO. 1
NARCISSISM IN THE DSM-5 SECTION III PERSONALITY DISORDER MODEL: PROBLEMS SOLVED?
Speaker: Donna S. Bender, Ph.D.

SUMMARY:
The DSM-5 Section II criteria for Narcissistic Personality Disorder (NPD) have not changed from those in DSM-IV. Therefore, the many well-documented problems with the diagnosis will continue to exist if clinicians choose to use the Section II version. However, a new alternative model for personality disorders has been published in Section III of DSM-5. The Section III model is a categorical-dimensional hybrid based on the assessment of core elements of personality functioning, and of pathological personality traits. The Section III NPD diagnosis was formulated to address some of the previous limitations, such as the inability to capture both vulnerable and grandiose aspects of narcissistic pathology using DSM-IV/Section II criteria. While the Section III NPD approach offers a significant improvement over the Section II criteria in characterizing narcissistic difficulties, questions remain about the validity of NPD as a distinct personality disorder.

NO. 2
AT THE NEXUS OF SCIENCE AND PRACTICE IN PATHOLOGICAL NARCISSISM: EMPIRICAL APPROACHES FOR EVALUATING AND REFINING THE DSM-5 SECTION III MODEL
Speaker: Aidan G.C. Wright, Ph.D.

SUMMARY:
The DSM-5 Section III personality disorder (PD) model provides the potential for greater integration with both clinical theory and the science of personality and its pathology. Although not adopted as the official model of PD, the new model may now be evaluated, and potentially refined, through targeted research efforts. First, this talk will discuss challenges that emerge from attempting to integrate the processes reflective of self/interpersonal impairment with trait-based individual differences within a comprehensive dimensional model of PD with a particular focus on pathological narcissism and narcissistic PD. Pathological narcissism in many ways provides a perfect exemplar of the challenges inherent in the Section III model in that it the clinical presentation involves basic individual differences and complex dynamic processes. Second, contemporary data collection and analytic techniques will be introduced that offer promising avenues for future research efforts and personalized assessment. These include intensive repeated measurement (e.g., ecological momentary assessment, experience sampling methodology, daily diaries) and associated quantitative methodology that can capture the dynamic processes in cognition, affect, and behavior that are central to the clinical description of narcissistic pathology.

NO. 3
EMPATHY IN NARCISSISTIC PERSONALITY DISORDER: BRIDGING CLINICAL AND EMPIRICAL PERSPECTIVES
Speaker: Arielle Baskin-Sommers, Ph.D.

SUMMARY:
Narcissistic personality disorder (NPD) is associated with an assortment of characteristics that undermine interpersonal functioning. A lack of empathy is often cited as the primary distinguishing feature of NPD. However, research illustrates that empathy is multidimensional, involving two distinct emotional and cognitive processes associated with a capac-

ity to respectively understand and respond to others' mental and affective states. In this talk, I will review the literature on empathy and NPD, which largely associates this disorder with deficient emotional empathy, and dysfunctional rather than deficient cognitive empathy. Since this research is limited, I also review empathy-based findings for related personality syndromes (BPD and psychopathy). Given the complexity of narcissism and empathy I propose multiple relationships between these constructs. Ultimately, by recognizing the multifaceted relationship between empathy and narcissism and moving away from an all or nothing belief that those with NPD simply lack empathy, therapists may better understand narcissistic patients' behavior and motivational structure.

NO. 4

PATHOLOGICAL NARCISSISM WITHIN THE FRAMEWORK OF OBJECT RELATIONS THEORY AND TRANSFERENCE-FOCUSED PSYCHOTHERAPY

Speaker: Eve Caligor, M.D.

SUMMARY:

Our group has developed an approach to pathological narcissism that is embedded in psychodynamic object relations theory. Our approach to the NPD diagnosis corresponds quite closely with the proposed framework developed for Section 3 of the DSM-5, which defines NPD in terms of specific pathology of identity formation and of interpersonal relations, in conjunction with pathological personality traits. Our approach to NPD, which, in contrast to the DSM-5, is embedded in a specific theoretical orientation, places NPD within a comprehensive model of personality pathology that is directly linked to a specific, psychodynamic treatment approach. We propose that, despite what can be adequate, or even in some cases, good surface functioning, at the core of narcissistic pathology is clinically significant pathology of identity formation; the descriptive features of NPD, including distorted or unstable self-appraisal and superficiality of interpersonal relations, in conjunction with variable, and sometimes quite, high levels of functioning, are understood as manifestations of the particular type of pathological identity formation characteristic of NPD. For my talk, I will present an overview of our model of personality pathology, placing NPD within this framework and addressing similarities and differences with BPD. Diagnostic issues pertaining to spectrum of severity, heterogeneity among patients presenting with pathological narcissism, and core, pathognomonic, features of NPD wi

NO. 5

A DIMENSIONAL CONCEPTUALIZATION OF NPD - TREATMENT IMPLICATIONS

Speaker: Elsa F. Ronningstam, Ph.D.

SUMMARY:

Studies have pointed to several central characteristics of pathological narcissism and narcissistic personality disorder, NPD; co-existence of grandiosity and vulnerability with both overt and covert expressions, functional fluctuations, and underlying inadequacy, insecurity, shame, rage , pain and fear.

A dimensional conceptualization of narcissistic personality disorder can guide the clinician at an early stage in treatment to attend to the patient's fragility in self-regulation, fluctuating sense of identity and agency, self-protective reactivity, and range of specific self-enhancing and self-serving behaviors and attitudes. This presentation will outline an exploratory and collaborative approach to alliance building and treatment that adjust to the patients' reflective ability, degree of self-awareness, and motivation to address both internal experiences as well as their external and interpersonal functioning. Special focus will be on improving the patients' emotion regulation, and sense of agency and self-direction in interpersonal and vocational functioning, and on encouraging acceptance of losses and limitations with ability for mourning.

THE SANDY HOOK DISASTER: CRISIS MANAGEMENT, RECOVERY, AND POLICY RESPONSE

Chair: Harold I. Schwartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the elements of the state agency response which coordinated multiple resources providing crisis support to school children, school staff, family members, responders and the community; 2) Participants should be able to recognize the role which the Connecticut Psychiatric Society played in organizing its members for the crisis response, identifying the challenges and lessons learned; 3) Participants should be able to identify the transition from crisis response to short and long term recovery goals, recognizing progress made and the challenges remaining for the Newtown community; 4) Participants should be able to recognize issues raised by resulting statutes on gun control, school safety and mental health and identify the elements of the national dialogue on mental health.

SUMMARY:

On the morning of December 14, 2012, a young man with an assault rifle killed 20 school children and six adults at the Sandy Hook Elementary School in Newtown, Connecticut setting off a disaster response at the local, state and national levels. The Connecticut Department of Mental Health and Addiction Services coordinated the crisis response which included clinical support to surviving family members, school children and personnel, support to town and school officials and strategic planning for longer term recovery. The Connecticut Psychiatric Society (CPS), many of whose members had the month before undergone disaster response training, organized a volunteer contingent which joined in the relief effort. Members of the CPS provided counseling to hundreds of men, women and children in the aftermath of this tragedy.

The National Child Traumatic Stress Network created the

Newtown Recovery Program which included a needs assessment; the selection of developmentally appropriate interventions and services for students, school staff, parents and families; the facilitation of partnerships with community, state and federal resources; organizing and delivering training and education and addressing ongoing secondary adversities. Mourning and maladaptive grief, as well as the unique needs of school and community leadership, are factors that must be considered in establishing any recovery program.

The Sandy Hook disaster reverberated throughout the nation. Several states passed stringent gun control laws as well as statutes addressing school safety and mental health. In at least two cases, these new laws create problematic requirements to report patients considered to be "dangerous" or who have been hospitalized. The Sandy Hook Advisory Commission was established to report out far reaching recommendations regarding gun control school safety and mental health. At the national level, the administration has intiated a "national dialogue on mental health" as part of a national action plan that addresses gun safety, school safety and mental health issues with a special focus on prevention, early intervention and access to care for adolescents and young adults.

This symposium will review the lessons learned regarding disaster response in a mass shooting event including the immediate crisis response and the short and longer term recovery strategies. The impact of Sandy Hook has been felt far beyond the confines of the Newtown community and the lessons learned extend beyond the community to the impact of state statutes passed by legislatures in the rush to "do something" before the impetus fades and to federal inititatives to address gun and school safety and access to mental health services.

NO. 1

PROMOTING RESILIENCE AND RECOVERY IN NEWTOWN

Speaker: Patricia Rehmer, M.S.N., R.N.

SUMMARY:

CT Department of Mental Health and Addiction Services (DMHAS) is designated as lead agency for behavioral health in Connecticut. In the wake of the Sandy Hook tragedy DMHAS coordinated a multi-tiered mental health response which included local, state and national resource coordination, clinical support to surviving family members, school children and personnel, community assistance and administrative support to town and school officials, as well as planning and referrals for long term recovery.

This session will explore the scope of the behavioral health response to this mass casualty event within the school and the community. The session will focus on strategies, interventions and resources used by DMHAS and behavioral health responders to promote resiliency and achieve response goals. The discussion will include a range of "lessons learned" at both the individual responder level and the state response level.

NO. 2

THE MENTAL HEALTH DISASTER RESPONSE TO THE NEWTOWN MASSACRE: LESSONS LEARNED, LESSONS NEVER TO FORGET

Speaker: Carolyn Drazinic, M.D., Ph.D.

SUMMARY:

On the morning of Friday, December 14, 2012, a young adult male with an assault rifle killed 20 school children and 6 adults. This tragedy occurred in a small town in CT, but it could have happened anywhere. The entire community was traumatized. A mental health disaster response was clearly needed, but how does one create it and, in particular, what role can a state psychiatric society play? There was no precedent for this type of response at such a large scale, even for the Connecticut Red Cross, which was accustomed to managing natural disasters like hurricanes and freak icestorms the previous year.

This presentation will explain how mental health providers and the Connecticut Psychiatric Society rose up to meet this challenge, counseling hundreds of men, women, and children, for days, weeks, and months after this terrible tragedy. There were many lessons learned from this moving and humbling experience, from both organizational and emotional perspectives. It was a unique moment in history: people of all ages, including first responders, sought counseling in the open, without fear of being publicly seen getting help from psychiatrists. Some mental health volunteers also experienced vicarious traumatization, even as they sought to help the Newtown community.

There were many lessons learned, and many lessons never to forget, for the future development of mental health disaster responses, and an open discussion will be encouraged.

NO. 3

A MODERN APPROACH TO BEHAVIORAL HEALTH AND ACADEMIC RECOVERY: CREATING THE PATH TO RECOVERY IN NEWTOWN

Speaker: Robert Pynoos, M.D.

SUMMARY:

This presenter will discuss how to move from the initial response to creating and implementing a long-term school-based behavioral health and academic recovery program for schools, such as Sandy Hook Elementary School, impacted by catastrophic violence. Dr. Pynoos will outline the strategies for how the National Child Traumatic Stress Network created the Newtown Recovery Program, including: 1) conducting an initial needs assessment to determine the "signature" of the school violence and identification of differentially affected populations; 2) selecting appropriate developmentally-appropriate interventions and services for students, school staff, parents, and families; 3) facilitating partnerships with community, state, and Federal partners; 4) organizing and delivering training and education; and 5) addressing ongoing secondary adversities. This presentation will also highlight how mourning and maladaptive grief needs to be taken into account while creating a recovery

program, as well as addressing the unique needs of school and community leadership. Finally, this presentation will highlight findings from previous school catastrophic events and lessons learned that should be considered to meet the longer-term needs for schools impacted by school violence.

NO. 4

POLICY RESPONSE AT THE STATE AND FEDERAL LEVEL: STATUTES, COMMISSIONS AND THE NATIONAL DIALOGUE ON MENTAL HEALTH

Speaker: Harold I. Schwartz, M.D.

SUMMARY:

The wake of the Sandy Hook disaster reverberated throughout the nation. The Connecticut legislature, along with legislatures in New York and Colorado, rapidly enacted new laws on gun control, school safety and mental health, including some of the most stringent gun control regulations in the nation. The Connecticut and New York statutes include controversial patient reporting requirements opposed by most in the psychiatric community. Connecticut's Governor Daniel Malloy established the Sandy Hook Advisory Commission which was charged with reporting out far reaching recommendations for the future of mental health services, gun control and school safety. At the national level, President Obama called for a "national dialogue on mental health" as part of a national action plan which emphasizes the closure of gun background check loopholes, banning military style assault weapons and magazines, making schools safer and increasing access to mental health services. Interventions are targeted on the young (16-25) and focus on early detection and intervention through programs such a Mental Health First Aid.

PATIENT SUICIDE IN RESIDENCY TRAINING: THE RIPPLE EFFECT

Chairs: Uyen-Khanh Quang-Dang, M.D., M.S., Sidney Zisook, M.D.

Discussant: James W. Lomax, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify feelings resident psychiatrists and supervising psychiatrists may have after a patient completes suicide; 2) Demonstrate understanding of a need for improvement in preparing residents for the likelihood of suicide in their career, and in supporting residents who experience patient suicide during training; 3) Demonstrate knowledge of strategies, including video training and post-vention protocols, used to prepare residents and support them after a patient suicides; 4) Make recommendations to their home training programs on how to improve support for residents who experience patient suicide.

SUMMARY:

According to the Centers for Disease Control and Prevention, in 2010, suicide was ranked as the 10th leading cause of death, accounting for 38,364 deaths. Studies estimate that 20-68% of psychiatrists will lose a patient to suicide in their career.

A significant number of residents will experience patient suicide during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents, their colleagues, and supervisors after a patient dies by suicide. We believe this lack of discussion interferes with the use of positive coping strategies by residents, and that residency training programs need improvement in supporting residents through this difficult experience and preparing them for the likelihood of losing a patient to suicide in their career.

The symposium will begin with three psychiatry residents from different residency programs across the U.S. sharing their experience of having a patient die by suicide. A residency training director will then discuss the challenges in educating trainees about the impact of patient suicide. She will show brief clips from a video, Collateral Damage: The Impact of Patient Suicide on the Psychiatrist, of a psychiatrist supervisor discussing his own experience of patient suicide. This DVD was developed as a discussion stimulus for residents, faculty, and private practitioners in psychiatry to help them with the experience of having a patient complete suicide. Small group sessions led by panelists will follow, allowing for sharing of experiences with patient suicide among audience participants.

An attending psychiatrist will then discuss the development of a support system (including education symposia and a post-vention protocol) for residents who experience patient suicide at two training programs (Columbia and UCSF). Next, a residency training director will discuss the collaborative project of making the training video of residents and faculty discussing patient suicide shown earlier. Then, an attending psychiatrist will present results from a resident-education research project that tested the efficacy of a new patient suicide curriculum that included the use of this training video. There will be a second small group session led by panelists for audience participants to discuss interventions to help residents deal with patient suicide in their own home training programs.

The final presenter, a residency training director and the Vice Chair of Education of an academic medical institution, will speak about the effect that patient suicide has on all levels of psychiatry training, from the resident, to the senior psychiatry attending, and to the academic medical environment. The symposium will close with Q & A from the audience.

NO. 1

REFLECTIONS OF A RESIDENT'S EXPERIENCE OF PATIENT SUICIDE

Speaker: Kimberly Brandt, D.O.

SUMMARY:
In my presentation, I will be discussing two cases where a patient completed suicide during my psychiatry residency training. The first case involves a patient that was seen on an inpatient and emergency basis during my second year of training. The second case involves a patient I was treating as a third year Resident in an outpatient setting. The discussion will involve a description of my own reactions, struggles and coming to terms with the loss of patients by means of suicide. The discussion will also include discovery of pertinent information about the patient's life that was withheld from the psychiatrist. Also included will be the way I have come to terms with and found meaning in these profound losses that have influenced my career for life.

NO. 2
PERSONAL ACCOUNT OF PATIENT SUICIDE EARLY IN RESIDENCY TRAINING
Speaker: Deepa Ujwal, M.D.

SUMMARY:
This section of the symposium will include a brief case presentation and a personal account of losing a patient early in residency training with an emphasis on transferred patients. I will discuss the role of resident's group as a helpful intervention in dealing with and coming to terms with patient loss.

NO. 3
RESIDENT EXPERIENCE OF PATIENT SUICIDE AND DEATH
Speaker: Katharina Schneiber, M.D.

SUMMARY:
I will discuss a case involving a patient suicide that occurred during my first year of residency while on an inpatient psychiatry ward. The suicide occurred during a period of a month when I experienced several other unexpected deaths at the hospital as well as at home. The discussion will involve reflections about legal constraints on psychiatrists' actions, patient autonomy, interactions with family members, and finding a sense of peace even after trying all available interventions to avert death.

NO. 4
CREATING A RESIDENT SYMPOSIUM REGARDING SUICIDE DURING RESIDENCY TRAINING
Speaker: Andrew Booty, M.D.

SUMMARY:
I will discuss symposia developed and implemented at UCSF regarding the myriad of issues that emerge during the suicide or suicide attempt of a resident case. I will discuss lessons learned from these symposia, and how such programs can be implemented at other institutions.

NO. 5
PATIENT SUICIDE CURRICULA: RESULTS FROM AN EDUCATIONAL INTERVENTION STUDY
Speaker: Deepak Prabhakar, M.D., M.P.H.

SUMMARY:
This presentation will discuss results from a resident-education research project that tested the efficacy of a new patient suicide curriculum. The curriculum aimed at educating residents about patient suicide, common reactions and steps to attenuate emotional distress while facilitating learning. Eight psychiatry residency-training programs participated in the study and 167 of a possible 240 trainees (response rate = 69.58%) completed pre and post evaluations. These results were compared to assess both knowledge and attitudes resulting from this educational program. Participants reported increased awareness of the common feelings physicians and trainees often experience after a patient suicide, available support systems, required documentation and the role played by risk management. This patient suicide educational program increased awareness of issues related to patient suicide and shows promise as a useful and long-overdue educational program in residency training.

NO. 6
LOSING A PATIENT TO SUICIDE. THE RIPPLE EFFECT
Speaker: Michael F. Myers, M.D.

SUMMARY:
Dr Myers will be speaking about the impact of suicide on all levels of residency training, from the resident to the senior psychiatry attending, and to the academic medical environment. He will be speaking from his experience as someone who lost patients to suicide during his residency as well as a psychiatrist who has lost patients to suicide throughout his career. He will also discuss his therapeutic work with clinician-patients who came for treatment having lost a patient/client to suicide.

TRAUMATIC BRAIN INJURY (TBI): MILD OR SEVERE, SINGLE OR MULTIPLE EPISODES: THE DIAGNOSIS AND TREATMENT

Chair: Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand neurocognitive features of mild TBI vs moderate/severe TBI; 2) Compare and contrast the clinical course between single vs repetitive TBI; 3) Discuss potential biomarkers to help diagnose and monitor patients post TBI.

SUMMARY:
Despite significant increases in research funding and public interest, the diagnosis and treatment of Traumatic Brain Injury (TBI) remains challenging and, in some cases, controversial. Four international consensus conferences led by the recognized experts in the field have not been able to define a gold standard for diagnosis or treatment. The need to establish uniform criteria for diagnosis is critical to developing meaningful research protocols and ultimately effective treat-

ments (immediate post injury and long term). TBI occurs in a number of settings: 1) accidents involving head trauma 2) to military and police officers exposed to repeated blast force trauma and combat-related head wounds, and 3) through sports-related concussions resulting from blows to head and neck. Most accident related brain injury involves significant, immediate alteration in brain functioning. This level of trauma is typically rated by a Glasgow Coma Scale, and often requires neurosurgical intervention. Mild repetitive TBI commonly occurs without loss of consciousness. Most blast injury and sports-related head trauma are considered mild TBI. The overwhelming majority of the extensive TBI literature on diagnosis and treatment is derived from severe TBI, not mild repetitive TBI seen in athletes and soldiers. This symposium will review the current knowledge comparing severe TBI with mild TBI in various patient populations. Special emphasis will be placed on diagnosis and treatment issues unique to each population.

NO. 1
POTENTIAL RISK FACTORS RELATED TO TYPES OF TBI AND TREATMENT ISSUES
Speaker: David Baron, D.O., M.Ed.

SUMMARY:
The obvious most significant risk factor for sports TBI is participation in a contact/collision sport. However, a number of interventions have been identified that lower the risk. Proper fitting head gear play an important role, but have a down side. Athletes often believe high tech injury-prevention equipment allow them to not be as concerned about injury, and play with greater reckless abandon. Rule changes play an important role, but the most significant risk factor is the culture of demonstrating toughness by playing hurt and not showing pain. Perhaps the most important treatment decisions in TBI is to rest and stay out of the game. Returning to play too soon, often immediately, is likely the single biggest risk factor for Second Impact Syndrome (SIS) in the world of sports. Heat appears to potentially play a role in concussion susceptibility. Existing animal data have clearly demonstrated this phenomenon. Genetics may also play an important role in determining risk for concussion.

NO. 2
DIFFERENCES AND SIMILARITIES IN RISK AND OUTCOME FOR TBI SUFFERED BY THOSE IN THE MILITARY
Speaker: Murray B. Stein, M.D., M.P.H.

SUMMARY:
Experience with civilian and, in particular, military personnel has led to the oft-replicated observation that TBI is frequently seen in conjunction with mental illness, notably (but not exclusively) posttraumatic stress disorder (PTSD). Differential diagnosis of mild TBI (mTBI) and PTSD requires consideration of the context of injury, longitudinal course of illness, and presence of particular symptoms (e.g., headache, visual or hearing disturbances) more common to mTBI. Very often true comorbidity exists between PTSD and mTBI, such that treatment should be directed at the symptomatic presentations of both disorders (e.g., mood disturbance; attentional problems). This presentation will combine a review of epidemiological literature and best-practices approaches to treatment of comorbid mTBI and related mental health conditions.

NO. 3
TBI AND ISSUES OF COMORBIDITY AND TREATMENT
Speaker: Michele T. Pato, M.D.

SUMMARY:
These presentations will review the symptoms of traumatic brain injury in general and discuss specific instruments for assessment both neurobiological and psychological. Functional imaging studies in animals and humans have given more specific knowledge and understanding of the variable impact of TBI on the brain. In discussing basic treatment issues there will be emphasis on comorbidity including anxiety disorders, depression, cognitive impairment and memory loss, and substance abuse. Dr. Stein will emphasize some of the differences in comorbidity for those with military service.

VALIDATING BIOLOGICAL MARKERS FOR PTSD

Chairs: Marti Jett, Ph.D., Charles Marmar, M.D.

Discussant: Thomas Neylan, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the biological characteristics of PTSD from the perspectives of neuroimaging, neurogenetic, multiomic, metabolic and neuroendocrine; 2) Recognize the effectiveness and validity of using biological markers for diagnosis of PTSD; 3) Identify relevant biological markers in PTSD patients.

SUMMARY:
This symposium will present findings from a multi-site study on biological markers of Posttraumatic Stress Disorder (PTSD), which accounts for about half of the total mental health burden in OEF/OIF veterans. Discovering biomarkers of PTSD would not only assist objective diagnosis, but also push forward redefining PTSD along biological homogeneous dimensions. This symposium will discuss biomarkers from a DoD funded multisite study in a discovery sample of 52 PTSD and 52 age, gender and ethnicity matched healthy deployed controls. We will also present data on two validation samples: repeat assessments after one to two years of biomarkers in 25 cases and 25 controls from the discovery phase; and 35 newly recruited PTSD cases and 35 new controls. Markers ascertained on all participants in the discovery and validation samples include neuroimaging, neurogenetic, multiomic, metabolic and neuroendocrine. Candidate PTSD biomarkers in the 52 cases and 52 controls from the discovery sample include the following: (1) Using

gray matter maps obtained from structural MRI, three PTSD subgroups were identified representing three patterns of gray matter volume atrophy; (2) Resting state fMRI analysis revealed that PTSD cases have increased spontaneous activity in the fear circuitry and decreased amygdala-frontal connectivity as well as decreased efficiecny in the global neural network; (3) Neurogenetics studies revealed significant group differences in BDNF polymorphisms, which were associated with BMI; (4) Multiomics findings include a panel of mRNA and brain specific proteins that discriminate cases from controls; (5) Neuroendocrine studies suggest GR sensitivity and GR gene methylation are most promising endocrine markers and that PTSD cases have characteristic epigenetic changes in the the glucocorticoid receptor gene; (6) Metabolic and immune system studies revealed increased fasting glucose and metabolic syndrome in PTSD cases, decreased mitochondrial function and increases in circulating pro-inflammatory cytokines. We will also present data on the findings from the validation studies on the sensitivity and specificity of these candidate biomarkers for PTSD.

NO. 1
STRUCTURAL IMAGING MARKERS FOR PTSD
Speaker: Susanne Mueller, M.D.

SUMMARY:
Previous studies of the structural imaging data of 104 combat-exposed OEF/OIF veterans with (PTSD+, n=52) and without PTSD (PTSD-, n=52) suggested a considerable heterogeneity regarding the degree of structural abnormalities. The current study investigates this heterogeneity with the aim to 1). Describe the range of structural abnormalities characterizing these two groups, 2). Use that information to build an image based classifier based on a Bayesian network approach using a randomly selected subset of 69 subjects. Spatially normalized gray matter maps were generated from the T1 images and whole brain z-scores calculated by comparing them to the gray matter maps of a population of non-veteran healthy control subjects. Cluster analysis is used to identify 3 subgroups in PTSD+ and PTSD- based on the whole brain z-scores. At the first level, each group's abnormality maps were compared with those from all the other groups using Graphical-Model-based Morphometric Analysis (GAMMA). GAMMA uses a Bayesian network and a contextual clustering method to produce voxel maps that provide the maximal distinction between two groups and calculates a probability distribution and a group assignment based on this. The information was combined in a second level Bayesian network and the probability of each subject to belong to one of the 6 groups calculated. The performance of this approach will be validated in the remaining 33 subjects from the original population and in the validation samples.

NO. 2
PAN-OMIC MARKERS FOR PTSD
Speaker: Rasha Hammamieh, Ph.D.

SUMMARY:
Current studies have focused on the discovery/training samples for which we compared pan-omics markers in 52 OEF/OIF veterans with PTSD and 52 matched controls. We ascertained global transcriptomics and DNA methylation responses, supplemented with directed protein analyses and other molecular confirmatory tests. Cross validation within the discovery samples was performed by leave one out analysis, with training set results averaged across validations. Using global approaches, we integrated the total transcriptomic, epigenetic and other molecular findings with the wealth of clinical information recorded for these volunteers. Panels of mRNA and DNA methylation and regulatory profiles were identified to be associated with PTSD, and were representative of biological pathways related to neuronal functions frequently observed in persons with PTSD. We have down-selected a panel of differentially methylated genes specific loci identified PTSD cases and combat controls with high sensitivity and specificity and current validation studies aim to confirm and/or extend these candidate multi-omic markers for PTSD in sets of newly recruited volunteers. Additionally, these overarching clinical and global multi-molecular studies indicate options for stratification of PTSD cases into several subtypes and our on-going studies are aimed at identifying features that potentially could be useful in predicting personalized therapeutic efficacy.

NO. 3
NEUROGENETIC MARKERS FOR PTSD
Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:
In the discovery sample we compared neurogenetics findings in 51 OEF/OIF veterans with PTSD and 51 matched controls. We predicted variants in FKBP5, COMT, APOE and BDNF will be associated with PTSD. We genotyped 107 SNPs in these four genes using GWAS data from Illumina Omni-Express. Logistic regression analyses were conducted with 10K permutations, threshold set at p=.013. Taken together a set of 25 BDNF SNPs over 92kb differentiated PTSD cases from controls (p=0.009). Major allele frequencies were lower in cases than controls indicating that these polymorphisms conferred resilience. Iraq and Afghanistan veterans with these polymorphisms were 2 to 3 times less likely to develop PTSD. We also found that BDNF genotype was associated with basal metabolic index. Findings will also be presented for these candidate genetic markers for PTSD as well as ADCYAP1R1, Oprl1, PACAP and SRD5A2 genes in the two validation samples.

NO. 4
METABOLISM, INFLAMMATION AND CELL AGING MARKERS FOR PTSD
Speaker: Owen Wolkowitz, M.D.

SUMMARY:
In the discovery sample we compared metabolism, inflammation and cell aging markers in 52 OEF/OIF veterans with PTSD and 52 matched controls. We found that PTSD

was associated with the cardio- metabolic syndrome with increased fasting glucose, HOMA, BMI, and weight. Pro-inflammatory cytokines are elevated in PTSD including IFN gamma, TNF alpha, IL-6 and hs CRP. PTSD is associated with natural killer cell senescence. Metabolism, inflammation and cell aging markers positively correlated with symptom severity in the PTSD group. We also found reduced citrate and increased pyruvate and lactate in PTSD, signatures of mitochondrial dysfunction, reflecting inefficient intracellular energy generation. These markers may help track and stage underlying physical pathology in PTSD and suggest novel prevention and treatment interventions. Findings will also be presented for these candidate metabolism markers for PTSD in the two newly recruited validation samples.

NO. 5
ENDOCRINE MARKERS FOR PTSD
Speaker: Rachel Yehuda, Ph.D.

SUMMARY:
In the discovery sample we compared endocrine markers in 52 OEF/OIF veterans with PTSD and 52 matched controls. We controlled for weight BMI and which were higher in the PTSD group. 24 hour urinary cortisol was lower in cases than controls. We found enhanced cortisol suppression following dexamethasone, greater for whites than blacks and Hispanics Lysosyme IC50-Dex measure of GR receptor sensitivity appears to be a promising marker, with greater levels in PTSD cases for white and black veterans but not Hispanics. GR gene methylation at 1F exon promoter region was decreased in cases. Plasma DHEAS was increased in cases across ethnic groups. The most promising markers are GR sensitivity and GR gene methylation. Findings will also be presented for these candidate endocrine markers for PTSD in the two newly recruited validation samples.

NO. 6
FUNCTIONAL IMAGING MARKERS FOR PTSD
Speaker: Xiaodan Yan, Ph.D.

SUMMARY:
In the discovery sample we compared functional imaging findings in 52 OEF/OIF veterans with PTSD and 52 matched controls. Resting state F MRI was acquired in 6.6 minutes, eyes open, TR=2s, voxel size = 3.125 x 3.125 x 3 .5 mm^3. Analysis with amplitudes of low frequency fluctuation which reflects spontaneous activity revealed that PTSD cases compared to controls had increased activity in the amygdala, insula, inferior frontal gyrus and ventral anterior cingulate cortex (vACC) and decreased spontaneous activity in thalamus, precuneus, dorsolateral prefrontal cortex and post central gyrus. Functional connectivity revealed that PTSD cases had decreased connectivity within the default mode network and decreased amygdala – frontal, insular-default mode network connectivity and vACC-frontal connectivity. Graph theory based analysis about the neural network properties revealed that the PTSD group had decreased efficiency in the neural network compared to controls. Findings will also be presented for these candidate functional imaging markers for PTSD in the two validation samples.

MOOD, ART AND POLITICS: VINCENT VAN GOGH, SYLVIA PLATH, EMILY DICKINSON, WINSTON CHURCHILL, AND ABRAHAM LINCOLN

Chairs: John P. O'Reardon, M.D., Michelle Landy, M.D.

Discussant: John P. O'Reardon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the links between mood disorders and outstanding achievement; 2) Appreciate the commonalities of mood disorders in great leaders and artists; 3) Appreciate the stressors that are linked to the onset and course of illness in politicians and artists.

SUMMARY:
Artists and leading politicians exhibit a higher prevalence of mood disorders compared to the general population. Great political leaders of the 19th and 20th century, namely Winston Churchill and Abraham Lincoln appear on the evidence now available to historians to have suffered in their liftimes from bipolar disorder and unipolar disorder respectively. Similarly great artists have suffered with debilitating mood disorders, with both Sylvia Plath and Vincent Van Gogh ending their lives by means of suicide.
This symposium will draw lessons from the lives and mood disorders of these great artists and politicians.

NO. 1
MOOD, ART AND POLITICS-EMILY DICKINSON
Speaker: Samar Jasser, M.D.

SUMMARY:
Emily Dickinson is an outstanding poet. There was, however, major cyclicity in her work output which is suggestive of bipolar disorder. Evidence in support of such a diagnosis and evidence against will be reviewed in this presentation.

NO. 2
MOOD, ART AND POLITICS-SYLVIA PLATH
Speaker: Michelle Landy, M.D.

SUMMARY:
This presentation will focus on the life and work of Sylvia Plath. It will examine the strong evidence in support of unipolar depression. Despite suffering from this illlness she became a much admired poet.

NO. 3
MOOD, ART AND POLITICS-VINCENT VAN GOGH, WINSTON CHURCHILL, ABRAHAM LINCOLN
Speaker: John P. O'Reardon, M.D.

SUMMARY:

These talks will examine the evidence in support of mood disorders in two outstanding leaders of men - Winston Churchill and Abraham Lincoln and the evidence that may support diagnoses of bipolar disorder and major depressive disorder. Finally a review of the life of and artistic output of Vincent VanGogh will be undertaken.

A CLINICAL AND RESEARCH UPDATE ON ANXIETY, EATING, AND MOOD DISORDERS

Chair: B. Timothy Walsh, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the changes in DSM-5 to the diagnostic criteria for depression, anxiety, and eating disorders; 2) Describe an overview of recent advances in understanding the neurobiology of these disorders; 3) Describe the current status of psychological and biological treatments for these disorders.

SUMMARY:
Significant changes have occurred in the last several years relevant to the assessment and treatment of individuals with mood, anxiety, and eating disorders. Among the most obvious developments is the introduction of revised criteria for all these groups of disorders in DSM-5. New methods of treatment, some of which extend across these frequently comorbid disorders, are under active development and have begun to be implemented. These developments in treatment are based on an emerging neuroscience of these disorders. This symposium brings together clinical researchers at the cutting edge of these developments, and will provide for the clinician a guide to recent changes relevant to clinical practice.
Dr. McGrath will describe the emerging neurobiology of mood disorders, and how it has been translated into DSM-5 and led to the development of new treatments such as rTMS and deep brain stimulation.
In DSM-5, anxiety disorders are grouped separately from obsessive-compulsive disorder (OCD) and from post-traumatic stress disorder (PTSD), resulting in a more homogeneous grouping of the anxiety disorders. Dr. Schneier will review some of the clinical implications of this change, and the application of the emerging neuroscience of fear circuitry to treatment approaches.
Dr. Simpson will review the key characteristics of OCD, and useful recent clarifications of what is and is not OCD. Her presentation will focus on state-of-the-art treatment methods, including those appropriate for refractory patients.
Dr. Neria will describe the first-line treatment for PTSD, which involves exposure to stimuli associated with trauma, and emerging knowledge regarding the neurobiological mechanisms underlying treatment responsivity.
Dr. Attia will review the significant changes to the DSM criteria for eating disorders, including the recognition of Binge Eating Disorder. She will also describe new treatment approaches for individuals with long-standing Anorexia Nervosa.

NO. 1
RECENT ADVANCES IN MOOD DISORDER THERAPEUTICS
Speaker: Patrick J. McGrath, M.D.

SUMMARY:
Burgeoning research in neuroscience is leading to new and clinically useful conceptualizations of the psychobiology of mood disorders. These allow clinicians to have a deeper understanding of their patients' disorders, and are beginning to inform everyday clinical decisions. We will present selected and clinically relevant recent advances in neuroscience which undergird such conceptualizations, beginning to be reflected in DSM 5. Relevant advances in standard therapeutics, including the best available data on antidepressant combination and augmentation strategies for unipolar depression, and the multiplying therapeutic strategies for bipolar disorder, will be reviewed. Innovative therapeutics, including rTMS, ketamine, and deep brain stimulation, will be surveyed with an eye for their current utility in usual clinical practice, which now necessarily must include decisions regarding utilizing these in selected treatment-resistant cases.

NO. 2
GETTING TO THE CORE OF ANXIETY: UPDATE ON PANIC DISORDER, SOCIAL ANXIETY DISORDER, AND GENERALIZED ANXIETY DISORDER
Speaker: Franklin Schneier, M.D.

SUMMARY:
DSM-5's separation of obsessive-compulsive disorder and posttraumatic stress disorder from the category of anxiety disorders has created a more homogeneous grouping of anxiety disorders. This presentation will offer an update on these disorders, focusing on panic disorder, social anxiety disorder, and generalized anxiety disorder. Several recent applications of cognitive neuroscience to anxiety disorders will be considered, drawing on recent studies of attention bias to threat, fear conditioning, and fear generalization. The presentation will offer practical considerations and pitfalls in the clinical assessment of anxiety disorders, including selected issues of comorbidity and atypical forms. The evidence for established treatments will be reviewed, with examples from recent studies on the refinement and integration of behavioral and psychopharmacologic therapies. Both diagnosis-specific and cross-diagnostic aspects of these treatments will be considered, as well as novel approaches such as cognitive enhancers and "third wave" behavioral therapies.

NO. 3
OBSESSIVE-COMPULSIVE DISORDER: CUTTING EDGE RESEARCH AND ITS PRACTICAL IMPLICATIONS
Speaker: Helen B. Simpson, M.D., Ph.D.

SUMMARY:

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

NO. 4
NEURAL MECHANISMS OF FEAR IN PTSD: LINKING BASIC SCIENCE TO CLINICAL RESULTS
Speaker: Yuval Neria, Ph.D.

SUMMARY:
This presentation will offer an update of diagnostic and treatment issues in posttraumatic stress disorder (PTSD), drawing on findings from translational research to illustrate new directions in treatment development. Patients with PTSD fail to attenuate learned fear responses to trauma-associated stimuli. Prolonged Exposure (PE) therapy, considered first line treatment, habituates patients to trauma reminders by enhancing extinction learning. Seeking biomarkers of treatment response, we examined whether clinical response to PE treatment correlates with beneficial changes in fear neurocircuitry. Findings from an ongoing NIMH study using a fear learning/extinction paradigm, functional magnetic resonance imaging (fMRI), and clinical assessments at baseline and post treatment, suggest that clinical improvement is associated with enhanced extinction recall and normalization of dysfunctional activation in key regions of the fear network.

NO. 5
CLINICAL UPDATE ON FEEDING AND EATING DISORDERS
Speaker: Evelyn Attia, M.D.

SUMMARY:
Feeding and Eating Disorders (FED) are serious psychiatric illnesses associated with significant morbidity and mortality. DSM-5 includes six disorders in this category: pica, rumination disorder, avoidant-restrictive food intake disorder (ARFID), anorexia nervosa, bulimia nervosa, and binge eating disorder. This clinical update will review the DSM-5 FED diagnoses and will summarize recently published epidemiology and treatment studies. Specifically, study results from a clinical trial examining the possible utility of a novel form of exposure therapy for the treatment of anorexia nervosa will be described. In addition, recruitment and participation data from a large, multisite ongoing clinical trial examining olanzapine versus placebo for adults with anorexia nervosa will be presented.

NEWER CHALLENGES, NEWER RESPONSES: EDUCATION, TRAINING, AND GLOBAL COLLABORATION FOR CAPACITY BUILDING IN LOWER AND MIDDLE-INCOME COUNTRIES

Chairs: Nitin Gupta, M.D., Amresh K. Shrivastava, M.D.

Discussant: Vihang N. Vahia, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To discuss implications and complexities of knowledge translation in countries with limited human resources.; 2) To formulate strategies for training in cross cultural background based upon outcome of experience of education for primary care physicians.; 3) To discuss response to prevailing challenges of global mental health for services, research and international collaborations relevant to Lower and Middle-Income Countries.

SUMMARY:
Society at large, particularly in the developing countries has been undergoing rapid socio-economic changes. There are newer risk factors for mental disorders playing a crucial role in pathogenesis e.g. economic transition and social inequalities. Newer challenges need befitting responses, which are seldom sufficiently available in any society. Most conspicuous barrier to identify and treat mental disorders is human resources, which is not only dismal but also unequally distributed amongst different geographical and social strata of society. Globalization has changed the agenda for mental health. It's now demonstrated that people immigrate, they share common problems, and their response to social challenges are similar. Lack of manpower is one of the main barrier for treatment of mental disorders besides stigma and lack of awareness In most of the places either mental health professional are not available or available professionals lack the skills to identify and manage suicidal patients. We believe that innovative educational initiatives e.g. an internet based course, for training program can address (1) the existing gap in health care professional's knowledge and competencies and increase their professional suicide assessment and intervention skills and (2) can encourage identification and intervention and (3) create opportunities for prevention of mental disorders .We also believe that such facilities can be economical, easily accessible and can be monitored using electronic media at any distance. Such training can utilize local, pre-exiting manpower so that consistent and sustainable services can be developed. In this symposium we will discuss outcome of global and local initiatives exploring education as a medium for enhancing capacity and human resource. Participants will present strategies, and outcomes of experiments for responding to newer challenges.

NO. 1
DEVELOPING TRAINING, QUALITY IMPROVEMENT AND LEADERSHIP SKILLS IN LAMI COUNTRIES
Speaker: Subodh Dave, M.D.

SUMMARY:

Globally, users of mental health services are vulnerable to abuse of their basic human rights and face discrimination in allocation of health-care resources. This problem is more acute in low and middle-income countries (LAMIC). Limited capacity of psychiatrists and trained mental health professionals leads to lack of adequate training thus creating a vicious cycle of deficient training and deficient practice standards.
A two-fold strategy is needed to tackle this problem. 1) Enhancing the knowledge, skills and attitudes of doctors and allied healthcare professionals especially those working in primary care. 2) Enhancing training and leadership skills amongst mental health professionals.
These efforts need to be focused at both individual and systemic levels and must be linked to demonstrably and measurably linked to improvements in the quality of care to patients.
The presenter has conducted capacity building workshops for educational and quality improvement in India and in Zambia. This has led to the adoption of skills and attitudes-focused training in India with a change in assessment strategy (Observed structured clinical examinations - OSCEs) for medical students. In Zambia, the post-graduate curriculum now incorporates quality improvement projects as part of trainees' training and assessment.
The presentation will focus on the particular challenges of change management in LAMIC countries and strategies for making such changes sustainable and scalable.

NO. 2
ENHANCING PSYCHIATRIC EDUCATION FOR MEDICAL STUDENTS IN INDIA TO INCREASE ACCESS TO CARE
Speaker: Ananda K. Pandurangi, M.D.

SUMMARY:
Background: India has 1.2 billion people, 367 medical colleges & 35000 graduates/year but only 4000 psychiatrists. Enhanced psychiatry education to students can increase access to MH care.
Aims: Teach a short course to medical students to arouse interest in current & future psychiatry.
Methods: 3 partnerships came together to enhance psychiatry education. These are (1) VCU-PGIMER, (2) Global Health Summit (IAPA, AAPI), and (3) IAPA and IPS. A course of 2-5 days by Indo-US faculty has been conducted in India since 2007.
Results: 3 psychiatric neuroscience courses have been held for 225 students and 40 non-psychiatry faculty. Post program surveys show strong positive effects of the course.
Conclusions: Short courses by teams of Indo-Global faculty have the potential to increase student and faculty interest, and bring home the state of the art in Psychiatry. Combined with CME and other work force development efforts, this can increase access to MH care for large numbers of people.

NO. 3
PROMOTE MENTAL HEALTH AWARENESS AND CARE IN A REMOTE REGION OF NORTHERN PAKISTAN
Speaker: Salim Zulfiqar, M.D.

SUMMARY:
Objective: To create awareness of mental health (MH) problems and improve access to care in a remote area of Pakistan.
Background: Chitral district in Khyber-Pakhtunkhwa region of Pakistan has 421,000 people (2011) and no psychiatrist. Awareness of MH issues is very limited. People travel to Peshawar or Islamabad to get help. Road conditions and bad weather make travel difficult for 8 months in a year.
Methods: Through partnership with Aga Khan Health Services, two psychiatrists from USA traveled to Chitral and delivered five presentations to the public on MH topics. Training was given to health workers, nurses, and 2 physicians in basic MH care. Response of the public and professionals was very positive, encouraging us to repeat the program.
Conclusions: It is possible to outreach big numbers of people in remote areas of developing countries and create awareness of MH. Local care givers are receptive to learning about MH and improving access to care.

NO. 4
GLOBAL PROBLEMS, LOCAL ANSWERS: EDUCATION AND TRAINING FOR HUMAN RESOURCE
Speaker: Amresh K. Shrivastava, M.D.

SUMMARY:
Mental health in metrocities: Mumbai: It has been repeatedly demonstrated that education, be it for primary care physician, community at large, care givers or family members, is an instrument for change for identification, intervention and prevention of mental disorders. Challenges of mental health are unique to geographical, cultural and social fabrics of the population. We conducted a number of studies involving education and training and kept the outcome criteria as increase in number of referrals and level of satisfaction of the clients in the metro city of Mumbai, which is 4th largest metro city in the world.
We also carried out a need assessment of mental health professionals for suicide prevention and identified a consistent pattern of need for more training amongst medical, psychiatric and non-medical professionals.
Our studies of health service research model showed that education of primary care physician's increases referrals and brings more patients into the treatments. It also offers possibility of early identification, reducing stigma, reducing duration of untreated psychosis and eventually maximizing the outcome of treatments
We discuss results of innovative experiments in health care delivery based on educational model.

NO. 5
AGGRESSION, RESTRAINTS, AND MENTAL HEALTH LEGISLATION IN INDIA: RECENT TRENDS IN MANAGEMENT AND TRAINING
Speaker: Nitin Gupta, M.D.

SUMMARY:
Seclusion and restraint are frequent forms of management used for handling a violent patient,despite generating debates over ethical,legal,and therapeutic issues with lack of availability of international guidelines;this scenario being more dismal from the lower and middle-income (LAMI) countries. There is practically no literature available from India where very high use of physical restraints has been reported.However, Indian psychiatry has made rapid progress in the areas of ethical and legislative aspects in the last decade as evidenced by the adoption of Human Rights Act and most recently the new Mental Health Care Bill 2013,with focus on stronger and more robust involvement of patients & carers.The Mysore Declaration on Coercion in Psychiatry (ratified jointly by the Indian Forensic Mental Health Association & European Violence in Psychiatry Research Group) emphasized about raising awareness amongst patients and their families.In keeping with these initiatives, the presenter has been involved in developing consensus concepts from the patient and carer perspective related to their experience of restraints. Additionally, he has developed a semi-structured questionnaire to [a]gather information around the knowledge, attitude and practice,and [b] impart education to the carers in various treatment settings related to use of restraints.The presenter shall contextualize the issue with recommendations for developing guidelines & implementing them using training modules.

BIOLOGICAL APPROACHES TO TREAT SUBSTANCE USE DISORDERS

Chairs: Ivan D. Montoya, M.D., M.P.H., Phil Skolnick, D.Sc., Ph.D.

Discussant: Ivan D. Montoya, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the progress in the development of biologics (i.e., vaccines, monoclonal antibodies, and enzymes) for the treatment of Subtance Use Disorders; 2) Understand the results of clinical trial of biologics for the treatment of SUDs; 3) Recognize the modern methods to develop biologics, including gene transfer techniques.

SUMMARY:
The pharmacological treatment of Substance Use Disorders has traditionally focused on small molecule approaches (e.g., naltrexone, varenicline) that target specific proteins (e.g., a receptor) in the brain. An alternative to this pharmacodynamic approach is a pharmacokinetic strategy using biologics. Biologics are macromolecules that do not cross the blood-brain barrier, but reduce the access of an abused drug to the brain either by sequestration or rapid enzymatic degradation. Biologics include immunotherapies (vaccines and monoclonal antibodies) and genetically modified enzymes that can catalyze the degradation of an abused drug (e.g. cocaine) orders of magnitude more rapidly than the wild-type enzyme. The purpose of this symposium is to provide an overview of this rapidly emerging area, with a focus on biologic approaches currently in clinical trials.

NO. 1
INTRODUCTION: BIOLOGICAL APPROACHES TO TREAT SUBSTANCE USE DISORDERS
Speaker: Phil Skolnick, D.Sc., Ph.D.

SUMMARY:
There are no medications approved to treat cocaine, methamphetamine, and cannabis use disorders. Moreover, medications that are approved to treat other substance use disorders (SUDs) [e.g., nicotine, opioid] are far from ideal. Biological approaches to treating SUDs promise to provide an alternative to conventional, small molecule therapies. Thus, conventional medications employ a pharmacodynamic approach, often targeting a specific receptor in the brain (e.g., opioid receptors in the case of naltrexone). In contrast, biologics employ a pharmacokinetic approach, limiting the amount of abused substance reaching the target organ (i.e., the brain). This is accomplished by either sequestering (as in the case of a monoclonal antibody) or destroying (as in the case of a bioengineered enzyme) the abused substance. Because of the relatively long half-lives of most biologicals currently in development, a major advantage of this approach is the requirement for a patient to make “one good decision” (e.g.) every few weeks to remain medication adherent compared to the “one or two good decisions a day” most often required for small molecules. This presentation will provide an overview of biologicals in development, including mechanism of action, safety, and efficacy for the treatment of nicotine, opioid, cocaine, and methamphetamine use disorders.

NO. 2
GENETICALLY ENGINEERED BUTYRYLCHOLINESTERASE: AN INNOVATIVE APPROACH FOR TREATING COCAINE USE DISORDER
Speaker: Phil Skolnick, D.Sc., Ph.D.

NO. 3
DEVELOPMENT OF A NOVEL CONJUGATE ANTI-NICOTINE VACCINE
Speaker: Heather L. Davis, Ph.D.

SUMMARY:
Vaccine-induced anti-nicotine antibodies (Ab) should reduce nicotine to the brain. Ph2 testing of NicQb (Cytos) and NicVax (Nabi) showed the top 1/3 of Ab responders had better 1yr quit rates than placebo, but both vaccines failed to show benefit in the intent-to-treat population. Since Ab function (ability to bind nicotine) depends on both quantity (titer) and quality (avidity), the poor overall efficacy of these vaccines, despite inducing high Ab titers, may be due to low avidity Ab.
NIC7, which was developed using functional readouts, is comprised of a nicotine-like hapten conjugated to CRM197

(~15 haptens/CRM) as antigen (NIC7), and aluminum hydroxide and CpG as adjuvants. Results in mice and non-human primates (NHP) show antigen characteristics generally had little influence on Ab titer but did influence Ab avidity and function. These characteristics included: choice of carrier, hapten, conjugation method, linkers, epitope density (number of nicotine per carrier) and content of high molecular weight species. Furthermore, the choice of adjuvant can further influence both titer and avidity of the anti-nicotine Ab response. When compared to a mimetic of NicQb, the Ab response in NHP with NIC7 was significantly superior to that observed with a NicQb mimetic (81% versus 7% reduction of nicotine entering the brain compared to non-vaccinated controls, P<0.0001), and this was due to higher Ab avidity since both vaccines induced similar high Ab titers.

NO. 4
PHASE II CLINICAL TRIAL RESULTS OF AN ANTI-COCAINE VACCINE
Speaker: Thomas Kosten, M.D.

SUMMARY:
Two clinical trials of an anti-cocaine vaccine have been completed. A single site placebo controlled trial enrolled 115 cocaine dependent patients who were methadone maintained and found that those attaining an antibody level above 42 ug/ml had a significant increase in cocaine-free urines compared to placebo or those with levels below 42 ug/ml. A subsequent multisite clinical trial enrolled 300 primary cocaine dependent patients and found no difference in cocaine free urines between the active and placebo vaccine groups. Furthermore, a substantial proportion of these vaccinated patients attained antibody levels above 42 ug/ml, but showed significantly fewer cocaine-free urines than the placebo group. Thus, this second multisite study failed to support the initial finding or efficacy and instead suggested that the vaccinated group increased their cocaine use to over-ride the competitive blockade induced by the vaccine.

NO. 5
MONOCLONAL ANTIBODIES AGAINST METHAMPHETAMINE USE DISORDER
Speaker: Michael Owens, Ph.D.

SUMMARY:
There are no specific medications for the treatment of medical problems caused methamphetamine (METH) abuse, yet METH addiction is a worldwide problem. We are developing an anti-METH monoclonal antibody (mAb) medication to treat METH addiction. The potential clinical indications for the medication include treatment of overdose, reduction of drug dependence, and protection of vulnerable populations from METH-related complications. The medication called ch-mAb7F9 is designed to bind METH with high affinity in the bloodstream and thereby reduce the effects of METH in the brain. The first clinical study of ch-mAb7F9 by InterveXion Therapeutics reports forty-two (42) non-METH using volunteer subjects were dosed with ch-mAb7F9 or placebo and that all subjects have completed follow-up appointments. Because of the expected long duration of action of ch-mAb7F9 (2-4 weeks), the subjects had safety assessments for the 21 weeks after ch-mAb7F9 dosing. No serious adverse events were reported. Preliminary and interim safety analyses (performed after each group was dosed) suggest that ch-mAb7F9 is safe for human administration. This work was supported by NIDA grants DA011560, DA028915, DA031944.

NO. 6
LOOKING TO THE FUTURE: NEW TECHNOLOGIES TO IMPROVE THE SAFETY AND EFFICACY OF VACCINES
Speaker: Ronald G. Crystal, M.D.

SUMMARY:
Addiction to drugs is a major worldwide problem for which there is no effective therapy. Using cocaine and nicotine as examples of commonly used addictive drugs, we have developed two platform strategies to evoke high-titer antibodies specific for the anti-addictive drug. In the first strategy, based on the highly immunogenic nature of the adenovirus capsid, analogs of the addictive drug are bound to adenovirus capsid proteins to create active vaccines that generate high-titer anti-drug antibodies. In the second strategy, the gene coding sequences for monoclonals against the addictive drug are expressed by adeno-associated virus gene transfer vectors capable of generating, with a single administration, persistent high titers of anti-drug antibodies. In experimental animal models, both strategies are highly effective, providing new paradigms for anti-addictive molecular vaccines.

ADDRESSING CRIMINOGENIC NEEDS TO PROMOTE RECOVERY AND REDUCE RECIDIVISM

Chair: Fred C. Osher, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe how criminogenic risk factors contribute to the involvement of individuals with mental and substance use disorders in the criminal justice system.; 2) List integrated approaches using evidence-based practices and programs that take into account individuals' criminogenic risk factors and their functional impairments.; 3) Identify how evidence-based Risk-Need-Responsivity (RNR) principles inform how psychiatrists and other treatment providers can effectively address the needs of individuals involved in the criminal .

SUMMARY:
Researchers estimate that nearly 17 percent of people admitted to jail have serious mental illnesses-rates three times higher for men and five times higher for women than in the general population. Nearly 70 percent of adults in jails have a substance use disorder, and almost three-quarters of jail inmates with serious mental illnesses (72 percent) have

co-occurring substance use disorders. The overrepresentation of people with behavioral health issues impacts the criminal justice system and public safety, stymies individuals' recovery, creates stress for their families, and represents an inefficient use of shrinking public resources. Emerging best practices have been identified for treatment providers to address the needs of people with behavioral health issues under criminal justice supervision. When implemented as designed, these evidence-based practices and programs (EBPs) are critical to improving outcomes, maximizing investments, and building support for further expansion of services. Current research points toward the "Risk-Need-Responsivity" (RNR) model for identifying and prioritizing justice-involved individuals to receive appropriate interventions. Found to be effective across settings and offender populations, RNR requires use of evidence-based risk assessment tools and calls for (1) matching the intensity of individuals' treatment to their level of risk for reoffending, (2) targeting criminogenic needs-dynamic factors that contribute to the likelihood of reoffending-and (3) addressing individuals' barriers to learning in the design of treatment interventions. This symposium will feature emerging research and best practices from the field, including real-world examples of how treatment providers have worked to address criminogenic needs in correctional and community settings. Through a series of presentations and case examples, panelists will discuss the importance of applying the risk-need-responsivity (RNR) principles to reduce recidivism and promote recovery, and introduce evidence-based practices and promising, recovery-oriented practices that improve outcomes for justice-involved individuals with behavioral health and criminogenic needs.

NO. 1
BEHAVIORAL HEALTH AND CRIMINOGENIC NEEDS OF ADULTS UNDER CORRECTIONAL SUPERVISION
Speaker: Fred C. Osher, M.D.

SUMMARY:
Behavioral health treatment providers are increasingly serving clients who are criminal justice involved and may have certain risk factors that compromise their recovery, create stress for their families, and impact public safety and government spending. Treatment providers have historically assessed and provided services to address some of these factors, but others—particularly those involving antisocial attitudes and behaviors—have not typically been perceived as part of their mission. Understanding criminogenic risk (or, the likelihood of committing crimes or violating conditions of release), however, is an important part of identifying and responding to dangerousness and violence, so assessing individuals' risk and needs (or, the factors that contribute to criminogenic risk) is essential to creating safe service environments. The presenter will discuss the application of risk-need-responsivity (RNR) principles to reduce recidivism and promote recovery—particularly what role treatment providers can take to not only address individuals' treatment needs, but also to address their criminogenic needs. This presentation will also introduce the Adults with Behavioral Health Needs Under Correctional Supervision Framework—a resource to help professionals in the behavioral health and criminal justice systems take a coordinated approach toward reducing recidivism and advancing recovery by providing a structure to identify subgroups within the larger group of justice-involved indi

NO. 2
ADDRESSING BEHAVIORAL HEALTH AND CRIMINOGENIC NEEDS IN JAILS AND PRISONS
Speaker: Amy Blank Wilson, M.S.W., Ph.D.; Michael Champion, M.D.

SUMMARY:
During this presentation, presenters will introduce evidence-based practices (EBPs) and promising, recovery-oriented practices associated with positive outcomes for justice-involved individuals with behavioral health and criminogenic needs that have been delivered in correctional settings. Presenters will discuss the most current research and provide real-world examples of activities in both jails and prisons to address both behavioral health and criminogenic needs, including the modification of an evidence-based, cognitive-behavioral intervention called "Thinking for a Change" that has demonstrated improvement in reducing criminogenic risk among individuals with serious mental illness. Presenters will introduce scenarios and discussion questions to illustrate the application of the evidence-based and promising programs and practices in correctional settings, encouraging questions from the audience throughout.

NO. 4
MAXIMIZE YOUR IMPACT WORKING WITH CLIENTS WITH CRIMINAL HISTORIES—ADDRESSING BEHAVIORAL HEALTH CRIMINOGENIC NEEDS IN THE COMMUNITY
Speaker: Merrill Rotter, M.D.

SUMMARY:
During this presentation, presenters will introduce evidence-based practices (EBPs) and promising, recovery-oriented practices associated with positive outcomes for justice-involved individuals with behavioral health and criminogenic needs that have been delivered by community-based providers. Presenters will introduce scenarios and discussion questions to illustrate the role that community-based treatment providers can take through a discussion of the application of the evidence-based and promising programs and practices in the community, encouraging questions from the audience throughout.

NO. 5
BEHAVIORAL HEALTH AND CRIMINOGENIC NEEDS OF ADULTS UNDER CORRECTIONAL SUPERVISION
Speaker: Ann-Marie Louison, M.S.W.

SUMMARY:
Behavioral health treatment providers are increasingly

serving clients who are criminal justice involved and may have certain risk factors that compromise their recovery, create stress for their families, and impact public safety and government spending. Treatment providers have historically assessed and provided services to address some of these factors, but others—particularly those involving antisocial attitudes and behaviors—have not typically been perceived as part of their mission. Understanding criminogenic risk (or, the likelihood of committing crimes or violating conditions of release), however, is an important part of identifying and responding to dangerousness and violence, so assessing individuals' risk and needs (or, the factors that contribute to criminogenic risk) is essential to creating safe service environments.

The presenter will discuss the application of risk-need-responsivity (RNR) principles to reduce recidivism and promote recovery—particularly what role treatment providers can take to not only address individuals' treatment needs, but also to address their criminogenic needs. This presentation will also introduce the Adults with Behavioral Health Needs Under Correctional Supervision Framework—a resource to help professionals in the behavioral health and criminal justice systems take a coordinated approach toward reducing recidivism and advancing recovery by providing a structure to identify subgroups within the larger group of justice-involved indi

USING BIOMARKERS TO SELECT TREATMENTS: AN ILLUSTRATION FROM THE INTERNATIONAL STUDY TO PREDICT OPTIMIZED TREATMENT FOR DEPRESSION (ISPOT-D)

Chairs: Alan F. Schatzberg, M.D., Leanne Williams, Ph.D.

Discussant: A. John Rush, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the design, rationale and clinical outcomes of the first 1008 iSPOT-D trial participants; 2) recognize the clinical factors that predict treatment outcomes for depressed outpatients, including age of onset and anxiety; 3) identify the genomic of response, particularly applying MDR-1 genotypes.; 4) understand the behavioral and cognitive tests that may predict which medication to select in the acute treatment of depression.; ; ; 5))appreciate combining data across classes of markers to predict response.

SUMMARY:

This session updates results in the ongoing International Study to Predict Optimized Treatment in Depression (iSPOT-D) that aims to identify practical, pretreatment measures to help select among three commonly prescribed antidepressants: escitalopram, sertraline or venlafaxine-XR (1).

Method: iSPOT-D mirrors routine practice while employing standardized pretreatment and post-treatment clinical and biological assessments in an 8 week randomized, 22 site acute treatment trial with up to a 44 week follow up. Academic and clinical sites in the US, Netherlands, Australia/New Zealand and South Africa are enrolling 2016 outpatients with nonpsychotic major depressive disorder (672 per treatment arm) and 672 matched healthy controls. The symposium presents the study rationale, design and initial results on the first 1008 subjects. Patients are either antidepressant medication naïve or willing to undergo an antidepressant medication washout. Baseline assessments include symptoms, risk factors (including exposure to early life trauma), behavioral tests of emotional and cognitive function, electroencephalography, blood draws for genotyping, and for 10% structural and functional brain imaging. Standardized assessments allow for a structural and functional appraisal of brain systems and circuits involved in depression and an integrated understanding of brain function and its relevance to treatment selection. This symposium presents: 1) clinical characteristics and acute outcomes (e.g. response and remission) of the sample; 2) clinical prediction of response and side effects using variants for the ABCB-1 gene that encodes for the P-glycoprotein pump that controls efflux of these agents from brain and the ability of these variants to improve prediction performance of other markers; 3) contribution of behavioral tests of emotion and cognition in predicting treatment outcomes or selecting among treatments; and 4) combining genetic and cognitive markers to predict outcome and select among treatments.

Results:

In 1008 patients, the overall response rate was approximately 62% (remission rate=45%). Concurrrent anxiety was associated with lower remission rates. Specific allelic variation for MDR-1 predicts likelihood of remission in subgroups of subjects. Pretreatment behavioral measures of emotional identification, decision speed, attention and working memory were significant predictors of remission, independent of symptom severity. Further, interactions among performance on cognitive and emotional measures and genetic variation predicted outcome. A corresponding profile of limbic hyperreactivity to emotional stimuli and frontal hypo-activity to cognitive and emotional tasks was revealed by functional neuroimaging.

Conclusions:

These initial results indicate that a number of measures obtained prior to starting antidepressant medication have alone and/or in combination the ability to predict overall outcomes independent of type of medication.

NO. 1

BARRIERS AND BENEFITS OF OBJECTIVE BIOMARKER TESTS IN DEPRESSION

Speaker: Evian Gordon, B.Sc., Ph.D.

SUMMARY:

An overview is provided of the cognitive and tempero-spatial complementary biomarkers in iSPOT that predict treatment remission in depression. Hypothesis-driven and hypothesis generating outcomes are contrasted, with the focus on replication. A context is provided of the limits and benefits of adoption of objective tests in psychiatry that might predict treatment response in depression. Barriers to

adoption, clinical scalability of tests, cost-benefits, workflow issues, test report integration into electronic medical records, and reimbursement issues are discussed. A stratified model of clinical severity versus cost-benefit of predictive tests and cost of intervention is outlined.

NO. 2
I-SPOT-D: OUTCOMES FROM THE ACUTE PHASE OF ANTIDEPRESSANT TREATMENT
Speaker: Radu V. Saveanu, M.D.

SUMMARY:
i-SPOT-D is an international study whose aim is to identify moderators and predictors of response and remission in depression. This study enrolled participants suffering from non-psychotic major depression at 17 sites in 5 countries. Patients were characterized,at baseline,by symptoms,clinical history,functional status and comorbidity. Subjects were randomized to receive one of three antidepressants (Escitalopram,Sertraline and Venlafaxine-ER).Symptoms, functio, quality of life, and side effect outcomes were assessed 8 weeks later. This presentation will summarize outcome findings from the acute phase of treatment and also the dimensional prognostic effect of comorbid anxiety symptoms.

NO. 3
ABCB1 (MDR1) GENETIC VARIATION AND CLINICAL OUTCOMES IN THE ISPOT-D STUDY
Speaker: Alan F. Schatzberg, M.D.

SUMMARY:
Background – The ABCB1 gene encodes P-glycoprotein (P-gp) which controls efflux from brain of specific substrate antidepressants. Variation at the ABCB1 locus has been associated with antidepressant efficacy and side effects in smaller studies.
Methods – We examined 10 ABCB1 SNPs in 705 patients with major depression randomized to open label treatment for 8 weeks with escitalopram, sertraline, or venlafaxine – all thought to be P-gp substrates. Antidepressant efficacy was assessed with HDRS-17 and the QIDS; side effects quantified using the FIBSER. Only those patients who completed at least 2 weeks of treatment were considered in the analysis.
Results – Strongest effects of ABCB1 SNPs on efficacy were observed in the subset of 270 patients from self-reported ethnic minority backgrounds, particularly in those treated with sertraline. Among patients with European Caucasian backgrounds, effects were less pronounced.
Conclusions – Our results demonstrate that ABCB1 polymorphisms affect antidepressant outcomes, but the results were largely confined to patients with ethnic minority backgrounds, and the magnitude of the effect depended on the medication. Future studies focusing on recruitment of patients with diverse ethnic backgrounds may provide new insights into the role of ABCB1 genetics in antidepressant outcomes.

NO. 4
USING IMAGING TO INFORM TREATMENT PREDICTION IN MAJOR DEPRESSIVE DISORDER
Speaker: Leanne Williams, Ph.D.

SUMMARY:
Neuroimaging provides an objective way to assess the circuits involved in the pathophysiology of depressive disorder, and the action of antidepressants. In the international Study to Predict Optimized Treatment in Depression (iSPOT-D) we use imaging to understand which brain circuits are central to the emotional and cognitive functions of major depressive disorder (MDD), and which predict its treatment outcomes.
Standardized protocols were used to acquire both structural and functional images. Brain volume, cortical thickness and white matter connectivity were quantified using high resolution structural scans and diffusion tensor imaging. Functional neuroimaging was recorded during cognitive and emotional tasks.
Compared to controls, MDD patients showed consistent hypoactivation of the dorsolateral and dorsomedial prefrontal cortex during cognitive tasks. By contrast, hyperactivation in the dorsomedial prefrontal and limbic amygdala regions was observed during implicit nonconscious emotion processing. Activations in both these prefrontal regions were correlated with behavioral and clinical symptom measures in MDD. Prefrontal and limbic circuits are implicated in the action of antidepressant treatments. These results provide a foundation from which to identify imaging predictors of treatment outcomes, and their interaction with behavioral tests and clinical characteristics.

CHALLENGING TREATMENT ISSUES IN SCHIZOPHRENIA

Chairs: S. Charles Schulz, M.D., Peter F. Buckley, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and develop a treatment plan for the Attenuated Psychosis Syndrome (Prodrome) patients; 2) Assess and extend interventions to the poorly responding patients with schizophrenia; 3) Treatment of patients with schizophrenia who have issues with addictions and adherence.

SUMMARY:
Schizophrenia is a complex illness with a substantial severity in symptoms at its outset and challenges to obtain the best outcomes. As psychiatrists and mental health professionals engage in planning treatment approaches, much of the textbook and clinical trial studies focus on very straight-forward issues in treatment of psychosis, but may not describe approaches to complexities of the disease. In this symposium, the presentations will describe and focus on the complexities of treatment issues in order for the attendees to learn about the assessment and treatment of difficult dilemmas in order to lead to better outcomes.

Dr. Thomas McGlashan has performed substantial and leading research in the prodromal phase of schizophrenia (now known as attenuated psychosis syndrome in DSM5). His work addresses tools to approach the assessment and identification of the prodrome in ways that can help clinicians identify those at high risk. He has performed very informative clinical trials and will discuss their impact on the field. Further, he will address the models of comprehensive care and the impact of early intervention.

The publications of medication treatments show statistically significant impact of antipsychotic medications on psychotic symptoms, but clinicians in the field of treating people with schizophrenia are aware that patients are not always consistent or adherent to the treatment plan. Dr. Peter Weiden will describe studies he has conducted examining the impact of cognitive behavior techniques and the role of long-acting injectable medication. The combination of these approaches can lead to more successful outcomes.

Dr. Douglas Ziedonis will approach the very concerning issue of comorbid substance use in psychiatry. This is a needed area of education as so many studies excluded research candidates for schizophrenia studies who have addictions or abuse. Further, this is a complex arena as drugs of abuse for psychotic people are not only addicting, but may be psychotomimetic.

Dr. Peter Buckley's background includes major approaches to dealing with the most seriously ill psychiatric patients. This is a crucial area for clinicians in order to recognize and assess non-responders – in other words knowing the criteria and then moving on to appropriate next steps. In the US, there is now data showing that less than a majority of people with schizophrenia receive clozapine.

In summary, there are a number of very challenging treatment issues in the management of schizophrenia. This symposium is designed to address and describe the issues for the attendees understanding and to provide the latest approaches for these issues.

NO. 1

THE ATTENUATED PSYCHOSIS SYNDROME: IDENTIFYING AND TREATING PSYCHOSIS IN ITS EARLIEST CLINICAL FORM

Speaker: Thomas McGlashan, M.D.

SUMMARY:

Psychotic disorders, and especially schizophrenia, once fully developed, can be disabling and lifelong. However, these disorders develop over relatively long periods of time. Recent work has demonstrated that early identification and treatment of such cases in their formative or "attenuated" psychotic forms can prevent or delay psychosis onset severity and functional deterioration. This knowledge has led to efforts at identifying, tracking, and treating persons who meet criteria for being at risk for psychosis and who display the signs and symptoms of an "attenuated psychosis syndrome."

NO. 2

AN INTEGRATED APPROACH TO ADHERENCE ISSUES IN SCHIZOPHRENIA

Speaker: Peter Weiden, M.D.

SUMMARY:

Nonadherence to maintenance antipsychotic medication has remained a vexing problem and is as relevant today as it was 50 years ago. If there were an easy way to deal with this problem, we would have found it by now. However, over the last decade, significant progress has been made, especially in applying adherence theory to selecting patients for specific adherence interventions. Interventions include monitoring platforms such as long-acting therapies or "smart phone" tracking interventions, pharmacy support, and CBT-oriented approaches for those individuals who do not accept a diagnostic label of schizophrenia. Also, in this presentation, there will a discussion of new treatment models that hypothesize that nonadherence is a basic element of the developmental trajectory of the illness, and rather than trying to "stop" nonadherence it is often better to use a "harm reduction" approach with a focus on the therapeutic alliance over and above adherence.

NO. 3

CO-OCCURRING SCHIZOPHRENIA AND ADDICTION: ASSESSMENT AND TREATMENT

Speaker: Douglas M. Ziedonis, M.D., M.P.H.

SUMMARY:

Co-occurring addiction is common amongst individuals with schizophrenia. Assessment factors that influence treatment planning and treatment will be discussed, including motivational level assessment. Motivation Based Treatment planning will be discussed, including how to do Dual Recovery Therapy which integrates psychosocial treatments from addiction treatment. Role of addiction medications will be discussed, including how to adapt to this population. All substances will be discussed, including tobacco addiction. The use of peer specialists in co-occurring disorders treatment will be described.

NO. 4

TREATMENT-REFRACTORY SCHIZOPHRENIA: WHAT SHOULD I DO NOW FOR MY PATIENT?

Speaker: Peter F. Buckley, M.D.

SUMMARY:

Schizophrenia is often associated with inadequate response to pharmacological and nonpharmacological treatments. The extent to which the refractory treatment status is present from the onset of a more severe form of psychosis or evolves over the course of a deteriorative illness is a fundamental issue - with evidence pointing in either direction. When to introduce clozapine – unequivocally the most powerful antipsychotic medication for this recalcitrant population – remains to be clinician choice rather than driven by best practices. As clinicians now tend to sequentially try each new antipsychotic, this deferred strategy inevitably relegates clozapine to a 'drug of last resort' use profile. Addi-

tionally, response to clozapine is not assured. A noteworthy proportion of patients will have an unsatisfactory outcome, thus posing the "what's next?" question. Many different adjunctive medication therapies have been tried with variable successes. The coming-on-line of new neuromodulatory approaches (e.g. repetitive transcranial magnetic stimulation) have provided more treatment options as well as renewed interest in the role of electroconvulsive therapy in this patient population. Pharmacogenetics might in time offer better individual outcomes. This presentation - clinically-focused, yet informed by the latest research findings - will provide a timely appraisal of the treatment of most severely ill patients with schizophrenia.

THE TIP OF THE SPEAR: WALTER REED NATIONAL MILITARY MEDICAL CENTER PSYCHIATRY CONTINUITY SERVICE

Chairs: Scott Moran, M.D., Raymond Lande, D.O.

Discussant: Jack Pierce, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) describe the core components of the WRNMMC Partial Continuity Service; 2) understand the evaluation and treatment processes used in WRNMMC Partial Hospital; 3) discuss research efforts in WRNMMC Partial Hospital and translate that practice into their own practice.

SUMMARY:
The WRNMMC Psychiatry Continuity Service (PCS) is an out-patient, time-limited, individualized day treatment service for active duty personnel and eligible beneficiaries who are in need of intensive treatment that is not available through the out-patient psychiatric clinic, but do not require in-patient hospitalization. This symposium will discuss the state of the art in partial hospital care for the US Military. Diagnoses range from adjustment disorders to psychotic disorders, but patients admitted to the PCS must be able to manage basic activities of daily living without assistance, and cannot be imminently dangerous to themselves or others. The discussants will describe the core components of the PCS, and the individual tracks into which patients are enrolled. They will then discuss the various treatments employed in the PCS, and describe the ongoing research efforts to improve the behavioral health of our Nation's warriors.

NO. 1
PSYCHIATRY CONTINUITY SERVICE RESEARCH
Speaker: Raymond Lande, D.O.

SUMMARY:
A core mission of the Psychiatry Continuity Service is research. The Psychiatry Continuity Service integrates research into clinical practice and smoothly integrate the two areas. Through the research process, the spirit of inquiry is promoted. Areas of active research have included interest in characteristics and correlations between sleep problems, alcohol relapse, and mood among active duty service members. Placebo-controlled, randomized, masked trials of the efficacy of Microcurrent Electrotherapy and Cranial Electrotherapy Stimulation for Joint Pain has been another. The Reasons for Living Scale – Military Version, expanding an established assessment tool for the military psychiatric population and suicide prevention has been developed. Seeking Safety in the military, alcohol biomarkers, psychological significance of tattoos in the military, military malingering, efficacy of light therapy, cranial electric stimulation, and biofeedback have all been areas of study. A summary of Psychiatry Continuity Service published research or an interim report on protocols in progress will be presented.

NO. 2
THE OTHER PROGRAMS AT PSYCHIATRIC CONTINUITY SERVICE AT WRNMMC-B: THE INTENSIVE OUTPATIENT, THE INNOVATIONS AND THE LIFE-SKILLS TRANSITIONS PROGRAMS
Speaker: Bhagwan A. Bahroo, M.D.

SUMMARY:
IOP is a 4 week partial hospitalization track to manage psychiatric disorders. IOP averages about 200 intakes a year. Patients are referred by inpatient facilities as a move to less-restrictive treatment or by outpatient services if needing higher level of care. IOP employs evidence-based medical and psychotherapeutic treatments as well as researching innovative treatments. IOP provides group and individual psychotherapies and utilizes core suicide prevention strategies, including safety assessments 4 times a day. Substance abuse treatment if needed is provided concomitantly. Each IOP team utilizes services of a psychiatrist, psychiatric nurse, social workers, psychiatric technician and recreation therapist. Besides IOP and TRP, a variety of treatment is provided under the heading of "Innovations", utilizing Complementary and Alternative Medicine. Biofeedback, Cranial Electrical Stimulation, Good Days Ahead, Light Therapy, Seeking Safety, VibroAcoustic Chair are some of the treatments provided. Another innovative program, the Morning Focus Group starts the morning schedule and runs for 30-45 minutes, and includes Yoga, Meditation and Mindfulness. Life-Skills Transitions Programs, such as Recreation therapy, Art therapy and Therapeutic Field-trips take over the afternoons to provide patients with vocational guidance for furthering their careers and helping recovery. The focus is on building basic skills necessary for a successful transition to a military or a civilian life.

NO. 3
THE TRAUMA RECOVERY PROGRAM AT WALTER REED NATIONAL MILITARY MEDICAL CENTER
Speaker: Paul J. Andreason, M.D.

SUMMARY:
The Trauma Recovery Program (TRP) is a four-week partial hospitalization track that has at its core the treatment of Posttraumatic Stress Disorder (PTSD). TRP averaged 105 new

patient-intakes per year over the last five years. Patients are referred by either inpatient facilities as a move to less-restrictive treatment or as referrals from outpatient services that were not adequately treating the patients' symptoms. Patients' conditions are complex and complicated by concomitant diagnoses and co-occurring conditions including chronic pain, substance abuse, bipolar disorder, psychotic disorders, personality disorders, and sexual trauma and other abuse. Evaluation is an ongoing process throughout TRP treatment. TRP employs evidence-based psychotherapeutic and medical treatments as well as researching innovative treatments. The TRP has a menu of group and individual psychotherapies that include prolonged exposure therapy, cognitive processing, psycho-education, dream imaging and retraining, cognitive behavioral therapy for insomnia, couples-based cognitive therapy for PTSD, art therapy, biofeedback, recreation therapy, and Seeking Safety. TRP employs two core suicide prevention strategies including "no alcohol use" policy for patients in treatment for PTSD and four safety assessments performed each day. Substance abuse treatment when needed is provided concomitantly. Multi-modality aftercare is planned, coordinated and put into action throughout the treatment process.

MAY 04, 2014

MANAGEMENT OF THE NONCOGNITIVE SIGNS AND SYMPTOMS OF DEMENTIAS/MAJOR NEUROCOGNITIVE DISORDERS (MNDS): A SYSTEMS VIEW OF INDIVIDUALIZED TREATMENTS

Chairs: Helen H. Kyomen, M.D., M.S., Robert P. Roca, M.B.A., M.D., M.P.H.

Discussant: Soo Borson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Comprehensively evaluate and manage specific patterns of acute and chronic noncognitive disturbances in patients with dementias/Mnds, and consider novel management strategies when usual treatments are intolerable or ineffective; 2) Describe how Lean production practice methods may stimulate cost effective access to and interventions for patients with behavioral disturbances; 3) Understand how appropriate, individualized dementia patient care can be strategically provided using a systemic approach with continuity of care.

SUMMARY:
Over 80% of patients with dementias/major neurocognitive disorders (Mnds) exhibit behavioral and psychological symptoms over the course of the illness. Such neuropsychiatric symptoms of dementias/Mnds are complex, difficult to manage and adversely impact patients, caregivers, and healthcare, financial and social systems. In this session, participants will learn: (1) how to comprehensively evaluate and manage specific patterns of acute and chronic noncognitive disturbances in patients with dementias/Mnds; (2) how Lean production practice methods may stimulate cost effective access to and interventions for patients with behavioral disturbances; and (3) how appropriate, individualized dementia patient care can be strategically provided using a systemic approach with continuity of care.

NO. 1
CURRENT PERSPECTIVES ON THE ASSESSMENT AND MANAGEMENT OF THE BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIAS/MAJOR NEUROCOGNITIVE DISORDERS (MNDS)
Speaker: Helen H. Kyomen, M.D., M.S.

SUMMARY:
Effective management of the noncognitive signs and symptoms of dementias/major neurocognitive disorders (NCSSDs/Mnds) incorporates behavior analysis techniques to formulate NCSSDs/Mnds into conditions that can be operably targeted for intervention. Such conditions include pain/discomfort, delirium, psychosis, mania, depression, anxiety, apathy, abnormal behavior, aberrantly regulated drives, aggressiveness and resistiveness. A unified plan integrating multidisciplinary interventions is then customized for each individual and updated as the patient's condition changes over time. Nonpharmacological interventions are maximized and may be augmented with pharmacological treatments. Nonpharmacological interventions encompass the full range of individual, group, family, behavioral and milieu psychotherapeutic approaches. They can include cognitive/emotion-oriented, sensory stimulation, animal assisted, exercise and behavior management techniques. Commonly used pharmacological interventions include psychotropic medications such as antipsychotics, mood stabilizers, antidepressants, sedative/hypnotics, and cognitive enhancers. Other somatic treatments include the use of nutritional supplements, hormonal therapy, cardiovascular agents and electroconvulsive therapy.
In summary, a framework for the assessment and management of NCSSDs/Mnds will be presented, incorporating commonly used and alternative interventions.

NO. 2
LEAN BEHAVIORAL MANAGEMENT OF NEUROCOGNITIVE DISORDERS
Speaker: Robert P. Roca, M.B.A., M.D., M.P.H.

SUMMARY:
"Lean" - a quality improvement method developed by Toyota - has been adapted for use in healthcare settings in the US and abroad. The core tasks of Lean are (1) to distinguish the processes that bring value to the patient (i.e., the processes that serve the goals of care) from processes that do not bring value (i.e., "waste") and (2) to focus effort and resources on the activities that bring value while rooting out and eliminating waste. Accomplishing these tasks requires the participation of front-line staff as well as managers and requires that processes be directly observed rather than dis-

cussed abstractly. These approaches are just now making their way into mental healthcare and being applied to some of our most challenging problems. Psychiatrists who treat patients with major neurocognitive disorders (i.e., dementia) recognize that the so-called non-cognitive behavioral symptoms are very difficult and costly to treat. This presentation will describe the use of Lean methods by a hospital-based multidisciplinary team of physicians, nursing staff, and pharmacists to develop therapeutic interventions that more effectively, safely, and cost-efficiently ameliorate behavioral and psychiatric signs and symptoms of major neurocognitive disorders. We will illustrate how to "map" a process (e.g., calming a patient), identify what helps (value) and what doesn't (waste), and develop sustainable countermeasures (standard work) that produce better outcomes at less cost.

NO. 3
HOW TO PROVIDE A COMPREHENSIVE CONTINUUM OF CARE PROGRAM FOR ELDERLY WITH DEMENTIAS/MAJOR NEUROCOGNITIVE DISORDERS (MNDS)
Speaker: Anne Ellett, M.S.N., N.P.

SUMMARY:
A comprehensive continuum of care program for elderly with dementia/Mnd addresses both the emotional and physical needs of individuals. Such programs provide an environment that is stimulating and allows maximization of independence and dignity throughout the progression of illness. Engagement activities that provide opportunities for purpose, and the philosophy of "dignity of risk," allow these individuals to maintain control and have choices in their lives. Elderly with dementia/Mnd also often have multiple co-morbid illnesses. To address these, a comprehensive continuum of care program includes physicians and nurses who are specially trained in geriatric and dementia care. The avoidance of unnecessary medicalization and hospitalization is emphasized. Care staff is trained to recognize and understand that the behavioral and psychological symptoms of dementia/Mnd represent efforts of the individual to communicate. A systematic approach for symptom interpretation and intervention is implemented to avoid the unneeded use of psychoactive medications. In addition, as individuals with dementia/Mnd progress in their illness, family support is offered and a comprehensive end-of-life program is put into place.

THE NEW YORK STATE SAFE ACT: MANDATORY REPORTING AS AN ATTEMPT TO LIMIT GUN VIOLENCE BY INDIVIDUALS WITH MENTAL ILLNESS

Chair: Elizabeth Ford, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Critically assess the evidence linking gun violence to mental illness and be able to use that evidence to improve clinical risk assessments ; 2) Identify at least two ethical dilemmas that arise when mental health clinicians disclose confidential information in the setting of mandatory reporting ; 3) Understand the clinical, legal and ethical challenges that have arisen in the course of the creation and implementation of the NYS SAFE Act.

SUMMARY:
A mere month after the Newtown, CT school shooting, New York became the first state in the country to pass legislation that, in relevant part, requires clinicians providing mental health treatment to report to the state criminal justice agency any patients in their care who are assessed to be dangerous to themselves or others, regardless of their access to weapons or planned method of injury. If any reported individual has a license to carry a firearm, that license is suspended or revoked and the weapon(s) are removed. While the Secure Ammunitions and Firearms Enforcement (SAFE) Act has important provisions for assault weapon and ammunition restrictions, there has been much debate in the New York mental health, legal and administrative communities about whether the SAFE Act, as written, has any chance of accomplishing the stated goals of reducing the uncommon, but catastrophic, mass shootings by individuals with mental illness.
The presenters at this symposium will offer a range of insights into the implications of the SAFE Act for practitioners, patients, family members and the public. Areas of focus will include the relationship between mental illness and firearms violence, risk assessment, the impact of mandatory reporting on mental health practitioners and their patients, ethical concerns about confidentiality and autonomy, the challenges involved with implementation of the law, and comments about alternative means of minimizing extreme gun violence.

NO. 1
ETHICAL CHALLENGES OF THE NY SAFE ACT
Speaker: Arthur Caplan, Ph.D.

SUMMARY:
The new NY State SAFE act raises numerous ethical issues for mental health providers. Among them are who is required to report, to whom, and on what basis? The act also raises concerns about intrusions into the therapeutic relationship and the ability of caregivers to protect confidentiality and privacy. Overall it is not clear whether notification of state authorities will increase public safety leading to questions about the ethics of compliance.

NO. 2
THE BROAD REACH OF THE NYS SAFE ACT: IS A LEGISLATIVE MANDATE IMPOSED ON MENTAL HEALTH PROFESSIONALS AN EFFECTIVE AND ETHICAL METHOD FOR ADDRESSING ACCESS TO FIREARMS BY POTENTIALLY DANGEROUS PATIENTS
Speaker: Wendy Luftig, J.D.

SUMMARY:
Enacted by the New York State legislature and effective on

March 16, 2013, the NY Secure Ammunition and Firearms Enforcement Act (the "SAFE Act") is arguably the nation's most sweeping gun control legislation. In part, the statute amends the NY Mental Hygiene Law to require that practitioners report mentally ill patients likely to engage in conduct that would result in serious harm to self and others to the criminal justice authorities. In turn, law enforcement officials then determine whether to suspend or revoke a gun license or if confiscation of the firearm is appropriate.
This paper explores whether legislative directives imposing mandatory reporting obligations on mental health professionals are the most effective and ethical method for resolving social problems such as gun violence. Specifically, the mental health provisions of the SAFE Act are analyzed in the context of a long series of "duty to warn" mandates with application to practitioners, including Tarasoff and its progeny, to evaluate the efficacy of these reporting laws. The statute's vague and overly broad definitions are also examined from a legal and ethical standpoint, particularly in light of the burdens placed on mental health professionals with respect to intrusion into the therapeutic alliance, breaches of confidential disclosure, and potential therapist liability.

NO. 3

THE NEW YORK STATE SAFE ACT: AN ATTEMPT TO LIMIT GUN VIOLENCE BY INDIVIDUALS WITH MENTAL ILLNESS THROUGH MANDATORY REPORTING

Speaker: Amit Rajparia, M.D.

SUMMARY:

Starting on March 16th, 2013, the New York State SAFE ACT mandated clinicians providing mental health treatment to report any patients assessed to be dangerous to themselves or others to the state criminal justice agency. The early days of implementing this law has been filled with vigorous debate and unanticipated consequences. With over 12,000 annual patient presentations and a large percentage involving questions of dangerousness, the Bellevue Hospital Comprehensive Psychiatric Emergency Program (CPEP) has been on the frontline of carrying out this mandate.
As director of the Bellevue CPEP and a panelist on this symposium, I hope to explore the following areas:
1. The initial process of interpreting the law and the evolution of the implementation approach in the Psychiatric ER.
2. Data related to the profile of patients being reported and initial outcomes.
3. Clinical and ethical challenges related to the reporting requirement.

RISK, VULNERABILITY AND RESILIENCE: AN EPIGENETIC TRAJECTORY OF PSYCHIATRIC DISORDERS

Chair: Amresh K. Shrivastava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To discuss pathogenesis of psychiatric disorder; 2) To discuss role risk vulnerability and resilience in pathogenesis; 3) To examine possibility of a pathway to explain pathogenesis of mental disorders.

SUMMARY:

Biopsychosocial model is generally widely accepted for pathogenesis of mental disorder, recent research shows a different concept. . Social, cultural, environmental factors possibly interact in a complex way to give rise to behavioral symptoms in a particular disorder. Such factors are considered 'risk factors'. but their discrete role in causation of illness is less clear.
Two main factors appear to play important role which may partially explain this process. 1. risk-vulnerability and stress diathesis model and the 2. Gene-environment interaction. Both may be operating simultaneously. Our understanding of psychosocial risk factors has been changing in recent years. Psychosocial risk can be defined as those fundamental etiopathological factors known to have a causal or correlational association to mental illness. The relationship between psychosocial stress and mental illness is complex. The experience of major psychosocial risk factors (such as poverty, traumatic stress, or abuse) can be sufficient in itself to trigger mental illness. However, most people are resilient and are typically able to persevere against major life stressors. .There are certain inherent factors which remain protective against potential trauma to some extent. Resilience is one of them. Resilience is a personal characteristic of an individual that enables one to adapt to environmental challenges and overcome adversities. There is growing evidence that positive psychological traits such as resilience, optimism, wisdom and social engagements are associated with significant positive health outcomes that include better overall functioning.
Most people, when exposed even to extraordinary levels of stress and trauma, manage to maintain normal psychological and physical functioning and adaptations due to high capacity of resilience.
A number of psychiatric disorders have been linked to resilience. It determines the outcome of trauma and disaster, abuse, adversities and severity of psychopathology.
There is growing focus on study the etiology of mental disorder according to 'endophenotypic' expression of traits. An endophenotype can be conceptualized as an intermediate stage between genotypic and phenotypic causes for normal and abnormal patterns of mental function. . Changes in gene expression through such epigenetic mechanisms appear to be powerful and lifelong (appearing just after birth and throughout an individual's lifespan; biological mechanism supporting adaptability of the human genome. Such powerful adaption at a genetic level helps us account for variability in symptom expression and evidence of neurological changes in response to psychosocial stress. In this symposium participants have attempted to highlight some of these aspects

NO. 1

HYPOTHALAMIC-PITUITARY-ADRENAL (HPA) AXIS GENES IN SUICIDE BRAIN: ROLE IN SUICIDE

Speaker: Ghanshyam N. Pandey, Ph.D.

SUMMARY:

Rationale: 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, and decreased levels of GR in the brain of depressed or suicide subjects. To study their role in teenage suicide we determined the protein and gene expression of CRF, CRF receptors, and GR in the prefrontal cortex (PFC), hippocampus and amygdala of teenage suicide victims and teenage normal control subjects. Methods: 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 DSM-IV (SCID). Protein expression was determined using Western blot and gene expression (mRNA) was determined using real-time RT-polymerase chain reaction (qPCR) technique. Results: We observed that the protein and gene expression of the CRF was significantly increased in the PFC (Brodmann area 9) and in amygdala, but not in the hippocampus, of teenage suicide victims compared with normal control subjects. The protein and gene expression of CRF-R1 was significantly decrease

NO. 2

EPIGENESIS: A NOVEL TOOL TO DISCOVER THE GENETIC MYSTERY OF PSYCHOSOMATIC DISORDERS

Speaker: Amarendra N. Singh, D.P.M., M.D.

SUMMARY:

Epigenesis or epigenetics, derived from the Greek word was coined by Waddington in 1942, refers to interaction of genetic and environmental factors. Changes by this genetic mechanism are developed due to outside influence rather than genetically determined and one that is outside conventional genetics. In psychosomatic disorders the influences of outside factors on genetic material from the very beginning to whole life are observed thus showing the involvement of the ongoing epigenesis process. The underlying mechanism of epigenesis thus involves non-interpreted genes induced by environmentally modified gene expression without altering DNA sequences. When responses are mismatched, the risk of psychosomatic disorders increase. Molecular basis of epigenesis is a complex and multiple inherited system and may play a role in forming cell memory. Epigenetic gene regulation in neurons producing complex behaviour has been implicated in may psychosomatic disorders including depression, anxiety, and drug addiction.

NO. 3

RESILIENCE: AN INDEPENDENT NEUROBEHAVIORAL CONSTRUCT FOR PSYCHOPATHOLOGY

Speaker: Amresh K. Shrivastava, M.D.

SUMMARY:

Recent thinking is public health is towards positive psychiatry which argues for an outcome in which we can move towards wellness from illness and try to achieve an outcome which can parovide social integration, personal contentment.

There is growing evidence that positive psychological traits such as resilience, optimism, wisdom and social engagements are associated with significant positive health outcomes that include better overall functioning

Recent investigations have sought to understand its neurobiology.

In one of our study for examining psychopathology we hypothesized that resilience of a patient is also responsible for relapse and rehosptalization due to diminished ability to adapt to a number of psychosocial situations. . The study shows that there is a critical window for effectiveness of resilience. It is observed that up to a certain level high resilience is protective against severity of psychopathology. However after a critical level, severity of psychopathology continues to increase despite presence of high resilience. This phenomenon could be possibly due to an 'exhaustion effect' caused by persistent symptoms of severe mental disorders.

NO. 4

NEUROCHEMISTRY OF CHRONIC STRESS: CORTISOL-INDUCED SEROTONIN REUPTAKE

Speaker: Gustavo E. Tafet, M.D., Ph.D.

SUMMARY:

Stress and depression are characterized by elevation of circulating cortisol, as well as by changes in physiological functions, mediated by the HPA axis. We hypothesized that abnormality of HPA axis, with increased levels of cortisol, may lead to serotonergic changes in chronic stress leading to anxio-depressive symptoms. We demonstrated that cortisol induces an increase in the expression of the serotonin transporter gene, associated with subsequent elevation in the uptake of serotonin. This stimulatory effect, produced upon incubation with cortisol in vitro, was observed in peripheral blood lymphocytes from normal subjects. We carried out studies to examine cortisol level and enhancement of serotonin uptake by cortisol in patients with generalized anxiety disorder and depression. We further studied changes in cortisol level with cognitive therapy (CT). A significant decrease in the HAM–A scores, along with significant changes in plasma cortisol levels, were observed after completion of treatment with CT in both groups. We concluded that neurobiological effects of chronic stress may involve enhancement of serotonin uptake by cortisol, due to increased HPA axis activation caused by stress. Psychopharmacological and psychotherapeutic approaches are considered.

WHAT'S THE DIFFERENCE THAT MAKES THE DIFFERENCE?

DEMONSTRATION OF COMMONALITIES AND DIFFERENCES ACROSS EFFICACIOUS TREATMENTS FOR BPD

Chair: Valerie Porr, M.A.

Discussant: Kenneth R. Silk, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Differentiate between the 3 evidence based BPD treatments; 2) Identify the specific areas and behaviors that each treatment targets; 3) Recognize the importance of training families to help people with BPD by reinforcing treatment goals.

SUMMARY:
Borderline personality disorder (BPD) is characterized by intense, labile emotions, conflict in interpersonal relationships, cognitive misperceptions, and extreme impulsivity. Over the last 20 years, several manualized, efficacious therapies have emerged, providing hope for people with BPD: mentalization-based treatment (MBT), Transference-Focused Psychotherapy (TFP), and Dialectical Behavior Theapy (DBT). Although people with BPD account for a disproportionately high use of psychiatric services, evidence based treatments are not generally available in most communities to meet the treatment needs of this patient population. (5.9% of the population, Grant, et al 2008). How do we motivate clinicians to get training in these newer, evidence based BPD d treatments and how does a clinician decide which treatment works for which client?
Conference attendees generally have many opportunities to learn about treatment theories with data showing their effectiveness. Rarely do they get a chance to see master clinicians, developers of a treatment, actually applying their treatment in a therapy session. Attendees will have the opportunity to experience a master clinician doing spontaneous therapy. The practice seminar will provide an opportunity to demonstrate and discuss the similarities and difference between MBT (Bateman), TFP (Kernberg), DBT (Bohus), and an emerging integration of DBTand MBT for families, the TARA Method of Family Psychoeducation.(Porr).
Some advocate for comparison trials between these three treatments to determine which is better. Others argue against so-called 'horse race' studies, advocating instead that attention be focused on improving each treatment through component analysis studies. Still others suggest a thorough examination of the similarities and differences between each approach to aid in treatment matching and to further refine each by identifying common elements used across all three treatments. Psychoeducation so as to engage families as treatment adjuncts has also been considered.
Panelists will first provide a high-level description of their respective treatments, followed by a live clinical demonstration, commentary, and discussion. Special attention will be devoted to highlighting the structural, strategic, and stylistic similarities and differences between the four approaches. The demonstrations will address how a clinician determines which therapy is best suited for which client. Observing a master clinician treat a client with borderline personality disorder in crisis will help destigmatize the disorder and gives the participants the opportunity to see how treatment is actually done. A discussion following the demonstrations will pose questions re: similarities and differences between each therapy and explore what might be needed for development of a new, integrated BPD treatment.

NO. 1
DEMONSTRATING MENTALIZATION-BASED THERAPY
Speaker: Anthony Bateman, M.D.

SUMMARY:
This presentation will provide an outline of the key features of Mentalization Based Treatment (MBT). The aim of MBT is to increase the mentalizing capacity of the individual, particularly in interpersonal relationships and during states of high emotional intensity. The steps undertaken by the therapist will be outlined. First, the therapist takes a specific not-knowing stance, then identifies any break in mentalizing, indicated by psychic equivalence, pretend mode, or teleological understanding. The emergence of these modes of thinking indicates that mentalizing is vulnerable and marks a point at which the therapist needs to try to re-stimulate mentalizing. Next, the therapist asks the patient to rewind to the moment before the break in subjective continuity occurred. Third, the therapist explores the current emotional context contributing to the break in the session by identifying the momentary affective state between patient and therapist. Fourth, the therapist explicitly identifies his own contribution to the break in mentalizing. It is only after this work has been done that the therapist seeks to help the patient understand the mental states implicit in the current state of the patient-therapist relationship which forms mentalizing the transference. In this clinical demonstration of a session, an actor playing a patient with bpd will be interviewed to illustrate the clinical interventions used in MBT. These will be contrasted with other treatments for BDP.

NO. 2
DEMONSTRATING TRANSFERENCE FOCUSED THERAPY (TFP)
Speaker: Otto F. Kernberg, M.D.

SUMMARY:
Transference Focused Psychotherapy (TFP) is the first manualized, psychoanalytic treatment for borderline personality disorder (BPD). TFP is a twice-weekly outpatient therapy with the option of conjunctive treatments to target specific problems (e.g., substance use or eating disturbances). By combining a highly structured treatment frame and a focus on mental and emotional experiences with the therapist (transference), TFP aims to transform the psychological and emotional processes that drive the symptoms and behaviors of BPD. By transforming the emotional processes that are the building blocks of personality, TFP endeavors to foster

stable and long term improvement in interpersonal relationships and work spheres for individuals with BPD. In this presentation, the TFP model of BPD will be introduced, followed by a brief description of the essential techniques and strategies of the treatment. The dynamics and aims of TFP will be illustrated by demonstrating a psychotherapeutic session between an individual with BPD and their TFP therapist. Finally, the commonalities and difference between TFP and other psychoanalytic approaches for BPD will be discussed.

NO. 3
DEMONSTRATING DIALECTIC BEHAVIOR THERAPY
Speaker: Martin Bohus, M.D.

SUMMARY:
Dialectical Behavior Therapy (DBT) is a comprehensive, multi-modal treatment for borderline personality disorder (BPD). DBT assumes that people with BPD lack important interpersonal self-regulation (including emotion regulation) and distress tolerance skills, and personal and environmental factors often block and/or inhibit the use of behavioral skills bpd individuals do have, and reinforce dysfunctional behaviors. DBT combines the basic strategies of behavior therapy with eastern mindfulness practices, within an overarching dialectical worldview emphasizing the syntheses of opposites. Outpatient DBT includes four modes: individual psychotherapy, skills training, phone consultation, and consultation team. More important than the modes themselves are the functions they facilitate. These include: building motivation, enhancing skills capabilities, ensuring generalization to the natural environment, and structuring the environment. By articulating the functions of treatment, DBT can be transported to novel treatment environments where fidelity to the treatment can be preserved. The goal of DBT is to bring individuals closer to their ultimate goals. To date, DBT has the most controlled randomized trails demonstrating its' efficacy. The presenter will describe and demonstrate specific dbt treatment strategies used by the therapist when treating a person with BPD. Special effort will be made to draw comparisons and contrasts with DBT to TFP and MBT.

NO. 4
DEMONSTRATING THE TARA METHOD OF FAMILY PSYCHO-EDUCATION
Speaker: Valerie Porr, M.A.

SUMMARY:
Family members deal with abusive and dangerous BPD behaviors without knowing how to avoid triggering emotional eruptions or deescalate them. With DBT and MBT training, family members can become therapeutic parents or partners, reduce environmental stressors and reinforce effective behaviors. Research shows 70% of people with BPD drop out of treatment leaving families on the front lines, spending more time with the BPD person than any clinicians. Gunderson states, 'failure to involve family as support for treatment of BPD makes patients' involvement in therapy superficial and is a major reason for premature dropout.' the presenter will describe DBT and MBT elements incorporated into the TARA Method, highlighting specific treatment strategies used by family members in daily interactions. MBT's focus on attachment relationships will generally lead to focus on family relationships. This presentation will illustrate a family crisis wherein a family member implements DBT and MBT techniques in the heat of the moment to restore mentalization and avert further emotional escalation by talking to their loved one in the compassionate, limbic DBT language of validation, not personalizing or controlling, reinforcing effective coping methods and building mastery while clarifying the nuances and subtleties of the intentions of the interaction to restore mentalization.

ADVANCES IN PEDIATRIC BIPOLAR DISORDER RESEARCH

Chairs: Joseph Biederman, M.D., Janet Wozniak, M.D.

Discussant: Andrew Nierenberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Gain new knowledge on predictors of mania switches in children with major depression; 2) Gain new knowledge on whether euphoria and grandiosity represent cardinal symptoms of pediatric bipolar-I disorder; 3) Gain new knowledge on the body of knowledge on glutamatergic dysregulation in pediatric bipolar disorder as assessed through MRS spectroscopy.

SUMMARY:
This symposium will address new scientific developments in the field of pediatric bipolar (BP)-I disorder. Dr. Biederman's presentation will report results from a recent investigation examining whether risk factors for switches from unipolar major depression (MDD) to BP-I disorder in youth can be identified. Results revealed that switches from unipolar MDD to BP-I disorder in children with ADHD and MDD can be predicted by baseline subthreshold BP-I disorder symptoms and deficits in emotional regulation. These results will be expanded by Dr Uchida's presentation, which will review the extant literature on predictors of manic switches in children with MDD. Dr. Wozniak's presentation will address results of a recently completed study that used familial risk analysis to investigate whether euphoria and grandiosity are uniquely important in making the diagnosis of BP-I disorder in youth (hence "cardinal"). Findings challenge the notion that euphoria and grandiosity represent cardinal symptoms of mania in children. They also support the use of unmodified DSM-IV criteria in establishing the diagnosis of mania in pediatric populations. Finally, Dr Spencer's presentation will address the body of knowledge on glutamatergic dysregulation as examined through MRS spectroscopy in pediatric BP-disorder.

NO. 1
RE-EXAMINING THE RISK FOR SWITCH FROM UNIPOLAR TO

BIPOLAR MAJOR DEPRESSIVE DISORDER IN YOUTH WITH ADHD

Speaker: Joseph Biederman, M.D.

SUMMARY:

Background: Recent studies have identified subthreshold forms of bipolar (BP)-I disorder and deficits in emotional regulation as risk factors for bipolar disorder in youth. To this end we investigated whether the presence of these risk factors can predict switches from unipolar major depression (MDD) to BP-I disorder in youth. Methods: We used data from two large controlled longitudinal family studies of boys and girls with and without ADHD. Subjects (N=522) were followed prospectively and blindly over an average follow up period of 11.4 years. Comparisons were made between ADHD youth with unipolar major depression (MDD) who did (N=24) and did not (N=79) switch to BP-I disorder at follow-up. Results: The rate of conversion to BP-I disorder at follow up was higher in MDD subjects with subthreshold BP-I disorder at baseline compared to those without (57% vs. 21%; OR=9.57, 95%CI=1.62-56.56, p=0.013) and in MDD subjects with deficient emotional self regulation (OR=3.54, 95%CI=1.08-11.60, p=0.037). Conclusions: Switches from unipolar MDD to BP-I disorder in children with ADHD and MDD were predicted by baseline subthreshold BP-I disorder symptoms and baseline deficits in emotional regulation. More work is needed to assess whether these risk factors are operant outside the context of ADHD.

NO. 2

THE CLINICAL CHARACTERISTICS OF UNIPOLAR VS. BIPOLAR DEPRESSION IN YOUTH: A QUALITATIVE REVIEW OF THE LITERATURE

Speaker: Mai Uchida, M.D.

SUMMARY:

While pediatric mania and depression can be distinguished from each other, differentiating between unipolar and bipolar depression poses unique challenges, and is of high clinical relevance. Our aim was to examine the current body of knowledge on whether unipolar and bipolar depression in youth can be distinguished in terms of clinical features and correlates. A systematic literature search was conducted of studies assessing the clinical characteristics and correlates of unipolar and bipolar depression in youth. The studies fit our a priori criteria were included in our qualitative review. Eleven scientific papers were identified. Together, these papers reported that bipolar depression is distinct from unipolar depression in terms of their earlier onset of mood symptoms, and higher levels of severity, dysfunction, comorbidity, behavioral difficulties and family history. These findings can aid clinicians in differentiating the forms of depression in youth.

NO. 3

HOW CARDINAL ARE CARDINAL SYMPTOMS IN PEDIATRIC BIPOLAR DISORDER?: A FAMILIAL RISK ANALYSIS

Speaker: Janet Wozniak, M.D.

SUMMARY:

Background: The main goal of this study was to use familial risk analysis to examine whether hypothesized cardinal symptoms of euphoria and grandiosity are truly “cardinal” in the diagnosis of pediatric bipolar (BP)-I disorder. Methods: Patterns of familiality with BP-I disorder were examined in pediatric probands satisfying DSM-IV criteria for BP-I disorder with and without cardinal symptoms of euphoria and grandiosity. Results: Among Criterion A, (abnormal mood) we found that severe irritability was the predominant abnormal mood rather than euphoria (94% vs 51%). We also found that among Criterion B items, grandiosity was not uniquely overrepresented in youth with mania, nor did the rate of grandiosity differ whether irritability or euphoria was the Criterion A mood symptom. Neither symptom profile, patterns of comorbidity nor measures of functioning differed related to the presence or absence of euphoria or grandiosity. Conclusions: These findings challenge the notion that euphoria and grandiosity represent cardinal symptoms of mania in children. Instead they support the clinical relevance of severe irritability as the most common presentation of mania in the young. They also support the use of unmodified DSM-IV criteria in establishing the diagnosis of mania in pediatric populations.

NO. 4

GLUTAMATERGIC METABOLITES IN PEDIATRIC BIPOLAR AND OTHER CHILDHOOD PSYCHIATRIC DISORDERS

Speaker: Andrea E. Spencer, M.D.

SUMMARY:

Glutamate plays a critical role in normal brain function, and a growing body of literature has investigated its role in the pathophysiology of childhood psychiatric disorders through magnetic resonance spectroscopy (MRS). We reviewed the existing literature and of 50 articles identified, 9 assessed glutamatergic metabolites in pediatric bipolar disorder and 2 in emotional dysregulation. The most consistent finding in pediatric bipolar disorder was decreased glutamatergic metabolites in the ACC and normalization with treatment, in contrast to increased glutamatergic metabolites in the ACC found in emotional dysregulation.

TESTIMONY REGARDING BEHAVIORAL GENOMICS AT CRIMINAL TRIALS

Chair: William Bernet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand current research regarding gene-by-environment interaction and its relation to human behavior.; 2) Explain the conceptual challenges to testimony regarding behavioral genomics, such as the lack of a definite link between the defendant’s genetic status and the criminal behavior.; 3) Know recent patterns of testimony regarding behavioral genomics and the outcomes in actual cases.

SUMMARY:
Should testimony regarding behavioral genomics be presented at criminal trials? Philosophers, physicians, mental health professionals, and legal practitioners have thought for hundreds of years that human behavior is driven by some combination of nature (heredity, genetics, genomics), nurture (parental upbringing, influence of peers, good and bad life experiences), and free will. There are three ways in which a person's genetic make-up may be relevant to his behavior: (1) The person's genotype may exactly designate a psychiatric or medical diagnosis that clearly explains the person's abnormal behavior. An example is Huntington's disease; the genotype determines the diagnosis and there is a distinct causal relationship between the genotype and abnormal behavior. (2) The person's genotype may support a psychiatric diagnosis that has been made on clinical grounds. For example, a person who is homozygous for the short allele of the SLC6A4 (serotonin transporter) gene is more likely to become depressed and suicidal after stressful situations than a person who is homozygous for the long allele of that gene. The genotype does not make the diagnosis of severe depression, but it supports the diagnosis that was made on clinical grounds. (3) The person's genotype may help to explain a person's violent or criminal behavior. For example, a male who has the low activity allele of the MAOA gene and who experienced serious child maltreatment is more likely to manifest violent and antisocial behavior as an adult than a male who has the high activity allele of this gene. Testimony regarding gene-by-environment interactions may be appropriate in some circumstances, such as the penalty phase of a trial when capital punishment is a consideration. The presenters at this symposium will summarize the scientific basis for testimony regarding behavioral genomics, review the ethical and legal issues that arise when such testimony is being considered, and describe the outcomes when behavioral genomic testimony has been presented in actual trials. The presenters, who represent different perspectives, will attempt to achieve consensus regarding the ethical, legal, and scientific basis for testimony regarding behavioral genomics.

NO. 1
RATIONALE FOR POSITING AN INTERACTION OF CHILDHOOD MALTREATMENT AND MAOA GENOTYPE IN THE PREDICTION OF ANTISOCIAL BEHAVIOR
Speaker: Stephen B. Manuck, Ph.D.

SUMMARY:
Several lines of evidence undergird the hypothesis that polymorphic variation in the gene encoding monoamine oxidase-A (MAOA) moderates effects of childhood maltreatment on adolescent and adult antisocial behaviors. These include effects of early life adversities on childhood conduct problems, modified by latent genetic risk; aggressive phenotype in Brunner syndrome; transgenic murine models of MAO-A deficiency; neural and neurocognitive correlates of common regulatory variation in MAOA; and laboratory studies of MAOA-environment interaction. It is suggested that early maltreatment may either interact with MAOA genotype to affect the maturation and function of key neural pathways, such as cortico-limbic circuitry of emotion processing, or engender antagonistic and antisocial motivations that are abetted by MAOA-modulated impairments in inhibitory control.

NO. 2
MAOA, CHILDHOOD MALTREATMENT AND ANTISOCIAL BEHAVIOR: META-ANALYSIS OF A GENE-ENVIRONMENT INTERACTION
Speaker: Amy L. Byrd, M.S.

SUMMARY:
In a seminal study of gene-environment (GxE) interaction, childhood maltreatment predicted antisocial behavior more strongly in males carrying an MAOA promoter variant of lesser, compared to higher, transcriptional efficiency. More studies have been reported since, including studies of other early life adversities and females. Here we report a meta-analysis of 27 studies testing the interaction of MAOA genotype and childhood adversities in predominantly non-clinical samples. Across 20 male cohorts, MAOA genotype moderated effects of early adversity on antisocial outcomes; stratified analyses showed the interaction specific to maltreatment, predictive of both violent and non-violent antisocial behaviors, and robust to several sensitivity analyses. Studies were both fewer and less consistent in females. In sum, our results lend confidence to this widely cited instance of GxE interaction, at least as seen in males and where environmental risk most closely matched the sentinel study.

NO. 3
BEHAVIORAL GENETIC EVIDENCE: CONCEPTUAL AND PRACTICAL CHALLENGES
Speaker: Paul S. Appelbaum, M.D.

SUMMARY:
Genetic evidence has been introduced in criminal trials, often to persuade the factfinder of the defendant's diminished responsibility or to mitigate punishment. The monoamine oxidase A (MAOA) gene has attracted the most attention in this regard. From a conceptual perspective, demonstrating diminished responsibility requires a clear link between the defendant's genetic status and the criminal behavior, which typically will be impossible to establish. Also, the mitigating effect of such testimony may be outweighed by the perception that defendants who are genetically predisposed to commit criminal acts should be punished more severely. Practically speaking, data from surveys of the general public suggest that they are unimpressed by claims for mitigation based on genetic data; the impact on judges appears to be slight. While we can expect to see efforts to use genetic evidence, especially in sentencing at death penalty hearings, its ultimate impact on the criminal courts is uncertain.

NO. 4

BEHAVIORAL GENETIC EVIDENCE IN CRIMINAL CASES: 1994-2011
Speaker: Deborah Denno, J.D., M.A., Ph.D.

SUMMARY:
The author studied all published criminal cases (totaling 81) that addressed behavioral genetics evidence from 1994 to 2011. In recent years, behavioral genetics evidence was applied almost exclusively as mitigation in death penalty cases, primarily to support claims of ineffective assistance of counsel for neglecting such evidence or to provide proof of a defendant's mitigating condition. This study found no case in recent years in which behavioral genetics factors were introduced by the State. These results suggest that behavioral genetics evidence has no discernable impact on a defendant's case or, at most, it becomes an effective tool along with a range of other variables in rendering a defendant ineligible for the death penalty. Courts appear willing to accept behavioral genetics evidence as part of a defendant's mitigation story. Another new trend in recent years was a clear increase in testimony regarding a genetic propensity for alcoholism or substance abuse.

NO. 5
TESTIMONY REGARDING MAOA AND SLC6A4 GENOTYPING AT CRIMINAL TRIALS
Speaker: William Bernet, M.D.

SUMMARY:
Research regarding human behavioral genomics has made significant progress in enhancing our understanding of the relative contributions of genetics and the environment for observed variations in human behavior. Research regarding behavioral genomics has been introduced in the U.S. criminal justice system, and its use will occur more frequently in the future. This presentation discusses two gene variants of particular interest in the criminal law (MAOA and SLC6A4) and recent expert testimony on behalf of criminal defendants with respect to these two gene variants. In conclusion, the presenter will propose that testimony regarding behavioral genomics is scientifically, ethically, and legally appropriate as long as: the testimony does not exaggerate the research; gene-by-environment data are presented as risk factors, not necessarily directly causing violence or mental disorders; and information regarding behavioral genomics is only one part of an extensive, comprehensive evaluation.

DIAGNOSTIC AND ASSESSMENT CONSIDERATIONS FOR THE TREATMENT OF COMORBID OPIOID ADDICTION AND CHRONIC PAIN

Chairs: Richard A. Denisco, M.D., M.P.H., Will M. Aklin, Ph.D.

Discussant: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the most recent changes in the objective diagnosis of pain conditions via. fMRIs and other imaging techniques; 2) Better understand how to treat acute and chronic pain in patients with a history of addiction; 3) Have a greater knowledge on mechanisms on the transition of acute to chronic pain, and to identify any of these mechanisms while treating their own patients; 4) Better understand how to use buprenorphine to treat both pain and the addiction to opioid analgesics; 5) Be familiar with recognizing and treating opioid tolerance and addiction potential in chronic pain patients with a possible diagnosis of hyperesthesia.

SUMMARY:
This symposium presents the clinician or researcher with the wide spectrum of recent developments in the diagnosis, assessment, and treatment of chronic pain and addiction. Objective diagnosis of chronic pain has long been a clinical challenge. Recent fMRI based biomarker studies are developing objective measures for pain will be presented. This will be followed by a broad overview of treatment considerations of acute and chronic pain in a patient with a substance abuse history. How each of these addiction histories should be considered by the clinician in order to establish specific treatment plans will also be explored. A more specific exploration of the transition from acute to chronic pain will then follow. Alternative and new explanations for tolerance, leading to analgesic failure in some patients when they are administered opioids on a long term basis will be presented. The symposium will conclude with the presentation of a large clinical study performed by the Clinical Trials Network (CTN) of NIDA concerning the use of buprenorphine for the treatment of opioid addiction. This should provide clinicians with useful guidance when beginning buprenorphine detoxification or maintenance treatment. The advantages and disadvantages of buprenorphine used to treat acute pain and addiction concurrently will also be part of this discussion.

NO. 1
FMRI-BASED BIOMARKER FOR CLINICAL PAIN AND ANALGESIA
Speaker: Tor Wager, Ph.D.

SUMMARY:
Objective measurements of pain continue to be very difficult. This session will explain one of the newest techniques of fMRI imiaging to serve as a biomarker for pain. Other diagnostic modalities that could provide an objective measure of pain will also be presented.

NO. 2
OVERVIEW OF THE TREATMENT OF ACUTE AND CHRONIC PAIN IN THE PATIENT WITH A HISTORY OF ADDICTION
Speaker: Sean Mackey, M.D., Ph.D.

SUMMARY:
Treatment of Acute and Chronic Pain in the Patient with a History of Addiction will be addressed. As more people are

recovering from the prescription drug problem, they continue to age and require medical and surgical proceedures. These will require carefull consideration of the medical team to get the patient optimal care without fueling the addictive disorder.

NO. 3
TRANSITION OF ACUTE TO CHRONIC PAIN
Speaker: Ian Carroll, M.D., M.S.

SUMMARY:
This presentation will explore the many factors involved in the optimal treatment of patients to prevent the exacerbation of thr chronic pain condition.

NO. 4
HYPERESTHESIA AND ITS RELATIONSHIP TO OPIOID TOLERANCE, CHRONIC PAIN AND ADDICTION POTENTIAL
Speaker: Roger Chou, M.D.

SUMMARY:
Hyperesthesia is being increasingly studed as a cause of tolerence and opioid misuse. This presentation will look at the wide variety of physiologic and behavioral factors that interact and may be responsible for this stuation.

NO. 5
CTN AND THE USE OF BUPRENORPHINE FOR ADDICTION TO OPIOID ANALGESICS
Speaker: Roger D. Weiss, M.D.

SUMMARY:
Prescription opioid dependence has become an increasingly prevalent problem. However, most treatment studies with opioid dependent patients have focused on those dependent upon heroin. The multi-site Prescription Opioid Addiction Treatment Study (POATS), conducted by the NIDA Clinical Trials Network, the largest clinical trial ever conducted with patients dependent upon prescription opioids, examined combinations of buprenorphine-naloxone (bup-nx)and drug counseling for this patient population. The study found very low rates of successful outcome (7%) with a brief bup-nx taper, with a 49% success rate (abstinence or near-abstinence from opioids) after 12 weeks of bup-nx stabilization. Counseling did not affect outcome.
This presentation will review both the main findings from this trial and a number of secondary outcomes, including predictors of successful outcome; the relation of specific opioid to level of difficulty of induction onto bup-nx; the impact of psychiatric comorbidity; and early indicators of outcome. The impact of chronic pain and co-occurring heroin use will also be discusses.

THE CLASSIFICATION OF PSYCHOTIC DISORDERS IN DSM-5 AND ICD-11: THE ROLE OF FIELD TRIALS AND HOW THEY INFORM CLASSIFICATION

Chairs: Wolfgang Gaebel, M.D., Ph.D., Geoffrey M. Reed, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the development of the classification of psychotic disorders over the recent years; 2) Know the classification criteria of psychotic disorders according to current classification manuals (DSM-5, ICD-11); 3) Be knowledgeable about the role of field trials for the development of classification criteria for psychotic disorders in DSM-5 and ICD-11.

SUMMARY:
Field trials play an important part in informing the development of the revised classification systems for mental disorders, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5) and the World Health Organization's International Classification of Diseases and Related Health Problems (Mental and Behavioural Disorders chapter, ICD-11), Field trials may serve to indicate whether clinicians can use the revised diagnostic descriptions and criteria accurately and easily, whether they are formulated clearly, and whether they reflect the clinical profiles encountered by psychiatrists in everyday clinical practice. Field trials may also serve to validate proposed diagnostic requirements, i.e., by comparing the results of classification obtained from a panel of expert psychiatrists in academic settings against the results obtained by general psychiatrists working in the clinical field, or by obtaining basic data on aspects like the intra- and inter-rater variability. In this symposium, experts who were actively involved in the development of the classification of psychotic disorders in both ICD-11 and DSM-5 will describe the general role of field trials in revising the classification of mental disorders, how the revision process was structured for the psychotic disorders and what the main revisions were or will be, and the design, implementation, and results of field trials informing the decisions taken in the development of the classifications.

NO. 1
CLASSIFICATION OF PSYCHOTIC DISORDERS IN DSM-5: THE IMPACT OF FIELD TRIALS
Speaker: Rajiv Tandon, M.D.

SUMMARY:
Results of field trials played an important role in influencing how decisions about proposed revisions in the DSM-IV definition of psychotic disorders were made. Proposed DSM-5 definitions of schizophrenia and schizoaffective disorder were found to exhibit moderate reliability comparable to or better than DSM-IV definitions. Whereas the reliability of rating the severity of four dimensional items was acceptable, that of the other four items was found to be poor. The sample size of patients with attenuated psychosis syndrome was too small to allow meaningful assessment of reliability. Consequently, proposed DSM-5 definitions of schizophrenia and schizoaffective disorder were accepted in section 2. On the other hand, the dimensional assessment scale was included in Section 3 and similarly attenuated psychosis

syndrome was included as a condition needing further study in section 3.

NO. 2
THE ROLE OF FIELD TRIALS IN DEVELOPING THE CLASSIFICATION OF MENTAL DISORDERS IN ICD-11
Speaker: Geoffrey M. Reed, Ph.D.

SUMMARY:
A key goal for the World Health Organization in developing the ICD-11 is improved clinical utility. This goal underlies a major field studies effort. Formative field studies were undertaken early in the development process to inform decisions about the basic structure and content of the new classification. WHO's Global Clinical Practice Network (GCPN), consisting of more than ten thousand global mental health professionals, is the primary vehicle for conducting internet-based studies to examine whether clinicians are able to use the new diagnostic guidelines. Examples of studies to test the use of the new classification in real-life clinical settings include studies on sexual disorders and sexual health in five middle-income countries (Brazil, India, Lebanon, Mexico, and South Africa) and a study of key aspects of a the proposed ICD-11 classification for mental and behavioural disorders in primary care in eight countries around the world (Brazil, China, India, Japan, Mexico, Pakistan, Spain, and Tanzania). Conducting field studies in all global regions and in multiple languages is fundamental to an examination of clinical utility and applicability in a global context. WHO particularly emphasizes the participation of low- and middle-income countries, where 85% of the world's population lives. Examples of findings from these different areas will be presented.

NO. 3
PSYCHOTIC DISORDERS IN ICD-11: SUGGESTIONS FOR REVISED CLINICAL DESCRIPTIONS AND DIAGNOSTIC GUIDELINES
Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:
For developing the revised clinical descriptions and diagnostic guidelines for schizophrenia and other primary psychotic disorders, the World Health Organization assembled a Working Group on Psychotic Disorders composed of members from all regions of the world. This group developed suggestions for a revised structure of the psychotic disorders section in ICD-11 and prepared a set of revised classification criteria. Major structural changes include the introduction of course and severity specifiers allowing a detailed description of the clinical characteristics of each individual patient with a psychotic disorder. The presentation will discuss both such structural changes and the most relevant changes in the single diagnostic entities of the psychotic disorders chapter of ICD-11 like schizophrenia and schizoaffective disorders. Both similarities and dissimilarities compared to DSM5 diagnostic criteria will be discussed.

NO. 4
DESIGN OF THE ICD-11 FIELD TRIALS FOR PSYCHOTIC DISORDERS
Speaker: Jürgen Zielasek, M.D.

SUMMARY:
The use of field trials in the development of classification systems for mental disorders has several aspects to serve. These include, as major points, assessments of the reliability (both inter-rater and intra-rater) of proposed criteria, validation of criteria against expert consensus standard, and the assessment of the utility and feasibility of the proposed criteria. For measuring these factors, several methods are feasible and need to be assessed for their applicability to the respective sets of criteria. These include internet-based assessments of case vignettes, questionnaires about utility and feasibility, and real-patient studies. Participants of field trials may include medical or psychological professionals using ICD-11 for clinical purposes, but also healthcare administrators. This presentation will discuss both general principles and the concrete ways of how the field trials for the primary psychotic disorders in ICD-11 were organized and implemented.

NO. 5
PRELIMINARY RESULTS OF ICD-11 INTERNET-BASED FIELD TRIALS FOR PSYCHOTIC DISORDERS
Speaker: Jared W. Keeley, Ph.D.

SUMMARY:
This presentation will discuss the results of the first portion of the ICD-11 electronic field trials for psychotic disorders. Specifically, data will be presented on clinicians' ability to consistently apply diagnostic guidelines and discriminate amongst psychotic disorders using a global sample. Given the advent of symptom specifier scales for both DSM-5 and ICD-11, the presentation will also discuss the results of a study examining the reliability of clinicians' ability to use dichotomous and multi-point rating scales of psychotic symptoms. Implications for the clinical utility of both DSM-5 and ICD-11 diagnostic systems will be discussed, as well as recommended revisions.

THE EVOLUTION OF CLINICAL TRIAL DESIGN METHODOLOGY IN BIPOLAR DISORDER

Chair: Mark Frye, M.D.

