



SYLLABUS & PROCEEDINGS



AMERICAN PSYCHIATRIC ASSOCIATION
168TH ANNUAL MEETING
Toronto, Canada • May 16-20, 2015

psychiatry.org/annualmeeting

**SYLLABUS
AND
SCIENTIFIC PROCEEDINGS**

IN SUMMARY FORM

**THE ONE HUNDRED AND SIXTY EIGHTH
ANNUAL MEETING OF THE
AMERICAN PSYCHIATRIC ASSOCIATION**

**Toronto, ON Canada,
May 16-20, 2015**

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AMERICAN PSYCHIATRIC ASSOCIATION

1000 Wilson Boulevard, Suite 1825

Arlington, VA 22209

May 2015



Dear Colleagues and Guests,

The American Psychiatric Association's 2015 annual meeting in vibrant Toronto promises to be an exceptional educational experience. You will have many outstanding sessions to choose from as we bring together some of the best minds in psychiatry to present compelling research, clinical, and practice-related sessions in one dynamic meeting.

This year's theme is "Psychiatry: Integrating Body and Mind, Heart and Soul." Psychiatry's position at the intersection of neuroscience and general medicine is reflected in the focus on advances in neuroscience, genetics and the integration of psychiatric and general medical care. Many sessions address the experience of illness: the heart and soul of the work we do.

Our Opening Session will be a lively and thought-provoking discussion with Helen S. Mayberg, M.D., the Hon. Patrick Kennedy and I discussing neuroscience research, advocacy, and the language of mental health. National Institutes of Drug Abuse Director Nora Volkow, MD will deliver the William Menninger Memorial Lecture at the Convocation of Distinguished Fellows, on Monday at 5:30 p.m. Kennedy will also deliver the Patient Advocacy Award lecture, titled "The Open Warmth of Community Concern and Capability: Achieving President Kennedy's Vision," on Tuesday at 9 a.m.

Several events will highlight the important role of psychiatry health care system transformation. On Monday at 9 a.m. I will chair a guest lecture by Ellen Zane, the Former CEO of Tufts Medical Center in Boston and a compelling speaker who will present on “Navigating Psychiatry and Health Care Reform.” I will also moderate a forum on psychiatrists as leaders with Herb Pardes, M.D., Darrell Kirch, M.D., Robert Golden, M.D., and Peter Buckley, M.D.

On Monday at 11 a.m. Karl Deisseroth, M.D., Ph.D will receive the Adolph Meyer award for his outstanding work in optogenetics and the recently developed CLARITY system and present the Meyer lecture on “Illuminating the Brain.”

Each year we work with one of the NIH institutes at the meeting, this year will focus on the National Institute on Alcohol Abuse and Alcoholism (NIAAA), under its director George Koob, Ph.D.

On Tuesday at 11 a.m. in a unique video event, we’ll show highlights of my in-depth interview with Ram Dass, a renowned American spiritual teacher, on meditation, healing, and aging.

The international lectures will showcase psychiatric experts and leaders from around the world, including Sir Simon Wessely, M.D., president of the Royal College of Psychiatrists and Florian Holsboer, M.D., director of the Max Planck Institute of Psychiatry in Munich among many others.

Presidential symposia include a session with Charles Nemeroff, M.D., Ph.D., Daniel Weinberger, M.D., Karl Deisseroth, M.D., Ph.D., and David Rubinow, M.D. on “21st-Century Psychiatry at the Interface of Genetics, Neurobiology, and Clinical Science.” Other presidential symposia focus on mood disorders and neuroinflammation among other topics.

My deepest thanks to the Scientific Program Committee, under the leadership of chair Philip R. Muskin, M.D., for its outstanding work.

This meeting provides hundreds of sessions to learn the latest science, sharpen your clinical skills, and inform you about new models of care delivery, along with plentiful networking and social opportunities. We look forward to sharing with you all the education and excitement which the APA’s Annual Meeting, the year’s premier psychiatric event, has to offer.

Paul Summergrad, M.D., President
American Psychiatric Association



Dear Colleagues and Guests,

Welcome to beautiful multicultural Toronto and the 168th APA Annual Meeting. The meeting offers the latest scientific research and new advances in clinical practice along with numerous special events and networking opportunities.

Please join us in honoring APA distinguished fellows, distinguished life fellows, international fellows, winners of several awards and others at the Convocation of Distinguished Fellows. We are honored to have National Institute on Drug Abuse Director Nora D. Volkow, M.D., presenting the William C. Menninger Memorial Convocation Lecture. The Convocation will be held Monday, May 18, 5:30 p.m.-6:30 p.m. in Exhibit Hall A, Toronto Convention Centre.

Among the many other award lectures being presented at the meeting are

- George Tarjan Award Lecture - Marie-Claude Rigaud, M.D.
- Simon Bolivar Award Lecture - Carlos Zarate, M.D.
- Alexandra Symonds Award Lecture - Carol A. Bernstein, M.D.
- Solomon Carter Fuller Award Lecture - Dorothy E. Roberts, J.D.
- Kun-Po Soo Award Lecture - Russell F. Lim, M.D., M.Ed.
- Adolf Meyer Award Lecture - Karl Deisseroth, M.D., Ph.D. Patient Advocacy Award - Patrick J. Kennedy.

This year's American Psychiatric Foundation annual benefit to support its public-education and research initiatives will be held on Saturday, May 16, 7 p.m. to 10 p.m. at Toronto's famous CN Tower. This special event at the Horizons restaurant on the LookOut level promises spectacular views of the city along with a program honoring recipients of the 2015 Awards for Advancing Minority Mental Health. (Ticket required.)

A special series of scientific sessions and events have been developed for residents. The always popular national Jeopardy-like competition for residents, *MindGames*, will be held Tuesday, May 19, 5:15 p.m.-6:15 p.m., Room 106, Toronto Convention Centre.

Of course, the city of Toronto has numerous choices to add excitement and entertainment to your visit. Tour an elegant 98-room castle, Casa Loma; visit the international exhibits of the Royal Ontario Museum; stroll the Art Gallery of Ontario; visit the Hockey Hall of Fame; or take in a Toronto Blue Jays game.

If you haven't already, be sure to download the APA Meetings app for easy access to program information and the latest update alerts during the meeting.

Follow and share your thoughts on Twitter, #APAAM2015.

Saul Levin, M.D., MPA, CEO and Medical Director
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The American Psychiatric Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The APA designates this live activity [The 168th 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. Chair
Scientific Program Committee

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ADVANCES IN MEDICINE

MAY 16, 2015

TOP 10 MEDICAL STORIES 2014: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW

Chair: Robert Boland, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Key medical literature published in 2014. Medical and behavioral conditions that increase cardiovascular risk will be emphasized.; 2) Likely impact of selected publications in terms of newsworthiness and potential to affect clinical practice; and 3) Critical appraisal of the evidence, including methodology and possible sources of bias.

SUMMARY:

This session will provide a review of the internal medicine literature published in 2014. Special attention will be devoted to conditions likely to be of interest to psychiatrists caring for patients with comorbid medical conditions. Publications related to cardiovascular risk factors, including lifestyle and behavioral conditions, will be emphasized. The selection of articles for this review will be based on likely clinical impact, including newsworthiness and the potential that this new evidence will alter clinical practice. A critical appraisal of the evidence will be offered, including a discussion of study methodology and potential sources of bias. Application of literature into clinical practice will be discussed.

MAY 17, 2015

REHABILITATION OF COMPLEX TRAUMA: IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS

Chairs: Paul F. Pasquina, M.D., Elspeth C. Ritchie, M.D., M.P.H.

Speaker: Paul F. Pasquina, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the incidence and prevalence of mental health problems in trauma victims ; 2) Recognize the long-term consequences

of aging with physical impairment, including limb loss; 3) Describe the unique challenges faced by Military/Veterans & Their Families who experience complex trauma; and 4) Understand the acute, sub-acute, and chronic rehabilitation strategies for individuals with complex trauma and how they overlap with mental health care.

SUMMARY:

This session will provide the attendee with an overview of the unique challenges facing individuals who sustain complex trauma, particularly blast casualties from war. Since military operations began in Iraq and Afghanistan over a decade ago, nearly 3 million U.S. Service members have been deployed, many sustaining complex and severe injuries from blast exposure. Today, trauma casualties, including combat casualties, are surviving wounds that in previous years would have been fatal. As a consequence, new interventions and rehabilitation strategies are needed to enhance functional recovery and independence. While advances in technology, including cognitive aids, wheelchairs, prosthetics and robotics are helpful in promoting enhanced mobility, paramount to success includes the coordination of inter-disciplinary teams to provide comprehensive holistic care. The intersection between rehabilitation teams and behavioral health experts is needed throughout the continuity of care for these patients. Therefore providers should not only be familiar with the acute care issues associated with complex trauma, but also the long-term consequences of aging with disability.

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

Chair: Robert M. McCarron, D.O.

Speakers: Y. Pritham Raj, M.D., Jeffrey T. Rado, M.D., M.P.H., Jaesu Han, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. The session faculty practice both internal medicine and psychiatry and will collaborate with the audience to review several case based "medical mysteries". A relevant and concise update on several "Med Psych" topics will be discussed. This session will consist of four case presentations each followed by a few minutes of questions and answer section. This session will be interactive using the Audience Response system (ARS). Questions will be multiple choice and/or polls of the audience to identify and address any gaps in learning.

WHY PSYCHIATRISTS SHOULD CARE ABOUT FRONTOTEMPORAL DEMENTIA

Chair: Catherine C. Crone, M.D.

Chair: Edward "Ted" Huey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize Frontotemporal dementia (FTD) and related disorders in the mental health setting; 2) Identify symptoms related to dysfunction of the frontal lobes; and 3) Consider the role of the frontal lobes in the etiology of psychiatric disorders.

SUMMARY:

Frontotemporal dementia and related disorders often manifest as changes in behavior, cognition, personality, and language. These patients usually initially present to a mental health setting and it often takes several years for the patients to be correctly diagnosed. In this session we will discuss ways to identify, evaluate, and treat these patients. In addition, we will discuss the role of the frontal lobes in psychiatric symptoms more generally.

MAY 19, 2015

CANCER CONTROL IN 21ST CENTURY CHALLENGES AND OPPORTUNITIES

Chair: Richard D'Alli, M.D., M.Ed.

Chair: Mary Gospodarowicz, M.D.

Speakers: David Hodgson, Malcolm Moore, Mary Gospodarowicz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the major sources of increasing cancer burden and major challenges in

global cancer control; 2) Recognize the progress that has been made in cancer treatment in the last two decades; and 3) Recognize late effects of cancer treatment and identify how they impact on the quality of life.

SUMMARY:

Cancer is a growing problem worldwide. In 2012, there were 14.1 million new cancer cases in the world and 8.2 million people died. As we make progress in eliminating deaths from infections, trauma, and heart disease, cancer is becoming the main cause of death in many countries. At present, it is estimated that about a third of all cancers are preventable, a third are potentially curable and the rest benefits from palliation. Tremendous progress has been achieved in our understanding of the molecular and genetic basis of cancer, availability of screening programs, progress in imaging have led to earlier diagnosis, much improved ability to define disease extent, progress in surgery, development of precision radiotherapy, and effective cancer drugs have all contributed to the improved survival in cancer. Currently, the identification of new targets and the availability of new drugs designed specifically to address these targets, so-called targeted therapies offer new hope for much improved outcomes and reduced treatment toxicity.

In 1970's only 25% of all patients survived 10 years after diagnosis and now, over 50 percent of all patients do. In fact, there is a steep increase in a number of patients who survive multiple cancers. A new discipline of cancer survivorship has emerged. However, the new therapies and patients surviving longer led to a concern about late effects of treatment. Previously only of concern in children and young adults, the subject of treatment late effects, their prevention, mitigation, diagnosis, and management is becoming a major area of study and action.

Cancer affects all parts of the body and all systems. Cancer medicine must partner with all other areas of medicine to address the needs of cancer patients and the public. In this session we will discuss the challenges presented by the growing number and complexity of cancer, talk about the promise offered by new therapies, and challenges presented by the late effects of treatment, both physical and psychosocial.

MODULATING NEUROLOGICAL AND PSYCHIATRIC BRAIN CIRCUITS WITH DEEP BRAIN STIMULATION

Chairs: Kenneth R. Silk, M.D., Gregory W. Dalack, M.D.

Chair: Andres M. Lozano, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand brain circuits for cognition; 2) Understand brain circuits for psychiatric disorders; and 3) Learn about treatments using deep brain stimulation.

SUMMARY:

Advances in functional imaging and in neurophysiology have led to greater understanding of the pathological activity in brain circuits leading to the signs and symptoms of neurologic and psychiatric disorders. This has in turn opened the possibility of using deep brain stimulation (DBS) to probe these dysfunctional circuits and to test the effects of modulating their activity with electrical stimulation. This approach is well established for patients with movement disorders, including Parkinson's disease and tremor and is being applied to a large number of brain targets for other conditions including depression, obsessive compulsive disorder, pain, epilepsy, anorexia and Alzheimer's disease. Further, there is accumulating evidence that stimulating these circuits has important cellular and biological effects. DBS is providing new insights into the function brain circuits while at the same time leading to new hope for the treatment of neurologic and psychiatric disorders that can continue to disable many patients.

ADVANCES IN RESEARCH

MAY 18, 2015

THE LATEST RESEARCH AND CLINICAL INFORMATION REGARDING MAJOR PSYCHIATRIC DISORDERS

Chairs: Herbert Pardes, M.D., Jack D. Barchas, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the linkages between newest research directions and clinical approaches in some of the most frequent psychiatric disorders like anxiety, depression, and personality disorders; 2) Better follow the most current literature and work regarding contributing factors to autism, depression, anxiety disorder and personality disorder; and 3) Understand some of the latest work on genetics and its complicated studies in schizophrenia.

SUMMARY:

There's renewed excitement regarding many psychiatric disorders propelled by recognition of the need to expedite progress in approaches to these disorders. Example: Anxiety disorders in teenagers and young adults have become more widely recognized. The effects on later personality and life functioning are profound. The treatments come both from the pharmacological as well as the behavioral arena. Systematic research and new clinical programs are being developed to expand our information and give greater attention to a field which has received inadequate attention. In depression there are attempts now to aggregate large numbers of patients and generate networks whose intent would be to improve the treatment of mood disorders and foster collaboration between clinicians and patients. Particular attention is being given to treatments, such as ketamine and such interventions as glutaminergic agents which challenge previous paradigms as the new agents become more likely to be used clinically. Despite many advances in our handling of depression, there still are great areas of need and many areas in which the effects of the treatments are unsatisfactory. By creating large mood related networks the intention is to accumulate large amounts of data on patients (de-identified) and numbers of clinicians and researchers to facilitate clinical research which by virtue of the

size of the population would increase the power of the resulting treatments. There are also new efforts to link personality disorders to neurobiology. Many emphasize a conception of these disorders as brain disorders, also looking at early developmental disruptions of the attachment process as a contributing cause. The work is international. It seems to reflect an increased appreciation for the role of psychotherapy. In schizophrenia the sophistication of gene sequencing technology and the banding together of large numbers of people in order to identify the multitude of genes involved is particularly exciting. It recognizes that many people with these disorders have early developmental problems. The combination of large amounts of data with particularly more sophisticated genetic research is producing more novel and potentially exciting scientific directions. Another area of great interest is the explosion of the epidemiology of autism. The profound effects on both patient and family create a demanding situation for new ways of understanding the contributing factors and generating a broad array of treatment approaches in order to afford clinicians better ways of treating these symptoms. This is a field which has become very active in recent years and been replete with a multitude of approaches, catalyzed by extraordinary growth in prevalence. These are examples of psychiatry research at the cutting edge. Clinicians informed by this work and patients and families affected by it should feel encouraged about the possibilities and better informed about the actual undertakings.

NO. 1

PATHWAYS TO NEW TREATMENTS IN AUTISM SPECTRUM DISORDER

Speaker: Jeremy Veenstra-VanderWeele

SUMMARY:

Increases in awareness, improvements in diagnostic tools, and changes in diagnostic criteria parallel a rise in Autism Spectrum Disorder (ASD) diagnosis. The evidence for treatments in ASD is also growing, with most data supporting intensive behavioral interventions in preschoolers. Beyond early childhood, the treatment data remain sparse. Pockets of research support the use of treatments for co-occurring symptoms in ASD, such as risperidone and aripiprazole for irritability/agitation or cognitive behavioral

therapy for anxiety. Emerging data on risk factors point to significant heterogeneity in ASD and in neurodevelopmental disorders more broadly, including multiple examples where both deletion or duplication of the same genomic region increase risk. Mouse models of rare causes of ASD point to potential avenues for treatment that are likely to apply to subgroups of children, leading to initial clinical trials in fragile X, tuberous sclerosis, and other genetic syndromes. In parallel, a long line of social neuroscience research has led to studies targeting the oxytocin and vasopressin systems to treat social symptoms in ASD. Ultimately, these emerging treatments will need to be combined in multimodal treatment by physicians who can integrate a sophisticated knowledge of neuroscience with thoughtful behavioral interventions and careful educational planning.

NO. 2
SCHIZOPHRENIA 2014: FROM GENES TO MECHANISMS OF ILLNESS

Speaker: Daniel R. Weinberger, M.D.

SUMMARY:

Archival twin and adoption studies of schizophrenia established that the lion share of risk is based on inheritance. The revolution in molecular genetics and the completed sequencing of the human genome has led to dramatic success in discovering susceptibility genes for common medical disorders, including psychiatric disorders. Genome wide analytic approaches have discovered literally hundreds and perhaps thousands of genes that contribute to risk in world populations. A recent study of over 150,000 individuals identified 108 regions of the genome containing susceptibility genes for schizophrenia. This study had sufficient statistical power to identify susceptibility loci having very small individual effects, with odds ratios of less than 1.10. While the effects of individual genes across the diverse populations included in the study are minor, in select populations they are likely to be greater and to interact with other genes to account for individual liability. Some of the risk-associated loci contain genes long implicated in schizophrenic pathogenesis, including the D2 receptor and glutamate and GABA receptors. While the biological mechanisms of genetic risk are obscure, many appear to involve early development. These new data represent a sea

change in research and provide the first objective evidence of causative mechanisms of psychiatric illness.

NO. 3
UNDERSTANDING AND EFFECTIVELY MANAGING ANXIETY IN THE TRANSITION TO YOUNG ADULTHOOD

Speaker: Anne M. Albano, Ph.D.

SUMMARY:

Anxiety disorders are stable and impairing conditions that emerge early in childhood and severely upset normal development. Childhood anxiety predicts later onset of depression, substance abuse, and comorbid anxiety diagnoses, which further complicate functioning and lead to significant disability in young adults. The Child/Adolescent Anxiety Multimodal Study (CAMS; Walkup, Albano et al., 2008) of 488 youth (ages 7 to 17) showed acute treatment results in significant improvement in reducing anxiety symptoms, especially when one combines cognitive behavioral therapy (CBT) and medication (81% response rate). However, a naturalistic follow-up study of 288 CAMS participants revealed a more sobering finding that nearly half of treatment responders had relapsed on average 6 years post-randomization (Ginsburg et al., 2014). This presentation will review outcomes from seminal clinical trials, and focus on moderators and predictors of treatment improvement and remission over the longer term. The role of development, which has not been a primary focus of randomized trials, will be presented as a key factor in the stability of anxiety and emergence of concomitant disorders in young adults, a critical age group presenting with unique and challenging needs. Data from our novel young adult clinical research program will be presented and future research goals defined.

NO. 4
ADVANCES IN RESEARCH IN MOOD DISORDERS: NEW OPPORTUNITIES, NEW TREATMENTS

Speaker: Andrew A. Nierenberg, M.D.

SUMMARY:

New Opportunities: In psychiatry and medicine, we lack evidence for most of our clinical decisions. Commenting on guidelines in cardiology, Tricoci and colleagues wrote,

the current system generating research is inadequate to satisfy the information needs of caregivers and patients in determining benefits and risks of drugs, devices, and procedures' 1. To address this gap, the Patient Centered Outcomes Research Institute (PCORI) has launched an ambitious network of networks (www.PCORnet.org) that includes a Mood Patient Powered Research Network (www.moodnetwork.org). The MoodNetwork aims to include at least 50,000 patients plus clinicians and researchers who will be asked to contribute data. I will discuss relevant details of the MoodNetwork and how patients and clinicians can collaborate to improve the care of people with mood disorders.

New Treatments: Ketamine and glutaminergic agents continue to excite the field and challenge previous paradigms as they move closer to clinical use " not quite ready for prime time but these are worth reviewing. Other advances include new research into targeting brain bioenergetics with ongoing studies of peroxisome proliferator activating receptor agonists (PPARs), the neurobiology of exercise, and near-infrared radiation. I will review the biology of these approaches as well as relevant clinical trials.

NO. 5 NEW RESEARCH ON PERSONALITY DISORDERS

Speaker: John M. Oldham, M.D.

SUMMARY:

A personality disorder can be understood as an extreme version of an otherwise useful personality style. Having too much of a particular style (or perhaps too little), like weight, can be distressing and disabling. We now know that personality disorders are brain disorders--moderately heritable conditions that reflect the collision of genetic endophenotypes with stressful life events. A great deal has been learned about the neurobiology and pathophysiology of personality disorders, and longitudinal studies have informed us about the natural course of these conditions across the life cycle. Developmentally, disruptions in the attachment process are common, often accompanied by frank neglect or abuse, impairing adult-level self-directedness and interpersonal relationships. Emotion dysregulation, impulsiveness, negativity, and mistrust characterize borderline personality

disorder, and research utilizing new technology is revealing abnormalities in brain structure and function in these patients. Evidence-based practice guidelines have been developed in 5 different countries, all of which support the effectiveness of psychotherapy as the primary, or core, treatment for this personality disorder. These new developments in our understanding of the personality disorders will be reviewed and discussed.

ADVANCES IN SERIES

MAY 16, 2015

ADVANCES IN SUBSTANCE ABUSE TREATMENT

Chairs: Marc Galanter, M.D., Herbert D. Kleber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify innovations in recent years in the substance abuse field ; 2) Treat substance abusers with more expertise with specific clinical problems; and 3) Identify the outcome of evaluation in contemporary addiction treatment.

SUMMARY:

The field of addiction treatment has seen major advances in recent years in relation to diverse areas of treatment. With the publication of the Fifth Edition of the American Psychiatric Publishing Textbook on Substance Abuse Treatment, the editors have selected five topics for presentation based on chapters which were developed specifically for this edition. They focus on the following areas: evaluation of substance abuse disorders, with particular focus on changes in format associated with the preparation of the DSM V; approaches to treatment of marijuana dependence, an issue of increasing importance with recent increases in marijuana use, some of this associated with current moves towards legalization; emerging findings in the area of opioid dependence, specifically focusing on recent experience with use of buprenorphine for maintenance; gender issues, with emphasis on the unique problems of female substance abusers; recent experience in the use of Alcoholics Anonymous for patients with moderate or severe substance use disorders, with focus on the neurophysiology of long-term abstinence. These talks will give attendees a perspective which can be applied most broadly for their clinical work with addicted patients.

NO. 1 ASSESSMENT OF PATIENTS WITH SUBSTANCE USE DISORDERS

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

SUMMARY:

Clinicians encounter patients with substance use disorders in all clinical settings. This presentation will review principles of eliciting key elements of the history, formulation of an accurate diagnosis according to DSM-5, use of screening tools, and enhancement of motivation through the interview. Proper diagnosis, particularly in relation to the latest DSM-5 criteria, is important in relation to compatibility with the expectations for treatment with insurers and with certifying bodies. It should be carried out on a multimodal basis both in institutional and individual office settings.

NO. 2 TREATMENT STRATEGIES FOR CANNABIS USE DISORDERS

Speaker: Frances R. Levin, M.D.

SUMMARY:

Marijuana is the most widely used illicit drug in the U.S. Cannabis use disorders tend to begin in late adolescence and early adulthood, with an estimated prevalence rate of approximately 4.3 million among individuals ages 12 or older. While both pharmacologic and psychotherapeutic treatment approaches have been studied, most commonly implemented therapeutic approaches have been 12-step facilitation counseling, motivational interviewing, cognitive behavioral therapy and contingency management. Although efficacious, many individuals have difficulties reducing or ceasing their use. Pharmacologic interventions for cannabis use disorders represent a viable treatment option. At present, medications for cannabis use disorders have been much less studied than agents for nicotine, alcohol or opiate use disorders. Currently, there are no FDA-approved pharmacotherapies for cannabis dependence. The limited number of clinical treatment trials evaluating medications to treat cannabis dependence may be in part due to a lack of awareness that there is a clear-cut withdrawal syndrome and/or the less dramatic physiological and psychosocial consequences associated with chronic use. There are some agents that have shown promise in laboratory and clinical research settings that are worthy of further investigation. Future treatment directions will be discussed.

NO. 3

BUPRENORPHINE IN THE TREATMENT OF ADDICTION: PAST, PRESENT, FUTURE

Speaker: Herbert D. Kleber, M.D.

SUMMARY:

Although buprenorphine has been available as an analgesic agent for over 2 decades, its use in the treatment of opioid dependence is relatively recent, made possible by congressional passage of the DATA act in 2000 and FDA approval as a schedule 3 narcotic in 2002, making office prescribing legal. Since then over 20,000 physicians have met the criteria for use, although many of these are not prescribing. Used both as a withdrawal agent or for maintenance, there are over 400,000 individuals currently using it and the drug has been significantly helpful to many. However, there are also problems including diversion, either for withdrawal or for getting high by injection, and early drop-out. Also many of the patients do not receive either psychosocial support or referral for this. There are also concerns over availability especially in rural areas such as West Virginia and Kentucky as well as in parts of big cities, leading to calls for increasing the maximum case load by hundreds. Future improvements could include weekly, monthly and even a 6 month injection as well as better methods for withdrawal from maintenance.

NO. 4 WOMEN AND ADDICTION: GENDER-SPECIFIC ISSUES

Speaker: Kathleen Brady, M.D., Ph.D.

SUMMARY:

Until the early 1990's, much of the research in the substance abuse area was focused on males or mixed gender samples without significant attention to gender differences. In 1994, the National Institutes of Health (NIH) published guidelines concerning the inclusion of women and minorities as subjects in clinical research. Since that time, the number of published research reports examining various aspects of substance use disorders in women and gender differences in substance use disorders has increased tremendously. There is now greater recognition that important biological and psychosocial differences between men and women influence the prevalence, presentation, comorbidity and

treatment of substance use disorders. This increase in awareness of gender-specific issues is also seen in the clinical sector, with approximately 40% of substance abuse treatment facilities now providing special programs or groups for women. This presentation will provide an overview of the current knowledge base concerning substance use disorders in women. Specifically, the epidemiology, neurobiology, psychiatric comorbidity, course of illness and treatment of substance use disorders in women will be reviewed. Emerging data concerning the influence of gonadal hormones on the reinforcing properties of drugs of abuse and gender differences in response to pharmacotherapy will be presented.

NO. 5 ALCOHOLICS ANONYMOUS AND SPIRITUALITY IN LONG-TERM RECOVERY

Speaker: Marc Galanter, M.D.

SUMMARY:

Alcoholics Anonymous is a valuable cost-free resource for continuing support of abstinence. Even for those who participate for a limited time, a positive outcome is found to be proportional to one's level of attendance. AA members' involvement is initially typically fostered by social support and mutuality in a setting where norms for communication are sustained by a preponderance of established members. Response to the spiritual nature of the fellowship, involving a personal transformation, usually comes later. The psychology of engagement in AA sheds light on cognitive and psychosocial aspects of long-term recovery from addiction. In order to clarify the biological substrate of the AA experience, pertinent findings from cognitive and social neuroscience will be reviewed.

MAY 17, 2015

THE DSM-5 CULTURAL FORMULATION INTERVIEW: IMPLEMENTING CULTURAL ASSESSMENT IN ROUTINE CLINICAL PRACTICE

Chair: Roberto Lewis-Fernandez, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the need for cultural assessment in mental health care and how it fits within the culture-related changes in DSM-5; 2) Describe the three components of the DSM-5 Cultural Formulation Interview and how to implement them in routine clinical practice; and 3) Identify video and web-based training approaches to the CFI as well as future directions for research and clinical care with the CFI and cultural assessment in general.

SUMMARY:

Culture shapes every aspect of patient care in psychiatry, influencing when, where, how, and to whom patients narrate their experiences of illness and distress, the patterning of symptoms, and the models clinicians use to interpret and understand symptoms in terms of psychiatric diagnoses. Culture also shapes patients' perceptions of care, including what types of treatment are acceptable and for how long. Even when patients and clinicians share similar cultural, ethnic or linguistic backgrounds, culture impacts care through other influences on identity, such as those due to gender, age, class, race, occupation, sexual orientation, and religion. Culture affects the clinical encounter for every patient, not only underserved minority groups, and cultural formulation therefore is an essential component of any comprehensive assessment. Cultural misunderstandings, biases, and communication gaps between providers and patients also contribute to disparities in the care of diverse populations, including by race/ethnicity, religion, gender identity, and sexual orientation, suggesting person-centered evaluation using the CFI may help reduce care disparities.

The Outline for Cultural Formulation (OCF) introduced with DSM-IV provided a framework for clinicians to organize cultural information relevant to diagnostic assessment and treatment planning. However, use of the OCF has been inconsistent, raising questions about the need for guidance on implementation and training in diverse settings. To address this need, DSM-5 introduced a cultural formulation interview (CFI) that revises the OCF in line with newer approaches to cultural assessment with clear guidelines for clinical implementation. The CFI is comprised of three components: a 16-question "core" version for interviewing patients, an informant version for obtaining collateral information, and 12 supplementary

modules for more comprehensive assessment that expand on the domains of the CFI and guide cultural assessment of specific populations, such as adolescents and older adults. Clinicians may choose to administer one or several of these components with individual patients.

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

NO. 1

ENHANCING THE ROLE OF CULTURE IN DSM-5: THE NEED FOR CULTURAL ASSESSMENT

Speaker: Roberto Lewis-Fernandez, M.A., M.D.

SUMMARY:

Culture affects the way symptoms are experienced, clinical communications occur, and treatments are considered. DSM-5 includes greater attention to cultural influences than previous diagnostic manuals. This presentation discusses the development of the CFI as a systematic method for cultural assessment based on international experience with the DSM-IV Outline for Cultural Information and in the context of other efforts to enhance the role of culture-relevant topics and assessments in DSM-5. An overview of the work of the DSM-5 Cross-Cultural Issues Subgroup will be presented, focusing on additions to criteria, descriptive text, and clinical assessment of patients and their families. This background will help clarify the structure and content of the three CFI components. Work on the CFI focused strongly on developing a standardized assessment tool that was person-centered and feasible in routine practice, yet could evaluate the cultural elements of symptom presentation, etiological understandings, stressors and supports, and treatment expectations from the

perspectives of the patient and his/her social network.

**NO. 2
THE CORE CULTURAL FORMULATION
INTERVIEW AND DSM-5 FIELD TRIAL
RESULTS**

Speaker: Neil K. Aggarwal, M.A., M.D.

SUMMARY:

This presentation reviews the core CFI and results of the DSM-5 field trials. First, each question of the core CFI is reviewed to demonstrate how clinically-relevant cultural aspects of care can be elicited. Examples of good responses will be provided as illustrations of competent interviewing. Second, key results from the DSM-5 field trial will be examined that indicate how the core CFI can be implemented in routine clinical practice. By the end of the presentation, participants will understand CFI theory and practice.

**NO. 3
THE FUTURE OF CULTURAL
FORMULATION IN PSYCHIATRY:
ADVANCING PERSON-CENTERED CARE**

Speaker: Laurence J. Kirmayer, M.D.

SUMMARY:

The introduction of the Cultural Formulation Interview in DSM-5 is a milestone in the development of cultural psychiatry and of person-centered mental health care. The challenges that remain include: i) refining the CFI through research on the assessment process; ii) developing frameworks for translating information collected by the CFI into clinically useful formulations and treatment plans; and iii) adapting the CFI to new contexts. Future refinements of the CFI will rest on better understanding of the social and cultural determinants of mental health including brain-environment interactions. Advances in social and cultural neuroscience are clarifying the ways in which the architecture of the brain emerges from developmental histories and social contexts shaped by culture, with implications for how we conceptualize, diagnose, and treat mental disorders. But culture itself is undergoing constant transformation, through new forms of networking and communication, giving rise to new mechanisms of psychopathology and

possibilities for intervention. Integrating the CFI into clinical services, through training and quality assurance, will improve mental health care for minorities. However, cultural assessment is crucial for international efforts to provide person-centered care for all by giving due attention to each individual's experiential lifeworld, including social and cultural contexts, histories, values and aspirations.

**NO. 4
THE SUPPLEMENTARY MODULES IN
DSM-5: OVERVIEW OF THE MODULES
AND EXAMPLES OF CLINICAL UTILITY**

Speaker: Devon E. Hinton, M.D., Ph.D.

SUMMARY:

The supplementary modules of the CFI help the clinician to conduct a more comprehensive assessment of the patient and his or presenting complaint, aiming to situate the patient and his or her complaint in socio-cultural context. There are three kinds of supplementary modules: (1) core CFI expansion modules, to amplify key sections of the core CFI (e.g., the explanatory model, the cultural identity module); (2) special populations modules, to assess particular populations (e.g., refugees) who may have specific needs and experiences as a result of certain aspects of their background or identity; and (3) informant perspectives modules, to clarify how individuals who assist the patient with her care and members of her social network view the patient's situation. This talk will give an overview of the structure of the supplementary modules. The talk will also discuss the clinical utility of the modules and present in more depth two CFI expansion modules: on the explanatory model of the presenting complaint and on cultural identity. The modules, like the core CFI itself, help to contextualize the patient and the patient's complaint.

**NO. 5
CULTURAL ASSESSMENT OF OLDER
ADULTS, CAREGIVERS, AND OTHER
SPECIFIC POPULATIONS USING THE
SUPPLEMENTARY MODULES**

Speaker: Ladson Hinton, M.D.

SUMMARY:

The CFI supplementary modules are valuable tools to amplify the core CFI and allow the

clinician to conduct more in-depth sociocultural assessment. The goal of this presentation is to provide an overview and clinical utility of the Special populations modules and the Informant perspective modules. The Special populations modules help the clinician in assessing particular populations who have specific needs and experiences as a result of their background or identity, including older adults, school-age children and adolescents, and refugees and immigrants. The informant version of the core CFI and the caregiver supplementary module can assist the clinician in eliciting the perspective of someone in the patient's social network who may assist him or her and/or knows him or her well. Several case examples will be used to illustrate the use of the informant version of the CFI and these supplementary modules in clinical practice.

NO. 6
**CULTURAL FORMULATION INTERVIEW:
TECHNOLOGY AND TRAINING**

Speaker: Ravi DeSilva, M.A., M.D.

SUMMARY:

The Cultural Formulation Interview represents the most up-to-date methodology for culturally competent psychiatric assessment. Video and online-based learning tools are increasingly being used in medical training and continuing education. This session will review development of CFI-related video and web-based teaching of psychiatric residents and training of practicing mental health providers and share examples of these scenarios with the aim of achieving proficiency in the use of this semi-structured interview.

**ADVANCES IN PSYCHODYNAMIC
PSYCHIATRY**

Chair: Elizabeth Auchincloss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify important trends in 21st century psychodynamic psychiatry including those related to therapeutic alliance; 2) Recognize and use interpretation properly in patients with severe personality disorder; and 3) Recognize, understand and treat patients whose use of modern technology interacts with their psychopathology.

SUMMARY:

The psychodynamic approach to mental suffering is one of the oldest and most important in the field of mental health. Every patient, no matter what the nature of their illness, has a psychology that influences the illness, the experience of illness, the way the patient engages in treatment, and in some case, if even the cause of the illness. Experts in the field will present several of the advances in the field of psychodynamic psychiatry, including the use of therapeutic alliance, the classification of personality disorders, the uses of interpretation, and psychopathology in the digital age.

NO. 1
**THE THERAPEUTIC ALLIANCE IN
CONTEMPORARY PSYCHIATRY: NEW
DEVELOPMENTS**

Speaker: Elizabeth Auchincloss, M.D.

SUMMARY:

Originating in the field of psychoanalysis, the therapeutic alliance is a concept that was initially designed to explain aspects of the doctor-patient relationship in psychodynamic psychotherapy. However, there is increasing empirical evidence that the therapeutic alliance is the strongest predictor for outcome in treatments of all kinds. Psychodynamic psychology is the most powerful way to understand how patients of all kinds engage in the therapeutic process, and have the capacity to form a therapeutic alliance. Therapists of all kinds need to understand the psychology, as well as interventions that might improve the alliance in patients where engagement poses special difficulties.

NO. 2
**PSYCHODYNAMIC TREATMENT OF
PERSONALITY DISORDERS: EVOLVING
PERSPECTIVES ON INTERPRETATION**

Speaker: Eve Caligor, M.D.

SUMMARY:

Experience in the psychodynamic treatment of severe personality disorders has led us to broaden conventional psychodynamic approaches to the process of interpretation. Classical approaches to interpretation emphasize the centrality of exploring unconscious meanings and motivations in promoting therapeutic gain. In contrast, current

views place greater emphasis on more basic interventions that involve articulating the patient's subjective experience and calling attention to conscious, but dissociated, mental states. These changes in our approach to interpretation have implications for the management of patients with personality disorders in a variety of settings.

**NO. 3
TRANSFORMATIONS OF THE
DEVELOPMENTAL PROCESS: HUMAN
DEVELOPMENT IN THE
TECHNOCULTURAL ERA**

Speaker: Karen J. Gilmore, M.D.

SUMMARY:

The 21st century has arrived with many developments in the use of technology, making ours a technocultural era. Psychological issues includes how persons of all ages deal with this rapidly changing technology. We have also seen changes in the family, news reproductive technology, the blurring of gender roles, a higher divorce rate, and many others. Above all, we have seen a massive transformation of the developmental context.

**NO. 4
THE CLASSIFICATION OF PERSONALITY
DISORDERS: NEW DEVELOPMENTS**

Speaker: Otto F. Kernberg, M.D.

SUMMARY:

Despite good understanding of how to best classify personality disorders, there are new developments based on changes in our understanding, new nosological systems, and new evidence. For example, borderline personality disorder (BPD) can be better distinguished from narcissistic personality disorder (NPD), leading to changes in our understanding as well as our therapeutic technique.

MAY 18, 2015

GUN VIOLENCE AND MENTAL ILLNESS

Chair: Liza Gold, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the primary

relationship between gun violence and mental illness as suicide, not homicide.; 2) Understand and discuss the mental health prohibited categories of firearms owners with patients who express concerns about treatment implications on gun ownership rights; and 3) Develop clinical skills in discussing firearms safety with patients and/or their families to decrease the risk of suicide by firearm.

SUMMARY:

Contrary to common belief, most individuals with serious mental illness are not violent, and when violent, rarely use firearms. Suicide, not mass shootings, is the connection between gun violence and mental illness. Approximately 30,000 people in the US die each year from gun violence; of these 20,000 are suicides. Suicide is the 10th leading cause of death in the US, and over 90% of people who commit suicide have a psychiatric disorder. Options to intervene when persons with mental illness may be at increased risk of harming themselves or others are limited. Most individuals with mental illness do not meet statutory firearm restriction criteria; many often do not meet involuntary commitment criteria. At times, even people who meet commitment criteria cannot be hospitalized because a bed cannot be located. Addressing gun violence and mental illness as public health crises presents opportunities to decrease morbidity and mortality of both. This symposium includes presentations that will discuss the problems of gun violence and mental illness emphasizing a public health model. Liza H. Gold, MD, will review the epidemiologic data, problems with our current approach and possibilities for interventions based on a public health model. Marilyn Price, MD, will discuss the National Instant Criminal Background Check System (NICS), federal mental illness prohibitions, recent legislation increasing psychiatrists' reporting responsibilities (the New York SAFE Act) and whether these can decrease firearm violence associated with mental illness. James Knoll, MD, will discuss the psychology of mass shooters and whether current proposals to further restrict the access of people with mental illness to guns is likely to be effective in decreasing the incidence of these tragedies. Debra Pinals, MD, will discuss available and practical preventive interventions when persons with mental illness present increased risk of violence and will review facets of a

comprehensive public health strategy to help ensure maximizing treatment and minimizing morbidity and mortality associated with firearms. Matthew Miller, MD, MPH, ScD, will review the epidemiological evidence in support of the hypothesis that firearm availability imposes suicide risk above and beyond the baseline risk. Alan Berman, PhD, will discuss why and how clinicians should talk with patients and their families about firearm safety to decrease the risk of firearm use in suicide attempts and the incidence of completed suicides.

NO. 1 GUN VIOLENCE AND MENTAL ILLNESS: PUBLIC HEALTH CRISES

Speaker: Liza Gold, M.D.

SUMMARY:

The public health crises of gun violence and mental illness take a devastating toll on individuals, families, communities, and society. Gun violence and mental illness are linked in the minds of the public and policy-makers by tragic mass shootings. One common myth promulgated after such incidents, whether the perpetrator has serious mental illness (SMI) or not, is that keeping guns out of the hands of individuals with mental illness will decrease the morbidity and mortality of gun violence. However, mass shootings account for less than one percent yearly of the 30,000 US firearm deaths. Individuals with SMI are rarely violent, and when they are, their violent behavior rarely involves firearms. In contrast, about two-thirds of all firearm deaths, about 20,000 people a year, commit suicide by firearms, and over 90% of people who commit suicide meet criteria for a psychiatric diagnosis. Defining these issues as public health problems and addressing them as such creates new possibilities for decreasing the morbidity and mortality of each, including decreasing the incidence of suicide by firearm.

NO. 2 NICS, MENTAL ILLNESS, AND FIREARMS LEGISLATION: WHAT YOU SHOULD KNOW

Speaker: Marilyn Price, M.D.

SUMMARY:

Legislative responses to mass murders by persons with mental illness have resulted in the

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

NO. 3 MASS DISTRACTIONS AND SOCIO- CULTURAL FACTORS IN MASS SHOOTINGS

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

SUMMARY:

Mass shootings are extremely rare events influenced by multiple, complex factors. Yet most public debate seeks to ascribe them to only one or two primary causes. Thus far, the debate has focused heavily on issues, which are: 1) highly politicized, 2) grossly oversimplified, and 3) very unlikely to result in productive solutions. Reports of mass murderer's diagnoses are largely anecdotal, and there is little reliable research suggesting that a majority of these rare events were primarily caused by serious mental illness, as opposed to psychological turmoil flowing from other sources. A definitional problem exists, in that the lay public may be prone to ascribe a motive of 'mental illness' to highly violent acts of horrific desperation. Thus, the behavior and motives of mass murderers have not been clearly distinguished from psychiatric diagnoses. This presentation will discuss what is known about the psychology of mass shooters, and why they are unlikely to be

thwarted by policies designed to single out persons with serious mental illness. Rather, this represents a regressive, fearful response that provides no substantive answers to the problem of violence in society. Finally, evolving areas of forensic mental health holding greater promise for resolution will be discussed.

**NO. 4
FIREARMS RISK PREVENTION:
CONSIDERING LEGAL AND CLINICAL
REFORMS**

Speaker: Debra Pinals, M.D.

SUMMARY:

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

**NO. 5
FIREARMS AND SUICIDE**

Speaker: Matthew Miller, M.D., M.P.H.

SUMMARY:

On an average day in the United States, more than 100 Americans die by suicide; half of these suicides involve the use of firearms. This

presentation will review the epidemiological evidence in support of the hypothesis that firearm availability imposes suicide risk above and beyond the baseline risk and help explain why, year after year, several thousand more Americans die by suicide in places with higher than average household firearm ownership compared with states with lower than average firearm ownership.

**NO. 6
REDUCING RISK OF SUICIDE: BEST
PRACTICES AND TALKING TO
PATIENTS ABOUT ACCESS TO
FIREARMS**

Speaker: Alan L. Berman, Ph.D.

SUMMARY:

Research has demonstrated that reducing access to lethal means reduces the risk of suicide. The National Action Alliance for Suicide Prevention's Research Prioritization Task Force, supported by the NIMH, estimated that separating suicidal individuals from access to firearms could save almost 4,000 lives a year. Psychiatrists are uniquely positioned to reduce suicide risk by discussing measures to limit access to firearms with patients at risk and their families. However, the 2014 Florida Appeals Court decision in the 'Docs versus Glocks' case upholding the gag law prohibiting physicians from asking patients about firearm ownership has had national ramifications, notably in inhibiting physician inquiry about firearms out of fear of medical board disciplinary action. Even if the Florida decision is upheld on appeal, psychiatrists should be trained in and comfortable with discussing access to firearms with potentially suicidal patients and their families. This presentation will discuss the rationale for direct inquiry about accessible means to suicide, loopholes in the gag law that make inquiry about and discussion regarding firearm safety possible without fear of repercussion, and methods of talking to patients and families about restricting access to firearms that may prevent death or injury from the intentional use of firearms.

**CARE OF MILITARY SERVICE
MEMBERS, VETERANS AND THEIR
FAMILIES**

Chair: Stephen J. Cozza, M.D.

Discussant: Harold S. Kudler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the unique psychiatric and health outcomes resulting from military service and combat exposure; 2) Identify risks associated with suicidal behavior in the military and veteran communities; and 3) Understand the challenges faced by military and veteran family members and be prepared to effectively incorporate them into treatment.

SUMMARY:

Over the past thirteen years, over two million military service men and women have been deployed to combat operations in Iraq and Afghanistan. They have represented every military service branch, hailed from every state in the country and have represented the active duty, National Guard and reserve components of the military. Many families have sustained repeated deployments, some as many as five or more. Since the start of combat operations over 6000 service members have died in combat theater, tens of thousands have suffered combat injuries, and hundreds of thousands continue to suffer with traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) of varying severity. Rates of suicide have also increased in both military and veteran populations. Recently, combat operations have slowed and many service members are returning from duty in war zones. While current combat experiences are decreasing, future exposure of military service men and women is likely given worldwide operations of the U.S. military. In addition, the sequelae from these combat related experiences and conditions are likely to continue to impact their health and functioning, as well as the health and functioning of their families for years to come.

This "Advances in Series" offers critical information to health care (mental health and others) providers in the community who will work with service members, veterans and their families in the coming years, and includes material that should inform health care practice and decision making. The following three points are essential to the successful treatment of service members and veterans. First, combat exposures result in clear and identifiable impact on physical and mental health outcomes and must be understood to understand risk, accurately diagnosis and effectively treat.

Second, combat related experiences and the health of service members and veterans is inextricably linked to the health and wellbeing of their family members. As a result, the most effective treatments for service and family members must be family focused, understanding and accounting for family impact and needs, as well as inclusive of family member involvement. Third, despite the tendency to view the U.S. military as monolithic and unchanging, the composition of its ranks is constantly changing. Veterans often move into communities where there are fewer resources to address their post-combat lives and where professionals likely have very little experience in the care of combat veterans or their families. The health of military service members, veterans and their families is a national health concern, not just a Department of Defense or Department of Veterans Affairs concern.

**NO. 1
COMBAT STRESS REACTIONS AND
PSYCHIATRIC DISORDERS AFTER
DEPLOYMENT**

Speaker: David M. Benedek, M.D.

SUMMARY:

The psychological response to combat experience is variable and ranges from transient and subclinical distress symptoms to well-characterized but nevertheless transient or self-limited psychiatric disorders to psychiatric disorders. Combat stress reaction and combat/operational stress reaction are the terms used to describe the wide range of generally transient psychological symptoms that may emerge in response to the stressors of the combat environment. Subclinical distress reactions may include anger, aggression, sleep disturbance, impulse control difficulties, hyperstartle reactions, social isolation or withdrawal, emotional numbing, substance misuse, and high-risk behaviors. PTSD and depression are disorders that commonly occur in the aftermath of combat exposure and, when present, are best managed with use of established evidence-based treatments. Combat-related PTSD may provoke a different response than does exposure to physical or sexual assault, motor vehicle accident, or even natural disaster; therefore, unique pharmacological and psychotherapeutic treatments may be required.

NO. 2 HEALTH CONSEQUENCES OF MILITARY SERVICE AND COMBAT

Speaker: Paula P. Schnurr, Ph.D.

SUMMARY:

Exposure to a traumatic event is associated with increased physical health problems such as cardiovascular diseases, diabetes, gastrointestinal disorders, dermatologic disorders, autoimmune diseases, increased risk for tobacco use, and obesity. In addition to physical trauma, illness, or injury directly resulting from an event, current evidence suggests that PTSD related to psychological trauma is the pathway by which trauma leads to subsequent physical health problems. Practitioners should consider the effect of allostatic load on the patient, such as PTSD-related biological changes combined with PTSD-related behavioral changes that may become sufficient to produce disease. The allostatic load model suggests that PTSD affects multiple body systems via various pathways. Practitioners in a medical setting should be especially vigilant in looking for signs of PTSD because individuals with PTSD often do not seek mental health care. Carefully assess the patient's health behaviors (overeating, alcohol use, tobacco use) and help him or her identify alternative, more adaptive, and healthier methods of coping with trauma-related stress.

NO. 3 SUICIDAL THOUGHTS AND BEHAVIORS IN MILITARY SERVICE MEMBERS AND VETERANS

Speaker: Matthew N. Goldenberg, M.D.

SUMMARY:

It is important for both clinicians and researchers to distinguish between the various types of self-injurious thoughts and behaviors, which have different base rates, risk and protective factors, courses, and treatment outcomes in military service members and veterans. Within a vulnerability-stress model, predisposing factors (vulnerabilities) are thought to interact with environmental events (stressors) to trigger suicidal behaviors. Vulnerability factors that contribute to suicidal behavior include mental disorders, previous suicidal behaviors, psychological factors, demographic

factors, family history, stressful life experiences, and situational factors. The DOD and the VA have developed a variety of universal, selective, and indicated prevention programs to address higher rates of suicidal behavior in service members and veterans. Effective management of suicide risk must start with universal assessment of risk in patients and requires expertise in hospital treatment, continuity of care, pharmacotherapy, psychotherapy, weapons management, safety planning, clinical practice guidelines, and accurate clinical documentation.

NO. 4 COLLABORATIVE CARE: MITIGATING STIGMA AND OTHER BARRIERS TO CARE

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

SUMMARY:

Current research indicates that between 23% and 57% of psychiatric needs of combat-exposed active duty service members and veterans go unmet. Barriers to care may be defined as any factor or collection of factors, either endogenous or exogenous, that tend to exert an inhibitory effect on treatment-seeking behavior and/or treatment adherence, ultimately limiting access to care. Service members and veterans with psychiatric conditions are less likely to self-report psychiatric symptoms or seek assistance and are more likely to endorse other barriers to care. People who are stigmatized have a lower overall quality of life, lower self-esteem, and lower sense of mastery and experience significant work and role limitations and greater social limitations. Collaborative care is an effective management strategy that coordinates roles for primary care providers, practice nurses, mental health specialists, and other allied health professionals in the treatment of chronic conditions and psychiatric illness. Promising collaborative care program models currently employed in military health care facilities designed to identify and treat depression and PTSD in service members will be discussed.

NO. 5 RISK AND RESILIENCE IN MILITARY FAMILIES

Speaker: Stephen J. Cozza, M.D.

SUMMARY:

The U.S. military community includes a population of families, many with young children that reside across the United States, some living on military installations, but others in remote areas around the country where community members and service providers may be unaware of their deployment related experiences. In addition, as combat veterans and their families leave the military, they are likely to relocate to areas that are distant from military installations where many do not recognize the challenges they faced or with which they continue to contend. Combat deployment not only results in single or multiple separations of parents from their families, but contributes to greater levels of family distress, parents' absences from children's important life events, and challenges of family reunification. Service members may return from deployment with combat stress disorders (including PTSD, depression or substance use disorders) or with combat-related injuries (including amputations, severe musculoskeletal injuries, burns or TBI). In the worst situations, service members who die during deployment never return to their families. This presentation will review the research pertinent to this area and describe intervention models that incorporate effective prevention strategies with traditional evidence-based clinical treatment.

MAY 19, 2015

MANAGING THE SIDE EFFECTS OF PSYCHOTROPIC MEDICATIONS: BALANCING RISKS AND BENEFITS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To describe a systematic overall approach for evaluating and managing suspected adverse effects of psychotropic medications; 2) To monitor for, diagnose, and manage basic cardiac and cardiovascular adverse effects of psychotropic drugs ; 3) To delineate the potential adverse metabolic (weight, glycemic, lipid) effects of atypical antipsychotics, antidepressants, mood stabilizers and other psychotropic medications; and 4) To recognize, describe and evaluate suspected drug rashes and hypersensitivity

reactions, and pursue a systematic approach to their management.

SUMMARY:

Amid the growth of agents within psychiatry's modern pharmacopoeia, psychiatrists must possess increasing familiarity with a range of end-organ drug effects, in order to make safe and well-considered treatment decisions. The ability to anticipate certain adverse effects has been aided in recent years by pharmacogenetics, clarification of predisposing factors for iatrogenic effects, and techniques for describing relative risks versus benefits from clinical trial outcomes (such as numbers needed to treat [NNT] or harm [NNH]). There remains a paucity of research and empirical data to help clinicians balance risks and benefits when making pharmacotherapy decisions tailored to individual patients' needs. This symposium will provide updated information on practical approaches to evaluating and managing common adverse effects from atypical antipsychotics, antidepressants, mood stabilizers, and other major psychotropic drug classes. A particular focus will be to help clinicians decide when the risks of highly effective medications are justified based on illness severity, available treatment alternatives, and viable strategies to safely manage adverse effects; or, when substantial treatment hazards outweigh potential benefits, favoring drug elimination. Specific examples will be reviewed and discussed that illustrate strategies for diagnosing and managing adverse drug effects with respect to cardiac and cardiovascular safety (reviewed by Dr. Ernst), metabolic dysregulation (reviewed by Dr. McIntyre), and dermatologic and drug hypersensitivity reactions (reviewed by Dr. Shear). Participants will gain state-of-the-art knowledge about feasible "antidote" strategies and their appropriateness for counteracting non-life-threatening adverse effects; how to recognize and differentiate "manageable" from medically serious adverse drug effects; and how to implement systematic risk-benefit decisions when choosing from among treatment options across diverse psychiatric disorders.

**NO. 1
CORE CONCEPTS IN THE EVALUATION AND MANAGEMENT OF ADVERSE DRUG EFFECTS**

Speaker: Joseph F. Goldberg, M.D.

SUMMARY:

This presentation will describe a systematic approach for evaluating and managing suspected adverse psychotropic drug effects. Core concepts will be reviewed that include how to determine whether cause-and-effect treatment relationships are pharmacodynamically plausible, how to differentiate drug side effects from primary illness symptoms, understanding and recognizing "nocebo" responses (i.e., nonpharmacodynamic, psychogenically-based negative reactions to treatment), appreciating the time course for emergence and resolution of common side effect and whether or not they may be dose-related, knowing the strengths and limitations of pharmacogenetic testing to anticipate side effects, attributing adverse effects to generic versus branded drug formulations, strategies for "pruning" redundant or ineffective agents from complex polypharmacy regimens, elucidating the impact of side effect perception on treatment adherence, and recognizing populations at greater or lesser vulnerability for particular side effects. A key focus will be on how clinicians can devise thoughtful and informed risk-benefit analyses for a given level of illness severity, gauging the uniqueness and magnitude of effect for a particular pharmacotherapy relative to the availability of alternative treatments and viable side effect "antidote" strategies, and differentiating medically dangerous from nonserious but bothersome drug side effects.

NO. 2 IDENTIFYING AND MANAGING CARDIAC SAFETY RISKS OF PSYCHOTROPIC DRUGS

Speaker: Carrie L. 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 QTc prolongation.

NO. 3 METABOLIC COMORBIDITY AND SIDE EFFECTS: HOW TO MANAGE

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Individuals with common and severe mental disorders are differentially affected by comorbidity including obesity, diabetes and metabolic syndrome. In many cases the foregoing comorbid conditions are consequence of medication prescription. For example replicated evidence indicates that atypical antipsychotics, antidepressants anticonvulsants as well as other psychotropic agents have differential effects on weight parameters glucose and metabolic status. The pertinence of metabolic problems in individuals with serious server with common and severe mental disorders is underscored by evidence indicating the concurrent metabolic problems increase the severity of the psychiatric illness, decrease the likelihood of recovery and are associated with increased mortality. This program will discuss common comorbid metabolic conditions in adults with persisting mental disorders; discuss pathogenetic mechanisms that are implicated in metabolic comorbidity and focus on disparate prevention and treatment modalities for metabolic problems. Treatment modalities discussed will include diet and lifestyle modification pharmacological treatment, behavioural treatment e.g. Exercise treatment including but not limited to aerobic and resistance training as well as novel multidimensional treatment approaches for metabolic conditions will be covered. Objectives: 1. to discuss common metabolic conditions that affect individuals with common and severe mental disorders, 2. to discuss treatment tactics

NO. 4

HOW TO EVALUATE AND MANAGE SUSPECTED DRUG RASHES

Speaker: Neil H. Shear, M.D.

SUMMARY:

Rashes can be confusing for clinicians and when the timing might suggest a drug-induced disease it can create a chaotic therapeutic environment. We have developed a clear strategic approach to possible drug rashes that is clinically-founded. The first step is to note the morphology of the rash (e.g., exanthem, urticarial, blistering), and if there is evidence of systemic involvement, most prominently fever. Second, one reviews all drugs and confirms the time lag between the start of the drug and the start of the reaction. Clinic decisions will follow these two steps and the use of a simple table. The presence of systemic features, especially fever, and the presence of tender skin are both warning signs. Some milder exanthems are transient and of no concern, or "sometimes a rash is just a rash."

Prevention of serious reactions is possible with pharmacogenetic screening. While this is not available for all drugs or all reactions it can be life-sparing for carbamazepine. It is clearly labeled that for this drug patients who are of Asian descent HLA-B*15:02 should be done prior to stating treatment. This allele is associated with Stevens-Johnson/Toxic Epidermal Necrolysis in specific populations. The nuances will be discussed.

ADVANCES IN INTEGRATED CARE: ACROSS THE COLLABORATION SPECTRUM

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

Discussant: Benjamin Druss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the reasons for premature mortality in the population with serious mental illness including contributors to preventable cardiovascular disease; 2) Understand the approaches to educating both psychiatric trainees and psychiatrists in practice in ways to improve their skills in evaluating and treating some common medical conditions; and 3) Explain why models of collaborative care are needed in the primary care setting and approaches to ensuring a workforce of

psychiatrists who can function confidently and competently in this setting.

SUMMARY:

The integration of primary care and behavioral health covers a range of opportunities for psychiatrists and their patients and is at the cutting edge of health care reform. With national efforts underway to achieve the promise of delivering better care at lower cost, psychiatrists have a unique opportunity to impact how treatment is delivered and establish an important role for the profession in the emerging health care arena.

In order to meet this goal, psychiatrists will need to understand the emerging models of care including addressing inadequately recognized and undertreated behavioral health conditions in the primary care setting as well as providing oversight and co-management of the common chronic health conditions that lead to premature mortality in patients with serious mental illnesses (SMI). This session will provide an opportunity to develop an in-depth understanding of both the rationale behind why we should be delivering these new models of care and a discussion of how to learn to do this competently. Henry Nasrallah, MD will lead off the list of presenters with a detailed examination of the chronic health burden faced by patients with SMI followed by Robert McCarron, MD who will describe training resources that are now available to help psychiatrists learn to provide better care to their patients through improving their knowledge of common medical conditions and prevention strategies. Jürgen Unutzer, MD will then present the evidence base and Core Principles of the collaborative care model and Lori Raney, MD will follow with a detailed look at the skills the consulting psychiatrists will need to be successful in the primary care setting and the educational resources that are now available to both trainees and practicing psychiatrists. Ben Druss MD will serve as the Discussant for the presentations.

NO. 1 THE DUAL JEOPARDY OF SERIOUS PHYSICAL AND MENTAL DISORDERS MANDATES AN INTEGRATED AND COLLABORATIVE APPROACH IN PSYCHIATRIC PRACTICE

Speaker: Henry A. Nasrallah, M.D.

SUMMARY:

It is practically impossible to implement good medical practice in psychiatry without a solid biopsychosocial approach. Diseases of the body and brain (especially its mind) are intertwined at the etiological, diagnostic, therapeutic, iatrogenic, outcomes and mortality dimensions. Optimal psychiatric evaluation and management requires a full medical history, physical exam, neuropsychiatric examination, and laboratory data in order to: 1) make the correct diagnosis and exclude general medical conditions as causing the psychiatric dysregulation, and 2) to select the most appropriate and least harmful medical intervention given the patient's physical status. For various reasons, including a heavy workload, some psychiatrists tend to assess the patient from the neck up, which means they must collaborate with other physicians to provide the patient with a comprehensive medical/psychiatric care. This collaboration has been accomplished with varying degrees of efficiency and although it is getting better, there is still room for better integration of the care of mentally ill patients. In this presentation, the ideal model of prevention, and intervention in serious mental syndromes (schizophrenia or bipolar disorder) is outlined. This will show why collaborative care with OBGYN, pediatricians, and primary care providers may at times, reduce the incidence of schizophrenia by about a third, and lower the cardiovascular risk factors and decrease premature mortality in patients.

**NO. 2
PREVENTING MEDICAL ILLNESS IN
PSYCHIATRY: JUST THE BASICS**

Speaker: Robert M. McCarron, D.O.

SUMMARY:

Patients with severe mental illness are vulnerable, with a much lower life expectancy. In order to make changes to the mental health care system, changes must be made to the way in which we train psychiatry trainees. An overview of how best to teach psychiatry residents and psychosomatic fellows (as well as postgraduate psychiatrists) how to deliver targeted preventive medical care to those with severe mental illness will be provided. Suggested topics, as well as recommendations of lecturers, will be detailed.

**NO. 3
THE COLLABORATIVE CARE MODEL
FOR THE TREATMENT OF MENTAL
ILLNESSES IN PRIMARY CARE**

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

SUMMARY:

Integrated Care programs in which psychiatrists support and work closely with primary care providers to care for defined populations of patients with common mental health and substance use problems offer exciting new opportunities for psychiatrists to extend their reach and help improve the health of populations. Evidence-based integrated care programs are informed by principles of good chronic illness care such as measurement-based practice, treatment to target, and population-based practice in which all patients are tracked in a registry to make sure no one falls through the cracks. We will discuss the evidence base for the development of such core principles of effective integrated care and give examples of integrated care programs with diverse patient populations.

**NO. 4
PREPARING PSYCHIATRISTS TO WORK
IN THE COLLABORATIVE CARE MODEL**

Speaker: Lori Raney, M.D.

SUMMARY:

Collaborative Care offers an exciting new model of practice for psychiatrists who will need to prepare for this role in order to be successful. This model has psychiatrists working in ways that are not taught in traditional educational programs and efforts are underway to prepare the workforce. This presentation will describe the daily activities of the consulting psychiatrist in the collaborative care model and the skills that have to be mastered in order to be a competent member of the team. It will also provide descriptions of emerging training resources for residents, fellows and psychiatrists currently in practice.

**TEST YOUR KNOWLEDGE WITH THE
EXPERTS: AN INTERACTIVE ADVANCES
IN SERIES ON PERSONALITY
DISORDERS, MENTALIZING AND
NETWORK THERAPY**

Chairs: Philip R. Muskin, M.D., Anna L. Dickerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the differences between categorical and dimensional approaches to the diagnosis of personality disorders; 2) Understand the use of Network Therapy in the treatment of patients with substance use disorders; 3) Define mentalizing and dysfunctional mentalization in clinical practice; 4) Appreciate the value of self-examination in the process of learning.

SUMMARY:

It is always challenging to test one's knowledge about a topic. Study guides provide such an opportunity as do self-assessment examinations and, of course, board certification and recertification. In the use of study guides we have the correct answer and the material from the textbook to review. A similar educational experience occurs during a self-assessment examination, such as the one available for this APA meeting, with references to support the correct answer. Research in education demonstrates that pre-testing enhances learning. We learn more from getting something wrong than we do from getting it right and thus explanations as to why a wrong answer is wrong enhances our knowledge about the topic. In this symposium we will present questions from three study guides that are in press to test the knowledge of the participants using an audience response system. Following the questions we will have experts from three different textbooks speak about the topic that was just tested. Following the lecture the audience will have another opportunity to test their knowledge by answering another set of questions; however, rather than read about the correct and incorrect answers each expert will speak about the questions and their answers, as well as interact with audience questions regarding the material.

NO. 1

PERSONALITY DISORDERS: CATEGORICAL OR DIMENSIONAL?

Speaker: John M. Oldham, M.D.

SUMMARY:

Historically, studies of personality in non-patient populations have emphasized a wide range of personality traits that can be specified, in various combinations, to portray the unique personality profile of any individual. In contrast, the APA DSM-5 diagnostic system employs a categorical approach, consistent with medical criteria-based definitions of specific illnesses. For over a decade, however, there has been a broad consensus that such a categorical system is somewhat artificial when applied to the personality disorders, which are more appropriately conceptualized as combinations of traits that, when extreme, constitute psychopathology. While section II of DSM-5 sustains the traditional categorical approach, section III contains a new 'alternative model for personality disorders' that revises the general definition of any personality disorder as moderate or greater impairment in self and interpersonal functioning, a dimensional defining principle for the PDS. The nature of that impairment is described for each PD, along with the applicable pathological personality traits. These developments are presented in detail in the American Psychiatric Publishing textbook of Personality Disorders, second edition, and they will be reviewed and discussed in this interactive session.

NO. 2

NETWORK THERAPY FOR ALCOHOL AND DRUG ADDICTION

Speaker: Marc Galanter, M.D.

SUMMARY:

Individual therapists in office practice may have difficulty in treating alcohol and drug dependent patients because of the unique problems they present. Network therapy is an approach developed to facilitate treatment of patients with moderate or severe DSM-5 substance use disorders. It employs individual psychodynamic and behavioral therapy, while engaging the patient in a support network composed of family members and/or close friends. The network is managed by the therapist to provide cohesiveness and support, undermine denial, and promote adherence to treatment. A cognitive-behavioral model of addiction, based on the role of conditioned abstinence is employed. It includes educating both patient and network members about alcohol and drug triggers, and in dealing with potential episodes of relapse. Examples will be given, such as the

application to work with patient and spouse, and education regarding cues for relapse related behavior. An illustrative video will be presented.

NO. 3

MENTALIZING IN PSYCHOTHERAPY

Speaker: Stuart C. Yudofsky, M.D.

SUMMARY:

This presentation will be based the topic of 'Mentalizing,' as featured in three American Psychiatric Publishing Texts: 1) 'Mentalizing in Psychotherapy' a chapter by Jon G. Allen, PhD and Peter Fonagy, Ph.D., in the Textbook of Psychiatry, Volume VI; Mentalizing in Clinical Practice, John G. Allen, Ph.D., Peter Fonagy, Ph.D., and Anthony W. Bateman, M.A.; and several chapters in Fatal Pauses, Getting Unstuck Through the Power of No and the Power of Go, by Stuart C. Yudofsky, M.D.

Mentalizing will be defined and several of the prominent theories of the psychobiological bases of problems with mentalization reviewed. Three varieties of potentially dysfunctional mentalization in clinical practice will be discussed: Hypermentaliaztion; Hypomentalization; and Supermentalization. Clinical examples of each of these potentially dysfunctional mentalization types will be presented to demonstrate how mentalization is utilized in psychotherapy. As Supermentalization is a new concept, emphasis will be placed on how this occurs in both adaptive and impaired behaviors, particularly as it relates to pleasing and over-pleasing others.

CASE CONFERENCE

MAY 16, 2015

KETAMINE TREATMENT OF MOOD DISORDERS: PROMISING NEW CLINICAL AVENUE OR DEAD-END ROAD?

Chair: Gerard Sanacora, M.D., Ph.D.

Speakers: Robert B. Ostroff, M.D., Sanjay J. Mathew, M.D., Steven Garlow, M.D., Ph.D.

SUMMARY:

Large "real world" studies demonstrating the limited effectiveness and slow onset of clinical response associated with our existing antidepressant medications has highlighted need for the development of new therapeutic strategies for major depression and other mood disorders. Yet, despite intense research efforts, the field has had little success in developing antidepressant treatments with fundamentally novel mechanisms of action over the past six decades, leaving the field wary and skeptical about any new developments. Yet, a series of relatively small proof-of-concept studies conducted over the last 15 years has gradually gained great interest by providing strong evidence that a unique, rapid onset of prolonged, but still temporally limited, antidepressant effects can be achieved with a single administration of ketamine. These studies have spurred recent efforts from academicians and the pharmaceutical industry to better understand the mechanisms of the drug's actions and to develop more "clinic friendly" approaches to treatment delivery. The findings have also attracted the attention of lay media outlets, who have repeatedly published stories such as; Special K, a Hallucinogen, Raises Hopes and Concerns as a Treatment for Depression, New York Times; Ketamine, or "Special K" effectively treats severe depression in study, CBS News; 'Club Drug' Ketamine Lifts Depression in Hours, Time Magazine; or, Is Ketamine the Next Big Depression Drug? Scientific American. These, and similar reports have increasingly made clinicians and patients aware of the limited empirical literature that exists in this field to date, and have led many to seek rapid access to the treatment. However, we continue to struggle with several questions regarding the true clinical meaningfulness of the findings, which has led many to wonder if we

are letting clinical practice outstrip our true understanding of the risks and benefits associated with the ketamine.

This session will include a series of case presentations involving the use of ketamine in the treatment of mood disorders. A panel of discussants will then facilitate discussions about the promise and limitations of this treatment approach, and address the major concerns that need to be considered when contemplating use of the drug in clinical practice. The overall goal of the session is to provide a fair and balanced overview of evidence and clinical experience related to this much discussed new development in the field. It is hoped that this information will better allow clinicians to more effectively counsel patients considering this treatment option.

COMPLEXITY, COMORBIDITY, AND CHALLENGES TO TREATMENT

Chairs: Priyanthy Weerasekera, M.D., M.Ed., John Manning, M.D.

Speaker: Patricia Rosebush

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of formulation of a complex case from a multiperspective approach; 2) Demonstrate differential diagnostic skills in a complex case; and 3) Identify a treatment plan for a complex case that integrates pharmacotherapy and several different forms of psychotherapy, and individual and group intervention, and inpatient and outpatient treatment.

SUMMARY:

This case conference will present a complex diagnostic and treatment case. The patient is a 45 year old married mother of 2 young children who was seen in treatment for almost 20 years. The patient initially presented with a complex history and multiple comorbidities including depression and several anxiety disorders, and childhood sexual abuse. Several treatment approaches were administered over the first 5 years. The patient worked hard and progressed well through each treatment. Over the subsequent 5 years the patient was seen less frequently, as she was doing well; but she was still involved in booster treatments sessions for many of her conditions. Over the years treatment included an integration of medication and several different forms of psychotherapy;

antidepressant medication, psychodynamic therapy, and cognitive-behavioural therapy, all integrated at various points in time. After the first ten years the patient was seen very infrequently; only for brief follow ups to ensure gains were maintained. The sessions were mainly to provide the patient with a sense of connection with a secure attachment figure which she had never had in her early years. The patient remained stable until 3 years ago when she developed new symptoms; an eating disorder and pseudoseizures. These symptoms contributed to a complex presentation and became a significant management issue. The patient became significantly worse, was not able to work and required specialized treatment. Multiple interventions were once again required and at present the patient is awaiting an inpatient treatment program.

This case illustrates many issues: the impact of childhood sexual abuse on later life, the significant impact of lifelong depression and comorbid anxiety disorders, and the development of complex new symptoms in an otherwise stable patient who had been successfully treated. First the case will be presented in detail. The discussants and audience will be given time to ask questions. Following this attention will be given to a case formulation and how this lends itself to treatment in this particular case. The discussants will present their perspective and offer their opinions regarding the formulation and treatment. The audience will be encouraged to participate in the discussion at all phases of the presentation.

COGNITIVE-BEHAVIOR THERAPY FOR MOOD AND ANXIETY DISORDERS: CASE CONFERENCE

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

Speakers: Jesse H. Wright, M.D., Ph.D., Ario Hosseini, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize key CBT methods for treating bipolar disorder and anxiety disorders; 2) Identify basic constructs of well-being therapy; and 3) Develop multi-faceted treatment plans for combined CBT and pharmacotherapy of complex psychiatric disorders.

SUMMARY:

Treatment of a woman with comorbid bipolar disorder and anxiety disorders was successful with long-term CBT, coupled with pharmacotherapy and methods from well-being therapy. Discussion of this case will illustrate use of a customized, multi-faceted treatment plan in treating complex psychiatric disorders. Attendees will be invited to discuss their own experiences in treating complex disorder with combination therapies. The case conference will focus on finding creative solutions to challenging clinical problems.

APA CASE CONFERENCE: ANOREXIA NERVOSA WITH CO-OCCURRING MENTAL ILLNESSES

Chairs: Walter H. Kaye, M.D., Sanjaya Saxena, M.D.

Speaker: Pernilla Schweitzer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Improved understanding and treatment of OCD; 2) New insights and approaches to interactions between OCD, anxiety, and eating disorders; and 3) Methods for working with anxiety and abnormal eating behaviors .

SUMMARY:

The patient is a 24 y/o, Native American female, full-time student in her junior year of college, living with her adoptive mother in Marin, CA since age 17. Patient has severe OCD and anorexia nervosa, health anxiety disorder, PTSD, alcohol use disorder, and has a H/O 10 previous psychiatric hospitalizations for suicidal ideations, cutting or malnutrition, most recently at age 20. She is severely impaired by her obsessions and compulsions which revolve around desire for perfectionism, having things be done or said "in a certain way," and issues related to food, including fears of contamination or illness. She refuses to take medication, even though she agrees that pharmacotherapy has been helpful in the past, because she is convinced it will impair her immune system making her more susceptible to infectious diseases. She adheres to an organic-only, vegan and gluten free diet, has elaborate rituals of preparing her food, and believes that if she eats food that does not meet her dietary criteria she will get cancer. When she is psychologically distressed she stops eating, and will go up to do days without eating or

drinking anything except water. Her BMI is 17 and she is terrified of gaining weight. She rarely drinks alcohol because of its high calorie content, but when she does, she drinks to the point of losing consciousness. Her symptoms limit her ability to form lasting relationships, complete courses necessary for graduation, find employment and housing. She has suicidal ideations daily, and talks frequently about giving up.

This case presents a number of potential issues to discuss:

• What do we know about the neurobiological overlap of anorexia and OCD?

• What kind of treatment is recommended?

• Who should provide treatment for this patient? If she decompensates should she be hospitalized on a psychiatric unit or a medical unit?

• How much insurance coverage is available for anorexia treatment? What about insurance coverage for inpatient or residential treatment?

• In what circumstances is it acceptable to force a higher level of care or treatment on an individual with an eating disorder, particularly given the high mortality? How is this negotiated with someone who might be otherwise logical and high functioning?

• How common is binge drinking in patients with anorexia? What are the risks and what type of treatment should be recommended?

• How do we define pathological eating and health anxiety from the growing number of people with very strict diets and convictions about food safety? A growing percentage of people living in Northern California adhere to strictly organic, vegan or gluten free diets. Many people in the local area are convinced that they have a gluten-sensitivity and that eating foods with gluten will lead to chronic debilitating illness. These diets can be expensive, socially alienating, and time consuming.

EMERGENCY PSYCHIATRY CASE CONFERENCE: THE PSYCHIATRIST IS ASSAULTED

Chair: Jodi Lofchy, M.D.

Speaker: Michael H. Allen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the risk of physical violence in emergency psychiatry practice; 2) Describe the major types of

violence, impulsive and premeditated, and the implications of each in a staff assault; 3) Identify common reactions to trauma both in oneself and in others; and 4) Describe the process and resources available to assist with recovery after assault.

SUMMARY:

Emergency departments are known to be settings prone to violence. Front-line staffs, including nurses and security guards, are at a much higher risk for assault than physicians but emergency medicine attendings, emergency psychiatrists and residents are all at risk. This case presentation will focus on an incident of assault by a psychotic patient in the emergency department (ED) towards the staff psychiatrist initiating the assessment. The presenter, the psychiatrist who experienced the assault, will discuss a case of a woman with schizophrenia who presented to the emergency department in a state of acute psychosis. Although the assessment took place in a safe and secure emergency psychiatry holding unit, contiguous with the general ED, staffed by experienced psychiatric nurses, assistants, clinicians and trainees, the patient escalated abruptly to assault the psychiatrist before a formal assessment could occur. This session will focus on post-assault reactions of both the psychiatrist and the team. A video interview with the Chief residents at the time who debriefed with the junior resident witnessing the assault will be included. This presentation will address risk factors for violence in the ED but also note that there will be times where it is difficult to predict imminent violence. Reactions to trauma are individual and complex. The presenter will discuss her own reactions to the assault and the wide range of responses from others including team members, colleagues and institutional supports. The impact on others was complicated in this case by the fact that the victim was the Department's director. The roles of debriefing, incident review, Employee Assistance Programs [EAP] and physician-specific resources will be addressed. Dr. Lofchy will be joined by Dr. Michael Allen, a renowned expert in emergency psychiatry and agitation. Dr. Allen will comment on the case and discuss the nature of violence and the clinical culture of acute services. There is a natural tendency to respond to violence with fear and anger and a need to counter this tendency both for the sake of morale and

professionalism but also to prevent a deterioration of the culture into a cycle of violence with staff hostility and repeated assaults.

MAY 17, 2015

COURT-MANDATED OUTPATIENT PSYCHIATRIC CARE FOR A PREGNANT WOMAN WITH PSYCHOSIS: A UNIQUE BRIDGE TO ALLIANCE

Chair: Dianna Dragatsi, M.D.

Speakers: Laura M. Polania, M.D., Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the risks of untreated psychosis in pregnancy; 2) Discuss the positive and negative impact of court mandated outpatient psychiatric care; 3) Identify how the benefits of court mandated outpatient psychiatric care could be a useful tool in unique high risk pregnancy cases, such as the one presented; and 4) Discuss ethical considerations of mandating outpatient psychiatric care for pregnant women with psychosis, using the case presented as a reference.

SUMMARY:

This presentation highlights issues that can arise in the treatment of a pregnant woman with psychosis across several systems of care-women's health, ethics and public psychiatry.

We describe the case of a young pregnant woman with schizoaffective disorder and limited resources, who also developed a substance use disorder, and the decision that was made to apply for court-mandated outpatient psychiatric treatment (Assisted Outpatient Treatment or AOT) in New York City. Unlike for many AOT applications, the patient was stable when this application was made, with AOT used as a preventive measure, given her serious prior episodes of illness. In making this decision, which involved extended discussions with a variety of consultants, the treatment team struggled between developing an overly protective treatment plan vs. risking a negative outcome for the patient and her pregnancy. The team considered the likely effectiveness of AOT in retaining the patient in treatment, the possibility of a negative reaction by the patient,

and whether independent obligations existed to the fetus as well as to the patient. They concluded that although they might not have employed court-mandated care if the patient had not been pregnant, the increased risk to the patient associated with her pregnancy warranted a more therapeutically aggressive approach. They also hoped that this strategy would optimize the possibility of developing a therapeutic alliance with the patient, given her longstanding failure to connect to outpatient care.

While there has been court-mandated outpatient obstetrical treatment, as far as we know this is the first report of mandated outpatient psychiatric treatment in connection with pregnancy. Although certainly not applicable to all cases of psychosis in pregnancy, the case offers the opportunity to explore a variety of issues related to use of involuntary interventions in the care of pregnant women. The audience will be invited to join in a discussion about the clinical and ethical considerations of court-mandated outpatient psychiatric care for pregnant women with psychosis.

MAY 18, 2015

A COMPLEX CASE OF A HISPANIC MALE PATIENT WITH DEPRESSION AND HISTORY OF SEXUAL TRAUMA

Chair: Renato D. Alarcon, M.D., M.P.H.

Speakers: Desiree Shapiro, M.D., Sidney Zisook, M.D., Steve Koh, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance of cultural aspects of care, emphasizing the attainment of skills in culturally oriented assessment, diagnosis, and treatment planning; 2) Appreciate the interplay between spirituality, sexuality, family dynamics, and culture in treating depression and post-traumatic stress disorder; and 3) Identify approaches to handle resistance to psychopharmacological intervention, especially involving social, religious, and cultural stigma about psychotropic medications. .

SUMMARY:

This presentation will review a male patient's clinical history and course as well as his

treatment (management and response) conducted during a third year psychiatric resident's outpatient clinic rotation. The case involves manifestations of severe post-traumatic stress disorder and major depressive disorder in a young Hispanic male who migrated to the U.S. following a significant sexual abuse experience. Important issues dealt with during his care included sexuality, religion, personal identity, family dynamics, and immigration phenomena, all in the context of cultural variables and circumstances in the individual and group spheres.

MIS(SED) DIAGNOSIS: TRAUMA, DISSOCIATION AND PSYCHOSIS REVISITED

Chairs: Jeffrey A. Sugar, M.D., David Spiegel, M.D.

Speakers: Jeffrey A. Sugar, M.D., John P. Daly, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that dissociation is not rare and often follows interpersonal trauma there is now a dissociative subtype of PTSD in DSM-5; 2) Be alerted to clinical signs of dissociation, especially those that can mimic psychosis, and to clinical tools that can help with the differential diagnosis; and 3) Recognize that treating dissociation requires special knowledge and skill, both of which are well within the reach of a supervised psychiatric resident.

SUMMARY:

Although Dissociative Disorders have been described in the medical literature for at least 200 years, they continue to go unrecognized and, therefore, un- or mis-treated. Published articles still question the existence of Dissociative Identity Disorder, although this diagnosis (formerly known as Multiple Personality Disorder) has been included in our nosology since DSM III. Because dissociated personality fragments are often experienced as hallucinated voices, these patients are often diagnosed as "Psychotic Disorder, NOS" or Schizophrenic and treated with antipsychotic medication-often with little effect other than the dampening of behavior and affect. This reinforces the mistaken diagnosis of schizophrenia but does not improve the apparent delusions and hallucinations.

Furthermore, links to childhood trauma are not explored and go unrecognized. Thus, what may have begun as a transient adaptation to a hostile interpersonal environment of child abuse and neglect is transformed into a chronic mental illness.

However, there are simple and effective alternatives. Preservation of affect and the experience that the hallucinations "take control" of the patient-with some degree of amnesia during these periods of altered control-should suggest dissociative pathology. Once identified, dissociation can be treated with psychotherapy. Hypnosis offers a simple and effective way to access dissociated states and to help patients reduce the amnestic barriers between these states.

We will present the case of a 17 year-old girl, admitted to an inner-city adolescent inpatient unit with a diagnosis of psychotic disorder, hospitalized for aggressive and suicidal behavior several times in previous months. Multiple trials of anti-psychotic medications had little effect on her constant stream of auditory hallucinations that took the form of several discrete named voices. After a careful history elicited dissociative symptoms, (confirmed by high scores on the Adolescent Dissociative Experiences Scale) we assessed her using the Hypnotic Induction Profile, (developed by H Spiegel and D Spiegel and adapted for children by J Sugar), and found her to be highly hypnotizable. Using hypnosis as an adjunct to psychotherapy, we made the diagnosis of Dissociative Identity Disorder, and let the patient know that our task would be to integrate the voices, rather than make "the bad ones go away," as she had unsuccessfully tried with a previous therapist. Over a period of only five days, Dr. Daly, a second-year resident, previously naive about dissociative pathology, was able with close supervision to work effectively with this patient, who was discharged home on less medication and much improved. She has turned 18 and Dr. Daly will now follow her in an adult outpatient clinic. Dr. Sugar will present background and a brief introduction. Dr. Daly will present the case. Dr. Spiegel will discuss the case. Audience participation in extended discussion period is strongly encouraged.

THE N-BOMB STRIKES AGAIN. A CASE OF SELF-INJURIOUS BEHAVIOR WHILE

UNDER THE INFLUENCE OF A NOVEL PSYCHEDELIC DRUG

Chairs: Petros Levounis, M.D., Jennifer Hanner, M.D., M.P.H.

Speakers: Kristel Carrington, M.D., Erin Zerbo, M.D., Jennifer Hanner, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify several classes of novel psychedelic drugs, including the NBOMe series; 2) Recognize the physiologic effects of NBOMe compounds in the body and identify the psychiatric sequelae of NBOMe intoxication; 3) Discuss the clinical management of potent psychedelic intoxication; and 4) Identify the public health concerns and legislative challenges related to research chemicals that are rapidly becoming drugs of abuse.

SUMMARY:

In recent years, the underground production and trafficking of new psychoactive drugs has increased. These drugs, which include synthetic cannabinoids (e.g. "Spice"), cathinones ("bath salts"), and hallucinogens are often unprofiled research chemicals advertised as "legal highs," though they are intentionally distributed for recreational use by exploiting inadequacies of existing controlled substance legislation. The NBOMe compounds (25B, 25C, 25I) are a relatively novel series of potent synthetic hallucinogen drugs that have recently emerged as popular designer drugs of abuse. They can be purchased online in a number of countries. Recreational use of NBOMe has been shown to carry significant risk of both physiologic and behavioral toxicity. Adverse events, including deaths, have been reported after use of these drugs. The adverse effects include tachycardia, hypertension, agitation, auditory and visual hallucinations, aggression, hyperpyrexia, and metabolic disturbances. As the NBOMe compounds cannot be detected on standard urine or blood screening toxicology tests, emergency medical clinicians are challenged to be aware of their potential role in cases evaluated in Emergency Departments. This discussion presents the case of a 24-year-old male with no past psychiatric history who presented with new onset psychosis and self-inflicted wounds to his head and neck in the context of 25I-NBOMe intoxication. This report serves to educate mental health providers on the effects of the NBOMe compounds and their

potential to cause psychosis and violence. It also brings attention to the broader public health concern of how easily available these drugs and others like them can be purchased on the internet. The reports of deaths and significant injuries attributed to the use of designer synthetic compounds have prompted some governments to enact legislation controlling their possession, production, and sale. Despite these efforts, the drugs are still easily available for inexpensive purchase online and clinicians must be aware of the increasing use of these novel compounds, particularly by young people.

MAY 19, 2015

TREATMENT-REFRACTORY SCHIZOPHRENIA: A CLINICAL CONUNDRUM THAT IS STILL NOT GOING AWAY

Chairs: S. Charles Schulz, M.D., David R. Williams, M.D.

Speakers: Peter F. Buckley, M.D., S. Charles Schulz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Illustrate the persistence of refractory psychosis despite the emergence of new pharmacological therapies; 2) Appreciate the complex issues - including drug intolerance - that arise in the management of refractory schizophrenia; and 3) Highlight the role of non-pharmacological approaches to care.

SUMMARY:

Schizophrenia is still best conceptualized as a chronic and debilitating mental disorder. Despite substantial and continued advances in both pharmacological and nonpharmacological approaches to the care of people with schizophrenia, it remains clear that a substantial minority of patients do not do well and that their illness is refractory. Treatment Refractory Schizophrenia unfortunately still remains as a clinical conundrum. The clinical case presentation for this symposium serves to illustrate salient aspects of the care for patients who do not respond. Details of this case were altered to protect patient confidentiality.

Ms. P. is a 36 year old Caucasian female with a history of schizophrenia who was admitted to the inpatient psychiatry unit of Saint

Elsewhere's hospital. The patient had been wandering from home and exhibited increasingly disorganized thoughts and behavior. She stayed up all night, experienced a decline in personal hygiene, and had poor oral intake. She had been placed in a personal care home four weeks prior to admission. Upon arrival Ms. P. appeared disheveled and maintained poor eye contact. She occasionally responded to questions with irrelevant answers though mostly mumbled and laughed to herself. The patient appeared internally preoccupied and endorses hearing "demons" talking to her. She had over 10 previous admissions and her past antipsychotic medications included haloperidol (oral and decanoate), ziprasidone, clozapine, perphenazine, quetiapine, risperidone, and aripiprazole. The patient was initially started on asenapine 5mg sublingually BID which was titrated to 10mg BID. This proved ineffective and the decision was made to restart clozapine along with haloperidol 2mg BID. Titration progressed slowly as the patient could only tolerate an average increase of 12.5mg every other day. She experienced significant orthostatic hypotension, tachycardia, and became febrile at times. The patient required one to one monitoring due to fall risk and unpredictable behavior. At times she would throw chairs, grab meal trays, and refused to keep her clothes on. She only responded to questions occasionally and with great latency. The patient required frequent PRN administrations of ziprasidone, lorazepam, and diphenhydramine for agitation. Clozapine was suspended briefly due to a significant drop in WBC and ANC. Attempts were made to taper haloperidol but this caused further deterioration. The patient began to talk more and exhibited less aggression with titration of clozapine, however her affect remained blunted and responses were illogical and disorganized. She continued to endorse auditory hallucinations that were frightening to her. The patient was not able to tolerate higher doses of the medication due to orthostasis and sedation. After forty-four days it was felt that she had achieved maximum benefit of hospitalization. The patient's father and step-mother visited only once and unfortunately were only peripherally involved in her care. Discharge medications included clozapine 75mg BID and haloperidol 1mg BID.

Following Dr Williams's presentation, Dr. Buckley will discuss clinical aspects relating to

the care of this patient and overall principles of care for Treatment Refractory Schizophrenia. Then, Dr. Schulz will discuss recent developments in the management of treatment refractory schizophrenia.

This session will be structured to facilitate and encourage audience participation and questions that address multiple facets of the care of patients with Treatment-Refractory Schizophrenia.

NEUROPSYCHIATRY CASE CONFERENCE: DEMENTIA WITH VISUAL SYSTEM DETERIORATION

Chair: Sheldon Benjamin, M.D.

Speaker: Margaret C. Tuttle, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Develop familiarity with the concept of posterior cortical dementia; 2) Learn to perform several bedside cognitive assessment techniques useful in evaluating cognitive decline; and 3) Become familiar with the components of neuropsychiatric assessment and formulation.

SUMMARY:

Neuropsychiatric evaluation requires flexible bedside cognitive assessment adapted to the clinical hypothesis being tested. Although rating scales such as the MMSE or the MOCA can be useful as general screening tools, they are not sufficient for differential diagnosis. In addition to the clinical hypothesis being tested, other factors that dictate varied examination techniques are the patient's intellectual level, ability to cooperate, the purpose of the examination, and whether subspecialists are available in one's area. Neuropsychiatric formulation consists of listing the symptoms and signs discovered in investigating the chief complaint, determining the level or neural network involved in causing the deficits, elaborating the differential diagnosis of the deficits, planning interventions to ameliorate the deficits, and determining the prognosis. A patient suffering from an early-onset dementing condition will be used to demonstrate neuropsychiatric assessment and formulation technique.

A 57-year old man with a 5-year history of forgetfulness presented with peculiar visual

system deficits including inability to find things in his environment and difficulty independently ambulating toward a desired object or goal. He was no longer able to work or drive. He was pleasant and cooperative but so impaired that he had to move to an assisted living facility for safety.

The patient's neuropsychiatric presentation, including video clips of his examination, will be used as the basis for a discussion of neuropsychiatric assessment, formulation, and the differential diagnosis of atypical dementia with visual system symptoms. Relevant bedside cognitive assessment tasks will be demonstrated. The discussion of less common conditions, such as this are useful in learning general neuropsychiatric principles, and approaches to patients with deficits of unknown cause.

MAY 20, 2015

THE TROUBLING RELATIONSHIP BETWEEN MOOD DISORDERS AND DEMENTIA IN OLDER ADULTS

Chairs: Kenneth I. Shulman, M.D., Nathan Herrmann, M.D.

Speakers: Kenneth I. Shulman, M.D., Nathan Herrmann, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the neurobiology of mood disorders and dementia in later life; 2) Appreciate the relationship between depression, bipolar disorder and dementia; and 3) Recognize the role of psychotropic agents in the management of mood disorders and their impact on cognition.

SUMMARY:

This case conference will include the presentation of three clinical cases of older adults that reflect the growing body of evidence that mood disorders are a significant risk factor for the development of dementia and are comorbid with dementia. The first case will involve Major Depression developing into Dementia in which several neurobiological factors may be contributing to this vulnerability. These include inflammation, neurotrophins, cerebrovascular disease and glucocorticoids. The second case is one of bipolar disorder in later life where cognitive impairment is well established but

controversy surrounds the nature of cognitive decline even in younger bipolar patients. Lithium's 'double-edged sword' will be highlighted including the risk of toxicity because of decreasing renal function and drug interactions in later life while potentially providing neuroprotection at therapeutic levels. The third case will be an example of recognizing and managing depression in a patient with well-established Alzheimer Disease.