Discussant: Terence A. Ketter, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Better understand historical development of clinical trials for acute mania that have culminated in a standard clinical trial design of 3 wk & placebo-control to the investigative study drug ; 2) Acquire greater appreciation for maintenance clinical trial design development with a consensus of a stabilization period & enriched sample being

randomized to ongoing maintenance treatment vs placebo; 3) Recognize 2 new areas of clinical trial, the added benefit of comparative effectiveness trials vs regulatory efficacy trial design & challenges of optimal trial design for bipolar depression.

SUMMARY:
Clinical trial design has been critical in regulatory approval for new drug development. This has been challenging in bipolar disorder, given the complexity of the illness and need to differentially optimally address acute mania, bipolar depression and maintenance pharmacotherapy. There are 10 regulatory approved treatments as mono or adjunctive therapy for acute mania, 7 regulatory approved treatments for maintenance pharmacotherapy, and 3 regulatory approved treatments for bipolar depression. This symposium will review clinical trial design evolution with a focus on outcome rating scales (YMRS, MADRS, IDS), metrics (response, remission, recovery), design elements (monotherapy, adjunctive, enriched sampling) for optimal power and statistical analysis, and generalizability (efficacy vs comparative effectiveness).
Dr. Mark Frye will be reviewing what is now a conventional trial design for acute mania which is a 3-week randomized, placebo-controlled evaluation with the Young Mania Rating Scale as the primary outcome measure. Dr. Charles Bowden will review the trial design changes in maintenance mood stabilization and the concept of enriched sampling. Dr. Joseph Calabrese will highlight, in contrast to acute mania, the challenges in optimal trial design in bipolar depression. Finally, Dr. Susan McElroy will review the emerging interest in comparative effectiveness trials vs efficacy trials and generalizability.

NO. 1
TRIAL DESIGN FOR ACUTE MANIA: CONSENSUS IN THE FIELD
Speaker: Mark Frye, M.D.

SUMMARY:
There are 10 regulatory approved treatments as mono or adjunctive therapy for acute mania (lithium, anti-convulsants divalproex sodium and carbamazepine, the typical antipsychotic chlorpromazine and the atypical antipsychotic aripoprazole, asenapine, olanzapine, quetiapine, risperidone, and ziprasidone.) Given a nearly 40-year span of clinical trial investigation for acute mania, there has been a very clear emerging consensus on trial design and outcome measures. The emerging consensus is a 3-week trial design for acute manic patients (mixed or euphoric, with or without psychosis, with or without rapid cycling) and a placebo-control to the investigative drug of interest. The primary outcome measure typically has been the Young Mania rating scale score with response/ remission criteria, as evidenced in 2 meta-analysis by Cipriani et al.,2011 and Yildez et al., 2011 . This has been the template for more than 60 studies.
Two references:
Cipriani Lancet 2011
http://www.ncbi.nlm.nih.gov/pubmed/21851976
Yildez and Vieta 2011
http://www.ncbi.nlm.nih.gov/pubmed/20980991

NO. 2
MAINTENANCE STUDY DESIGN THAT YIELDS PATIENT LEVEL RELEVANCE AND ADVANCE SCIENTIFIC KNOWLEDGE ON TREATMENTS FOR BIPOLAR DISORDER
Speaker: Charles L. Bowden, M.D.

SUMMARY:
Enriched design maintenance treatment studies in bipolar disorder have generally reported completion rates below 30%. To address these problems, adaptive designs have been developed both in bipolar and other chronic diseases. We conducted a maintenance comparison of two treatment strategies designed to provide a randomized sample enriched only for tolerability to the drugs while providing equipoise for their maintenance phase efficacy on depressive outcome. The design replicated routine clinical care provided for bipolar patients, in which efforts are made to retain patients on regimens that have provided some benefits with adequate tolerability. Study designs that retain high proportions of subjects allow insights into illness course and drug effects lost in standard survival analyses and LOCF imputation.
One particularly useful adaptive design is Sequential Multiple Assignment Randomized Treatment (SMART). SMART includes a second randomization based on a patient's response in the trial. This resembles the adaptive nature of treatment selection in clinical settings. The design allows causal inference and eliminates confounds associated with non randomized treatment decisions. Most traditional efficacy designs randomize to 1 of 3 treatments: standard, new drug or placebo. If any option is unacceptable, the patient chooses not to enter or is excluded from the study. SMART designs largely eliminate problems of high rates of drop out/ censoring and missing data.

NO. 3
BALANCING GENERALIZABILITY AND ASSAY SENSITIVITY NEEDS IN BIPOLAR DEPRESSION TREATMENT TRIALS
Speaker: Joseph R. Calabrese, M.D.

SUMMARY:
Drug development in bipolar depression (BD) is complicated by high rates of lifetime comorbidity (Merikangas et al 2007), which places patients at high risk for suicidality (Nock et al 2010). Pharma drug development begins with a lesser challenge of establishing efficacy, which prioritize internal validity (assay sensitivity) at the expense of external validity (generalizability) (Calabere et al 2008). Once efficacy is established, there exists a need to move forward on the continuum of improved generalizability by studying more heterogeneous subgroups (anxiety, substance abuse, metabolic burden). Efficacy studies are allowed/expected to artificially inflate therapeutic effect size by excluding hard-to-treat patients, whereas effectiveness studies deflate

effect size by including them. The field attempts to manage this heterogeneity by increasing sample size, but sample sizes continue to be modest due to pragmatic considerations. Everything done by Pharma is just a beginning and no one drug development effort is ever good enough. The challenge for the field is how fast do we move forward on this continuum of improved generalizability and how do we do so without compromising assay sensitivity. This presentation will contrast recent bipolar depression efficacy trials with recent bipolar effectiveness trials, including STEP-BD, LiTMUS, BALANCE, and CHOICE studies.

NO. 4
COMPARATIVE EFFECTIVENESS RESEARCH IN BIPOLAR DISORDER
Speaker: Susan McElroy, M.D.

SUMMARY:
Comparative effectiveness research (CER) is the direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms. CER is defined by the Institute of Medicine as "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care. The purpose of CER is to assist customers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels." In contrast to randomized placebo-controlled trials, which assess efficacy and safety, CER uses pragmatic trials to measure effectiveness – the benefit and harms a treatment produces in routine clinical practice. CER in bipolar disorder is just beginning to emerge. In this presentation, CER will be defined and contrasted with efficacy research. Then, several of the first pragmatic clinical trials in bipolar disorder will be presented, including BALANCE, Litmus, and CHOICE. Knowledge gained from these trials will be summarized and compared to that from efficacy trials.

IMAGING BIOMARKERS FOR NEUROPSYCHIATRIC DISORDERS: ARE WE THERE YET?

Chairs: Cameron S. Carter, M.D., Yvette I. Sheline, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the general characteristics of biomarkers in improving diagnosis; 2) Describe for each of the topics (cognitive decline, psychotic disorders, mood disorders and disorders of childhood) biomarkers that can improve diagnosis; 3Describe the current limitations of biomarkers.

SUMMARY:
As a field we have been searching for objective, biologically-based tests for psychiatric illnesses, which would improve our ability to predict treatment response, differentiate between related diagnostic categories and provide prospective treatment for at-risk patients. In this workshop we will examine the progress to date in identifying imaging validated biomarkers: namely those identified in one patient cohort and tested in an independent cohort. Dr Carter will discuss biomarkers for schizophrenia and how they can be used to distinguish among other psychotic disorders. Dr Drevets will discuss imaging biomarkers in the context of mood and anxiety disorders. Dr Castellanos will discuss imaging biomarkers for disorders of childhood, including autism and attention deficit disosrder. Dr Sheline will discuss imaging biomarkers that distinguish among etiologies involved in cognitive decline. Audience participation will be actively encouraged and there will be ample time for questions.

NO. 1
IMAGING BIOMARKERS ASSOCIATED WITH COGNITIVE DECLINE
Speaker: Yvette I. Sheline, M.D.

SUMMARY:
Traditionally, the clinical work up of dementia has focused on clinical assessment, neuropsychological testing, and exclusion of other etiologies. The National Institutes of Aging (NIA) and the Alzheimer's Association have issued new diagnostic criteria for AD and mild cognitive impairment (MCI) that now suggest that the use of biomarkers and neuroimaging can enhance diagnostic confidence. In this workshop participants will learn about functional and structural neuroimaging biomarkers that improve diagnostic accuracy. With the advent of improved molecular imaging, it is now possible to rule out dementia from etiologies other than Alzheimer's disease. Discussion of specificity and sensitivity of specific imaging agents will be included. In addition data will be presented to show how well imaging markers track with clinical course. By the end of the session, participants should be able to describe clinical situations in which agents will (and won't) improve diagnosis.

NO. 2
THE DEVELOPMENT OF IMAGING BIOMARKERS FOR MOOD DISORDERS
Speaker: Wayne Drevets, M.D.

SUMMARY:
The application of neuroimaging technology in psychiatric research has revolutionized clinical neuroscience perspectives on the pathophysiology of mood disorders. Research using a variety of neuroimaging techniques has shown these conditions are associated with abnormalities of brain function, structure and receptor pharmacology. The variability evident results from these studies, however, also corroborates the conclusions reached from areas of research, under the current nosology, major depressive disorder and bipolar disorder encompass groups of disorders that are heterogenous with respect to pathophysiology and etiology. One consequence of this variability has been, despite the invaluable leads neuroimaging studies provide regarding the neurobiological bases for mood disorders, they have yet

to impact the diagnosis or treatment of individual patients. While interest persists in the development of objective, biologically based tests that can predict treatment response, differentiate between related diagnostic categories, and identify at-risk, the effect size of imaging abnormalities identified has been relatively small, such that these measures do not provide sufficient specificity and sensitivity to accurately classify individual cases. Research focus has shifted toward using imaging and other biomarker data in bioinformatic approaches aimed at elucidating illness subphenotypes that will prove clinically distinct in their illness course and/or responsiveness to treatment.

NO. 3
THE DEVELOPMENT OF IMAGING BIOMARKERS FOR PSYCHOTIC DISORDERS
Speaker: Cameron S. Carter, M.D.

SUMMARY:
Over three decades of neuroimaging research has established the presence of structural, functional and neurochemical alterations in the brains of individuals with schizophrenia and other psychotic disorders. The reliable presence of these changes at the group level has raised the hope in the near future we may be able to use imaging to enhance diagnosis, especially during the early stages of the illness when early identification and targeted treatment can have the greatest impact on illness course and clinical and functional outcomes. It is hoped the use of imaging biomarkers can enhance the treatment development process by validating target engagement by novel therapeutics during first in human and phase 1 clinical trials. However to data most imaging measures have been limited by substantial overlap between patients and healthy subjects and have fallen far short of the 80% positive and predictive value needed for a diagnostic measure. Recent advances in computational imaging analysis using pattern classification methods have increased the likelihood we will be able to reach this goal. Participants will understand major changes in brain structure, function and chemistry have been identified in schizophrenia and other psychotic disorders, the opportunities and challenges these results present for imaging biomarker development and the role new computational analytic approaches might play in achieving neuroimaging guided diagnosis and treatment development in psychosis.

NO. 4
TOWARDS NEURAL BIOMARKER IDENTIFICATION IN ADHD AND AUTISM SPECTRUM DISORDERS
Speaker: Francisco X. Castellanos, M.D.

SUMMARY:
Discovering clinically and investigationally useful biomarkers is a priority for neuroimagers. Resting-state fMRI methods are being increasingly adopted as they are amenable to aggregation of large multi-site samples and can be used to explore relationships with myriad phenotypes. Progress towards meeting the goal of developing biomarkers needs to be assessed in terms of sensitivity, specificity, positive and negative predictive power. Early efforts demonstrate that brain imaging indices can claim substantial predictive power when contrasted to healthy comparisons, with values easily exceeding chance levels; accuracy estimates tend to cluster around 80% for both ADHD and ASD. More challenging tests of predictive power of putative biomarkers, including contrasts to other psychiatric conditions, remain to be implemented.

DSM-5 AS SEEN FROM FRANCE AND IN NORTH AMERICA: VIVE LA DIFFERENCE!

Chairs: John A. Talbott, M.D., Francois Petitjean, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the views of DSM5's treatment of grief and bereavement in France and North America; 2) Understand the views of DSM5's treatment of Schizophrenia in France and North America; 3) Understand the views of DSM5's treatment of mixed states in France and North America.

SUMMARY:
The French Psychiatric Association and American Psychiatric Association have held joint symposia at the Annual meeting of the APA for over two decades on the subject of differences in approaches to psychiatric issues. This year's symposium is entitled DSM5 as seen from France and in North America: Vive La Difference!
Dr John A Talbott (US) will chair the symposium and introduce the session. Dr Francois Petitjean (FR) will co-chair the session and lead the discussion.
Dr. Maxime Freton (FR) will begin by addressing the French reactions to the changes in DSM regarding grief, bereavement and the bereavement exclusion. He will be followed by Dr. Ronald Pies (US) who will speak about the American views of grief, bereavement and the bereavement exclusion. Then Dr Clara Brichant (FR) will talk about the French psychiatric community's reaction to the DSM's dimensional approach to Schizophrenia and Dr. William T. Carpenter (US) will explain the rationale behind the approach.
Finally, Dr. Marc Adida (FR) will discuss the French views on Bipolar: Mixed States and Dr. Joel Paris (CA) will do the same from the point of view of North America.
There will be ample time for questions and answers.
John A Talbott MD Chair (USA)
Francois Petitjean MD Co-chair (France)

NO. 1
COMPLICATED GRIEF AND AUTOBIOGRAPHICAL MEMORY IMPAIRMENT: TWO CASE STUDIES OF BEREAVEMENT-RELATED DEPRESSION TREATED WITH ELECTROCONVULSIVE THERAPY
Speaker: Maxime Freton, M.D.

SUMMARY:

Bereavement is associated with more severe depression and a high risk for suicide (1). Although electroconvulsive therapy (ECT) results in autobiographical memory impairment, it is highly effective in severe depression (2). Here, we report a clinical and neuropsychological longitudinal study in two bereavement-related depressed patients treated with ECT. Both patients remitted after the course of ECT. Six months after, they had complicated grief associated with persistent deficits in autobiographical memory for events close to the death date and ECT course. These results provide an unique opportunity to discuss controversial issues surrounding grief-related mental disorders (1), emphasizing : 1) the specific risk-benefit balance of ECT use in bereavement-related depression ; and 2) the clinical course of the two studied cases, compared to the diagnostic criteria for the new category of persistent complex bereavement disorder in the DSM-5.

1. Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., ... & Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. Depression and anxiety, 28(2), 103-117.
2. Lisanby, S. H. (2007). Electroconvulsive therapy for depression. New England Journal of Medicine, 357(19), 1939-1945.

NO. 2

DSM-5 INNOVATIONS IN THE PSYCHOSES CHAPTER

Speaker: William T. Carpenter, M.D.

SUMMARY:

An important question is whether timing of DSM-5 was right for the Schizophrenia and other Psychotic Disorders chapter. The hope that the syndromes represented in this chapter could be reconceptualized as disease entities with known neurobiological substrates could not be achieved. More timely was the opportunity to address the role of reality distortion in schizophrenia, the question of value of subtypes, the conceptual basis for schizoaffective disorder, and how to deal with catatonia at the diagnostic level.

Complimenting the diagnsotic category with a new paradigm based on psychopathology domains was timely in terms of evidence for reliability, validity, and clinical application, but was assigned to Section 3 based on considerations outside the DSM-5 development process.

Perhaps the most important advance considered, and the most controversial, was the potential inclusion of the attenuated psychoses syndrome as a disorder class. Uncertain reliability as a diagnosis in ordinary clinical settings made inclusion premature and the field had not reached consensus on best strategy. Assignment to Section 3 may encourage progress in what appears to be the best opportunity to dramatically alter the life course of potentially chronic forms of psychosis.

NO. 3

GRIEF, MAJOR DEPRESSION, AND THE BEREAVEMENT EXCLUSION: DSM-5'S VIEW

Speaker: Ronald Pies, M.D.

SUMMARY:

"Bereavement" properly refers to the death of a loved one or significant other. Removal of DSM-IV's "bereavement exclusion" (BE) from the DSM-5 was among the most controversial decisions approved for the new diagnostic manual. Nonetheless, there are compelling reasons for elimination of the BE, and for the fundamental distinction between ordinary grief and major depression. The essential position of the DSM-5 is that the occurrence of a recent death should not preclude a diagnosis of major depressive disorder (MDD), if the bereaved person meets all symptom, duration, and severity criteria for MDD. Despite some contrary data from epidemiological surveys, most clinical evidence suggests that major depressive syndromes following a recent death are not fundamentally different from MDD following any other loss, or from MDD occurring "out of the blue". Recognition of post-bereavement MDD is critical to the care and treatment of depressed patients, who face a substantial risk of suicide. Elimination of the BE is in no sense an endorsement of "medicalizing" ordinary grief, or of reflexively prescribing an antidepressant. Concerns of this nature are best addressed via continuing medical education and close collaboration between primary care physicians and psychiatrists--not by retaining an exclusion principle that was never founded on carefully-controlled studies of depressed patients, with vs. without bereavement.

NO. 4

MIXED FEATURES IN DSM 5: NOT A MOOD STATE BUT A SPECIFIER OF ANY MOOD STATE?

Speaker: Marc Adida, Dr.P.H., M.D.

SUMMARY:

The fifth Diagnostic and Statistical Manual of Mental Disorders (DSM-5) revision is finalized. This presentation examines DSM-5 changes for diagnosing mixed state, explains their rationale, and considers pros and cons.

DSM-5 changes for diagnosing mixed state includes a replacement of mixed manic episodes with a 'mixed features' specifier applicable to mania or hypomania in the context of major depressive disorder or bipolar disorder when depressive features are present, and to major depressive episodes when features of mania/hypomania are present. The DSM-IV diagnosis of bipolar I disorder, mixed episode, requiring that the individual simultaneously meet full criteria for both mania and major depressive episode, has been removed. Instead, a new specifier, "with mixed features," has been added.

No explicit justification for including this specifier was provided on the DSM-5 web site. Nervertheless, 5 studies were cited as supportive evidence.

Advantages of the specifier 'with mixed features' include improvements in its clinical utility, its research utility and overall diagnostic validity. The main advantage is that it allows the clinician to indicate the presence of subthreshold comorbid 'opposite pole' symptoms during a mood episode.

Drawbacks of the specifier 'with mixed features' include reductions in clinical utility owing to implementation of proposals that increase clinician burden, an increase in diagnostic false positives related to the lowering of dx thresholds.

NO. 5
THE NORTH AMERICAN VIEW OF BIPOLARITY
Speaker: Joel Paris, M.D.

SUMMARY:
Bipolar disorder diagnoses have become more frequent in North America, due to the concept of an expanded bipolar spectrum. While criteria were not changed in DSM-5, bipolar-II is often identified in the absence of hypomania, and bipolar-NOS covers questionable cases. DSM-5 discouraged bipolar diagnosis in childhood by introducing disruptive mood dysregulation disorder. However spectrum disorders are diagnosed in spite of the absence of biomarkers to supplement clinical observation. Expansion of the spectrum tends to include affective instability, which may be a separate neurobiological phenomenon. One result is the overprescription of mood stabilizers and antipsychotic drugs.

NO. 6
WHAT HAPPENS TO LATE-ONSET SCHIZOPHRENIA IN DSM-5?
Speaker: Clara Brichant-Petitjean, M.D.

SUMMARY:
Late-onset schizophrenia (LOS) remains a controversial diagnosis. In DSM-5, there is a clinical description of these "late-onset" cases but it is still not clear whether LOS should be considered as an extreme of typical schizophrenia or rather an independent group of patients with a specific diagnosis, such as the French diagnosis "Psychose Hallucinatoire Chronique" which has always been part of a classificatory debate between European and American psychiatrists. This question is now officially raised in DSM-5 and remains open. The aim of our study is to characterize the memory cognitive profile of LOS patients without related organic factors (N=25), compared to early-onset schizophrenic patients (EOS, N=44), matched for the duration of the disorder, and healthy controls (HC, N=23), matched for the age of patients. Lifetime clinical symptoms and functioning were collected and components of memory capacity were assessed with the Forward and Backward Digit Span Tasks, Rey Complex Figure and Verbal Fluency Tests. Results show that LOS had intermediate memory performances compared to EOS and HC. LOS can therefore be in line with a dimensional clinical approach of schizophrenia, whereby it presents few memory deficits, few disorganization and negative symptoms and mostly positive symptoms. It is essential to continue research on this late-onset condition. The dimensional assessment required in DSM-5 should facilitate the characterization of such clinical presentations.

TEMPERAMENT AND ADVERSITY IN BPD

Chair: Joel Paris, M.D.

Discussant: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review research showing on interactions between temperamental vulnerability and life adversity in BPD; 2) Demonstrate how these interactions express themselves at different developmental stages; 3) Relate these interactions to neurobiological mechanisms.

SUMMARY:
Like other mental disorders borderline personality disorder (BPD) emerges from interactions between temperamental vulnerability and life adversity. The importance of this principle is shown by the fact that children brought up in the same family are non-concordant for the disorder. These relationships can be observed in pre-adolescents at risk for the disorder, as well as in adolescents who meet full criteria. The temperamental factors in BPD are traits that are also related to underlying neurobiological mechanisms that are unleashed by psychosocial adversity.

NO. 1
CONCORDANCE AND DISCORDANCE IN BPD FAMILIES
Speaker: Joel Paris, M.D.

SUMMARY:
Family studies of BPD show that the most common disorders in first-degree relatives are substance abuse, antisocial personality, and depression. Bipolar disorder is rare, and BPD itself is uncommon. These findings are consistent with a model in which externalizing and internalizing dimensions interact to shape temperamental factors behind the disorder.
BPD is also discordant between probands and siblings, in spite of being brought up in the same family and exposed to the same adversities. Differences in personality trait profiles, again reflecting temperament, best explain these differences. These findings support the conclusion that childhood trauma is neither a necessary nor sufficient condition for BPD, and that effects of adversity depend on temperamental vulnerability.

NO. 2
THE ASSOCIATION BETWEEN BORDERLINE PERSONALITY DISORDER IN ADOLESCENTS, CHILDHOOD ADVERSITY, AND TEMPERAMENT
Speaker: Mary Zanarini, Ed.D.

SUMMARY:
Objective: The first purpose of this study was to compare the rates of 11 forms of childhood adversity reported by two groups of adolescents age 13-17: inpatients with borderline personality disorder (BPD) and psychiatrically healthy comparison subjects. The second purpose was to determine the risk factors for the development of BPD. Method: 104

hospitalized girls and boys who met rigorous criteria for BPD and 60 psychiatrically healthy adolescents from the community were interviewed concerning childhood adversity. In addition, the NEO-FFI was administered to both groups of adolescents. Results: 10 of 11 forms of abuse and neglect studied were reported by a significantly higher percentage of adolescents with BPD than comparison subjects. The mean scores on neuroticism and openness were significantly higher for adolescents with BPD than healthy comparison subjects. In contrast, the mean scores on extraversion, agreeableness, and conscientiousness were significantly lower for adolescents with BPD than healthy comparison subjects. In multivariate analyses, five variables reflecting both childhood adversity and normal personality increased the risk of BPD in adolescents: any sexual abuse, severity of other forms of abuse, a higher neuroticism score, and a lower agreeableness and conscientiousness score. Conclusions: Taken together, the results of this study suggest that BPD in adolescents is associated with both childhood adversity and a vulnerable temperament.

NO. 3
BORDERLINE PERSONALITY IN YOUNG PEOPLE: RISK FACTORS, PRECURSORS AND EARLY SIGNS
Speaker: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:
Studies of biological and environmental risk and protective factors and patterns of continuity leading to borderline personality disorder demonstrate relatively consistent environmental risk factors. However, neurobiological and experimental psychopathology findings are still inconsistent. Studies of individuals earlier in the course of BPD have also demonstrated temperamental and mental state abnormalities that resemble aspects of the BPD phenotype, which emerge in childhood and adolescence and presage the BPD syndrome in adolescence or adulthood. Further work is required to better understand the roles that all these factors play in the developmental pathways to BPD and to increase their specificity for BPD in order to facilitate prevention and early intervention.

NO. 4
PERSONALITY TRAITS AND NEUROBIOLOGICAL MECHANISMS UNDERLYING BPD
Speaker: Antonia New, M.D.

SUMMARY:
Phenomenological studies of BPD provide evidence for a latent temperamental factor, or possibly factors, that predispose an individual to BPD. These studies have employed factor analyses of DSM_IV BPD criteria and have supported the presence of three factors, but the colinearity among the factors is high, suggesting a unitary latent factor. A limitation of such studies is that they do not elucidate the nature of that factor. For instance, affective instability is common in BPD but lacks diagnostic specificity. Perhaps a core characteristic leads to the development of affective instability but is not well capture in the necessarily simplified model of BPD in the DSM.

Much research has recently focused on social cognition in BPD, stemming from the observation that emotional storms emerge in BPD in the context of interpersonal triggers. This presentation will describe how neurobiological models might shed light on a latent factor using a model of genetic studies of attachment. We will present data on the relationship between attachment style and genetic variation in genes underlying neuropeptides that have been implicated in social behavior (opioid genes, oxytocin and vasopressin). Our preliminary data show that variation in the OPRM1 gene was significantly associated with anxious attachment. These data provide a conceptual framework for how neurobiological markers might help to define core characteristics of BPD.

AN ALTERNATIVE MODEL FOR PERSONALITY DISORDERS: DSM-5 SECTION III AND BEYOND

Chairs: Robert F. Krueger, Ph.D., Andrew Skodol, M.D.

Discussant: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand that a new alternative approach to the diagnosis of personality disorders was developed for DSM-5 and can be found in Section III; 2) Recognize the empirical basis for the alternative model and be aware of data that have accumulated on its components since the publication of DSM-5; 3) Apply the alternative model personality functioning, trait, and disorder constructs in clinical practice.

SUMMARY:
The diagnostic criteria for 10 personality disorders in DSM-5 Section II "Essential Elements: Diagnostic Criteria and Codes" are unchanged from DSM-IV, despite myriad well-documented problems. Axis II (and the entire multiaxial system) has been eliminated from DSM-5, however. A new approach to the diagnosis of personality disorders based on impairments in personality functioning and on pathological personality traits was developed for DSM-5 and can be found in Section III "Emerging Measures and Models."
For the general criteria for personality disorder, a personality functioning criterion (Criterion A) was developed based on a literature review of reliable clinical measures of core impairments central to personality pathology and validated as specific for semi-structured interview diagnoses of personality disorders in over 2000 patients and community subjects. Furthermore, the moderate level of impairment in personality functioning required for a personality disorder diagnosis in Section III was set empirically to maximize the ability of clinicians to identify personality disorder pathology accurately and efficiently.
The diagnostic criteria for six specific personality disorders in the alternative model are consistently defined across disorders by typical impairments in personality functioning and

by representative pathological personality traits. Diagnostic thresholds for both the A and the B criteria have been set empirically to minimize change in disorder prevalence and overlap with other personality disorders and to maximize relations with psychosocial impairment. A diagnosis of personality disorder-trait specified (PD-TS) replaces PD-NOS and provides a much more informative diagnosis for patients who are not optimally described as having a specific personality disorder.

Personality functioning and personality traits also can be assessed whether or not the individual has a personality disorder, providing clinically useful information about the personalities of all patients. The DSM-5 Section III model provides a clear conceptual basis for all personality disorder pathology and an efficient assessment approach with considerable clinical utility.

This symposium will review 1) the development of the Section III alternative model for personality disorders, including the empirical basis of its diagnostic decision rules (Skodol); 2) the reliability of ratings of impairment in personality functioning and of pathological personality traits by untrained and clinically inexperienced raters (Zimmerman); 3) current research on the alternative model and how it enhances clinical characterization of personality pathology (Krueger), and 4) how to apply the alternative model in clinical practice, using specific case examples (Bender). The symposium will conclude with a formal discussion of the four presentations (Oldham), followed by a question and answer period.

NO. 1

DEVELOPMENT AND INITIAL EMPIRICAL DATA ON THE ALTERNATIVE MODEL FOR PERSONALITY DISORDERS IN DSM-5

Speaker: Andrew Skodol, M.D.

SUMMARY:

A new approach to the diagnosis of personality disorders based on impairments in personality functioning and on pathological personality traits was developed for DSM-5 and can be found in Section III "Emerging Measures and Models." Section II antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders are rendered by Section III criteria with high fidelity and a new diagnosis of personality disorder-trait specified (PD-TS) is used for all other personality disorder presentations. The Section III approach provides a clear conceptual basis for all personality disorder pathology, empirically-developed criteria sets, and an efficient assessment approach with demonstrated clinical utility. This presentation will review the development of the alternative model, including the results of a survey of 337 clinician assessments of patients that provided the empirical basis of its diagnostic decision rules.

NO. 2

CAN LAYPERSONS ASSESS DSM-5 LEVELS OF PERSONALITY FUNCTIONING AND MALADAPTIVE PERSONALITY TRAIT FACETS

Speaker: Johannes Zimmermann, Ph.D.

SUMMARY:

We investigated whether competently assessing people's levels of personality functioning and maladaptive personality trait facets requires training and clinical experience on the side of the rater. In Study 1, 22 untrained and clinically inexperienced students assessed the levels and trait facets of 10 female psychotherapy inpatients based on videotaped clinical interviews. In Study 2, 110 students who had previously worked together in seminars assessed each others' trait facets in small groups of 4 or 5 persons. Expert ratings (Study 1) and self-reports (Study 2) were employed as criterion measures. Interrater reliability and accuracy of individual raters were mostly acceptable, but significantly lower in Study 2 as compared to Study 1. We conclude that assessing people's levels and trait facets seems possible for laypersons when based on clinical interview material, but might require data aggregation from multiple informants when based on everyday interactions.

NO. 3

CURRENT RESEARCH ON THE DSM-5 ALTERNATIVE MODEL FOR PERSONALITY DISORDERS AND ITS USE IN THE CLINIC

Speaker: Robert F. Krueger, Ph.D.

SUMMARY:

The DSM-IV approach to personality disorders (PDs) does not accord with theory or data, limiting its utility in the clinic. Fortunately, DSM-5 provides an alternative model of PDs, derived more directly from the empirical literature on the nature of personality pathology. This talk will review research on the DSM-5 alternative PD model, with an eye toward how the model's better connection with data makes it more useful. For example, PD patients rarely present with symptoms and concerns that place them readily in one and only one PD category. The DSM-5 alternative model can handle these presentations because it contains dimensional elements that help to characterize diverse patients. For example, a patient's overall level of personality functioning is characterized, along with trait specifiers that help to tailor the formulation to the specific concerns of the patient. This talk will review the evidentiary basis of these aspects of the alternative DSM-5 model.

NO. 4

CLINICAL APPLICATION OF THE DSM-5 SECTION III PERSONALITY DISORDER MODEL

Speaker: Donna S. Bender, Ph.D.

SUMMARY:

The problems and limitations of the DSM-IV/DSM-5 Section II categorical approach to personality diagnosis have been well documented. An alternative dimensional model has been developed for DSM-5 and is presented in Section III of the manual. The "Section III Model" includes a new definition of personality disorder that identifies problems with self and interpersonal functioning as core impairments that distinguish personality psychopathology. In addition to the

revised general criteria for personality disorder, the Section III Model includes the Level of Personality Functioning Scale severity measure, a set of personality trait domains and facets, and six personality disorder types. Using specific case examples, this presentation will demonstrate how to apply the Section III Model in clinical practice, including its flexibility in specifying varying degrees of detail, the utility of having a severity assessment, and the added value of including trait components.

GENDER IDENTITY AND GENDER DYSPHORIA FOR THE PRACTICING PSYCHIATRIST

Chair: William Byne, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Distinguish between gender variance and DSM-5 defined Gender Dysphoria; 2) Understand the range of approaches to, and treatments for, Gender Dysphoria in children, adolescents, and adults, and in individuals with intersex conditions; 3) Appreciate the roles of psychiatrists in the provision of care to individuals with Gender Dysphoria, including those with serious mental illness; 4) Appreciate the medical necessity of treating Gender Dysphoria and the challenges in expanding access to care.

SUMMARY:
Gender Dysphoria (GD) -- defined in DSM-5 (2013) as a marked incongruence between one's experienced/expressed gender and assigned gender -- can develop in children, adolescents, and adults both without and with a somatic intersex condition. GD is sufficiently prevalent to be encountered by psychiatrists in most practice settings, but receives little attention in psychiatric training. The role of mental health professionals in providing services to persons with GD has evolved considerably over the past few decades. This is evidenced in the six revisions of the most widely used Standards of Care (SOC), the World Professional Association for Transgender Health (WPATH) SOC. Moreover, numerous clinics have drafted their own protocols and guidelines for the treatment of gender identity-variant persons, which have increasingly been based on principles of patient autonomy and harm reduction. While the role of the psychiatrist overlaps considerably with that of other health professionals, it is unique in some respects, particularly in the assessment and management of co-occurring serious mental illness requiring psychopharmacology. To date, no guidelines specifically address the unique role of the psychiatrist in treating GD. In order to be fully effective, the psychiatrist needs to have a comprehensive understanding of all aspects of GD. This symposium aims to update psychiatrists in 1) Distinctions between the concepts of gender variance, transgenderism, transsexuality, and GD; 2) The spectrum of clinical presentations of individuals who experience GD at different ages, including those with intersex conditions; 3) The range of treatment approaches and current services available to individuals with GD at different ages; 4) The implications of serious mental illness and its management in the context of GD; 5) Current treatment controversies in GD; 6) The medical necessity of treatment for GD along with insurance parity. Attendees will also acquire vocabularies for communicating respectfully with gender variant individuals and unambiguously with colleagues.

NO. 1
GENDER IDENTITY, TERMINOLOGY, NOMENCLATURE, AND CONCEPTS IN MODERN PSYCHIATRIC APPROACHES TO GENDER VARIANCE
Speaker: Jack Pula, M.D.

SUMMARY:
There is currently little guidance for the practicing psychiatrist in the provision of care to transgender patients that is culturally competent, evidence-based, and clinically sound. In order to construct optimal clinical approaches we must better understand gender identity and depathologize gender variance. Present efforts to do so occur in the context of tension between psychiatry and transgender communities over historical pathologization that discouraged those with psychiatric needs from seeking care. This talk reviews current terminology, language, and concepts that promote trans- affirming approaches to care. It examines older concepts and language to illustrate why transgender people have felt unsafe within psychiatry as well as other mental health and healthcare fields. It draws from the language of psychiatry, medicine, humanities, and popular culture, and aims to promote understanding, empathy, and patient-centered treatment. At a time when psychiatry seeks a relevant role in the care of transgender patients, it is essential that we be ever mindful of the nuanced interplay between psychiatry, language, and culture.

NO. 2
GENDER VARIANCE AND GENDER DYSPHORIA FROM CHILDHOOD THROUGH ADOLESCENCE
Speaker: Richard R. Pleak, M.D.

SUMMARY:
Most clinicians lack experience with gender dysphoric youth, who have unique issues. They may express desires and behaviors that can be experienced as challenging by others and elicit a range of responses. Their families and their society may accept, support, ignore, reject, or even harm these children. They suffer from isolation, depression, and suicidality at high rates. Most gender variant/dysphoric children do not grow up to be gender variant/dysphoric adolescents or adults. This presentation will detail the development and progression of gender variance from childhood through adolescence. Cases of children will be described, with different outcomes on follow-up. A range of approaches to working with these children and their families will be reviewed including those outlined in the Report of the American Psychiatric Association's Task Force on Treatment of Gender Identity Disorder and the American Academy of Child & Adolescent Psychiatry's Practice Parameter on Gay,

Lesbian, or Bisexual Sexual Orientation, Gender Nonconformity, and Gender Discordance in Children and Adolescents. These publications have practical clinical utility for helping these youth, including educating and supervising less experienced providers, and are useful for all clinicians in assessing, treating, and advocating for these youth.

NO. 3
EVOLUTION OF APPROACHES TO GENDER IN SOMATIC INTERSEXUALITY
Speaker: Heino F. L. Meyer-Bahlburg, Ph.D.

SUMMARY:
Individuals born with genital ambiguity pose gender-related challenges to the psychiatrist at all phases of life: from birth (gender assignment, decisions on gender-confirming genital surgery, stigma, parental stress) to early childhood (physician-initiated gender re-assignment and related issues) through childhood, adolescence, and adult life (questions concerning gender-nonconforming behavior, sexual orientation, disclosure of biological status and medical history, gender dysphoria, stigma, genital surgery). Recent decades have brought major revisions to pertinent gender policies. These were prompted by rapid changes of the material foundations of gender differences in society and related ideologies; profound advances in human rights; IT-related facilitation of access to others with the same rare conditions and to condition-specific information; improved knowledge of long-term outcomes; and progress in the development of medical technology relevant to hormone treatment and surgery.

NO. 4
ADULT PSYCHIATRIC PRACTICE IN TRANSGENDER MEDICAL AND MENTAL HEALTH CARE
Speaker: A. Evan Eyler, M.D., M.P.H.

SUMMARY:
Adults who are transgender or gender variant seek psychiatric services for the same reasons as their peers who are not transgender, and for specific reasons related to gender identity and gender transition. This presentation will briefly review: (a) the concerns commonly experienced by adults who are exploring gender identity or beginning gender transition as encountered in psychotherapy; (b) psychiatric consultation considerations during the transition process; (c) clinical evaluation of transgender patients who are experiencing significant psychiatric symptoms or illness. Case examples will be provided.

NO. 5
EXPANDING ACCESS TO TRANSITION-RELATED CARE: CLINICAL IMPLICATIONS FOR PSYCHIATRISTS
Speaker: Dan H. Karasic, M.D.

SUMMARY:
An innovative program through the San Francisco Department of Public Health (SFDPH) provides transgender surgery to low-income San Francisco residents, through Healthy San Francisco and MediCal, which is newly expanded through the Affordable Care Act. In the 1990's, SFDPH's primary care clinics pioneered the "informed consent" model for expanding access to hormone therapy for its low-income transgender patients; in now providing surgery, SFDPH is melding this model with that of the Standards of Care, Version 7 of the World Professional Association for Transgender Health. Lessons learned from creating and implementing this model will be discussed, highlighting implications for psychiatrists in other health systems attempting to expand access to transgender surgery. Discussion of case vignettes will illustrate complex clinical issues for the psychiatrist in evaluating those seeking surgery, including gender spectrum patients, those with co-occurring mental illness and substance abuse, and those with unstable housing and lack of social support.

"TO SLEEP OR NOT TO SLEEP": PSYCHOTROPICS AND SLEEP ARCHITECTURE

Chairs: Vishal Madaan, M.D., Durga Prasad Bestha, M.B.B.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the basic physiology and neurobiological aspects of sleep ; 2) Recognize the effects of psychotropic medications on sleep architecture ; 3) Understand the potential benefits and adverse effects of psychotropic medications on sleep, leading to better and safer prescribing patterns.

SUMMARY:
Sleep disruption is an important concern for patients with a variety of psychiatric disorders. In addition, primary sleep disorders are also more prevalent in this population. Disturbance in sleep patterns may increase not only the morbidity of psychotic, affective and anxiety disorders, but also have been commonly shown to have a detrimental impact on the functioning of cardiovascular and immune systems. Different classes of psychotropic medications such as sedative-hypnotics, anti-depressants and anti-histamines have been used to promote sleep and these can have a wide array of differential effects on the sleep architecture. This can be beneficial in certain aspects but can also interfere with the role of sleep in learning and cognition, lead to emergence of nightmares and sleep-related behavioral disorders.
This symposium will begin with an overview of the essentials of physiology and neurobiology of sleep. Using this as the core foundation, speakers will then explore the effects of sedative-hypnotics, followed by non-sedative-hypnotic psychotropic medications used for sleep disorders. The speakers will also discuss some specific considerations while prescribing psychotropics for managing childhood sleep disorders. An understanding of the medication-induced changes in the sleep architecture will help the audience become familiar with the potential positive and negative clinical outcomes, so that we can better educate and monitor patients. Following this, an overview of the unintended effects of commonly used psychotropic medications (such

as anti-depressants, mood stabilizers, anti-psychotics and stimulants) on sleep wave patterns will be discussed. Throughout the symposium, there will be an emphasis on audience participation, especially promoting behavioral interventions as an essential adjunct to help patients and practitioners have a more realistic understanding of the complexities faced in managing the morbidity arising from poor sleeping patterns.

NO. 1
NEUROBIOLOGY OF SLEEP
Speaker: Durga Prasad Bestha, M.B.B.S.

SUMMARY:
Sleep is intricately regulated by multiple pathways formed by nuclei predominantly located in a column running from the hypothalamus down to the medulla, with some of them having synergistic actions and others showing antagonistic actions. This is orchestrated by the use of various neurotransmitters and neuropeptides. This session of the symposium will provide a concise, practical review of the essentials of neurobiology of sleep which will form the foundation to understand the sleep architecture, sleep disorders and the effect of mental illness and psychotropics on sleep. It will include a discussion of the Reticular activating system, REM/ NREM pathways, locus coeruleus, dorsal raphe, tuberomandibular and the suprachiasmatic nuclei and the involved neurotransmitters such as norepinephrine, serotonin, histamine, dopamine and orexin/hypocretin. Process C and S which together regulate onset and duration of sleep will also be discussed.

NO. 2
SLEEP ARCHITECTURE AND PSYCHIATRY
Speaker: Venkata B. Kolli, M.B.B.S.

SUMMARY:
Understanding normal sleep architecture and how it changes across the life span, is essential to comprehend the impact of psychiatric disorders on sleep. During this presentation, we will initially review the physiology of Rapid Eye Movement (REM) and Non Rapid Eye Movement (NREM) sleep, and EEG changes across sleep and wakefulness. We will follow this review with an appraisal of the physiological factors impacting sleep EEG and sleep changes across the life span. Thereafter, we will apply this foundation to understand the sleep architectural changes associated with substance intoxication and withdrawal. In addition, we will evaluate relevant neurobiology and resulting sleep changes across mood disorders, anxiety disorders, psychotic disorders and dementia. Furthermore, characteristic REM sleep changes in Post-Traumatic Stress Disorder and associated REM disorders such as REM behavioral disorder and Periodic limb movement disorder will also be discussed. Throughout the presentation, we will appraise the impact of various psychiatric disorders on sleep efficacy, sleep latency, REM sleep and slow wave sleep parameters.

NO. 3
PSYCHOTROPICS AND SLEEP
Speaker: Alexandra E. Schuck, M.D.

SUMMARY:
Several psychotropic medications are utilized in clinical practice for their effect on sleep. These include medications from a variety of drug classes, each of which exert their own impact on sleep architecture. This session of the symposium will go through each class and their individual effects on total sleep time, slow-wave sleep, sleep latency, frequency of awakenings, and REM sleep. We will specifically focus on classes including benzodiazepines, "Z" drugs, melatonin-receptor drugs, antidepressants and antipsychotics. The presentation will also include a brief synopsis of the receptor-based mechanisms through which these actions are mediated. In addition, we will briefly review the adverse effect profiles of these psychotropics in relation to their sedative properties.

NO. 4
'INVITING THE SLEEP FAIRY': DEVELOPMENTAL SLEEP PATTERNS AND CHALLENGES IN PEDIATRIC SLEEP DISORDERS
Speaker: Vishal Madaan, M.D.

SUMMARY:
A significant number of normally developing children and adolescents experience difficulties with sleep initiation or maintenance, and this number increases significantly if youth with psychiatric disorders are included. This presentation will discuss some of the developmental changes in sleep patterns that are commonly seen in children and adolescents, as well as those associated with childhood psychiatric disorders. Furthermore, some of the neurobiological advances in pediatric sleep disorders will be presented. In addition, currently available pharmacological interventions for sleep disorders in children and adolescents will be reviewed.

QUICKSAND IN PSYCHOSOMATIC MEDICINE: PROVIDING CARE FOR OUR PREGNANT PATIENTS

Chairs: Linda L. M. Worley, M.D., Leena Mittal, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the impact of evolving regulatory and legal precedents that conflict with best practices in perinatal mental health care; 2) Identify the current evidence based treatment guidelines for treating pregnant women with opiate dependence; 3) Advocate for evidence based practices in perinatal care.

SUMMARY:
Recent cases of pregnant women facing the loss of autonomy and personal freedom have become increasingly common, placing the psychosomatic medicine women's health care provider in an untenable position as either a mandated

reporter or a criminal. Rather than be helpless, it is critically important that psychiatrists practicing at this interface of psychiatry and obstetrics and gynecology understand the issues to be better informed and prepared to effectively advocate on behalf of patients to facilitate the continued delivery of evidence based, high quality health care.
This symposium will begin with a discussion of highly visible court cases from a judicial perspective by expert and executive director of the National Advocates for Pregnant Women. Next, an expert in ethical issues in Women's Mental Health, will provide vexing clinical examples encountered in the perinatal mental health setting.
This will be followed with an overview of the latest evidence based guidelines in the management and treatment of pregnant women with opiate dependence and will conclude with a discussion of advocacy strategies needed to insure the continued delivery of high quality, evidence based medical care for pregnant patients.

NO. 1
SHOULD PSYCHIATRISTS TREAT PREGNANT WOMEN UNEQUALLY?
Speaker: Lynn M. Paltrow, J.D.

SUMMARY:
In no state in the US is a suicide (or its attempt) a crime. Yet the state of Indiana took the position a pregnant woman who makes such an attempt is guilty of the crime of attempted feticide and attempted murder. If such a view is upheld, would psychiatrists/ health care providers be obligated to report pregnant patients to law enforcement authorities if they expressed an intent to take an action that could cause the death (murder) of a fertilized egg, embryo or fetus? Through a judicial interpretation of the word "child" to include the "unborn" the Alabama Supreme court has made the "chemical endangerment of a child" law applicable to pregnant women using any controlled substance, even one prescribed by a physician. As judicially re-interpreted, doctors who prescribe controlled substances to the pregnant woman are also violating the law. New Jersey child welfare authorities have taken the position pregnant women who obtain methadone treatment and give birth to newborns who exhibit the transitory and treatable side effects of the medication, are guilty of civil child abuse or neglect. Are doctors who recommend and prescribe medication guilty of aiding and abetting such abuse?
This session will discuss current legal trends, current political climate, updates on evidence based best practices in women's health care currently in jeopardy and prevailing attitudes about women making such cases as well as ongoing, epidemic levels of violence against women possible in the US today.

NO. 2
ETHICAL DILEMMAS IN PERINATAL MENTAL HEALTH
Speaker: Laura Miller, M.D.

SUMMARY:
This session will use case illustrations to describe ethical dilemmas in perinatal mental health practice, along with a practical ethical framework to guide clinical decision-making for challenging
situations. We will cover:
• Relational ethics to reframe situations that appear to pit the needs of the mother against the needs of her fetus or baby
• How the principle of autonomous decision making applies when a woman's medical decisions affect herself and her fetus
• How omission bias can affect psychotropic medication prescribing during pregnancy
• How the principle of justice can be practically applied to ensure that women are not stigmatized by having psychiatric disorders or
by being pregnant
• How the ethics of perinatal psychiatric screening programs can vary depending on how they are set up
• How clinicians can practice preventive ethics when treating women of reproductive age for psychiatric disorders

NO. 3
BEST PRACTICES IN THE TREATMENT OF PREGNANT WOMEN WITH OPIATE DEPENDENCE
Speaker: Leena Mittal, M.D.

SUMMARY:
A clinical scenario of a pregnant woman who desires treatment for opiate dependence will be discussed including present day social and legal challenges. An overview of the latest evidence based guidelines for management will be provided with pertinent findings from the literature.

NO. 4
ADVOCACY EFFORTS GONE AWRY: BEST PRACTICES IN BEING HEARD?
Speaker: Linda L. M. Worley, M.D.

SUMMARY:
Speaking up on behalf of our pregnant patients in the current political climate has become increasingly difficult. Well-meaning policy makers have become so determined to effect the change they believe in, they are unwilling to consider the consequences of their policies (e.g. requiring a woman carrying a fetus with a universally fatal fetal anomaly to term). Vocal advocates for reproductive rights stand up in small numbers and feel targeted, worn down, discouraged and in many cases retreat. Those who are quietly horrified about the infringement on the doctor patient relationship express their appreciation to those on the front lines, but this hasn't been sufficient to protect those rights. Future directions and the key ingredients of effectively advocacy will be discussed.

BIPOLAR DISORDER: AN UPDATE ON DIAGNOSIS AND TREATMENT

Chairs: S. Nassir Ghaemi, M.D., M.P.H., Michael J. Ostacher, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Become familiar with recent studies on anticonvulsants, antidepressants, and lithium in bipolar disorder; 2) Analyze the debate about over versus underdiagnosis of bipolar disorder; 3) Apply recent treatment research in bipolar disorder to clinical practice.

SUMMARY:
In this symposium, we will review recent studies of diagnosis and treatment of bipolar illness, providing an update of that literature to clinicians. Diagnosis will be discussed in the context of the debate about over versus underdiagnosis of bipolar disorder. The conflicting and controversial literature will be analyzed and a potential solution provided. Specific medication classes will be examined based on recent randomized clinical trials, including new unpublished data in some cases, and their evidence for effectiveness as well as side effects or harm. Drug classes to be examined include lithium, anticonvulsants, antipsychotics, and antidepressants. Sufficient time will be provided for discussion between the audience and the panel throughout the presentation and at the end.

NO. 1
ANTIDEPRESSANTS IN BIPOLAR ILLNESS: AN UPDATE
Speaker: Frederick K. Goodwin, M.D.

SUMMARY:
In this presentation, I will review current and past randomized clinical trials of antidepressant efficacy and safety in bipolar depression, both for acute and maintenance treatment. New unpublished randomized data will be presented, as well as an analysis of recent meta-analytic reviews of the topic. Clinical interpretation of this controversial literature will also be provided.

NO. 2
EFFICACY AND EFFECTIVENESS: HOW THE BALANCE AND LITMUS TRIALS SHOULD INFORM LITHIUM USE IN BIPOLAR DISORDER
Speaker: Michael J. Ostacher, M.D., M.P.H.

SUMMARY:
In this presentation, I will present and analyze results from two large recent randomized clinical trials of lithium effectiveness and safety in bipolar disorder. BALANCE found benefit with lithium alone, and even more so in combination with valproate. Litmus found little benefit with low-dose lithium added to standard treatments for bipolar illness. These data will be interpreted based on research design considerations, and discussed in their relevance to clinical practice.

NO. 3
THE BIPOLAR DIAGNOSIS DEBATE: OVER, UNDER, OR NEITHER?
Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:
There has been extensive debate in recent years about whether bipolar illness is over or underdiagnosed. Evidence has been presented in both directions, and in different settings, such as children versus adults. In this presentation I will review and analyze that literature, as well as provide an interpretation based on the statistical concept of positive predictive value demonstrating a solution, using clinical features that are not part of DSM-5 definitions, to the concern about overdiagnosis.

NO. 4
ANTICONVULSANTS IN BIPOLAR DISORDER: AN UPDATE
Speaker: Terence A. Ketter, M.D.

SUMMARY:
In this presentation, the use of anticonvulsants in bipolar illness will be reviewed, including a discussion of biological mechanisms, efficacy based on randomized clinical trials, and evidence regarding safety and side effects. Novel anticonvulsants will be considered in detail, and clinical interpretation of this literature will be provided.

NO. 5
TREATING DEPRESSION WITH DSM-5-DEFINED MIXED SPECIFIER
Speaker: Roger S. McIntyre, M.D.

SUMMARY:
The DSM-5 has provided the mixed specifier which would apply to both bipolar disorder and major depressive disorder. Adults with bipolar depression frequently present with mixed symptoms that are suboptimally responsive to conventional antidepressants and correlate with mood destabilization with antidepressants. This presentation will present new data regarding the epidemiology of bipolar depression meeting criteria for mixed specifier. Clinical correlates and comorbidity with mixed specifier will be presented. Novel treatment strategies for treating mixed specifier will also be presented.

QUALITY IMPROVEMENT INITIATIVES: INTERNATIONAL PERSPECTIVES

Chairs: John S. McIntyre, M.D., Wolfgang Gaebel, M.D., Ph.D.

Discussant: Eliot Sorel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the development of “measures” and their importance in quality improvement initiatives ; 2) Identify 5 of the measures in the Physician Consortium on Performance Improvement “Major Depressive Disor-

der Measure Set."; 3) Recognize the major elements in the Fukushima Nuclear Disaster Stress Relief Project; 4) Understand core features of quality improvement initiatives in low resource countries; 5) Recognize general principles in the reduction of mental health care disparities .

SUMMARY:

This symposium is a joint submission by WPA Section on Quality Assurance and APA Workgroup on International Psychiatrists.

Over the past decade there have been major initiatives in many countries focusing on improving the quality of medical care. A major stimulus for these efforts was the 2001 Institute of Medicine landmark study "Crossing the Chasm: A New Health System for the 21st Century".

This symposium will include presentations on recent Quality Improvement initiatives in three high resource countries (Germany, Japan and the United States.) The presentation on initiatives in Germany will discuss the efforts to establish a national common framework of standardized quality measures that address both processes and outcomes of mental health care. The presentation from Japan focuses on the impact of a nuclear disaster and what can be done to decrease the mental health outcomes on a population. Learning from the experiences in the Chernobyl disaster, the Fukushima Nuclear Disaster Stress Relief Project has been developed. The presentation will describe the four pronged project and preliminary results of the project. The presentation from the United States focuses on the AMA convened Physician Consortium on Performance Improvement (PCPI), a leading developer of measures to advance quality improvement efforts. The work of PCPI generally and one of PCPI's recent measurement sets – on Major Depressive Disorder will be discussed.

In addition there will be two additional presentations, one on Quality Improvement efforts in Low and Lower Middle Income Countries and the final presentation on initiatives to provide culturally and linguistically competent mental health care and decrease health care disparities.

NO. 1

GUIDELINES, QUALITY INDICATORS, QUALITY MANAGEMENT: REGULATIONS AND RESULTS FROM GERMANY

Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:

The German mental healthcare system is currently undergoing discussions regarding the assessment of mental healthcare quality and the identification of potentials for improvement. Internal and external quality management procedures and quality assurance initiatives play an important role in the optimization of mental healthcare in Germany. In numerous national and regional initiatives, evidence-based quality instruments and measures are being developed, including clinical practice guidelines, quality indicators and instruments for measuring patient satisfaction. One of the main challenges is the implementation and evaluation of quality measures as well as the establishment of a common framework of standardized quality measures that address both processes and outcomes of mental healthcare. This presentation will describe current initiatives and initial results of quality indicator evaluations in mental healthcare in Germany.

NO. 2

FUKUSHIMA PROJECT: NUCLEAR DISASTER STRESS RELIEF

Speaker: Tsuyoshi Akiyama, M.D., Ph.D.

SUMMARY:

Evelyn Bromet reported that mental health is a leading cause of disability, physical morbidity and mortality as consequence of Chernobyl disaster. In order to prevent the health damage in Fukushima, we are planning to carry out Fukushima Project: Nuclear Disaster Stress Relief Project as follows;

1.Parent child play and peer discussion

Young mothers play with their children and exchange peer discussion with other mothers. The purpose is to reactivate the contacts between mothers and children and to enhance peer support and self-affirmation among the mothers.

2.Focus group with public health nurse

The purpose is to gather information on the experience of the public health nurse in providing care to the residents and to formulate it into a useful material.

3. Outside of the Wire care

The purpose is to enhance peer emotional support among the public health nurse and young mothers, utilizing Outside of the Wire method. This method comprises dramatic theater reading and following discussion and has been used for various mental health support purposes in the States.

4. Lecture and discussion with residents

A combination of lecture on general health topics and small group discussion after the lecture will be provided. The purpose of small group discussion is to assist the residents to assimilate the lecture contents.

The project team is composed of experts in Fukushima, Tokyo and New York.

NO. 3

PHYSICIAN CONSORTIUM ON PERFORMANCE IMPROVEMENT (PCPI) AND MAJOR DEPRESSIVE DISORDER MEASURE SET

Speaker: John S. McIntyre, M.D.

SUMMARY:

The American Psychiatric Association has been a leader in the development of practice guidelines for the treatment of mental illnesses. A major challenge for all developers of guidelines is the implementation stage – assisting physicians and systems of care in actually using the guidelines in daily practice. A major step in the implementation phase is the development of measures from the guidelines. The Physician Consortium on Performance Improvement (PCPI) is a national physician-led initiative in the U.S. dedicated to improving patient health and safety. The PCPI develops, tests, implements and disseminates measures that reflect best

practices in medicine. This presentation will highlight some of the work and products of PCPI which has been functioning for over a decade. In particular one of the measurement sets on Major Depressive Disorder MDD) will be reviewed. This set, approved in February 2013, contains 10 measures with an aim to improve outcomes for patients with MDD. These measures include screening, evaluation, suicide risk assessment, appraisal for alcohol or drug abuse, antidepressant medication management, patient education, follow up care and coordination of care of patients with co-morbid conditions. The measures, their use and the impact of their use will be reviewed.

NO. 4
QUALITY IMPROVEMENT IN LOW AND LOWER MIDDLE INCOME COUNTRIES
Speaker: Jagannathan Srinivasaraghavan, M.D.

SUMMARY:
World Bank defines countries by their Gross National Income per capita level. In the Low income countries it is less than $1005 and in Lower Middle income countries it ranges $1006 to $ 3975. These countries share common problems such as low health care budget, even lower mental health care budget, lack of infrastructure and trained mental health professionals. Further in many of these countries, many traditional healers practice other forms of medicine. With that background, this paper articulates a vision to improve the quality of care in a stepwise fashion by defining core features to deliver initially. The role of psychiatrists has to be expanded in training new generation of mental health practitioners including nurses, graduate students, community workers and teachers, emphasizing teaching methods in specialty training in research methods and community program development, supervision of mental health workers and advocating for mental health care and stigma reduction. The World Psychiatric Association can encourage the teaching of a mandatory course on mental health in undergraduate medical education and with the help of high income countries make it possible for tele-psychiatry consultations from tertiary care centers.

NO. 5
PATIENT-CENTERED AND EQUITABLE HEALTH CARE AS QUALITY INDICATORS: APPLICATIONS FOR MENTAL HEALTH
Speaker: Francis Lu, M.D.

SUMMARY:
In the 2001 Institute of Medicine landmark study "Crossing the Quality Chasm: A New Health System for the 21st Century," patient-centered and equitable health care were defined as two of the six principles of quality health care. This presentation will first review how these fundamental concepts have evolved toward synergism and have been applied to healthcare organizations both at the system and clinical levels. Specifically, this presentation will review the 2013 US Dept. of Health and Human Services Office of Minority Health "National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care" (the "National CLAS Standards"), which is intended to advance health equity by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Also, the presentation will review the Joint Commission's 2010 "Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care" monograph. Secondly, the presentation will show how these quality principles have been applied in mental health with the focus on reducing mental health disparities and providing culturally and linguistically competent mental health care. The DSM-5 Outline for Cultural Formulation and the DSM-5 Cultural Formulation Interview will be reviewed as specific clinical tools. Finally, the presentation will discuss some possible new directions for further development in this area.

ADVANCES IN TREATMENT STRATEGIES FOR AGITATION IN ALZHEIMER'S DISEASE

Chair: Davangere P. Devanand, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the role of antipsychotic treatment and the risk/benefit ratio of antipsychotic discontinuation in patients with Alzheimer's disease who develop agitation or psychosis; 2) Discuss new options for treating agitation in Alzheimer's disease with an understanding of the role of selective serotonin reuptake inhibitors; 3) Learn about the evidence supporting the use of non-pharmacological approaches to treat agitation in dementia and of a new novel algorithmic approach designed for ease of use.

SUMMARY:
Patients with Alzheimer's disease (AD) commonly develop neuropsychiatric symptoms, particularly agitation. The evidence on this topic will be reviewed and recent research findings on antipsychotic use and its discontinuation, SSRI treatment, and behavioral treatment strategies for agitation in AD will be presented.
Dr. Devanand will review antipsychotic use in dementia and discuss the NIA-funded Antipsychotic Discontinuation in Alzheimer's Disease (ADAD) trial in which 180 AD patients with agitation and/or psychosis initially received 16 weeks of open risperidone treatment. 110 responders were randomized, double-blind, to (1) continuation risperidone for 32 weeks, (2) risperidone for 16 weeks followed by placebo for 16 weeks, (3) placebo for 32 weeks. In the first 16 weeks after randomization, discontinuation to placebo showed greater relapse (60%) than continuation risperidone (32.9%; P=0.004). In the next 16 weeks, 48.1% relapsed with discontinuation to placebo compared to 15.4% on continuation risperidone (P=0.017). Survival analyses for placebo discontinuation in the two 16-week periods showed hazard ratios of 1.94 and 4.88, respectively. The results raise questions about current Federal nursing home guidelines for antipsychotic discontinuation.

Dr. Lyketsos will present the results of the NIH-funded Citalopram for Agitation in Alzheimer's Disease Study (CitAD). Patients with probable AD and clinically significant agitation were randomized, double-blind, to receive citalopram (target 30 mg/day) or placebo for 9 weeks. Patients and partners received a standardized psychosocial intervention. Of 186 subjects, 94 were assigned to citalopram and 92 to placebo. The vast majority (89% on citalopram and 86% on placebo) completed the 9-week trial, and 80% of both groups remained on treatment. The clinical implications of the findings will be discussed in light of complexities in the treatment of agitation in patients with AD.
Non-pharmacologic approaches to treat agitation in dementia have significant benefits without the physical risks of medications, and are a critical part of comprehensive, state-of-the-art dementia care. Most front-line providers are not trained to assess and treat behavioral symptoms in dementia, and current non-pharmacological treatment methods are manualized, costly to deliver, and require extensive training. Dr. Kales will review the evidence from behavioral treatment trials for agitation in patients with dementia, and current guidelines. She will describe the "DICE Approach" developed by an expert panel that created an evidence-based algorithmic treatment approach for clinical ease of use. Dr. Kales will also present qualitative data from caregivers and providers being used to refine and tailor the novel behavioral approach toward pairing it with technology.
The panel will end with a discussion of clinical strategies to treat agitation in dementia.

NO. 1
ANTIPSYCHOTIC TREATMENT AND DISCONTINUATION IN PATIENTS WITH ALZHEIMER'S DISEASE
Speaker: Davangere P. Devanand, M.D.

SUMMARY:
Background: In patients with Alzheimer's disease (AD), optimal treatment and discontinuation strategies with antipsychotic medications are not established. There were no clear advantages for any atypical antipsychotic in the CATIE-AD trial, with increased side effects offsetting efficacy advantages for risperidone and olanzapine compared to quetiapine and placebo.
Methods: In the ADAD trial, 180 patients with psychosis or agitation/aggression received 16 weeks of open treatment with risperidone followed by randomized discontinuation to continuation risperidone or placebo (3 arms; switches at 16, 32 weeks after randomization).
Results: 110 of 180 patients responded and were randomized. In both the first 16 weeks and final 16 weeks after randomization, discontinuation to placebo showed greater relapse than continuation risperidone, with double the risk of relapse in the first 16 weeks after randomization and four times the risk of relapse in the next 16 weeks.
Conclusions: In patients who responded to antipsychotic treatment, discontinuation was associated with increased risk of relapse for 4 to 8 months. These results raise questions about current Federal guidelines for patients in nursing homes. Other data show that psychosis and agitation are associated with increased mortality and the contribution of antipsychotics to mortality is not clear-cut. Clinical strategies relating to antipsychotic efficacy, discontinuation, and mortality risk will be discussed.

NO. 2
EFFECT OF CITALOPRAM ON AGITATION IN ALZHEIMER'S DISEASE—THE CITAD RANDOMIZED CONTROLLED TRIAL
Speaker: Constantine Lyketsos, M.D., M.H.S.

SUMMARY:
Neuropsychiatric symptoms including agitation are very common in Alzheimer's Disease (AD), affecting 60 – 80%. They are persistent, resistant to treatment and associated with serious adverse consequences. The Citalopram for Agitation in Alzheimer's Disease Study (CitAD) was designed to evaluate the efficacy, safety and tolerability of citalopram for the treatment of agitation in patients with AD. CitAD study is an NIH-funded, investigator-initiated multicenter, randomized, placebo-controlled, double-blind, two-armed, parallel group trial that randomized patients with probable AD and MMSE scores of 5-28 with clinically significant agitation and without major depression. Participants randomly receive citalopram (target 30 mg/day) or placebo for 9 weeks. Study participants and partners received a standardized psychosocial intervention. Primary outcome measures were the agitation subscale of the Neurobehavioral Rating Scale and the modified Alzheimer Disease Cooperative Study-Clinical Global Impression of Change in agitation. Of 186 subjects randomized, 94 were assigned to citalopram and 92 to placebo. 46% were women, the mean age was 78 years (sd 8). Baseline characteristics of the treatment groups were comparable. The vast majority (89% on citalopram and 86% on placebo) completed the 9-week trial. 80% of both groups remained on treatment. The clinical implications of findings will be discussed in light of complexities treating agitation in Ad patients.

NO. 3
MANAGING THE NEUROPSYCHIATRIC SYMPTOMS OF DEMENTIA: ROLLING THE DICE WITH USUAL CARE VS. THE INTERDISCIPLINARY DICE APPROACH
Speaker: Helen C. Kales, M.D.

SUMMARY:
Neuropsychiatric Symptoms (NPS) of dementia are among the most complex, stressful and costly aspects of caring for people with dementia, and often dominate disease presentation more than memory and cognitive impairments. Few treatment options are widely available for NPS. Although physicians routinely prescribe antipsychotics for their management, these medications have modest efficacy and introduce risks of significant side effects and mortality, making their routine first-line use a poor strategy. Non-pharmacologic approaches have been shown to have significant benefits without the physical risks of medications, and are recognized as a critical part of comprehensive,

state-of-the-art dementia care. Unfortunately, their use is severely limited. Even when aware of these techniques and their value, most front-line providers lack even basic training in assessing NPS and choosing strategies for patients. Additionally, current methods of delivering nonpharmacological treatments are manualized, costly to deliver, and require extensive training. "The DICE Approach" originated from a meeting of 12 national dementia-care experts. This expert panel collaborated to create an evidence-based algorithmic treatment approach for ease of use by clinicians. Dr. Kales will describe and discuss the DICE Approach, as well as present qualitative data from caregivers and providers that is being used to further refine and tailor the approach toward pairing it with technology.

THE ROLE OF SUBSTANCE USE IN VIOLENCE AGAINST SELF AND OTHERS: HOW RESEARCH CAN INFORM CLINICAL UNDERSTANDING OF RISK

Chair: Naimah Z. Weinberg, M.D.

Discussant: Wilson M. Compton, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) 1) Recognize the role that substance use plays in augmenting the risk for violence against self and others in general population and clinical studies;; 2) 2) Understand the mechanisms by which substance use may enhance risk for danger to self and others, such as impulsivity, alterations in mood and perspective, and interpersonal conflict;; 3) 3) Assess patterns of substance use in clinical practice that may indicate an increased risk for self-harm and harm to others;; 4) 4) Identify tools for assessing increased risk in association with substance abuse in clinical contexts;; 5) 5) Understand implications of substance abuse comorbidity for clinical service delivery systems and mental health policy.

SUMMARY:
Epidemiologic, clinical, and laboratory studies have demonstrated that drug and alcohol use augment the risk for suicidal and homicidal acts by individuals with other psychiatric conditions. While not yet fully understood, the increased risk associated with substance abuse may be mediated through a variety of mechanisms, including increased impulsivity, enhanced aggression, impairment of mood and perspective, and interpersonal conflict. Clinicians often face challenges in recognizing and addressing comorbid substance use disorders in their clinical assessments of risk for harm. This invited symposium seeks to present clinicians with research findings that highlight the role of substance use in these impulsive acts by vulnerable individuals, discuss possible mechanisms for this enhanced risk, and outline important implications for clinical assessment and intervention, mental health service delivery, and public mental health policy.

NO. 1
THE ROLE OF SUBSTANCE USE IN COMMUNITY VIOLENCE BY PEOPLE WITH MENTAL DISORDERS
Speaker: Edward P. Mulvey, Ph.D.

SUMMARY:
The literature will be reviewed about how substance use increases the likelihood of involvement in violence in the community in individuals with mental disorder. The strengths and weaknesses of these types of studies will be presented. Research results indicating the relative strength of substances use as a dynamic predictor of violence compared to symptom levels will also be presented. Implications of these findings for clinical practice and policy will be highlighted.

NO. 2
ALCOHOL AND SUICIDAL BEHAVIOR: ROLE OF ACUTE ALCOHOL USE AND ALCOHOL USE DISORDER
Speaker: Kenneth R. Conner, M.P.H., Psy.D.

SUMMARY:
The research on associations between substances of abuse and suicidal behaviors is a large and complex area. This presentation is based on a framework for research and intervention that I developed with colleagues Courtney Bagge, PhD, Mark Ilgen, PhD, and David Goldston, PhD, for the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention. In this presentation I examine alcohol, the most commonly abused intoxicant worldwide, with a focus on two topics: 1) acute use of alcohol (AUA) shortly prior to suicidal behavior and, 2) more chronic alcohol use disorder (AUD) and suicidal behavior. I provide a brief summary of what is known about AUA (and AUD) and suicidal behavior followed by a discussion of near-term and long-term research that is needed to inform intervention efforts. My focus is on clinical intervention strategies for individuals at-risk for suicidal behavior that use alcohol and/or have developed AUD. Throughout, I focus on applied research that may most directly lead to practical prevention efforts. Although clinical interventions are important components of a comprehensive suicide prevention strategy, they should be complemented with primary prevention efforts.

NO. 3
SUBSTANCE USE AS A PROXIMAL RISK FACTOR FOR SUICIDAL BEHAVIOR IN ADOLESCENTS WITH BIPOLAR DISORDER
Speaker: Tina R. Goldstein, Ph.D.

SUMMARY:
Background: Bipolar disorder and substance use are consistently among the most potent risk factors for suicidality in adolescents. Yet, the specific and temporal nature of the near-term association between substance use and suicidality in this population remains unclear. We thus aimed to examine this association prospectively over 1 year in a well-characterized sample of adolescents with bipolar disorder. Methods: Thirty adolescents diagnosed with bipolar disorder via semi-structured interview completed clinical

interview and self-/parent-report assessments of suicidality, substance use and mood at 3 timepoints over 1 year (intake, 6, 12 months).
Results: Results will characterize the temporal order of acute substance use and mood exacerbation preceding instances of suicidal ideation and behavior over follow-up. We will apply cox proportional hazards regression analysis with time-varying covariates to identify hazard for suicidality associated with acute substance use and mood exacerbation.
Clinical Implications: Suicide risk assessment and treatment planning with at-risk adolescents should systematically include proximal risk associated with substance use.

NO. 4
IMPULSIVITY AND UNDERLYING MECHANISMS OF RISK FOR SUICIDE AND AGGRESSION IN SUBSTANCE-ABUSING ADOLESCENTS
Speaker: Donald M. Dougherty, Ph.D.

SUMMARY:
Both research and theory identify close links between impulsivity, aggression, and suicidal behavior. Substance use and abuse interacts with each of these behaviors individually as well as the relationships between them. Understanding predictive or causal relationships of these behaviors is further complicated because they are not static and vary depending on development and experience. For instance, adolescence is a period defined by large changes in social and neural development of impulse control. The timing of these changes in impulse control may interact with substance use exposure, which in turn may alter future development of impulse control. Besides the issue of timing, relationships with impulsivity, aggression, and/or suicidal behavior with substance use depend on the phase (initiation, problem use, discontinuation, and relapse) of substance use involvement. Finally, past experience with aggressive and suicidal behaviors affect their future expression. Impulsivity and/or substance use involvement may alter their further expression. The purpose of this presentation is to describe different approaches to understand relationships between impulsivity, substance use, aggression and suicidal behaviors, with special emphasis on their adolescent developmental course.

COLLABORATING FOR CHANGE: THE TARA METHOD: IMPROVING BORDERLINE PERSONALITY DISORDER FUNCTIONING AND OUTCOMES WITH FAMILY AND CONSUMER PSYCHOEDUCATION

Chair: Valerie Porr, M.A.

Discussant: Lisa B. Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the impact of Borderline Personality Disorder on families and the negative effect of professional stigma on both patients and families; 2) Provide an overview of the TARA method curriculum emphasizing the effectiveness of teaching BPD neurobiology. Identifying the specific components needed in BPD psychoeducational programs for parents, siblings, partners/spouses and children of individuals with BPD.; 3) Recognize the efficacious role family and consumer psychoeducation can play to avoid triggering explosive, problematic interactions with BPD loved ones and improving treatment outcomes. ; ; .

SUMMARY:
An overview of key components of TARA's Method curriculum for Family Psychoeducation, an intensive and well specified family program designed to increase relative's repertoire of coping strategies, will be presented emphasizing what families need to learn to collaborate in recovery and become therapeutic allies, effectively helping their loved ones. The curriculum includes BPD symptomatology, etiology, underlying BPD neurobiology, explanation of evidence based treatments, communication skill training, tools and skills to navigate stressors, problem-solving skills training and social support. The program is not a support group or designed to reduce family burden. The TARA Method teaches family members how to avoid or decrease volatile incidents, reduce their intensity and frequency, reinforce therapeutic goals and techniques and improve overall interpersonal relationships. The TARA Method targets understanding the relationship between BPD behaviors and cutting edge neurobiology findings, emphasizing the role of shame as the common denominator of BPD reactions, decreasing family anger, frustration and fear by changing anger to compassion and reframing manipulation and intentions. A unique group ritual acknowledging family grief to help families radically accept BPD will be presented. Data demonstrating the effectiveness of the TARA method will show reduction in intensity and frequency of incidents, adherence to therapy and overall improvement in family relationships.

NO. 1
A PERSON WITH BPD'S PERSPECTIVE: "FINALLY, I GET ME" THE POSITIVE IMPACT OF BPD PYCHOEDUCATION ON MY RELATIONSHIPS, WHO I AM, AND MY TREATMENT.
Speaker: Maria Scazzero

SUMMARY:
The TARA method of BPD psychoeducation developed as an outcome of a TARA survey indicating 89% of those with BPD wanted a psychoeducation program. The presentation chronicles the impact of TARA's BPD psychoeducation program on a young woman with BPD in various therapies for many years. Now in DBT, she acknowledges having BPD but has never understood what it is, why she has it or ever considered there was a neurobiological basis to BPD. Instead, she judged herself.
She will present how attending this group changed how she looks at the world and herself. The program helped her understand why her emotions are always so high and why she is so affected by them. "I am like this because of the way my brain is wired. No one had every explained this to me. The group itself and understanding the neurobiology allowed me

to understand myself better and have more compassion for myself."

She attended the group because she wanted to be around others like herself. Being in a room with other people was validating, knowing she is not alone. Hearing other people share their experiences, "I felt that what each person said was my story. We all were one another's stories." She will describe her realization that, although her family cares about her, knows her well and has read books on BPD, she didn't feel understood by her family and couldn't have the relationship with them she wanted. The BPD psychoeducation group showed her how to educate them and others so that they know how to help her.

NO. 2

APPLYING TARA METHOD TRAINING IN NEUROBIOLOGY AND FAMILY ISSUES TO DEVELOP COMPASSION FOR INDIVIDUALS WITH BPD IN PSYCHOLOGY GRADUATE PROGRAMS

Speaker: Olivia Mandelbaum

SUMMARY:

The presenter is a graduate student in clinical psychology who will speak about her unique experience interning for the TARA National Association for Personality Disorder and the ways in which this shaped her graduate training. She will give a address the ways in which the Tara Method education in BPD neurobiology and a compassionate understanding of the BPD family can lead to a holistic understanding of the patient by increasing empathy, influencing case conceptualization and treatment protocol, impacting understanding of etiology and theory, and helping her to develop new research questions. BPD neurobiology and family concerns have shaped her training in a her psychodynamic Ph.D. program in clinical psychology.The talk will conclude with potential suggestions as to how graduate programs can incorporate courses in neurobiology and family psychoeducation to help future clinicians in their work with BPD patients and will provide further information on how clinical students can come to work with BPD families.

NO. 3

DEMONSTRATION OF THE TARA METHOD: TALKING TO THE AMYGDALA IN EMOTIONAL LANGUAGE TO IMPROVE COMMUNICATION, TRUST AND REPAIRS RELATIONSHIPS AND CHANGE STRATEGIES TO DEVELOP INDEPENDENCE, TRUST AND COMPETENCY

Speaker: Regina Piscitelli, B.A.

SUMMARY:

The presentation will demonstrate through role-play how families can communication with validation and mentalizing techniques, communicating emotionally rather than logically, speaking amygdala language so as to decrease dysregulations and improve relationships. The presentation will emphasize the importance of facial expressions, (using Ekman training) voice tones and body language to clarify intent and meanings in interpersonal interactions and will demonstrate effective DBT and MBT strategies to develop independence, trust and competency in a loved one with BPD. Emphasis on the need for family members to learn how to actually implement DBT and MBT techniques in the moment rather than be taught DBT skills with the patient, the current norm for most family programs. The presenter will discuss why "Tough Love" and "Boundaries" are ineffective means of changing behavior and how consequences rather than rules or punishment can be effective. Ceding control though freedom of choice and creating masery through cheerleading and validation will also be demonstrated.

NO. 4

HIGHLIGHTS OF KEY COMPONENTS OF THE TARA METHOD CURRICULUM FOR BPD FAMILY PSYCHOEDUCATION

Speaker: Valerie Porr, M.A.

SUMMARY:

An overview of key components of TARA's Method curriculum for Family Psychoeducation, an intensive and well specified family program designed to increase relative's repertoire of coping strategies, will be presented emphasizing what families need to learn to collaborate in recovery and become therapeutic allies, effectively helping their loved ones. The curriculum includes BPD symptomatology, etiology, underlying BPD neurobiology, explanation of evidence based treatments, communication skill training, tools and skills to navigate stressors, problem-solving skills training and social support. The program is not a support group or designed to reduce family burden. The TARA Method teaches family members how to avoid or decrease volatile incidents, reduce their intensity and frequency, reinforce therapeutic goals and techniques and improve overall interpersonal relationships. The TARA Method targets understanding the relationship between BPD behaviors and cutting edge neurobiology findings, emphasizing the role of shame as the common denominator of BPD reactions, decreasing family anger, frustration and fear by changing anger to compassion and reframing manipulation and intentions. A unique group ritual acknowledging family grief to help families radically accept BPD will be presented. Data demonstrating the effectiveness of the TARA method will show reduction in intensity and frequency of incidents, adherence to therapy and overall improvement in family relationships.

NO. 5

IMPACT OF BPD ON SIBLINGS, PARTNERS/SPOUSES AND CHILDREN OF PEOPLE WITH BPD; ADAPTATIONS OF THE TARA METHOD TECHNIQUES FOR SPECIFIC RELATIONSHIPS.

Speaker: Sarah Piscitelli, M.A.

SUMMARY:

The presentation highlights TARA Method family psychoeducation curriculum for siblings, partners and children of people with BPD, addressing specific needs differing from parents or primary caregivers. She discusses ambivalent feelings and discord created within the family due to growing up with a BPD sibling. Siblings deal with competition and

struggles for attention. TARA's sibling curriculum validates the experience of having a BPD sibling, addresses problems faced inside and outside the family, helps siblings understand and accept their sibling's behaviors, teaches skills and helps them ally themselves with parents to maintain the safety and emotional well-being of the family.
Partners' expectations and needs differ from those of parents The curriculum targets the effect of BPD on trust, open communication, reciprocity and dependency. BPD neurobiology explains how BPD sensitivity and reactions negatively impacts abilities to problem solve, manage emotions, maintain intimacy and complicates sexual relationships. The program integrates coping techniques from Gottman, DBT, and MBT, provides better listening and negotiating skills, and helps deescalate volatile disagreements. Partners separating or divorcing learn skills to manage proceedings and co-parent. Partners committed to continuing the relationship learn how to maintain and enhance their relationship. Presentation will discuss how to teach children of a person with BPD to cope with difficult parental behaviors.

TRAUMA AND STRESS-RELATED AND DISSOCIATIVE DISORDERS IN DSM-5

Chair: Katharine A. Phillips, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the rationale for the DSM-5 PTSD criteria and why PTSD is longer classified as an anxiety disorder.; 2) Understand the rationale for changes to the criteria for acute stress disorder.; 3) Diagnose the new dissociative subtype of PTSD as well as dissociative identity disorder, dissociative amnesia, and depersonalization/derealization disorder.; 4) Understand the difference between normal bereavement and persistent complex bereavement disorder.

SUMMARY:
A new chapter in DSM-5 consists of disorders in which the onset of symptoms is preceded by a traumatic or stressful event. The rationale for this new category (which contains several disorders previously classified as anxiety disorders) will be addressed. This symposium will discuss DSM-5 criteria for posttraumatic stress disorder (PTSD), acute stress disorder and the section 3 diagnosis of persistent complex bereavement disorder. Finally, disorders characterized by dissociative symptoms will be reviewed. These include the dissociative subtype of PTSD as well as the major dissociative disorders which are in a separate chapter of DSM-5: dissociative amnesia, dissociative identity disorder, and depersonalization/derealization disorder. Substantial time will be reserved for questions from the audience.

NO. 1
TRAUMA AND STRESSOR-RELATED DISORDERS
Speaker: David Spiegel, M.D.

SUMMARY:
The rationale for including a new chapter in DSM-5, consisting of disorders that were preceded by exposure to a traumatic or stressful event, will be discussed. This chapter includes PTSD, acute stress disorder, adjustment disorders, reactive attachment disorder, disinhibited social engagement disorder and (for section 3) persistent complex bereavement disorder. The presentation will then review the evidence for major revisions in PTSD diagnostic criteria. These include four (rather than DSM-IV's three) symptom clusters, revision of the A (stressor) criterion, addition of preschool PTSD, and addition of a dissociative subtype.

NO. 2
ACUTE STRESS DISORDER IN DSM-5
Speaker: Robert J. Ursano, M.D.

SUMMARY:
Acute Stress Disorder (ASD) was introduced for the first time in DSM-IV. It was constructed to capture early responses to traumatic events since PTSD could only be diagnosed after one month. There was limited evidence at that time relating early responses to later risk for disorders (PTSD in particular) and impairment. Dissociation was thought to be a pivotal response. Now with DSM 5, substantial evidence has accumulated to allow for changes in the diagnostic criteria. The presentation will review the original rationale for ASD and the evidence leading to changes in DSM-5. DSM-5 ASD criteria will be reviewed and discussed in the context of early responses and subsequent risk and illness.

NO. 3
DISSOCIATIVE DISORDERS AND THE DISSOCIATIVE SUBTYPE OF PTSD
Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:
The rationale, research literature, and changes to the dissociative disorders and the dissociative subtype of PTSD in DSM-5 will be presented. Criteria for dissociative identity disorder refer to pathological possession and identity fragmentation to make the disorder more applicable cross-culturally. Dissociative amnesia now includes dissociative fugue as a subtype, since fugue is a rare disorder that always involves amnesia but does not always include confused wandering or loss of identity. Depersonalization disorder now also includes derealization, since the two often co-occur.
A dissociative subtype of PTSD, defined by the presence of depersonalization or derealization in addition to other PTSD symptoms, is now included, based upon epidemiological and neuroimaging evidence linking it to an early life history of adversity and a combination of frontal activation and limbic inhibition.

NO. 4
PERSISTENT COMPLEX BEREAVEMENT DISORDER (PCBD)
Speaker: Robert Pynoos, M.D.

SUMMARY:

Recent research evidence and clinical observation indicates that a sub-group of bereaved individuals suffers persistent bereavement-related symptoms with significant impairment that warrants consideration of a bereavement-related disorder, independent of other psychiatric conditions. Persistent complex bereavement disorder (PCPD) combines the most empirically supported criteria across theoretical orientations to provide an integrated, multi-faceted set of diagnostic criteria in DSM-5's section 3. This presentation will: 1) present the DSM-5 diagnostic features for PCBD; 2) describe a multidimensional model that underlies the diagnostic criteria for PCBD; 3) discuss the empirical basis and rationale for these diagnostic criteria; 4) describe and discuss the traumatic death specifier under PCBD that is reserved for bereavement due to death by homicide or suicide; and 5) discuss considerations regarding grief, mourning, and bereavement in relation to the category of adjustment disorders.

MAY 05, 2014

TURNING PARITY FOR MENTAL AND PHYSICAL HEALTH FROM RHETORIC TO REALITY

Chairs: Sue Bailey, M.D., Dinesh Bhugra, M.D., Ph.D.

Discussant: Kenneth Busch, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the concept and implications of a Rights Based Parity approached to Mental Health - Whole person care; 2) Identify and learn from practical examples of Parity in Action the impact of poor physical health on those with mental illness. Participants will put this learning into their own clinical practice; 3) Identify and share opportunities to assist all medicine to improve the mental health of those with physical illness to deliver better outcomes. Enable psychiatrists to become key influence in building psychosocial resilience of individuals, families and communities.

SUMMARY:
The long standing and continuing worldwide lack of parity between mental and physical health is inequitable and socially unjust. The 'mental health treatment gap' exemplified by lower treatment rates for mental health conditions, premature mortality of people with mental health problems, falls short of any governments commitment to International Human Rights Conventions which recognize the rights of people with mental health problems to highest attainable standards of health; yet it can be argued that this lack of parity is so embedded in healthcare and in society that it is tolerated and hardly remarked upon. It also affects people with physical health problems who also have mental health needs that may not be recognised in more physical healthcare orientated settings. The poorer outcomes that result are considered by many, both within and outside mental healthcare, as all that can be expected.
An overview of parity and its development in England will be followed by a vision for Rights Based Parity across the world. A practical example of Parity, the HeAL initiative, will be described. Finally a vision for Parity at a community level will be put forwards. How to build psychosocial resilience within communities especially for those who experience mental illness

NO. 1
DEVELOPING PSYCHOSOCIAL RESILENCE IN COMMUNITIES ITS APPLICATION IN PUBLIC MENTAL HEALTH CARE
Speaker: Richard Williams O.B.E., M.D.

SUMMARY:
Resilience of people lies at the core of developing psychosocial care for families, groups of people and communities. A concept that lies in relationship to horizontal epidemiology mental health recovery and social identity.
We should pay attention to not only phenomenology and neuroscience, but also the social sciences in determining how to progress parity of esteem for people's mental and physical mental health in our societies. Concepts important in planning how to advance coproduction through which practitioners, the public and patients come together collectively to design and deliver effective, responsive and acceptable services.
The concept of horizontal epidemiology gives scientific expression to principles that underpin the recovery and resilience approaches. The premise of horizontal epidemiology is that psychosocial difficulties associated with mental disorders are by no means exclusively determined by diagnosis. It focuses on the experiences of people who have disorders and concentrates on what is relevant to their lives to improve planning of interventions and improve people's quality of life. providing further evidence to support the recovery approach.
The importance of people's social identities to understanding how well they cope with events that befall them and their families and how they recover from the mental disorders they may develop.

NO. 2
HUMAN RIGHTS-BASED PARITY BETWEEN PHYSICAL AND MENTAL HEALTH
Speaker: Dinesh Bhugra, M.D., Ph.D.

SUMMARY:
In western medical practice, physical and mental health have often been treated as separate entities in structures which appear to be very solitary features. Training and clinical practice both have been compartmentalised. As a result mental health often gets ignored in physical health settings and vice versa. To provide total and holistic care it is imperative that parity between physical and mental health is based on rights that all human beings must have. Human rights allow civilising effects but also influence prevalent political, social and economic conditions and norms. Rights include right to access health care as and when needed but they

also about appropriate therapeutic interventions. Rights are about recognition by the society that individuals have certain values that are to be acknowledged. These rights are also embedded within any system which allows cultural, social and personal identities as part of the whole spectrum of health. In some traditional health care systems such as Ayurveda, physical and mental health go hand in hand and also take into account climate, environment and diet. Lessons can be learnt to take this parity into account when delivering health care. Health must be seen in its totality.

NO. 3

KEEPING THE BODY IN MIND: IMPROVING PHYSICAL HEALTH IN YOUNG PEOPLE WITH PSYCHOSIS: CHANING PRACTICE TO CREATE PARITY

Speakers: Philip B. Ward, B.Sc., Ph.D., David Shiers, M.B.

SUMMARY:

Maintaining good physical health is a challenge for young people experiencing psychosis. Weight gain and metabolic disturbances may occur rapidly after commencing antipsychotic medications, combining with physical inactivity and tobacco smoking to create vulnerability to future cardiovascular disease and diabetes. Self-esteem, added stigma and social exclusion resulting from weight gain and poor physical health pose additional burdens. Inequalities in healthcare frequently exacerbate these problems. The implementation of an integrated approach: Keeping the Body In Mind in an early psychosis programme will be described, highlighting the lived experiences of young consumers, as well as novel prevention and early intervention approaches to reducing cardiometabolic risks.

Building on this experience, the International physical health in youth stream (iphYs) was established to enhance collaborative links. IphYs has supported the development of an international consensus, the Healthy Active Lives (HeAL) declaration. Responding to the challenges young people with psychosis face, the declaration sets out clear principles, goals and processes including five-year targets that emphasise the importance of cardiometabolic risk prevention to avoid future physical health complications. HeAL challenges us to imagine a world where young people experiencing psychosis have the same life expectancy and expectations of life as their peers who have not experienced psychosis.

NO. 4

TWELVE STEPS TO PARITY: AN ENGLISH EXPERIENCE

Speaker: Sue Bailey, M.D.

SUMMARY:

In Essence, 'Parity Of Esteem' Is thus best described as: 'Valuing mental health equally with physical health'. More fully, and building on the US definition, parity of esteem means that, when compared with physical healthcare, mental healthcare is charcterised by:

•equal access to the most effective and safest care and treatment
•equal efforts to improve the quality of care
•the allocation of time, effort and resources on a basis commensurate with need
•equal status within healthcare education and practice
•equally high aspirations for service users: and
•equal status in the measurement of health outcomes.

For simplicity, and to shift the focus from equally valuing mental health and physical health to the next stage, of taking action to achieve parity, this report refers simply to achieving 'parity' in order that mental health has equal status with physical health. inherent in this. However, is the need to value mental and physical health equally.

This paper will share how parity has been adopted by health and social care in England and the 12 steps for change to deliver parity.

DEVELOPING AND IMPLEMENTING INTERVENTIONS FOR MILITARY PATIENTS TARGETING PTSD AND RELATED CO-MORBIDITIES IN "REAL WORLD" NONSPECIALTY SETTINGS

Chairs: Robert J. Ursano, M.D., Douglas Zatzick, M.D.

Discussant: Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand characteristics of non-specialty mental health delivery in active duty military contexts; 2) Introduce methodologic innovations required to deliver interventions in non-specialty mental health settings for active duty service members and their family members; 3) Appreciate the evidence-base supporting the effectiveness of combined interventions targeting active duty service members and their family members.

SUMMARY:

A recent Institute of Medicine (2012) report highlighted that active duty military personnel frequently present to "real world" non-specialty mental health settings for their initial and ongoing treatment of posttraumatic stress disorder and related co-morbid conditions. These "real world" non-specialty in-theater and acute and primary care medical service delivery contexts present unique challenges with regard to the delivery of evidence-based mental health interventions. This symposium presents the development and implementation of randomized clinical trials of treatments for PTSD and related comorbidity in these unique non-specialty contexts. Dr. Hoge will describe issues of barriers and access to receiving mental health care in unique military settings such as in-theater contexts. Dr. Zatzick will describe population-based automated screening and associated stepped care interventions that have successfully targeted PTSD and alcohol use problems in the wake of traumatic injury. Dr. Cozza will describe the development and early implementation of a randomized clinical trial that combines injury care management and family preventive intervention into the FOCUS-CI intervention framework. Dr. Engel will describe the development and implementation of the STEPS UP collaborative care intervention that targets PTSD and depression in active

duty military patients seen in primary care. Dr. Ursano will moderate a discussion that encourages active audience questions and comments.

NO. 1
ACCESS AND BARRIERS TO MENTAL HEALTH CARE
Speaker: Charles Hoge, M.D.

SUMMARY:
Dr. Hoge will present data from several studies that document issues related to access and barriers to mental health care among active duty personnel. Active duty military personnel who suffer from post-traumatic stress disorder (PTSD) and other mental disorders frequently do not seek, drop out of care, or present to non-specialty mental health settings. This talk will synthesize information from several studies on stigma and barriers to care, receipt of minimally adequate treatment, providers fidelity to evidence-based treatment, and reasons for dropping out of care. The implications of this research, including clinical trials to enhance treatment engagement and retention will be presented.

NO. 2
DEVELOPING AND IMPLEMENTING COLLABORATIVE CARE INTERVENTIONS FOR PTSD AND RELATED COMORBIDITY IN ACUTELY-INJURED TRAUMA SURVIVORS
Speaker: Douglas Zatzick, M.D.

SUMMARY:
Few investigations have evaluated interventions for injured patients with posttraumatic stress disorder (PTSD) and related impairments that can be feasibly implemented in military or civilian acute care medical settings after traumatic injury. This presentation will first describe two-stepped collaborative interventions (Zatzick et al Arch Gen Psych 2004 & Zatzick et al Annals of Surgery 2013) that have successfully targeted reductions in PTSD and improvements in physical function by combining injury care management, pharmacotherapy, motivational interviewing and cognitive behavioral therapy elements embedded within care management. These stepped collaborative care investigations with civilian injury survivors have also been associated with reductions in subsequent injury risk behaviors including reductions in alcohol consumption and weapon carrying. After describing the evidence-base supporting the stepped care intervention targeting PTSD the presentation will describe adaptations of the model for active duty military patients. The investigation will also describe efforts to integrate state of the art information technology innovations including web and smart phone applications developed by the Department of Defense. Finally, the presentation will describe policy activity targeting the sustainable implementation of the stepped collaborative care model in acute care medical settings.

NO. 3
DEVELOPING AND IMPLEMENTING THE FOCUS-CI RANDOMIZED CLINICAL TRIAL PROTOCOL FOR INJURED WARFIGHTERS AND THEIR FAMILY MEMBERS
Speaker: Stephen J. Cozza, M.D.

SUMMARY:
Dr. Cozza will present the development and implementation of the focus-ci family preventive intervention trial. Dr. Cozza will first present the theoretical rationale and underpinning prior studies that inform the manualized Focus-CI treatment that targets psychological adjustment for military families, including spouses and children. He will then describe the integration of the traditional focus model with active injury care management. He will describe a 240-person randomized clinical trial taking place at three military and civilian sites around the United States. The trial actively engages and recruits OIF/OEF veterans returning with combat injuries. The trial engages injured warfighters, their spouses, and children in a combined protocol that targets psychological and functional improvements through care management and manualized Focus-CI sessions. Dr. Cozza will give an in-depth description of project implementation including experience working with combat injured families, as well as the successes and challenges in implementation of the ongoing protocol.

NO. 4
DEVELOPMENT AND IMPLEMENTATION OF THE STEPS UP MULTI-SITE COLLABORATIVE CARE INTERVENTION PROTOCOL TARGETING PTSD AND DEPRESSION IN PRIMARY CARE SETTINGS
Speaker: Charles C. Engel, M.D., M.P.H.

SUMMARY:
Dr. Engel will present the development and implementation of the Steps Up protocol. Steps Up derives from a long-standing tradition of primary and acute care medical collaborative care intervention trials targeting depression in primary care and PTSD in acute care medical settings. Dr. Engel will describe the theoretical rationale and design and implementation of the protocol which includes current recruitment from six active duty military bases in the USA. The trial will recruit and randomize over 600 patients to a Steps Up active intervention protocol or usual care respect-mil. The Steps Up protocol involves active case management, evidence-based psychopharmacology and evidence-based cognitive behavioral therapy. Active duty military personnel with PTSD and depressive symptom levels are engaged in the protocol and interventions are delivered in a stepwise manner. Evidence-based, measurement-based care is implemented. Nurse care managers are coached by md supervisors and cognitive behavioral therapy is delivered targeting PTSD and depression. Dr. Engel will discuss barriers to implementation of the protocol in active-duty military non-specialty context.

DISRUPTIVE BEHAVIOR IN THE WORKPLACE: DEALING WITH THE DISTRESSED AND DISRUPTIVE PROFESSIONAL

Chairs: Martha E. Brown, M.D., Debra A. Troupe, M.S.

Discussant: Mark S. Gold, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize different types of behavior in the workplace that may be disruptive and harmful to patient care; 2) Identify the etiologies of distressed and disruptive behavior in physicians and other healthcare professionals; 3) Identify referral and treatment options that can appropriately and effectively address distressed and disruptive behavior ; 4) Recognize when a referral to a professional health program is appropriate and needed; 5) Recognize potential risk factors and learn preventive strategies through audience participation in several mindfulness exercises and case discussions.

SUMMARY:
Only a small number of physicians and other healthcare professionals (3-5%) exhibit disruptive behavior in the workplace. However, 97% of physicians and nurses report they have experienced disruptive behavior in the workplace. The Joint Commission in 2008 published a Sentinel Alert on disruptive behavior defining it as "behaviors that undermine a culture of safety." It is known that disruptive behavior can result in increased workplace stress and poor workplace environments, which ultimately results in reduced quality of patient care and an increased risk of litigation. There has also been recognition that disruptive behavior can foster medical errors, contribute to preventable adverse outcomes, and lead to loss of qualified medical staff. Communication breakdowns as a result of disruptive behavior have been directly correlated in studies to adverse events involving residents and OR errors. The spectrum of disruptive behaviors that affect the workplace range from aggressive behaviors (such as profane language, throwing objects, sexual comments, or demeaning behavior), to passive-aggressive behaviors (refusing to do tasks or derogatory comments about the hospital), to passive behaviors (not responding to calls or pages, inappropriate chart notes, or being chronically late). Barriers to dealing with the problems vary. It has become increasingly clear that medical practices, administrators, and hospitals do not know how to recognize or intervene upon disruptive behavior in the workplace. Many times the behaviors are not extensively documented, there is a lack of policies or training regarding approaches to this type of situation, and there is reluctance to supposedly "harm" careers by addressing the issues. The presenters will discuss the etiologies, risk factors, and symptoms of disruptive behavior. They have developed a protocol and a behavioral health model for medical practices and hospitals to follow concerning disruptive behavior in the workplace. This session will cover the above issues, as well as discuss types of treatment options, monitoring of behavior, use of 360 surveys, and prevention techniques. Audience participation will be strongly encouraged with mindfulness exercises and case presentations. The audience is encouraged to bring case scenarios to the symposium they wish to discuss.

NO. 1
UNDERSTANDING OUR BEHAVIOR: WHAT IS DISRUPTION?
Speaker: Martha E. Brown, M.D.

SUMMARY:
Many students, professionals, and staff in a medical setting may be experiencing substance abuse or other types of problems that may cause impairment issues in the workplace. Increasingly the issue of "disruptive behavior" in the workplace is seen to be causing professional impairment. Disruptive behavior has been shown to affect staff moral, patient safety, group and hospital liability, and communication in a medical setting. Disruptive behavior is no longer just the stereotypical surgeon who throws an instrument. The spectrum of disruptive behaviors range from aggressive behaviors, to passive-aggressive behavior, to passive behaviors. It has become increasingly clear that medical practices, administrators, and hospitals do not know how to recognize or intervene upon disruptive behavior in the workplace. Many times the behaviors are not extensively documented, there is a lack of policies or training regarding approaches to this type of situation, and there is reluctance to supposedly "harm" careers by addressing the issues. This presentation will address the prevalence, etiologies, and recognition of disruptive and distressed behaviors in professionals.

NO. 2
TREATMENT OPTIONS FOR DISRUPTIVE BEHAVIOR
Speaker: Debra A. Troupe, M.S.

SUMMARY:
Hospitals and medical practices have struggled with what types of interventions and treatment resources are needed to help physicians and professionals who have disruptive behavior. Numerous treatment programs have worked to standardize substance abuse treatment for professionals. However, given the large spectrum of disruptive behaviors, less is know about how to best treat the distressed and disruptive professional in order to ensure they can practice with reasonable skill and safety. A behavioral health model will be presented with an algorithm for addressing treatment interventions and options for disruptive behavior in the workplace. Types of treatment options from CME activities to inpatient evaluation, monitoring of behavior, use of 360 surveys, and prevention techniques will be discussed.

NO. 3
MONITORING THE DISRUPTIVE PROFESSIONAL
Speaker: Penelope P. Ziegler, M.D.

SUMMARY:
Physician and Professional Health Programs have traditionally in the past dealt mainly with substance abuse issues. However, there are an increasing number of referrals for other psychiatric disorders including disruptive behavior in the workplace. Unfortunately disruptive behaviors that are affecting patient safety are often not well documented, thus referrals to a physician health program or hospital wellness

committee often do not have the necessary documentation to ensure that the complaint will be taken seriously by the Medical or other licensure board if the professional is uncooperative with evaluation, treatment, and monitoring. The Professionals Resource Network (PRN) in Florida has been increasing the education of referral sources, medical practices, and hospitals about the prevention of disruptive behavior, thus assuring that the professional with problems gets the appropriate help. A model for program monitoring of disruptive behavior will be presented with components of: evaluation, treatment, neuropsychological testing, workplace monitoring, individual psychotherapy, coaching, continuing medical education, and 360 surveys. Better team communication, improved patient safety, increased quality of patient care, reduced litigation risk and a healthier work environment are only some of the benefits to be achieved from dealing with disruptive behavior in the workplace. Specific case examples will be presented and discussed.

BORDERLINE PERSONALITY DISORDER IN ADOLESCENTS: THEORY, RESEARCH, AND TREATMENT

Chairs: Elizabeth W. Newlin, M.D., Carla Sharp, Ph.D.

Discussant: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the major developmental theories explaining the emergence of BPD in adolescence; 2) Recognize important empirically informed correlates and predictors of emergent BPD in adolescence; 3) Treat emerging BPD in adolescents.

SUMMARY:
The diagnosis and treatment of BPD in adolescence has traditionally been avoided by clinicians and researchers (Sharp & Tackett, in press). Explanations for this reluctance have included the notion that a BPD label connotes severity and nonmalleability, which may negatively affect a developing child's self-concept or bias others' perceptions of the child (Kernberg, Weiner, & Bardenstein, 2000). Some have questioned diagnosing BPD prior to the onset of puberty and prior to the completion of identity formation (Shapiro, 1990), based on the idea that personality lack cohesiveness and stability prior to age 18 (Crick, Murray-Close, & Woods, 2005). And others have emphasized the problem of distinguishing borderline features from the normal developmental trajectory of adolescence (Meijer, Goedhart, & Treffers, 1998; Miller, Muehlenkamp, & Jacobson, 2008).
However, over the last 15 years we have seen an unprecedented increase in research activity aimed at examining the theoretical and empirical basis of the construct of adolescent BPD (Sharp & Tackett, in press). There has also been a concerted effort to develop new treatment approaches specially aimed at addressing the needs of adolescents with BPD features and their families. In this volume, we have brought together several of the researchers and clinicians who have been active in this area of research and clinical work.
We organize the symposium around a translational theme and therefore begin the session with a presentation by Peter Fonagy on the theoretical approach to adolescent BPD. This presentation is followed by two presentations presenting data from ongoing studies of adolescent BPD. Carla Sharp will present data collected at the Adolescent Treatment Program of the Menninger Clinic examining the proposition that adolescent BPD is associated with unique parenting. We then move further along the translational spectrum with Andrew Chanen introducing a prevention program for adolescent BPD, and Elizabeth Newlin reporting on a treatment approach in an adolescent inpatient setting. John Gunderson will round off the symposium by reflecting on the work presented in the symposium.
Our overall goal is to provide participants with a helpful clinical and empirical-based perspective on the adolescent BPD.

NO. 1
THE THEORETICAL APPROACHES TO ADOLESCENT BPD
Speaker: Peter Fonagy, Ph.D.

SUMMARY:
BPD typically emerges in adolescence, at least in terms of clinical accounts of adults with the diagnosis. BPD is known to be caused by a combination of biological (genetic) and psychosocial factors but emerges as part of a developmental process. The presentation will contextualize the biology of BPD against a background of recent findings from neuroscience and adolescent brain development and present the biopsychosocial model of BPD as the consequence of an unsuccessful struggle on the part of the young person to deal with the social and biological challenges of adolescence in a productive, age-appropriate way. The developmental perspective is particularly helpful in this context because it offers a framework within which preventive interventions can be initiated. Better understanding of the nature of the developmental struggle of adolescents at risk of BPD helps us not just in addressing the problems experienced by these young people, but also in thinking about modifying the social environment in which they exist in the direction of reducing the risk for BPD.

NO. 2
ADOLESCENT BORDERLINE PERSONALITY DISORDER: THE ROLE OF PARENTING VARIABLES
Speaker: Carla Sharp, Ph.D.

SUMMARY:
Most developmental theories of BPD emphasize the role of problematic interactions between parents and children as an important etiological factor. While this hypothesis has been investigated through behavioral genetic studies, studies of sexual trauma, and studies of borderline mothers, to our knowledge, no study has examined parenting variables (parenting style and parenting stress) in adoles-

cents with BPD vs. adolescents without. To this end, 148 female adolescents were carefully assessed with standardized and interview-based psychiatric assessment tools to derive two groups: 74 with DSM-IV criterion-based BPD, and 74 psychiatric controls without BPD. The groups were carefully matched on the total psychiatric problems so that any group difference may be attributable to borderline pathology. Measures of parenting style, parenting stress and attachment were administered. Results showed significant elevation in poor monitoring, overprotection, poor adolescent-parental relationship quality and parenting life stress. Results are discussed in the context of developmental theories of BPD.

NO. 3
THE PSYCHOSOCIAL FUNCTIONING OF ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER
Speaker: Mary Zanarini, Ed.D.

SUMMARY:
Objective: The purpose of this study was to compare the psychosocial functioning of two groups of adolescents age 13-17: inpatients with borderline personality disorder (BPD) and psychiatrically healthy comparison subjects. Method: 104 hospitalized girls and boys who met rigorous criteria for BPD and 60 psychiatrically healthy adolescents from the community were interviewed concerning their social and vocational functioning. Results: Adolescents with BPD were significantly less likely than psychiatrically healthy comparison subjects to report that they had an emotionally supportive relationship with their mother, father, and friends than psychiatrically healthy comparison subjects. They were also significantly less likely to report a good work and/or school record. However, adolescents with BPD were significantly more likely to report an emotionally supportive relationship with a romantic partner. Conclusions: Taken together, the results of this study suggest that adolescents with BPD are impaired in many, but not all, aspects of psychosocial functioning.

NO. 4
THE HELPING YOUNG PEOPLE EARLY (HYPE) PREVENTION AND EARLY INTERVENTION PROGRAM FOR BORDERLINE PERSONALITY DISORDER
Speaker: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:
Borderline personality disorder (BPD) is a leading candidate for prevention and early intervention because it is common in clinical practice, it is among the most distressing and functionally disabling of all mental disorders, it is often associated with help-seeking, and it responds to treatment. Moreover, BPD can be reliably diagnosed in its early stages and it demarcates a group with high levels of current and future distress, morbidity and mortality, making intervention a clinically justified and humane response. Data also suggest considerable flexibility and malleability of borderline personality disorder traits in youth, making this a key developmental period during which to intervene.

The HYPE program is a comprehensive and integrated indicated prevention and early intervention program for youth (15–25 years of age) with BPD. HYPE includes both a service model and an individual therapy, and incorporates the principles of Cognitive Analytic Therapy (CAT) into both components. CAT is a time-limited, integrative psychotherapy that is practical and collaborative in style. It has particular advantages for early intervention in BPD because its integrative and 'transdiagnostic' approach can encompass the myriad co-occurring problems that are the norm in this patient group.

NO. 5
MENTALIZATION BASED TREATMENT (MBT) IN ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER
Speaker: Elizabeth W. Newlin, M.D.

SUMMARY:
The design and implementation of an integrated psychotherapeutic program for adolescent inpatients is described. Mentalization-Based Treatment (MBT) provides a coherent approach to the treatment of vulnerable adolescents who are struggling with emotional dysregulation and/or overcontrol and a lack of coherent self-structure as a result of repeated and sustained difficulties within relationships. With their impaired capacity to resolve emotional distress by relying upon available relationships, these adolescents are left with an unbearable sense of alone-ness. Mentalization Based Treatment (MBT) outlines a method for working with the adolescent to restore their capacity to feel a sense of security within relationships, and to reduce pathological avoidance and reliance on self-destructive coping strategies. Clinically relevant material and a case presentation demonstrate the use of Mentalization Based Treatment to support mentalizing and restore trust and resiliency in an adolescent with Borderline Personality Disorder.

CONTROVERSIES IN THE TREATMENT OF TRANSGENDER CHILDREN AND ADOLESCENTS

Chairs: Jack Drescher, M.D., William Byne, M.D., Ph.D.

Discussants: Lawrence Hartmann, M.D., Jack Pula, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and differentiate clinical distinctions between DSM-5 Gender Dysphoria and non-pathological cases of gender variance in children and adolescents; 2) Manage and arrange for appropriate treatments, consultations and referrals of children and adolescents with Gender Dysphoria; 3) Recall some of the controversies and unanswered clinical questions surrounding the long-term treatment of children and adolescents with Gender Dysphoria.

SUMMARY:

Objections have been raised to diagnosing children with a stigmatizing mental disorder known as "Gender Identity Disorder of Childhood" (DSM-IV) or Gender Dysphoria in Children (DSM-5). Further, expert clinicians working from a variety of perspectives are unable to differentiate between those children whose **gender dysphoria will persist into adolescence and adulthood and those in whom it will desist.** Consequently, as noted in a recent APA Task Force report, "Opinions vary widely among experts, and are influenced by theoretical orientation, as well as assumptions and beliefs (including religious) regarding the origins, meanings, and perceived fixity or malleability of gender identity." What is viewed as essential for promoting the well-being of the child, however, differs, as does the selection and prioritization of goals of treatment. In particular, opinions differ regarding the questions of whether or not minimization of gender atypical behaviors and prevention of adult transsexualism are acceptable goals of therapy.

To further explore some of these complex issues, this symposium features representatives of three different clinical approaches from Canada, the Netherlands and the United States. Presenters will use clinical material to illustrate their methods of assessment as well as their treatment approaches. The discussants will take up some of the clinical and ethical issues raised in the various treatment approaches.

NO. 1
A DEVELOPMENTAL, BIOPSYCHOSOCIAL TREATMENT MODEL FOR CHILDREN WITH GENDER DYSPHORIA
Speaker: Kenneth J. Zucker, Ph.D.

SUMMARY:
The best-practice treatment approach for children with gender dysphoria is currently "up in the air." This presentation will consider a developmental, biopsychosocial model in providing therapeutic care to children and their families. Parameters to be reviewed include biological factors, psychosocial factors, social cognition, co-occurring psychopathology, and psychodynamic mechanisms. This presentation will also consider what is known about long-term psychosexual and psychosocial differentiation under treatment conditions in which one of the therapeutic goals is to align the child's gender identity with his or her natal sex.

NO. 2
THE GENDER AFFIRMATIVE MODEL IN CHILD AND ADOLESCENT TREATMENT
Speaker: Diane Ehrensaft, Ph.D.

SUMMARY:
This presentation outlines the theory and practice of the gender affirmative model, first outlining the major underlying premises 1) gender variations are not disorders; 2) gender presentations are diverse and varied across cultures; 3) gender involves an interweaving of body, psyche, and society; 4) gender is not binary, but rather fluid, both within an individual at a particular time and as changes within an individual across time; 5) if there is pathology, it more often lies in anxieties and prejudices in the culture surrounding the child rather than within the child. The goals in this model:
to listen to the child and decipher with the help of parents or caregivers the information the child is communicating to us about both gender identity and gender expressions. Gender health is defined as a child's opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at later risk for developing a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, homelessness, incarceration, post-traumatic stress, and suicide ideation and attempts. Clinical data from four sites using this model will be presented to demonstrate the effectiveness of the model in promoting positive mental health outcomes.

NO. 3
WATCHFUL WAITING AND CAREFUL CONSIDERING ELIGIBILITY; THE DUTCH APPROACH
Speaker: Annelou de Vries, M.D., Ph.D.

SUMMARY:
The Dutch approach on clinical management of both prepubertal children under the age of 12 and adolescents starting at age 12 with gender dysphoria, starts with a thorough assessment of any vulnerable aspects of the youth's functioning or circumstances and, when necessary, appropriate intervention. In children with gender dysphoria only, the general recommendation is watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty. Gender dysphoric adolescents can be considered eligible for puberty suppression and subsequent cross-sex hormones (when they reach the age of 16 years). Currently, it seems that not medically intervening is more harmful for the adolescents' wellbeing during adolescence and in adulthood.

SUBSTANCE USE DISORDERS IN DSM-5

Chairs: Wilson M. Compton, M.D., Charles P. O'Brien, M.D., Ph.D.

Discussant: Charles P. O'Brien, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and identify new criteria for DSM-5 Substance Use Disorders; 2) Recognize and identify the rationale for changes from DSM-IV; 3) Recognize and identify the implications of the changes for clinical practice and research.

SUMMARY:
The diagnosis of substance use disorders in DSM-IV had

important strengths but also many clearly-identified weaknesses that required change. The DSM-5 Substance-Related Workgroup recommended a set of changes in the criteria for Substance Use Disorders that were designed to preserve the strengths while solving the problems of DSM-IV, based on research evidence from over 200,000 participants and feedback from many professional meetings and several hundred internet postings. In this symposium, the DSM-5 substance-related disorders will be presented. Major changes will be reviewed, including their rationale and clinical implications. One major change pertains to the structure of the disorder. In DSM-IV, two disorders were given, dependence and abuse, with abuse only diagnosed when dependence was not present. While abuse was a problematic diagnosis, dependence had many strengths. In DSM-5, this system has been replaced with one disorder that is indicated by at least two of eleven criteria (7 DSM-IV dependence, 3 DSM-IV abuse and one new criterion: craving). The diagnostic threshold was selected to maintain consistency in prevalence of substance use disorders between DSM-5 and DSM-IV. Severity indicators (mild, moderate and severe) were also included in the new DSM-5 based on the number of diagnostic criteria endorsed. Remission criteria were simplified in DSM-5 compared to DSM-IV. New criteria for withdrawal for cannabis and caffeine were introduced, and the criteria for tobacco-related disorders s were aligned fully with those for the other substances. The DSM-5 approach to substance-induced disorders should eliminate problems from DSM-IV by increasing the clarity of the guidelines for when substance-induced disorders can be diagnosed. The rationale for moving gambling disorders to the same chapter as substance disorders will be reviewed, as well as the state of the evidence for other non-substance, behavioral "addictions". While future studies are needed to continue to address some issues that remain, the recommended changes overcome many problems and are intended to reduce clinician burden given the need to consider only one main disorder rather than two.

NO. 1
COMBINING ABUSE AND DEPENDENCE INTO A SINGLE DISORDER FOR ALCOHOL, TOBACCO AND OTHER DRUG USE DISORDERS AS WELL AS SUBSTANCE INDUCED PSYCHIATRIC DISORDERS IN DSM-5
Speaker: Deborah Hasin, Ph.D.

SUMMARY:
Revisions for DSM-5 include combining abuse and dependence criteria into one Substance Use Disorder (SUD) diagnosis and defining a dimensional indicator of SUD. Multiple national and international studies, with over 200,000 participants in over 39 published studies, supported combining the abuse and dependence categories. Several other DSM-5 SUD issues were also addressed. [1] Selection of a reasonable diagnostic threshold for DSM-5 SUD. [2] Desire to shorten the criteria list led to dropping legal problems due to lack of evidence that it contributed to diagnosis. [3] Interest in craving as a biologically-based addiction indicator and evidence that craving is an important target for treatment led to the inclusion of this criterion in DSM-5. This presentation will also review the approach to substance-induced disorders in DSM-5. Basically, the CNS impact of substances of abuse, all of which change brain functioning, and some medications are important to psychiatric practice because they can produce symptoms identical to those seen in independent psychiatric disorders. However, psychiatric syndromes related to substances are likely to clear with abstinence and rarely require the same long term treatments that are needed for independent disorders. DSM-5 approaches to these conditions continue the same basic approach as in DSM-IV but with a greater emphasis on full blown, clinically relevant syndromes that meet, or come close to meeting, the independent disorder.

NO. 2
CANNABIS AND CAFFEINE-RELATED DISORDERS IN DSM-5
Speaker: Alan Budney, Ph.D.

SUMMARY:
In DSM-IV, neither Cannabis nor Caffeine withdrawal syndromes were recognized as diagnoses. Yet, since the time of publication of DSM-IV, important research has documented the validity, reliability and clinical importance of both of these conditions. Based on multiple epidemiological and laboratory based studies with clinical and general population samples, both Cannabis Withdrawal and Caffeine Withdrawal have been added to DSM-5. This presentation will review the research that inspired this addition to the diagnostic nomenclature and will review the content of both of these diagnoses in DSM-5. In addition, Caffeine Use Disorder is included in DSM-5 as a disorder in need of further research to assess it's validity and clinical significance. The presentation will also review the research on Caffeine Use Disorder and discuss the reasons for including it as a condition in need of further study.

NO. 3
GAMBLING DISORDER AND OTHER BEHAVIORAL ADDICTIONS IN DSM-5
Speaker: Wilson M. Compton, M.D.

SUMMARY:
The DSM-5 includes gambling disorder in the same chapter as the substance-related disorders. The justification for this location in the manual is based on overlapping diagnostic criteria, neural substrates, biomarkers, and temperamental and environmental risk factors. Changes to the DSM-IV category of Pathological Gambling include a change in the diagnostic nomenclature to Gambling Disorder in DSM-5. In addition, the criterion related to committing illegal acts was eliminated and the threshold for diagnosis was reduced to 4 of 9 criteria (instead of 5 of 9 in DSM-IV). These changes are based on literature reviews showing that illegal acts are rarely endorsed in the absence of multiple criteria, and a reduction in threshold improves diagnostic accuracy. Other potential disorders were also considered and will be dis-

cussed: excessive internet gaming, shopping, eating, and sex. In particular, Internet Gaming Disorder has been added to the DSM-5 under the section for disorders in need of further research and will be reviewed.

MILITARY CULTURAL COMPETENCE: HOW IT IMPACTS CARE, MEDICAL STUDENT EDUCATION, RESIDENCY TRAINING, AND RESEARCH, AND WHAT YOU CAN DO ABOUT IT

Chair: Eric G. Meyer II, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants should be able to appreciate pertinent impacts military culture has on care, medical education and research ; 2) Recognize the barriers between military patients and the health care system; 3) Identify the resources available to improve military cultural competence.

SUMMARY:
Ten percent of the current US population has served in the military, and 45 million Americans are directly related to a service member. At the same time, only 33% of veterans receive their care from the VA, the military medical system is decreasing through recurrent base re-alignment efforts and an increasing number of deployed military members are National Guard Members who return home to providers who may not know they have served in the military. Despite meeting most accepted definitions of a culture, military culture rarely receives the same consideration that other cultures do when it comes to culturally competent health care delivery. Military members, especially sensitive to whether their military service is understood and appreciated, report difficulty trusting and participating in behavioral health care efforts. Similarly, many providers, military and civilian alike, feel frustrated by the paucity of tools designed to help them understand the cultural impact the military has on their patients. This colloquium will explore the historical context of military culture and it's relationship to behavioral health care, the impact that military culture has on medical student education and psychiatric graduate medical education, along with the influences that military culture currently has on behavioral health care delivery for Veterans. As a capstone to this exploration, the colloquium will also provide a first look at a new, state of the art curriculum on military culture designed through a partnership between the Department of Defense and the Veterans' Administration that is available online to all behavioral health providers.

NO. 1
MILITARY CULTURE & PSYCHIATRY: A HISTORIAN REFLECTS
Speaker: Dale C. Smith, Ph.D.

SUMMARY:
The modern military culture has identified certain functional character traits as essential components of professionalism. Contrary character traits are therefore evidence of professional failure. To be the basis of professional culture the traits (and so their contraries) must but within the voluntary control of the practitioner. Modern chronic disease epidemiology focuses on risk factors, many of these risk factors, e.g. smoking, obesity, alcohol use, have a history as character flaws. While literature and the writings of participants confirm that what we might term psychiatric sequelae have accompanied war at various points in human history, from the nineteenth until the later third of the twentieth century psychiatric explanation of sequelae to trauma was essentially functional, again related in a Calvinistic western society to character. These three traditions limited the general acceptance of psychiatric explanation of posttraumatic symptoms as disease. The successes of neuropsychiatric pharmacy improved acceptance of psychiatric disease, and combined with advances in imaging, has inspired a new seriousness about research on psychiatric casualties. Yet, popular re-interpretation of neuropsychiatric casualties as mTBI suggests some stigma remains. The heritage of eugenics suggests genomics may not provide easy answers. Attention to the complex cultural context will be essential for continued progress.

NO. 2
MILITARY CULTURE AND MEDICAL STUDENT PSYCHIATRIC EDUCATION
Speaker: Patcho N. Santiago, M.D., M.P.H.

SUMMARY:
Medical students interested in treating military patients and with a desire for immersion in military culture often attend the only military medical school in the United States – the Uniformed Services University of the Health Sciences. While at this institution, medical students learn the values of not only the medical profession, but those of their parent services. Shared values such as community change the dynamic of the medical student ethos and enable future medical providers are better able to appreciate the community that they will be serving. Similarly, military medical students are exposed to the stressors of military life, and better able to appreciate how normalizing versus pathologizing certain responses can promote resilience.

NO. 3
MILITARY CULTURE AND PSYCHIATRIC RESEARCH
Speaker: David M. Benedek, M.D.

SUMMARY:
Military culture impacts the core values and practices of every military member. Military traditions and practices reflect these values at the individual, unit, and leadership/policy levels. Concern for how research may impact military values and priorities, such as fitness for duty, and stigma associated with mental health can impact a service members desire to participate in research. Knowledge of military values may be used to promote clinical research in active duty military and veteran populations as it reduces challenges resulting from the "clash of cultures" that may occur

at the interface between civilian and military investigators and institutions. Mechanisms for incorporating military cultural knowledge and overcoming cross-cultural research challenges will also be highlighted.

NO. 4
MILITARY CULTURE AND PSYCHIATRY GRADUATE MEDICAL EDUCATION
Speaker: Derrick Hamaoka, M.D.

SUMMARY:
Military psychiatry residency can be thought of as a multi-year cultural competency immersion experience. In addition to the core competencies of the discipline, residents are expected to develop the knowledge base, skills, and attitudes necessary in order to assess and treat service members and their families. Residents are provided a variety of clinical venues, mentors, and didactics throughout their education. These provide the basis for balancing the often times complex roles of the military psychiatrist, providing care while keeping in mind the service member's ability to satisfactorily perform duties. The University of Texas Health Science Center San Antonio (UTHSCSA) residency program is unique program; it not only provides this experience to its United States Air Forces residents but also provides these experiences to the program's civilian residents. Discussing the program's education model, experiences, and strengths/areas of improvement is the primary aim of this part of the presentation.

NO. 5
MILITARY CULTURE AND THE PSYCHIATRIC TREATMENT OF VETERANS
Speaker: Julianne Flynn, M.D.

SUMMARY:
The influence of military culture, to include use of chain of command, order and discipline, and exposure to the combat role and combat continues to impact veterans as they receive health care after military service or if guard or reservist, once off active duty. This part of the symposium will provide a brief historical perspective on the provision of mental health care for military veterans, followed by a discussion of the current state, to include focused efforts to improve provision of care and staff expertise, and efforts toward education and de-stigmatization in such areas as military sexual trauma (MST). We will also discuss current challenges facing mental health providers caring for veterans and how these are being addressed.

NO. 6
IMPROVING MILITARY CULTURAL COMPETENCE FOR HEALTHCARE PROVIDERS: EFFECTIVENESS AND AVAILABLE RESOURCES.
Speaker: William L. Brim, Psy.D.

SUMMARY:
The Department of Defense (DoD) and the Department of Veterans Affairs (VA) have placed an emphasis on training healthcare providers in military culture and are working on integrated training efforts. A major component of this effort is headed by the DoD's Center for Deployment Psychology (CDP). It is posited that these efforts will improve the quality of care received by service members and veterans and may contribute to a reduction in the stigma associated with seeking behavioral healthcare specifically. The data from over six years of military culture courses by the CDP will be reviewed. The results of over 150 hours of video interviews of providers, service members, veterans and family members about military culture and health care will be introduced. An outline of the important components of military culture training revealed by the interviews and feedback from previous courses will be discussed. Finally, the resources currently available and being developed for training in Military Cultural Competence will be discussed.

HYPERSEXUAL BEHAVIORS: DIAGNOSTIC, CATEGORICAL, GENDER, ORIENTATION, PSYCHOPATHOLOGICAL, AND TREATMENT CONSIDERATIONS

Chairs: Marc N. Potenza, M.D., Ph.D., Galit Erez, M.D.

Discussant: Rory C. Reid, M.S.W., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify different types of problematic sexual behavior and assess them in their patients; 2) Comprehend problematic sexual behaviors as encountered by women and men and understand gender-related differences in the associations between problematic sexual behaviors and psychopathology; 3) Understand the importance of sexual impulsivity, pornography craving and hypersexuality, demonstrate the ability to assess the constructs, and recognize their relevance to psychiatric conditions; 4) Understand current approaches for pharmacological and psychotherapeutic treatments of excessive sexual behaviors; 5) Grasp the importance of screening for problematic sexual behaviors among their patients and of psychoeducational approaches aimed to reduce risky sexual behaviors.

SUMMARY:
Excessive engagement in sexual behaviors has been described as hypersexuality, hypersexual disorder, compulsive sexual behavior, sexual addiction, amongst other terms. Emerging data suggest that these behaviors are associated with multiple psychiatric concerns and carry significant public health costs. The proposed symposium will address a current understanding of hypersexual behaviors with a particular focus on how one might assess and treat individuals exhibiting impulsive, compulsive or addictive sexual behaviors. Dr. Erez will present on the relationships between sexual impulsivity and Axis-I and Axis-II disorders in a large community sample of US individuals, with data indicating stronger links between sexual impulsivity and psychopathology in women as compared with men. Dr. Levounis will pres-

ent on the relationships between hypersexuality and drug use (e.g., stimulants and "bath salts") in gay and bisexual men, with a focus on diagnosis and treatment of men with addictions. Dr. Kraus will present data on the psychometric properties of a scale assessing pornography craving and pornography addiction, and will describe the psychiatric and clinical correlates of these constructs. Dr. Kafka will present data on the psychiatric comorbidities in men with paraphilia-related disorders and provide recommendations on the pharmacological treatments for these men. Dr. Krueger will discuss current conceptualizations of hypersexuality in the contexts of DSM-5 and ICD-11, given his participation in APA and WHO committees involved in these processes. He will also discuss current pharmacological treatments for hypersexuality with androgen reduction therapy, antidepressant treatment and other approaches. Dr. Rory Reid, a clinician and investigator leading the DSM-5 field trial for hypersexual disorder, will place the discussed findings within a current framework, specifically considering the assessment of clinically relevant constructs to identify people with hypersexual disorder and the best approaches for treating such individuals. Together, the presentations and discussion will provide participants with state-of-the-art information on the assessment, clinical correlates and treatment of hypersexuality within a psychiatric setting.

NO. 1
GENDER-RELATED DIFFERENCES IN THE ASSOCIATIONS BETWEEN SEXUAL IMPULSIVITY AND PSYCHIATRIC DISORDERS
Speaker: Galit Erez, M.D.

SUMMARY:
Sexual impulsivity (SI) has been associated with conditions that have substantial public health costs, such as sexually transmitted infections and unwanted pregnancies. However, SI has not been examined systematically with respect to its relationship to psychopathology. Results from a secondary data analysis of Wave-2 of the National Epidemiologic Survey on Alcohol and Related Conditions, a national sample of the United States population that surveyed 34,653 adults using the Alcohol Use Disorder and Associated Disabilities Interview Scheduled DSM-IV version, will be presented. SI was found in 14.7% of individuals, with men more likely to report SI than women. Associations between SI and Axis-I and Axis-II disorders were found in both men and women, with stronger associations seen in women. The need for screening and interventions related to SI for individuals with psychiatric concerns and the importance of gender-oriented perspectives in targeting SI will be discussed.

NO. 2
STIMULANT USE AMONG GAY MEN OVER THE PAST 40 YEARS AND ITS RELATION TO HYPERSEXUALITY
Speaker: Petros Levounis, M.D.

SUMMARY:
The rise in stimulant use (crack cocaine, MDMA, crystal meth and recently synthetic cathinones – "bath salts") among gay and bisexual men in urban centers over the past 20 years has resulted in a greater understanding of the biological, psychological, and cultural dimensions of the problem. In this context, the co-occurrence of stimulant use and hypersexuality has been found to be significant. Concurrently, the development of specific treatments for this population of substance-abusing men has progressed and will be discussed. The most effective therapeutic approach involves culturally informed individual counseling and group psychotherapy, based on the principles of Motivational Interviewing and frequently organized around the MATRIX Model - a multi-faceted cognitive-behavioral modality that includes contingency management and addresses frequently co-occurring hypersexuality. On the other hand, pharmacotherapy appears limited to the treatment of co-occurring psychiatric disorders.

NO. 3
THE PORNOGRAPHY CRAVING QUESTIONNAIRE: PSYCHOMETRIC PROPERTIES
Speaker: Shane W. Kraus, Ph.D.

SUMMARY:
Despite the prevalence of pornography use and recent conceptualization of problematic use as an addictive disorder, no published questionnaire existed to measure craving for pornography. Three studies were conducted using male pornography users to develop and evaluate a pornography-craving questionnaire. The questionnaire demonstrated a high internal consistency reliability coefficient, good one-week test-retest reliability and predictive validity. Craving score correlations with preoccupation with pornography, sexual history, compulsive internet use and sensation-seeking provide support for convergent validity, criterion validity and discriminant validity, respectively. Frequent users of pornography reported higher craving scores than less frequent users. The questionnaire could be applied in clinical and research settings to plan and evaluate treatment needs and to assess the prevalence of craving among problematic users of pornography.

NO. 4
DSM-IV-TR AXIS-I PSYCHIATRIC COMORBIDITIES ASSOCIATED WITH HYPERSEXUAL DISORDER: NEW DATA
Speaker: Martin Kafka, M.D.

SUMMARY:
Axis-I psychiatric comorbidity has been previously reported to be highly prevalent amongst men with hypersexual disorder and its congeners (e.g, sexual addiction/compulsivity, paraphilia-related disorders). Most notably, mood disorders, psychoactive substance abuse and ADHD have been noted as prevalent amongst such men. Dr. Kafka will present and discuss new data gathered primarily by administrating the multi-axial international neuropsychiatric interview (MINI-PLUS V.6) to over 100 men with paraphilia-related disorders in a clinical practice setting. Implications for a careful psychi-

atric assessment and consideration for pharmacotherapy to augment psychotherapies for the treatment of hypersexual disorders will be discussed.

NO. 5
PROPOSED DIAGNOSTIC CRITERIA AND BIOLOGICAL THERAPIES FOR COMPULSIVE SEXUAL BEHAVIOR DISORDER: DSM-5 AND ICD-11 CONSIDERATIONS
Speaker: Richard B. Krueger, M.D.

SUMMARY:
Dr. Krueger will present the current conceptualization of (e.g., addiction versus impulse-control disorder) and proposed diagnostic criteria for compulsive sexual behavior disorder as discussed during DSM-5 deliberations and currently being considered for the International Classification of Diseases (ICD). Dr. Krueger will discuss ongoing WHO committee findings relating to sexual disorders (paraphilic and non-paraphilic disorders) in the ICD-11 process. Dr. Kruger will also present a review of the evidence underlying the efficacy and tolerability of biological therapies for hypersexual or compulsive sexual behavior disorder, including relevant animal literature, clinical studies and standards of care. Androgen reduction therapy, serotonin-specific re-uptake inhibitors, and other agents and modalities will be discussed.

PSYCHOPHARMACOLOGICAL TREATMENT OF DEPRESSION AND ANXIETY: AN AMERICAN JOURNAL OF PSYCHIATRY SYMPOSIUM

Chair: Robert Freedman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know about current problems in the treatment of bipolar depression, unipolar depression, and anxiety disorders; 2) Be informed of new research evidence relevant for pharmacological treatments in these conditions; 3) Understand the limitation of the evidence for current pharmacological interventions.

SUMMARY:
Depression, both bipolar and unipolar, and anxiety disorders are unexpectedly among the most difficult-to-treat disorders that psychiatrists encounter. Although these disorders respond well to psychopharmacological and psychotherapeutic treatments in many patients, many other patients have symptoms that are not fully responsive. Robert Freedman, M.D., Editor of the American Journal of Psychiatry has selected four recently published papers that address pharmacological treatment of these illnesses; their senior authors will present their findings. Sanjay J. Mathew, M.D. recently completed a double-blind trial comparing ketamine and midazolam as single-dose intravenous interventions for carefully selected patients with acute depression. Eduard Vieta, M.D., Ph.D. led an international consortium that reviewed evidence supporting acute and chronic treatment of patients with bipolar depression with antidepressants. Kara Zivin, Ph.D., examined high-dose citralopram for cardiovascular safety in patients of the VA Healthcare System. Mark H. Pollack, M.D., performed double-blind comparisons of antidepressants and anxiolytics and their combination for patients with anxiety disorders who did not respond to initial antidepressant treatment. Each author will summarize his or her study, discuss the implications for current clinical practice, and answer questions from audience members.

NO. 1
AN UPDATE FROM THE INTERNATIONAL SOCIETY FOR BIPOLAR DISORDERS (ISBD) TASK FORCE RECOMMENDATIONS ON THE USE OF ANTIDEPRESSANTS IN BIPOLAR DISORDERS
Speaker: Eduard Vieta, M.D., Ph.D.

SUMMARY:
The International Society for Bipolar Disorders (ISBD) convened a task force to seek consensus recommendations on the use of antidepressants in bipolar disorders. An expert task force iteratively developed consensus through serial consensus based revisions using the Delphi method. Integrating the evidence and the experience of the task force members, a consensus was reached on 12 statements on the use of antidepressants in bipolar disorder. Because of limited data, the task force could not make broad statements endorsing antidepressant use but acknowledged that individual bipolar patients may benefit from antidepressants. Most recommendations focused on situations where antidepressant use should be avoided.

NO. 2
ANTIDEPRESSANT EFFICACY OF KETAMINE IN TREATMENT-RESISTANT MAJOR DEPRESSION: A TWO-SITE, RANDOMIZED CONTROLLED TRIAL
Speaker: Sanjay J. Mathew, M.D.

SUMMARY:
The glutamate N-methyl-D-aspartate (NMDA) receptor antagonist ketamine has shown rapid antidepressant effects, but small sample sizes and inadequate control conditions in prior studies have precluded a definitive conclusion. We conducted a two-site, parallel-arm, randomized controlled trial of a single infusion of ketamine compared to an active placebo control condition (e.g. the anesthetic midazolam). Patients with treatment-resistant major depression experiencing a major depressive episode were randomized under double-blind conditions to receive a single intravenous infusion of ketamine or midazolam in a 2:1 ratio (n=73). The ketamine group had greater improvement in the MADRS score at the primary study outcome (24 hours post-treatment) compared to the midazolam group ($P<0.0014$). After adjusting for baseline scores and site, ketamine was superior to midazolam in improving the MADRS score by 7.95 points (95% confidence interval [CI], 3.20 to 12.71). Treatment with ketamine increased the likelihood of response at 24 hours compared to midazolam (odds ratio, 2.18, 95% CI, 1.21 to 4.14; $P<0.006$; response rate 64% vs. 28%). Ketamine demonstrated rapid antidepressant effects in an

optimized study design, further supporting NMDA receptor modulation as a novel mechanism for accelerated improvement in severe and chronic forms of depression.

NO. 3
IS THE FDA WARNING AGAINST PRESCRIBING CITALOPRAM AT DOSES EXCEEDING 40MG WARRANTED
Speaker: Kara Zivin, M.A., M.S., Ph.D.

SUMMARY:
A recent FDA warning cautioned that citalopram doses >40mg may cause abnormal heart rhythms including Torsades de Pointes. We assessed relationships between citalopram use and ventricular arrhythmias and mortality. We conducted a cohort study using Veterans Health Administration (VHA) data from 2004-2009 from depressed patients prescribed citalopram (N=618,450), or a comparison medication with no FDA warning, sertraline (N=365,898). We examined associations of antidepressant dosing with ventricular arrhythmia, cardiac, non-cardiac, and all-cause mortality using Cox regression models, adjusted for demographic and clinical characteristics. Citalopram daily doses >40mg were associated with decreased risks of ventricular arrhythmia (HR=0.68, 95%CI, 0.61-0.76), all-cause mortality (HR=0.94, 95% CI, 0.90-0.99), and non-cardiac mortality (HR=0.90, 95%CI, 0.86-0.96) compared with 1-20mg; no increased risks of cardiac mortality were found. Citalopram doses of 21-40mg were associated with decreased risks of ventricular arrhythmia (HR=0.80, 95%CI, 0.74-0.86), but did not have significantly different risks of any cause of mortality compared to 1-20mg. The sertraline cohort revealed similar findings. This large study found no increased risks of ventricular arrhythmia nor mortality associated with citalopram doses >40mg. Findings revealed higher doses were associated with fewer adverse outcomes. These results raise questions regarding the continued merit of the FDA warning.

NO. 4
TREATMENT OF REFRACTORY ANXIETY
Speaker: Mark H. Pollack, M.D.

SUMMARY:
Despite the availability of many evidence-based treatments for anxiety disorders, many patients remain symptomatic after initial intervention. In this presentation we will discuss the issue of treatment refractory anxiety disorders and review results from what we believe is the first randomized controlled trial to provide systematic, prospectively derived data on the relative benefits of “next-step” pharmacotherapies to improve outcome for individuals with generalized social anxiety disorder remaining symptomatic after initial treatment.

COMORBIDITY OF DEPRESSION AND DIABETES: THE CHALLENGE AND THE RESPONSE

Chairs: Sidney H. Kennedy, M.D., Norman Sartorius, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be aware of the seriousness of the public health and clinical problems arising because of the co-morbidity of diabetes sand depression; 2) Recognize and competently treat depressive disorders occurring in patients with diabetes; 3) Have an interest in initiating or supporting research into the epidemiology and pathogenesis of co-morbidity of diabetes and depression.

SUMMARY:
Depressive disorders are frequently co-morbid with diabetes. The course of diabetes becomes profoundly worse in depressed patients. Depression can lead to poor self-care, affect glycaemic control and compromise quality of life in patients with diabetes. The prognosis of both diabetes and depression – in terms of severity of disease, complications, treatment resistance and mortality – as well as the costs to both the individual and society is worse for either disease when they are co-morbid than it is when they occur separately.
Depression in diabetic patients is also a risk factor for dementia, cardiovascular illness and premature death. In the case of dementia, diabetes and depression are independent risk factors for vascular and Alzheimer-type dementias, and comorbid they impart substantially more risk than either one alone. Appropriate treatment of depression and diabetes may thus be an effective way of reducing the incidence and prevalence of dementia and cardiovascular illness.
The management of comorbid depression and diabetes did not, so far, receive the attention that its public health importance requires. Psychiatrists, diabetologists, general practitioners and other health workers – as well as the health care systems in many countries – are not adequately prepared to deal with comorbidity. The current trend of super-specialization in medicine contributes to the problems of providing appropriate and timely care to people with comorbid diseases.
The diagnosis of depression in the context of diabetes and other chronic medical conditions can be challenging. Many of the symptoms of depression can overlap with a chronic disorder such as diabetes, and depression itself is associated with an increased likelihood of the patient experiencing diabetic symptoms.
The introduction to the symposium will review the public health issues related to the comorbidity of diabetes and depression. This will be followed by a review of knowledge about the pathogenesis of comorbidity and exemplified by the presentation reviewing diabetes and depression as independent risk factors of dementia and multi-morbidity. The symposium will also address the recognition, differentiation and management of diabetic distress and depression in the context of diabetes as well as the health service models that were shown to be effective in the management of comorbidity.

NO. 1

AN INTERNATIONAL INVESTIGATION INTO THE PATHWAYS OF CARE FOR PEOPLE WITH COMORBID DIABETES AND DEPRESSION

Speaker: Cathy E. Lloyd, Ph.D.

SUMMARY:

People with Type 2 diabetes are at an increased risk of depression, however little is known about the pathways to care for people with these two long-term often devastating conditions across the globe. INTERPRET-DD is a new international study which investigates the prevalence and treatment of co-morbid diabetes and depression in 19 countries in 4 continents. Adults with Type 2 diabetes (n=200 in each country) receiving care in leading diabetes care institutions are being recruited and followed up for one year, in order to establish how many of those receiving care for their diabetes have a depressive disorder which has not been recognized and for which they are not receiving treatment. Current referral and treatment arrangements for people with co-morbid diabetes and depression, as well as the correlates of depressive disorder in people with diabetes will be investigated over a one-year period. The one year incidence of depression in people with Type 2 diabetes and the potential risk factors for the onset of depression will be examined. This study also provides the opportunity to examine the relationship between the clinical diagnosis of depression and the reporting of depressive symptoms identified by two different screening tools (the PHQ-9 and the WHO-5). This presentation will report on the preliminary results of INTERPRET-DD and discuss the future plans for the study as it moves into the follow-up phase.

NO. 2

MOOD DISORDERS AND DIABETES -- BRAIN DISORDERS?

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Available evidence indicates that mood disorders are best conceptualized as brain disorders, with abnormalities in brain structure, function and connectivity noted. A separate line of evidence also indicates that diabetes is associated with significant CNS complications (e.g. mood disorders, dementia, Alzheimer's). The convergent effects on the brain provide the basis for exploring overlapping pathoetiological mechanisms. Moreover, this trans-disciplinary view provides the basis for evaluating "metabolic-based treatments" for novel molecular targets in depression. This presentation will review the pathoetiological overlap between diabetes and mood disorders with a particular emphasis on brain physiology and pathophysiology.

NO. 3

PATHOGENESIS OF COMORBIDITY OF DIABETES AND DEPRESSION

Speaker: Alan Jacobson, M.D.

SUMMARY:

Although there is a well-recognized association of depression with diabetes, the pathogenesis of this co-morbidity is not well understood. This talk examines the mechanisms affecting these disorders and their possible interrelations. Basic and clinical research suggest that psychosocial and behavioral factors influence development of depression and diabetes. Multiple biological mechanisms are also relevant for the interplay between these conditions. These include: deleterious effects of effects of hyper and hypoglycemia; altered insulin action in the brain; changes in inflammatory cytokines, and impacts on patterns of sleep. Obesity and insulin resistance can induce changes in insulin action and in cytokines that may impact on brain function, structure and chemistry, thereby increase risk for both disorders.
A better understanding of the intertwined pathways of these frequently co-morbid conditions might yield new approaches to treatment and improve outcomes.

NO. 4

TEAMCARE: AN INTERVENTION FOR DEPRESSION AND DIABETES THAT MEETS THE TRIPLE AIM OF HEALTH REFORM

Speaker: Wayne J. Katon, M.D.

SUMMARY:

Comorbid major depression occurs in up to 20% of patients with type 2 diabetes and has been shown to increase symptom burden, functional impairment and medical costs. Longitudinal studies have also shown that depression in type 2 diabetes is a risk factor for poor adherence to self care regiments (ie checking blood glucose, diet, exercise, quittting smoking), microvascular and macrovascular complications, serious hypoglycemic episodes, ICU admissions, dementia and mortality.
A new model of care that utilizes a team approach, including a medical nurse supervised by both a psychiatrist and primary care doctor, has been integrated into primary care in order to treat patients with comorbid depression and poorly controlled diabetes and or heart disease (ie HbA1c of at least 8.5%, LDL>130, or Systolic blood pressure>140). This model of care was tested in a randomized trial and was found to improve depression and medical disease control, improve quality of mental health and medical care and patient satisfaction and save medical costs. This TEAMcare model is now being disseminated to approximately 8000 patients in 8 health care organizations as part of a Center for Medicaid and Medicare Innovation grant. This model of care is also being adapted to improve medical and psychiatric care of patients with severe mental illness and comorbid medical conditions like diabetes.

BUILDING A COMMUNITY MENTAL HEALTH RESPONSE TO TRAGEDY: LESSONS FROM NEWTOWN

Chair: John Woodall, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the scope and complexity of the major personal, familial, community and institutional psychological

pressures that are released in the complex phenomena of a communal tragedy; 2) Appreciate the complex issues involved in prioritizing the key clinical and administrative tasks required to mount a sustainable community response to a communal tragedy; 3) Contrast the distinguishing features between a traditional mental health community trauma response and a resilience-building response to crisis.

SUMMARY:
A tragedy like that which occurred in Newtown, CT poses extreme challenges to an already burdened mental health system. Identifying the key psychological needs and coordinating a meaningful response through the immediate crisis, the stabilization phase and long term are daunting tasks in the extreme. This symposium looks at the challenging psychological issues involved in personal, familial and community grief and trauma, as well as the complex issues involved in coordinating helpers with different theoretical assumptions and training and from various individual, local, state, federal and not-for-profit initiatives. Achieving mental health goals through non-clinical means by mobilizing established community resources becomes an important part of a sustainable resilient response over time. Lessons learned from Newtown will be shared by clinicians most directly involved with providing services to the community since the tragic shooting.

NO. 1
CHAIRMAN, DEPARTMENT OF PSYCHIATRY, DANBURY HOSPITAL
Speaker: Charles Herrick, M.D.

SUMMARY:
Coordinating an immediate and long term response is fraught with many obstacles from an organizational standpoint. Sandy Hook prompted a response simultaneously from multiple local, state and national agencies making coordination of services challenging. These agencies included not only mental health agencies but also local and state private providers, organizations such as the Connecticut Psychiatric Society, the APA, and other professional organizations, as well as national mental health experts from major academic and federal institutions such as Harvard, Yale, the FBI and Homeland Security. Additionally, providing immediate psychological first aid required the location of an adequate venue, as well as the linking up with city and school district officials. Finally, building capacity to meet the longterm community needs is an ongoing task. Coordinating these agencies into an organized and coherent structure was the primary goal and community hospitals are in the best position from the standpoint of their central location, ED services and access to communications and linkage with local and State providers.

NO. 2
ACHIEVING MENTAL HEALTH GOALS THROUGH NON-CLINICAL MEANS: BUILDING A COMMUNITY-WIDE RESILIENT RESPONSE TO THE NEWTOWN TRAGEDY
Speaker: John Woodall, M.D.

SUMMARY:
The mental health model and the system that supports it are neither theoretically nor institutionally suited to deal with the aftermath of severe and widespread community trauma. While proper training, referral to and coordination of mental health resources are essential parts of a response to a communal tragedy, they are nowhere near sufficient meet the flood of human needs after a severe communal crisis given the paucity of resources and slowness of the system in dealing with even current loads. To meet this wide-spread need, a different model of approach is needed to augment and complment the essential clinical interventions. To achieve mental health goals a resiliency theoretical approach focuses on reducing risk and strengthening personal, familial and community assets instead of a symptom reduction model. Innovative examples of how this is being approached in Newtown will be shared to inform future tragic situations.

NO. 3
THE CLINICAL COMMUNITY'S IMMEDIATE RESPONSE TO THE NEWTOWN TRAGEDY
Speaker: Irvin Jennings, M.Med.

SUMMARY:
In the hours following the morning of December 14, 2012, clinicians in all parts of Connecticut as well as from states near and far sought a way to help. Three local mental health agencies were able with the cooperation of the Newtown school administration to establish a walk-in clinic for any person needing counseling in a local, easily accessible location by early Friday evening. Less than 24 hours after the shooting, scores of clinicians arrived at the Reed Intermediate School to help large numbers of Newtown citizens seeing help. This is to share the experiences of all those impacted by this effort over the following four months.

NO. 4
CREATING A SCHOOL-BASED RECOVERY PROGRAM AFTER CATASTROPHIC VIOLENCE
Speaker: Melissa Brymer, Ph.D., Psy.D.

SUMMARY:
This presentation will highlight the steps taken in Newtown public schools to create a long-term school-based recovery program after the catastrophic shooting in December 12, 2012. Dr. Brymer will discuss the initial assessment that informed the key elements of the recovery program including: establishing a district-wide program to address the overall impact on this small community; identifying developmentally-appropriate trauma and grief evidence-based interventions and services; creating structures to handle the outpouring of assistance from outside individuals and families; and coordinating with community, state, and federal partners. She will mention the key accomplishments of the program, highlight the role social media played in the

recovery, and how they addressed the numerous secondary adversities that impacted this community. Finally, lessons learned will be noted with an emphasis on what psychiatrists need to consider when working in communities after mass violence.

NO. 5
RESPONDING TO NEWTOWN: CHALLENGES TO PROVIDING EVIDENCE-BASED EARLY INTERVENTION AND LONGER TERM TRAUMA CARE
Speaker: Steven Marans, M.S.W., Ph.D.

SUMMARY:
In the wake of the tragedy in Newtown, there was an outpouring of support from local, regional and national mental health providers. However, too few of these providers had experience or training in evidence-based trauma-focused treatment and too few were to remain available to the community over the long haul. The response of the Yale Trauma and Recovery Program was to provide support, consultation and training to local mental health and primary health care providers as well as direct clinical care and engagement in the Sandy Hook elementary school. This presentation will review those activities and review principles that informed Yale Trauma and Recovery Program efforts to enhance local capacity and to help develop continuity of care at the local level from acute to peri-traumatic to long-term phases of post-event reactions.

THE MEANING OF DESPAIR: EXISTENTIAL AND SPIRITUAL DIMENSIONS OF DEPRESSION AND ITS TREATMENT

Chair: John R. Peteet, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the existential and spiritual dimensions of depression ; 2) Understand the role of belief in God as a factor in the treatment outcome of depression; 3) Appreciate the relationship between religious coping and mood in late life; 4) Formulate strategies for treating depressed patients who are influenced by religious thinking.

SUMMARY:
Depression often has an existential and spiritual dimension, and many studies have found an inverse correlation between religious/spiritual involvement and depression. Yet the implications of these findings for clinicians have remained unclear. Presenters in this symposium will explore the evidence for belief in god as a factor in the recovery of depressed patients (dr. Rosmarin); the relationship between religious coping and mood in late life (dr. Braam); existential aspects of depression (dr.Glas); a conceptual framework for spiritually integrated treatment of depression (dr. Peteet); and depression and religious thinking from a Muslim perspective (dr. Sarhan). Discussion will focus on challenges and opportunities in treating patients suffering from emotional, spiritual and/or existential distress.

NO. 1
BELIEF IN GOD AND CHANGES IN DEPRESSION OVER THE COURSE OF ACUTE PSYCHIATRIC TREATMENT: MECHANISMS OF EFFECT
Speaker: David H. Rosmarin, Ph.D.

SUMMARY:
We examined relationships between belief in God and treatment outcomes, and identified mediating mechanisms of effect in a prospective study with 159 patients from McLean Hospital. Belief in God was significantly higher among treatment responders than non-responders $F(1,114) = 4.81$, $p < .05$. Higher levels of belief were also associated with reductions in depression ($r. = 21$, $p<.05$) and self-harm ($r. = 24$, $p<.01$), and improvements in psychological well-being ($r.=19$, $p<.05$) over the course of treatment. Treatment credibility/expectancy, but not other factors, mediated relationships between belief in God and reductions in depression. Religious affiliation was also associated with treatment credibility/expectancy but not treatment outcomes. In sum, belief in God, but not religious affiliation, was associated with better treatment outcomes. With respect to depression, this relationship was mediated by belief in the credibility of treatment and expectations for treatment gains.

NO. 2
ABANDONMENT OR FOXHOLE: DEPRESSION AND FEELINGS ABOUT GOD AND RELIGIOUS COPING IN STUDIES OF OLDER DUTCH CITIZENS
Speaker: Arjan W. Braam, M.D.

SUMMARY:
Empirical studies consistently show a relationship between negative feelings toward God and negative religious coping and depression. In melancholia, the feeling of being abandoned by God has been described in phenomenological studies and textbooks, and may even be considered a symptom of depression. In the current population based study, religious coping, feelings toward God and other aspects of religiousness and personality traits (FFM) are examined in older adults in the Netherlands (N=343), with several types of trajectories of depressive symptoms over 12 years. To a certain degree, positive religious coping co-occurs with negative feelings toward God, and the same pertains to prayer and considering God as a supportive. Therefore, negative religious feelings may not always exclude or oppose the motivation to derive support from religion.

NO. 3
DEPRESSION AND THE SELF: INTEGRATING EXISTENTIAL ISSUES IN THE TREATMENT OF DEPRESSED PATIENTS
Speaker: Gerrit Glas, M.D., Ph.D.

SUMMARY:
This presentation develops a conceptual model which shows why it is legitimate and necessary to pay attention to existential issues in the treatment of depressed patients.

The model first shows how the patients relates to herself in depression. It then highlights how the depressive condition itself affects the way the patient relates to her depression. The example is demoralization, which itself is a symptom of depression and at the same affects the way people relate to their illness. Finally attention will be paid to the role of the self, or: one's personhood, in the relationship to one's depression. The self is shaped by core values. Depression threatens these core values. Helping the patient to keep in touch with these core values is an important element in the treatment of depressed patients. All philosophical arguments in the paper will be explained by clinical material and case vignettes.

NO. 4
DEPRESSION AND THE SOUL: AN APPROACH TO SPIRITUALLY INTEGRATED TREATMENT
Speaker: John R. Peteet, M.D.

SUMMARY:
This presentation suggests a framework for approaching the spiritual dimension of the depression. Integrated treatment rests on a unified view of human experience (having emotional, existential, and spiritual dimensions); spirituality seen as a response to existential concerns (in domains such as identity, hope, meaning/purpose, morality and autonomy in relation to authority, which are frequently distorted and amplified in depression); a rationale for locating spiritually oriented approaches within a clinician's assessment, formulation and treatment plan; and clear recognition of the challenges, and potential pitfalls of comprehensive treatment in patients from a particular spiritual tradition, or from none.

NO. 5
DEPRESSION AND RELIGIOUS THINKING FROM A MUSLIM PERSPECTIVE
Speaker: Walid Sarhan, M.D.

SUMMARY:
Islam is not just a religion but a way of life; its rules and regulations govern both daily living and matters of mental health. All Muslims are influenced by the teachings of Islam, even if they claim they are not believers. Most Muslims are aware of Islamic teachings about how to deal with sadness and misery, but many harbor misconceptions about depression. Some believe that depression implies that their faith is lacking and others think that the Quran should be enough to treat them; accordingly they may refuse treatment. Another group feels that depression is a punishment from god or a test of their faith. Some of these accept depression as a challenge, and benefit from the positive influence of prayer, and reading the Quran. Islam's prohibition against suicide is helpful in prevention. Clinicians can help Muslim patients to better understand both problematic ways of thinking religiously about depression, and how their faith can be helpful in treatment.

VIOLENCE AND MINORITIES

Chair: Gail E. Robinson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define the nature of a hate crime; 2) Recognize the variety of different types of violence experienced by minorities; 3) Identify factors that make minorities more likely to be victims of crime; 4) Recognize the discrepancies between the incarceration of whites versus minorities.

SUMMARY:
Violence against minorities can present in many ways ranging from discrimination to being victims of violent hate crimes. The experience of violence may differ somewhat between various minority groups. In 2005, the average annual rates of violence per 1000 people were reported as follows: American Indians/Alaskan Natives 56.8; blacks/Afro-American 28.7; hispanic/latinos 24.3; whites 22.8; and Asian/Pacific Islanders 10.6. Blacks are about twice as likely as whites to be a victim of a crime, much of it black on black crime. In the US, 1 out of every 21 black men can expect to be murdered, a death rate double that of American servicemen in WWII. Minority groups may also be more vulnerable to other types of crime such as human trafficking. Rates of incarceration also vary widely. Although blacks make up only 12 % of the general population, they are 40% of the prison population. Similarly Hispanics (15% of the general population) make up 20% of prisoners. American Indians and Alaskan Natives were jailed, paroled, or on probation at 932 per 100,000, 25% higher than for non-Indians/Natives. In 2011, the FBI reported 1,572 hate crime victims targeted based on a sexual orientation bias, making up 20.4% of the total hate crimes for that year. The National Coalition of Antiviolence Projects reported 2016 incidents of ant-LGBT violence in 2012 including 25 homicides. LGBT people of color were 1.82 times as likely to experience physical violence. This symposium will explore some of these issues to help broaden understanding of why these discrepancies occur.

NO. 1
PSYCHIATRIC PERSPECTIVE ON "BLACK-ON-BLACK" VIOLENCE
Speaker: Stephen A. McLeod-Bryant, M.D.

SUMMARY:
A brief review of the phenomenon of "black-on-black" violent crime, including recent statistics, psychological and sociological perspectives on the roots of this crime (beginning with psychiatrist Frantz Fanon's seminal study, The Wretched of the Earth. NY:Grove Press, 1963), and evidence-based interventions to reduce the phenomenon will be presented.

NO. 2
HUMAN TRAFFICKING AND VIOLENCE AGAINST WOMEN: PUBLIC HEALTH ISSUES AND THE ROLE OF HEALTH CARE PROFESSIONALS
Speaker: Ludmila De Faria, M.D.

SUMMARY:
Human trafficking is widespread and highly prevalent. It is the fastest growing form of commerce and area of organized crime in the world. It is the third largest source of revenue for organized crime, following drugs and arms sale. It is not only a global but also a domestic concern. Recent data estimates that between 50 and 80% of trafficking victims are women and girls and 50% are minors. Women and girls worldwide are already at increased risk for being victims of violence. This risk increases when they are separated from their social safety nets and are forced to live in isolation. Victims can develop an array of medical problems, including infectious disease (HIV and other STDs), reproductive health problems (unplanned pregnancies and abortions), substance abuse, and mental illness due to their adverse living conditions and physical and emotional abuse. These medical conditions contribute to poor public health in the communities where they occur. Although victims may receive medical care while under trafficker's control, health care professionals are often unaware and poorly trained to identify and care for the trafficking victims. Despite recent proliferation of media news and academic interest, there is a scarcity of professional medical literature on the subject. Educating health care professionals to identify victims will increase access to treatment and eventually contribute to address the problem from a public health perspective.

NO. 3
ANTI-LGBT VIOLENCE
Speaker: Philip Bialer, M.D.

SUMMARY:
Recently there have been disturbing reports of anti-LGBT violence in New York City including one very tragic homicide. According to the National Coalition of Anti-Violence Programs (comprised of 15 programs collecting data in 16 states) there were 2016 incidents of anti-LGBT violence in 2012. LGBT people of color were 1.82 times as likely to experience physical violence and gay men were 1.56 times as likely to require medical attention. This report also documented 25 anti-LGBT homicides in 2012. Once again, people of color were over-represented as were transgender women. Disturbingly, many victims of anti-LGBT violence also reported police misconduct and hostility when reporting incidents to the authorities. Much work still needs to be done to educate the public about anti-LGBT violence and to address the cultural and institutional attitudes that contribute to this behavior.

NO. 4
VIOLENCE FROM WITHIN
Speaker: Linda Nahulu, M.D.

SUMMARY:
It has been well documented that external violence against minorities exists. We would like to explore minority violence from a different angle. This presentation serves as an introduction to literature, individual perspectives, and innovative strategies to the scope and type of violence that occurs within our Native American population, focusing on the Native Hawaiian people. What are we learning and experiencing in our homes, in our community, and outside our community that lead to violence amongst ourselves. Violent behavior related to alcohol and drug use, sexual abuse, dating violence victimization, and intimate partner violence have been recognized previously. We must be able to identify cultural values and practices that prevent these behaviors from occurring. More importantly, we must also be able to identify and modify the cultural values and practices that appear to perpetuate the violent behaviors. In recent years, various groups, some more successful than others, have introduced pioneering, empowering strategies. These approaches have responded to the overwhelming needs of a diverse population, whose common element is their Native Hawaiian bloodline and heritage.

NO. 5
A COMPARISON OF MINORITIES AND CAUCASIAN WOMEN ON FACTORS RELATED TO LEAVING A VIOLENT RELATIONSHIP WITH INTIMATE PARTNERS
Speaker: Rahn K. Bailey, M.D.

SUMMARY:
Domestic violence (DV) is a pattern of abusive behavior in relationships that is used by one partner to gain or maintain power and control over another close partner. DV includes physical, sexual, emotional, economic, or psychological actions or threats of actions. We compared Hispanic, African American, and Caucasian women regarding the influence of socioeconomic status, family investment, and psychological abuse on leaving a violent relationship. Women who departed from the home usually did so for less than 30 days. The risk factors associated with leaving for all racial groups were assaults with weapons, psychological abuse, single status, and having fewer adults in the household. The National Violence Against Women Survey sampled 8,000 women 18 years of age and older within households in all 50 states and the District of Columbia. It concluded that violence against women is primarily intimate partner violence: 64.0% of the women who reported being raped, physically assaulted, and/or stalked were victimized by a current or former husband, cohabiting partner, boyfriend, or date. Approximately 1.3 million women are physically assaulted by an intimate partner annually in the USA. For many abused women, leaving is not a one-time event but a very lengthy process that requires careful planning. The decision to leave an abusive relationship involves a wide variety of psychological and social factors. Some of these are shared by Hispanic, African American, and Caucasian women in

EVOLUTIONARY PSYCHIATRY: CLINICAL PEARLS FROM A PARADIGM SHIFT

Chair: Drew Ramsey, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Use an evolutionary lens in order to assist psychiatric patients in a safe, evidenced based, and meaningful way; 2) Appreciate the changes in mineral intake and how that might influence behavior and psychopathology; 3) Knowledge about the interaction between the microbiome, parasites, inflammation, and mental health; 4) Psychiatrists will appreciate the clinical implications of phytochemicals, ketogenic diets, and antioxidants.

SUMMARY:
"Nothing in medicine makes sense except in the light of evolution." Dobzhansky. Our symposium will explore the biochemical and immune interface between our modern lifestyles, brain pathology, and behavior, with a goal to advance practical and low risk strategies for improving health and to influence further research in the area of evolutionary psychiatry. We begin with discussing modulation of the immune system via our co-evolved parasites, commensals, and pseudocommensal bacteria and the animal and human evidence of how it affects behavior. Then we discuss the influence of minerals on the stress response and the HPA axis. Finally we discuss the implications of historical scarcity, fat availability, and how to take advantage, clinically, of brain responses to these stimuli.

NO. 1
GUEST OR HOST: PARASITES, MICROBIOME, AND BEHAVIOR
Speaker: Emily Deans, M.D.

SUMMARY:
Humans have co-evolved with parasitic infections and the microbiome, with massive changes occurring very recently in the history of our species. Copious animal evidence and a smattering of human trials show us that eukaryotic and prokaryotic guests in our guts influence our mental health via immunomodulatory and neurotransmitter mechanisms. Practical implications will be explored.

NO. 2
IT'S ELEMENTAL: MINERALS AND THE BRAIN
Speaker: Drew Ramsey, M.D.

SUMMARY:
Zinc, Magnesium, Calcium, Chromium, Manganese, and Iron all play critical roles in neurotransmission and the stress response. Modern diets, changes in mineral availability, and modern chronic stress affect the interplay of these minerals, hormones, and resiliency. We will discuss the up to date evidence and clinical implications of this data.

NO. 3
FEAST OR FAMINE: STARVATION, SUGAR, GLUTEN, AND HORMESIS
Speaker: Georgia Ede, M.D.

SUMMARY:
Human evolutionary history included some periods of starvation along with a reliance on a wide-ranging variety of foods compared to modern industrial diets. Ketosis from starvation, phytochemicals from plants, and fructose from fruits all play an essential role in antioxidant production, neuroregeneration, and repair. We will discuss the counter-intuitive role of fats and plants and the brain both in health and in neurodegenerative states.

PSYCHIATRIC COMPLICATIONS ASSOCIATED WITH SLEEP AND FATIGUE IN THE MILITARY POPULATION

Chair: Vincent F. Capaldi II, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe current research and proposed link between sleep and post-traumatic stress disorder; 2) Explain the role of sleep disordered breathing and the exacerbation of psychiatric conditions in military personnel; 3) Understand the association between sleep and resiliency.

SUMMARY:
Emerging evidence shows that combat exposure has deleterious effects on sleep of veterans at post-deployment. Approximately one-third of all service members report complaints of sleep disturbances at three to four months post deployment, with 58.3% of veterans who suffered a head injury with loss of consciousness complaining of disturbed sleep. Some evidence suggests that sleep problems may worsen over time, as some samples of veterans from the Vietnam War have rates of sleep disturbance as high as 90% or more.
The etiology and nature of these sleep disturbances is poorly understood. Most studies of sleep disorders in veterans have focused on those suffering from post-traumatic stress disorder (PTSD), a debilitating anxiety disorder characterized by symptoms of hyperarousal, avoidance, and re-experiencing of traumatic events. Recent estimates suggest that rates of PTSD range from about 5 to 20% but may reach as high as 33 to 39% of returning combat veterans. Sleep disruption associated with nightmares and insomnia is a core feature of PTSD. But a variety of other sleep-related problems are also evident in patients with PTSD, including obstructive sleep apnea (OSA), periodic leg movement disorder (PLMD), sleep terrors, nocturnal anxiety attacks, and sleep avoidance. Some evidence suggests that the severity of sleep disturbance is a function of the severity of PTSD symptoms. During this symposium presenters will discuss the proposed associations between sleep and psychiatric comorbities experienced by returning combat veterans. Recently collected sleep-related data from in-theater will be presented by WRAIR researchers. Learners will be educated on current hypotheses regarding the role of sleep disorders and sleep fragmentation in development and perpetuation of post-traumatic stress symptoms. Presenters will also address the role of sleep in enhancing and maintaining psychological

resilience. As sleep disturbances are associated with poor psychiatric outcomes in military populations, presenters will discuss best practices in screening for and treating sleep-related illness as it presents in returning veterans.

NO. 1
SLEEP, FATIGUE, AND PSYCHOLOGICAL RESILIENCE IN MILITARY SAMPLES
Speaker: Anne Germain, Ph.D.

SUMMARY:
Sleep disturbances and fatigue are among the most prevalent complaints endorsed by military personnel who have served in the Armed Forces since 2001, and have consistently been found to increase the risk of poor psychiatric outcomes in military samples. Posttraumatic stress, depression, suicidality, and alcohol and substance misuses are more prevalent among civilian and military samples with sleep and fatigue complaints. Sleep and fatigue complaints contribute to more severe psychiatric distress, and predict poor psychiatric treatment outcomes. Thus, targeted sleep interventions may improve outcomes in military samples. The goal of this presentation is detail how behavioral sleep treatments can improve psychiatric distress and enhance resilience in military samples. The neurobiobehavioral framework behind the sleep-focused treatments will also be discussed.

NO. 2
THE EFFECTS OF CLASS START TIME CHANGES ON SLEEP, ACADEMIC PERFORMANCE, AND MOOD AT A FEDERAL MILITARY ACADEMY
Speaker: Jeff Dyche, Ph.D.

SUMMARY:
United States Air Force Academy (USAFA) Cadets are a population of late adolescents with naturally occurring partial sleep deprivation. Due to military obligations and class schedules, past research indicates that Cadets only obtain approximately 5-6 hours of sleep per night, much lower that the recommended 9 hours sleep for this age group. However, in the past several years, USAFA has delayed class start times, thereby extending sleep opportunities. Specifically, we were able to examine Cadets across class start times of 0700, 0730, and 0750. As such, we found significant changes in academic performance, clinic visits, mood, and total sleep time across all classes at USAFA. However, notwithstanding increased sleep time and better performance, data indicate that sleep tendency among Cadets is approaching pathological levels. Moreover, we will present results of sleep onset latency and REM onset as measured by Multiple Sleep Latency Tests (MSLT) after a week of natural partial deprivation (on a Friday) and after two nights of partial sleep recovery on a weekend (on a Sunday). Finally, after screening with an Epworth Sleepiness Scale, we will compare MSLT results on Cadets that report high subjective sleepiness and those that report low subjective sleepiness.

NO. 3
COMORBID INSOMNIA AND OBSTRUCTIVE SLEEP APNEA: THE MOST FREQUENT SLEEP DISORDER IN MILITARY PERSONNEL?
Speaker: Vincent Mysliwiec, M.D.

SUMMARY:
Nightmares and disruptive nocturnal behaviors (DNB) are frequently reported by combat veterans and their spouses, often associated with post-traumatic stress disorder (PTSD). There are few published polysomnographic findings to corroborate these self-reports. A 29-year-old male U.S. Army Soldier with recent combat exposure had a polysomnographic documented nightmare in early-onset REM sleep with increased movements, vocalizations, tachycardia and tachypnea. Veterans with nightmares and DNB respond to different treatments than patients with REM sleep behavior disorder. These clinical features, polysomnographic findings and treatment responses support Trauma Enactment Dream Disorder (TEDD) as a unique sleep disorder.

NO. 4
SLEEP & SUICIDALITY: SPECULATIONS ON SLEEP APNEA AND REM SLEEP EFFECTS
Speaker: Barry Krakow, M.D.

SUMMARY:
Emotional exhaustion has been described as a key precursor to suicide. Sleep disorders almost invariably produce degrees of sleep fragmentation and deprivation likely to produce a physiological exhaustion that manifests as daytime fatigue or sleepiness or both, yet it is unknown whether this sleep impairment influences suicidal behavior. Adding to this speculation are regularly occurring media reports about military personnel dying in their sleep, either from suicide, unintended drug overdoses, or unknown factors. This talk delves into a scenario in which military personnel may suffer from covert sleep apnea, which on the surface manifests as intractable insomnia that requires increasing dosages of medications. Sedating or pain medications may inadvertently aggravate sleep breathing problems as well as oxygen desaturations. In addition, sleep apnea is also a proven disruptor of Rapid Eye Movement (REM) sleep, which is a stage of sleep presumed to be critical to learning, memory, and emotional processing. Speculatively, the worsening of covert sleep apnea may be associated with untoward effects on mental health and possibly suicidal behavior by deleterious effects on breathing, oxygenation, and REM sleep.

REAL LIFE CONSEQUENCES OF MISDIAGNOSIS AND MISTREATMENT OF BORDERLINE PERSONALITY DISORDER

Chair: Valerie Porr, M.A.

Discussant: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be

able to: 1) Identify the importance of improving accuracy of diagnosis of borderline personality disorder in clinical practice; 2) Clarify differences between bipolar I and II and Borderline Personality Disorder to avoid misdiagnosis and ensure patients receive appropriate treatment ; 3) Recognize borderline personality disorder in children and adolescents so that appropriate evidence based treatment can begin earlier, before maladaptive coping behaviors develop; ; .

SUMMARY:

Borderline Personality Disorder (BPD), is characterized by a high degree of comorbidity with other psychiatric disorders and personality disorders, is routinely misdiagnosed in clinical practice and often co-occurs with axis I disorders (major depressive disorder, (MDD), bi polar disorders I and II anxiety disorders, panic disorder, social phobia, post traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), eating disorders (particularly bulimia) attention deficit hyperactivity disorder (ADHD), substance abuse and many somatoform disorders such as chronic pain disorders (fibromyalgia) and immune disorders. The comorbid disorder may often be diagnosed accurately while the BPD diagnosis is overlooked. Stigma against the BPD diagnosis, reliance on unstructured diagnostic assessments, clinical evaluation, intuition, self report questionnaires and clinical confusion between bpd, bipolar disorder, ADHD and MDD and the age of the patient (under 18) often dissuades the clinician from making the diagnosis. However, a primary diagnosis of BPD can parsimoniously explain these complex presentations while also ensuring that proper treatment is received. When an individual enters a treatment facility that treats axis I diagnoses, no standard operating procedure exists to evaluate underlying personality disorders yet 20%-25% of the consumers treated diagnositically qualify as BPD. Failing to recognize and treat BPD appropriately can have dire consequences, including difficulty effectively treating the comorbid disorders (e.g., BPD and substance abuse requires simultaneous treatment of both disorders).

Family members often seek help for emerging BPD symptoms, beginning in early childhood or adolescence, yet BPD is generally not diagnosed nor offered as a consideration. Misdiagnosis sets families off on a whirlwind, going from clinician to clinician, learning in depth about each subsequent diagnosis, coping with medication side effects and treatment failures. Patients and families are left confused, hopeless, frustrated, financially drained and frequently far worse off than when the search for diagnosis and treatment began. The diagnosis and treatment merry-go-round sometimes ends up with families coping with avoidable suicides. This symposium will present research findings on the misdiagnosis of BPD and its consequences, including inaccurate bipolar disorder diagnoses, childhood externalizing disorders as precursors, and data from the TARA National Association for Personality Disorder BPD helpline. Importantly, the presentation will include discussions from a family member and a person with BPD relating their experiences as they cycled through the mental health system, providing an up-close examination of the real life consequences of misdiagnosis and mistreatment of BPD.

NO. 1

BORDERLINE PERSONALITY DISORDER (BPD) AND ITS' RELATIONSHIP TO THE OVERDIAGNOSIS OF BIPOLAR DISORDER

Speaker: Mark Zimmerman

SUMMARY:

Borderline Personality Disorder (BPD) and Its' Relationship to the Overdiagnosis of Bipolar Disorder

NO. 2

CAUSES AND CONSEQUENCES OF MISDIAGNOSIS AND MISTREATMENT OF BORDERLINE PERSONALITY DISORDER

Speaker: Valerie Porr

SUMMARY:

Borderline Personality Disorder (BPD) has a 5.9% prevalence rate in the US general population (NIAAA, Grant et al., 2008) yet generally goes undiagnosed, misdiagnosed and mistreated. BPD is responsible for major public health problems including substance abuse, alcoholism, domestic violence, impulse control disorders leading to high incarceration and use of mental health services. Professional stigma against BPD patients, seen as patients to be "avoided", "treatment refractory," or "untreatable" and a "liability" due to increased risk of self-injurious and suicidal behavior (Magnavita et al., 2009) is a contributing factor to BPD misdiagnosis. Data from the Treatment and Research Advancements (TARA) National Association for Personality Disorder helpline and internet surveys will demonstrate how most patients take an average of 10.44 years from entry into the mental health system before actually being diagnosed with BPD and receive an average of 5 diagnoses before receiving a diagnosis of BPD. Because BPD is so often comorbid with Axis I disorders, clinicians need to use assessment instruments or structured interviews rather than relying upon clinical judgment so as to avoid misdiagnosing patients meeting criteria, especially children and adolescents. Clinical education in evidence based BPD treatments, training, and supervision and patient and family psychoeducation as an aid to improving outcome will be discussed.

NO. 3

FROM GRIEF TO ADVOCACY, A MOTHER'S JOURNEY

Speaker: Regina Piscitelli

SUMMARY:

A parent of a young woman eventually diagnosed with borderline personality disorder (BPD) will describe her family's journey through the mental health and substance abuse system. Starting in early childhood when the first signs of something awry appeared in their child, they attempted to find help only to meet with frustration, blame and misdiagnosis. Their experiences with various therapists, therapeutic

boarding schools and residential treatment facilities, rehabs, DBT treatment facilities, DBT specialists and family therapists will be discussed. The financial and emotional costs to the family of each new diagnosis and how each relapses, crisis and involvement with the law impacted all of them will be described. The family dreaded the professional stigma & blame they generally received, felt alienated, isolated, angry, demoralized, without hope and, as treatment failed, blamed their loved one for being uncooperative. Coping with BPD affected their marriage and their younger daughter. This family was empowered to help themselves and their loved one by finding TARA and, with extensive psychoeducation, developed into family education teachers and fierce advocates for improvement of earlier diagnosis, family education and effective treatment of BPD.

NO. 4
FROM GRIEF TO ADVOCACY, THE JOURNEY OF A YOUNG WOMAN WITH BPD.
Speaker: Anna Smithee

SUMMARY:
A young woman will describe the pathos of her experiences as a casualty of the mental health system wherein, over 28 years of seeking help, not one clinician correctly diagnosed her. Eventually, after much searching and suffering, she actually diagnosed herself and found her way to the diagnosis of BPD and effective, non-drug treatment of BPD at the Gunderson Residence at McLean Hospital. Over the years she received costly treatments for eating disorders, depression, bi polar disorder, and other Axis I disorders. If you receive a cancer diagnosis, typically that information is not withheld from you. The etiology, prognosis and treatment of cancer is explained to you. Sadly, within the mental health system, the misdiagnosis, omission or withholding of the diagnosis of Borderline Personality Disorder is a typical, and known phenomena. As a person who had always sought out therapy, admitted herself to residential treatments and intensive therapies, she will describe her search in hundreds of books, mining them for clues to what she was experiencing. She will describe the grief she feels over the years she has lost to misdiagnosis and inappropriate treatment, to hopelessness, frustration and disappointment and what she is doing now to advance the awareness of BPD.

NO. 5
EXPOSING BORDERLINE PERSONALITY DISORDER IN ADOLESCENTS: COMORBIDITY WITH CHILDHOOD DISORDERS AND FUNCTIONAL IMPAIRMENTS
Speaker: Stephanie Stepp, Ph.D.

SUMMARY:
Borderline personality disorder (BPD) and childhood externalizing disorders (attention deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder) share underlying behavioral and neural impairments. However, clinical convention limits the assessment of BPD in children and adolescents, and longitudinal studies of children rarely measure BPD, obfuscating developmental pathways and treatment options for at-risk children. Our aim was to examine childhood externalizing disorders as a precursor to BPD in adolescent girls, and to investigate impairments associated with their comorbidity. This study is based on 12 annual waves of longitudinal data from the Pittsburgh Girls Study, an urban sample of girls (N=2,451), ages 5-8 at wave 1. BPD was measured beginning at age 14. Externalizing disorders were measured since wave 1. Substance use and school absences were assessed during adolescence. Girls with externalizing disorders during childhood were classified with BPD during adolescence 2.26 more times than girls without externalizing disorders. Externalizing disorders and BPD were also highly comorbid during adolescence. Comorbid youth reported more substance use and school absences than youth with only one of these conditions. These findings highlight the need to assess BPD in younger populations, especially those among children with externalizing disorders. Early identification of youth with BPD may lead to improved treatment response and quality of life.

ISSUES RELATED TO COMPLICATED GRIEF

Chair: M. Katherine Shear, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand complicated grief as a stress response syndrome; 2) Demonstrate knowledge of issues related to complicated grief in suicide bereaved individuals; 3) Demonstrate knowledge of strategies and techniques for treatment of complicated grief; 4) Demonstrate knowledge of complicated grief in military families.

SUMMARY:
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, estimated to be about 7% of bereaved people, or about 10 million people in the United States, mourning is derailed, leading to development of complicated grief (CG). CG can be reliably identified, different from DSM-V mood and anxiety disorders, and is associated with substantial distress and impairment, including a high risk for suicidal ideation and behavior. People with CG need need treatment. Thus, clinicians need to be able to understand, recognize and treat complicated grief. This symposium will focus on different aspects of diagnosis and treatment of complicated grief, including evidence focused on CG as a stress response syndrome, issues involved in diagnosis and treatment of CG in suicide bereaved individuals, diagnosis of CG in military families, and an overview of current treatment for CG.

NO. 1
BEREAVEMENT EXPERIENCES IN MILITARY FAMILIES
Speaker: Stephen J. Cozza, M.D.

SUMMARY:
Since September 11, 2001, approximately 16,000 United States service members have died as a result of injuries suffered in combat, and from accidents, illnesses, suicide and homicides. Despite the large number of casualties, information is limited as to the impact of service member death on surviving family members. In order to assess grief support and treatment needs of military families, it important to understand the similarities and differences in bereavement experiences between civilians and military families.

NO. 2
COMPLICATED GRIEF AS A STRESS RESPONSE SYNDROME AND CLINICAL CORRELATES
Speaker: Naomi Simon, M.D., M.Sc.

SUMMARY:
Loss of a loved one is one of life's greatest stressors and is universal in nature. While most individuals adapt to loss over time, a subset have grief that persists in an intense, distressing and disabling form. Complicated Grief (CG) has been well described in the literature under a number of names, and there is a provisional diagnosis for this condition in DSM5 referenced within the new trauma and stressor related disorders section. While there is some overlap and comorbidity with neighboring conditions that can onset in response to stress, such as depression and posttraumatic stress disorder (PTSD), this is not different from other mood and anxiety conditions. CG also has distinct symptom profiles, associated risk for suicide, and impact on quality of life. In CG, since loss is permanent, individuals must overcome separation distress and adapt to life without their loved one. Nonetheless, CG may be conceptualized as a post-loss stress disorder. In this presentation, we will discuss core features of CG including proposals for CG as a diagnosis, data from recent and ongoing studies examining CG symptom profiles, risk factors and comorbidity, and the ways CG is similar and different from its nearest neighbors-depression and PTSD.

NO. 3
PRINCIPLES AND EVIDENCE FOR CGT
Speaker: M. Katherine Shear, M.D.

SUMMARY:
Complicated grief is a debilitating disorder that does not respond well to efficacious treatments for depression. This presentation will review principles of healthy mourning and described what we think happens when grief is complicated and mourning is derailed. Results from a series of international trials point to an approach to treatment that entails work on both loss-related and restoration-related problems and resolution of common grief complications. Evidence from our own studies and those of others will be presented.

NO. 4
SUICIDE BEREAVEMENT AND COMPLICATED GRIEF
Speaker: Sidney Zisook, M.D.

SUMMARY:
The 10th leading cause of death in the US, suicide was reported in over 38,000 individuals in 2010. For every suicide, an average of 6-8 loved ones is left behind. Suicide survivors often feel plagued by a myriad of unanswered; they are often beset with self-blame, 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, differentiating them from other mourners. These negative emotions and social problems predispose to complicated grief (CG), which, in turn, may increase the risk for suicide among the survivors. Yet, there is a paucity of empirically based treatments to offer for suicide survivors, including for those with CG. As the state of our knowledge about how, when, and with whom to intervene after a suicide is still quite primitive, we are currently trying to learn more about those important questions by including at least 40 suicide bereaved participants in an ongoing 4-site interventional study of antidepressants and/or complicated grief therapy (CGT) in bereaved individuals with CG. This presentation focuses on baseline and preliminary results of that study to answer the following questions: 1) is the grief of suicide survivors fundamentally different and more severe than of other (non-suicide) bereaved individuals? And 2) do suicide bereaved individuals with complicated grief respond to targeted treatment similarly to other (nonsuicide) bereaved individuals?

CANNABIS USE AND YOUTH: RISK ASSESSMENT AND IMPLICATIONS FOR CLINICAL PRACTICE

Chairs: Geetha Subramaniam, M.D., Marsha Lopez, M.H.S., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the landscape of youth cannabis use/misuse and attitudes over time, and discuss potential impacts on risk for use and addiction; 2) Distinguish among medicalization, decriminalization and legalization of Cannabis and become knowledgeable about its impact on youth's risk perception, access to and use of cannabis; 3) Impact of early adolescent onset of MJ use on neurocognition and its impact on the developing brain thereby justifying the need for prevention and early interventions; 4) Gain knowledge of the research evidence for these psychosocial and pharmacological interventions for cannabis use disorders, clinical guidance and strategies to address practical challenges.

SUMMARY:
According to the Monitoring the Future Survey, the increase in cannabis use among 10th and 12th graders has been sustained since 2008, with approximately 36% and 28% of 12th and 10th graders reporting past-year use in 2012. Data from Treatment Episode Data Set indicates that marijuana is the primary substance of abuse for 72% of 15 to 17 year-olds admitted to SUD treatment programs. The overall objective

of this symposium is to provide an overview of the recent updates on cannabis research and clinically relevant information potentially helpful in the management of cannabis using youth patients at psychiatric settings.
In this symposium, the speakers will cover the continuum of translational research ranging from clinical epidemiology to treatment guidance, to provide the audience a comprehensive overview of recent research findings and implications for clinical practice. Dr. Kerry Keyes will review recent trends in the U.S. adolescent marijuana use, focusing on prevalence, perceptions and attitudes, and the course of development of addiction. Dr. Sharon Levy will discuss the evolving changes in state laws on medicalization, decriminalization and legalization of cannabis, shifts in public perception and the unintended impact on children and adolescents. Dr. Krista Listahl will review the literature on the impact on cannabis use on neurocognition in the developing adolescent brain and resultant consequences in young adulthood. Dr. Kevin Gray will review the scientific literature on treatments for cannabis use disorders in youth and describe the management of cannabis abusing youth at a psychiatric practice setting. Geetha Subramaniam and Marsha Lopez will serve as moderators during the Question and Answer Session.

NO. 1
NEUROCOGNITIVE EFFECTS OF CANNABIS USE ON YOUTH: WHAT IS THE EVIDENCE?
Speaker: Krista Lisdahl, Ph.D.

SUMMARY:
Throughout the world, drug and alcohol use has a clear adolescent onset. Cannabis is the second most popular drug in teens, and use has been rising in the past decade. The initiation of drug use coincides with significant neurodevelopmental changes in both gray and white matter. Animal studies have suggested that adolescents may be particularly vulnerable to the neurotoxic effects of cannabis. In this talk, Dr. Lisdahl will provide a detailed overview of studies that examined the impact of early adolescent onset of MJ use on neurocognition, with a special emphasis on recent prospective longitudinal studies. Collectively, these data provide evidence that early exposure to cannabis impacts the developing brain and emphasize the need for prevention and early interventions aimed at delaying the onset of regular drug use.

NO. 2
CANNABIS USE AMONG YOUTH – WHAT ARE THE RISKS? WHAT ARE THE RISK FACTORS?
Speaker: Deborah Hasin, Ph.D.

SUMMARY:
Cannabis is the most commonly used illicit drug. Use often begins during youth, and heavy adolescent cannabis use is associated with numerous serious consequences. These include poorer cognitive functioning and permanently lower intelligence, lower educational and adult occupational achievement, and increased risk for later use of other drugs and drug dependence. Preventing cannabis use among youth is therefore a high public health priority. Childhood maltreatment and externalizing behavior difficulties are known risk factors. However, national increases in youth cannabis use in the past several years suggest the importance of identifying modifiable risk factors operating at a broader level. Individual- and group-level attitudes, perceptions, and laws are all potential broad-scale influences on the risk for youth cannabis use. These include the perceived social acceptability of cannabis use, and perceived riskiness of its use. In addition, the rapidly changing landscape of state laws governing the legality of marijuana use for medical and recreational purposes may also influence adolescent decisions on whether to use cannabis or not.

NO. 3
"MEDICALIZATION", DECRIMINALIZATION AND LEGALIZATION OF CANNABIS: DOES IT MATTER?
Speaker: Sharon Levy, M.D., M.P.H.

SUMMARY:
The question of whether and how legalized marijuana affects teen use rates is critically important to the public. A nationally representative household survey conducted in 2011 found that adults rated drug abuse as the number one health concern for youth, and reducing adolescent drug use remains a fixture of the federal government's Healthy People plans. Debates over marijuana policy frequently center on the concern that legalization in any form (i.e. for medical or recreational purposes) will increase adolescent use by a combination of reducing perceived harm, increasing supply or access and "marketing" of marijuana, which could affect adolescent behavior even if campaigns are targeted at adults. Legalization proponents often counter that despite a wealth of data, to date there is no convincing evidence of increased youth marijuana use rates in states that have legalized "medical marijuana". This presentation will 1) define the differences in intent between "medical marijuana", legalization for recreational use and "decriminalization", 2) review the theoretical concerns in regard to these policies and 3) review the data on adolescent marijuana use rates focusing primarily on a comparison between states that have legalized "medical use" of marijuana to those who have not, as well as the limitations to this approach.

NO. 4
TREATMENTS FOR CANNABIS USE DISORDERS IN YOUTH: A REVIEW OF THE EVIDENCE AND A "HOW-TO" GUIDE
Speaker: Kevin M. Gray, M.D.

SUMMARY:
Cannabis use disorders are prevalent in youth, and may have particularly serious implications for those with comorbid psychiatric disorders. Psychiatrists and other mental health professionals are well positioned to provide clinical care targeting cannabis use disorders, but must overcome a number of barriers (e.g., lack of training, limited time in busy practice) to make an impact. A number of individual, group,

and family-targeted psychosocial interventions have been developed to address cannabis use disorders, and recent evidence demonstrates a complementary role for pharmacotherapy. This presentation will provide an overview of the research evidence base for these interventions, followed by guidance on efficient delivery within busy clinical settings. Practical challenges (e.g., urine testing, confidentiality, time constraints) will also be addressed, and the presentation will conclude with relevant "real world" case examples to highlight critical strategies for implementing effective cannabis use disorder treatment in practice.

THE NIMH STUDIES OF THE PHARMACOTHERAPY OF PSYCHOTIC DEPRESSION II (STOP-PD II): BACKGROUND AND EARLY RESULTS FROM "THE SUSTAINING REMISSION TRIAL"

Chairs: Barnett S. Meyers, M.D., Matthew V. Rudorfer, M.D.

Discussant: J. Craig Nelson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will learn current knowledge about the phenomenology and acute treatment of unipolar psychotic depression.; 2) Learn the rationale and design for the ongoing NIMH study "Sustaining Remission of Psychotic Depression" that compares post-remission combination pharmacotherapy to antidepressant monotherapy. ; 3) Learn how the responses of psychotic depression to open treatment with an antidepressant plus an antipsychotic compares to responses to the same medications when treatment was double-blind.; 4) Learn about baseline cognitive functioning in late-life psychotic depression and the relationship between treatment response and course of cognition.; 5) Learn the rationale for studying the long-term effects of olanzapine on brain structures and functioning under placebo-controlled conditions.

SUMMARY:
Although the use of combination medications in the treatment of psychotic major depression has long been recognized as standard practice, the optimal continuation and maintenance phases of pharmacotherapy of this serious mental disorder beyond the acute stage remain ill-defined. This symposium will review studies of the phenomenology and treatment of psychotic major depression that comprise the background for the ongoing NIMH Study of the Psychopharmacology of Psychotic Depression II entitled "Sustaining Remission of Psychotic Depression". The "Sustaining Remission" study assesses the efficacy and tolerability of 36 weeks of continuation/maintenance pharmacotherapy with the olanzapine plus sertraline combination that was associated with a stable remission during acute open treatment. The continued combination treatment is compared to sertraline monotherapy using a double-blind placebo-controlled discontinuation design. Subjects are randomized by age 60 and older on a 1:1 basis to determine age effects. The trial design and rationale for design choices will be described. The characteristics and acute phase responses of STOP PD II subjects to open combination therapy will be compared to the characteristics and treatment responses of historical controls from STOP PD I who received the same medications in a placebo-controlled double-blind condition. The baseline prevalence and course of cognitive functioning in elderly participants and the relationship between improvement in cognition functioning and clinical improvement in these patients during treatment of psychotic depression will be described. The rationale and design for a supplemental NIMH project that uses the placebo-controlled continuation/maintenance study to assess the effects of olanzapine on brain structures and function will be presented. The relevance of the STOP PD studies to our understanding of psychotic depression will be discussed.

NO. 1
CHALLENGES IN THE ACUTE AND MAINTENANCE TREATMENT OF PSYCHOTIC DEPRESSION
Speaker: Anthony J. Rothschild, M.D.

SUMMARY:
Psychotic depression is associated with significant morbidity and mortality but is underdiagnosed and undertreated. In recent years, there have been several studies that have increased our knowledge regarding the optimal treatment of patients with psychotic depression. The combination of an antidepressant and antipsychotic is significantly more effective than either antidepressant monotherapy or antipsychotic monotherapy for the acute treatment of psychotic depression. Most treatment guidelines recommend either the combination of an antidepressant with an antipsychotic or ECT for the treatment of an acute episode of unipolar psychotic depression. The optimal maintenance treatment after a person responds to the antidepressant/antipsychotic combination is unclear particularly as it pertains to length of time the patient needs to take the antipsychotic medication.

NO. 2
SUSTAINING REMISSION OF PSYCHOTIC DEPRESSION: RATIONALE AND METHODOLOGY OF STOP-PD II
Speaker: Alastair Flint, M.B., M.D.

SUMMARY:
Expert guidelines recommend the combination of antidepressant and antipsychotic medications in the acute pharmacologic treatment of psychotic depression (PD). However, little is known about the continuation treatment of PD. Specifically, it is not known whether antipsychotic medication needs to be continued once an episode of PD responds to pharmacotherapy. The primary goal of STOP-PD II is to assess the risks and benefits of continuing antipsychotic medication in persons with PD once the episode of depression has responded to treatment with an antidepressant and an antipsychotic. Secondary goals are to examine age and genetic polymorphisms as predictors or moderators of treatment variability, potentially leading to more personalized treatment of PD. Individuals aged 18-85 years with uni-

polar psychotic depression receive up to 12 weeks of open-label treatment with sertraline and olanzapine. Participants who achieve remission of psychosis and remission/near-remission of depressive symptoms continue with 8 weeks of open-label treatment to ensure stability of remission. Participants with stability of remission are then randomized to 36 weeks of double-blind treatment with either sertraline and olanzapine or sertraline and placebo. Relapse is the primary outcome and metabolic changes are a secondary outcome. This presentation will provide an overview of the design and methods of STOP-PD II and discuss the rationale for key aspects of the design.

NO. 3
BASELINE CHARACTERISTICS AND ACUTE TREATMENT RESPONSE IN STOP-PD II
Speaker: Barnett S. Meyers, M.D.

SUMMARY:
Baseline characteristics and treatment responses to open olanzapine plus sertraline of the first 129 subjects enrolled in the acute phase of STOP II are reported. Data from STOP PD II subjects are compared to those of the 129 subjects who had been randomized under double-blind conditions to receive combination therapy with the same medications in STOP PD I. Factors that may have contributed to differences in clinical characteristics and treatment responses between two samples are described.

NO. 4
COGNITIVE FUNCTIONING IN PSYCHOTIC MAJOR DEPRESSION IN LATE-LIFE: THE RELATIONSHIP BETWEEN COGNITIVE FUNCTIONING AND TREATMENT RESPONSE
Speaker: Ellen M. Whyte, M.D.

SUMMARY:
Many individuals (across the lifespan) demonstrate significant cognitive impairment during an episode of major depression with psychosis (MD-psy). The expectation is that cognitive function improves with the resolution of the MD-psy. In this presentation, we will review the need to differentiate those older individuals with cognitive impairment as part of their episode of MD-psy from those with early dementia with concurrent depression and psychosis. We will review the methods being used, including the use of both an informant and of sequential testing, in the current STOP PD study to identify (and exclude) persons with likely dementia. We will present data from fifty older adults in the current study describing cognitive status upon treatment response especially among those participants with a history suggestive of cognitive decline, but not dementia, prior to study enrollment. Finally, we will present data from both STOP PD studies comparing treatment response among 192 older adults with and without evidence of cognitive impairment.

NO. 5
EFFECTS OF MAINTENANCE TREATMENT WITH ANTIPSYCHOTICS ON BRAIN STRUCTURE AND CONNECTIVITY: THE STOP-PD II PROJECT
Speaker: Benoit Mulsant, M.D., M.S.

SUMMARY:
Untreated psychosis associated with schizophrenia or mood disorders may have toxic effects on the brain and it is believed that antipsychotic treatment, particularly atypical antipsychotics, may mitigate these effects. However, recent animal and human data suggest that antipsychotics themselves may be neurotoxic and associated with substantial reductions in cortical brain volumes. Interpretation of these data is limited by lack of placebo-control. Thus, in the face of conflicting evidence, the overall impact of antipsychotics on brain structure and connectivity in humans remains undetermined. This important question has not been directly addressed in patients with schizophrenia or bipolar disorder due to methodological and ethical challenges associated with randomizing them to long-term treatment with an antipsychotic vs. placebo. In this context, the STOP-PD II offers a unique opportunity to assess the effect of maintenance treatment with olanzapine on brain structure and connectivity. This presentation will discuss the background for this study and the methods that are being used to do so.

CHANGING PERSPECTIVES ON MENTAL HEALTH TREATMENT CHALLENGES IN UNIVERSITY STUDENTS

Chairs: Doris Iarovici, M.D., Ayesha Chaudhary, M.B.B.S., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Differentiate emerging psychopathology from normal developmental distress among emerging adults in the college setting; 2) Understand the rationale for and benefits of integration and multidisciplinary collaborative care models on college campuses; 3) Describe a multidisciplinary approach to treatment of eating disorders in college students as well as the ethical and legal challenges which can complicate this work; 4) Identify a systematic approach to the prevention and treatment of prescription drug abuse on campus.

SUMMARY:
Mental health problems among college students have increased in incidence & severity in the new millennium. Students often seek psychiatric care for the first time in their lives while on campus--for anxiety, depression, substance abuse, eating disorders, and ADHD, as well as for non-illness driven developmental needs. The use of psychiatric medications among college-aged students has tripled, to 26% in 2008 from 9% in 1994(1). And rare but tragic and highly publicized episodes of violence on campuses in the United States have generated greater societal awareness and acceptance of the need for accessible psychiatric resources for students, faculty and staff. Meanwhile, the growing diversity of culture, ethnicity, faith, age, gender and socioeconomic background among the students we treat demands

extra knowledge, skill and sensitivity of those who attend to the mental health of college students. Universities must be prepared to provide expert, specialized mental health care, while communicating clearly to all stakeholders the reasonable limits of a university-based health center.
This symposium reviews the diagnostic challenges, treatment opportunities, and developmental needs that are unique to university students. It provides an overview of both clinical and administrative practices for mental health clinicians and others who provide healthcare to this population.
The first talk will review collaborative models of care within college mental health, including an overview of relevant epidemiological trends and demographics. The second talk will summarize general principles of psychiatric care for student populations, including a review of developmental stages in emerging adults and the critical role of campus culture as related to identity formation. Chronic psychiatric disorders often present for the first time in young adults; we will discuss how to differentiate psychopathology from developmental distress.
Eating disorders and disordered eating are common among college students, and the more severely ill in this spectrum can significantly outstrip university resources. The third talk will present evidence-supported assessment and treatment guidelines, exploring legal and ethical challenges faced by the multidisciplinary teams who deliver eating disorder treatment on campus.

The fourth talk will address prescription medication abuse and diversion on campus, notably among students treated for ADHD and those seeking stimulants, but also among students using other forms of medications.
The symposium will emphasize student-centered care which incorporates multidisciplinary treatment and collaboration. Attendees will take away practical systems-level procedures and evidence-based clinical guidelines. There will be time for audience participation, including
facilitated case discussions which illustrate commonly encountered clinical & ethical challenges.
(1) American College Health Assoc. NCHA 2008.

NO. 1
CHANGES IN THE PRACTICE SYSTEMS OF COLLEGE MENTAL HEALTH
Speaker: Ayesha Chaudhary, M.B.B.S., M.D.

SUMMARY:
Four-year colleges and universities are growing their levels of commitment to address student mental health needs. The trend is to increase multidisciplinary collaboration among student affairs divisions, to integrate health services and medical record systems, and improved inter-departmental communication to identify and intervene early for acutely mentally ill and high-risk students.
While smaller, private 4-year schools are at the forefront of rapidly reconfiguring mental health care systems toward integration at multidisciplinary and intra-departmental levels, some changes among larger public 4-year universities are also in progress. However, there continues to remain a service-needs gap among 2-year colleges, who have traditionally had limited campus health services.
This section focuses on the changing student demographics necessitating the redesigning of campus services. The speaker will identify key components of a multidisciplinary campus team approach and review examples of health care systems and models currently implemented on US university campuses. The attendees will be encouraged to consider integrating these systems changes into their university campus practice models.

NO. 2
PRINCIPLES OF CLINICAL CARE IN COLLEGE STUDENTS: DIFFERENTIATING PSYCHOPATHOLOGY FROM DEVELOPMENTAL CONCERNS
Speaker: Doris Iarovici, M.D.

SUMMARY:
College enrollment has accelerated in the new millennium, increasing by 26% between 1997 and 2007 compared with 14% in the preceding decade.(1) This population is also increasingly demographically diverse. Emerging adults encompass a developmental stage with unique characteristics. Campus culture, including use of technology, binge drinking, “hooking up,” and sleep deprivation, significantly influences student mental health. In 2012, depression negatively affected academic performance for 11.3% of students, and anxiety for 19.3%; almost half reported “overwhelming anxiety,” a third felt “so depressed it was difficult to function,” and nearly 7% considered suicide(2). Among veterans returning to college, suicidal thoughts are significantly higher. Many major psychiatric illnesses first present during college; the biggest diagnostic challenge is distinguishing these from developmental distress. DSM-5 describes several new symptom clusters, including attenuated psychosis syndrome and internet gaming disorder, which may be disproportionately represented in this population. This talk will focus on common problems encountered in college psychiatry, collaborative treatment approaches that best address these, and ways to maintain a developmental perspective within a culturally sensitive framework in order to be most effective in treating students.
(1)National Center for Education Statistics. “Fast Facts: Enrollment.” http://nces.ed.gov/fastfacts/display.asp?id=98,
(2)ACHA NCHA 2012

NO. 3
EATING DISORDERS ON CAMPUS
Speaker: Amy Alson, M.D.

SUMMARY:
Eating disorders commonly surface during adolescence and young adulthood; these disorders carry a 4-6% mortality rate. According to the 2012 U-SHAPE Survey of over 3,000 U.S. university students, 13% of women and 7% of men thought they needed help for issues related to eating and/or

body image. But only 15% of women and 9.6% of men who screened positive for an eating disorder had received relevant counseling or therapy. To best respond to the mental & physical health needs of these students requires a firm grasp of relevant medical, psychological, ethical and legal issues. This talk will describe assessment and out-patient treatment emphasizing a multidisciplinary team approach, clinical risk stratification and guidelines. Resources vary widely among schools, and various care models will be included. An approach to the critically ill student who refuses medical leave will be described. Appropriate interaction between doctor and college administrators will be defined, and the role for engaging parents of adult children in their child's care, with and without the student's consent will be discussed

NO. 4
PREVENTION AND TREATMENT OF PRESCRIPTION DRUG ABUSE ON THE COLLEGE CAMPUS
Speaker: Joshua Hersh, M.D.

SUMMARY:
Prescription drug overdoses by college students are increasing and are now one of the most common causes of death among college students. Common prescription drugs used by college students include prescription opiates, prescription stimulants, and prescriptions benzodiazepines. This presentation will provide statistics on the use of these drugs by college students. It will also discuss reasons why these drugs are misused. The presentation will then discuss ways to prevent prescription drug abuse such as education and the creation of treatment algorithms to manage ADHD, anxiety, insomnia, and pain. Finally, it will discuss what happens if prevention fails and how to identify and treat students that have developed a problem with prescription drugs.

PERSISTENCE AND DESISTANCE OF COMORBID DRUG ABUSE AND PSYCHIATRIC DISORDERS IN ADOLESCENCE

Chairs: Cheryl A. Boyce, Ph.D., Karen Sirocco, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the developmental course of comorbid drug and alcohol use in adolescence, including demographic factors; 2) Determine the biological, behavioral and socioenvironmental influences of substance use disorders; 3) Learn the current evidence of alcohol involvement in suicide among adolescents from national data source that may inform prevention and treatment.

SUMMARY:
While there is significant evidence that alcohol and drug abuse disorders are highly comorbid with other psychiatric disorders, the trajectories of comorbidity throughout the developmental lifespan are poorly understood. In addition, diagnostic criteria may not reflect the unique nature of adolescent drug abuse and dependence. Factors such as genetic/family history, neurocognition, biobehavioral regulatory processes and socio-environmental contribute to the etiology and persistence of drug abuse and psychiatric disorders. These common underlying factors present unique challenges to diagnosis, treatment, and successful outcomes. The purpose of this session is to review nosology and conceptual models that underlie comorbidity; and antecedent developmental, intrapersonal, and social/environmental factors that contribute to the etiology and progression of drug addiction.

NO. 1
DEVELOPMENTAL PATHWAYS FOR RISK AND PERSISTENCE OF DRUG ABUSE DISORDERS
Speaker: Kenneth J. Sher, Ph.D.

SUMMARY:
Multiple pathways are involved in the etiology and course of substance use disorders (SUDs): (1) pathways related to pharmacological vulnerability to general and specific drug effects, (2) pathways related to affect regulation, and (3) pathways related to proneness to social deviance. These pathways, although conceptually distinct, can act in concert in a given individual, and often share common risk factors. Consideration of each of these pathways is important for developing phenotypic measures of risk, measure the effect that symptomatic treatments have on underlying risk mechanisms, and identify novel targets for treatment and preventive interventions. From the multiple pathway perspective, the underlying nature of the myriad comorbidities that occur with SUDs can be conceptualized such as common vulnerabilities, unidirectional and bidirectional causation, misdiagnosis, and independent disorders.

NO. 2
DEVELOPMENTAL CONSIDERATIONS IN PATHWAYS OF RISK FOR DRUG ABUSE DISORDERS AND THEIR INTERGENERATIONAL TRANSMISSION: WHY DOES DEVELOPMENT MATTER?
Speaker: Laurie Chassin, Ph.D.

SUMMARY:
Substance use and substance use disorders show predictable age-related patterns of onset and desistance and are predictable from early childhood, suggesting the importance of considering etiology from a developmental perspective. This presentation will characterize the importance of developmental factors within each of three major biopsychosocial etiological models of substance use disorders and their intergenerational transmission. As described earlier in this symposium, these risk pathways include those related to pharmacological vulnerability to substance use effects, those related to affect regulation, and those related to social deviance proneness. Building on those models, we illustrate the importance of considering these risk pathways within a developmental framework. We emphasize the unique features of childhood, adolescence, and emerging adulthood as developmental periods of particular significance. Developmental considerations for etiological models include age-re-

lated variation in pharmacological vulnerability to substance use effects and in gene-environment interplay, the effects of early experience in constraining later adaptation, developmental changes in social context, and the developmental course of reward sensitivity and cognitive control.

NO. 3
GENERAL AND SPECIFIC MECHANISMS IN PERSISTENCE AND DESISTANCE OF DRUG MISUSE AND COMORBID PROBLEMS FROM ADOLESCENCE TO AGE 33
Speaker: Karl G. Hill, Ph.D.

SUMMARY:
Defining phenotypes (outcomes) in studies of tobacco and alcohol misuse is difficult given their strong association with each other and with other problem behaviors. This paper suggests a strategy that partitions variance in outcomes into either general comorbid or behavior-specific components. This approach is also used to model environmental influences. Data are drawn from a longitudinal study of 808 youth assessed 13 times from age 10 through age 33. Structural equation modeling is used to define general and drug-specific measures of childhood family and peer environments and individual behavioral disinhibition, and to examine their contribution to shared variance in problem behavior (comorbidity) versus specific variance in substance misuse in late adolescence and whether these continue to predict persistence in these outcomes in adulthood (age 33).

NO. 4
LINKING SUICIDE AND COMORBIDITY TO UNCOVER RISK MECHANISMS AND GUIDE PREVENTION
Speaker: Mark Kaplan, Dr.P.H.

SUMMARY:
Chronic alcohol use is widely regarded as a suicide risk factor, but acute alcohol use is also essential to consider as an important factor in suicidal behaviors. Little is known about the patterns of alcohol involvement based on alcohol consumption immediately before death. This study examined restricted data for 72,798 decedents aged 9 years and older from the 2003-10 National Violent Death Reporting System. Blood alcohol content (BAC) derived from the toxicological analysis requested by the coroner or medical examiner. Results showed that the fraction of suicide decedents with BAC > 0 g/dl declined with age and was higher among men than women across the age span. Nearly three-quarters of decedents who consumed alcohol immediately prior to their suicide were legally intoxicated (BAC ≥ .08).

CLINICAL RISK FOR PSYCHOSIS AND EARLY SERIOUS MENTAL ILLNESS

Chair: Robert Heinssen, Ph.D.

Discussant: Patrick D. McGorry, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify neurobiological factors associated with risk for progression to psychosis in those at clinical high risk; 2) Identify key cognitive deficits in persons at elevated clinical risk for psychosis; 3) Identify characteristics of a syndrome for long-term functional disability that overlaps with risk for psychosis but is substantially broader and has independent implications for early intervention; 4) Identify the optimal features of a step-wise treatment model for early stages of psychosis.

SUMMARY:
Over the past two decades, several hundred published reports have explored the construct of a clinical high risk (CHR) state for psychosis. Research conducted in Australia, Europe, and North America has established the predictive validity of risk criteria based on the presence of attenuated psychotic symptoms, transient psychotic episodes, or trait vulnerability combined with functional deterioration. Meta-analysis of transition to psychosis among approximately 2,500 individuals who met CHR criteria reported mean transition rates of 22%, 29%, and 32% at one, two, and three years respectively. Other studies find that while most CHR persons do not develop overt psychosis over an extended period, many experience ongoing problems with attenuated positive symptoms (e.g., 41% at 2 years) as well as persistent functional disability. Every year, many thousands of children and adolescents in the United States experience problems in thinking, mood, and social functioning suggestive of a clinical risk state for serious mental illness. In this symposium we present new information from the North American Prodrome Longitudinal Study concerning (1) biomarkers of risk versus progression to psychosis; (2) neurocognitive and social cognitive factors implicated in emerging psychosis; and (3) early interpersonal and academic problems that signal risk for a social deficit syndrome characterized by long-term functional disability. Evidence supporting a stepped-care approach to intervention during the CHR period will be presented, along with data on an empirically derived prediction tool that stratifies help-seeking individuals according to psychosis risk. Progress in achieving earlier detection and intervention for serious mental illness in the United States will be compared to recent advances in Australia and Europe, where Early Psychosis Prevention and Intervention Centers offer an integrated, community-based specialist care treatment program for young people who are in the early stages of serious mental illness.

NO. 1
ELUCIDATING PREDICTORS AND MECHANISMS OF ONSET OF PSYCHOSIS USING THE CLINICAL HIGH-RISK STRATEGY
Speaker: Tyrone D. Cannon, Ph.D.

SUMMARY:
Some factors that predispose to schizophrenia and related psychotic disorders are present premorbidly and remain stable, while other factors show evidence of progression in the pre-onset and early phases of illness. While some

stable markers of risk may be necessary contributors, they are unlikely to be sufficient in provoking illness expression, as they are present pre-onset and may also appear in unaffected first-degree relatives. Markers that progress during the periods immediately preceding and following onset have the potential to play mechanistic roles in the emergence of psychosis. That is, they could represent proximal, sufficient conditions for psychosis onset. This interpretation depends, however, on the unambiguous dissociation of factors reflecting the natural course of illness rather than secondary phenomena. This talk will address research strategies used to segregate biomarkers of risk for versus progression to psychosis, using neuroimaging assays of brain structure, physiology, and metabolism as primary examples and drawing upon recent evidence from genetic and clinical high-risk studies. This evidence supports that view that the emergence of psychosis is marked by a dynamic and potentially reversible process that results in a reduced structural and functional connectivity in circuits involved in cognitive control, learning and memory, emotional regulation, and auditory-verbal processing.

NO. 2
COGNITIVE FACTORS IN EMERGING PSYCHOSIS
Speaker: Larry J. Seidman, Ph.D.

SUMMARY:
Cognitive factors in emerging psychosis (i.e., neurocognition, social cognition, and self-reflective cognition) will be discussed regarding their utility for predicting psychosis onset and relevance to outcome. Neurocognitive dysfunction is a hallmark feature of schizophrenia and is evident across all phases of the illness. Two meta-analyses comparing individuals at clinical high risk (CHR) for psychosis yielded small-to-medium impairments across virtually all neurocognitive domains (Cohen's d = -0.26 to -0.67). Seven studies reported (Giuliano et al., 2012) on CHR individuals who later developed psychosis (n=175) and their baseline performance level generally yielded moderate-to-large effect sizes (d = -0.35 to -0.84). In more recent work from the North American Prodrome Longitudinal Study, neurocognitive dysfunction was associated with impaired social and role functioning. Moreover, psychomotor speed measured by digit symbol, and verbal learning measured by the HVLT, both predict conversion to psychosis independent of symptoms. Most research has been carried out on neurocognitive measures, and less is known about the impact of social cognition (e.g., theory of mind, emotional perception, etc.) and self-reflective cognition (e.g., source monitoring, aberrant salience) and these will be discussed. Finally, these data provide important support for the growing relevance of cognitive enhancement interventions for the psychosis prodrome.

NO. 3
ORIGIN AND COURSE OF FUNCTIONAL IMPAIRMENT IN EARLY SMI
Speaker: Barbara Cornblatt, M.B.A., Ph.D.

SUMMARY:
Over the past several years it has become increasingly clear that functional deficits, i.e., impaired social skills and an inability to function independently in the community, play an essential role in the development of serious mental illness. Early problems in school and peer relationships characterize youngsters considered to be at risk for psychosis often years before the positive symptoms characterizing psychosis are observable. These deficits have increasingly been tied to underlying brain abnormalities, such as reduced plasticity, and may represent a broad population at risk for long term functional disability, regardless of whether full psychosis eventually develops. Structural equation modeling, multivariate regression, and survival analyses conducted on data from clinical high risk samples identify a cluster of deficits involving early social and role-functioning, neurocognition, and negative symptoms that are inter-related during mid- to late-adolescence and that these factors contribute meaningfully to subsequent functional outcome in young adult years. It is possible that youngsters displaying this syndrome will benefit most from early non-pharmacological psychosocial treatment. Such early intervention has considerable potential to improve independent functioning in the community, and, particularly in the case of social interactions, may help to reduce to the increasing isolation associated most directly with risk for psychosis.

NO. 4
DEVELOPING A STEP-WISE TREATMENT MODEL FOR THE EARLY STAGES OF PSYCHOSIS
Speaker: Scott Woods, M.D.

SUMMARY:
Patients with the clinical high risk (CHR) syndrome for psychosis are in need of care, both to address current symptoms and incapacities and to prevent the possibility of future worsening. Optimal care for CHR patients requires a step-wise treatment model grounded upon reliable and valid methods of segmenting the CHR population on level of psychosis risk and severity of symptoms and impairments. Individualized risk prediction algorithms offer a promising approach. Segmentation should also address depression, anxiety, suicidality, and substance abuse comorbidities. Ideally, the treatment model should be populated by results from controlled clinical trials of treatments that enroll patients in specific CHR segments. Candidate treatments should target mechanisms of illness underlying the respective segment and should offer benefits and carry risks appropriate for that segment. In general, patients with lower psychosis risk and less severe symptoms/incapacities should be offered safer treatments first. The model should call for continuous reassessment of the patient's clinical state, response to previous steps of care, and need for continuing treatment in the event of persistence or progression of symptoms. Finally, evidence-based guidelines for sustaining remission and preventing relapse are required. Successful implementation in US treatment systems will require appro-

priate diagnostic billing codes for reimbursement.

REDUCING ETHNIC/RACIAL DISPARITIES ACROSS THE LIFE-CYCLE IN THE AGE OF PPACA

Chairs: Roberto Lewis-Fernandez, M.D., Margarita Alegría, Ph.D.

Discussant: Margarita Alegría, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Evaluate salient examples of potential interventions that may be implemented to reduce racial/ethnic disparities in mental health care in the age of PPACA; 2) Understand the importance of tackling racial/ethnic disparities across the lifecycle and at various stages in the care pathway, including prevention, engagement, treatment, and symptom mitigation; 3) Describe the value of cultural tailoring and attention to facilitators and barriers to implementation in the development of disparity-reduction interventions.

SUMMARY:
US racial/ethnic minorities face substantial disparities in mental health care, including in access to psychiatric services, quality of care, and treatment outcomes. General quality improvement efforts that do not specifically target the elimination of disparities have proven insufficient. In some circumstances, these general approaches may even accentuate disparities by only improving the care of easier-to-reach populations, thereby widening the gap between more and less advantaged groups. Disparity-reduction interventions are under development, but their evidence base is still limited. The implementation of the Patient Protection and Affordable Care Act (PPACA) presents an opportunity to assess the state of the art of disparity-reduction intervention research in order to determine to what extent these interventions can be incorporated into PPACA guidelines. This symposium, organized by the American Society of Hispanic Psychiatry in collaboration with the APA Office of Minority and National Affairs, will review several interventions that have been developed for racial/ethnic minority groups across the lifecycle that aim to reduce or eliminate disparities in their access to, use of, or engagement with mental health services. The overall focus of the symposium will be to critically assess the evidence base of these interventions in the age of PPACA.
The symposium first focuses on adolescents, describing the evidence base of Familias Unidas, a Hispanic-specific, parent-centered intervention that reduces externalizing and internalizing symptoms and disorders among Hispanic youth. Our focus then moves along the lifecycle to adults. The next talk characterizes the communication behaviors of psychiatrists in medication management appointments with low-income and depressed African American outpatients. The study also assesses the impact of these behaviors on appointment adherence, identifies what patients perceived as valuable in these appointments, and suggests potential psychiatrist and patient-directed intervention strategies to reduce racial disparities in mental healthcare. The third talk introduces Motivational Pharmacotherapy, a novel patient-centered approach that uses motivational interviewing strategies to decrease ambivalence about antidepressant therapy among depressed Latinos, resulting in higher treatment retention and medication adherence. The last presentation focuses on older adults from diverse racial/ethnic backgrounds. Using community-based data, the talk discusses differences in rates and slopes of cognitive decline across population groups, and develops implications based on these findings for the development of interventions to mitigate cognitive decline in the increasingly diverse US population. The discussant will frame the state of the evidence base as illustrated by these interventions in light of their possible implementation during the age of the PPACA.

NO. 1
REDUCING EXTERNALIZING AND INTERNALIZING SYMPTOMS AND DISORDERS AMONG HISPANIC YOUTH
Speaker: Guillermo Prado, M.S., Ph.D.

SUMMARY:
Preventing/reducing externalizing and internalizing symptoms and disorders among Hispanic youth is essential to eliminating health disparities and improving the overall health of this population. The objective of this presentation is to describe a program of research involving Familias Unidas, a Hispanic-specific, parent-centered intervention, found to be efficacious in reducing both externalizing and internalizing symptoms and disorders among Hispanic youth. This presentation will focus on the theoretical foundation of the intervention, the intervention model itself, and the findings of the program of research to date. Mediators and moderators of intervention efficacy will be highlighted when discussing the results of this research program. Finally, the implications of these findings to both research and clinical practice will be discussed.

NO. 2
PSYCHIATRIST COMMUNICATION BEHAVIORS WITH DEPRESSED AFRICAN AMERICANS. DOES WHAT WE SAY (AND HOW WE SAY IT) MATTER?
Speaker: Mario Cruz, M.D.

SUMMARY:
Improving depressed African American treatment adherence is a major mental health care issue. African Americans are less likely to continue in depression treatment than their white American counterparts. Most effective treatment adherence interventions have targeted patient behaviors. Another approach that has received little attention is improving the communication behaviors of psychiatrists in medication management appointments. Medication management appointments, also referred to in the extant literature as med checks or pharmacotherapy, dominate outpatient mental health care. There is concern that psy-

chiatry's limited role as pharmacotherapists in outpatient service delivery is insufficient to provide patient-centered and culturally competent care. Not providing such care could negatively impact African American appointment and treatment adherence. This presentation will report findings from a multi-method provider-patient communication research study with psychiatrists serving a predominantly low income and depressed African American patient population. The study characterized psychiatrist communication behaviors in medication management appointments, assessed the impact of psychiatrist communication behaviors on appointment adherence, and identified what patients' perceived as valuable in these appointments. The findings suggest potential psychiatrist and patient directed intervention strategies that could reduce racial disparities in mental health care.

NO. 3
IMPROVING ANTIDEPRESSANT ENGAGEMENT AMONG DEPRESSED LATINOS
Speaker: Roberto Lewis-Fernandez, M.D.

SUMMARY:
Compared to non-Latino whites, US racial/ethnic minority groups show higher non-adherence with outpatient antidepressant therapy, including lower retention, despite adjusting for sociodemographic and insurance covariates. Culturally salient concerns about antidepressants leading to ambivalence about treatment engagement may contribute to this discrepancy. To improve treatment adherence among depressed Latinos, we developed Motivational Pharmacotherapy (MPT), a novel patient-centered approach that combines Motivational Interviewing (MI), standard pharmacotherapy, and attention to Latino cultural concerns about antidepressants. MPT appears to work by increasing patient participation in medication decisions, thereby decreasing ambivalence about treatment and leading to higher adherence. This presentation will describe the aspects of MI that were incorporated into MPT, the intervention itself, and the findings of a randomized controlled trial with nearly 200 Latino outpatients with major depression that compared MPT against standard pharmacotherapy. Outcome measures include treatment retention, medication adherence, session duration, symptom response, quality of life, level of impairment, and patient satisfaction. The potential impact of MPT on adherence disparities affecting underserved racial/ethnic groups will be discussed, as well as facilitators and barriers affecting the implementation of MPT.

NO. 4
DISPARITIES IN COGNITIVE FUNCTION AND RATE OF DECLINE BY RACE/ETHNICITY.
Speaker: Maria P. Aranda, M.S.W., Ph.D.

SUMMARY:
Drawing from the National Alzheimer's Coordinating Center Uniform Data Set, we examined the trajectory of cognitive function over time among 1,483 older Asians, African Americans, Latinos, and non-Latinos while adjusting for demographic and medical comorbidity. Using latent trajectory model analysis, we measured cognitive decline across multiple assessments using the mean value of neuropsychological battery test scores.
The results indicated an overall declining average trajectory at successive assessments for all subjects. Each minority group had a lower intercept than non-Hispanic whites, and intercepts were significantly lower with increased age and administration in Spanish. However, the intercept was greater with number of assessments, higher education, and was higher on average among women compared with men. While Latinos did not differ from non-Hispanic whites in the rate of decline, the slope was significantly less steep among African Americans and Asians. Implications for the development of interventions to mitigate cognitive decline in older diverse groups will be discussed.

COERCION, CAPACITY, AND THE LIMITS OF AUTONOMY: CLINICAL, ETHICAL AND PHILOSOPHICAL PERSPECTIVES

Chairs: Dominic Sisti, Ph.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify and describe historical episodes that have created the perception that psychiatry is needlessly coercive; 2) Describe various perspectives on justifiable coercion in psychiatric treatment; 3) Describe ethical arguments and philosophical critiques relating to key concepts such as autonomy, self-determination, and capacity, that often complicate cases involving coercion.

SUMMARY:
Many hold the view that psychiatry is needlessly coercive or abusive of its power to involuntarily treat mentally ill persons. Cogently and sensitively addressing this view will be imperative if the perception of psychiatry is to be improved. In this symposium, four speakers will offer perspectives on the concepts of coercion, capacity, and patient autonomy drawing on clinical experience, ethical argument and philosophical analysis. The first speaker (Appelbaum) will review the history of the use of coercion in US psychiatry, and will reflect on the possible reasons for its persistence. This will include an overview of the patients' reactions to coercive interventions, and the variables that may mitigate negative responses. The second speaker (Szmukler) will present an international perspective in analyzing justifications for coercive interventions. This would involve an examination of 'decision-making capacity', 'best interests', how 'values' might be taken into account, and a possible formulation in terms of 'will and preferences' that takes account of the UN Convention on the Rights of Persons with Disabilities. The third speaker (Caplan) will argue that relatively brief, reversible interventions aimed at restoring autonomy (e.g. detoxing and then treating addicts with medicine or therapy or both for days or weeks) are morally defensible if they succeed in enhancing diminished autonomy in a person who is not clearly incompetent. The fourth speaker (Sisti) will

present several philosophical critiques of the liberal theory of autonomy, which strike at the core of standard models of capacity and coercion invoked in medical and behavioral health care ethics.

NO. 1
COERCION, CAPACITY, AND THE LIMITS OF AUTONOMY: LESSONS FROM HISTORY
Speaker: Paul S. Appelbaum, M.D.

SUMMARY:
Dr. Appelbaum will review the history of the use of coercion in US psychiatry, and will reflect on the possible reasons for its persistence. In the early 21st century, however, it is apparent that, even as coercive treatment in institutions has diminished, new forms of coercion have developed to enforce treatment in the community. These include mental health courts, probation and parole requirements, outpatient commitment, and use of informal leverage over patients' money, housing, parenting rights, and the like. Coercive treatment in psychiatry has not disappeared, and may not even have diminished. Rather it has moved from the institution to the community. This presentation will describe this evolution, the complex reactions of patients to the use of coercion, and the lessons that may be drawn regarding the future of psychiatric treatment and systems of care.

NO. 2
PHILOSOPHICAL CRITIQUES OF AUTONOMY AND COERCION
Speaker: Dominic Sisti, Ph.D.

SUMMARY:
The ethical keystones of American biomedical ethics—the principles of respect for persons and respect for autonomy—aim to ensure that persons who have competence or capacity retain their fundamental right to accept or refuse psychiatric treatment. Thus, the onus is on the clinician to clearly show and document that a patient is incapacitated before initiating treatment without obtaining consent. However, coercion may be much more subtle and difficult to recognize. Although coercion can be beneficent and morally licit, it can also be insidious and harmful. Coercion may occur in situations where choices are intentionally limited, information is offered in a manner that is biased or confusing, or within institutional settings that are oppressive or that serve primarily as instruments of social control. Coercion may also be a result of oppressive social conditions related to poverty, gender, and race.

NO. 3
OVERRIDING AUTONOMY TO ENHANCE AUTONOMY
Speaker: Arthur Caplan, Ph.D.

SUMMARY:
American bioethics affords extraordinary respect to the values of personal autonomy and patient self-determination. Many would argue that the most significant achievement deriving from bioethics in the past forty years has been to replace a paternalistic model of health provider-patient relationships with one that sees patient self-determination as the normative foundation for practice. This shift away from paternalism toward respect for self-determination has been ongoing in behavioral and mental health as well especially as it is reflected in the 'recovery movement'. As a result of the emphasis placed on patient autonomy arguments in favor of mandatory treatment are rare and often half-hearted. Restrictions on autonomy are usually grounded in the benefits that will accrue to others from reigning in dangerous behavior—'threat to self or others'. A person has the fundamental right to refuse care even if such a refusal shortens their own life or has detrimental consequences for others. So while the few proponents of mandatory treatment for those afflicted with mental disorders or addictions are inclined to point to the benefit such treatment could have for society it is exceedingly unlikely that any form of treatment that is forced or mandated is going to find any traction in American public policy on this basis. But, is benefit for the greater good the only basis for arguing for mandatory treatment? Can a case be made which acknowledges the centrality and importance

NO. 4
COERCION: AN INTERNATIONAL PERSPECTIVE
Speaker: George Szmukler, M.B.B.S., M.D.

SUMMARY:
The term 'coercion' is difficult to define. There is a range of pressures that can be exerted on patients to accept treatment ranging from 'persuasion', through 'leverage' within a especially close relationship with a key-worker, 'threats', and 'force' (or 'compulsion') as in involuntary community treatment orders. Morally relevant distinctions between these types of pressure can be drawn which have implications for how their use in the course of treatment could be justified. 'Coercion' can be given a fairly narrow definition and refer to particular threats made in the context of what has been termed the relevant 'moral baseline'. A further dimension concerns the patient's 'subjective' experience of coercion. Justifications for coercive treatment will be discussed, both 'paternalistic' and in relation to the protection of others. A clear distinction needs to be drawn between these two types of justification. I will pay special attention to a 'decision-making capability'/'best interests' approach that I argue is applicable across the whole range of coercive interventions. The role of 'values' requires special consideration, as does the notion of a person's 'authentic' will and preferences. The UN Convention on the Rights of Persons with Disabilities poses major challenges to 'substituted decision making' and non-consensual treatment. On one interpretation, virtually all current mental health legislation would be considered discriminatory.

MANAGING THE MEDICAL COMPLICATIONS OF TRAUMATIC BRAIN INJURY

Chairs: Scott Moran, M.D., Lobna A. Ibrahim, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the neuroanatomy and mechanisms of injury of traumatic brain injury; 2) Identify different types of seizure presentation and how to manage acute and long term seizure in traumatic brain injury; 3) Choose appropriate medications and recognize possible side/adverse effects of these medications in traumatic brain injury patients.

SUMMARY:
Traumatic Brain Injury is a signature wound of the US Military involvement in Iraq and Afghanistan. However it is also a leading cause of behavioral health issues in civilian populations as well. In this symposium, the speakers will describe the neuroanatomy of traumatic brain injury and the common injury mechanisms seen in TBI. The speakers will then describe the characteristics and presentations of various types of seizures seen in TBI and how to manage these in the acute and long term phases. Finally, the speakers will discuss current, evidenced based medical management of seizure disorder in traumatic brain injury patients and discuss the possible side effects and adverse effects of these medications in this population.

NO. 1
DIAGNOSIS AND MANAGEMENT OF POSTTRAUMATIC EPILEPSY
Speaker: Lobna A. Ibrahim, M.D.

SUMMARY:
Patients with traumatic brain injury can present with varied manifestations of epilepsy following a TBI. Using visual aids and case examples, this presentation will discuss the risk factors for post traumatic epilepsy, the classification of different seizure types, the clinical presentation of seizures based on anatomical location of the trauma, and post-ictal complications with a focus on issues that are of interest to psychiatrists such as post-ictal psychosis, post-ictal depression, and post-ictal mania, how to differentiate these presentation from non-epileptogenic disorders.

NO. 2
THE MEDICAL MANAGEMENT OF POSTTRAUMATIC EPILEPSY
Speaker: Jonathan Wolf, M.D.

SUMMARY:
This presentation will review anti-epileptic drugs (AED) available, their unique adverse effects, how to avoid complications in this patient population, and the scientific basis for usage of these medications. The presentation will review the effect of early treatment on short and long term outcome of TBI patients, and the role for prophylaxis with AEDs for post-traumatic epilepsy.

NO. 3
TRAUMATIC BRAIN INJURY FOR PSYCHIATRISTS
Speaker: Scott Moran, M.D.

SUMMARY:
This presentation will discuss the basic neuroanatomy and neurophysiology of traumatic brain injury. Using visual aids and case examples, the presentation will focus on mechanism by which trauma to brain tissue leads to epilepsy and distinguish between early seizures versus post-traumatic epilepsy. Finally the presentation will cover classification of traumatic brain injury severity.

THE INFLUENCE OF DOMAINS IN UNDERSTANDING AND TREATING SCHIZOPHRENIA

Chairs: S. Charles Schulz, M.D., Stephen R. Marder, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Assess and intervene in working with patients who have negative and/or cognitive symptoms; 2) Recognize and approach issues of insight in patients with schizophrenia; 3) Identify and understand the interactions of domains of mood and psychosis.

SUMMARY:
Schizophrenia began to emerge as a diagnosis at the end of the 19th century and a number of leading psychiatrists described symptoms of the illness from hallucinations and delusions to anhedonia and autism. Further in the development of describing the illness, the schizoaffective concept emerged illustrating a combination of symptomatic factors. More recently, problems in insight and cognition have emerged as a significant feature of the illness. Understanding the background of these domains is quite important in working with patients with schizophrenia – especially in mastering the impact of these domains on functioning and outcome. Further, in this symposium, approaches to intervene on the domains will be described.
Dr. Stephen Marder has investigated the domain of negative symptoms as a part of schizophrenia and he and his colleagues have described the impact of this domain and functional outcome. Further, and of importance to our field, Dr. Marder will describe approaches to this significant domain.
Dr. Xavier Amador's book, I Am Not Sick, I Don't Need Help, has had an outstanding influence on the field of psychiatry in helping understand the domain of insight. This domain is felt to be challenging in clinical work and it is an excellent advance by Dr. Amador to develop and describe how clinicians can approach this domain.
With the development of utilizing approaches in measuring cognition in neurology and then psychiatry, the field began to recognize cognitive symptoms-such as being able to pay attention-and their impact on daily living and their relationships to real-world outcome. Dr. Philip Harvey investigated cognition as a domain in schizophrenia, has performed extensive research on the methods to measure cognition, and, more recently, on approaches to improve cognition.

As noted above, the diagnosis of schizoaffective disorder arose in the early part of the 20th century; however, now there is significant interest in the relationship of psychotic and mood symptoms and the best approaches for improvement. Dr. Alan Schatzberg has studied and published in the area of delusional depression throughout his career and will be describing the characteristics of the two domains and approaches to intervention.
In conclusion, there has been substantial interest in understanding domains of the illness schizophrenia – especially as investigators have illustrated the definitions, impact and, most recently, interventions. This symposium will approach the latest update of these domains in a clinically relevant fashion which can contribute to understanding and treatment of schizophrenia.

NO. 1
THE INFLUENCE OF NEGATIVE SYMPTOMS IN UNDERSTANDING AND TREATING SCHIZOPHRENIA
Speaker: Stephen R. Marder, M.D.

SUMMARY:
Negative symptoms including restricted expressiveness, apathy, and avolition affect a high proportion of individuals with schizophrenia. Their severity is strongly related to a schizophrenia patient's functioning in the community and to the likelihood of success in rehabilitation. Moreover, there are no approved treatments that specifically target negative symptoms. This talk will describe recent progress in understanding the neurobiology that underlies these deficits, particularly the impairments in an individual's ability to anticipate reward. The presentation will review the processes for assessing negative symptoms and ruling out other causes of apathy and avolition. It will also review recent progress in developing new psychosocial and pharmacological approaches for treating negative symptoms. These approaches include cognitive behavioral approaches to negative symptoms and pharmacological agents that act at cholinergic and glutamate receptors.

NO. 2
UNAWARENESS OF ILLNESS: ETIOLOGY, CLINICAL SIGNIFICANCE, AND TREATMENT STRATEGIES
Speaker: Xavier Amador, Ph.D.

SUMMARY:
"Poor insight", or unawareness of illness, has been described since schizophrenia was first defined. Forty years ago the WHO's International Pilot Study on Schizophrenia found it to be the most common symptom and especially useful in distinguishing patients with schizophrenia from other psychotic disorders. In the last twenty years this domain of psychopathology has been found to affect approximately 50% of all patients across all stages of the illness with similar results: i.e., poor adherence to treatment, poorer course of illness and other negative consequences. It has been linked to executive dysfunction. A consensus project led by the APA fond "poor insight" to be a symptom of the illness, much like anosognosia in neurological disorders, rather than a coping strategy. The research supporting these conclusions will be described briefly. The main focus of the presentation will be a description of the LEAP communication strategy that has been shown to improve adherence and positive attitudes about treatment in patients with lacking insight.

NO. 3
APPROACHES TO THE DOMAIN OF COGNITION IN SCHIZOPHRENIA
Speaker: Philip Harvey, Ph.D.

SUMMARY:
Cognitive impairment has been recognized as an important domain of schizophrenia since the initial definitions of the condition by Kraepelin and Beluler in the 19th century. Impairments in cognitive functioning are wide ranging and functionally relevant, as they are associated with deficits in everyday living skills, vocational outcomes, social outcomes, and medically relevant self-care. These impairments have been shown to directly impact the ability to perform critical functional skills required for everyday function. These skills deficits, referred to as "functional capacity", have been shown to predict specific real-world functional limitations such as the ability to live independently. Treatment studies aimed at cognitive impairments also measure improvements in functional capacity as an outcome. Treatments for cognitive deficits are being developed and include both pharmacological strategies and cognitive remediation interventions. Cognitive remediation has shown considerable evidence of success, particularly in patients receiving concurrent psychosocial interventions. Pharmacological interventions have shown less success to date, but there are many promising candidates. Further, all of these interventions, pharmacological and remediation-focused, have shown considerable promise in patients very early in the course of their illness. As a result, the upcoming developments in the treatment of cognitive impairments may have promise to alter the course of the illness.

NO. 4
DEPRESSION/PSYCHOSIS INTERFACE: BIOLOGICAL PERSPECTIVES
Speaker: Alan F. Schatzberg, M.D.

SUMMARY:
Psychosis is found in approximately 18% of subjects in the community who meet criteria for major depression. Our group explored the role the hypothalamic pituitary adrenal (HPA) axis plays in the development of psychotic features. In this report, we review recent studies by our group and others on HPA axis activity in the disorder. Patients with the disorder demonstrate elevated evening/nocturnal cortisol from 6pm to 1am. In addition, patients with the disorder have significant impairment in a number of cognitive measures, often performing significantly more poorly than similarly depressed non-delusional depressives. In addition, evening cortisol levels are significantly correlated with performance

on attention, response inhibition, and memory tasks with higher levels associated with poorer performance. We have recently explored the relationship of allelic variation for 6 HPA axis genes to cortisol levels, psychosis, and depression in 95 subjects. Variation for NR3C1 (the gene that encodes for the glucocorticoid receptor—GR) was significantly associated with mean cortisol levels from 6pm-1am as well as 1am-9am. Closer study revealed significant contribution of GR to hourly cortisol from 6pm to 12 am as well as at 8am and 9am—hours when cortisol levels are higher and GR's are expected to be occupied. In addition, GR variation was associated with psychosis ratings. Variation for corticotropin releasing hormone type 1 receptor (CRH-R1) was associated with both depression and psy

MAY 06, 2014

ADDING AN OUNCE OF PREVENTION: APPLYING PREVENTION PRINCIPLES TO MODERN 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 three universal preventive interventions developed to reduce the incidence of alcohol and/or drug abuse and dependence.

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 such 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.

NO. 1
AN INTRODUCTION TO PREVENTION PRINCIPLES
Speaker: Ruth Shim, M.D., M.P.H.

SUMMARY:
Dr. Shim will discuss classifications of prevention, the concepts of risk and protective factors, the justification for an increasing focus on prevention in psychiatry, recommendations for enhancing training in prevention, and the ways that prevention can be incorporated into integrated care settings.

NO. 2
APPLYING PREVENTION PRINCIPLES IN PSYCHIATRIC PRACTICE SETTINGS
Speaker: Frederick J.P. Langheim, M.D., Ph.D.

SUMMARY:
Dr. Langheim will provide practicing clinicians with suggestions on how to become prevention-minded and to incorporate the principles of prevention into routine clinical encounters with patients and their families.

NO. 3
SUBSTANCE ABUSE PREVENTION
Speaker: Rebecca Powers, M.D., M.P.H.

SUMMARY:
Dr. Powers will discuss the prevention of alcohol and drug abuse, ranging from preventive approaches in clinical settings to the various types of universal preventive interventions that target whole communities.

NO. 4
SUICIDE PREVENTION: AN UPDATE
Speaker: Carol Koplan, M.D.

SUMMARY:
Dr. Koplan will provide an overview of suicide prevention efforts in both clinical and community settings, as exemplified by the Suicide Prevention Strategy in the state of Georgia. She will review priorities for prevention in communities including universal, selective and indicated interventions. She will also address a "preventive-minded" approach in clinical practice. Recent interventions in Georgia will be highlighted.

FRONTIERS IN SUICIDE RISK ASSESSMENT

Chairs: Zimri Yaseen, M.D., Igor Galynker, M.D., Ph.D.

Discussant: Matthew Nock, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand differing approaches to suicide risk assessment; 2) Identify major demographic risk factors for suicide attempts and assess their contribution to suicide risk; 3) Identify implicit measures of suicidality and assess their contribution to suicide risk; 4) Recognize acute suicidal states and their potential effects on treaters.

SUMMARY:
Suicide remains a leading cause of mortality in the Western world, particularly among adolescents and adults of working age. Despite years of work, suicide risk assessment remains modest at the individual level. This symposium aims to present new data on leading approaches to the assessment of suicide risk including actuarial approaches, implicit measures of suicidality, acute state measures of suicidality, and clinician focused approaches.
In this symposium data will be presented on the results of a meta-analysis of 500 prospective suicide prediction studies, a study of multiple implicit measures of suicidality including physiological measures of response to suicide-related stimuli and measures of attentional bias and associative shifts towards suicide-related stimuli. Further, we will present results of a prospective study of self-assessed measurement of an acute "suicide trigger state" demonstrating significant acute predictive value in an ultra-high risk sample. Finally, we will discuss implicit and explicit clinician assessment of suicide risk with presentation of data from a large-scale study comparing clinician risk categorization with a checklist approach, and preliminary data on clinicians' distinctive emotional responses to suicidal patients and the implications thereof.

NO. 1
DISTINCTIVE CLINICIAN EMOTIONAL RESPONSES TO SUICIDAL PATIENTS: A COMPARATIVE STUDY.
Speaker: Igor Galynker, M.D., Ph.D.

SUMMARY:
Background: Clinician responses to patients have been recognized as an important factor in treatment outcome, but responses to suicidal patients have received little attention.
Methods: Clinicians' feelings when last seeing patients prior to patients' suicide attempt or unexpected non-suicide deaths were assessed retrospectively with the Countertransference Questionnaire (CQ), administered anonymously via on-line survey. CQ scores were compared between groups, and linear discriminant analysis used to determine the combination of individual items that best discriminated between groups.
Results: Clinicians reported on 82 patients who completed suicide, made high-lethality attempts, low-lethality attempts, or had unexpected non-suicide deaths. Clinicians had less positive feelings towards imminently suicidal patients than for non-suicidal patients, but had higher hopes for their treatment. The specific paradoxical combination of hopefulness and distress/avoidance was a significant discriminator between suicidal patients and those with unexpected non-suicide deaths with 90% sensitivity and 56% specificity.
Conclusion: Clinicians' emotional responses to patients at risk versus not at risk for imminent suicide attempt may be distinct and identifiable. Our findings demonstrate the feasibility of using quantitative self-report methodologies for investigation of the relationship between clinicians' emotional responses to suicidal patients and suicide risk.

NO. 2
PREDICTIVE VALIDITY OF THE SUICIDE TRIGGER SCALE (STS-3) IN HIGH-RISK PSYCHIATRIC INPATIENTS
Speaker: Zimri Yaseen, M.D.

SUMMARY:
Background: The markedly increased risk of suicide after psychiatric hospitalization is a critical problem, yet we are unable to post-discharge suicide attempt (SA). The STS-3 was designed to measure an acute 'suicide trigger state' hypothesized to precede SA. This study aims to test the predictive validity of the STS-3.
Methods: The STS-3 and a psychological test battery were administered to 161 adult psychiatric patients hospitalized following suicidal ideation (SI) or SA. Predictive power of the STS-3 for SA in the 6-month period following discharge from the hospital was assessed.
Results: STS-3 score distributions differed markedly between patients with versus without post-discharge SA. Transforms were applied to the raw scores to distinguish high and low scores from intermediate scores. The transformed STS-3 score was a significant predictor of post-discharge suicide attempt (OR = 4.95). Ultrahigh STS-3 scorers differed significantly from ultralow scorers on measures of affective intensity, depression, impulsiveness, abuse history, and fearful attachment. Neither raw nor transformed scores on C-SSRS or BSS were predictive of post-discharge SA.
Conclusion: Transformed STS-3 scores predicted suicide attempts following hospital discharge. Post-discharge attempters appear to comprise two clinically distinct groups; an impulsive, affectively intense, fearfully attached group of high scorers and a low-impulsivity, low affect and low trauma-reporting group of low scorers.

NO. 3
IMPROVING THE PREDICTION OF SUICIDAL BEHAVIOR AMONG ADOLESCENTS
Speaker: Catherine R. Glenn, Ph.D.

SUMMARY:
Suicide is the third leading cause of death among 10-24 year-olds. However, predicting suicide and suicidal behavior has proven difficult. The development and use of objective markers of suicidal thinking that move beyond self-report may significantly improve the prediction of suicide risk. The current presentation will describe a project aimed at identifying several objective (behavioral and psychophysiological) markers for suicidal behavior among adolescents.

Participants for this project are adolescents ages 12-19 years with a current emotional disorder or who are currently receiving mental health treatment: one third have a history of suicidal behavior, one third have a history of suicidal thoughts but not suicidal behavior, and one third have no suicide history. During the baseline laboratory assessment, adolescents complete a series of objective measures that assess several emotional and cognitive processes that may predict risk for suicide: greater implicit associations with death/suicide, greater attentional bias toward suicide, and less fearful responding during suicide-related stimuli. Adolescents are being followed over the subsequent year to examine the utility of these measures for prospectively predicting risk for suicide. This presentation will report findings from over 100 adolescents who have completed the battery of objective measures at baseline, as well as a subset of participants who have been followed up over the subsequent year.

NO. 4

COMPARING CLINICIAN OPINION AND RISK FACTOR CHECKLISTS IN PREDICTING FUTURE SUICIDE ATTEMPTS: A LONGITUDINAL STUDY FROM TERTIARY CARE EMERGENCY DEPARTMENTS

Speaker: James Bolton, M.D.

SUMMARY:

Objective: To compare clinician opinion against checklist risk factors for accuracy in predicting suicide attempts within 6 months.

Methods: The study included consecutive presentations to psychiatric services at the emergency departments of the two tertiary care hospitals in Manitoba, Canada, between February 26, 2011, and December 31, 2012 (n=3974). All patients were assessed by a psychiatrist or psychiatric resident. A scale (0-10) was completed based on the clinician's opinion of suicide attempt within 6 months. 20 variables (demographics, mental disorders, suicidal behavior) were recorded. Logistic regression and receiver operating characteristic curve analyses examined the predictive ability of risk variables and clinician opinion risk score for future suicide attempts.

Results: There were 26 suicide attempts within 6 months. Measures of suicidal behavior most strongly influenced clinician opinion. Only 2 variables were associated with future attempts (childhood abuse and previous suicide attempts or psychiatric care). The clinician's opinion of high risk was significantly but moderately accurate in predicting suicide attempts (area under the curve=0.72, 95% confidence interval 0.60-0.83, $p<0.01$), despite the fact that 20 checklist risk factors accounted for only 51% of the variance in clinician opinion.

Conclusions: Almost 50% of a clinician's opinion about future attempt risk is not based on conventional risk factors, and this opinion performs moderately well.

NO. 5

META-ANALYSIS OF RISK FACTORS FOR SUICIDAL BEHAVIOR

Speaker: Joseph C. Franklin, Ph.D.

SUMMARY:

Robust predictors of suicide are crucial for identifying individuals at-risk for suicidal behaviors and advancing knowledge about the mechanisms that generate suicidal behavior. Over the past 60 years, hundreds of studies have tested the ability of a wide range of factors to predict suicidal behavior. However, studies on the same predictor often find highly discrepant results (e.g., odds ratios for hopelessness range from .76 to 8.81), complicating interpretations of this massive literature. Additionally, it is unclear how the various categories of predictors (e.g., psychopathology, biological measures, prior self-injury, implicit measures) compare to one another. To resolve such questions, we have identified approximately 500 studies (resulting in approximately 5,000 cases) that prospectively predict suicidal behavior. Preliminary meta-analytic results indicate that most categories of predictors produce an average weighted odds ratio around 2.0, with clinician prediction proving to be the weakest overall category and implicit measures emerging as the strongest overall category. This analysis will shed new light on the extant suicide prediction literature and provide direction for future suicide prediction studies.

EVIDENCE-BASED PSYCHOTHERAPIES FOR BORDERLINE PERSONALITY DISORDER

Chair: John M. Oldham, M.D.

Discussant: Antonia New, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Integrate recommendations of international practice guidelines into treatment planning for borderline patients; 2) Develop personal evidence-based strategy to use to conduct psychotherapy with borderline patients; 3)

SUMMARY:

Increasing lines of evidence demonstrate the effectiveness of psychotherapy as the primary, core treatment for borderline personality disorder (BPD). The 2001 publication of the American Psychiatric Association practice guideline for BPD reviewed the published randomized controlled trials (RCTs) at the time that demontrated the effectiveness of Dialectical Behavior Therapy (DBT) and Mentalization-Based Therapy (MBT). Subsequently, RCTs have shown that other forms of psychotherapy are effective for BPD, including Transference-Focused Psychotherapy (TFP), Schema-Based Therapy (SBT), Cognitive Behavior Therapy (CBT), General Psychiatric Management (GPM), and many others. In 2009, the United Kingdom National Institute for Health and Clinical Excellence published Guideline #78 on the treatment of BPD, endorsing the recommendation of psychotherapy for BPD, as did similar guidelines for The Netherlands (2008) and German (2009). Additionally, in 2013, the National Health and Medical research Council of the Australian Government published

a clinical practice guideline for the management of BPD, in which they recommended DBT, MBT, TFP, CBT, SFP, and other forms of psychotherapy such as Manual-Assisted Cognitive Therapy (MACT). In this symposium, the latest research will be presented on the effectiveness of DBT, MBT, TFP, and GPM for the treatment of BPD.

NO. 1
EVIDENCE-BASED PSYCHOTHERAPIES FOR BPD: MENTALIZATION-BASED TREATMENT
Speaker: Peter Fonagy, Ph.D.

SUMMARY:
The presentation will review randomized and non-randomized controlled and correlational studies which provide the evidence base for mentalization-based treatment (MBT). A number of studies suggest that, on balance, MBT is effective beyond generic psychological therapies in the treatment of BPD. However, there are limitations both to its effectiveness and to the evaluation studies that have been reported so far. We urgently need independent replication of RCTs not involving the developers and further evidence that the treatment works for the reasons suggested by the originators of the approach. More generally, other evidence-based treatments for BPD may involve a mentalization component, and evaluating changes in mentalizing associated with the implementation of these protocols may be important. Neurobiological changes associated with successful treatment are of particular relevance, and ongoing work in relation to these will be described.

NO. 2
EVIDENCE FOR THE EFFECTIVENESS OF TFP
Speaker: John F. Clarkin, Ph.D.

SUMMARY:
The empirical assessment of TFP has involved an initial study using patients as their own controls, followed by two randomized controlled trials, one in New York and the other across two sites in Munich and Vienna. TFP compares well with other treatments in reduction of symptoms, and is superior to treatment by community therapists in treating individuals with borderline personality disorder. In addition to reducing symptoms, TFP has been found to significantly increase reflective functioning and improve personality functioning. Our most recent research indicates that change in symptom domains in TFP is accompanied by changes in neurocognitive processes as measured by functional magnetic resonance imaging.

NO. 3
CURRENT DATA AND ONGOING RESEARCH IN DBT
Speaker: Martin Bohus, M.D.

SUMMARY:
DBT has initially been designed and evaluated as an outpatient treatment for chronic suicidal females. Meanwhile it has been adapted, extended and morphed to meet the requirements for the multiplicy of different pathological manifestations of emotion dysregulation disorders. But what are the essentials of DBT and is there really a need for further adapations? This presentation gives an overview on the most recent studies and ongoing research strategies in DBT.

NO. 4
GOOD PSYCHIATRIC MANAGEMENT
Speaker: John Gunderson, M.D.

SUMMARY:
This talk will identify the characterizations of Good Psychiatric Management (GPM) that overlap with other evidence-based-treatments of borderline personality disorder (BPD), and then elaborate on GPM's distinctive characteristics. Amongst these are its theoretical model (interpersonal hypersensitivity) and establishing reasonable boundaries for expectations of change based on the disorder's natural course and its significant heritability. GPM offers a model of treatment to be used by all clinicians with the promise that it will be effective for the vast majority of BPD patients.

STATE-OF-THE-ART THERAPEUTICS FOR REPETITIVE BEHAVIORAL DISORDERS

Chairs: Phillip J. Seibell, M.D., Eric Hollander, M.D.