The role of psychotropics and cognitive enhancers in the management of mood disorders and dementia will be integrated into the cases and discussion. There will be ample opportunity for discussion and the sharing of clinical experience. The two presenters are both geriatric psychiatrists. KS has a particular interest in bipolar disorder in late life while NH is a dementia specialist with expertise in neuropharmacology.

MASTER COURSES

MC0787

Transference-Focused Psychotherapy for Borderline Personality Disorder (Master Course)

Director: Frank Yeomans, M.D., Ph.D

Faculty: Otto F. Kernberg, M.D.; John Clarkin, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Communicate the concept of psychological structure and its relation to the specific symptoms of borderline personality; 2) Convey the range of borderline pathology and its different presentations; 3) Teach the centrality of identity diffusion in borderline personality disorder (BPD) and the role of identity integration in resolution of BPD; 4) Teach the strategies, tactics, and techniques of effective psychodynamic psychotherapy for borderline personality; and 5) Teach how to perceive and identify object relations dyads (pairing of internal representations of self and other) as they are enacted in the therapy.

SUMMARY:

Transference-Focused Psychotherapy (TFP) is a manualized, evidence-based treatment for severe personality disorders, in particular borderline and narcissistic personality disorders. These patients often represent a daunting challenge to the therapist. To help the therapist in meeting the clinical needs of this challenging patient population, TFP combines a psychodynamic approach with structure and limit-setting. The goals of the treatment are ambitious - personality change, as reflected in the patients' functioning and satisfaction in their interpersonal and work lives, as well as symptom change. TFP builds on a psychodynamic object relations model of psychological functioning. The treatment focuses on internalized images of self and other that organize the patient's interpersonal experience. The exaggerated, distorted, and unrealistic internal images of self and other characteristic of severe personality disorders are associated with problems in mood regulation, self-esteem, and interpersonal relationships. The aim of the treatment is to modify these internalized relationship patterns by exploring them as they are activated in the

therapeutic relationship and in the patient's interpersonal life. The ultimate aim is to create more stable, realistic and better-integrated experiences of self and other, leading to improved interpersonal functioning and adaptation to life. This course will offer: 1) discussion of a diagnostic system for personality disorders based on psychological structure 2) an overview of the essential concepts of object relations theory 3) presentation of the principles and techniques of TFP. 4) discussion of case material, including video material that illustrates how TFP is practiced.

Course Level: Basic

MC2769

2015 Psychiatry Review (Master Course)

Director: Robert Boland, M.D.

Faculty: Arden Dingle, M.D.; Richard Balon, M.D.; Josepha Cheong, M.D.; Vishal Madaan, M.D.; Mark Servis, M.D.; Joseph Layde, J.D., M.D.; Anthony Rostain, M.D.; Marcy Verduin, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Essential psychiatric and neurology topics will be reviewed and discussed using multiple-choice questions (MCQ). After a brief introduction covering the basic structure and format of MCQs typically used in psychiatric examinations, participants will review and answer MCQs in various formats using an audience response system. After viewing a summary of the audience responses, faculty members will lead and facilitate a review and discussion of the topic covered by the MCQs. The questions will be grouped by topic and will

cover a number of core subjects in psychiatry and neurology. The clinical topics are development, diagnostic methods, psychopathology, psychiatric treatment, neurosciences and neuropsychiatry, research and literature literacy, forensics, ethics and special topics (e.g. history, administration). Audience members will use an audience response system to respond to the multiple choice format before correct answers and full explanations and references are provided.

Course Level:

MC0517

DSM-5: What You Need to Know (Master Course)

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

Faculty: William Narrow, M.D., M.P.H.;

Katharine A. Phillips, M.D.; Robert J. Ursano, M.D.; Rajiv Tandon, M.D.; Wilson M. Compton, M.D.; Sue Swedo, M.D.; J. Raymond DePaulo, Jr., M.D.;

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List the primary significant changes in the classification of and diagnostic criteria for mental disorders from *DSM-IV* to *DSM-5*; 2) Discuss some of the major clinical modifications that might be needed to implement the major changes in *DSM-5*; and 3) Describe some of the important revisions to nondiagnostic specific areas of *DSM-5*, including the manual's organization and section content.

SUMMARY:

Release of *DSM-5* marks the first major revision to the classification of and diagnostic criteria for mental disorders since *DSM-IV* was released in 1994. The focus of this master course is to educate clinicians and researchers on the major changes from *DSM-IV* to *DSM-5*, including diagnosis-specific changes (e.g., criteria revisions) as well as broader, manual-wide changes (e.g., revised chapter ordering, use of dimensional assessments, integration of neuroscience and developmental material across the manual). The primary emphasis is on ensuring clinicians understand how these changes might impact patient care and knowing what modifications might be necessary to implement these revisions in their practice. The session will be led by the *DSM-5* Task Force

Vice-Chair, Darrel A. Regier, M.D., M.P.H., and *DSM-5* Task Force Research Director, William E. Narrow, M.D., M.P.H. Presentations will be provided by members of select *DSM-5* Work Groups, specifically Neurodevelopmental Disorders; Depressive and Bipolar Disorders; Schizophrenia and Psychotic Spectrum Disorders; Obsessive-Compulsive and Related Disorders; Trauma and Stress-Related Disorders; and Substance Use and Other Addictive Disorders.

Course Level: Advanced

MC2768

Psychopharmacology (Master Course)

Director: Alan F. Schatzberg, M.D.

Faculty: Charles DeBattista, M.D.; Kiki Chang, M.D.; Rona Hu, M.D.; Charles Nemeroff, M.D., Ph.D.; Terence Ketter, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

Course Level: Intermediate

MC2766

Update on Pediatric Psychopharmacology (Master Course)

Director: Christopher Kratochvil, M.D.

Faculty: John Walkup, M.D.; Karen Wagner, M.D., Ph.D.; Christopher McDougle, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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.

Course Level: Intermediate

COURSES

Saturday, May 16, 2015

C0209

Updates in Geriatric Psychiatry

Director: Rajesh R. Tampi, M.D.

Faculty: Ilse Wiechers, M.D., M.H.S., M.P.P.;

Louis Trevisan, M.D., M.Ed.; Kristina Zdanys,

M.D.; Kirsten Wilkins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the epidemiology of mood disorders, anxiety disorders, psychotic disorders and substance use disorders in late life; 2) Elaborate the neurobiology of mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life; 3) Enumerate the assessment of mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life; and 4) Discuss the latest evidence based treatments for mood disorders, anxiety disorders, psychotic disorders, and substance use disorders in late life.

SUMMARY:

Psychiatric disorders are not uncommon in late life. Illnesses like dementias, delirium, mood disorders, anxiety disorders, psychotic disorders, and substance use disorders are frequently encountered in older adults. The population of older adults is growing rapidly. This has led to an increase in the number of older adults with psychiatric disorders. Currently, there are less than 1,900 board-certified geriatric psychiatrists in the United States. Given the current educational models, it will be impossible to train adequate numbers of geriatric psychiatrists to meet the growing needs for clinical services for older adults with psychiatric illness. Due to the shortage of geriatric psychiatrists, general adult psychiatrists, primary care clinicians, advance practice nurses and physician associates will be expected to see many of the older adults with psychiatric illness. Only a limited number of educational courses for clinicians are focused on psychiatric disorders in late life. Many clinicians who want to receive information through such courses have difficulty accessing them given the limited number of such courses. In this course we will discuss four major psychiatric disorders in late life: mood disorders, anxiety disorders, psychotic disorders, and substance use disorders. This course intends to be a one-stop shop for those who intend to receive the most up-to-date information on these psychiatric disorders in late life. This course will be taught by award-winning geriatric psychiatrists who have expertise in the teaching courses in geriatric psychiatry.

Course Level: Basic

C0328**Interpersonal Psychotherapy**

Director: John C. Markowitz, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the basic rationale and techniques of interpersonal psychotherapy for depression; 2) Understand key research validating its use; and 3) 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 1970s to treat outpatients with major depression. Its strategies help patients understand links between environmental stressors and the onset of their mood disorder and to explore practical options to achieve desired goals. IPT has had impressive research success in controlled clinical trials for acute depression, prophylaxis of recurrent depression, and other Axis I disorders such as bulimia. It may also benefit patients with PTSD. This course, now in its 22nd consecutive year at the APA Annual Meeting, presents the theory, structure, and clinical techniques of IPT along with some of the research 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 that 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 Level: Intermediate

C0357**Buprenorphine and Office-Based Treatment of Opioid Use Disorder**

Director: Petros Levounis, M.D.

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Physicians who complete this course will be eligible to request a waiver to practice medication-assisted addiction therapy with buprenorphine for the treatment of opioid use disorder. The course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder and review: 1) DSM-5 criteria for OUD and the commonly accepted criteria for patients appropriate for office-based treatment of OUD, 2) confidentiality rules related to treatment of substance use disorders, DEA requirements for recordkeeping, and billing and common office procedures, 3) the epidemiology, symptoms, and current treatment of anxiety, common depressive disorders, ADHD, and how to distinguish independent disorders from substance-induced psychiatric disorders, and 4) common clinical events associated with addictive behavior. Special treatment populations, including adolescents, geriatric patients, pregnant addicts, HIV-positive patients, and chronic-pain patients will be addressed, and small-group case discussions will be used to reinforce learning.

Course Level: Basic

C0392

Conversion Disorder: Update on Evaluation and Management

Director: Gaston Baslet, M.D.

Faculty: John J. Barry, M.D.; W. Curt LaFrance, M.D., M.P.H.; Adriana Bermeo-Ovalle, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Perform a clinical evaluation in patients with conversion disorder, in collaboration with a neurologist; 2) Communicate the diagnosis to the patient, his/her family and the collaborating physician in a way that reinforces engagement in treatment; 3) Recommend, seek advice or execute the most appropriate treatment plan based on the current evidence from the medical literature; and 4) Understand the complexity and heterogeneity of this population, and recognize various modifiable risk factors that should be considered targets for treatment.

SUMMARY:

Conversion Disorder (also named Functional Neurological Symptom Disorder in DSM-5) is diagnosed in a sizable proportion of patients seen in neurological practice. Treatment as usual involves referral to a mental health professional, including psychiatrists. During the last decade there has been increased interest in the development of treatment options for this disorder, yet clear guidelines for the management of this complex population do not exist. This course will review the role of the psychiatrist during the diagnosis and management of patients with Conversion Disorder. We will provide an overview of our current understanding of the risk factors and pathogenic models of this disorder. These include biological and psychosocial etiologic factors. The course will focus on practical interventions including guidelines for a comprehensive initial psychiatric evaluation. The effective communication of the diagnosis to patients, families, and collaborating providers is crucial. We will discuss the different stages of treatment including engagement, evidence-based short-term interventions, and strategies for the long-term treatment of patients suffering from Conversion Disorders. The course will emphasize how to collaborate with the

multitude of disciplines involved in the care of these patients. This will be facilitated by including speakers from neurology and neuropsychiatry who possess a wealth of clinical experience with the evaluation and treatment of these patients. We will present illustrative cases showcasing the complexity and heterogeneity of patients with Conversion Disorder.

Course Level: Basic

C1691

ADHD in Adults: From Clinical Science to Clinical Practice

Director: Craig Surman, M.D.

Faculty: Paul Hammerness, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify when it is appropriate to diagnose ADHD; 2) Apply efficient methods for assessing ADHD symptoms and impairment; 3) Practice methods of personalizing treatment for ADHD patients, including optimal pharmacologic and non-pharmacologic supports; 4) Recognize the evidence, and limits of that evidence, for pharmacologic and non-pharmacologic therapies; and 5) Apply principles for managing common complex presentations, including patients with non-attention executive function deficits, mood disorders, anxiety disorders, and substance abuse disorders.

SUMMARY:

ADHD impacts 4% of adults and is often accompanied by other clinical concerns in adult patients, including other mental health diagnoses, and varying forms of organizational challenges. This program will emphasize the implications, and limits, of clinical research for approaching ADHD, including complex presentations. The presenters will model strategies for identifying ADHD, creating treatment goals, and optimizing a plan to apply available medication and behavioral therapy resources. Cases will be discussed with the audience as a basis for exploring the principles and thought process for optimizing personalized care.

Course Level: Intermediate

C0346

Treatment of Schizophrenia

Director: Philip Janicak, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the psychopathological dimensions, recent DSM-5 diagnostic criteria and neurobiological underpinnings of schizophrenia. 2) Appreciate the growing emphasis on early recognition and interventions to favorably alter the prognosis of high-risk individuals. 3) Describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics, as well as novel therapies. 4) Better understand the efficacy, safety and tolerability of antipsychotics when used for acute and long-term management of schizophrenia. 5) Describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs.

SUMMARY:

The treatment of schizophrenia and related psychotic disorders is rapidly evolving. There are now 10 second-generation antipsychotics available in various formulations (i.e., clozapine, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, iloperidone, paliperidone, asenapine, lurasidone). Further, there is a growing focus on early identification (e.g., high-risk individuals) and appropriate interventions to favorably alter one's long-term prognosis. The relative effectiveness of antipsychotics is also an important issue (e.g., the CATIE and CUTLASS trials) and continues to be clarified. Increasingly, novel pharmacological and nonpharmacological strategies are being tested to improve cognition, mood, and negative symptoms as well as safety and tolerability. The integration of cognitive therapeutic approaches, psychosocial interventions, and rehabilitation programs with medication is critical to improving long-term outcomes (i.e., recovery). As our understanding of the neurobiology and psychopathology of schizophrenia progresses, it will guide the development of future, more effective therapies for acute and maintenance strategies.

Course Level: Basic

C0831

Evidence Based Psychodynamic Therapy: A Clinician's Workshop

Director: Richard Summers, M.D.

Faculty: Jacques P. Barber, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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 Level: Intermediate

C1658

Essentials of Assessing and Treating ADHD in Adults and Children

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Once understood as a disruptive behavior of childhood, ADHD is now recognized as developmental impairment of the brain's executive functions. Although initial diagnosis of ADHD is usually in childhood or adolescence, many individuals do not recognize their ADHD impairments until they encounter 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 interventions into a multimodal treatment plan tailored for specific adults and/or children or adolescents with ADHD.

Course Level: Basic

C1721 Integrating Behavioral Health and Primary Care: Practical Skills for the Consulting Psychiatrist

Director: Anna Ratzliff, M.D., Ph.D.

*Faculty: Lori Raney, M.D.; Robert Hilt, M.D.;
John Kern, M.D.; Jurgen Unutzer, M.D., M.P.H.*

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

Course Level: Basic

C0260

A Psychiatrist's Guide to Patients with Severe Obesity: Assessment and Beyond

Director: Sanjeev Sockalingam, M.D.

Faculty: Stephanie Cassin, Ph.D.; Timothy Jackson, M.D., M.P.H.; Jessica Van Exan, Ph.D.; Katie Warwick, B.Sc.; Raed Hawa, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe predisposing psychosocial factors to obesity and psychiatrists' role in medical and surgical interventions for weight loss; 2) Identify patient characteristics pre-bariatric surgery that inform patients' post-surgery psychosocial interventions; and 3) Apply psychopharmacology protocols and brief psychological interventions that improve psychiatric care after massive weight loss.

SUMMARY:

Due to the obesity epidemic in North America and bidirectional relationship between obesity and mental illness, psychiatrists are now considered integral to the management of severe obesity in hospital and community-based settings. Furthermore, bariatric surgery, an effective and growing treatment for severe obesity, has resulted in more psychiatrists involved in pre- and postsurgery patient care. Nearly 60%-70% of severely obese individuals have a history of a psychiatric illness, and treatments such as bariatric surgery may precipitate additional psychopathology, such as cross-addictive behaviors and eating psychopathology. Many patients have iatrogenic metabolic disturbance and weight gain from psychotropic medications requiring further reassessment and monitoring in the context of obesity interventions. Further, psychiatric assessment is now a requirement prior to bariatric surgery by insurers and recommended in best-practice guidelines. Therefore, psychiatrists are expected to have an array of skills to manage behavioral, relational, and psychiatric aspects of severe obesity management while also having an understanding of the armamentarium of medical and surgical obesity treatment options. This course is aimed at psychiatrists and other mental health care providers who are caring for severely obese patients. The course outline will include presentations by an interprofessional

team working within the University of Toronto Bariatric Surgery Collaborative, a American College of Surgeons Level 1A-certified Centre of Excellence. Dr. Jackson (bariatric surgeon) will present on the obesity epidemic and current state of obesity management interventions available for severe obesity. Ms. Warwick (bariatric dietitian) will provide participants with an update on diet interventions in obesity management to assist psychiatrists in clinical practice and will provide an overview of neuropsychiatric complications related to nutritional deficiencies due to severe weight loss. Dr. Hawa (psychiatrist and sleep medicine specialist) will provide an approach to assessing psychiatric readiness for weight loss procedures and will discuss evidence-based assessment tools for surgery and for sleep in obese patients, specifically sleep apnea. Dr. Sockalingam (psychiatrist) will review common postoperative complications related to severe weight loss including impact on mood disorders, problematic alcohol use (cross-addiction), suicide risk, body image issues and psychopharmacological issues postsurgery. Dr. Van Exan (psychologist) focuses exclusively on the differential diagnosis for eating psychopathology in severe obesity, including a discussion of DSM-5 eating disorders in obese patients. Lastly, Dr. Cassin (psychologist) will provide practical approaches to integrating motivational interviewing and CBT as part of psychosocial care of patients undergoing weight loss interventions. Psychosocial screening tools and protocols will be shared.

Course Level: Basic

C0369

Late Life Mood Disorders: Achieving Accurate Diagnosis and Effective Treatment

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

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the varied and sometimes obscure presentations of late life mood disorders (unipolar and bipolar) and describe an organized approach to differential diagnosis and treatment; 2) List and describe

evidence-based approaches to psychotherapy of late life mood disorders including the newly developed ENGAGE protocol; 3) Plan and implement an evidence-based treatment program for late life mood disorders, integrating psychosocial and somatic therapies; and 4) Explain the complex and reciprocal relationship between late life mood disorders and cognitive impairment.

SUMMARY:

In light of the unprecedented growth of our aging population, clinicians need to understand diagnostic assessment and effective treatment of late-life mood disorders. These debilitating syndromes are widespread and disabling among older adults but very treatable through the use of standard and newer approaches drawing on psychosocial and somatic therapies. This course provides an interdisciplinary overview of late-life mood disorders emphasizing a biopsychosocial approach. The attendee will acquire an organized approach to assessment and a systematic and evidence-based approach to treatment planning incorporating both psychotherapeutic and somatic interventions. In addition, the attendee will learn to distinguish among the cognitive symptoms associated with mood disorders, the cognitive changes associated with normal aging, and the impairments associated with Major Neurocognitive Disorder. The discussion of psychotherapy for older adults with mood disorders will review evidence-based approaches with particular emphasis on Cognitive Behavior Therapy, Interpersonal Therapy, and Problem-Solving Therapy. The newly developed ENGAGE protocol will also be described. The discussion of somatic approaches will include a discussion of the syndrome of Vascular Depression and describe an approach to treating resistant disorders. The faculty will lecture, using illustrative slides, and there will be ample time for interactive discussion. This course is designed primarily for general psychiatrists seeking greater understanding and expertise in treating older patients. For psychiatric residents and fellows, it will provide an advanced introduction. For geriatric psychiatrists, it will provide a review and update. It will be of greatest practical value to attendees who already possess a basic familiarity with principles of pharmacotherapy and psychotherapy.

Course Level: Intermediate

C0471

Mentalization Based Treatment for Borderline Personality Disorder

Director: Anthony Bateman, M.D.

Faculty: Peter Fonagy, Ph.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, and reasons). We mentalize interactively and emotionally when with others. Each person has the other person's mind in mind (as well as his or her own), leading to self-awareness and other awareness. We have to be able to continue to do this in the midst of emotional states, but BPD is characterized by a loss of capacity to mentalize when emotionally charged attachment relationships are stimulated. The aim of MBT is to increase this capacity to ensure the development of better regulation of affective states and to increase interpersonal and social function. In this course we will consider and practice interventions that promote mentalizing, contrasting them with those that are likely to reduce mentalizing. Participants will become aware of which of their current therapeutic interventions promote mentalizing. The most important aspect of MBT is the therapeutic stance. Video and role plays will be used to ensure participants recognize the stance and can use it in their everyday practice. Small-group work will be used to practice basic mentalizing interventions described in the manual. In research trials MBT has been shown to be more effective than treatment as usual in the context of a partial hospital program both at the end of treatment and at eight-year follow-up. A trial of MBT in an

outpatient setting has also been completed. This shows effectiveness when applied by nonspecialist practitioners. Independent replication of effectiveness of MBT has been shown in cohort studies, and additional randomized controlled trials are in progress. The course will therefore provide practitioners with information about an evidence-based treatment for BPD, present them with an understanding of mentalizing problems as a core component of BPD, equip them with clinical skills that promote mentalizing, and help them recognize nonmentalizing interventions.

Course Level: Intermediate

C0672

Melatonin and Light Treatment of SAD, Sleep and Other Body Clock Disorders

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

This course will enable practitioners to advise patients on how to use melatonin and bright light to treat circadian sleep and mood disorders. There are two categories for these disorders: phase advanced and phase delayed. The prototypical patient with SAD (seasonal affective disorder, or winter depression) is phase delayed; however, some are phase advanced (Lewy et al., PNAS, March 9, 2006). Shift work maladaptation, nonseasonal major depressive disorder (Emens, Lewy et al., Psychiatry Res., Aug. 15, 2009), and ADHD can also be individually phase typed and then treated with a phase-resetting agent at the appropriate time. Phase-advanced disorders are treated with evening bright light exposure and/or low-dose (0.5 mg) morning

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

Course Level: Basic

Sunday, May 17, 2015

C0169

Evaluation and Treatment of Behavioral Emergencies

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

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand goals of emergency triage and medical assessment for the psychiatric patient; 2) Complete an emergency psychiatric evaluation and perform a comprehensive risk assessment; 3) Manage and treat the agitated patient with both de-escalation techniques and medications; and 4) Create alliances with patients and families in crisis.

SUMMARY:

Behavioral emergencies may occur in any setting - outpatient, inpatient, emergency departments, and in the community. When psychiatric emergencies do occur, psychiatrists should be prepared to deal with surrounding clinical and system issues. One of the most important challenges is the initial assessment and management of a psychiatric crisis/emergency. This includes differentiating a clinical emergency from a social emergency. This 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 course faculty will delve into when laboratory or other studies may be necessary and note instances when this information does not change treatment course. Tools, such as protocols, to aid in collaboration with the emergency physician will be examined. The art of creating alliances and tools for engaging the crisis patient will be discussed. The participants will also learn about the management of agitation (de-escalation and medication use) 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 faculty includes psychiatrists and an emergency medicine physician to help provide various viewpoints and allow for rich discussion.

Course Level: Basic

C0390**Good Psychiatric Management (GPM) for Borderline Personality Disorder (BPD): What Every Psychiatrist Should Know**

Director: John Gunderson, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the diagnosis to patients and families and establish reasonable expectations for change (psychoeducation); 2) Manage the problem of

recurrent suicidality and self-harm while limiting personal burden and liability; 3) Expedite alliance-building via use of medications and homework; and 4) Know when to prioritize BPD's treatment and when to defer until a comorbid disorder is resolved.

SUMMARY:

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 psychiatrist's concerns and limitations are explicit. Techniques and interventions that facilitate the patient's trust and willingness to become a proactive collaborator will be described. Guidelines for managing the common and usually most burdensome issues of managing suicidality and self-harm (e.g., intersession crises, threats as a call for help, excessive use of ERs or hospitals) will be reviewed. How and when psychiatrists can usefully integrate group, family, or other psychotherapies will be described.

Course Level: Basic

C1407**Management of the Cognitive and Neuropsychiatric Symptoms of Dementia**

Director: Mark Rapoport, M.D.

Faculty: Nathan Herrmann, M.D.; Andrew Wiens, M.D.; Tarek Rajji, M.D.; Dallas Seitz, M.D., Ph.D.; Zahinoor Ismail, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Develop an approach to the diagnosis of dementia, including the flexible use of bedside cognitive testing; 2) Understand the latest evidence for pharmacological management of the cognitive and neuropsychiatric symptoms in dementia, and appreciate tools for implementing the evidence in practice; and 3) Learn about non-pharmacological strategies for treating neuropsychiatric symptoms in dementia and develop an approach to assessing and advising about risks associated with driving in dementia.

SUMMARY:

As the population ages and the prevalence of dementia climbs, general psychiatrists are increasingly called upon to assess and manage older patients with Alzheimer's disease and other dementias. Six psychiatrists from the Canadian Academy of Geriatric Psychiatry have assembled a course to present a practical evidence-based approach to the diagnosis and management of dementia. The use of the cognitive examination for screening and diagnosis will be presented, and a comprehensive approach to the differential diagnosis of dementia will be outlined. The pharmacological treatment of cognitive impairment in dementia will be described, and the pharmacological treatment of neuropsychiatric complications in dementia will be discussed. Nonpharmacological approaches to the treatment of neuropsychiatric symptoms in dementia will be reviewed, and an approach to assessing the risks posed by older drivers with dementia will be discussed.

Course Level: Intermediate

C2350**Street Drugs and Mental Disorders: Overview and Treatment of Dual Diagnosis Patients**

Director: John W. Tsuang, M.D.

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

According to the ECA, 50 percent of general psychiatric patients suffer from a substance abuse disorder. These patients, so-called dual-diagnosis patients, are extremely difficult to treat, and they are big utilizers of public health services. This course is designed to familiarize participants with diagnosis and state-of-the-art treatment for dual- diagnosis patients. We will

first review the different substance of abuse, including club drugs, and their psychiatric manifestations. The epidemiological data from the ECA study for dual-diagnosis patients will be presented. Issues and difficulties relating to the treatment of dual- diagnosis patients will be stressed. The available pharmacological agents for treatment of dual- diagnosis patients and medication treatment for substance dependence will be covered. Additionally, participants will learn the harm reduction versus the abstinence model for dual-diagnosis patients.

Course Level: Basic

C0315**Transgender and Intersex for the Practicing Psychiatrist**

Director: William Byne, M.D., Ph.D.

Faculty: Jack Pula, M.D.; Richard Pleak, M.D.; A. Evan Eyler, M.D.,M.P.H.; Dan Karasic, M.D.; Heino Meyer-Bahlburg, Ph.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

Transgender people are sufficiently common that even psychiatrists whose practice does not

focus on gender variance encounter patients who are transitioning gender or contemplating gender transition. On the other hand, transgender and other gender-variant people are perceived to be too uncommon in the population for prioritization of their clinical needs in the curricula of medical school and psychiatric residency training programs. This applies even more so to individuals with somatic intersexuality, although they often have great needs for mental health services beginning at the time of medical diagnosis. This course will provide psychiatrists and other mental health professionals with the tools needed to deliver respectful, culturally competent and up-to-date mental health care to gender-variant patients, including those with somatic intersex conditions. An emphasis will be placed on those who are, or who are contemplating, transitioning gender. While the program will provide a useful general overview and roadmap for psychiatrists and other health professionals new to treating gender-variant patients, it will also provide an update for psychiatrists, residents, medical students, nurses, and clinical social workers who are already experienced in working with gender-variant individuals. The following areas will be addressed: 1) The evolution of concepts of gender, gender variance, and associated terminology; 2) The evolution of medical approaches to gender variance including the changing roles of mental health professionals in transgender health care as reflected in successive versions of the World Professional Association for Transgender Health Standards of Care (WPATH SOC) and the emergence of informed consent models; 3) Common child and adolescent presentations; evaluation of gender variant youth; assessment and management of coexisting psychopathology in minors; treatment options, including pubertal suppression; persistence and desistence of gender dysphoria of childhood; and family concerns; 4) Common adult presentations; the process of gender transition and other options for authentic gender expression; assessment and management of concurrent psychiatric illness, and stage of life concerns; 5) Mental health assessments for initiation of treatment with cross-sex hormones and gender-affirming surgery; 6) Complex presentations, nonbinary gender identities, and the role of the mental health professional in alternative models of treatment; 7) Presentations, evaluation, and

management of gender dysphoria in patients with somatic intersexuality; 8) Recent policy changes that impact access to transgender health services including those of the Affordable Care Act, the Department of Health and Human Services, Medicare, and the Veterans Health Administration.

Course Level: Basic

C0649

Sleep Medicine - A Review and Update for Psychiatrists

Director: Thomas Hurwitz, M.D

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

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

of parasomnias will describe behavioral disorders of sleep that can be mistaken for nocturnal manifestations of psychiatric disorders. The course will close with a discussion of sleep disorders associated with various psychiatric disorders.

Course Level: Basic

C0867

Dialectical Behavior Therapy for Psychiatrists: Using DBT Strategies in Your Psychotherapy and Psychopharmacological Practice

Director: Beth Brodsky, Ph.D.

Faculty: Barbara Stanley, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use DBT interventions for outpatient management of suicidal and nonsuicidal self-injurious behaviors and medication management particularly for patients with borderline personality disorder (BPD); 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, nonsuicidal 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 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 Level: Intermediate

C1020

Practical Assessment and Treatment of Behavior Disturbance in Patients with Moderate to Severe Dementia

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

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Have a working knowledge of how to assess and differentiate between varying types of dementia and delirium; 2) List common causes of delirium in the elderly and identify high risk factors, causes, and prevention strategies; 3) Understand the current literature and practical applications of current pharmacological and non-pharmacological interventions for people with dementia; 4) Describe evidence based treatment for effective symptom management of behaviors in common types of dementia; and 5) Recognize and encourage use of appropriate interventions to improve the quality of life in those with advanced dementia.

SUMMARY:

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

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

Course Level: Intermediate

C1595

Radically Open Dialectical Behavior Therapy (RO-DBT) for Disorders of Overcontrol: Remembering our Tribal Nature

Director: Thomas R. Lynch, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) 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) Introduced to new approaches for engaging and maintaining OC client's in therapy, manage therapeutic alliance-ruptures, and develop individualized treatment targets for OC; and 3) Learn skills to activate specific neural substrates by directly activating its antagonistic autonomic nervous system - in particular the ventral vagal complex linked to social-safety.

SUMMARY:

Radically Open Dialectical Behavior Therapy (RO-DBT) is a new transdiagnostic treatment targeting a spectrum of disorders characterized by emotional OC - such as refractory depression, anorexia nervosa and obsessive-compulsive personality disorder. Efficacy is supported by two randomized controlled trials (RCTs) targeting refractory depression, one nonrandomized trial targeting treatment-resistant overcontrolled adults, two open-trials

targeting adult anorexia nervosa, and an ongoing multicenter RCT (www.reframed.org.uk). RO-DBT does not believe one size fits all. Reflecting NIMH RDoC initiatives, RO-DBT posits that core genotypic/phenotypic differences between groups of disorders necessitate oftentimes vastly different treatment approaches. A novel mechanism linking the communicative functions of emotional expression to the formation of close social bonds and new skills activating neural substrates associated with social safety and cooperative social signaling targeting emotional loneliness will be introduced.

Course Level: Intermediate

C2361

Yoga of the East and West Experiential for Stress, Anxiety, PTSD, Mass Disasters, Military, Schizophrenia, and Stress-Related Medical Conditions

Director: Patricia L. Gerbarg, M.D.

Faculty: Richard Brown, M.D.; Beth Abrams, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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) Identify patients who could benefit from voluntarily regulated breathing practices, determine when to introduce this option, and be able to discuss this treatment augmentation with patients; 3) Experience Coherent Breathing and 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 nonreligious practices, participants will experience VRBPs, including Coherent Breathing, Breath Moving, 'Ha' Breath, 4-4-6-2 Breath with Movement, and healing sounds. They will also experience Qigong-based movements, Open Focus attention training, and meditation. Through repeated rounds of movement, breathing, and meditation 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, depression, PTSD, military trauma, ADHD, schizophrenia, pain, and stress-related medical conditions. A study of these practices in schizophrenic patients showing cognitive improvements and genomic changes 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 PTSD, including disconnection syndrome, will be explored from the perspective of neuroscience, polyvagal theory, the vagal-GABA theory of inhibition, and neuro- endocrine response. This will also highlight clinical issues to consider when introducing mind-body practices in treatment. This course is suitable for novices as well as experienced practitioners.

Course Level: Intermediate

Monday, May 18, 2015

C0229

Identifying and Helping Older Adults with Mild Neurocognitive Disorders

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

Faculty: Courtney Carroll Spilker, Psy.D.; Donald Davidoff, Ph.D.; David Hsu, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the spectrum of cognitive changes that accompany normal aging, subjective cognitive impairment, and mild neurocognitive disorder; 2) Recommend health-promoting interventions for

a person with mild cognitive changes, taking into account lifestyle factors, medical issues, physical activity, social activity, and cognitive stimulation; and 3) Help caregivers to optimize their support for a person with mild cognitive decline.

SUMMARY:

Longer survival and more effective management of chronic medical diseases means we are facing an epidemic of cognitive impairment in our aging population. Psychiatrists are in a position to lead health care providers in preventing, delaying, or mitigating cognitive decline. Behavioral health clinicians can lead the way in earlier detection of cognitive impairment, effective intervention, and support of caregivers helping people with the full spectrum of cognitive difficulties. In this course, we will focus on the spectrum of cognitive changes that ranges from the expected consequences of normal aging to the more distressing experience of people with subjective cognitive impairment and the objectively impaired functioning of those with mild neurocognitive disorder. We will discuss the early detection and identification of these syndromes. We will review the medical factors that can impair cognition with emphasis on those that can be reversed. We will outline a systematic approach to neurocognitive assessment including the use of input from neuropsychology and neuroimaging. We will discuss the lifestyle choices that can delay or prevent cognitive decline, focusing on physical activity, cognitive stimulation, nutrition, social engagement, medical disease management, and restorative sleep. Finally, we will discuss how caregivers of individuals with mild cognitive decline can be supported. This course will be taught through integrated lectures, discussion of illustrative case vignettes, and time for questions and discussion with attendees.

Course Level: Intermediate

C0629

Teaching Psychotherapy? Let Hollywood (and Cable TV) Help!

Director: Steven Hylar, M.D.

Faculty: Prameet Singh, M.D.; Rachna Kenia, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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) View scenes from multiple vantage points and consider therapeutic technique, psychopathology, diagnostic issues, controversies, as well as popular cultural issues; and 3) Learn how to find an appropriate film or TV clip to illustrate just about any aspect of the therapy.

SUMMARY:

The film industry has, almost since its inception, shown a fascination for portraying the emotionally disturbed and those who treat them. The purpose of this course is to familiarize the course participants with readily available commercial film and TV clips so as to use them as adjunctive teaching aides that illustrate various aspects of the therapy process. 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 Level: Basic

C0783

Transference-Focused Psychotherapy for Narcissistic Personality Disorder

Director: Frank Yeomans, M.D., Ph.D.

Faculty: Otto F. Kernberg, M.D.; Eve Caligor, M.D.; Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate and to understand the range of narcissistic pathology; 2) Understand the psychological structure referred to as the pathological grandiose self and its role as the core of narcissistic personality disorder; 3) Understand treatment techniques that address narcissistic resistances and help engage the patient in therapy and in the process of looking beyond his or her rigid narcissistic stance; and 4) Learn treatment techniques that help the patient and therapist 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 countertransference feelings of being incompetent, bored, disparaged, and dismissed, or, at the other extreme, massively and unnervingly idealized. This course will present a framework for conceptualizing, identifying, and treating individuals diagnosed with narcissistic personality disorder (NPD) or with significant narcissistic features. Narcissism encompasses normative strivings for perfection, mastery, and wholeness as well as pathological and defensive distortions of these strivings. Such pathological distortions may present overtly in the form of grandiosity, exploitation of others, retreat to omnipotence or denial of dependency, or covertly in the form of self-effacement, inhibition, and chronic, extreme narcissistic vulnerability. Adding to the difficulties in diagnosing and treating narcissistic disorders is the fact that they can manifest themselves in multiple presentations depending on the level of personality organization, subtype, or activated mental state. In this course we will review the levels of narcissistic pathology. We will go on to discuss a specific theoretical and clinical formulation of narcissism and a manualized psychodynamic psychotherapy, transference focused psychotherapy (TFP), that has been modified to

treat patients with narcissistic disorders. We will review therapeutic modifications that can help clinicians connect with and treat patients with narcissistic pathology at different levels.

Course Level: Basic

C1661

Advanced Assessment & Treatment of ADHD

Director: Thomas E. Brown, Ph.D.

Faculty: Anthony Rostain, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Explain the new model of ADHD as developmental impairment of executive functions and its implications for assessment and treatment; 2) Describe research that supports this new model of ADHD; 3) Utilize research-based criteria to select and fine-tune medications for ADHD, modifying as needed for various comorbid disorders; 4) Design and monitor treatment for patients with ADHD that utilizes effective integrated medication and psychosocial approaches; and 5) Consider strategies for effective treatment of ADHD complicated by other medical or psychosocial problems.

SUMMARY:

This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and have mastered basic concepts and skills for treatment of this disorder. It will discuss implications of the new model of ADHD as developmental impairment of executive function, highlighting research that supports this model and describing implications for assessment and treatment. A revised model of ADHD comorbidities will be described. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by bipolar disorder, substance abuse, learning disorders, OCD, anxiety disorders or Autism Spectrum 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 Level: Advanced

C2338**ECT Practice Update for the General Psychiatrist**

Director: Peter B. Rosenquist, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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 Level: Basic

C2340**Exploring Technologies in Psychiatry**

Director: John Luo, M.D.

Faculty: Robert Kennedy, M.A.; Carlyle Chan, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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 health care management, there are many ways and reasons to connect. The movement toward digitizing health care information is making the numerous apps and mobile devices a great way to integrate and streamline all aspects of the medical process for enhanced care. This course will explore many of the ways that clinicians can use technology to manage and improve their practice, 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 medical records, privacy and security. This course is not intended for novices. It will get the experienced computer user up to speed on cutting edge technologies, practice trends and technologies that will impact the profession over the next decade.

Course Level: Intermediate

C0433

Psychodynamic Psychopharmacology: Applying Practical Psychodynamics to Improve Pharmacologic Outcomes With Treatment Resistant Patients

Director: David Mintz, M.D.

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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, the techniques of psychodynamic psychopharmacology inform prescribers about 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 Level: Intermediate

C1557

Autism Spectrum Disorders: Diagnostic Considerations, Genetic Research, and Treatment Review

Director: Alice Mao, M.D.

Faculty: Jennifer Yen, M.D.; Matthew Brams, M.D.; Stephanie Hamarman, M.D.; Oscar Bukstein, M.D., M.P.H.; Julie Chilton, M.D.; Christian Marshall, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Provide a review of advances in genetic, behavioral/educational interventions, and pharmacological interventions for children with autism; 2) Increase awareness of the multiple domains in diagnosis and treatment that will

help the child and adolescent or general psychiatrist to develop a realistic plan for helping their patient with ASD; and 3) Review current research advances in autism, as well as discuss the impact of future directions of study on diagnosis and treatment.

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 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, behavioral/ educational interventions and pharmacological interventions for children with autism. Increased awareness of the multiple domains that diagnosis and treatment can encompass will help the child and adolescent psychiatrist to develop a realistic plan for helping their patient with ASD to achieve optimum functioning and adaptive life skills. Obstacles to achieving appropriate care because of parental denial, lack of information and limited financial resources will be identified. The importance of providing support to the parents or caretakers of children with autism in order to help them navigate through often conflicting and confusing treatment recommendations will be discussed. This autism course will review clinical translational research and then help the clinician to integrate psychopharmacologic, behavioral

and educational interventions for individuals with ASD through the lifespan.

Course Level: Intermediate

C1141

Evaluation and Treatment of Sexual Dysfunctions

Director: Waguih W. IsHak, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

Course Level: Intermediate

C2062

Motivational Interviewing for the Routine Practice of Psychiatry

Director: Steven Cole, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the three questions and five skills of Brief Action Planning (B.A.P.); 2) Explain how B.A.P. aligns with the core processes and 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 eight 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 1,000 publications and 200 clinical trials, 1,500 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 and technique, '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 three core questions and five 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 Level: Basic

Tuesday, May 19, 2015

C0186

Restoring Professionalism: Integrating Body and Mind, Heart and Soul for Distressed Physicians

Director: Alistair Finlayson, M.D.

Faculty: Linda L. M. Worley, M.D.; William Swiggart, M.S.; Ron Neufeld, B.A., B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the reasons why physicians may be referred for comprehensive fitness-for-duty evaluations, the common diagnoses made and the remedial recommendations that are offered; 2) Identify and practice specific strategies and techniques to restore resilience and help physicians to avoid trouble with medical boards and colleges; and 3) Self-evaluate their individual Flooding Score and have practiced at least one grounding skill.

SUMMARY:

Medical Boards or Colleges, physician health programs, hospitals and practice groups often seek consultation in dealing with problematic physician behaviors that threaten patient safety or interfere with optimal functioning of clinical teams. This course will present findings from comprehensive evaluations of over 500 physicians and describe continuing education programs developed to educate over 1,000 physicians with behavior problems that involved prescribing improperly, violating boundaries and distressing clinical teams. Participants will review the 360 feedback tool that is used to evaluate professional interactions as a way to reinforce and augment change. They will participate in experiential exercises such as the flooding test, some grounding exercises, and DRAN concepts. Available outcome data, including follow up 360 feedback data will be presented and discussed.

Course Level: Intermediate

C0520

The Clinical Assessment of Malingered Mental Illness

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVES:

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

SUMMARY:

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

C0370

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 OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe evidence that psychosocial factors play a role in the cause and effective treatment of treatment resistant mood disorders; 2) Explain the contribution to treatment resistance of personality disorders, including immature defenses like splitting; 3) Define the practice of 'psychodynamic psychopharmacology' and explain its role in effective treatment of treatment resistant mood disorders; and 4) Utilize specific psychodynamic principles to improve outcomes in patients with treatment resistant mood disorders.

SUMMARY:

Although algorithms help psychiatrists select biological treatments for patients with treatment resistant mood disorders, the subset of patients with early adverse experiences and comorbid personality disorders often fails to respond to medications alone. These treatments frequently become chronic crisis management, with high risk of suicide. This course describes a comprehensive approach to this subset of treatment resistant patients derived from longitudinal study of patients in extended treatment at the Austen Riggs Center. The course offers an overview of psychoanalytic object relations theory to facilitate an understanding of how immature defenses may lead to treatment resistance. Ten psychodynamic principles extracted from study

of successful treatments are presented and illustrated with case examples. Among these are listening beneath symptoms for therapeutic stories, putting unavailable 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 the conduct of psychotherapy, but also guides adjunctive family work, helps integrate the psychopharmacologic approach and maximizes medication compliance. Time will be included to allow course participants to discuss their own cases, as well as the case material offered by the presenters. The course is designed to help practitioners improve outcomes with these patients.

Course Level: Basic

C2767

Neuropsychiatric Masquerades: Medical and Neurological Disorders That Present With Psychiatric Symptoms

Director: José R. Maldonado, M.D.

Faculty: Yelizaveta Sher, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this 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 porphyria), to infectious diseases (e.g. syphilis, herpes and HIV), to autoimmune disorders (e.g. SLE, MS), to malignancies (e.g., paraneoplastic syndromes and pancreatic cancer), to neurological disorders (e.g. seizure disorders, NPH, dementia and delirium). In this course, we will discuss the presentation and symptoms of the most common masquerades, focusing on pearls for timely diagnosis, and discuss potential management and treatment strategies.

Course Level: Advanced

FOCUS LIVE

MAY 18, 2015

FOCUS LIVE! PSYCHOPHARMACOLOGY

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

Speakers: Carol A. Tamminga, M.D., Ana Stan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) This FOCUS LIVE session will assist clinicians in testing their knowledge and in staying current regarding psychopharmacology and psychopharmacology treatment of mental disorders; 2) Answer board-type questions designed to increase their knowledge and help them identify areas where they might benefit from further study; and 3) Relate multiple choice question-based learning to their general knowledge of the topic and to their own patient care strategies.

SUMMARY:

It is fortunate that treatments for serious mental illnesses continue to accrue, providing new pharmacologic and other biological treatments to support clinical care in areas of high medical need. How to utilize these new treatments to their fullest is a critical topic for practicing physicians. This multiple choice question-and-answer presentation focuses on information that is important to practicing general psychiatrists in the treatment of disorders such as schizophrenia, major depressive disorder, depression and mixed state in bipolar II disorder and anxiety disorders. 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.

Literature References
FOCUS: Psychopharmacology: Evidence and Treatments: Volume 12 Issue 2, January 2014
Stan AD, Tamminga CA; New options for the treatment of schizophrenia: a clinical review of the three most recent antipsychotic drugs.
FOCUS 2014 12(2) 127-135

FOCUS LIVE! SLEEP DISORDERS

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

Speaker: Karl Doghramji, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to 1) This FOCUS LIVE session will assist clinicians in testing their knowledge and in staying current regarding clinical and diagnostic aspects of sleep 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; and 3) Understand treatment strategies and evidence and relate multiple choice question based learning to their own patient care.

SUMMARY:

This FOCUS LIVE session presents an update and review of major developments in our understanding and management of sleep disorders, with an emphasis on those disorders that are commonly confronted by psychiatrists and other mental health practitioners. A staggering one-third of all humans are affected by sleep disorders. A variety of cognitive/behavioral and pharmacological management techniques are available to treat the sleep disorders that can coexist with a variety of medical and psychiatric disorders. Sleep-related complaints are also disproportionately high in prevalence in psychiatric practice, and are actively expressed by patients suffering from almost all major psychiatric conditions. Proper identification, clinical evaluation, and effective management of sleep disorders are, therefore, of significant importance for psychiatrists. In This FOCUS LIVE session Karl Doghramji 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.

Doghramji K. Recent advances in the understanding of insomnia. FOCUS 2014; 12(1) 3-8

MAY 19, 2015

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

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

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

which instantly presents the audience responses as a histogram on the screen.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

Using Audience Response System technology, this multiple choice question based discussion will review evidence for off label use of atypical antipsychotics.

In 2011, the Agency for Healthcare Quality and Research (AHRQ) published a comprehensive report, Off-Label Use of Atypical Antipsychotics: An Update, Comparative Effectiveness Review No. 43 (1) summarizing the evidence for off-label use of antipsychotics for treatment of mental disorders. As described in the report, prescribing of atypical antipsychotics has moved beyond approved indications; however, the effectiveness, benefits, and adverse effects in off-label uses are not well understood. This session is supported in part by a grant from the Agency for Healthcare Research and Quality (R18 HS021944), to disseminate the conclusions of the AHRQ report and to update clinicians about new developments regarding the evidence.