Discussant: Daphne Simeon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the role of glutamate in the pathophysiology and treatment of obsessive-compulsive disorder; 2) Discuss emerging treatments in the treatment of repetitive behaviors in autism spectrum disorders; 3) Discuss the current state of knowledge regarding the use of transcranial magnetic stimulation in the treatment of obsessive-compulsive disorder and autism spectrum disorders; 4) Explain the similarities and differences in the biological and behavioral treatments for OCD and related disorders.

SUMMARY:
We will review several areas of knowledge with regards to expert treatment of repetitive behaviors in several disorders, including OCD, autism spectrum disorders (ASD), body dysmorphic disorder, trichotillomania, and skin-picking. First, we will review the latest in glutamate imbalance in the pathophysiology of OCD and as a therapeutic target. We will then discuss the latest emerging treatments of repetitive behaviors in ASD, and also describe the use of transcranial magnetic stimulation (TMS) in the treatment of both OCD and ASD. Finally, we will again specifically address OCD, and also related disorders, by reviewing the similarities and differences in their biological and behavioral treatments. After each individual presentation, we will summarize and discuss all of the presented information, with particular attention to repetitive behaviors across disorders and their expert treatment. Audience participation in discussion will

be encouraged.

NO. 1
GLUTAMATE IMBALANCE IN THE PATHOPHYSIOLOGY OF OCD AND AS A THERAPEUTIC TARGET
Speaker: Christopher Pittenger, M.D., Ph.D.

SUMMARY:
Up to 30% of cases of obsessive-compulsive disorder are refractory to state-of-the-art treatment. New therapeutic interventions are urgently needed. Evidence from genetics, neurochemical studies, and other lines of investigation suggests that dysregulation of the ubiquitous excitatory neurotransmitter glutamate may contribute to OCD. This has spurred increasing interest in the possibility that glutamate-modulating drugs, many of which are already FDA-approved and clinically available for off-label use, may be of benefit in refractory disease. The convergent evidence for a contribution of dysregulated glutamate homeostasis to the pathophysiology of OCD will be reviewed. Major open questions will be considered. Next, the growing literature on the use of glutamate-modulating medications to treat refractory OCD will be reviewed. While promising studies of a number of agents have been described, most are small and uncontrolled. This remains an active area of ongoing research.

NO. 2
EMERGING TREATMENTS FOR REPETITIVE BEHAVIORS IN AUTISM SPECTRUM DISORDERS
Speaker: Eric Hollander, M.D.

SUMMARY:
Treatment for the core symptoms of autism spectrum disorder (ASD), including persistent deficits in social communication and restricted and repetitive behaviors, remains elusive. The “positive symptoms” of ASD, including disruptive and repetitive behaviors, have been some of the most heavily studied, likely because they are most burdensome to caregivers and result in severe personal morbidity. With underwhelming results, pharmacologic interventions for repetitive behaviors have emerged via extrapolation from observational improvements in other disorders. Agents based upon hypothesized pathophysiology of ASD including oxytocin, trichuris suis ova and glutamatergics are beginning to emerge. A growing body of evidence has shown that ASD is a heterogeneous disorder. Therefore, agents which failed to demonstrate efficacy in treating repetitive behaviors previously are being revisited. By stratifying distinct subgroups of ASD, more efficacious, personalized interventions can be attained. Early efficacy biomarkers and personalized treatments based on known molecular mechanisms for homogeneous syndromal forms of ASD are also promising developments. In this context, results from novel experimental therapeutics for the repetitive behavior domain in ASD will be presented, and next step strategies for early stage drug discovery will be discussed.

NO. 3
REPETITIVE BEHAVIOR DISORDERS AS A TARGET FOR FOCAL TREATMENT: TMS FOR ASD AND OCD
Speaker: Stefano Pallanti, M.D., Ph.D.

SUMMARY:
Repetitive behaviors are core clinical symptoms both in Autism Spectrum Disorders (ASD) and Obsessive-Compulsive Spectrum Disorders (OCSD) in DSM 5. According to Research Domain Criteria (RDOC), circuitries underpinning involving the Orbitofrontal Cortex (OFC) and the Dorsal Striatum may be considered as a target for focal neuromodulatory treatment. Given the aberrant neural activation of these areas and the high percentage of pharmacoresistance for repetitive behaviors, Transcranial Magnetic Stimulation (TMS) appears as a promising therapeutic tool. We will review encouraging results that have emerged for low-frequency bilateral rTMS on the supplemental motor area (SMA) in a sample of 22 refractory-OCD patients (59.1% responders with 31.8% remitters). We will also describe a case series in ASD which revealed similarly favorable results.

NO. 4
THE TREATMENT OF OCD AND RELATED DISORDERS: SIMILARITIES AND DIFFERENCES
Speaker: Steven Poskar, M.D.

SUMMARY:
With DSM V, a new category has been created under the heading of OCD and Related Disorders. These include OCD, body dysmorphic disorder, hoarding, trichotillomania and skin picking. Phenomenologically, all share the commonality of repetitive behaviors, though the complexity, reinforcement, conditioning, and ego syntonicty of these behaviors are quite variable. Some of these disorders share commonalities in neural substrates and genetics, while others do not. Levels of insight differ between these illnesses as well. While there is quite a bit of overlap in both the pharmacological and psychotherapeutic treatment of these disorders, there are also important differences. In this presentation we will review the treatment of each of these disorders, placing special emphasis on the similarities and differences in their biological and behavioral treatments.

ELECTRONIC HEALTH RECORD PRIVACY UPDATE 2014

Chairs: Zebulon Taintor, M.D., Robert Kolodner, M.D.

Discussant: Glenn Martin, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Cite the main points in the national electronic health record privacy policy and how it is developed and revised.; 2) Describe some of the real-world successes and barriers in implementation of privacy policy; 3) Describe how Health Information Exchanges operate to create particular privacy concerns; 4) Describe how open source software can contribute to resolving privacy issues; 5) List

mechanisms involved in privacy breaches, theft and sale 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, who will report on recent developments.. The challenge is adapting to changing technology and increasing integration and sharing of health information.
b) How privacy policies work in practice will be discussed by Joy Pritss, chief privacy officer at the Office on the National Coordinator for Health Information Technology. She will describe issues in receiving, maintaining, and transmitting health information, including the hazards and benefits of different technologies, esp. mobile devices, connections shared by multiple sites, cloud computing, and the benefits and burdens of compliance with laws and regulations.
c) Open source software has traditionally been viewed as a competitive alternative to commercial software. More recently, OSS has been offered as modules that can be used in a full OSS solution or included in commercial software. Dr. Robert Kolodner, a leader in the development of the VistA system at the Department of Veterans Affairs, was the second National Coordinator for Health Information Technology. He will discuss recent national efforts to promote the use of OSS modules to improve health IT interoperability, security, and privacy.
d) Steven Daviss, co-chair of the Behavioral Health work group on the Certification Commission on Health Information Technology (CCHIT) and chair of the APA's Committee on electronic Health Records will describe how the standards evolved in relation to privacy and the impact of other certifications. Co-author of Shrink Rap, he will discuss the resistance of Health Information Exchanges to granularity of patient permission and acceptance of psychiatric information.
e) Breaches in protected health information were reported voluntarily and in news media, but required reporting has been in place for four years. Breaches involving more than 500 people are reported separately: 495 major breaches have involved more than 21 million people. Zebulon Taintor will describe how trends in breaches, who is least protective, increasing criminality, lagging prosecutions, personal losses, and consequences of breaches. Medical information for sale bears little resemblance to what has been known to be breached, implying there are many undetected breaches.

NO. 1
PRIVACY AS HEALTH IT ENABLER: WHERE ARE WE?
Speaker: Deven C. McGraw, J.D., LL.M., M.P.H.

SUMMARY:
The privacy policy landscape is changing: HITECH changes to federal privacy policies went into effect September 23, 2013, and a number of policies recommended by the Health Information Technology Policy Committee Tiger Team, chaired by Deven McGraw, have been adopted for federal grantees; additional policy recommendations intended to facilitate a trusted and more certain environment for health information exchange have been put forth. Federal regulators have stepped up enforcement, the ONC is making progress on pilots to test "data segmentation" technologies that enable granular patient choices to be honored. At the same time, in an era of tightening policies, expectations for information exchange for treatment, care coordination, and secondary "analytic" uses are increasing. Recent legal and technology developments will be reviewed, and continued gaps in the health information exchange trust fabric will be explored.

NO. 2
PRIVACY PROBLEMS AND SOLUTIONS: A NATIONAL PERSPECTIVE
Speaker: Joy Pritts, J.D.

SUMMARY:
The office of the National Coordinator for Health Information Technology provides a national viewpoint for implementation of privacy policies. Most physicians now have EHRs and increasingly are connected to each other, hospitals, patients, etc. Some EHR software has not proved to be as compatible for interoperability as claimed. The shifting technical landscape has engendered many questions, especially around data sharing. As yet there is no easy solution to granular consent, i.e., allowing access to some data to some participants in a Health Information Exchange or Regional Health Information Organization but not to others. Many HIEs and RHIOs were funded with grants that have since run out, and so are struggling for viable business models, leading to less funding for maintenance of data and foreshortening of plans. Government at several levels has stepped in with technical assistance. Foremost among these efforts has been maintenance of confidentiality and protection of privacy. Specific efforts include organizing the Health Information Policy Committee and the Tiger Team, the HITECH program, the Cybersecurity16 Checklist that lists simple best practices to maintain data security, privacy criteria in certification of EHR software, patient and provider identification improvement, cybercrime prevention, etc. The format of the presentation will be a list of specific problems reported by users ,along with proposed solutions.

NO. 3
HEALTH INFORMATION EXCHANGES: ARE PATIENTS BEING THROWN UNDER THE HEALTH IT BUS?
Speaker: Steven R. Daviss, M.D.

SUMMARY:
HIEs are the new fax machines. Health information exchanges (HIE) serve to connect healthcare providers to securely share patient information and coordinate their care. However, most HIEs are preventing patients from any of the benefits of electronic care coordination if they have mental health or substance use conditions that they want to share

with only certain providers. Some HIEs refuse to accept any information from psychiatrists, for example. SAMHSA has helped develop open source software that is hoped to allow patients more control over their sensitive health information, while HIEs remain compliant with privacy laws. These trends will be discussed.

NO. 4
CAN OPEN SOURCE SOFTWARE HELP MEET THE HEALTH IT PRIVACY CHALLENGE?
Speaker: Robert Kolodner, M.D.

SUMMARY:
Rather than the traditional view of Open Source Software (OSS) being competitive with commercial solutions, some recent efforts have been made to develop vendor-neutral OSS modules that can either be incorporated into commercial software or be used as components in solutions that are fully open source.
If widely adopted, these modules can be used to commoditize the cost of software capabilities that are so pervasive that they no longer provide competitive advantages to any company. In other cases, OSS modules can be developed to facilitate much more reliable and uniform implementations of critical software capabilities across all health information technology products that patients and the healthcare system cannot risk being done poorly or inconsistently – such as health IT interoperability, security, and privacy.
Initial steps have been taken by the Office of the National Coordinator and others to create communities of interest to develop some of these vendor-neutral OSS modules. This presentation will review these recent activities, summarize their status, and identify issues and barriers that have to be resolved to achieve widespread interoperability among secure health IT systems in a manner that protects the privacy of health information, consistent with patient preferences.

NO. 5
BREACHES: AN UPHILL BATTLE
Speaker: Zebulon Taintor, M.D.

SUMMARY:
Since the September 2009 implementation of mandated reporting, 57,000+ breaches have been reported to the Department of Health and Human Services; individually noted are any breaches involving more than 500 individuals. Only (about a third) cases investigated, closed are summarized. The HITRUST analysis of the breaches involving more than 500 individuals (495 total, involving 21.42 million people) as of October 2012.shows less from health plans and more from physician practices. Theft was the primary motivation, both of hardware and content. Time to detection and reporting breaches is increasing, with breaches involving business associates touching 56% of all people affected. Many breaches are not detected. State deidentified data is readily identified by marketers. The Coalition Against Insurance Fraud estimates medical identity theft has involved more 1.4 million Americans by 2009 at an average incident cost of $20,000, plus paying for unreceived medical care, higher premiums, losing heath care coverage and good credit, with often no settlement after months. Medical records mix data from thief and victim.
New technology is coming into use ahead of protection. Connections are vulnerable at the weakest link. Mobile devices, cloud computing and file-sharing devices are hard to secure.
A recent NBC expose showed that stolen, identified data had passed through servers in several countries, offered for sale by a criminal comfortably ensconced with Costa Rica. Enforcement lags

CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE USE DISORDERS

Chairs: Herbert D. Kleber, M.D., Edward V. Nunes, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize clinical signs/symptoms of abuse of sedative-hypnotic or stimulant medications, understand strategies to manage patients, and recognize risks/benefits of prescribing these medications ; 2) Understand problem of opioid abuse among chronic pain patients, know screening tools to reduce likelihood of abuse, and understand pharmacological approaches to manage pain in high-risk patients; 3) Be familiar with the various approaches in the clinical development of new cocaine dependence pharmacotherapies and recent research findings, particularly medications that may be used clinically; 4) Understand major empirically supported behavioral treatments for substance use disorders, potential for combining behavioral and pharmacologic approaches, and obstacles in delivering these treatments; 5) Understand impact of increased marijuana potency and availability and subsequent need for improved treatments and become aware of treatment trials of pharmacological and psychological approaches .

SUMMARY:
Substance use disorders remain a major public health problem with financial costs and important implications for health and criminal justice systems. Shifts continue to occur in cost, purity, and geographic spread of various agents. The fastest growing problem is hazardous use of stimulants and prescription opioids, along with a recent rise in heroin use, while cocaine use remains endemic, methamphetamine use has decreased, marijuana has higher potency and greater availability, and marijuana use has lower age of onset. The symposium combines current scientific knowledge with discussion of the most efficacious treatments for all of these agents, as well as strategies to manage patients with comorbid pain. Emphasis is on office-based approaches, and presentations include discussion of both pharmacological and psychological treatment methods. The speakers are nationally recognized experts in substance use disorders and will discuss practical and cutting edge treatments.

NO. 1
DETECTING AND MANAGING SEDATIVE, HYPNOTIC, OR ANXIOLYTIC USE DISORDER AND STIMULANT USE DISORDER
Speaker: John J. Mariani, M.D.

SUMMARY:
Despite extensive clinical experience, concerns about overprescribing, abuse liability, and the behavioral safety of sedative-hypnotics and stimulants still remain, an especially concerning problem given the marked rise of stimulant use. While these medications are effective treatments for psychiatric disorders, specifically sedative-hypnotic agents for anxiety disorders and stimulants for attention-deficit/hyperactivity disorder, both classes of medication have a significant risk of abuse, and the incidence of non-prescribed use is substantial. An overview of the strategies to detect and manage abuse of these controlled substances will be provided. Special attention will be focused on the complex clinical issues that arise when prescribing these agents in the presence of co-occurring substance use disorders.

NO. 2
TREATMENT OF CHRONIC PAIN AND OPIOID USE DISORDER: ROLE FOR OPIOID AGONISTS AND ANTAGONISTS
Speaker: Maria A. Sullivan, M.D., Ph.D.

SUMMARY:
Prescription opioid abuse has reached epidemic proportions in the U.S. Clinicians face the significant challenge of maintaining therapeutic access to opioids for legitimate analgesic use while minimizing the potential for opioid abuse and diversion. Addiction in pain patients is often more difficult to identify than in illicit substance users. Screening and risk stratification, universal precautions, identification of aberrant behaviors, and adherence monitoring techniques will be considered. We will discuss treatment options for patients with opioid dependence and chronic pain, including abuse-deterrent formulations, as well as risks and benefits of long-acting opioids (e.g., buprenorphine, methadone). The role of opioid antagonist maintenance with long-acting naltrexone (Vivitrol) in cases of opioid abuse and hyperalgesia will be examined. Advantages and disadvantages of various pharmacologic choices for treating opioid dependence in chronic pain patients will be summarized.

NO. 3
CHOOSING THE RIGHT TREATMENT FOR COCAINE USE DISORDER
Speaker: Adam Bisaga, M.D.

SUMMARY:
Cocaine dependence remains a severe health problem, with no commonly accepted pharmacotherapies. Strategies to enhance rather than block the dopaminergic neurotransmission have proven effective to induce abstinence in cocaine-using individuals. Practical and safety concerns involved in prescribing psychostimulant medications to cocaine users will be discussed. Other pharmacological strategies, such as medications that enhance GABAergic neurotransmission, have potential as abstinence-maintenance treatments. A recent trial showed a combination of d-amphetamine and topiramate to be effective in producing abstinence in heavy cocaine users. Strategies to prevent cocaine from entering the brain are also being developed, and results with a "cocaine vaccine" are promising. A combination of pharmacological (possibly more than one medication) and behavioral interventions, such as contingency management or relapse prevention CBT, will likely be required for patients to achieve and maintain abstinence.

NO. 4
COMBINING MEDICATION AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE USE DISORDERS
Speaker: Edward V. Nunes, M.D.

SUMMARY:
Several types of psychosocial-behavioral interventions, including cognitive-behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-step facilitation), have been studied for use either alone or in combination with medications for treatment of substance use disorders. Such interventions have served as means of helping patients to achieve abstinence, encouraging lifestyle change, and promoting compliance with medications. An overview of these models and a brief review of findings in treatment outcome research will be provided. Obstacles encountered in delivery of these approaches, the clinical implication of integrating such models, and the efforts to generalize research findings to community settings will be addressed.

NO. 5
CHOOSING TREATMENT FOR CANNABIS USE DISORDER
Speaker: Frances R. Levin, M.D.

SUMMARY:
Cannabis is the most widely used illicit drug in the United States, with 10% of users ending up dependent. Underlying psychopathology increases this risk, and, in others, marijuana use may increase risk of depression and psychosis. The increased availability of cannabis via medical marijuana exacerbates the problem. Heavy chronic cannabis use can lead to a characteristic withdrawal syndrome, especially with current THC levels averaging 7-10%. Such symptoms may hinder ability to reduce or cease use. Various psychotherapeutic treatment approaches have been efficacious, but no one type of psychotherapy has been found to be superior, and relapse rates are high. Efficacy of pharmacologic interventions has had only limited trials. In the laboratory setting, agonists (e.g., dronabinol (oral THC), nabilone) have shown some promise as well as combined pharmacotherapies (such as dronabinol and lofexidine). There have been a limited number of outpatient clinical trials, with dronabinol and gabapentin showing some benefit. A recent adolescent

study of a combination of n-acetyl cystine with contingency management showed promising results. To date, pharmacologic trials in cannabis-dependent adults with concurrent psychiatric disorders have not found that the active psychiatric medication is superior to placebo in reducing cannabis use or psychiatric symptoms. An overall review with treatment implications will be presented.

BRINGING TRAUMA EXPERTISE TO IMMIGRANT SURVIVORS: FORENSIC EVALUATIONS OF ASYLUM SEEKERS

Chair: Jillian M. Tuck, J.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Develop a greater understanding of the immigration and asylum processes in the United States the important role of the psychiatrist and forensic documentation in these processes; 2) Identify, diagnose, evaluate, and describe the variety of presentations of emotional and psychological sequelae characteristic of torture survivors and others seeking humanitarian protection in the US; 3) Utilize expertise to provide medical-legal documentation of human rights abuses, including competently writing an affidavit for submission to immigration authorities and testify in immigration court; 4) Understand considerations for specific populations, such as LGBTI individuals and unaccompanied youth, and be able to adjust interview skills and evaluation techniques according to their unique needs.

SUMMARY:
People fleeing persecution, torture, and ill treatment may seek asylum or other humanitarian protection so that they may live, work, and rebuild their lives safely in the United States. US law governing asylum, however, is complex and challenging. Attorneys can greatly improve asylum seekers' chances of success by helping them navigate the legal framework and to tell their stories in a way that resonates with adjudicators.
Attorneys' contribution and ability to present a compelling case may be limited, however, by the amount and types of evidence that a victim can provide. Most people fleeing persecution have left home in a hurry, and they rarely have time to gather photos, witness accounts, or other evidence that would support their claims, if such direct evidence even exists. In many cases, victims have only their narrative account and mental scars to attest to the horror they have endured. Across the US, there is a need for trained mental health professionals who are willing to use their expertise to assist this underserved and traumatized population.
Mental health professionals can assist asylum seekers and other seeking safety in the US by providing forensic evidence of trauma. They can elicit diagnostic information and contextualize mental status findings (e.g. poor eye contact, guarding, and flat affect), within the applicant's trauma history and culture, which may help explain perceived deficits in credibility or delays in filing the asylum application. Mental health clinicians can also define mental health treatment needs, describe the possible impact of deportation, and elicit trauma narrative from asylum applicants safely and efficiently.
The overall goal of a forensic evaluation is to assess the degree of consistency between a victim's account of torture and the psychological findings observed during the evaluation. This requires taking a careful clinical history and examination that is sensitive to cross cultural issues and interpersonal dynamics between traumatized persons and people in positions of authority. The evaluator should also be knowledgeable about the medical and psychosocial consequences of torture and violence.
This symposium is intended to provide attendees the knowledge and skills necessary to conduct forensic evaluation of asylum seekers and other noncitizens seeking safety. It is based on the prevailing international guidelines for medical-legal documentation of torture that are contained in the Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, known colloquially as the "Istanbul Protocol." The presenters include an asylum attorney from Physicians for Human Rights, and three veteran evaluators.

NO. 1
ASYLUM LAW, HUMAN RIGHTS LAW, AND THE CRITICAL ROLE OF THE MENTAL HEALTH PROFESSIONAL
Speaker: Jillian M. Tuck, J.D.

SUMMARY:
Each year thousands of immigrant survivors of torture and other severe human rights abuses seek humanitarian protection in the U.S. When they apply for protection, they often have nothing but their own words to substantiate their suffering. Some of the most compelling evidence available—psychological sequelae of torture, domestic violence, and other abuses—will go unnoticed and unheeded by adjudicators. Documentation of the trauma they endured can make the difference between safety in the U.S. and a return to a country where the survivor's life and safety would be at risk. This presentation will provide health professionals a broad overview of the federal and international law as it applies to this population. By providing the legal context, mental health professionals will have a greater understanding of the purpose of forensic evidence and their role in supporting applicants.

NO. 2
DOCUMENTING SEQUELAE OF TORTURE AND ILL TREATMENT FOR ASYLUM SEEKERS
Speaker: Judy Eidelson, Ph.D.

SUMMARY:
Psychiatrists and other mental health professionals are uniquely qualified to assist trauma survivors in recounting traumatic experiences in a safe and validating environment. This presentation will highlight the essential elements of evaluations that are conducted to document asylum-seekers' claims. In addition to describing the degree of concor-

dance between symptoms and reported trauma history, this presentation will outline strategies for addressing issues that often interfere with the asylum-seeker's ability to successfully pursue his or her claim, such as shame-based avoidance.

NO. 3
SPECIFIC VULNERABLE POPULATIONS: FORENSIC EVALUATIONS OF LGBTI INDIVIDUALS
Speaker: Joanne Ahola, M.D.

SUMMARY:
Persecution based on sexual orientation or gender identity is the basis for a growing number of asylum claims and these cases can present particular challenges for the evaluating clinician. Topics covered include assessing sexual orientation and gender identity in asylum seekers, understanding and documenting identity development and complex trauma in asylum seekers, and working with applicants who have not met the one year filing deadline because of a "freezing" of development in repressive conditions and/or complex PTSD. Homosexuality is criminalized in 76 countries...asylum is a real possibility in only a few. The goal is professional confidence and skill in evaluating these vulnerable and marginalized asylum seekers.

NO. 4
SPECIFIC VULNERABLE POPULATIONS: FORENSIC EVALUATIONS OF CHILDREN AND ADOLESCENTS
Speaker: Carol L. Kessler, M.D.

SUMMARY:
Children and adolescents present a unique set of issues in the asylum seeking process that psychiatrists can competently address. There are occasions wherein undocumented parents of U.S. citizen children are faced with the prospect of deportation. In these circumstances, evidence of the harm that would be inflicted by the separation on the children can be presented to the court in an effort to prevent such familial disruption. Asylum-seeking youth have survived a myriad of overwhelming situations in their countries of origin – they may be fleeing gang violence, threats of honor killing, domestic violence, or the chaos of war. Children present with particular manifestations of PTSD that will be delineated within this presentation. The category of "special immigrant juvenile status" will also be addressed as applying to those youth who have been abused, neglected or abandoned by their biological parents. The role of the psychiatrist in providing a voice for these youth through documentation of the impact of such traumatic events on their psyche will be delineated.

MANAGEMENT OF ALCOHOL ABUSE, WITHDRAWAL AND DEPENDENCE: A PRACTICAL GUIDE FOR GENERAL PSYCHIATRISTS.

Chair: José R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the neurobiology of alcohol dependence and neurochemical mechanisms of withdrawal; 2) Demonstrate knowledge of the use of non-benzodiazepine treatment protocols as alternative management of alcohol withdrawal syndromes; 3) Demonstrate knowledge of the use of pharmacological agents for the treatment of alcohol dependence.

SUMMARY:
Alcohol use disorder (AUD) is the most serious substance abuse problem in the United States (US) and worldwide. Alcoholism has been reported in 20% to 50% of hospitalized medical patients. Most of the alcohol dependent patients admitted to the general medical wards will develop alcohol withdrawal symptoms, significant enough to require pharmacological intervention regardless of the cause for admission. Alcohol abuse and withdrawal are associated with an increased risk for medical comorbidities (e.g., infections; cardiopulmonary insufficiency; cardiac arrhythmia; bleeding disorders; need for mechanical ventilation) and longer, more complicated hospital and ICU stays making it particularly important for Psychosomatic Medicine specialist to be adept in the recognition and management of alcohol dependence and withdrawal states.
Alcohol renders its depressant central effects through its agonistic effect on GABAA receptors primarily in the cerebral cortex, medial septal neurons, and hippocampal neurons. But is through its disinhibition of GABA-mediated dopaminergic-projections to the ventral tegmental area, leading to increases in extracellular dopamine in the nucleus accumbens that it mediates the initially pleasurable effects of alcohol and thus the impulse to drink more. The development of alcohol tolerance is a neuroadaptive process directed at reducing the acute effects of alcohol and thereby providing homeostasis via an adaptive suppression of GABA activity, mediated by internalization and down regulation of GABAA-BZ receptor complexes; increased synaptic glutamate release; and overactivity of noradrenergic neurons in the CNS and the peripheral nervous system. The symptoms of alcohol withdrawal syndromes (AWS) are then associated with abnormalities in the levels of NE (i.e., symptoms of autonomic hyperactivity, DA (i.e., agitation & psychosis), and GLU (i.e., seizures). Certainly the use of benzodiazepines and other GABAergic agents (e.g., barbiturates, propofol) can lead to suppression of excess activity of all these neurotransmitters and associated receptors, but at a high cost: significant neurological (e.g., ataxia), medical (e.g., respiratory depression), and cognitive (e.g., amnesia, delirium) impairment; as well as possible development of iatrogenic benzodiazepine dependence.
This workshop will review the neurobiology of alcohol dependence and neurochemical mechanisms of withdrawal and address the state of the art regarding the use of benzodiazepine and explore the potential of non-benzodiazepine agents (i.e., anticonvulsants, antipsychotics and alpha-2 agonists) in the management and treatment of AWS. We

will examine the available evidence for their effectiveness and compare these results to what benzodiazepines can do; highlighting advantages and pitfalls in treatment. The currently available treatment options for alcohol dependence will be summarized and reviewed, covering acamprosate, naltrexone, and disulfiram.

NO. 1
NEUROBIOLOGY OF ALCOHOL DEPENDENCE AND WITHDRAWAL
Speaker: José R. Maldonado, M.D.

SUMMARY:
Alcohol renders its depressant central effects through its agonistic effect on GABAA receptors primarily in the cerebral cortex, medial septal neurons, and hippocampal neurons. But is through its disinhibition of GABA-mediated dopaminergic-projections to the ventral tegmental area, leading to increases in extracellular dopamine in the nucleus accumbens that it mediates the initially pleasurable effects of alcohol and thus the impulse to drink more. The development of alcohol tolerance is a neuroadaptive process directed at reducing the acute effects of alcohol and thereby providing homeostasis via an adaptive suppression of GABA activity, mediated by internalization and down regulation of GABAA-BZ receptor complexes; increased synaptic glutamate release; and overactivity of noradrenergic neurons in the CNS and the peripheral nervous system. The symptoms of alcohol withdrawal syndromes (AWS) are then associated with abnormalities in the levels of NE (i.e., symptoms of autonomic hyperactivity, DA (i.e., agitation & psychosis), and GLU (i.e., seizures). Certainly the use of benzodiazepines and other GABAergic agents (e.g., barbiturates, propofol) can lead to suppression of excess activity of all these neurotransmitters and associated receptors, but at a high cost: significant neurological (e.g., ataxia), medical (e.g., respiratory depression), and cognitive (e.g., amnesia, delirium) impairment; as well as possible development of iatrogenic benzodiazepine dependence.

NO. 2
TREATMENT OF ALCOHOL DEPENDENCE
Speaker: Yelizaveta Sher, M.D.

SUMMARY:
This lecture will address the phenomena of alcohol dependence and will review evidence-based treatment techniques for the management of dependence and the prevention of relapse.

NO. 3
PREVENTION AND MANAGEMENT OF ALCOHOL WITHDRAWAL SYNDROMES: BEYOND BENZODIAZEPINES
Speaker: José R. Maldonado, M.D.

SUMMARY:
Certainly the use of benzodiazepines and other GABAergic agents (e.g., repiratory depression), and congnitive (e.g., amnesia, delirium) impairment; as well as possible development of iatrogenic benzodiazepine dependence. This workshop will review the neurobiology of alcohol dependence and neurochemical mechanisms of withdrawal and address the state of the art regarding the use of benzodiazepine and explore the potential of non-benzodiazepine agents (i.e., anticonvulsants, antipsychotics and alpha-2 agonists) in the management and treatment of AWS. We will examine the available evidence for their effectiveness and compare these results to what benzodiazepines can do; highlighting advantages and pitfalls in treatment.

ADVANCES IN NEUROIMAGING AND PSYCHOTHERAPY ACROSS DISORDERS

Chairs: Marianne Goodman, M.D., Eunice Chen, Ph.D.

Discussants: Thomas Zeffiro, M.D., Ph.D., Larry J. Siever, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify similarities and differences in neuroimaging findings for psychotherapy across disorders; 2) Recognize how neuroimaging informs clinicians about the underlying neurobiological processes of successful psychotherapy; 3) Understand the clinical implications of neuroimaging findings of psychotherapy across disorders.

SUMMARY:
The identification of biological mechanisms of change for psychotherapy is in its infancy however there is an accumulating database of research assessing neural responses to psychotherapy. The ability to visualize brain activity has provided a window to better understand the impact of psychotherapy on the brain and to begin to develop biomarkers of change and biological predictors of psychotherapy treatment effect. Additionally this research enhances our understanding of the underlying neurobiology of various disorders allowing us to identify similarities and differences in neurocircuitry between disorders. This information is essential for the development of future, more effective treatment and personalized medicine approaches. However, synthesizing the neuroimaging psychotherapy data available to-date is complicated by multiple therapy approaches, underlying conditions, imaging tasks and techniques. This symposium aims to examine imaging similarities and differences across psychotherapy approach and disorder.
Presentations will include: 1) Dialectical Behavioral Therapy (DBT) and Borderline Personality Disorder (Dr. Marianne Goodman- Change in Amygdala Activation in Borderline Personality Disorder with Dialectical Behavioral Therapy, 2) Predicting Treatment Response and Cognitive Behavioral Therapy (CBT) and Depression (Dr. Greg Siegle- Use of fMRI to predict recovery from unipolar depression with cognitive behavior therapy), 3) Behavioral therapies for binge-eating disorder and obesity (Dr. Eunice Chen), 4) Social anxiety and CBT (Dr. Susan Whitfield-Gabrieli - Predicting Treatment Response in Social Anxiety Disorder from Functional Magnetic

Resonance Imaging); 5) Mindfulness meditation and depression (Dr. Norman Farb - Mindfulness meditation training alters cortical representations of interoceptive attention). Discussion of imaging parameters (Dr. Tom Zeffiro) and neurobiological and clinical implications (Dr. Larry Siever) will complete the symposium.

NO. 1
BEHAVIORAL THERAPIES FOR BINGE-EATING DISORDER AND OBESITY
Speaker: Eunice Chen, Ph.D.

SUMMARY:
In the United States, Binge-Eating Disorder (BED) is the most frequently occurring eating disorder, while obesity as a chronic medical illness affects a third of the population and is the second leading preventable cause of death. Approximately 40 to 70% of individuals with BED are overweight with longitudinal data suggesting that overeating leads to later obesity. While obesity is associated with high rates of medical comorbidity BED confers a greater risk of psychiatric comorbidity, medical and psychosocial problems than obesity alone. More than half of individuals with BED respond to brief Guided Self-Help Cognitive-Behavior Therapy (gCBT) with sustained effects on binge-eating and weight loss. In contrast, Behavior Weight Management for obesity leads to short-term weight loss that is difficult to sustain. Our understanding of changes in reward neurocircuitry in BED and in obesity in response to treatment is poorly understood. This presentation explores reward neurocircuitry responses to food in BED and overweight as predictors of treatment outcome in respectively gCBT and Behavior Weight Management as well as changes in these neural responses in the course of treatment.

NO. 2
CHANGE IN AMYGDALA ACTIVATION WITH DIALECTICAL BEHAVIORAL THERAPY IN BORDERLINE PERSONALITY DISORDER
Speaker: Marianne Goodman, M.D.

SUMMARY:
Background: Siever and Davis (1991) psychobiological framework of borderline personality disorder (BPD) identifies affective instability as a core dimension characterized by prolonged and intense emotional reactivity. Recently, deficient amygdala habituation has emerged as a biological correlate of affective instability. Dialectical behavior therapy (DBT), an evidence-based treatment, targets emotion regulation (ER). This study examined whether DBT influences amygdala activity and habituation to emotional pictures.
Methods: Event-related functional magnetic resonance imaging (fMRI) was obtained pre- and post- 12-months of DBT in unmedicated BPD patients. During each scan, participants viewed an intermixed series of unpleasant, neutral and pleasant pictures presented twice (novel, repeat).
Results: fMRI results showed the BPD group exhibited an overall decrease in amygdala activation post-treatment. Improved amygdala habituation to repeated-unpleasant pictures was associated with improved ER. Non-responders failed to show amygdala habituation.
Conclusion: These findings have promising treatment implications and support the notion that amygdala hyper-reactivity underlies emotional dysregulation in BPD.

NO. 3
PPRETREATMENT INTRINSIC FUNCTIONAL ARCHITECTURE PREDICTS CLINICAL OUTCOME IN SOCIAL ANXIETY DISORDER
Speaker: Susan Whitfield-Gabrieli, Ph.D.

SUMMARY:
Social anxiety disorder (SAD), one of the most common psychiatric conditions in the United States, is a chronic and disabling disorder associated with persistent anxiety and avoidance behavior which ultimately results in substantial impairment, decreased quality of life, and psychiatric comorbidity. We used pre-treatment bilateral amygdalae seed resting state functional connectivity (RSFC) in patients with social anxiety disorder to predict subsequent clinical response to cognitive behavioral therapy. Amgydalae – Ventromedial prefrontal cortex RSFC, which was significantly hyperconnected in patients, predicted clinical response significantly better than current clinical scales. Our results suggest that the intrinsic functional architecture of the human brain revealed by RSFC can provide biomarkers that substantially improve predictions for success of clinical interventions, and suggest that such biomarkers may offer evidence-based, personalized medicine approaches for optimally selecting treatment options.

NO. 4
SELECTING PATIENTS INTO COGNITIVE THERAPY FOR DEPRESSION IN THE REAL WORLD: WHERE DO BRAINS FIT IN?
Speaker: Greg Siegle, Ph.D.

SUMMARY:
Cognitive Therapy is efficacious for approximately 50% of adults with unipolar depression who undergo this treatment, and the costs of treatment failure are immense, ranging from lost productivity to suicide. fMRI has proved a strong but prohibitively expensive prognostic indicator for selection into this treatment. Here, we describe the construction and evaluation of “lowest cost” algorithms that incorporate multiple prediction modalities including neuroimaging, and show that for 80% of patients, CT outcome can be predicted for low cost and without fMRI. For the remaining individuals, fMRI is useful in both statistical prediction and case formulation, and thus may be warranted in otherwise hard-to-formulate cases.

NO. 5
WHAT DOES IT MEAN TO ‘TURN TOWARD EXPERIENCE’? NEURAL MECHANISMS OF MINDFULNESS MEDITATION TRAINING IN REMITTED DEPRESSION
Speaker: Norman A. S. Farb, Ph.D.

SUMMARY:
Emerging evidence suggests that mindfulness-based interventions (MBIs) are prophylactic against relapse in recurrent Major Depression. Theoretically, MBIs reduce ruminative responses to emotion provocation by directing attention non-judgmentally towards momentary experience. However, the neural mechanisms underlying mindfulness-based prophylaxis are poorly understood. In an active-control fMRI study of patients with remitted depression, Mindfulness-Based Stress Reduction was compared to a Progressive Relaxation intervention. Results suggest that while both training interventions improved well-being, mindfulness was uniquely associated with increased acceptance of emotional experience, increasing rather than suppressing visceral processing of emotion along an insula-based pathway. These findings begin to provide a neuroscientific account of 'turning towards' emotional experience as a form of emotion regulation, one that may particularly important for sustained recovery from Major Depression.

MAINTENANCE OF CERTIFICATION: WHY, WHAT, AND HOW

Chairs: Mark H. Rapaport, M.D., Deborah J. Hales, M.D.

Discussant: Mark H. Rapaport, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the American Board of Medical Specialties rationale for time-limited Board Certification, and the organization of the ABMS; 2) Know the current requirements of MOC for the ABPN, and the ABPN relationship to ABMS and APA; 3) Learn the available activities that meet MOC requirements for psychiatrists.

SUMMARY:
Maintenance of Certification (MOC) is an initiative mandated by the American Board of Medical Specialties (ABMS) to ensure that physician specialists offer quality patient care through an ongoing process of self-improvement and performance improvement. The American Board of Psychiatry and Neurology, the certifying board for psychiatrists, is one of 24 member boards of the American Board of Medical Specialties. The ABMS oversees the 24 member specialty boards and dictates the basic requirements of MOC.
Certificates issued by the American Board of Psychiatry and Neurology (ABPN) after October 1, 1994, are 10-year, time-limited certificates and expire on December 31, 10 years from the year of the successful board certification. MOC entails four basic components (for all physicians certified after 1994):
Part 1 - professional standing (an unrestricted license to practice medicine)
Part 2 –self-assessment (ABPN-approved) and continuing medical education (CME)
Part 3 - cognitive expertise (the recertification examination)
Part 4 - Performance in Practice (ABPN-approved chart review and feedback modules)
This symposium will cover the ABMS history and planned 2015 standards for MOC, the ABPN MOC requirements for psychiatrists and a number of ways that psychiatrists can meet those requirements.

NO. 1
ABMS CONTINUING CERTIFICATION: FOR OUR PATIENTS, THE PUBLIC, AND OUR PROFESSION
Speaker: Lois M. Nora, J.D., M.B.A., M.D.

SUMMARY:
The American Board of Psychiatry and Neurology (ABPN) is one of 24 Member Boards of the American Board of Medical Specialties (ABMS). ABMS Continuing Certification includes initial board certification and, for the past decade, continuing certification through the Program for Maintenance of Certification (MOC). The ABMS Program for MOC is relatively young and has been implemented by the ABPN for about seven years. In this presentation, the speaker will provide a brief historical overview of ABMS Board Certification, including the rationale for MOC. Identified strengths and weaknesses of the overall ABMS Program for MOC will be reviewed together with steps that are being taken to build upon the strengths and remediate weaknesses. New standards, scheduled to be implemented in January 2015, will be reviewed. The importance of the Program for MOC to medical professionalism and public accountability, and the potential value of high-value MOC programs to psychiatrists will be discussed.

NO. 2
ABPN PERSPECTIVES ON MAINTENANCE OF CERTIFICATION
Speaker: Larry R. Faulkner, M.D.

SUMMARY:
As mandated by the American Board of Medical Specialties, the American Board of Psychiatry and Neurology has developed a maintenance of certification program for specialists and subspecialists that has four components: professional standing (licensure); self-assessment and continuing medical education (CME); cognitive expertise (computerized multiple-choice examination); and assessment of performance in practice, including peer and patient ratings. The phase-in schedule for the components and the options that are available for meeting the requirements will be presented. The computerized multiple-choice examinations will be described, as will examination results. Participation rates will also be presented. Related issues such as research on the development and maintenance of professional expertise and maintenance of licensure will also be discussed.

NO. 3
HOW THE APA CAN HELP MAKE MOC EASY FOR YOU
Speaker: Deborah J. Hales, M.D.

SUMMARY:
The APA has a number of programs to assist psychiatrists

participating in MOC. Focus: the Journal of Lifelong Learning in Psychiatry offers subscribers a complete ongoing program for MOC which includes annual self-assessments, clinical reviews, columns on core competencies and Performance in Practice Modules. All APA members have free access to Performance in Practice modules, and several options for self-assessment, as well as an MOC workbook series. All APA programs will be discussed in detail.

NO. 4
I DID IT AND IT AIN'T ROCKET SCIENCE
Speaker: Philip R. Muskin, M.A., M.D.

SUMMARY:
I will review how I completed the MOC requirements necessary to sit for the recertification examination in Geriatric Psychiatry in 2011. The process was not horrible and I actually learned things along the way. My message is simple, "If I can do it, anyone can do it."

DSM-5 PSYCHOSIS CHAPTER

Chairs: William T. Carpenter, M.D., Rajiv Tandon, M.D.

Discussant: William T. Carpenter, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of the session, the participant should be; ; able to: 1) Understand changes from DSM -IV to DSM -5; ; 2) At the conclusion of the session, the participant should be; ; Appreciate the role of dimensions and cognition in psychotic; ; disorders; 3) Anticipate differences between DSM -5 and; ; ICD -11.; ; ; 4) Understand the controvery regarding Attenuated Psychosis Syndrome.

SUMMARY:
In this symposium we intend to present the most critical changes relating to the psychotic disorders. The symposium is designed for audience participation with each speaker and extensive Q and A time at the end of the five presentations. The chair [Carpenter] will introduce the symposium. Dr. Tandon will describe the DSM-5 process andl present the important changes associated with concepts, criteria and overall organization of the chapter. Dr. Malaspina will describe the addition of a new paradigm based on domains of psychopathology as dimensions. Dr. Gur will present information on the role of cognition impairment in the psychoses and related disorders. Dr. Tsuang will present on the controversial issue of attenuated psychosis syndrome as a new classification. Dr. Gaebel, a member of the DSM -5 Psychoses Work Group and Chair of the Psychosis Section for ICD -11 will present points of difference between the two classification systems. Dr. Carpenter will engage the audience in discussion

NO. 1
ATTENUATED PSYCHOSIS SYNDROME
Speaker: Ming Tsuang, M.D., Ph.D.

SUMMARY:
Existing diagnostic criteria of schizophrenia lack specific information which describe and differentiate its early stages. To address this, and based on the experience of the various early psychosis programs, the Psychotic Disorders Workgroup has considered the inclusion of a new category " Attenuated Psychosis
Syndrome (APS)" within the appendix of DSM -V. APS describes a condition with recent onset of modest, psychotic like symptoms, and clinically relevant distress and disability. The inclusion of APS within the appendix shall encourage more research in order to verify its criteria. A family history of psychosis places the individual with APS at increased risk for developing a full psychotic disorder. In the DSM V context, clinicians can use this category to identify individuals who are at high risk of serious mental illness, and plan suitable interventions that specifically target the very early stages. The implications and application of APS will be discussed.

NO. 2
CONCEPTUAL AND CRITERIA CHANGES FROM DSM-5
Speaker: Rajiv Tandon, M.D.

SUMMARY:
Changes in the psychotic disorders section in DSM-5 incorporate new knowledge about these conditions and address current limitations in their clinical utility and application. Changes from DSM-IV include: (i) better delineation of boundary between schizophrenia and schizoaffective disorder; (ii) deletion of the current subtypes of schizophrenia; (iii)introduction of specific illness dimensions; (iv) consistent definition and treatment of catatonia across the manual and introduction of a residual category of catatonia NEC; (v) clarification of boundary between delusional disorder and psychotic manifestations of anxiety and somatoform disorders. Proposed changes are intended to increase clinical utility (fewer diagnoses, better demarcation between disorders, greater treatment relevance [dimensions]) and modestly improve validity, while retaining the reliability in diagnosing various psychotic disorders.

NO. 3
DOMAINS AND SYMPTOMS OF PSYCHOSIS IN THE DSM-5
Speaker: Dolores Malaspina, M.D., M.P.H., M.S.

SUMMARY:
New information is being continually added to our understanding of psychiatric disease entities from research on phenomenology, course and outcome studies, neuroscience and epidemiology. This information has shaped the subtle transformations in the psychosis chapter in the DSM 5. Crucially however, the DSM is retaining the historical approach of making categorical diagnoses even though overlapping behaviors, genes, neurocircuitry and domains of psychopathology clearly cut across quite different disease catego-

ries. Unfortunately this information is not yet sufficiently delineated and established to transform the DSM 5, which must serve clinicians, patients and systems of care. It is anticipated that the field will depart from using categorical diagnoses in the future and adopt a system that quantitates dysfunction in separate domains for symptom-specific treatment. The DSM 5 has an enhanced focus on dimensions of psychopathology and the capability to usefully bridge with future classifications, including those that may emerge from the NIMH Research Diagnostic Criteria (RDoC) Initiative.

NO. 4
NEUROCOGNITION IN PSYCHOSIS
Speaker: Raquel E. Gur, M.D., Ph.D.

SUMMARY:
Cognitive deficits are evident in individuals with psychotic disorders. In schizophrenia, the impairment is associated with poor functional outcome. Furthermore, psychosis-prone youths also show impaired performance before symptoms meet diagnostic criteria. This presentation will first highlight the literature where diverse measures of neurocognitive domains have been applied with consistent findings implicating fronto-temporal dysfunction. Against this background, data will be presented on the application of a computerized neurocognitive battery that examines accuracy and response time on tests that evaluate executive (abstraction and mental flexibility, attention, working memory), memory (verbal, facial, spatial), cognition (language, non-verbal reasoning, spatial processing) and social cognition (emotion identification, emotion differentiation and age discrimination) domains. Individuals with schizophrenia are impaired in accuracy and response time in multiple domains compared to those endorsing sub-threshold psychotic symptoms.

NO. 5
PSYCHOTIC DISORDERS IN DSM-5: ANTICIPATED DIFFERENCES WITH ICD-11
Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:
DSM -5 created a section on “Schizophrenia Spectrum and Other Psychotic Disorders”, which includes both the primary psychotic disorders and those related to other medical conditions or substance use/withdrawal. In ICD -11, the section is entitled “Schizophrenia Spectrum and other primary psychotic disorders” and will only include the primary psychotic disorders. Functional impairment will not be a mandatory general requirement to diagnose a mental disorder in ICD -11. ICD -11 will have a set of specifiers of course and symptoms while DSM -5 will have a similar “dimensional assessment”. Course specifiers will be similar in both systems. Catatonia will be a specifier, also the other schizophrenia subtypes will be represented in symptom specifiers. In schizophrenia, the time criterion of four weeks will be kept in ICD -11 and that of six months in DSM -5. In ICD -11, the delusional and the acute and transient psychotic disorders will be reorganized to better represent similar clinical presentations in the same group of disorders. An “attenuated psychosis syndrome” will most probably not be a “full” mental disorder in ICD -11.

ETHICAL ISSUES SURROUNDING NEUROSTIMULATION IN OLDER ADULTS

Chairs: Maria I. Lapid, M.D., Osama Abulseoud, M.D.

Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate the complexities of decision making process in selecting psychiatric patients for deep brain stimulation (DBS) in clinical and research settings; 2) Learn about the multidisciplinary approach in the selection process; 3) Identify ethical issues surrounding DBS as a novel psychiatric treatment .

SUMMARY:
The unique capability of Deep Brain Stimulation (DBS) to modulate human behavior creates ethical challenges that require articulation and consideration as part of the decision to use this treatment. The ethical principles of beneficence, non-maleficence, autonomy and justice need to be integrated in the discussion of DBS use at a multidisciplinary level. Open discussion of tensions among these ethical principles is needed as the use of DBS expands to patients with psychiatric disorders. In this symposium we will illustrate these vital issues through two case reports of patients with treatment refractory Parkinson’s disease. The first patient had successful surgery while the second patient was not offered the surgery. The outcome in both cases was unfavorable, which brings these very concerns to the forefront. We then will discuss the concept of a multidisciplinary selection committee, including a psychiatrist, neurosurgeon, neuro-ethicist, neuropsychologist, neurologist, among others, working together to optimize the risk/benefit ratio and make sure that patients’ autonomy is respected. Ethical issues in DBS research and clinical care will be reviewed in the context of patients with treatment-refractory psychiatric disorders.

NO. 1
TREATMENT CONSIDERATIONS FOR MANIA STATUS POST DBS FOR PARKINSON’S DISEASE
Speaker: Osama Abulseoud, M.D.

SUMMARY:
Subthalamic Nucleus Deep Brain Stimulation (STN-DBS) has proven efficacious in the treatment of selected cases of Parkinson’s disease (PD). Motor symptoms are the main target of STN-DBS, yet it can also have an impact on mood, behavior and cognition. We present a 77 year-old male with dopamine replacement therapy (DRT)-responsive idiopathic PD who underwent bilateral STN-DBS. Past psychiatric history and baseline neuropsychological testing were unremarkable.

Motor improvement was significant (i.e., clinical improvement and ability to reduce levodopa equivalent daily dosing by more than 40%) but complicated by the development of manic symptoms requiring multiple hospitalizations and legal interventions including court appointed guardianship and conservatorship and authorization to impose neuroleptic drugs (Jarvis). The patient died two years later with complications of PD –associated aspiration pneumonia. This case highlights the challenges in selecting appropriate candidates for DBS and the possibility of psychiatric adverse outcomes in the context of motor symptom improvement.

NO. 2
DBS CONSIDERATIONS FOR PARKINSON'S DISEASE (PD) COMPLICATED BY MANIA SECONDARY TO GENERAL MEDICAL CONDITION
Speaker: Mark Frye, M.D.

SUMMARY:
Early data suggests Parkinson's disease (PD) patients with psychiatric comorbidity can achieve the same motor improvement with Subthalamic Nucleus Deep Brain Stimulation (STN-DBS) as PD patients without psychiatric comorbidity (Chopra et al., 2013). The unanswered question is whether PD patients with psychiatric comorbidity are at greater risk for DBS-associated serious adverse events (i.e., mania, psychosis, suicide). We present a 44-year old man who was diagnosed with early onset PD. Carbidopa-levodopa resulted in significant short-term improvement, though associated with intolerable "off symptoms" of stiffness and dyspnea. Past medical history included secondary dysautonomia, REM behavior sleep disorder, and manic induction with pramipexole treatment. His pattern of self-increasing carbidopa-levodopa dose to achieve greater motoric improvement fueled psychotic manic symptomatology requiring multiple antimanic treatments and more than 5 psychiatric hospitalizations over 10 months. Given the ongoing mania and psychosis and multiple hospitalizations, the DBS clinical committee recommended 6 months of stability prior to DBS implantation. During that interval, when divorce proceedings were finalized, the patient committed suicide. This case highlights that while there may have been theoretical benefit of restricting access to oral medications, the clinical stability of psychiatric comorbidity is critical in optimal identification of appropriate patients for DBS treatment.

NO. 3
DEEP BRAIN STIMULATION CLINICAL COMMITTEE AT THE MAYO CLINIC
Speaker: Maria I. Lapid, M.D.

SUMMARY:
The Deep Brain Stimulation (DBS) program at Mayo Clinic completes ~ 80 surgeries on an annual basis. The DBS clinical committee, composed of representatives from Neurosurgery, Neurology, Psychiatry, Neuropsychology, Neuroradiology, Speech Pathology, and Ethics, meets on a weekly basis to review each case that is being considered for deep brain stimulation. In general, the DBS clinical committee would have concerns and reservations about pursuing DBS for a patient who has evidence of any of the following: significant neuropsychological cognitive impairment, unrealistic expectations of DBS outcomes by patient and/or family members, or unstable psychiatric symptoms. In the case presented by Dr. Abulseoud, with no past psychiatric history or evidence of neurocognitive impairment on exam, the DBS clinical committee approved STN deep brain stimulation for his Parkinson's disease. In the case presented by Dr. Frye, given the unstable psychiatric condition, the DBS clinical committee declined extending an invitation for DBS surgery. This presentation will further review the operation of the clinical committee and future IRB considerations of DBS for primary psychiatric conditions.

NO. 4
CAPACITY IN DBS RESEARCH AND TREATMENT FOR PATIENTS WITH PSYCHIATRIC DISORDERS AND SYMPTOMS: CONCEPTUAL AND EMPIRICAL ISSUES
Speaker: Laura B. Dunn, M.D.

SUMMARY:
Increased use of DBS for treatment-refractory psychiatric and neurologic disorders has raised ethical concerns about the adequacy of safeguards for human subjects. The nature of DBS and potential vulnerability of participants have raised worries about whether study participants have capacity to give informed consent. Empirical inquiry into these concerns suggests that the vast majority of prospective participants under consideration for early trials of DBS for treatment-resistant depression (TRD) had adequate decisional capacity. Most understood the risks and had reasonable expectations of benefit. However, in the clinical cases presented here, while assessing capacity to consent for DBS research was not the primary task of the DBS program, there are overlapping issues including assessing the patient's expectations of benefit and understanding of risk. Unpredictable psychiatric complications of DBS in PD patients (including those with no psychiatric history) may raise additional ethical concerns for this intervention. Arguments for and against additional safeguards in this context will be presented. Existing data on capacity to consent to treatment and research in patients with serious psychiatric and neurological disorders will be reviewed, and an agenda for further research on ethical issues in DBS research and clinical care will be presented.

INTEGRATIVE AND NON-MEDICATION TREATMENTS FOR ATTENTION DEFICIT/HYPERACTIVITY DISORDER: HERBS, NUTRIENTS, MINDFULNESS, YOGA, BREATHING, AND MOVEMENT

Chairs: Lidia Zylowska, M.D., Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss scientific research on herbs, nutrients, mindfulness training and breath-body-mind practices

relevant to improving treatment options for ADHD and co-morbid impairments.; 2) List non-medication treatment options that could benefit individuals and families living with ADHD.; 3) Describe a framework for integration of natural and mind-body treatments with standard ADHD approaches and locate additional educational resources to optimize such integration. .

SUMMARY:

ADHD impairs attention, executive function, impulse control, and emotion and behavioral self-regulation. It negatively impacts academic and work performance, self-esteem, stress level, socialization, and family relationships. Although pharmacotherapy is helpful, it is generally not sufficient to address the many facets of this complex disorder. Co-morbid conditions such as anxiety, insomnia, depression, PTSD, learning disabilities, and substance abuse are common. This workshop explores emerging non-drug ADHD treatment options that can be integrated with standard approaches to improve patient outcomes and minimize the burden of medication side effects. For each modality, the speakers present the neuro-psychiatric treatment rationale, research evidence, practical techniques, precautions, potential adverse effects, and their experiences using these treatments in clinical work. The mindfulness, yoga and breath-body-mind segments include illustrative experiential components. Dr. Gerbarg reviews natural supplements with evidence of benefits in ADHD, including herbs, nutrients, nootropics, and melatonin. Dr. Zylowska discusses mindfulness techniques for work with children, families, and adults. Attendees will participate in mindfulness exercises that can foster self-regulation skills in patients with ADHD. Ms. Bennett will describe and demonstrate methods she has used successfully for children with ADHD, PTSD, and behavioral dysregulation who could not be placed in regular schools. Dr. Brown and Dr. Gerbarg demonstrate movement and breathing practices that improve attention, cognitive function, emotion regulation, and behavioral control while reducing anxiety, insomnia, anger, and depression.

Attendees will have opportunities for questions, answers and discussion with the presenters.

NO. 1

NATURAL TREATMENTS FOR ADHD: DIET, HERBS, NUTRIENTS, NOOTROPICS AND MELATONIN

Speaker: Patricia L. Gerbarg, M.D.

SUMMARY:

Dr. Patricia Gerbarg discusses complementary and alternative methods to enhance the benefits of standard treatments and reduce medication dependence and side effects. For the following treatments, the speaker will present neuro-physiological mechanisms, “nutromics” (genetic aspects), research evidence, clinical experience, and guidelines for deciding which supplements to use based upon patient history, symptoms and characteristics.

1.Dietary Issues: When is it worth the battle?

2.Herbs: Rhodiola rosea, ginseng, ginkgo, French maritime pine tree bark, Lemon balm, Passionflower, Valerian

3.Nutrients: Omega-3 fatty acids, B vitamins, folate, minerals, acetyl-L-carnitine, S-adenosylmethionine, racetams,

4.Melatonin

NO. 2

MINDFULNESS-BASED THERAPIES FOR ADHD ACROSS THE LIFESPAN

Speaker: Lidia Zylowska, M.D.

SUMMARY:

Mindfulness (or mindful awareness) is meditation-based training of attention/cognitive and emotion regulation skills. Mindfulness-based therapies are increasingly incorporated into treatment of a variety of mental health conditions. Dr. Lidia Zylowska focuses on the application of mindfulness into ADHD care across the lifespan, supporting children, families, and adults managing ADHD. The rationale for incorporating mindfulness into ADHD care and research regarding mindfulness and ADHD will be discussed. Studies of mindfulness and working memory, attention and emotion regulation will be reviewed together with research on parenting and stress management. Up-to-date research and clinical work regarding mindfulness-based training for adults and families with ADHD will be outlined. Participants will have opportunities to experience formal mindfulness exercises used in mindfulness-based therapies and learn ways to incorporate brief moments of mindfulness into daily life.

NO. 3

EFFECTIVE SCHOOL YOGA PROGRAM FOR CHILDREN WITH ADHD, PTSD, SEVERE BEHAVIORAL AND EMOTIONAL DYSREGULATION

Speaker: Joy Bennett

SUMMARY:

Joy Bennett, ERYT-500, LFYP-2 will demonstrate and discuss the yoga methods she developed for teaching elementary school children with ADHD, PTSD, and severe behavioral and emotional dysregulation, who could not be managed in any other school. During the first two years she was able to engage highly distractible children in yoga classes and provide techniques the teachers used to help the children cope with stressful situations. She will also describe how she improved the children’s awareness of their bodies, their abilities to self-soothe, their emotion regulation, and behavior. Positive effects on the teachers and classroom were also noted.

NO. 4

BREATH-BODY-MIND TREATMENTS FOR ADHD

Speaker: Richard P. Brown, M.D.

SUMMARY:

Breath-body-mind practices were developed to provide rapid and long-term relief for stress, anxiety, depression, and PTSD by balancing the stress-response systems, improving mental focus, emotion regulation, calmness, bonding, and awareness of self and others. These effects are particu-

larly applicable to individuals and families living with ADHD. Dr. Brown and Dr. Gerbarg derived practices from yoga, qigong, Orthodox Christian monks, and meditation to create techniques that are simple to learn, easy for everyone, rapidly effective, and safe regardless of physical or emotional condition. Neuro-physiology and research evidence base, risks, benefits, and contraindications will be reviewed. Participants will experience breath practices suitable for patients with ADHD, including Coherent Breathing with Breath Moving, "Ha" breath, and a mild brief kapalabhati. For more experiential practice see APA 2013 Course by Drs. Brown and Gerbarg, Yoga of the East and West or www.haveahealthymind.com.

WALTER REED FROM 9-11 TO TODAY: HOW THE LONGEST WAR CHANGED MILITARY PSYCHIATRY

Chairs: Scott Moran, M.D., Brett J. Schneider, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Initial mental health response to 9-11 attacks on the Pentagon; 2) Describe and appreciate how the US Military evolved in mental health care over the period from 2003 to today; 3) Recognize the future mental health challenges which will result from US Military involvement in war over a long period of time.

SUMMARY:
America has been at war longer than in any period in its history. This symposium will discuss the evolution of military psychiatry from 9-11 through today. The discussants will review and discuss the initial mental health response to 9-11 attacks on the Pentagon describing their actual experience at the Pentagon following the attacks. Then we will review how the US Military health care focus changed from one of physical injuries to mental injuries over the period from 2003 to today, with special emphasis on TBI, PTSD and suicide. Finally the discussants will review and predict some of the mental health challenges faced by our nation in the future as a result of 13 years of war

NO. 1
MENTAL HEALTH RESPONSE TO THE 9-11 PENTAGON ATTACK: IMMEDIATE AND LONG TERM IMPACTS
Speaker: Charles S. Milliken, M.D.

SUMMARY:
Within days of the September 11, 2001 attack on the Pentagon, the number of pentagon employees, military and civilian, presenting for interventions in the on-site Pentagon clinic had slowed to a trickle. Operation Solace, the behavioral health response to the Pentagon attack adopted methods of prevention and outreach that operated both inside and outside the clinical setting and reached thousands of workers and their families. Awareness of sensitized senior military leaders that responding to stress-related trauma would be a priority led to a military-wide focus on proactive preventive interventions that included enhanced MH screening, evidence-based psychoeducation, unprecedented access to Active Duty Soldiers and Marines for confidential research both in theater and upon return home, and programs such as Military One Source and the Deployment Cycle Support Program.

NO. 2
PSYCHIATRY CONSULTATION LIAISON APPROACH AFTER THE PENTAGON ATTACK
Speaker: Harold J. Wain, Ph.D.

SUMMARY:
The Pentagon Attack of 2001 created a new approach for the Walter Reed Army Medical Center Psychiatry Consultation Service (PCLS) that led to the new prototype of responding to patients with medical surgical injuries following a traumatic event. This approach has been continued in that patients are seen without a formal consult within 24-48 hours of arrival into the hospital. Another early barrier to early psychiatric intervention considered was the stigma this could have presented for the patients and their families. In order to attempt destigmatize mental health and to decrease chronic psychiatric co-morbidity the Psychiatry Consultation Liaison Service fashioned an innovative approach labeled Preventive Medical Psychiatry. Though, capturing some of the more traditional bio-psycho-social approaches every hospitalized patient is seen within 48 hours of arrival routinely. The approach provides a framework to explore vital issues such as the injury, mortality, grief and loss, physical limitations, anxiety, impact of personality styles, self efficacy, resiliency, depression, delirium PTSD, TBI and any prior traumatic exposure or pre-morbid, post morbid medical or psychiatric issues. A myriad of tailor-made medical, supportive, psychotherapeutic and pharmacological treatments are crafted together to address the unique needs of these patients.

NO. 3
THE EVOLUTION OF MILITARY TRAUMATIC BRAIN INJURY
Speaker: Louis M. French, Psy.D.

SUMMARY:
While military traumatic brain injury research and clinical care over about the last 75 years had largely focused on the penetrating craniocerebral wound, current military conflicts presented a need for assessment and treatment of mild TBI (concussion), both on the battlefield and in military healthcare facilities. Walter Reed, along with the Defense and Veterans Brain Injury, led that effort. This presentation will discuss some of the history around military TBI, the challenges in developing care models, and the ongoing debate about the relative contribution of brain pathology and emotional distress to symptom presentation.

NO. 4
TRANSFORMATION OF MENTAL HEALTH SERVICES TO MEET THE NEEDS OF THE DEPLOYED SOLDIER

Speaker: John Bradley, M.D.

SUMMARY:
The terrorist attacks of 9/11/01 shifted the Nation's focus toward a wartime footing to combat islamic extremism. The largescale military mobilization necessary to deploy to two theaters of operations required a focus on combat stress control to minimize the psychological impact of deployment on the military force. While many lessons from previous operations had been learned and forgotten, this new type of military operation would require transformational change. This presentation will review the concepts of psychiatric care and prevention across the continuum of the operational cycle and focus on the advancements in the organization and delivery of clinical care for Soldiers and their Families with newly recognized clinical syndromes and needs.

USING CLOZAPINE: PUBLIC AND ACADEMIC APPROACHES TO FULL RECOVERY

Chairs: Cassis Henry, M.A., M.D., Matthew D. Erlich, M.D.

Discussant: Lloyd Sederer, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the rationale for using clozapine as part of recovery-oriented prescribing; 2) Determine site-specific barriers to clozapine use and list strategies to address barriers in public, academic, and community mental health settings; 3) Understand approaches to training early-career psychiatrists (ECPs) to use clozapine safely and appropriately; 4) Recognize ways to engage consumers, prescribers and administrators in shared decision-making involving clozapine; 5) Identify elements of initiatives to improve evidence-based clinical care in a public mental health system.

SUMMARY:
Clozapine's underutilization is the quintessential science-to-service gap in behavioral health services. Long-recognized as the most efficacious medication for treatment-refractory schizophrenia, clozapine has gained the unfortunate reputation of being difficult to tolerate, prescribe, and disseminate as an evidence-based practice for consumers, prescribers, and advocates alike. Moreover, there are clinical and geographic disparities in the use of clozapine nationally and statewide. Importantly, there is also limited teaching on and clinical exposure to clozapine in psychiatry residency training, leading to a dearth of experienced clinicians and administrators and further stigmatizing the use of clozapine. This symposium addresses the following: first, strategies to improve trainee exposure to and familiarity with clozapine in order to promote its appropriate use among early-career and other psychiatrists; second, approaches to disseminating evidence-based policies and practices including the use of clozapine (and complementary initiatives) within a large public mental health system; third, compatibility of clozapine with other recovery-oriented practices; and finally, we will review methods for "crossing the quality chasm" between knowledge and practice through academic-public collaboration.

NO. 1
FORGING THE PATHWAY FROM RESEARCH TO PRACTICE FOR SERIOUS MENTAL ILLNESS (SMI)
Speaker: Gregory A. Miller, M.B.A., M.D.

SUMMARY:
State Mental Health Agencies face demands to deliver evidence based practices that are individualized, community based, and recovery oriented to people with serious mental illness (SMI). The New York State Office of Mental Health (NYS OMH) directly operates a large public mental health system, licenses state mental health services, and oversees Medicaid for behavioral health services, making it one of the largest public mental health systems worldwide. NYS OMH develops initiatives aiming to reduce the research to practice gap that make the most of system embedded advantages: large population data; partnership with academic health services researchers; and systematic outcomes review. NYS OMH has implemented clinical initiatives that couple data with dissemination of evidence based interventions that reduce the burden of chronic medical illness on people with SMI. People with SMI die early, largely due to preventable chronic medical illness such as cardio-metabolic syndrome, smoking related illness, and medical complications from psychotropic medications. NYSOMH initiatives that will be summarized: Appropriate clozapine treatment, cardio-metabolic monitoring , an electronic checklist for anti-psychotic prescribing, integrated Tobacco Dependence Treatment , medicaid Data Quality Indicators. The summary of these initiatives will set the stage for discussion of approaches to dissemination of evidence based use of clozapine in large public mental health system.

NO. 2
HIGH-VOLUME, SPECIALIZED OUTPATIENT CLOZAPINE CLINICS FOR TIMELY AND SAFE CLOZAPINE PRESCRIBING
Speaker: Oliver Freudenreich, M.D.

SUMMARY:
High-volume specialty clinics offer an opportunity for excellent clinical care and learning. Establishing special clozapine outpatient clinics that allow for routine, timely and safe use of clozapine should be a priority for psychiatry as such clinics can remove some barriers to prescribing. In this presentation we describe elements of one exemplary local solution of a clozapine clinic that represents a collaboration between an academic program (MGH Schizophrenia Program) and a community provider (Erich Lindemann Mental Health Center). Centralizing care in our clozapine clinic has allowed us to 1) routinely offer clozapine to any patient in our system, including refractory first-episode patients, and 2) focus on the early prevention of medical morbidity and mortality as an integral aspect of care. Our clinic provides rotating psychiatry residents with a model of longitudinal and integrated

medical-psychiatric care that includes prevention.

NO. 3
PREDICTORS OF CLOZAPINE USE IN THE U.S.
Speaker: Thomas S. Stroup, M.D., M.P.H.

SUMMARY:
Background: Antipsychotic medications are largely ineffective for patients with treatment-resistant schizophrenia. Clozapine is the only antipsychotic approved for treatment-resistant schizophrenia, but it is rarely used. This study examined clinical and geographic factors associated with clozapine use in the U.S. to help identify ways to improve its use.
Methods: A retrospective study using U.S. Medicaid claims data from 45 states was conducted among 326,119 individuals with a schizophrenia disorder who started one or more new antipsychotic treatment episodes between January 2002 and December 2005. Multivariable logistic regression models were used to calculate odds ratios of baseline factors associated with clozapine initiation.
Results: Among 629,809 new antipsychotic treatment episodes, clozapine accounted for 2.5% of new antipsychotic starts among patients in the overall sample. Among patients with service use patterns consistent with treatment resistance, 5.5% started clozapine. Clozapine initiation was associated with male sex, younger age, white race, more frequent outpatient service use for schizophrenia, and greater prior-year hospital use for mental health. Living in a county with historically high rates of clozapine use was among the strongest predictors of clozapine use.
Conclusions: The clozapine initiation rate was low and strongly affected by local treatment practices. Quality improvement efforts are indicated to improve recovery opportunities.

NO. 4
VARIATIONS IN OUTPATIENT CLOZAPINE UTILIZATION: THE NEW YORK STATE OFFICE OF MENTAL HEALTH EXPERIENCE
Speaker: Jay Carruthers, M.D.

SUMMARY:
The underutilization of clozapine is perhaps the quintessential science to service gap in behavioral health services. Despite being regarded as the most efficacious antipsychotic for treatment refractory schizophrenia for the past 30 years, it remains underutilized across the United States, including within the New York State Office Office of Mental Health (OMH) system, the largest public psychiatry system in the nation.
OMH directly operates a public mental health system that treats about 3000 inpatients and over 25,000 community based patients across the state. Treatment refractory psychosis is the most prevalent form of serious mental illness treated witihin the OMH system. The population served is particularly suited to benefit from appropriate utilization of clozapine. To that end, OMH launched a multifaceted “Clozapine Best Practices Initiative” in the fall of 2011 aimed at increasing outpatient utilization. Focusing on adult services, data collected to date reveal wide variations across and within State Operated systems. Despite the vast heterogeneity of the OMH system, certain patterns have emerged in examining relatively high and low utilization rates that inform current efforts.

POSITIVE PSYCHIATRY AND RESILIENCE

Chairs: Dilip V. Jeste, M.D., Dennis S. Charney, M.D.

Discussant: P. Murali Doraiswamy, M.B.B.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define and describe the characteristics of positive psychiatric outcomes such as well-being and positive traits such as resilience; 2) Understand the biological basis of resilience and related positive psychological traits; 3) Use psychotherapeutic interventions in regular clinical practice that focus on enhancing patients’ well-being.

SUMMARY:
Psychiatry has traditionally been defined and practiced as a branch of medicine focused on diagnosis and treatment of mental illnesses. This definition warrants expansion to include the concept of Positive Psychiatry –the science and practice of psychiatry that seeks to understand and promote well-being through assessment and interventions involving positive psychological attributes in people who suffer from or are at risk of developing mental or physical illnesses. Positive Psychiatry includes positive mental health outcomes (e.g., well-being) as well as positive psychological traits such as resilience and hardiness, optimism, social engagement, and wisdom. These traits are associated with significant positive health outcomes that include better overall functioning, reduced susceptibility to cardiovascular, metabolic, and other physical diseases and depression, and greater longevity. This symposium will focus on defining and describing resilience as well as other positive traits and outcomes such as reduced perceived stress. Additionally, there will be a discussion of the neurobiology underlying these constructs and also of various interventions to enhance well-being that are pragmatic and can be used in regular clinical practice. By strengthening the development of positive traits though psychotherapeutic, behavioral, psychosocial, and eventually biological, interventions, Positive Psychiatry has the potential to improve health outcomes and reduce morbidity as well as mortality in people with mental as well as physical illnesses. Thus the Positive Psychiatry of future is likely to be at the center of overall healthcare.

NO. 1
POSITIVE PSYCHIATRY ACROSS THE LIFESPAN
Speaker: Dilip V. Jeste, M.D.

SUMMARY:
Positive Psychiatry extends Psychiatry beyond treatment

of mental illnesses, and focuses on promoting well-being through assessment and interventions involving positive psychosocial attributes in people with mental or physical illnesses. We are conducting longitudinal psycho-bio-social studies of over 1,500 randomly selected community-dwelling adults as well as adults with schizophrenia and HIV-infected people. We find that, across board, contrary to the usual stereotypes of aging, older age is associated with higher well-being and better psychosocial functioning, despite worsening physical health. Resilience and absence of depression have effects on self-rated successful aging with magnitudes comparable to that of physical health. By strengthening the development of positive traits though psychotherapeutic and other interventions, Positive Psychiatry has the potential to improve health outcomes and reduce morbidity and mortality in people with mental and physical illnesses.

NO. 2
RESILIENCE: FROM PSYCHOLOGY TO BIOLOGY
Speaker: Dennis S. Charney, M.D.

SUMMARY:
Many of us will be struck by one or more major traumas sometime in our lives. Perhaps you have been a victim of sexual abuse, domestic violence, or assault. Perhaps you were involved in a serious car accident. Perhaps you are a combat veteran. Or maybe you are among the millions who have suffered a debilitating disease, lost a loved one, or lost a job. Based upon work discussed in my book, Resilience: The Science of Mastering Life's Greatest Challenges, I will present how new research into the psychological, biological and social impact of trauma can help us manage our own stressors and tragedies. Drawing on two decades of work with trauma survivors, I along with my co-author, Dr. Steven Southwick, have woven the latest scientific findings together with extraordinary stories of people who have overcome seemingly impossible situations. The question that is frequently asked is "How did you do it?" I will present the ten "resilience factors" that we found survivors use to cope, and how individuals can learn to become stronger and more resilient. This can provide a vital roadmap for overcoming and potentially growing from the adversities we all face at some point in our lives.

NO. 3
PERCEIVED STRESS, DEPRESSSION, AND TELOMERES
Speaker: Owen Wolkowitz, M.D.

SUMMARY:
Chronic stress and depression are associated with diseases seen with aging, e.g. cardiovascular disease. These associations raise the possibility that accelerated biological aging, indexed by peripheral leukocytes' telomere length and telomerase activity, is a key mechanism. Telomeres are an important nexus between psychological and physical health, and shortened telomeres are associated with increased risk of medical illnesses and premature mortality. As telomere dynamics become better understood, novel interventions to treat or prevent accelerated biological aging may become available. This presentation will focus on pharmacological and behavioral/lifestyle changes that may slow the "biological clock" by increasing telomerase activity and/or preserving telomeres. Orientations toward life, expectations of adversity, effective coping and health behaviors may all affect the progression of aging at the level of the cell and may be harnessed for novel therapeutic approaches.

NO. 4
A DOSE OF POSITIVE PSYCHOLOGY FOR PSYCHIATRY
Speaker: Samantha Boardman, M.D.

SUMMARY:
This paper combines my experience and training in psychiatry with what I have learned from the field of positive psychology. It is a discussion of the potential ways psychiatrists can integrate positive psychology into their practice and, more broadly, how positive psychology enhances our understanding of the full range of human experience. Using the "tools" of positive psychology, psychiatrists can expand their range of treatment options and better engage patients in the treatment process. With this in mind, a psychiatrist's goal is two-fold: To (1) to treat the patient's symptoms and (2) to increase the patient's well-being. Positive psychology can help psychiatrists achieve this.

THE NEW DSM-5 DISSOCIATIVE SUBTYPE OF PTSD: DIAGNOSIS AND TREATMENT

Chair: Eric Vermetten, M.D., Ph.D.

Discussant: Robert J. Ursano, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn to diagnose the dissociative subtype of PTSD; 2) Perform differential diagnostic assessment in trauma-related disorders; 3) Apply new treatment opportunities for dissociative subtype of PTSD.

SUMMARY:
A Dissociative Subtype has been added to the diagnosis of Post-Traumatic Stress Disorder the DSM-5. This requires all of the DSM-5 PTSD symptoms plus depersonalization and/or derealization. This addition was made on the basis of latent class analyses of symptom clusters indicating a relatively distinct subgroup with more prominent dissociative symptoms, epidemiological data linking this subgroup to a history of early life trauma and suicidality, and neuroimaging evidence of frontal overactivity and limbic inhibition, rather than the more common hypofrontality and hyperarousal often seen with PTSD. Effective treatment of this disorder involves a primary focus on psychotherapy, with adjunctive use of medication for symptom control and treatment of comorbid disorders such as depression and anxiety. There is evidence that those with these dissociative symptoms benefit from

psychotherapies that emphasize stabilization, mood regulation, and relapse prevention, in addition to working through trauma-related memories. This symposium will address the array of treatments available for PTSD and dissociation, and how the presence of prominent dissociative symptoms affects the choice of psychotherapy and medication.

NO. 1
RECOGNIZING AND DIAGNOSING THE DISSOCIATIVE SUBTYPE OF PTSD
Speaker: Eric Vermetten, M.D., Ph.D.

SUMMARY:
Psychiatry has for long time struggled with the concept of dissociation. Earlier versions of DSM have not incorporated the clinical core of dissociation in trauma-related disorders or framed descriptors of dissociation beyond dissociative flashbacks and dissociative amnesia. This PTSD subtype in DSM5 has brought dissociation closer into the awareness for clinicians. The inclusion of this subtype is based on concurrent, biological and therapeutic/prognostic factors. The symptoms associated with this subtype, embedded in depersonalization and derealization, indicate detachment from personal experience and the surrounding world. A subgroup of PTSD patients meet these criteria. They can manifest in different populations, civilian groups, but also in the military and other uniformed personnel. Neuroimaging data indicate frontal hyperactivity and limbic suppression in response to script-driven trauma imagery among these individuals. Does diagnosis of the subtype require specific tools, observations, scales? Therapy is thought to be tailored to the ability to cognitively process information related to the self as well as trauma memories and requires new strategies and clinical approaches to the standard exposure-based therapies for PTSD. These questions will need to be addressed to encourage clinicians to use the new classification for the treatment of this subgroup of PTSD patients.

NO. 2
EMERGENT BIOLOGICAL EVIDENCE SUPPORTING THE DISSOCIATIVE SUBTYPE
Speaker: Rachel Yehuda, Ph.D.

SUMMARY:
The dissociative PTSD subtype represents an important advance in classification by recognizing a wide range of emotional states, including fear, anger, guilt and shame, in addition to dissociation and numbing. It has been of interest to examine the extent to which these symptoms may be uniquely associated with biological alterations, particularly those that represent enduring manifestations of trauma exposure. This presentation will demonstrate relationships with neuroendocrine and glucocorticoid receptor methylation in association with trauma and PTSD, and will explore whether these associations are mediated by childhood exposures. These molecular and endocrine data contribute to an already well established set of findings demonstrating unique neural pathways related to emotional regulation. The literature has debated the extent to which emotional dysregulation is best viewed as an outcome of fear conditioning through stress sensitization and kindling or rather, a distal vulnerability factor that contributes to trauma-related responses in the dissociative realm. In this presentation, epigenetic and molecular findings will help support the idea of emotional dysregulation and dissociation as traits with biological antecedents that may have origins in early development.

Lanius RA, Frewen PA, Vermetten E, Yehuda R. Fear conditioning and early life vulnerabilities: two distinct pathways of emotional dysregulation and brain dysfunction in PTSD. EJPT. 2010, 1:5467

NO. 3
CLINICAL STRATEGIES AND INTERVENTIONS THAT TARGET DISSOCIATIVE SYMPTOMS IN THE TREATMENT OF INDIVIDUALS WITH THE DISSOCIATIVE SUBTYPE OF PTSD
Speaker: Richard Loewenstein, M.D.

SUMMARY:
Specific strategies and interventions need to be applied to the treatment of patients that have high levels of dissociation. Since these patients often have the most severe PTSD symptoms, usually related to multiple early life traumatic events, specific strategies for stabilization of these symptoms are crucial to allow treatment to proceed. it is important to emphasize a focus on safety for these patients, many of whom are highly self-destructive and suicidal. In addition, the evidence base for specific interventions in this population will be discussed, as well as the need for additional treatment outcome research to provide a more rigorous framework for treatment.

NO. 4
FINDING FEELING: PSYCHOTHERAPY OF THE DISSOCIATIVE SUBTYPE OF PTSD
Speaker: David Spiegel, M.D.

SUMMARY:
Dissociation is a failure of integration, so the treatments for it must integrate emotion, cognition, memory, and somatic control. Suppression of emotion inhibits the neural connectivity that would facilitate integration of information about memory, identity, and consciousness. Dissociation during traumatic memory processing thus may interfere with habituation, a critical process for resolving PTSD during exposure-based treatments. Effective psychotherapy requires helping the patient to identify and manage affect associated with traumatic experiences, thereby reducing the need for suppression of it. Dissociation calls for re-integration, with an emphasis on acknowledging, bearing, and putting into perspective stressors and associated affect that contribute to the fragmentation of identity, memory, and consciousness. The role of dissociation in post-traumatic stress disorder, highlights its role in both regulating strong emotional response to trauma, and in suppressing such reactions to the point that treatments that should work, such

as prolonged exposure, may instead trigger further dissociation and prevent access to and working through of trauma-related memories. Thus effective treatment involves training in emotion regulation, cognitive restructuring, and danger avoidance, in addition to exposure-based working through of traumatic memories.

AFFECTIVE INSTABILITY: A SYMPTOM IN SEARCH OF A DIAGNOSIS

Chairs: Joseph F. Goldberg, M.D., Larry J. Siever, M.D.

Discussant: Michael First, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the phenomenology and clinical psychopathology associated with affective instability across borderline, bipolar and other disorders involving affective dysregulation; 2) Discuss the developmental, interpersonal, and neurobiological dimensions of affective instability as a possible endophenotype in multiple disorders; 3) Review current evidence-based pharmacologic and psychotherapeutic approaches to treating affective instability as a target symptom arising within its broader diagnostic clinical context; 4) Discuss the nosologic implications of affective instability as reflected in DSM-5.

SUMMARY:
This symposium will provide a comprehensive overview of the phenomenology of affective instability from developmental, neurobiological and psychodynamic perspectives, focusing on pharmacologic and psychotherapeutic treatment rationales as well as nosologic considerations within DSM-5. Affective instability is a nonpathognomonic psychiatric symptom associated with diverse clinical conditions, including borderline personality disorder, bipolar disorder, substance use disorders, and posttraumatic stress disorder, among others. Its clinical context varies widely, yet it is often wrongly taken in and of itself as synonymous with bipolar disorder. Developmental theories posit that affective instability reflects an impaired capacity to self-regulate emotional responses to interpersonal and other stresses. As a component of borderline personality organization, affective instability is thought to reflect core deficits in modulating aggression, driven by insecure attachment styles, heightened interpersonal sensitivities, and poor capacity to tolerate distress. In bipolar disorder, the validity of constructs such as ultradian cycling or moment-to-moment mood variability are controversial when considered apart from the context of state-dependent changes in energy, sleep and motor activity that define manic or depressive syndromes. Common neurobiological mechanisms across affective instability may involve corticolimbic dysregulation with a loss of "top down" control over more primitive subcortical structures, but phenotypic variation and environmental context may lead to heterogeneous presentations, in turn suggesting different treatment modalities. Serotonergic antidepressants represent first-line treatments for dysphoria, mood reactivity and impulsivity in non-bipolar disorders but they can also destabilize mood when a bipolar diathesis is suspected. Mood stabilizers have limited efficacy for affective symptoms in nonbipolar patients, while atypical antipsychotics may hold a broader spectrum of efficacy. Pharmacotherapies meant to target affective instability may yield variable results depending on associated symptoms (such as impulsive aggression, substance use, and the autonomic sequelae of trauma). Treatment considerations require careful diagnostic assessment and tailored approaches based on the clinical context in which affective instability arises.

NO. 1
PHENOMENOLOGY AND PHARMACOTHERAPY OF AFFECTIVE INSTABILITY IN BIPOLAR, UNIPOLAR, AND SUBSTANCE USE DISORDERS
Speaker: Joseph F. Goldberg, M.D.

SUMMARY:
Mood "swings" colloquially describe the nature of affective symptoms in bipolar disorder, yet mood lability or moment-to-moment vicissitudes of affect are not part of the formal criteria for defining affective episodes that comprise bipolar disorder. The construct of affective instability has been applied both clinically and in the empirical literature but has received limited descriptive study in bipolar disorder versus other conditions that involve emotional dysregulation. This presentation will review known findings on differentiable patterns of affective instability in patients with bipolar, unipolar and substance use disorders as trait- and state-dependent features, drawing on data using Koenigsberg's Affective Lability Scale as well as measures of impulsivity, hostility, and prospective mood charting. The concept of trait affective instability as a diagnostically non-specific endophenotype across disorders that involve mood and impulsivity is discussed from a nosologic and therapeutic standpoint.

NO. 2
NEUROBIOLOGY OF AFFECTIVE INSTABILITY
Speaker: Larry J. Siever, M.D.

SUMMARY:
Affective instability drives much of the pathology of borderline personality disorder as well as contributing to antisocial and narcissistic psychopathology. There is increasing understanding of the brain circuitry and modulators involved in the predispositions to affective instability. Overactivity of limbic circuitry including regions such as the amygdala and insula play an important role in perpetuating this hyperreactivity or instability of emotions characteristic of these disorders, while diminished cortical controls are permissive to the emergence of this dysregulation. Novel mood stabilizers and serotonergic interventions may be helpful in dampening the affective instability, while psychophysiologic markers of this limbic hyperactivity such as the blink startle response or functional imaging of limbic system structures may help to both design new interventions and predict outcomes to

existing treatments. For example, amygdala hyperactivity in borderline personality disorder predicts better responses to dialectical behavioral therapy, a treatment that emphasizes reregulation of emotions. There seem to be both genetic and environmental influences on affective instability that can illuminate the susceptibilities to this phenomena. Thus, the neurobiology of affective instability will have important implications for our understanding of its causes and for psychosocial as well as pharmacologic treatments.

NO. 3
A PSYCHODYNAMIC APPROACH TO AFFECTIVE LABILITY
Speaker: Otto F. Kernberg, M.D.

SUMMARY:
This presentation will outline a clinical approach to the differential diagnosis of affective lability and the treatment of that segment of this condition that corresponds to a symptom of severe personality disorders rather than to an expression of a predominantly affective disorder. A psychodynamic treatment approach to this particular condition, forming part of severe personality disorders, will be outlined, and a tentative hypothesis regarding the effectiveness of this treatment approach and its probable impact on underlying neurobiological structures outlined.

NO. 4
DISRUPTIVE MOOD DYSREGULATION DISORDER: LONG-TERM NOSOLOGIC IMPLICATIONS
Speaker: David Axelson, M.D.

SUMMARY:
Disruptive mood dysregulation disorder (DMDD) is a new diagnosis in the DSM-5 created in response to concerns that children and adolescents with severe, chronic irritability were being inappropriately diagnosed with bipolar disorder. This presentation will review the scientific and clinical rationale for including DMDD in the DSM-5, including studies demonstrating that youth with chronic irritability are at higher risk for developing depression and anxiety disorders in the future. Next it will examine recently published studies regarding the application of the DMDD criteria in pre-existing datasets of community and clinical populations and the reliability of the DMDD diagnosis in the DSM-5 field trials. New data will be presented regarding the longitudinal course of youth meeting DMDD criteria from the community and clinical cohorts, as well as from a cohort of offspring of parents with bipolar disorder. Data will also be presented looking at irritability as a dimensional measure in these populations. The presentation will conclude with a discussion of the implications of the DMDD diagnosis and the potential benefits and problems of viewing irritability as categorical as opposed to a dimensional construct.

COMPARING BORDERLINE PERSONALITY DISORDER AND BIPOLAR DISORDER: OVERLAP, DIFFERENCES, AND EFFECTS OF COMORBIDITY

Chairs: Lisa Cohen, Ph.D., Igor Galynker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the clinical and etiological differences between borderline personality disorder and bipolar disorder; 2) Identify the clinical impact of comorbid borderline personality disorder traits on patients with bipolar disorder; 3) Appreciate the privileged role of interpersonal impairment in borderline personality disorder relative to bipolar disorder; 4) Improve diagnostic accuracy when distinguishing between patients with borderline personality traits or disorder and bipolar disorder.

SUMMARY:
Borderline Personality Disorder (BPD) and Bipolar Disorder (BD) are both characterized by high morbidity, mortality, and social cost. There is significant overlap in diagnostic criteria however, resulting in frequent difficulties with differential diagnosis. BPD and BP can be misdiagnosed as one another or can co-occur in the same patient. As there are significant treatment implications for improper diagnosis, a fuller understanding of the relationship between these two disorders is of great clinical importance. The focus of this symposium therefore is to examine the overlap, differences, and interaction between BPD and BP. Drs. Bender and Cohen will both present models of BPD as primarily a disorder of self and interpersonal functioning in contrast to a model of BD as primarily a disorder of mood. Dr. Bender will discuss this in the context of DSM 5. Dr. Cohen will present data showing strongly elevated rates of maladaptive interpersonal schemas in BPD but not BD. Dr. Zimmerman will present data comparing depressed patients with BPD with patients with BP II, supporting the distinct nature of the two conditions. Dr. Galynker will discuss the clinical correlates of comorbid BPD traits in BP patients presenting for family-oriented treatment. Finally Ruifan Zeng will examine the degree to which comorbid BPD traits and disorder increases risk of suicidal attempt in patients with depression, mania and psychotic symptoms. The differential role of anxiety in mood and psychotic symptomatology in patients with and without BPD will also be addressed.

NO. 1
MALADAPTIVE INTERPERSONAL SCHEMAS AS MARKER FOR BORDERLINE PERSONALITY DISORDER BUT NOT BIPOLAR DISORDER
Speaker: Lisa Cohen, Ph.D.

SUMMARY:
Diagnostic criteria for Borderline Personality Disorder (BPD) and Bipolar Disorder (BP) share marked overlap in symptom presentation, leading to significant difficulties in differential diagnosis. In large part this is related to lack of conceptual clarity about personality disorders. The current study tests the hypothesis that BPD but not BP is linked to maladaptive schemas of interpersonal relations (MIS) derived from disturbances in early attachment relationships. One hun-

dred psychiatric inpatients were assessed by SCID I, SCID II and the Young Schema Questionnaire (YSQ). Logistic regression analyses were used to investigate the association between MIS (as assessed by 5 YSQ scales) and BPD as well as between MIS and bipolar, major depressive and schizoaffective disorder. Receiver Operator Curve analyses were also performed. Adjusted odds ratios for BPD regressed against 4 out of 5 YSQ schema domains were significant, even when covaried for comorbidity with each of 3 affective disorder (AORs = 3.4 – 8.8). There were no significant associations between the 3 affective disorders and any of the 5 YSQ schema domains. Area under the curve analysis was strongest for the Disconnection and Rejection domain at AUC=.795. A cut point of 81 on this YSQ domain showed maximal sensitivity and specificity (Sensitivity=80%, Specificity=72%). These data support the privileged role of maladaptive interpersonal schemas in borderline PD.

NO. 2

BORDERLINE PERSONALITY DISORDER IN DSM-5 SECTION III: A NEW MODEL DEFINING CORE PATHOLOGY

Speaker: Donna S. Bender, Ph.D.

SUMMARY:

There has been considerable debate about the relationship of Borderline Personality Disorder (BPD) and Bipolar Disorder, in part because of a certain amount of overlap in the phenomenology such as affective and behavioral instability, and patients with BPD are often misdiagnosed as Bipolar. One basis for the difficulty in distinguishing the two disorders has been a lack of conceptual clarity about the nature of personality psychopathology. The DSM-IV/DSM-5 Section II general criteria for Personality Disorder (PD) indicate that an enduring pattern of inner experience and behavior is manifest by two or more of the following areas: cognition, affectivity, interpersonal functioning, and impulse control. These very broad criteria do not appear to be very specific for personality disorders, nor are they always consistent with the specific criteria for individual PDs in the DSM. The DSM-5 Section III PD model has established new general criteria for all PDs that require the presence of core impairments in the realms of self and interpersonal functioning. As well, specific self-other difficulties are enumerated in the criteria for BPD, along with defining pathological traits. Establishing this clearer self-other conceptualization of what constitutes the core of personality psychopathology should address some the problems in differential diagnosis between PDs and other symptom disorders.

NO. 3

DISTINGUISHING BIPOLAR II DEPRESSION FROM MAJOR DEPRESSIVE DISORDER WITH COMORBID BORDERLINE PERSONALITY DISORDER: DEMOGRAPHIC, CLINICAL, AND FAMILY HISTORY DIFFERENCES

Speaker: Mark Zimmerman, M.D.

SUMMARY:

Objective: Because of the potential treatment implications, it is clinically important to distinguish between bipolar II depression (BPII) and major depressive disorder with comorbid borderline personality disorder (BPD). In the present study, we compared these two patient groups on demographic, clinical, and family history variables.
Method: From 1995 to 2012, 3,600 psychiatric outpatients were evaluated with semi-structured diagnostic interviews for DSM-IV Axis I and Axis II disorders. The focus of the present study is 206 patients with DSM-IV major depressive disorder and borderline personality disorder (MDD-BPD) and 62 patients with DSM-IV bipolar II depression without BPD. Results: The patients with MDD-BPD were significantly more often diagnosed with PTSD, current substance use disorder, somatoform disorder and other nonborderline personality disorder. Clinical ratings of anger, anxiety, paranoid ideation, and somatization were significantly higher in the MDD-BPD group. The MDD-BPD patients were rated significantly lower on the Global Assessment of Functioning, with poorer current social functioning and more suicide attempts. Patients with BPII had significantly higher morbid risk for bipolar disorder in first-degree relatives than the MDD-BPD patients. Conclusions: Patients diagnosed with BPII depression and major depressive disorder with comorbid BPD differed on multiple clinical and family history variables, thereby supporting the validity of this distinction.

NO. 4

CLINICAL FEATURES OF BORDERLINE PSYCHOPATHOLOGY IN BIPOLAR DISORDER

Speaker: Igor Galynker, M.D., Ph.D.

SUMMARY:

Introduction: Prodromal or subsyndromal Bipolar Disorder (BD) often resembles Borderline Personality Disorder (BPD). Differentiating the two or diagnosing BD comorbid with BPD or vice versa is a difficult but important task because clinical management of the two disorders is quite different. In this context we tested the hypothesis that the presence of comorbid BPD traits has the greatest impact on interpersonal and self-related factors related to the illness rather than core symptoms of BD. Methods: Family Center for Bipolar (FCB) is a unique treatment center which uses a Family Inclusive Treatment (FIT) for treatment of BD and only accepts families who seek such treatment. Patients presenting for intake at FCB with a previous diagnosis of BD (n=63) and their caregivers were administered a large psychological test battery. Results: In preliminary analysis, there were highly significant correlations between patients' MCMI borderline scores and their scores on a measures of perceived stigma re BD (ISMI: r=0.57, p<0.001), depression (CESD: r=.0.696, p<0,001), perceived stress (r=0.44, p<0.001) and substance abuse history. No significant association was found with knowledge about BD, age of onset, and age of psychiatric diagnosis. Conclusions: Among patients with BD presenting for family-oriented treatment, those with borderline traits differ from those without both with regard to mood symptoms and attitude towards illness. Implications of these findings will be discussed.

NO. 5
EFFECT OF COMORBID BORDERLINE PERSONALITY DISORDER ON SUICIDE RISK IN BIPOLAR PATIENTS
Speaker: Ruifan Zeng, M.A.

SUMMARY:
Both borderline personality disorder (BPD) and severe mood disorders confer significant risk of suicidal behavior. Comorbid personality and mood pathology may further increase suicidal risk. This study aims to clarify the degree to which comorbid BPD diagnosis or traits increase the likelihood of a history of suicide attempt in patients with mood and psychotic syndromes/disorders. Psychiatric inpatients (n=113) with varying diagnoses were assessed by SCID I, SCID II, and the Columbia Suicide Severity Rating Scale. Logistic regression analyses investigated associations between previous suicide attempt and BPD diagnosis and traits in the context of Bipolar Disorder (BP), Major Depressive Disorder (MDD), as well as history of manic, psychotic, or depressive episodes. Comorbid BPD diagnosis significantly increased the risk of suicide in patients diagnosed with MDD or BP, as well as those with a previous depressive or psychotic episode (ORs=5.6 – 21.5). Each additional BPD trait increased risk of suicide attempt in MDD patients as well as those with a prior depressive or psychotic episode by 20-50% (ORs=1.2 – 1.5). In a secondary analysis, we considered the impact of the Suicide Trigger State (STS), a panic-like state previously linked to suicide attempts. Significant interaction effects on ANOVA suggest a positive association between STS and psychosis in BPD patients but a negative association in patients without BPD and a similar but marginally significant finding for mania.

POLICE ENCOUNTERS WITH INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES AND THE CRISIS INTERVENTION TEAM (CIT) MODEL

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 how the CIT model can be adapted for implementation in a low-income, post-conflict country.

SUMMARY:
This session will provide psychiatrists with an overview of recent research and developments pertaining to the all-too-frequent 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 one-third 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 psychiatric-triage 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, now in its 25th year of dissemination, 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, first-line 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 evidence to date suggests that this police-based program may result in less use of force and presumably fewer injuries, as well as a lower likelihood of arrest and a greater likelihood of referral to mental health services.
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.
In addition to describing the CIT model in the United States, and giving an overview or research on CIT to date, the first attempt at adapting the CIT model in a low-income country will be described. Specifically, the process by which the Liberian National Police and their partners in Liberia (West Africa) have adapted CIT for use in a very different setting will be described.

NO. 1
PERCEIVED PROCEDURAL JUSTICE AND ITS RELEVANCE TO CIT
Speaker: Amy C. Watson, M.S.W., Ph.D.

SUMMARY:
Research in a variety of contexts suggests that when people perceive they have been treated in a procedurally just manner by an authority figure, they are more likely to cooperate and be satisfied with the interaction, regardless of whether the outcome of the interaction is objectively favorable to them. This presentation will describe the procedural justice framework and the empirical support for the role of per-

ceived procedural justice in improving cooperation in and the experience of encounters with the police for individuals with serious mental illnesses. While not explicitly guided by the procedural justice framework, the CIT model contains elements consistent with it. The relevance of procedural justice for the CIT model will be explored.

NO. 2
TAKING CIT ACROSS THE ATLANTIC: OVERVIEW OF CIT ADAPTATION IN LIBERIA, WEST AFRICA
Speaker: Michael T. Compton, M.D., M.P.H.

SUMMARY:
CIT is being implemented broadly across the United States and has begun to reach into other developed countries. However, the CIT approach has yet to be adapted for low- and middle-income countries, especially those whose infrastructures are devastated by years of civil war. This workshop will describe a recent visit to the West African nation of Liberia. The mental health infrastructure of Liberia was greatly compromised by two decades of violent conflict and government instability. The government of Liberia is now rebuilding mental health services with training and technical support from The Carter Center Mental Health Program. The presenter will describe his needs assessment, site visits, and meetings with stakeholders from an August 2013 visit to Liberia. The culmination of this visit was a curriculum-development workshop conducted in coordination with the Liberian national police force and mental health clinicians trained by The Carter Center. The Core Elements of CIT will require substantial modification to fit the needs of diverse law enforcement and mental health systems, especially in low- and middle-income countries, and in post-conflict settings in particular. This initial attempt at adapting the CIT approach in Africa will inform future attempts at translating CIT in other parts of the world.

NO. 3
THE CRISIS INTERVENTION TEAM (CIT) MODEL
Speaker: Beth Broussard, C.H.E.S., M.P.H.

SUMMARY:
To improve officers' responses to individuals with serious mental illnesses, the Crisis Intervention Team (CIT) program was developed in 1988 in Memphis. This program, now in its 25th year of dissemination, 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, first-line 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. In her first presentation, Ms. Broussard will provide an overview of the CIT model. In her second, she will present results on a recent survey of Sheriffs, Chiefs of Police, CIT officers, and non-CIT officers in Georgia.In describing survey results, she will answer questions such as: How do CIT-trained and non-CIT-trained officers view the local mental health system? What barriers do police chiefs report with regard to implementing a CIT program? What are sheriffs' perceptions about the usefulness of CIT? What are their opinions about the effect of CIT on reducing arrests and increasing referrals to mental health services? This survey also gives the first information about job satisfaction and work burnout in CIT-trained compared to non-CIT trained officers.

NEW FRONTIERS OF ADHD ACROSS THE LIFESPAN

Chair: Thomas E. Brown, Ph.D.

Discussant: Luis A. Rohde, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand a new model of ADHD as developmentally-impaired executive functions; 2) Describe clinical implications of five new frontiers of research on ADHD; 3) Recognize and diagnose ADHD-related impairments of executive function as they appear in adult and child patients who may be suffering from ADHD, possibly in conjunction with another disorder; 4) Identify executive function impairments similar to ADHD that have initial-onset in some women during mid-life hormonal changes associated with menopause; 5) Utilize appropriate treatments that may be effective in alleviating ADHD-related impairments of executive functions in children, adolescents and/or adults.

SUMMARY:
Recent developments in clinical and neuroscience research have opened new frontiers which have expanded understanding of ADHD beyond diagnostic criteria of DSM-5. This new research is shaping a novel paradigm of ADHD as developmental impairment of executive functions, the complex management system of the brain. This new model highlights cognitive, motivational and affective impairments of the disorder. It recognizes the important role of functional connectivity in development and operation of these executive functions across the lifespan. It acknowledges the reciprocal influence of ADHD impairments and sleep/arousal and has begun to explore the role of hormones in mid-life onset of ADHD-like cognitive changes in women. This symposium describes these developments and presents clinical implications of these new frontiers for clinical practice.

NO. 1
EMOTIONS, CONTEXT, AND THE DYNAMICS OF CHEMISTRY OF MOTIVATION IN ADHD
Speaker: Thomas E. Brown, Ph.D.

SUMMARY:
One of the most puzzling features of ADHD in both children and adults is the contextual variability of the symptoms. Although they have chronic difficulties in focusing attention,

activating for tasks, sustaining effort and utilizing working memory, those with ADHD typically exercise these executive functions quite well in certain specific tasks or activities. Currently an important frontier in ADHD research is to identify factors that shape the chemistry of motivation for those with ADHD. PET studies have shown that disruption of dopamine reward pathways is associated with motivation deficits in adults with ADHD. This presentation will suggest ways in which working memory and idiosyncratic emotions may create or resolve those situationally specific motivation deficits.

NO. 2
NEUROIMAGING OF CONNECTIVITY IN ADHD
Speaker: Francisco X. Castellanos, M.D.

SUMMARY:
The connectivity of neuronal systems is their most fundamental characteristic, and neural models of ADHD are increasingly being formulated in terms of both structural and functional connectivity within the context of the interplay of large-scale brain systems. Structural connectivity is inferred through diffusion tensor imaging approaches. Functional connectivity can be identified from task-based fMRI studies, and increasingly from task-free functional imaging, also known as resting state fMRI. This presentation will relate frontoparietal, dorsal and ventral attention, motor, visual and default networks to the burgeoning functional and structural brain imaging literatures. These integrative perspectives are beginning to provide mechanistic models that promise to transform our understanding of the neurobiology of ADHD.

NO. 3
MOOD REGULATION IMPAIRMENTS IN ADHD AND IN BIPOLAR DISORDER IN YOUTH
Speaker: Gabrielle Carlson, M.D.

SUMMARY:
Children with serious problems regulating activity level, attention, planning, and emotions have been variously described for the past 100 years. The prototypic “hyperkinetic child” originally described by Drs. Laufer and Denhoff (1957) reveals a much more volcanic, mercurial child with hyperactivity and distractibility, but also more mood lability and variation in behavior than is now defined as “ADHD”. When DSM III chose to break off the mood lability symptom from hyperkinesis because it was not felt to be central to the ADHD concept, diagnosis for those children merely went to the only other diagnostic home they could go to – mania/bipolar disorder. DSM 5 will siphon off some with the Disruptive Mood Dysregulation Disorder diagnosis. The question of best diagnosis and treatment of such children remains. This presentation will help the clinician sort these questions out.

NO. 4
SLEEP & ALERTNESS IN ADHD: FROM NEUROBIOLOGY TO CLINICAL PRACTICE
Speaker: Samuele Cortese, M.D., Ph.D.

SUMMARY:
This presentation will address the complex interplay between ADHD and alertness/sleep, focusing in particular on the overlaps and differences in brain circuits implicated in ADHD/executive functions and sleep/alertness regulation. It will also present a review of empirical evidence and clinical experience related to the assessment/treatment of the most common sleep problems in ADHD in children, adolescents, and adults, e.g. management of behavioral insomnia, circadian rhythm disorder, sleep-disordered breathing, restless legs syndrome/periodic limb movement disorder, and sleep disturbances due to comorbid psychiatric disorders or ADHD medications. Future research perspectives will be discussed to show better understanding of the neurobiology of ADHD and sleep/alertness has the potential to improve the management of individuals with ADHD and sleep problems.

NO. 5
MID-LIFE ONSET OF ADHD-LIKE COGNITIVE IMPAIRMENTS IN MENOPAUSAL WOMEN
Speaker: C.Neill Epperson, M.D.

SUMMARY:
The menopause transition is associated with an increase in executive function (EF) complaints, particularly those related to attention, affect regulation and working memory. Thirty menopausal women participated in a double-blind, placebo-controlled study to determine whether the psychostimulant lisdexamphetamine (LDX) is effective in reducing subjective, new-onset EF difficulties, and improving performance on verbal recall (paragraph recall), working memory (N-Back), and attention tasks (Continuous Performance Task). A subset of women also underwent multi-modal brain imaging with functional magnetic resonance imaging (fMRI) and proton magnetic resonance spectroscopy (1H-MRS) to assess brain activation (during N-Back performance) and dorsal lateral prefrontal cortex (DLPFC) neurochemistry, respectively. Preliminary data analyses suggest that EF complaints are reduced during active versus placebo conditions and DLPFC chemistry and activation are significantly modified by LDX treatment.

NOVEL THERAPEUTICS

Chair: Linda S. Brady, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Assess the utility of computerized cognitive training as an intervention targeting auditory processing to improve cognitive function in chronic and recent-onset schizophrenia; 2) Understand the current state of development of new neurostimulation technologies and devices and the challenges involved in optimizing the ‘dose-response’ function for delivering brain stimulation; 3) Understand

the current use of Dialectical Behavioral Therapy (DBT) for the treatment of suicide risk in individuals with BPD and its potential to treat emotion dysregulation; 4) understand the current state of development of rapid-acting antidepressants (iv ketamine and scopolamine) for treatment resistant depression.

SUMMARY:
Psychiatric disorders are the leading causes of disability worldwide. There is an urgent need for new treatments to reduce the severity of symptoms, improve functional outcome, and preempt the developmental trajectory of disease. Despite the remaining unmet medical need and market potential many large pharmaceutical companies have recently reduced or terminated their programs in psychiatric drug development due, in part, to the many challenges and risks in developing truly novel treatments. This session will provide insights into the discovery and development of behavioral and cognitive therapies, neuromodulatory devices, and pharmacologic treatments. Rachel Loewy will describe studies to assess the effectiveness of a computerized cognitive training intervention that targets auditory perception and working memory as an intervention to improve cognitive function. She will present studies that assess the efficacy and durability of targeted cognitive training (TCT), delivered in both lab and home settings, on MATRICS-based neuropsychological functioning in chronic and recent-onset schizophrenia. Sarah Lisanby will present an overview of promising new neurostimulation technologies such as transcranial direct or alternating current stimulation, synchronized transcranial magnetic stimulation and low field magnetic stimulation for treating psychiatric disorders. She will highlight the technical and scientific challenges associated with selecting an optimal 'dose-reponse' function for brain stimulation (e.g., stimulus parameters, spatial and temporal distribution) delivery by neuromodulatory devices. Marsha Linehan will present an overview of Dialectical Behavioral Therapy (DBT) as an intervention to treat individuals at high risk for suicide, primarily those with Borderline Personality Disorder. She will describe the development and pilot testing of DBT for the treatment of emotion dysregulation in other mental and behavioral disorders and will touch on current development challenges such as determining the mechanism of action of DBT and developing guidelines for implementing DBT model components. Carlos Zarate will describe the development and testing of antidepressants with a rapid onset of action (e.g., intravenous ketamine or scopolamine) in individuals with treatment resistant depression. He will describe ongoing research to identify biological markers that can be incorporated into studies of rapid-acting antidepressants to predict treatment response and prognosis of depression.

NO. 1
COGNITIVE TRAINING OF IMPAIRED NEURAL SYSTEMS IN PSYCHOTIC DISORDERS
Speaker: Rachel Loewy, Ph.D.

SUMMARY:
Neurocognitive dysfunction is a hallmark of schizophrenia associated with impaired social and occupational functioning for which there has, as yet, been no effective treatment. We report here on a series of studies of a computerized cognitive training intervention for psychotic disorders that uses adaptive psychophysical exercises to train auditory processing, from auditory perception to complex auditory working memory. We have tested this targeted cognitive training (TCT) with both chronic and recent-onset schizophrenia groups, delivered via desktop computer in the laboratory and portable computers for at-home training. Compared to participants who completed equivalent hours of control computer games (CG), TCT participants showed improvement on MATRICS- based neuropsychological tasks from before to after training, and durability of gains at 6-month follow-up. Chronic patients in the TCT condition (but not CG subjects) also showed changes in neural activation patterns via MEG recordings during a syllable identification task and an auditory working memory task that correlated with behavioral changes. These data suggest that cognitive training effects enduring changes in cortical processing that reflect "restoration" of key neurocognitive processes. Our ongoing studies are assessing the impact of TCT on real-world functioning when combined with psychosocial supports and as a potentially pre-emptive intervention in prodromal psychosis.

NO. 2
NEUROMODULATORY DEVICES: THE DEVIL IS THE DOSING
Speaker: Sarah H. Lisanby, M.D.

SUMMARY:
Neuromodulatory devices hold great promise for psychiatric therapeutics and neuroscience discovery. Today we have newly FDA-approved therapies (transcranial magnetic stimulation (TMS), deep TMS (dTMS)), and promising new technologies on the horizon (transcranial direct current stimulation (tDCS), transcranial alternating current stimulation (tACS), synchronized TMS (sTMS), low field magnetic stimulation (LFMS), etc.). Examples of modest effect sizes and lingering unanswered questions about mechanisms of action. Major advances will require a sophisticated understanding of mechanism and dosimetry at the level that we presently understand neuropsychopharmacology. A rational approach to dosing is essential to true progress in the optimal use of these technologies to discover brain/behavior relationships and to advance therapeutics. What is the basic science governing the response of the brain to electrical fields? Fortunately, engineers and neuroscientists are pioneering this new field that seeks to provide the basic science behind neuromodulation device dosing. It will take such interdisciplinary collaborations to shed light on the basic principles governing dose/response functions. Brain stimulation 'dose' is multifactorial, encompassing spatial components of the stimulus field distribution in the brain, and temporal components of the pulse waveform and train dynamics. Understanding dosing for devices will facilitate the clinical application of these powerful new tools.

NO. 3
DIALECTICAL BEHAVIOR THERAPY (DBT): WHERE WE WERE, WHERE WE ARE, AND WHERE ARE WE GOING
Speaker: Marsha Linehan, Ph.D.

SUMMARY:
Dialectical Behavior therapy (DBT) is a trans-diagnostic modular behavioral intervention integrating principles of behavioral science with Zen mindfulness practice to provide a synthesis of change and acceptance at the level of the treatment provider's actions and at the level of new behaviors taught to clients. The treatment was designed to treat individuals with high risk for suicide ordinarily associated with high emotion dysregulation. Because of its high association with intentional self-injury and high rates of suicide, most of the DBT suicide research has been done with individuals meeting criteria for borderline personality disorder. The modular design of the treatment, with emphases on both protocol based and principle based approaches to treatment have led to a number of studies indicating DBT is effective with a range of less severe disorders such as treatment resistant depression, substance dependence, eating disorders and other disordered behavioral patterns. To date, over 17 RCTs have been conducted on DBT across a range of investigators. It is one of the few treatments replicated as effective for both reducing risk of suicide and for treating BPD. Current questions of importance deal with determining mechanisms of action in DBT and developing guidelines for who needs what components of the treatment for how long. Preliminary hypotheses and data addressing these questions will be presented.

NO. 4
NEUROBIOLOGY OF DEPRESSION AND THE DEVELOPMENT OF RAPID-ACTING ANTIDEPRESSANTS
Speaker: Carlos Zarate, M.D.

SUMMARY:
Major depressive disorder and bipolar disorder are among the most disabling and costly of all medical illnesses. Although a number of antidepressant treatments are available in clinical practice, many patients still do not adequately respond to them and undergo multiple and lengthy medication trials before experiencing relief of symptoms. Therefore a tremendous need exists to develop more rapid, successful medications for patients suffering from the deleterious neurobiological effects of ongoing depression. To achieve this goal, ongoing research is exploring the identification of biomarkers that might be involved in prevention, diagnosis, treatment response, severity, or prognosis of depression. Developing antidepressants with a rapid onset of action and biomarkers evaluating treatment response will be the focus of this lecture, given the importance of providing relief to patients in a more expedient and systematic manner. A novel approach to developing such biomarkers of response would incorporate interventions with a rapid onset of action - such as intravenous drugs (e.g., ketamine or scopolamine) or sleep deprivation. This alternative translational model for developing next generation treatments in mood disorders would facilitate shorter studies, improve feasibility, and increase higher compound throughput testing for these devastating disorders.

OBSESSIVE-COMPULSIVE AND RELATED DISORDERS IN DSM-5

Chair: Katharine A. Phillips, M.D.

Discussant: Norman Sartorius, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize conditions that are included in the DSM-5 chapter on obsessive-compulsive and related disorders; 2) Diagnose newly recognized disorders in the DSM-5 chapter on obsessive-compulsive and related disorders i.e., hoarding disorder and excoriation (skin-picking) disorder; 3) Identify ongoing questions about the optimal classification and evaluation of obsessive-compulsive and related disorders.

SUMMARY:
Obsessive-compulsive and related disorders comprise a new chapter in DSM-5. The chapter includes obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), excoriation (skin-picking) disorder, substance/medication-induced obsessive-compulsive and related disorders, obsessive-compulsive and related disorders due to another medical condition, and other specified obsessive-compulsive and related disorder.

Dr. Phillips will open the symposium by reviewing the construct of obsessive-compulsive and related disorders, and the rationale for including a separate chapter on these prevalent and impairing conditions in DSM-5. Her presentation will also include discussion of body dysmorphic disorder in DSM-5, and of insight as a dimension that cuts across a number of these conditions. Dr. Simpson will review the DSM-5 diagnostic criteria for obsessive-compulsive disorder (OCD). Her presentation will include discussion of a number of issues in the nosology in OCD, including symptom dimensions, and OCD associated with infectious agents. Dr. Frost will discuss the rationale for including hoarding disorder as a new condition in DSM-5. His presentation will include discussion of the field survey of the proposed diagnostic criteria and specifiers. Dr. Grant will review the diagnostic criteria for trichotillomania (hair-pulling disorder) and the rationale for including excoriation (skin-picking) disorder as a new disorder in DSM-5. His presentation will include findings from the DSM-5 field surveys for these two conditions.

NO. 1
CHANGES FOR OBSESSIVE-COMPULSIVE AND RELATED DISORDERS IN DSM-5: THE META-STRUCTURE, INSIGHT SPECIFIERS, AND CRITERIA FOR BODY DYSMORPHIC DISORDER

Speaker: Katharine A. Phillips, M.D.

SUMMARY:
This presentation will discuss the DSM-5 chapter of obsessive-compulsive and related disorders, which has not been included in prior editions of DSM. This chapter will include disorders that were classified in other chapters in DSM-IV as well as new disorders that were not included in DSM-IV. The rationale for including this new chapter, and the organization of DSM-5 chapters more broadly, will be discussed. Dr. Phillips will then discuss the dimension of insight, which is a specifier for BDD, OCD, and hoarding disorder. Finally, Dr. Phillips will discuss changes for BDD, a common and impairing disorder that was classified in DSM-IV as a somatoform disorder. In addition to the new insight specifier, changes for BDD include: 1) addition of a criterion indicating the presence of compulsive repetitive behaviors or mental acts that are performed in response to the appearance preoccupations, and 2) addition of a muscle dysmorphia specifier.

NO. 2
OBSESSIVE-COMPULSIVE DISORDER IN DSM-5
Speaker: Helen B. Simpson, M.D., Ph.D.

SUMMARY:
This talk will review the DSM-5 diagnostic criteria for obsessive-compulsive disorder (OCD). Changes to the DSM-IV criteria will be highlighted, including the rationale for various specifiers. In addition, key changes to the text will be discussed, including descriptions of associated features that help in making the diagnosis (such as the presence of symptom dimensions and OCD beliefs and cognitions), conditions with which OCD is commonly comorbid, risk and prognostic factors, clinical expression of OCD across the lifespan and the globe, and how to distinguish OCD from other disorders with which it can be confused (e.g., other anxiety disorders, obsessive-compulsive personality disorder, hoarding disorder, body dysmorphic disorder, and delusional disorder).

NO. 3
HOARDING DISORDER
Speaker: Randy Frost, Ph.D.

SUMMARY:
Hoarding disorder (HD) is a new diagnostic category that is included in the DSM-5 Obsessive-Compulsive and Related Disorders chapter. This talk will review the rationale for its inclusion, discuss its diagnostic criteria, explore the boundaries of HD with other DSM-5 disorders, and discuss the qualitative differences between HD and normative collecting. Finally, the findings of two surveys which tested the reliability, validity, perceived acceptability, clinical utility, and stigma associated with the new diagnosis will be summarized and discussed.

NO. 4
TRICHOTILLOMANIA (HAIR-PULLING DISORDER) AND EXCORIATION (SKIN-PICKING) DISORDER

Speaker: Jon Grant, M.D.

SUMMARY:
The DSM-5 chapter on Obsessive-Compulsive and Related Disorders includes both Trichotillomania (Hair-Pulling Disorder) and Excoriation (Skin-Picking) Disorder, conditions that are surprisingly prevalent and impairing. Also, the concept of Body-Focused Behavior Disorder, which refers to other impairing body-focused behaviors, are noted as examples of "Other Specified Obsessive-Compulsive and Related Disorder." Trichotillomania was classified in DSM-IV as an impulse control disorder not elsewhere classified, while Excoriation Disorder was not recognized as an independent diagnostic entity. This presentation will review the questions of how best to classify these conditions and the new diagnostic criteria. Findings from DSM-5 commissioned literature reviews, data analyses, and field surveys will be presented. It is hoped that DSM-5 will help improve the recognition and management of these often overlooked conditions.

ADVANCES IN PTSD

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

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

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

Defense and Veterans Affairs Clinical Practice Guidelines in comparison to other guidelines and recommendations.

NO. 1
ADVANCES IN PHARMACOTHERAPY FOR PTSD
Speaker: John Krystal, M.D.

SUMMARY:
The pharmacotherapy of PTSD has emerged as an exemplar of the science and art of psychiatry. This presentation will present a brief critical overview of the pharmacotherapy of PTSD. It will attempt to link each class of medication to advances in our understanding of the biology of stress response and PTSD. It will cover serotonergic antidepressants, drugs targeting noradrenergic systems, GABAergic medications, and new directions emerging from translational neuroscience.

NO. 2
ADVANCES IN PSYCHOTHERAPY FOR PTSD
Speaker: Paula Schnurr, M.D., Ph.D.

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

NO. 3
EPIDEMIOLOGY AND PHARMACOLOGY FOR PTSD
Speaker: Gary H. Wynn, M.D.

SUMMARY:
This presentation will review the most recent findings and up to date understanding of the epidemiology of PTSD. The epidemiology presentation will focus on risk factors for the development of PTSD for the general population and for those who have experienced a traumatic event.
Pharmacologic treatment of PTSD has been and remains the most controversial aspect of the overall management of PTSD. Despite the controversy there has been little research into medications to treat PTSD. A few medications have found investigators to champion them through the complexities of research while many others have only a small study or a few case reports backing up clinical practice. This session will review the current state of the evidence for a number of medications and classes of medications.

NO. 4
COMPLEMENTARY/ALTERNATIVE MEDICINE AND GUIDELINES FOR PTSD
Speaker: David M. Benedek, 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.
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. In addition the Institute of Medicine recently released further perspective on this topic.

MAY 07, 2014

TREATMENT OF PERSONALITY DISORDERS

Chairs: John Gunderson, M.D., Lois W. Choi-Kain, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Update and summarize knowledge about the treatment of major personality disorders; 2) Highlight new perspectives on treatment of personality disorders; 3) Evaluate the relative strength of different therapeutic modalities; 4) Identify areas requiring research and their priorities.

SUMMARY:
Reviews on treatment of personality disorders will be presented by expert clinicians. The symposium will include updated reviews of Obsessive-Compulsive Personality Disorder (Glen Gabbard), Antisocial Personality Disorder (Don Black), Narcissistic Personality Disorder (Salman Akhtar), Borderline Personality Disorder (John Gunderson), and mixed cluster B Personality Disorders (Choi-Kain). Each talk will include clinical vignettes and will examine the role of different therapeutic modalities (e.g., psychotherapy, group, medications). Presenters will then highlight recent advances in clinical practice, the current status of their empirical validation, and the areas where research attention are most needed.

NO. 1
CLINICAL MANAGEMENT OF CO-OCCURRING BORDERLINE, ANTISOCIAL, AND NARCISSISTIC PERSONALITY DISORDERS
Speaker: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:
The co-occurrence of cluster B disorders with other personality diagnoses may be more common than not. While general practitioners are faced with the daunting task of understanding multiple treatment approaches for a multitude of personality disorders, they are faced with an even more complex reality of the patient with personality disorder features which span several different personality diagnoses. This symposium will use case vignettes to illustrate technical

approaches to prioritizing diagnoses in a case management and therapeutic approach to co-morbid borderline, antisocial, and narcissistic personality disorders. Cases highlighting 1) mistrust in co-occuring borderline and antisocial personality disorders and 2) a need to be special (alongside with tendencies towards devaluation) in borderline and narcissistic individuals, will be presented with relevant strategies for case management.

NO. 2
PSYCHOTHERAPY OF BPD: A NEW MODEL
Speaker: John Gunderson, M.D.

SUMMARY:
This paper will present a new evidence-based approach to treatment of borderline patients that utilizes what has been learned from prior treatment models; specifically from TFP, DBT, and MBT, but that significantly differs from them by focusing on the patient's life outside of treatment (e.g., relationships and work), by psychoeducation about the genetics and course of the disorder (and their clinical implications), and by using a theoretical model that innate interpersonal hypersensitivity causes the secondary problems of emotional and behavioral dyscontrol. Clinical examples will be used to illustrate this approach.

NO. 3
PSYCHOTHERAPY OF OBSESSIVE-COMPULSIVE PERSONALITY DISORDER
Speaker: Glen O. Gabbard, M.D.

SUMMARY:
Obsessive-compulsive personality disorder is the most common personality disorder in the United States. It is differentiated by obsessive-compulsive disorder by the absence of ego-dystonic obsessional thoughts and obligatory rituals. By contrast, it involves ego-syntonic features that in moderation lead to success in many occupations, but in excess lead to paralysis of effective vocational functioning. It also leads to difficulties in intimate personal relationships. Psychotherapy has been shown to be efficacious with OCPD in randomized controlled trials involving Cluster C Personality Disorders. The focus must be on affect phobia, perfectionism, and interpersonal relatedness. Many of these difficulties will occur in the therapeutic relationship. The patient tends to want to control the sessions and avoid any surprises by filling the sessions with his own "agenda" and not leaving space for the therapist to make observations and interpretations. The patient may also repeatedly correct the therapist's word choice because the words are

NO. 4
TREATMENT OF ANTISOCIAL PERSONALITY DISORDER
Speaker: Donald Black, M.D.

SUMMARY:
This presentation reviews the treatment of antisocial personality disorder (ASPD). Despite being the oldest recognized personality disorder, there are few data regarding treatment for ASPD. This has led what has been called the "untreatability myth," which is the widespread belief that antisocials are unable to profit from treatment. While no drugs are approved to treat ASPD or are routinely used, some are used "off-label" to treat symptoms of aggression and irritability or for comorbid disorders. Lithium carbonate can reduce anger and threatening behavior. Phenytoin has been shown to reduce impulsive aggression. Antipsychotics have been shown to deter aggression in adults and youth. Other drugs used have been used to treat aggression and include: carbamazepine, valproate, propranolol, buspirone, and trazodone. Response to medication is variable. Medication may help treat co-occurring psychiatric disorders. Because benzodiazepines are habit forming and have been shown to increase "acting out" behaviors in patients with borderline personality disorder, they should be avoided. Stimulant medications should be used with caution as well. Cognitive behavioral treatment models have been developed for ASPD and emerging data suggest they may be useful in milder cases. The model focuses on evaluating situations in which distorted beliefs and attitudes interfere with functioning or in achieving success. Antisocial persons often possess traits that interfere with the process of psychoth

NO. 5
TREATMENT OF NARCISSISTIC PERSONALITY DISORDER: STRUCTURAL, PHENOMENOLOGICAL, AND LIFE-SPAN VARIABLES
Speaker: Salman Akhtar, M.D.