Overall, a class effect of the atypical antipsychotics for each disorder cannot be assumed, and for most atypicals, adequate supporting evidence for either efficacy or comparative effectiveness is still lacking for many indications. The study of the evidence provided in this program will assist the physician in making informed decisions and provide a foundation for discussions with patients about the risks and benefits of this class of medications.

In This FOCUS LIVE session expert clinicians will lead a lively multiple choice question-based discussion. Participants test their knowledge with an interactive Audience Response System,

FORUM

MAY 16, 2015

GUN VIOLENCE, HUMAN RIGHTS, AND THE NEED FOR MORE PHYSICIAN PARTICIPATION IN CIVIC ENGAGEMENT

Chairs: John H. Halpern, M.D., Andres J. Pumariega, M.D.

Speakers: Vivek Murthy, M.B.A., M.D., Nada L. Stotland, M.D., M.P.H., Steven Sharfstein, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To learn how ongoing gun violence and the lack of Federal legislative reform in this matter is a significant and ongoing public health menace.; 2) To learn how matters of social importance can improve when physicians become active in civic engagement. Sometimes, the only opportunity to help improve mental health of our patients is via activism!; 3) To learn of the accomplishments of Dr. Vivek Murthy in service to our Nation and that are important for the improvement of mental health & as such to receive the AASP's 2015 Humanitarian Award.

SUMMARY:

Gun violence in the United States continues to have far reaching and devastating harm. At present, close to 30,000 Americans die each year by gun. Many had hoped the Sandy Hook Elementary School shooting in 2012 would prove to be a watershed moment to bring more sensible gun control measures into law and to help screen better for those with mental illness who are at risk to become violent. Yet even though 20 children and 6 adults were murdered at Sandy Hook, no new Federal laws have since been enacted and close to 54,000 more Americans have since died by guns. This issue of gun violence is a clear public health threat and it greatly impacts the practice of psychiatry directly: approximately 20,000 complete suicide by gun each year. Where attempt to suicide by gun has an 80% success rate, medication overdose proves lethal less than 2% of the time. Here then is where lack of reform of gun laws becomes a matter of human rights and where the need to protect those most vulnerable to suicide by gun essentially remains ignored. If improvements could be realized through more

research, new therapy practices, or in medication development, physicians would, as is true for other medical disorders, play a central role in advancing solutions. Gun violence is different for the problem is entrenched within politics and social mores. Psychiatry's responsibility to our patients and their families require our involvement in these matters then just as much as in our familiar direct role of improving our services. The gun violence problem in the United States is an important example of why we need more physician participation in civic engagement. This forum will explore the significance of this problem and how psychiatrists can and should become more involved to create the positive conditions necessary for significant gun reform. Should we remain on the sidelines, thousands of preventable deaths shall remain the status quo. Our 2015 recipient of the American Association for Social Psychiatry's Abraham L. Halpern Humanitarian Award is Dr. Vivek Murthy, who by the time of the 2015 Annual Meeting may be confirmed as the next U.S. Surgeon General. Dr. Murthy has co-founded and led Doctors for America - a nationwide organization involving doctors and medical students in all matters of civic engagement for creating a better healthcare system. Dr. Murthy will present on physician civic engagement and our discussants, APA Past Presidents Drs. Stotland and Sharfstein, will reflect on how our membership and organized medicine can and must improve our voices, not just by one patient encounter at a time, but also within the public square. The AASP seeks to call attention to improving gun regulation as well as all matters of human rights that impact mental health. We welcome your participation in this interactive forum and in the AASP, itself.

YOUTH ALCOHOL AND MARIJUANA USE AND SUBSTANCE USE POLICY

Chair: Sharon Levy, M.P.H., Ph.D.

Speaker: Sharon Levy, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the neurologic basis of the vulnerability to substance use related harms that occurs during adolescence; 2) Identify associations between college alcohol policies and student drinking; 3) Identify associations between medical marijuana policies and adolescent marijuana use ; 4)

Describe the impact of industrialization on product evolution, including changes to marijuana that have occurred in conjunction with policy changes.

SUMMARY:

For adolescents and young adults, use of alcohol, marijuana and other substances use is associated with greater morbidity and mortality than use by adults. The neurobiology underlying the developmental vulnerability is currently being elucidated, though the risk has long been appreciated. Federal law has long restricted sales and marketing of tobacco products to anyone under age 18 and the legal "drinking age" has been set at 21 for more than a generation. New laws that allow recreational use of marijuana prohibit use by youth under age 21, and even laws that allow access to marijuana as a medication are more restrictive for youth. Despite these prohibitions, rates of substance use peak during adolescence and young adulthood, and patterns of consumption and attendant harms are distinct. The impact of specific policies designed to limit youth access, youth use rates and harms remain a perennial topic of debate. Policy approaches to reducing college student binge drinking vary widely - from interventions at the individual level to stricter environmental controls to reducing the legal drinking age to 18. Debates over marijuana policy frequently center on the concern that legalization in any form (i.e. for medical or recreational purposes) will increase youth access by 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 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". Marijuana legalization for recreational purposes in Colorado and Washington are still too recent for definitive conclusions regarding impact. This presentation will begin with a brief overview of how brain development impacts behavior related to alcohol and marijuana use leading to unique patterns of use in youth. The forum will also include a review of college alcohol policies and their impact on campus drinking, medical marijuana laws and their impact on adolescent marijuana use and then discuss the potential

impacts of full legalization of marijuana, using the tobacco industry as an historical analogy.

MAY 18, 2015

A PREVIEW OF BREAKING NEW RESEARCH ON ADOLESCENT DRINKING, SCHIZOPHRENIA AND SUICIDE FROM THE AMERICAN JOURNAL OF PSYCHIATRY AND MOLECULAR PSYCHIATRY

Chairs: Robert Freedman, M.D., Julio Licinio, M.D.

Speakers: Adolf Pfefferbaum, M.D., Gunter Schumann, M.D., Ph.D., Lindsay M Squeglia, Ph.D., Edith V Sullivan, Ph.D., Thomas Weickert, Ph.D., Nicholas Hoertel, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Update participants on molecular findings in heavy drinking.; 2) Learn how adolescent heavy drinking initiates persisting brain damage; 3) Learn a potential new treatment strategy for schizophrenia; 4) Understand risk factors for suicide attempts.; 5) Assess the impact of these factors on clinical practice, including education of affected families.

SUMMARY:

The Annual Meeting will feature for the first time four new journal articles to be released by the American Journal of Psychiatry and Molecular Psychiatry online this morning. Two papers from the American Journal Psychiatry concern the clinical problem of adolescent alcohol drinking. The first paper describes the consequence for brain development of early heavy drinking in adolescents. The authors have found an 8-year trajectory of increasing frontal and temporal damage and loss of myelination. The second paper identifies an epigenetic abnormality in pairs of heavy-drinking adolescents whose twins do not drink. Dr. George Koob of the National Institute of Alcohol Abuse and Alcoholism will comment on the clinical and scientific importance of both papers. Two papers will be released by Molecular Psychiatry today; one of them shows the outcome of a new treatment for schizophrenia and the other presents data from a national study of mental disorders on psychopathology liability and the risk of suicide attempts. The relevance of both

papers to clinical practice will be discussed by Dr. Ma-Li Wong of the South Australian Health and Medical Research Institute and Flinders University. All four papers will be presented by their authors.

EBOLA: BE AFRAID BUT NOT THAT AFRAID

Chairs: Mary Anne Badaracco, M.D., Philip R. Muskin, M.D.

Speakers: Mary Anne Badaracco, M.D., Philip R. Muskin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess an isolated Ebola Virus Disease (EVD) patient's psychiatric needs, and to communicate effectively with the patient via remote monitors ; 2) Assess the needs of staff caring for the EVD patient, and to make available flexible, 24/7 means of support; 3) Communicate risk and self-care effectively to the Hospital and larger communities .

SUMMARY:

Before a patient presents with suspected or confirmed Ebola Virus Disease (EVD), the psychiatrist or another designated mental health professional needs to be a full participant in the Hospital's EVD Planning Group, to ensure maximum preparation for anticipated psychiatric needs of the patient and staff, and for public health education. Once the patient arrives, the mental health team needs to be available to the front line staff, in particular emergency room and intensive care nursing personnel, as well as to laboratory workers, housekeepers, security, and general hospital staff. Interventions include 24/7 presence in the clinical areas, offering active listening, individual encounters, and group sessions, both in the clinical and non-clinical areas of the Hospital. Employee Assistance Programs, with readily available telephone contact, and Pastoral Care are essential additional resources to staff. The mental health team also needs to be present at Town Hall meetings to maintain accurate, up to date information, assess the needs of the community, and be available to Hospital leadership, who area facing daunting challenges and may need reminders to take care of themselves. As soon as the patient is medically stable, the psychiatrist should introduce himself/herself to the team and patient, with

clear contact and coverage information. Patient privacy issues can be challenging, as nursing staff are almost always in the room with the patient, and as communication is through remote means. The mental health team does not enter the patient's room, to minimize the number of staff trained in rigorous protective procedures. At each visit, the psychiatrist or other mental health professional assesses the patient's mental status, coping strategies, and need for specific psychiatric intervention. Attention, of course, to sleep and anxiety is crucial, as are offers to communicate with loved ones during and after the hospitalization. Issues faced by staff include fear, concern regarding adequacy of training, risks to loved ones, media attention, and community stigma. Coordinated public health messaging with local health and hospital leadership is essential but not sufficient to remove all fears of contamination. Otherwise well-educated and trained staff admit to avoiding others in elevators who might breathe on them. Staff routinely report shunning in their communities, despite official clarification of safety and publicly expressed gratitude towards those who care for the victims. Security personnel require specific attention re: fear of infection should they be asked to restrain patients. This can be modified by assurance of adequate personal equipment training and adherence to other protocols. Long term staff issues include boredom, difficulty maintaining vigilance over time with meticulous and repetitive procedures, anger at staff who are not assigned to EVD care, and concerns re: anticipated quarantine after care of the patient ends. Availabi

ETHICAL PERSPECTIVES ON THE PSYCHIATRIC EVALUATION OF PUBLIC FIGURES

Chair: John S. Martin-Joy, M.D.

Speakers: Meredith Levine, M.A., Jerrold Post, M.D., Paul S. Appelbaum, M.D., Sagar Vijapura, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the APA's ethics annotation on offering professional opinions about public figures (section 7.3 of the Principles of Medical Ethics with Annotations Specific to Psychiatry); 2) Identify ethical principles and forms of ethical reasoning that a) have been used to support the ethics

annotation and b) have been used to explore potential alternatives.; 3) Describe two non-psychiatric perspectives on the psychiatric assessment of public figures (e.g., the perspectives of a public figure and a journalist) and their implications for psychiatric ethics.

SUMMARY:

This roundtable discussion will explore the ethics of psychiatrists commenting on the mental health of public figures. The so-called Goldwater Rule (section 7.3 of the APA's Principles of Medical Ethics with Annotations Specific to Psychiatry) is a policy adopted in 1973 that prohibits APA members from diagnosing public figures they have never examined. The policy arose in response to a 1964 incident in which Fact magazine surveyed psychiatrists and published their comments about presidential candidate Barry Goldwater; he successfully sued for libel. The principle of respecting public figures' dignity is now well established, but in recent years there has been a debate about whether the ban is too absolute and whether some exceptions are ethically justified.

The panel will examine the issue from the vantage point not only of psychiatry, but of the public figure and of the press. Participants will include two distinguished psychiatrists--one who has been critical of the APA rule and one who has served as president of APA; a journalist who specializes in ethics; and (via excerpts from a videotaped interview conducted for this session) 1988 Democratic presidential candidate Michael Dukakis. The session will aim to identify ethical dilemmas that arise when a psychiatrist comments on public figures; to educate APA members about the annotation's origins and purpose; and to explore ethical principles and ethical reasoning that might be employed in reviewing the annotation and its possible alternatives. Participants and audience members will be asked to adhere to the ethics annotation during the discussion.

MAY 19, 2015

GLOBALIZATION OF PSYCHIATRY: APA AND WPA PERSPECTIVES

Chairs: Rama Rao Gogineni, M.D., Roy A. Kallivayalil, M.D.

Speakers: Pedro Ruiz, M.D., Dinesh Bhugra, M.D., Ph.D., Anne E. Becker, M.D., Ph.D., Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Will learn the impact of Globalization on mental health, psychiatric disorders, treatment; 2) Will find ways of contributing, collaborating globally with international and other national organizations; 3) IMGs will learn how they can contribute to the advancement of science of psychiatry with their countries of origin and Diaspora due to their unique position; 4) Members will learn ways of working with APA, WPA to learn and offer more evidence based services to patients in US and abroad.

SUMMARY:

Globalization is the process in which traditional boundaries of nations are changing due to multi-national companies, expanding technology, urbanization of developing countries and influence of the media. But globalization can increase economic disparities. Globalization contributed to the rise of non-communicable diseases, psychiatric related disorders and increased the global burden of disability and mortality in low-to-middle-income countries. Neurological and psychiatric conditions account for 31% of all disability-adjusted life-years. Depression is projected to be the leading contributor to the global disease burden by 2030. Globalization contributing to shifts in population with tremendous increase in migration, refugees, and asylum seekers. Migration has significant effects on health, showing higher rates of both physical and mental illness. Human Rights is a concern in relation to people with mental illness. In 2002 the WPA resolved to investigate allegations of abuse of psychiatry in China. Current global militarized conflicts are contributing to an increase in prevalence of post-traumatic disorders in military personnel, their families and civilians.

Pedro Ruiz, M.D., as past President of APA and WPA has been very eloquent in underscoring the globalization of mental health for the last two decades. Dinesh Bhugra, M.B.B.S., MRCP, president of the Royal College of Psychiatrists and president elect of WPA as well as, several other international leaders the United Nations and WHO have been addressing global

psychiatric issues. Dilip Jeste, M.D., was appointed to the Council on International Psychiatry to address this important time sensitive topic.

The presenters, Drs. Ruiz, Bhugra, Summergrad and Kallivayalil, all have international recognition and bring a wealth of knowledge about this topic area. They will discuss how globalization of psychiatry impacts the profession and how collaboration with the World Health Organization and Cross-national collaboration can enhance research, education, training, responsive mental health care. They will illustrate how International Medical Graduates who comprise 25-40% of work force in US and Europe will enhance global mental health. In addition, they will address the educational and training needs that need to be addressed to meet this growing need.

VALUE OF COMPARATIVE EFFECTIVENESS RESEARCH IN IMPROVING MENTAL HEALTH OUTCOMES

*Chair: Grayson S. Norquist, M.D., M.P.H.
Speakers: Romana Hasnain-Wynia, M.S., Ph.D.,
David Hickam, Grayson S. Norquist, M.D.,
M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how PCORI views Patient-Centered Outcomes Research " and how this is related to mental health; 2) Understand PCORI's major funding mechanisms-broad announcements, targeted announcements, and pragmatic clinical studies; 3) Identify the impact of PCOR on treatment and management of serious mental illness.

SUMMARY:

The Patient-Centered Outcomes Research Institute (PCORI) was authorized by Congress in 2010 to fund research designed to give patients, caregivers and clinicians the information they need to make better-informed decisions about health and health care. In this plenary, learn how PCORI is pursuing that ambitious challenge, and what PCORI hopes to learn from the research supported through our research funding programs. Panelists will provide an overview of PCORI's Research Agenda and refining the agenda in response to input from patients and other stakeholders

across the country. Nearly a third of PCORI-funded projects explore the area of prevention, diagnosis, and treatment of mental illness. Particularly in the area of serious mental illness, the problem of early mortality and increased morbidity in this population is well known. It is a top-priority topic area identified by a number of stakeholder and patient advocacy groups as well as health-related policy think-tanks, including the Institute of Medicine. For this reason, PCORI has identified specific research gaps in the area of early morbidity and mortality for serious mental illness through a process of systematic review, discussions with other funders, and discussions with stakeholder groups such as patients, payers, and policy makers. We will present these research gaps in detail, discuss ways in which PCORI's funded projects address those gaps, and particularly outline how these projects fit within the model of patient-centered outcomes research.

PSYCHIATRISTS AS LEADERS

*Chair: Paul Summergrad, M.D.
Speakers: Darrell G. Kirch, M.D., Herbert Pardes, M.D., Peter F. Buckley, M.D., Robert N. Golden, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the key issues facing the health care system ; 2) Discuss the role of psychiatry in health care reform ; 3) Recognize the particular skills of psychiatrists as leaders .

SUMMARY:

The session is structured as a moderated roundtable discussion we will focus on four questions:

Many psychiatrists have assumed positions of leadership in healthcare systems, general health care and educational advocacy organizations, universities and medical schools. This symposium brings together distinguished leaders from all these areas to to reflect on the changes in health care, education and public policy and the important role that psychiatrists as leaders are playing.

How do our panelist view the evolution of the healthcare system in particular the impact of healthcare reform? In those contexts what are the special opportunities and challenges for psychiatry? There are many psychiatrists in leadership positions in health systems medical

schools and major organizations –“Why do you think that is so? What if anything does that say about the skills of psychiatrists and the needs of the current era? Finally, what keeps you up at night in regard to health care reform? and in regard to psychiatry? We hope there will be a vigorous and enlightening discussion and time for questions from the audience.

A CO-RESIDENT S SUICIDE: GRIEVING TOGETHER AND RETHINKING TRAINEE MENTAL HEALTH

Chairs: Matthew L. Goldman, M.D., M.S., Ravi N. Shah, M.D.

Speakers: Laurel Mayer, M.D., Carol A. Bernstein, M.D., Christine Moutier, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of addressing the immediate crisis of a resident’s suicide by working with Psychiatry faculty to facilitate process groups and provide grief counseling for affected trainees.; 2) Identify the major risk factors for trainee burnout, depression, and suicide as well as methods for screening and treating mental illness in trainees.; 3) Collaborate with other medical specialty training programs to effectively promote resident mental well-being over the long-term.

SUMMARY:

In August of 2014, two medicine interns in New York City died by apparent suicides. These tragic events precipitated major institutional responses aimed at caring for the colleagues of these residents as well as instituting future programming to address the topic of physician suicide.

Physicians die by suicide at a disproportionately elevated rate compared to the general population in the United States, and residents are at particular risk given the high prevalence of depression among medical trainees. Residency is an inherently stressful experience and is likely to remain emotionally challenging even after widespread enforcement of recent changes such as work hour restrictions. It is therefore imperative that residency programs implement strategies aimed at fostering resident wellness. Residency is an important time to intervene given the increased opportunities for departments of psychiatry to offer assistance

and oversight to residency programs in other specialties, in addition to the fact that residency is a particularly formative moment in a physician's career in which we begin to establish patterns of balancing work, life, and our own well-being.

The panelists will reflect on the lessons they learned from working with hospital systems affected by these tragedies during a time of crisis. They will also discuss the current state of resident mental health nationwide and open a discussion about how psychiatrists can help their medical colleagues to promote mental well-being during the challenges of medical training.

INTERACTIVE SESSIONS

MAY 16, 2015

CHALLENGES AND CONTROVERSIES IN PERSONALITY DISORDERS AND PSYCHOANALYSIS

Chair: Otto F. Kernberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify through this overview the presently challenging and controversial aspects of the field of personality disorders; 2) Recognize through this overview the presently challenging and controversial aspects of psychoanalytic theory, knowledge, and application to psychotherapeutic treatments; and 3) Discuss some of the challenges and controversies relating to personality disorders and psychoanalytic theory.

SUMMARY:

This interactive session will cover the entire spectrum of psychodynamic treatments, including psychoanalysis proper, that have been developed, and, in part, empirically tested in treatment of personality disorders. It will focus on the "moving target" of our present understanding and classification of personality disorders, the changes and controversies in this field, and their implication for indications, prognosis, and techniques of psychodynamic treatments. This presentation will also focus on the fundamental changes in contemporary psychoanalytic theory and in the corresponding techniques in the therapeutic approach to personality disorders. Two mutually corresponding frames of 1) classification of personality disorders, and of 2) definition of essential psychotherapeutic techniques common to all psychodynamic treatments will be outlined as basis for an updated view of this field.

CHALLENGES IN COGNITIVE-BEHAVIOR THERAPY: OVERCOMING BARRIERS TO EFFECTIVE TREATMENT

Chairs: 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) Understand the common challenges in delivering effective CBT treatment; 2) Discuss modifications of CBT for personality disorders and treatment resistant depression; and 3) Identify from session leaders ways to be creative, flexible and persistent when finding treatment options when faced with CBT treatment challenges.

SUMMARY:

Two authors of widely used texts on cognitive-behavior therapy (CBT) will discuss common challenges in delivering effective treatment and invite participants to present dilemmas they have encountered in implementing CBT. The initial focus of the discussion will be on modifications of CBT for personality disorders and treatment resistant depression. An open forum will follow in which participants can share their experiences in treating difficult cases and receive suggestions from session leaders and other participants. Flexibility, creativity, and persistence will be emphasized in finding solutions to treatment challenges.

MAY 17, 2015

AN UPDATE ON ANTIDEPRESSANT TREATMENT: PHARMACOGENETICS, RAPIDLY ACTING AGENTS, AND BRAIN STIMULATION

Chair: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand potential use of pharmacogenetics to treat major depression; 2) Appreciate where we are in terms of developing new antidepressants; and 3) Discuss updates in antidepressant treatments using pharmacogenetics, rapidly acting agents and brain stimulation.

SUMMARY:

A number of intriguing research and commercial developments are offering opportunities for improving treatment outcomes in major depression. We will review a number of these with an eye toward anticipating how they are likely to affect clinical practice. We first will review findings from a number of groups on pharmacogenetic predictors of response. To date, much data have emerged that genetic

variation can predict risk of side effects. These approaches have included assessment of genes that involve either regulation of drug metabolism (pharmacokinetics) or those that may affect the direct effects of the agent's receptor and reuptake sites (pharmacodynamics). We first discuss a number of candidate genes and what they signify for decision-making in routine clinical practice. We then present data from a number of perspective trials that point to potential applications for both weighing side effects risk and potential prediction of differential efficacy. To date, side effects have been more easily predicted by genetic variation and we provide possible explanations. We then discuss recent studies on novel antidepressants, first reviewing where we are with ketamine and other glutamatergic agents. Data on ketamine – a rapidly acting parenterally administered antidepressant that is thought to work primarily via antagonism of the NMDA receptor – are reviewed as are studies on other putative glutamatergic agents are presented. We discuss whether alternative mechanisms of action may explain ketamine's effects and the potential significance for further antidepressant development. Potential examples are provided. Last, we discuss recent studies on brain stimulation (both r-TMS and DBS) and explore reasons for recent failed trials with DBS.

LET'S TALK ABOUT MARIJUANA

Chair: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe current trends in marijuana use, treatment admissions, and emergency room mentions attributed to marijuana use; 2) Understand the distribution of cannabinoid receptors throughout the brain and the short and long term neurobiological and behavioral effects marijuana use can have; and 3) Appreciate the potential implications of changing policies on marijuana use.

SUMMARY:

In most countries, marijuana is the most frequently used illicit drug. In the U.S. the recent legalization of marijuana in many states for medical or recreational purposes is associated with a parallel increase in its abuse across all ages. In fact, currently among American youth, the prevalence for smoking marijuana has

exceeded the prevalence of cigarette smoking. Of particular concern is that among 12th grade high schools students 6.5% report regular use of marijuana (several times a week) since this pattern of use is likely to be the most harmful for the developing brain. This session will highlight recent epidemiological data on marijuana use and will summarize what we currently know about the cannabinoid system including the distribution of receptors within the human brain and the many functions they regulate. It will also review recent research findings illustrating the short and long term consequences of marijuana use on the brain and its potential consequences in cognitive function and in the risk for other substance use disorders and mental illness.

THE BEHAVIORAL ADDICTIONS

Chairs: Petros Levounis, M.D., Michael S. Ascher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the similarities between both behavioral addictions and chemical addictions; 2) Identify ways that clinicians can strengthen the therapeutic alliance with patients suffering from behavioral addictions; and 3) Identify resources in the community that can help patients in their recovery.

SUMMARY:

Behavioral Addictions such as shopping, work, food, sex, love texting, e-mailing, gambling, etc., present with unique and poorly researched challenges in everyday clinical practice. The overarching hallmarks of addiction- continued engagement in an action despite negative consequences and loss of control over one's own life- seem to be quite similar for both substances and behaviors that hijack a person's pleasure and reward brain circuitry. When it comes to the behavioral addictions, we have a lot more work to do in order to arrive at reliable diagnostic criteria, build useful assessment tools, and develop effective psychosocial and pharmacological treatments. In this session, we will help clinicians to conceptualize these conditions.

SPORTS PSYCHIATRY: OVERCOMING MEDICAL, SOCIAL, AND

PSYCHOLOGICAL RECOVERY BARRIERS FROM SERIOUS ATHLETIC INJURY

Chair: David R. McDuff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify increasing trends & types of serious injury among athletes in collision and contact sports at all competitive levels & the need for psychiatrist to get involved in their collaborative care; 2) Recognize the reasons for the rising serious injury rates and trends for earlier and repeat surgeries and how to reverse these trends; 3) Develop the general knowledge and skills needed to consult or work collaboratively with sports professionals who care for injured athletes and help them return to play; and 4) Develop the necessary psychotherapeutic, psychopharmacologic, and alternative medicine approaches needed to provide ongoing collaborative care to injured athletes.

SUMMARY:

Serious injuries requiring surgery and/or prolonged absences from practice and competition

are increasing in most collision and contact sports among male and female athletes at all competitive levels. Complex concussions, cervical spine/cord trauma, elbow and knee ligaments tears, muscle and tendon tears, complex or compound fractures, shoulder, knee and hip articular surface disruptions, and serious eye and dental injuries are all on the rise. Surgery is being done on younger and younger athletes and repeat surgeries are quite common. These trends are alarming and likely due to early single sport specialization, year round practice/competition resulting in overtraining/overuse, inadequate rest periods or cross training, increase in athletic size/mass from aggressive lifting programs and enhanced nutrition, expansion of women's sports, and inconsistent availability of athletic trainers and sports trained physicians.

Absences from competition for serious injuries can range from a few months to more than a year and are associated with a range of problems that can become barriers to healing and return to play. These include acute and chronic pain, insomnia, grief, anxiety, depression, anger, fear of re-injury, boredom, resentment, fatigue, social isolation, identity

crisis, self-doubt, low-self-esteem, and shame. In addition, those that can't return to play or are unable to return to the prior level of play (common at the higher competitive levels) may need assistance in transitioning to another area of interest or career. Psychiatrists in collaboration with sports medicine professionals (athletic trainers, physicians, chiropractors, physical therapists, etc) are ideally suited to manage many of these medical, social, emotional, and psychological barriers to injury recovery and return to play. In almost every area of the country there is a growing need for psychiatrists with comfort at the interface of sports medicine, orthopedics, and rehabilitation to become a member of an integrated care team.

This workshop will describe the knowledge and skills needed for psychiatrists to give consultative advice to sports medicine or other mental health professionals or become directly involved in the ongoing care of the seriously - injured athlete. Using his two decades of experience working with high school, club, collegiate, professional and Olympic athletes and teams, the workshop leader will describe a four stage model for injury recovery and return to play. He will use case examples and audience discussion to highlight key points. Special emphasis will be placed on the types of therapy (motivational, behavioral, cognitive-behavioral) and specific medications for sleep, pain, anxiety/depression/aggression and alternative medicine approaches (stretching, relaxation, massage) that are most compatible with successful return to play.

HELPING KIDS IN CRISIS

Chair: Fadi Haddad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify crisis, symptoms and onsite stabilization; 2) Recognize when to send patients to the Emergency room Vs treating them in the community; and 3) Discuss all aspects of the psychiatric evaluation, risk assessment, stabilization and decision making in assisting children in crisis.

SUMMARY:

Child psychiatric emergencies are high-risk, high-liability situations. The recent high-profile school shootings, controversies about use of psychiatric medication for children and

adolescents, and increasing awareness of the prevalence of child psychiatric illness combined with lack of access to care has heightened public interest in and concern about managing child psychiatric emergencies. This presentation will discuss some of the chapters in my book "Helping Kids in Crisis." We will discuss aspects of psychiatric evaluation, risk assessment, decision-making, and stabilization for children in crisis. In addition, you will receive guidance of when symptoms are severe enough to warrant an emergency room referral.

REFLECTIONS ON A DECADE OF RESEARCH INVESTIGATING DEEP BRAIN STIMULATION FOR DEPRESSION

Chair: Helen S. Mayberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the current status of ongoing studies of DBS for treatment resistant depression; 2) Understand the trajectory of clinical effects facilitated by DBS in patients with TRD; and 3) Consider the potential contribution of adjunct psychotherapy for patients receiving DBS.

SUMMARY:

It is now more than 10 years since the first subcallosal cingulate DBS implant. The research has made steady progress with emerging clues as to which patients are most likely to benefit and mechanisms mediating DBS antidepressant effects. Novel imaging methods have also been developed to optimize surgical targeting. Despite these advances, alleviation of core symptoms is just the first step to functional recovery in patients with chronic treatment resistant depression.

Towards this goal, ongoing studies are now examining new methods to facilitate and maximize the full rehabilitative potential of patients once the DBS itself is optimized. These issues will be open for discussion in this session.

Further Reading

1. Mayberg, HS, et al. *Neuron*, 45:651-660, 2005.
2. Holtzheimer PE and Mayberg HS. *Trends Neurosci*. 34:1-9, 2011
3. Holtzheimer PE et al. *Archives Gen Psychiatry* 69:150-158, 2012
4. Riva-Posse, Choi KS, et al. *Bio Psychiatry*. doi:10.1016/j.biopsych.2014.03.029.

MAY 18, 2015

THE NATIONAL NEUROSCIENCE CURRICULUM INITIATIVE: BRINGING NEUROSCIENCE INTO THE CLINICAL PRACTICE OF PSYCHIATRY

Chairs: Melissa Arbuckle, M.D., Ph.D., Michael J. Travis, M.D., David A. Ross, M.D., Ph.D., Jane Eisen, 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) Understand some of the challenges to effectively teaching and learning neuroscience; and 3) Describe various resources and approaches for teaching and learning neuroscience.

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. In addition, 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 separate from developing a therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience is progressively assuming within psychiatry, we continue to under-represent this essential perspective in our work. In this session participants will discuss historical barriers to integrating a neuroscience perspective into their clinical training/work and review new approaches to bridge this gap. Attendees will have an opportunity to experience some of the interactive and participatory new learning approaches developed by the National Neuroscience Curriculum Initiative (NNCI) to engage trainees in active, learning exercises focused on consolidating foundational

knowledge while highlighting the relevance of incorporating a neuroscience perspective to the practice of psychiatry.

FATAL PAUSES: STUCK IN PLEASING OTHERS. AN INTRODUCTION TO SUPERMENTALIZATION

Chair: Stuart C. Yudofsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand why and how people become “stuck” with persistent and disabling symptoms and life problems, notwithstanding extensive previous treatment; 2) Utilize the “Fatal Pauses’ 3-D Method of Getting Unstuck” to treat people with persistent and disabling symptoms and life problems; and 3) Discuss the special opportunities and challenges afforded to people with “Supermentalization.”

SUMMARY:

Based on his new book, *Fatal Pauses: Getting Unstuck Through the Power of No and the Power of Go*, Stuart Yudofsky, M.D. will present an evolutionary and neurobiological explanation of how people become stuck with a broad range of disabling problems and symptoms. Examples include people who cannot disentangle themselves from dysfunctional relationships with people with personality disorders; people who remain overweight or obese notwithstanding many attempts at dieting and exercise; people with prolonged alcohol use disorders and other dependencies despite psychotherapy, AA, and rehabilitation programs; people who endure jobs which they despise; people who waste inordinate amounts of time surfing the internet, playing video games, viewing pornography; people who cannot relax, participate in family activities, or even retire because of their devotion to their professions or occupations.

Dr. Yudofsky will review the elements of his “Fatal Pauses’ 3-D Method of Getting Unstuck,” which combines psychodynamic, mentalization, and cognitive behavioral approaches. He will present a clinical example of a young woman, a gifted student and dancer, who suffers from severe anorexia nervosa, complicated by a pervasive need to please others. In this presentation, he will introduce the novel concept of “Supermentalization,” which he defines as “People who, at rare and exceptional

levels not only keep the minds of themselves and others in mind but also the feelings of themselves and others in their minds and feelings.” He will discuss the special opportunities and challenges afforded to people with “Supermentalization.”

Ample time will be devoted to audience interaction with the presenter.

THE NOTORIOUS PAST AND BRIGHT FUTURE OF PSYCHIATRY

Chair: Jeffrey A. Lieberman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss and be informed about the history of our profession; 2) Understand the cause of stigma toward mental illness and psychiatry; and 3) Discuss the current status and future course of psychiatry.

SUMMARY:

Psychiatry has long been the stepchild of medicine with a checkered history and notorious reputation. However, in recent decades it has transformed itself into a scientifically based discipline with clinical competence and effective treatments. In *Shrinks: The Untold Story of Psychiatry*, former APA President Jeffrey Lieberman tells the fascinating story of psychiatry's evolution from a mystical pseudoscience to a respected medical specialty that saves lives. The field has come a long way since the days of chaining patients in cold cells, Snake Pit “like asylums, ice pick lobotomies, and preposterous theories like animal magnetism and orgones. Today, thanks to psychopharmacology, brain imaging, genetics, neuroscience, and modern methods of psychotherapy and rehabilitative treatments, persons with mental illnesses can finally receive treatment that can enable them to live productive and happy lives.

Yet despite this amazing progress, because of the skepticism that still plagues the profession, many people who would benefit enormously from treatment are either too wary or too ashamed to seek it. Instead they-and their loved ones-suffer in silence. In *Shrinks*, Lieberman makes an urgent call to arms to dispel the stigma of mental illnesses by treating them as diseases rather than unfortunate states of mind or moral or psychological flaws.

CULTURALLY APPROPRIATE ASSESSMENT: USING THE CULTURAL FORMULATION INTERVIEW AS AN ASSESSMENT TOOL AND FOR TEACHING MEDICAL STUDENTS AND RESIDENTS

Chair: Russell F. Lim, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use the DSM-5 Cultural Formulation Interview (CFI) to interview a patient ; describe methods and use questions from the DSM-5 (CFI) and its supplementary modules, to elicit the cultural conceptualizations of distress

- a) Identify interviewing techniques, using questions from the DSM-5 (CFI) and its supplementary modules to assess the various aspects of cultural identity
- b) Describe methods to elicit the stressors and supports as well as cultural features of vulnerability and resilience of a patient by using a focused developmental and social history and questions from the DSM-5 (CFI) and its supplementary modules
- c) Discuss and identify ethno-cultural transference and countertransference
- d) Describe how to formulate a case with a culturally appropriate differential diagnosis and how to negotiate a treatment plan with a patient

2) Write a cultural formulation of a patient using the DSM-5 Outline for Cultural Formulation; and
3) Use the Cultural Manual of Psychiatry, Second Edition as a text for training residents and medical students.

SUMMARY:

Being able to perform a culturally appropriate assessment is a skill required by current RRC Accreditation Standards, including the ACGME core competencies and milestones for all graduating psychiatric residents. In addition, the Institute of Medicine's (IOM) report, "Unequal Treatment," showed that patients belonging to minority populations received a lower level of care than mainstream patients, when matched for income, insurance status, age, severity of illness. A culturally appropriate assessment can reduce mental health disparities by improving the quality of care provided to minority and underserved groups, improving their engagement, diagnosis, and

treatment outcomes. There are many tools that can be used for a culturally appropriate assessment, such as the DSM-5 Outline for Cultural Formulation (OCF), and the Cultural Formulation Interview (CFI), and various mnemonics. The DSM-5 OCF and CFI are excellent tools for the assessment of culturally diverse individuals. Both provide a framework to assess cultural identity, cultural conceptualizations of distress, psychosocial stressors and cultural features of vulnerability and resilience, the clinician-patient relationship, and overall cultural formulation. The interactive session will also present Hay's ADDRESSING framework for assessing cultural identity, Arthur Kleinman's eight questions to elicit an explanatory model, and the LEARN model used to negotiate treatment with patients. Attendees of the interactive session will learn how to assess their own and their patient's cultural identities, and how the ethnicity and culture of the clinician and patient affects transference and counter transference.

The interactive session will teach clinicians specific skills for the assessment of culturally diverse patients. Participants will go through the Cultural Formulation Interview and see how they could use them in an interview Discussion of case vignettes will enable attendees to gain an understanding of the skills used in culturally appropriate assessment. Participants will be encouraged to share their own approaches, and then modify their approaches based on material presented in the course. Clinicians completing this course will have learned interviewing skills, including the use of the DSM-5 OCF and CFI, useful in the culturally appropriate assessment, differential diagnosis, and treatment planning of culturally diverse patients.

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; and 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.

MAY 19, 2015

THE PERSON WITH THE DIAGNOSIS

Chair: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the shortcomings of a "person-less" approach; 2) Identify key components of the person; and 3) Identify strategies to keep the person in psychiatry.

SUMMARY:

The emphasis on "disorders" in psychiatry has resulted in a neglect of the person who has the disorder. A shift towards brief appointments, "med checks," and the delegating of psychotherapy to nonpsychiatrists has contributed to this trend. In this session the presenter will discuss the implications and strategies of response.

MANAGEMENT OF TREATMENT-RESISTANT DEPRESSION: THE ART AND THE SCIENCE

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use evidence based findings from randomized controlled clinical trials to treat patients with treatment-resistant depression; 2) Diagnose subtypes of depression and related mood disorders and devise optimal

treatments for each; and 3) Understand the role of pharmacotherapy, psychotherapy and non-pharmacological somatic treatments in the treatment of mood disorders.

SUMMARY:

Treatment resistant-depression (TRD) is an all too common occurrence in clinical practice. Only one-third of patients with unipolar major depression attain remission after monotherapy with selective serotonin reuptake inhibitors (SSRIs) and the results with evidence based psychotherapies such as CBT are no better. A bewildering number of strategies have been developed to manage TRD including: switch to another antidepressant or psychotherapy, combination of two antidepressants from different classes; combination pharmacotherapy and psychotherapy; augmentation with lithium, atypical antipsychotics, thyroid hormone, estrogen and other agents; and non-pharmacological somatic treatments including vagus nerve stimulation (VNS) and deep brain stimulation (DBS). Which of these treatments work best for various subtypes of major depression including post-partum, atypical, and psychotic depression is also a topic of much confusion and debate. This session will feature Drs. Charles B. Nemeroff and Zachary Stowe, who will lead a discussion of these issues and describe the science and art of managing TRD.

CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY: CURRENT CONTROVERSIES AND HOT TOPICS

Chair: Barbara Coffey, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify recent controversial studies in pediatric psychopharmacology; 2) Recognize important adverse effects in child adolescent psychopharmacology; and 3) Apply recent uses/indications and adverse effects to clinical practice.

SUMMARY:

The evidence base for use of psychopharmacological agents in child and adolescent psychiatry has grown exponentially in recent years, but as might be expected controversies regarding use of these agents have also arisen. However, following a long

tradition in pediatric psychopharmacology, use of off label indications by pediatric practitioners continues to be both common and necessary. Inevitably, unusual responses and adverse effects, both predictable and unpredictable, arise. In addition each year new data and studies may result in new indications that are essential for practitioners to know. The challenge is to sort through this new and often contradictory information to understand how to apply it to patients.

This workshop will provide brief introductory remarks regarding controversial indications, off label uses adverse effects of stimulants, antidepressants anticonvulsants, antipsychotics and antibiotics of importance to pediatric practitioners There will be ample opportunity for discussion among attendees.

MAY 20, 2015

A CONVERSATION WITH RESIDENT FELLOW MEMBERS AND PAUL SUMMERGRAD, M.D., APA PRESIDENT

Chair: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify key issues in current practice of psychiatry; 2) Describe current trends in psychiatric research; and 3) Discuss implications of Health Care Reform for psychiatry.

SUMMARY:

In this session, Dr. Summergrad will discuss with Resident Fellow Members key issues in research, education, and practice of psychiatry. An open dialogue with audience participants will be encouraged.

LECTURES

MAY 16, 2015

PSYCHIATRY UNDER NATIONAL SOCIALISM: REMEMBRANCE AND RESPONSIBILITY

Lecturer: Frank Schneider, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the history of psychiatric patients in Germany during World War II between the years of 1933-1945; 2) Understand the role of the German Association of Psychiatry, Psychotherapy and Psychosomatics (GAPPP) predecessors involvement in the crimes committed under National Socialism in World War II; and 3) Understand the efforts of the German Association of Psychiatry, Psychotherapy and Psychosomatics to take responsibility for their past and preserving this important history for future generations.

SUMMARY:

Between 1933 and 1945, more than 400,000 patients were forcibly sterilized and more than 200,000 were murdered. The guiding principle for the selection of patients was the person's alleged "value". Doctors, nursing staff and functionaries judged the people committed to their care on the basis of their "curability", "learning ability" or "capacity to work". This took place within the institutional and hospital system. Furthermore, many of the psychiatrists working in academia emigrated from the Reich. Psychiatrists of Jewish descent or those who had the wrong political views were forced out of their jobs. For many years, German medical societies, including the psychiatric society, remained silent about the crimes committed under National Socialism. In 2009, the German Association of Psychiatry, Psychotherapy and Psychosomatics (DGPPN) began systematically addressing its past. During a memorable general meeting, the society added the following text to the first paragraph of its articles of association: "the DGPPN recognizes that it bears a special responsibility to protect the dignity and rights of people suffering from mental illness. This responsibility is the result of its predecessors' involvement in the crimes of national socialism, in killing and forcibly

sterilizing hundreds of thousands of patients." Furthermore, the DGPPN acknowledged its historical responsibility in a widely recognized commemorative event with more than 3,000 psychiatrists taking place during the Berlin Congress 2010. The association funded an expert panel of historians who investigated the involvement of the DGPPNs predecessor organization in the mass murders of ill people and forced sterilizations. The DGPPN also made another important gesture. At its general meeting 2011, it revoked the honorary memberships of two former presidents of the society, Friedrich Mauz and Friedrich Panse. In their role as "T4" assessors they were actively involved in selecting which mentally ill and disabled people should die. In 2011 the DGPPN launched a fundraising campaign. This allowed for the development of an English-German exhibition dealing with the prerequisites for the murders, summarizing the events of exclusion and forced sterilizations up to mass extermination, and inquiring about the analysis of those events from 1945 until today. Exemplary biographies of victims, perpetrators, involved persons and opponents run throughout the entire exhibition. The exhibition was opened under the patronage of the German president at the Bundestag on Holocaust Remembrance Day 2014. The exhibition will be shown next at various locations in Germany and Europe. A website and a catalogue are available (<http://dbtg.tv/cvid/3078317>; <http://www.DGPPN.de/history/exhibition.html>). The DGPPN does not want to stop at the activities that it has undertaken in recent years, and hopes to permanently overcome the decades of silence and to take responsibility for the past. German psychiatrists have learned from their failure, and they want to, and must, continue to learn from them.

References:

Schneider, F. (Ed.). (2011). *Psychiatry under National Socialism – Remembrance and Responsibility*. Heidelberg: Springer.
Schneider, F. & Lutz, P. (Eds.). (2014). *Registered, persecuted, annihilated: the sick and the disabled under National Socialism*, Exhibition Catalogue. Berlin Springer.

INNOVATIVE PHARMACOLOGICAL STRATEGIES TO TREAT ALCOHOL USE DISORDER

Lecturer: Barbara J. Mason, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify symptoms of protracted alcohol withdrawal that may be associated with heightened relapse risk; 2) Understand appropriate human laboratory models to screen medications for therapeutic potential in Alcohol Use Disorder; and 3) Evaluate the research data assessing the safety and efficacy of gabapentin (Neurontin), pregabalin (Lyrica) and duloxetine (Cymbalta) as treatments for Alcohol Use Disorder.

SUMMARY:

Fewer than 5% of the 17 million Americans currently afflicted with alcohol use disorder (AUD) are treated with approved medications for AUD, and development of more effective medications to treat AUD is a large, unmet medical need. We have applied three strategies for drug development for AUD: 1.) Address a novel therapeutic target in the addiction cycle: the brain stress systems; 2.) Screen drug candidates in pre-clinical and human lab models to assess therapeutic potential for AUD; and 3.) Evaluate selected drug candidates in randomized controlled trials to assess safety and efficacy in outpatients with aud.

The transition from alcohol use to dependence involves powerful neuro-adaptations in the extended amygdala which manifest clinically as persisting disturbances in sleep, mood and alcohol craving. Gabapentin (Neurontin), a generic calcium channel/GABA-modulating medication, was shown pre-clinically to restore homeostasis in GABA-CRF interactions in the extended amygdala in dependent rats, and to significantly reduce craving and sleep disturbance relative to placebo in dependent participants in a human lab study of alcohol cue reactivity. Subsequently, a 3-arm, double blind, randomized, dose-ranging clinical trial of 0, 900, and 1800 mg/d gabapentin in 150 outpatients with AUD of moderate severity found significant linear dose effects in the rates of complete abstinence and no heavy drinking and in sleep, mood and craving over the 12-week study; the rate of complete abstinence was 4x greater in the 1800mg group relative to placebo ($p=0.04$, $nnt=8$) and the rate of no heavy drinking twice that of placebo ($p=0.02$, $nnt=5$). A 3-arm ($n=150$) double-blind placebo-controlled trial was conducted with Pregabalin (Lyrica), 300-600mg/d, to validate and extend gabapentin results, vs. The

serotonin/norepinephrine reuptake inhibitor (SNRI) duloxetine (Cymbalta), 40-60mg/d, which suppressed binge drinking in rats. Outpatients treated with Pregabalin had significantly lower levels of craving in response to alcohol cues, and higher rates of abstinence and no heavy drinking over the 12-week treatment study, relative to placebo. Conversely, outpatients treated with duloxetine had higher levels of craving in response to alcohol cues in the lab, and showed no advantage in drinking outcomes relative to placebo.

Positive effects of gabapentin and Pregabalin on drinking outcomes provide clinical validation of central stress systems as pharmacological targets for the treatment of AUD. Results of cue reactivity testing were congruent with clinical trial outcomes for all 3 drugs studied, and support the predictive validity and reliability of this method for screening medications for therapeutic potential in AUD.