SUMMARY:
This presentation will begin by delineating three types of narcissictic personalities (i) overtly grandiose type, (ii) shy type, and (iii) malignant type.It will then highlight the different ways narcissistic patients present for help , eg at the time of entering college or job force, around issues of marital infidelity, and while facing late middle age issues or actual physical illness.It will be argued that the (i) phenomenological variable of defended vs flaunted the grandiosity , (ii) the structural variable of superego strength vs the sway of instinctual pleasures, and (iii) the life span variable of youth vs declining psychophysical prowess inpact upon the treatment strategies and the prognostic outlook in these cases.

PSYCHIATRISTS WORKING ON THE GLOBAL STAGE

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) Diagnose and treat psychiatric disorders when working in a field experience outside of the ordinary practice setting; 2) Identify caveats and personal motivations for working temporarily as a psychiatrist in another country; 3)

Advise and teach medical students who seek to create clinics that provide psychiatric evaluations for torture survivors who are seeking asylum in the United States; 4) Learn how to get involved with the non-governmental organizations that advocate for psychiatry at the United Nations; 5) Treat individuals and families traumatized by political violence and disasters.

SUMMARY:
This Symposium will explore international working experiences for psychiatrists. Three psychiatrists will present lessons learned from practicing in Haiti, Burundi and Tanzania. Haiti had a catastrophic earthquake in 2010 resulting in severe loss of life and disruption of the country's resources. Burundi underwent years of political violence and conflict, seriously traumatizing their population. Tanzania has been a stable country but without adequate health care. The country accepts U.S. medical students and residents who spend a month in their hospitals and clinics. One psychiatrist has worked in a non-governmental capacity at the United Nations and will share her experience. One psychiatrist advises a medical student clinic that evaluates and treats torture survivors. Efforts of these psychiatrists to diagnose, treat, and advocate for psychiatric patients will be presented.

NO. 1
"DO ONE AND TEACH ONE:" USING INNOVATIVE PROGRAM DESIGN TO CREATE A HUMAN RIGHTS CLINIC FOR ASYLUM SEEKERS
Speaker: Joanne Ahola, M.D.

SUMMARY:
Joanne Ahola, M.D., will discuss multiplying your effectiveness in providing pro bono psychiatric evaluations for torture survivors seeking political asylum in the U.S. by creating medical student clinics where attending clinicians can simultaneously provide evaluations and teach medical students to do this critically important work. Such a clinic can be started at no financial cost, using trained volunteer students and faculty, borrowed space, technology and partnerships with non-profit organizations. Weill Cornell Medical College has the first such clinic, but several other medical schools have begun sister clinics, and all provide exciting and rewarding clinical experiences: global health at home.

NO. 2
INTERNATIONAL PSYCHIATRY: LESSONS FROM TANZANIA
Speaker: John W. Barnhill, M.D.

SUMMARY:
Increasing numbers of medical students, psychiatry 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.

NO. 3
EXPERIENCE OF PRACTICING PSYCHIATRY IN A HAITIAN TRAUMA HOSPITAL
Speaker: Joseph Carmody, M.D.

SUMMARY:
This talk will focus on the description of experiences and lessons learned in the practice of psychiatry in a Haitian Trauma Hospital. Topics will include a discussion of the cultural, ethical, and clinical questions that I encountered as the first psychiatrist to work as such a clinic.

NO. 4
CHAIRING THE NGO COMMITTEE ON THE STATUS OF WOMEN AT THE UNITED NATIONS
Speaker: Vivian B. Pender, M.D.

SUMMARY:
The NGO Committee on the Status of Women was established 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 well being of women and girls. As Chair of the NGO CSW, Vivian Pender was able to advocate for the mental health of women and girls with Member states of the UN Commission on the Status of Women.

NO. 5
COLLECTIVE TRAUMA
Speaker: Jack Saul, Ph.D.

SUMMARY:
Political violence and disasters confer significant mental health vulnerability to individuals, families and communities. Mental health and health professionals working in response to large scale political violence or natural disaster are starting to play a larger role on the global stage in various ways. During this symposium, the speakers will discuss specific case studies on how to address mental health issues from a community and systems perspective.
Jack Saul PhD will present narratives from his book 'Collective Trauma, Collective Healing: Promoting Community Resilience in the Aftermath of Disaster' and discuss the idea of a collective approach to trauma with a specific focus on resilience and coping within families and communities at large.

NO. 6
COMMUNITY RESPONSES TO MENTAL HEALTH IN BURUNDI AND BEYOND: A COLLECTIVE APPROACH TO TRAUMA
Speaker: Sonali Sharma, M.D.

SUMMARY:
Political violence and disasters confer significant mental health vulnerability to individuals, families and communi-

ties. Mental health and health professionals working in response to large scale political violence or natural disaster are starting to play a larger role on the global stage in various ways. During this symposium, the speakers will discuss specific case studies on how to address mental health issues from a community and systems perspective.
Sonali Sharma MD MSc will present a framework for strengthening mental health care in post-conflict settings focused on the integration of mental health into primary care and a qualitative research component which formed a basis for operational work.

MOVING FROM TREATMENT AS USUAL TO GOOD CLINICAL CARE OF PERSONALITY DISORDER TRAITS

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

Discussant: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize some underlying biological bases of personality disorder traits and understand how these can be used as a rationale for drug treatment; 2) Identify common aspects of different psychotherapy techniques for personality disorder traits that could be used in practice to help with personality integration; 3) Recognize commonalities of personality disorder traits treatment studies which could be used as part of an office based practice of psychiatry.

SUMMARY:
As research into the treatment of personality disorder traits has evolved over time there has developed a gap between the research literature and clinical practice. This symposium would look at the status of various modalities for treatment with a focus on helping the clinician reach the goal of good clinical care for personality disorder traits. One talk will examine treatment based on the underlying brain pathology and specifically targeting these biological deficits. Recent biological research has created intriguing possible approaches to treatment. This talk will include current status of drug treatment for personality traits. Psychotherapy has always been a mainstay of treatment for personality traits. The goal has always been to create more integrated personality functioning. A presentation will examine common the key elements of different psychotherapy approaches for personality disorder traits and explain how to incorporate some of these common approaches into clinical practice. This will focus especially on diagnosis and assessment of personality traits as they relate to treatment. As clinicians in office practice treat personality traits, often without extensive support, there will be a presentation on the approach for a non specialist psychiatrist. Major personality trait treatment studies will be reviewed and findings relevant for office practice highlighted. The aspect of how to incorporate aspects of "good clinical care" as used in research studies to clinical practice will be examined. Personality traits do not exist in a vacuum. One common comorbidity is that of major depression and personality traits. A presentation will examine aspects of this overlap focusing on clinical treatment.

NO. 1
TOWARDS A RATIONAL BASIS FOR THE PHARMACOLOGIC TREATMENT OF PATHOLOGIC PERSONALITY TRAITS
Speaker: Larry J. Siever, M.D.

SUMMARY:
Pathologic personality traits drive interpersonal and occupational dysfunction of many psychiatric patients, but these inflexible, persistent traits are often not satisfactorily addressed in treatment as usual and interfere with the successful resolution of comorbid conditions such as depression or anxiety as well as the persistent problems of living engendered by these traits. While the mainstay of psychiatric treatment of personality traits continues to be psychosocial interventions, the most persistent and serious of the pathologic personality traits often require pharmacologic intervention so that they are more amenable to changes in psychotherapeutic treatments. Emerging evidence in our understanding of the neurobiology of these pathological traits holds promise for new and more effective treatments. For example, pronounced emotion dysregulation can be associated with cortical/limbic imbalances with deficient modulation by serotonin and glutamatergic/gabaminergic systems. New agents may help address these imbalances. Similarly new interventions are emerging for the cognitive impairment that characterizes schizotypal and paranoid personality disorders. Oxytocin and novel opioid agonists may offer new tools to enhance interpersonal learning. Novel serotonergic receptors selective serotonergic compounds may ameliorate impulsive aggression. A rational approach to selective pharmacologic interventions and potential new prospects for such interventions will be discussed.

NO. 2
STRATEGIES FOR PROMOTING MORE INTEGRATED PERSONALITY FUNCTIONING
Speaker: John Livesley, M.D., Ph.D.

SUMMARY:
Personality disorder involves pervasive impairment to the integrative and organizational aspects of personality. These impairments serve to define disorder and differentiate it from more ubiquitous personality dysfunction. Despite the importance of integrative processes and mechanisms for understanding and conceptualizing personality disorder, most treatments largely neglect the importance of promoting integration focusing instead on the more symptomatic aspects of personality pathology. This paper will examine the integrative features of personality and the way these features are impaired in disordered personality. Particular attention will be given to impairments to the the self and identity system which form a key element of the DSM-5 definition of personality disorder. These problems with be described in terms of difficulty developing a differentiated and integrated sense of self that is capable of acting as a

center of agentic activity. Subsequently, strategies for developing a more coherent self system will be discussed. It will be argued that variety of change mechanisms are important in promoting integration ranging from generic mechanisms used to increase self-understanding and self-reflection and build links and connection within self knowledge to more specific interventions to construct a more coherent self-narrative and a more adaptive relationship with the individual's social environment.

NO. 3
MOVING FROM TREATMENT AS USUAL TO GOOD CLINICAL CARE FOR PERSONALITY DISORDER TRAITS FOR THE OFFICE-BASED CLINICIAN.
Speaker: James Reich, M.D., M.P.H.

SUMMARY:
There is now a body of treatment research on personality disorder traits. These studies usually take place in a university or specialized treatment settings far different from the setting where the office based clinician practices. Many of the techniques used in these studies require extensive training that most office based psychiatrists often have not completed. However, many psychotherapy research studies have used a control arm of manual codified "good clinical care" as a control group. In these studies good clinical care is a highly effective treatment. The presentation will examine commonalities of this research defined good clinical care and how they might be translated to office based care. This presentation will also review other key treatment studies using various modalities of treatment and examine how these findings might translate to approaches to care for office based psychiatrists. Not all of the techniques will transfer, of course. On the other hand the office based clinician may have more flexibility to focus on an individual's specific needs with techniques drawn from a variety of modalities and this flexibility may be highly beneficial to an individual patient.

NO. 4
COMORBID BPD AND DEPRESSION: DIAGNOSTIC TOOLS AND CLINICAL PITFALLS
Speaker: Simone Kool, M.D., Ph.D.

SUMMARY:
Objectives: Most BPD patients also meet criteria for depressive disorders which leads to complex dilemmas in the process of diagnosis and treatment of both disorders. For the clinician it is important to discern the distinctions and overlapping characteristics of both disorders and to be aware of the pitfalls that will be met.
Methods: Based on the findings in literature and the state of the art knowledge, an overview will be given of specific characteristics of patients with BPD and comorbid depression as well as the implications for diagnosis and treatment.
Results: Overlapping characteristics will be summarized as well as distinctive symptoms. For example, the quality of the depressive experience of borderline patients is unique and distinct from that of depressed patients. Recommendations for diagnosing and treating BPD patients with depression will be given.
Conclusion: In diagnosing and in the treatment of BPD patients with depression, the clinician should be aware of the implications of this type of comorbidity as this will lead to improvement in remission for both borderline and depressive symptoms.

BIPOLAR DISORDER: PATIENT STRATIFICATION TOWARDS PERSONALIZED MEDICINE

Chairs: Roger S. McIntyre, M.D., Natalie Rasgon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize, define and understand the clinical effect size of cognitive dysfunction and cognitive remediation in bipolar disorder; 2) Identify and recognize DSM-V defined mixed feature specifier as it appears in real-world clinical situations; 3) Discuss the influence of gender on bipolar phenomenology, comorbidity, course and outcome in bipolar disorder; 4) Recognize bipolar depression and list 3 evidence-based pharmacologic and/or psychosocial treatments for bipolar disorder; 5) Identify the long-term symptomatic structure of bipolar disorder and its relevance to functional outcome; .

SUMMARY:
During the past decade there has been a substantial refinement of the phenomenology, course and outcome in bipolar disorder. These advances coincide with the introduction in widespread availability of DSM-V in 2013. Available evidence indicates that bipolar disorder is a life-long disorder characterized by high rates of non-recovery, inter-episodic dysfunction and chronicity.
The overarching theme of these series of presentations will be on the phenomenology of bipolar disorder during the short and long-term in well-characterized clinical cohorts. We will focus on cognitive dysfunction, mixed features defined according to DSM-V, depressive symptoms/episodes as well as the impact of gender on illness onset, comorbidity and course of illness. We will also focus on treatment aspects as it is relevant to a busy practitioner.

NO. 1
BIPOLAR DISORDER IN WOMEN
Speaker: Natalie Rasgon, M.D., Ph.D.

SUMMARY:
Objectives: The purpose of this study was to investigate the reproductive function of women with bipolar disorder (BD) compared to healthy controls.
Methods: Women diagnosed with BD and healthy controls with no psychiatric history ages 18 to 45 were recruited from a University clinic and surrounding community. Participants completed a baseline reproductive health questionnaire, serum hormone assessment, and ovulation tracking

for three consecutive cycles using urine LH-detecting strips with a confirmatory luteal-phase serum progesterone.
Results: Women with BD (n=103) did not differ from controls (n=36) in demographics, rates of menstrual abnormalities (MA), or number of ovulation-positive cycles. Of women with BD, 17% reported a current MA and 39% reported a past MA. DHEA-S and 17-hydroxyprogresterone were higher in controls (p=0.052 and 0.004), otherwise there were no differences in biochemical levels. Medication type, dose, or duration was not associated with MA or biochemical markers except those currently taking an atypical antipsychotic indicated a greater rate of current or past MA (80% versus 55%, p=0.013). In women with BD, 22% reported a period of amenorrhea associated with exercising or stress, versus 8% of controls (p=0.064). Self-reported rates of Bulimia and Anorexia Nervosa were 10% and 5%, respectively.

NO. 2

COGNITION IN BIPOLAR DISORDER: TREATMENT IMPLICATIONS

Speaker: Eduard Vieta, M.D., Ph.D.

SUMMARY:

Cognitive functioning has been largely neglected in bipolar disorder, with the false assumption that manic-depressive illness was not a deteriorating condition. Over the past 15 years we learnt that cognitive performance is a key player in patient outcome, and we have identified tha major variables involved in the process. However, most studies were unable to control in a proper way for the influence of medications, and we are left with the uncertainty of which are best and which are worst as far as cognition is concerned. This presentation will provide an overview of the literature on this topic, the potential mechanisms of action involved in benefits and harms of drugs on cognitive performance, and novel data on medications aimed at improving cognitive functioning in patients with bipolar disorder. Antipsychotics, mood-stabilizers, antidepressants, dopamine agonists, benzodiazepines and other compounds including pro-cognitive agents will be reviewed and critically discussed in this context. Implications for the clinical care of patients with bipolar disorder will be provided. Cognition is a key component of personalized or stratified medicine in the field of Psychiatry and, particularly, in the rapidly changing scope of bipolar illness.

NO. 3

MORE LIBERAL "WITH MIXED FEATURES" THRESHOLD FOR BIPOLAR DEPRESSION MAY BE NOT ONLY MORE INCLUSIVE, BUT ALSO MORE CLINICALLY RELEVANT

Speaker: Terence A. Ketter, M.D.

SUMMARY:

Objective: Assess prevalence and clinical relevance of "with mixed features" using a more liberal (2 opposite pole symptoms) compared to the more conservative DSM-5 (3 opposite pole symptoms) threshold in depressed bipolar disorder (BD) patients.
Methods: BD outpatients were assessed with the Systematic Treatment Enhancement Program for BD (STEP-BD) Affective Disorders Evaluation. Prevalence and clinical correlates of baseline depressive episodes "with mixed features" were compared using a more liberal threshold and the more conservative DSM-5 threshold.
Results: Among 151 BD patients with baseline syndromal major depressive episodes, "with mixed features" occurred in 22.5% (34/151) using a more liberal threshold, but in only 9.9% (15/151) using the more conservative DSM-5 threshold. Hence, the rate of "with mixed features" for depressive episodes using the more liberal compared to the conservative threshold was more than twice (2.3 times) as high (Chi-square=8.8, p=0.004). Moreover, the more liberal threshold yielded more statistically significant clinical correlates of "with mixed features" compared to pure depressive episodes (i.e. more anxiety disorder and alcohol use disorder comorbidity, and less antidepressant use).
Conclusion: Further studies are warranted to assess our preliminary observation that a more liberal "with mixed features" threshold for bipolar depression may be more inclusive and have more clinical relevance.
Support:
Pearlstein Family Foundation.

NO. 4

PREDICTING LONGITUDINAL OUTCOMES IN BIPOLAR DISORDER

Speaker: Roy H. Perlis, M.D., M.Sc.

SUMMARY:

For many patients, bipolar disorder is both a chronic and recurrent illness. A major challenge for patients and clinicians is anticipating prognosis, in terms of course of illness. The ability to stratify risk for more severe or chronic course could facilitate the development and targeting of specific interventions to improve those outcomes. Recently, a model for stratifying risk for treatment-resistance in major depressive disorder was developed and validated. This presentation will address analogous work in bipolar disorder, focusing on depression and drawing on data from large effectiveness studies and population-based cohorts. Beyond individual predictors of outcome, the derivation of multivariate models integrating sociodemographic and clinical features will be demonstrated and discussed. The challenges in translating such models to clinical practice, and in incorporating biological markers, will also be addressed.

NO. 5

IMPROVING TREATMENT OUTCOME IN BIPOLAR DEPRESSION

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Depressive symptoms and episodes are the predominate symptom presentation of bipolar disorder. Moreover, depressive symptoms are the principal mediator of poor functional outcomes in bipolar disorder and presage suicidality.

Relatively fewer treatments have been developed for bipolar depression when compared to bipolar mania. This presentation will broadly review evidence-based treatment strategies for bipolar depression. In addition, the presentation will also provide the rationale and evidence for mechanistic novel treatments for bipolar depression that target disparate systems including, but not limited to, immunoinflammatory, metabolic, oxidative, and amino acid targets. Results from psychosocial interventions, neurostimulation, and dietary interventions will also be reviewed.

VICARIOUS TRAUMA IN CATASTROPHIC EVENTS: FROM THE PERSPECTIVE OF MENTAL HEALTH PROVIDERS AT VARIOUS PHASES OF A DISASTER

Chair: Gertie Quitangon, M.D.

Discussant: Charles Figley, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Increase understanding of Vicarious Trauma and related concepts in the setting of large scale disasters; 2) Recognize disaster stage-specific strategies and interventions to prevent Vicarious Trauma and promote resilience in mental health clinicians on an individual and organizational level; 3) Identify opportunities for further empirical validation of Vicarious Trauma in the context of massive disasters to inform best practices and shape policy and programs in disaster planning.

SUMMARY:
Floods, hurricanes, tornadoes, acts of terrorism and other large-scale catastrophic events have increased in the last decade and emergency preparedness and disaster resilience have become a national imperative. Mental health professionals play many important roles in helping communities prepare and respond to disasters. What happens when mental health providers share the trauma and vulnerability from the toll taken by a disaster with the victims they care for? How can clinicians increase resilience during various phases of a disaster and provide mental health services effectively?

NO. 1
HURRICANE KATRINA: A PHYSICIAN'S WHIRLWIND COURSE IN DISASTER PSYCHIATRY
Speaker: Shane S. Spicer, M.D.

SUMMARY:
This article chronicles one mental health provider's experiences during Hurricane Katrina and the immediate aftermath. The author talks about surviving the storm; opening a make-shift clinic in a hotel restaurant to help people with mental disorders and anxiety, as well as physical symptoms; and dealing with the chaos and the decline of social order.

NO. 2
THE AFTERMATH OF 9/11 VIEWED THROUGH THE LENS OF A PSYCHIATRIST IN TRAINING AT ST. VINCENT'S HOSPITAL
Speaker: Jeremy Winell, M.D.

SUMMARY:
A psychiatrist will transport the audience back to a dark time and draw insight from the vantage point of a PGY3 resident in a teaching hospital most proximal to the towers that fell on 9/11. From staffing the Family Crisis Center to running group psychotherapy for New York City firefighters, evaluating children and teens schooled near Ground Zero, and witnessing the awestruck response of friends, colleagues, teachers, and mentors in the mental health community. What happens during an unprecedented act of terror where the clinicians themselves are traumatized?

NO. 3
WITNESSING THE IMPACT OF PROVIDING DISASTER BEHAVIORAL HEALTH SERVICES IN THE COMMUNITY
Speaker: April J. Naturale, Ph.D.

SUMMARY:
Disaster Behavioral Health is an emerging discipline that is being informed rapidly with the increase in both natural events and incidents of mass violence over the past decade in the US as well as globally. Mental health providers, substance counselors, faith-based workers and other community volunteers are being called for multiple and longer term disaster mental health deployments than ever before even though they are disaster survivors themselves. While mental health and public health professionals comprise the largest percentage of this group, many students and community workers become immediately involved. The presenter will illustrate the impact of providing disaster behavior health services during large scale disasters including the terrorist attacks of 9/11, the Newtown school shooting, the Boston Marathon bombing alongside natural disasters, including Hurricane Katrina, the Joplin tornado and the huge spate of additional tornados that tore through the Southern section of the US in 2011.

NO. 4
VICARIOUS TRAUMA AND DISASTER RESPONSE TO SANDY: THE NYU WORLD TRADE CENTER HEALTH PROGRAM RESPONSE
Speaker: Mark Evces, Ph.D.

SUMMARY:
A psychologist will discuss his experience of being dislocated from the NYU World Trade Center Mental Health Clinic for several months following Hurricane Sandy. Clinic offices became inaccessible due to flooding, and mental health staff were relocated to a temporary office. Patients were reachable by phone only as no clinic space was available until clinic facilities at Bellevue Hospital could be repaired. The presenter will discuss effects of being unexpectedly prevented from seeing patients face to face, and the experience of providing support to 9/11 first responders during Sandy, many of whom experienced retraumatization during and

following the storm. The presenter will discuss the interaction between feeling impacted by the storm and supporting patients who were also impacted. These experiences will be described using the construct of vicarious trauma: shifts in emotions, thoughts and behaviors resulting from indirect exposure to trauma via empathic engagement with patients' traumatic material.

COGNITIVE THERAPY AND MEDICATIONS IN THE TREATMENT OF DEPRESSION AND THE PREVENTION OF SUBSEQUENT RECURRENCE

Chairs: John Zajecka, M.D., Jay D. Amsterdam, M.D.

Discussant: Andrew Nierenberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Determine when to add cognitive therapy to antidepressant medications; 2) Treat patients in accordance with a principle-based medication algorithm; 3) Determine who can withdraw from medications following recovery.

SUMMARY:
From the patient's perspective, full normalization of symptoms (remission) is better than simple improvement (response) and getting over the current episode (recovery) is better still. Similarly, preventing the return of the treated episode (relapse) is to be desired, but preventing the onset of wholly new episodes (recurrence) is even better. It is likely that different patients need different lengths of treatment to meet these milestones, but most clinical trials treat patients for a fixed period of time rather than to the point of remission, much less recovery, and few studies follow those samples long enough to determine whether prior or ongoing treatment can prevent relapse, much less recurrence. In this trial, 452 patients meeting criteria for MDD were randomly assigned to medication treatment with or without cognitive therapy and treated for up to 18 months to the point of remission (minimal symptoms for at least 4 weeks) and then continued in treatment for up to 36 months until the point of recovery (six months without relapse following remission). Patients could be treated with whatever medications were clinically indicated and switched or augmented as necessary. At the point of recovery, cognitive therapy was phased out for those in combined treatment and patients in both conditions were randomized to either stay on maintenance medication or medication withdrawal and followed across the next three years to ascertain rates of recurrence. Combined treatment showed a modest but significant increment in rates of recovery relative to medications alone through the end of continuation (11%). This main effect was moderated by both chronicity and severity such that non-chronic patients with more severe depressions (about a third of the sample) were considerably more likely to recover in combined treatment than in medication treatment alone (81% versus 52%), whereas treatment differences were negligible for less severe or chronic patients (each about a third of the sample). Presence of a personality disorder slowed rates of recovery in either condition. Maintaining recovered patients on medications greatly reduced rates of recurrence and patients without personality disorders could afford to come off medications if they previously had been treated with cognitive therapy, whereas patients with personality disorders could not. Patients treated with combined treatment were less likely to experience severe adverse events. These findings can be used to determine who benefits from combining cognitive therapy with medications (non-chronic patients with severe depressions) and who can most afford to come off maintenance medications following recovery (patients without personality disorder who received prior cognitive therapy). They also can suggest how long it will take to produce a desired outcome in a given patient and that controlled trials can be done in a clinically representative fashion.

NO. 1
COGNITIVE THERAPY AND MEDICATIONS IN THE TREATMENT OF DEPRESSION
Speaker: Steven Hollon, Ph.D.

SUMMARY:
A total of 452 MDD patients at three different sites were randomized to up to three years of medication with or without cognitive therapy and treated first to remission (four weeks of minimal symptoms) and then recovery (six months post remission without relapse). Patients in combined treatment were more likely to recover than patients treated with medication alone, but this effect was moderated by both chronicity and severity such that non-chronic patients with more severe depressions benefited greatly from adding cognitive therapy, whereas no such advantage was seen for less severe or chronic patients. Presence of a personality disorder slowed rates of recovery in either condition. Optimally implemented pharmacotherapy can bring the vast majority of patients to remission and recovery and the pace of recovery can be enhanced by the addition of cognitive therapy for non-chronic patients with more severe depressions.

NO. 2
COGNITIVE THERAPY AND MEDICATION IN THE PREVENTION OF RECURRENCE IN DEPRESSION
Speaker: Robert J. DeRubeis, Ph.D.

SUMMARY:
A total of 292 patients meeting criteria for recovery from major depression following treatment with antidepressant medications with or without cognitive therapy were randomly assigned to maintenance medication or medication withdrawal. Cognitive therapy was phased out for patients in the combined condition early in the maintenance phase and all patients were followed over a three-year period to ascertain rates of recurrence. Keeping patients on maintenance medication greatly reduced the rates of recurrence, whereas the preventive effect of prior cognitive therapy was moderated by presence of a personality disorder such

that patients without personality disorders could afford to come off medications if they had previously been treated with cognitive therapy, whereas patients with personality disorders could not. These findings indicate that cognitive therapy's enduring effect may extend to the prevention of recurrence but only for patients free from personality disorders.

NO. 3
PRINCIPLE-BASED ALGORITHM FOR THE TREATMENT AND PREVENTION OF DEPRESSION
Speaker: Richard C. Shelton, M.D.

SUMMARY:
Patients were treated in accordance with a principle-based algorithm that could involve all of the antidepressant medications (ADMs) and any of the augmenting or adjunctive agents used in clinical practice. Doses were raised as rapidly as the patient could safely tolerate and kept at maximally-tolerated levels for at least four weeks. Patients who exhibited only partial response were augmented, whereas patients who showed little or no response were switched to another ADM. Patients were given multiple trials on different SNRIs or SSRIs before being switched to more difficult-to-manage TCAs and then on to MAOIs. Rates of full remission (minimal symptoms for a month) were 29% at three months, 44% at six months, 53% at nine months, and 66% at one year. Partial remission was allowed thereafter and rates increased to 73% at fifteen months and finished at 79% at month eighteen. Adhering to a principle-based algorithm can facilitate personalizing medicine in a flexible and powerful fashion.

NO. 4
MAOIS ARE SAFE AND EFFECTIVE IN THE TREATMENT OF RESISTANT DEPRESSION
Speaker: Jan Fawcett, M.D.

SUMMARY:
MAOIs are perceived to be difficult to manage and often avoided in clinical practice. Patients in this study were given multiple trials of ADM (SNRIs, SSRIs, TCAs and augmentation) and failed to adequately respond prior to being switched to an MAOI. Of the 452 patients in this study, 73 (16%) received an MAOI. Thirty-nine (9%) received an MAOI during acute treatment, and 16 (41%) remitted. Another nineteen (4%) patients started on an MAOI during continuation treatment and 10 (53%) remitted. Sixteen (46%) of patients who remitted in acute and continuation, recovered and entered maintenance treatment. An additional 15 patients started an MAOI during maintenance treatment. Among the 73 patients receiving an MAOI, there was only one serious adverse event, not related to the use of the MAOI. When adequately managed, MAOIs can be a safe and effective treatment for patients resistant to other ADM.

TMS THERAPY FOR PHARMACO-RESISTANT MAJOR DEPRESSIVE DISORDER
Chair: Linda L. Carpenter, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the basic equipment, physics and physiology underlying delivery of TMS therapy; 2) Review and synthesize the clinical trials data regarding efficacy and safety of TMS therapy that supported FDA clearance of two devices for treatment of patients with Major Depressive Disorder; 3) Have information useful for navigating a number of administrative and systems issues related to incorporation of TMS therapy services into standard psychiatric practice.

SUMMARY:
The majority of adults treated for Major Depressive Disorder (MDD) do not achieve remission with standard antidepressant medication therapy, and up to a third will not find relief after multiple serial drug and psychotherapy trials. In 2008, the FDA approved the first device for delivering repetitive transcranial magnetic stimulation (rTMS or simply "TMS") for treatment of pharmacoresistant depression, and a second device was cleared in January of 2013. TMS focuses MRI-strength pulsed magnetic fields on targeted brain regions to directly stimulate neuronal activity several centimeters under the scalp in an awake patient. Data from multi-center TMS trials sponsored by both industry and NIH show efficacy of TMS in patients with pharmacoresistant MDD, and the growing evidence base has been reflected by an increasing number of health insurance payers covering TMS therapy in the past few years. As TMS therapy becomes a "standard of care" option for patients with MDD, psychiatrists need to become familiar with this novel treatment modality and understand the scientific data that surrounds its use in current practice. In this symposium, we will start with a basic introduction to TMS physiology and research findings that address its mechanisms of action. Results from controlled trials in depression will be presented, along with a glimpse at "next generation" TMS devices in development. Finally, we will discuss practical issues encountered during implementation of TMS in clinical practice, including patient selection/referral, billing and reimbursement for TMS.

NO. 1
WHAT IS TRANSCRANIAL MAGNETIC STIMULATION? TMS AND RTMS THERAPY BASICS
Speaker: Amit Etkin, M.D., Ph.D.

SUMMARY:
Dr. Etkin will provide a basic overview for a general clinical audience of how TMS works, focusing on the equipment, physics and physiology. Basic properties of TMS coils and stimulation will be tied to an understanding of what kind of effects it can exert in the brain, and the relevance of these for thinking about current and potential future TMS applications. Both strengths and limitations of this non-invasive brain stimulation approach will be considered. Additionally, data will be presented on the mechanisms of action of therapeutic TMS for major depression and insights into this pro-

cess from experimental studies in human subjects. Together, these data will illustrate how our emerging understanding of brain circuit abnormalities in depression can inform research and clinical practice with TMS and realize potential for this tool beyond the present clinical standard.

NO. 2
PIVOTAL RTMS CLINICAL TRIALS: EFFICACY, SAFETY, AND THE PATH TO FDA CLEARANCE
Speaker: William M. McDonald, M.D.

SUMMARY:
In October 2008, the Neuronetics® rTMS device was approved for use by the Food and Drug Administration (FDA) for patients with major depression who have not responded to at least one antidepressant medication in their present episode. Dr. McDonald will review the data from the industry sponsored pivotal trial that led to the approval for rTMS as well as the NIMH trial that confirmed the pivotal trial. He will also discuss the largely naturalistic post-approval trials that generally support the role of rTMS in clinical practice and outline where rTMS fits along the treatment paradigm in treatment intolerant and resistant depressed patients.

NO. 3
NEXT GENERATION DEVICES AND PUSHING THE TMS PARAMETERS
Speaker: Mark George, M.D.

SUMMARY:
The TMS depression field is evolving rapidly in several new directions. The first phase of TMS use in depression generally used figure eight coils positioned over the prefrontal cortex (largely the left). Most recently, scientists have begun experimenting with novel coils, and challenging the necessity of early delivery patterns of daily weekday treatment for 4-6 weeks. This talk will review the new deep TMS coil built by Brainsway, and their pivotal trial which resulted in FDA approval. We will also review depression trials involving multiple coils in combination (Cervel), and low intensity coils (Neosync) and low-frequency magnetic stimulation. With respect to new delivery patterns, we will present data from a most recent trial involving accelerated TMS (9 treatments in 3 days, 54000 stimuli) for the treatment of suicidal crisis.

NO. 4
DELIVERY OF TMS THERAPY IN CLINICAL PRACTICE SETTINGS
Speaker: Linda L. Carpenter, M.D.

SUMMARY:
Incorporating a novel treatment like TMS therapy into clinical practice presents many new challenges for psychiatrists who are not familiar with the delivery of medical procedures (with the associated administrative burden). Insurance coverage for TMS therapy by commercial and federal payers does not necessarily reflect the FDA label or the full spectrum of the published scientific evidence base for TMS, but it does open access to millions who have not had a safe and effective new treatment option for pharmacoresistant depression. This talk will review some critical steps for setting up a TMS clinical practice, such as how to identify and consent appropriate candidates for TMS therapy, how to incorporate measurement-based care into the TMS clinic, consideration of "on-label" versus "off-label" treatment strategies, and management of critical reimbursement issues encountered TMS in clinical practice.

UPDATES IN BARIATRIC PSYCHIATRY: MANAGING PSYCHOPATHOLOGY ASSOCIATED WITH OBESITY AND WEIGHT LOSS SURGERY

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Contrast the neurobiological pathways and impact on clinical outcomes in patients with obesity and psychiatric illness; 2) Describe the risk and prognosis of patients with psychiatric illness undergoing bariatric surgery; 3) Identify pharmacological and non-pharmacological evidence-based interventions to manage psychiatric complications related to bariatric surgery; 4) Apply an attachment theory model for understanding obesity related psychopathology and engagement in severe obesity interventions.

SUMMARY:
The World Health Organization has declared obesity as global epidemic and extreme obesity is increasing rapidly in many parts of the world, including North America. Obesity has a high degree of co-morbidity with psychiatric illness, such as mood disorders, and this relationship is bi-directional in nature. Recent research has hypothesized links between obesity, depression and metabolic syndrome through multiple mechanisms including iatrogenic and non-iatrogenic factors, such as immune-inflammatory processes and adipokines. As a result, psychiatrists caring for the obese patients are increasingly faced with untangling the impact of obesity on mood disorders amidst other medical co-morbidities. In addition, the growing acceptance of bariatric surgery for severe obesity and to improve quality of life has required the involvement of psychiatrists given the high prevalence of severe obesity in psychiatric populations and need for ongoing psychiatric needs of patients after bariatric surgery. Psychiatrists equipped with skills to manage obesity across the weight and intervention spectrum are well positioned to provide evidence-based pharmacological and non-pharmacological treatment to improve overall obesity-related outcomes. The following symposium will focus on psychiatric management across the obesity spectrum. Symposium content will be based on research conducted by the presenters, which will be situated in an up-to-date review of the literature. Dr. Riccardo Paoli will begin the symposium presenting a synthesis of the literature on the neuropsychiatric complications of obesity, focusing specifically on the bi-directional relationship with mood

disorders. Dr. Raed Hawa will provide an update on the psychiatric assessment of bariatric surgery patients, specifically focusing on pre-surgery psychosocial predictors and data on specific assessment measures. Dr. Kathleen Bingham will present on specific pharmacokinetic changes of psychotropic agents following bariatric surgery and will discuss potential post-surgery medication monitoring for psychotropic agents. Dr. Susan Wnuk will present on the evolving field of eating disorders following weight loss surgery. She will summarize evidence-based approaches to managing unique eating psychopathology in this patient population. Dr. Sanjeev Sockalingam will conclude by reviewing the relationship between attachment theory and obesity. He will present data from two recently published research studies from the University of Toronto Bariatric Surgery Collaborative showing the impact of attachment style on pre-surgery psychopathology and post-surgery adherence to care. Case discussions will be used to generate discussion and to apply symposium content to real world clinical scenarios.

NO. 1

MOOD DISORDERS AND OBESITY: NEUROPSYCHIATRIC PATHWAYS TO HIGHLY COMORBID CONDITIONS

Speaker: Riccardo A. Paoli, M.D.

SUMMARY:

Obesity is highly co-morbid with psychiatric disorders, such as mood disorders and associated with a range of neuropsychiatric effects. The relationship between psychiatric illness and obesity is multi-factorial with genetic, environmental, illness related and medication related causes. Furthermore, the effects of an increased BMI on cognitive function (impaired working memory, verbal, fluence and executive functioning) can lead to further functional impairment in mood disorder patients who have a pre-existing propensity for cognitive dysfunction. Dr. Paoli will discuss the complexity of this relationship including clinical implications of obesity in patients with mood disorders. Neurobiological mechanisms including role maladaptive eating behaviours and treatment recommendations for obesity in mood disorders will be discussed.

References:

1. Lopresti AL, Drummond PD Obesity and psychiatric disorders: Commonalities in dysregulated biological pathways and their implications for treatment Prog Neuropsychopharmacol Biol Psychiatry. 2013 Aug;45:92-9.

2. Ramacciotti CE, Paoli RA, Marcacci G, Piccinni A, Burgalassi A, Dell'Osso L, Garfinkel PE. Relationship between bipolar illness and binge-eating disorders. Psychiatry Res. 2005 Jun 15;135(2):165-70

3. McIntyre RS et al. The CANMAT task force recommendations for the management of patients with mood disorders and comorbid metabolic disorders. Ann Clin Psychiatry 2012; 24: 69-81.

NO. 2

PSYCHIATRIC ASSESSMENT OF BARIATRIC SURGERY CANDIDATES: AN UPDATED REVIEW

Speaker: Raed Hawa, M.D.

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 requires psychiatric involvement to determine potential risk, anticipate post-operative complications and to improve long-term surgical outcomes.

Dr. Hawa will present an update on the psychiatric assessment of bariatric surgery candidates. He will provide an up-to-date review of the evidence for negative prognostic factors, pre-surgery psychological assessment tools and challenges with pre-bariatric surgery suitability assessment. Dr. Hawa will also share an interprofessional model for pre-surgery assessment from the Toronto Western Hospital Bariatric Surgery Program, an American College of Surgeons Level 1A Centre of Excellence. Quality data on bariatric surgery psychosocial patient outcomes from this interprofessional program will be shared with participants.

NO. 3

PSYCHOTROPIC MEDICATIONS POST-BARIATRIC SURGERY: PHARMACOKINETIC CHANGES AND MANAGEMENT CONSIDERATIONS

Speaker: Kathleen Bingham, M.D.

SUMMARY:

Given the frequency of psychiatric diagnoses among bariatric surgery candidates and the documented changes in psychiatric medication absorption post-operatively, pharmacokinetics of psychotropic medications following bariatric surgery is an emerging area of investigation. It is particularly relevant when one considers the potentially negative prognostic implications of psychiatric disorders in post-operative bariatric surgery patients.

This presentation will begin by outlining the anatomical and functional changes of gastric bypass surgery affecting pharmacokinetics in general. Evidence from the literature for post-operative alterations in pharmacokinetics of specific psychotropic medications (antidepressants, mood stabilizers and antipsychotics) will then be reviewed. Finally, management considerations, including medication choice and formulation, dosing, and monitoring parameters in the perioperative period will be presented, drawing from both the literature and clinical experience.

References:

1. Hamad GG, Helsel JC, Perel JM, Kozak GM, McShea MC, Hughes C, Confer AL, Sit DK, McCloskey CA, Wisner KL: The effect of gastric bypass on the pharmacokinetics of serotonin reuptake inhibitors. Am J Psychiatry. 2012; 169:256–263

2. Roerig JL, Steffen KJ, Zimmerman C, Mitchell JE, Crosby RD, Cao L. A comparison of duloxetine plasma levels in postbariatric surgery patients versus matched nonsurgical control subjects. J Clin Psychopharmacol 2013;33:479-84.

NO. 4

EATING DISORDERS POST-BARIATRIC SURGERY: DETECTION AND TREATMENT
Speaker: Susan Wnuk, Ph.D.

SUMMARY:
In recent years, as bariatric surgery has been performed in greater numbers, clinicians and researchers have become increasingly concerned about the occurrence of eating disorders in post-surgery patients. While eating disorder symptoms can be severe in this population, they nonetheless appear to be an under-recognized consequence of bariatric surgery. Since the behaviours typical of a post-surgery bariatric patient such as food restriction and concern about body weight and shape can mimic eating disorder symptoms, determining when these behaviours become problematic can be difficult. The published literature will be summarized and reviewed, with the aim of describing the etiology and symptoms of patients who develop eating disorders post-surgery, and evidence-based approaches to treatment. Case studies will be presented to illustrate the concepts described.

NO. 5
USING ATTACHMENT THEORY TO UNDERSTAND WEIGHT LOSS OUTCOMES: BARIATRIC SURGERY PERSPECTIVES
Speaker: Sanjeev Sockalingam, M.D.

SUMMARY:
Although social support has been linked to weight loss and quality of life after obesity interventions, attachment style is an additional mediating factor in patients' ability utilize social support. Insecure attachment style may exacerbate quality of life and increase vulnerability to psychopathology in patients with severe obesity. In addition, avoidant attachment style has been linked to poor adherence to treatments in chronic diseases, such as diabetes. Dr. Sockalingam will present data from two studies: one involving bariatric surgery candidates and the second involving post-bariatric surgery patients. The first study will explore the effects of attachment insecurity as a predictor of quality of life in a Canadian sample of bariatric surgery candidates. The second study will focus on the role of attachment style on patient adherence to post-bariatric surgery clinic appointments. Patient adherence has been linked closely to improved outcomes after weight loss surgery and this study summarizes the impact of attachment style on this important outcome. Evidence based psychosocial interventions to manage insecure attachment styles in severe obesity management will be summarized.
1. Sockalingam S, Cassin S, Hawa R, Khan A, Wnuk S, Okrainec A. Predictors of post-bariatric surgery appointment attendance: the role of relationship style. Obes Surg 2013 (in press)

BIPOLAR DISORDER: SPECIAL TOPICS

Chair: Michael Gitlin, M.D.
Discussant: Robert M. Post, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be familiar with the recent data evaluating the efficacy of lithium in naturalistically treated bipolar patients; 2) Be aware of the ongoing research into pharmacogenomics approaches to optimize the treatment of bipolar disorder; 3) Be knowledgeable about rational polypharmacy in the treatment of bipolar individuals; 4) Be familiar with the data supporting the use of adjunctive psychotherapy in the optimal treatment of bipolar disorder.

SUMMARY:
Beyond the classic treatments for bipolar disorder, a number of more cutting edge topics are supremely relevant to clinical practice. This symposium will cover a number of these topics. Lithium, our oldest mood stabilizer has been the subject of a number of recent trials. First, we will present data from a recent analysis on reassessment of the evidence for the use of lithium in relapse prevention of bipolar disorder, including placebo-and comparator controlled trials, as well as naturalistic long-term (> 10 years) data from the International Group for the Study of Lithium-Treated Patients (IGSLi). Second, pharmacogenomic approaches to the varied treatment approaches in bipolar disorder has also been a topic of recent inquiry and the state of this art will be reviewed. Third, more than any other disorder in psychiatry, bipolar disorder treatment is characterized by polypharmacy-the use of multiple medications prescribed simultaneously. We will review those combinations that are demonstrated as effective by data and others that make sense though unproven. Finally, medications are frequently necessary but not sufficient for optimal treatment of bipolar disorder. The use of adjunctive psychotherapies for bipolar patients is poorly utilized but can be clinically very effective and will be reviewed.

NO. 1
LITHIUM'S EFFICACY IN RELAPSE PREVENTION OF BIPOLAR DISORDER: OLD AND NEW EVIDENCE FROM CONTROLLED AND NATURALISTIC STUDIES
Speaker: Michael Bauer, M.D., Ph.D.

SUMMARY:
More than 60 years from the breakthrough of identifying lithium salts to have antimanic and prophylactic activity, modern research serves to further substantiate lithium's position at the front-line in the treatment of bipolar disorder. The drug continues to prove itself as an effective mood stabilizer, which also possesses unique anti-suicidal and antidepressant properties. Unfortunately, lithium is not widely used in clinical practice in many countries. In this presentation, the latest research into the effects of lithium on different levels of clinical investigation, from placebo-controlled trials to naturalistic investigations will be covered. This includes data from a recent analysis on reassessment of the evidence for the use of lithium in relapse prevention of

bipolar disorder, including placebo-and comparator controlled trials, as well as naturalistic long-term (> 10 years) data from the International Group for the Study of Lithium-Treated Patients (IGSLi).

NO. 2
BIOMARKERS FOR BIPOLAR DEPRESSION: THE PHENOTYPE AND GENOTYPE OF ANTIDEPRESSANT-INDUCED MANIA
Speaker: Mark Frye, M.D.

SUMMARY:
Identification of risk factors for antidepressant induced mania (AIM), including genetic variants associated with this serious adverse event, may aid in establishing individualized treatment strategies for bipolar disorder. Studies have investigated the association between AIM and variation in the serotonin transporter gene (SLC6A4), focusing primarily on the promoter region (5HTTLPR) with meta-analyses inconclusive. In the present study, a sample of 295 Caucasian subjects (113 AIM+ cases, 182 AIM- controls) from the Mayo Clinic Bipolar Biobank were genotyped for three SLC6A4 variants: the 5HTTLPR, SNP rs25531, and the intron 2 VNTR. Tests of association with AIM were performed for each polymorphism, and for haplotypes of the three polymorphisms. While this sample did not provide significant evidence of association of 5HTTLPR with AIM (p=0.16), a meta-analysis combining this sample with prior studies provided marginally significant evidence of association between the S allele of 5HTTLPR and AIM (p=0.059). The haplotype composed of the 5HTTLPR, rs25531, and the intron 2 VNTR was significantly associated with reduced risk of AIM (global haplotype test p=0.02). These findings suggest that further effort into understanding the relationship between SLC6A4 variation and risk of AIM should evaluate the role of the intron 2 VNTR as well as other variants in SLC6A4, rather than focusing exclusively on the promoter long/short variant.

NO. 3
COMBINATION TREATMENTS IN BIPOLAR DISORDER: SCIENCE AND ART
Speaker: Michael Gitlin, M.D.

SUMMARY:
More than any other disorder in psychiatry, bipolar disorder is characterized by polypharmacy, the simultaneous prescription of multiple medications. This talk will review the use of polypharmacy in bipolar disorder. The prevalence of polypharmacy in bipolar disorder will be presented. Next, we will evaluate the medication combinations-in acute mania, bipolar depression and in maintenance treatment that are supported by at least some data. Combination data are strongest for acute mania and in maintenance treatment. For acute mania, the combination of an antipsychotic added to either lithium or valproate has solid research support. Similarly, for maintenance treatment, a second generation antipsychotic augments the preventive efficacy of lithium and/or valproate. Lithium plus valproate is somewhat more effective than either agent alone. The strength of these data will be examined in some detail. Then, we will examine the types of treatment combinations that are frequently used but without a great deal of supportive data. Finally, we will discuss some combinations that can be thought of as unorthodox but that still should be considered in some cases.

NO. 4
ADJUNCTIVE PSYCHOTHERAPY FOR BIPOLAR DISORDER: CURRENT CLINICAL AND RESEARCH APPROACHES
Speaker: David J. Miklowitz, Ph.D.

SUMMARY:
There are now at least 20 randomized controlled trials of adjunctive psychotherapy for bipolar disorder. This talk will review some of the more recent randomized trials of family therapy, cognitive-behavioral therapy, interpersonal and social rhythm therapy, and group psychoeducation for adults and children with bipolar disorder. Rather than go through each study in detail, the speaker will review key themes in the literature, common elements in the treatment approaches, and limitations of the existing research. New approaches have included family-based psychoeducation for children at risk for bipolar disorder; functional remediation therapy for patients with neurocognitive limitations; mindfulness-based CBT; and treatments that emphasize sleep/wake regularity (including some that incorporate smart phone technology into mood and sleep monitoring). The problems in implementing these approaches in community mental health centers, which often have limitations on the length and frequency of treatment and the degree to which clinicians can be trained in specialized techniques, are discussed.

RDOC (RESEARCH DOMAIN CRITERIA): NEW APPROACHES TO DIAGNOSTICS

Chair: Bruce Cuthbert, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify and discuss the major components of the RDoC matrix and its rationale; 2) Discuss the significant aspects of an RDoC research design and how it differs from traditional approaches; 3) Explain in detail how RDoC could be used to explore two different mechanisms in cognitive and/or affective neuroscience to examine important questions regarding psychopathology.

SUMMARY:
Translational and clinical research increasingly indicates that traditional psychiatric disorders do not map well onto genetics, neural systems, and behavioral functions. Rather, our disorders are heterogeneous syndromes comprised of several components, varying in presence and extent from patient to patient. In addition, any given component (such as disinhibition, fear, anhedonia, or working memory) cuts across multiple disorders. This heterogeneity frustrates attempts to understand pathophysiology and develop efficacious new

treatments. In response, the NIMH Research Domain Criteria project (RDoC) was initiated in late 2009 to "develop, for research purposes, new ways of classifying mental disorders based on dimensions of observable behavior and neurobiological measures." RDoC is a research framework designed to foster cross-cutting studies based upon neural systems and behavioral functions, that can inform future versions of psychiatric nosologies. This symposium, following a brief introduction to the project by the head of the NIMH RDoC workgroup, features four leading scientists who will discuss applications of RDoC in genetics, cognitive and affective neuroscience, and informatics. An extensive question and answer session will follow the talks in order to explore the facets of this exciting new research approach.

NO. 1
PSYCHIATRIC GENETICS: DNA BEYOND DSM
Speaker: Jordan W. Smoller, M.D., Sc.D.

SUMMARY:
Psychiatric disorders are familial and heritable. In recent years, large-scale genomic studies have identified genetic variants influencing a range of disorders using DSM criteria . However, there is growing evidence that genetic influences transcend these clinically-defined categories. Research also suggests that genetic variation can have quantitative effects on neural and psychological traits related to multiple disorders, supporting a dimensional model of psychopathology. In addition, recent studies have begun to examine the functional impact of genetic risk factors on neural and behavioral phenotypes that may underlie clinical disorders. This presentation will address the genetic basis of psychiatric disorders, evidence for cross-disorder genetic influences, and implications for informing a "bottom-up" classification of psychopathology.

NO. 2
NEURAL AND PSYCHOLOGICAL MECHANISMS OF COGNITIVE CONTROL AND MOTIVATION: RELEVANCE TO RDOC
Speaker: Deanna Barch, Ph.D.

SUMMARY:
A large body of research has indicated that many forms of psychopathology involve impairments in processes related to motivation, cognitive control and reward processing. Fortunately, the past twenty years has seen a surge of research in human and animal cognitive and affect neuroscience examining the neural and psychological mechanisms that contribution to various components of motivation and cognitive control, as well as their interactions. As such, the field of clinical neuroscience is ripe to use this accumulated knowledge to examine the mechanisms that may be contributing to impairments in these domains in psychopathology. The Research Diagnostic Criteria project has focused on these domains as part of positive valence and cognitive systems, outlining a range of potentially dissociable constructs that may make differential contributions to function. This presentation will focus on work examining the potential role of a subset of these constructs (hedonics, reinforcement learning, and cognitive control) to emotional and motivational impairments trans-diagnostically, with a focus on common and distinct mechanisms contributing to anhedonia and amotivation associated with mood and psychotic pathology, and the potential implications for treatment development and intervention.

NO. 3
PERCEIVING SOCIAL SALIENCE: A RESEARCH DOMAIN LINKING NORMAL AND PATHOLOGICAL HALLUCINATIONS
Speaker: Ralph E. Hoffman, M.D.

SUMMARY:
Some non-pathological auditory hallucinations, such hearing one's name spoken in a crowd and pager hallucinations experienced by medical interns, seem related to the brain's "search" for experience with high social salience. A related model of auditory/verbal hallucinations (AVHs) in schizophrenia will be described whereby speech processing systems are reorganized to generate spurious experiences of "otherness." Suggesting this model are studies showing that social disconnection imposes a sense of social salience on nonhuman percepts, and that social disconnection generally precedes first onset of AVHs in schizophrenia. At a systems level, right temporal regions play a crucial role in generating the experience of social "otherness" during normal perception; using fMRI we have shown that right temporal activity precedes and possibly triggers activity across a speech processing network producing AVHs in schizophrenia. This pathophysiology could arise from social disconnection in vulnerable individuals driving network reorganization to fill a social void with socially salient experience, a process analogous to sensory deafferentation-induced connectivity shifts yielding hallucinations that fill the perceptual void. Phenomenological, functional connectivity, and genetic findings suggesting the plausibility of this model will be discussed. Thus, social salience systems may comprise a research domain usefully linking normal and pathological hallucinations.

NO. 4
MULTI-LEVEL MODELS OF RESEARCH DOMAINS: MISSION IMPOSSIBLE?
Speaker: Robert M. Bilder, Ph.D.

SUMMARY:
Systematic efforts are underway to address major flaws in the current diagnostic taxonomy of mental disorders, fostering hope for a new nosology based on brain biology. The NIMH Research Domains Criteria (RDoC) initiative aims to redefine mental illness on dimensions spanning molecular to behavioral levels. Major efforts are needed to forge multi-level models capable of representing knowledge within and across these levels. The development of these models can help refine and share complex hypotheses, and reduce the risk of replacing the current taxonomy with dimensions and/or categories that manifest little incremental biological validity. To create useful models we need to define concepts,

relations among concepts, and links to supporting evidence. Existing methods enable representation of concepts and measures within behavioral and basic biological processes, but a major gap at the level of neural circuitry must be bridged to link these levels to each other. A framework is provided to illustrate representation of "working memory" concepts and evidence across multiple levels of analysis as these have been described in the RDoC Workshops. This example highlights challenges and solutions that may help clarify the aims of research projects and promote integration of diverse efforts in the RDoC initiative.

SYMPOSIUM 103

THE MILLENNIUM COHORT FAMILY STUDY: A LARGE, PROSPECTIVE COHORT STUDY OF THE HEALTH AND WELL-BEING OF MILITARY FAMILIES

Chairs: Nancy Crum-Cianflone, M.D., M.P.H., William Schlenger, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recall the most common mental health and well-being issues in military families, and realize the impact of the recent wars, including deployments and combat, on all individuals within the family unit; 2) Identify military-specific factors of spousal mental health outcomes and the co-occurrence of conditions in the marital dyad; 3) Identify the relationships between parental military deployments and the well-being of children in order to develop policies, programs, and best practices to meet their specific needs.

SUMMARY:

The need to understand the impact of war on military families has never been greater than during the past decade, with more than 3 million military spouses and children affected by the deployments to Iraq and Afghanistan. Understanding the impact of the recent conflicts on mental health and well-being of military families is a national priority. However, most studies to date have examined spouses and children individually, rather than concurrently as families. The Department of Defense (DoD) has recently initiated the largest study of military families in U.S. history (the Millennium Cohort Family Study), which includes dyads of military service members and their spouses (n>10,000 married couples). The study includes U.S. military families across the globe with planned follow-up for 21+ years to evaluate the impact of military experiences on families, including both during and after military service time. This symposium will provide an overview of this landmark study including data on the overall study population as well as research findings including: a) the co-occurrence of mental health conditions (PTSD, depression, anxiety, alcohol misuse) among the military service member-spouse dyads; b) the association of service member military deployment experiences (combat, cumulative deployment lengths) and spouse mental health outcomes; and c) to describe the impact of these deployment experiences on the outcomes of children within these families. In summary, understanding the associations between military experiences, including deployments, on the health and well-being of families is critically important. The Millennium Cohort Family Study offers a unique opportunity to define the challenges that military families experience, and to advance the understanding of protective and vulnerability factors that will benefit military families today and into the future.

NO. 1

OVERVIEW OF THE FAMILY STUDY WITH STUDY POPULATION CHARACTERISTICS

Speaker: Nancy Crum-Cianflone, M.D., M.P.H.

SUMMARY:

The Millennium Cohort Family Study consists of 10,065 military spouses of current active duty members from all service branches and components of the military. Each military spouse completed a comprehensive survey (consisting of >500 questions) including 14 specific areas of demographics, physical health, mental health, coping skills, life experiences, modifiable behaviors, military service (for dual military families), marital relationship, their service members' deployment, return and reunion experiences after deployment, their service members' behavior, military life, family functioning, and their children's' health and well-being. In addition, data from the service members' survey and official military and medical records will be linked. We will report an overview and initial findings of the Family Study, the most comprehensive epidemiologic study of the health of military families to date.

NO. 2

CO-OCCURRENCE OF MENTAL HEALTH CONDITIONS (PTSD, DEPRESSION, ANXIETY, ALCOHOL ABUSE) AMONG THE MILITARY SERVICE MEMBER-SPOUSE DYADS

Speaker: Toni Rush, M.P.H.

SUMMARY:

The Family Study possesses the ability to link survey data between a spouse and his/her military service member to create a dyad that can be evaluated to better understand the intricate relationships between military stresses and family life. Using the dyad, we will report univariate and multivariate analyses of the co-occurrence of mental health conditions between military service members and their spouses. In preliminary analyses of the first 7,500 participants, 13% of spouses screened positive alcohol misuse, 10% panic/anxiety symptoms, 7% PTSD, and 5% depression. In the unadjusted models, spouses had a 4 to 6-fold higher odds of screening positive for a mental health condition if the service member screened positive for the same mental health condition. Adjusted modeling results will be discussed by each mental health condition.

NO. 3

ASSOCIATION OF SERVICE MEMBER DEPLOYMENT EXPERIENCES AND SPOUSE OUTCOMES

Speaker: Charles Marmar, M.D.

SUMMARY:
This study includes female and male spouses from more than 10,000 U.S. military families across the globe from all five service branches and all military components (active duty, Reserves, and National Guard), providing an ideal platform for determining the relationships among service member deployment characteristics and spousal well-being. We will report on the univariate and multivariate relationships among service member deployment characteristics including number of tours of duty, length of tours, war zone exposure, being injured in combat, length of time between deployments, and spousal outcomes. Spousal measures include the SF-36V assessing mental and physical health, PTSD Checklist–Civilian Version and the Patient Health Questionnaire-8 to screen depression. We will also relate service member deployment experiences to spousal measures of alcohol use, sleep quality, eating disorders, marital relationship, and family communication and satisfaction.

NO. 4
THE RELATIONSHIP BETWEEN MILITARY SERVICE MEMBER DEPLOYMENT EXPERIENCES AND THE BEHAVIORAL AND EMOTIONAL ADJUSTMENT OF CHILDREN IN MILITARY FAMILIES
Speaker: John A. Fairbank, Ph.D.

SUMMARY:
This presentation describes baseline demographic characteristics and prevalence of emotional and behavioral problems in children and adolescents in military families participating in the Millennium Cohort Family Study. Data on children's emotional and behavioral problems were provided by military spouses on their children from 3 to 18 years using the Strengths and Difficulties Questionnaire (SDQ). In addition, we will report on the relationships between the occurrence and number of parent service member deployments and the emotional and behavioral problems in the children of military families taking into account children's developmental stages (i.e., pre-school age, school age, adolescent). Identifying the relationship between parental military deployments and the emotional and behavioral well-being of children can inform efforts to develop policies, programs, and best practices to meet their specific needs.

SYMPOSIUM 104
UNMET NEEDS IN THE TREATMENT OF DEPRESSION: THE SEARCH FOR MORE RAPID AND EFFECTIVE ANTIDEPRESSANTS

Chair: Dan V. Iosifescu, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the limitations of current antidepressant treatments, especially their modest efficacy and slow onset of action; 2) Understand the goals of the NIMH-sponsored RAPID study, aiming to validate rapidly acting antidepressants; 3) Understand the potential of ketamine as a rapidly-acting and efficacious antidepressant; 4) List several novel potential treatments impacting glutamate metabolism currently in development; 5) Name several promising non-invasive neurostimulation strategies .

SUMMARY:
Current pharmacological treatments for major depressive disorder have significant limitations, primarily related to moderate efficacy and to slow onset of antidepressant effects. This represents a major challenge for patients and their clinicians. This symposium will highlight major topics related to the search for more efficacious and rapid acting antidepressants, which represents a significant priority for the psychiatric community and for the research agenda of the NIMH. Dr. Papakostas will present the NIMH-sponsored RAPID study, aiming to validate rapidly acting antidepressants with novel mechanisms. Dr. Murrough will summarize very promising data related to the rapid antidepressant effect of ketamine in treatment-resistant depression. In this context Dr. Mathew will present the emerging field of antidepressants affecting glutamate metabolism. Finally Dr. Iosifescu will discuss several novel non-invasive neurostimulation modalities with promising antidepressant effects.

NO. 1
THE SEARCH FOR RAPID-ACTING ANTIDEPRESSANT TREATMENTS: FOCUS ON THE NIMH RAPID STUDY
Speaker: George I. Papakostas, M.D.

SUMMARY:
Major Depressive Disorder (MDD) is a serious, debilitating, life-shortening illness that affects many persons of all ages and backgrounds. All FDA-approved antidepressants used as monotherapies have shown only modest benefits. In fact, in acute (6-8 week) studies, typically with relatively uncomplicated, non-chronic forms of MDD, remission rates range between remission rates range between 30.0-35.0%. To make matters worse, as currently delivered, none of these pharmacologic and non-pharmacologic treatments have been shown to result in rapid symptom resolution (defined as a sizeable and statistically significant treatment effect versus placebo that is apparent as early as 24 to 72 hours post-initiation of therapy), despite the tremendous need for rapid antidepressant therapies that would allow for meaningful clinical improvements within the context of very short hospital admissions for TRD patients. The goal of the NIMH-funded RAPID (rapidly acting treatments for major depressive disorder) program is explore treatments that could meet this need. This lecture will review the rational and structure of the RAPID program and its components.

NO. 2
THE ROLE OF KETAMINE IN DEPRESSION: WHERE DO WE STAND?
Speaker: James W. Murrough, M.D.

SUMMARY:
Treatment-resistant depression (TRD) represents a large public health burden and innovative, more effective therapies are urgently needed for this disabling disorder. Ketamine is a glutamate N-methyl-d-aspartate receptor antagonist with significant potential to move the field towards identifying novel, non-monoamine-based disease models and treatments approaches. The evidence base for ketamine as a novel treatment for TRD will be reviewed, including data from a recently completed multi-site randomized controlled trial. New data concerning neurocognitive and neurobiological parameters regulated by ketamine in patients with TRD will also be presented.

NO. 3
GLUTAMATERGIC DRUG TARGETS IN TREATMENT-RESISTANT DEPRESSION
Speaker: Sanjay J. Mathew, M.D.

SUMMARY:
Several neuropharmacologic mechanisms with varied impact on glutamate metabolism have recently emerged as candidate antidepressants. This presentation reviews the history of glutamate pharmacology relevant to mood disorders, and discusses molecular targets of several agents in development. The strengths and limitations of this approach will be discussed.

NO. 4
NOVEL DEVICES FOR THE TREATMENT OF DEPRESSION: THE PROMISE OF NONINVASIVE NEUROSTIMULATION
Speaker: Dan V. Iosifescu, M.D., M.Sc.

SUMMARY:
One of the most active areas of research in the quest for novel, rapid acting and more efficacious antidepressants, is represented by device-based neurostimulation (characterized by direct administration of energy to the brain, via magnetic or electrical fields). This presentation will discuss the rationale of neurostimulation for antidepressant treatment and the current data for several such devices in different stages of development. We will discuss the strengths and limitations of these treatments and the promise for enhancing both clinical outcomes and the our understanding of the biology of depression.

INFLAMMATORY AND AUTOIMMUNE MECHANISMS IN THE PATHOPHYSIOLOGY AND TREATMENT OF NEUROPSYCHIATRIC AND NEURODEVELOPMENTAL DISORDERS

Chairs: Eric Hollander, M.D., Rachel Noone, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the biological basis of immune-inflammatory mechanisms in neuropsychiatric and neurodevelopmental diseases; 2) Describe immune-inflammatory mechanisms currently thought to play a role in the pathophysiology of depression, schizophrenia and autism spectrum disorders; 3) Identify current experimental therapeutic trials targeting immune-inflammatory mechanisms in depression, schizophrenia and autism spectrum disorders.

SUMMARY:
A Pubmed search with the terms “inflammation, psychiatry” reveals a dramatic increase in the number of manuscripts discussing the role of inflammation in the pathophysiology and treatment of psychiatric disorders in recent years. Links between metabolic syndrome, glucose intolerance, obesity, cardiovascular disease, autoimmune disease and gestational maternal inflammation to neuroinflammation and the development of neuropsychiatric disorders are being revealed at a rapid pace. To date, the underlying pathophysiology of psychiatric disorders remains elusive and genetic and neurochemical studies have not fully explained the pathogenesis of complex disorders such as mood disorders, schizophrenia and autism. Recent research has demonstrated that the blood brain barrier is more permeable than once thought, with greater communication between peripheral and central immune function, and active modulation of the CNS by activated microglia influenced by cytokines. Psychiatry can benefit from studying the interplay between the CNS and the immune system, as well as the interplay between the endocrine system, genetics, epigenetics and the body’s reaction to stress and infection. This can lead to the development of targeted experimental treatments, early intervention strategies and potentially prevention of developmental and neuropsychiatric disorders. This symposium will familiarize the audience with neuroinflammatory mechanisms thought to play a role in the pathophysiology of autism, schizophrenia and depression, and highlight novel experimental therapeutic strategies that target these immune-inflammatory mechanisms.

NO. 1
MECHANISMS OF ANTI-INFLAMMATORY TREATMENT IN SCHIZOPHRENIA
Speaker: Norbert Muller, M.D.

SUMMARY:
Persistent infection and neuro-inflammation is a possible etiological factor in schizophrenia. Reports show increased serum IL-6, a product of activated monocytes and the Th-2 immune response, to be elevated in schizophrenia. Also, several markers of Th-1 immune response are decreased. Due to immune imbalance and signs of inflammation including microglial activation, anti-inflammatory treatment could be advantageous. Mechanisms involved in the inflammatory process in schizophrenia will be outlined focusing on the role of microglial cells, the macrophages of the brain. Short term studies of the COX-2 inhibitor celecoxib, which reduces pro-inflammatory cytokines and impacts gluatmatergic neurotransmission and influences tryptophan/kynurenine, will be discussed. Other approaches including the use of antibiotics and antiviral agents with emphasis on the role of monocyte activation and the phenomenon of ‘endotoxin

tolerance' in schizophrenia will also be presented.

NO. 2
GESTATIONAL IMMUNE DYSREGULATION AND AUTISM
Speaker: Judy Van de Water, Ph.D.

SUMMARY:
Maternal immune dysregulation during gestation has been described as a risk factor for neurodevelopmental disorders such as autism and schizophrenia. Such dysregulation can be manifest as inflammation or cytokine dysregulation, as well as maternal autoantibodies that recognize proteins in the developing fetus. We have identified fetal-brain reactive maternal IgG antibodies in a 23% subset of mothers of children with autism spectrum disorder (ASD), and an association between presence of these antibodies and severe behavioral manifestations. Fetal exposure during gestation to brain-reactive IgG may be the underlying cause of the behavioral symptoms noted in some ASD cases and unraveling the molecular interactions between these antibodies and their targets may open new avenues for treatment and prevention.

NO. 3
INFLAMMATION AND ITS BEHAVIORAL DISCONTENTS: LESSONS FROM CYTOKINE ADMINISTRATION AND ANTAGONISM
Speaker: Andrew H. Miller, M.D.

SUMMARY:
Studies using interferon (IFN)-alpha have demonstrated that cytokines can access the brain and alter the function of the basal ganglia as measured by brain imaging. Cytokine-induced alterations in basal ganglia function in turn have been associated with psychomotor slowing, reduced motivation and fatigue and are related to altered dopamine and glutamate metabolism. Cytokines also activate the dorsal anterior cingulate cortex which is associated with anxiety, arousal and alarm. Blocking TNF-α, a cytokine mediator of IFN-alpha effects, has been found to reverse these symptoms in depressed patients with high inflammation. These data indicate that cytokines have a relatively specific profile of activity in the brain. Given the presence of increased inflammation in mood and anxiety disorders and schizophrenia, the link between cytokines and behavior may be relevant to specific symptom profiles across diagnoses that may be uniquely responsive to immune-targeted therapies.

NO. 4
EXPERIMENTAL THERAPEUTIC TRIALS TARGETING ANTI-INFLAMMATORY MECHANISMS IN AUTISM SPECTRUM DISORDERS
Speaker: Eric Hollander, M.D.

SUMMARY:
Autism spectrum disorder (ASD) is a heterogeneous neurodevelopmental disorder thought to be caused or exacerbated in part by immune-inflammatory dysregulation. Studies have demonstrated an imbalance of Th1 (pro-inflammatory) vs. Th2 (anti-inflammatory) T-lymphocytes in ASD as well as an imbalance of pro-inflammatory vs. anti-inflammatory cytokines. Our group has studied novel treatments targeting these inflammatory mechanisms, including trichuris suis ova (TSO) helminths and oxytocin (OXT). TSO is a porcine whipworm studied in autoimmune diseases including ulcerative colitis and type-I diabetes, and which has also been used to target irritability and compulsive-rigidity in ASD. It is hypothesized that TSO achieves its effects by modulating the Th1/Th2 balance. OXT is a neuropeptide synthesized by the paraventricular nucleus of the hypothalamus that has demonstrated efficacy in reducing repetitive behaviors and improving social cognition in ASD. It is hypothesized that OXT achieves its effects in part by modulating the cytokine milieu and attenuating inflammation.

THE NATION INTREPID CENTER OF EXCELLENCE MODEL OF CARE OF TRAUMATIC BRAIN INJURY AND PTSD IN THE U.S. MILITARY

Chair: Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Assess the novel clinical model at the NICoE and the relationship of satellite centers deployed throughout the country; 2) Describe the unique pattern of substance abuse in military populations including iatrogenic addictions in pain patients.; 3) Describe a multi-axial model of TBI injury; 4) Identify research objectives and preliminary findings from the NICoE Research Platform.

SUMMARY:
The US Military has been at war for a decade. Repeated deployments and the nature of the battlefield have presented significant challenges to the mental health of our service members. Large numbers of service members have developed Post Traumatic Stress Disorder, Major Depression, Brain Injury, Addictions, and other effects of combat. The National Intrepid Center of Excellence (NICoE) was created to provide a holistic, patient and family centered, intensive care model to a cohort of patients refractory to standard medical interventions. The NICoE also serves as a research platform for the characterization of the TBI population, its biologic correlates, and long term sequel. At the end of the presentations the Chairman will lead a discussion with the audience on these issues.

NO. 1
THE NATIONAL INTREPID CENTER OF EXCELLENCE MODEL OF CARE
Speaker: James Kelly, M.D.

SUMMARY:
Over the past three years the National Intrepid Center of Excellence (NICoE) Institute has utilized a novel interdisciplinary holistic patient and family based clinical care para-

digm which has resulted in improvement in service members with TBI and PTSD that were previously unresponsive to conventional therapy. The NICoE Institute has integrated complimentary alternative medicine, mind-body interventions, with traditional neurologic, psychological, psychiatric, neuroimaging, electrophysiological assessment and treatment to address the complex clinical presentation. Centered on the service members' interactive selection of egosyntonic skills based mind-body techniques, factors that result in suffering and prevention of goal achievement are identified and addressed. The lessons learned from this model of care have been shared with clinical providers from the first 2 NICoE satellites in addition to representatives of the services supporting the other 7 proposed satellites. Through sharing of best practices among the clinical teams, a standardization of clinical capabilities is emerging in the network.

NO. 2
MULTI-AXIAL MODEL OF TBI INJURY AND SEQUELA
Speaker: Thomas DeGraba, M.D.

SUMMARY:
To achieve national goals of improving health care for patients, a more precise characterization, grading and staging of TBI and comorbid health conditions must be developed in order to create clinical algorithms that identify subpopulations for individualized treatment strategies. The development of a multidimensional characterization matrix is needed is needed to replace the previous rubric of mild, moderate and severe TBI. Utilization of advanced technology including MRI, magnetoencephalopathy, neural stress paradigms, genomic expression and comprehensive autonomic evaluation will provide more precise quantitative characterization of the injured brain. When combined with exquisitely detailed data elements from standardized interdisciplinary evaluation, we hypothesize that profiles will emerge that will allow identification of subpopulations that will respond to specific treatment strategies.

NO. 3
COMORBID SUBSTANCE USE CONSIDERATIONS IN THE TBI AND PTSD POPULATIONS
Speaker: Jonathan Wolf, M.D.

SUMMARY:
Active duty military members demonstrate different patterns of drug abuse than civilian drug abusers, in part due to frequent drug testing and a zero tolerance policy in the military, which bias drug users towards agents that evade standard drug testing. Patients with PTSD and TBI are exposed to iatrogenic risks associated with opioid use that may escape traditional techniques of detection. Patient may also seek other agents not readily detected on routine drug monitoring such as dextromethorphan or synthetic cannabanoids. Ongoing substance use may cloud the clinical picture and hinder recovery. Presentation will cover enhanced detection, evaluation and treatment of substance use in this select population.

NO. 4
RESEARCH PLATFORM AND PRELIMINARY FINDINGS FROM THE NICOE
Speaker: Geoffrey Grammer, M.D.

SUMMARY:
During the last decade a significant amount of attention has been given to the acquisition of clinical data from patients suffering mTBI and/or PTSD. Most of the data collection and analysis have focused on particular aspects of TBI (e.g. neuropsychological, neuroimaging, sleep, vestibular, etc…) related to individual patient diagnosis. Unfortunately, this approach does not easily translate to a broader understanding of the complex biological state of mTBI patients and the associations between the vast number of clinical and imaging variables. A quick look at the multi-modal clinical data produced by different organizations shows that there is still a considerable gap between the answers that are obtained from the individual datasets and the knowledge that can be extracted from them. The informatics core deployed at the NICoE plans to use the rich set of multi-modal clinical and imaging data produced by the NICoE and NICoE satellites as well as clinical data found within the Air Force Medical System's Health Service Data Warehouse (HSDW) to better characterize this disease state. Preliminary findings suggesting subclinical detection using magneto-encephalogram (MEG), subspecialty neuroimaging, physiologic challenge tests to be reviewed.

EMERGING NEUROSCIENCE OF MIND/BODY INTERVENTIONS FOR STRESS-RELATED NEUROPSYCHIATRIC DISORDERS ACROSS THE LIFE CYCLE

Chair: Helen Lavretsky, M.D., M.S.

Discussant: David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the effect of Mindfulness-Based Stress Reduction on anxiety symptoms in patients with generalized anxiety disorder; 2) Discuss the effects of meditation training on coping and stress during a laboratory stress challenge; 3) Understand the effects of MBSR on immune, cognitive, and emotional function among older adults ; 4) Understand the structure of the Cognitively-Based Compassion Training (CBCT) and its impact on stress-related physiology relevant to psychiatric illness; 5) Understand the relationship between the autonomic nervous system, brain GABA levels, stress related illness and yoga practices.

SUMMARY:
Recent clinical studies elucidated neurobiology of response to mind-body interventions such as mindfulness-based stress reduction (MBSR), compassion meditation, and yoga. The tools of investigation include clinical assessments, stress-response experimental paradigms, neuroimaging of

pathways related to stress-response and emotional processing, and stress-response biomarkers. Such investigations involve populations with mood and anxiety disorders across the life cycle. This panel will highlight recent findings demonstrating clinical improvement with the use of mind-body interventions for stress-related mood and anxiety disorders and the underlying neural mechanisms for these interactions. Discussion will include the evidence of the effects of Mindfulness-Based Stress Reduction on anxiety symptoms in patients with generalized anxiety disorder and in the context of a laboratory stress challenge; as well as the effects of MBSR on immune, cognitive, and emotional function among older adults. Two additional presentations will focus on the review of Cognitively-Based Compassion Training (CBCT) and its impact on stress-related physiology relevant to psychiatric illness; and the relationship between the autonomic nervous system, GABA levels and yoga practices in stress-related illnesses such as depression and anxiety.
First, Elizabeth Hoge, M.D. will discuss the results of the recent trial of Mindfulness-Based Stress Reduction program for patients with anxiety disorders. Second, Autumn Gallegos, Ph.D. will discuss the effect of MBSR on immune, cognitive, and emotional function among healthy older adults. Third, Thaddeus Pace, Ph.D. will review the program components of Cognitively-Based Compassion Training (CBCT) and its impact on stress-related physiology relevant to psychiatric illness with particular focus on improved interoceptive awareness during stress. And fourth, Chris Streeter, M.D. will present the results of the recently completed trial of Yoga Versus Walking on Mood, Anxiety and Brain GABA Levels: A Randomized Controlled MRS Study in relation to stress-related illnesses. Lastly, David Spiegel will provide a discussion of the presentation and the panel will be concluded by the general discussion of the emerging field of neuroscience of mind-body interventions used for stress-related disorders.

NO. 1
MINDFULNESS MEDITATION'S EFFECT ON ANXIETY, RESILIENCE, AND STRESS BIOMARKERS
Speaker: Elizabeth A. Hoge, M.D.

SUMMARY:
Objectives: We conducted an RCT of Mindfulness-Based Stress Reduction (MBSR) in individuals with generalized anxiety disorder (GAD). Methods: Participants with GAD were randomized to either 8 weeks of MBSR or an active control class ("Stress Management Education," (SME)). We measured stress hormones and ratings of anxiety and distress during a laboratory behavioral stress challenge that included a public speaking task and arithmetic testing, the Trier Social Stress Test (TSST). An intent-to-treat analysis of MBSR (N=48) or SME (N=41) showed that both interventions led to significant reductions in HAM-A scores. Results: MBSR was associated with a sig greater reduction in anxiety as measured by the Clinical Global Impression (CGI-S and CGI-I), and the Beck Anxiety Inventory (BAI)(all p's<0.05). MBSR was also associated with greater reductions than SME in anxiety and distress ratings in response to the TSST stress challenge (P<0.05), and a greater increase in positive self-statements (P=0.004). Participants in the MBSR group had a greater drop in their ACTH compared to those in the SME class (p=0.027). Analysis of fMRI functional connectivity between the amygdala and regions in the prefrontal cortex increased significantly pre- to post-intervention within the MBSR correlated with scores on the BAI. Conclusion: Mindfulness meditation training in GAD was associated with an attenuated stress response and improved resilience and coping in patients with GAD.

NO. 2
MINDFULNESS-BASED STRESS REDUCTION AND THE AGING POPULATION
Speaker: Autumn Gallegos, Ph.D.

SUMMARY:
Background: We investigated the effects of an 8-week MBSR program on immune, cognitive, and emotional function among older adults. Methods: Community-dwelling older adults (N=207) were randomized to either treatment (MBSR) or wait-list control (WLC). We examined the role of MBSR on IgG antibody response to an antigen, keyhole limpet hemocyanin (KLH), and to immune function, circulating insulin-like growth factor (IGF)-1, and positive affect among older adults. Results: MBSR group had higher baseline antibody titers immediately post-intervention ($p < .01$), but lower responses to challenge 24 weeks post-intervention ($p < .04$). MBSR participants had lower Trails B/A ratio immediately post-intervention ($p<.05$). A greater shift to left frontal patterns in the alpha rhythm of resting EEG post-intervention was also observed (p=.03). Yoga practice was associated with higher post-treatment IGF-1 levels and greater improvement in positive affect. Sitting meditation was positively associated with post-treatment IGF-1. Greater use of body scanning was associated with reduced antigen-specific IgM and IgG 3-weeks post intervention. Conculsions: MBSR produced meaningful changes in executive function and left frontal brain alpha asymmetry. MBSR improved positive affect for older adults with lower depressive symptom severity. MBSR yoga provided benefits for specific aspects of physiological function and positive affect. Changes in adaptive immunity in older adults warrant further study.

NO. 3
DOES ENGAGEMENT WITH COGNITIVELY-BASED COMPASSION TRAINING INCREASE STRESS-ASSOCIATED INTEROCEPTIVE AWARENESS?
Speaker: Thaddeus Pace, Ph.D.

SUMMARY:
Objectives: Inappropriate or excessive physiological responses to stress may play a role in the development of a number of illnesses including major depression. Excessive stress responses may result from a lack of subjective awareness of internal physiological states. This study examined the degree to which engagement with Cognitively-Based Compassion Training (CBCT), a meditation program designed

to cultivate compassion, influenced the agreement between subjective distress and physiological responses during a laboratory psychosocial stress task, the Trier Social Stress Test (TSST). Methods: Participants were randomized to 6 weeks of CBCT (n=33) or a health discussion control (n=28) followed by challenge with the TSST. Responses to the TSST were determined by assessments of plasma concentrations of interleukin (IL)-6 and cortisol as well as distress scores on the Profile of Mood States (POMS). Results: Increased CBCT practice was correlated with decreased TSST-induced IL-6 and POMS scores. Moreover, individuals with above median CBCT practice time exhibited lower TSST-induced IL-6 and POMS scores. Importantly, individuals with above median CBCT practice time also exhibited a significant positive association between POMS scores and plasma IL-6 concentrations as a result of the TSST. Conclusion: These observations suggest that CBCT may encourage interoceptive awareness during exposure to stressors with respect to inflammatory immune components of the stress response.

NO. 4
A THEORY OF THE RELATIONSHIP BETWEEN YOGA, THE AUTONOMIC NERVOUS SYSTEM, BRAIN GAMMA AMINO BUTYRIC ACID (GABA), ALLOSTASIS AND PSYCHIATRIC DISEASE
Speaker: Chris C. Streeter, M.D.

SUMMARY:
Background: Yoga practices can reduce allostatic load in stress response systems and restore homeostasis. Depression, epilepsy, post traumatic stress disorder (PTSD), and chronic pain exemplify medical conditions that are exacerbated by stress, have low heart rate variability (HRV) and low GABAergic activity, respond to pharmacologic agents that increase activity of the GABA system, and show symptom improvement in response to yoga-based interventions. It is hypothesized that yoga-based practices 1) correct underactivity of the PNS and GABA systems in part through stimulation of the vagus nerves, the main peripheral pathway of the PNS, and 2) reduce allostatic load. Methods: we conducted several studies of yoga compared to walking in treatment resistant depression and epilepsy. Results: We will report on association between yoga asana practices, mood scales, and brain GABA levels as measured by magnetic resonance spectroscopy (MRS) in normal populations and in depressed subjects will be reviewed. Treatment-resistant cases of epilepsy and depression respond to vagal nerve stimulation and supports the need to correct PNS underactivity. Yoga practice can correct the decreased PNS and GABAergic activity that underlies stress-related disorders. Conclusion: This has far-reaching implications for the integration of yoga-based practices in the treatment of a broad array of disorders exacerbated by stress.

MANAGEMENT OF THE DIFFICULT SERVICE MEMBER OR VETERAN

Chairs: Wendi M. Waits, M.D., Sebastian R. Schnellbacher, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize at least three unique and challenging patient populations they are likely to encounter in a military or VA setting; 2) Gain practical tips on how to manage these patient populations while maintaining a therapeutic alliance; 3) Understand how to adapt supportive, motivational, and cognitive-behavioral psychotherapeutic techniques in the management of these patient populations.

SUMMARY:
Many behavioral health providers experience anxiety and frustration when dealing with certain populations of military service members and combat veterans. While caring for most veterans can be extremely rewarding, some can present as “difficult patients,” bringing with them a challenging array of values and behaviors. This workshop will provide practical tips for managing three of the most challenging military populations: the “angry” service member, the “historically inconsistent” service member, and the “poorly resilient” service member. Participants will be oriented to contextual clues to suggest that they may be dealing with one of these patient types, will learn about specific interventions to address problematic behaviors while maintaining a therapeutic alliance, and will learn how to incorporate military and VA-specific community resources into their treatment plans.

NO. 1
MANAGEMENT OF THE ANGRY VETERAN OR SERVICE MEMBER
Speaker: Wendi M. Waits, M.D.

SUMMARY:
Anger is one of the most common symptoms with which service members and veterans present and its presence reflects physiological, cultural, and psychological influencing factors. Psychiatrists working with this population must be able to confidently and swiftly manage anger in order to provide optimal treatment and model appropriate limit-setting. This presentation will cover the differential diagnosis of anger and suggest effective preventive and de-escalating management strategies.

NO. 2
MANAGEMENT OF THE HISTORICALLY INCONSISTENT VETERAN OR SERVICE MEMBER
Speaker: Sebastian R. Schnellbacher, D.O.

SUMMARY:
Psychiatrists working in the military or VA environment are likely to encounter patients whose self-reported history and symptoms are not fully consistent with their personnel files, medical records, and/or reports from collateral sources of information. Differentiating fact from fiction can be extremely challenging, particularly when serving in the role of

treating provider, where maintaining a positive therapeutic alliance is critical. This presentation will explore factors contributing to symptom embellishment/fabrication and will suggest ways to manage these issues in a way that optimizes care and maintains rapport between patient and provider.

NO. 3
MANAGEMENT OF THE HISTORICALLY INCONSISTENT VETERAN OR SERVICE MEMBER
Speaker: Rachel M. Sullivan, M.D.

SUMMARY:
Psychiatrists working in the military or VA environment are likely to encounter patients whose self-reported history and symptoms are not fully consistent with their personnel files, medical records, and/or reports from collateral sources of information. Differentiating fact from fiction can be extremely challenging, particularly when serving in the role of treating provider, where maintaining a positive therapeutic alliance is critical. This presentation will explore factors contributing to symptom embellishment/fabrication and will suggest ways to manage these issues in a way that optimizes care and maintains rapport between patient and provider.

NO. 4
MANAGEMENT OF THE POORLY RESILIENT SERVICE MEMBER
Speaker: Judy Kovell, M.D.

SUMMARY:
The military culture is built upon a presumption of mental strength and resiliency, either inborn or instilled by highly-disciplined instructors during basic training/boot camp. Occasionally, however, poorly-resilient service members and veterans will struggle and become hopeless in the context of fairly routine psychosocial stress. This presentation will provide the audience with concrete strategies to motivate and reorient these patients to a position of psychological strength, allowing them to maintain personal dignity and achieve success.

PREVENTING AND REDUCING HARM IN COLLEGE STUDENTS

Chair: Daniel J. Kirsch, M.D.

Discussant: Michelle Riba, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the factors contributing to suicide risk in college students; 2) Describe risks associated with substance use in college students; 3) Understand common interventions to address substance use on college campuses; 4) Know the differences in indications for use of atypical antipsychotics in children and adults; 5) Use recommended guidelines for atypical antipsychotic drug monitoring.

SUMMARY:
This symposium examines risk to college students in 3 areas - suicide, substance use, and atypical antipsychotic (AAP) use in this vulnerable population.
Compared with children, adolescents including emerging adults, are bigger, stronger, and faster, can endure more physical pain and temperature extremes, and have more robust immune systems. They are sexually mature and their cognitive capacities approach those of adults. Yet their morbidity and mortality rates increase dramatically due to behavioral issues – self-injurious behaviors and suicide and accidents, and violence – themselves the results of impulsivity, risk taking behaviors, and poor judgment. Substance use dramatically increases the risks.
We will review the physical, cognitive, psychological, and neurological development taking place in adolescence and college students and examine in more detail how this leads to increased risk from behavioral injury.
Suicide is the 3rd leading cause of death among American college-aged youth (ages 20-24). Among college students it is second only to accidental death. Suicide and attempted suicide are the tip of the iceberg of a larger mental health and substance abuse problem among college students. Studies point to serious mental health problems among college students. We will review the most recent epidemiological data regarding campus mental health, with an emphasis on the risks for suicide and suicidal behaviors. Evidence-based suicide prevention approaches will be reviewed.
About 1500 college students die from suicide annually. A roughly equal number die as a consequence of alcohol use. Substances, particularly alcohol dramatically increase the risks of accidental death and suicide, contribute to the morbidity of co-existing mental illnesses, and impair role-appropriate intellectual, psychological, and social development and accomplishment. The epidemiology of substance use is reviewed, risks in the college population explicated, and the evidence base for substance use risk reduction programs reviewed. Specific extant harm and risk reduction programs aimed at substance use in college students will be presented.
Use of AAP's has skyrocketed in the US. Prescribing rates in children and adults are reviewed. Indications for use, particularly in children have expanded and off-label use has increased dramatically. Indications differ in child/adolescent and adult populations. Downstream medical associated with AAP's risks are explicated and extant guideline for use reviewed.
A pilot study examining the prescribing of AAP's to college students referred for psychiatric evaluation is presented and findings reviewed. Risk with AAP use occurs in several forms: 1) withholding use when therapeutically indicated; 2) off-label use with insufficient evidence to support increased risk; 3) non-adherence to standard guidelines.

NO. 1
SUICIDE RISKS AND THE PREVENTION OF SUICIDE ON COLLEGE CAMPUSES
Speaker: Morton M. Silverman, M.D.

SUMMARY:
There is a need for comprehensive, multi-systematic efforts to promote mental health and provide mental health services at colleges and universities. Among college-age youth (aged 20-24 years) in the U.S.A., suicide is the third leading cause of death. Among college students, it is estimated that suicide is the second leading cause of death with an estimated 1,500 suicides occurring on campuses each year. Although the suicide rate of college students is only about half the national rate for a sample matched by age, gender, and race, suicide and attempted suicide are the tip of the iceberg of a larger mental health and substance abuse problem among college students. Studies point to serious mental health problems among college students. This presentation will review the most recent epidemiological data regarding campus mental health, with an emphasis on the risks for suicide and suicidal behaviors. Evidence-based suicide prevention approaches will be reviewed.

NO. 2
PREVENTION AND HARM REDUCTION STRATEGIES FOR SUBSTANCE MISUSE AMONGST COLLEGE STUDENTS
Speaker: Douglas M. Ziedonis, M.D., M.P.H.

SUMMARY:
Substance use and misuse are common amongst college students which can lead to poor school performance, mental health issues, and addiction. Strategies for risk prevention and early intervention for alcohol, tobacco, and other substances can be effective. Integrated addiction and mental health treatment models have been developed, including Recovery Dorms. This presentation will review strategies and models from the literature and the presenter's experiences while at UCLA, Yale University, Rutger's University, and the University of Massachusetts. The use of social networking and peer support models will be included.

NO. 3
ATYPICAL ANTIPSYCHOTIC (AAP) USE IN COLLEGE STUDENTS: BACKGROUND, EPIDEMIOLOGY, LESSONS FROM CHILD AND ADOLESCENT PSYCHIATRY
Speaker: Mirjana Jojic, M.D.

SUMMARY:
Over the past 20 years, atypical antipsychotic (AAP) use has increased 8-fold, and their use in teens has quintupled. While the rise in use of AAPs is best documented in children and adolescents, there is growing interest in AAP use in college students. Off-label prescribing of AAPs in this population is upwards of 75%, not only for undifferentiated mood disorders, but for eating disorders, anxiety disorders, and personality disorders. Many of these disorders emerge in young adults and can be exacerbated by the transition from high school to college; unfortunately, accurate representations of AAP use in this population are sparse. Furthermore, the risks of substance use and suicide risk secondary to increased academic rigors is high in this population, resulting in both inaccurate diagnoses and hazardous prescribing habits. The risks associated with AAP use, including weight gain and metabolic syndrome will be discussed. Substance use, suicide risk, and other hazards unique to college students will be addressed. Lastly, detailed strategies to discuss and reduce these risks will be presented. These include best practices for monitoring patients on AAPs, utilizing mobile technology to motivate change, and information on harm reduction in experimentation.

NO. 4
RISK ASSOCIATED WITH ATYPICAL ANTIPSYCHOTIC (AAP) USE IN COLLEGE STUDENTS
Speaker: Daniel J. Kirsch, M.D.

SUMMARY:
Prescriptions for antipsychotic medications have skyrocketed. Atypical antipsychotics (AAP's) have almost entirely replaced older antipsychotics. Indications for use, particularly in children have expanded and off-label use has increased dramatically. In 2011 two AP's, quetiapine and aripiprazole were the 5th and 6th best selling drugs in the US. This has raised concerns about downstream medical problems associated with AAP's. A pilot study of college students referred for psychiatric consultation was examined and students were identified with exposure to AAP's. Their charts were reviewed in detail for clinical diagnosis, diagnostic certainty, response, and course of treatment. Almost all cases met an acceptable standard of care. Of note, however a third of the cases showed higher diagnostic uncertainty, higher degrees of pathology, and poor treatment response with exposure to more then one AAP. These findings will be discussed along with implications for broader treatment protocols to include vigorous careful diagnosis of at-risk students, non-medication treatments, ongoing surveillance, adherence to extant guidelines, and therapeutic watchfulness

VIOLENCE IN CLINICAL PSYCHIATRY: OVERCOMING THE BARRIERS TO IMPROVING SAFETY ON THE UNIT

Chair: Yad M. Jabbarpour, M.D.

Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Determine and analyze the challenges associated with violence for persons served in inpatient psychiatric settings; 2) Identify and develop strategies to improve assessment of violence; 3) Apply methods to overcome the barriers to improve inpatient safety, including methods to assess, prevent and mitigate violence risk.

SUMMARY:
Violence in hospital psychiatric settings impacts the quality and safety of the health care experience for both patients and providers. High risk aggression is one of the primary criteria leading to psychiatric hospitalization. A large cohort

of patients being admitted to hospitals is by very definition meeting criteria for commitment via the "harm to others due to a mental illness" prong. Simply said: many patients requiring inpatient psychiatric services are at high risk for violence; staff working with these patients are at potentially higher risk for being assaulted; peers living in the same milieu are at potentially higher risk for being assaulted. Problem-solving this violence issue requires overcoming the barriers: acknowledging the extent of the problem, untangling the complex issues, and supporting the provision of best practices to support timely and high quality aggression risk assessment, risk management and risk prevention. Supporting clinicians who provide this high risk work is the key to inpatient psychiatric services.

Application of evidence-based and promising practices in complex work environments is crucial to mitigating violence risk. The ability to treat, including treatment over objection, can be a clinical, legal and ethical challenge. Occupational health, including physical and psychological sequelae from assaults, affects the ability for providers to work in a safe environment. In addition, perceived and real safety fears can impact the ability for clinicians to provide a therapeutic relationship with patients. Attention to recovery and decreasing coercive measures, including restraint and seclusion use, has been a focus in the field. However, these cultural paradigms can result in different approaches when working with violent patients. Psychiatrists and others in the field are grappling with the provision of natural consequences for violence, including the risks and benefits of pursuit of charges and prosecution for illegal behavior. Violence might also be prevented through a secondary prevention model to prevent relapse of aggression risk due to mental illness. One of the potential failure modes is the "slipping through the cracks" for patients in the transition of care and in community mental health services. Transition of Care is receiving more focus in the health care field in general, including a proposed Joint Commission National Patient Safety Goal on the topic. Salient post-discharge planning may include consideration of psychiatric advance directives, assisted outpatient commitment, timely follow-up or other strategies.

In the setting of high acuity, psychiatrists, nursing staff and other care providers are balancing complex issues, including legal, ethical, clinical, and oversight agency standards to support a safe work environment for staff and safe milieu for patients. This symposium focuses to support a healthy debate in problem-solving strategies to prevent, manage and mitigate violence risk.

NO. 1

DANGEROUS GAPS BETWEEN KNOWLEDGE AND IMPLEMENTATION

Speaker: Ian Needham

SUMMARY:

There is a vast body of scholarly and practical knowledge on how to predict, prevent, and handle violence in psychiatric inpatient settings. Although the knowledge we have to date is by no means perfect, it can – when implemented well – go a long way to help avoid dangerous situations of violence or minimize adverse sequelae caused by violent behavior. This presentation is based on an actual case of fierce physical and sexual patient violence I was addressed to assess. In the reconstruction of the episode, I will attempt to locate dangerous gaps between the knowledge we have and the actual implementation of this knowledge. I will employ model of violence of Nijman et al. (1999) on inpatient psychiatric wards – entailing characteristics of the patient, the professionals and the environment – and address the issues of prediction, the training of personnel, communication, the characteristics of ward outlay, alarm systems, and policy. Given that current knowledge may be necessary but not sufficient to handle all cases of (extreme) violence, I will point to some to some (to date seemingly) insurmountable problems related to managing violence.

NO. 2

PSYCHIATRIC ADVANCE DIRECTIVES AND OTHER TOOLS TO IMPROVE PATIENT SAFETY

Speaker: Marvin Swartz, M.D.

SUMMARY:

Psychiatric advance directives (PADs) represent an opportunity for behavioral healthcare systems to implement patient-centered approaches to care and treatment decision-making during mental health crises. All states permit competent adults to legally document some form of advance planning for mental health treatment during a future period of incapacity, typically by authorizing a durable power of attorney for health care. PADs offer a legal mechanism for people with mental illness to declare in advance their specific treatment preferences, plans, arrangements, and instructions, and to give or withhold consent to future psychiatric interventions and hospitalization. PADs can also provide clinicians and healthcare facilities with timely patient-history information, advance consent to preferred treatment options, and a legally-empowered agent who is available to communicate directly with providers and make decisions for the patient during an incapacitating crisis.

PADs are usually conceptualized as tools to enable self-directed or patient-centered care, but as communication devices they can also be viewed as useful tools to prevent and de-escalate potential violent incidents. This presentation will discuss and illustrate how PADs and other related tools may serve to prevent violent incidents on inpatient units and ways in which their greater use may be supported.

NO. 3

THE STRUGGLE TO REDUCE INPATIENT VIOLENCE: DOES IT NEED TO BE A STRUGGLE?

Speaker: Elizabeth Ford, M.D.

SUMMARY:

Violence on inpatient psychiatric units can have a significant and lasting impact on patients and staff, can interfere with unit functioning, can lead to increased cost burdens, and can drive disposition decisions. In the United States, there

is evidence that the frequency and intensity of interpersonal violence on psychiatric units has increased such that prevention of inpatient violence has become a major clinical goal. This presentation will highlight the clinical, legal and environmental challenges that inpatient units face in reducing violence, including mental health laws that favor "dangerousness" as a requirement for admission, statutory guidelines that often result in delays of weeks to months to treat patients over their objection, a growing percentage of inpatients who have experienced criminal justice involvement, and a treatment model that is often focused on medication at the exclusion of other, potentially more violence-reducing, therapies. Noting these challenges, suggestions for potentially effective interventions such as "Universal Violence Precautions" and a reward-based privilege system, will be offered using experience and data from Bellevue Hospital, the flagship public hospital in New York City. Discussion about arresting violent inpatients as a form of unit protection and behavioral intervention will also be included, using data collected from NYC hospitals and the jail psychiatry service at Bellevue Hospital.

NO. 4
VIOLENCE AS SENTINEL EVENTS
Speaker: Paul Schyve, M.D.

SUMMARY:
Accredited healthcare organizations have reported to The Joint Commission episodes of violence toward patients that resulted in serious harm. There are both similarities and differences in the root causes of these events between medical-surgical and psychiatric settings. Based in part on these reports and their associated root cause analyses, the barriers to effective prediction of, prevention of, and intervention in violence will be examined, and tactics to overcome these barriers explored.

BORDERLINE PERSONALITY DISORDER AT ADOLESCENCE: MYTH OR REALITY? ANSWERS FROM THE EUROPEAN RESEARCH NETWORK ON BORDERLINE PERSONALITY DISORDER

Chairs: Maurice Corcos, Ph.D., Alexandra Pham-Scottez, M.D., Ph.D.

Discussant: Mario Speranza, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and correctly diagnose a borderline personality disorder in adolescence; 2) Be aware of axis I and axis II comorbidities of borderline personality disorder in adolescence; 3) Manage the borderline and eating disordered adolescent patient; 4) deal with treatment of borderline personality disorder in adolescence.

SUMMARY:
The concept of Borderline Personality Disorder (BPD) in adolescence has been a topic of debate in these last years.
The European Network for Borderline Personality (EUR-NET-BPD) is a multicentre prospective study which was developed with the aim of investigating the diagnostic validity of BPD in adolescence, and its stability into adulthood.
This study included 85 adolescents (15-19 years old) with a BPD, and 85 matched controls, from five european academic centers, all specialized in BPD; patients were followed for three years.

First, overview (main goals of the study, hypotheses, study population, assessment instruments) of the study design will be developed.
We will detail Axis I and Axis II comorbidity in this sample of BPD adolescent patients; our comorbidity data supports a continuum between BPD in adolescents and in adults.
We will focus on a frequent comorbidity of our sample, comorbidity with an eating disorder,
Self-injurious behaviors are a very frequent symptom in BPD patients; we will explore which defense mechanisms are specifically associated with non-suicidal self-injury in our sample of BPD adolescents.
We will explore the role of the developmental levels of interpersonal relatedness, and self-definition in the clinical presentation of these BPD patients.
Relational maturation and identity formation are two essential developmental lines of the personality, which may be specifically be implied in the psychopathology of BPD.
We will then present a comprehensive model of BPD at adolescence, integrating childhood risk factors, traumas, and attachment modalities.
To conclude, first data from the retest of the sample will be commented, validating or not our first hypothesis of stability of BPD over time.
Our European results will be discussed by a specialist of BPD in adolescence, and a large time will be left for debate, questions and commentaries from the assistance about this controversial topic of BPD in adolescence.

NO. 1
AXIS I COMORBIDITY OF BORDERLINE ADOLESCENTS
Speaker: Lionel Cailhol, M.D., Ph.D.

SUMMARY:
Using the data from the European Research Network on Borderline Personality Disorder (EURNET BPD) we describe axis I comorbidities for BPD adolescents. At inclusion, 2 (6.3%) control subjects presented an axis I diagnosis while 75 (89.3%) participants in the borderline group presented at least one. BPD patients with a mood disorder reported higher scores on the CTQ physical abuse subscale (1.54 > 1.19, p=.002), compared to those with no mood disorder. BPD patients with a post-traumatic stress disorder reported higher scores on the CTQ on the sexual abuse subscale (2.20>1.26, p<.005). For the 75 BPD patients with at least one diagnosis, the comorbidity distribution was: 1 diagnosis: n = 29 (38.6%), 2: n = 32 (42.7%), 3 or more: n = 14 (18.7%).
We will also provide information concerning the follow-up

of these patients. These findings suggested that while rates of Axis I comorbodity in BPD adolescents are high, their impact in terms of overall psychopathology and functioning is limited.

NO. 2
BORDERLINE PERSONALITY DISORDERS IN ADOLESCENTS : SPECIFICITIES OF CHILDHOOD RISK FACTORS
Speaker: Marie Douniol, M.D.

SUMMARY:
The objective of this study was to examine the relationship between borderline personality disorder and NSSI with respect to the role of trauma exposure and the médiation of specific psychopathological dimensions. A path analysis was conducted to investigate the predictive weight of both different childhood trauma and specific psychopathological dimensions in contributing to NSSI. Affective instability and impulsivity appeared as mediators between childhood trauma and non-suicidal self-injury in adolescents with borderline personality disorder. Affective lability mediated all type of trauma to NSSI whereas impulsivity only mediated sexual and physical abuses.

NO. 3
CHILDHOOD TRAUMA FOR ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER : PATHWAYS FROM CHILDHOOD TRAUMA TO NON-SUICIDAL SELF-INJURY
Speaker: Ludovic Gicquel, M.D., Ph.D.

SUMMARY:
The objective of this study was to examine the relationship between borderline personality disorder and NSSI with respect to the role of trauma exposure and the médiation of specific psychopathological dimensions. A factorial analysis and a path analysis were conducted to investigate the predictive weight of both different childhood trauma and specific psychopathological dimensions in contributing to NSSI. Affective instability and impulsivity appeared as mediators between childhood trauma and non-suicidal self-injury in adolescents with borderline personality disorder. Affective lability mediated all type of trauma to NSSI whereas impulsivity only mediated sexual and physical abuses.

NO. 4
EATING DISORDER COMORBIDITY IN BORDERLINE ADOLESCENTS
Speaker: Alexandra Pham-Scottez, M.D., Ph.D.

SUMMARY:
We examine the influence of eating disorder comorbidity on Axis I and Axis II comorbidity, depression and functioning in the sample of 85 borderline adolescents.. 34% had a current diagnosis of eating disorder: anorexia nervosa (16.5%) or bulimia nervosa (17.6%). Obsessive-compulsive personality disorder comorbidity was significantly more frequent in the anorexia nervosa group (64.3%) and in the bulimia nervosa group (46.7%) than in the non-eating disorder group (26.3%). Conduct disorder, disruptive disorder were more comorbid in the non-eating disorder group, suicide attempts were more frequent in the bulimia nervosa group. No difference was found for self-injurious behaviors, for GAF and BDI-II scores. Similarly to adult patients, borderline adolescent patients with or without an eating disorder have different patterns of Axis I and II comorbidity. Consequences of this eating disorder comorbidity will be discussed, focusing on treatment priorities.

NO. 5
EMOTIONAL DYSREGULATION IN ADOLESCENTS WITH BORDERLINE PERSONALITY DISORDER
Speaker: Mario Speranza, M.D., Ph.D.

SUMMARY:
Emotional dysregulation is considered as a core feature of borderline personality disorders. Emotional dysregulation can express itself both as emotional instability (i.e. an inability to modulate affects than can become uncontrolled) or in terms of poor emotional awareness (i.e. emotional numbing, alexithymic features). Whereas the first dimension is closely related to symptoms such as impulsivity, suicidal behaviours or inappropriate anger, the latter can be associated with dissociative experiences and chronic feeling of emptiness. Although both dimensions have been related to negative experiences during childhood, however little is known about the specific developmental pathways leading to emotional instability or emotional awareness in borderline adolescents. In this presentation we will show some data concerning these specific traumatic pathways in a sample of borderline adolescents issued from the European Network on borderline personality disorders.

ANXIOUS YOUTH IN TRANSITION TO ADULTHOOD: A TRANSLATIONAL PERSEPCTIVE

Chairs: John T. Walkup, M.D., Helen B. Simpson, M.D., Ph.D.

Discussant: David Shaffer, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the unique clinical needs of youth transitioning to adulthood; 2) Identify sensitive periods for extinction learning and fear regulation across development; 3) Discuss the importance of translational research to advance clinical care.

SUMMARY:
Translational neuroscience offers the opportunity to move from “bench to bedside”; from animal models to normal humans and ultimately to understanding the development and the treatment of psychiatric disorders (M Rynn). Recent studies have shown that there is a sensitive period during adolescence with regard to fear regulation. Adolescent mice and humans as compared to their younger and older counterparts exhibit poor extinction learning in experimen-

tal paradigms. In clinical samples of anxious adolescents, extinction based CBT also appears to be less effective. In this presentation we will review the development of extinction learning in animals (F. Lee), humans (BJ Casey) and clinical samples (S Bennett). The presentation will also discuss the implication of these translational neuroscience findings for the treatment of anxious adolescents transitioning to adulthood. (AM Albano).

NO. 1
IMPROVING TREATMENT OUTCOMES FOR YOUNG ADULTS WITH ANXIETY
Speaker: Moira A. Rynn, M.D.

SUMMARY:
Untreated, anxiety in childhood and adolescence leads to accumulated disability over time. Avoidance of academic, social or occupational tasks during development interrupts the pathway to independence for many adolescents and young adults resulting in a "failure to launch". Youth who fail to meet the tasks of transition to adulthood such as independent living and/or success in post-high school academic, occupational, and inter-personal pursuits, often find themselves dependent on their parents and cut adrift from their peers. Finding a therapist who understands the origin of their difficulties in untreated childhood anxiety is a challenge. Therapists who are sensitive to the role of anxiety in transitioning to adulthood often do not have the tools to treat the anxiety disorder and address the myriad of problems that have developed from childhood through adolescence. Translational neuroscience offers the opportunity to move from bench to bedside and improve outcomes for young adults with anxiety disorders. This presentation will review translational neuroscience approaches to the study of childhood onset anxiety disorders with special emphasis on identifying important developmental differences in fear extinction learning and discuss novel treatment paradigms that address the complex needs of anxious of youth in transition to adulthood.

NO. 2
DEVELOPMENTAL TRAJECTORY OF FEAR LEARNING AND MEMORY IN MICE
Speaker: Francis Lee, M.D., Ph.D.

SUMMARY:
Highly conserved neural circuitry between rodents and humans has allowed for in-depth characterization of behavioral and molecular processes associated with emotional learning and memory. This presentation will provide an overview of our studies examining fear learning across development in mice that have been informed by parallel human studies. During a discrete period in peri-adolescence, mice exhibited attenuated cue fear extinction relative to their younger and older counterparts. Probing neural circuitry in mice revealed altered synaptic plasticity of prefrontal cortical regions implicated in suppression of fear responses across development. In addition, during this same developmental window, there is altered hippocampal structure as well as suppression of hippocampal-dependent contextual fear expression, suggesting that the contextual components of fear memories are also altered in adolescent mice. Together these findings suggest that during adolescence there is a lack of top-down regulation of amygdala output that is necessary for successful fear extinction, as well as altered hippocampal-dependent fear regulation. By defining these non-linear developmental aspects of fear learning and memory during a transition period into and out of adolescence, alternative ways to enhance the degree and durability of extinction learning will be discussed that may provide insights into therapeutic strategies for treating anxiety in adolescents.

NO. 3
DEVELOPMENT OF FEAR AND ANXIETY: HUMAN IMAGING AND MOUSE GENETICS
Speaker: BJ Casey, Ph.D.

SUMMARY:
Anxiety disorders (e.g., social phobia, separation and generalized anxiety) are the most common of the psychiatric disorders with a lifetime prevalence of nearly 20% and peak in diagnosis during adolescence. One of the most commonly used therapies to treat these disorders is exposure-based cognitive behavioral therapy that relies on basic principles of fear learning and extinction. A substantial portion of patients improves with this therapy, but 40-50% do not. This presentation will provide an overview of our recent empirical studies employing both human imaging and mouse genetics to examine how fear related processes differ across individuals and across development, especially during adolescence. Behavioral, genetic and brain imaging data will be provided to offer insights for whom may be at risk for anxiety and for whom and when, during development, exposure based treatment may be most effective for treating individuals with anxiety disorders.

NO. 4
EXTINCTION LEARNING AND EXPOSURE THERAPY IN ANXIOUS YOUTH
Speaker: Shannon M. Bennett, Ph.D.

SUMMARY:
Anxiety disorders are common, typically onset in childhood or adolescence, and when inadequately treated follow a chronic course with multiple functional impairments. Exposure therapy is considered one of the gold-standard interventions for anxiety, yet a significant number of youth remain symptomatic after what is thought to be an adequate course of treatment. Extinction learning is a key factor in the efficacy of exposure therapy tasks. Drs. Lee and Casey will present data in this symposium supporting developmental differences in extinction learning, such that in mouse and non-clinical human samples, adolescents show poorer extinction learning as compared to children and adults. However, adolescent mice exposed to extinction training that includes both the fear cue (tone) and context (cage), as

opposed to cue-only extinction, appear to be more successful in extinction learning and have less fear as adults. This presentation will discuss the clinical applications of these findings to maximize efficacy of exposure therapy. Many practitioners utilize cue-only extinction in exposure tasks within the therapy office. These finding suggests that this type of exposure may not be sufficient for extinction learning, particularly in adolescence. Contextual exposure tasks with anxious youth will be presented and the role of extinction learning as marker predictive of outcome in exposure therapy will be discussed.

NO. 5
A DEVELOPMENTAL APPROACH TO EXPOSURE TREATMENT FOR EMERGING ADULTS
Speaker: Anne M. Albano, Ph.D.

SUMMARY:
Often overlooked in randomized controlled studies of treatments for children and adolescents with anxiety disorders are developmental impairments due to the disability and distress associated with early onset anxiety disorders. Increased anxiety is expected throughout development, however clinically impairing anxiety takes children off track developmentally as compared with their non-affected, same-aged peers. This presentation reviews the role and tasks of development in adolescents and emerging adults, and offers new methods for assessing and treating the ways in which anxiety interferes with achieving appropriate and long-term developmental milestones. Data supporting our novel, developmental, exposure based treatment model that is focused on managing anxiety and achieving age appropriate goals for emerging adults will be presented. Implications for clinical practice will be addressed.

REDEFINING THE DISTINCTIONS BETWEEN BORDERLINE MOODS AND MOOD DISORDERS: A ROADMAP TO EVOLVING TREATMENT AND RESEARCH

Chairs: Lois W. Choi-Kain, M.D., M.Ed., John Gunderson, M.D.

Discussant: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the overlaps and distinctions between moods characteristic of borderline personality disorder and mood disorders; 2) Recognize evidence guiding clinical priorities in treating patients with both borderline personality and mood disorders; 3) Understand longitudinal course and interaction between borderline personality and mood disorders; 4) Identify temperamental aspects of clinical presentation and their relevance to borderline personality and mood disorders.

SUMMARY:
The overlaps and distinctions between mood disorders and borderline personality disorder (BPD) has long been a controversial subject driving fierce debates about diagnosis and treatment of patients with complex presentations that span affective, behavioral, relational, and temperamental features. On the one hand, the variety of symptoms encompassed in the BPD diagnoses have been increasingly understood as in terms of core unifying vulnerabilities such as emotional dysregulation and interpersonal hypersensitivity. On the other hand, there has been an expansion in the territory of features included in the bipolar spectrum of mood disorders, including interpersonal sensitivity as well as cyclothymic tendencies. In order to better understand the boundaries and overlaps between mood disorders and BPD, this proposed symposium will present a number of developmental, diagnostic, and therapeutic approaches that define distinctions between and commonalities between affective and personality disturbances. Joel Paris will introduce the topic by outlining the overlaps and confusions between BPD, depression, and bipolar disorder and then describing the simplicity of mood disorders and their treatments in contrast to the complexity of personality disorders and its relevant treatments. Andrew Chanen will discuss diagnostic and therapeutic dilemmas in childhood and adolescence where clinical presentations are commonly mixed, atypical, and distinct from adult forms of mood and personality problems. Diogo Lara will present an integrative approach to assessing affective and temperamental features contributing to adaptive and dysfunctional expressions of mood and personality. Both Ken Silk and Lois Choi-Kain will present ways to distinguish depression and bipolar disorder symptoms from the moods of BPD in context of both psychopharmacological (Silk) and psychotherapeutic (Choi-Kain) treatments. Lastly, John Gunderson will provide commentary on all these presented perspectives and then lead a discussion among symposium presenters and participants.

NO. 1
CLINICAL STAGING OF BORDERLINE PERSONALITY AND MOOD DISORDERS IN YOUNG PEOPLE.
Speaker: Andrew M. Chanen, M.B.B.S., Ph.D.

SUMMARY:
Mood disorders and borderline personality disorder both have their onset during adolescence and young adulthood. However, diagnostic clarity is often only possible in retrospect. In reality, young people often present with an evolving mixture of symptoms and our limited understanding of the prospective relationships between the symptoms of the major mental disorders and the disorders themselves suggests a more complicated picture. Even without a clear diagnosis, the presence of psychopathology and distress can have adverse developmental consequences, particularly when treatment is delayed. However, spurious diagnostic certainty can lead to the misapplication of both diagnostic labels and treatments.

An alternative to the diagnostic category approach is to develop a range of risk syndromes, or warning signs for the development of a range of disorders. Key to this cross

diagnostic, 'clinical staging' approach is eschewing diagnostic categories and arbitrary age restrictions in favour of a focus on the severity and persistence of symptoms. This approach is consistent with evidence from developmental psychopathology and potentially more useful in determining which and what type of treatment is most effective during this period.

NO. 2
COPING AND INTERPERSONAL FOCUS IN PSYCHOTHERAPIES FOR BPD AND MOOD DISORDERS
Speaker: Lois W. Choi-Kain, M.D., M.Ed.

SUMMARY:
In the treatment of borderline personality disorder (BPD), psychotherapeutic interventions are central while pharmacologic treatments are adjunctive. In the treatment of mood disorders, the reverse is true. A variety of manualized empirically validated treatments, such as dialectical behavioral therapy (DBT), mentalization based treatment (MBT), and general psychiatric management (GPM) have been developed for the treatment of BPD, which to varying extents focus on coping, self-care, and management of interpersonal relationships. Fewer, but nonetheless important, manualized psychotherapeutic approaches to both major depressive disorder and bipolar disorder also involve cognitive behavioral and interpersonally focused strategies. A comparative review of the evidence bases for psychotherapeutic interventions for BPD and mood disorders will be presented with a discussion of the overlaps and distinctions between these treatments.

NO. 3
MOOD DISORDERS AND PERSONALITY DISORDERS: SIMPLICITY AND COMPLEXITY
Speaker: Joel Paris, M.D.

SUMMARY:
Mood disorder is a relatively simple concept while personality disorder is much more complex. Expansion of a mood disorder spectrum has been driven by a desire for simplicity, as well as the belief that patients with complex disorders can be treated effectively with the same drugs used for mood disorders. These trends are also consistent with the biological reductionism that dominates psychiatry, and the medicalization of human suffering.

NO. 4
REDEFINING THE DISTINCTIONS BETWEEN BORDERLINE MOODS AND MOOD DISORDERS: A ROADMAP TO CURRENT PHARMACOLOGIC TREATMENT AND FUTURE RESEARCH
Speaker: Kenneth R. Silk, M.D.

SUMMARY:
While patients with borderline personality disorder (BPD) frequently complain of depression, there needs to be a careful determination as to what constitutes the specific mood symptoms complaints. The word "depression" used by the patient does not automatically mean that the patient is in a major depressive episode (MDE). MDE needs to be distinguished from the chronic dysphoria, loneliness and emptiness that patients with BPD frequently experience and the mood swings attendant to bipolar disorder need to be distinguished from the emotion dysregulation of BPD. Cochrane and other systematic reviews of pharmacologic treatment of mood problems conclude that there is scant evidence for the effectiveness of medications in the treatment of depression in BPD except for use of antidepressants in a bona fide comorbid MDE. The current trend for using either mood stabilizers or atypical antipsychotics for emotion dysregulation is based on weak evidence that needs further substantiation. Future research into the pharmacologic treatment of mood abnormalities in BPD must thoroughly, systematically and objectively assess the nature of the mood difficulties and study the specific effects of different classes of psychotropic medications on these subgroupings of mood complaints that are presented by patients with BPD.

NO. 5
THE INTEGRATION OF MOOD, BEHAVIOR AND TEMPERAMENT IN MOOD SPECTRUM DISORDERS
Speaker: Diogo Lara, M.D., Ph.D.

SUMMARY:
Current psychiatric diagnosis relies on the assumption of discrete mental disorders as discrete categories, artificially separating mood, behavioral, personality and cognitive disorders and producing extensive comorbidity. As an alternative, we propose an integrated framework based on temperament and applicable to both adaptive and dysfunctional situations. The Affective and Emotional Composite Temperament (AFECT) model adopts both an analytic approach based on emotional traits to represent specific neurobehavioral subsystems (Volition/Energy, Desire, Anger, Fear, Caution, Emotional Sensitivity, Anxiety, Control, Coping and Stability), and the affective temperaments as synthetic typology of twelve global configurations divided in four groups: internalized (depressive, anxious, apathetic), unstable (cyclothymic, dysphoric, volatile), stable (euthymic, hyperthymic, obsessive) and externalized (euphoric, irritable and disinhibited). This range of features covers the whole mood spectrum from mania to depression, contemplating mixed features and euthymia. This model is operationalized with the AFECTS, a short self-report scale, which has shown substantial variations associated with being a victim of bullying, cocaine abuse and circadian preference. Here we show that those with a diagnosis of bipolar disorder or borderline personality disorder have strong cyclothymic traits, high Desire and Anger, and low Control, Caution and Stability, and share with subjects with Major Depression

HIV NEUROPSYCHIATRY IN THE ERA OF EFFECTIVE ART

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 neuropsychiatric disorders in the HIV/AIDS patient; 2) Understand the basic neuropathogenesis of HIV; 3) Discuss the potential role of laboratory markers and neuroimaging in the diagnosis and clinical features of HIV-associated neurocognitive disorders (HAND); 4) Understand the diagnostic and treatment approaches to neuropsychiatric and psychiatric symptoms in people with HIV/AIDS.

SUMMARY:
Advances in the treatment of the human immunodeficiency virus (HIV) have dramatically improved survival rates over the past decade. As life expectancy increases, however, more and more clinicians are likely to encounter neuropsychiatric manifestations of HIV disease. Some patients present may with cognitive deficits due to an HIV triggered neurotoxic cascade in the central nervous system, while others might present with a spectrum of psychiatric disorders during the course of their illness. These disorders can adversely influence the progression of HIV disease, lead to noncompliance with prescribed medication and treatment and, if missed, can lead to irreversible damage. As quality of life becomes a more central consideration in the management of HIV as a chronic illness, better awareness of these neuropsychiatric manifestations is paramount. During this symposium participants will receive an up-to-date medical review (including the most recent advances in antiretroviral therapy); discuss the pathology, assessment and diagnosis of neuropsychiatric disorders; and identify the most current and effective psychopharmacologic treatment options.

NO. 1
PSYCHOPHARMACOLOGY
Speaker: Stephen J. Ferrando, M.D.

SUMMARY:
The current psychopharmacology for HIV/AIDS recognizes particular drug interactions between antiretroviral medications and psychotropic drugs. Effective ART is the drug regimen which needs to be taken every day for viral suppression to non-detectable levels, immune reconstitution, and the control of clinical disease. Effective ART is divided into a number of categories by specific mechanism of action. These drugs are reviewed in terms of hepatic metabolic pathways with particular reference to the cytochrome p450 iso-enzyme system. Effective ART can compete with psychotropic medications for CYP P450 enzymes, slow down or inhibit these pathways, or increase the activity of or induce these pathways. During this session pharmacologic treatment strategies will be discussed and an overview of the clinically significant interactions will be offered.

NO. 2
MEDICAL OVERVIEW

SUMMARY:
: There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. While antiretroviral regimens have fewer side effects, adherence to treatment is as crucial as ever to maintain a non-detectable 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 co-infection, and mental illness. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.

NO. 3
HIV NEUROPATHOGENESIS
Speaker: Karl Goodkin, M.D., Ph.D.

SUMMARY:
: HIV-associated neurocognitive disorders (HAND) are a common and potentially devastating complication of HIV infection, affecting over 50% of HIV-seropositive individuals in the in the current era of effective antiretroviral therapy (ART). Because HAND also independently predicts the mortality due to HIV, there is an urgent need to better understand these disorders to develop therapeutic approaches. However, the clinical spectrum of HAND and its underlying neuropathology [HIV-encephalitis (HIVE)] are complex and incompletely understood. This presentation will review the current understanding of the virology and neuropathogenesis of HIV that contribute to HIVE and HAND. The role of neurotransmitters, neuroinflammation, and neuroimaging will be discussed.

NO. 4
NEUROCOGNITIVE DECLINE
Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:
The introduction of effective ART for HIV has had a substantial effect on morbidity and mortality in the HIV-infected population. Notably, the incidence of severe neurocognitive disorders, including HIV-associated dementia, dementia, has decreased markedly among HIV-infected patients during the last 15 years. The prevalence of milder neurocognitive abnormalities, however, has been reported to remain high, including patients treated with effective ART. This session will provide an update on the nature, extent, diagnosis and treatment of HAND, review diagnostic criteria and revised nomenclature, outline the impact of medical co-morbidities; address mild neurocognitive disorder, and present asymptomatic neurocognitive impairment in patients with subclinical impairment.

THE USE OF ACT, CBASP, AND DBT FOR TREATMENT-REFRACTORY PSYCHIATRIC ILLNESS

Chair: Eric Levander, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize when to utilize ACT, CBASP, and DBT in the treatment of complex psychiatric illness; 2) Learn the basic theories behind ACT, CBASP, and DBT; 3) Develop an understanding of the basic techniques utilized in ACT, CBASP, and DBT.

SUMMARY:
Cognitive behavioral therapy (CBT) has long been used in the treatment of affective illness, anxiety disorders, and other psychiatric disorders. Unfortunately, not all psychiatric conditions respond as well to standard courses of CBT and many patients remain symptomatic. Acceptance and commitment therapy (ACT), the cognitive behavioral analysis system of psychotherapy CBASP), and dialectical behavioral therapy (DBT) are other therapies that fall under the umbrella of CBT have shown efficacy in the treatment of refractory psychiatric disorders in evidence based trials. These three evidence based therapies have been found to be effective in trials of treatment refractory anxiety disorders, depression, obsessive compulsive disorder, psychosis, substance abuse disorders, eating disorders and borderline personality disorder. Yet few clinicians are familiar with these novel psychotherapies. ACT utilizes mindfulness and acceptance strategies to decrease avoidance, attachment to difficult thoughts, and increase a focus on the present. ACT teaches patients to live a valued life utilizing more effective behavioral strategies. CBASP utilizes structured tools to teach chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Therapists utilize the technique of disciplined therapist personal involvement to target problematic interpersonal behaviors. DBT combines both individual therapy and group behavioral skills training for patients along with a consultation team for the therapist. In DBT, therapists and patients focus on hieratical behavioral targets to decrease self-injurious behaviors and behaviors that would interfere with the therapeutic process and learn strategies both tolerate emotional distress and make changes to create a more effective environment. This seminar will provide an overview to the clinician on ACT, CBASP, and DBT.

NO. 1
CBASP IN THE TREATMENT OF CHRONIC MAJOR DEPRESSION
Speaker: Eric Levander, M.D., M.P.H.

SUMMARY:
As recent evidence from STAR-D demonstrates, treating both acute and chronic depression to remission remains a difficult task for the physician. Chronic depressive disorders are more treatment refractory to medication and psychotherapy. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) was developed specifically to treat the chronically depressed adult. Results from the largest psychotherapy and medication trial ever with 681 subjects showed 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 responsivity (CPR). With few effective evidence based psychotherapies used to treat chronic depressive illness, this presentation is designed to give an overview of the CBASP as well as an introduction to its major techniques.

NO. 2
DIALECTICAL BEHAVIOR THERAPY
Speaker: Lynn McFarr, Ph.D.

SUMMARY:
Dialectical Behavior Therapy (DBT) is an empirically supported treatment for Borderline Personality Disorder. Developed by Marsha Linehan at the University of Washington, DBT is principle driven variation of CBT which combines behavioral science, zen practice and dialectical philosophy. This symposia will introduce participants to the biosocial model of borderline personality disorder as well as key assumptions about patients and providers. The structure of the therapy, treatment hierarchy, and stages of treatment will be discussed. Core components of validation, mindfulness, behavioral therapy and dialectics will be reviewed.

NO. 3
ACCEPTANCE AND COMMITMENT THERAPY: A MINDFUL APPROACH TO BEHAVIOR CHANGE
Speaker: Robyn Walser, Ph.D.

SUMMARY:
Acceptance and Commitment Therapy (ACT) is a principle-based behavioral intervention that is designed to address human suffering in a mindful and compassionate way. ACT also aims to support individuals in engaging commitments to behavior change that are consistent with personal values and well-being. Applied to multiple diagnoses, ACT helps clients to accept their feelings, accompanying bodily sensations, worrisome thoughts and other internal struggles that are barriers to healthy living while also re-orienting clients to values-based behavior that is instantiated by making and keeping commitments and creating ever larger patterns of behavioral change. The core of many disorders is not only the internal experiences they engender, but also

the great effort used through attempts to control emotions and thoughts which restricts life and causes a great deal of suffering. ACT seeks to reduce these rigid and inflexible attempts to control negative emotions by fostering acceptance through mindfulness and defusion techniques. The client is guided to experience internal events without effort in unworkable control. The ultimate goal is psychological and behavioral flexibility in the service of a more workable life. We will briefly explore the theoretical underpinnings of ACT in addition to the six core components of ACT and how they are used to treat experiential avoidance and problematic rule following. A broad overview of the intervention techniques will also be presented.

THE FUTURE OF PSYCHIATRIC MEASUREMENT

Chairs: Robert Gibbons, Ph.D., David J. Kupfer, M.D.

Discussant: Nina R. Schooler, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn about item response measurement theory and the bifactor model as it applies to measuring psychiatric symptoms.; 2) Learn about computerized adaptive testing as it applies to measuring psychiatric symptoms.; 3) Discuss how item response measurement, the bifactor model and computerized adaptive testing can improve the measurement of psychiatric symptoms.; 4) Describe the results of validation studies using these methods in different psychiatric patient populations when compared with gold standard assessment: SCID, HAM-D, CESD, PHQ9.

SUMMARY:
The Computerized Adaptive Test-Mental Health suite or CAT-MH, is a collection of three adaptive tests for depression, anxiety, and mania, accompanied by a diagnostic screening test for major depressive disorder (CAD-MDD) developed as part of a 5-year grant from the National Institute of Mental Health. The CAD-MDD produces a screening diagnosis of depression and a corresponding confidence level associated with that diagnosis. The three computerized adaptive tests (CAT), the CAT-Depression Inventory or CAT-DI, the CAT-Anxiety or CAT-ANX and the CAT-bipolar disorder or CAT-BP, are dimensional measures that produce continuous severity scores based on symptomatology experienced in the past two weeks. The paradigm shift between traditional screening and assessment tools and those associated with these tests is that they begin with a large "bank" of items (1008 psychiatric symptom items) and adaptively administer a small and statistically optimal subset of the items (on average 12 items for each of the three CATs and 4 items for the CAD-MDD). Nevertheless, each of the CATs maintains a correlation of close to r=0.95 with the entire bank of items for each test (389 depression items, 431 anxiety items, 88 mania/hypomania items). As such, with only 12 items completed in 2 minutes over the Secure Internet Protocol Router Network (SIPRNet), we can extract the information contained in hundreds of items in the item bank. Results for the CAT-DI (depression test) have recently been published in JAMA Psychiatry (Gibbons et.al. 2012a). In terms of our ability to screen for depression, the CAD-MDD has remarkably high sensitivity of 0.95 and specificity of 0.87 with an average of only 4 items (max=6 items). As a comparison, the PHQ-9 used in these same subjects had similar specificity, but sensitivity of 0.70 indicating that for every 100 true cases the PHQ-9 would miss 30, whereas the CAD-MDD would only miss 5. This advantage is achieved despite the fact that the CAD-MDD uses less than half the number of items. As part of the item bank, there are 14 suicide assessment items that may be adaptively administered as a part of the CAT-DI. In the event of that a suicide item has not been administered, between 1 and 4 suicide items will be administered and a suicide alert generated if any item is endorsed at moderate or above. Thus, this suite of measures allows us to simultaneously screen for depression, anxiety, mania/hypomania, and suicide risk.

NO. 1
OVERVIEW
Speaker: David J. Kupfer, M.D.

SUMMARY:
An overview of the program of research that led to the development of the CAT-MH (Computerized Adaptive Testing – Mental Health) suite of tests which provide adaptive screening diagnoses and dimensional measures is provided. Its connections with DSM-5, mental health assessment and treatment in primary care and longitudinal assessment are discussed. The opportunity for global mental health and population level assessment of mental health disorders via cloud computing environments using secure servers and electronic health record integration are highlighted.

NO. 2
THE FUTURE OF PSYCHIATRIC MEASUREMENT
Speaker: Robert Gibbons, Ph.D.

SUMMARY:
The Computerized Adaptive Test-Mental Health or CAT-MH, is a suite of three adaptive tests for depression, anxiety, and mania, and a diagnostic screening test for major depressive disorder (CAD-MDD) developed as part of an ongoing program of research funded by the National Institute of Mental Health. The CAD-MDD produces a remarkably accurate screening diagnosis of depression. The three computerized adaptive tests produce continuous severity scores that can be used for both assessment and monitoring. The paradigm shift between traditional screening and assessment tools and those associated with these tests is that they begin with a large "bank" of items (1008 psychiatric symptom items) and adaptively administer a small and statistically optimal subset of the items (on average 12 items for each of the three CATs and 4 items for the CAD-MDD). Nevertheless, each of the CATs maintains a correlation of close to r=0.95 with the entire bank of items for each test (389 depression

items, 431 anxiety items, 88 bipolar items).

NO. 3
THE MAKING OF A CAT FOR MENTAL HEALTH ASSESSMENT
Speaker: Ellen Frank, Ph.D.

SUMMARY:
In this presentation we describe the process by which a Mental Health CAT is constructed. The process includes (a) constructing an item bank, (b) sampling items from subdomains (e.g. mood, cognition, and somatic factors), factors (e.g. increased negative affect, decreased positive affect), and facets (e.g. sadness, irritability, moodiness), (c) qualitative review and consensus, (d) selecting a time-period and response formats. We describe the factors that go into selecting an appropriate subject population, including exclusion criteria and sample size determination. We describe the various stages of CAT development which include calibration, simulated CAT, and live CAT. Finally, we consider issues related to the use of CAT in practice, which include incorporating developmental stages in the assessment of youth, and translation and item functioning in different cultures (e.g. Latinos), and nativities (e.g. Cuban, Puerto Rican, Mexican).

NO. 4
VALIDATION OF COMPUTERIZED ADAPTIVE TESTING IN A COMMUNITY
Speaker: Eric D. Achtyes, M.D., M.S.

SUMMARY:
This study sought to validate the utility of the diagnostic screening test CAD-MDD as well as the CAT-MH suite of tests (CAT-DI, CAT-ANX, and CAT-BP) for assessing cross-cutting psychiatric symptom severity in a community sample of adult psychiatric outpatients. One hundred forty-five individuals, aged 18-70 years, with a range of psychiatric diagnoses who sought access to care at Pine Rest Christian Mental Health Services, a large, free-standing psychiatric treatment facility located in Grand Rapids Michigan, as well as healthy controls, were evaluated using the above measures in addition to gold-standard diagnostic and severity scales including the SCID for DSMIV-TR, CES-D, PHQ9, HAM-D25 and GAF. The level of patient satisfaction with computerized testing was also measured. Results from this cross-sectional, prospective study will be discussed.

USING OPTOGENETICS TO BETTER UNDERSTAND THE NEUROBIOLOGY OF MOOD DISORDERS

Chairs: Eric J. Nestler, M.D., Ph.D., Karl Deisseroth, M.D., Ph.D.

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the new tools of optogenetics and how they are contributing to novel insight into the neurobiological underpinnings of psychiatric disorders; 2) Understand the contribution of complex neural circuits to anxiety-, depression-, and mania-related behavioral abnormalities in animal models; 3) Recognize the importance of behavioral context in determining the functional consequences of any given neural circuit.

SUMMARY:
Optogenetics describes new experimental tools that have made it possible for the first time to control the activity of a precise population of neurons in the brain with extraordinary temporal and spatial resolution. The goal of this Symposium is to present to psychiatrists the basic principles of this exciting technology and to illustrate its importance to the field by providing a progress report on mood disorders. After an overview of optogenetic approaches, the speakers will present new data that use optogenetic tools to define the precise neural circuits in the brain that control anxiety-, depression-, and mania-related behavioral abnormalities in animal models.

NO. 1
COMPLEX NEURAL CIRCUITRY OF DEPRESSION AND ITS TREATMENT
Speaker: Kafui Dzirasa, M.D., Ph.D.

SUMMARY:
Optogenetics has emerged as a powerful tool for probing the neuronal circuit components that contribute to the manifestation of neuropsychiatric endophenotypes in preclinical models. One advantage of the optogenetic approach is that neural circuit components can be directly activated with millisecond resolution without inducing the major electrical artifacts intrinsic to other classic stimulation techniques. As such, the neural network dynamics that result during the delivery of neuropsychiatric therapeutics such as deeo brain stimulation (DBS) can be directly explored using this approach. In this presentation, we will explore the limbic network responses that accompany direct stimulation of prefrontal cortex (a primary brain target for DBS in preclinical models of depression). We will also describe how these network changes may serve as circuit-based biomarkers for future therapeutic development.

NO. 2
NEW INSIGHT INTO THE NEUROBIOLOGY OF MANIA
Speaker: Colleen A. McClung, Ph.D.

SUMMARY:
The mechanisms that underlie the switch into bipolar mania have remained largely unknown. We find that mood cycling in a rodent model coincides with abnormal daytime spikes in ventral tegmental area (VTA) dopaminergic activity, tyrosine hydroxylase (TH) levels, and dopamine synthesis. To determine the significance of daytime increases in VTA dopamine activity to manic behaviors, we developed a novel optogenetic stimulation paradigm that produces a sustained

increase in dopamine neuronal activity and find that this induces a manic-like state only if stimulations are performed during the daytime and not during the night. Furthermore, dampening of TH activity during the day (and not the night) reverses manic-like behavior. These data suggest that the switch to mania involves inappropriate surges of dopamine at the wrong time of day. Furthermore, these studies demonstrate the utility of chronic optogenetic stimulation paradigms for the mechanistic study of complex psychiatric disorders.

NO. 3
OPTOGENETIC DISSECTION OF NEURAL CIRCUITS UNDERLYING ANXIETY
Speaker: Kay M. Tye, Ph.D.

SUMMARY:
Although anxiety is the most common class of psychiatric disorders, currently available treatments are only moderately effective and have undesirable side-effects. To develop more effective treatments with fewer side-effects we must first identify the specific targets and neural circuits that control anxiety. This talk will focus on evidence showing that it is the connectivity between brain regions rather than any individual region in isolation that controls anxiety-related behaviors in animal models.

NO. 4
OVERVIEW OF OPTOGENETIC APPROACHES
Speaker: Karl Deisseroth, M.D., Ph.D.

SUMMARY:
Achieving insight into the neural circuit dynamics that underlie psychiatric symptoms has long proven elusive. Optogenetics is a technology that allows targeted, fast control of precisely defined events in biological systems as complex as freely moving mammals. It typically involves the expression of a light-activated ion channel or pump in a selected population of nerve cells in the brain and control over the activity of the channel or pump via fiber optic cables. By delivering optical control of neuronal activity at the speed (millisecond-scale) and with the spatial precision (cell type specific) required for neural processing, optogenetic approaches have opened fundamentally new landscapes for psychiatry. Recent years have seen a growing wave of such applications, resulting in insights into crucial aspects of circuit function, as well as circuit dysfunction and treatment in pathological states such as depression, anxiety, social dysfunction, and substance abuse.

NO. 5
ROLE OF CRF IN GATING BDNF SIGNALING IN THE BRAIN'S MESOLIMBIC REWARD CIRCUIT
Speaker: Ming-Hu Han, Ph.D.

SUMMARY:
Brain derived neurotrophic factor (BDNF), acting in the mesolimbic dopamine reward pathway, plays a key role in determining susceptibility versus resilience in a social defeat mouse model of depression. However, the mechanisms controlling its release remain unknown. Utilizing multiple viral, circuit-probing optogenetic tools, we have found that phasic but not tonic activation of this reward pathway increases BDNF levels in the nucleus accumbens (NAc) of socially stressed mice, but not stress-naïve mice. This stress gating of BDNF signaling is mediated by the neuropeptide corticotrophin releasing factor (CRF) in the NAc. These results unravel a stress-context detecting function of the brain's mesolimbic circuit and provide novel insight into the pathophysiology of depression and other stress-related syndromes.

NO. 6
ROLE OF THE PREFRONTAL CORTEX AND ITS PROJECTIONS IN DEPRESSION
Speaker: Melissa R. Warden, Ph.D.

SUMMARY:
Major depression is common, yet remains poorly understood, and current treatments are often inadequate. Evidence suggests an important role for the prefrontal cortex (PFC) and its downstream projections. Of particular interest is PFC communication with the dorsal raphe nucleus (DRN), the major source of serotonin to the forebrain, and the lateral habenula (LHb), a novel target for deep brain stimulation treatment of depression. We describe a combined projection-specific optogenetic and electrophysiological approach to investigating these circuits in behaving rats, and report on both acute and long-lasting changes in depression-related behaviors and circuit properties. This work is providing new insight into our neurobiological understanding of depression.

RESILIENCY DEVELOPMENT IN ARMED FORCES INDIVIDUALS, GROUPS, AND COMMUNITIES: TOOLS AND PROTOCOLS IN THE FIGHT AGAINST STRESS IN COMBAT AND AT HOME

Chairs: David J. Reynolds, Ph.D., Angela Matysiak, M.P.H., Ph.D.

Discussant: Angela Matysiak, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Address the aspects of traditional mental health programs that contribute to stigma in military populations and how to resolve them.; 2) State the basic path or steps for increasing resiliency using the Resource Development and Installation protocol. ; 3) Identify resiliency-building strategies for interdisciplinary helping professionals.; 4) Identify ways in which the Post Deployment Open House promoted resiliency in service members.

SUMMARY:
Efforts to assist US military members in coping with associ-

ated stressors and developing resilience before, during or after deployment are being pursued by various agencies within the Department of Defense (DOD), Veterans Affairs Administration (VA) and civilian agencies. While some attempts to bolster resilience occur at the individual or group level as applied by mental health professionals as a form of treatment, others can be more readily applied by well-taught, military personnel and administered in the context of routine training. As the DOD and VA look to both deepen and broaden the training of mental health professionals working with military members during and after their service, various training schools are tailoring their courses towards working with the military. The panel will present information (theory, application, and research results) related to several resiliency-building programs at the individual, group and community level, which can be applied, before, during or after deployment.

NO. 1

TRAINING THE HELPERS: RESILIENCY AS AN INTERDISCIPLINARY RESPONSIBILITY

Speaker: Nancy Brown, M.S.W.

SUMMARY:

Building resilience is an interdisciplinary endeavor. Improving and reinforcing resilience in military members, veterans and their families requires not only a knowledge of what is resiliency but specific strategies in how to assist those in need to acquire it. Professionals in disciplines as diverse as social work, nursing and the medical professions, education, and chaplains require specific training around the skills of resiliency assessment, and the means to establish and reinforce resilience in military members as well as family members. This part of the presentation provides methods that can be used to "train the helpers." Information will be provided about educational approaches to teaching strategies to improve resilience in military members, veterans and their families that can be utilized by interdisciplinary helpers.

NO. 2

POST DEPLOYMENT OPEN HOUSE: BUILDING RESILIENCY ONE WINGMAN AT A TIME

Speaker: Ericka S. Jenifer, Ph.D.

SUMMARY:

Exposure to traumatic events in a deployed setting increases service members' risk for developing mental health problems and interpersonal difficulties. Service members returning from deployments often have difficulty re-integrating to their home and work environments. In order to assist with re-integration efforts, the Post Deployment Open House (PDOH) initiative was developed. The PDOH promoted resiliency by encouraging help seeking behaviors in deployed members and their families. Additionally, it aided supervisors with the early identification of at-risk troops. From 2009 – 2011, 140 service members and their family members completed the PDOH. Intervention results and implications for future program development will be discussed.

NO. 3

RESOURCE DEVELOPMENT AND INSTALLATION AS A RESILIENCY BUILDING PROTOCOL

Speaker: David J. Reynolds, Ph.D.

SUMMARY:

Resource Development & Installation (RDI), an effective relapse prevention/performance enhancement protocol, was modified to address military-related situations. For some, a feared event (retrieving body parts) had not yet occurred, while for others something traumatic happened (mortar attack) and there was concern it might happen again. After addressing the worst aspects of the event (real or predicted), positive qualities deemed necessary to cope better were identified. Next, relevant internal resources were developed and linked to the feared event during imaginal exposure. Overall, a majority (79%) reported decreased distress after RDI. No differences were found between those who had already experienced a negative event and those who anticipated one. A review of individual medical records 6 months post intervention indicated 4% of those in the anticipated group had attended some form of mental health service, as compared to 21% of those who had already experienced a negative event.

NO. 4

DEFENDER'S EDGE (DEFED): A CULTURALLY SENSITIVE PROGRAM FOR TRAINING MILITARY POLICE IN PSYCHOLOGICAL PRINCIPLES

Speaker: Craig J. Bryan, Psy.D.

SUMMARY:

Despite DoD and VA efforts, mental health stigma continues to be a significant barrier to military personnel seeking help, highlighting the need for new modes of thought. The fundamental difference between traditional mental health approaches and the military culture contributes to this stigma. Defender's Edge (DEFED), a prevention initiative, was developed to fit military police to prevent psychiatric morbidity during deployment. DEFED adopts a strengths-based philosophy and integrates empirically-supported principles: sleep hygiene, stimulus control, relaxation, mindfulness, cognitive restructuring, positive self-bias, and positive meaning-making. Developed in 2009, over 2000 personnel have participated in DEFED. Results support high programmatic acceptability among both student and instructors. Outcomes of an independent curriculum review indicate DEFED can be delivered by trained instructors with high fidelity. Implications for further program development will be addressed.

MILITARY SEXUAL TRAUMA IN WOMEN VETERANS: ADVANCES IN UNDERSTANDING BIOLOGICAL MECHANISMS, BIOMARKERS, DIAGNOSIS, PREVENTION, AND TREATMENT

Chairs: Nancy Lutwak, M.D., Paula Schnurr, M.D., Ph.D.

Discussant: Paula Schnurr, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the consequences of military sexual trauma in women veterans; 2) Recognize posttraumatic stress disorder; 3) Treat posttraumatic stress disorder with STAIR Therapy; 4) Identify biomarkers associated with military sexual trauma and posttraumatic stress disorder.

SUMMARY:
Military sexual trauma has 20-40% prevalence in women Veterans. Our symposium will shed light on its consequences, screening, biomarkers, biological mechanisms leading to posttraumatic stress disorder and newest treatment modalities. We will present an overview while outlining its complexities and most recent scientific and clinical advances in understanding.
Military sexual trauma, MST, is the term used by the Veterans Health Administration (VHA) to refer to sexual assault or repeated, threatening sexual harassment that a veteran experienced during military service. It is the leading cause of posttraumatic stress disorder (PTSD) in women veterans and can lead to substantial physical and psychological morbidity. Approximately 20% of women Veterans screened in clinic settings nationally report experiencing MST. At VA New York Harbor Healthcare System, Emergency Department, we have implemented a separate, quiet treatment area for women Veterans where there is privacy. The positive rate of screening in that secure location is 38%. We will discuss the negative consequences of MST in women as well as factors that impact the screening process.
PTSD accounts for half of the mental health burden in Iraq and Afghanistan (OEF and OIF) veterans. Discovering biomarkers in female veterans with military sexual trauma and other service related PTSD will assist in objective diagnosis and clarification of gender differences in the biological mechanisms of PTSD. We will discuss findings on structural and functional brain imaging, genomic, proteomic, endocrine and metabolism markers in females with military sexual trauma (MST) and other service related PTSD, healthy deployed females and male veterans with PTSD. Animal models of PTSD have shown differences in male and female biomarkers. Translating this knowledge to support men and women who have served in Iraq and Afghanistan, including those with MST, has high potential to advance prevention and treatment interventions.
Veterans who have experienced MST typically present with multiple psychiatric comorbidities and impaired functioning in various domains. Mental health treatment often involves addressing these comorbidities and areas of impaired functioning in addition to treating the symptoms of PTSD. We will provide an overview of a promising treatment for veterans with MST that addresses these complex issues. STAIR Narrative Therapy is a phase-based treatment that incorporates skills training in affective and interpersonal regulation (STAIR), and a modified prolonged exposure protocol to address trauma memories (Narrative Therapy). To illustrate the application of individual STAIR Narrative Therapy, we will discuss a case study in which we treated a female Army Veteran with MST. We will also provide preliminary pilot data, including BSI-18 and PCL scores, for veterans who received a group format of STAIR.

NO. 1
EMERGENCY MEDICINE FOCUS ON WOMEN VETERANS AND MILITARY SEXUAL TRAUMA
Speaker: Nancy Lutwak, M.D.

SUMMARY:
Military sexual trauma, MST, is the term used by the Veterans Health Administration (VHA) to refer to sexual assault or repeated, threatening sexual harassment that a veteran experienced during military service. It is the leading cause of posttraumatic stress disorder in women veterans and can lead to pain, medical illness, depression, substance abuse, and suicidal ideation. About 20% of women screened in the VA Clinics New York Harbor Healthcare System and VA nationally have experienced MST.
Two questions comprise VA screening for MST. We have found that women are less likely to discuss MST in the presence of male veterans. At the Emergency Medicine Department, we have designated completely separate areas for the care of women only. In these areas women feel more comfortable discussing MST they never previously revealed and 38% have screened positive for MST. We will discuss consequences of MST and factors that influence the screening process.

NO. 2
BIOMARKERS FOR PTSD IN FEMALE OEF/OIF VETERANS
Speaker: Charles Marmar, M.D.

SUMMARY:
Title: Biomarkers for PTSD in female OEF/OIF veterans
This presentation will report findings from a study on biomarkers of PTSD, which accounts for half of the mental health burden in Iraq and Afghanistan (OEF and OIF) veterans. Discovering biomarkers in female veterans with military sexual trauma and other service related PTSD will assist in objective diagnosis and clarify gender differences in the biological mechanisms of PTSD. We will present findings on structural and functional brain imaging, genomic, proteomic, endocrine and metabolism markers in 20 females with military sexual trauma (MST) and other service related PTSD, 20 healthy deployed female controls and 20 age and ethnicity matched male veterans with PTSD. Animal models of PTSD have shown differences in male and female biomarkers, Translating this knowledge to support men and women who have served in Iraq and Afghanistan, including those with MST, has high potential to advance prevention and treatment interventions.

NO. 3
TREATING MST IN VETERANS WITH STAIR NARRATIVE

THERAPY

Speaker: Christie Jackson, Ph.D.

SUMMARY:

Veterans who have experienced MST typically present with multiple psychiatric comorbidities and impaired functioning in various domains. Mental health treatment often involves addressing these comorbidities and areas of impaired functioning in addition to treating the symptoms of PTSD. We will provide an overview of a promising treatment for veterans with MST that addresses these complex issues, STAIR Narrative Therapy (Cloitre, Cohen, & Koenen, 2006). STAIR Narrative Therapy is a phase-based treatment that incorporates skills training in affective and interpersonal regulation (STAIR), and a modified prolonged exposure protocol to address trauma memories (Narrative Therapy). To illustrate the application of individual STAIR Narrative Therapy, we will discuss a case study in which we treated a female Army Veteran with MST. We will also provide preliminary pilot data, including BSI-18 and PCL scores, for veterans who received a group format of STAIR.

MAY 03, 2014

NEW DEVELOPMENTS IN THE IDENTIFICATION OF SUICIDE RISK

Chair: W. Vaughn McCall, M.D., M.S.

Speakers: Peter B. Rosenquist, M.D., Adriana Foster, M.D., W. Vaughn McCall, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand how to leverage the electronic health record to comply with JCAHO requirements for suicide risk assessment on psychiatric, medical and surgical settings; 2) Understand the option of using simulation in teaching suicide risk assessment to healthcare trainees ; 3) Understand the role of sleep disturbance as a risk factor for suicide.

SUMMARY:
Global advances in the control of communicable diseases have resulted in an escalation in the rank order of suicide as a cause of death, rising from 14th to 13th place in the world in 2010. As a result, assessment of suicide risk becomes increasingly important. Comprehensive assessment of suicide risk becomes more complex as science identifies new risk factors, and as the standards of accrediting health agencies such as JCAHO become more explicit in how suicide risk is to be measured. Further teaching suicide risk assessment to trainees may be hampered by over-full curricula that are straining to teach the basics of mental health. This workshop presents new data on how to address some of these needs, including (1) how to leverage the electronic health record to meet accreditation requirements, (2) how to use computer simulation to systematically teach suicide risk assessment to trainees, and (3) understanding the role of one of the newest suicide risk factors, namely, the role of sleep disturbance.

COGNITIVE BEHAVIOR THERAPY FOR PERSONALITY DISORDERS

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Conceptualize personality disorder patients according to the cognitive model; 2) Improve and use the therapeutic alliance in treatment; 3) Engage Axis II patients in treatment; 4) Set goals and plan treatment for Axis II patients; 5) Describe 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 (e.g., Fournier et al., 2008; Davidson et al, 2006; Matusiewicz et al., 2010). 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.

PSYCHIATRIC AND JUDICIAL COLLABORATION: WORKING TO ADDRESS THE OVER-REPRESENTATION OF JUSTICE-INVOLVED PEOPLE WITH MENTAL DISORDERS

Chair: Fred C. Osher, M.D.

Speakers: Honorable Paula M. Carey, Regina Carney, M.D., Steven Leifman, J.D., Debra Pinals, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the importance and value of psychiatric-judicial partnership to improve public safety and advance public health goals; 2) Construct an approach to reach out to judicial leaders to collaboratively affect system change in their communities; 3) Consider the effect of stigma on individuals with behavioral health disorders who are involved in the criminal justice system ; 4) Discuss how psychiatrists can collaborate with the judiciary to improve outcomes for justice-involved persons with behavioral health disorders.

SUMMARY:
Researchers estimate that nearly 17 percent of people admitted to jail have serious mental illnesses-rates three times higher for men and five times higher for women than in the general population. Nearly 70 percent of adults in jails have a substance use disorder, and almost three-quarters of jail inmates with serious mental illnesses (72 percent) have co-occurring substance use disorders. The substantial number of individuals who are served by the behavioral health system that are also involved in the criminal justice system have complex needs that cannot be adequately resolved by one system alone, prompting the need for effective partnership and collaboration between the two systems. Indeed, behavioral healthcare providers and criminal justice professionals across the country are already collaborating in various ways to keep these individuals out of the criminal justice system and advance their recovery. Yet despite these efforts, community-based treatment providers are increasingly serving clients who are involved with the criminal justice system and have risk factors that compromise their recovery, create stress for their families, and negatively impact public safety

and government spending.
This workshop will feature real-world examples of collaboration among treatment providers and criminal justice professionals to develop cross-system strategies that advance public health and public safety goals and emphasize a shared understanding that each system has unique roles and responsibilities in addressing the needs of individuals involved with the criminal justice system. Through a discussion of examples of psychiatric-judicial collaboration, panelists from both the psychiatry and criminal justice fields will approaches that criminal justice and treatment administrators and providers can pursue collaboratively to address this problem, and share successes and challenges.

TEACHING RESIDENTS COLLABORATIVE CARE IN NONCOLLABORATIVE SETTINGS

Chairs: Andres Barkil-Oteo, M.D., M.Sc., Hsiang Huang, M.D., M.P.H.

Speakers: Andres Barkil-Oteo, M.D., M.Sc., Hsiang Huang, M.D., M.P.H., Anna Ratzliff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Conceptually understand and be ready to use a population health perspective and validated scales in caring for patients; 2) Describe the difference in providing consultation for the team (case load consultant) vs individual patient (direct consultant); 3) Develop an understanding on how to introduce Collaborative Care skills in non-collaborative settings.

SUMMARY:
Collaborative Care--where primary care doctors, behavioral care managers, and psychiatrists work as a team-- is a rapidly growing field of behavioral health care. Multiple randomized-controlled studies have demonstrated the efficacy and cost-effectiveness of delivering behavioral health care to patients in primary care settings. Collaborative Care interventions are based on population group information: active case-identification, patient registries, and medical instrument screenings. Care is delivered initially by the primary care provider and the behavioral care manager, using evidence-based algorithms, and regularly scheduled systematic case reviews between a psychiatrist and the care manager for those patients who do not improve on specified behavioral health outcomes (e.g. PHQ-9). This treatment approach has the potential to provide more patients with increased access to psychiatrists, specialists who currently are in short supply.
Despite its strong evidence base, the Collaborative Care model has not been widely adopted; yet this is likely to change with the implementation of Accountable Care Organizations, in accordance with the Affordable Care Act. Academic centers are largely lagging behind in teaching essential skills for practicing Collaborative Care. Although psychiatry residents are not currently being trained in these models of care, graduates are somehow expected to be able to function effectively in these novel settings. Practicing psychiatry within Collaborative Care models is not a simple matter of organizing existing services: it requires new skills from psychiatrists, skills not normally provided in the course of their training. Some residency programs are now training residents in Collaborative Care clinics, however, the majority of psychiatry residencies do not have opportunities for rotations in fully running Collaborative Care settings.
This curriculum is designed to introduce residents to the role of the consulting psychiatrist in a primary care system. We identify specific skill sets that are needed in that context, skills that residents could practice in class as well as in any normal clinic environment. The curriculum design utilizes two mini-modules, covering the fundamentals skills necessary to assume the role of a consultant psychiatrist on a collaborative care team. The modules include in-class activities.
The new use of milestones in psychiatry residency education creates an opportunity to better assess the competencies of residents. One of the competencies related to system-based practices is: “Works effectively in various health care delivery settings and systems relevant to one’s clinical specialty.” The consultation milestone that relates to this issue is SBP4: Consultation. This provides a strong basis for equipping residents with specific skills as consultants in systems, and for training programs to assess residents’ performance in that competency.

HOW OBAMACARE FAILS THE PEOPLE WITH MENTAL ILLNESS

Chairs: Leslie H. Gise, M.D., Steven Sharfstein, M.D., M.P.A.

Speakers: J. Wesley Boyd, M.D., Ph.D., Amy Funkenstein, M.D., Leslie H. Gise, M.D., Steven Sharfstein, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the APAs position on access to health care and psychiatric care ; 2) Appreciate how our 2010 federal health care law affects the access, quality and affordability of psychiatric care; 3) Recognize the barriers to delivering universal, quality, affordable psychiatric care.

SUMMARY:
APA supports universal access to health care and universal access to quality psychiatric care. We also need health care to be affordable both for our country and for our citizens. The 2010 federal health care law does some good things but it continues the domination by insurance and drug companies which adversely affects access, quality and affordability. With regard to universality, the Congressional Budget Office estimates that the law will leave 31 million uninsured which includes a disproportionate number of people with mental illness. With regard to the quality of psychiatric care, outcomes are hard to measure but people with mental illness are uninsured, under-insured, on the streets and in jail

and the US lags behind other developed countries in mental health spending. While many OECD countries increased their investment in mental health services, the US has slashed its expenditures for psychiatric and mental health services. The law also discriminates against women who are charged more because they have higher health costs. Insurance and drug companies have negatively affected the quality of mental health treatment specifically limiting talk therapy, including psychotherapy, psychoanalysis, counseling, marriage therapy, family therapy, group therapy, psycho-educational groups, addiction treatment groups, parent training groups, anger management programs and others. Insurers have not only drastically cut talk therapy sessions, but they have also invaded privacy and taken the choice of therapist out of the patients' control. These actions conflict with the evidence that psychotherapy has been found to be cost-effective and associated with better work functioning and less hospitalization.

Three psychiatric groups, including APA, are suing insurers who interfere with psychiatric care by violating the parity law, paying less, driving psychiatrists out of their networks, inhibiting access to care for which patients and employers have paid and other abuses. Regarding affordability, our new law is modeled on Massachusetts where people are still experiencing financial hardship and medical bankruptcy. Recent studies have found that access to outpatient psychiatric care in Boston is severely limited, even for people with reputedly excellent private health insurance and that psychiatrists waste 1 million hours a year seeking insurance approval before hospitalizing patients from the emergency room. Over the past 20 years mental health spending has remained 1% of the economy while total health spending has climbed from 10% to 17%. With one risk pool, social insurance in a publicly funded system we could fulfill the APAs positions on universal access to quality psychiatric care for everybody and save money as well.

THE MEFLOQUINE TOXIDROME IN CLINICAL AND FORENSIC PSYCHIATRY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Remington L. Nevin, M.D., M.P.H.

Speakers: Remington L. Nevin, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe key neuropsychiatric features of the mefloquine toxicity syndrome (or toxidrome); 2) Identify considerations in the clinical diagnosis and management of the mefloquine toxidrome; 3) Recognize the relevance of the mefloquine toxidrome to forensic psychiatry particularly in relation to military service members and veterans.

SUMMARY:

Mefloquine (previously marketed in the U.S. as Lariam) is a quinoline derivative antimalarial with significant intoxicating and neurotoxic potential. In this session, the history of mefloquine's development and use within U.S. military populations are discussed, and the key neuropsychiatric features of mefloquine intoxication and its chronic sequelae are described. Considerations are discussed to aid the psychiatrist in the clinical diagnosis and management of its toxicity syndrome, including recommendations for obtaining additional specialist referrals. The mefloquine toxidrome has significant relevance in forensic psychiatry, and may complicate and confound diagnosis of other conditions comorbid with military service and deployment, particularly posttraumatic stress disorder, traumatic brain injury, somatoform and personality disorders. The potential role of mefloquine toxidrome in cases of violence and suicide are discussed.

RISK MANAGEMENT AND LIABILITY CONSIDERATIONS IN THE INTEGRATED CARE SETTING

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

Speakers: Lori Raney, M.D., D. Anton Bland, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify risk management and liability issues when providing consultations in the integrated practice setting; 2) Recognize the relationships and potential liability issues arising between the psychiatrist and other medical/non-medical providers within the integrated care practice setting;; 3) Examine common claims against psychiatrists in the integrated care setting; 4) Identify risk reduction strategies.

SUMMARY:

Increasingly, patients needing psychiatric care are being treated in integrated care practice settings. Numerous integrated practice models have recently emerged, all requiring collaboration among multiple medical and non-medical mental health providers. Depending upon the integrated care practice model utilized, the role of the psychiatrist may differ from that found in a traditional psychiatric treatment setting. Specifically, when working in these practice settings, the psychiatrist may encounter novel liability issues when supervising mid-level practitioners or when asked to provide consultations on a formal or informal basis.

This 1.5 hour workshop will outline some of the risk management and liability issues that psychiatrists must understand and consider when working in the integrated care setting and case examples will be used to further demonstrate types of patient care situations involving an increased liability exposure for the psychiatrist. Risk reduction strategies will be identified to help lessen these liability exposures.

ETHICAL CONSIDERATIONS IN THE USE OF IMPLANTABLE DEVICES FOR PSYCHIATRIC TREATMENT AND RESEARCH

Chairs: Andrew M. Siegel, M.A., M.D., Mahendra T. Bhati, M.D.

Speakers: Andrew M. Siegel, M.A., M.D., Mahendra T. Bhati, M.D., Marna S. Barrett, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn several key ethical issues involved in psychiatric clinical research; 2) Explore three ethical issues unique to the use of implantable devices for the treatment of depression; 3) Develop an understanding of these issues using case examples.

SUMMARY:
Research and treatment of depression using Deep Brain Stimulation (DBS) and Vagus Nerve Stimulation (VNS) have grown significantly over the past decade. Despite the increased use, these treatment modalities are still in a nascent stage of development. Moreover, because they involve surgical implantation within a highly vulnerable population (severe depression), there are a number of unique ethical concerns that arise. For example, evolving evidence regarding treatment efficacy and safety question the determination of "adequate" informed consent. The fact that DBS and VNS require surgical intervention for implantation of device hardware raises additional concerns about treatment feasibility extending beyond the duration of a research trial. Device maintenance creates further difficult questions regarding responsibility for long term costs. In this workshop, we will utilize several clinical examples to illustrate the ethical challenges unique to these treatments. Discussion and debate about these issues will be encouraged and ways to address the resulting ethical dilemmas will be presented.

CIVILIAN MANAGEMENT OF MILITARY PATIENTS

Chair: Nathan E. Hartvigsen, M.D.

Speaker: Blanca Osorio-Candelaria, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the unique background of military patients in need of psychiatric services; 2) Describe the treatment of military PTSD in accordance with Department of Defense Clinical Practice Guidelines; 3) Identify effective strategies for confident interaction with military patients of varying backgrounds and experiences.

SUMMARY:
Military patients encounter unique stressors both at war and at home. While their treatment needs are the same as those of their civilian counterparts, their singular culture often represents a barrier to effective engagement with non-military providers. As its treatment population continues to grow, the U.S. Military relies heavily on civilian partnerships to ensure adequate access to care. session participants will gain insight into the motivations of today's treatment seeking military patients after more than a decade of war. Individual presentations address essential aspects of military experience including "Establishing a Therapeutic Alliance," "Clinical Approach to Veterans and Their Families" and "PTSD Medication Management." Additionally, key jargon will be reviewed for familiarization with everything from a "15-6" to an "Article 15." Through exposure to this range of military specific topics, civilian providers will acquire the skills to confidently address the needs of this deserving segment of the population, our nations military heroes.

EMBEDDED MENTAL HEALTH PROVIDERS IN THE U.S. MILITARY: CARING FOR THOSE AT THE TIP OF THE SPEAR

Chairs: James C. West Jr., M.D., Bryan L. Bacon, D.O., M.D.

Speakers: Benjamin R. Hershey, M.D., Dennis White, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Explain the philosophy of embedded mental health care in the U.S. Army and Marine Corps; 2) Describe current practices of embedded mental health in the U.S. Army and Marine Corps; 3) Compare and contrast the strengths and opportunities presented by each approach.

SUMMARY:
Combat trauma and operational stress are a predictable part of combat deployments for U.S. troops. In the current conflicts, the U.S. military has approached this problem by embedding mental health providers within ground combat units. Their role is to prepare and educate troops and leaders, identify and intervene early, and provide a consistent, credible, and accessible presence for troops. This workshop will present philosophies and practices of embedded mental health in the U.S. Army and Marine Corps and will discuss the strengths of each as well as opportunities to further develop.

END OF LIFE CARE AND DIGNITY THERAPY: A RESIDENT'S PERSPECTIVE

Chairs: Patrick Cleary, M.D., Anson Liu, M.D.

Speaker: Jamie Siegel, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Verbalize their own concerns, fears and successes in dealing with a dying patient; 2) Demonstrate knowledge of what Dignity Therapy is and recognizing potential areas of use; 3) Demonstrate knowledge of how to conduct dignity therapy with patients who are suffering with end of life diseases.

SUMMARY:
As physicians, and specifically as psychiatrists, one of our greatest challenges is to help those patients who are facing end-of-life achieve a sense of dignity. Lack of dignity has

been associated with depression, anxiety, hopelessness, and often a desire to hasten death. Dignity therapy is a brief, individualized psychotherapeutic intervention designed to address the psychosocial and existential distress among terminally ill patients in an effort to reduce suffering in these patients as they near death. Patients are offered the opportunity to address issues that matter most to them or speak to things they would most want remembered. At the end of their therapy, they are presented with a transcript of the sessions that they may share with loved ones of their choosing. Dignity therapy deals with themes such as generativity, continuity of self, role preservation, maintenance of pride, hopefulness, aftermath concerns, and care tenor.

Death is a topic that, despite years of theoretical training, still causes discomfort amongst medical professionals. As psychiatrists, we are often unexposed, especially in our training years, to patients who are dealing with a prolonged dying process (in comparison to the acuity of suicide). This can often lead us to feeling inadequately prepared to handle this situation when it arises.

The focus of this workshop is to discuss end-of-life patients from the perspective of the resident physician, though all physicians at all levels will benefit. Presentations and discussions will be led by psychiatry residents and a board certified oncologist who worked specifically with end-of-life issues. The aim will be to help participants become comfortable with providing end-of-life care to patients by becoming familiar with a treatment option such as dignity therapy. This workshop would potentially be most beneficial to those psychiatrists who are considering or currently working on a Consult and Liaison service. Even further, it is the hope that participants evaluate the potential broad utilization of this therapeutic process in areas outside the realm of palliative and end-of-life care. Participants will be asked to utilize dignity therapy techniques during the workshop to develop a brief narrative on other participants in an attempt to become familiar and comfortable with these techniques.

NPS ARE FROM MARS, PHYSICIANS ARE FROM VENUS: MULTIDISCIPLINARY TRAINING AND COLLABORATIVE PRACTICE

Chair: Patrick S. Runnels, M.D.

Speakers: Rosa Ruggiero, N.P., Farah Munir, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explore key areas of training, practice and role confusion between psychiatric APNs and psychiatrists;2) Describe multiple models for shared training experiences between psychiatrists and psychiatric APNs – including public and community psychiatry fellowship training; 3) Discuss results and benefits of training psychiatric APNs and psychiatrists collaboratively in fellowship; 4) Understand how multidisciplinary, collaborative learning environments can prepare clinician leaders to more effectively meet the needs of patients; 5) Develop a foundation for discussing the future of collaborative working relationships between psychiatrists and psychiatric APNs.

SUMMARY:

Over the past 5 years, psychiatric nurse prescribers have grown to represent more than one third of the graduating psychiatric workforce each year. Yet, despite representing an increasing share of the workforce, studies suggest that physicians remain unclear and misinformed about relevant practice issues for advanced practice nurses, and have little sense of how collaborative care models can and should work. Developing shared training experiences could go a long way toward helping to address these issues, and potentially improve the overall delivery of mental health care, but a literature search prior to 2013 reveals absolutely no articles in the medical literature outlining any such programs. In this presentation, we will explore key aspects of APN training and practice across the country, then we will outline a novel approach to shared training: the inclusion of psychiatric advanced practice nurses in public and community psychiatry fellowship training programs. We will highlight the results over two years of this intervention, discuss the ramifications on the overall practice of psychiatry, and suggest multiple models for expanding future shared training experiences.

PHYSICIAN HEAL THYSELF: AN INTERACTIVE WORKSHOP ADDRESSING BARRIERS TO TRAINEES SEEKING MENTAL HEALTH TREATMENT

Chairs: Rachel Caravella, M.D., Marra Ackerman, M.D.

Speaker: Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of trainees seeking mental health or substance abuse treatment when appropriate; 2) Describe the existing barriers to trainees seeking mental health treatment; 3) Demonstrate the ability to discuss medical trainees' mental health with colleagues.

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 15-30% of residents (Tyssen, 2002; Center, 2003; Broquet, 2004; Goebert, 2009), and substance abuse or dependence is identified in 7-15% of housestaff (Center, 2003; Broquet, 2004). While the prevalence of suicide among resident physicians is not well-documented, aggregate suicide rates for both male and female physicians are higher than the general population.

Despite the high prevalence and significant negative consequences of mental illness and substance use disorders, as many as two-thirds of affected residents do not seek treatment (Tyssen, 2002). In this interactive workshop, we

will discuss - what we define as "the GAP" - the disparity between the high rates of mental health issues among trainees contrasting with low rates of treatment-seeking. We will engage the audience in a discussion of barriers hindering residents and medical students from addressing mental health issues. Afterwards, we will break into small groups for a vignette-based activity to practice discussing these issues with colleagues. At the conclusion of this workshop, we will facilitate a discussion of the practical challenges confronted by trainees seeking mental health treatment. We will also highlight models of care and resources available in some training programs which aim to address these common barriers and promote wellness.

1.Center C et al. (2003). Confronting depression and suicide in physicians: A consensus statement. JAMA, 289 (23): 3161-3166

2.Yarborough, WH. (1999). Substance use disorders in physician training programs. The Journal of the Oklahoma State Medical Association, 92 (10): 504 – 7 as cited in Broquet KE and Rockey PH. (2004). Teaching residents and program directors about physician impairment. Academic Psychiatry, 28: 221-225.

3.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.

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.

MEDIA TRAINING 101 FOR RESIDENTS AND EARLY CAREER PSYCHIATRISTS: A HANDS-ON, INTERACTIVE EXPERIENCE

Chairs: Uyen-Khanh Quang-Dang, M.D., M.S., Yvonne S. Yang, M.D., Ph.D.

Speakers: Steve Koh, M.B.A., M.D., M.P.H., James Tyll, Patricia Dickmann, M.D., Hassan M. Minhas, M.B.B.S., M.D., Arshya B. Vahabzadeh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Employ methods of engaging with live media via mock interviews with immediate video feedback; 2) Identify key media training concepts of developing a message and on-camera strategies such as bridging, blocking, and flagging techniques; 3) Recognize the common pitfalls psychiatrists make when engaging with the media; 4) Understand key concepts of successfully publishing in print and electronic media regarding mental health topics; 5) Feel more confident in one's ability to participate in psychoeducational media opportunities and subsequently reduce mental health stigma.

SUMMARY:

Media coverage of mental health issues, including psychiatric treatments, is often negatively biased, contributing to the stigma of mental health issues. Psychiatrists are uniquely positioned with the ability to educate the public by providing their expertise directly to the public if they choose to take advantage of media opportunities. As the future of the mental health field, residents and early career psychiatrists could elevate psychiatry's standing and reduce stigma by effectively engaging with the myriad print, electronic, and live media coverage opportunities that continue to be evermore increasingly widespread. However, most psychiatrists have never engaged in media training and feel uncomfortable participating in interviews or publishing an article in the local paper.

The APA Leadership Fellows (Patty Dickmann, M.D., Hassan Minhas, M.B.B.S., M.D., Uyen-Khanh Quang-Dang, M.D., M.S., Arshya Vahabzadeh, M.D., Yvonne Yang, M.D., Ph.D.) would like to help address this gap by providing an interactive media training workshop where audience members will come away with concrete, practical skills that they can employ immediately. The workshop will be organized in two main blocks. In the first block, James Tyll, Deputy Director of the APA Office of Communication and Public Affairs, will teach key media concepts of how to develop a message as well as on-camera strategies. Audience members will then break up into small groups and, with the guidance of Steve Koh, MD, MPH, MBA, practice developing a message around a specific mental health topic.

In the second block, audience members will get "on-camera" time during which they will be mock-interviewed in front of a camera about the aforementioned mental health topic. The videotape will be reviewed and immediate feedback on presentation and communication style will be provided to each audience member by the experienced facilitators. This workshop is meant to be highly interactive and it is expected that every resident/early career psychiatrist in attendance will actively participate in some aspect of the media training. Due to the interactive nature of this workshop, Due to the interactive nature of this workshop, active participation will be limited to 20 participants with others observing (first come, first serve).

PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS AND THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT: PRAGMATIC AND CONCEPTUAL ISSUES

Chairs: Hoyle Leigh, M.D., Jon Streltzer, M.D.

Speakers: Don Lipsitt, M.A., M.D., Seth Powsner, M.D., Beena Nair, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the implications of recent events such as the Newtown shootings and increase in prescription drug related fatalities to the need for psychiatry training in primary care; 2) Discuss the implications of the implementation of the Affordable Care Act for teaching psychiatry to primary care physicians; 3) Discuss the role of the integrative care model, and the knowledge and skills to teach in different venues such as the pain clinic, Ob & Gyn department, and the emergency room.

SUMMARY:
Recent events such as the Newtown shootings and an increase in prescription opiate related fatalities, which has now surpassed traffic fatalities in the United States (CDC, 2012), call for a heightened awareness of potential and latent psychiatric problems in the general population and an urgent need to train primary care physicians in how to recognize, diagnose, treat or refer patients with psychiatric and substance use problems. As more people benefit from the Affordable Care Act, there will be an increase in the number of patients seeking primary care. 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 and what is challenging in teaching psychiatry to primary care physicians. The moderator of this workshop (HL) will briefly describe the challenges we face, and the concept of integrative care(Unutzer, 2012) in bridging psychiatry and primary care. Dr. Streltzer will present his experiences and ideas in teaching primary care physicians about chronic pain. He will describe attempts to curb the prescription drug problem by state legislatures and initiatives to change the labeling indications for opioids approved by the FDA. This will be followed by Dr. Powsner's discussion of teaching emergency psychiatry, including suicidal and homicidal ideation and attempts. He will also demonstrate innovative multimedia teaching techniques in the emergency room setting. Dr. Lipsitt will discuss the perceived needs, barriers and practice of primary care physicians in caring for patients diagnosed with somatoform disorder and the pros and cons of referral. Dr. Nair will present her experience in teaching women's mental health, particularly psychopharmacology during pregnancy and breastfeeding to Ob & Gyn. 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(Leigh et al., 2006a, b).
References:
CDC, 2012. CDC Grand Rounds: Prescription Drug Overdoses - a U.S. Epidemic. CDC Grand Rounds, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a6103.htm.
Leigh, H., Stewart, D., Mallios, R., 2006a. Mental health and psychiatry training in primary care residency programs. Part I. Who teaches, where, when and how satisfied? Gen Hosp Psychiatry 28, 189-194.
Leigh, H., Stewart, D., Mallios, R., 2006b. Mental health and psychiatry training in primary care residency programs. Part II. What skills and diagnoses are taught, how adequate, and what affects training directors' satisfaction? Gen Hosp Psychiatry 28, 195-204.
Unutzer, J., 2012. IMPACT Model of Integrated Care.

PERSONAL EXPERIENCES OF PSYCHIATRISTS IN THE COMBAT ZONE

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Patcho N. Santiago, M.D., M.P.H., Alyssa Soumoff, M.D., Kenneth E. Richter Jr., D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the challenges for military psychiatrists who have gone to war; 2) Understand the ethical dilemmas around dual agency and confidentiality; 3) Recognize unique challenges for deploying mothers and fathers.

SUMMARY:
After 13 years of war, there are approximately 2.5 million veterans who have served overseas in wars in Iraq and Afghanistan. Side by side with the troops have been military psychiatrists. Many psychiatrists have deployed several times. This unique workshop will draw upon their personal experiences in Iraq, Afghanistan and elsewhere. Military doctors treat not just the American military, but also local nationals, and detainees. Basic principles of combat stress control will be demonstrated and updated. Complexities of balancing the needs of command and the troops will be highlighted, including ethical issues around dual agency and confidentiality. Finally some of the issues around treating detainees will be discussed.

COMORBIDITY IN SCHIZOPHRENIA: DIAGNOSTIC AND CLINICAL ISSUES

Chairs: Michael Hwang, M.D., Henry A. Nasrallah, M.D.

Speakers: Peter F. Buckley, M.D., Lewis A. Opler, Ph.D., Robert F. Krueger, Ph.D., Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be familiar with the current state of clinical and research issues of comorbidity in schizophrenia; 2) Recognize, assess and diagnose the common co-morbid psychiatric conditions in schizophrenia; 3) Describe and discuss the dimensional symptom assessment in schizophrenia and it's significance in DSM-V diagnostic criteria; 4) Discuss the clinical and research implications of co-morbid psychiatric conditions in schizophrenia.

SUMMARY:
Schizophrenia presents with diverse clinical phenomena with varied bio-psychosocial pathogeneses. While the nature and clinical significance of comorbidity in schizophrenic illness has been debated over the years, its significance and management remain unclear. Recent clinical and research evidence suggest greater prevalence rate and more than one or multiple pathogeneses. Increasing emphasis in recognition of symptom dimensions in DSM-V, as well as emerging evidence of biological nature of specific psychopathology has further intensified the diagnostic debate and research interests. Whether the comorbid disorder in

schizophrenia constitutes; (i) a distinct comorbid disorder, or (ii) represents a symptom dimension in a schizophrenic spectrum illness, currently available evidence supports recognition and treatment of comorbidity schizophrenia for optimal outcome.
The proposed workshop will review the recent research and clinical advances and discuss the diagnostic, clinical and research implications of selected comorbid disorders in schizophrenia. Dr. Buckley will review the current clinical and research evidence and discuss the diagnostic issues of comorbidity in schizophrenia. Dr. Opler will discuss the psychopathology in schizophrenia within the context of current clinical practice utilizing both the symptom dimension and diagnostic category. Dr. Krueger will present evidence for the dimensional views in psychiatric disorders and discuss clinical and research implications of comorbidity in schizophrenia. Finally, Dr. Nasrallah will discuss the current diagnostic issues and future research implications of comorbidity in schizophrenia.

ETHICAL VIEWS OF RESPONSIBILITY FOR ALCOHOL DEPENDENCE AND PERCEPTIONS OF NALTREXONE

Chair: Rebecca A. Johnson, M.A.

Speakers: Jonathan M. Lukens, Ph.D., Rebecca A. Johnson, M.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify which views of responsibility for substance dependence contribute to reluctance about medication use; 2) Understand directions for future research on the interplay between organization-level characteristics that affect medication utilization and individual-level characteristics; 3) Critically analyze the "double-edged" sword of holding clients responsible for substance dependence.

SUMMARY:
Views about personal responsibility for addiction may play a role in suppressing uptake of appropriate, evidence-based treatment for various forms of substance dependence. Naltrexone (Revia) is one such evidence-based treatment for alcohol dependence that is persistently under-prescribed relative to its safety and efficacy in reducing heavy drinking. In this workshop, we discuss the results of our vignette-based study of addiction counselors that investigates the relationship between a clinician's views of personal responsibility for addiction and his/her assessment of the evidence base for using naltrexone as part of treatment for alcohol dependence. In this workshop, we will 1) report and review findings related to the connection between clinicians' views about client responsibility and how clinicians feel about medications to help treat addiction; 2) outline important areas of future research aimed at increasing support for medication-assisted addiction treatment; and 3) analyze broader implications for research investigating how philosophical beliefs about the causes of addiction contribute to stigma.

PRACTICAL APPROACHES TO DECREASING COGNITIVE BIAS AND IMPROVING RECOGNITION OF MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS

Chair: Vincent F. Capaldi II, M.D., M.S.

Speakers: Vincent F. Capaldi II, M.D., M.S., Adam L. Hunzeker, M.D., Rohul Amin, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize clinical reasoning and heuristics used by individual participants in day-to-day clinical encounters; 2) Understand possible cognitive biases and errors that may prevent appropriate clinical diagnosis; 3) Identify ways to mitigate cognitive errors and biases; 4) Understand basic principles to suspect primary medical condition mimicking a psychiatric disorder; 5) Understand the basic diagnostic workup of medical conditions on the spectrum of inflammatory disorders, endocinropathies, autoimmune neurologic sequelae and central nervous system malignancies.

SUMMARY:
Introduction: Symptoms of psychiatric and medical illness may overlap and present a significant diagnostic challenge. Approaching these patients requires a carefully constructed diagnostic heuristic. Failure to identify the interplay and contributions of both general medical conditions and primary psychiatric disorders may complicate diagnosis and may result in adverse outcomes. The disjunctive diagnostic schema of psychiatry versus the conjunctive approach of medical diagnostic algorithms presents a challenge that requires an integrated diagnostic approach.
One identified diagnostic barrier to timely and accurate diagnosis are cognitive biases. Cognitive bias is a series of deviations in judgment that are introduced into the clinical scenario by inaccurate inferences. Failure in recognition of these cognitive biases can impede clinical decision making. Provider education has been shown to mitigate and decrease the influence of cognitive biases during the clinical decision making process. The aim of this workshop is to enhance provider familiarity with various cognitive biases and ultimately reduce diagnostic errors through a practical small group workshop.
Methods: The workshop will consist of two parts: didactic session utilizing PowerPoint, and small group exercises using illustrative medical cases mimicking psychiatric disorders. The goal will be to begin a narrative discussion with an educational strategy to teach recognition of cognitive bias, common diagnostic pitfalls, analysis, and cognitive bias avoidance strategies
Conclusion: Diagnostic errors are common and costly. Diagnostic clarity is not always possible in complex patients. The goal of providers should always be to minimize contributions of diagnostic ambiguity. There should be special focus on eliminating any source of cognitive bias on the part of the

physician. Through education and experience the contributions of cognitive bias can be mitigated enabling physicians to accurately diagnose and ultimately treat complicated patients.

INNOVATIVE APPROACHES TO TEACHING PROFESSIONALISM

Chairs: Kathleen A. Crapanzano, M.D., L. Lee Tynes, M.D., Ph.D.

Speakers: Ann Schwartz, M.D., Jacob Sperber, M.D., Susan Stagno, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the components of professionalism that must be taught to residents; 2) Be aware of the limitations of solely using didactics as a teaching approach for professionalism; 3) Be able to name at least 3 innovative ways to teach professionalism other than didactic lectures.; 4) Understand the benefits and limitations of various approaches to teaching professionalism.

SUMMARY:
Professionalism is fundamental to the identity of a physician in our society. The ACGME has wisely placed the teaching and evaluation of a resident's professionalism on par with a resident's medical knowledge and patient care abilities. However, when professionalism is solely approached with checklists of rules and behaviors or didactic lectures, a young physician is unlikely to develop a mature, internalized value system nor understand the complexities of the professional challenges they will face in practice. This workshop will discuss a definition of professionalism to include altruism, accountability, compassion, integrity, fidelity, and self-effacement. By demonstrating examples from training programs, innovative ways to teach these values will be explored, such as the use of simulated patients, self-reflection, facilitated oath development, and digital media . Strengths and limitations of these teaching methods as well as a "how to" approach will be discussed, allowing participants to utilize these methods in their own teaching encounters.

LEARNING TO IMPROVE: CREATING A MODEL FOR TEACHING SYSTEMS-BASED PRACTICE AND IMPROVEMENT SKILLS WITHIN A PSYCHIATRIC HEALTHCARE SETTING

Chair: Sunil Khushalani, M.D.

Speakers: Steven Sharfstein, M.D., M.P.A., Robert P. Roca, M.B.A., M.D., M.P.H., Antonio DePaolo, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the relevance of the competency of System-Based Practice and its need in the current psychiatric healthcare environment; 2) Describe three key characteristics of Learning and Highly Reliable Organizations and their applications to psychiatric healthcare; 3) Identify key components of a curriculum created to teach quality improvement skills developed for mental health professionals.

SUMMARY:
How can practitioners provide and learn great patient care, if they are working in a system that does not ensure the delivery of such exemplary care? The complexity of healthcare delivery has increased dramatically over the years making it essential for physicians to understand how complex systems affect the care of an individual patient. It is not uncommon for a patient to encounter a multitude of practitioners from various disciplines as they receive care in our current complex healthcare system. We are sometimes as good as our weakest link. If a fantastic physician functions as part of an interdisciplinary team that is providing substandard care, the likelihood of outstanding outcomes is reduced.
It is within this context that the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have identified systems-based practice as one of the six core competencies in which physicians must be proficient. A simple way to understand systems-based practice is for all of us to ask ourselves, "How can I improve the system of care in which I operate, so that we can provide the best care for my patients?" Even though this has been formulated as one of the six core competencies, most of us who practice get so busy in delivering care that we hardly pause to think how we can improve the system in which we provide it. Even if we think this competency is important, we do not have a specific improvement skill set that we can easily deploy in improving our systems of care. Making this a priority can simultaneously improve the care delivered to a large number of patients if one puts forth a concentrated effort to redesign care systems, with a relatively small investment of time and effort.
One of the goals in imparting such a competency within a large organization is to help it proactively learn from its own near-misses and errors over time, and gradually work towards becoming a High Reliability Organization. One way it would do so would be by systematically eliminating the vulnerabilities that make it possible for the system to be prone to such errors. Another model talks about a continuously improving the quality of a system. This is the model of a 'Learning Organization' which facilitates the growth and skill development of its members while continuously improving itself.
We have developed a curriculum to teach such improvement skills within the context of a busy healthcare system. It will allow healthcare professionals to learn some of these improvements skills while they work to improve the system in which they deliver care. As the participants solve safety and quality problems as part of the curriculum, their systems-based practice competency and self-efficacy will grow and along with which the system will continuously become better.

THE HEALING POTENTIAL OF LISTENING: A WORKSHOP FOR

THE MODERN PSYCHIATRIST

Chair: Michael S. Ascher, M.D.

Speakers: Salman Akhtar, M.D., J. Christopher Muran, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify ways that clinicians can strengthen the therapeutic alliance; ; 2) Discuss how mindfulness can provide the catalyst for better listening, more meaningful engagement and better therapeutic outcome; ; 3) Explore the complexity of listening and the need to develop more discourse on the topic; .

SUMMARY:
In today's time-pressed practice of psychiatry with its emphasis on the brief medication management visit, clinicians and patients often feel rushed and disconnected, which may result in a poor therapeutic alliance and even poorer clinical outcomes. Listening is an artful skill that requires decades of practice and can help enhance the clinical experience. Every psychiatrist can benefit from periodic personal reflections on the quality of the listening that they provide to patients. Dr. Ascher will discuss listening for and evoking "change talk" in patients who are ambivalent about making a change. Dr. Muran will discuss the various ways that a clinician can listen, reflect and respond to the patient while in the midst of a therapeutic rupture with a special focus on "mindfulness." Dr. Akhtar will discuss how clinicians can "listen" to their own internal voices in order to understand themselves and their patients better. This workshop will culminate in a group discussion that will hopefully be meaningful and helpful to attendees.

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL: HOW TO PARTICIPATE

Chairs: Arshya B. Vahabzadeh, M.D., Robert Freedman, M.D.

Speakers: Misty Richards, M.D., M.S., David C. Hsu, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the purpose of the Residents' Journal; ; 2) Identify ways to be involved in the Residents' Journal, such as authoring manuscripts, peer review and guest editing; ; 3) Identify the different manuscript types that 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 Journal has now grown into the largest resident-led journal in medicine. The Journal features 5 to 7 papers per month, and has regular contributors from over 50 psychiatric residencies nationwide. The 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 Journal and demonstrates ways in which one can be involved and further strengthen their academic writing, peer review and even editing skills.

FOOD INSECURITY AMONG INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES: SCREENING FOR AND ADDRESSING AN UNDER-RECOGNIZED PROBLEM IN YOUR PRACTICE

Chair: Michael T. Compton, M.D., M.P.H.

Speaker: Beth Broussard, C.H.E.S., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define food insecurity and give prevalence statistics for the United States; 2) State the prevalence of food insecurity among individuals with serious mental illnesses treated in community mental health settings; 3) Recognize the associations between food insecurity and clinical and functional outcomes among individuals with serious mental illnesses; 4) Proficiently screen for food insecurity among their patients with serious mental illnesses; 5) Discuss the implications of these findings for mental health professionals, researchers, and policymakers.

SUMMARY:
The term "food insecurity" refers to a family's or individual's not having enough financial resources to ensure adequate access to food. Food insecurity is associated with a multitude of adverse physical health, mental health, and social outcomes. While national and state-level statistics are available, very little is known about the prevalence of food insecurity among people with disabilities. Even less is known about food insecurity among individuals with serious mental illnesses. We conducted a study of 300 individuals with serious mental illnesses being treated in five community mental health agencies in the District of Columbia. The prevalence of food insecurity will be presented, along with comparisons to national and state-level statistics in the general population. Associations between food insecurity and a number of other variables also will be presented, including sociodemographic characteristics, food quality, body-mass index, symptom severity, substance use, quality of life, social support, community functioning, and recovery. Workshop participants will: (1) discuss their own ideas and experiences pertaining to food insecurity among persons with serious mental illnesses, (2) view segments from a documentary on food insecurity in the United States, (3) be given an overview of recent research on food insecurity and mental health, (4) be provided with brief, ready-to-use measures of food insecurity for clinical practice, and (5) discuss several cases involving persons with serious mental illnesses who have comorbid food insecurity. Implications for practicing mental health professionals, and tips for screening for and

addressing food insecurity, will be presented.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Chairs: Larry R. Faulkner, M.D., Barbara S. Schneidman, M.D., M.P.H.

Speakers: Kailie R. Shaw, M.D., Robert J. Ronis, M.D., M.P.H., George A. Keepers, M.D., Paramjit T. Joshi, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the ABPN's requirements for certification in psychiatry; 2) Describe the new format for certification in psychiatry and in child and adolescent psychiatry, including the clinical skills requirements for applicants; 3) Describe the ABPN's requirements for certification in the psychiatry subspecialties and in the multi-disciplinary subspecialties.

SUMMARY:
The purpose of this workshop is to present information on the ABPN's requirements for certification in psychiatry and in the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as in the multi-disciplinary subspecialties of clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine and in the new subspecialty of brain injury medicine. Training and licensure requirements will be outlined, and the requirements for the assessment of clinical skills during residency training (and post-residency if needed) in psychiatry and in child and adolescent psychiatry will be delineated. The on-line resident tracking and application systems and payment options will be described. 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 along with examination results. A substantial amount of time will be available for the panelists to repond to queries from the audience.

SELF-CARE MEDITATION APPROACHES USED ADJUNCTIVELY IN PTSD MANAGEMENT

Chairs: Marina A. Khusid, M.D., Matthew Fritts, M.P.H.

Speakers: Matthew Fritts, M.P.H., Marina A. Khusid, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of conceptual and practical definitions of mindfulness and its neural mechanisms in the context of PTSD care continuum. ; 2) Demonstrate knowledge of the current level of evidence for mindfulness meditation, mantram repetition, relaxation response training, and yoga use as self-management techniques in addition to standard ; 3) Demonstrate knowledge of how to design a self-management mindfulness strategy tailored to specific indications and goals of their PTSD patients, and resources available to support this. ; 4) Demonstrate knowledge of how to effectively describe, chart and bill for these specific mindfulness techniques, and how to refer patients for more extensive training in these techniques.

SUMMARY:
In recent years, the evidence base for meditation interventions for PTSD has been rapidly expanding, as reflected in the 2010 Veterans Administration/ Department of Defense Clinical Practice Guideline. Considering the high prevalence, and chronic, debilitating nature of PTSD among US Service members and Veterans, engaging patients in collaborative care and educating them on how to self-manage their chronic mental illness can to lead to increased levels of functioning, reduced pain, improved health outcomes, and decreased health care costs. Because mindfulness approaches are safe, portable, affordable, and easy to learn, with increasing evidence of effectiveness as adjunctive PTSD treatment, they may help optimize standard PTSD care and prevent comorbidities. We will focus on modalities with the most evidence for PTSD: mindfulness meditation, mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), mantram repetition, compassion meditation, and yoga. To help providers and policy makers to care for veterans, service members, and military families facing PTSD-related sequelae, this session reviews mindfulness from several aspects: how it is defined, its mechanism, key research findings, and the clinical applications of mindfulness for PTSD. In addition to a lecture section, a case study will be discussed and two practical skills taught: mindfulness meditation, and a brief yoga session. We will provide patient handout templates and a list of resources that could be easily adopted in clinical practice.

PSYCHOACTIVE MEDICATION USAGE IN ACTIVE DUTY SERVICE MEMBERS

Chair: Patcho N. Santiago, M.D., M.P.H.

Speakers: Daniel J. Lee, M.D., Carla W. Schnitzlein, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize military specific regulations pertaining to psychotropic medication; 2) Identify factors which influence decisions when and when not to treat with a medication; 3) Suggest certain medications that may be better than others given these constraints.; 4) Identify pharmacologic points of contention between treatment services, strategies for reducing polypharmacy; 5) Discuss management of delirium that results from the interplay of injury and polyphar-

macy, and strategies for effective coordination of care.

SUMMARY:
Part One: An Overview of Psychiatric Prescribing for Active Duty and Special Operations Service Members.
In caring for active duty service members, psychiatric providers have additional considerations regarding the use of psychotropic medication that are not present in civilian psychiatry. Certain medications render the service member unable to deploy, while others require waivers to deploy. Rarely, certain branches will even administratively separate service members requiring certain classes of medication for extended periods. In the deployed environment, psychiatric follow up can be intermittent due to operational necessity and the use of psychotropic medication and choice treatment agent need always be weighed against the risks of potential withdrawal from the medication, going without the medication for weeks at a time, and the effect of the medication on alertness and reaction speed. Speed of therapeutic response to a medication also has bearing on this decision as is the speed in which a provider can increase a medication to minimum therapeutic dosing. The purpose of this session is to familiarize the attendants with military specific regulations pertaining to psychotropic medication, as well as factors which influence decisions when and when not to treat with a medication and suggest certain medications that may be better than others given these constraints.
Part Two: Psychopharmacology in Wounded Warriors
Following injury on the battlefield, service members are rapidly evacuated to major military treatment facilities following acute stabilization. Care and rehabilitation of these service members is complex, requiring orthopedic surgery, neurosurgery, plastic surgery, urology, neurology, psychiatry, physical medicine and rehabilitation, and/or pain medicine to coordinate care. It is not uncommon for a single service member to require care for traumatic amputation of limbs, urethral/penile injury, facial injuries, burns, traumatic brain injury, acute stress disorder, depression, and severe pain. Pharmacologic regimens often become equally complex with significant polypharmacy and disagreements between the respective services regarding treatment. Use of SSRIs, SNRIs, tricyclic anti-depressants, sleep aids, prazosin, opiates, benzodiazepines, neuroleptics, anti-seizure medications, and anesthetic agents are often particular points of contention between services. The purpose of this session is aimed educating attendants on pharmacologic points of contention between treatment services, strategies for reducing polypharmacy, management of delirium that results from the interplay of injury and polypharmacy, and strategies for effective coordination of care.

ISAAC BONSALL AND THE QUAKER CONNECTION IN EARLY AMERICAN PSYCHIATRY

Chair: David Roby, M.D.

Speaker: David Roby, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review events surrounding the creation of Friends Hospital in 1817; 2) Discuss Isaac Bonsall's early Quaker experience and his role as superintendent of Friends Hospital from 1817-1823; 3) Summarize Bonsall's insight to patients, treatments, and outcomes as well as the unique qualities of Friends Hospital as a reflection of early moral treatment.

SUMMARY:
As early as 1669, George Fox, the founder of the Quaker faith advocated kind treatment towards those with mental illness. This principle was embodied in the York Retreat, opened in 1796, and Friends Hospital opened in 1817. Isaac and Mary Bonsall served as co-superintendents from 1817-1823. Isaac kept a daily diary which describes the unique ambiance of Friends Hospital, as well numerous anecdotes about the patients, their progress, and visitors to the hospital. This beautifully written diary describes in a poignant and powerful way the distinctive quality of moral therapy which would serve as a dominant force in early American psychiatry.

VIOLENCE AND THE AMERICAN SOLDIER

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

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Marvin Oleshansky, M.D., Christopher H. Warner, M.D., David E. Johnson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) What is known and known about the relationship between violence and the Soldier; 2) Understand patterns of domestic violence; 3) describe factors which contribute to suicide and suicide-homicides.

SUMMARY:
The murders and murder/suicides at ft bragg in 2002 highlighted the perils of rapid return from the battlefields in afghanistan to civilian life. investigations showed continuing problems with access to care, as well as the reluctance of career minded soldiers to seek treatment. While the rising suicide rate has been a major concern for all in the army, episodes of violence, to include homicide, in general have not been as well studied. However epidemiological consultation teams were down on the homicides at ft. bragg in 2003 and ft carson in 2009. This lecture will outline some of the trends in both self-directed and externally directed violence, to include homicide and suicide-homicide. Domestic violence and the murder of a spouse/partner share many of the dynamics seen in suicide. The combination of unit and individual risk factors include: exposure to combat, the high operations tempo, feelings of disconnectedness on return home, problems at work or home, pain and disability,

alcohol, and easy access to weapons. The use of mefloquine (lariam) has also been associated with suicide and violence. The prolonged effects of exposure to violence and death are not easy to change but there are strategies for mitigation. Both psychiatrists and psychiatric patients were shooters and victims in 2009. Mental health and medical clinics need to ensure that they are prepared to react and protect their personnel in the event of an active shooter. Basic strategies to survive those events will be outlined. Finally, the possible contribution of mefloquine (lariam) will be discussed.

CHILDREN OF PSYCHIATRISTS

Chairs: Michelle Riba, M.D., M.S., Leah J. Dickstein, M.A., M.D.

Speakers: Kate Drury, Andrew Bearnot, B.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize and understand how as psychiatrist-parents, our children think and feel about us as psychiatrist-parents; 2) Discuss coping strategies when confronted with clinical/pesonal issues regarding having a parent as a psychiatrist; 3) Review impact of having a psychiatrist parent in determining academic/career choice.

SUMMARY:
This annual workshop which enables children of psychaitrists to share personal anecdotes with an audience of psychiatrist-parents and parents-to-be, has been offered to standing room audiences annually. While stigma toward psychiatry in general has diminshed, psychiatrists, because of training and professional work, in addition to their professinal life, bear emotinoal fears and concerns of how they will and do function as parents. The presenters will speak about their personal experiences and also offer advice to attendees. There will be a brief introduction by Dr. Riba to set the tone for the audience, and she and Dr. dickstein will lead the discussion.

REACHING ACROSS THE AISLE: THE IMPERATIVE, EXPERIENCE, AND CHALLENGES OF WORKING WITH A SYSTEMS ENGINEER TO IMPROVE A PSYCHIATRIC SYSTEM OF CARE

Chair: Sunil Khushalani, M.D.

Speakers: Steven Sharfstein, M.D., M.P.A., Robert P. Roca, M.B.A., M.D., M.P.H., Antonio DePaolo, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the challenges facing the current and future psychiatric system and why collaborating with the field of engineering is crucial; 2) Describe the needs of our system of care and learn how a systems engineer can help improve a psychiatric healthcare system; 3) Identify key aspects of collaboration, see early results, and appreciate challenges of such a meeting of the minds and cultures .

SUMMARY:
Universally, there is a pressing need to for the psychiatric healthcare system to demonstrate continuous improvements in effectiveness, efficiency, safety and quality. The demand for psychiatric services seems to be massive, whereas the resources available seem to always be insufficient. At an individual level, the growing body of knowledge that any practitioner has to contend with seems insurmountable. Nationally, our care system has evolved in a way that we have become better at dealing with crises and individual episodes of care. On the other hand, we are far from creating a comprehensive preventive and primary care system. Our system is unable to effectively and reliably take care of patients with chronic conditions. The general health of our chronically mentally ill continues to remain poor and a majority of them are still dying a couple of decades earlier than their non-mentally ill peers. From all corners of the country, we hear of many examples of inconsistent application of the best available evidence. We also see examples of significant waste of resources, due to poor quality, fragmented care and limited access. All this leads to a lack of patient-centered care, safety and quality concerns and increasing costs. Our current psychiatric healthcare system is complex. It offers many urgent opportunities for improvement. We need to make our system more patient-centered. Additionally, there is a need to accelerate development, dissemination and consistent implementation of available evidence. There is also a need to work optimally in teams, rather than as individuals and a need to deal mindfully with many competing priorities (a full-fledged implementation of an electronic medical record quickly brings this to light). Furthermore, our medical and psychiatric training doesn't adequately prepare us in systems-based thinking or the science of process improvement.
To address many of these shortcomings, reform efforts have to look beyond financing as a way to facilitate significant changes in the culture, practice, and delivery of psychiatric healthcare. The Institute of Medicine's (IOM's) Roundtable on Value & Science-Driven Health Care foresees that such a desired system will be the product of collaboration across major healthcare stakeholders, and could draw significant benefits from the field of engineering.
Locally, in our own psychiatric healthcare system, we have begun collaborative work with a systems engineer to help us redesign our system. We would like to share the reasons for this move, our process and the early results of our efforts. We would also like to share the challenges from the perspective of a systems engineer from manufacturing, as we experience each other's language and culture.

SURVIVING SANDY: A PERSPECTIVE OF HURRICANE SANDY FROM THE VIEWPOINT OF PSYCHIATRY RESIDENTS AT METROPOLITAN HOSPITAL CENTER, NEW YORK CITY

Chairs: Joshua R. Ackerman, M.A., M.D., Cliff S. Hamilton, M.D.

Speaker: Peter Kakatsos, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the general impact of Hurricane Sandy on Metropolitan Hospital Center (ability to provide care, facilities, personnel); 2) Describe the acute requirements of psychiatric chief residents as a result of the storm in terms of staffing, safety, and service; 3) Discuss the unique circumstances caused by the closures of NYU/Bellevue Hospitals and the impact this had on Psychiatric residents at Metropolitan Hospital (patient volume, new staff); 4) Analyze what was learned and how this experience impacted the psychiatric residents.

SUMMARY:
As a result of Hurricane Sandy in Oct 2012, the NYC healthcare system was stretched to its limits. As major hospitals (NYU/Bellevue) suffered catastrophic facility failures, Metropolitan Hospital in Spanish Harlem remained open during the storm. In the days, weeks, and months following the hurricane, Metropolitan Hospital provided ongoing care for the displaced psychiatric patients as well as physician/support staff. This required a massive coordination between HHC hospitals, administration, and individual staff members. Specifically, our workshop will focus upon the challenges faced by the residents of the Department of Psychiatry at Metropolitan Hospital Center. Every aspect of the mental services provided by this group was effected; outpatient, inpatient, and psychiatric ER. The immediate increase in volume of patients in need of care seemed to be an unsurmountable task. Add to this the absorption of psychiatrists, psychiatric residents, and support staff from the closed hospitals and the full spectrum of the challenge can be appreciated. Also included during the workshop will be photographic documentation recorded by residents at Metropolitan Hospital illustrating the storm as well as it's aftermath. Participating in this workshop will be the Director of The Department of Psychiatry, the Director of the Psychiatry Residency Program, and the 4 Chief Residents on duty during the storm. They will provide a detailed description as well as a focused discussion of the unique requirements faced by the psychiatry residents.

PSYCHIATRIST EXPERIENCE WITH THE RA1SE CONNECTION PROGRAM: CLINICAL CHALLENGES AND REWARDS IN WORKING WITH YOUNG PEOPLE WITH NEW ONSET PSYCHOSIS

Chair: Ann Hackman, M.D.

Speakers: Ilana Nossel, M.D., Lisa B. Dixon, M.D., M.P.H., Ann Hackman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe key aspects of the RA1SE connection program; 2) Identify challenges unique to working with young people with new onset psychosis (including challenges around engagement, education, substance use and psychopharmacology); 3) Recognize approaches to addressing family concerns and optimizing family involvement in treatment ; 4) Demonstrate understanding of recovery oriented strategies useful in working with young people with new onset psychosis and their families.

SUMMARY:
Serving as a psychiatrist who is part of a team treating young people with new onset psychoses is, in some ways, unique from other psychiatric work. In this workshop we will discuss the challenges and rewards for psychiatric providers in the RA1SE (Recovery After Initial Schizophrenia Episode) Connection program. The RA1SE Connection Program is an NIMH funded initiative evaluating an innovative, multi-element, multi-disciplinary two-year intervention designed to reduce disability among young adults with new onset psychoses. Clients served by the teams were ages 15-35 and within two years of the onset of psychotic illness. The intervention was delivered at two urban sites, one in Baltimore, Maryland and the other in Manhattan, New York. The two psychiatrists had academic affiliations and were an early career psychiatrist with some research background and a community psychiatrist with twenty years of clinical experience working with people with serious mental illness. Challenges for psychiatrists in working with the RA1SE population included the following: involving families and dealing with the trauma which often accompanies an initial psychiatric hospitalization, simultaneously providing education and nurturing hope, engaging young individuals who were sometimes extremely ambivalent about treatment, effectively utilizing shared decision making to develop optimal psychopharmacological interventions, addressing co-occuring substance use (including use of novel and emerging substances), dealing with high risk of suicide, finding appropriate places for referral at the completion of RA1SE treatment. Rewards for psychiatric providers included establishment of effective treatment collaborations with clients and families, and work with clients who engaged in treatment, and had symptom improvement as well as life successes such as high school and colleges graduations, new jobs. Psychiatrists also enhanced their recovery based treatment skills We will describe our work and will invite our audience to share their stories, strategies and experiences in working with young adults with new onset psychosis

THREE SHADES OF GREY: COMMON CHALLENGES FACED BY BEGINNING RESIDENT PSYCHOTHERAPISTS

Chairs: Joan Anzia, M.D., Priyanthy Weerasekera, M.D., M.Ed.

Speakers: John Manring, M.D., Kara Brown, M.D., Jackie Landess, J.D., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe several of the common challenges and potential pitfalls that residents face when beginning their psychotherapy training; 2) Engage patients in exploring at least three different difficult situations in the early stages of therapy; 3) Make maximal use of psychotherapy supervision to address early therapy challenges.

SUMMARY:

Resident psychotherapists enter their outpatient clinical training with a modicum of information from textbooks, didactics and supervision, but the core learning occurs as the resident attempts to apply this information with real-life patients. Residents often find themselves in clinical therapy situations in which they feel unprepared. The earliest period in psychotherapy is critical to building a therapeutic alliance; residents may feel confused about how to use - or alter -the frame of therapy to support complex, challenging patients, and often encounter pitfalls in the process of trying to establish rapport.

This workshop will examine common scenarios that prove challenging to the beginning resident-psychotherapist. Examples include lack of engagement (The Absent or Late Patient), invitations for self-disclosure (The Intrusive Patient), erotic transference (The Seductive Patient) or early empathic breaks. Cases will be presented by both residents and experienced senior clinicians using video patient vignettes. Each case will contain questions at various points of the vignette regarding transference/counter-transference and specific methods/techniques for management of these difficult situations, with encouragement of active participation and discussion by attendees. Workshop participants will leave with increased knowledge and comfort in identifying common pitfalls in psychotherapy but also with real-time demonstration of skills and techniques used to engage and manage these challenging patients.

PHYSICIAN HEALTH AND THE PHYSICIAN AS PATIENT

Chair: Glen O. Gabbard, M.D.

Speakers: Holly Crisp-Han, M.D., Gabrielle Hobday, M.D., Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify aspects of the psychology of the physician and stressors at developmental phases in the physician's career and life cycle; 2) Recognize and treat symptoms of burnout and psychiatric illness in physician patients; 3) Identify and address challenges facing psychiatrists and psychotherapists when treating physicians as patients.

SUMMARY:

As physicians, none of us like to be patients. However, we face the challenge of providing psychiatric treatment and psychotherapy to other physicians as our patients. In this workshop, we will explore physician health issues as they are shaped by the slings and arrows of adult development. The psychological dimensions of physicians-- perfectionism, overwork, self-doubt, burnout, exaggerated sense of responsibility, difficulties with intimate relationships-will all be discussed, as they appear across the life cycle. The stress of decreased time, electronic records, increased regulatory scrutiny will also be examined. The particular struggles of female physicians will be discussed as well. Balancing work and personal lives is a task that challenges all physicians but often presents a greater conflict for female doctors.

As psychiatrists, we are asked to evaluate and treat other physicians at a variety of points in the life cycle. Psychotherapy and prescribing are often a major struggle when the patient is a physician. Problems scheduling, competing with the therapist, questioning the treatment, and acting like a peer rather than a patient are all common problems. Moreover, the axiom that doctors often get the worst treatment may also apply. Common transferences and countertransferences will be illustrated as well.

CURRENT CONCEPTS REVIEW: THE GROWING EVIDENCE-BASE FOR THE USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE FOR TREATING POSTTRAUMATIC STRESS DISORDER

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Brian Engdahl, Ph.D.

Speakers: Anita H. Hickey, M.D., Maryam Navaie, Dr.P.H., Salahadin Abdi, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the evolving evidence-base for multiple complementary and alternative medicine (CAM) modalities for the treatment and management of post-traumatic stress disorder (PTSD); 2) Recognize PTSD patient characteristics that may be well-suited for referral to CAM treatment modalities; 3) Discuss how to build effective interdisciplinary collaborative partnerships across psychiatry and other medical disciplines ; 4) Discuss how to advance optimal health care delivery and management of PTSD among military, veteran and civilian patient populations.

SUMMARY:

One of the consequences of >12 years of war is the high incidence of post-traumatic stress disorder (PTSD). An estimated 10-20% of active duty service members and 35-40% of veterans suffer from PTSD. Evidence-based treatments have a <30% overall success rate, leading clinicians to explore the potential benefits of complementary and alternative medicine (CAM) to better manage PTSD. In this workshop, a comparative review of the evidence-base for leading CAM modalities for PTSD will be presented synthesizing treatment effects across empirical studies, discussing their strengths and shortcomings, and examining implications for research, practice and policy. The most commonly used CAM therapies for PTSD include virtual reality exposure therapy (VRET), acupuncture,

animal-assisted therapy, and mindfulness-based cognitive therapy and meditation. Another emerging treatment is stellate ganglion block (SGB), a common treatment for upper extremity pain. Among these modalities, VRET has the best documented efficacy, most notably among veterans with PTSD, with significant improvements observed in avoidance and hyperarousal symptom clusters. Acupuncture techniques have also shown promise for reducing trauma spectrum response including headaches, hypervigilence, sleep disturbances, depression, and chronic pain. Service dog and equine-assisted therapy, interventions aimed at facilitating social and functional improvements, have been shown to increase patience, impulse 3 control, and emotional regulation; improve positive affect, responses to stress, and sleep; and
lower depressive symptoms, hypervigilence and pain medication use. The collective evidence specific to mindfulness-based cognitive therapies and meditation has demonstrated significant improvements in patient compliance with treatment, PTSD severity, and mental health-related quality of life. Another hopeful treatment is SGB which has been shown in 25 published case reports to yield rapid symptom relief by producing what appears to be "a calming effect" in PTSD patients across multiple populations including US Army and Navy service members,
veterans, and civilians. Sustained effects have ranged from months to years following typically 2 SGB injections. Although the current CAM evidence-base for PTSD precludes the ability to draw definitive conclusions to inform practice and policy, the promising results point to a timely opportunity to consider a much needed paradigm shift in PTSD treatment.

EMPLOYING MIND-BODY MEDICINE MODALITIES IN THE MILITARY HEALTH SYSTEM

Chairs: Jeffrey Millegan, M.D., M.P.H., Paul Sargent, M.D.

Speakers: Paul Sargent, M.D., Jeffrey Millegan, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand mind body medicine as a treatment model; 2) Demonstrate knowledge of a developing system to efficiently deliver mind body medicine modalities within a major medical center; 3) Be familiar with the current experience using acupuncture on special operational forces.

SUMMARY:
With many of our veterans facing multiple, chronic medical and psychological conditions that require multifaceted treatments involving numerous providers, often conflicting pharmaceutical therapies and invasive, risky procedures, interest has grown in more holistic approaches to health care that promote self-empowerment, wellness and resilience. Growing evidence in the medical literature supports the use of multiple mind body medicine modalities including meditation and acupuncture as a complement in the treatment of multiple conditions in mental health. LCDR Jeffrey Millegan, M.D., M.P.H., reports on the development of an integrative mind body medicine program being implemented at a major navy medical center. LCDR Paul Sargent, M.D., reports on the use of acupuncture and other integrative medicine modalities in the treatment of special operations forces.

YOU CAN'T GO HOME AGAIN: ISSUES IN LONG TERM CARE OF GERIATRIC ASIAN AMERICANS

Chairs: Kimberly Yang, M.D., Russell F. Lim, M.D., M.Ed.

Speakers: Kenneth Sakauye, M.D., Ipsit Vahia, M.B.B.S., M.D., Helen H. Kyomen, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know how to develop a cultural formulation in order to facilitate clinical care and build rapport with geriatric Asian American patients and their caregivers; 2) Understand the role of gender effects on depression and suicidality in geriatric Asian women, discuss risk/protective factors, and points for intervention; 3) Understand cultural issues that elderly Asians in nursing homes face, and work toward developing more culturally competent care; 4) Utilize non-pharmacologic interventions in psychiatric treatment of elderly Asian patients.

SUMMARY:
The goal of this workshop is to deepen understanding of the unique barriers to diagnosis and treatment of mental disorders in elderly Asian patients, to discuss culturally competent care, and to share strategies to facilitate treatment in this group. Asian Americans comprise nearly 6% of the total population, and recently surpassed Latino Americans as the fastest growing minority group. Although Asian populations tend to concentrate on the coasts and major metropolitan areas, increasing numbers live in smaller cities, making it important for all clinicians to be culturally competent.

The literature suggests that Asians of all ages underutilize mental health services. Misdiagnosis and missed diagnoses make this group particularly difficult to engage. Language barriers are particular problems with elderly Asians. Problems seem to differ by generation level due to varying degrees of acculturation and enculturation. Gender and family issues, and the stigma of mental illness, all play a role in development of mental disorders. The clinician should be mindful of these in developing a cultural formulation. Model programs and teaching references will be discussed.

HEALTH AND WELLNESS: A HOLISTIC APPROACH TO TREATMENT OF PATIENTS WITH SERIOUS MENTAL ILLNESS

Chair: Aniyizhai Annamalai, M.D.

Speakers: Aniyizhai Annamalai, M.D., Jeanne Steiner, D.O., Michael Sernyak, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the high medical co-morbidity in seriously mentally ill patients and review strategies to improve their health; 2) Describe models of integrated care and steps in program implementation; 3) Identify wellness services appropriate for mentally ill patients; 4) Identify benefits of academic-community partnership in improving health of mentally ill patients.

SUMMARY:
Integrated health care is the new gold standard for individuals with chronic medical and psychiatric illnesses and this has become a focus of multiple policy initiatives. Models where primary care services are incorporated in mental health settings are rapidly gaining momentum beyond large integrated settings such as Veterans Health Administration. It is well known that patients with serious mental illness have high rates of cardiovascular risk factors; eliminating geographic and organizational barriers is expected to reduce mortality in these patients.
Core features of an integrated program are care management and wellness services. Care management improves coordination of care and access to services. Promoting a wellness lifestyle that includes adopting healthy habits such as a balanced diet and adequate physical activity is important for illness prevention. In addition, it is important to ensure a healthy living environment and improve social connectedness as social factors impact health outcomes in patients. Peer wellness coaches can be critical in providing education and support.
Our integrated program is funded by the Primary and Behavioral Health Care Integration (PBHCI) grant administered by Substance Abuse and Mental Health Services Administration (SAMHSA). We are a unique partnership between an academic department, a community mental health agency and Federally Qualified Health Center (FQHC).
Recognizing that health is not simply medical management of chronic illness we have developed a range of wellness programs that are not limited to core preventive services such as smoking cessation and nutrition support. We have partnered with community agencies to provide wellness services; examples include building a fitness center, providing bicycling support, animal therapy, a farmers market, promoting healing through a community garden.
In this workshop we will present our practical experiences building an integrated program and developing wellness services so our seriously mentally ill patients not only receive high quality medical care but also have a healthy and satisfying lifestyle. We will discuss the benefits of the academic-community collaboration in promoting wellness programs. The workshop will be very interactive with time for participants to share their own experiences as well as small group discussions to brainstorm innovative ideas.

THE HISTORY OF NEW YORK CITY'S CENTRAL PARK AND ITS STATUAY

Chair: Meredith M. Wortzel, M.A.

Speaker: Meredith M. Wortzel, M.A.

Educational Objective:
At the conclusion of the session, the participant should be able to: 1) Know the history of New York City's Central Park and its designers, Frederick Law Olmstead and Calvert Vaux; 2) Know the transformations that occurred in sculpture in the nineteenth century and the role that statuary played within the landscape of Central Park; 3) Know a select number of statues located throughout the park and its boundaries, and recognize the diversity of sculptural styles seen in the landscape.

Summary:
This workshop will explore the history of New York City's central park, the guidelines for the inclusion of statuary into its landscape and evaluate a select number of sculptures that are located throughout the park and its boundaries, which range greatly in subject matter.
The creation of central park in New York City was a momentous achievement for the United States. it acted as proof that Americans were cultured and could design public spaces even better than their European counterparts. The designers of central park, Frederick law Olmstead (1822-1903) and Calvert Vaux (1824-1895), viewed the inclusion of sculpture in central park as a conflicting element with their design for a beautiful landscape. They believed any addition to their 1858 greensward plan that was not natural was excessive and unnecessary. With the new transformations in American sculpture and sentiment, however, Americans wanted to create commemorative and dramatic monuments to fill this grand public space.
A committee was created in 1860 in order to evaluate and set guidelines for the inclusion of works into the park. It was not until 1873 though, that criteria were truly established that determined the suitability of statuary and monuments in relation to the design of the landscape.
Discussing all sixty-six sculptures within the park and its boundaries, would not be feasible in such a short time, so about a dozen have been selected to demonstrate the diversity of work throughout the park. They vary from commemorative monuments, *animalier*, statuary aimed to please children, dramatic subject matter, and fountains, which are made from diverse materials such as bronze, granite, and marble.

MAY 04, 2014

TELEPSYCHIATRY: UPDATES AND OPPORTUNITIES FOR PSYCHIATRISTS AND ACOS

Chair: Daniel J. Balog, M.D.

Speakers: Janice A. Brannon, M.A., Monica Lovasz, M.D., Ricardo Mendoza, M.D., Robert Kolodner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify key telemedicine concepts and how organizations and individual/small group practices are employing these to meet patient needs, reach new patients and improve clinical and business processes; 2) List essential administrative considerations and relevant resources essential to begin telepsychiatry services in a small or large organization; 3) Understand essential clinical considerations for practice of telepsychiatry.

SUMMARY:
The provision of psychiatric treatment via live videoconferencing has markedly increased as Health Information Technologies improve and as patients migrate to communication forums that meet their mobile needs. Psychiatrists and medical treatment organizations are responding to these opportunities are using telepsychiatry to reach geographically dispersed patients, provide new treatment options and increase their bottom line. This workshop presents the current status of telepsychiatry in US, updates attendees on administrative considerations, introduces clinical considerations and presents examples of how individual/small group psychiatrists, and larger organizations, are expanding their clinical offerings via telepsychiatry.

TRAINING THE 21ST CENTURY PSYCHIATRIST

Chair: Art Walaszek, M.D.

Speakers: Melissa Arbuckle, M.D., Ph.D., Sheldon Benjamin, M.D., Roberto Lewis-Fernandez, M.D., Claudia L. Reardon, M.D., Donna Sudak, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe methods of preparing psychiatrists to care for the U.S. population of the 21st century, namely one that is increasingly diverse and is aging; 2) Describe techniques to ensure that newly trained psychiatrists are able to provide care, including psychotherapy, that is evidence-based and informed by advances in neuroscience; 3) Describe curricula that prepare psychiatrists for changes in the delivery of health care, including quality improvement & patient safety initiatives, and integrated primary care & behavioral health.

SUMMARY:
The psychiatrist of the 21st century will face a number of changes: a population that is both increasingly diverse and aging; a health care system that will be focused on quality, safety and patient-centered care; and an evolving understanding of the nature of mental illness and of the evidence for various therapies. In this workshop, we present models for ensuring that we are training psychiatrists to be ready for these changes. The pace of discovery in the neurosciences is staggering. Psychiatrists are challenged with both keeping up with these changes and with determining how to apply them to clinical practice. We will present models for incorporating neuroscience into residency curricula and stimulating future psychiatrists' interest in learning neuroscience and neuropsychiatry. There is an increasing need in psychiatry training and practice for effectiveness in multicultural settings, which are increasing due to migration and globalization. We will describe various training models and strategies in cultural psychiatry for residents, including diverse combinations of didactic and experiential methods. Emphasis will be placed on a training approach based on the DSM-5 Cultural Formulation Interview, a questionnaire that provides a standardized, patient-centered template for a cultural assessment during a mental health evaluation. Psychiatrists will need to meet the Triple Aim of improving patient care, improving the health of populations, and reducing health care costs. Directives from multiple sources will require psychiatrists to be engaged in efforts to improve the quality and safety of patient care. We will describe models of teaching residents how to conduct and participate in such efforts. Psychotherapy is an integral part of psychiatric practice, and psychiatrists are uniquely positioned to provide a combination of somatic and psychotherapeutic care. But a gap exists between the strong evidence base supporting the efficacy of psychotherapy and clinical practice. We will describe models of ensuring that residents are learning evidence-based psychotherapy. Integrating behavioral health care into primary care represents an area of potentially explosive growth in psychiatric practice. Future psychiatrists will increasingly need to be comfortable working with primary care providers within settings such as medical homes. Thus, we will present models of training residents in primary care consultation, integrated care, collaborative care and telemedicine. We are facing the "silver tsunami" but are training fewer physicians able to care for older adults. Given the growing gap between supply of and demand for geriatric psychiatrists, we will present models of incorporating geriatric training into residencies. Advantages and shortcomings of these approaches will be discussed, including logistical questions such as how to take make use of limited time in residency and challenges posed by increasing regulatory and financial pressures.

ETHICAL AND LEGAL ISSUES IN GERIATRIC PSYCHIATRY: A REVIEW

Chair: Rajesh R. Tampi, M.D.

Speaker: Deena Williamson, M.S.N., R.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define the four ethical principles; 2) Describe the decisional capacity in older adults with psychiatric illness; 3) Discuss surrogate decision making in older adults with psychiatric illness; 4) Enumerate end of life care in older adults with psychiatric illness; 5) Highlight legal issues in the care of older adults with psychiatric illness .

SUMMARY:
As the population of the United States ages, the number of older adults with psychiatric illness is bound to grow. Ethical issues and conflicts are often seen in the care of these older individuals. Major ethical issues include the maintenance of autonomy while ensuring the safety of the individual and those others around them. Family dynamics further complicate the care needs of these individuals. In this workshop we will discuss two cases that highlight common ethical issues seen in the care of older adults with psychiatric illness. We will also review various ethical issues seen during the care of these individuals. We will conclude the workshop with an overview of important legal aspects of caring for older adults with psychiatric illness.

AT THE CUSP OF THE FUTURE: MEMBER-IN-TRAINING AND EARLY CAREER PSYCHIATRIST PERSPECTIVES ON THE TRANSFORMATIONS IN PSYCHIATRY

Chairs: Sharat Parameswaran, M.D., Matthew D. Erlich, M.D.

Speakers: Sharat Parameswaran, M.D., Matthew D. Erlich, M.D., Andres Barkil-Oteo, M.D., M.Sc., Barney Vaughan, M.D., Michael J. Yao, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the impact of the structural and economic transformations in behavioral health care and the implications to the future of service delivery; 2) Identify novel approaches being used for the delivery of substance abuse treatment services, particularly relating to technology; 3) Address the growing importance of team-based models of care and the integration of consumer/peer specialists in clinical care; 4) Understand how to change research priorities in order to reduce physical health disparities for people with mental illness, improve recovery, and disseminate evidence-based treatments; 5) Determine 21st century psychiatry residency training needs to train future psychiatrists in the Collaborative Care Model.

SUMMARY:
The rapid transformation of psychiatry comprises a "fourth psychiatric revolution" that is reshaping the field, in the areas of service delivery, policy, research, and education. While many experts opine about the potential impacts this may have, the views of the newest psychiatrists entering the field amidst these changes is not a central focus.
New psychiatrists find the ground moving beneath them, with health care reform policies such as increased accountability and quality standards being shaped through economic drivers such as managed care, accountable care organizations, and financial incentives such as pay-for-performance. The rapid pace of reform, and its commensurate technology, challenges new psychiatrists to not only keep up with such changes, but also impacts relationships with our consumers, with professional and para-professional peers, and with society itself.
Furthermore, although our profession has become skilled at managing the symptoms of mental illness, consumers continue to struggle to achieve their recovery goals and continue to die of undertreated physical health co-morbidities. There is also a growing shift of treatment responsibility to non-physician providers, including consumers, which new psychiatrists will need to negotiate. We continue to face an "evidence gap" of the dissemination and implementation of evidence-based treatments into community-based care. Unfortunately, despite these ongoing changes, we continue to train new psychiatrists in a model of care that is no longer viable.
The promises of the future, however, have never been brighter. Health care reform offers new opportunities to improve the care of people with mental illnesses at a population level, including improving coordination of care and communication across silos, and opening avenues for research into integrated models of care. Advances in technology not only help accomplish this goal, but offer revolutionary new modalities of treatment. Using peer providers helps to address consumer recovery goals, highlighting the critical need for consumer engagement. Indeed, increased clinical stakeholder input in the research process can provide unique and powerful opportunities and new funding sources, and will be critical to successfully implement research findings. Finally, with the ever-changing landscape of psychiatric research and treatment comes the novel opportunity to reshape psychiatry training to better address future models of care.
This workshop will provide an interactive discussion on various viewpoints on the future of psychiatry. We will discuss how to best confront these changes with a panel of Members-in-Training and Early Career Psychiatrists in roles that span the spectrum of the field, though the discussion will seek to include psychiatrists at all stages to help guide the future of psychiatry.

BODY DYSMORPHIC DISORDER: UPDATE ON A COMMON, IMPAIRING, AND OFTEN UNDER-RECOGNIZED DISORDER

Chairs: Katharine A. Phillips, M.D., Jamie D. Feusner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will be able to recognize the clinical features of body dysmorphic disorder (BDD) and diagnose it in their patients.; 2) Participants will be able to identify visual processing abnormalities that characterize BDD and other factors that may contribute to this disorder's onset and maintenance.; 3) Participants will be able to demonstrate knowledge of recommended pharmacologic and psychosocial treatments for BDD.

SUMMARY:
Body dysmorphic disorder (BDD) is an often-debilitating disorder that is classified in the DSM-5 chapter of Obsessive-Compulsive and Related Disorders. BDD is common but

often overlooked in clinical practice. It consists of preoccupation with perceived defects or flaws in appearance that are not observable or appear only slight to others. The preoccupation causes clinically significant distress or impairment in functioning. All individuals with BDD, at some point during the course of the disorder, perform excessive repetitive behaviors (for example, mirror checking, grooming, skin picking, reassurance seeking) or mental acts (for example, comparing his/her appearance with that of others) in response to the appearance concerns. Patients typically experience marked impairment in psychosocial functioning and very poor quality of life. A high proportion experience suicidal ideation or attempt suicide, and rates of completed suicide appear markedly elevated. The development of BDD in any given individual is likely the result of a complex interaction between genetic and environmental influences, which include developmental, social, neuropsychological, cultural, cognitive-behavioral, and neurobiological factors. Although the field is still young in terms of understanding their relative contributions, examples of such potential contributory factors include a history of abuse or teasing, distorted cognitions, tendency for obsessive thoughts and compulsive behaviors, evolutionary and cultural influences regarding physical appearance, and visual perceptual abnormalities. Some of these factors may be etiologic whereas others may contribute to the maintenance of BDD symptoms.
Dr. Phillips will review BDD's key clinical features and will discuss evidence-based treatment approaches, both pharmacologic and psychosocial. Dr. Feusner will discuss findings that may be relevant to this disorder's etiology and maintenance, both biological and psychosocial, with a focus on abnormalities in visual processing. This will lead to an interactive session in which audience members can ask questions and discuss their cases. The workshop will help audience members develop a broader understanding of factors that likely combine in any individual patient to result in the expression of symptoms in BDD. Such knowledge will be useful for individually tailored treatment planning, which includes psychoeducation as well as pharmacotherapy and/or cognitive-behavioral therapy that is tailored to BDD's unique symptoms.

OPERATIONAL BEHAVIORAL HEALTH STRATEGIES DURING WITHDRAWAL OF OPERATION NEW DAWN (IRAQI) FORCES: A COMMAND-CENTERED APPROACH

Chair: Samuel L. Preston, D.O.

Speakers: Andrew L. Hagemaster, B.S., Ramona Deveney, M.D., Samuel L. Preston, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Generally understand the multidisciplinary behavioral health mission during OND; 2) Outline non-traditional behavioral health structures used to augment a dwindling provider force; 3) Recite ways to ensure "espirit de corps" and personal BH hygiene while deployed under stressful situations; 4) Understand the importance of command-centered behavioral health interventions.

SUMMARY:
Deployment Behavioral Health As the psychiatric consultant for the withdrawal of forces during Operation New Dawn (OND), valuable "lessons learned" were made in regards to personnel and resource management as well as individual self-care and team work. The intent of this 90 minute discussion is to 1) Outline the mission of the behavioral health/psychiatric provider during the withdrawal of forces from Iraq (2) Discuss unique challenges during the withdrawal of support structures and mitigating services available (3) Discuss interpersonal relationship building across disciplines to ensure Behavioral Health mission was met.
Target Audience: Those interested in Operational Behavioral Health services.

AN APPROACH TO REDUCE OPIATE USE IN INTEGRATED PRIMARY CARE-PSYCHIATRIC PRACTICE WITH CHRONIC PAIN PATIENTS

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

Speakers: Lewis Mehl-Madrona, M.D., Ph.D., Barbara Mainguy, M.A., M.F.A., Magili Chapman-Quinn, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the workings of an integrative pain management practice utilizing family physician, psychiatrist, psychotherapist, and nurse; 2) Identify three ways to facilitate chronic pain patients attending pain management group; 3) Describe the literature on chronic opiate use and chronic pain which shows that opiates actually increase chronic pain; 4) Describe the workings of an effective pain management group for chronic pain patients which results in reduction of opiate use; 5) Describe the potential role for movement educators and physical therapists in the integrated treatment of chronic pain.

SUMMARY:
A movement exists to integrate primary medical care with behavioral health care, which can involve psychiatrists. We present one approach for such integration in the care of chronic pain patients. The team consisted of a family physician-psychiatrist, psychotherapist, and nurse. Patients wanting to continue chronic opiate therapy were required to attend a 2 hour pain management group at least twice monthly. They were also required to show evidence of moving at least weekly (walking, exercise group, yoga, t'ai chi that was offered at the hospital, etc.). Patients who did not meet these criteria in any given month received a 10% taper of dosage. Increases in dosages were only made when patients could justify that their functionality was increased on a higher dose. Increased functionality was defined as volunteering (at all or more hours), caring for children

(longer or more children), working part-time (at all or more hours), or working full-time. The pain management group combined narrative perspectives with cognitive-behavioral-experiential therapy (CBET) and dialectical behavior therapy (DBT). Within that framework, patients shared their life stories, learned about emotional regulation techniques, self-soothing techniques, radical acceptance, non-violent communication, relaxation techniques, mindfulness meditation, chi gong, and more. The general format of the group consisted of completion of pain and quality of life rating forms for the first 10 minutes, then check-in for the next 20-30 minutes, in which patients gave an update of how their life and pain had been going for the past week, followed by an exercise in one of the above mentioned modalities, followed by some general discussion, and concluded with mindfulness meditation and/or guided imagery. Refills of pain medication were made with the help of the nurse by pulling patients out of group after the first hour, taking vital signs, and providing routine refills. We present data on the process of care among the staff and each other and the staff and the patients. We present outcome data showing that 60% of patients reduced opiate doses voluntarily through their activities in this program. We present billing and financial data showing that this model is viable for both private practice and clinic settings and describe how to bill. We present some potential pitfalls of this approach and how to prevent them. We present data showing that time increased in the family medicine office to see other patients through extracting those patients who simply were receiving refills and putting them into the group format. Outcome data showed that despite statistically significant reductions in opiate pain medications, pain ratings did not increase and quality of life ratings improved. We discuss the implications of these findings for encouraging mental health professionals, psychiatrists, and family doctors to work together in a more integrated fashion in the area of chronic pain.

RISK MANAGEMENT: OVERCOMING BARRIERS TO IMPLEMENTATION IN TELEPSYCHIATRY

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) 1) Understand professional, boundary and safety and security considerations as well as general standard of care issues when using telepsychiatry. ; 2) 2) Recognize ethical, policy and legal considerations when using telepsychiatry with patients. ; 3) 3) Explore risk management and liability exposures when using telepsychiatry with patients and identify risk mitigation strategies, including case example discussions.

SUMMARY:
Telemedicine is growing every day and is projected to reach 1.8 million patients by 2017. Telepsychiatry is the application of telemedicine to psychiatry and has been one of the most successful telemedicine applications thus far. One of the primary drivers behind telepsychiatry's growth is the national shortage of psychiatrists, particularly in specialty areas and in underserviced and rural areas. Since psychiatry relies predominantly on conversation and observational skills, telepsychiatry provides a reasonable and prevalent alternative to an office visit for patients not able to readily access care. Using telepsychiatry does not change the standard of care, but there are additional considerations which differ from when the patient is physically in your office. This 1.5 hour risk management workshop will examine standard of care issues, as well as ethical, legal, licensure, informed consent and privacy concerns involved with providing telepsychiatry services. This program will provide real life case examples, will examine the benefits of providing telepsychiatry services and explore the potential risk and liability concerns for the psychiatrist. Additionally, risk reduction strategies will be identified. (Presented by risk management from APA-endorsed professional liability carrier.)

ANABOLIC STEROID AND SUPPLEMENT USE IN THE MILITARY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Christina Rumayor, M.D.

Speakers: Christina Rumayor, M.D., Sebastian R. Schnellbacher, D.O., Christopher S. Nelson, M.D., Remington L. Nevin, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the different types and uses of anabolic steroids and exercise/workout supplements that Service Members may be consuming; 2) Identify the potential adverse effects of anabolic steroid and exercise/workout supplement use as well as how to mitigate and/or treat those adverse effects; 3) Recognize how to differentiate symptoms of steroid and supplement use from other Behavioral Health conditions such as Post-Traumatic Stress Disorder or Traumatic Brain Injury.

SUMMARY:
A survey conducted by the department of defense in 2008 (the last year for which figures were available), showed that 2.5 percent of army personnel had illegally used anabolic steroids within the past 12 months. This was up from 1.5 % three years prior. Anecdotally the numbers are still rising. Military officials do not routinely test for anabolic steroids unless abuse is suspected and the costs of those tests are significant. Soldier's use of over the counter exercise/workout supplements is also increasing and in some cases causing significant adverse reactions. An Army Times article in March, 2013 noted that a pre-workout supplement was indicated in the sudden death (during exercise) of at least 2 young army soldiers. Other DoD branches have had similar findings. Clinicians who are working with military service members should be vigilant and educated on anabolic steroid use, as well as the use of other legal over the counter

exercise supplements. Effects of exercise supplements can include insomnia, mood swings, exercise intolerance, dehydration, and cardiac arrhythmias. Steroids can be injected or taken orally. Effects of steroids include irritability, insomnia, mood swings and angry outbursts. These symptoms are often confused with similar symptoms of post-traumatic stress disorder and traumatic brain injury.

SUBSTANCE USE AMONG LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) PEOPLE: AN OVERVIEW OF EPIDEMIOLOGY AND TREATMENT

Chairs: Amir Ahuja, M.D., Alexander Berger, D.O.

Speaker: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify epidemiologically important substances that are used / abused within the LGBT Community; 2) Identify potential causes / aggravating factors of substance use among LGBT people; 3) Identify areas of special concern regarding LGBT Adolescents and substance use; 4) Identify and employ specific interventions to reduce substance use within the LGBT population based on the current research.

SUMMARY:
In the US, substance use continues to be a major problem, with a lifetime prevalence for alcohol abuse at 13% and drug abuse at 8% (1). Among LGBT (lesbian, gay, bisexual and transgender) people, substance use is a special concern. Past studies of substance use among LGBT people contain considerable flaws and little consensus, but a few trends have emerged. Gay men are significantly less likely to abstain from alcohol than heterosexual men and more likely to have tried illegal drugs, such as ecstasy and GHB(1). Lesbians are more likely to abuse alcohol and illegal drugs than heterosexual women(2). Bisexuals have a higher risk of alcohol and drug use than either heterosexuals or homosexuals(1). There is limited research on transgender populations, though high levels of social instability and discrimination make this population vulnerable to substance use and limit access to treatment.
Many theories exist to support these findings. One theory, the “minority stress model,” explains that minorities experience more lifetime stress through discrimination, thus are at higher risk(3). Another theory is “social learning theory,” which states that LGBT people connect in environments (like bars, circuit parties) where drugs and alcohol are more common, and using them is more a social norm than in heterosexual communities(1).
Among LGBT youth, studies have consistently shown higher substance use among LGBT youth than their heterosexual counterparts. Drugs such as cocaine and heroin are particularly more abused in young LGBT populations(3). Following the adult epidemiology, lesbian youth are at particularly high risk, but bisexual adolescents are at the highest risk, 400% that of heterosexual youth(3). Theories include the prevalence of heteronormative influences leading to isolation of LGBT youth, frequency of bullying (physical and verbal) and the immature coping skills of youth versus adults. What can clinicians do with this information? Clinicians can better identify cases of substance abuse in LGBT populations and may better target their questioning. In addition, clinicians can address risk factors such as minority stress with counseling referrals, or social instability with referrals to community and LGBT-specific resources. Finally, clinicians can offer evidence-based treatment in an LGBT-friendly environment to maximize success for these patients.
1.Green, K.E. & Feinstein B.A. Substance Use in Lesbian, Gay, and Bisexual Populations: An Update on Empirical Research and Implications for Treatment. Psychology of Addictive Behavior. 2012, Vol. 26, No. 2, 265–278
2.Substance Abuse and Mental Health Services Administration. A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals. Health and Human Services, Inc. Rockville, MD, 2012.
3.Marshal, M.P. et al. Sexual orientation and adolescent substance use: a meta-analysis and methodological review. Addiction. 2008 April ; 103(4): 546–556

MULTIMODAL APPROACHES TO PTSD TREATMENT

Chair: Paul Sargent, M.D.

Speakers: Melissa S. Walker, M.A., Rebeeca Vaudreuil, Ed.M., Gary Adler, J.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate modalities of treatment with a growing evidence base; 2) Understand how partnering with community organizations can expand treatment options; 3) Understand how to appropriately refer and utilize art, music, and equine programs in the treatment of PTSD.

SUMMARY:
Since 2001, Approximately 300,000 service members returning from Iraq and Afghanistan have been diagnosed with Post Traumatic Stress Disorder, Traumatic Brain Injury, and other manifestations of combat-related trauma. Evidence based treatment protocols based on extinction and cognitive models have been implemented for many of those who seek treatment. Other therapy modalities are now also beginning to develop an evidence base to support their use, and are being combined with standard therapies in several DOD treatment facilities. Patient satisfaction with art therapy, music therapy, and equine assisted therapy is generally high, and patients endorse that they are able to express thoughts and feelings in ways that would otherwise be difficult. These programs offer support, structure, social and expressive outlets, trauma processing, transitory support, re-integration and continuing education. In this session Ms Walker will discuss the art therapy program at the National Intrepid Center of Excellence which has now been a core part of treatment for over 3 years. Ms Vaudreuil will discuss

music therapy for combat veterans especially based on her experience with residential PTSD treatment. Mr Adler will discuss Pegasus Rising, an equine assisted therapy program in San Diego, California which has been a involved with PTSD treatment for both active duty service members and veterans. Understanding the paradigms of these programs and how they work with standard evidence base treatments will help audience members to identify cost effective opportunities for expanding services in their own communities.

NO PUBLICATION, NO POSTER, NO PROBLEM

Chair: Rashi Aggarwal, M.D.

Speakers: Cristina Montalvo, M.B.B.S., M.D., Nicole Guanci, M.D., M. Pilar Trelles, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify barriers to productivity in the scholarly activity process; 2) Understand concrete steps towards choosing a topic for an abstract; 3) Follow specific guidelines for undertaking a literature search and steps for writing .

SUMMARY:
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry residents will choose research as a career, but publications such as abstracts are important for any psychiatrist interested in an academic career or in compiling a more competitive curriculum vitae. However, many residents do not know how to approach choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. According to a study, only 30% of residents had national presentations with 54% having no publications. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities.
The goal of this workshop is to assist participants with scholarly activity at the beginner level –whether medical student, resident, fellow, or practicing physician. We aim to facilitate the scholarly activity process by identifying barriers to lack of productivity and delineating specific techniques for tackling these barriers. We will provide concrete guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. These guidelines are not only helpful for potential writers, but are also useful for residency program directors and clerkship coordinators wanting to create an academic environment that fosters scholarly activity. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports.
During this workshop, we will offer examples of scholarly activities by residents in our own program, which produced 13 posters at the APA's Institute for Psychiatric Services and 19 posters at the Annual Meeting during the 2012-2013 academic year. This is in comparison to a previous precedent of only a few resident posters presented per year, which highlights the utility of our proposed tips. Our workshop will be highly interactive and the process of taking a rough idea and then narrowing it into a research question will be demonstrated by role-play. Participants will be able to discuss some of their own research ideas or ideal patients for case reports and will be guided through the process in order to be more prepared to tackle their first poster or first publication. By the end of this workshop, participants will be better equipped with practical knowledge of progressing from the inception of an idea to completing a scholarly activity.

WHEN A PSYCHIATRIST LOSES A PARENT

Chair: Lisa Mellman, M.D.

Speakers: Richard F. Summers, M.D., William H. Sledge, M.D., Francine Cournos, M.D., John Herman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate understanding of the personal and professional impact of loss of a parent, including cognitive, emotional and behavioral reactions; 2) Identify means of support, self-care, and coping strategies after such loss; 3) Demonstrate knowledge of a developmental perspective of parental loss.

SUMMARY:
Despite the psychiatrist's familiarity with death of a loved one gained from didactic teaching in classroom and clinical experiences during medical school, medical rotations in the PGY1 year, psychiatry residency, and clinical practice, the death of the psychiatrist's own parent may be a surprisingly profound and difficult loss. For psychiatrists who have experienced the death of a parent earlier in life, medical school, residency training and psychiatric practice present new challenges and opportunities to re-work the original grief and adaptation to parental loss. Senior psychiatrists will describe their own personal experience with losing a parent and grieving, addressing their surprises, challenges, what they found supportive, and their coping strategies and means of resilience. Members of the audience will have the opportunity to share some of their own experiences of grieving, coping and resilience. The workshop is aimed to increase a feeling of community amongst mental health professionals and enhance clinical skills when the mental health clinician experiences their own parental loss and/or when treating patients with parental loss.

THE INTEGRATION OF BEHAVIORAL HEALTH IN ACCOUNTABLE CARE

Chair: Rajesh R. Tampi, M.D.

Speaker: Deena Williamson, M.S.N., R.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand Accountable Care- why, what, where, who, how? ; 2) Define quality and safety measures; 3) Discuss the benefits and challenges accountable care; 4) Describe the payment concepts in accountable care; 5) Enumerate the importance of the integration journey.

SUMMARY:
In March, 2010, President Obama signed into law the Affordable Care Act (ACA) which seeks to make health insurance coverage more affordable for individuals and their families. When fully implemented, the law will provide access to coverage for an estimated 32 million Americans who are currently uninsured. The ACA included a variety of services that should be available for individuals with mental health needs. A key provision of the ACA is the formation of accountable care organizations (ACOs) which facilitates care coordination across provider settings and link reimbursement to quality improvement and reductions in healthcare costs for an assigned population of Medicare patients. ACOs are focused on organizing care around patients and the use of continuous, anticipatory, team-based care that seeks to improve quality and outcomes. Mental health disorders are the leading causes of disability worldwide and are associated with increased medical care and employer costs along with increased premature mortality. A quarter of primary care patients suffer from a mental health disorder and over two-thirds of these individuals experience general medical conditions. In order for ACOs to achieve their triple aim of improved care for patients and populations at lower cost, mental health care must be integrated with primary care. Given this change in healthcare landscape and the pivotal role that mental health professional will be providing in the implementation and success of the ACA and the ACOs, it is important for mental health professionals to have an understanding of the ACA and the ACOs. In this workshop, we will discuss various aspects of the ACA and the ACOs. We will also answer questions from the participants and encourage dialogue among the participants and also with the presenters.

BLURRED LINES: CHALLENGES ENCOUNTERED BY PSYCHIATRY TRAINEES IN MAINTAINING PROFESSIONALISM IN THE DIGITAL AGE

Chairs: Jennifer L. Laidlaw, M.D., Kathleen Sheehan, D.Phil., M.D.

Speakers: Kathleen Sheehan, D.Phil., M.D., Adrienne Tan, M.D., Jennifer Laidlaw, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify potential lapses in professionalism by psychiatry trainees using technology and social media; 2) Describe existing guidelines for resident physicians and medical students regarding the use of social media and technology; 3) Apply existing guidelines to issues unique to psychiatry, such as the psychotherapeutic relationship and safety assessments, that may require special consideration when discussing online profession; 4) Use clinical examples to reflect on and discuss the challenges of teaching and maintaining professionalism in the context of rapid changes in technology.

SUMMARY:
New technologies, including smart phones and tablets, in concert with social media platforms, such as Facebook, Twitter, Instagram and Blogger, are revolutionizing how the world communicates. The effects of this revolution are now apparent in medicine where the internet has significantly altered how patients and health care practitioners interact. Patients and practitioners are increasingly communicating via email. Practitioners can Google patients and patients can Google their practitioners to find information not disclosed within the confines of the patient-clinician relationship. Case studies, once restricted to presentations at conferences and publication in academic journals, can now be published on a blog or a Facebook wall. As such, the boundary between practitioners' personal and professional lives can be blurred, as an online post or email may reach a much larger audience than intended.
While the internet has greatly facilitated patient care and medical education, the digital world can also be a perilous place that is ripe for lapses in professional behavior; even defining professionalism in the context of this new online environment can be challenging. Although there is limited research in this area, there is a growing body of literature indicating that lapses in online professionalism by trainees are a concern that merits attention in medical education. Given this, medical schools and residency programs, as well as governing bodies such as the American Medical Association and the American Association of Directors of Psychiatric Residency Training, have developed recommendations for appropriate online behavior.
In this workshop, residents and faculty supervisors will lead discussion about online practices by psychiatry trainees, the potential for lapses in professionalism online, and possible factors that may potentiate these lapses. The complexity of the issues involved in maintaining professionalism with the proliferation of social media will be illustrated through clinical examples and multimedia presentations. Clinical situations unique to psychiatric practice, such as psychotherapeutic relationships and safety assessments, will be highlighted. Interactive exercises, including small group discussion and role play, will be a key component of the workshop to engage the audience in an active debate of currently available guidelines.

PTSD OPEN FORUM

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the basic aspects of PTSD both within the military and veteran context as well as among other populations (e.g. natural disaster survivors) who suffer from PTSD; 2) Discuss the ways in which PTSD impacts various groups and the possible ways that management of PTSD may vary within these groups; 3) Understand those practices discussed within the session that have relevance to a provider's clinical practice and develop a means of 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 as well as their experience putting together the text. The majority of the session will be dedicated to taking questions and facilitating discussion of topics of interest to the audience, including but not limited to pharmacology, psychotherapy, CAM treatments, and interacting with PTSD patients. Please come prepared with questions and ready to participate in the discussion regarding this timely topic.

FIRST PSYCHIATRIC HOSPITALIZATION FOR PSYCHOTIC ILLNESS: IMPROVING THE EXPERIENCE FOR CONSUMERS AND FAMILY MEMBERS

Chairs: Ann Hackman, M.D., Stephanie R. Knight, M.D.

Speakers: Stephanie R. Knight, M.D., Ann Hackman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify challenges to providing sensitive inpatient services to young adults experiencing a first psychotic episodes and a first psychiatric hospitalization; 2) Describe the culture of the inpatient unit and recognize challenges to individuals during a first psychiatric hospitalization; 3) Consider ways in which to make an initial hospitalization a positive experience for the consumer and a way for the consumer to initiate connect with and enhance recovery oriented treatment.

SUMMARY:
Young adults experiencing a first psychotic break are often hospitalized, many times on an involuntary basis and in ways which can be quite traumatic. This is particularly true in the context of already disturbing psychotic symptoms. As such, in addition to the trauma of a first psychotic episode, the culture of the inpatient unit is often completely unfamiliar to consumers and their families and serves to increase anxiety.
In this workshop, we will provide the perspectives of both inpatient and outpatient providers in providing the most positive experience for young adults with new onset psychosis who are experiencing an initial psychiatric hospitalization. We will discuss ways to minimize trauma of inpatient experience for both consumers and families, including ways to minimize stigma and ways to optimize to continued treatment. Discussion will include intensive psychoeducation and shared decision making around medications. We will consider ways to facilitate linkage to outpatient treatment and ways to best facilitate consumer engagement in person centered, recovery oriented care, including case information.
With our audience we will consider diverse experiences with young adults with new onset psychosis. We will explore approaches to minimizing the trauma of inpatient hospitalization, enhancing person centered treatment and psychoeducation and optimizing linkage with continued care.

HISPANIC DIVERSITY: ONE LANGUAGE, DIVERSE CULTURES

Chairs: Esperanza Diaz, M.D., Jose E. De La Gandara, M.D.

Speakers: Elena Garcia Aracena, M.D., Magdalena Reyes, M.D., Humberto Marin, M.D., Guillermo Valdes, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify Hispanic groups and its characteristics focusing on mental health services needs; 2) Recognize the difference between ethnicity and race and understand the fluidity of culture, immigration influences and tools to be culturally sensitive ; 3) Understand the diversity of Hispanics and applications in patient centered care ; .