MAY 17, 2015

AN UPDATE ON THE TREATMENT AND RESEARCH OF TREATMENT-RESISTANT DEPRESSION AND BIPOLAR DISORDER

Lecturer: Carlos A. Zarate Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand causes of treatment-resistant depression; 2) Learn on how to assess and manage a patient with treatment-resistant depression; 3) Recognize and become familiar with research on treatment-resistant depression; and 4) Understand research on biomarkers of treatment response.

SUMMARY:

Existing treatments for major depressive disorder (MDD) usually take weeks to months to achieve their antidepressant effects, and a significant number of patients do not have adequate improvement even after months of treatment. In addition, increased risk of suicide attempts is a major public health concern during the first month of standard antidepressant therapy. Thus, improved therapeutics that can exert antidepressant effects within hours or a few days of their administration, particularly in treatment-resistant is urgently needed, as is a better understanding of the presumed

mechanisms associated with these rapid antidepressant effects. In this context, the N-methyl-D-aspartate (NMDA) antagonist ketamine has consistently shown antidepressant effects within a few hours of its administration. This makes it a valuable research tool to identify biomarkers of response in order to develop the next generation of fast-acting antidepressants. In this lecture, I review the latest on managing individuals with treatment-resistant depression. In addition, research on treatment-resistant depression and rapid response (within hours) with glutamatergic modulators and other compounds in suicidal ideation, major depression (unipolar) and bipolar depression will be reviewed. Finally, clinical, electrophysiological, and imaging correlates of antidepressant response in treatment-resistant depression will be discussed.

UP THE DOWN STAIRCASE: CONTINUING CHALLENGES FOR WOMEN IN LEADERSHIP

Lecturer: Carol A. Bernstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand some of the current barriers which remain for women in leadership positions in medicine in general and in psychiatry in particular; 2) Appreciate the historical context for these challenges; and 3) Identify several pro-active strategies for academic and leadership advancement going forward.

SUMMARY:

The literature is replete with articles about the ongoing challenges facing women in leadership positions both in academic medicine and in American society in general. The lecture will present an overview of changes which have occurred over the past several decades, identify some of the incremental improvements which have taken place and the challenges which still remain. The lecture will focus on both external barriers and internal conflicts which have contributed to the slow pace of change as well as changes to generational expectations about lifestyle among both men and women. The lecture will also attempt to identify effective strategies to enhance the role of women in leadership, particularly in medicine and psychiatry.

GLOBALIZATION, THE MEDIA, AND EATING DISORDERS: WHAT CAN WE LEARN FROM FIJI?

Lecturer: Anne E. Becker, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the evidence linking media exposure to eating disorder risk and implications for advocacy and social policy; 2) Understand the potential health and social hazards associated with globalization and rapid social and economic change; and 3) Appreciate how the media could be used as a platform to reduce health risk.

SUMMARY:

The global health burden attributed to eating disorders has risen steeply over the past two decades and there is also evidence for their increasingly worldwide distribution. How can we understand and respond to this globalization of eating disorders and how might it illuminate etiologic models and inform interventional strategies closer to home? The emergence of disordered eating in Fiji over the past several decades is a vivid illustration of the potentially catalytic impact of briskly changing social norms following novel Western cultural exposures. Prior to the arrival of Western-produced television to Fiji's rural areas in the mid-1990s, Fijian cultural ideals were remarkable for their striking contrast with the prevailing preference for slenderness-along with cultural pressures to be thin-that emerged and became entrenched in modern Western societies during the 20th Century. In traditional Fijian culture, there was instead an explicit idealization of large body size, alongside cultural practices and values that effectively encouraged a robust appetite and discouraged self-management of weight. Evidence that eating disorders were clinically rare there prior to broad access to televised media as well as unknown in the indigenous nosology raised interesting questions about culturally moderated resilience to eating pathology. Things changed rapidly, however, after television was introduced in newly electrified rural villages. The initial exposure to televised program content, largely imported from Western countries, appeared to have profound influence on ethnic Fijian teenage girls and their risk for disordered

eating. This presentation will outline the meta-story of the emergence of disordered eating in Fiji, concomitant with rapid economic and social transition there over the past few decades. In aggregate, observational and experimental studies support adverse impacts of media exposure on disordered eating but an understanding of media's influence has been generally limited to the effects of individual exposure, rather than also encompassing potential secondary impacts via social norms. Evidence of the 'secondhand' effects of media exposure on eating pathology in Fiji-difficult to discern in regions where television access is virtually ubiquitous-sheds light on the potential collateral impact of peer-group media exposure. Findings from a series of studies examining health and social outcomes unfolding in the context of media exposure in Fiji will be used as a springboard for discussion of potential interventions to mitigate the adverse impacts of media exposure and the trans-national migration of risk via media products. More than just a cautionary tale, the implications for the health of young women in Fiji and elsewhere on the globe will be considered along with advocacy and social policy that could be protective. Finally, ways in which the media could be used as a platform for engineering positive impacts on health will be discussed.

DSM-IV-5 AND CULTURE: LESSONS LEARNED FROM 20 YEARS OF TEACHING CULTURAL PSYCHIATRY- APPLIED CULTURAL HUMILITY

Lecturer: Russell F. Lim, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview; 2) Recognize the rationale for teaching cultural psychiatry; 3) Identify the tension between how knowing more about a cultural group, or knowing a little can help or hinder the assessment process; and 4) Describe teaching methods used in cultural psychiatry, such as case presentations, videotaped interviews, small group discussions, films, and diversity training.

SUMMARY:

The Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), marked the first inclusion of

cultural considerations in the American Psychiatric Association's Diagnostic and Statistical Manual, with its Outline for Cultural Formulation, Glossary of Culture Bound Syndromes, the inclusion of cultural factors in diagnosis in the text of some chapters, and new diagnoses such as a Spiritual Crisis, or Acculturation Problem. Since then, much has been written about how to perform a culturally appropriate assessment. Various methods of teaching, curricula, and guides to cultural norms such as the Clinical Manual of Cultural Psychiatry, Second Edition, have been published to help guide the content of such teaching in many professional fields, including nursing, medicine, social work, and psychology. In recent years, cultural competence education has been required by the American Association of Medical Colleges (AAMC), for medical student education and by the Psychiatry Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME) in residency training, and by some states licensing boards. In our multicultural society, clinicians need to be able to perform a culturally appropriate assessment for culturally appropriate diagnosis and treatment of diverse individuals. The Institute of Medicine (IOM) recognized that being a member of a cultural minority group led to health disparities in the care received by mainstream patients and minority patients in their report, Unequal Treatment.

Creating and delivering culture competence training is challenging, depending upon the learner and where they are in their awareness of their cultural identity and their relationships with others that are different from them, as well as the expertise and experience of the instructor. The learners need to work with a diversity patient and obtain appropriate supervision from culturally diverse faculty. The lecture will describe various approaches to teaching cultural competence in medical student education, resident education, and continuing medical education. Cultural competency can reduce health disparities and improve health outcomes resulting in better attendance, engagement, and adherence to treatment plans. The lecture will outline the presenter's twenty-year experience with teaching cultural psychiatry using the DSM-IV Outline for Cultural Psychiatry and Cultural Formulation Interview, as well as review the literature for best practices. Examples of teaching materials will

be shown such as case conferences and videotaped cases. A discussion of strategies, such as stimulus films like "For The Bible Tells Me So," for engaging learners into discussing difficult topics such as racism, homophobia, sexism, and white privilege will be included in the lecture.

ONE HUNDRED YEARS OF SHELLSHOCK: RIP OR ALIVE AND KICKING?

Lecturer: Simon Wessely, M.A., M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the history the term "Shell Shocked" and whether this may have been the first instances of PTSD; 2) Identify characteristics of PTSD as it was understood in the past as compared to modern times; 3) Discuss past and modern treatment of PTSD and answer was it as bad as we now believe back then? How far have we really come in understanding and treating PTSD?.

SUMMARY:

It is a hundred years since Charles Myers, Renaissance man extraordinaire, coined the term shell shock. Dead and buried in 1917, the phrase he coined remains alive and well. But is it just the first glimpse of modern PTSD? And were they back then as bad as we now believe, and are we really as good as we think? Come and be surprised, challenged, irritated but hopefully not bored.

Professor Sir Simon Wessely is Professor of Psychological Medicine at the Institute of Psychiatry, London; President of the Royal College of Psychiatrists; Consultant Advisor in Psychiatry to the British Army, but above all, a Limey.

GLIAL CELLS IN SLEEP AND DEPRESSION

Lecturer: Philip G. Haydon, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify Astrocytes signal to neurons through the accumulation of adenosine; 2) The importance of the astrocyte to a neuron signaling pathway in the control of sleep homeostasis; and 3) The rapidly acting anti-depressive effects of sleep deprivation and

ketamine in models require the astrocyte, opening opportunities for the development of new therapies for the treatment of depression.

SUMMARY:

In 1994 we made the exciting discovery that astrocytes, a sub-type of glial cell release chemical transmitters that can modulate neuronal activity and synaptic transmission. This led to numerous studies to identify the network and behavioral roles of astrocytes with the long term view of determining whether this glial cell type might offer new insights for the development of therapeutics. In these studies we demonstrated that the tonic and slowly changing levels of adenosine in the extracellular space are modulated by the astrocyte and that this gliotransmitter modulates network activity in the cortex underlying slow wave activity in non rapid eye movement (NREM) sleep. Further examinations demonstrated that the astrocyte is a critical component in the regulation of sleep homeostasis. Given the ability of sleep deprivation to immediately elevate mood in the depressed population we asked whether the astrocyte might contribute to anti-depressive like effects in mouse models. Convincingly we showed that the astrocyte and its adenosine signaling pathway is required for antidepressant-like effects of sleep deprivation. Given that ketamine also exerts antidepressant effects in the clinical population we have asked whether astrocytes similarly contribute. Again the astrocyte was shown to be necessary for ketamine's behavioral outcomes in mice. Given that astrocytes preferentially express specific G protein coupled receptors we are now in the process of asking whether they could act as therapeutic targets for rapidly acting antidepressant treatments in place of either sleep deprivation or ketamine.

THE FUTURE OF ANTIDEPRESSANT DRUG DISCOVERY AND DEVELOPMENT

Lecturer: Florian Holsboer, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to; 1) Understand why research and development has failed to deliver innovative drugs; 2) Recognize that a focus on human biology is needed to discover new antidepressants and predictive biomarkers; and

3) Apply methods from personalized medicine to administer a tailor-made treatment based on genetic and biomarker information.

SUMMARY:

The serendipitous discovery of antidepressants in the 1950's was followed by large numbers of drugs enhancing monoaminergic neurotransmission. That mainstream strategy failed to improve efficacy, but improved safety and tolerability.

This current stagnation is sobering if one considers the huge number of neuroscientists and the money spent for brain research that has yet not helped to identify and disentangle the various mechanisms underlying depressive syndromes.

To improve the situation for our patients an extensive reengineering of the research and discovery process is needed. Necessary changes will include:

(1) Departure from animal models for prediction of treatment efficacy. These models will remain important for basic brain research. For resolving clinical questions we need to acknowledge that the mouse brain is 4000 times smaller leaving less opportunity for changes in connectivity. These changes are considered to be important causal mechanisms underlying depression.

(2) Strengthening human biology aiming for discovery of disease mechanisms and biomarkers that allow stratification of patient populations that share similar causal mechanisms.

(3) A profound overhaul of traditional diagnostic algorithms that must incorporate neuroscience results is needed. Sources for creating future diagnoses are based not only on verbally communicated information but also on biosignatures from the laboratory and include genetics, imaging, neurochemistry and neuropsychology.

(4) A joint initiative of academic and industrial research to repurpose existing drug candidates and to develop and share new compound libraries will facilitate discovery of target engagement and brain penetrance of new drug candidates.

Progress in these areas will enhance personalized therapy of depression where the clinician is informed how to maximize clinical outcome and minimize adverse effects of antidepressant treatment.

METALS AND OXIDATIVE STRESS IN ALZHEIMER'S DISEASE

Lecturer: Ashley I. Bush, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Apprehend the roles of biological metals and oxidative stress in the pathogenesis of Alzheimer's disease; 2) Appreciate that the major proteins implicated in Alzheimer's disease, amyloid protein precursor, tau, apolipoprotein E and presenilin normally function to regulate brain metal levels; and 3) Understand the mechanism of action of novel drugs in development that target metal and oxidative neurochemistry as potential treatments for Alzheimer's disease.

SUMMARY:

While Alzheimer's disease (AD) is most commonly formulated as a brain proteinopathy ("plaques and tangles"), this pathology has never been verified as the primary mechanism of the disease, and so far pharmacological interventions that target the proteinopathy alone have been disappointing in clinical trials. Yet genetic evidence points to key proteins in AD pathogenesis: mutations of presenilins and the amyloid precursor protein (APP) cause familial AD, and tau mutations cause frontotemporal dementia (FTD). The brain also houses high concentrations of transition metals zinc, copper and iron. Zinc and copper are released during glutamatergic neurotransmission, and their reuptake fatigues with age. This increases the average concentration of extracellular zinc and copper leading to A β aggregation (plaque formation) and other downstream adverse consequences for cognitive function. Elevation of cortical iron levels is a feature of aging, and is exaggerated in AD where iron is trapped by neurofibrillary tangles. Miscompartmentalization of metals leads to oxidative stress and exhaustion of glutathione, characteristic of dementias. We hypothesized that the key proteins implicated in the pathology of AD and FTD are in proximity to these metals because they function to regulate neuronal metal homeostasis. APP plays a key role in facilitating iron export from various cells. Tau plays a role in iron homeostasis in neurons by trafficking APP to the surface. Presenilins promote the uptake of metal ions into cells. Apolipoprotein E, the major risk allele for AD, interacts with brain iron. Pharmacological agents that lower or

transfer metal ions, and that inhibit oxidative stress, rescue neurodegeneration in animal models and are being explored in the clinic with promising results.

MAY 18, 2015

NAVIGATING PSYCHIATRY AND HEALTH CARE REFORM

Lecturer: Ellen M. Zane, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Educate attendees on the Affordable Care Act and its relationship to behavioral health care; 2) Examine the impact to hospitals and physicians of changes in policy regarding behavioral health; and 3) Provide attendees with general tools for managing during a time of significant change.

SUMMARY:

Session will provide attendees with a comprehensive overview of federal health reform (the Affordable Care Act) and the state program in Massachusetts on which it was modeled, and the impact that these programs are having on behavioral health care. Reimbursement for behavioral health care has changed dramatically as the result of policies and programs put in place by health plans and the behavioral health companies that they contract with to manage care. This program will forecast the future of behavioral health care in a post-reform environment. After many years of stigma, mental illness is finally being viewed on the same plane as physical illness by health plan administrators and policy makers. This program will explore how this change is impacting behavioral health care at the street level, as well as changes that have been made by hospitals and physicians to adapt to post Affordable Care Act reform environment.

"BUT WE NEED THE EGGS": PERSPECTIVES ON WHAT PSYCHIATRY HAS BEEN, CAN DO, AND MUST BECOME

Lecturer: Jerrold F. Rosenbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reflect on how Psychiatry has evolved as field, what was gained and lost

in the process; 2) Identify the essential elements for our field to be valued and admired by colleagues; and 3) Formulate a perspective on what may lie ahead for the field of psychiatry.

SUMMARY:

Psychiatry has been a field of paradoxes with expectations from society of nearly magical abilities to understand the complexity of human suffering and to deliver powerful and effective treatments, but simultaneously enduring stigma and disparagement as to our effectiveness. In truth we are far better than our critics allege and yet remain humbled by the gaps in our knowledge and the limitations of our therapies, especially as to the need for "personalized" treatments and sustained remission. As I have been privileged to grow up and older professionally over the last 40 years in a remarkable medical institution where psychiatry has prospered, perspectives about where the field has been and where we can be now will be drawn from that journey. Issues to be touched on will be foundational concepts, mentors (the good, the bad and the ugly), past and present psychiatry training, controversies in clinical trials, clinical evidence and art, research efforts and the potential to make things better, and the possibilities for psychiatry in the future of healthcare.

IS PSYCHIATRIC MEDICATION SELECTION VIA GENETIC TESTING BECOMING THE PREFERRED PRACTICE

Lecturer: James L. Kennedy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify genetic factors involved in psychopharmacology; 2) Learn the relevant genetic targets for testing in the liver and the brain; and 3) Recognize when genetic testing for medication and dosage is appropriate.

SUMMARY:

In genomic medicine the amount of information available and the speed of its accessibility is increasing at a rapid pace. At the same time our knowledge of inter-individual differences in terms of response and side effects to medications is at an early stage of development. The importance of these individual differences can be seen in the

estimates of over 100,000 deaths per year in the US due to adverse drug reactions with a further 2.2 million serious events that cause significant clinical impairment. In terms of psychiatric medications, there have been important developments of useful genetic tests that help guide the clinician in their choice of the type of drug and the optimal starting dosage. For example, an important dilemma facing psychiatrists when they need to select an antipsychotic medication for their patient is the forced choice between the risk for weight gain and diabetes with the newer generation drugs versus the risk of tardive dyskinesia and other motor side effects with first generation antipsychotics. The genetic investigations of our group and others on this dilemma has produced fruitful results for prediction of whether a given patient is more at risk for antipsychotic induced weight gain versus tardive dyskinesia. Following genome wide association studies of antipsychotic induced weight gain as well as hypothesis driven studies of genes involved in appetite and satiety, we have developed a model of eight genes that predicts over 60% of the variance in risk for this weight gain. In terms of antidepressant treatment there are now several replicated studies showing a significant benefit of gene guided medication selection (using an algorithm pioneered by Mrazek et al) over treatment as usual. In addition to significant clinical improvement and reduction of side effects there is also a documented reduction in health care costs when genetic guidance is used in antidepressant treatment. One data set shows that, for a major depression patient who has failed their first medication trial, a savings of over \$5000 is realized during the year following their initiation of treatment with gene guided medication. Regarding the concern that physicians will not be able to efficiently translate complex genetic information into clinical decision-making, we have surveyed over 200 psychiatrists and family practitioners in our Toronto-based pharmacogenetics study (n=2,400 patients tested) and found that the overwhelming majority of physicians found our user-friendly genetic report to be readily understandable, and over 90% believe that pharmacogenetics testing will become standard of care in the future.

FROM EFFICACY TO BIOMARKERS TO PRECISION MEDICINE IN DEPRESSION

Lecturer: Madhukar H. Trivedi, M.D.

EDUCATIONAL OBJECTIVE:

At the end of the presentation participants will be able to: 1) Discuss the efficacy of treatments for depression; 2) Discuss the need and state of the art for biosignatures for depression outcomes; and 3) Discuss the need for novel experimental medicine approaches for treatment development.

SUMMARY:

This presentation will address this progression from the early meta-analytic work from the AHCPR guidelines for diagnosis and treatment of depression in primary care through development of treatment algorithms in the Texas Medication algorithm Project, the efficacy of now standard anti-depressant treatments including medications, psychotherapy, neurostimulation and exercise and synthesis of these findings. This presentation will also describe results from various large scale landmark treatment studies including the Sequential Treatment Alternatives to Relieve Depression, Combining Medications to Enhance Outcomes, Augmenting medications with psychotherapy etc. Finally, the presentation will make the case for a biosignature based pursuit of biomarker development and validation approaches to match patients with treatments as well as informed experimental medicine guide for future treatment development. The presentation will culminate with a suggested model to incorporate the NIMH Research Domain Criteria based studies to enhance the efficacy of novel treatments to ensure early identification, rapid and precise treatment selection and reduce the negative long term consequences of major mood disorders.

ILLUMINATING THE BRAIN

Lecturer: Karl Deisseroth, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the latest developments in neuroimaging; 2) Understand the animal models tested with Optogenetics; and 3) Learn neural activity imaging

SUMMARY:

This talk will address optical tools for precise, high-resolution investigation of intact

biological systems, and application of these tools to study the neural circuit underpinnings of adaptive and maladaptive behavior. Over the past decade our laboratory has created and developed both optogenetics (a technology for precisely controlling millisecond-scale activity patterns in specific cell types using microbial opsin genes and fiberoptic-based neural interfaces) and CLARITY (a technology to optically resolve high-resolution structural and molecular detail within intact tissues without disassembly). Most recently in optogenetics, our team has developed strategies for targeting microbial opsins and light to meet the challenging constraints of the freely-behaving mammal, engineered a panel of microbial opsin genes spanning a range of optical and kinetic properties, built high-speed behavioral and neural activity-readout tools compatible with real-time optogenetic control, disseminated the tools to thousands of investigators, and applied these optogenetic tools to develop circuit-based insight into anxiety, depression, and motivated behaviors. Distinct from optogenetics, our CLARITY technology can be used to transform intact biological tissue into a hybrid form in which components are removed and replaced with exogenous elements, resulting in a transparent tissue-hydrogel that both preserves, and makes accessible, structural and molecular information for visualization and analysis. With CLARITY, whole mouse brains have now been labeled and imaged, and molecular markers have been used to identify individual structures and projections in banked human brain tissue, thereby unlocking rich sources of information for probing disease mechanisms as well as the native structure and complexity of the nervous system, in a manner complementary to optogenetic approaches.

EPIGENETIC PROCESSES MEDIATING THE IMPACT OF SOCIAL ENVIRONMENTS ON MENTAL HEALTH AND DISEASE

Lecturer: Moshe Szyf, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how basic epigenetic processes stably regulate gene expression; 2) Understand current hypotheses

defining how epigenetic processes mediate the effects of early life stress on mental health; and 3) Get an appreciation of potential diagnostic and therapeutic implications of epigenetic concepts for psychiatric disorders.

SUMMARY:

Early life adversity is known to have long-lasting impact on the phenotype of the offspring; particularly important are the associations between early life adversity and development of psychiatric disorders later in life. What are the mechanisms that mediate between exposure to stress during gestation and long-term effects on mental health? DNA methylation is a mechanism that marks genes during development and provides identical DNA sequences with different identities. Experiments in rodents demonstrated that low maternal care resulted in changes in DNA methylation in the glucocorticoid receptor gene in the hippocampus, which remained throughout life and altered the life-long behavior of the offspring increasing anxiety and responsivity to stress. Similarly in humans we noted differences in DNA methylation in the glucocorticoid gene in hippocampi of adults who were abused as children. Our recent studies show that these changes in DNA Methylation in response to early adversity affect broad regions of the genome and that they are not limited to the brain and occur in the immune system as well. Data from nonhuman primates and humans shows overlapping genes that are altered in response to both prenatal and postnatal stress in multiple tissues; placenta, the immune system and the prefrontal cortex. A fraction of these alterations in the Methylome remain in a gender specific way into adulthood. We have evidence from a study of a natural disaster in humans that objective stress is associated with changes in DNA methylation that are detectable in t cells and remain into adolescence. The DNA methylation changes in t cells in the 5htt transporter are associated with serotonergic activity in the brain. We propose that the changes in DNA Methylation in response to early life adversity are "adaptive genomic" mechanisms that adapt life-long genome programming to the anticipated life-long environment based on signals received during gestation and early life. These data have both diagnostic and therapeutic implications that will be discussed.

DEPRESSION AND OBESITY: THE CLINICAL AND RESEARCH INTERFACE OF TWO MODERN DISEASES

Lecturer: Julio Licinio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) identify obesity as a potential risk factor of antidepressant treatment; 2) understand the reciprocal clinical relationship between obesity and depression; and 3) discuss the clinical biology, pharmacology and psychosocial challenges of treating depression and obesity.

SUMMARY:

The response to stress prepared us biologically, in terms of endocrine and sympathetic nervous system responses as well as behaviour, to address acute changes in homeostasis. Depression and obesity have arisen as major public health problems in the context of stressors becoming chronic, enduring events. Those include, among others, prolonged exposures to social imbalances, trauma, war, work-related tensions, migrations, overfeeding, chronic light and sedentary life styles. Our research suggests that chronic stress can result in obesity or depression, often in combination. In addition to dysregulation of hypothalamic-pituitary-adrenal axis activity our work has shown that immune dysregulation may exist in depression. The adipose tissue is a source of cytokines and immune mediators. Therefore, in those who are obese and depressed there is chronic activation of immune function, which can further accelerate cardiovascular morbidity. In terms of causation, extensive evidence exists to support the concepts that depression can cause obesity and that obesity can cause depression. Having depression makes it challenging to treat co-morbid obesity, and having obesity complicates the treatment of depression. Moreover, we have shown that exposure to antidepressants, which are among the most prescribed drug classes, can lead to chronic obesity, in the context of a high fat diet. Conversely, treatments for obesity, such as the cannabinoid receptor antagonists, can lead to depression-like states and suicidality. Brain circuits and neurotransmitters that regulate food intake, such as corticotropin-releasing hormone (CRH), the cannabinoids, and leptin also regulate mood. There is ample evidence to

show considerable overlap in the biology, pharmacology and psychosocial challenges of these two modern disorders, obesity and depression.

IMPROMPTU MAN: J.L. MORENO AND THE ORIGINS OF PSYCHODRAMA, ENCOUNTER CULTURE, AND THE SOCIAL NETWORK

Lecturer: Jonathan Moreno, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe a landmark debate at the 1931 APA meetings in Toronto about the psychoanalysis of historical figures.; 2) Describe the first applications of social network analysis -- also as a result of events at the 1931 APA meeting -- to problems of prison organization in the early 1930s.; 3) Note the way that the term "group therapy" first emerged in its modern meaning.; and 4) Describe the role of the pioneer of psychodrama therapy and action methods, J.L. Moreno, M.D., in these developments.

SUMMARY:

In 1931 and 1932, at consecutive APA meetings in Toronto and Philadelphia, three of the most remarkable events in the history of American psychiatry took place in connection with a young and ambitious Viennese psychiatrist named J.L. Moreno. Later a diplomate of the APA, through the 1960s J.L. was known for his colorful and controversial presentations of his method of psychodrama therapy, but in the early years at the APA he became famous for a critique of A.A. Brill's psychoanalysis of Abraham Lincoln (a talk that led a New York State legislator to advocate the outlawing of psychoanalysis in the state), the first use of the term group therapy, and the first account of social network analysis that was performed at Sing Sing Prison. Moreno died forty years ago, an anniversary marked by the publication of his intellectual biography, "Impromptu Man: J.L. Moreno and the Origins of Psychodrama, Encounter Culture, and the Social Network." Written by his son, an historian and philosopher, "Impromptu Man" reconstructs the intellectual currents that influenced J.L. Moreno and the lasting impact of his ideas and techniques that have helped shape the modern world.

TRANSFORMING RACE IN MEDICINE: BODY AND MIND, HEART AND SOUL

Lecturer: Dorothy E. Roberts, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to; 1) Understand the concept of racial diseases, including mental disorders, and its role in perpetuating a biological construction of race and social inequalities; 2) Identify how race continues to shape the study, diagnosis, treatment, and prevention of disease in inequitable ways; and 3) Propose ways to transform the use of race in medicine that reject a biological concept of race and incorporate a structural understanding of how racism is embodied.

SUMMARY:

The concept of racial diseases, including mental disorders-that people of different races suffer from peculiar different diseases and experience common diseases differently-has long played a critical role in perpetuating a biological construction of race and social inequalities. White slaveholders argued that the biological peculiarities of blacks made enslavement the only condition in which blacks could be productive and disciplined and explained black resistance as mental disorders. Today, the concept of biological races continues to shape the study, diagnosis, treatment, and prevention of disease in inequitable ways that help to maintain health and other disparities in a supposedly post-racial society. We must explore radical avenues to transform the use of race in medicine that reject a biological concept of race and incorporate a structural understanding of how racism is embodied.

THE ROLE OF PSYCHODYNAMIC TREATMENTS IN ANXIETY DISORDERS: A RELATIVELY NEGLECTED AREA

Lecturer: Barbara Milrod, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the evidence base supporting dynamic treatments for anxiety disorders; 2) Recognize barriers to conducting high quality dynamic research in anxiety disorders; 3) Identify attachment and separation problems that underlie many anxiety disorders

and that can play a part in treatment non-response.

SUMMARY:

This lecture will outline aspects of the evidence base that supports dynamic interventions in anxiety disorders. It will also outline the role played by attachment problems and separation anxiety in anxiety in adults. Separation anxiety in childhood is often a precursor to adult panic disorder and other anxiety disorders. The author's research in dynamic treatment of panic disorder, and in prevalence of separation anxiety among non-responders will be highlighted.

MAY 19, 2015

MODELING NEUROPSYCHIATRIC DISORDERS USING HUMAN STEM CELLS

Lecturer: Fred H. Gage, M.S., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain how somatic cells from the adult human body can be reprogrammed to the equivalent of human Embryonic Stem Cells (hESCs) called induce pluripotent Stem Cells (iPSCs); 2) Demonstrate how iPSCs from mature and aged humans can be induced to functional mature human neurons, both in vitro and in vivo; and 3) Describe several examples where reprogrammed somatic cells (iPSCs) from patients with Psychiatric Diseases can be used to reveal novel insights to the biological basis of the diseases.

SUMMARY:

Cellular reprogramming of somatic cells provides an important advance for the study of human neurodegenerative and psychiatric diseases in live human neurons. Great progress is being made in the study of developing neurons from patients. For example, reprogramming cells from patients with neurological diseases allows the study of molecular pathways particular to specific subtypes of neurons (ex: hippocampal neurons in schizophrenia or bipolar disease); such an experiment can only be done using neurons differentiated from programmed or reprogrammed somatic cells, as it is too invasive to isolate

these neurons from patients' brains. In addition, reprogramming technology allows for the study of human neurons during development, where disease-specific pathways can be investigated prior to and during disease onset. Detecting disease-specific molecular signatures in live human neurons, as opposed to late stage post-mortem tissues, opens possibilities for early intervention therapies and new diagnostic tools. Importantly, it is now feasible to obtain neurons that capture the genetic material from the patient, which includes not only the mutated gene(s) - if the gene is known - but also the genetic modifiers that play an important but yet largely unknown role in the pathology of neurological and psychiatric diseases. Examples of recent findings obtained from this approach will be presented.

THE OPEN WARMTH OF COMMUNITY CONCERN AND CAPABILITY: ACHIEVING PRESIDENT KENNEDY'S VISION

Lecturer: Patrick J. Kennedy, J.D.

A SPECIAL CONVERSATION WITH RAM DASS AND PAUL SUMMERGRAD (PRERECORDED)

Lecturer: Paul Summergrad, M.D.

HOW SCIENCE CAN INFORM THE DIAGNOSIS, PREVENTION, AND TREATMENT OF ALCOHOL USE DISORDERS

Lecturer: George Koob, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the cycle of addiction and the neurobiological circuits involved in each stage; 2) Understand the role of the rewards system, the stress system, and executive function in the neuropathological progression of the addiction cycle; and 3) Identify research areas of high priority at NIAAA that derive from this scientific framework.

SUMMARY:

Alcohol use disorders cause an enormous amount of human suffering, loss of productivity and cost to our medical care system. The aim is to show advances in the neuroscience of alcohol use disorders can lead the way to better

diagnosis, treatment and prevention of this health problem. Conceptualizing alcoholism as a three-component cycle composed of a binge/intoxication stage, a withdrawal/negative affect stage, and a pre-occupation/anticipation (craving) stage has allowed identification of key neurocircuits underlie addiction to alcohol and many other drugs. Each stage of the addiction cycle is hypothesized to be mediated by a different circuit: the binge-intoxication stage involves recruitment of reward neurotransmission in the basal ganglia; the withdrawal-negative affect stage involves loss of reward neurotransmission and gain of stress in the extended amygdala; and the preoccupation-anticipation stage involves loss of prefrontal cortical function. Key neuropathological elements are hypothesized to parallel the stages of the addiction cycle providing a powerful impetus for the drug-seeking behavior associated with alcohol use disorders: increases in incentive salience in the binge-intoxication stage, decreases in reward function and sensitization of brain stress systems in the withdrawal negative affect stage and disruption of prefrontal executive function, in the preoccupation-anticipation stage. Understanding multiple stages and presentations of alcohol use disorders can inform clinical practice by identifying clinically relevant endophenotypes for neurobiological mechanisms ultimately may lead to better diagnosis and biomarkers of vulnerability. Understanding the combination of dysregulated incentive salience-reward function, sensitized stress systems and disrupted orbitofrontal/prefrontal executive function may lead to the development of novel treatments for alcohol use disorders particularly in the domain of stress and negative affect regulation. A priority for the scientific agenda at NIAAA will be the identification of common elements in negative affect systems relative to co-occurring psychiatric disorders such as post-traumatic stress disorder. Strengthening knowledge about the neuroscience of alcohol use disorders can also inform a second NIAAA priority: underage drinking. The frontal cortex does not fully develop until age 25, understanding the neurocircuitry neuroadaptations in executive function systems will provide new insights into identifying vulnerability to addiction in adolescents. Understanding of the pathological trajectory of adolescent alcohol use can inform the

development of novel, science-based approaches to prevention and treatment of alcohol use disorders. Recent advances in behavioral approaches to the treatment of alcohol use disorders and NIAAA's work on understanding barriers to the implementation evidence-based practice in primary care, mental health, and other health care settings will be discussed.

MIND OVER DISASTER: OVERCOMING THE CHALLENGES OF MENTAL HEALTH PLAN IMPLEMENTATION IN LOW INCOME COUNTRIES

Lecturer: Marie-Claude Rigaud, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase awareness of World Health Organization Mental Health (WHO MH) plans and strategies; 2) Recognize the role played by behavioral, social and cultural! determinants in the; implementation of WHO MH goals, and objectives in low income countries; and 3) Identify methods to enhance and facilitate successful implementation in such countries.

SUMMARY:

The World Health Organizations Mental Health plans, vision, goals and methods will be reviewed. How are these achieved in low income countries? Using Haiti as a case study, the presentation explores how language, education, stigma, among other social and environmental determinants act as barriers to ultimate population mental health in such countries. Bolstered by an unending string of disasters, economic hardship and political upheaval, these barriers can appear unsurmountable. Lessons from attempts to implement "WHO" MH Plan in Haiti will be discussed with emphasis on the necessity for mental health professionals and administrators to understand successful population mental health in low income countries depends on identification of such determinants and, on a modified, collaborative approach to address these unique challenges.

DELIVERING ON THE PROMISE OF TRANSLATION IN PSYCHIATRY: FROM NOVEL THERAPIES TO ENHANCED PUBLIC HEALTH

Lecturer: Scott L. Rauch, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe major examples of successful translational research in the field of psychiatry; 2) Recognize the complexity of assessing costs and benefits of new interventions; and 3) Explain new models of care in psychiatry that promise enhanced public health.

SUMMARY:

The principal purpose of medical science is to accomplish the translation of research into improved modes of diagnosis and treatment, to deliver enhanced outcomes, and ultimately prevention or cures. With advances in neuroscience, genetics, imaging and psychotherapy research as well as progress in technology and new models of care, examples are emerging that reflect a deliberate path from research to new and better modes of intervention for psychiatric illness. In the current session, specific cases of translational science in psychiatry will be presented to illustrate how knowledge gleaned from various modes of inquiry have been leveraged to advance the field and deliver on the promise of translation. In this context, some of the major challenges and limitations as well as future opportunities will be highlighted. Moreover, public health considerations, including enhanced access and cost-efficiency will likewise be discussed.

PRESIDENTIAL SYMPOSIA

MAY 16, 2015

CURRENT DEVELOPMENTS IN FORENSIC PSYCHIATRY

Chairs: Robert Weinstock, M.D., Jeffrey S. Janofsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Distinguish between malingered and genuine hallucinations; 2) Use methods to reduce suicides on inpatient units; 3) Manage challenging forensic roles.

SUMMARY:

This symposium will review a number of recent developments in forensic psychiatry. Dr. Weinstock will introduce the session. Debra Pinals MD will present the many facets of stalking. Dr. Resnick will then discuss the malingering of hallucinations and give suggestions for distinguishing between malingered and genuine hallucinations. Dr. Scott will review some significant legal cases regarding the death penalty and will discuss the role of psychiatrists in the process. Dr. Weinstock will discuss the challenges of practicing at the interface of psychiatry and the law and the need to balance conflicting duties. He will suggest forensic psychiatry is not unique but even treating psychiatrists have conflicting duties. The difference is which duties are primary. Dr. Janofsky will discuss reducing the risk of suicide on inpatient wards. Dr. Scott will conclude with predicting and preventing juvenile violence including a discussion of risk factors for violence. Questions will follow each presentation.

NO. 1

STALKING: OVERVIEW AND CLINICAL RISK MANAGEMENT

Speaker: Debra Pinals, M.D.

SUMMARY:

Stalking has gained increased attention in recent years. Anti-stalking legislation was promulgated across the country fairly quickly after some high profile deaths became a focus of attention. The stalking-victim dynamic is complex, and various typological constructs

exist that can help determine approaches to risk management. Basic characteristics, including the underlying motivation of the stalker, the presence of particular mental health symptoms and the nature of the relationship between the stalker and the victim are all important to consider. This presentation will review the epidemiology of stalking, examining particular subtypes of stalking, as well issues pertaining to treatment of the stalker and assistance in helping the victim cope and minimize collateral consequences related to being stalked.

NO. 2

THE DETECTION OF MALINGERED HALLUCINATIONS

Speaker: Phillip Resnick, M.D.

SUMMARY:

One of the easiest ways for a person to accomplish an unjustified hospital admission or to attempt to fake an insanity defense is to mangle auditory or visual hallucinations. This session will review research on genuine auditory and visual hallucinations and identify signs of malingered hallucinations. Psychotic hallucinations will be distinguished from non-psychotic hallucinations. Suspect auditory hallucinations are continuous rather than intermittent, vague or inaudible, and not associated with delusions. Persons faking auditory hallucinations may say they have no strategies to diminish malevolent voices and claim that all command hallucinations were obeyed. Malingerers are more likely to report extreme severity and intensity of their hallucinations. Suspect visual hallucinations are more likely to be reported as black and white rather than in color, be dramatic, and are more likely to include miniature or giant figures. Resolution of genuine hallucinations with antipsychotic treatment will be covered. The audience will have an opportunity to analyze a brief videotape to identify clues to whether the individual has genuine or faked hallucinations.

NO. 3

PSYCHIATRY AND THE DEATH PENALTY: DUTIES, DILEMMAS, AND DEATH

Speaker: Charles Scott, M.D.

SUMMARY:

Thirty-two states, the federal government, and the military have the death penalty. In criminal cases involving a potential capital sentence, psychiatrists are frequently requested to conduct a mental health evaluation of the defendant for a variety of reasons. These evaluations may include an assessment of the defendant's competency to stand trial, competency to represent oneself, criminal responsibility, competency to be sentenced, assessment of aggravating or mitigating circumstances, and competency to be executed. Courts may also request psychiatrists to evaluate and testify about the potential emotional harm caused to surviving victims. This presentation summarizes key U.S. Supreme Court cases that establish the constitutionality of the death penalty with a focus on recent cases that address capital punishment on minors and those with intellectual disability. In addition, ethical guidelines for psychiatrists' participation in executions will also be reviewed.

**NO. 4
THE CHALLENGES OF PRACTICING AT
THE INTERFACE OF PSYCHIATRY AND
LAW**

Speaker: Robert Weinstock, M.D.

SUMMARY:

Forensic psychiatrists face the challenge of practicing at the interface of the disciplines of psychiatry and law with very different goals and ethics and a different hierarchy of duties than treatment. Unlike treatment the primary duty of the forensic psychiatrists is to answer a legal question. Duties to an individual evaluated are secondary. Society expects certain roles from physicians including duties to individuals. A secondary duty to an individual does not imply that it always is outweighed by the primary duty to answer legal questions such that any role is permissible. For example, helping execute an individual is not. Since questions must be answered honestly some roles may not be appropriate. It can be a challenge to balance conflicting duties but forensic psychiatry is not unique. Even in the treatment context where patient welfare is unique that duty can be outweighed by duties to society in contexts like child abuse reporting where the secondary duty to society can become primary and require actions that can be harmful to a patient. But a

challenge does not mean practitioners should avoid complex roles and conflicting duties.

**NO. 5
REDUCING INPATIENT SUICIDE RISK:
IMPROVING OBSERVATION PRACTICES**

Speaker: Jeffrey S. Janofsky, M.D.

SUMMARY:

Of the 32,000 yearly U.S. suicides a year, 5% to 6% occur in the hospital. Hanging and jumping are the most common ways inpatients complete a suicide. Participants will understand how a human factors analysis approach can improve inpatient observation practices, and can reduce potential critical errors that could lead to completed inpatient suicide. Participants will understand how the failure-modes-effects analysis (FMEA) process can increase collaboration and communication between a multi-disciplinary staff to reduce inpatient suicide risk. The standard of care for inpatient suicide risk prediction will also be reviewed.

**NO. 6
ASSESSMENT OF JUVENILE VIOLENCE:
FROM PREDICTION TO PREVENTION**

Speaker: Charles Scott, M.D.

SUMMARY:

In 2011, law enforcement agencies in the U.S. made nearly 1.5 million arrests of persons under age 18. Although high profile cases involving juvenile offenders suggest a rise in juvenile violence, the 2011 juvenile violent crime index arrest rate was at its lowest level in more than three decades. This presentation summarizes key risk factors important to identify when assessing a juvenile's risk of violence. Particular attention is provided to concerns that surround the labeling of a youth as a "psychopath." Updates on violence characteristic of juvenile gangs and school shooters will be provided. Suggested intervention and prevention program are reviewed. Finally, key U.S. Supreme Court cases that address the imposition of life without the possibility of parole for juvenile offenders will be discussed.

**MARIJUANA IN 2015: STATE OF THE
POLICY AND TREATMENT**

Chairs: Laurence Westreich, M.D., Kevin P. Hill, M.D.

Discussant: Herbert D. Kleber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the science supporting the use of cannabinoids for various medical indications and how the science to current medical marijuana laws in North America; 2) Discuss the impact of legalization of marijuana on the State of Washington and how this relates to the future of legalization of marijuana; 3) Diagnose and treat patients with cannabis use disorders based upon the latest scientific evidence.

SUMMARY:

Marijuana continues to be a hot topic in North America. In the United States, state after state has been faced with questions around decriminalization, medical marijuana, and, most recently, legalization of marijuana. Fifty-eight percent of Americans currently are in support of the legalization of marijuana. While these debates rage, use of marijuana among Americans, particularly young Americans, continues to rise as the perception of marijuana's risk decreases. Unfortunately, there appears to be a wide gap between the science and the public perception of issues related to marijuana, and it is increasingly difficult to obtain evidence-based information about marijuana from unbiased sources. Psychiatrists are in a difficult position as experts on marijuana—often being asked by both patients and colleagues to comment on the risks of marijuana in the face of these complex policy issues. In this Presidential Symposium, we will address the important and often polarizing policy issues from an evidence-based perspective and we will also help psychiatrists feel more comfortable diagnosing and treating patients who suffer from cannabis use disorders. First, we will set the stage for our symposium by briefly reviewing the latest epidemiological data regarding marijuana use among both young people and adults, as well as the evidence for the adverse health effects of regular marijuana use. We will then discuss the science supporting the use of cannabinoids in various medical conditions and how that relates to current medical marijuana laws in North America. We will then begin to explore the complicated issue of legalization of the

recreational use of marijuana, using the experiences thus far from the state of Washington as a reference point. Arguments both for and against legalization of the recreational use of marijuana will be presented. Finally, we will help psychiatrists feel more comfortable diagnosing and treating the subset of marijuana users who develop cannabis use disorders by examining the latest research in behavioral interventions and pharmacotherapies. The symposium will conclude with a lively discussion of the issues we covered.

NO. 1 MEDICAL MARIJUANA: WHAT A PSYCHIATRIST NEEDS TO KNOW

Speaker: Kevin P. Hill, M.D.

SUMMARY:

As of late 2014, twenty-three states and the District of Columbia had enacted laws allowing their residents access to medical marijuana and many more states are currently debating the merits of medical marijuana. At the same time, we are learning more about the risks associated with the regular use of marijuana while use of marijuana among young people is rising and their perception of its risk is declining. Thus, psychiatrists have a potentially vital role to play in educating their patients, the public, and policymakers about the science of marijuana and cannabinoids. Dr. Hill will review both the epidemiology of marijuana use as well as the latest data on the potential harms associated with the regular use of marijuana. He will then discuss the scientific evidence on the use of marijuana and cannabinoids in various medical conditions and how this relates to medical marijuana laws already in place in North America. Finally, Dr. Hill will review the practical aspects of medical marijuana laws and how they might affect your clinical practice.

NO. 2 LEGALIZATION OF THE RECREATIONAL USE OF MARIJUANA: ARE WE READY?

Speaker: Andrew J. Saxon, M.D.

SUMMARY:

Legalization of the recreational use of marijuana has been a polarizing topic in North America recently, and the issue is not going away. In many instances, the debate has devolved into

advocates on either side of the debate cherry-picking some data and spinning other data, so there is a critical need for an evidence-based, balanced perspective. Two states, Washington and Colorado have already legalized the recreational use of marijuana and we are beginning to see how this is playing out. Psychiatrists are looked at as experts on the topic of marijuana and thus have the potential to play a key role in important policies such as legalization of marijuana. Dr. Saxon will look at legalization from the lens of the experiences of Washington state. He will review both the pros and cons of legalization from an evidence-based perspective and comment on how these arguments fit with his observations from Washington to this point.

NO. 3 DIAGNOSING AND TREATING CANNABIS USE DISORDERS

Speaker: Frances R. Levin, M.D.

SUMMARY:

Marijuana is the most commonly-used illicit drug in North America by far, and millions of North Americans currently meet DSM 5 criteria for cannabis use disorder. The evolving policies related to medical marijuana and legalization of the recreational use of marijuana may increase the numbers of North Americans addicted to marijuana. Psychiatrists are often looked to by patients, the public, and colleagues as experts on marijuana and increasing numbers of patients we treat use marijuana. Therefore, psychiatrists must be comfortable in diagnosing and treating patients with cannabis use disorders. Dr. Levin will describe how she approaches the evaluation of a patient who may have a cannabis use disorder. She will then review the latest evidence on the use of both behavioral interventions and pharmacotherapies as treatments for cannabis use disorders. She will then review what a comprehensive treatment plan might look like for a patient with a cannabis use disorder.