SUMMARY:
Hispanics are the largest minority group in America. The United States government came up with the term Hispanics referring to people who came from Spanish speaking countries or those who trace their roots to Spain, Mexico, Central and South America and the Caribbean. The name might mislead the public to think that all Hispanics are about the same. Keeping in mind that culture is fluid our goal is to provide the participants with understandings of the rich diversity, unique characteristics, and mental health needs of each group. We are aiming to understand their roots, reasons for migration and their unique ways to cope and seek mental health services in North America. Their history, causes for migration, major influences on the their mental health seeking and crucial characteristic marking their experiences in the new country. Evolution of their migrations and the unique contributions to America will be examined as well. Multiple brief presentations will describe each of the groups from Mexico, countries from the Caribbean, Central and South America, and the second and third generation Hispanics born in America. Reexamining the diversity and uniqueness of each group will demonstrate the need for psychiatry to be culturally sensitive and patient-center to address diversity in mental health services. The material presented will frame the final interactive small group discus-

sions engaging the participants to share their experiences in the practice of psychiatry serving Hispanics.

SEX OFFENDERS: A PRACTICAL GUIDE TO ASSESSMENT AND TREATMENT

Chairs: Lisa Murphy, M.A., Paul Fedoroff, M.D.

Speakers: R. Gregg Dwyer, Ed.D., M.D., Lisa Murphy, M.A., Natasha Knack, B.A., Paul Fedoroff, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) To provide practical and effective strategies for the assessment of sexual offenders and people with problematic sexual interests; 2) To provide an overview of the current treatment strategies used among sexual offenders and people with problematic sexual interests; 3) To provide clinicians with an understanding of the similarities and differences between the Canadian and American approaches to the assessment and treatment of this population; 4) To present unique clinical data from Canada and the U.S. that has been used to establish these innovative assessment strategies, and which also supports their effectiveness; 5) An interactive portion of the workshop will allow for participants to discuss complex cases and seek advice from the panel or audience regarding particular cases.

SUMMARY:
This workshop will provide an overview of the current methods used to assess and treat sexual offenders and people with problematic sexual interests, from both an American and Canadian perspective. The first part of the workshop will focus on methods of assessment, including results of an ongoing clinical research project exploring a new assessment technique. Dr. Gregg Dwyer will begin by discussing the use of penile plethysmography and other physiological and psychometric assessment methods. This will include the development of a novel phallometric stimuli set that uses professionally recorded age and sex congruent voices and sound effects, as well as preliminary empirical data from an ongoing study on this set of stimuli. Lisa Murphy will then present innovative techniques used in the assessment of problematic sexual interests and will review data comparing Canadian and American phallometric stimuli. Following this, Natasha Knack will provide an overview of the current treatment strategies used with sexual offenders and people with problematic sexual interests, and the controversies surrounding their effectiveness. Dr. Paul Fedoroff will conclude the workshop with a review of the evidence that treatment of the paraphilias really does work. At the end of the presentations the audience will be encouraged to discuss difficult cases and seek advice from the panel and audience regarding particular cases involving the assessment and treatment of men or women with paraphilias.

ANIMAL-ASSISTED THERAPY IN THE U.S. MILITARY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Christina Rumayor, M.D.

Speakers: Rick Yount, B.S., M.S., Elspeth C. Ritchie, M.D., M.P.H., Christina Rumayor, M.D., Robert L. Koffman, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) An understanding of the history, theoretical foundations, and research on Animal Assisted Therapy; 2) How to incorporate Animal Assisted Therapy into psychotherapy as a complementary alternative to treatment; 3) The current varied use of Animal Assisted Therapy in the U.S. Military.

SUMMARY:
The military is using complementary and alternative medicine (CAM) or integrative medicine in a variety of different ways and programs, especially for the treatment of PTSD. The simplest definition of CAM is medical treatments that fall outside the tradition of western medicine and scientific mechanisms of action. Some forms of CAM may have been developed using the reasoning of science, but are outside traditional practice because there is not enough evidence to properly evaluate the technique. This presentation will discuss: 1) The historical basis for animal assisted interventions as a cam practice; 2) The theoretical foundations in psychotherapy for animal assisted therapy; 3) Current research findings on animal assisted therapy; 4) Current use of animal assisted interventions/therapy in us military programs as a cam.

CARING FOR VETERANS WITH CHRONIC PAIN, PTSD, TBI AND CO-OCCURRING SUBSTANCE USE DISORDERS: UNDERSTANDING THE NEW OEF/OIF COMBAT SYNDROME

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

Speakers: Ann M. Rasmusson, M.D., John Otis, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the most common psychiatric disorders seen in OEF/OIF veterans with chronic pain syndromes; 2) Describe the implications of new findings that highlight the shared neurobiology of chronic pain and PTSD; 3) Describe evidence-based treatments for veterans with co-occurring PTSD, chronic pain, TBI and substance use disorders.

SUMMARY:
Recent conflicts in the Middle East and Afghanistan have produced new patterns of combat injury. The signature syndrome for OEF/OIF veterans is the combination of PTSD, Chronic Pain, and Traumatic Brain Injury. In a recent sample of 340 OEF/OIF veterans, 68.2 % were diagnoses with PTSD, 81.5% with chronic pain and 66.8% with TBI. There were multiple overlaps in presentation, include 42.1% who

presented with all three syndromes. Data on co-occurring substance use disorders in this population has been inconsistent and may not be reliable. In some studies, over 30% of chronic pain patients met criteria for opioid use disorders. Patients with these co-occurring disorders are increasingly common and present significant management challenges for both mental health professions and primary care clinicians. Recent research has revealed a clear Neuroanatomical basis for the high co-prevalence and negative synergy between chronic pain and PTSD. In addition, there are several neurobiological factors with a pathophysiological role in both disorders. These include neuropeptide Y (NPY), the GABAergic neuroactive steroids such as allopregnanolone, the endogenous endocannabinoid system, and the opioid system (e.g., the ORL1 or NOP/orphanin FQ receptor). Understanding the shared neurobiology of chronic pain and PTSD will likely aid in the development of new interventions that enhance the prevention and treatment of both. This workshop will review (1) the epidemiology & overlap of PTSD, Pain, TBI & Substance Use Disorders, (2) the shared neurobiology of chronic pain & PTSD, and (3) will present models for the integrated treatment of chronic pain, PTSD and substance use disorders. Participants will be engaged in an active dialogue to develop creative models for integrating new evidence-based treatments for this complicated patient group.

INTEGRATED CARE AND THE PATIENT CENTERED MEDICAL HOME IN THE VETERANS HEALTH ADMINISTRATION AND DEPARTMENT OF DEFENSE

Chair: Paul Sargent, M.D.

Speakers: Andrew S. Pomerantz, M.D., Patricia Gibson, M.D., Brian E. McKinney, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Improved understanding of the medical home model; 2) Improved understanding of rendering psychiatric care within the medical home model; 3) Vision of planned future developments in the medical home model of care.

SUMMARY:
The Veterans Health Administration (VHA) and the Department of Defense have led the nation in integrating mental health services into primary care. With the passage, implementation of the Affordable Care Act, the integration programs of both agencies may serve as models for other public and private sector programs seeking to create patient centered medical homes. This workshop will highlight the development, current status and projected future development of these programs in VHA and DoD, as well as describe some of the commonalities and differences.
Adapting to the primary care environment can be a challenge for any specialist, particularly for psychiatrists, who must adopt a new paradigm for evaluation and treatment. We will provide a first hand perspective from three vantage points: 1) a senior psychiatrist who developed and worked in one of the early programs that became a model for VHA, 2) a midcareer psychiatrist currently working in such a clinic, and 3) a psychiatrist-in-training in a DoD primary care clinic. We will also review the current state of outcome evaluations of the programs in the two agencies, as well as results of ongoing research and local program evaluations.

COMBINED PHARMACOLOGIC AND PSYCHOTHERAPEUTIC MANAGEMENT OF TOURETTE'S DISORDER

Chair: Deepak Prabhakar, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the importance of combined therapeutic approach in the management of Tourette's Disorder ; 2) Treat patients using behavioral techniques; 3) Identify various pharmacologic entities for the management of Tourette's Disorder .

SUMMARY:
Tourette's disorder is characterized by the presence of chronic motor and phonic tics. Tics are common but are usually transient in childhood. The estimated prevalence of Tourette's ranges from 3 to 8 per 1000 school-age children (1). Tic severity peaks around adolescence often declining by adulthood. According to the Center for Disease Control and Prevention (CDC), about 27% of children report moderate to severe symptoms (2). Generally tics warrant treatment only of they are a source of functional impairment in the patient's everyday life. Management of Tourette's disorder should include careful assessment of risks and benefits of initiating and withholding treatment and where indicated using medications and psychotherapy (3). This workshop will be divided into 3 segments. In the first segment we will present an overview of evidence-based pharmacological and psychotherapeutic approaches for the treatment of Tourette's disorder. In the second segment we will use case vignettes to illustrate the utility of combined medication and behavioral management. In the third segment participants will engage in a problem based learning exercise emphasizing some of the core principles of behavioral therapy for Tourette's.
1.Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Arlington, VA, American Psychiatric Association, 2013, pp 81-85
2.Centers for Disease Control and Prevention (CDC). Prevalence of diagnosed Tourette's syndrome in persons aged 6-17 years - United States, 2007. MMWR Morb Mortal Wkly Rep. 2009 Jun 5;58(21):581-5
3.Piacentini J, Woods DW, Scahill L, Wilhelm S, Peterson AL, Chang S, Ginsburg GS, Deckersbach T, Dziura J, Levi-Pearl S, Walkup JT. Behavior therapy for children with Tourette's disorder: a randomized controlled trial. JAMA. 2010 May19;303(19):1929-37.

COMPREHENSIVE CARE FOR PATIENTS WITH MEDICAL AND

PSYCHIATRIC COMORBIDITY: A NEW MODEL OF CARE AND OPPORTUNITY FOR PSYCHIATRISTS

Chair: Steven Frankel, M.D.

Speakers: Steven Frankel, M.D., James A. Bourgeois, M.D., O.D., Roger Kathol, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Define "case complexity." What are the characteristics associated with common definitions of "complex case" and "complex patient?"; 2) What are the explanations for the commonly encountered separation of systemic medical and mental health care? What are the chief arguments, economic and medical, for the integration of the two?; 3) The "Medical-Psychiatric Coordinating Physician" (MPCP) model of care delivery is offered as an antidote to fragmentation of care for complex patients. Describe the features of this model; 4) In what ways is the MPCP model an extension of outpatient psychosomatic medicine? How does it potentially supplement primary care practice?.

SUMMARY:
Objective: We propose an innovative clinical role, the "Medical-Psychiatric Coordinating Physician (MPCP)," involving psychiatrist-led multispecialty teams for managing the most challenging of complex outpatients. "Complex patients" (Kathol et al.) present with significant comorbid systemic medical and psychiatric illnesses and challenging management requirements (de Jonge et al.). We developed the MPCP method for improving the care of these patients. Specific roles for the MPCP include team leadership, organizing workups, collaboration with patients and their families, and tracking treatment progress. Liaison with the patient's PCP places psychiatric/systemic medical co-morbidity central to the patient's management.
Method: We pilot tested this model with 52 complex office-based cases followed for at least 18 months and selected as follows: at least two other professionals had been involved in their care; at least two other treatments had failed; the patient required frequent non-scheduled contacts.
Results: Clinical review indicated sustained improvement in at least two of four clinical dimensions (utilization of resources, treatment adherence, decrease in systemic medical and/or psychiatric symptoms, quality of life) in 44 patients following adoption of MPCP care. Pre-post scores on Hamilton Anxiety (Ham-A) and (Ham-D) Depression Scales, and two out of four measures (sick days and sense of well being) on a modified CDC HRQOL-14 were significant beyond .0001.

Conclusions: Examples of other models to manage complex outpatients include patient centered medical homes, care managers embedded in primary care offices, and stepped care. The MPCP-led model differs from these with the psychiatrist taking the central and an ongoing clinical role. It is a preferred model for complex patients who fail other integrated care models, including those with severe cases of somatically expressed psychiatric illness (e.g. somatoform disorder, chronic pain). -- It represents a new role for psychiatrists interested in the comprehensive management of complex patients.
An example of an MPCP managed case:
Solomon was referred for psychiatric care after his wife left him, unable to tolerate his disfigurement from scleroderma. Associated with scleroderma were esophageal fibrosis; festering skin lesions; and pulmonary fibrosis. Depressed and immobilized, he was unwilling to cooperate with his physicians or adhere to advice from family members.
Workshop proposal: Both presenters will describe the MPCP model of care. The first presentation will explicate the MPCP model, the second the experience with an embedded psychiatrist in an MPCP-like role at a university medical center. Roger Kathol, MD, an internationally recognized expert on integrated care, will be discussant. The development of an MPCP treatment program will be included as a topic. Ample time will be allocated for participant and audience discussion.

OMNA ON TOUR: COMMUNITY CONVENER AND CATALYST FOR COLLABORATIVE ACTION TO IMPROVE MENTAL HEALTH IN DIVERSE AND UNDERSERVED POPULATIONS

Chair: Annelle Primm, M.D., M.P.H.

Speakers: Charles Huffine, M.D., Charlotte N. Hutton, M.D., Jean B. Tropnas, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify key strategies that OMNA on Tour utilizes to engage diverse and underserved communities in discussion of mental health disparities and related issues in their area; 2) Recognize at least 3 topic areas of focus of OMNA on Tour programs and learn about the impact of those programs on respective communities; 3) Identify key success factors and outcomes of OMNA on Tour programs and recognize the need of these programs in today's era.

SUMMARY:
OMNA on Tour is the APA's traveling community engagement and educational program focused on raising awareness about the need for action to rectify mental health disparities among diverse and underserved populations. Since its inception in 2005, over 20 OMNA on Tour programs have been conducted in a variety of regions throughout the U.S. in both urban and rural areas and in red states and blue states.
Organized by the APA's Office of Minority and National Affairs, the initials of which form the acronym, OMNA, the program is unique in that it involves not only psychiatrists and mental health professionals, but also community leaders from a variety of sectors with which mental health intersects: primary care, the faith community, human services, criminal justice, education, employers, grass roots

organizations and others. Each program is customized to the demographics, political environment, system realities and local knowledge of the geographic area.
OMNA relies on local planning groups to provide advice on what the topic of the program should be as well as where and when programs should be held to enlist maximum participation and buy-in. Respect for what each community is interested in is paramount and as a result, programs have focused on a wide variety of topics including the mental health concerns of: refugees and migrant communities, survivors of disasters, people experiencing economic crises, residents of rural communities and military personnel, veteran and their families. Depending on community preference, OMNA on Tour programs have been presented in a variety settings and formats including interactive panel discussions, workshops, seminars, discussion groups and town hall meetings. These modes of engagement facilitate community leaders in addressing their concerns and networking and collaborating to bring change with the help of local resources and local leadership.
With the help of a panel of APA members who have had a leadership role in developing OMNA on Tour programs in their communities, this workshop aims to analyze various approaches used to engage different communities around the country to understand and be mobilized to act in a sustainable way to address the mental health concerns of their citizens. The session will also highlight the positive outcomes of these programs including how they raise the profile of the APA, the field of psychiatry, and local psychiatrists as contributors to the mental health of communities around the nation.

SOMATIC SYMPTOM AND RELATED DISORDERS (SSRD) IN CHILDREN AND ADULTS: A CLINICAL APPROACH

Chair: Jessica Crawford, M.D.

Speakers: John J. Barry, M.D., Kim D. Bullock, M.D., Eva Szigethy, M.D., Ph.D., Deborah M. Weisbrot, M.D., Cynthia M. Stonnington, M.D., W. Curt LaFrance Jr., M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn a framework for conceptualizing the etiology and treatment of somatic symptom and related disorders (SSRD) in children and adults; 2) Understand how individual factors impact the ability to manage distressing emotions and the development of somatization as a defense mechanism; 3) Describe how evidence-based treatments can target etiology; 4) Discuss how treatment can be an opportunity to destigmatize SSRD.

SUMMARY:
Although Somatic Symptom and Related Disorders (SSRD) are common, relatively few clinicians are comfortable with their recognition and management. This workshop aims to provide a conceptualization of SSRD, which can be applied to understand and treat patients. The first presentation will introduce a framework to conceptualize these disorders and will delve into recent literature on their etiology, including what is known of the neurobiology of affect regulation. A dynamic view of SSRD will be built through consideration of genetic factors, childhood stressors, language development, family conflicts and cultural scripts, which influence the ability to manage distressing emotions and the tendency to somaticize. This will be followed by a second presentation focusing on a specific treatment modality, which uses dialectical behavioral therapy (DBT) for patients with functional neurological disorders (FND). This example will be used to explore the commonalities seen in SSRD and to propose that such treatment potentially could be applied to various SSRD. The final presentation will consist of two case examples, one child and one adult. An expert panel will provide input and demonstrate how the aforementioned conceptualization can inform treatment. Throughout the workshop, the therapeutic benefit and imperative of changing perceptions and stigmatization of this disorder during clinical interactions from diagnosis through treatment will be highlighted. The intended audience will be comprised of clinicians and researchers involved in neuropsychiatry, residents and medical students interested in child and adolescent psychiatry, neuropsychiatry and psychosomatic medicine.

MIND/BODY PRACTICES FOR TRAINEES: REDUCING STRESS, ENHANCING EMPATHY, AND TREATING PATIENTS INTEGRATIVELY

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

Speaker: Heather Mason

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the value of education in mind-body techniques during medical school and residency training; 2) Understand the relevance of practicing basic breathing, movement, and meditation techniques for personal stress relief, psychological well-being, and stress-resilience; 3) Describe therapeutic benefits of mind-body techniques, including Voluntarily Regulated Breathing Practices. .

SUMMARY:
Heather Mason, MA will discuss why education in mind-body techniques (MBTs) during medical school and residency is important for future doctors and their patients, based on pre-existing research and a recent study at the Boston University School of Medicine (BUSM) on the effects of an Integrative Psychiatry elective called “Embodied Health” in which medical students learned about research and clinical applications, and obtained practical experience in MBTs such as therapeutic movement, breathing practices, and meditation. Pre- and post-elective tests completed by thirty-one first and second year medical students showed significant reductions in perceived stress and increased mindfulness, and a trend towards increased empathy. Qualitative analysis revealed a shift towards greater interest in integrative men-

tal health treatments. The level of a physician's empathy affects patient compliance and, therefore, can contribute to better treatment outcomes. The stresses of professional training and a career in medicine are known to cause burnout (with loss of empathy) and adverse effects on physician health and longevity. MBTs learned during medical school and residency would provide methods to alleviate career stress, maintain empathic ability, and extend to patients the benefits of adjuctive MBTs to improve mental and physical health.
Patricia L Gerbarg, MD will discuss Voluntarily Regulated Breathing Practices (VRBPs) that rapidly reduce stress and anxiety, improve stress resilience, facilitate sleep, and enhance attention, cognitive function, bonding, empathy, and problem solving. Physiological mechanisms that contribute to these effects and studies showing benefits in healthcare professionals and disaster relief will be reviewed.
Richard P. Brown, MD will guide participants through a set of Voluntarily Regulate Breathing Practices (VRBPs) with movements and meditation used in the studies reviewed by Dr. Gerbarg. These practices have been shown to be effective in healthcare professionals, military personnel, survivors of mass disasters, and patients with anxiety disorders, depression, post-traumatic stress disorder, schizophrenia, and stress-related medical conditions.

AMYLOID IMAGING: USING A NEW BIOMARKER TO IMPROVE DIAGNOSIS

Chair: Yvette I. Sheline, M.D.

Speakers: Peter Herscovitch, M.D., Keith A. Johnson, M.D., Norman L. Foster, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe issues associated with the recent availability of 18-F florbetapir in the clinic; appropriate clinical questions and referrals, limitations, and appropriate training.; 2) Discuss recent professional society guidelines for the appropriate role of beta amyloid detection using imaging or CSF biomarkers for revised diagnostic and nosologic criteria for Alzheimer's dementia; 3) Identify new directions in brain PET amyloid imaging, including the incorporation of normative databases and quantitative measures of regional brain amyloid deposition.

SUMMARY:
The purpose of this course is to provide participants an update on the clinical implementation of recently approved PET radiotracers for detecting brain amyloid deposition. The emphasis will be on appropriate clinical use and difficult diagnostic and disease monitoring issues. In particular, focus will be on training, clinical challenges of image interpretation, appropriate referrals, as well as forward looking issues of incorporating image quantitation into clinical practice. A discussion of cases with audience and faculty will be conducted to focus on whether to scan or not.

RETHINKING KENDRA'S LAW: THE ETHICS OF ASSISTED OUTPATIENT TREATMENT

Chair: Candice T. Player, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the mechanics of Kendra's Law; 2) Appreciate the ethical issues that arise when courts order assisted outpatient treatment over the respondent's objection; 3) Assess the strengths and weaknesses of alternatives to Kendra's Law including voluntary mental health treatment. .

SUMMARY:
In the wake of deinstitutionalization and its failures, one of the most important questions in mental health policy may be this: how can we care for psychiatric patients in the community who require care, but resist treatment nonetheless? In New York, Kendra's Law authorizes court ordered assisted outpatient treatment ("AOT") for people living with a mental illness in the community. Supporters of Kendra's Law will argue that assisted outpatient treatment can be justified on the ground that many people with mental illnesses lack insight into their illness, and this impaired insight puts them at risk of harming themselves or others. I argue that impaired insight fails to provide a principled distinction between people with mental illnesses and others who might also reject medical treatment. Instead, when our primary concern is one of self-regarding harm, a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who are unable to make competent treatment decisions on their own. At times we will worry that a decision to refuse outpatient treatment could not only result in harm to oneself, but harm to others. When our primary concern is one of other-regarding harm, a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who are unlikely to appreciate the wrongfulness of their conduct or lack the capacity to conform their conduct to the requirements of the law.

THE ROLE OF THE PSYCHIATRIST IN DEEP BRAIN STIMULATION

Chair: Sarah M. Fayad, M.D.

Speakers: Herbert Ward, M.D., Sarah M. Fayad, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the FDA approved indications for DBS and experimental uses of DBS and will understand the role of the interdisciplinary team; 2) Identify psychiatric symptoms which may be a barrier to successful DBS; 3) Learn which rating scales are commonly employed in assessing patients for DBS; 4) Identify treatment strategies for manag-

ing patients following DBS.

SUMMARY:
Deep Brain Stimulation has been shown to be an effective treatment for movement disorders such as Parkinson's disease, dystonia, and essential tremor, and has also recently received a humanitarian device exemption from the Food and Drug Administration for use in carefully selected cases of obsessive compulsive disorder. It has also been utilized experimentally in the treatment of Tourette's syndrome, treatment resistant depression and most recently for memory issues in early Alzheimer's disease.

Due to the many complexities in these patient populations, and also due to neurobehavioral manifestations, most expert centers employ a multidisciplinary approach for screening and also follow DBS subjects pre- and post-operatively. This team can involve experts in neurosurgery, neurology, psychiatry, neuropsychology, and in many cases specialists in speech/language pathology, occupational therapy, physical therapy, and social work services. The role for the psychiatrist on these DBS multi-interdisciplinary teams has been expanding, and in many cases will prove critical to the overall successful outcome of the procedure.
The role of the psychiatrist is integral to multi-interdisciplinary DBS team success, especially in light of the high prevalence of psychiatric co-morbidities in DBS eligible movement disorder populations. In addition to the standard diagnostic interview, there are specific things to note. Specifically, the psychiatrist establishes the presence or history of current major mood and behavioral disorders such as major depressive disorder or bipolar disorder, anxiety disorders, psychotic disorders, substance use disorders and impulse control disorders. Psychiatrists also assess for suicide risk, and screen for previous psychiatric hospitalizations. The presence of one of these disorders does not exclude a patient from being considered for surgery, however, surgery may need to be postponed until symptoms are stable.
There is no standard battery of tests for the psychiatrist pre- and post-operatively, but most centers advocate screening for depression, anxiety, mania, obsessive compulsive symptoms, and impulsive/compulsive behaviors, as well as the employment of careful pre- and post-operative suicidal thought screening. The psychiatrist typically performs a variety of standardized rating scales and also screens for impulse control disorders and dopamine dysregulation syndrome in the Parkinson's disease population.
The psychiatrist uses a combination of scales and clinical judgment to arrive at recommendations about whether or not a patient should be considered at a particular moment in time for impending DBS. The psychiatrist also stabilizes medication regimens in patients pre-operatively. Finally, the psychiatrist establishes the potential need and frequency of post-operative follow-up visits and manages the treatment of unique psychiatric problems which can arise in the post-operative phase.

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM I

Chairs: Marra Ackerman, M.D., Rachel Caravella, M.D.

Speakers: Annaheta Salajegheh, M.D., Jeffrey Seal, M.D., Sarah Richards Kim, M.D., Yael Holoshitz, M.D., Adam Demner, M.D., Erica Greenberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Clearly identify the aims and responsibilities of the chief resident in each of the following roles: Administrator, Liaison, Educator, and Mentor; 2) Recognize and develop effective problem-solving strategies through shared learning experiences with other participants; 3) Build a network with Chief Residents from other programs to provide ongoing support and consultation.

SUMMARY:
Abstract: This is Part I in a two-part workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences.
Many psychiatric Chief Residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the Chief Resident's duties again. However, the literature suggests several problems inherent in the role, including poorly defined description of responsibilities, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to clearly delineate the roles of the Chief Resident, discuss frequently encountered challenges, and provide a forum for shared learning and support.
In this workshop, outgoing Chief Residents will briefly present common situations encountered during their term followed by discussion and small group activities to foster interaction and exchange among participants. Issues to be addressed in Part I of this workshop will include (1) Administrative and logistical issues such as scheduling, call coverage, and retreats; (2) Liaison experiences between residents, program administrators, hospital administrators, and other departments.
Literature Reference #1 Lim RF, Schwartz E, Servis M, Cox P, Lai A, & Hales R: the Chief Resident In Psychiatry: Roles and Responsibilities. Academic Psychiatry 2009: 56 – 59.
Literature Reference #2 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280
Literature Reference #3 Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31:270-276
Literature Reference #4 Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47:277-280

SPECIAL PSYCHIATRIC RAPID INTERVENTION TEAM (SPRINT) AND THE ART OF DISASTER PSYCHIATRY IN THE NAVY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Jeffrey Millegan, M.D., M.P.H.

Speakers: Jeffrey Millegan, M.D., M.P.H., William Sauve, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand Psychological First Aid as a framework for a disaster mental health response; 2) Understand the challenge of adapting the mental health response to the unique aspects of a particular disaster; 3) Be familiar with practical lessons learned in the field to increase the effectiveness of the response.

SUMMARY:
The special psychiatric rapid intervention team (sprint) is a rapid response multidisciplinary team of mental health professionals and chaplains in the navy who provide short-term mental health and emotional support prior to and immediately after a disaster with the goal of preventing long-term medical psychiatric dysfunction or disability. The response provided is based on the Hippocratic principle of "first, do no harm" and has its foundation in the principles of psychological first aid. The team has the ability to mobilize in response to a disaster anywhere in the world within eight hours of being requested. The principle challenges for the team are to, first, quickly tailor a response to the particular trauma and people affected, and second, to find a way to rapidly gain rapport and the trust of the affected community. Gaining the confidence of leaders and local support personnel is critical. Given the short duration of a sprint mission, every effort should be made to empower the community to aid in its own recovery. By keeping communications open with the community after the immediate mission, sprint is able to continue to support the recovery into the future. The sprint model of mental health disaster response is illustrated in a real world case study.

COGNITIVE BEHAVIOR THERAPY—BASED GROUP TREATMENT OF DEPRESSION

Chairs: Rachel C. Leonard, Ph.D., Jerry Halverson, M.D.

Speakers: Rachel C. Leonard, Ph.D., Jerry Halverson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify pharmacologic treatment options and recognize how behavioral activation and other cognitive-behavioral treatment approaches can be used for individuals with treatment-resistant depression.; 2) Recognize how multiple treatment strategies can be integrated to address the needs of patients with treatment-resistant depression; 3) Demonstrate understanding of the treatment rationale and how this may be presented to patients.

SUMMARY:
Depression contributes to significant distress and disability. In fact, it has been estimated that by 2020, depression will be the second most common health problem world-wide. Unfortunately, while numerous treatment approaches exist, many individuals fail to significantly respond to standard outpatient treatment. This workshop will present a multimodal intensive treatment approach with a strong cognitive behavioral therapy (CBT) component for individuals with treatment-resistant depression. We will start by presenting background information on patients likely to benefit from this approach. Then, referring to accepted treatment guidelines, we will provide detailed information regarding pharmacologic approaches to severe, treatment-resistant depression and their combined use with psychotherapies in depression. Following this, specific CBT treatment techniques will be presented. This will include an in-depth presentation of behavioral activation, which is an efficacious and specific empirically supported treatment for major depressive disorder (Hollon & Ponniah, 2010) that may be particularly beneficial for individuals with more severe depressive symptoms (Coffman et al. 2007; Dimidjian et al., 2006). Specific treatment strategies for implementing behavioral activation will be discussed, including presentation of the treatment rationale, basic activity monitoring and activity scheduling, and more advanced techniques to address specific difficulties in implementing behavioral activation. Discussion of activity scheduling techniques will include a focus on values assessment in order to identify activity assignments that are meaningful to the patient. Additional treatment strategies to be presented include contingency management, skills training, and mindfulness in order to address rumination. In addition to behavioral activation, additional CBT treatment techniques used to address co-occurring anxiety symptoms will be presented. Finally we will discuss the integration of these techniques in a novel group based approach. We will present real world outcomes data for this combined approach in refractory patients. Audience participation will be strongly encouraged, with significant time allotted to group discussion. We will wrap up with a case based discussion of constructing a treatment plan using this combined approach.

SLEEP DISORDERS: ASSESSMENT AND INTERVENTION IN MILITARY SERVICE MEMBERS

Chair: Paul Sargent, M.D.

Speakers: Christopher S. Nelson, M.D., Heather C. King, Ph.D., Rachel Markwald, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the importance of sleep within the context of mental health and risk for disease; 2) Show knowledge of sleep measurement devices used to provide sleep and sleep stage metrics in laboratory/hospital and at-home environments and identify which devices perform

best for the population; 3) Better understand assessment and novel treatment options to meet the needs of our patients.

SUMMARY:
Sleep disruption –having known health and warfighter readiness implications which include neurocognitive deficits, neuroendocrine abnormalities, and increased risk of mental health problems – is an evolving concern in the United States military. In a recent study of a highly deployed military population, clinical evidence suggests that three out of four personnel reporting for general medical issues within 6 months after deployment also endorsed sleep disruption. Many patients experience side effects from pharmacological approaches. Dr Heather King will discuss the results of a controlled pilot/feasibility study utilizing auricular acupuncture as an intervention to improve sleep among veterans with PTSD and sleep disturbance. The study has just been completed at a residential PTSD treatment program at a major military medical facility. Dr. Chris nelson will discuss common sleep problems among currently operational forces. A large percentage of returning marines and sailors suffer from disturbed sleep and decreased libido. As well, the predominant complaint is usually severe nightmares with night sweats, but their sleep problems can extend to sleep state misperception and rem intrusion phenomena. Techniques for assessment and intervention will be discussed by dr nelson. Dr Rachel Markwald directs several research projects at the naval health research center to validate sleep measurements from commercial devices. This research will improve clinician's ability to gather objective sleep data from their patients and more effectively guide treatments. Dr Markwald will discuss several devices and future directions of routine sleep monitoring.

THE B IN LGBT

Chair: Daniel Medeiros, M.D.

Speakers: Littal Melnik, M.D., Brian Donohue, M.D., Sarah C. Noble, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize current and past contributions to the study of bisexuality, including the prevalence of, and process of acknowledging bisexual attractions/identity; 2) Identify unique issues and risks of people with bisexual identity/behaviors; 3) More effectively treat patients with diverse sexual attractions/identities.

SUMMARY:
Freud believed we all had innate bisexual capacities, and the Kinsey studies demonstrated a range of sexual attraction from exclusively heterosexual to exclusively homosexual. Sexuality includes fantasy/attraction, behaviors, and identity, and these three components are not always consistent. Most studies of sexual behavior/identity have not separated out bisexuality, often classifying these subjects as 'nonheterosexual', which also included lesbian and gay people. However, several studies have noted different risks in the population of individuals who identify as bisexual, and intimacy issues can be different for this group as compared to the gay/lesbian population. This workshop will review some of the past and current literature regarding bisexuality, with an emphasis on a descriptive study of bisexual people and intimacy issues. The developmental process, issues and risks of bisexuality in adolescents will be presented. Finally, cases of treatment with bisexual patients will be presented, followed by audience questions and discussion.

FOOD AND THE BRAIN

Chairs: Drew Ramsey, M.D., Emily Deans, M.D.

Speakers: Emily Deans, M.D., Drew Ramsey, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Psychiatrists will understand the influence of food choice on brain health and the evidence linking dietary patterns and mental illness; 2) Psychiatrists will appreciate how to do quick, practical dietary assessments and how to integrate evidence and stages of change in the process of motivating healthy dietary habits; 3) Psychiatrists will learn about the pluses and pitfalls of various popular diet plans, with case examples.

SUMMARY:
The adage "you are what you eat" holds some core biological truth, particularly with respect to the brain. In this workshop we will explore the evidence linking diet to psychopathology and practical tips on how to address diet in clinical practice. The workshop will be composed of three sections and a question and answer period. 1) This is your brain on food: evidence and fundamentals. In this section, we discuss studies from many cultures and links to mental illness. 2) Food as a vital sign: the simple food assessment. We will demonstrate quick and practical dietary assessments and how to integrate available evidence and stages of change in the process of motivating healthy dietary habits. 3) Implications of the specialty diet. We review how various special diets (such as veganism, low carb, Weight Watchers ™, Paleo, etc.) may affect neurochemistry and behavior, with case examples.

TREATING PATIENTS WITH VISUAL LOSS: FINDING LIGHT IN THE DARKNESS

Chairs: Sharon Packer, M.D., Michael S. Ascher, M.D.

Speakers: Melinda S. Lantz, M.D., Shruti Matalik, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the relationship between visual loss

and other co-occurring psychiatric and medical conditions and distinguish between different types of visual loss and the challenges they impose; 2) Identify and strategize for special psychological and psychopharmacological needs of visually-impaired psychiatric patients (and their families, especially when visual loss is inheritable); 3) Describe side effect profiles of commonly prescribed medications that affect vision and identify symptoms of clinical emergencies and know when/how to collaborate with specialists or refer to ER; 4) Identify relatively common medical conditions that can affect CNS function, psychiatric symptoms and vision (DM, MS) and anticipate concerns about potential visual problems that can arise; 5) Identify community-based resources that help visually-impaired patients gain a greater sense of agency, meaning and purpose in life and ensure their safety and help with vocational/financial issues.

SUMMARY:

Most clinicians know of the Oedipus myth about self-induced blindness, but fewer are familiar with fine points of treating patients with visual loss. Yet 285+ million people worldwide are visually impaired (39 million are blind; 246 million have moderate to severe visual impairment). Numbers are expected to explode as the population ages. Visually impaired people have twice the rate of depression as the general population, making psychiatric consultation likely. Because current patients can develop visual loss or ophthalmologic SE of psychotropic meds (dry eyes, glaucoma, rarely, retinitis pigmentosa, cataracts), it is prudent for treaters to consider the interface between psychiatry and ophthalmology.

We discuss the epidemiology of low vision in varied populations (age, race, gender). We review the prevalence of low vision in people with systemic disease (DM), neurological disease (MS, CVA), genetic or congenital disease (RP, hyperbaric oxygen exposure), age-related (MD), immunological/infectious (BD, HIV) and trauma (self or other-inflicted, accidental or intentional). We discuss how representations of blindness in religion, myth, literature, film, comics, and music influence patients and providers.

In covering psychodynamic aspects of vision loss, we stress the impact of pre-morbid and co-morbid psychiatric and substance-related conditions on accommodation to loss and willingness to accept palliative remedies (Braille, computer aids, dogs, canes). We address family dynamics and treaters' counter-transference.

We review treatments of common accompaniments of vision loss (depression, anxiety, PTSD, psychosis from sensory deprivation, sleep disturbance/circadian rhythm disruption, seasonal affective disorder). We explore risks and benefits of various psychotherapeutic modalities and psychopharmacological interventions, highlighting ways to avoid potentially deadly pharmacy errors that can occur when new meds are introduced or are not labeled or explained appropriately.

We cover extra-medical services that improve quality of life: occupational therapy, visiting nurses, ADA protection/vocational rehab, Lighthouse services, computerized readers, talking books, Braille, dogs, government subsidies for economic losses, even touchable or talking art exhibits.

We compare medico-legal concerns in treating low vision patients vs. hearing-impaired persons.

Each presenter begins with a case history that encourages participants to discuss their own cases.

MENTORS! FIND ONE, BE ONE

Chairs: Nada L. Stotland, M.D., M.P.H., Sheila Hafter-Gray, M.D.

Speakers: Quang-Dang Uyen-Khanh, M.D., M.S., Richard Balon, M.D., Paul J. O'Leary, M.D., Stephen A. McLeod-Bryant, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and appreciate the roles of mentors in career and personal development; 2) Effectively serve as a mentor for colleagues; 3) Identify and collaborate with personal mentors.

SUMMARY:

Mentors are key actors in the practice and the perception of psychiatry. By sharing knowledge, by helping each other, we broaden our reach and improve our image. As you begin and pursue psychiatric practice, mentors can be the key to your success at every stage. What electives should you choose? Should you do a fellowship after residency? Do you want to be a practitioner, a researcher, a teacher, an administrator, a policy maker? How do you move from one of these roles to another, or combine them? How do you get your foot in the door? What should you look for in an employment contract? How can you balance your professional and personal lives?

You may not see a potential mentor in your current practice location, but there is no need to be limited by geography or practice situation; very likely there are one or more mentors in the profession who would be happy to help you using modern communication technology. In this workshop, you will learn what a mentor can do for you, how to find one, and how to use one.

For psychiatrists with years of experience, using that experience to help a mentee is not only a professional responsibility, but a joy-an opportunity both to nurture an individual and to enrich and insure the future of our profession. In this workshop, you can learn from senior psychiatrist mentors how to offer mentees the benefit of your rich experiences.

Psychiatric organizations provide networks ideal for mentoring. The Senior Psychiatrists' group and the American Psychiatric Association have initiated a project to link members with a wide range of experiences with members at all career stages who are seeking mentors. Because each psychiatrist has unique needs and resources, speakers in this workshop include leaders in residency and early career psychiatry; mentorship for international medical graduates, minorities, and women; and senior colleagues with experience in academia, private and public sector practice, and adminis-

tration. Active interaction and mentoring will begin, live, in this workshop.

MEET THE AUTHOR: THE EVIDENCE-BASED GUIDE TO ANTIDEPRESSANT MEDICATIONS AND ANTIPSYCHOTIC MEDICATIONS

Chair: Anthony J. Rothschild, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have a better understanding of the use of antidepressant and antipsychotic medications for major depressive disorder, bipolar disorder, psychotic depression, and treatment-resistant depression; 2) Have a better understanding of the use of antidepressant and antipsychotic medications in the management of anxiety disorders, obsessive-compulsive disorder, and specific phobias; 3) Have a better understanding of the use of antidepressant and antipsychotic medications in medically-ill patients, patients with schizophrenia and substance abuse disorders, and geriatric patients.

SUMMARY:
This small, interactive session will be an informal, interactive session with Anthony J. Rothschild, M.D., editor of The Evidence-Based Guide to Antidepressant Medications and The Evidence-Based Guide to Antipsychotic Medications. The two books in the Evidence-Based Guides series provides a clear reference to the current knowledge and evidence base for the use of antidepressant and antipsychotic medications among a variety of patients across a wide range of disorders including patients with major depressive disorder, bipolar disorder, posttraumatic stress disorder, schizophrenia, and personality disorders, as well as those with medical illnesses. In addition, antidepressant and antipsychotic medications are increasingly being prescribed by clinicians for so-called off-label use-to treat illnesses for which the medications do not have U.S. Food and Drug Administration (FDA) approval-making it more important than ever for practicing clinicians to understand the use of these psychotropic medications among several special populations, including children and adolescents, the geriatric patient, and pregnant and lactating women. Chapters within these books are authored by experts in their respective areas of practice. Together, they have synthesized a large amount of medical literature into a comprehensive, yet understandable, concise, reader-friendly guide that features useful tables pertaining to the efficacy of specific medications and summaries of important clinical pearls of wisdom that are summarized at the end of each chapter into Key Clinical Concepts. These books are a must-have reference for psychiatrists and other practicing clinicians, residents-in-training, psychiatric nurses, social workers, and researchers. Dr. Rothschild will also discuss his other book, the Clinical Manual for Diagnosis and Treatment of Psychotic Depression (2009).

HELPING YOUR PATIENTS WITH SERIOUS MENTAL ILLNESSES HAVE A MEANINGFUL DAY: LESSONS LEARNED FROM THE OPENING DOORS TO RECOVERY PROJECT

Chair: Michael T. Compton, M.D., M.P.H.

Speaker: Beth Broussard, C.H.E.S., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe key features of the recovery paradigm, including the meaningful day construct; 2) Discuss qualitative and quantitative research findings from the Opening Doors to Recovery project in southeast Georgia; 3) Recognize the importance of helping patients develop a meaningful day as part of their recovery journey; 4) Discuss implications for practicing mental health professionals.

SUMMARY:
Individuals with serious mental illnesses and a history of repeated hospitalizations often do not have the needed community-based support to successfully reintegrate into their communities and embrace recovery. Rather, they often find themselves struggling with repeated hospitalizations, arrests/incarcerations, and even homelessness. Public mental health systems need new, innovative approaches to addressing these problems. The "Opening Doors to Recovery" model was designed by the Georgia affiliate of the National Alliance on Mental Illness and diverse local partners as a fresh new approach to help persons with serious mental illnesses stay out of hospitals and jails/prisons, have better housing outcomes, and embrace the tenets of recovery, (including hope, empowerment, peer support, shared goal-setting, and developing a meaningful day). Workshop participants will: (1) discuss their own ideas about recovery and how developing a meaningful day is a central aspect of recovery, (2) be provided with an overview of the Opening Doors to Recovery project in southeast Georgia, (3) view an 8-minute video about Opening Doors to Recovery, (4) be given an overview of qualitative and quantitative research findings on Opening Doors to Recovery, and (5) discuss ways to support recovery among their patients with serious mental illnesses, especially as it pertains to developing a meaningful day. Implications for practicing mental health professionals will be emphasized.

THE ISSUE OF BIAS IN FORENSIC PSYCHIATRY

Chairs: Robert L. Sadoff, M.D., Claire Pouncey, M.D., Ph.D.

Speakers: Solange Margery Bertoglia, M.D., Clarence Watson, J.D., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the ethical issues for forensic psychiatrists as published by the American Academy of Psychiatry and the Law; 2) Recognize the areas of bias inherent in the practice of forensic psychiatry; 3) Refuse to participate in

forensic cases in which his/her bias will interfere with "striving for neutrality".

SUMMARY:
The Ethics Guidelines for forensic psychiatrists published by the American Academy of Psychiatry and the Law clearly declare the concept of honesty and striving for neutrality as they recognize the inherent bias in many cases both criminal and civil. This workshop will address the guidelines and point out areas of bias both by the forensic expert and toward the psychiatrist. Our panel includes a psychiatrist who is also an expert in biomedical ethics, one who is also an attorney and one who specializes in immigrants involved in the justice system. The Chair has written on the vulnerable populations encountered by forensic psychiatrists and how to minimize harm they encounter in the justice system. Some cases are so egregious and horrendous that one may not be able to participate and should refuse to participate. One goal of the workshop is to help participants recognize their own particular biases associated with specific cases. Such cases may include child pornography, child molestation, spouse abuse, mass murder, torture and in civil cases, malingering illness.

MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM II

Chairs: Marra Ackerman, M.D., Rachel Caravella, M.D.

Speakers: Sarah Richards Kim, M.D., Yael Holoshitz, M.D., Jeffrey Seal, M.D., Adam Demner, M.D., Annaheta Salajegheh, M.D., Erica Greenberg, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Clearly identify the aims and responsibilities of the chief resident in each of the following roles: Administrator, Liaison, Educator, and Mentor; 2) Recognize and develop effective problem-solving strategies through shared learning experiences with other participants; 3) Build a network with Chief Residents from other programs to provide ongoing support and consultation.

SUMMARY:
This is Part II in a two-part workshop for incoming Chief Residents. Outgoing and former Chief Residents, residency directors and others interested in administrative psychiatry are encouraged to attend and share their experiences. Many psychiatric Chief Residents report having satisfying, positive experiences, with the majority (90.6%) saying they would choose to perform the Chief Resident's duties again. However, the literature suggests several problems inherent in the role, including poorly defined description of responsibilities, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to clearly delineate the roles of the Chief Resident, discuss frequently encountered challenges, and provide a forum for shared learning and support. In this workshop, outgoing Chief Residents will briefly present common situations encountered during their term followed by discussion and small group activities to foster interaction and exchange among participants.
Issues to be addressed in Part II of this workshop will include: (1) Educational opportunities such as orientation, curriculum review, junior attending positions, and clinic rounds; and, (2) Mentoring activities including building program morale, supporting individual residents through clinical or personal crises.
Literature Reference #1 Lim RF, Schwartz E, Servis M, Cox P, Lai A, & Hales R: the Chief Resident In Psychiatry: Roles and Responsibilities. Academic Psychiatry 2009: 56 – 59.
Literature Reference #2 Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280
Literature Reference #3 Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31:270-276
Literature Reference #4 Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47:277-280

CRIMINAL DEFENSE CONSULTING ON DEFENDANTS WITH PTSD RELATED TO DEPLOYMENT IN IRAQ AND AFGHANISTAN

Chairs: Keith A. Caruso, M.D., Anna Makela, M.D.

Speakers: Kevin D. Moore, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Know procedures for evaluating criminal defendants for PTSD-related defenses; 2) Understand how PTSD symptoms may support an insanity defense; 3) Identify how PTSD symptoms may impact upon the capacity to form mens rea.

SUMMARY:
Recent conflicts in Iraq and Afghanistan have taken their toll on military service members, resulting in an increase in cases of Posttraumatic Stress Disorder (PTSD). Some of those afflicted with PTSD have subsequently been charged with offenses allegedly committed in theater, back in the United States or later on in civilian life following discharge. PTSD-related defenses may included insanity, which is defined as the inability to appreciate the nature and quality or wrongfulness of one's conduct due to severe mental disease or defect according to The Uniformed Code of Military Justice. More frequently, PTSD cases hinge on negation of the capacity to form the requisite mens rea for the alleged offense(s). Workshop format with entail multiple case vignettes followed by presenters leading audience discussion. Case vignettes will include an in-theater defendant with comorbid PTSD, traumatic brain injury and mefloquine exposure; a second in-theater defendant whose threatening behavior allegedly stemmed from his irritability and hyper-

vigilance; a third defendant claiming PTSD who had fatally shot his wife Stateside; and a veteran with PTSD alleged to have participated with his wife in a case of fatal child abuse. The impact of PTSD symptoms of irritability, hypervigilance, and dissociation upon mens rea will be addressed.

WORKFORCE DEVELOPMENT IN INTEGRATED CARE: A MULTIDISCIPLINARY APPROACH FOR HEALTHCARE SYSTEMS

Chairs: Robert C. Joseph, M.D., M.S., Kimberlyn Leary, M.P.A., Ph.D.

Speakers: Hsiang Huang, M.D., M.P.H., Kimberlyn Leary, M.P.A., Ph.D., Jessie A. Fontanella, Ph.D., Colleen J. O'Brien, Psy.D., Robert Joseph, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand our multidisciplinary curriculum for training staff and trainees in Primary Care Behavioral Health integration; 2) Adapt the training modules to the specific needs of your organization; 3) Train your organizations in Primary Care Behavioral Health Integration.

SUMMARY:
The integration of mental health care into ambulatory primary care clinics has become one of the darlings of health care delivery reform. The evidence base supporting this approach has grown tremendously over the past several decades and integration has increasingly been adopted and promoted by payers and policy makers. This effort is now accelerating along with the advent and development of the "medical home" where mental health integration is usually felt to be essential.
Despite the research base supporting integration the implementaion of such models has been slow and has met with mixed success. The reasons for this are myriad and include many structural, administrative and financial barriers. These include divided leadership between mental health and primary care, insurance carve outs, mixed payment incentives, confidentiality concerns, and the simple lack of space to accommodate mental health staff. As various organizations have overcome these barriers we have begun to recognize that the work in integrated mental health services is significantly different than traditional mental health delivery and that little/no attention is paid to this work in most training programs (regardless of the discipline).
In response to this we will present a multidisciplinary curriculum that we have designed to be used for both staff development and in the various training programs at Cambridge Health Alliance (Adult Psychiatry, Psychosomatic Medicine, Psychology). The curriculum is designed in a series of "modules" which focus on the essential elements of which any clinician should know to be effective in primary care settings. These include: background and rationale for integrated care; the "cultural" differences between traditional primary and mental health care; necessary skill sets (Behavioral Activation, Problem Solving Therapy, Motivational Interviewing); and the role of mental health clinician in primary care. The modules are designed to be flexible and adaptable to different organizational needs. Our next goal will be to jointly teach this curriculum with our primary care colleagues and to develop modules that will be appropriate for their staff and trainees.

THE SUICIDAL PATIENT: ASSESSMENT AND MANAGEMENT

Chairs: Jan Fawcett, M.D., Rodrigo Escalona, M.D.

Speaker: Brant Hager, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify patients at high long-term and current risk for suicide; 2) Perform and document an adequate suicide risk assessment; 3) Manage and document management of high short-term suicide risk.

SUMMARY:
Despite advances in treatment, national rates of suicide are the highest in the past 20 years and suicide has reached epidemic proportions in the military and veterans. In treated patients, suicide is not uncommon. The standard of care requires a clinician to adequately assess and manage suicide risk, but does not require that suicide be prevented. This workshop will review a suicide assessment, evidence based short-term suicide risk factors, the VA program for suicide reduction, and the management and documentation of assessment and management for patients at short-term risk for suicide.

MAY 05, 2014

BEYOND SILVER LINING PLAYBOOKS: ADVANCED METHODS FOR COGNITIVE BEHAVIOR THERAPY WITH YOUTH

Chair: Robert Friedberg, Ph.D.

Speaker: Robert Friedberg, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Acquire 3-4 ways to transform vague patient complaints into target goals; 2) Identify elements of the new modular approach to CBT with youth; 3) Acquire a basic grasp of several psychoeducational, self-monitoring, basic behavioral tasks, cognitive restructuring, and exposure/experiment procedure; 4) Become familiar with creative modifications of traditional empirically based approaches; 5) Recognize 4-5 measures useful for documenting clinical effectiveness.

SUMMARY:
Cognitive Behavior Therapy with youth is often mistakenly seen as a set of cookbook techniques to enhance positive thinking. However, genuine CBT works to move beyond find-

ing silver linings in young patients' lives to integrate assessment and treatment in order to produce powerful, enduring changes. Moreover, with the emergence of Health Care Reform, developing and documenting treatment effectiveness is becoming pivotal. Accordingly, this workshop teaches attendees ways to transform vague complaints into specific treatment goals. Additionally, both traditional and more innovative CBT techniques will be demonstrated. Procedures using child friendly materials and technology will be presented. Finally, broad and narrow band measures suitable for treatment to target goals assessment will be explained. The first section of the workshop focuses on developing treat to target goals which involves processes to transform obtuse complaints into measurable therapeutic goals. Specific guidelines for establishing target goals are presented. The second part of the workshop explains a modular based cognitive behavioral approach to children (Chorpita, 2006,; Friedberg, McClure & Garcia, 2009, Friedberg et al., 2011; Weisz & Chorpita, 2010). The modular approach allows transdiagnostic application of psychotherapeutic procedures. Accordingly, the prototypical modules (psychoeduation, self-monitoring, basic behavioral tasks, cognitive restructuring, and exposures/experiments) are explained and the particular techniques are demonstrated. Further emphasis is given to describing innovative variations of the traditional techniques. Finally, recommendations for using both narrow-band and broad band assessment measures to document therapeutic progress will be made. Attendees will leave the session equipped with handy skills and tools to augment their clinical practice. Detailed handouts, examples, and references are included in the session.

TRIPLE C: A NEW TREATMENT PHILOSOPHY FOR PATIENTS WITH SEVERE MENTAL ILLNESS

Chairs: Victor J.A. Buwalda, M.D., Ph.D., Lisa B. Dixon, M.D., M.P.H.

Speakers: Victor J.A. Buwalda, M.D., Ph.D., Lisa B. Dixon, M.D., M.P.H., Hans van Wouwe, M.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Gain insight into the Triple C philosophy introduced by ASVZ; 2) Gain insight into the first experiences in mental healthcare. At the end the participants will have an idea what is needed to implement the philosophy within mental health programs and how to achieve concrete and measurable results; 3) See first visable results .

SUMMARY:
In the 90s, ASVZ, an organization for the treatment of people with intellectual disabilities in The Netherlands, developed a new treatment philosophy for the care of individuals with mild intellectual disabilities. The name, "Triple-C," stands for Client, Coach and Competence. A coach, the client's nurse, works together with the client towards building competencies in order to live as normal a life as possible. The client partners with the coach who provides unconditional support and an optimistic hopeful spirit. They work together to identify meaningful daily activities. This strategy completely changed the outlooks of clients and transformed the impossible to the possible. Research has demonstrated the positive impact of Triple C in the treatment of people with intellectual disabilities and normally gifted people with autism spectrum disorder (van Wouwe et al, 2013).
In regular mental healthcare a problem-oriented approach created paternalism. Patients were often detained on the basis of the so-called "hazard criteria"-the equivalent of involuntary treatment in the US. Control and monitoring created a culture of fear and anxiety. Staff members were anxious and positive energy disappeared.
After 20 years of developing the Triple C approach for individuals with mild intellectual disabilities, ASVZ began to work with an inpatient mental health unit serving patients with severe mental illnesses who were languishing, receiving care consistent with the prevalent approach of responding to problems rather than building competencies. Implementing the Triple-C philosophy gave energy back to the nurses; patients were again seen as competent human beings. Paternalism disappeared and the involuntary treatment--detentions-was minimized.
In this workshop, the founders of Triple-C describe and illustrate the model as it was developed for individuals with developmental disabilities. We explain the adaptation of the philosophy and approach to mental health, especially for patients with severe mental illness. The entrepreneurs in mental health will reflect on their own personal changes as well their first hopeful experiences for their SMI patients.

CHANGING THE PRACTICE OF FORENSIC PSYCHIATRY

Chair: Ezra E. H. Griffith, M.D.

Speakers: Michael Norko, M.A., M.D., Madelon V. Baranoski, Ph.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the main areas in which we believe forensic psychiatry has undergone change in recent decades, and the factors contributing to this gradual transformation; 2) Outline the evolution of the ethics of forensic practice and its application to evaluation and forensic treatment settings; 3) Illustrate the expanded involvement of mental health professionals in activities designed to prevent, mediate or mitigate the involvement of individuals with mental illness in the criminal justice ; 4) Analyze the growth in the depth and breadth of knowledge and skills development necessary to forensic training in order to facilitate professional participation in the full range of activities asso.

SUMMARY:
During the last few decades, the discipline of forensic psychiatry has undergone substantial change. This transforma-

tion has been fueled by developments in mental health law; advances in therapeutics and neuroscience; human rights advocacy and medical ethics; and formal recognition of the specialty itself, which has expanded its influence, further enhanced by emerging empirical knowledge, ethics, and theory. These features all demand new consideration of the parameters that define the activities of the modern forensic mental health professional.

In this workshop, we will outline a new structure for the discipline, as we lead an extended conversation about key areas that we believe have impacted the field. First, we will consider how the basic discourse in the specialty has been influenced by these factors, generating new and expanded roles and mandates, including administrative, consultative and legislative roles for forensic mental health professionals; and the need to manage ever-increasing mandates from government and monitoring bodies.

We will then discuss the evolution of the ethics of forensic practice, including the concepts of compassion for the evaluee and maintenance of the evaluee's dignity during the evaluation process. Next we examine developments in the management and treatment of individuals who have had involvement with law enforcement systems, including diversion from prosecution and reintegration into the individuals' home communities following incarceration.

We will conclude our discussion by focusing on the task facing training programs charged with translating the ideas about these new developments into syllabi for the preparation of the future forensic mental health professional.

CLINICAL ISSUES IN SCHIZOPHRENIA WITH COMORBID DISORDERS: UPDATE

Chairs: Michael Hwang, M.D., Peter F. Buckley, M.D.

Speakers: Michael Hwang, M.D., Alec Roy, M.D., Jean-Pierre Lindenmayer, M.D., E. Cabrina Campbell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and diagnose schizophrenia with challenging comorbid psychiatric disorders; 2) Be familiar with and able to discuss multi-disciplinary assessment of schizophrenia with common comorbid conditions; 3) Understand psychosocial and pharmacological treatment intervention of challenging comorbid disorders in schizophrenia; 4) Be familiar with clinical management and discuss the clinical implications of schizophrenia with comorbid disorders.

SUMMARY:

Patients with schizophrenic disorder presents with diverse clinical phenomena and treatment outcome. This is due to the underlying heterogeneity in bio-psycho-social pathogenesis that may affect their symptom manifestation and treatment response. The clinical and biological nature of co-morbid disorders in schizophrenia has been long debated and remains a clinical challenge. Current clinical and research evidence support recognition and treatment of comorbid disorders for the optimal outcome. Emerging evidence in recent years also suggest that some comorbid conditions in patients with schizophrenia may constitute a schizophrenic subtype with distinct psycho-biological pathogenesis that requires specific pharmacological and behavioral treatment intervention.

Furthermore, increasing emphasis on recognition and treatment of associated symptoms in schizophrenia, as well as the recent advances in symptom specific pharmacological treatment, have raised clinician awareness in patients with schizophrenia and comorbid disorders. Recent clinical and research findings suggest that specific comorbid disorders, such as panic and OCD, impulsive-aggressive or suicidal behaviors further compound the clinical course and call for specific treatment interventions.

In this proposed issues workshop we will review the current clinical and research advances in challenging comorbid conditions in schizophrenia and discuss their treatment issues. Dr. Hwang will discuss the diagnostic issues and treatment challenges in schizophrenia with obsessive-compulsive and panic symptoms. He will discuss the systematic approaches to develop individualized treatment interventions. Dr. Lindenmayer will review the current clinical and research evidence of pharmaco-behavioral treatment in impulsive-aggressive schizophrenic patients. Dr. Roy will discuss the treatment issues in high-risk suicidal schizophrenic patients and present current evidence for specific pharmacological psychosocial treatment interventions.

Dr. Campbell will review the bio-psycho-social factors of substance abuse in schizophrenia and discuss multi-disciplinary treatment approaches.

Finally, Dr. Buckley will review and discuss current clinical issues and treatment approaches in schizophrenia with comorbid disorders.

WHAT TO DO WHILE WAITING FOR BETTER ANTIDEPRESSANT TREATMENTS: ANTIDEPRESSANT EFFICACY AND OPTIONS

Chair: Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Address recent challenges in media to usefulness of antidepressants; 2) Review methodological challenges to evaluating antidepressant efficacy; 3) Consider options for treating depression; 4) Case-based discussion that illustrates the challenges and promise of staying the course.

SUMMARY:

There is a broad range of views of the role of medications in the treatment of Depressive Disorders ranging from strongly positive advocacy of their efficacy and usefulness to claims of being no better than side-effect laden placebos. The views that support the latter opinion fail to consider the real methodological challenges to proving efficacy in large clinical trials as currently conducted. Further, practitioners know that standard dose monotherapy is unlikely to achieve

and sustain benefits for the majority of sufferers over time. Using a case based history, this interactive workshop will review options and discuss these issues.

COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) IN THE MILITARY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Gary H. Wynn, M.D.

Speakers: Paul Sargent, M.D., Joseph M. Helms, M.D., Gary H. Wynn, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Improve the assessment of resilience promoting factors in service members who may respond to CAM interventions; 2) Improve understanding of CAM as an adjunctive treatment modality for combat stress; 3) Improve understanding of treatment programs available to military service members.

SUMMARY:
The military is using complementary and alternative medicine (CAM) or integrative medicine in a variety of different ways and programs, especially for the treatment of PTSD. The simplest definition of CAM is medical treatments that fall outside the tradition of western medicine and scientific mechanisms of action. In some instances traditional physicians may accept that certain CAM practices work, and even apply them, but reject the historical or spiritual basis for the treatment. Other forms of CAM may have been developed using the reasoning of science, but are outside traditional practice because there is not enough evidence to properly evaluate the technique. This presentation will discuss: 1) CAM overall; 2) acupuncture specifically; 2) research on CAM in the military; 3) use of CAM in military programs; 4) the use of CAM in the management of special military populations and 5) animal-assisted therapy.

SEXUAL TRAUMA AMONG U.S. MILITARY WOMEN: PREVALENCE, RISK FACTORS, AND OUTCOMES

Chairs: Cynthia A. LeardMann, M.P.H., Jeffrey Millegan, M.D., M.P.H.

Speakers: Cynthia A. LeardMann, M.P.H., Nancy Crum-Cianflone, M.D., M.P.H., Kathy M. Magruder, M.P.H., Ph.D., Jeffrey Millegan, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) State the prevalence of sexual trauma among military women; 2) Describe the risk factors for sexual trauma among women in the military; 3) Explain the association of sexual trauma with various short- and long-term health and military-related effects.

SUMMARY:
Sexual harassment and sexual assault in the military has increasingly received attention from researchers, clinicians, policymakers, and the media. Recent studies indicate that approximately 7% of servicewomen reported unwanted sexual contact in the past year, and 15% of female veterans who had deployed to the recent conflicts and subsequently sought care in VA medical centers screened positive for military sexual trauma. While sexual trauma has been recognized as an important issue within the military, further knowledge of the epidemiologic trends and outcomes of servicewomen who have experienced sexual trauma are needed. Data from two large cohort studies will be used to examine the prevalence, risk factors, and health and military consequences of sexual trauma among US military women and veterans. Using data from the Millennium Cohort Study, a large cohort of current service members from all service branches (including active duty, Reserve and National Guard personnel), risk factors associated with sexual trauma among women will be discussed. The association of sexual trauma with functional health and military-related outcomes among these servicewomen will also be presented. Using data from a large cohort of women veterans who served during the Vietnam Era, the prevalence of sexual trauma will be presented. The timing of these traumas (before, during, or after military service) and long term mental health consequences will also be explored. In addition, by using case report data from those who have presented for care at the Navy Medical Center San Diego, we will discuss concerns and issues expressed by women who have experienced sexual trauma while serving in the military. Women who served during the Vietnam War era and the recent conflicts in Iraq and Afghanistan have experienced high rates of sexual harassment and assault. Our findings indicate that some of the risk factors may be related to the type of environment (eg, combat experience, branch of service), while others are related to individual characteristics and resiliency factors (eg, age, marital status, mental health conditions). In designing and testing interventions to prevent sexual trauma, it may be practical to target these environments, and focus on enhancing resiliency factors. Our findings reveal that sexual trauma is associated with numerous negative effects (including decreased functional health, increased work difficulties, increased mental health problems, and more demotions), suggesting that reduction of sexual trauma in the military is critical for ensuring a health and fit force. To reduce sexual trauma in the military, complex and unique obstacles inherent within the military structure must be considered including the structure for reporting sexual trauma, protecting victims, and prosecuting perpetrators. Continued efforts are needed to design and measure the effectiveness of prevention programs and policies to acheive a military free of sexual trauma.

ALIGNING ETHICS AND EVIDENCE IN THE DISTINCTION BETWEEN 'SUICIDALITY' AND 'DESIRE FOR HASTENED DEATH' IN HOSPICE PATIENTS

Chairs: Timothy W. Kirk, Ph.D., Nathan Fairman, M.D., M.P.H.

Speakers: Timothy W. Kirk, Ph.D., Nathan Fairman, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize ethical and clinical imperatives for identifying and assessing desire for hastened death (DHD) in hospice patients; 2) Appreciate the current lack of evidence-based tools to distinguish DHD from suicidality in hospice patients; 3) Formulate research aims to develop, validate, and implement such tools in hospice practice.

SUMMARY:
State regulations, organizational policies, and recommended clinical procedures addressing legal options for terminally ill patients to hasten their deaths often require clinicians to ensure that patients who wish to participate are not "suicidal," but rather are exhibiting a "desire for hastened death." Similarly, ethical discussion about the right of patients to hasten their own deaths, in lay and peer-reviewed publications alike, frequently assumes that there is a bright line between patients who are suicidal and patients who desire to hasten their deaths.
Clinically, however, we are not aware of any evidence-based tools designed to facilitate evaluation of terminally ill patients in such a manner as to support a robust distinction between the two phenomena. While experts in palliative care psychiatry may be able to use their clinical judgment to make such distinctions with some confidence, almost all U. S. hospice programs depend on clinicians with no specialized psychiatric training in making such determinations.
This session explores the significant disconnect between the public ethical discussion and the clinical reality of distinguishing between suicidality and a desire for hastened death in terminally ill patients. Following, it engages participants to identify ways in which the psychiatric and hospice & palliative care communities might partner to formulate research questions and develop evidence-based assessment tools to help close the gap between ethics and evidence at the end of life.

THE NEW, CONFUSING CPT CODES: HOW TO GET PAID WHAT YOU DESERVE

Chairs: Vikram Shah, M.B.A., M.D., Stuart L. Lustig, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate a working knowledge of the new CPT codes; 2) Understand the documentation requirements for the new CPT codes used by psychiatrists; 3) Identify the appropriate CPT codes that optimally reflect actual clinical work.

SUMMARY:
The American Medical Association has recently revised the current procedural terminology (CPT) codes used by mental health professionals who file claims for payment, for 2013 and beyond. Mental health prescribers are now obligated to use evaluation and management (E/M) codes for any medical services related encounter, along with a number of add-on codes for additional services, such as psychotherapy, in the same encounter. Determination as to the appropriate E/M code is dependent upon the complexity of history, examination and medical decision making. Although the revisions attempt to better align both the time spent in the clinical encounter and the conceptual complexity of the visit with the structure of reimbursements, many clinicians find this new, complex algorithmic approach to coding to be time consuming, bewildering, and very frustrating.
This workshop is presented by managed care medical directors who use a specially designed auditing tool to review claims submitted with the new CPT codes. The purpose of the workshop is to provide participants with an understanding of the process, rationale, and application of the numerous changes to the CPT codes so that they can then 1) choose the appropriate CPT code to accurately reflect their clinical work; 2) maximize their reimbursement; and 3) ensure that their documentation is sufficiently rigorous to meet the requirements of a potential managed care audit. To enhance their understanding and skills at optimizing their reimbursement correctly, they will play the role of auditors reviewing samples of notes from patients' charts. They will also discuss examples of well-documented cases and managed care reviewers' feedback on those cases that do not meet the documentation standards. Finally, attendees will also use a self-assessment guide to determine their readiness to correctly apply the new CPT codes.
By the completion of the workshop, clinicians should thoroughly understand how best to represent their clinical work using the new CPT codes with insight and ease.

USE OF AACAP PRACTICE PARAMETER FOR CULTURAL COMPETENCE AND DSM CULTURAL FORMULATION IN EVALUATION AND TREATMENT OF EATING DISORDERS

Chairs: Alican Dalkilic, M.D., M.P.H., Andres J. Pumariega, M.D.

Speakers: Hatice Yilmaz, M.D., Consuelo C. Cagande, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the role and impact of culture in development, course, and treatment of eating disorders (ED); 2) Use the American Academy of Child Adolescent Psychiatry Practice Parameter for Cultural Competence & DSM cultural formulation in evaluation & treatment of culturally diverse youth with ED; 3) Evaluate, diagnose, & treat eating disorder patients & co-occurring conditions from various cultural backgrounds; 4) Review and learn about clinical presentation of ED patients from minority populations.

SUMMARY:

Use of AACAP Practice Parameter for Cultural Competence and DSM Cultural Formulation in Evaluation and Treatment of Eating Disorders

Recent studies demonstrate that eating disorders (ED) have gone from being culture-bound syndromes seen mostly in Caucasian women in Western, industrialized societies to having increasing prevalence in non-Western countries and among minority populations. The prevalence of anorexia nervosa (AN) and binge eating disorder (BED) have recently been similar among non-Latino whites, Latinos, Asians, and African Americans (AA) and bulimia nervosa (BN) was more common among Latinos and AA than non-Latino whites in the US (1). This increase has been a result of both greater awareness as well acculturation and acculturation stress driven by the media influence of mainstream Western cultural values on diverse cultures, within the US and globally (2).

ED are among the most lethal psychiatric disorders, but often go unrecognized in ethnic minorities or only diagnosed after progressing to a severe stage (3). Most people with eating disorders do not receive treatment, either because ED are not diagnosed or because they refuse treatment due to shame, denial of ED, and their pursuit of the Westernized "ideal." Therefore, it is important for clinicians to be familiar with the role of cultural factors in development and course of ED and recovery of patients.

In this workshop we will introduce the use of the American Academy of Child Adolescent Psychiatry (AACAP) Practice Parameter for Cultural Competence in Child & Adolescent Psychiatric Practice to guide the evaluation and treatment of diverse youth suffering from ED. We will also discuss ED cases from diverse backgrounds and DSM cultural formulation and address the impact of acculturation stress, acculturative family distancing, therapeutic alliance and transference, community stigma, and culturally informed treatment of co-morbid conditions in eating disorders.

References

1. Smink FR, van Hoeken D, Hoek HW. Epidemiology of eating disorders: incidence, prevalence and mortality rates. Curr Psychiatry Rep. 2012 Aug;14(4):406-14.

2. Miller MN, Pumariega AJ. Culture and eating disorders: A historical and cross-cultural review. Psychiatry 64(2), Summer 2001.

3. Cummins LH, Simmons AM, and Zane NWS. Eating disorders in Asian populations: A critique of current approaches to the study of culture, ethnicity, and ED. American Journal of Orthopsychiatry 2005, Vol. 75, No. 4, 553-574.

4. Pumariega AJ, Rothe E, Mian A, et al. Practice parameter for cultural competence in child and adolescent psychiatric practice. http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/Cultural_Competence_Web.pdf

Keywords: Eating disorder, cultural competence, co-morbid condition, acculturation stress

PERINATAL MENTAL HEALTH AND THE MILITARY FAMILY

Chairs: Tangeneare Singh, M.D., Melinda A. Thiam, M.D.

Speakers: Karen Weis, Ph.D., Elizabeth Greene, M.D., Melinda A. Thiam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the many different ways maternal perinatal illness can present and the consequences of untreated perinatal illness on mothers, fathers and children and mother-infant relationship; 2) Identify the unique mental health challenges of military spouses and children as well as affects of perinatal mental illness on the military family ; 3) Identify two different treatment models for addressing perinatal depression that have been implemented in the military setting.

SUMMARY:

Introduction:Perinatal depression is a mood disorder that occurs in the time period associated with pregnancy, childbirth and the initial year postpartum. The consequences of perinatal depression extend beyond just the mother and also negatively impact mother-infant attachment, infant development, relationship with spouse and family. The military family is particularly at risk for perinatal depression given the challenges of adapting to parental role while simultaneously coping with the psychosocial stressors and challenges that are inherent to military lifestyle.

The Military Family: Military families often are faced with frequent geographical separation from the Service Member for deployment/trainingr, frequent relocations and inherent struggles the come with military lifestyle. The military family is particularly affected around the perinatal period. Studies examining the incidence and prevalence of perinatal depression in military spouses and Active Duty mothers have found rates high as 20-25% compared to 10-15% in the general population.

Impact of perinatal depression: Maternal mental health has a long-lasting impact the mental health of the infant, mother, and the mother-infant bond. It also affects the father of the infant and the relationship between the two parents .Studies on infant mental health and attachment have demonstrated the impact of parental illness on infant growth and development. The normal mother-infant interaction is dependent on the mother's ability to emotionally attune to her infant's emotional state and reflect this state back to infant which teaches infants that their actions have affects on their environment. Mothers who are depressed are often emotionally unavailable to engage in non-verbal dialogue, often interpret infant's facial cues negatively and perceive their infants to be more fussy. Infants, in turn, are less sensitive to changes in verbal expression, less attuned to their environment, less playful, potentially more irritable and less emotional which can lead to poor attachment that is essential of social, cognitive and emotional growth and development. In addition to the infant, partners of depressed mothers can also be negatively affected. Maternal depression often leads to relationship/marital distress such as fear of rejection from partner, misdirected anger, withdrawal, marital dissatisfaction as well as communica-

tion difficulties of needs/expectations. Discussion: President and First Lady Obama have pledged to focus government resources on addressing mental health challenges of military families. Perinatal depression is one specific mental health challenge that is under-recognized, and under treated in the military population. This workshop will review perinatal depression in general population as well as address specific challenges for the military family. Finally, we will describe two treatment modalities that have been implemented at two different military treatment facilities.

CREATIVE WAYS OF HEALING FROM SUICIDE LOSS

Chair: Michael F. Myers, M.D.

Speakers: Carla Fine, M.S., Christopher Lukas, B.A., Kathie Russo, B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify factors that distinguish suicide bereavement from mourning associated with other types of deaths; 2) Recognize key dynamics that are pivotal in therapeutic work with survivors of suicide; 3) Incorporate themes of creativity in goal setting with grieving patients.

SUMMARY:
Each year in the United States, more than a quarter of a million people become survivors i.e. individuals who lose a family member, friend, or colleague to suicide. An unknown number of these people become our patients as they attempt to prevail (or simply remain alive!) through this most devastating of losses. This workshop highlights the creative process as a key therapeutic factor. Dr. Myers will give a brief overview of suicide loss and its clinical significance for mental health professionals, followed by 15 minute presentations by the three speakers. Kathie Russo, producer of "Spalding Gray: Stories Left to Tell" (Off-Broadway, 2007) and "And Everything is Going Fine" (film directed by Steven Soderbergh) and widow of writer, actor and monologuist Spalding Gray will discuss her journey – both before her anguished husband killed himself and since. Christopher ("Kit") Lukas is a film-maker, actor, and writer. . He is the author of "Blue Genes: A Memoir of Loss and Survival" and "Shrink Rap: A Guide to Psychotherapy from a Frequent Flier". He has survived 5 suicide deaths in his family including the loss of his mother while growing up and, in 1997, the loss of his brother, a writer and winner of two Pulitzer Prizes. Lukas will talk about how the various forms of creativity in which he has been engaged are responsible for keeping him from serious depressive episodes. Carla Fine, author of the international best seller (now in its 14th. printing) "No Time to Say Goodbye: Surviving the Suicide of a Loved One, lost her physician husband to suicide. She will describe how her personal journey of healing and growth has been shaped by writing, conducting workshops and lecturing on the subject. One third of the allotted time will be protected for interactive discussion with the audience.

UPDATE ON MOVEMENT DISORDERS: CLINICAL FEATURES AND DIAGNOSIS

Chair: Vasant P. Dhopesh, M.D.

Speakers: James Morley, M.D., Ph.D., Stanley N. Caroff, M.D.

EDUCATIONAL OBJECTIVE:
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; 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.

DYNAMIC THERAPY WITH SELF-DESTRUCTIVE PERSONS WITH BORDERLINE PERSONALITY DISORDER: AN ALLIANCE-BASED INTERVENTION FOR SUICIDE

Chair: Eric Plakun, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference; 2) Utilize principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients; 3) Understand common factors in treating self-destructive borderline patients derived from study of 6 behavioral and dynamic psychotherapies.

SUMMARY:
Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practi-

cal clinical guidance is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from non-lethal self-destructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) non-punitively interpret the patient's aggression in considering ending the therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (9) provide an opportunity for repair. These principles are compared to a set of common factors derived from review of 6 evidence-based therapies for suicidal borderline patients. After the presentation the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS VERSUS PSYCHIATRIC DISORDERS MIMICKING MEDICAL CONDITIONS: DIAGNOSTIC AND TREATMENT CHALLENGES

Chairs: Catherine C. Crone, M.D., Lorenzo Norris, M.D.

Speakers: Neil V. Puri, M.D., Yu Dong, M.D., Ph.D., Baiju Gandhi, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Provide the participant with clinical information to help discern psychiatric disorders whose symptoms and presentation may mimic medical/physical disorders; 2) Provide the participant with clinical information to help discern medical disorders whose symptoms and presentation may mimic psychiatric disorders ; 3) Provide the participant with approaches to diagnose and manage psychiatric disorders that mimic medical disorders in their presentation; 4) Provide the participant with approaches to diagnose and manage medical disorders that mimic psychiatric disorders in their presentation.

SUMMARY:
Medical Conditions Mimicking Psychiatric Disorders vs. Psychiatric Disorders Mimicking Medicine Conditions: Diagnostic and Treatment Challenges
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, post-traumatic stress disorder, panic disorder, and schizophrenia. However, exposure to cases that initially appear to be primary psychiatric disorders but are actually due to underlying medical conditions is often lacking, despite their common occurrence. Infections, hypoxia, electrolyte imbalances, endocrine disorders, autoimmune disorders (e.g. lupus, sarcoidosis) neurologic conditions (e.g. epilepsy, multiple sclerosis, delirium/encephalopathy) and medications are just some of the causes of patient presentations that mimic primary psychiatric disorders. Awareness of these "mimics" is needed as patients may otherwise appear to have "treatment-resistant" psychiatric disorders or, of greater concern, actually worsen when given psychotropic medications.
An additional area of clinical knowledge that would benefit 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 intervention.
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 case-based format with opportunities for questions and discussion with residents, fellows, and attending physicians with experience and/or expertise in psychosomatic medicine patient populations.
Workshop Structure:
Introduction (5-10minutes): presentation about the concept and causes of medical mimics of psychiatric disorders as well as psychiatric disorders mimicking medical conditions
Case 1 (10 minutes/ 10 minutes discussion)
Case 2 (10 minutes / 10 minutes discussion)
Case 3 (10 minutes / 10 minutes discussion)
Overall Questions/ Discussion (25 minutes): provides an opportunity for attendees and discussants to interact and address ask further questions about the case material presented as well as to bring up additional issues pertaining to the diagnosis and treatment of these patients.

SYMPATHETIC SYSTEM MODULATION TO TREAT POST TRAUMATIC STRESS DISORDER (PTSD): A REVIEW OF CLINICAL EVIDENCE AND NEUROBIOLOGY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Jerald J. Block, M.D.

Speakers: Eugene Lipov, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the mechanisms and efficacy of available oral sympatholytic agent on PTSD symptoms. At the completion of this session participants will be able to demonstrate knowledge of clinical use of o; 2) Review the mechanisms and efficacy of available selective sympathetic blockade on PTSD symptoms. At the completion of this session participants will be able to demonstrate knowledge of clinical use; 3) Review the mechanisms and efficacy of SGB on PTSD symptoms, specifically memory dysfunction and alcohol abuse. At the completion of this session participants will be able to demonstrate knowledge o.

SUMMARY:

The sympathetic nervous system (SNS) is part of the autonomic nervous system. Its role is to mobilize body's resources under stress, to induce the fight-or-flight response. It is also constantly active at a basal level in order to maintain homeostasis. In PTSD, the SNS is known to be chronically activated over the normal baseline levels. In large part, the activation of the SNS is accomplished by the increase of catecholamines, mainly epinephrine and norepinephrine. The role of norepinephrine in the brain is that of a neurotransmitter leading to arousal, selective attention, and vigilance. Such notable increases in noradrenergic activity among subjects with PTSD suggest that reducing CNS noradrenergic activity could be effective, especially for arousal symptoms such as nightmares and startle reactions. Orally active noradrenergic blocking or deactivating agents that have been used to moderate an over-active SNS include clonidine and prazosin, both were original as antihypertension medication. Both have been previously reported to have psychiatric effects on PTSD. In addition to these oral agents, it is now possible to directly affect the sympathetic nervous system with selective blocking techniques. The stellate ganglion and upper thoracic ganglion (T2) are the upper sympathetic ganglions that innervate the upper chest, the head and the brain. Many of the efferent sympathetic fibers from the thoracic ganglia (T2) pass through the stellate ganglion. A connection from the stellate ganglion and the brain has been shown by the use of the pseudorabies virus injections. Those virus injection techniques have been used to identify cortical areas connected to the stellate ganglion, such as the amygdala, a structure that is known to be involved in the development of PTSD based on a functional MRI .

Selective, sympathetic system manipulation as a potential treatment for anxiety disorders was pioneered in Finland by Dr. Telaranta (1998) which was accomplished by clipping the sympathetic ganglia, via an endoscopic sympathetic block (ESB) at the second thoracic vertebra (T2).

A less invasive technique to produce selective, sympathetic system manipulation is a stellate ganglion block (SGB), where a local anesthetic is placed next to the stellate ganglion. The procedure has been used to treat chronic pain since 1925, first successfully report of the of SGB use to treat PTSD was published by our team (Lipov, 2008). Since 2008 a number of other teams have reported similar observations: Mulvaney, S.W., 2010 Walter Reed Military Hospital , ALINO, J. 2013 Tripler Army Medical Center. SGB has been shown to have significant effect on PTSD in 30 minutes following the procedure (Lipov, 2011) as well as significant memory improvement , reduction of alcohol intake in conjunction with reduction of PTSD symptoms (Lipov, 2012).

RECOVERY, RACE, AND SOCIAL JUSTICE

Chairs: Ippolytos A. Kalofonos, M.D., M.P.H., Ph.D., Helena Hansen, M.D., Ph.D.

Speakers: Joel Braslow, M.D., Ph.D., Samuel K. Roberts, Ph.D., Anand Pandya, M.D., Kenneth Thompson, M.D., Keris J. Myrick, M.B.A., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the term "recovery" and its historical evolution in mental health services; 2) Discuss the implications of the recovery-oriented approach in community mental health for historically underserved and marginalized groups; 3) Identify successes, challenges, and opportunities for a social justice-oriented recovery movement.

SUMMARY:

Recovery has been an organizing principle of public mental health services since the 2003 publication of the New Freedom Commission on Mental Health's report, Achieving the Promise. SAMHSA defines recovery from mental disorders and substance use disorders as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" and outlines 10 fundamental principles of a recovery-oriented system: hope, person-driven, personalized, holistic, peer support, supported through relationship and social networks, culturally-based and influenced, supported by addressing trauma, strengths- and responsibility-based, and respect. The multiple meanings and interpretations of the word and the complex history of the term have lead to a heterogeneous and diverse recovery "movement" that is claimed and subscribed to by policy makers, activists, practitioners, institutions, and critics.

This workshop considers the relationship between the recovery movement and historically underserved populations. Where does the concept come from? For whom is it meant? Does the turn to recovery represent a revolutionary paradigm or does it represent a continued disinvestment in the social safety net? What are the implications of the approach for the underserved, particularly for the incarcerated, a population that has grown over recent decades alongside the recovery movement? What opportunities, synergies, and contradictions, challenges and successes, can be identified by considering the recent history and possible futures of the recovery movement?

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) YOUTH IN JUVENILE DETENTION AND THE FOSTER CARE SYSTEM

Chairs: Cory D. Jaques, M.D., Niranjan Karnik, M.D., Ph.D.

Speakers: Christina Gilbert, J.D., Gerald P. Mallon, D.S.W., Charles J. Sophy, D.O., Leanne Stoneking, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the mental health needs of LGBT youth in foster care and juvenile justice facilities; 2) Comprehend the emerging legal issues and rights that focus on LGBT youth in juvenile justice facilities and foster care; 3) Deploy best practices within a cultural competence framework to understand and address the diverse needs of LGBT youth in juvenile detention and foster care.

SUMMARY:
Despite increased education and awareness of society regarding issues lesbian, gay, bisexual, and transgender people face, LGBT youth continue to experience disapproval, rejection, and hostility from their families, classmates, peers, and social institutions. LGBT youth are overrepresented in the child welfare and juvenile justice systems, and these systems often are not equipped to meet the unique needs of these youth.
All youth under the supervision of the state are guaranteed certain federal and state constitutional rights, including a right to safety, freedom of speech, and freedom of expression. Youth who identify as or are perceived to be LGBT are especially vulnerable to continued societal prejudice and may ultimately be harmed/mistreated as a result. It is the responsibility of the child welfare and juvenile justice systems to provide equal treatment, services, and provide a safe environment free from harassment, discrimination, and violence. Unfortunately, many LGBT youth experience discrimination and unequal while in these systems.
Many LGBT youth in out-of-home care enter these systems for reasons directly related to their LGBT identities. Many LGBT youth are forced to leave their families of origin as a result of conflicts with parents regarding sexual orientation or gender identity. Almost two-thirds of homeless LGBT youth previously have been in child welfare placements. Once in "the system," they often hide their sexual orientation or gender identity for fear of discrimination and denial of services.
Youth who have been the victims of abuse can be at greater risk to engage in behaviors that may bring them to the attention of the juvenile justice system, this includes LGBT youth. Once in juvenile detention, LGBT could possibly face victimization due to their sexual orientation/gender identity. It is not known whether U.S. juvenile detention facilities are equipped to or have developed appropriate guidelines in order to protect LGBT youth from ongoing victimization. Advocates from around the country have brought this issue to light through traditional legal approaches as well as through efforts to reform these systems. Because LGBT youth are at increased risk of suicide and substance abuse, mental health providers would benefit in understanding the unique needs and experiences of LGBT youth in out-of-home placements and collaboratively work with a range of service providers to develop the tools and support these systems need to create a safe and healthy environment for LGBT youth.

HOW TO THINK ABOUT THE DIFFICULT, DEFIANT PATIENT WITH BORDERLINE PERSONALITY DISORDER

Chairs: Kenneth R. Silk, M.D., Nancy N. Potter, Ph.D.

Speakers: Kenneth R. Silk, M.D., Nancy N. Potter, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Appreciate what issues make patients difficult and how patients with borderline personality disorder fit into that idea of being difficult; 2) Appreciate how certain expectations of behavior in our culture perhaps predisposes us to see these patients as difficult; 3) How the structured effective treatments for BPD may help us view patients with BPD as being less difficult.

SUMMARY:
Abstract: Patients with personality disorders present unique ethical challenges in clinical encounters. A person diagnosed with Borderline Personality Disorder is the quintessential 'difficult' patient, hard to empathize with, maddeningly demanding, and alternatingly needy and rejecting. Empathy for the difficult patient is sometimes hard to come by, but clearly empathy is both therapeutic and ethical for clinicians to cultivate. But beyond this, clinicians may benefit from reflecting on some additional rich problems that undergird diagnosis and treatment of BPD patients. This workshop presents three central questions for clinicians to consider when working with BPD patients: 1) how should we think about the concept of 'difficult' when characterizing a patient as difficult; 2) what cultural ideas about these patients affect discernment and treatment; and 3) when is the defiance of BPD patients working against them, and is it ever appropriate for a patient to be defiant? From a clinical point of view, the structured effective treatments for BPD allow us some guidance. For example, being mindful of our own mood and affect is as important as the patient being mindful of his or her affect. The ability to validate the patient's feelings (even if we do not validate their behavior) involves being able to accept and expect more simultaneously. The opportunity to work with a consultation group of peers also helps us as therapists to straddle the challenging dichotomies that such patients continuously present to us. But ultimately from both a clinical as well as an ethical point of view, treating BPD patients involves being able to see through our own overwhelming affect (that is to be able to mentalize) in response to the patients and the predicaments they create so that we can remain reflective, mindful, and helpful to them in the clinical arena. Case studies will accompany this discussion.

PARAPHILIAS: DISORDERED OR DISTURBED?

Chair: Renee Sorrentino, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Become familiar with the scientific basis for the inclusion of paraphilias in the DSM-V; 2) Understand the basic components of a risk assessment of the paraphilias; 3) Understand the recent changes in the DSM-V which resulted in the inclusion and exclusion of specific paraphilias .

SUMMARY:
Although scientific evidence does not clearly indicate whether deviant sexual interest is a mental disease or defect, evidence supports the notion that sexual urges, fantasies, and behaviors can both impair an individuals functionality as well as affect the capacity to confirm one's own conduct to the requirements of the law. Attorneys and policymakers have brought these academic explanations for deviant sexual behavior into the legal arena. As a result, the courts have been confronted with such legal questions, as whether sex offenders are criminally responsible, eligible for civil commitment to acute psychiatric hospitals, or entitled to disability and workplace accommodations. Currently almost half of the states have enacted laws for the civil commitment of sexually violent persons (SVP). However, there is no established standard of practice with regard to individuals who are not legally eligible for SVP commitment but present with sexual urges and fantasies to harm others. For example, a Pedophile or Sexual Sadist is not traditionally considered to have a mental illness, which requires civil commitment to a general psychiatric unit. This is counter-intuitive as both Pedophilic Disorder and Sexual Sadistic Disorder are DSM-V diagnoses. Furthermore an individual who suffers from a Paraphilic Disorder is not traditionally viewed as in need of services covered by the Department of Mental Health.
This workshop will introduce the scientific basis for the conceptualization of paraphilic disorders as major mental illnesses. The legal, ethical and scientific challenges in the determination of criminal responsibility, civil commitment to acute psychiatric hospitals, and disability will be presented. A model for performing risk assessment evaluations addressing such legal questions as criminal responsibility, civil commitment and disability will be presented. In conclusion, the audience will be invited to participate in case vignettes, which examine the quandary of legal, medical and sociologic dilemmas which are found at the crossroads of paraphilic disorders and the law.

ADVANCES IN ASSESSMENT AND TREATMENT OF MILD TRAUMATIC BRAIN INJURY (MTBI)

Chair: Paul Sargent, M.D.

Speakers: James Kelly, M.D., Josh Duckworth, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate cutting edge techniques for assessment of post-concussive symptoms; 2) Understand management options available to clinicians in an outpatient environment; 3) Understand the role of neuro-imaging and interdisciplinary treatment planning in improving outcomes in refractory cases.

SUMMARY:
More than 273,000 service members have sustained a traumatic brain injury (TBI) between 2000 and the first quarter of 2013.The majority of these (approximately 85%) occurred in the non-deployed environment and 82.4% were classified as mild TBI (mTBI), also known as concussion. Current literature reports that 10-15% of individuals who sustain trauma, are alert and have grossly normal neurological function including a Glasgow Coma Scale score of 15 will have an acute brain lesion on CT. Although most of these lesions do not require medical intervention, a few patients will continue to report headaches, vestibular, speech, or neurocognitive symptoms well after the triggering event. Many psychiatrists are now seeing patients with a history of repeated concussion which may influence the clinical psychiatric presentation. In the US military significant attention is being paid to addressing the needs of these patients. In Washington DC, the National Intrepid Center of Excellence (NICoE) has developed an intensive approach to assessment and treatment planning for patients with co-morbid PTSD and TBI. Dr Jim Kelly is the Director of the center and will discuss the center's interdisciplinary approach and increase awareness of TBI as a complicating factor in the treatment of psychiatric illness. Dr Josh Duckworth is the Medical Director for TBI Clinical Services at Naval Medical Center San Diego and will discuss clinical advances in the outpatient assessment and treatment of patients with TBI. The discussion will not only update the audience on recent advances but will also provide clinicians with improved understanding of how to care for these patients. Clinical vignettes will be used to illustrate teaching points.

PROFESSIONALISM IN THE ERA OF 2.0: THE DO'S AND DON'TS OF BLOGGING, TEXTING, POSTING, EMAILING, AND TWEETING

Chair: Almari Ginory, D.O.

Speakers: Wesley Hill, M.D., Almari Ginory, D.O., Michelle Chaney, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize inappropriate and unprofessional uses of social networking; 2) Maintain appropriate boundaries in online patient interactions; 3) Knowledge of how to proceed if inappropriate content is posted by colleagues; 4) Discuss real case examples of unprofessional content in Web 2.0 interactions.

SUMMARY:
The world of Web 2.0 involved the shift of media from passive viewing to active bidirectional interface. The new generation of technology makes access to others much easier through social networking, blogging, emailing, and the abundance of information available via search engines. A simple Google search of a physician's name will grant a patient access to their health grades, reviews by other patients, publications, office website, Facebook/Twitter/Linkedin accounts and on some occasions cell phone number, email, and home address. With more and more young physicians using the web for both personal and professional reasons, caution should be taken in the amount of information available and be wary of possible HIPAA and boundary violations. Young physicians should also be aware of potential pitfalls of patients have easy accessibility to physicians such as a suicide threat sent via Facebook message, text, or email. Several physicians (young and old) have made national headlines over information posted on social networking sites, such as the OB/GYN who reprimanded her patient over Facebook for being late to appointments. Examples such as this, affect the publics perception of physicians and damage the profession.
The purpose of this workshop will be to provide education to residents and medical students about the specific guidelines as they relate to interfacing with Web 2.0 including using social networking sites, blogs, email and text in both personal or professional interactions. The use of email and text messaging contracts with patient will be reviewed. We will review guidelines put forth by state, national, and international organizations. Potential boundary and HIPAA violations will be presented using real life examples. Discussion will be fostered among attendees on ways to handle situations such as a friend request from a patient, an inappropriate post from a colleague, a suicide threat over email, and how to monitor one's Internet presence. We will also encourage attendees to return to their programs and foster education on these topics.

EEG IN PSYCHIATRIC PRACTICE

Chairs: Oliver Pogarell, M.D., Nash N. Boutros, M.D.

Speakers: Oliver Pogarell, M.D., Nash N. Boutros, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the clinical EEG as auxiliary diagnostic tool in psychiatry; 2) Decide whether a clinical EEG is indicated for a particular patient; 3) Identify abnormalities and clinical consequences.

SUMMARY:
EEG remains an underutilized method for assessing organic factors influencing psychiatric presentations. Through this course clinicians will achieve an understanding of several clinical areas where EEG may provide valuable differential diagnostic information. Following a brief summary of historical developments, the psychiatrist will learn the basics of a normal EEG exam and understand both the limitations of EEG testing and the general classes of medical and organic variables that are reflected in abnormal EEG patterns. Specific clinical indicators ("red flags") for EEG assessment will be stressed. More detailed coverage of selected areas will include (1) EEG in psychiatric assessments in the emergency department (2) EEG in the assessment of panic and borderline patients (3) the value of EEG in clinical presentations where diagnostic blurring occurs (i.e. differential diagnosis of dementia, differential diagnosis of the agitated and disorganized psychotic patient, and psychiatric manifestations of non-convulsive status epilepticus). Specific flow charts for EEG evaluations with neuropsychiatric patients in general and for EEG evaluations of repeated aggression will be provided. Numerous illustrated clinical vignettes will dramatize points being made. This course is intended for the practicing clinician. In conclusion, this course is designed to enable the practicing clinician to utilize EEG effectively (i.e. avoid over or under-utilization), to help with the differential diagnostic question and to be able to determine when an EEG test was adequately (technically) performed.
At the conclusion of this workshop, the participant should be able to: understand the limitations of EEG and broad categories of pathophysiology that produce EEG abnormalities. The participants will also have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG. Attendees will also develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy.

THE EMERGING CRISIS IN THE CARE OF OLDER ADULTS WITH SCHIZOPHRENIA: WHAT CAN BE DONE?

Chairs: Carl Cohen, M.D., John Kasckow, M.D., Ph.D.

Speakers: Kimberly Williams, Ipsit Vahia, M.B.B.S., M.D., Paul D. Meesters, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand new findings regarding epidemiology, remission rates, recovery, depression, cognitive dysfunction, and physical disease in older adults with schizophrenia; 2) Understand new research regarding the potential for attaining a satisfactory quality of life, community integration, and successful aging in older adults with schizophrenia; 3) Understand novel neurocognitive and social cognitive approaches, pharmacological strategies, model programs, and public initiatives for older adults with schizophrenia; 4) Discuss the implications of the recent findings and interventions with respect to public policy, clinical care, and research.

SUMMARY:
Older adults with schizophrenia comprise the most rapidly growing segment of persons with mental illness. By 2025, one-fourth of persons with schizophrenia--over 1 million

people-- will be age 55 and over. However, only 1% of the schizophrenia literature has been devoted to older adults and the service delivery system is ill-equipped to deal with the needs of this population. The aim of this workshop is to address the emerging crisis with respect to the care of older persons with schizophrenia. Using a multinational, interdisciplinary, geographically diverse panel, we will review recent research that has shown a much more complex picture of outcome in later life than had been reported in earlier studies as well as describe novel interventional approaches to the special needs of persons with schizophrenia as they grow old. In so doing, we will first provide a brief update on the epidemiology of schizophrenia in later life; present new data on remission rates, recovery, and co-occurring depression, cognitive dysfunction, and physical disease; and describe novel findings regarding the possibilities for attaining a satisfactory quality of life, community integration, and successful aging. Next, we will provide an update on treatment strategies in this population: innovative neurocognitive and social cognitive approaches; pharmacological treatment including tapering of medications; model programs using collaborative care and case management approaches; and recent public initiatives. Based on this review, presenters and workshop participants will discuss the implications of the recent findings and interventions with respect to public policy, clinical care, and research.

AMERICAN HORROR FILM AND PSYCHIATRY

Chair: Fernando Espi Forcen, M.D.

Speakers: Fernando Espi Forcen, M.D., John P. Shand, M.D., Susan Hatters-Friedman, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be familiar with the way mental illnesses have been represented throughout the genre and history of American horror film; 2) Participate in a discussion that considers what various horror films (and their directors) demonstrate about mental illness, and link this with lay views of mental illness; 3) See the impact and importance of mental illness in a film trough several of the most representative horror films; 4) participate in an open forum dialog that discusses the degree in which the American horror genre of film has impacted or could impact stigma in psychiatry; 5) Discuss the commonalities and profiles of serial killers -a classic archetype of the horror genre- from a forensic perspective .

SUMMARY:
Of the many film genres, horror has likely made more references to psychiatry than any other; this workshop will analyze American horror films and its relation to mental illness. The use of psychiatric pathology to terrorize audiences is historically very evident; however, for the most part, this film genre has been underutilized as a learning tool in our field.

The depiction of psychiatry in horror film has been parallel to its own history. Some scholars have proposed that horror films can be a teaching tool psychopathology. “Repulsion” (1965) by Roman Polanski is a beautiful depiction of a woman suffering a psychotic episode. The influence of this film is noticeable in many other later films such as “Black Swan” (2010) by Darren Arenofsky. In “The Cabinet of Dr. Caligari” (1920) by Robert Wiene, “Dracula” (1931) by Tod Browning and “The Testament of Doctor Mabuse” (1933) by Fritz Lang the spectator can appreciate the influence and popular depictions of hypnotherapy and psychoanalysis which may weigh heavily on the stigma of psychiatry today.
The psychopathology of serial killers in slasher films can also be an object of study: Norman Bates (“Psycho” (1960) by Alfred Hitchcock) has traditionally been referred to as a person who suffered dissociative identity disorder, however in the film, many clips indicate symptoms more consistent with schizophrenia. Michael Myers in the “Halloween” (1978) saga shows traits of voyeurism and autism. Jason Vorhees (“Friday 13th, 1980) habitus displayed significant congenital malformation that likely implied intellectual disability and his limitations resulted in an enmeshed relation with his mother. Freddy Krueger (“A Nightmare in Elm Street”, 1984) is depicted as a man with antisocial personality and pedophilia.
Demonic possession syndrome is a type of dissociative disorder that has significantly impacted American horror film since William Friedkin’s “The Exorcist” in 1973 to James Wan’s “The Conjuring” this year in 2013.
Zombies in Horror films where initially approached as a result of voodoo and hypnosis, which also implies a cultural bound syndrome from Haiti with dissociative traits. After George Romero’s “The Night of the Living Dead” (1968), zombies become ghouls surviving on flesh and brains. Recently, Steven Scholzman, M.D. (Psychiatrist at Massachusetts General Hospital) published “The Zombie Autopsies” where he explores the neuroscience of the zombie which demonstrates the interest in not only the psyche of the zombie, but the neuroanatomy as well. Zombie films can also be analyzed from a sociological perspective; for example, in most films, the zombie epidemic initiates chaos and anarchy and a regression of society to its most primitive forms, in which survival is the only objective. In times of financial crisis and dissatisfaction, this might give insight into the revitalization of the zombie genre and culture.

TOP 10 GERIATRIC PSYCHIATRY ISSUES FOR THE GENERAL PSYCHIATRIST

Chairs: Josepha A. Cheong, M.D., Iqbal Ahmed, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) identify the key issues in the geriatric patient presenting in a general clinic setting; 2) initiate appropriate treatment and management of cognitive disorders; 3) Manage behavioral disturbances in an elderly patient with cognitive disorders.; 4) identify strategies for assisting caregivers

of patients with dementia.

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.

TREATING CANNABIS USERS WITH MOOD DISORDERS: AN OPEN DISCUSSION

Chairs: Zimri Yaseen, M.D., Igor Galynker, M.D., Ph.D.

Speakers: John J. Mariani, M.D., Amanda Reiman, M.S.W., Ph.D., Mary Q. Pedersen, B.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe approaches to prioritizing treatment objectives for cannabis users with mood disorders.; 2) Describe approaches to managing cannabis use and stopping cannabis abuse.; 3) Recognize cases where cannabis may be harmless or even beneficial for the patient's over-all mental health.; 4) Understand potential implications of medical marijuana laws on practice in treating mood disorders in patients who use marijuana.

SUMMARY:
Marijuana (MJ) use has been linked to increased morbidity in psychotic disorders, however its effects in mood disorders remain poorly understood. To date a single published study (Jones, et al., Clin. Psychol. Psychother. 18, 426–437 (2011)) has examined a combined CBT and motivational interviewing approach to treating bipolar patients with co-morbid cannabis use, reporting on a series of three cases.
In this workshop we present a series of brief case reports and preliminary psychometric and outcome data based on our experience in Beth Israel's CUBSS and Columbia's STARS programs treating mood disordered cannabis users using a similar agnostic motivational interviewing informed framework.
Cases will cover a spectrum ranging from marijuana use as a biological cause, psycho-social causal factor in, symptom of, and treatment of mood disorder. Presentation of cases will be supplemented by a direct patient/family report of her experience of interaction between mood disorder and marijuana use.
Psychometric and outcome data report on a series of 20 subjects, presenting rates of co-morbid personality disorders measured by MCMI (>80%), levels of marijuana use based on clinical interview, and relationships between level of marijuana use and change in level of marijuana use and treatment outcome, measured by the global assessment of function, and level of perceived marijuana associated problems as measured by the cannabis problems questionnaire ($r=-0.68$, $p<0.001$ for MJ at intake vs. level of perceived problems with MJ). A brief discussion on the psychopharmacology of cannabinoids and treatment approaches will follow.
Finally, we will discuss the policy landscape for medical marijuana and the role of psychiatrists in shaping medical marijuana policies and programs, followed by an anonymous interactive poll of workshop participants on their experiences with cannabis use in mood disorder patients with live presentation of poll results as a seed for an active audience participatory discussion.

BRIEF BEHAVIORAL INTERVENTIONS FOR INTEGRATED CARE

Chairs: Anna Ratzliff, M.D., Ph.D., Kari A. Stephens, Ph.D.

Speaker: Anna Ratzliff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List the fundamental principles of two evidence-based brief behavioral interventions used in primary care integrated behavioral health programs (Modular Anxiety Treatment, and Behavioral Activation; 2) Apply the knowledge of these brief behavioral skills to practice change.; 3) Recommend specific brief behavioral interventions to primary care providers (both care managers and primary care providers).

SUMMARY:
The role for the psychiatrist is expanding and developing in the area of primary care behavioral health. An important part of this role is to support the integration and delivery of evidence-based brief behavioral interventions through a variety of roles including direct delivery, team leadership and providing support to a behavioral health specialist or care manger. This workshop is designed to present the fundamentals of two evidence-based brief behavioral interventions used in primary care settings: Modular Anxiety Treatment and Behavioral Activation for depression. Participants will learn the fundamental principles of each treatment and engage in an interactive brainstorming activity to explore how this knowledge can lead to practice change. We will conclude with a discussion of how the consulting psychiatrist can support the delivery of these interventions

in primary care settings.
This course complements the information presented in the course directed by Dr Raney- Primary Integrating Behavioral Health and Primary Care: Practical skills for the Consulting Psychiatrist with more specific behavioral skills knowledge.

PTSD RELATED TO MILITARY SERVICE, FITNESS FOR DUTY AND DISABILITY EVALUATIONS

Chairs: Keith A. Caruso, M.D., Anna Makela, M.D.

Speakers: Kevin D. Moore, M.D., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Criteria used in pre-deployment mental health screening and in-theater resources.; 2) Criteria used for determining retirement from the military due to PTSD.; 3) Impact of events during deployment on subsequent civilian employability and disability.

SUMMARY:
Recent conflicts in Iraq and Afghanistan have taken their toll on military service members, resulting in an increase in cases of Posttraumatic Stress Disorder (PTSD). Many of those afflicted with PTSD remain on active duty and must be assessed for fitness for duty and deployability. These recent conflicts and the increased rates of PTSD among service members have led to modifications in the use of medications during deployment. The presenters will discuss criteria used in performing these evaluations and the in-theater resources for treatment. The screening for deployment to Afghanistan of a soldier with PTSD and Major Depression related to experiences while embedded with an Iraqi unit will serve as an example. The presenters will also discuss current practices for evaluation and processing for medical board retirement of service members rendered unfit for continued service due to PTSD, with case examples. In addition, many former service members are now presenting with PTSD subsequent to discharge and are applying to the Veterans Administration or civil disability carriers for disability. Examples of these cases will also be presented and discussed, including a coroner's assistant claiming disability due to PTSD; a postman referred for fitness for duty evaluation; and a school bus driver with PTSD from an improvised explosive device whose condition was re-triggered by an event with a violent special needs child. Workshop format will entail multiple case vignettes followed by presenters leading audience discussion.

HONING SKILLS FOR SUICIDE RISK REDUCTION IN THE ELDERLY

Chairs: Joseph E. Thornton, M.D., Uma Suryadevara, M.D.

Speaker: Stephen Welch, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe 3 key difference in suicide in elderly vs middle aged adults; 2) Describe 3 areas of conflict between risk management and treatment; 3) Describe at least 4 appropriate interventions along the suicide risk timeline ; 4) Link with other healthcare professionals in performance improvement to increase overall effectiveness of patient safety, resident education and cross discipline communication.

SUMMARY:
Suicide is the 10th leading cause of death in the United States; approximately 38,000 people per year die by suicide. Suicide risk increases in the elderly, particularly older white males. Older patients are twice as likely as younger patients to have their most recent contact prior to suicide with a primary care provider. Conducting a suicide risk assessment in an efficient and thorough fashion within a limited time period is a fundamental skill for a clinician. In general, this skill is lacking, and often performed in a perfunctory manner as a risk management mandate rather than a clinical service. To improve this clinical service, colleagues in other disciplines and psychiatry residents need to be taught how to incorporate suicide risk reduction into their clinical comfort zone. We created three heuristic tools to help colleagues reduce suicide risk factors in the elderly: the Suicide Combination Lock, the Suicide Prevention Toolkit and the Suicide Timeline. These tools complement the SAFE-T (Suicide Assessment Five-step Evaluation and Triage) framework for suicide risk assessment. The Suicide Combination Lock uses visual imagery to organize suicide risk factors into non modifiable (demographic and historical) and modifiable (contextual and trigger) factors. The Suicide Prevention Toolkit is an empowerment tool to assist the clinician to recognize a larger set of options in contrast to typical risk management algorithms. The Suicide Timeline is a matching tool of interventions with risk status. A key component to this tool is to show the conflicting forces that may mitigate immediate risk yet increase long term risk for suicide.
This workshop will begin with a clinical vignette and participatory exercise for the audience to describe interventions to prevent suicide over a six month time frame. The three clinical tools will then be presented in comparison with the processes elicited in the opening exercise. Two more clinical exercises will be conducted and the audience will compare and contrast the methodologies used. Data will be collected in real time by way of web based survey and paper forms. This data will be used in the final discussion section of the workshop.

DEMENTIA: WHAT KIND IS IT AND WHAT DO YOU DO ABOUT IT?

Chairs: Lisa K. Catapano-Friedman, M.D., Cynthia Murphy, M.B.A., Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand diagnostic criteria for various types of dementia, including how to differentiate a dementia from the often confusing presenting psychiatric symptoms; 2) Understand how an appropriate work-up for dementia is performed, including use of biomarkers and other new modalities; 3) Have familiarity with the types of treatments, including medications and behavioral interventions, available and effective for various types of dementias, with some discussion of the newest treatments.

SUMMARY:
Using interesting cases of dementia (aka neurocognitive disorders), selected from those new to our clinic since last year's workshop, we will discuss various types of dementia, particularly those which often present first to psychiatrists due to confusing, apparently psychiatric, symptoms. We will review diagnostic criteria for the various neurocognitive disorders, and we will discuss how a complete work-up for dementia is performed, including the use of biomarkers and other modalities. We will then also discuss various treatment possibilities for the different dementias, including discussion of new treatments.
This will be done in a participatory case discussion format. Included will be discussion of neurocognitive disorders with Lewy Bodies, frontotemporal disorders of both behavioral and semantic variants, and atypical Alzheimer's disease as well as the more common presentations of Alzheimer's disease.

DEPRESSION: RESILIENCE WITH OMEGA 3 FATTY ACIDS

Chair: Paul Sargent, M.D.

Speakers: Daniel T. Johnston, M.D., M.P.H., Bill Harris, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the biological effects of Omega-3 fatty acids in the brain; 2) Understand the evidence base for using Omega-3 fatty acids in treatment of depression and PTSD; 3) Understand the risks, benefits, and dosing of Omega-3 fatty acids.

SUMMARY:
The 2007 National Health Interview Survey (NHIS) concluded that 17.7% of American adults had used a non-vitamin/non-mineral natural product, the most common being fish oil/omega 3s. Despite natural products being the most widely used CAM modality within the 2007 NHIS (NCCAM, 2007), many nutrition experts report that the modern western diet provides an ample supply of most vitamins, and nutritional supplementation beyond a daily multivitamin adds little benefit (U.S. Preventive Services Task Force, 2003). The use of Omega-3 Fatty acids to reduce anxiety and depression may result from or contribute to changes in immunomodulation (Hjorth et al, 2012). In addition it has been reported that Omega 3 supplementation may modulate the effect of biogenic monoamines (Ness at al, 2013), thus influencing two of the pathways most suspected in the etiology of depression. In addition, vagus nerve tone is felt to be important in promoting relaxation and stress mediation in the body (Porges & Furman, 2011). Indeed, both depression and psychological stress have well-documented negative effects on vagal activation: omega-3 fatty acid intake can boost mood and vagal tone, dampen nuclear factor-kappa B activation and responses to endotoxin, and modulate the magnitude of inflammatory responses to stressors (Kiecolt-Glaser 2010). Recent reports have implicated the use of omega-3 fatty acids with increased risk of certain tumors (), leaving questions for providers on the risks relative to benefits of utilizing Omega -3 fatty acids as part of a their treatment plan. Dr. Daniel Johnston will discuss the impact of Omega -3 fatty acids on resilience and depression as well as clarifying the recent controversy over their use.

IS PRECISION MEDICINE RELEVANT TO PSYCHIATRY?

Chairs: Amjad Hindi, M.D., Ramotse Saunders, M.D.

Speaker: Michael Garrett, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the barriers to implementing a "precision medicine" model in Psychiatry ; 2) Identify the contrasting models of categorical and domain based nosology ; 3) Explore the suitability of "brain based" psychiatry as a model of precision ; 4) Identify the role of psychoanalytic theory in the matter.

SUMMARY:
The question of orthophysiology of mind/brain has been vexing psychiatry since its early stages of development. While many believe that pathological mental functions exist and can be described nosologically, others add that the nature of consciousness and culture make it impossible to pin down biologically once and for all a universal model. Notwithstanding the philosophical implications of this divide, recent advances in neuroscience and evolutionary psychology have led some to question the dominant model of nosology, namely the atheroretical categorical description of the DSM; and call instead for framing psychiatry in a brain-based "precision model". While the RDoC project will take several years to realize the promise of a comprehensive scientific theory of the mind, its introduction affords us the opportunity to rethink atheoreticality. Can a clinically useful transitional theory be developed? The field of Psychiatry can realize immediate benefit from a practical placeholder model that channels brain-based understanding into clinically utilizable information. This workshop posits that with our current level of clinical knowledge an even more precise psychiatry can be constructed. Obstacles to precision which we will analyze are linguistic imprecision, hidden dualism, and isolating symptom content from putative neuropsychiatric process. We will explore the feasibility of a model of

two-level concordance, the first level addressing a semantically precise phenomenology and the second neuro-integrative. Panelists' expertise includes psychoanalysis, CBT for psychosis, Critical Thinking, Neurodynamics, psychosomatic medicine and clinical psychiatry.

References:
1-"The six most essential questions in psychiatric diagnosis…" J. Phillips et al, Philosophy, Ethics, and Humanities in Medicine 2012; 7:3
2-"Toward the future of psychiatric diagnosis: the seven pillars of RDoC" B.N. Cuthbert and T. Insel, BMC Medicine 2013, 11:126
3-"An historical framework for psychiatric nosology: K.S. Kendler, Psychological Medicine 2009, 39:12
4-"Towards a functional neuroanatomy of pleasure and happiness" M.L. Kringelbach, K.C. Berridge, Trends in Cognitive Science, 2009, 13:11
5-"Indeterminacy of definitions and criteria in mental health: case study of emotional disorders" G. Nikolaidis, J Eval Clin Pract. 2013, 19: 3
6-"The archeology of mind: neuroevolutionary origins of human emotions" J. Panksepp, L. Biven ISBN-10: 0393705315

SOCIAL MEDIA, INTERNET SEARCHING, AND THE PATIENT/ PSYCHIATRIST RELATIONSHIP IN 2014

Chair: David Brendel, M.D., Ph.D.

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand how social media and internet technologies may be useful in psychiatric practice; 2) Identify potential pitfalls of using social media and internet technologies in psychiatric practice; 3) Employ a pragmatic approach to weighing risks and benefits of employing these technologies to find information about patients.

SUMMARY:
Social media and Internet technologies provide significant opportunities in medical/psychiatric practice, but they also raise ethical questions and concerns that careless or improper use can threaten the clinical relationship. This presentation will explore possible benefits and pitfalls of using in clinical practice such digital technologies as Google, LinkedIn, Facebook, Twitter, and Tumblr. Since there are no firmly established regulatory or medico-legal guidelines as to appropriate usage of these technologies in medical/psychiatric practice, a pragmatic weighing of risks and benefits is generally the optimal approach. Online searching for patient information and interactions with patients via social media may be ethically permissible (or even required) in limited situations. This presentation will include discussion of a well-developed pragmatic model that guides clinical reasoning about whether and how to use social media and Internet searches in medical/psychiatric practice.

THE SIXTH VITAL SIGN: ASSESSING COGNITIVE IMPAIRMENT IN HIV

Chair: Marshall Forstein, M.D.

Speakers: Kenneth Ashley, M.D., Karl Goodkin, M.D., Ph.D., Jordi Blanch, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the increased risk of cognitive impairment among HIV; 2) Discuss the signs and symptoms of cognitive decline; 3) Recognize the strategies for assessing and managing impairment.

SUMMARY:
HIV infection frequently results in cognitive impairment. The impact of cognitive impairment on HIV-infected individuals is related not only to their functional status but also to their adherence to the complex drug treatment regimens and medical care, their abilty to cope and to work, their adherence to protective sexual practices, and their risk of mortality. Cognitive impairment can present as a spectrum of impairment severity and functional status impact ranging from mild subclinical impairment to severe dementia. Cognitive impairment can affect a variety of neuropsychological functions, including verbal memory, information processing speed, visuospatial ability, and executive functioning. Typically, changes in the language domain occur only in late stage disease, with the exception of verbal fluency. Each of these presentations has distinctive criteria defining the condition, along with specific excluding factors that must first be ruled out. Psychiatrists play a very important role in helping to identify and treat these conditions.
This workshop is designed for practicing clinicians who diagnose, treat and manage patients with, or at risk for, HIV/AIDS. Faculty will discuss symptoms and signs of cognitive decline, identify the factors warranting exclusion of these disorders, and review the diagnostic issues and assessment criteria for HIV-associated cognitive disorders. Faculty will also discuss the therapeutic and pharmacological strategies for managing impairment. A combination of case studies, interactive audience participation, and lecture will be used for this workshop. A resource guide will be provided to participants.

NEW TREATMENTS IN SCHIZOPHRENIA

Chair: Donald C. Goff, M.D.

Speaker: Donald C. Goff, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the newer antipsychotic agents; 2) Demonstrate knowledge of approaches to enhance adherence in schizophrenia; 3) Demonstrate knowledge of treatment approaches for refractory symp-

toms in schizophrenia.

SUMMARY:
New models for illness onset and progression have been associated with encouraging findings in early clinical trials. In this session both basic and emerging principles for the treatment of schizophrenia will be reviewed. Topics will include a brief review of the newer antipsychotic agents, early intervention strategies, enhancement of adherence, approaches to treatment resistance, polypharmacy and prevention of medical morbidity. New approaches including cognitive remediation and rTMS will also be discussed. The primary focus of the session will be on clinical practice; however, experimental approaches may also be discussed including recent trials with anti-inflammatory agents, folate, glutamatergic agents and the combination of cognitive enhancing agents with psychosocial interventions. Audience participation will be encouraged, including the presentation of relevant clinical problems and experience with new treatment approaches.

PATIENTS IN CRISIS: CLINICAL CHALLENGES DURING THE PERIOD FOLLOWING A VISIT TO THE PSYCHIATRIC EMERGENCY DEPARTMENT

Chairs: Camilla L. Lyons, M.D., M.P.H., Adria N. Adams, Psy.D.

Speakers: Elizabeth B. Simpson, M.D., William Lawson, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Name 3 factors that limit a patient's access to psychiatric care after an emergency room visit; 2) Name 3 factors that elevate a patient's risk for suicide in the period following an emergency room visit; 3) Name 3 treatment strategies that can be implemented in the weeks following an emergency room visit to stabilize patients in crisis and to decrease acute risk for suicide.

SUMMARY:
The period following an emergency department (ED) visit is a vulnerable period for patients. More often than not the crisis prompting the visit is not fully resolved. They may not have adequate follow up treatment in place. Clinicians who made the referral to the ED may have decided the patients are "too high risk" for their practice. Or the outpatient appointment following the ED visit may be for intake evaluation, and there may be a delay in starting treatment. Other factors--including diagnosis, insurance status, socioeconomic status and race--can limit a patient's access to care during a high risk period. Referral and linkage to appropriate outpatient services from the ED can minimize unnecessary and costly inpatient admission.
The Interim Crisis Clinic at Bellevue's Comprehensive Psychiatric Emergency Program provides short-term care through continued access to the emergency department psychiatrist and psychologist, while linking patients to the appropriate services in the community. A variety of clinical challenges arise in this setting. One of the biggest obstacles is the limited access to specialized treatments--especially those for Personality disorders and Eating disorders--for patients in this urban hospital setting, who often lack health insurance and face ongoing crises (including housing, financial, marital, custody, separation from family).
This workshop aims to examine these challenges and to present practical therapeutic approaches for engaging these multi-problem, high-risk patients in treatment during the acute phase following a psychiatric emergency room visit.

"DOCTOR I CAN'T TAKE MY JOB, SIGN ME OFF WORK," STRATEGIES TO NAVIGATE DISABILITY ASSESSMENT AND MANAGEMENT WHILE PROVIDING PSYCHIATRIC TREATMENT

Chairs: Paul Pendler, Psy.D., Robert S. Benson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the interplay between diagnostic symptoms and functional impairments in work assessment; 2) Understand the research about how mental health conditions impacts overall workplace functioning in terms of numbers and economic variables; 3) Learn practical guidelines to operationalize a diagnostic assessment into a work impairment framework.

SUMMARY:
Psychiatric training programs are busy teaching risk assessments, safety plans, and treatment plans. But there is rarely time to learn the skill that will challenge every psychiatrist seeing patients – the work assessment, impairment, and the return to work plan. To Love and Work has been continuously thought of as a sign of overall health. What happens when a patient is unable to do so? How does the psychiatrist navigate the road between impairment, symptom improvement and work? What are the current methods used that a psychiatrist documents to support the decision not to work? What happens when there is a disagreement between patient and physician? Between patient, physician and employer? This presentation will go over some of the methods used to assess and document impairment from work and will discuss the crucial distinction between "impairment" with "disability." (Williams & Schouten, 2008). Case examples taking attendees through understanding how diagnostic decisional trees do not necessarily all lead to an off work recommendation and how that can be communicate to their patients. Karasek's "job strain model" will be explored in order to understand why there may be an increase in requests for time off work citing psychiatric conditions. (Crouser, 2008).

SUPERSIZE ME! NEUROBIOLOGY POLICING OUR APPETITE

Chairs: Durga Prasad Bestha, M.B.B.S., Vishal Madaan, M.D.

Speakers: Vishal Madaan, M.D., Venkata B. Kolli, M.B.B.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the basics of neurobiological pathways regulating appetite; 2) Recognize the orexogenic and anorexogenic pathways; 3) Become familiar with the pharmacology of appetite stimulating and suppressing agents.

SUMMARY:
The recent American Medical Association (AMA) classification of obesity as a disease, made the medical community concentrate on a variety of factors that regulate appetite. This sweeping epidemic of obesity has already become a major public health concern worldwide. Psychiatrists work with an array of closely intertwined issues ranging from binge eating, bulimia and depression as well as some unintended consequences of psychotropics such as metabolic syndrome. In addition, there has been a recent surge in our understanding of the importance of managing affective, anxiety and sleep disorders that are often comorbid with obesity.
This interactive workshop will provide a practical neurobiological review of different facets regulating hunger and satiety. It will begin with an overview of the essential neurobiological aspects of appetite by exploring the basics of orexogenic and anorexogenic pathways and the involved peptides and hormones such as ghrelin, cholecystokinin and leptin which are crucial in maintaining an adequate body weight. Also included in this discussion would be the functions of neuropeptide Y, agouti-related protein, hypocretin and the pro-opiomelanocortin neurons. Using this as a foundation, speakers will then explore the pharmacology of anti-obesity agents such as phentermine, orlistat, lorcaserin, phentermine/topiramate and bupropion/naltrexone. There will also be a brief discussion of psychological aspects of gastric bypass surgery, and the assessments done before such procedures. Throughout the workshop, there will be an emphasis on the use of effective behavioral interventions, which go hand in hand with medications in managing obesity.

VIRTUAL REALITY GOES TO WAR: ADVANCES IN THE PREVENTION, ASSESSMENT AND TREATMENT OF PTSD

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Barbara Rothbaum, Ph.D., Albert "Skip" Rizzo, Ph.D., Michael Roy, M.D., M.P.H., JoAnn Difede, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe and define Virtual Reality (VR) and explain how it can generally be used for clinical and research applications; 2) Describe and evaluate the rationale for the use of VR as a tool to deliver exposure therapy for anxiety disorders and PTSD; 3) Describe, Analyze and Evaluate the clinical outcomes from the initial rsrch using VR to deliver a prolonged exposure approach in the treatment of PTSD with OIF/OEF Service Mbrs,Vets and survivors; 4) Describe and differentiate the use of VR as a tool for psychological resilience training with Service Members prior to a combat deployment and as an assessment tool upon redeployment home.

SUMMARY:
A relatively new medium for delivering exposure therapy uses Virtual reality (VR). VR offers a human–computer interaction system in which users are no longer simply external observers of images on a screen but are active participants within a computer-generated three-dimensional virtual world. The first presentation will detail the history of VR leading to the first system used to treat PTSD in Vietnam combat Veterans. This will be followed by a presentation that will detail the development and clinical results from use of the Virtual Iraq/Afghanistan exposure therapy system with active duty Service Members and Veterans. This will be followed by a presentation of how the system has been repurposed for psychological resilience training at pre-deployment for reducing the later occurrence of PTSD and as a tool for assessment with particular attention to sub-threshold PTSD. The next presentation will discuss the development of VR software for the treatment of PTSD and the facilitation of exposure therapy with a cognitive enhancer (d-cycloserine: DCS). DCS, a broad spectrum antibiotic, has been shown to facilitate extinction learning, the mechanism hypothesized to underlie exposure therapy, in animal models of conditioned fear. This will present unblinded data from an NIMH-sponsored study with VR Exposure Therapy (VRE) combined with either 50 mg d-Cycloserine, pill placebo, or .25 mg alprazolam (Xanax) for Iraq Veterans with PTSD. The results showed a significant decrease in CAPS across time, $F(3,93)=31.81, p<.001$. Mean CAPS pre-treatment = 85.8 (SD 18.00); post-treatment = 67.9 (SD 25.71); 3-mo FU = 60.42 (SD 28.58, n = 65); 6-mo FU = 58.67 (SD 30.32, n = 55); 12-mo FU = 51.05 (SD 32.21, n = 42). Regarding remission, at the 12-Month FU, 35% were below 30 on the CAPS. There was a significant change in cortisol in response to the VR scene, $F(1,22)=8.10, p<.01$, and a significant decrease in cortisol reactivity across treatment, $F(3,66)=2.70, p=.05$. Current research will also be presented which showed that VR exposure (VRE) therapy was a promising new treatment for World Trade Center-related PTSD.

THE ADMSEP CLINICAL SIMULATION INITIATIVE: UTILIZING TECHNOLOGY AND CLINICAL SIMULATION MODULES TO ENHANCE PSYCHIATRIC EDUCATION

Chairs: Sarah B. Johnson, M.D., M.Sc., Chelsea L. Neumann, M.D.

Speakers: Joyce Spurgeon, M.D., Rebecca L. Tamas, M.D., Adriana Foster, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand how use of technology can enhance

psychiatric education by addressing practice gaps and engage the younger generation of learners ; 2) Identify areas in residency and medical student education curricula where computer simulation and other interactive programs may be used; 3) Conceptualize the process of developing an online learning module and increase awareness of existing online educational resources.

SUMMARY:

There is increasing evidence that simulation based medical education may offer an advantage over traditional instruction in clinical skills acquisition. A systematic review of high fidelity medical simulation suggests that the most effective learning occurs when simulations include high quality feedback, curricular integration, repetitive practice, and multiple learning strategies. In psychiatry, computer-assisted instruction is emerging as an educational tool that enhances traditional methods of instruction at all levels of training. Over the last decade, online simulated case libraries have become an important teaching tool in pediatrics, family medicine, surgery, and internal medicine clerkships.

This workshop will share the experience of a group of psychiatric educators from the ADMSEP (Association of Directors of Medical Student Education) Clinical Simulation Initiative task force who have developed simulated modules and integrated them into existing curricula. An overview of several completed modules, which are available for open-access online, will be presented. Research data aimed at determining student and attending feedback on specific modules will be reviewed. Discussion with a Clerkship Director and Residency Training Director who have utilized these modules in educational practice will also be included. Participants will have the opportunity to work in small discussion groups to explore existing modules and plan ways that they can use the information gained from this workshop to improve their own educational programs.

EXPLORING DIETS, E-GAMES, AND EXERCISES TARGETING EPIGENOMICS IN BOOSTING COGNITIVE HEALTH AND IN ALZHEIMER'S DEMENTIA: EVIDENCE AND CHALLENGES

Chair: Simon Chiu, M.D., Ph.D.

Speakers: John Copen, M.D., Mariwan Husni, M.D., Michael Woodbury-Farina, M.D., Simon Chiu, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how cognition can be regulated through dietary interventions targeting Epigenomics in aging & Alzheimer dementia(AD); 2) Evaluate the benefit-to-risk ratio and evidence of clinical cognitive studies of specialized diets , dietary supplements and functional foods in preventing cognitive decline in aging and in AD; 3) Gain insight into the benefits of aerobic exercise and e-delivered video games in reprogramming gene expression and neural circuits involved in cognitive aging and in modifying the course of AD; 4) Identify fiscal and systemic issues involved in translating new research findings on brain foods, exercise and e-delivered brain exercises to evidence-based practices in geriatric areas; 5) Understand how epigenomics may shed light on the link of nutrition, cognition and AD and has the potential to transform bioactive phytochemicals to promising drugs for treating and preventing AD.

SUMMARY:

Recently, increased interest has been expressed in developing diverse strategies to optimize cognitive aging and to modify the onset and course of Alzheimer's dementia (AD). The interaction of Gene and Environment in modulating cognitive decline is best understood within the framework of Epigenetics. Epigenetics refers to heritable changes in gene expression and chromatins remodeling independent of alterations in DNA sequence, and comprise of three key components; DNA methylation, histone modifications (acetylation and deacetylation) and non-coding microRNA. Epigenetics targets play major role in reprogramming of neural network and neural repair. There is emerging evidence supports the model of dysregulation in epigenomics in age-related cognitive decline and AD. A large number of studies have shown that nutrition factors: diets, dietary and herbal supplements, functional foods, are capable of regulating the epigenetic states and targets in reversing abnormal gene activation or silencing. Physical exercises and e-delivered brain games likewise can change various domains in aging and in AD through the epigenetics signatures.

We review the evidence from preclinical and clinical studies demonstrating the dietary phytochemicals from diverse dietary sources; grapes, green and black coffee, soya beans and fava beans, curry extract, peanuts, have positive impact on epigenomics in facilitating translational and transcriptional events involved in memory, attention and executive functions. The findings from the studies on DASH and Mediterranean diets reinforce the relevance of epigenetic diet menu, along with the proposed Epigenetics diet for cognitive aging platform. We will also discuss the multi-faceted actions of herbal supplements : Panax Ginseng ,and diet menus in reducing cardio-vascular and cancer risks in aging. We will apply the criteria of the levels of evidence to evaluate the cognitive health claims in aging and AD and balance the evidence against the popular myths and realities. Epigenetics targets are also sensitive to physical exercises and e-delivered cognitive challenge tasks eg puzzles, video games. The evidence is promising in terms of the putative effects in reprogramming neural circuitry for cognition and reactivating neurogenesis in the hippocampus.

We conclude that the field of epigenomics-driven lifestyle measures are promising in cognitive aging and more randomized controlled trials are required to establish the efficacy of diet intervention and exercise and e-brain stimulation on the progression of AD. We anticipate in the near future we will have evidence-based dietary and exercise and e-stimulation guidelines to be implemented at various levels of geriatric care. We believe that biotechnology can transform bioactive factors to CNS drugs for AD treatment and

prevention.

DRUG-INDUCED MOVEMENT DISORDERS IN THE ELDERLY: TEACHING TEACHERS TO EMPLOY VIDEO ON RECOGNIZING DYSKINESIA, DYSTONIA, AKATHISIA, AND PARKINSONISM

Chair: Bruce L. Saltz, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Teach educators how to use video images to teach residents and students about drug induced movement disorders; 2) Teach educators how to teach students to recognize the four major movement disorders of parkinsonism, tardive dyskinesia, dystonia, and akathisia in older adults; 3) Teach educators how to teach residents and students to employ some common rating scales to identify and document the presence of drug induced movement disorders.

SUMMARY:
Psychotropics are crucial for the treatment of many psychiatric illnesses, but in older adults, these medications are frequently misused. This problem has become even more serious in the era of managed care, and the information explosion from the news media, pharmacies and pharmaceutical company advertising. The proposed educational initiative will will teach physicians and other educators how to teach students and residents to recognize the movement disorders that occur as side effects of antipsychotic drugs. Americans over the age of 65 spend one-fourth of all monies spent nationally on medications; psychotropic medications are now among the most frequently prescribed medications for the elderly. The vast majority of these are prescribed by practitioners without specialized training in their use. This results in a currently unfulfilled need for educational materials about these drugs, designed for physicians and other care givers

EMERGING TECHNOLOGIES IN THE ASSESSMENT AND TREATMENT OF RESILIENCE AND TRAUMA

Chair: Paul Sargent, M.D.

Speakers: Martin Paulus, M.D., Marc Capobianco, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1)Have an improved understanding the neural basis of resilience; 2) Understand the neural structural patterns of elite performers; 3) Recognize the usefulness and challenges of rTMS as used in the treatment of PTSD.

SUMMARY:
There is substantial evidence that exposure to extreme situations or environments have profound cognitive, affective, and social effects. Following exposure, neural structures of elite performers appear to mitigate the effect of stress, while other individuals develop symptoms which may progress to a mental disorder. Emerging technologies play a role in both understanding the neural basis of the human response to trauma, as well as treating the effects of trauma by activating or suppressing some of those same underlying structures. In this workshop Dr. Martin Paulus of the UCSD Optibrain Research Consortium will discuss the neural mechanisms of elite performers and how those structures may confer an advantage under extreme circumstances. Dr. Marc Capobianco, and Dr. Donald Hurst will discuss the use of rTMS in the treatment of PTSD in military service members.

CONTROVERSIES SURROUNDING PEDIATRIC PSYCHOPHARMACOLOGY: LEARNING TO INTEGRATE PSYCHOPHARMACOLOGY AND PSYCHOTHERAPY

Chairs: Harmony R. Abejuela, M.D., Wun Jung Kim, M.D., M.P.H.

Speakers: Julie M. Zito, Ph.D., Daniel Safer, M.D., Timothy F. Dugan, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Examine the rising trends and discuss the marked increase in the use of psychotropic medications in children and adolescents; 2) Gain a greater understanding of how the increase in diagnosing emotional and behavioral disturbances in pediatric patients have led to a rise in the prescription use of psychotropic medications; 3) Discuss examples of the overuse and under use of certain psychotropic medications in relation to the over and under diagnoses of certain disorders and their risks versus benefits profile; ; 4) Identify the practical, ethical, financial, and evidence-based concerns regarding psychotropic pharmacological and non-pharmacological treatments in children and adolescents; 5) Discuss the impact of psychotropic pharmacological versus non-pharmacological and psychological treatments (e.g., CBT, DBT, psychodynamic therapy, etc.) in child psychiatrists' practices.

SUMMARY:
The increase in the recognition and diagnoses of child and adolescent emotional and behavioral disturbances has contributed to the upsurge in psychotropic medication use. With the continued growth in the use of these psychotropic medications stem various controversies, primarily between psychotropic pharmacological versus non-pharmacological treatments, such as CBT, DBT, psychodynamic therapy, and other psychological treatments in pediatric patients. While non-pharmacological treatments in children and adolescents generally remain the preferred modality among most parents and providers, psychopharmacology is rapidly becoming a significant part of management in many child psychiatrists' practices. The ongoing debate pitting non-pharmacological treatments versus psychopharmacology as the gold standard of care in children and adolescents with emotional and behavioral disturbances remains, with most

psychiatrists left in the middle, advocating for the judicious use of both. However, establishing evidence-based guidelines to determine when, how, and to what extent one modality of treatment should be used over the other persists. The validity of off-label use, short- and long-term safety, and potential abuse of psychotropic medications, combined with the stigma in children and adolescents prescribed these medications, continue to stir the controversy surrounding this highly debated issue. Supporters of non-pharmacological treatments contend the unknown effects and plausible perils of psychotropic medications in young developing brains as sufficient to ethically and morally limit their use in pediatric patients, arguing that cultural and social influences play a larger role; therefore, efforts should be directed towards providing more stable environments to treat and even preclude future emotional disturbances in children and adolescents. On the other hand, supporters of psychopharmacology defend its efficacy, combined with the allure of psychotropic medications as easier to administer, a quicker fix, and a cheaper alternative over more costly and time-consuming psychological treatments. The media and pharmaceutical industries are also major players fueling this debate as they advertise and sensationalize the need for medications, such as stimulants for ADHD. Because the dispute between psychopharmacology and non-pharmacological treatments in children and adolescents is multifaceted involving child psychiatrists, pediatricians, parents, pharmaceutical industries, the media, and most importantly, pediatric patients, further research and discussion is essential for this ongoing debate. Audience members will have an opportunity to voice their clinical experiences, opinions, and concerns fueling for a healthy and active discussion regarding this highly controversial and important issue.

MAY 06, 2014

EXERCISE PRESCRIPTION FOR MAJOR DEPRESSIVE DISORDER

Chairs: Chad Rethorst, Ph.D., Madhukar H. Trivedi, M.D.

Speakers: Chad Rethorst, Ph.D., Madhukar H. Trivedi, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify patients suitable for exercise prescription; 2) Provide an exercise prescription to patients; 3) Engage patients in a discussion of barriers to exercise.

SUMMARY:
Response and remission rates for treatment of MDD indicate the need for complementary and alternative empirically-supported treatment approaches. The use of exercise in the treatment of MDD has gained support, as evidenced by the inclusion of exercise treatment in the American Psychiatric Association's most recent treatment guidelines. Despite the evidence supporting exercise in the treatment of MDD, data suggests that clinicians do not often prescribe exercise to patients with MDD. Potential barriers to the prescription of exercise in the treatment of MDD include clinicians being unaware of the empirical evidence for exercise as a treatment and clinicians being unfamiliar with the prescription of exercise. The goal of this workshop is to address these barriers by: 1) providing an overview of the research evidence supporting exercise in the treatment of MDD, and 2) providing practical advice on the prescription of exercise to patients. Workshop participants will also have the opportunity to engage in small group activities focused on developing an exercise prescription and strategies to improve patient adherence to the exercise prescription.

HOW TO INVOLVE FAMILIES IN THE ASSESSMENT AND TREATMENT OF PATIENTS

Chair: Gabor I. Keitner, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the value of including a patient's family in the assessment and treatment process; 2) Be familiar with a method for including families when assessing a patient's problems.; 3) Be familiar with a treatment approach that can be used with the families of patients with a wide range of disorders.

SUMMARY:
Ilnesses unfold and evolve in a social context. Case formulation and treatment planning that does not take into consideration relationship aspects of the presenting illness may miss potentially important forces that could be very helpful in the treatment process. Mnay psychiatrists and psychotherapists do not involve families in the care of their patients due to lack of familiarity and comfort with models of family functioning and interventions.
This workshop will provide a conceptual framework that helps to integrate pharmacotherapy, psychotherapy and family interventions. Common factors of different family therapy approaches will be reviewed. There will be a particular focus on one method of family assessment and intervention ,the McMaster Model of Family Functioning and the Problem Centered Systems Therapy of the Family, an approach that is clearly delineated, has validated assessment instruments and has been tested in clinical trials. This approach is applicable to patients regardless of diagnosis or treatment setting. There will be time allocated to review videotapes of family sessions and to discuss specific clinical situations of concern to the participants.

EVOLUTION OF THE PSYCHOTHERAPIST

Chair: T. Byram Karasu, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize generic psychotherapeutic diagnose; 2) Identify generic psychotherapeutic techniques; 3) Tran-

scend the schools of psychotherapy.

SUMMARY:
There are three phases in evolution of the psychotherapist: Training, Experiential, Formative.
While all psychotherapy schools harbor an all-encompassing illusion of autonomy, a therapist can't relate to every patient the same way, nor is a single theory suitable for understanding and treating every type of psychopathology. During the training evolution phase, a young therapist can become an expert clinician by transcending his own school of therapy. Every young therapist attempts to perfect his skills by anchoring onto a single paradigm and becoming an expert technician of that particular school. After all, one has to have something to transcend.
Within 5-10 years of practice, in the experiential evolution phase, the therapist begins to appropriate techniques from other schools of psychotherapy, and by shifting paradigms, synchronizes himself with the patient's mind. It is from this synchronization that his techniques begin to evolve. This is the essence of the "transtheoretical paradigm."
The therapist who has transcended his own school of psychotherapy now must transcend the field of psychotherapy itself. Furthermore, if he wants to address the patient's existential issues as well, the therapist first has to come to terms with those issues himself. After all, the therapist can take the patient only so far as he himself has come.
This formative evolution phase of a therapist encompasses a broad education especially in philosophy and spirituality-secular values distilled from all religions. He must find the meaning and the purpose of his life, cultivate an authenticity and become someone whose presence is itself therapeutic. All "therapeutic messages" will then naturally emanate from within the therapist's very self.

EMOTIONAL AND SEXUAL INTIMACY AMONG GAY MEN: MENTAL HEALTH ISSUES IN STARTING AND SUSTAINING RELATIONSHIPS

Chairs: Robert Kertzner, M.D., Marshall Forstein, M.D.

Speaker: Stewart Adelson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify common psychological issues related to difficulties starting or sustaining relationship intimacy among gay men; 2) Recognize the impact of the social context on the achievement of intimate relationships among gay men; 3) Identify psychotherapeutic interventions to enhance the capacity of gay male patients to achieve aspirations for greater relationship intimacy.

SUMMARY:
Gay men may seek psychotherapy for help in starting or sustaining intimate relationships. A variety of mental health issues underlie difficulties in the realization of this aspiration including depression, internalized homophobia, discomfort with emotional dependency needs, and developmental dynamics in some gay men that lead to separate pathways for the pursuit of emotional and sexual intimacy. Recent US Supreme Court decisions support same sex relationships by recognizing marital rights, but also amplify some gay men's unresolved conflicts about partner choice and sustained intimacy. This workshop will center on a case presentation with discussion of clinical, psychological, and social case dimensions and will explore mental health approaches to helping gay male patients achieve greater emotional and sexual intimacy in their relationships.

BOOTCAMP FOR BURNOUT: STRATEGIES FOR BUSY PROFESSIONALS AT ALL STAGES AND AGES

Chair: Eva Szigethy, M.D., Ph.D.

*Speakers: Patricia I. Ordorica, M.D., Christina T. Khan, M.D., Ph.D., Silvia W. Olarte, M.*D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the signs and symptoms of burnout in healthcare professionals including psychiatrists at every age and every stage of career; 2) Identify behavioral strategies to counter burnout such as time management, scheduling hobbies, seeking social support, addressing negative cognitions and other stress management techniques; 3) Defining relaxation, meditation, and self-hypnosis strategies to counter stress; 4) Recognize when burnout could benefit from assessment and treatment by a professional.

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.
Medical students are at risk for burnout during the course of their medical education. Burnout may influence specialty choice and impact the affected individual's perception of work-life balance. 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 physicians meeting established criteria for burnout. Increased stress and burnout also lead to health consequences including chronic headaches, hypertension, depression and anxiety. The data regarding the negative impact of burnout are alarming and sound a clear bell for the need for effective interventions to promote resilience and wellness among physicians and physicians-in-training. Krasner and colleagues described an intervention in which the indicators of stress and burnout were reduced following physician completion of a mindfulness based stress reduction pro-

gram. The goals of this workshop are to address burnout among physicians and discuss and demonstrate methods to reduce burnout and promote resilience and wellness including behavioral techniques, stress management strategies, meditation, and self-hypnosis. The workshop will also cover stages of burnout and when evaluation and treatment by a professional may be helpful. Format will include lecture as well as experiential components.

ASSERTIVE OR COERCIVE: THE ETHICAL DIMENSIONS OF ASSERTIVE COMMUNITY TREATMENT (ACT)

Chair: John Maher, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session, the participant should be able to understand and appreciate the ethical challenges faced by ACT teams as they deliver psychiatric care in the community.; 2) Participants will have thoughtfully considered the merits of ethical justifications proffered in defence of intrusive client interventions.; 3) Participants will develop an appreciation for those elements of clinical practice within ACT that support the broad ethical goal of helping clients not just maintain wellness, but to flourish. .

SUMMARY:
This presentation provides an overview of the major ethical theories that are applied to psychiatry generally, along with some discussion of what it is about psychiatry that makes applied ethics a different undertaking than across medicine broadly. Next, the ethical landscape and unique features of community psychiatry are considered, with ACT practices specifically brought under scrutiny. It then explores and answers the question, "Is it possible to be assertive without also being coercive at the same time given client vulnerability, dependence on care, stigma, poverty, and power differentials?" And finally, it considers the elements necessary to achieve the broad ethical mandate of making life worth living even within, and because of, the constraints of ACT operating structures.

SERVING TWO MASTERS: MAINTAINING MILITARY READINESS, SECURITY CLEARANCE, MILITARY MEDICAL STANDARDS, MEDICAL RETIREMENT, AND ADMINISTRATIVE SEPARATION

Chairs: KyleeAnn S. Stevens, M.D., Paul Sargent, M.D.

Speakers: Christopher H. Warner, M.D., Elspeth C. Ritchie, M.D., M.P.H., Michail Charissis, M.D., Elizabeth C. Henderson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) describe the process of psychiatric evaluation for security clearances, military schools and assignments, and involuntary separations; 2) demonstrate knowledge of the Integrated Disability Evaluation System and how a Service Member moves through the medical board process; 3) Discuss the process of determining duty limitations on active duty, the use of retention standards to evaluate continued readiness for active duty service ; 4) Understand the difference between civilian "disability" and meeting or not meeting retention standards in the military.

SUMMARY:
We will highlight some areas where the psychiatrist functions as a member of the medical team in preserving the fighting force. Possessing the clinical skills needed to diagnose and treat active duty service members is important. A function of a Military Psychiatrist is to evaluate the Service Member's ongoing ability to safely and effectively execute the military mission. The psychiatrist serves as a consultant to the service member's command, assisting them in support of the service member through treatment. A psychiatrist has the responsibility to notify command if there are duty limitations and risks. A civilian psychiatrist who decides to practice in a military setting must adjust and learn to manage the administrative side of military psychiatry that has a mission oriented command structure. We will provide an overview of the administrative role of the psychiatrist that balances patient confidentiality with the need to preserve the fighting force. The importance of standards limiting access to classified information has been highlighted by recent events such as the trial of a soldier who passed information to Wiki-leaks. Fear of becoming ineligible for clearance due to mental health treatment affects the willingness to come forward for treatment. We discuss criteria used to examine a service member who requires a mental health clearance and changes in reporting requirements to address the reluctance of some to come forward for treatment. When a service member is no longer able to perform safely and effectively in the military, a referral is made to the Medical Evaluation Board (Army) or equivalent in other branches. To make an accurate determination of functional limitations a psychiatrist must be familiar with basic military skills and demands of the service member's occupational specialty. For example medication requiring laboratory monitoring is an inconvenience in garrison but a significant risk when deployed. Once a service member is medically retired they transition to care and benefits through the VA (a process that took months in the past.) To close the gap between leaving military service and entering the VA system, DOD and VA agreed to integrate systems of evaluation and rating. We will give an overview of the current integrated disability evaluation system including a discussion of the psychiatrist's role in the evaluation process. The line between misconduct and psychiatric symptoms may become blurred, bringing the process of involuntary administrative separations under scrutiny. The Army has increased its oversight and review of these cases to insure that the process of administrative separation is properly applied. Situations do arise where an administrative separation is appropriate and serves the interest of maintaining unit readiness, even if the service member does not agree. We will discuss the administrative

separation process including the requirement for screening by behavioral health.

YOGA-MINDFULNESS INTERVENTIONS IN MENTAL HEALTH AND ILLNESS: MOVING TOWARDS SYMPTOM-SPECIFIC MODELS

Chairs: Basant K. Pradhan, M.D., Barry Sarvet, M.D.

Speakers: Basant K. Pradhan, M.D., Vijoy K. Varma, M.D., Andres J. Pumariega, M.D., Madhusmita Sahoo, M.D., Anup Sharma, M.D., Ph.D., Nitin Gupta, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Summarize the basic concepts of yoga-mindfulness as originally proposed in ancient India as expositions about mind and its basic operations; 2) Discuss the basic research surrounding these mind-body practices; 3) Apply psychotherapeutic use of specific yogic techniques in health as well as in specific psychiatric and psychosomatic symptoms.

SUMMARY:
Originally yoga-mindfulness was conceptualized as self-exploratory cognitive-emotive strategy under guidance of a teacher or "Guru" to gain insight into one's experiences. The therapeutic nature of this insight helps re-access a natural, positive state of mind, which in turn leads to experiencing sustained day-to-day calm, insight and well-being, regardless of the circumstances (1). Despite more than 3,000 years of rich history, much of the yogic techniques have not been examined systematically in the rigors of 'scientific' evidence-based format, and thus still remain mystified and underutilized despite their great potentials (2,3,4).
Speakers in this workshop will present a synthesis - integrating insights from the yogic traditions of ancient India with evidence-based medical approaches developed in the West. This workshop will include both theoretical concepts and evidence of yoga-mindfulness interventions and will discuss integrative yoga-mindfulness treatment models using symptom specific approaches in mental illnesses. In addition, data will be presented from clinical practices in India and USA including the Yoga-Mindfulness Based Cognitive Therapy (Y-MBCT) Program at Cooper University Hospital, New Jersey. Data related to symptom specific use of these interventions in various psychiatric and psychosomatic symptoms in youth and adults as well as a part of medical student wellness will be presented. Discussion will also focus on the utility of these interventions in primary care settings as well as the cultural aspects of treatment implementation.
REFERENCES:
1.Eliade, M. (1969). Yoga, Immortality and Freedom. Princeton University Press.
2.Segal, Z. v., Williams, J. M. G., & Teasdale, J. D. (2002, 2013). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York: Guilford Press.
3.Pradhan B.K. (2005): Impact of yoga-mindfulness interventions on the visual span and neuropsychological performances of children with attention deficit hyperactivity disorder (ADHD); research study at the Post-Graduate Institute of Medical Education and Research, India.
4.Pradhan B.K. (2013). "Yoga and Mental Health: Demystification, Standardization and Application"; Rowman Littlefield Publishers (book, in the process of getting published).

PROVIDING MEDICAL CARE WITHIN COMMUNITY MENTAL HEALTH: THE ROLE AND PERSPECTIVE OF ASSERTIVE COMMUNITY TREATMENT TEAMS

Chairs: Erik Vanderlip, M.D., Maria Monroe-DeVita, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Compare the structure and functioning of Assertive Community Treatment Teams to emerging models of primary care delivery (medical homes), and contrast differences; 2) Identify particular areas in which their local Assertive Community Treatment programs may influence the medical care of clients with Severe Mental Illness; 3) Integrate the feedback from experiences in Washington State PACT to develop their own initiatives in medical care delivery within Assertive Community Treatment Teams.

SUMMARY:
Emerging models of primary care delivery are becoming increasingly team-based, interdisciplinary, patient-centered, accessible, proactive and holistic. Community Psychiatry discovered a very similar approach to effective management of complex behavioral disorders, and has developed and refined Assertive Community Treatment (ACT, PACT) over the past 30 years to incorporate nearly all of the basic tenets of a medical home. As disparities in health outcomes mount for those with Severe and Persistent Mental illnesses (SMI), healthcare systems are struggling to delivery better primary care and preventive health services to those most vulnerable in community mental health settings. The similarities in processes of care between PACT and the Patient Centered Medical Home (PCMH) provide for a natural collaboration with potential to systematically address health disparities for those with SMI. This workshop will review the overlay between PACT teams and the PCMH, present results from an in-depth survey and qualitative assessment of primary care activities and attitudes amongst a large network of Washington State PACT Teams, and provide potential avenues for primary care consultation within the PACT framework with a discussion on evolving incentives and rewards tied to medical care within PACT.

EXPERT CONSULTATION AND TESTIMONY ON ALCOHOL INTOXICATION IN MILITARY RAPE TRIALS

Chair: David E. Johnson, M.D.

Speakers: Dennis White, M.D., Ryan-Marie Chiarella, D.O.,

Rebecca M. Webster, M.A., M.D., Jennifer Yeaw, Psy.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Analyze fact patterns in a rape case ; 2) Know the limits of knowledge in determining blackouts and pass outs for remote events; 3) Know how to testify competently and within medical ethical parameters.

SUMMARY:
Use of psychiatrists and clinical psychologists at military courts-martial (trials) as expert witnesses is common in cases where the victim was under the influence of alcohol. Civilian experts are commonly utilized for either the prosecution or defense. The most litigated question involves the role of alcohol in causing blackouts (anterograde amnesia) or passing out. With blackouts, the issue is whether the victim might have consented to intercourse and not remember it. This session will prepare clinicians for serving as experts by reviewing the ins and outs of assessing degree of intoxication through reports of third-party observations, methods and sources of error for estimating blood alcohol content, factors that influence the propensity for developing blackouts, and an overall review of the level of certainty we have about the effects of alcohol on different individuals. Mock testimony with cross-examination will be featured. Discussion will include the basics of providing courtroom testimony.

MENTAL ILLNESS, MASS SHOOTINGS, AND THE POLITICS OF AMERICAN FIREARMS

Chair: Jonathan Metzl, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Analyze the historical relationships between gun violence and mental illness; 2) Recognize ways in which cultural responses to mass shootings are shaped by stigmatizations of mental illness and race; 3) Consider new strategies for talking about the relationships between mental illness and guns.

SUMMARY:
This session explores the historical and sociological connections between gun violence, mass shootings, and mental illness. I will begin by discussing the American political and media responses to the December, 2012 mass shooting in Newtown, Connecticut. In the aftermath of that horrific crime, the state of New York passed a bill that required mental-health professionals to report "dangerous patients" to local officials, National Rifle Association vice president Wayne LaPierre's called for a "national registry" of persons with mental illness, and conservative commentator Ann Coulter provocatively claimed that "guns don't kill people--the mentally ill do." Then we will systematically and critically examine three central assumptions that underlie these and other associations between mental illness and gun crime: (1), that mental illness "causes" gun violence; (2), that psychiatric diagnosis can predict gun crime before it happens; and (3), that mentally ill shooters are "dangerous loners." Building on the work of Jeffrey Swanson and others, I will discuss how mass shootings represent statistical aberrations that reveal more about particular instances than they do about population-level actions. And, how decisions about which crimes American culture diagnoses as "crazy" and which crimes it labels as "sane" are driven as much by the politics and anxieties of particular cultural moments as by the actions of individually disturbed brains. The workshop concludes with discussion around the limitations of a system in which questions of whether "the insane" should be allowed to bear arms become the only publically permissible ways to talk about questions of gun control.

SHAMANISM IN MENTAL HEALTH CARE: VIEWS FROM THE OUTSIDE AND THE INSIDE

Chairs: Janet L. Lewis, M.D., Cecile A. Carson, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize transpersonal moments in ordinary healthcare encounters and possible responses to them; 2) Demonstrate knowledge of the state of the current evidence base for the therapeutic use of shamanic practices; 3) Demonstrate knowledge of the controversies in the therapeutic use of shamanic practices; 4) Demonstrate knowledge of the basic attitude and approach of shamanic work and of a transpersonal framework for understanding the subjective shamanic experience.

SUMMARY:
Growing popular interest in shamanism and "neoshamanism" has spurred professional and academic interest in these subjects within the mental health fields. Case reports and small studies claim salutary effects of shamanic practices and within transpersonal psychotherapy there is a subcategory of "shamanic counseling." There are particular reports of its application in Posttraumatic Stress Disorder, Substance Use Disorders, Complicated Grief, and Chronic Pain and some physicians are reporting the use of shamanic practices in medical settings. However, important controversies exist regarding the encouragement of non-rational states, the mental health and professional integrity of shamans, the developmental maturity of the practice, and the appropriation of native practices by non-natives.
Particularly since the inclusion in DSM-IV of "Religious or Spiritual Problem," psychiatry has striven to recognize the spiritual dimension of the lives of patients. However, shamanism, wherein practitioners are encouraged to "journey" for encounters with spirits may engender particular discomfort in many clinicians. Clinicians may have understandable concerns about possible contraindications to shamanic practice and about the extent of evidence base in support of its use as a mental health intervention. At the same time, clinician countertransference issues may hamper understanding

of shamanism and therefore hamper understanding of its role within a patient's life.
In this workshop, led by an internist with a shamanic counseling practice and a psychiatrist with academic interest in psychodynamic psychotherapy and the "integral model," we will explore shamanism from two standpoints - examining the objective scientific evidence and exploring the internal subjective experience. Differing models of healthcare (biomedical, biopsychosocial, and transpersonal medicine) and two aspects of the integral model of Ken Wilber (the 4 quadrants and the pre/trans fallacy,) will be presented as frameworks for recognizing both important perspectives. Elements of the basic attitude and approach of shamanism will be reviewed and participants will have opportunity to discuss their own clinical or personal experiences. Lecture, small and large group discussion will be employed. We will explore what the relationship of psychiatry is or should be to this oldest of healing traditions and to its popular resurgence.

PHYSICIAN ASSISTANTS IN PSYCHIATRY: THE BOTTOM LINE ON BENEFITS TO YOUR PRACTICE

Chair: Greg Thomas, M.P.H., P.A.

Speakers: Greg Thomas, M.P.H., P.A., Michael Flaum, M.D., Don St. John, P.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize how working with certified physician assistants (PAs) can benefit you and your practice; 2) Gain a better understanding of the role certified PAs are playing in psychiatry today; 3) Become familiar with the voluntary Certificate of Added Qualifications (CAQ) program, available to certified PAs practicing in psychiatry and the impact this can have on patient care.

SUMMARY:
With more patients seeking treatment and growing physician shortages, certified PAs serve ever more critical roles in the delivery of psychiatric patient care. By sharing some duties and responsibilities with certified PAs, physicians can reduce their workload and focus their efforts in areas that will allow them to practice more efficiently and effectively. Ultimately, many physicians appreciate that certified PAs allow them to spend more time with patients who have more critical or complex issues, as well as to fill gaps when they are not available. A physician-PA team will provide insights into a "day-in-the-life" and how their team approach works to benefit their practice.
This session will also provide an overview of the PA profession, including demographics of and functions performed by certified PAs, focusing on data pulled from a professional profile and practice analysis of PAs in psychiatry (conducted by the National Commission on Certification of Physician Assistants). Information on the financial and administrative advantages of incorporating PAs into a psychiatric practice will be discussed.
Finally, in addition to being grounded in generalist medicine, certified PAs now have the opportunity to earn the voluntary Certificate of Added Qualifications (CAQ) in psychiatry, which documents their knowledge, training and experience in the specialty. The speaker will close with information about the requirements for and benefits of this new psychiatric credential.

HUMAN TRAFFICKING: TRAINING PHYSICIANS FOR IDENTIFICATION, REPORTING, AND TREATING

Chair: Vivian B. Pender, M.D.

Speakers: Ruth Fischer, M.D., Megan Mroczkowski, M.D., Prudence Gourguechon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the distinct features of a man, woman or child who is being trafficked for labor or sexual exploitation; 2) Treat the unique trauma that a trafficked victim suffers: physical and mental abuse, neglect, isolation, alienation, anxiety, and depression; 3) Train other physicians, for example Emergency Room doctors to identify and refer patients to the appropriate resources.

SUMMARY:
There are an estimated 240 million migrants globally. Many of these people are subjected to a particular form of repeated abuse, exploitation and humiliation. They may also be stateless, that is they have no citizenship in any country and therefore not have any rights and privileges. How can psychiatrists engage in individual identification, reporting and treatment as well as in this global phenomenon? How can psychiatrists assist other health care providers in order to identify and refer? The American Psychoanalytic Association recently submitted a request for the Department of Justice Office for Victims of Crime to draw on the expertise of mental health professionals and partner to develop effective treatment programs. This workshop will include programs from the U.S. Department of State, Delta Airlines, Equality Now, UN High Commissioner for Refugees, Physicians for Human Rights Asylum Network and the NGO Committee on Trafficking.

THE USE OF ACT, CBASP, AND DBT FOR TREATMENT-REFRACTORY PSYCHIATRIC ILLNESS

Chair: Eric Levander, M.D., M.P.H.

Speakers: Lynn McFarr, Ph.D., Robyn Walser, Ph.D., Eric Levander, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize when to utilize ACT, CBASP, and DBT in the treatment of complex psychiatric illness; 2) Learn the

basic theories behind ACT, CBASP, and DBT; 3) Develop an understanding of the basic techniques utilized in ACT, CBASP, and DBT.

SUMMARY:
Cognitive behavioral therapy (CBT) has long been used in the treatment of affective illness, anxiety disorders, and other psychiatric disorders. Unfortunately, not all psychiatric conditions respond as well to standard courses of CBT and many patients remain symptomatic. Acceptance and commitment therapy (ACT), the cognitive behavioral analysis system of psychotherapy CBASP), and dialectical behavioral therapy (DBT) are other therapies that fall under the umbrella of CBT have shown efficacy in the treatment of refractory psychiatric disorders in evidence based trials. These three evidence based therapies have been found to be effective in trials of treatment refractory anxiety disorders, depression, obsessive compulsive disorder, psychosis, substance abuse disorders, eating disorders and borderline personality disorder. Yet few clinicians are familiar with these novel psychotherapies. ACT utilizes mindfulness and acceptance strategies to decrease avoidance, attachment to difficult thoughts, and increase a focus on the present. ACT teaches patients to live a valued life utilizing more effective behavioral strategies. CBASP utilizes structured tools to teach chronically depressed patients, with global and defeatist perspectives, adaptive and effective interpersonal problem solving skills. Therapists utilize the technique of disciplined therapist personal involvement to target problematic interpersonal behaviors. DBT combines both individual therapy and group behavioral skills training for patients along with a consultation team for the therapist. In DBT, therapists and patients focus on hieratical behavioral targets to decrease self-injurious behaviors and behaviors that would interfere with the therapeutic process and learn strategies both tolerate emotional distress and make changes to create a more effective environment. This seminar will provide an overview to the clinician on ACT, CBASP, and DBT.

ANOREXIA NERVOSA AS A PASSION: AN ETHICAL AND HISTORICAL ANALYSIS

Chair: Louis C. Charland, Ph.D.

Speaker: Louis C. Charland, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Introduce a specific 19th century historical version of the concept of 'Passion; 2) Defend the empirical hypothesis that Anorexia Nervosa may be a Passion in this sense; 3) Explore ethical implications of the hypothesis that Anorexia Nervosa is a Passion.

SUMMARY:
Contemporary diagnostic criteria for anorexia nervosa explicitly refer to affective states of fear and anxiety regarding weight gain, as well as a fixed and very strong attachment to the pursuit of thinness as an overarching personal goal. Yet current treatments for that condition often have a decidedly cognitive orientation and the exact nature of the contribution of affective states and processes to anorexia nervosa remains largely uncharted theoretically. Taking inspiration from the history of psychiatry, I argue that conceptualizing anorexia nervosa as a passion is a promising way forward in both our understanding and treatment of that condition. Building on the theory of the passions elaborated by Théodule Ribot, the founder of scientific psychology in France, we argue that there is convincing empirical evidence in defense of the empirical hypothesis that anorexia nervosa is a passion in Ribot's specific, technical, sense. We will then explore the implications of this finding for current approaches to treatment, including cognitive behavioral therapy, and clinical and ethical issues associated with treatment refusals.

DEPRESSION, INFLAMMATION, AND ADIPOSITY: OBESITY AS A CAUSAL AND PERPETUATING FACTOR FOR DEPRESSION

Chair: Richard C. Shelton, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the connections between inflammation and depression; 2) Articulate how stress and depression contribute to visceral adiposity, and how visceral fat may lead to depression; 3) Describe how obesity and depression risk interact to perpetuate the illness.

SUMMARY:
There is now convincing evidence that inflammatory factors such as the interleukins and interferons are associated with depression. They can induce depression, but they also are elevated in depressed patients without known inflammatory disease. There is growing evidence that obesity, particularly visceral (intra-abdominal and deep subcutaneous) fat, may be the causal factor mediating this relationship. This presentation will outline the relationship between depression and inflammation and build the case for a bi-directional relationship between depression and obesity with inflammatory factors serving as the intermediaries. The discussion will also review the evidence that recurrent stressors, including depression, can alter diet, increase total body fat, and shift fat from extravisceral (e.g., subcutaneous) to visceral fat. This, then, would be expected to increase inflammatory factors such as interleukin-1beta (IL-1beta), IL-6, tumor necrosis (TNF) alpha, and interferon gamma. We also will review obesity as a factor the inhibits responsiveness to antidepressants, and alternative treatment strategies to manage comorbid depression and obesity.

ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

Chairs: Richard D. Milone, M.D., Richard Harding, M.D.

Speakers: William Arroyo, M.D., Mark S. Komrad, M.D.,

Stephen C. Scheiber, M.D., Claire Zilber, M.D., Laura Roberts, M.A., M.D., Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize ethical dilemmas and common situations which may signal professional risk; 2) The participant should understand what resources are available to them; 3) Identify boundary issues and conflicts of interest; 4) Identify practical resolutions to ethical dilemmas.

SUMMARY:
The 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.

FOSTERING RESILIENCE IN COLLEGE STUDENTS: CHANGING PRACTICES IN COLLEGE PSYCHIATRY

Chair: Doris Iarovici, M.D.

Speakers: Victor Schwartz, M.D., Holly Rogers, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand new roles psychiatrists can play in campus community-wide mental health outreach and developmental programming via collaboration with other campus professionals; 2) Recognize innovative approaches to preventative psychiatry, including the JEDCampus program initiative to enhance mental health promotion and suicide prevention programs for university students; 3) Identify positive outcomes of a developmentally targeted, evidence-based mindfulness and meditation program for college students.

SUMMARY:
As mental health problems continue to increase in both incidence and severity among university students, it's increasingly clear that in addition to providing traditional diagnosis and treatment, psychiatrists can have a significant positive impact on the university community by contributing to efforts at prevention. In 2010, college freshmen reported the lowest levels of emotional health in 25 years (1). Almost one in two college students turns to binge drinking for recreation and stress relief, often with harmful health consequences(2). Suicide is the second leading cause of death among college-aged students, and one in twelve US college students has made a suicide plan(3). And the majority of students with depression, anxiety and substance abuse problems continue to not seek treatment. Creative new approaches to building resilience in this population might begin to stem the tide of distress.
Resilience, or the ability to adapt to adversity or trauma, results from a complex interaction of genetic, epigenetic and environmental factors. Among college students, resilience can promote positive mental well-being independent of levels of stress, or even when students engage in maladaptive responses to stress (4). This workshop will present several new approaches to building resilience in college students. First, we will look at collaborative developmental programming and outreach on campus, and ways that psychiatrists can partner with other campus professionals in these efforts. Then we will present the JED Campus initiative, which helps universities systematically assess and bolster their mental health promotion and suicide prevention efforts. We will also present new data from a controlled trial of a mindfulness meditation program, Koru, which was developed specifically for university students. We will address how these approaches can be incorporated both into treatment regimens for student psychopathology, and into developmental programming at the community level for students facing more typical developmental distress during emerging adulthood.
1. Higher Education Research Institute Web page, http://www.heri.ucla.edu/pr-display.php?prQry=55, accessed June 16, 2011.
2.Marczinski, CA et al. "Binge Drinking in Adolescents and College Students." NY: Nova Science, 2009.
3. "Safeguarding your Student Against Suicide." The JED Foundation, 2002.
4. DeRosier, M et al,. "The Potential Role of Resilience Education for preventing mental health problems for college students." Psychiatric Annals, scheduled for Dec. 2013.

"LAST GLIMMER OF DAY": A FILM ABOUT THE DEATH OF A PHYSICIAN BY SUICIDE AND ITS LASTING LEGACY

Chair: Michael F. Myers, M.D.

Speakers: Jeff Wolk, Phyllis G. Wolk, M.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify factors that stigmatize physician suicide; 2) Recognize the ways in which family members are affected by not being told the truth about suicide death; 3) Treat survivors of suicide with better understanding and empathy.

SUMMARY:
Suicide has historically been defined by its denial, shame and secrecy. In the house of medicine this shroud of silence is/was particularly prominent, especially in the first half of the twentieth century. In 1939, Cleveland physician Dr Maurice Grossberg killed himself at the age of 43. His children and grandchildren were told that he died of a heart attack. His widow Sylvia and his substantial extended family closed ranks and kept this dark secret for decades, until very

recently. In this moving 16 minute film produced by Maurie's grandson Jeff Wolk (and Josh Hetzler), we learn that Jeff decides to address something that doesn't seem right, a family mystery. He and his brother Scott interview 90 year old Leo, Maurie's nephew, who had spent a lot of time with and was particularly fond of his Uncle Maurie. Leo reveals the truth and the brothers consult with their brother Martin about how to tell their mom, Phyllis. This revelation is sad but enlightening given that both Maurie's daughter Phyllis and her son Jeff suffer from depression. His conversation with his mother about her attempted suicide and his own self-disclosure about his suicidal planning are particularly gripping. Other highlights of the film are interviews with Maurie's son Paul (Phyllis's older brother), Phyllis's husband Alan, Jeff's brother Martin, Jeff's grandmother Sylvia (age 98), family photographs, childhood re-enactments and excerpts from Maurie's journal in 1932 about his depressive symptoms. In this workshop, Dr Myers will give a brief overview about physician suicide and its aftermath followed by showing the film. At its conclusion, Dr Myers, Mr Wolk and family members who were interviewed in the film will engage the audience in discussion. "Last Glimmer of Day" has been described as a meditation on family, depression, hope and love. Clinicians will gain much by attending.

FOOD FOR THOUGHT: EATING WELL FOR PSYCHIATRIC HEALTH

Chair: Nubia G. Lluberes, M.D.

Speakers: Kaitlin Mock, M.S., Nubia G. Lluberes, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize the diertary problems often endured by mentally ill patients; 2) Identify signs and symptoms of nutritional imbalances that may require treatment; 3) Review state of the art recommendations for dietary deficiencies; 4) Review results of vitamin B12 and Vitamin D screening in a small inpatient sample of rural population; 5) Discuss nutritional strategies as prophylactic measures.

SUMMARY:
People suffering from mental illness face a great deal of difficulty to afford, prepare and consume high quality foods. Obesity and malnutrition go hand in hand for this population for whom deficiencies can present as a cause of a psychiatric manifestation, as a factor that increases resistance to recovery, or both. In this group, drugs/alcohol use and other habits play an overt role while medications needed for their recovery may also interact with their eating habits (adding numerous unwanted effects) and genetic predispositions play a quiet, yet important, role making the interplay of all these factors a convoluted story in their trajectory towards wellness.
Mental health providers encounter a great challenge when attempting to use a holistic approach to the treatment by keeping nutritional concerns as part of the evaluation and treatment plan. Time constrictions and limited training in the aspects of nutrition make it difficult to identify abnormalities and its consequences in a case by case approach. Nevertheless, to be equipped with this knowledge is an asset that increases one's ability to provide more thorough primary prevention and to improve outcomes.
During this workshop we will be discussing major micronutrient problems in the psychiatric population (vitamin deficiencies and excesses), the recommended approach for their evaluation and treatment, as well as other important nutritional problems in this population (obesity, metabolic syndrome, dietary interactions with medications, and other problematic eating behaviors). Our objective is to give a well-rounded overview of the important role of the psychiatrist as a nutritionist and to highlight opportunities of collaboration by requesting a nutritional consult. The ultimate goal is to recognize our role in helping patients to change behaviors in order to prevent chronic effects and dysfunction while moving forward in their recovery.

IN HARM'S WAY: WORK STRESS AND MENTAL HEALTH IN THE MILITARY

Chair: Steven Pflanz, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the prevalence and causes of work stress in the military; 2) Discuss the impact of work stress on the mental health in military personnel; 3) Examine strategies for managing and reducing the impact of job stress on employee health.

SUMMARY:
Objective:: The stressors of the deployed environment, frequent deployments, and combat-related trauma exposure on military personnel have been clearly demonstrated in the literature. Multiple studies have additionally identified high levels of job stress for in garrison state-side military personnel. These studies parallel the literature on the impact of work stress on the mental health of civilian employees. This research examined the relationships among job stress, depression, work performance, types of stressors, and perceptions about supervisors in military personnel.
Methods: Four groups of military personnel at three locations (including one deployed location), totaling 1,705 individuals, answered written survey questions addressing work stress, physical and emotional health, work performance, perceptions about leadership, sources of job stress, and demographics.
Results: More than one- quarter (28.9%) of this military population reported suffering from significant work stress. Both the report of work stress and depression were significantly related to multiple measures of impaired work performance, more days of missed work, poorer physical and emotional health, and negative perceptions about the abilities of supervisors and commanders. Depression and job stress were significantly and positively related to each other.

Conclusions: These results support accumulating data indicating that work stress is a significant occupational health hazard in the routine military work environment. These health risks are in addition to and independent of those associated with wartime deployments. The policy implications for targeting and eliminating unnecessary sources of job stress amongst military personnel, as well as developing strategies to preserve and protect the mental health of military personnel, are discussed. Parallels with the civilian workplace are explored, including how lessons learned can be translated to other work environments.

WOMEN IN PSYCHIATRY: CAREER LADDER, ACADEMICS, ADVOCACY, AND MOTHERHOOD: OPPORTUNITIES AND CHALLENGES

Chair: Isabel Schuermeyer, M.D.

Speakers: Margo C. Funk, M.A., M.D., Tatiana Falcone, M.D., Kathleen S. Franco, M.D., M.S., Karen Jacobs, D.O.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify obstacles that women in psychiatry face compared to their male colleagues and learn ways to promote equality in their workplace; 2) Recognize the impact of advocacy on their career and how to further develop this; 3) Identify ways of managing outside pressures (such as motherhood), despite working in a high pressured field.

SUMMARY:
Although psychiatry is one of the more attractive fields for women to enter after medical school, there are still challenges that women face. Leadership positions remain primarily held by men and pay equality continues to be an issue faced in most work places. Evidence suggests that in practice, the scientific efforts of women are not as well recognized as the ones of men, commonly referred to as the "Matilda Effect". Further within advocacy groups, men are often in positions of power. These trends are very slowly changing and there are many things women can do to increase our representation. Studies evaluating the Matilda Effect in different areas of science have concluded that women continue to face major disparities in academia. Specifically, these are evident in research funding, publication rates, scientific achievement awards and academic ranking. In addition, women in psychiatry who choose to have children must negotiate two very demanding positions. Motherhood has challenges that vary as children go through different stages of development. Add this to a rigorous career in psychiatry, and mothers can find themselves under significant stress. Specific challenges for mothers working in psychiatry can include long work hours, schedule unpredictability, and limited female peer support. Often women will favor outpatient work because of the schedule, which can result in more reliable ability to leave work at a set time.
In this workshop, many of the challenges that women in psychiatry face will be discussed. There will be a general overview of these issues by women who have succeeded in many of these areas, including a medical school dean, past president of the state chapter of the APA, an associate residency director and specific subspecialty program directors. Small group discussions will follow based on specific concerns that audience members are facing.

LESSONS LEARNED: THE IMPACT OF HURRICANE SANDY ON THE ORGANIZATIONAL DYNAMICS OF A RESIDENCY TRAINING PROGRAM AND A MULTI-HOSPITAL SYSTEM

Chairs: Jennifer L. Goldman, M.D., Carol A. Bernstein, M.D.

Speakers: Kerry J. Sulkowicz, M.D., Elizabeth S. Albertini, M.D., Meredith Bergman, M.D., Megan Borkon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the ramifications a natural disaster like Hurricane Sandy had on the psychiatric care of patients in private, state and federal health care center ; 2) Discuss the impact of Hurricane Sandy on a residency training program as well as the effect on residency and hospital leadership; 3) Share recommendations with other hospitals, residency programs and clinics on how best to prepare or respond to such a crises; 4) Create an opportunity for an open dialogue amongst other psychiatric and medical institutions, programs or clinics that were faced with natural disasters or other overwhelming crises.

SUMMARY:
Hurricane Sandy touched down October 29th, 2013 and not only took lives but also devastated NYC infrastructure for weeks and months to follow. This included the closure of several New York City hospitals and outpatient clinics which supply care to thousands of patients.
As especially vulnerable members of society, psychiatric patients were greatly affected by the storm as both their personal lives were interrupted and as they were unable to obtain mental health services in lower Manhattan. Care was funneled to other city hospitals, most of whom were overwhelmed by the demand, and patients were left stranded without resources or information on how to access treatment.
The NYU psychiatry residency program supplies most of major mental health services in lower Manhattan, encompassing Bellevue Hospital, NYU Langone Medical Center, the Manhattan VA and outpatient offices in midtown. This is a vast infrastructure of public, private and military mental health treatment
This workshop will provide a summary of how the leadership of the NYU residency program dealt with this crisis, and the experience of the residents who were personally and professionally affected. Additionally we will share the steps that were taken to allow residents to continue to provide excellent psychiatric care to a traumatized community.
As this is an interactive platform for sharing, we welcome stories and feedback from APA members regarding crises

that their organizations have suffered.

Through this, we hope to provide ideas and suggestions for residency programs on how to survive future organizational traumas. This workshop will also highlight areas of improvement on how mental health care might be better served in times of crisis.

PSYCHIATRIC LEADERSHIP IN THE BEHAVIORAL HEALTH HOME

Chairs: Lori Raney, M.D., Benjamin Druss, M.D.

Speakers: Jaron Asher, M.D., Benjamin Druss, M.D., John Kern, M.D., Joseph Parks, M.D., Patrick S. Runnels, M.D., Michael A Silver, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the regulations, definition and components of a behavioral health home; 2) Describe the skills that a psychiatrist needs to develop to effectively participate in health home teams and appreciate the contribution of effective psychiatric leadership ; 3) Comprehend team based care tasks in heath homes that lead to desirable outcomes, including population based data analysis to guide population based treatment recommendations.; 4) Define current models of care that meet the spirit and intent of a behavioral health home while appreciating the ongoing potential for innovation .

SUMMARY:
Healthcare reform is sweeping the nation with new models of care that wield the promise of the Triple Aim: better outcomes, better experience of care and cost containment. One of the components of the Affordable Care Act is the expansion of health homes to include “one serious mental health condition” in the definition of allowable diagnoses for health home recognition and funding. It also for the first time allows the location of treatment to be a community mental health center. Many state public mental health agencies are moving forward to implement health homes under this rule and receive the additional funding allowed to provide this enhanced system of care. To date, 6 states including Missouri, Ohio, Rhode Island, Iowa, Idaho and New York have implemented health homes for the SMI population with several choosing to locate these in the CMHC environment. Only 1 has dedicated funding for psychiatric time, which is proving to be a barrier and oversight in the design of the health homes in other locations.
While the Joint Principles of the Patient Centered Medical Home stipulate each patient will have a “personal physician” and a “physician-directed care team”, it is less clearly defined who will play the crucial role of directing patient centered care in public mental health settings. The most obvious candidate for this role in public mental health settings, due to training, experience and the enduring relationship with the SMI population is psychiatrists. However, like many projects pushing the leading edge of innovation, this can seem quite daunting for the profession given the lack of understanding and training in implementing these models. This Symposium aims to begin articulating the knowledge and skill set psychiatrists need to competently and effectively engage in leading teams in behavioral health homes. Ben Druss, MD will provide an overview of Behavioral Health homes and Joe Parks, MD will describe the details required in the ACA using the Missouri model which served as the first implementation nationally. This will be followed by 4 examples of psychiatrist involvement in these initiatives including John Kern, MD who will discuss psychiatrist leadership in Primary Care Behavioral Health Integration grantee sites, Michael Silver, MD who will discuss implementation in Rhode Island, Jaron Asher, MD will describe his experience in Missouri and Patrick Runnels will give the Ohio example. Discussion with the audience by Dr. Druss and the other presenters will allow time to ask questions but also give input into how these roles could evolve which may help shape future efforts as other states implement health homes.

PLANNING BEYOND SURVIVAL: RESTORING PSYCHIATRIC SERVICES IN LONG ISLAND AFTER A DISASTER (ONE-YEAR UPDATE FOLLOWING HURRICANE SANDY

Chairs: Damir Huremovic, M.D., M.P.P., Nyapati R. Rao, M.D., M.S.

Speakers: Lisa Jacobson, M.S.W., Rajvee Vora, M.D., M.S., Ronke L. Babalola, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the challenges mental health agencies faced during preparation and in the aftermath of a major hurricane-force storm in NY; 2) Understand how to identify and utilize the local and federal resources available to health providers following a major disaster; 3) Understand the need for coordinated response planning to ensure adequate mental health care services after a disaster; 4) Develop strategies for a coordinated mental health care response and for sustained recovery strategy planning in a disaster affected area.

SUMMARY:
Unlike some natural disasters (e.g. earthquakes), hurricane-force storms have a unique feature of being forecast, giving the communities in their path limited, but crucial time to prepare. During this little lead time, that often barely allows only for evacuation, mental health care agencies and providers must make difficult professional and personal choices about how to weather the storm and how to continue to operate and provide services in its aftermath.
Contingency plans for such events mostly deal with preserving assets for continued and uninterrupted provision of services. Most of such plans also contain provisions for addressing a spike in disaster-related emotional distress in the population. What is often overlooked when preparing

for such events, however, is that storms of such magnitude change the landscape of the mental health services as much as they change the physical landscape of the affected area. If such catastrophic magnitude storms tend to repeat at more or less regular intervals, then learning lessons from the experience of others becomes a worthwhile endeavor for mental health professionals from certain regions.
Having survived the storm, mental health agencies and providers find themselves multitasking at different levels: providing for own inpatients while caring for patients evacuated from other facilities, reconnecting with own outpatients while attending to never-before-seen patients who now cannot reach their own providers, coordinating assistance with local, state, and federal disaster management agencies while personnel's own homes are in dark, flooded, or completely destroyed.
A remarkable part of recovery after a major disaster is the task of re-mapping and reestablishing the fabric of community mental health services, a challenge that cannot be addressed by a single agency or provider. A portion of precious time communities have to prepare for an impact of a major storm that is spent on coordinating care can be leveraged enormously in the aftermath of the disaster.
This workshop reviews the challenges and adversities that a pivotal Long Island mental health facility – Nassau University Medical Center, faced during Sandy, a hurricane-force storm affecting the metro NYC area in the Fall of 2012. Leadership of the Department of Psychiatry provides a personal account of own experiences as well as analysis of what was done well through preparations and in the aftermath and what could have been done better. A special consideration will be given to the aspect of coordinating response with and relying on assistance from local, state, and federal agencies (e.g. FEMA, PHS, and Disaster Area Management Teams). Also underscored and charted is the progress in sustained recovery at one-year mark following the storm.
Ample time will be allowed for questions and answers and for interaction with participants.

THE ETHICAL IMPLICATIONS OF PEDIATRIC NEUROENHANCEMENT

Chairs: Dominic Sisti, Ph.D., Martha Farah, Ph.D.

Speakers: Martha Farah, Ph.D., William D. Graf, M.D., Anthony Rostain, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the ethical dimensions of pediatric neuroenhancement and present the findings of the position paper from the American Academy of Neurology; 2) Compare and contrast novel issues related to pediatric neuroenhancement with those related to neuroenhancement in adults; 3) Identify the clinical implications of pediatric neuroenhancement. .

SUMMARY:
Pediatric neuroenhancement-- which includes the use of prescription medications in otherwise healthy children aimed at increasing particular capabilities-- appears to be increasing. It is now not uncommon to hear stories about parents requesting prescriptions for Adderall for their child in an attempt to give them 'an edge' in school or in other competitive activities. In this workshop three speakers will explore the clinical and ethical implications of this trend. The first speaker (Graf) will offer background on the issue and present the main arguments for the development of a recent American Academy of Neurology ethics position paper. The second speaker (Farah) will place the issues in the context of ongoing debates about neuroenhancement by adults. The third speaker (Rostain) will discuss the clinical implications of pediatric neuroenhancement using case examples to illustrate how common ethical dilemmas might be addressed in practice. Audience members will be encouraged to participate in a discussion about this ethically fraught issue.

FEMALE MILITARY PSYCHIATRISTS AT WAR

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Evelyn R. Vento, M.D., Paulette Tucciarone, M.D., M.P.H., Alyssa Soumoff, M.D., Sarah L. Martin, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the similarities and differences in men and women who have gone to war; 2) Understand the unique challenges of being a female military psychiatrist in a combat zone; 3) Recognize unique challenges for deploying mothers.

SUMMARY:
2.5 million Service members have deployed in the 13 years since 9/11/2001. Approximately 15% of the military is female. Eleven percent of the U.S. military force deployed in support of major military conflicts in Southwest Asia from 2002-2011 were women (223,000 women). One-fourth of these women deployed to OEF only; 64% deployed to OIF or OND only; and 11% deployed at least once to both OEF and OIF/OND. Half of the deployed women were under 25 years of age at time of their first deployments, while 30% were over age 29. Fifteen percent were officers with the remainder in the enlisted ranks.
Thus more women have been exposed to combat in the wars in Afghanistan and Iraq than in any other conflict in our history. This workshop will highlight both personal experiences of female psychiatrists and the available data on female soldiers and other service members. There are a number of emerging sources of data about post-traumatic stress disorder (PTSD) in female army soldiers who have served in the conflicts in Iraq and Afghanistan. These data, gathered on both sexes, include: 1) Self-report anonymous surveys completed during and after combat deployments; 2) Post-deployment health assessment (PDHA) and re-

assessment (PDHRA) screening data; 3) Medical utilization data collected for all medical encounters; 4) Evacuations from theater for behavioral health reasons and 5) Self-report surveys by medical personnel. Generally, these recent data show very little difference in the rates of PTSD among male and female army soldiers. It is unclear why this differs from the civilian rates of PTSD, where several studies have estimated the female lifetime prevalence for PTSD being approximately twice as high as among men. Further study is required to understand the observed similarity in PTSD symptom prevalence and healthcare utilization among male and female soldiers who have served in the wars in Iraq and Afghanistan. This workshop will also highlight the challenges for deploying mothers.

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART I OF II)

Chair: Brian Palmer, M.D., M.P.H.

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

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

SUMMARY:
This is a repeat of three workshops held in New Orleans in 2010, Philadelphia in 2012, and San Francisco in 2013. Those resident-only workshops were very successful, with high levels of attendance and engagement. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations.
Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects 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 are presented, 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.

CPT CODING AND DOCUMENTATION 2014: QUESTION AND ANSWER SESSION

Chairs: Ronald Burd, M.D., Allan A. Anderson, M.D.

Speakers: Gregory G. Harris, M.D., M.P.H., Jeremy S. Musher, M.D., David Nace, M.D., Sarah Parsons, D.O., Junji Takeshita, M.D., Tracy Gordy, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of recent CPT coding changes; 2) Understand Medicare reimbursement concerns; 3) Better understand CPT coding, documentation and reimbursement.

SUMMARY:
The goals of the workshop are to inform practitioners about changes to the CPT Coding and current issues associated with documentation guidelines including the major changes for 2014. This year's workshop will focus on 1) a brief review of the new CPT coding framework implemented in 2013; changes in the CPT coding structure for 2014 and beyond; 2) a review of current Medicare and commercial payer reimbursement issues and concerns, and 3) discussion of documentation guidelines for psychiatric services as well as the evaluation and management service codes. The majority of the 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. This dialogue provides necessary and important feedback on coding and documentation issues to APA's representatives to reimbursement related entities (CMS, CPT Editorial Panel, AMA RUC, etc.).

AVATAR THERAPY AND COGNITIVE BEHAVIOR THERAPY (CBT): NEW DEVELOPMENTS IN TREATMENT OF MEDICATION-RESISTANT PSYCHOSIS

Chairs: Basant K. Pradhan, M.D., Rama Rao Gogineni, M.D.

Speakers: Tom Craig, M.D., Ph.D., Donna Sudak, M.D., Doug-

las Turkington, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Summarize the theoretical constructs underlying CBT for psychosis; 2) Apply several basic cognitive behavioural strategies for treating medication resistant psychotic symptoms in patients; 3) Discuss the advantages of AVATAR therapy in the treatment of medication resistant psychotic symptoms.

SUMMARY:
One in four patients with schizophrenia responds poorly to antipsychotic medication (1). In the past several years there has been an increased interest in the development of alternative strategies to augment pharmacological interventions in psychotic patients. This work stemmed various observations: (a) recovery from psychosis was far from complete with pharmacological treatments; (b) non-adherence to medications is a substantial problem; (c) adjunctive treatments are known to be quite effective at enhancing treatment adherence.
CBT for psychosis has been increasingly well researched as a modality that enhances responsiveness to pharmacotherapy over and above the expected results (2). CBT for psychosis has particular usefulness in the amelioration of negative symptoms which are notoriously treatment refractory. Cognitive behaviour therapy can be helpful for reducing distress associated with the enduring auditory hallucinations but have only modest benefit in terms of frequency and intensity of hallucinations. Also CBT can be relatively expensive and lengthy therapy (16 one hour sessions over a year typically). AVATAR therapy is a new development in which computer software is used to enable the patient to match a face and voice (an 'avatar') to the entity they believe they are hearing. This therapy is provided over 6 half-hour sessions and proceeds by helping the patient to develop skills for responding to the voice and changes the balance of power between the subject and the voice. Participants are also provided with an MP3 recording of the session and asked to listen to this between sessions. A pilot study that compared AVATAR therapy with a treatment as usual wait list control, showed significant reductions of intensity and frequency of hallucinations that were sustained over a 3 month follow up (1).
Emphasizing the importance of collaborative therapeutic relationship with the patient, in this workshop Dr. Sudak will orient clinicians to the theoretical constructs underlying CBT for psychosis and introduce them to several basic strategies that are employed with patients. In addition, specific techniques for managing hallucinations and delusions will be discussed.
Dr. Craig in this workshop will provide more detail on the therapy, refinements to the computer modelling and the description of an ongoing randomised controlled trial comparing AVATAR to a supportive counselling control condition. Also participants will have the opportunity to participate in a role play of a therapy session.

References:
1.J.Leff, G.Williams, M. Huckvale, A. Arbuthnot and A.P. Leff (2013). British Journal of Psychiatry, 202, 428-433.
2.Jesse H. Wright, Donna M. Sudak, Douglas Turkington, Michael E. Thase (2010). High-yield Cognitive-behavior Therapy for Brief Sessions: An Illustrated Guide.

MILD TRAUMATIC BRAIN INJURY: ASSESSMENT AND INITIAL MANAGEMENT WITH NEUROPHARMACOLOGY

Chairs: David B. FitzGerald, M.D., Josepha A. Cheong, M.D.

Speakers: David B. FitzGerald, M.D., Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand multiple areas of impairment/symptoms brought about by mild TBI; 2) Identify pharmacological interventions which are appropriate for treating mild TBI; 3) Identify non-pharmacological interventions for treating mild TBI.

SUMMARY:
Loss of consciousness or alteration of consciousness for a short duration (less than 30 minutes) is thought to be a relatively benign experience, either in military settings or in civilian settings. The strengths and weaknesses of the current classification system of TBI are reviewed, with examples. A proportion of those experiencing brief loss of consciousness or alteration of consciousness (or mild TBI) have chronic adverse symptoms, which are only now being characterized. The magnitude of the problem in both military and civilian areas is discussed. Recent imaging data using conventional anatomical imaging as well as a review of diffusion weighted imaging after mild TBI are also presented to provide better insight as to mechanisms of damage. Current therapeutic approaches, both pharmacologic and non-pharmacologic approaches are discussed.

CURRENT CONTROVERSIES IN CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY

Chair: Barbara Coffey, M.D., M.S.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Have knowledge of the use of off label indications in child and adolescent psychopharmacology which are "way beyond the evidence base," particularly use of atypical antipsychotics, mood stabilizers; 2) Have knowledge of the use of antibiotics and conventional psychotropic agents for PANS/PANDAS; 3) Understand guidelines for good clinical practice in addressing symptoms in children and adolescent psychiatry in which there is diagnostic uncertainty.

SUMMARY:
Use of psychopharmacological agents in child and adoles-

cent psychiatry has grown exponentially in the past decade, as has the evidence base for efficacy of treatment, but as might be expected, controversies regarding use of these agents have also arisen. Among those that are most current which will be discussed include 1) use of off label indications which are "way beyond the evidence base," particularly atypical antipsychotics and mood stabilizers, and 2) use of antibiotics and conventional psychotropic treatment in PANDAS/PANS in child and adolescent psychopharmacology practice. This workshop will provide brief introductory remarks regarding these current issues and ample opportunity for discussion amongst attendees.

A COGNITIVE BEHAVIORAL APPROACH TO WEIGHT LOSS AND MAINTENANCE

Chairs: Judith Beck, Ph.D., Deborah Beck Busis, L.C.S.W.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Teach dieters specific "pre-dieting" cognitive and behavioral skills; 2) Keep motivation high long-term; 3) Facilitate permanent changes in eating.

SUMMARY:
A growing body of research demonstrates that cognitive behavioral techniques are an important part of a weight loss and maintenance program, in addition to exercise and changes in eating (see, for example, Stahre & Hallstrom, 2005; Shaw, 2005; Werrij et al, 2009, Spahn et al, 2010; Cooper et al, 2010). An important element that is often underemphasized in weight loss programs is the role of dysfunctional cognitions. While most people can change their eating behavior in the short-run, they generally revert back to old eating habits unless they make lasting changes in their thinking. This interactive workshop presents a step-by-step approach to teach dieters specific skills and help them respond to negative thoughts that interfere with implementing these skills every day. Participants will learn how to engage the client and how to solve common practical problems. They will learn how to teach clients to develop realistic expectations, motivate themselves daily, reduce their fear of (and tolerate) hunger, manage cravings, use alternate strategies to cope with negative emotion, and get back on track immediately when they make a mistake.
Techniques will be presented to help dieters respond to dysfunctional beliefs related to deprivation, unfairness, discouragement, and disappointment, and continually rehearse responses to key automatic thoughts that undermine their motivation and sense of self-efficacy. Acceptance techniques will also be emphasized as dieters come to grips with the necessity of making permanent changes and maintaining a realistic, not an "ideal" weight that they can sustain for their lifetime.

OFFICE-BASED SPORTS PSYCHIATRY: COMMON PROBLEMS AMONG ADOLESCENT ATHLETES

Chair: David R. McDuff, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recite recent unhealthy trends in youth sports; 2) Identity the most common concerns among parents of middle and high school aged athletes; 3) Recognize and treat the common problems in high achieving adolescent athletes; 4) Recognize the different issues faced by athletes in individual and team sports; 5) Identify gender differences of common personal and performance problems in adolescent athletes.

SUMMARY:
Youth sports participation rates have risen steadily over the past twenty years and now exceed fifty percent in most high schools. High achieving athletes experience stress and pressure from long practices, intense competition, negative coaching, parental over-involvement, team acceptance, life balance and injury. Over the last decade a number of unhealthy trends like year round training, one sport specialization, early jumps to the highest competitive levels, excessive time commitments, emphasis on winning at all cost and playing with injuries have developed. These pressures result in inconsistent play, poor focus, precompetitive anxiety, internalized disappointment, low confidence and self-esteem, burnout, insomnia, substance misuse, and chronic injury and somatization. Most office-based mental health providers will see younger athletes in their practices, but may not have a framework for assessment and intervention. Typical cases from the practice of a busy sports psychiatrist will presented and discussed. These cases will highlight differences by sport, age, gender, and competitive level and will serve as a basis for basic and advanced practice skills with this population and other performers.
Reference
McDuff DR. "Sports Psychiatry: Strategies for Life Balance & Peak Performance" American Psychiatric Publishing, Inc, Washington DC 2012

RISK MANAGEMENT AND CLAIMS PERSPECTIVES WHEN TREATING SUICIDAL AND VIOLENT PATIENTS

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize liability risks when treating patients who are violent/suicidal ; 2) Understand and explore the types of claims brought against psychiatrists resulting from a patient's violent/suicidal actions. 3) Understand applicable state/national laws regarding duty to warn and rencent proposals and changes to state and federal laws.; 4) Discuss documentation principles; 5) Identify risk management strategies and best practices to minimize professional liability claims.

SUMMARY:

Recent violent incidents have thrust the issues of mental health and violence to the forefront of a national debate. A central theme in this debate involves the role of psychiatrists in the prevention of violence and safeguarding the general public. As a result, new laws are being proposed at both federal and state levels that may result in changes to the established standards of care in treating these patients as well as the privacy protections traditionally afforded to patients seeking psychiatric treatment.
Malpractice suits often involve the treatment of patients involved in violent incidents-either directed at themselves or towards others. This program will explore the liability risks inherent in treating this patient population, as well as types of claims brought against psychiatrists after violent incidents occur. This program will provide interactive case discussions and will provide timely updates to state/national gun control laws and state/national "duty to warn" laws. This program will discuss strategies to minimize risks that psychiatrists may face when treating these patients.

PSYCHIATRY IN THE COURTS: APA CONFRONTS LEGAL ISSUES OF CONCERN TO THE FIELD

Chair: Paul S. Appelbaum, M.D.

Speakers: Marvin Swartz, M.D., Howard Zonana, M.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases; 2) Appreciate the issues involved in challenges to psychotherapist-patient privilege based on mandated disclosures and actions taken to protect third parties; 3) Recognize the dilemmas inherent in bans on forms of therapy believed to be ineffective or even harmful; 4) Grasp the legal arguments that have resulted in courts upholding parental notification requirements in cases of adolescent abortion.

SUMMARY:
The Committee on Judicial Action reviews on-going court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year, and to provide their input concerning APA's role in the these cases. Three cases will be summarized and the issues they raise will be addressed: 1) People v. Rivera – Rivera disclosed to his psychiatrist involvement in sexual abuse of a minor. When the disclosure was reported to the appropriate state agency, he was arrested. At trial, his psychiatrist was compelled to testify against him, offering what an appellate court described as "the most damaging evidence against the defendant." Now on appeal, Rivera raises the question of whether mandated reporting or a disclosure aimed at protecting third parties vitiates psychotherapist-patient privilege in subsequent proceedings; 2) Pickup v. Brown – Plaintiffs in this case challenged California's new statute that bars the use of therapy aimed at changing the sexual orientation of minor. Although the statute was upheld by the federal 9th Circuit Court of Appeals, the case raises some difficult issues about the proper scope of state regulation. When ineffective therapies are offered, is the proper response to ban them or should dissatisfied patients simply have recourse to the usual remedies, including claims of malpractice?; 3) Hope Clinic for Women v. Flores – A growing number of states are implementing new restrictions on women's access to abortions. Among the approaches commonly used is a requirement that adolescents seeking abortions notify their parents about their situation. APA has consistently opposed parental notification requirements, since they may be counterproductive and place pregnant adolescents at risk. However, Hope Clinic resulted in a decision by the Illinois Supreme Court upholding that state's notification law, highlighting what are likely to be difficult choices for pregnant young women. 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.

CONTROVERSIES ABOUND AROUND PTSD

Chair: Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Elspeth C. Ritchie, M.D., M.P.H., Harold Kudler, M.D., Christopher H. Warner, M.D., Remington L. Nevin, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand the importance of the debate over "disorder" vs "injury"; 2) Know the potential unintended consequences of automatic 50% disability; 3) Learn about the possible burden from mefloquine.

SUMMARY:
Despite the publication of DSM V (and, sometimes, because of it), controversies about PTSD continue to abound. The panel will engage the audience on a wide range of issues including: 1) The question its proper name (Posttraumatic Stress Disorder vs. Posttraumatic Injury?) and the best logic for making this decision; 2) Its relationship to the old concept of compensation neurosis and the best approach to compensation in modern disability systems including DoD and VA; 3) The best working definition of psychological trauma and its relationship to biological, psychological, and spiritual models; 4) The question of whether Service Members diagnosed with PTSD should be re-deployed into combat areas; 5) Its relationship to "moral injury"; and 6) The possible contribution to PTSD symptoms resulting from mefloquine prophylaxis for malaria as a routine step in preparation for deployment.

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISOR-

DER: FROM THE EXPERTS (PART II OF II)

Chair: Brian Palmer, M.D., M.P.H.

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

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

SUMMARY:
This is a repeat of three workshops held in New Orleans in 2010, Philadelphia in 2012, and San Francisco in 2013. Those resident-only workshops were very successful, with high levels of attendance and engagement. We thus are submitting two workshops here in the same manner in which we submitted the prior presentations.
Patients with BPD represent approximately 20% of both inpatient and outpatient clinical practice, and their effective treatment requires specific knowledge, skills, and attitudes that will be addressed in this workshop. This workshop is designed for and limited to residents, fellows, and medical students who, in training, often struggle with the treatment of these patients. In a highly interactive format, trainees will learn from and along with experts in the field of borderline personality disorder (BPD) to broaden and deepen their understanding of the disorder and its treatment. Alternating brief presentations of salient points with audience participation will allow participants to increase their knowledge and skill and to synthesize and apply the content as presented in the workshop. The workshop will be presented in two sessions (Part I and Part II). The workshop moves from an overview of BPD to essentials of psychotherapy and psychopharmacology, family therapy, and residency training objectives. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects 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 are presented, 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.

BUILDING USER-FRIENDLY PRACTICE GUIDELINES: LESSONS LEARNED FROM PRACTICING PSYCHIATRISTS' USE OF CLINICAL INFORMATION RESOURCES

Chair: William Narrow, M.D., M.P.H.

Speakers: Farifteh Duffy, Ph.D., Laura Fochtmann, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Participants will discuss their own experiences in using information resources in clinical practice as compared to the experiences reported by a broad sample of psychiatrists.; 2) Participants will identify clinicians' sources for gathering information and their current unmet information needs.; 3) Participants will provide feedback to further inform the development of user-friendly practice guidelines and other clinical information resources.

SUMMARY:
Psychiatrists are faced with an ever-increasing body of clinical evidence and an ever-shrinking amount of time to digest and incorporate it into their practice. Clinical practice guidelines can serve as a valuable resource for clinicians by compiling and synthesizing recent scientific knowledge with expert consensus on best practice. However, when guidelines are developed using a traditional narrative structure, they can rapidly become outdated and are time-consuming to access and apply at the point of care within a busy clinical environment.
The APA Department of Quality Improvement and Psychiatric Services (QIPS) received funding support from the National Library of Medicine to develop a prototype, Web-based, clinical practice guideline for the treatment of patients with major depressive disorders. This prototype and future APA guidelines will be offered in a Web-based, modular format rather than as traditional narrative books. They will provide evidence-based recommendations for disorder-specific clinical questions as well as questions addressing clinical care issues that may cut across multiple disorders, such as sleep problems. This format is expected to better serve the needs of busy psychiatrists at the point of care. It will also allow the APA to provide timely updates of current supporting evidence to specific recommendations in a more efficient manner. Finally, this approach to guideline development will facilitate eventual integration of practice guidelines into electronic decision support, a component of many electronic health record (EHR) systems.
In this session, the APA Practice Guidelines team will describe work underway for making guidelines more user-friendly, relevant, and accessible at the point of care. The team will also describe progress made in developing an electronic format for presenting guidelines, and will present examples of how guidelines will be accessed in this new user-centered form. Additionally, APIRE and QIPS staff will present data from a recent study of psychiatrists' current practices, sources of clinical information, and clinical information needs of practicing psychiatrists. Session participants

will be encouraged to share their own experiences using clinical information resources at the point of care, and provide feedback to further inform the development of APA practice guidelines and other information resources that are clinically useful and user-friendly.

TAKING CARE OF THE HATEFUL PATIENT: SAME PATIENT, DIFFERENT HEALTHCARE SETTING OF THE 21ST CENTURY

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

Speakers: Sermsak Lolak, M.D., Neil V. Puri, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify the pattern of behaviors associated with the Hateful Patient; 2) Recognize how the changes in the modern healthcare system and setting affect the management of the Hateful Patient; 3) Develop and implement various strategies to manage more effectively the Hateful Patient in the contemporary integrated healthcare setting; 4) Assist non-psychiatrist healthcare providers in the management of the Hateful Patient.

SUMMARY:
In 1978, the New England Journal of Medicine published the article "Taking Care of the Hateful Patient" by James E. Groves, MD. This now-classic article has become required reading in most training programs regarding a difficult challenge faced by most clinicians at least a handful of times during a career. Groves' paper helped to provide healthcare providers with a way to conceptualize the patients that were particularly difficult to care for in the hospital setting. These patients could be demanding, manipulative, hostile, help-rejecting, overly needy, and generally capable to creating chaos on a hospital ward. Suggestions were offered on various approaches to these patients that could help staff to tolerate the patients and still provide effective care. Many of the suggestions provided in this and other articles of its time were based on a different model of healthcare than is oftentimes available nowadays. Contemporary healthcare settings have changed to ones in which inpatient hospital stays are much briefer, staff turnover and greater nurse-patient ratios are more common, and greater emphasis on outpatient care models are present. The presenters seek to re-evaluate and update the information about the management approaches for the difficult/ challenging patient to better fit with the needs of the present healthcare environment. Case presentations, evaluation of available literature, and interactive role play will be utilized in this workshop to assist the participants with the development of various strategies for managing the Hateful Patient in the contemporary healthcare setting of outpatient and integrated care.

CHANGING STYLES OF PRACTICE

Chairs: Malkah T. Notman, M.D., Elissa P. Benedek, M.D.

Speakers: Simha Ravven, M.D., Olaya L. Solis, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Become familiar with historical changes in psychiatric practice; 2) Become familiar with changes in psychiatric practice that occur across the life span of the psychiatrist; 3) Become familiar with the impact of new health care models on psychiatry and psychotherapy, including the place of psychotherapy in these models.

SUMMARY:
Psychiatry is a changing field, historically and for each generation. These changes affect practice, both institutional and private. We will discuss these changes and their effects in relation to four topics:
1. Specific historical changes. These include the increasing dominance of psychopharmacology, the role and influence of insurance, the reliance on DSM categories to define psychopathology, the changing technology such as the internet and the use of electronic medical records.
2. Changes in health care systems such as from fee for service to newer models. We will discuss the effect of an increased integration of psychiatry and primary care and the place of psychotherapy in this model.
3.Changes in career patterns such as shifts from solo practice to group and institutional practice and from primarily psychotherapy to combined treatment
4. Changes in views about confidentiality and how one considers protecting confidentiality, including possible generational differences in acceptance of electronic medical records that can circulate within a large medical system.
There are two senior psychiatrists- the two co chairs- and two early career psychiatrists. The two early career psychiatrists will discuss their views of current practice, particularly insurance and issues of confidentiality. Dr. Raaven will discuss patient therapist boundaries in relation to the internet. Concerns about the meaning of relationships patients have on social media will b e addressed.
The two senior psychiatrists will describe the changes they have observed from a longer term perspective, the effects on their practices, and changes over the course of a career. They will predict the future in relation to specific changes, including Obamacare, and changes in career patterns.
There will be a brief introduction, four presentations of 15 minutes each, and the remaining time for discussion.

EARLY CAREER PSYCHIATRY 101: PEARLS, PITFALLS, AND STRATEGIES FOR NEGOTIATING YOUR FIRST JOB AND OTHER TRANSITIONS AFTER RESIDENCY

Chair: Sarah B. Johnson, M.D., M.Sc.

Speakers: Claudia L. Reardon, M.D., Joyce Spurgeon, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand different job opportunities and set-

tings available for graduates of psychiatry training programs; 2) Become familiar with issues that early career psychiatrists may deal with when negotiating new jobs, including contractual and medico-legal issues; 3) Address work-life balance issues that may impact career satisfaction.

SUMMARY:
The completion of residency training is an exciting and dynamic time. As trainees transition into the "real world" they are faced with many challenges. While current psychiatric education standards and current board certification processes ensure a certain level of proficiency in the practice of psychiatry and patient care, many residents and early career psychiatrists feel under-prepared to deal with other challenges and transitions following graduation. The first challenge that emerging psychiatrists face is negotiating their first job. This workshop will include an overview of types of jobs available, pros and cons of different work settings and negotiating strategies to aid in the process. Once entering the workforce, early career psychiatrists frequently feel overwhelmed by business aspects of medicine as well as medico-legal issues. A discussion of these topics and resources available for self-guided learning in these areas will allow residents to better prepare for these challenges during training and potentially lessen the learning curve as they transition into their careers. The parallel process of life transitions including married life or partnership, parenthood, and/or caring for aging parents as one transitions into their career is common, and this workshop will include discussion of these issues and strategies for achieving balance. Finally, mentorship and having a supportive professional network in place can be a valuable asset in successfully navigating these changes. We will discuss the importance of having these resources, and how the APA can be a valuable resource for young psychiatrists.
The presenters for this workshop include early career psychiatrists who work in a variety of psychiatric settings and have been involved with the APA in leadership roles. All consider themselves "survivors" of the transition from residency into early careers and hope that attendees will benefit from both evidence based overview of issues facing early career psychiatrists and lively discussion during this presentation.

MAY 07, 2014

INTERDISCIPLINARY TREATMENT TEAM: A PSYCHODYNAMIC SYSTEMS APPROACH

Chair: Samar Habl, M.D.

Speakers: Cathleen Morey, L.C.S.W., Samar Habl, M.D., Eric Plakun, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe a psychodynamic systems approach to interdisciplinary treatment teams; 2) Identify the various functions of a psychodynamic treatment team; 3) Explain how a psychodynamic systems approach to team functioning enhances the treatment of difficult patients.

SUMMARY:
For clinical reasons and as a result of the Affordable Care Act patient care increasingly involves interdisciplinary treatment teams. In this workshop, we will discuss interdisciplinary treatment teams utilizing a psychodynamic systems approach that is especially useful with complex and often treatment resistant patients, and that is based on our experience at the Austen Riggs Center. We will describe how to apply our approach to team functioning in a variety of clinical settings.
A psychodynamic systems approach to treatment teams is anchored by fundamental principles, including fostering treatment alliance, engaging patient authority, and pursuing the meaning of symptoms and behaviors. A primary aspect of psychodynamic team functioning involves recognizing and engaging enactments, which involve team members unwittingly acting in ways that mirror the patient's problematic family dynamics. In addition to managing patient crises, team members contain anxiety, identify and metabolize negative feelings among team members, understand these feelings in the context of the family and the patient's struggles, and create space for examining the impact and meaning of behavior. The team also provides a holding function for the patient and a consultative function to team members.
Using vignettes, we will illustrate clinical situations in which team members experience intense feelings towards patients who engage in self destructive behaviors. In these instances, the team can be enactment prone and experience conflicts amongst each other and with the patient.
A team that responds only by managing the patient with limits and expectations rather than interpreting the meaning of the patient's and the team's behavior risks collapse of the team's reflective functioning, leading to yet another iteration of the patient's repetitive, self-defeating treatment resistant behaviors. When team members effectively engage enactments and regain their interpretive stance, new understandings about the patient and family dynamics frequently emerge, and have the potential to be turning points in the treatment.

PREMENSTRUAL DYSPHORIC DISORDER

Chairs: Teri Pearlstein, M.D., Meir Steiner, M.D., M.Sc., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Accurately evaluate premenstrual dysphoric disorder and differentiate it from other conditions; 2) Effectively identify antidepressant treatment regimens for women with premenstrual dysphoric disorder.; 3) Effectively recognize hormonal and other treatments for women with premenstrual dysphoric disorder.

SUMMARY:

This workshop will primarily discuss diagnostic and assessment issues with premenstrual dysphoric disorder (PMDD), including revisions in the DSM-5 diagnostic criteria, and current treatment options. Epidemiology and etiology of PMDD will be briefly presented. Case presentations will illustrate assessment and treatment issues and serve to initiate participant discussion.

Diagnosis: At least 65 instruments have been identified that were developed specifically to measure premenstrual symptoms. The ones that are most commonly used are: the Prospective Record of the Impact and Severity of Menstruation (PRISM), the Calendar of Premenstrual Experiences (COPE), the Daily Diary for Premenstrual Syndrome (DPS), the Visual Analogue Scale (VAS) for Premenstrual Mood Symptoms, and the Daily Record of Severity of Problems (DRSP). DSM-III-R and DSM-IV criteria for PMDD have been used as inclusion/exclusion criteria in well over 50 open-label and randomized placebo-controlled trials using a variety of psychotropic as well as hormonal therapies. Most of these studies have used prospective daily rating scales both as part of the inclusion criteria and as an outcome measure. However the requirement to prospectively chart symptoms daily for a minimum of two symptomatic cycles to establish a diagnosis of PMDD is impractical and unrealistic in a busy primary care practice. Based on the clinical experience of the reluctance of patients as well as feedback from primary health care providers to initiate treatment only after completion of daily charting for two symptomatic cycles, we developed a simple, user-friendly screening tool, the Premenstrual Symptoms Screening Tool (PSST), in line with the DSM-IV diagnostic criteria for PMDD. Both the PSST and the DRSP can be used to assess not only PMDD but also lesser degrees of severity of premenstrual symptoms. A PSST version has also been developed for adolescents.

Treatment: Treatment options for premenstrual disorders include antidepressant medications, hormonal treatments that suppress ovulation, benzodiazepines, dietary modifications, nutritional supplements, herbal treatments, and cognitive-behavior therapy. Selective serotonin reuptake inhibitors (SSRIs), gonadotropin-releasing hormone agonists, estrogen, oral contraceptives, calcium, and chasteberry will be specifically discussed. Advantages of the SSRIs include their tolerability and efficacy with administration during the luteal phase of the menstrual cycle only. An oral contraceptive containing drospirenone administered in a 24/4 regimen may be an optimal treatment choice for a woman with PMDD who also desires contraception. More research study is needed of the continuous use of oral contraceptives (menses induced every 90-120 days) and combined treatments.

YOGA AND BREATH PRACTICES AS ADD-ON TREATMENTS FOR SCHIZOPHRENIA: EFFECTS ON COGNITION, EPIGENETICS, PANSS SYMPTOMS, OXYTOCIN, AND BRAIN IMAGING

Chairs: Robert C. Smith, M.D., Ph.D., Patricia L. Gerbarg, M.D.

Speakers: Shivarama Varambally, M.D., Robert C. Smith, M.D., Ph.D., Richard P Brown, M.D., Elizabeth R. Visceglia, M.D., Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the implication of current scientific research on the effects of yoga and mind-body practices on improving cognitive function; 2) List several biological mechanisms that may contribute to beneficial effects of yoga in schizophrenic patients; 3) Describe a model for the integration of mind-body approaches with standard care in the treatment of schizophrenic patients.

SUMMARY:

Yoga and breath practices have been shown to be effective treatments for a variety of stress related and anxiety conditions. This workshop will review recent studies showing that certain types of yoga and breathing practices can be beneficial as add-on treatments for patients with schizophrenia. Biological effects of yoga may ameliorate some of the neurochemical deficits, brain structure variants, or metabolic abnormalities related to the underlying neuropathology of schizophrenia.

Dr. Varambally will review studies of Yoga treatment for schizophrenia done at the National Institute of Mental Health and Neurosciences of India, which have shown positive effects on cognition, negative symptoms, facial emotion recognition, and increased oxytocin levels. He will also report on studies of yoga effects on BDNF, cortisol, vagal activation, and brain function (MRI).

Dr. Smith will present a study of yoga, qigong, and breathing practices in a group of 35 chronic schizophrenic patients in the U.S., which found highly significant effects on improving measures of cognitive function and underlying epigenetic related abnormalities in the DNA methylating and demethylating enzymes, mRNA and glucocorticoid receptor mRNA in patients' lymphocytes.

Dr. Brown will demonstrate movement and breathing practices derived from yoga and qigong which have been shown to be practical and effective in the study of 35 chronic schizophrenic patients presented by Dr. Smith. Dr. Visceglia will discuss how the practices were adapted to engage patients who were heavily medicated, sedentary, obese or lethargic. She will describe patient responses to the intervention. Dr. Gerbarg will briefly review neurophysiological effects of these practices that may be relevant to the clinical, epigenetic, and neurobiological findings of the studies described by Drs. Varambally and Smith.

Ample opportunity will be provided for questions and participant interaction with speakers.

EFFECTIVE MANAGEMENT OF REASSURANCE-SEEKING BEHAVIOR IN OCD: STRATEGIES FOR CLINICIANS AND FAMILY MEMBERS

Chairs: Phillip J. Seibell, M.D., Megan E. Hughes, Ph.D.

Speakers: Phillip J. Seibell, M.D., Megan E. Hughes, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Explain why reassurance seeking is a compulsion and why providing reassurance makes OCD worse; 2) Describe how to effectively use the "reassurance notebook" to gradually reduce reassurance-providing over time; 3) Describe strategies that can be used by psychiatrists and other clinicians to gradually decrease reassurance-providing during treatment of patients with OCD; 4) Learn how to provide psychoeducation to family members regarding how to gradually reduce reassurance-providing at home; 5) Discuss reassurance-seeking regarding medications and their effects during medication management sessions in the context of effectively providing appropriate medication education.

SUMMARY:
Reassurance-seeking is a common symptom of OCD. Although it is natural to want to help a patient (or family member) with OCD feel better by answering reassurance-seeking questions, we know that providing reassurance makes OCD worse. In the first part of this workshop, Drs. Seibell and Hughes will provide background information about reassurance-seeking behavior. They will explain how to provide psychoeducation to family members so they can distinguish between true information-seeking and reassurance-seeking, how to respond to reassurance-seeking, and how they can regroup after accidentally providing reassurance. Dr. Seibell will also specifically discuss reassurance-seeking regarding medications and their effects during medication management sessions in the context of effectively providing appropriate medication education. Part of the presented strategy will include demonstrating and describing how to effectively use the "reassurance notebook" to gradually decrease reassurance-providing over time. Next, Drs. Seibell and Hughes will roleplay a therapy session in which an OCD client attempts to seek reassurance. The reassurance-seeking will be effectively managed by the therapist. Finally, Drs. Seibell and Hughes will elicit examples from the audience and engage audience members in an interactive, lively discussion about the management of reassurance-seeking behavior in OCD.

HIGH-YIELD COGNITIVE BEHAVIOR THERAPY FOR BRIEF SESSIONS

Chair: Donna Sudak, M.D.

Speakers: Jesse H. Wright, M.D., Ph.D., Judith Beck, Ph.D., David Casey, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify CBT methods that can be delivered effectively in treatment sessions lasting less than 50 minutes; 2) Recognize strategies for enhancing the efficiency of CBT in brief sessions; 3) Describe key methods of integrating CBT with pharmacotherapy in brief sessions.

SUMMARY:
In modern clinical practice, most psychiatrists spend the majority of their time with patients in sessions that are shorter than the traditional "50-minute hour." Yet, traditional psychotherapy training emphasizes full-length therapy sessions. In this workshop, methods are described and illustrated for drawing from the theories and strategies of CBT to enrich briefer sessions. Examples of specific interventions that are detailed include enhancing adherence to medication, using targeted behavioral strategies for anxiety disorders, cognitive restructuring in brief sessions, and CBT for insomnia. Participants will have the opportunity to discuss how they could implement CBT in brief sessions in their own practices.

REDUCING STIGMA FOR GREATER ACCESS: A MULTIFACETED INITIATIVE IN PHILADELPHIA

Chairs: Timothy Clement, M.P.H., Alyson Ferguson, M.P.H.

Speakers: Timothy Clement, M.P.H., Alyson Ferguson, M.P.H., Joe Pyle, M.A.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of stigma and its specific components. Participants will have the ability to identify public stigma and self-stigma; 2) Demonstrate knowledge of the effect stigma has on help-seeking behavior; 3) Demonstrate knowledge of proven methods to reduce stigma and which ones are most effective.

SUMMARY:
Background: Stigma is comprised of three components: stereotypes, prejudice, and discrimination (Corrigan & Watson., 2002). Stigma has been identified as a significant barrier to help-seeking behavior and is correlated with poor treatment adherence. It is estimated that between 60% and 70% of adults with diagnosable mental illnesses in the United States do not seek treatment (Corrigan., 2004). Mental illness costs employers $63 billion each year in lost productivity while, treatment has been shown to improve employee productivity (Insel, 2008; Simon et al., 2001). A recent article in the American Journal of Public Health identified four primary reasons for this low rate of treatment seeking, two of which were directly related to stigma: prejudice against those with mental illness; and expectations of discrimination against those with a diagnosis of mental illness (Henderson, Evans-Lacko, & Thornicroft., 2013). These findings reveal that reducing prejudice and discrimination is not only a social justice issue but also a means of increasing mental health service utilization. In addition, individuals with mental illness receive less care and services in general health settings than patients without comorbid psychiatric conditions due to the phenomenon known as diagnostic and treatment overshadowing. This phenomenon is thought to be caused by stigma. (Thornicroft., 2011). There are three proven strategies to

reduce stigma: protest/advocacy; education; and contact (Rusch, Angermeyer & Corrigan., 2005). In this time of healthcare reform, reducing stigma could potentially impact access, quality, and cost of behavioral health care.
Methods: The Thomas Scattergood Behavioral Health Foundation is implementing a project to address stigma beginning July 1, 2013. The project seeks to raise awareness about stigma among our grantees, local mental health organizations, and other entities within the healthcare industry in Philadelphia so that there is greater clarity about stigma and its effects. This entails defining stigma precisely, describing how it impedes help-seeking, and explaining how it can be reduced using clinically tested methods. The Foundation's website and social media accounts will be used to employ strategies with broader reach. The website will host an education strategy and a video contact strategy. Twitter will be used to implement a protest/advocacy strategy and to direct web traffic to the website. The preliminary findings of this project will be presented.

ARE YOU A SITTING DUCK ONLINE? WHAT YOU CAN (AND CAN'T, OR SHOULDN'T) DO ABOUT NEGATIVE REVIEWS YOUR PATIENTS POST ABOUT YOU

Chair: Robert C. Hsiung, M.D.

Speakers: Paul S. Appelbaum, M.D., John Luo, M.D., Dinah Miller, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List 3 web sites at which patients can post reviews of psychiatrists; 2) Give 1 example of how a psychiatrist could respond to a negative review that would be likely to be constructive; 3) Give 1 example of how a psychiatrist could respond to a negative review that would not be likely to be constructive.

SUMMARY:
Online reviews that your patients post about you may affect the vitality of your practice. Review sites enable a prospective patient to take into account the opinions of your current -- and past -- patients when choosing a psychiatrist. Do you know what your patients are saying about you online? Are you prepared for a negative review? Do you feel anxious? Have you already received a negative review? Do you feel angry?
In this workshop, we visit representative review sites and learn in detail about one psychiatrist's personal experience of a negative review. In small groups, participants explore in depth different possible ways to respond to negative reviews. The groups present the pros and cons of the strategies they consider to the workshop as a whole. We conclude with recommendations for individual psychiatrists and the psychiatric profession and discussion.
APA provides free wireless Internet access for this workshop. We encourage participants to bring laptops, tablets, or smartphones to search for reviews of themselves.

WEIGHT MANAGEMENT IN PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISORDERS: LESSONS FROM PRADER-WILLI SYNDROME

Chairs: Robert J. Pary, M.D., Janice L. Forster, M.D.

Speakers: Chenelle C. Joseph, M.D., Jarrett Barnhill, M.D., Jeffrey I. Bennett, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss behavioral approaches to weight control in persons with Prader-Willi syndrome; 2) Discuss neurophysiology of appetite and food-seeking in persons with Prader-Willi syndrome; 3) Discuss neurobiology of appetite regulation, neurohormonal aspects of fat cell metabolism, and obesity in non-PWS children; 4) Discuss psychotropic and obesity in adults with intellectual and developemntal disability.

SUMMARY:
Persons with Prader-Willi syndrome (PWS) have a nearly constant struggle with appetite and weight management. This workshop will share clinical experiences from years of working with persons with PWS. Although the focus is on weigh control in persons with PWS, there will be a brief overview of genetic testing, physical features and common syndromes of PWS. Often, it is the near constant struggle with food that drives families or caregivers to seek psychiatric attention. At times, the successful behavioral strategies may appear quite restrictive, but are usually needed to live in the community. The workshop will also discuss neurobiology of appetite regulation, neurohormonal aspects of fat cell metabolism, and obesity in non-PWS children. The session will conclude by examining strategies to control weight in adults with intellectual and developmental disabilities who are prescribed psychotropics.

PEARLS OF PSYCHOSOMATIC MEDICINE

Chairs: Philip R. Muskin, M.A., M.D., Thomas N. Wise, M.D.

Speakers: Catherine C. Crone, M.D., Linda L. M. Worley, M.D., Madeleine Becker, M.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Review the clinical imperatives of a consultation request; 2) Outline the elements of a psychiatric consultation to a hospitalized patient; 3) Assess management of the personality disordered patient in a medical setting; 4) Discuss issues in consultations with ambulatory patients; 5) Explore the consultative process for psychiatrists not formally trained in psychosomatic medicine.

SUMMARY:
According to AHRQ data approximately 25% of general

hospital admissions are for patients with mental illness and or substance abuse. Many hospitals lack formal consultation-liaison psychiatry services. This demands that general psychiatrists, who are in private practice but on the medical staff of a hospital, perform such consultative duties for medical patients with psychiatric problems, or the "complex medically ill." In addition to inpatient consultations the growing trend of attached ambulatory primary clinics may also generate consultative requests. Thus it is important for such general psychiatrists to have a basic knowledge of such collaborative tasks. This workshop will focus on "pearls" of wisdom applicable to consultation for complex medically ill patients in both the inpatient and outpatient setting. The workshop will concentrate on the process of psychiatric consultation, key elements in the evaluation of the complex medically ill patient, therapeutic concerns for patients with medical and surgical disorders, issues related to evaluation and treatment of the perinatal patient, and psychotherapeutic maneuvers central to managing patients with personality disorders in the medical setting.
Reference: Friedman E, Muskin PR: Best Practices in Consultation-Liaison Psychiatry. Focus (in press)

A MODEL FOR THERAPEUTIC RISK MANAGEMENT OF THE SUICIDAL PATIENT

Chairs: Hal S. Wortzel, M.D., Morton M. Silverman, M.D.

Speakers: Beeta Homaifar, Ph.D., Bridget Matarazzo, Psy.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Augment clinical suicide risk assessment with structured instruments; 2) Stratify suicide risk in terms of both severity and temporality; 3) Develop and document a safety plan; 4) Be familiar with the concept of therapeutic risk management, and able to integrate it into their practice by deploying the above skills.

SUMMARY:
Few scenarios are as clinically and emotionally demanding as managing the patient who is at high risk for suicide. Much of the challenge relates to caring for an individual in severe emotional distress and wanting to reduce suffering while keeping that person safe from harm. Part of the challenge derives from the fact that optimal management sometimes forces us to make tough choices, selecting between two of our highest-ranking ethical principles, autonomy and beneficence. Navigating such clinical dilemmas can be emotionally taxing and medicolegally disconcerting.
All mental health professionals need to be attuned to suicide risk, and competent at risk assessment and management. Suicides and suicide attempts remain among the leading sources of malpractice claims against psychiatrists. We need to be assessing and managing suicide risk not only to take good care of our patients, but also to take good care of ourselves. Risk management is a reality of psychiatric practice, and this necessitates practicing (and documenting) thoughtful suicide risk assessment and management. The Veterans Integrated Service Network (VISN) 19 Mental Illness Research, Education and Clinical Center (MIRECC) has developed a multidisciplinary suicide consultation service for Veterans thought to be at high risk for suicide. The service has evolved over half a decade to accommodate the needs of Veterans and providers in various treatment settings while employing medicolegally informed clinical and documentation practices to realize what Simon and Shuman have termed "therapeutic risk management." This workshop will provide an overview of the model that has evolved, starting with a review of the concept of therapeutic risk management, and then briefly discussing core aspects of our risk assessment and management consultation process including: augmenting clinical risk assessment with structured instruments; stratifying risk in terms of both severity and temporality; and developing/documenting a safety plan. These elements are readily accessible to and deployable by mental health clinicians in most disciplines and treatment settings, and they collectively yield a suicide risk assessment and management process (and attendant documentation) that should withstand the scrutiny that often occurs in the wake of a patient suicide or suicide attempt.

FREE ARTISTIC EXPRESSION AND PLAY AS MEANS OF SURVIVING TRAUMA

Chairs: Andrei Novac, M.D., Bonita N. Jaros, Ph.D.

Speaker: Barton J. Blinder, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Be familiar with the literature on the role of free artistic expression/play in human resiliency; 2) Understand the role of development of new personal narratives in the process of psychotherapy; 3) Learn about the need for a multidisciplinary approach to treatment after trauma.

SUMMARY:
Over the past decades, the ever increasing interest in the field of traumatic stress by clinicians and researchers has fueled numerous contributions both in scientific and popular literature. In spite of the expanding understanding of human reactions, group dynamics, and family systems after trauma, and the addition of a large body of neuroscientific literature, there still remain numerous unanswered questions about the impact of trauma on individual personalities, motivation, and the stimulation of the creative process. This workshop by a psychiatrist and a linguist/musician will cover the subject of free artistic expression (FAE) and play as means of resiliency during and after traumatic events. A history of the relationship between FAE and maintenance of resiliency and health during catastrophic historical events will be presented (1). Examples of creative productions during and after the Holocaust by survivors will be presented by means of clinical material. The neuroscience of trauma, traumatic memories, emotional regulation, and attachment

will be examined in light of new personal narratives created by artistic endeavors. The power of such new narratives in healing and transformation will be discussed (2,3,4). Clinical vignettes will be presented and audience participation will be encouraged.

1. Jaros, BN. (2005). Sounds of survival and regeneration: A microstoria of the Holocaust, 1940-1945. Ann Arbor, MI: ProQuest.
2. Novac, A. & Bota R. (2013). Transprocessing: Neuro-biologic Mechanisms of Change during Psychotherapy-A proposal Based on a Case Report. Perm J; 17(1):67-71.
3. Novac, A. "Narrative and Healing Processes During Psychotherapy: The Reloading and Implicit Relegation Hypothesis." Academy Forum (The American Academy of Psychoanalysis and Dynamic Psychotherapy), in press.
4. Blinder BJ. (2007). The Autobiographical Self: Who We Know and Who We Are. Psychiatric Annals, 37(4), 276-284.

LONELINESS AND SOCIAL ISOLATION: A CBT APPROACH FOR THE BUSY PSYCHIATRIST

Chairs: Michael S. Ascher, M.D., Hetal Bhingradia, M.D.

Speakers: Donna Sudak, M.D., Renu M. Culas, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Describe the association between social relationships and support in the maintenance of mental health and well-being; 2) Assist patients in responding to negative cognitions that interfere with the process of engaging in social behaviors; 3) Identify resources in the community that can help patients to gain a greater sense of connectedness.

SUMMARY:
Social relationships and support are critical for the maintenance of mental health and well-being, particularly for those suffering from mental illness. Social inclusion aids recovery, and helps patients to feel valued and respected. Clinicians can work to cultivate a greater sense of agency in patients. An important part of providing comprehensive care should include an exploration of the patient's social sphere, including his or her interests, activities, and relationships. Psychiatrists are in a good position to quickly screen and assess patients' social connectedness. We also can provide empathy, encouragement, and psychoeducation to patients while stressing the importance of community engagement. During this process, we should aim to elicit the patient's motivations for enriching his or her social outlets. Assessing the degree of patient functioning and the potential skill deficits that might impair a patient's ability to participate in social activities is paramount. Patients with limited motivation also will likely benefit from an exploration of the negative cognitions that might interfere with the process of engaging in social behaviors. Numerous types of community resources that can help patients broaden their social lives will be discussed.

VETERANS AT EASE: INTEGRATING COMPLEMENTARY AND ALTERNATIVE THERAPIES

Chair: Jennifer Cho, L.C.S.W., M.S.W.

Speakers: Harita Raja, M.D., Jennifer Cho, L.C.S.W., M.S.W., Gail Feagans, R.N.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Recognize presentations of PTSD likely to benefit from alternative and complementary practices; 2) Describe three alternative and complementary practices in use at the DC VAMC (hatha yoga, iRest yoga nidra, and mindfulness-based stress reduction) and experience them first-hand; 3) Describe how these practices are integrated into conventional treatment for PTSD and the benefits of these practices and integrated treatment for patients. ; 4) Identify and refer to qualified providers of complementary and alternative practices.

SUMMARY:
There are over 20 million Veterans in the US, including over 2.7 million having served in Vietnam, over 0.5 million having served in Desert Storm/Shield, and over 2.25 million having served in Iraq and Afghanistan over the last decade. Of the Veterans who have been in a theater of combat, approximately 15% will develop Posttraumatic Stress Disorder. While many of these Veterans will be treated in the VA system, many others will be seen in general psychiatry offices. In 2007, 38% of US adults spent over $33 billion out-of-pocket on complementary and alternative practices and those numbers continue to increase as interest continues to grow. Integrating complementary and alternative practices with conventional evidence-based therapies allows mental health providers to custom tailor treatments to the needs of their patients. Studies have indicated that an integrative approach results in lower drop-out rates and increased patient engagement in their mental recovery.
This workshop will provide the generalist psychiatrist with a review of PTSD symptoms as typically presented by military service members and Veterans and will discuss symptom presentations that would benefit from complementary and alternative practices. The workshop will additionally introduce hatha yoga, iRest yoga nidra, and mindfulness-based stress reduction (MBSR), three complementary and alternative practices in use at the Washington DC Veterans Affairs Medical Center (DC VAMC). The integration of these practices into conventional care will be discussed as well as the benefits of these practices as experienced by patients. This workshop will be very experiential and participants will be led through brief experiences of hatha yoga and mindfulness and a 20 minute practice of iRest yoga nidra. Participants will be provided with a resource for free internet-based hatha yoga classes and will be provided a CD of yoga nidra and mindfulness practices to take home with them. Lastly, this workshop will conclude with a discussion of how

to identify and refer to qualified providers of complementary and alternative practices.

NEUROIMAGING AND THE LAW

Chair: Carl Erik Fisher, M.D.

Speakers: Paul S. Appelbaum, M.D., Steven Hoge, M.B.A., M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify several ways that brain imaging has been used in legal proceedings; 2) Describe the practical issues involved with the use of neuroimaging in forensic psychiatry; 3) Discuss the broader ethical, legal, and social implications of the use of brain imaging in legal proceedings related to mental health.

SUMMARY:
It is increasingly common for brain imaging to be used and discussed in legal proceedings. For example, in capital cases, defendants have asserted that they should have access to psychiatric examinations that include "modern brain imaging" such as positron emission tomography or functional magnetic resonance imaging to support the claim that an execution would be unconstitutional as cruel and unusual punishment. Beyond these individual uses, neuroimaging research about brain function and mental illness has been used to justify the evolving treatment of certain groups, such as the US Supreme Court's recent series of decisions abolishing life without parole for juveniles, which cited neuroscience research about delayed development of the frontal lobe.
The general public, including the media, often put much stock in the power of brain imaging to reveal abnormal brain activity associated with psychiatric illness, and this credibility may spill over into the courtroom. While there may be little role for brain imaging in the ordinary practice of psychiatry, neuroimaging in forensic psychiatry is on the rise. This workshop will address a number of issues that arise at the intersection of psychiatry, neuroscience, and law, including:
- how is neuroscience being used as psychiatric evidence in courts?
- how are courts responding to these claims?
- what ethical and conceptual issues are raised by the use of neuroscience evidence to contest responsibility and mitigate punishment? and,
- what does the use of neuroscience in court indicate about public attitudes regarding punishment, responsibility, and mental illness?

These questions will point the way toward important issues related both to the use of neuroimaging methods in psychiatry and to public attitudes about mental illness in general.

CULTURAL COMPETENCE REVISITED: CHALLENGING DIVERSITY STEREOTYPES

Chairs: Silvia W. Olarte, M.D., Patricia I. Ordorica, M.D.

Speakers: Christina T. Khan, M.D., Ph.D., Joanna Quigley, M.D., Lourdes Dominguez, M.D., Sherry Katz-Bearnot, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the relevance of cultural competence concepts in diagnosis and treatment of diverse populations; ; 2) Demonstrate knowledge of variations of such concepts as they apply to subgroups within a given diverse population; 3) Apply of such concepts in the treatment of diverse populations.

SUMMARY:
Traditionally cultural competency has addressed the ability of members of different ethnic and racial groups to successfully communicate. This occurs through reaching a shared understanding of specific behavioral patterns and belief systems. Successful delivery of health care, particularly mental health services, depends in large part on satisfactory interpersonal transactions between provider and patient. It is crucial to enhance these encounters through sound knowledge of the other's language, beliefs, values, customs. Institutions showing respect for, and acknowledging these differences is crucial.
In the past ten years this country has made excellent strides to enhance the cultural competence within health care delivery systems. However, health care delivery, and mental health systems have typically approached cultural competency to diverse groups treated as a totality; example: cultural competency treating Latinos, Asian Americans, or African Americans.
This workshop will address the cultural diversity that exists within groups often considered homogenous in their needs (in reference to the host culture). Participants will use clinical material to discuss the diversity of needs found within these populations.
The first presenter Christina Kahn, MD will present her work with adolescent Latinas in the San Francisco Bay Area. Joanna Quigley MD will present her work with adolescent transgender patients from the Pittsburgh area. Lourdes Domingues MD will discuss her work with female police officers in NYC, of Latina descent and lesbian sexual orientation. Finally Sherry Katz Bearnot MD will discuss her work with multiple members of extended family groups of an orthodox Hassidic community in NY State.
The format of short clinical vignettes with pertinent theoretical information will be geared to facilitate active participation and discussion from the floor.
References:
Lim RF;Luo JS;Hales RE. Diversity Initiatives in academic psychiatry: applying cultural competence. Acad Psychiatry. 2008; 32(4): 283-90 (ISSN: 1042-9670
O'Donnell DA. Meditation and movement therapy for children with traumatic stress reaction. In: Brooke SL, ed.

Creative Arts Therapies Manual. Springfield, IL: Charles C. Thomas; 2006:156–167
Snelgrove JW, Jasudavisius AM, Rowe BW, Head EM, Bauer GR. "Completely out-at-sea" with "two-gender medicine": a qualitative analysis of physician-side barriers to providing healthcare for transgender patients. BMC Health Services Research 2012,12:110

COGNITIVE BEHAVIOR THERAPY FOR SUICIDE RISK

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

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

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) List risk factors for suicide that may be remediable with CBT; 2) Describe CBT methods for generating hope; 3) Outline key elements of CBT generated anti-suicide plans; 4) Detail CBT methods for coping with triggers for increased suicidal risk.

SUMMARY:
CBT has been shown to substantially reduce the risk for subsequent suicide attempts in persons who have attempted suicide. This workshop will describe risk factors for suicide that can be modified with CBT and will assist participants in building skills for reducing suicide risk with CBT. These methods will include increasing hopefulness with CBT, identifying positive reasons to live, developing effective anti-suicide plans, implementing behavioral strategies to reduce despair, and using cognitive-behavioral rehearsal to prepare patients for future stressors. Role play demonstrations will show participants how to implement CBT for suicide risk, and interactive discussion will focus on troubleshooting potential problems in using CBT for suicide risk.

FEELING BURNED OUT? THERE'S AN APP FOR THAT! MINDFULNESS TRAINING AND COMPASSION CULTIVATION AS A POTENTIAL ANTIDOTE FOR BURNOUT

Chair: Sermsak Lolak, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Discuss the syndrome of clinician burnout; 2) Describe the basic concepts and exercises in mindfulness and compassion cultivation as potential tools to prevent clinician burnout; 3) Outline how to apply these concepts to the learner's personal and professional areas.

SUMMARY:
Physician wellness, work-life balance, and burnout are among the top challenges affecting quality of life of the physician, regardless of level of training or practice setting. These issues are now more important than ever given growing distractions, responsibilities, and demands both from professional and family areas. Up to one-third of physicians are affected by burnout, which has negative impacts on health, well-being, job satisfaction, productivity, in addition to patient care. This interactive workshop will offer participants an overview of syndrome of burnout and suggestions of how to prevent or reduce it using contemplative practices backed by scientific evidence, including mindfulness training and compassion cultivation.
The first part of the workshop will offer a summary of the latest literature regarding issues of burnout, as well as possible interventions especially in the area of mindfulness training and compassion cultivation. Participants are encourage to complete the measure of burnout during the session and reflect on their scores. During the second part of workshop, we will focus on practical solutions to the problem, with the emphasis on utilizing contemplative practices in a secular context. There will be an experiential component of guided meditation, dyad exercise, and other exercise aimed to increase mindfulness and compassion, followed by suggestions of adapting these concepts and practices to everyday life. The last part of this workshop will be an interactive discussion and sharing. This workshop is open to participants from all health-related disciplines, regardless of their level of training.

GENDER TRENDER: GENDER VARIANCE AND THE LAW

Chair: Renee Sorrentino, M.D.

Speaker: Daniel R. Reilly, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Learn the diagnostic basis and theoretical considerations in the DSM-IV and proposed DSM-5 disorders of transgenderism.; 2Be familiar with the legal landmark cases, which involve transgender issues in the court.; 3) Identify the common ethical challenges in working with this patient population.

SUMMARY:
In September 2012, a Massachusetts federal Judge ordered a prison to provide sex reassignment surgery as the necessary medical treatment for a transsexual inmate. This controversial ruling, the first of it's kind, has renewed the debate of whether transgenderism exists. Despite inclusion of Gender Dysphoria in the DSM, general acceptance of transgenderism as a psychiatric or mental disorder does not exist. An international survey on various issues related to the DSM-IV gender identity disorder diagnosis was conducted among 201 organizations concerned with the welfare of transgender people. 55.8% believed the diagnosis should be excluded from the DSM (Vance et al, 2010). The major reason for wanting to keep the diagnosis in the DSM was health care reimbursement (Vance et al, 2010). The DSM-V proposed that the name gender identity disorder (GID) be replaced by "Gender Incongruence" (GI) because the latter is a descriptive term that better reflects the core

of the problem: an incongruence between the identity one experiences and/or expresses and how one is expected to live based on assigned gender.
The prevalence of transgenderism is not known within the United States, and international studies are generally limited by the complications associated with terminology. The epidemiological studies tend to underestimate the number of gender variant individuals, because studies are typically limited to transsexual individuals. However, Bakker et al., in a 1993 study from the Netherlands, estimated that transsexualism occurred in one out of every 11,900 males and one out of every 30,400 females. Data from the Human Rights Campaign estimate that 0.25%- 1 % of the US population has undergone at least one sex reassignment surgery.
The population of gender variant individuals in the prison system is even more poorly understood, despite data from the Transgender Law Center that suggest that transgender individuals are two to three times more likely to be incarcerated than the general population. As such, clinicians working in the correctional setting should be familiar with the diagnostic and treatment implications of this patient population. This workshop will address the framework for the diagnostic criterion of Gender Identity Disorder, review the landmark cases relevant to gender variance and the law and conclude with a discussion of the ethical implications implicit in this population.

YOU BE THE NEUROLOGIST: DIAGNOSIS AND TREATMENT OF MILD TBE IN A CASE STUDY FORMAT

Chairs: David B. FitzGerald, M.D., Josepha A. Cheong, M.D.

Speakers: David B. FitzGerald, M.D., Josepha A. Cheong, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand criteria for diagnosis of mild TBI; 2) Identify diagnostic steps to be considered when evaluating a symptomatic patient with mild TBI; 3) Identify alternative diagnoses to be considered when elements of the patient's history and time course do not seem to fit with the diagnosis of mild TBI.

SUMMARY:
Mild TBI is defined clinically. This clinical definition has an expected set of symptoms and an expected time course of recovery from these symptoms. However, not all patients presenting with a diagnosis of mild TBI have mild TBI. Some patients may have moderate to severe TBI based on imaging. Some patients may have additional diagnoses which confuse the diagnostic work-up and prevent resolution of symptoms or result in suboptimal diagnostic approaches. Cases with a presenting diagnosis of "mild TBI" are reviewed with a brief history, imaging as appropriate, other diagnostic tests and test results as indicated, a final diagnosis, treatment and outcome. This session is intended to be interactive with "what should the next step be?" as part of the presentation. Although presented by a neurologist, neurological jargon will be kept to a minimum.

DOES WORKPLACE MATTER? JOB CHOICE INFLUENCE ON PRACTICE AND HOME

Chairs: Christine L. Wolfe, M.D., Colleen J. Northcott, M.D., Ph.D.

Speakers: Melanie Morin, M.D., Raymond M. Reyes, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Identify potential work and home-related benefits of different types of practice (e.g. employed v. private practice) ; 2) Discuss possible professional and personal-life downsides of different genres of practice; 3) Explore setting-specific dilemmas that arise from competing interests of employer versus physician's duty to the patient.

SUMMARY:
This panel will seek to highlight what important differences may exist for the psychiatrist in different types of practice. Our panel will consist of four presenters, each panelist with the perspective of their own type of practice: military, corrections-based, hospital/community-based, and clinical/academic. Discussion points will include the advantages of shared call responsibilities and opportunities for leadership and mentoring more commonly enjoyed in organized practice, as well as the greater autonomy in private practice. Potential financial considerations, as well as opportunities for growth in different types of employment will also be considered. The role that a professional organization such as apa plays in the different work settings will also be explored. After the panelist discussion, a 30-minute question/answer and discussion period will be opened to the audience. We hope audience members will gain a more concrete sense of differences of personal and professional import between the varied types of psychiatric practice--perhaps informing future employment decisions.

PRACTICING COGNITIVE BEHAVIOR THERAPY: AN EXPERIENTIAL WORKSHOP

Chair: Judith Beck, Ph.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Implement standard components of the session structure;; 2) Elicit and evaluate key cognitions; 3) Elicit and use patient feedback to strengthen the therapeutic alliance; .

SUMMARY:
A large empirical literature has demonstrated that cognitive behavior therapy (CBT) is efficacious in the treatment of depression and anxiety, as well as many other psychiatric dis-

orders and psychological problems. While many psychiatrists have read about or attended professional presentations of this approach, they have not had the opportunity to practice fundamental strategies. In this experiential workshop, basic techniques of CBT will be discussed and then demonstrated through roleplays. Participants will then practice techniques in dyadic roleplays. The roleplaying "patient" will provide the roleplaying "therapist" with feedback and a large group discussion will address questions and hone participants' performance. Techniques will include how to set goals with clients; how to educate patients about the cognitive model; how to set an agenda; and how to identify and evaluate automatic thoughts.

COMPLEX ADAPTIVE SYSTEMS: EVOLUTIONARY ALGORITHMS IN PSYCHIATRY AND PSYCHOTHERAPY

Chairs: Yakov Shapiro, M.D., Rowan Scott, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Apply the concepts of dynamical systems theory in the diagnosis and treatment of a broad range of clinical syndromes; 2) Become familiar with key neural networks contributing to psychopathology and their adaptive evolutionary functions; 3) Understand the concept of adaptive self-organization as a key process in normal and pathological development; 4) Use complexity approach Dynamical Systems Therapy) in facilitating individual and group therapy process.

SUMMARY:
An earlier version of this presentation titled: "The Neuroscience of Psychotherapy: A Dynamical Systems Approach" was offered at the 2009 Canadian Psychiatric Association meeting, with a lot of positive feedback and subsequent e-mails. Interest was expressed by both dynamic and biological psychiatrists, as well as psychiatric residents, in learning more about this integrated approach.
The updated version integrates the advances in understanding complex adaptive systems (CAS), a subset of non-linear dynamical systems, within a broad evolutionary framework, which applies to both phylogenetic history of the human species and individual brain development. CAS applications range from epigenetics and neural network dynamics all the way to economy, culture, and ecology. The emphasis of this approach is on the adaptive nature of the emergent patterns of psychological complexity in individual health and psychopathology, with specific application to individual and group psychotherapy process.
Notwithstanding its great advances, the reductionist paradigm in the natural sciences is facing its limits. It cannot incorporate the emergence of complexity at successive levels of physical organization, and it has failed to account for the ultimate evolutionary expression of biological complexity – subjective mental processes. We can finally glimpse a new holistic paradigm that incorporates biological complexity and its emergent properties of subjective experience into a comprehensive naturalistic picture of the world. Re-casting the language of psychological sciences in non-linear informational terms has the potential of liberating us from the Cartesian trap of body/mind dualism, and re-unifying the third-person perspective of neuroscience and biological psychiatry with the psychodynamics of individual meaning and intentionality.
CAS approach to neural network functioning offers the most comprehensive theoretical foundation for psychotherapy available to us today. Recurrent patterns of thinking, feeling, and relating can be analyzed by modeling cortical and subcortical network processes. The emerging Dynamical Systems Therapy (DST) stands as a trans-theoretical model with the explanatory power to integrate systems of synaptic networks with systems of meaning. It powerfully argues for shifting the emphasis from maladaptive patterns as the problem to be fixed – to seeing these patterns as the patient's imperfect solutions to their inner and relational conflicts. We begin to see patients as active agents that create their own subjective and interpersonal reality based on their specific developmental templates. Therapeutic relationship becomes our tool in re-shaping the topology of the patient's adaptive landscape and re-establishing self-organizing process.

BENZODIAZEPINES IN PATIENTS WITH ADDICTION: WHEN AND HOW DO WE USE THEM? CONSIDERATIONS AND STRATEGIES FOR USE: A CASE-BASED WORKSHOP

Chairs: Margaret M. Haglund, M.D., Meredith A. Kelly, M.D.

Speakers: Michael Gitlin, M.D., John J. Mariani, M.D., Larissa Mooney, M.D.

EDUCATIONAL OBJECTIVE:
At the conclusion of the session, the participant should be able to: 1) Understand risks and benefits of benzodiazepine treatment in patients with a history of addiction; 2) Identify strategies for the use of benzodiazepines in patients with current or past alcohol use disorders ; 3) Discuss considerations related to the use of benzodiazepines in patients with bipolar disorder and a history of addiction.

SUMMARY:
The use of benzodiazepines in patients with addictive disorders is controversial. Clinicians learn that it is safest to avoid the use of these medications in patients with remote or current addictions, due to concerns that there may be increased risk of addiction to the prescribed benzodiazepine and/or relapse to other substances of abuse. In practice however, there are situations in which benzodiazepines may be used to good effect in patients with addictive disorders, whether for management of underlying disorders during acute exacerbations or for long term therapy. The purpose of this workshop is to review the existing evidence, discuss current clinical practice, and provide a framework for clinicians who may be faced with the dilemma of when and how to use benzodiazepines in their patients who have struggled

with addiction.

In patients with substance use disorders, anxiety and mood disorders are common comorbidities. Symptoms from primary anxiety or mood disorders may worsen in the setting of intermittent withdrawal, and a careful history may reveal that this phenomenon has fueled the patient's addiction. In cases in which a pre-existing mood or anxiety disorder has been diagnosed, symptoms may worsen as patients transition to abstinence, and short-term treatment with benzodiazepines may be useful to alleviate symptoms until antidepressants or mood stabilizers reach therapeutic levels. Longer term benzodiazepine treatment of mood or anxiety disorders in patients with alcohol use disorders may also be indicated in some cases, and may not lead to dependence or relapse. Bipolar patients may be at increased risk for benzodiazepine misuse, however. Clinical management strategies for using benzodiazepines in each of these contexts will be discussed.

References

1. Malcolm RJ. GABA systems, benzodiazepines, and substance dependence. J Clin Psychiatry 2003; 64 S 3: 36-40.

2. Lader M. Benzodiazepine Harm: How can it be reduced? Br J Clin Pharmacol 2012; doi: 10.1111/j.1365-2125.2012.04418.x. [Epub ahead of print]

3. Maremmani AG, Rovai L, Rugani F, Bacciardi S, Pacini M, Dell'osso L, Maremmani I. Clonazepam as agonist substitution treatment for benzodiazepine dependence: a case report. Case Rep Psychiatry 2013; epub Jan 30.

4. Ries R, Wolitzky-Taylor KB, Operskalski JT, Craske MG, Roy-Byrne P. Treatment of comorbid substance use and anxiety disorders: a case study. J Addict Med. 2011 Dec;5(4):248-53.

5. Mueller TI, Pagaono ME, Rodriguez BF, Bruce SE, Stout RL, Keller MB. Long-term use of benzodiazepines in participants with comorbid anxiety and alcohol use disorders. Alcohol Clin Exp Res. 2005 Aug;29(8):14118.

6. Brunette MF, Noordsy DL, Xie H, Drake RE. Benzodiazepine use and abuse among patients with severe mental illness and co-occurring substance usedisorders. Psychiatr Serv. 2003 Oct;54(10):1395-401.