HOW THE MIND AFFECTS THE BODY AND THE BODY AFFECTS THE MIND: INFLAMMATION, DEPRESSION, DRUGS, AND DISEASE

Chair: S. Nassir Ghaemi, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how depression and bipolar illness worsen the pathophysiology of cardiovascular disease and dementias; 2) Describe the evidence for benefit, lack of benefit, and/or harm with antidepressants, antipsychotics, and lithium for cardiovascular diseases; 3) Describe the evidence for benefit with lithium in prevention of dementias.

SUMMARY:

The central organizing feature of these presentations will be about two aspects the relation between the body (medical illnesses and the effects of psychotropic drugs) and the mind (mood conditions). First, the audience will learn about new ideas regarding how the body affects the mind: Specifically, we will examine how psychotropic medications affect the brain and body in ways that are outside usual discussions about neurotransmitters, but rather involve inflammatory mechanisms and long-term neuroplastic changes. Second, the audience will learn about new ideas regarding how the mind affects the body: Specifically, we will examine how depressive conditions, including bipolar illness, can worsen medical outcomes of cardiovascular disease, metabolic syndrome, and dementias. Individual presentations will discuss how depression and mania relate to heart disease and inflammation, and how antidepressants and neuroleptic agents are, or are not, helpful for those conditions. Further, the audience will hear about how lithium reduces risks of medical mortality, including from cardiovascular disease, and may help prevent Alzheimer's dementia.

NO. 1 ANTI-INFLAMMATORY AGENTS AS ANTIDEPRESSANTS: TRUTH OR DARE

Speaker: Charles Raison

NO. 2 INTEGRATING INFLAMMATION WITH OTHER DISEASE MODELS IN MOOD DISORDERS

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

A convergent mechanism hypothesized in mood disorders is the immunoinflammatory system. Disturbances in components of

immunoinflammatory system have been implicated in the pathogenesis phenomenology, comorbidity, and treatment of mood disorders. Available evidence indicates that conventional pharmacotherapy, as well as, psychosocial treatments may also engage immunoinflammatory systems. Several agents that are currently approved for the treatment of inflammatory based disorders, e.g., inflammatory Bowel Disease, pain may also have utility in the treatment of mood disorders. Moreover, the availability of these treatments in generic form as well as their scalability provides an opportunity to repurpose these agents to suppress systems and possibly modify symptoms across the domains of psychopathology encountered in mood disorders. Moreover, the use of such treatments serves as a probe to test hypothesis regarding illness pathogenesis and treatment. This presentation will provide a theoretical background for such an approach with a particular view to discuss a strategic approach for developing these agents in mood and cognitive disorders. In addition, inflammation as a convergent target for psychosocial and behavioural strategies, e.g., aerobic exercise will also be discussed. A practical clinical perspective will also be offered.

NO. 3 DEATH, DEPRESSION AND HEART DISEASE

Speaker: Steven Roose, M.D.

SUMMARY:

The complex relationship between depression and ischemic heart disease (IHD) has multiple dimensions including:

1) depression early in life is a risk factor for the development of ischemic heart diseases(IHD); Among otherwise healthy subjects, depression increases the risk of IHD 1.5- to 2-fold.

2) Patients with IHD and depression have an increased rate of cardiovascular mortality in post-MI patients with Depression. This increased risk may result from increased risk of arrhythmias, increased platelet aggregation associated with psychological stress and depression, decreased adherence to lifestyle changes or to medical regimen.

The mean relative risk of mortality in depressed vs. non depressed post MI patients is 4.1 (range, 2.3 to 7.5), the highest risk occurs in first

6 months post-MI, and the risk is proportionate to depression severity and even minor symptoms of depression contribute to significant additional mortality risk.

3) Data from a number of studies suggest that treatment with SSRIs relatively safe in post-MI patients and may reduce the risk serious cardiovascular events. The mechanism for this risk reduction may well be in part due to the decreased platelet activation associated with SSRI treatment

NO. 4 LITHIUM FOR PREVENTION OF DEMENTIAS AND REDUCTION OF MORTALITY

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

In this presentation, the audience will be presented evidence that depression and bipolar illness increase the risk of dementias (as well as cardiovascular disease, which will be presented by other speakers). The scientific literature will be systematically examined to describe the effects of lithium on prevention of dementias and reduction of mortality. The evidence reviewed will be of two types: epidemiological studies and randomized trials. Epidemiological studies often relate to geological analyses of medical outcomes in areas with high lithium content in drinking water; in those studies, lithium is associated with reduced cardiovascular mortality rates, reduced suicide rates, and reduced homicide rates. Prospective clinical studies include a 50 year outcome study in Zurich which also found marked reduction in suicide and cardiovascular disease with lithium treatment of mood illnesses, as well as notable reduction in dementia rates. Other such observational data will be examined linking lithium to reduction in dementia, and some recent randomized trials of lithium in mild cognitive impairment will be presented. The basic neurobiology of lithium's extensive neuroprotective effects will be described.

MAY 17, 2015

UTILIZING PSYCHODYNAMIC PSYCHIATRY IN THE MEDICAL SETTING

Chair: Michael Blumenfeld, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session participants will be able to better recognize countertransference of physicians working in the medical setting. ; 2) At the conclusion of this session participants will be able to use psychodynamics to address nonadherence to medical care by patients with HIV/AIDS.; 3) At the conclusion of this session participants will be able to better utilize psychodynamic psychotherapy to treat somatoform disorders in children. ; 4) At the conclusion of this session participants will be able to use psychodynamic techniques to treat dying soldiers undergoing surgical treatment. ; 5) At the conclusion of this session participants will be able understand how learning psychodynamics will help medical students become better physicians.

SUMMARY:

Dr. Michael Blumenfield as Chair of the symposium will note that the the application of psychodynamic theory has great value in the medical setting from the early work of Sigmund Freud to present day psychiatry. Dr. Cesar Alfonso will show that by understanding countertransference, physicians can be more effective in treating medical illness. He will review how using this approach can protect patients from under-treatment, delayed care and the failure of empathy. Dr. Mary Ann Cohen will specifically look at HIV/AIDS and give examples how psychodynamic theory is pertinent to this condition. This becomes particularly important in helping persons with HIV adhere to medical care and antiretroviral therapy. Somatoform Disorders in childhood and adolescence present special challenges and Dr. Clarise Kestenbaum will discuss how psychodynamic psychotherapy should be integrated into the treatment of these young patients. Dr. Chris Perry will then draw upon his experience observing the surgical treatment of dying soldiers. He will explain how dignity and meaning in the face of illness and injury open the door for psychodynamic treatment for those suffering the psychological wounds of war. Dr. Nada Stotland will make the case that the medical student rotation is the ideal place to teach psychodynamics to future physicians. This will help them obtain informed consent, deal with non-adherence to medical advice and communicate with patients and families about

adverse prognoses and outcomes including death. Dr. Paul Summergrad, APA President will conclude the symposium with a discussion of these presentations with a view of how psychodynamics continues to be an important part of modern psychiatry.

NO. 1 PSYCHODYNAMIC ASPECTS OF LIAISON PSYCHIATRY - UNDERSTANDING COUNTERTRANSFERENCE IN PSYCHOSOMATIC MEDICINE

Speaker: Cesar A. Alfonso, M.D.

SUMMARY:

Psychodynamic factors are inherent in the interactions between doctors and patients. At times, interpersonal tension contributes to conflict and may negatively impact clinical care. Examining the multidimensional aspects of countertransference in a general hospital setting could prove useful in understanding psychological dynamics between patients and healthcare providers, as well as among collaborating providers themselves. Liaison Psychiatrists are implicitly expected to consider and recognize countertransference when offering clinical recommendations in the psychosomatic medicine service. The presenter will give a brief historical review of how our understanding of countertransference has changed over the last century towards the more current definition that considers the totality of emotions experienced by the clinician. The presenter's case vignettes will illustrate the vicissitudes of liaison work, clinical care, and supervision of trainees. Group dynamics in hospitals can be elusive and complex, and collaborative multidisciplinary interventions need to be carefully coordinated in order to protect patients from under-treatment, delayed care, and failure of empathy.

NO. 2 PSYCHODYNAMIC APPROACHES TO NONADHERENCE TO HIV MEDICAL CARE

Speaker: Mary Ann Cohen, M.D.

SUMMARY:

Adherence to medical care affects the course and prognosis of every complex and severe

medical illness. Adherence has multidimensional implications for individuals, their loved ones, and their physicians and can prevent suffering, morbidity, and mortality. For persons with HIV, adherence also has public health implications. Persons with HIV need to adhere to medical care and antiretroviral therapy. Indicators of adherence include an undetectable viral load and a normal CD4 count. In the US, of the 1.1 million persons with HIV, only 25% have attained viral suppression. Nonadherence to medical care and risk reduction can lead to HIV transmission. Understanding the psychodynamics of nonadherence to medical care can help both patients and clinicians. The psychodynamics of nonadherence to HIV medical care has biopsychosocial determinants. Early childhood trauma-induced posttraumatic stress disorder is a significant factor in nonadherence to HIV medical care. It is associated with dependence on alcohol and other drugs to numb the pain of trauma as well as with inadequate self-care and mastery through repetition. This presentation explores psychodynamic approaches to nonadherence to medical care in persons with HIV and AIDS.

NO. 3 MEDICAL STUDENTS, CLINICAL EXPERIENCE, PSYCHODYNAMICS

Speaker: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

The medical rotation is an ideal place to teach psychiatry and psychodynamics to medical students. It is a fast and effective way to disabuse students of the notion that they will not need to understand or use psychodynamics in their chosen, non-psychiatric, specialties. They are impressed to learn that a majority of outpatient visits in primary care involve psychiatric problems; if they dismiss those problems as out of their areas of responsibility, they can anticipate a frustrating career. They must learn to understand psychodynamics so as to obtain informed consent for medical and surgical procedures; to deal with non-adherence to medical advice; and to communicate with patients and families about adverse prognoses and outcomes, including death. A common situation involves patients who refuse to tell loved ones about serious medical conditions, or to accept their needed

help. Such patients often have based their self-images on their ability to care for their families. Students can come to understand their fear of being helpless and burdening their families. They can help these patients by saying 'The most generous thing you can do for your family right now is to let them show their appreciation for all you have done by helping you. This will be a new kind of challenge for you.

NO. 4 SOMATOFORM DISORDERS IN CHILDHOOD AND ADOLESCENCE

Speaker: Clarice J. Kestenbaum, M.D.

SUMMARY:

What's in a name? The nomenclature describing somatoform disorders: psychosomatic, psychophysiologic, hypochondriacal and malingering disorders has been superseded in DSM5 by Illness Anxiety Disorder, Conversion Disorder, Psychological Factors Affecting Other Medical Conditions and Factitious Disorder. The effort to bridge the gap between somatic and psychological spheres has led to greater understanding of the mind-body interface by primary care physicians and neurologists, as well as mental health practitioners. For example, pediatricians are now better equipped to diagnose and differentiate among a variety of syndromes and often can determine which treatment is most suitable for an individual patient: DBT, CBT, pharmacotherapy, psychodynamic psychotherapy or combined treatment. Nevertheless, the question remains: who provides the treatment? Most primary care physicians do not have the time nor the training to provide the treatment. A team approach is discussed and clinical vignettes (school refusal, ulcerative colitis and temporal lobe epilepsy) are provided.

NO. 5 HOW DEATH CAN INFORM PSYCHODYNAMIC TREATMENT

Speaker: Christopher Perry, M.D.

SUMMARY:

While deployed to a war zone, I had the opportunity to observe and participate in the surgical treatment of a dying Soldier. The unending compassion and professionalism of the treating team in the face of tragic human

suffering can inform the psychodynamic treatment of war casualties. The injuries suffered by the dying soldier were but an obstacle overcome in the search for meaning and dignity of the treating surgical team. Dignity and meaning in the face of illness and injury open the door for psychodynamic treatment for those suffering the psychological wounds of war.

INTEGRATED AND SHARED CARE IN THE U.S. AND CANADA: LEARNING FROM OUR NEIGHBORS

Chairs: Lori Raney, M.D., Nick Kates, M.B.B.S.

Discussants: James R. Rundell, M.D., Nick Kates, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe and contrast the models of collaborative care currently being utilized in the primary care setting in the US and Canada to identify and adequately treat behavioral health conditions; 2) List the advantages of current models of addressing the health burden of patients with serious mental illness in both US and Canadian models of care; 3) Define the role of the psychiatrist in the models of integrated and shared care in the two countries and describe the responsibility of the psychiatrists in the larger health care arena.

SUMMARY:

The integration of primary care and behavioral health is major focus of health care reform in the US with well-defined models for better treatment of mental illness in primary care settings and emerging models for addressing the physical health of patient with serious mental illnesses. It is well established that untreated behavioral health conditions increase overall health care costs and the American Psychiatric Association has been on the forefront of establishing this connection and looking for solutions and opportunities for psychiatric intervention. With the current and projected psychiatric workforce shortage we must begin to look at models that allow us to extend our expertise in new ways.

In the United States and Canada there have been efforts since the 1990's to integrate primary care and behavioral health with some overlap and distinctiveness among the models that have been developed and are emerging in

the two countries. This Symposium aims to highlight the existing models in each country and have the Discussants and audience compare and contrast the models to distill what we can learn from each other to improve the models of care and further define the roles for psychiatrists' intervention and leadership in these models.

The Symposium will pair speakers from each country (Jurgen Unutzer MD- US and Roger Bland MD "Canada) first on the topic of integrating behavioral health into primary care settings. The second pair of speakers (Ben Druss MD "US and Vicky Stergiopoulos, MD "Canada) will delve into the topic of improving the health status of the SMI population by integrating primary care into specialty behavioral health systems of care. Discussants James Rundell MD "US and Nick Kates MD "Canada- will discuss these models and look at opportunities for both countries to enhance the care they are currently providing along the range of integration. The audience will be invited to participate with an opportunity to ask questions and provide their own observations as we share the stage with our Canadian counterparts in the developing field of Integrated Care.

NO. 1

COLLABORATIVE CARE AND SHARED CARE IN THE PRIMARY CARE SETTING

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

SUMMARY:

Integrated Care programs in which psychiatrists support and work closely with primary care providers to care for defined populations of patients with common mental health and substance use problems offer exciting new opportunities for psychiatrists to extend their reach and help improve the health of populations. Evidence-based integrated care programs are informed by principles of good chronic illness care such as measurement-based practice, treatment to target, and population-based practice in which all patients are tracked in a registry to make sure no one falls through the cracks. We will discuss such core principles of effective integrated care and give examples of psychiatrists working in integrated care programs with diverse patient populations.

NO. 2
COLLABORATIVE MENTAL HEALTH CARE IN CANADA

Speaker: Roger C. Bland, C.M., M.B.

SUMMARY:

Canada has universal healthcare with programs administered by the provinces. The College Of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) formed a joint committee to examine ways for family physicians and psychiatrists to work better together to meet patient and population needs. Two position papers, 1997 and 2011 were published. This latter defines collaborative care, outlines primary care psychiatry and gives a vision for the future. A broader group produced toolkits and research papers. Psychiatry training programs have been changed to include collaborative care. An annual conference is supported.

A program example is in the province of Alberta, which, as part of primary care reform, developed Primary Care Networks (PCNS). There are currently 42 PCNS in the province with 2917 family physician participants and serving 76% of the provincial population. Each has a mental health program. These vary widely but all incorporate some of the principles of collaborative mental healthcare.

NO. 3
PREMATURE MORTALITY IN PATIENTS WITH MENTAL ILLNESSES: THE U.S. EXPERIENCE

Speaker: Benjamin Druss, M.D.

SUMMARY:

This presentation will provide an overview of the problem of premature mortality including updated data from a systematic review of the international literature. It will present current opportunities to address this problem in the United States, particularly under the Affordable Care Act, and consider how these might translate to a Canadian context.

NO. 4
INTEGRATING CARE FOR HIGH RISK AND DISADVANTAGED ADULTS WITH SERIOUS MENTAL ILLNESS: LESSONS LEARNED IN A SYSTEM OF UNIVERSAL ACCESS TO HEALTH CARE

Speaker: Vicky Stergiopoulos, M.D., M.H.Sc.

SUMMARY:

In a mental health system plagued by fragmentation, inequities in access, poorly developed quality measurement or improvement infrastructure and departures from evidence based practice, supporting the primary care needs of high risk and disadvantaged individuals with serious mental illness has become a system priority. This population, including individuals who are homeless and those making frequent use of acute care services, experiences complex comorbidities, premature mortality and challenges accessing appropriate health care. Both co-located and integrated models of collaborative or shared mental health care have been developed in Canada, ranging from community or hospital based to assertive outreach approaches. Lessons learned from integrating primary care within ambulatory specialty mental health care, Assertive Community Treatment, scattered site Housing First and Critical Time Interventions will be described, along with preliminary findings of studies examining factors affecting access, outcomes and health service utilization of the target population within a system of universal access to health care.

GERIATRIC PSYCHIATRY: TREATMENT UPDATES AND NEW PERSPECTIVES

Chair: Susan Schultz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the critical role of listening to the patient's story in the care of the older adult.; 2) Identify the potential benefits and risks associated with the use of citalopram for agitation in patients with Alzheimer Disease; 3) Review the issues involved in the decision to use antipsychotic medication in persons with cognitive decline.

SUMMARY:

Distinct facets of caring for older adults will be addressed in a series of three presentations offered by the American Association for Geriatric Psychiatry. In the first, we will explore the importance of understanding the unique stories of our older patients, and how the dramatic effects of technology have changed

the way we communicate. The essential need for a "compassionate ear" in clinical practice will be illustrated through a case example of an older adult receiving treatment in an emergency care setting. In the second presentation, the challenging issue of medication selection for behavioral disturbances in dementia will be discussed, reflecting an increasingly common problem that is often refractory to non-pharmacologic interventions. The results of the Citalopram for Agitation in Alzheimer Disease Study (CitAD) study will be described, with attention to the cognitive and cardiac effects observed in this large treatment trial. Finally, the third presentation will describe strategies for approaching clinical situations where antipsychotic medications appear indicated for the patient with cognitive decline and persistent behavioral disturbances. The relative roles of side effect management and monitoring, family communication and goals of care will be placed in the context of a clinical case where an antipsychotic medication regimen is utilized.

**NO. 1
OLDER PATIENTS TELLING STORIES TO
DOCTORS IN A TECHNOLOGICAL AGE**

Speaker: Dan G. Blazer II, M.D., M.P.H., Ph.D.

SUMMARY:

This presentation will reflect on the dramatic impact that technology has had on the patient experience, particularly for the older patient trying to convey their illness history. Technology applies knowledge for practical purposes independent of subjective dispositions, personal talents, or moral character of those involved. Technology names the problem and by doing so defines the problem without story. Diagnoses including DSM-5 diagnoses eliminate the need for a "formulation." Yet "illness stories" are deeply therapeutic for tellers / patients. Particularly the older patient requires special attention to ensure they are heard and allowed to hear themselves tell and retell their stories. While this may drive clinicians to distraction, it is essential for older adults to unravel the truth of their experiences, particularly in later life where with illness there may be intermittent disorientation. The essential need for a "compassionate ear" in clinical practice will be highlighted in a case example.

**NO. 2
THE CITALOPRAM FOR AGITATION IN
ALZHEIMER DISEASE STUDY: EFFECT
OF CITALOPRAM ON AGITATION IN
DEMENTIA**

Speaker: Bruce G. Pollock, M.D., Ph.D.

SUMMARY:

This presentation addresses the important need for pharmacologic interventions for agitation in dementia that avoid the use of antipsychotic medications. Given the growing population with dementia and the common occurrence of agitation, the Citalopram for Agitation in Alzheimer Disease Study (CitAD) sought to evaluate the efficacy of citalopram for agitation in patients with Alzheimer disease who were also receiving psychosocial interventions. The results of the CitAD study will be summarized as well as the implications for implementation in clinical practice. Overall, the addition of citalopram reduced agitation and caregiver distress. These positive findings will be discussed in reference to the cognitive and cardiac adverse effects of citalopram. Directions for future efforts to address the problem of behavioral disturbances in dementia will be discussed as well.

**NO. 3
ANTIPSYCHOTIC MANAGEMENT IN THE
ELDERLY: GUIDELINES AND GOALS OF
CARE**

Speaker: Susan Schultz, M.D.

SUMMARY:

This presentation will reflect on the multifactorial nature of optimal behavioral outcomes in the care of persons with advanced dementia. Despite the many concerns regarding antipsychotic medication, they remain in common usage in clinical practice and require special attention in selection and monitoring. Most importantly, the goals of care for each patient must be considered in each individual case. The role of movement disorders, extrapyramidal side effects and management of complex drug interactions will also be addressed briefly in relation to guidelines and summary data addressing the comparative effectiveness of antipsychotic use in dementia. Finally, evidence will be discussed regarding the relative impact of psychiatric symptoms and

psychotropic medications in long terms outcomes in the older patient with a neurocognitive disorder.

UNDERSTANDING RESILIENCE IN THE FACE OF TRAUMA: FROM MOLECULES TO CIRCUITS TO BEHAVIORS

Chair: Charles R. Marmar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize pre-trauma neurobiological and behavioral factors that prospectively promote resilience; 2) Understand the post-trauma neurobiological and behavioral cascade leading to resilience; 3) Identify neurobiological and behavioral factors underlying the clinical presentation of resilient individuals.

SUMMARY:

Exposure to psychological trauma is ubiquitous. Indeed, epidemiological estimates of lifetime trauma exposure in the population are as high as 90%. Despite nearly universal exposure, rates of posttraumatic psychopathology remain relatively low (between 10-20%). These heartening statistics have led to the emergence of a new area of research into factors that promote optimal psychological outcomes following trauma exposure, or resilience. The neurobiology of resilience is a particularly important and understudied area of inquiry. Nested soundly within the RDoc framework of research, the researchers presenting as part of this symposium are working collaboratively and independently, to empirically characterize the multidimensional cascade from molecules to circuits to behavior. This area of inquiry holds great promise as the identification and characterization of the neurobiological development of resilience following trauma can lead to new treatment targets that promote resilience and ultimately prevent the development of posttraumatic psychopathology.

NO. 1 PSYCHOSOCIAL AND GENETIC MARKERS OF RESILIENCE FOLLOWING REPEATED CHILDHOOD TRAUMA EXPOSURE

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

Exposure to stressful events during development has consistently been shown to produce long-lasting hormonal, neural, and behavioral effects, which lead to significant increase in risk for neuropsychiatric disorders such as posttraumatic stress disorder and depression. Recently reported genetic association studies indicate that these effects may be mediated, in part, by gene x environment interactions involving polymorphisms in a number of gene pathways, including CRHR1, FKBP5, and ADCYAP1R1 within the hypothalamic pituitary adrenal (HPA) stress pathway. Data suggest that these genes regulate HPA axis function in conjunction with exposure to child maltreatment or abuse. Other gene pathways including BDNF, NPY, and OXT may be related to neural plasticity and recovery from fear despite severe trauma. In addition to these prior candidate-focused pathways, genome-wide association studies are suggesting other, previously unknown, avenues for exploration in understanding risk and resilience. This talk will review the genetic literature associated with resilience, and how these genetic markers interact with psychosocial variables, despite repeated childhood trauma exposure. Early life trauma leads to disease through the developmental interaction of genetic variants with neural circuits that regulate emotion, together mediating risk and resilience in adults. By understanding neural circuit, hormonal and psychological pathways associated w/resilience [see folder for full abstract]

NO. 2 TRAJECTORIES OF POSTTRAUMATIC STRESS AND RESILIENCE: IDENTIFICATION OF PHENOTYPIC PATTERNS OF TRAUMATIC STRESS RESPONSE ACROSS CONTEXTS AND SPECIES

Speaker: Isaac R. Galatzer-Levy, Ph.D.

SUMMARY:

Individuals respond to traumatic stressors in diverse ways. Many will be resilient; others will develop significant posttraumatic stress responses but recover over time, while still others will develop chronic non-abating posttraumatic stress pathology. Characterizing

these phenotypic responses can increase the discovery of novel predictors, causal mechanisms, and long-term consequences of these heterogeneous stress responses. Further, it can facilitate the development of treatments that are targeted to alter the course of traumatic stress. The panelist will review current findings on: a) trans-diagnostic trajectories of posttraumatic stress and resilience identified in diverse populations responding to heterogeneous traumatic stressors; b) the identification of prospective psychological and neuroendocrine risk factors along with long-term consequences for mortality; c) the benefit of identifying posttraumatic stress and resilience phenotypes to identify heterogeneity in treatment effects; and d) the identification of phenotypes in animal models of threat (fear) extinction learning and active avoidance acquisition.

**NO. 3
CAUSAL PATHS FROM GENETIC
INFLUENCE TO RESILIENCE: EVIDENCE
FROM A PROSPECTIVE COHORT STUDY
OF HIGHLY TRAUMA EXPOSED URBAN
POLICE OFFICERS**

Speaker: Charles R. Marmar, M.D.

SUMMARY:

There is accumulating evidence that resilience is influenced by a complex neurobiological cascade beginning with genetic variability ultimately leading to individual differences in behavioral and neuroendocrine responses to traumatic stressors. In the current work, we utilize multimodal data including genetics, peripheral neuroendocrinology, along with in depth clinical and social features in a large cohort of highly trauma exposed urban police officers followed from academy training to 7 years into active duty. Trajectories of risk and resilience were identified empirically using Latent Growth Mixture Modeling and a causal graph analysis was utilized to integrate all sources of subject information to identify the chain of transmission from genetics to pre and post-deployment neuroendocrine and clinical vulnerabilities. We find that SNps associated with Neuropeptide S receptor gene, FKBP5, MR and GR genes, FAAH, COMT influence diurnal and stress response peripheral neuroendocrinology, substance use patterns, general distress, appraisals about safety, and

sleep both before and following trauma exposure leading to trajectories of maladaptive stress or resilience. This unique prospective design allows for the identification developmental pathways to risk and resilience based on individual differences in neurobiology prior to trauma exposure.

**NO. 4
NEUROBIOLOGICAL MECHANISMS OF
RECOVERY FROM POSTTRAUMATIC
STRESS**

Speaker: Amit Etkin, M.D., Ph.D.

SUMMARY:

A hallmark of post-traumatic stress disorder (PTSD) is its persistence for many years following a major life trauma. Despite this, some individuals can experience a striking recovery after a relatively brief psychotherapeutic intervention, even despite years of chronic and disabling illness. Thus, a capacity for resilience exists for some patients, and its neural mechanisms are largely unknown. Brain circuits important for emotional reactivity, various types of emotion regulation, and cognitive control have all been implicated in PTSD. Contributing to and resulting from these impairments are historical factors (e.g. childhood maltreatment), symptom burden, and cognitive/emotional style (e.g. dissociative features). This talk will focus on new findings from a recently completed comprehensive study of the neurobiological and psychological factors associated with recovery versus non-recovery from PTSD using a well-characterized psychotherapy – prolonged exposure (PE). Central to PE is confrontation by the patient of memories and physical reminders of feared or avoided stimuli. Successful outcome with PE is predicted by specific emotional reactivity patterns, capacity for emotion regulation and cognitive control, and specific psychological factors. Together, these findings illustrate a resilient profile even in the context of chronic illness.

MAY 18, 2015

UPDATES IN WOMEN'S HEALTH

Chairs: Linda L.M. Worley, M.D., Christina L. Wichman, D.O.

Discussant: Michelle Riba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the consequences of intimate partner violence. ; 2) Describe the psychological impact infertility and pregnancy loss can have on a patient and her partner. ; ; 3) Describe the risks of psychotropic medication use to the fetus and breast-feeding infant. ; 4) Compare risk and benefits of methadone versus buprenorphine in pregnancy. ; 5) Describe common sexual difficulties associated with sexual trauma, infertility and fetal loss.

SUMMARY:

Working in the field of women's mental health is both challenging and extremely rewarding. The rapid influx of literature addressing whether a medication is safe to prescribe in pregnancy and lactation creates great angst for the clinician in the field. Staying abreast of state of the art perinatal pharmacotherapy is critically important. It is also essential to recognize the prevalence of trauma in the lives of the women who seek relief from ongoing pain and suffering. Psychosomatic medicine physicians treating women throughout their reproductive years encounter many women who continue to struggle with complex presentations including tobacco, alcohol and illicit substance use along with co-morbid medical and psychiatric conditions. This symposium will focus on the practical treatment of these women.

We will begin by reviewing the scope of the problem of trauma and violence in the lives of women and how it is often associated with co-morbid medical, psychiatric and substance use disorders. Psychosomatic medicine experts in women's health will discuss the psychological impact of infertility and pregnancy loss, and strategies in working with these women and their partners. Psychopharmacological management for pregnant and breast-feeding women who suffer with depression, anxiety, PTSD, bipolar and psychotic disorders, and substance use disorders (including tobacco, alcohol and opioids) will be reviewed in detail. Examples of clinical documentation will be provided. Participants will be armed with the tools to critically analyze future publications. Lastly, addressing the sexual well-being of these patients will be discussed. Throughout the symposium, clinical cases will be interwoven demonstrating the implementation of evidence-based practices in a clinical setting.

NO. 1

INTIMATE PARTNER VIOLENCE AND PSYCHOSOMATIC MEDICINE

Speaker: Donna Stewart, M.D.

SUMMARY:

Intimate partner violence (IPV) is a global human rights and public health issue that disproportionately affects women. Physical and mental health disorders are common sequelae of IPV and both have relevance to general psychiatrists and psychosomatic medicine specialists. In addition to signs of acute trauma (e.g., fractures, contusions, lacerations etc.), less obvious physical symptoms (chronic pain, musculoskeletal complaints, chronic fatigue, irritable bowel and medically unexplained symptoms) may be seen by psychiatrists, often without the patient disclosing IPV. Psychological disorders which may follow IPV include depression, anxiety, PTSD, sexual disorders and insomnia, again without IPV disclosure.

This presentation will review the epidemiology, risk factors, physical and mental health sequelae of IPV and how to inquire about, and respond to, IPV by mental health professionals.

NO. 2

MANAGEMENT AND ASSESSMENT OF ALCOHOL, TOBACCO AND OPIOID USE DISORDERS DURING PREGNANCY

Speaker: Leena Mittal, M.D.

SUMMARY:

Substance use disorders in women can present differently than in men, often with a distinct natural history, and their persistence during pregnancy raises unique concerns for treaters. While pregnancy is a time of great motivation to improve health-related behaviors resulting in decreases in use of tobacco, alcohol and other addictive substances, there is a subset of women who are unable to stop use of substances during pregnancy. These patients represent a more refractory subpopulation of substance use disorders requiring a collaborative approach informed by principles of perinatal psychiatry and a knowledge of their obstetrical needs. In this presentation, assessment and management of alcohol, tobacco and opioid use disorders during pregnancy will be discussed.

NO. 3

INFERTILITY AND PERINATAL LOSS: WHEN THE BOUGH BREAKS

Speaker: Nancy Byatt, D.O., M.B.A.

SUMMARY:

A substantial number of women and their partners suffer from perinatal loss and infertility. Approximately half of stillbirths occur in seemingly uncomplicated pregnancies. Despite evaluative efforts, in half of all stillbirths, no cause for fetal demise is ever found. Women suffering from a stillbirth may experience sadness, guilt, or anxiety symptoms, including symptoms consistent with PTSD. Evidence is controversial regarding how to best handle perinatal loss, especially regarding delivery and contact with the infant. Additionally, up to 10% of couples suffer from infertility. Women who suffer from infertility have higher rates of depression and anxiety and these rates may increase as fertility treatment progresses. The presentation will provide the knowledge base that providers need when evaluating and treating women with infertility and/or perinatal loss. The presentation will describe: 1) the psychological effects of infertility and perinatal loss; 2) how to best support and treat women and their partners who are suffering from infertility and/or a perinatal loss; and, 3) how to collaborate with other providers (reproductive medicine, OB/GYN, and maternal-fetal medicine) to provide the best care.

NO. 4 PSYCHOTROPIC MEDICATION MANAGEMENT IN PREGNANCY AND POSTPARTUM FOR DEPRESSION AND ANXIETY.

Speaker: Madeleine Becker, M.D.

SUMMARY:

Depression and anxiety are common in pregnancy and in the postpartum period. Untreated psychiatric illness during and after pregnancy has been associated with adverse effects on the mother and the baby. Despite this, many women are either undertreated, or untreated, as doctors may be hesitant to recommend medications to pregnant or lactating mothers. Subsequently, women may not be well informed of the risks and benefits associated with the use of taking medications during pregnancy. This presentation will: 1) discuss the impact of untreated depression and

anxiety disorders in pregnancy and postpartum; 2) Discuss treatment decision-making, both to help guide the practitioner and to help educate the patient; 3) summarize the current data on the safety of antidepressant/anxiolytic medication use in pregnancy; 4) provide an overview of the safety of antidepressants and anxiolytics in lactation.

NO. 5 PSYCHOPHARMACOLOGIC APPROACHES IN THE PERINATAL PERIOD: MOOD STABILIZERS AND ANTIPSYCHOTICS

Speaker: Christina L. Wichman, D.O.

SUMMARY:

Psychiatric disorders during pregnancy and the postpartum period are very common and as such, psychiatrists are often asked to evaluate and treat pregnant and postpartum women. Unfortunately, psychiatrists often do not feel well-equipped to manage treatment of perinatal patients, especially with the use of mood stabilizers and antipsychotics; this is in part due to the concerns about the potential impact of medications on the fetus, pregnancy and delivery itself, and/or lactation. Trying to navigate the literature on the safety of these medications during pregnancy and lactation can also be confusing and frustrating due to conflicting and controversial evidence. We will provide an overview of the current evidence for the using mood stabilizers and antipsychotics during pregnancy and lactation. Additionally, information as to how to document these conversations with patients will be provided.

NO. 6 PROMOTING SEXUAL HEALTH AND WELL-BEING

Speaker: Linda L.M. Worley, M.D.

SUMMARY:

Sexual difficulties (e.g. decreased desire, discomfort, dissatisfaction and difficulty achieving orgasm) are highly common in the lives of the women we treat, yet limited curricula exist within medical school or psychiatric training devoted to achieving competence in this area. This brief presentation will address 1) What our patients need from us when they have sexual complaints; 2) How to ask about sexual

health; and 3) What to recommend to help achieve overall sexual health and wellbeing. Clinical examples will be provided.

ONE DREAM, THREE PERSPECTIVES: THE PLACE OF THE DREAM AND DREAMING IN CLINICAL PRACTICE AND TRAINING

*Chairs: Mark D. Smaller, L.C.S.W., Ph.D.,
Harriet L. Wolfe, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the controversy over the place of the dream in clinical practice; 2) Differentiate between three theoretical views of dreams: Freudian, British School and Jungian; 3) Recognize opportunities for dream interpretation within a clinical hour.

SUMMARY:

Dreams have held interest for individuals and cultures for millennia and in the last century were thought to be a "royal road to the unconscious". Concurrent with growing cultural interest in fast news and medical/economic interest in fast cures, many clinicians' interest in dreams has waned. Nonetheless, the creation of a dream and the place of dreaming in a person's life and in the context of a clinical treatment offer unique points of access to personal meaning and clues to a patient's strengths as well as his/her psychological challenges. The way a dream is understood and discussed holds great potential for enhanced resilience.

This Presidential Symposium will offer three different psychoanalytic perspectives on dreaming and emphasize the value of dreams clinically and pedagogically. An analytic session with a dream embedded in it will be presented. Three psychoanalysts representing Freudian, British School and Jungian perspectives will discuss their understanding of the dream, show how they would use the dream in the clinical hour with the patient and describe how they would introduce a psychiatric resident to analytic theory and technique as it relates to understanding and discussing a dream with a patient.

NO. 1 A DREAM WITHIN AN ANALYTIC SESSION

Speaker: Jan A. Seriff, Psy.D.

SUMMARY:

The presenter will first introduce the clinical context for an analytic hour in which a particular dream was reported by her patient. This is the dream that three analysts will discuss from three different psychoanalytic perspectives. After commenting on how she herself thinks about dreams and their use in a psychoanalytic treatment, the presenter will read the entire clinical hour in which the dream appeared and will repeat the dream to help the audience hold it in mind.

NO. 2 A FREUDIAN PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Harriet L. Wolfe, M.D.

SUMMARY:

A Freudian perspective on dreaming is often focused on the symbolic meaning of dream elements and on references to unconscious aspects of a patient's conscious experience and symptoms. Contemporary Freudians are also interested in how the dream informs the patient's transference to the therapist (its relational meaning) and the developmental level of the patient's effort to solve an aspect of his/her dilemma. Technical questions related to if and when to interpret a dream directly and how to listen to a patient's associations to a dream will be discussed.

NO. 3 A BRITISH SCHOOL PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Adam J. Goldyne, M.D.

SUMMARY:

This discussion will focus on a number of aspects of British thinking about dreams and dreaming. First, for British psychoanalysts influenced by Bion, the colloquial/Freudian definition of "dream" (a conscious experience occurring while asleep) coexists with use of the term "dream" to denote the mental function that generates unconscious meaning from raw emotional experience. It is possible for a patient to have a dream in the colloquial sense, but not to be "dreaming" in the Bionian sense. Conversely, dreaming in a Bionian sense can occur while asleep or while

awake (â€œwaking dream thoughtâ€). When the dreaming function is working, everything that the patient says during the session may be heard as a waking dream, narrating the patientâ€™s here-and-now emotional experience of the session and the transference. We will consider the patientâ€™s dream (colloquially defined) and the rest of the session (the waking dream) with these ideas in mind.

NO. 4

A JUNGIAN PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Barbara Zabriskie, Ph.D.

SUMMARY:

In a Jungian approach, as in contemporary emotions research, dreams emerge from the experience of an individual as a mind-body continuum. Stimulated by charged emotions arising from a psycho-physical self, they employ narratives, images, and personifications to represent and symbolize unmetabolized affects and states of mind. Integration of the issues emerging from dreams can enhance the dreamer's capacity to calibrate feelings and projections. Dreams focus attention on unconscious dynamics which complement or compensate daytime consciousness, called the â€œremembered present" by the neuroscientist Gerald Edelman. In an analytic process, when patient and clinician engage a dream together, the insights often augment, amend, and relativize embedded attitudes. References to similar images in mythologies and religions place dreams in a historical and generational perspective.

21ST CENTURY PSYCHIATRY AT THE INTERFACE OF GENETICS, NEUROBIOLOGY AND CLINICAL SCIENCE

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

Discussant: Paul Summergrad, M.D.

SUMMARY:

This presidential symposium focuses on the future of psychiatry, namely how the remarkable recent advances in neuroscience are currently, and will in the future, being utilized to both elucidate the pathophysiology of the major psychiatric disorders and develop novel treatments.

Charles B. Nemeroff (University of Miami) will describe the burgeoning data base on the long term neurobiological consequences of child abuse and neglect and how these untoward early life stressors interact with genetic polymorphisms and induce epigenetic alterations that result in increased vulnerability to mood and anxiety disorders. The resistant endophenotype is relatively treatment resistant and will require novel strategies based upon its unique pathophysiology.

Daniel Weinberger (Lieber Institute and Johns Hopkins University) will describe the complex mechanisms recently described by which genetic variations produce cellular alterations and ultimately changes in CNS circuits that underlie vulnerability to schizophrenia. More specifically, the pioneering work on epistasis, gene x gene interactions, in this process as an explanation for the results of recent GWAS studies will be explained.

David Rubinow (University of North Carolina) will focus on the critical role of gonadal steroids and the hypothalamic-pituitary-gonadal axis in the etiology of mood disorders in women and the treatment implications of these findings.

Karl Deisseroth (Stanford University) will describe his groundbreaking findings using novel high resolution optical methods to identify and measure the activity of behaviorally relevant neural circuits and determine their role in neuropsychiatric disorders. Both preclinical and post mortem tissue findings will be presented.

Finally APA President, Paul Summergrad (Tufts University) will serve as the symposium discussant.

NO. 1

PARADISE LOST: THE PERSISTENT BIOLOGICAL AND PSYCHIATRIC CONSEQUENCES OF CHILD ABUSE AND NEGLECT

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

SUMMARY:

Brain imaging, neuroendocrine and neurotransmitter studies have revealed the many long-term biological consequences of child abuse and neglect. These changes underlie the increased vulnerability to mood and anxiety disorders in adulthood. Our group and others have demonstrated a number of long term neurobiological consequences of child abuse and neglect including structural and

functional brain imaging changes, neuroendocrine and immune alterations. In particular, alterations in the hypothalamic-pituitary-adrenal (HPA) axis, the major mediator of the mammalian stress response, contribute to the long standing effects of early life trauma. However, not all exposed individuals demonstrate altered HPA axis physiology, suggesting that genetic variations influence the psychiatric consequences of trauma exposure. Variants in the genes encoding the CRF R1 receptor, FKBP5, PAC1, oxytocin receptor, and others interact with adverse early environmental factors to predict risk for stress-related psychiatric disorders. Epigenetic mechanisms have now been shown to play a seminal role in mediating the effects of early life stress. These studies have suggested new molecular targets for drug development, biological risk factors, and predictors of treatment response. Patients with a history of child abuse and neglect exhibit a more severe disease course in terms of earlier age of onset and symptom severity, and exhibit a poorer treatment response to both (see file for complete abstract)

NO. 2 THE SIMPLE TRUTH ABOUT THE GENETIC COMPLEXITY OF SCHIZOPHRENIA

Speaker: Daniel R. Weinberger, M.D.

SUMMARY:

The past decade of genetic studies of patients with schizophrenia have generated enormous datasets with potentially profound insights about the causative mechanisms of illness at a very basic cellular level. This has led to a rethinking of many of the traditional concepts about psychiatric illness. In a nutshell, we can conclude the following from this generation of work. Complex behaviors are the result of multiple factors that interact biologically. Genes are the first objective clues to the causative mechanisms of psychiatric disorders. Across world populations, individual genes by themselves account for very small increments in risk. A small percentage of cases with the diagnosis of schizophrenia have a simpler genetic etiology. There are many developmental pathways to what we call schizophrenia. Many genes implicated in risk for schizophrenia based on single locus and epistatic interactions show predictable associations at the level of cortical

function in normal subjects. The genetics of psychiatric illness is the game changer both in understanding mechanisms and in finding therapeutic targets based on causation, not phenomenology. This presentation will review the scientific basis for these conclusions.

NO. 3 ILLUMINATING NEURAL CIRCUITRY

Speaker: Karl Deisseroth, M.D., Ph.D.

SUMMARY:

This talk will address optical tools for precise, high-resolution investigation of intact biological systems, and application of these tools to study the neural circuit underpinnings of adaptive and maladaptive behavior. Over the past decade our laboratory has created and developed both optogenetics (a technology for precisely controlling millisecond-scale activity patterns in specific cell types using microbial opsin genes and fiberoptic-based neural interfaces) and CLARITY (a technology to optically resolve high-resolution structural and molecular detail within intact tissues without disassembly). Most recently in optogenetics, our team has developed strategies for targeting microbial opsins and light to meet the challenging constraints of the freely-behaving mammal, engineered a panel of microbial opsin genes spanning a range of optical and kinetic properties, built high-speed behavioral and neural activity-readout tools compatible with real-time optogenetic control, disseminated the tools to thousands of investigators, and applied these optogenetic tools to develop circuit-based insight into anxiety, depression, and motivated behaviors. Distinct from optogenetics, our CLARITY technology can be used to transform intact biological tissue into a hybrid form in which components are removed and replaced with exogenous elements, resulting in a transparent tissue-hydrogel that both preserves, and makes accessible, structural and molecular information for

NO. 4 EVERYTHING YOU NEVER WANTED TO KNOW ABOUT SEX: THIS IS YOUR BRAIN ON STEROIDS

Speaker: David R. Rubinow, M.D.

SUMMARY:

The survival of our species (or any mammalian species) is dependent on the ability of reproductive steroids to generate behavioral states by acting centrally to integrate a wide array of peripheral actions, perceptions, and behaviors. The importance of this capacity is such that reproductive steroids also powerfully modulate many non-reproductive behavioral states and play a role in affective disturbances linked to changes in reproductive endocrine function. In addition to regulating virtually every system implicated in depression – both activationally and organizationally – reproductive steroids reveal the exquisite context-dependency of biology/physiology, thus providing critical insights into what is arguably the most important question in psychiatry, namely why do different individuals respond differently to the same stimulus. Mechanisms underlying the context-creating and context-dependent effects of reproductive steroids help explain processes fundamental to our understanding of psychiatric disorders, including sensitization, signal amplification, response programming, differential sensitivity and pharmacodynamics, susceptibility, and network (gene and neural) regulation. These mechanisms further demystify both the therapeutic and adverse behavioral effects of reproductive steroids.

THE PRACTICE OF CHILD AND ADOLESCENT PSYCHIATRY IN THE 21ST CENTURY

Chair: Paramjit T. Joshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the differences between pediatric and adult integrated care systems; 2) Identify ways to improve and enhance mental health care for all youth in diverse populations; 3) Identify the future challenges, opportunities, and changes in the practice of child and adolescent psychiatry.

SUMMARY:

A rapidly evolving knowledge-base and overwhelming financial challenges place child and adolescent psychiatry at a critical juncture that will surely shape its future. Major barriers exist in accessing children's mental health care, healthcare delivery systems are in a constant state of change due to healthcare reform and

mental health parity, and federal research money is declining while we're experiencing exponential growth in developmental neuroscience, developmental psychology, and developmental psychopathology. In addition, healthcare providers experience significant challenges in evaluating and treating youth in diverse populations. This symposium addresses these and other opportunities and challenges in children's mental health with a focus on models for continuing to improve and expand upon the care of children and adolescents with mental illnesses.

NO. 1 INTEGRATED CARE: UNIQUE ASPECTS OF CHILD MENTAL HEALTH

Speaker: Gregory K. Fritz, M.D.

SUMMARY:

Three major forces are behind the inexorable movement toward integrated care: health care reform, mental health parity and existing major barriers to children's access to mental health care. Developmental differences, the epidemiology of pediatric illness, and financial issues unique to the pediatric population differentiate child and adult integrated care systems. The AACAP has taken these factors into account in developing a "best principles" model for integrating child psychiatry into the pediatric health home. A number of barriers to instituting effective integrated care still exist, and fundamental changes in the US healthcare system are essential to broadly implement this fundamental change in service delivery. However, examples of effective pilot programs provide evidence of feasibility and substantial benefit.

NO. 2 WORKING WITH DIVERSE POPULATIONS: HIV, SEXUAL, ETHNIC, AND RACIAL MINORITY YOUTH

Speaker: Warren Y.K. Ng, M.D.

SUMMARY:

As we look towards the future of child and adolescent psychiatry, there are lessons learned in providing mental health services to diverse and often underserved populations. Youth who are HIV positive, sexual, ethnic, or racial minorities, face specific challenges and experience disparities in accessing and utilizing

mental health services. The psychiatrist must understand and navigate the complex family and parental issues since the youth are minors. Creating an empowering treatment alliance with the youth and facilitating an effective support network is critical. The role of stigma with mental health issues is compounded by the additional stigmas specific to the underserved population. Youth born with HIV or acquired afterwards encounter HIV stigma in addition to the complexities of medical treatment, family involvement, disclosure, and consent for care. Sexual minority youth who are lesbian, gay, bisexual, or transgender may be concerned about confidentiality, alliance, and acceptance. Ethnic and racial minority youth and their families experience wider systemic barriers such as socioeconomic differences, racism, educational inequities, and decreased access to care. It is important that we learn from our diversity, especially our underserved populations, in order to improve and enhance mental health care for all youth.

NO. 3 CHILDREN'S MENTAL HEALTH: A CALL TO ACTION

Speaker: Paramjit T. Joshi, M.D.

SUMMARY:

We need to shift our dialogue about children's mental health and think differently. In the decade to come, we will experience continued population growth and an increasing need for mental health care and wellbeing of our children and their families globally. We are certainly at the cusp of great change in our health care system that begs the questions "what will the delivery of mental health services look like in the near future, will the treatments be evidence-based, how much will they cost and will our patient's get better, and how will these outcomes be measured? Children's mental health problems have been called "the major chronic diseases of childhood. We cannot underestimate the magnitude of two forces that have come to bear on us and the change they will bring over the next few decades. The first is the rapidly rising cost of health care and the second the increasing pace and momentum of scientific discovery. A large majority of mental illnesses seen in adults have their origins in childhood. This presentation will focus on how we need to

seize all opportunities to improve and advocate for health care for millions of children.

NO. 4 THE FUTURE OF CHILD AND ADOLESCENT PSYCHIATRY TRAINING AND RESEARCH

Speaker: Bennett L. Leventhal, M.D.

SUMMARY:

As for all of academic medicine, change has been hard and swift for child and adolescent psychiatry (CAP). Declining Federal dollars for training and research have had a tremendous impact on career development. Similarly, reimbursement for clinical services, even with the ACA, makes it difficult for academic medical centers to meet clinical demands for evidence-based care, even if they can recruit skilled practitioners. In all settings, especially primary care, demand for child and adolescent psychiatrists has never been higher while the resources may have reached the nadir. This comes at a time of exponential growth in developmental neuroscience, developmental psychology, and developmental psychopathology, as well as broad concerns about burgeoning numbers of individuals affected by childhood onset psychiatric disorders. A rapidly evolving knowledge-base and overwhelming financial challenges place child and adolescent psychiatry at a critical juncture that will surely shape its future if not determine its survival. These challenges and opportunities will demand unprecedented creativity, flexibility, and tenacity for child and adolescent psychiatry as well as a clear understanding of the evolving policies and other exigencies related this "new era" of support for patient care, research, and clinical training. Critical, strategic actions will be necessary to preserve and advance the field.

MAY 19, 2015

TALKING ABOUT THE BRAIN WITH PATIENTS: SCIENCE, METAPHOR, AND COMMUNICATION

Chairs: Adrienne L. Bentman, M.D., Richard F. Summers, M.D.

Discussant: Christopher K. Varley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the use of neuroscience concepts in several common treatment modalities; 2) Describe the elements one should consider when introducing such concepts in treatment; 3) Participate in a case discussion using the concepts learned.

SUMMARY:

Practice Gap:

The National Neuroscience Curriculum Initiative (NNCI), an educational collaborative sponsored by the APA Committee on Medical Education and Life-long Learning and the American Association of Directors of Psychiatric Residency Training intends to provide an accessible, comprehensible, and practical online neuroscience curriculum to psychiatrists and others in the field. This will allow us to consider the best ways to present this information to our patients, family members, and medical colleagues. This Symposium address some initial ideas regarding how best to accomplish this.

Abstract:

Advances in neuroscience offer psychiatrists the opportunity to understand behavior, emotions, and the illnesses we treat in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Beyond learning the core elements of the functioning of our organ - the brain, remains the discovery of how we will integrate this knowledge into the care of our patients, and more importantly, into our conversations with patients, their family members, and our colleagues in other medical fields. Last year, the AADPRT-APA Symposium introduced audience members to the content of the NNCI and to the ways in which members could use the content to teach themselves and their students about brain function. This year program director/clinician-educators will discuss the use of cognitive neuroscience concepts in their work with patients, family members, and primary care colleagues. We have organized this discussion by treatment modality and relationship. We will address issues of appropriateness, timing, office tools, and "meeting the patient where they are". And we will address the ways in which timing, attunement, and the language of metaphor sometimes speaks best for the science. Lastly, audience and panel members will have the chance to participate in a case discussion using

the concepts learned. The case presentation will include illustrative video clips. The audience will participate in a discussion of the case along with members of the panel.

NO. 1

TALKING THE BRAIN WITH PARENTS

Speaker: Adrienne L. Bentman, M.D.

SUMMARY:

Parents wish for healthy children who are spared a painful youth and grow to adulthood engaged in life and supportive relationships and able to live on their own. Psychiatric illness challenges this parental wish and often derails their child's developmental trajectory along with other family members. Now that we, like our medical peers, have a brain model to plunk on our desks; when, where, how, and with whom should it be shared? How does knowing the neuroscience facilitate the alliance, enhance adherence, and assist the patient and family in charting a new course for the future? These questions will be addressed in the context of common scenarios psychiatrists confront.

NO. 2

NEUROSCIENCE AND COGNITIVE-BEHAVIOR THERAPY: INTEGRATING KNOWLEDGE AND PRACTICE

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

SUMMARY:

After a brief review of key research findings that illustrate the effects of cognitive-behavior therapy on the brain, methods are described for using neuroscience concepts in the practice of cognitive-behavior therapy (CBT). Opportunities for influencing the delivery of CBT with neuroscience concepts include: 1) enrichment of case conceptualizations and treatment plans; 2) enhancement of psychoeducational and normalizing processes of treatment; 4) instillation of hope; and 5) improvement of adherence to both pharmacotherapy and psychotherapy. Clinical examples and patient materials will highlight the usefulness of this approach in practice.

NO. 3

TALKING "THE BRAIN" IN COMBINED TREATMENT

Speaker: Art Walaszek, M.D.

SUMMARY:

Our patients come to us seeking relief from emotional suffering, and they bring with them varied ideas about what is causing that suffering and what will bring relief. Psychotherapy and pharmacotherapy can seem so different from each other that it may surprise patients that these treatments are complementary, that they act in overlapping ways, and that they reinforce each other. After all, why would an antidepressant be effective for depression that seems due entirely to life's stressors, and why would cognitive-behavioral therapy be effective for depression that seems have arisen out of the blue without a precipitant?

A modern neuroscience approach, as taught in the NNCI model, can help us answer these questions for patients and explain to them why combined psychotherapy and pharmacotherapy is the treatment of choice in many situations. This session will discuss this approach, including the models of (a) psychotherapy as a "top-down" modulator of limbic circuitry and psychotropic medications as a "bottom-up" regulator of emotional functioning, and (b) failure of neuroplasticity as a model of mental illness and enhancement of neuroplasticity as a final common pathway for both psychotherapy and medications. These models also help us explain why other approaches, such as exercise, may be effective elements of combined treatment.

NO. 4 TALKING THE BRAIN IN PSYCHODYNAMIC PSYCHOTHERAPY

Speaker: Richard F. Summers, M.D.

SUMMARY:

The psychodynamic model posits that earlier painful life experiences result in later repeated subjective experiences, perceptual distortions and out-of-date behavioral responses. The contemporary psychodynamic therapist recognizes that this process takes place in the brain as well as the mind, and supports the notions of associational networks, a lifelong attachment system, and trauma as a reflection of processes understandable from both perspectives. Psychodynamic therapy is seen as a process of "top down" change that involves selective brain plasticity. In addition to the traditional psychodynamic frame of

treatment that focuses on intra-psychic conflict and maladaptive responses to important relationships and lifecycle stress, a there is a new opportunity for psychodynamic therapy to address difficulties with adaptation to temperament and the experience of psychiatric illness.

NO. 5 TALKING 'THE BRAIN' WITH OUR MEDICAL COLLEAGUES

Speaker: Deborah Cowley, M.D.

SUMMARY:

In their approach to psychiatry and psychiatric patients, our medical colleagues range from being engaged and skilled to lacking confidence, knowledge, or interest. Our jobs as consultants are to meet them where they are, forge effective collaborations, and, in their language, facilitate the care their patients and families need. This experience often feels like that of a cross-cultural interpreter. Neuroscience, the "physiology" of the mind/brain, provides us with an architecture and language we can share and use as a bridge toward a better understanding of the interface of medicine and psychiatry. This session will address the ways in which discussions of neuroscience can facilitate relationships with our primary care colleagues and mental health care for their patients. By highlighting neuroscientific underpinnings of psychiatric disorders and insecure attachment, our discussions may also help combat misconceptions about mental illness, reduce stigma, and help our colleagues better understand and provide mental health care to patients in primary care settings. Common scenarios will be used to illustrate how, when, and where this is useful, and when it is not.

FRONTAL-SUBCORTICAL NETWORKS AND NEUROPSYCHIATRIC CONCEPTS FOR GENERAL PSYCHIATRISTS

Chairs: Sheldon Benjamin, M.D., David Silbersweig, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide several clinical examples of the importance of neuropsychiatry knowledge to general psychiatry practice ; 2) Describe what is meant by prefrontal / executive

function and prefrontal-limbic-subcortical circuits; 3) List several syndromes seen by psychiatrists in the setting of prefrontal dysfunction, including disorders of motivation, traumatic brain injury, and movement disorders.

SUMMARY:

General psychiatrists are increasingly called upon to evaluate and treat neuropsychiatric disorders. The inclusion of milestones in clinical neuroscience for general psychiatry trainees by the Accreditation Council on Graduate Medical Education (ACGME) is one indicator of the importance of neuropsychiatric education for general psychiatrists. Another indicator is the enhanced role psychiatrists will play in Accountable Care Organizations if they can manage the complex differential diagnosis and treatment of patients with neuropsychiatric disorders, whose care can otherwise be quite costly.

Neuropsychiatric training may be acquired by combined or dual neurology-psychiatry residency training, by fellowship training following general psychiatry or neurology training, or by specialization during general psychiatry or neurology residency. The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5 areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social neuroscience.

After presenting a review of prefrontal/executive function and prefrontal-limbic-subcortical circuits, three families of disorders at the interface of psychiatry and neurology that commonly present to psychiatrists will be reviewed: disorders of motivation, traumatic brain injury, and psychiatric comorbidities of extrapyramidal disorders. Each of these families of disorders impacts prefrontal-subcortical circuits of importance to psychiatrists. In all of them, knowledge of the relevant neuroanatomy, pathophysiology, and bedside neuropsychiatric examination leads to better understanding of the patient and increased treatment sophistication. These disorders also embody the aforementioned clinical neuroscience milestones.

This presidential symposium is presented by the American Neuropsychiatric Association (ANPA), an education, advocacy and sub-specialty group for psychiatrists, neurologists, neuropsychologists and clinical neuroscientists who share interests in brain-behavior relationships.

NO. 1 INTRODUCTION TO CLINICAL NEUROSCIENCE EDUCATION FOR PSYCHIATRISTS

Speaker: Sheldon Benjamin, M.D.

SUMMARY:

The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5 areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social and emotional neuroscience. The recent development of these milestones combined with the increased value to accountable care organizations of psychiatrists competent to manage complex neuropsychiatric presentations make neuropsychiatric knowledge. This presentation will include an overview of the clinical neuroscience milestones, a review of neuropsychiatry training pathways, and an introduction to the symposium theme.

NO. 2 A USERS GUIDE TO THE FRONTAL LOBES: WHY PREFRONTAL EXECUTIVE FUNCTION MATTERS

Speaker: Sheldon Benjamin, M.D.

SUMMARY:

Psychiatrists have often looked to their neuropsychology colleagues for testing and interpretation of executive deficits. Yet prefrontal and executive function are major determinants of success in rehabilitation from any psychiatric or neuropsychiatric disorder, so psychiatrists should be expert in this area. After providing simple explanations of prefrontal and executive function and frontal-subcortical circuits, psychiatric and neuropsychiatric

disorders that may involve dysfunction in these circuits will be considered. Prefrontal syndromes with predominantly dorsolateral, orbitofrontal, and cingulate dysfunction will be reviewed. Finally, a few easy to use bedside tests of prefrontal/executive function will be presented with an emphasis on real-world behavioral correlates.

NO. 3 FRONTO-LIMBIC-SUBCORTICAL DISORDERS OF MOTIVATION

Speaker: David Silbersweig, M.D.

SUMMARY:

Neuropsychiatric disorders of motivation offer insights ranging from the clinical (e.g. diagnosis, treatment) to the philosophical (e.g. free will). The frontal-limbic-subcortical brain circuitry underlying goal directed behavior will be reviewed. Examples of related disorders and syndromes will be discussed. These include Tourette's Syndrome, OCD, anhedonia, apathy, akinetic mutism, and impulsivity. These considerations will be integrated into a neuropsychiatric model and approach that transcends neurology-psychiatry distinctions.

NO. 4 NEUROANATOMY AND NEURAL CIRCUITRY OF NEUROBEHAVIORAL CHANGES AFTER TRAUMATIC BRAIN INJURY

Speaker: Thomas W. McAllister, M.D.

SUMMARY:

Traumatic brain injury (TBI) represents the quintessential neuropsychiatric paradigm: it is difficult to appreciate what an individual with TBI and their family experience without understanding the brain regions impacted by biomechanical trauma, and it is equally critical to understand the effect of injury-related neurobehavioral sequelae on outcome after TBI. The neurobehavioral effects of TBI include changes in cognition, changes in personality, and increased risk of developing a host of psychiatric disorders. These neurobehavioral sequelae follow logically from the typical profile of injury associated with TBI. Several cortical regions including frontal cortex, temporal cortex, and hippocampus are particularly vulnerable to TBI. Furthermore, sub-cortical

white matter, particularly in frontal regions and the corpus callosum, are often damaged. Catecholaminergic, cholinergic, and serotonergic systems are vulnerable to disruption acutely and chronically in TBI. These brain regions and neurotransmitter systems are critical components of key frontal subcortical circuits that modulate complex human emotional expression and behavior. This profile of structural and neurochemical injury plays a direct role in the common neurobehavioral sequelae associated with TBI.

NO. 5 TREATING PARKINSON'S DISEASE AND OTHER NEUROPSYCHIATRIC DISORDERS: THE ADVANTAGES OF COMBINED TRAINING IN NEUROLOGY AND PSYCHIATRY

Speaker: John F. Sullivan, M.D.

SUMMARY:

One historical distinction between neurologic and psychiatric pathology is the ability of "neurologic" illness to be more clearly localized neuroanatomically. Advances in our understanding of brain function, catalyzed by evolving imaging technology, have demonstrated that psychiatric illnesses and symptoms do have neuroanatomic correlates, but may be better localized to networks rather than to discrete neural structures. Parkinson disease, long considered primarily a movement disorder and purely "neurologic," is now accepted as a neuropsychiatric disorder with hallmark psychiatric and cognitive symptoms that emerge and evolve in parallel with the motor symptoms. Awareness of meso-cortical and meso-limbic dopaminergic pathways, as well as the role of the basal ganglia in multiple frontal-subcortical networks, is helpful to understand, predict, and manage the non-motor symptoms of Parkinson Disease and related disorders. Combined training in neurology and psychiatry is invaluable in treating neuropsychiatric disorders, providing a thorough grounding and familiarity with the natural history, diagnostic tools, and treatments used by clinicians in both fields to assess and care for these patients.

MEDIA WORKSHOPS

MAY 16, 2015

"THE WAY HE LOOKS": A BRAZILIAN FILM ABOUT BEING YOUNG, GAY, AND BLIND

*Chairs: Richard R. Pleak, M.D., Jose Vito, M.D.
Speakers: Sarah E. Herbert, M.D., M.S.W., Shervin Shadianloo, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how a blind adolescent may experience and explore his sexuality; 2) Recognize risks and derailments in sexual identity formation for blind and gay youth; 3) Provide improved support for blind and gay adolescents. .

SUMMARY:

Background: Blind teenagers and young adults may have more complex and risky psychosexual development than in sighted youth. Blindness may increase the risks and adverse consequences of disclosure of being gay in youth, which can include isolation, bullying, suicidality, and violence. Methods: The film "The Way He Looks" (Brazil, 2014, 95 min., in Portuguese with English subtitles), is about a Brazilian high school student who is blind and gay, and shows how he explores his friendships and sexuality. This sunny, delightful, and moving film was shot in São Paulo and has won multiple international awards, including the Teddy and FIPRESCI Awards at the 2014 Berlin Film Festival, and Audience Awards at the 2014 NewFest, Outfest, Torino Internacional LGBT Film Festival, Guadalajara Internacional Film Festival, and Peace & Love Film Festival (Sweden), among others. Additional videos about the film and filmmaker Daniel Ribeiro will be shown. The screening will be followed by discussion of the issues presented with the audience, using cases from the presenters and provided by the audience. Results and Conclusion: This film offers a wonderful illustration of gay development in a blind teen in a different culture, which helps to stimulate discussion and understanding to improve our care of, and advocacy for, our blind gay and lesbian patients and their families.

THERAPEUTIC USES OF MUSIC/SOUND IN PSYCHIATRIC PRACTICE

Chair: David M. Perez-Martinez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the theoretical foundations of sound and music therapy and their applications in psychiatric practice; 2) Learn to play and use sound healing instruments ; 3) Design sound healing protocols for specific individuals and conditions; 4) Experience the therapeutic effects of sound in group and individual sessions.

SUMMARY:

Music and sound have been used continuously throughout time and across human cultures as therapeutic agents in medical/healing practices throughout the world. Every human culture known has incorporated music and sound into its healing/medical practices. Our culture is no exception. Unfortunately, the practice of modern medicine breaks from this legacy and does not incorporate the use of music or sound in the training of medical doctors. Music Therapy has become a separate discipline disentangled from the training and practice of medicine with a considerable body of research indicating its clinical efficacy and/or usefulness in the management of stress, anxiety and arousal states (Pelletier,C.L.(2004),depression(Maratos,A.S.et.al(2008),substance abuse(Baker,F.A.et.al(2007),and pain. It is particularly useful also to promote relaxation and to decrease muscle tension. When used in groups it promotes group cohesiveness and enhanced interpersonal relationships. Psychiatry is arguably the best suited of all medical specialties for the use of sound in a Therapeutic manner. That explains why nearly a quarter of Sound Therapists work in mental health (Silverman,MJ(2007);"more so than any other specific client population". Sound and vibration, in general, have powerful effects on the brain, nervous system and emotions. Used therapeutically in a clinical setting, sound is synergistic with psychotherapeutic and psychopharmacological interventions. It is particularly useful in conjunction with Cognitive-Behavioral techniques designed to increase self observation and awareness using cognitive restructuring and relaxation exercises essential

to achieve the overall goal of modifying underlying behavioral and affective components of specific disorders.

The workshop is didactic and experiential. Participants will learn about the principles of sound therapy and their application in psychiatric practice. They will be trained on the use of various sound healing instruments in mock clinical sessions. Strong emphasis will also be given to the use of sound in group processes. All participants will have hands on experience imparting and receiving sound treatments.

David Moises Perez is an integrative psychiatrist, sound and music therapist, and former anthropologist/ethnomusicologist who started working therapeutically with music and sound in 1976. In 1995 he began integrating sound to select patients in his psychiatric practice and presently treats the majority of them with a combination of therapy, medications, and sound. He uses sound healing instruments, protocols and procedures that are unique to each case and individual sessions. Dr. Perez will teach participants how to use the breath, voice, Himalayan and quartz crystal singing bowls, gongs, drums, shruti boxes and tuning forks in sessions with individuals and groups.

"I": A VIEWING AND DISCUSSION OF THE FILM.

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

Speaker: Gail E. Robinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how the past lives in the present.; 2) Discover how the past must be mastered to be free in the present.; 3) Appreciate that the path to psychological liberation is fraught with pain and mystery - yet a path that can be walked.

SUMMARY:

Whether you see IDA as another chapter in the story of the holocaust, or as a tale of liberation, or as a road movie, no one sees this film without being left quietly awed.

The film, black and white and a terse 80 minutes, is set in Communist Poland in 1962. Through two protagonists, a novice, ingÅ©nue nun and a hardened middle aged judge (the

novice's mother's sister), we join them on a journey of discovery, historical and personal, that dates back almost 70 years.

This film has won many awards, and for reasons you will understand when you view it. It may be set in the 60s, in bleak Polish cities, towns and countryside, but it is timeless and universal in its story of people who by no acts of their own are thrown into the suffering and injustice that blackened Europe in the mid-20th century and continues in so many places today. It is a film that portrays how we must enter the past and its agonies in order to emerge more fully alive today, or at least more at peace with what has become our fate.

In this media symposium, we will view the film, have comments by Drs. Alan Stone, Mary Seeman and Lloyd Sederer, and then open discussion among all attendees.

MAY 17, 2015

"CAN": A VIETNAMESE-AMERICAN'S FIRST-PERSON ACCOUNT OF BIPOLAR DISORDER AND THE PATH TOWARD RECOVERY: APPLYING THE DSM-5 OUTLINE FOR CULTURAL FORMULATION

Chair: Francis G. Lu, M.D.

Speaker: Pearl Park, B.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the 2 major cultural competence tools in the DSM-5; 2) Construct a DSM-5 Outline for Cultural Formulation; 3) Recognize the stigma of mental illness in Asian Americans; 4) Identify the value and importance of the consumer movement for hope and recovery.

SUMMARY:

"Can" is a 65-minute documentary film (2012) that depicts a first-person account of 37 year-old Can Truong, a refugee who was among the millions of boat people who fled Vietnam, as he searches for healing and recovery from Bipolar Disorder. "Can" is one of the first documentary films which highlights the experience of mental illness from an Asian-American perspective not only from the point of view of the patient, but also of his father and mother. Due to the very strong stigma of mental illness in Asian American cultures and systemic barriers in care,

Asian Americans utilize mental health services at significantly lower rates than the general population in the U.S. Yet Southeast Asian refugees have rates of mental illness of about 60% due to the traumatic experiences of war, migration, and acculturation. The Asian-American "model minority" stereotype presents an inaccurate picture of their mental and physical health needs, thereby limiting education, prevention, and treatment efforts for mental illness to this community. Over a 12-year period, Can tried more than 20 different medications and was hospitalized 7 times. Fighting despair and suicidal impulses, Can became active in the mental health consumer movement and began to have hope for recovery through self-determination and peer support. Inspired by his peers, he also embarked on a healing journey: trying to reconcile cultural differences with his very traditionally acculturated Confucian father; attempting to make sense of some of his painful childhood wounds related to war, migration, and acculturation in America; serving as a volunteer for mental health organizations that promote recovery; and exploring spiritual and holistic healing modalities. The film received an Honorable Mention in the 2012 Voice Awards, awarded by SAMHSA, and the filmmaker will discuss the film with the audience after the screening of the film.

Prior to the film showing, the Chair Francis Lu, MD, will present a brief overview of the DSM-5 Outline for Cultural Formulation (revised from the one in DSM-IV) and the new Cultural Formulation Interview to prepare the audience to watch the film with these 2 cultural competence tools in mind. After the presentation, he will work with the audience in constructing an Outline for Cultural Formulation of the patient and the family showing how to apply these tools in a clinical setting. The Outline for Cultural Formulation consists of 5 sections: Cultural identity, Cultural concepts of distress, Cultural stressors and supports, Cultural features of the clinician-patient relationship, and Overall assessment. Small groups of 4 will work on each of the 5 sections in sequence with large group discussion about each section in between the small groups.

SCREENING AND DISCUSSION OF THE FILM "ANONYMOUS PEOPLE"

Chairs: George Koob, Ph.D., Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the perspective of people in long term recovery from alcohol and other drug abuse, especially relating to social stigma; 2) Understand the history of recovery advocacy in the United States; 3) Describe the impact of public policy on the recovery movement.

SUMMARY:

The anonymous people is a documentary film about the 23.5 million Americans living in long-term recovery from addiction to alcohol and other drugs. The story is told through the faces and voices of the leaders, volunteers, corporate executives, and celebrities who are telling their stories to save the lives of others just like them. This new public recovery movement is fueling a changing conversation that aims to transform public opinion. Dr. George Koob, the Director of the National Institute on Alcohol Abuse and Alcoholism, and Dr. Nora Volkow, Director of the National Institute on Drug abuse, will lead a discussion on the film.

COMPLIANCE: ABU GHRAIB IN A FAST-FOOD JOINT

Chair: Lynn Maskel, M.D.

Speakers: Craig Zobel, Kevin D. Moore, M.D., Mark G. Frank, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Classify the hierarchy of power demonstrated between late adolescents and perceived authority figures as depicted in the film; 2) Inventory at least three examples from the film of blind adherence to authority directives; 3) Appraise the factors contributing to both criminal and civil consequences arising from the true incident portrayed in the film.

SUMMARY:

On a hectic day, the manager of a fast food restaurant receives an urgent phone call from an insistent and authoritative individual who convinces her to detain, interrogate, and eventually strip search a young female employee. When the horrific incident concludes four hours later, no one involved at the restaurant is left unharmed.

This compelling story is the basis for "Compliance", a 2012 independent feature film from writer/director Craig Zobel. His riveting narrative captures, literally and viscerally, the shocking impact of the real-life episode which it portrays. Suffice it to say, the viewing experience itself is pivotal to the exploration of the many issues raised. Audience reaction at film festivals and other venues has proved to be divisive and sometimes combative. Many viewers have a difficult time comprehending that the incident actually happened in the manner depicted, despite Zobel's meticulous and thorough rendering of the events. The wider context of the "Compliance" story, including evidence of a pattern of similar transgressions, along with the results of the eventual civil and criminal proceedings surrounding this case, will be discussed after the complete film screening.

Director Craig Zobel will be on hand as an integral part of the panel to give his unique insights into the crafting of this film. Preparing to write the screenplay, he turned to two seminal psychological studies. The first was Stanley Milgram's "electric shock" experiments of the early 1960s. Milgram's results have been confirmed by later follow-up studies conducted throughout the world. The second was the Stanford Prison Experiment devised by Philip Zimbardo in 1971. Dr. Zimbardo went on to summarize much of that work in his best-selling book, "The Lucifer Effect: Understanding How Good People Turn Evil". More recently, Dr. Zimbardo has gone on record to state that he believes that abuse by U.S. Army Military Police at Abu Ghraib prison in 2003 serves as a real-life example of his original experiment and, as a result, he subsequently consulted for defense lawyers acting on behalf of one of the accused guards.

Although "Compliance" specifically addresses an incident that occurred at a McDonald's restaurant in Mount Washington, Kentucky on April 9, 2004, the disturbing issues it raises speaks to broader questions that still remain highly relevant a full decade later. The film effectively forces viewers to confront their own psyche and to consider the potential circumstances that might lead them to go down the "slippery slope of compliance" to a persuasive authority figure. Would we have complied or balked as the situation escalated?

Given the right conditions, could this happen to anyone? Would we, so to speak, pull the lever which sends a "fatal shock" if so directed? Or are we still like the professionals queried about the probable results of Milgram's experiments and were dead wrong about how far individuals would go to please authority?

REVIEWING (MENTAL) DISORDERS WITH A REVERENT UNDERSTANDING OF THE MACABRE (REDRUM)

Chairs: Anthony Tobia, M.D., Domenick Sportelli, D.O.

Speaker: Tom E. Draschil, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the role film can play in teaching topics germane to psychiatry; 2) Understand the role social media can play in enhancing curricula for medical students and residents; 3) Diagnose various examples of mental illness in fictional characters in film and literature; 4) Collaborate with course directors (who use film and literature) through social media.

SUMMARY:

In our General Psychiatry Residency curriculum, first- and second-year residents attend a weekly Psychopathology course that encompasses a broad range of mental illness. The course; Reviewing (Mental) Disorders with a Reverent Understanding of the Macabre (REDRUM), is taught through the use of horror movies, and is divided into three modules over the academic year. Generally speaking, the lecture topic is introduced through plot summary and/or character analysis from the selected work. Lecture content is primarily taken from the required text, Kaplan & Sadock's Synopsis of Psychiatry 10th edition. In addition to reviewing the recommended chapter in the reference text, residents are encouraged to have familiarized themselves with the selected film prior to the weekly PowerPoint presentation. Our seminar's primary goal is to enhance learning through creative discussion. This is achieved by selected works serving a metaphorical or symbolic role in the etiology, clinical features, course and prognosis of the mental illnesses highlighted in our course syllabus.

REDRUM has been patented as intellectual property, and is taught to four levels of education at Rutgers University. For undergraduates (at the Center for Alcohol Studies) and medical students, the movie viewing itself is the focal point of the course; participants congregate in an assigned room instead of watching the movie independently. This allows for the integration of social media that transforms the movie into a novel, interactive educational experience. For our medical student elective, participants watch a movie in the main lecture hall where a live Twitter® feed is shown at the bottom the screen. This allows for students to tweet questions about the psychopathology portrayed, while residents and teaching faculty provide their perspective by returning the tweets.

After a brief introduction of our novel resident curriculum, we propose to show a full-length movie on TweetDeck to allow for a demonstration of the Rutgers Robert Wood Johnson Medical School experience.

In addition to providing education through the use of film and social media, our course also allows for the movie encounter to parallel a therapist's countertransference experienced when interacting with individuals with illnesses similar to those depicted on the screen. By showing Stephen King's Misery at the APA media workshop, this objective will be highlighted by a guest speaker who will give insight to his character's (Paul Sheldon's) development.

MAY 18, 2015

UNICORN AND ALONE WITH PEOPLE - A DOUBLE FEATURE ON YOUNG GAY/LESBIAN IDENTITIES: EXPLORING SEXUAL ORIENTATION

Chairs: Richard R. Pleak, M.D., Sarah E. Herbert, M.D., M.S.W.

Speakers: Jose Vito, M.D., Shervin Shadianloo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand and discuss aspects of gay and lesbian identity formation. ; 2) describe how psychosexual development may be derailed in gay and lesbian youth. ; 3) outline steps and resources to help foster

healthy gay and lesbian development. ; 4) use film to explore issues such as sexual orientation in youth. .

SUMMARY:

Background: Psychosexual development in gay and lesbian teenagers and young adults is more complex and risky than in their heterosexual counterparts. Gay and lesbian youth are often rightly afraid of adverse consequences of disclosure, which can include isolation, violence against them, subsequent depression and suicidality. Methods: A double feature of two remarkable short films will be screened to explore these issues. In "Unicorn" (Bolivia, 2013, 30 min.), a young German/Bolivian Mennonite risks his life escaping his strict religious community to explore his sexuality and freedom. This striking film was mostly shot in a Mennonite settlement in Bolivia, and opens our eyes to a neglected and hidden population. "Alone with People" (USA, 2014, 29 min.) is the story of a high school girl growing up lesbian in Georgia, seeking support from a therapist who helps her realize that she must first accept herself before she can expect anyone else to. Quinn Marcus, the writer and star of "Alone with People", plans to provide a video about the film for the discussion. Additional videos about the films and the filmmakers will be shown. The screening will be followed by discussion of the issues presented with the audience, using cases from the presenters and provided by the audience. Results and Conclusion: These films offer powerful illustrations of gay and lesbian development in different cultures, which stimulate discussion and understanding to improve our care of, and advocacy for, our gay and lesbian patients and their families.

WHAT'S WRONG WITH LISBETH SALANDER? PSYCHOPATHOLOGY OF "THE GIRL WITH THE DRAGON TATTOO"

Chair: Scott Snyder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine if Lisbeth Salander fulfills criteria for Autism Spectrum Disorder, Schizoid Personality Disorder and/or Schizotypal Personality Disorder as defined by DSM-5.; 2) Recognize how prevalent are the

problems of rape and other forms of hostile sexism in Sweden as reflected in the life experience of Lisbeth Salander and other women portrayed in the film.; 3) Examine the violent and life-threatening events in Salander's Swedish sociocultural narrative, including the rise of neo-Nazism, that have led to in her developing DSM-5 Posttraumatic Stress Disorder.; 4) Understand the psychological and social significance of Salander's 9 tattoos and 6 body piercings especially as they relate to concepts of beauty and body image in contemporary Western societies.; 5) Identify how a dangerous and unstable family life and abuse by the mental health establishment resulted in issues with trust and attachment in Salander as found in Cluster B personality disorders.

SUMMARY:

"The Girl with the Dragon Tattoo" is one of the most popular works of this century, having sold more than 30 million copies worldwide. Its protagonist, Lisbeth Salander, embodies fearlessness, brilliance, and resourcefulness admixed with a core of insecurity, rage, and cunning. She has been the subject of a significant amount of analysis and controversy as to what psychopathology she may personify. Axis I conditions such as autism spectrum disorder, posttraumatic stress disorder, and dysthymia and Axis II diagnoses including schizotypal, antisocial, borderline, and narcissistic personality disorders/traits have been proffered as disorders that plague her. Lisbeth both encompasses and examines child abuse, misogyny, gender outlaws, eidetic memory, rape trauma, resilience/survival, Goth stereotypes/body art and related social psychological themes in the novel. Sociocultural themes she reflects in the book include feminism and "polarizing" women, misogyny, hacker society, vengeance, violence, conscience/morality, neo-Nazi ideology, and the degeneration of Swedish society.

The Swedish film adaptation, released in 2009, features Noomi Rapace in the role of Lisbeth. Selected pivotal excerpts from the film will be presented that demonstrate these topics as reflected in the central role of its heroine/anti-heroine. Commentary on these film clips will be provided from the fields of psychiatry, psychology, sociology, and contemporary culture.

POWER, GENDER AND "THE DEVIL WEARS PRADA"

Chairs: Rashi Aggarwal, M.D., Petros Levounis, M.D.

Speakers: Nahil Chohan, M.D., Michelle Benitez, M.D., Afiah Ahsan

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss societal expectations from women; ; 2) Identify self-expectations and internalized barriers women face; ; 3) Recognize gender issues and utilize them to better understand and treat patients.

SUMMARY:

The central theme of the movie, "The Devil wears Prada" (2006, 109 minutes) is women in power. The main characters are women, as are the main sub-characters. They are women who are comfortable using power – the main being, Miranda, the ruthless but powerful boss of the fashion magazine.

The movie chronicles the growth of another strong woman - Andrea - as Miranda's second assistant. Even though the focus is on her relationships and growth in her career, the changing dynamics of her relationships as she advances in her career are an important reflection of the ever present conflict for a woman in balancing her personal and work lives.

The movie provides fantastic material for the discussion of societal and self-expectations based on gender. Portrayal of the powerful boss as a "devil" and "not nice" provides a platform for discussions about expectations we have of women leaders, bosses and chairs. According to a recent Gallup poll (November, 2013), both men and women have a higher preference for a male boss. The movie depicts the lack of support Andrea gets from her father, boyfriend and her best female friend. The difficulties Andrea faces in her relationships with her boyfriend and her ultimate choice of going back to her boyfriend provide rich material for discussion.

The workshop discussants will provide a framework for understanding the role of gender in today's society and its application to our patients and ourselves. The discussants will also lead the workshop participants in examining the role of Miranda and Andrea in

relationship to female power and internal conflict of balancing power and relationships. We will also examine the role supporting characters played in relationship to the societal expectations of women.

MAY 19, 2015

UPDATE: A CASE OF XENOGLOSSY AND THE NATURE OF CONSCIOUSNESS (FIRST PRESENTED AT THE 2013 APA ANNUAL MEETING)

Chair: Samuel H. Sandweiss, M.D.

Speakers: Jonathan Lieff, B.S., M.D., Sthaneshwar Timalsina, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a better understanding of basic research in consciousness, mind, neuroplasticity, and learning -- increase treatment options and helps us recognize unusual states of consciousness ; 2) Understand how spiritual concepts can be used in CBT and problem-solving; 3) Determine how spiritual activities like meditation and yoga reduce stress in psychiatric practitioners; 4) Have a better understanding of the religious and spiritual backgrounds of our patients effect the healing process; 5) Improve our ability to provide better psychiatric care to poorly served large populations.

SUMMARY:

ABSTRACT -- A Case Of Xenoglossy And The Nature Of Consciousness, part 2

By Samuel Sandweiss M.D., discussants Jon Lieff M.D and Professor Sthaneshwar Timalsina Ph.D

At the 2013 annual meeting of the American Psychiatric Association our team presented a well-received case of Xenoglossy as described below. We have refined the media presentation with a more in depth study of the Sanskrit productions of the patient, a refined version of our documentary, and in addition will relate the case findings to the newest scientific understanding of mind.

Is consciousness an outgrowth of the physical brain - is it the primary substance of reality -- or is there a middle ground, as some scientists posit, where energy, mind, and matter all exist in a continuum as parts of basic nature? What relevance is mind research to psychotherapy?

Dr. Jon Lieff, past-president of the American Association for Geriatric Psychiatry (AAGP), consulting editor of the American Journal of Geriatric Psychiatry for 10 years, and an expert in psychopharmacology, has kept abreast of the latest research related to mind, summarized in his blog, "Searching for the mind." He will discuss how current theories about mind relate to our case of xenoglossy. Dr. Sthaneshwar Timalsina, Professor of Religious Studies at San Diego State University will review literature and his own work on mediums in various cultures and how mediumship relates to our case of xenoglossy. I will discuss the case in detail and how it relates to the providing of psychiatric care to large poor populations.

In June -- July, 1983, in San Diego, CA, I observed and videotaped remarkable phenomena in the course of treating a 32-year-old Western Caucasian female patient who suffered from a severe headache disorder. Without having had prior knowledge of Sanskrit, my patient spontaneously began to speak Sanskrit fluidly, write it down phonetically, and translate it into English. Sanskrit scholars identify 4 Sanskrit related languages from different time periods used in a novel expression of complex spiritual concepts from various traditions. They felt that it would be impossible for the patient to have learned these complicated languages while being debilitated and without anyone observing her in the process -- let alone be able to express such foreign spiritually sophisticated ideas expressed in the notes. This case provides compelling information about the possibility that consciousness extends beyond our physical brain and personal life experience.

I have developed an engrossing 19 min video describing this case, including showing raw footage of the patient speaking Sanskrit, describing her experiences, and translating the notes -- and including an in-depth analysis of the passages by a Sanskrit scholar. We welcome an active discussion.

WHAT'S ART GOT TO DO WITH IT?

Chair: Isabel Fryszberg, B.Sc., O.T.

Speakers: Isabel Fryszberg, B.Sc., O.T., Linda Monteith, B.A., Janet Parsons

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how a community-based program can be designed to both teach

arts practice and tend to the needs of clients with concurrent disorders ; 2) Learn how community-based programming is a stepping stone during recovery for clients with mental health and addictions issues who are regaining their independence; 3) Recognize the importance of meaningful occupation and a supportive environment in community reintegration; 4) Understand how arts-based practices can inform your own experiences as a health care practitioner and foster greater understanding of clients' experiences.

SUMMARY:

"What's Art Got To Do With It?" is a research-based documentary film that looks at Creative Works Studio – an arts-based occupational therapy program in Toronto that serves clients with a wide range of mental health and addictions issues. The project identified seven themes reflecting the effects of the program: building relationships; being seen and heard; a place to go to create art; being productive; a culture of acceptance; freedom and opportunity to learn; and economic opportunities. This presentation will include a screening of the film, followed by a question and answer session. In addition, the workshop will conclude with a hands-on activity facilitated by members of the studio who have relevant lived experiences. Attendees will have the opportunity to explore creative practice and engage with their own experiences and those of members, in order to gain insights into the impact of art-based activities on body, mind, heart and soul.

"LARS AND THE REAL GIRL": THE POWER OF EROTOMANIC DELUSIONS: A CASE AND MEDIA STUDY HIGHLIGHTING THE PERSONAL AND SOCIAL IMPACTS

Chairs: Kristel Carrington, M.D., Justin Kung, M.D.

Speaker: Jose Vito, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the key features of erotomanic delusions; 2) Discuss the prevalence and characteristics of patients with primary and secondary erotomanic delusions; 3) Recognize the impact of persistent erotomanic delusions on patients' psychosocial functioning; 4)

Discuss the data regarding chronic delusions and chance of recovery.

SUMMARY:

Delusions are one of the central and hardest symptoms to treat in chronic psychotic illness. This workshop will review features of the erotomanic delusion, which is a persistent delusional belief that a person, often of higher social status, is in love with the individual. This particular type of delusion can have several forms: a primary form where it presents alone, and a secondary form, where it is part of a broader psychotic disorder as in schizophrenia or bipolar affective disorders. Erotomanic delusions can be extremely persistent, respond poorly to treatment, and can lead to potentially dangerous behaviors such as stalking and other forms of harassment. Prognosis has generally been considered poor for erotomania in the sense that patients show resistance to both pharmacotherapy and psychotherapy and their condition becomes chronic. The persistence of this symptom can lead to consequences that impede a patient's recovery and result in continued vulnerability, disability, and poor functioning in a community setting. In this workshop we present the case of Ms. S, a 45 year old Japanese woman with a history of schizophrenia who traveled to the US, with no financial or social supports, under the influence of an erotomanic delusion that she was going to marry a well known celebrity. This patient has been somewhat stabilized on medications but still remains very delusional. This, in addition to her undocumented status, creates a unique challenge for her clinicians in terms of providing care beyond pharmacological management and restoring her to a level of independent social functioning. We will also present the film *Lars & The Real girl* which details the story of a young man experiencing a delusion that he is in love and in a romantic relationship with an anatomically correct doll. The film explores how this delusion affects not only him but the surrounding community. Examining these two cases will help the audience to understand the important factors that influence erotomanic delusions, challenges to its treatment, and methods of helping patients cope with its psychosocial effects.

MAY 20, 2015

"THE HUNDRED-FOOT JOURNEY": FROM CULTURE CLASH TO COLLABORATION

*Chairs: Jose Vito, M.D., Nyapati R. Rao, M.D.,
M.S.*

Speaker: Francis G. Lu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand cultural identity of the characters in the film.; 2) Recognize conscious and unconscious biases arising from cultural identity differences; 3) Utilize compassion as a way to overcome biases related to cultural identity differences; 4) Apply the understanding of cultural identity, biases, and compassion to work situations.

SUMMARY:

The Hundred-Foot Journey (2014) tells the story of the Kadam family from India fleeing political persecution and settling down in Saint-Antonin-Noble-Val, a quaint village in the South of France. Continuing their work in India, the family opens an Indian restaurant across the street from Madame Mallory's Michelin-starred haute cuisine establishment. Initially, cultural clashes tinged with conscious and unconscious biases arising from this unlikely pairing of cuisines and customs intensifies the escalating rivalry until it goes too far. Compassion is awakened leading to understanding, good will, and eventual collaboration that is a win-win for all. The film stars Oscar awardee Helen Mirren as Madame Mallory, and the great Indian actor Om Puri plays the father of the Indian family. The film will be processed after the film through silent reflection on the audience member's experience of the film, journaling, and dyadic sharing focused on understanding how cultural identity differences led to conscious and unconscious biases and how they were overcome in the film. Second, large group discussion will allow sharing of these experiences. Thirdly, groups of four will discuss how conscious and unconscious biases related to cultural differences can be successfully recognized and managed in work situations with patients and colleagues. Fourth, large group discussion will allow sharing of insights discovered.

GOD LOVES UGANDA: FAITH, HOMOSEXUALITY, AND AMERICAN EVANGELICALS

*Chairs: Mary E. Barber, M.D., Eric Yarbrough,
M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the role American evangelical leaders have played in promoting anti-LGBT sentiment and laws in Uganda; 2) Discuss the potential and real harms to Ugandan faith leaders who have questioned fundamentalist beliefs and to LGBT Ugandans that have occurred as a result of the evangelicals' efforts; 3) Begin a dialogue about the role of psychiatrists and faith leaders in addressing issues of faith, sexuality, and culture.

SUMMARY:

"God Loves Uganda" details the role of American evangelical churches, which have sent missions to Uganda both to build schools and hospitals, and also to promote fundamentalist beliefs which are condemning of homosexuality. Years of this advocacy culminated in a law passed in Uganda last year extracting harsh prison sentences for homosexual behavior, a law that has been condemned by the APA, the US government, and many human rights groups, and that was ultimately struck down by the Ugandan court. The film follows evangelical leaders such as Lou Engle, creator of The Call, and missionaries in Uganda. It also profiles Ugandan Bishop Christopher Senyonjo, who was excommunicated and ostracized for his tolerant preaching, and gay activist David Kato who was murdered shortly after completion of the film. In the end, "God Loves Uganda" raises important issues about the complicated relationship between faith, sexuality, and the meeting of different cultures.

PRESIDENTIAL SYMPOSIA

MAY 16, 2015

CURRENT DEVELOPMENTS IN FORENSIC PSYCHIATRY

Chairs: Robert Weinstock, M.D., Jeffrey S. Janofsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Distinguish between malingered and genuine hallucinations; 2) Use methods to reduce suicides on inpatient units; 3) Manage challenging forensic roles.

SUMMARY:

This symposium will review a number of recent developments in forensic psychiatry. Dr. Weinstock will introduce the session. Debra Pinals MD will present the many facets of stalking. Dr. Resnick will then discuss the malingering of hallucinations and give suggestions for distinguishing between malingered and genuine hallucinations. Dr. Scott will review some significant legal cases regarding the death penalty and will discuss the role of psychiatrists in the process. Dr. Weinstock will discuss the challenges of practicing at the interface of psychiatry and the law and the need to balance conflicting duties. He will suggest forensic psychiatry is not unique but even treating psychiatrists have conflicting duties. The difference is which duties are primary. Dr. Janofsky will discuss reducing the risk of suicide on inpatient wards. Dr. Scott will conclude with predicting and preventing juvenile violence including a discussion of risk factors for violence. Questions will follow each presentation.

NO. 1

STALKING: OVERVIEW AND CLINICAL RISK MANAGEMENT

Speaker: Debra Pinals, M.D.

SUMMARY:

Stalking has gained increased attention in recent years. Anti-stalking legislation was promulgated across the country fairly quickly after some high profile deaths became a focus of attention. The stalking-victim dynamic is complex, and various typological constructs

exist that can help determine approaches to risk management. Basic characteristics, including the underlying motivation of the stalker, the presence of particular mental health symptoms and the nature of the relationship between the stalker and the victim are all important to consider. This presentation will review the epidemiology of stalking, examining particular subtypes of stalking, as well issues pertaining to treatment of the stalker and assistance in helping the victim cope and minimize collateral consequences related to being stalked.

NO. 2

THE DETECTION OF MALINGERED HALLUCINATIONS

Speaker: Phillip Resnick, M.D.

SUMMARY:

One of the easiest ways for a person to accomplish an unjustified hospital admission or to attempt to fake an insanity defense is to malingere auditory or visual hallucinations. This session will review research on genuine auditory and visual hallucinations and identify signs of malingered hallucinations. Psychotic hallucinations will be distinguished from non-psychotic hallucinations. Suspect auditory hallucinations are continuous rather than intermittent, vague or inaudible, and not associated with delusions. Persons faking auditory hallucinations may say they have no strategies to diminish malevolent voices and claim that all command hallucinations were obeyed. Malingerers are more likely to report extreme severity and intensity of their hallucinations. Suspect visual hallucinations are more likely to be reported as black and white rather than in color, be dramatic, and are more likely to include miniature or giant figures. Resolution of genuine hallucinations with antipsychotic treatment will be covered. The audience will have an opportunity to analyze a brief videotape to identify clues to whether the individual has genuine or faked hallucinations.

NO. 3

PSYCHIATRY AND THE DEATH PENALTY: DUTIES, DILEMMAS, AND DEATH

Speaker: Charles Scott, M.D.

SUMMARY:

Thirty-two states, the federal government, and the military have the death penalty. In criminal cases involving a potential capital sentence, psychiatrists are frequently requested to conduct a mental health evaluation of the defendant for a variety of reasons. These evaluations may include an assessment of the defendant's competency to stand trial, competency to represent oneself, criminal responsibility, competency to be sentenced, assessment of aggravating or mitigating circumstances, and competency to be executed. Courts may also request psychiatrists to evaluate and testify about the potential emotional harm caused to surviving victims. This presentation summarizes key U.S. Supreme Court cases that establish the constitutionality of the death penalty with a focus on recent cases that address capital punishment on minors and those with intellectual disability. In addition, ethical guidelines for psychiatrists' participation in executions will also be reviewed.

**NO. 4
THE CHALLENGES OF PRACTICING AT
THE INTERFACE OF PSYCHIATRY AND
LAW**

Speaker: Robert Weinstock, M.D.

SUMMARY:

Forensic psychiatrists face the challenge of practicing at the interface of the disciplines of psychiatry and law with very different goals and ethics and a different hierarchy of duties than treatment. Unlike treatment the primary duty of the forensic psychiatrists is to answer a legal question. Duties to an individual evaluated are secondary. Society expects certain roles from physicians including duties to individuals. A secondary duty to an individual does not imply that it always is outweighed by the primary duty to answer legal questions such that any role is permissible. For example, helping execute an individual is not. Since questions must be answered honestly some roles may not be appropriate. It can be a challenge to balance conflicting duties but forensic psychiatry is not unique. Even in the treatment context where patient welfare is unique that duty can be outweighed by duties to society in contexts like child abuse reporting where the secondary duty to society can become primary and require actions that can be harmful to a patient. But a

challenge does not mean practitioners should avoid complex roles and conflicting duties.

**NO. 5
REDUCING INPATIENT SUICIDE RISK:
IMPROVING OBSERVATION PRACTICES**

Speaker: Jeffrey S. Janofsky, M.D.

SUMMARY:

Of the 32,000 yearly U.S. suicides a year, 5% to 6% occur in the hospital. Hanging and jumping are the most common ways inpatients complete a suicide. Participants will understand how a human factors analysis approach can improve inpatient observation practices, and can reduce potential critical errors that could lead to completed inpatient suicide. Participants will understand how the failure-modes-effects analysis (FMEA) process can increase collaboration and communication between a multi-disciplinary staff to reduce inpatient suicide risk. The standard of care for inpatient suicide risk prediction will also be reviewed.

**NO. 6
ASSESSMENT OF JUVENILE VIOLENCE:
FROM PREDICTION TO PREVENTION**

Speaker: Charles Scott, M.D.

SUMMARY:

In 2011, law enforcement agencies in the U.S. made nearly 1.5 million arrests of persons under age 18. Although high profile cases involving juvenile offenders suggest a rise in juvenile violence, the 2011 juvenile violent crime index arrest rate was at its lowest level in more than three decades. This presentation summarizes key risk factors important to identify when assessing a juvenile's risk of violence. Particular attention is provided to concerns that surround the labeling of a youth as a "psychopath." Updates on violence characteristic of juvenile gangs and school shooters will be provided. Suggested intervention and prevention program are reviewed. Finally, key U.S. Supreme Court cases that address the imposition of life without the possibility of parole for juvenile offenders will be discussed.

**MARIJUANA IN 2015: STATE OF THE
POLICY AND TREATMENT**

Chairs: Laurence Westreich, M.D., Kevin P. Hill, M.D.

Discussant: Herbert D. Kleber, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the science supporting the use of cannabinoids for various medical indications and how the science to current medical marijuana laws in North America; 2) Discuss the impact of legalization of marijuana on the State of Washington and how this relates to the future of legalization of marijuana; 3) Diagnose and treat patients with cannabis use disorders based upon the latest scientific evidence.

SUMMARY:

Marijuana continues to be a hot topic in North America. In the United States, state after state has been faced with questions around decriminalization, medical marijuana, and, most recently, legalization of marijuana. Fifty-eight percent of Americans currently are in support of the legalization of marijuana. While these debates rage, use of marijuana among Americans, particularly young Americans, continues to rise as the perception of marijuana's risk decreases. Unfortunately, there appears to be a wide gap between the science and the public perception of issues related to marijuana, and it is increasingly difficult to obtain evidence-based information about marijuana from unbiased sources. Psychiatrists are in a difficult position as experts on marijuana—often being asked by both patients and colleagues to comment on the risks of marijuana in the face of these complex policy issues. In this Presidential Symposium, we will address the important and often polarizing policy issues from an evidence-based perspective and we will also help psychiatrists feel more comfortable diagnosing and treating patients who suffer from cannabis use disorders. First, we will set the stage for our symposium by briefly reviewing the latest epidemiological data regarding marijuana use among both young people and adults, as well as the evidence for the adverse health effects of regular marijuana use. We will then discuss the science supporting the use of cannabinoids in various medical conditions and how that relates to current medical marijuana laws in North America. We will then begin to explore the complicated issue of legalization of the

recreational use of marijuana, using the experiences thus far from the state of Washington as a reference point. Arguments both for and against legalization of the recreational use of marijuana will be presented. Finally, we will help psychiatrists feel more comfortable diagnosing and treating the subset of marijuana users who develop cannabis use disorders by examining the latest research in behavioral interventions and pharmacotherapies. The symposium will conclude with a lively discussion of the issues we covered.

NO. 1 MEDICAL MARIJUANA: WHAT A PSYCHIATRIST NEEDS TO KNOW

Speaker: Kevin P. Hill, M.D.

SUMMARY:

As of late 2014, twenty-three states and the District of Columbia had enacted laws allowing their residents access to medical marijuana and many more states are currently debating the merits of medical marijuana. At the same time, we are learning more about the risks associated with the regular use of marijuana while use of marijuana among young people is rising and their perception of its risk is declining. Thus, psychiatrists have a potentially vital role to play in educating their patients, the public, and policymakers about the science of marijuana and cannabinoids. Dr. Hill will review both the epidemiology of marijuana use as well as the latest data on the potential harms associated with the regular use of marijuana. He will then discuss the scientific evidence on the use of marijuana and cannabinoids in various medical conditions and how this relates to medical marijuana laws already in place in North America. Finally, Dr. Hill will review the practical aspects of medical marijuana laws and how they might affect your clinical practice.

NO. 2 LEGALIZATION OF THE RECREATIONAL USE OF MARIJUANA: ARE WE READY?

Speaker: Andrew J. Saxon, M.D.

SUMMARY:

Legalization of the recreational use of marijuana has been a polarizing topic in North America recently, and the issue is not going away. In many instances, the debate has devolved into

advocates on either side of the debate cherry-picking some data and spinning other data, so there is a critical need for an evidence-based, balanced perspective. Two states, Washington and Colorado have already legalized the recreational use of marijuana and we are beginning to see how this is playing out. Psychiatrists are looked at as experts on the topic of marijuana and thus have the potential to play a key role in important policies such as legalization of marijuana. Dr. Saxon will look at legalization from the lens of the experiences of Washington state. He will review both the pros and cons of legalization from an evidence-based perspective and comment on how these arguments fit with his observations from Washington to this point.

NO. 3 DIAGNOSING AND TREATING CANNABIS USE DISORDERS

Speaker: Frances R. Levin, M.D.

SUMMARY:

Marijuana is the most commonly-used illicit drug in North America by far, and millions of North Americans currently meet DSM 5 criteria for cannabis use disorder. The evolving policies related to medical marijuana and legalization of the recreational use of marijuana may increase the numbers of North Americans addicted to marijuana. Psychiatrists are often looked to by patients, the public, and colleagues as experts on marijuana and increasing numbers of patients we treat use marijuana. Therefore, psychiatrists must be comfortable in diagnosing and treating patients with cannabis use disorders. Dr. Levin will describe how she approaches the evaluation of a patient who may have a cannabis use disorder. She will then review the latest evidence on the use of both behavioral interventions and pharmacotherapies as treatments for cannabis use disorders. She will then review what a comprehensive treatment plan might look like for a patient with a cannabis use disorder.

HOW THE MIND AFFECTS THE BODY AND THE BODY AFFECTS THE MIND: INFLAMMATION, DEPRESSION, DRUGS, AND DISEASE

Chair: S. Nassir Ghaemi, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how depression and bipolar illness worsen the pathophysiology of cardiovascular disease and dementias; 2) Describe the evidence for benefit, lack of benefit, and/or harm with antidepressants, antipsychotics, and lithium for cardiovascular diseases; 3) Describe the evidence for benefit with lithium in prevention of dementias.

SUMMARY:

The central organizing feature of these presentations will be about two aspects the relation between the body (medical illnesses and the effects of psychotropic drugs) and the mind (mood conditions). First, the audience will learn about new ideas regarding how the body affects the mind: Specifically, we will examine how psychotropic medications affect the brain and body in ways that are outside usual discussions about neurotransmitters, but rather involve inflammatory mechanisms and long-term neuroplastic changes. Second, the audience will learn about new ideas regarding how the mind affects the body: Specifically, we will examine how depressive conditions, including bipolar illness, can worsen medical outcomes of cardiovascular disease, metabolic syndrome, and dementias. Individual presentations will discuss how depression and mania relate to heart disease and inflammation, and how antidepressants and neuroleptic agents are, or are not, helpful for those conditions. Further, the audience will hear about how lithium reduces risks of medical mortality, including from cardiovascular disease, and may help prevent Alzheimer's dementia.

NO. 1 ANTI-INFLAMMATORY AGENTS AS ANTIDEPRESSANTS: TRUTH OR DARE

Speaker: Charles Raison

NO. 2 INTEGRATING INFLAMMATION WITH OTHER DISEASE MODELS IN MOOD DISORDERS

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

A convergent mechanism hypothesized in mood disorders is the immunoinflammatory system. Disturbances in components of

immunoinflammatory system have been implicated in the pathogenesis phenomenology, comorbidity, and treatment of mood disorders. Available evidence indicates that conventional pharmacotherapy, as well as, psychosocial treatments may also engage immunoinflammatory systems. Several agents that are currently approved for the treatment of inflammatory based disorders, e.g., inflammatory Bowel Disease, pain may also have utility in the treatment of mood disorders. Moreover, the availability of these treatments in generic form as well as their scalability provides an opportunity to repurpose these agents to suppress systems and possibly modify symptoms across the domains of psychopathology encountered in mood disorders. Moreover, the use of such treatments serves as a probe to test hypothesis regarding illness pathogenesis and treatment. This presentation will provide a theoretical background for such an approach with a particular view to discuss a strategic approach for developing these agents in mood and cognitive disorders. In addition, inflammation as a convergent target for psychosocial and behavioural strategies, e.g., aerobic exercise will also be discussed. A practical clinical perspective will also be offered.

NO. 3 DEATH, DEPRESSION AND HEART DISEASE

Speaker: Steven Roose, M.D.

SUMMARY:

The complex relationship between depression and ischemic heart disease (IHD) has multiple dimensions including:

1) depression early in life is a risk factor for the development of ischemic heart diseases(IHD); Among otherwise healthy subjects, depression increases the risk of IHD 1.5- to 2-fold.

2) Patients with IHD and depression have an increased rate of cardiovascular mortality in post-MI patients with Depression. This increased risk may result from increased risk of arrhythmias, increased platelet aggregation associated with psychological stress and depression, decreased adherence to lifestyle changes or to medical regimen.

The mean relative risk of mortality in depressed vs. non depressed post MI patients is 4.1 (range, 2.3 to 7.5), the highest risk occurs in first

6 months post-MI, and the risk is proportionate to depression severity and even minor symptoms of depression contribute to significant additional mortality risk.

3) Data from a number of studies suggest that treatment with SSRIs relatively safe in post-MI patients and may reduce the risk serious cardiovascular events. The mechanism for this risk reduction may well be in part due to the decreased platelet activation associated with SSRI treatment

NO. 4 LITHIUM FOR PREVENTION OF DEMENTIAS AND REDUCTION OF MORTALITY

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

In this presentation, the audience will be presented evidence that depression and bipolar illness increase the risk of dementias (as well as cardiovascular disease, which will be presented by other speakers). The scientific literature will be systematically examined to describe the effects of lithium on prevention of dementias and reduction of mortality. The evidence reviewed will be of two types: epidemiological studies and randomized trials. Epidemiological studies often relate to geological analyses of medical outcomes in areas with high lithium content in drinking water; in those studies, lithium is associated with reduced cardiovascular mortality rates, reduced suicide rates, and reduced homicide rates. Prospective clinical studies include a 50 year outcome study in Zurich which also found marked reduction in suicide and cardiovascular disease with lithium treatment of mood illnesses, as well as notable reduction in dementia rates. Other such observational data will be examined linking lithium to reduction in dementia, and some recent randomized trials of lithium in mild cognitive impairment will be presented. The basic neurobiology of lithium's extensive neuroprotective effects will be described.

MAY 17, 2015

UTILIZING PSYCHODYNAMIC PSYCHIATRY IN THE MEDICAL SETTING

Chair: Michael Blumenfeld, M.D.

Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session participants will be able to better recognize countertransference of physicians working in the medical setting. ; 2) At the conclusion of this session participants will be able to use psychodynamics to address nonadherence to medical care by patients with HIV/AIDS.; 3) At the conclusion of this session participants will be able to better utilize psychodynamic psychotherapy to treat somatoform disorders in children. ; 4) At the conclusion of this session participants will be able to use psychodynamic techniques to treat dying soldiers undergoing surgical treatment. ; 5) At the conclusion of this session participants will be able understand how learning psychodynamics will help medical students become better physicians.

SUMMARY:

Dr. Michael Blumenfield as Chair of the symposium will note that the the application of psychodynamic theory has great value in the medical setting from the early work of Sigmund Freud to present day psychiatry. Dr. Cesar Alfonso will show that by understanding countertransference, physicians can be more effective in treating medical illness. He will review how using this approach can protect patients from under-treatment, delayed care and the failure of empathy. Dr. Mary Ann Cohen will specifically look at HIV/AIDS and give examples how psychodynamic theory is pertinent to this condition. This becomes particularly important in helping persons with HIV adhere to medical care and antiretroviral therapy. Somatoform Disorders in childhood and adolescence present special challenges and Dr. Clarise Kestenbaum will discuss how psychodynamic psychotherapy should be integrated into the treatment of these young patients. Dr. Chris Perry will then draw upon his experience observing the surgical treatment of dying soldiers. He will explain how dignity and meaning in the face of illness and injury open the door for psychodynamic treatment for those suffering the psychological wounds of war. Dr. Nada Stotland will make the case that the medical student rotation is the ideal place to teach psychodynamics to future physicians. This will help them obtain informed consent, deal with non-adherence to medical advice and communicate with patients and families about

adverse prognoses and outcomes including death. Dr. Paul Summergrad, APA President will conclude the symposium with a discussion of these presentations with a view of how psychodynamics continues to be an important part of modern psychiatry.

NO. 1 PSYCHODYNAMIC ASPECTS OF LIAISON PSYCHIATRY - UNDERSTANDING COUNTERTRANSFERENCE IN PSYCHOSOMATIC MEDICINE

Speaker: Cesar A. Alfonso, M.D.

SUMMARY:

Psychodynamic factors are inherent in the interactions between doctors and patients. At times, interpersonal tension contributes to conflict and may negatively impact clinical care. Examining the multidimensional aspects of countertransference in a general hospital setting could prove useful in understanding psychological dynamics between patients and healthcare providers, as well as among collaborating providers themselves. Liaison Psychiatrists are implicitly expected to consider and recognize countertransference when offering clinical recommendations in the psychosomatic medicine service. The presenter will give a brief historical review of how our understanding of countertransference has changed over the last century towards the more current definition that considers the totality of emotions experienced by the clinician. The presenter's case vignettes will illustrate the vicissitudes of liaison work, clinical care, and supervision of trainees. Group dynamics in hospitals can be elusive and complex, and collaborative multidisciplinary interventions need to be carefully coordinated in order to protect patients from under-treatment, delayed care, and failure of empathy.

NO. 2 PSYCHODYNAMIC APPROACHES TO NONADHERENCE TO HIV MEDICAL CARE

Speaker: Mary Ann Cohen, M.D.

SUMMARY:

Adherence to medical care affects the course and prognosis of every complex and severe

medical illness. Adherence has multidimensional implications for individuals, their loved ones, and their physicians and can prevent suffering, morbidity, and mortality. For persons with HIV, adherence also has public health implications. Persons with HIV need to adhere to medical care and antiretroviral therapy. Indicators of adherence include an undetectable viral load and a normal CD4 count. In the US, of the 1.1 million persons with HIV, only 25% have attained viral suppression. Nonadherence to medical care and risk reduction can lead to HIV transmission. Understanding the psychodynamics of nonadherence to medical care can help both patients and clinicians. The psychodynamics of nonadherence to HIV medical care has biopsychosocial determinants. Early childhood trauma-induced posttraumatic stress disorder is a significant factor in nonadherence to HIV medical care. It is associated with dependence on alcohol and other drugs to numb the pain of trauma as well as with inadequate self-care and mastery through repetition. This presentation explores psychodynamic approaches to nonadherence to medical care in persons with HIV and AIDS.

NO. 3 MEDICAL STUDENTS, CLINICAL EXPERIENCE, PSYCHODYNAMICS

Speaker: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

The medical rotation is an ideal place to teach psychiatry and psychodynamics to medical students. It is a fast and effective way to disabuse students of the notion that they will not need to understand or use psychodynamics in their chosen, non-psychiatric, specialties. They are impressed to learn that a majority of outpatient visits in primary care involve psychiatric problems; if they dismiss those problems as out of their areas of responsibility, they can anticipate a frustrating career. They must learn to understand psychodynamics so as to obtain informed consent for medical and surgical procedures; to deal with non-adherence to medical advice; and to communicate with patients and families about adverse prognoses and outcomes, including death. A common situation involves patients who refuse to tell loved ones about serious medical conditions, or to accept their needed

help. Such patients often have based their self-images on their ability to care for their families. Students can come to understand their fear of being helpless and burdening their families. They can help these patients by saying 'The most generous thing you can do for your family right now is to let them show their appreciation for all you have done by helping you. This will be a new kind of challenge for you.

NO. 4 SOMATOFORM DISORDERS IN CHILDHOOD AND ADOLESCENCE

Speaker: Clarice J. Kestenbaum, M.D.

SUMMARY:

What's in a name? The nomenclature describing somatoform disorders: psychosomatic, psychophysiologic, hypochondriacal and malingering disorders has been superseded in DSM5 by Illness Anxiety Disorder, Conversion Disorder, Psychological Factors Affecting Other Medical Conditions and Factitious Disorder. The effort to bridge the gap between somatic and psychological spheres has led to greater understanding of the mind-body interface by primary care physicians and neurologists, as well as mental health practitioners. For example, pediatricians are now better equipped to diagnose and differentiate among a variety of syndromes and often can determine which treatment is most suitable for an individual patient: DBT, CBT, pharmacotherapy, psychodynamic psychotherapy or combined treatment. Nevertheless, the question remains: who provides the treatment? Most primary care physicians do not have the time nor the training to provide the treatment. A team approach is discussed and clinical vignettes (school refusal, ulcerative colitis and temporal lobe epilepsy) are provided.

NO. 5 HOW DEATH CAN INFORM PSYCHODYNAMIC TREATMENT

Speaker: Christopher Perry, M.D.

SUMMARY:

While deployed to a war zone, I had the opportunity to observe and participate in the surgical treatment of a dying Soldier. The unending compassion and professionalism of the treating team in the face of tragic human

suffering can inform the psychodynamic treatment of war casualties. The injuries suffered by the dying soldier were but an obstacle overcome in the search for meaning and dignity of the treating surgical team. Dignity and meaning in the face of illness and injury open the door for psychodynamic treatment for those suffering the psychological wounds of war.

INTEGRATED AND SHARED CARE IN THE U.S. AND CANADA: LEARNING FROM OUR NEIGHBORS

Chairs: Lori Raney, M.D., Nick Kates, M.B.B.S.

Discussants: James R. Rundell, M.D., Nick Kates, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe and contrast the models of collaborative care currently being utilized in the primary care setting in the US and Canada to identify and adequately treat behavioral health conditions; 2) List the advantages of current models of addressing the health burden of patients with serious mental illness in both US and Canadian models of care; 3) Define the role of the psychiatrist in the models of integrated and shared care in the two countries and describe the responsibility of the psychiatrists in the larger health care arena.

SUMMARY:

The integration of primary care and behavioral health is major focus of health care reform in the US with well-defined models for better treatment of mental illness in primary care settings and emerging models for addressing the physical health of patient with serious mental illnesses. It is well established that untreated behavioral health conditions increase overall health care costs and the American Psychiatric Association has been on the forefront of establishing this connection and looking for solutions and opportunities for psychiatric intervention. With the current and projected psychiatric workforce shortage we must begin to look at models that allow us to extend our expertise in new ways.

In the United States and Canada there have been efforts since the 1990's to integrate primary care and behavioral health with some overlap and distinctiveness among the models that have been developed and are emerging in

the two countries. This Symposium aims to highlight the existing models in each country and have the Discussants and audience compare and contrast the models to distill what we can learn from each other to improve the models of care and further define the roles for psychiatrists' intervention and leadership in these models.

The Symposium will pair speakers from each country (Jurgen Unutzer MD- US and Roger Bland MD "Canada) first on the topic of integrating behavioral health into primary care settings. The second pair of speakers (Ben Druss MD " US and Vicky Stergiopoulos, MD " Canada) will delve into the topic of improving the health status of the SMI population by integrating primary care into specialty behavioral health systems of care. Discussants James Rundell MD " US and Nick Kates MD " Canada- will discuss these models and look at opportunities for both countries to enhance the care they are currently providing along the range of integration. The audience will be invited to participate with an opportunity to ask questions and provide their own observations as we share the stage with our Canadian counterparts in the developing field of Integrated Care.

NO. 1

COLLABORATIVE CARE AND SHARED CARE IN THE PRIMARY CARE SETTING

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

SUMMARY:

Integrated Care programs in which psychiatrists support and work closely with primary care providers to care for defined populations of patients with common mental health and substance use problems offer exciting new opportunities for psychiatrists to extend their reach and help improve the health of populations. Evidence-based integrated care programs are informed by principles of good chronic illness care such as measurement-based practice, treatment to target, and population-based practice in which all patients are tracked in a registry to make sure no one falls through the cracks. We will discuss such core principles of effective integrated care and give examples of psychiatrists working in integrated care programs with diverse patient populations.

NO. 2
COLLABORATIVE MENTAL HEALTH CARE IN CANADA

Speaker: Roger C. Bland, C.M., M.B.

SUMMARY:

Canada has universal healthcare with programs administered by the provinces. The College Of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) formed a joint committee to examine ways for family physicians and psychiatrists to work better together to meet patient and population needs. Two position papers, 1997 and 2011 were published. This latter defines collaborative care, outlines primary care psychiatry and gives a vision for the future. A broader group produced toolkits and research papers. Psychiatry training programs have been changed to include collaborative care. An annual conference is supported.

A program example is in the province of Alberta, which, as part of primary care reform, developed Primary Care Networks (PCNS). There are currently 42 PCNS in the province with 2917 family physician participants and serving 76% of the provincial population. Each has a mental health program. These vary widely but all incorporate some of the principles of collaborative mental healthcare.

NO. 3
PREMATURE MORTALITY IN PATIENTS WITH MENTAL ILLNESSES: THE U.S. EXPERIENCE

Speaker: Benjamin Druss, M.D.

SUMMARY:

This presentation will provide an overview of the problem of premature mortality including updated data from a systematic review of the international literature. It will present current opportunities to address this problem in the United States, particularly under the Affordable Care Act, and consider how these might translate to a Canadian context.

NO. 4
INTEGRATING CARE FOR HIGH RISK AND DISADVANTAGED ADULTS WITH SERIOUS MENTAL ILLNESS: LESSONS LEARNED IN A SYSTEM OF UNIVERSAL ACCESS TO HEALTH CARE

Speaker: Vicky Stergiopoulos, M.D., M.H.Sc.

SUMMARY:

In a mental health system plagued by fragmentation, inequities in access, poorly developed quality measurement or improvement infrastructure and departures from evidence based practice, supporting the primary care needs of high risk and disadvantaged individuals with serious mental illness has become a system priority. This population, including individuals who are homeless and those making frequent use of acute care services, experiences complex comorbidities, premature mortality and challenges accessing appropriate health care. Both co-located and integrated models of collaborative or shared mental health care have been developed in Canada, ranging from community or hospital based to assertive outreach approaches. Lessons learned from integrating primary care within ambulatory specialty mental health care, Assertive Community Treatment, scattered site Housing First and Critical Time Interventions will be described, along with preliminary findings of studies examining factors affecting access, outcomes and health service utilization of the target population within a system of universal access to health care.

GERIATRIC PSYCHIATRY: TREATMENT UPDATES AND NEW PERSPECTIVES

Chair: Susan Schultz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the critical role of listening to the patient's story in the care of the older adult.; 2) Identify the potential benefits and risks associated with the use of citalopram for agitation in patients with Alzheimer Disease; 3) Review the issues involved in the decision to use antipsychotic medication in persons with cognitive decline.

SUMMARY:

Distinct facets of caring for older adults will be addressed in a series of three presentations offered by the American Association for Geriatric Psychiatry. In the first, we will explore the importance of understanding the unique stories of our older patients, and how the dramatic effects of technology have changed

the way we communicate. The essential need for a "compassionate ear" in clinical practice will be illustrated through a case example of an older adult receiving treatment in an emergency care setting. In the second presentation, the challenging issue of medication selection for behavioral disturbances in dementia will be discussed, reflecting an increasingly common problem that is often refractory to non-pharmacologic interventions. The results of the Citalopram for Agitation in Alzheimer Disease Study (CitAD) study will be described, with attention to the cognitive and cardiac effects observed in this large treatment trial. Finally, the third presentation will describe strategies for approaching clinical situations where antipsychotic medications appear indicated for the patient with cognitive decline and persistent behavioral disturbances. The relative roles of side effect management and monitoring, family communication and goals of care will be placed in the context of a clinical case where an antipsychotic medication regimen is utilized.

**NO. 1
OLDER PATIENTS TELLING STORIES TO
DOCTORS IN A TECHNOLOGICAL AGE**

Speaker: Dan G. Blazer II, M.D., M.P.H., Ph.D.

SUMMARY:

This presentation will reflect on the dramatic impact that technology has had on the patient experience, particularly for the older patient trying to convey their illness history. Technology applies knowledge for practical purposes independent of subjective dispositions, personal talents, or moral character of those involved. Technology names the problem and by doing so defines the problem without story. Diagnoses including DSM-5 diagnoses eliminate the need for a "formulation." Yet "illness stories" are deeply therapeutic for tellers / patients. Particularly the older patient requires special attention to ensure they are heard and allowed to hear themselves tell and retell their stories. While this may drive clinicians to distraction, it is essential for older adults to unravel the truth of their experiences, particularly in later life where with illness there may be intermittent disorientation. The essential need for a "compassionate ear" in clinical practice will be highlighted in a case example.

**NO. 2
THE CITALOPRAM FOR AGITATION IN
ALZHEIMER DISEASE STUDY: EFFECT
OF CITALOPRAM ON AGITATION IN
DEMENTIA**

Speaker: Bruce G. Pollock, M.D., Ph.D.

SUMMARY:

This presentation addresses the important need for pharmacologic interventions for agitation in dementia that avoid the use of antipsychotic medications. Given the growing population with dementia and the common occurrence of agitation, the Citalopram for Agitation in Alzheimer Disease Study (CitAD) sought to evaluate the efficacy of citalopram for agitation in patients with Alzheimer disease who were also receiving psychosocial interventions. The results of the CitAD study will be summarized as well as the implications for implementation in clinical practice. Overall, the addition of citalopram reduced agitation and caregiver distress. These positive findings will be discussed in reference to the cognitive and cardiac adverse effects of citalopram. Directions for future efforts to address the problem of behavioral disturbances in dementia will be discussed as well.

**NO. 3
ANTIPSYCHOTIC MANAGEMENT IN THE
ELDERLY: GUIDELINES AND GOALS OF
CARE**

Speaker: Susan Schultz, M.D.

SUMMARY:

This presentation will reflect on the multifactorial nature of optimal behavioral outcomes in the care of persons with advanced dementia. Despite the many concerns regarding antipsychotic medication, they remain in common usage in clinical practice and require special attention in selection and monitoring. Most importantly, the goals of care for each patient must be considered in each individual case. The role of movement disorders, extrapyramidal side effects and management of complex drug interactions will also be addressed briefly in relation to guidelines and summary data addressing the comparative effectiveness of antipsychotic use in dementia. Finally, evidence will be discussed regarding the relative impact of psychiatric symptoms and

psychotropic medications in long terms outcomes in the older patient with a neurocognitive disorder.

UNDERSTANDING RESILIENCE IN THE FACE OF TRAUMA: FROM MOLECULES TO CIRCUITS TO BEHAVIORS

Chair: Charles R. Marmar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize pre-trauma neurobiological and behavioral factors that prospectively promote resilience; 2) Understand the post-trauma neurobiological and behavioral cascade leading to resilience; 3) Identify neurobiological and behavioral factors underlying the clinical presentation of resilient individuals.

SUMMARY:

Exposure to psychological trauma is ubiquitous. Indeed, epidemiological estimates of lifetime trauma exposure in the population are as high as 90%. Despite nearly universal exposure, rates of posttraumatic psychopathology remain relatively low (between 10-20%). These heartening statistics have led to the emergence of a new area of research into factors that promote optimal psychological outcomes following trauma exposure, or resilience. The neurobiology of resilience is a particularly important and understudied area of inquiry. Nested soundly within the RDoc framework of research, the researchers presenting as part of this symposium are working collaboratively and independently, to empirically characterize the multidimensional cascade from molecules to circuits to behavior. This area of inquiry holds great promise as the identification and characterization of the neurobiological development of resilience following trauma can lead to new treatment targets that promote resilience and ultimately prevent the development of posttraumatic psychopathology.

NO. 1 PSYCHOSOCIAL AND GENETIC MARKERS OF RESILIENCE FOLLOWING REPEATED CHILDHOOD TRAUMA EXPOSURE

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

Exposure to stressful events during development has consistently been shown to produce long-lasting hormonal, neural, and behavioral effects, which lead to significant increase in risk for neuropsychiatric disorders such as posttraumatic stress disorder and depression. Recently reported genetic association studies indicate that these effects may be mediated, in part, by gene x environment interactions involving polymorphisms in a number of gene pathways, including CRHR1, FKBP5, and ADCYAP1R1 within the hypothalamic pituitary adrenal (HPA) stress pathway. Data suggest that these genes regulate HPA axis function in conjunction with exposure to child maltreatment or abuse. Other gene pathways including BDNF, NPY, and OXT may be related to neural plasticity and recovery from fear despite severe trauma. In addition to these prior candidate-focused pathways, genome-wide association studies are suggesting other, previously unknown, avenues for exploration in understanding risk and resilience. This talk will review the genetic literature associated with resilience, and how these genetic markers interact with psychosocial variables, despite repeated childhood trauma exposure. Early life trauma leads to disease through the developmental interaction of genetic variants with neural circuits that regulate emotion, together mediating risk and resilience in adults. By understanding neural circuit, hormonal and psychological pathways associated w/resilience [see folder for full abstract]

NO. 2 TRAJECTORIES OF POSTTRAUMATIC STRESS AND RESILIENCE: IDENTIFICATION OF PHENOTYPIC PATTERNS OF TRAUMATIC STRESS RESPONSE ACROSS CONTEXTS AND SPECIES

Speaker: Isaac R. Galatzer-Levy, Ph.D.

SUMMARY:

Individuals respond to traumatic stressors in diverse ways. Many will be resilient; others will develop significant posttraumatic stress responses but recover over time, while still others will develop chronic non-abating posttraumatic stress pathology. Characterizing

these phenotypic responses can increase the discovery of novel predictors, causal mechanisms, and long-term consequences of these heterogeneous stress responses. Further, it can facilitate the development of treatments that are targeted to alter the course of traumatic stress. The panelist will review current findings on: a) trans-diagnostic trajectories of posttraumatic stress and resilience identified in diverse populations responding to heterogeneous traumatic stressors; b) the identification of prospective psychological and neuroendocrine risk factors along with long-term consequences for mortality; c) the benefit of identifying posttraumatic stress and resilience phenotypes to identify heterogeneity in treatment effects; and d) the identification of phenotypes in animal models of threat (fear) extinction learning and active avoidance acquisition.

**NO. 3
CAUSAL PATHS FROM GENETIC
INFLUENCE TO RESILIENCE: EVIDENCE
FROM A PROSPECTIVE COHORT STUDY
OF HIGHLY TRAUMA EXPOSED URBAN
POLICE OFFICERS**

Speaker: Charles R. Marmar, M.D.

SUMMARY:

There is accumulating evidence that resilience is influenced by a complex neurobiological cascade beginning with genetic variability ultimately leading to individual differences in behavioral and neuroendocrine responses to traumatic stressors. In the current work, we utilize multimodal data including genetics, peripheral neuroendocrinology, along with in depth clinical and social features in a large cohort of highly trauma exposed urban police officers followed from academy training to 7 years into active duty. Trajectories of risk and resilience were identified empirically using Latent Growth Mixture Modeling and a causal graph analysis was utilized to integrate all sources of subject information to identify the chain of transmission from genetics to pre and post-deployment neuroendocrine and clinical vulnerabilities. We find that SNps associated with Neuropeptide S receptor gene, FKBP5, MR and GR genes, FAAH, COMT influence diurnal and stress response peripheral neuroendocrinology, substance use patterns, general distress, appraisals about safety, and

sleep both before and following trauma exposure leading to trajectories of maladaptive stress or resilience. This unique prospective design allows for the identification developmental pathways to risk and resilience based on individual differences in neurobiology prior to trauma exposure.

**NO. 4
NEUROBIOLOGICAL MECHANISMS OF
RECOVERY FROM POSTTRAUMATIC
STRESS**

Speaker: Amit Etkin, M.D., Ph.D.

SUMMARY:

A hallmark of post-traumatic stress disorder (PTSD) is its persistence for many years following a major life trauma. Despite this, some individuals can experience a striking recovery after a relatively brief psychotherapeutic intervention, even despite years of chronic and disabling illness. Thus, a capacity for resilience exists for some patients, and its neural mechanisms are largely unknown. Brain circuits important for emotional reactivity, various types of emotion regulation, and cognitive control have all been implicated in PTSD. Contributing to and resulting from these impairments are historical factors (e.g. childhood maltreatment), symptom burden, and cognitive/emotional style (e.g. dissociative features). This talk will focus on new findings from a recently completed comprehensive study of the neurobiological and psychological factors associated with recovery versus non-recovery from PTSD using a well-characterized psychotherapy “prolonged exposure (PE). Central to PE is confrontation by the patient of memories and physical reminders of feared or avoided stimuli. Successful outcome with PE is predicted by specific emotional reactivity patterns, capacity for emotion regulation and cognitive control, and specific psychological factors. Together, these findings illustrate a resilient profile even in the context of chronic illness.

MAY 18, 2015

UPDATES IN WOMEN'S HEALTH

Chairs: Linda L.M. Worley, M.D., Christina L. Wichman, D.O.

Discussant: Michelle Riba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List the consequences of intimate partner violence. ; 2) Describe the psychological impact infertility and pregnancy loss can have on a patient and her partner. ; ; 3) Describe the risks of psychotropic medication use to the fetus and breast-feeding infant. ; 4) Compare risk and benefits of methadone versus buprenorphine in pregnancy. ; 5) Describe common sexual difficulties associated with sexual trauma, infertility and fetal loss.

SUMMARY:

Working in the field of women's mental health is both challenging and extremely rewarding. The rapid influx of literature addressing whether a medication is safe to prescribe in pregnancy and lactation creates great angst for the clinician in the field. Staying abreast of state of the art perinatal pharmacotherapy is critically important. It is also essential to recognize the prevalence of trauma in the lives of the women who seek relief from ongoing pain and suffering. Psychosomatic medicine physicians treating women throughout their reproductive years encounter many women who continue to struggle with complex presentations including tobacco, alcohol and illicit substance use along with co-morbid medical and psychiatric conditions. This symposium will focus on the practical treatment of these women.

We will begin by reviewing the scope of the problem of trauma and violence in the lives of women and how it is often associated with co-morbid medical, psychiatric and substance use disorders. Psychosomatic medicine experts in women's health will discuss the psychological impact of infertility and pregnancy loss, and strategies in working with these women and their partners. Psychopharmacological management for pregnant and breast-feeding women who suffer with depression, anxiety, PTSD, bipolar and psychotic disorders, and substance use disorders (including tobacco, alcohol and opioids) will be reviewed in detail. Examples of clinical documentation will be provided. Participants will be armed with the tools to critically analyze future publications. Lastly, addressing the sexual well-being of these patients will be discussed. Throughout the symposium, clinical cases will be interwoven demonstrating the implementation of evidence-based practices in a clinical setting.

NO. 1

INTIMATE PARTNER VIOLENCE AND PSYCHOSOMATIC MEDICINE

Speaker: Donna Stewart, M.D.

SUMMARY:

Intimate partner violence (IPV) is a global human rights and public health issue that disproportionately affects women. Physical and mental health disorders are common sequelae of IPV and both have relevance to general psychiatrists and psychosomatic medicine specialists. In addition to signs of acute trauma (e.g., fractures, contusions, lacerations etc.), less obvious physical symptoms (chronic pain, musculoskeletal complaints, chronic fatigue, irritable bowel and medically unexplained symptoms) may be seen by psychiatrists, often without the patient disclosing IPV. Psychological disorders which may follow IPV include depression, anxiety, PTSD, sexual disorders and insomnia, again without IPV disclosure.

This presentation will review the epidemiology, risk factors, physical and mental health sequelae of IPV and how to inquire about, and respond to, IPV by mental health professionals.

NO. 2

MANAGEMENT AND ASSESSMENT OF ALCOHOL, TOBACCO AND OPIOID USE DISORDERS DURING PREGNANCY

Speaker: Leena Mittal, M.D.

SUMMARY:

Substance use disorders in women can present differently than in men, often with a distinct natural history, and their persistence during pregnancy raises unique concerns for treaters. While pregnancy is a time of great motivation to improve health-related behaviors resulting in decreases in use of tobacco, alcohol and other addictive substances, there is a subset of women who are unable to stop use of substances during pregnancy. These patients represent a more refractory subpopulation of substance use disorders requiring a collaborative approach informed by principles of perinatal psychiatry and a knowledge of their obstetrical needs. In this presentation, assessment and management of alcohol, tobacco and opioid use disorders during pregnancy will be discussed.

NO. 3

INFERTILITY AND PERINATAL LOSS: WHEN THE BOUGH BREAKS

Speaker: Nancy Byatt, D.O., M.B.A.

SUMMARY:

A substantial number of women and their partners suffer from perinatal loss and infertility. Approximately half of stillbirths occur in seemingly uncomplicated pregnancies. Despite evaluative efforts, in half of all stillbirths, no cause for fetal demise is ever found. Women suffering from a stillbirth may experience sadness, guilt, or anxiety symptoms, including symptoms consistent with PTSD. Evidence is controversial regarding how to best handle perinatal loss, especially regarding delivery and contact with the infant. Additionally, up to 10% of couples suffer from infertility. Women who suffer from infertility have higher rates of depression and anxiety and these rates may increase as fertility treatment progresses. The presentation will provide the knowledge base that providers need when evaluating and treating women with infertility and/or perinatal loss. The presentation will describe: 1) the psychological effects of infertility and perinatal loss; 2) how to best support and treat women and their partners who are suffering from infertility and/or a perinatal loss; and, 3) how to collaborate with other providers (reproductive medicine, OB/GYN, and maternal-fetal medicine) to provide the best care.

NO. 4 PSYCHOTROPIC MEDICATION MANAGEMENT IN PREGNANCY AND POSTPARTUM FOR DEPRESSION AND ANXIETY.

Speaker: Madeleine Becker, M.D.

SUMMARY:

Depression and anxiety are common in pregnancy and in the postpartum period. Untreated psychiatric illness during and after pregnancy has been associated with adverse effects on the mother and the baby. Despite this, many women are either undertreated, or untreated, as doctors may be hesitant to recommend medications to pregnant or lactating mothers. Subsequently, women may not be well informed of the risks and benefits associated with the use of taking medications during pregnancy. This presentation will: 1) discuss the impact of untreated depression and

anxiety disorders in pregnancy and postpartum; 2) Discuss treatment decision-making, both to help guide the practitioner and to help educate the patient; 3) summarize the current data on the safety of antidepressant/anxiolytic medication use in pregnancy; 4) provide an overview of the safety of antidepressants and anxiolytics in lactation.

NO. 5 PSYCHOPHARMACOLOGIC APPROACHES IN THE PERINATAL PERIOD: MOOD STABILIZERS AND ANTIPSYCHOTICS

Speaker: Christina L. Wichman, D.O.

SUMMARY:

Psychiatric disorders during pregnancy and the postpartum period are very common and as such, psychiatrists are often asked to evaluate and treat pregnant and postpartum women. Unfortunately, psychiatrists often do not feel well-equipped to manage treatment of perinatal patients, especially with the use of mood stabilizers and antipsychotics; this is in part due to the concerns about the potential impact of medications on the fetus, pregnancy and delivery itself, and/or lactation. Trying to navigate the literature on the safety of these medications during pregnancy and lactation can also be confusing and frustrating due to conflicting and controversial evidence. We will provide an overview of the current evidence for the using mood stabilizers and antipsychotics during pregnancy and lactation. Additionally, information as to how to document these conversations with patients will be provided.

NO. 6 PROMOTING SEXUAL HEALTH AND WELL-BEING

Speaker: Linda L.M. Worley, M.D.

SUMMARY:

Sexual difficulties (e.g. decreased desire, discomfort, dissatisfaction and difficulty achieving orgasm) are highly common in the lives of the women we treat, yet limited curricula exist within medical school or psychiatric training devoted to achieving competence in this area. This brief presentation will address 1) What our patients need from us when they have sexual complaints; 2) How to ask about sexual

health; and 3) What to recommend to help achieve overall sexual health and wellbeing. Clinical examples will be provided.

ONE DREAM, THREE PERSPECTIVES: THE PLACE OF THE DREAM AND DREAMING IN CLINICAL PRACTICE AND TRAINING

*Chairs: Mark D. Smaller, L.C.S.W., Ph.D.,
Harriet L. Wolfe, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the controversy over the place of the dream in clinical practice; 2) Differentiate between three theoretical views of dreams: Freudian, British School and Jungian; 3) Recognize opportunities for dream interpretation within a clinical hour.

SUMMARY:

Dreams have held interest for individuals and cultures for millennia and in the last century were thought to be a "royal road to the unconscious". Concurrent with growing cultural interest in fast news and medical/economic interest in fast cures, many clinicians' interest in dreams has waned. Nonetheless, the creation of a dream and the place of dreaming in a person's life and in the context of a clinical treatment offer unique points of access to personal meaning and clues to a patient's strengths as well as his/her psychological challenges. The way a dream is understood and discussed holds great potential for enhanced resilience.

This Presidential Symposium will offer three different psychoanalytic perspectives on dreaming and emphasize the value of dreams clinically and pedagogically. An analytic session with a dream embedded in it will be presented. Three psychoanalysts representing Freudian, British School and Jungian perspectives will discuss their understanding of the dream, show how they would use the dream in the clinical hour with the patient and describe how they would introduce a psychiatric resident to analytic theory and technique as it relates to understanding and discussing a dream with a patient.

NO. 1 A DREAM WITHIN AN ANALYTIC SESSION

Speaker: Jan A. Seriff, Psy.D.

SUMMARY:

The presenter will first introduce the clinical context for an analytic hour in which a particular dream was reported by her patient. This is the dream that three analysts will discuss from three different psychoanalytic perspectives. After commenting on how she herself thinks about dreams and their use in a psychoanalytic treatment, the presenter will read the entire clinical hour in which the dream appeared and will repeat the dream to help the audience hold it in mind.

NO. 2 A FREUDIAN PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Harriet L. Wolfe, M.D.

SUMMARY:

A Freudian perspective on dreaming is often focused on the symbolic meaning of dream elements and on references to unconscious aspects of a patient's conscious experience and symptoms. Contemporary Freudians are also interested in how the dream informs the patient's transference to the therapist (its relational meaning) and the developmental level of the patient's effort to solve an aspect of his/her dilemma. Technical questions related to if and when to interpret a dream directly and how to listen to a patient's associations to a dream will be discussed.

NO. 3 A BRITISH SCHOOL PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Adam J. Goldyne, M.D.

SUMMARY:

This discussion will focus on a number of aspects of British thinking about dreams and dreaming. First, for British psychoanalysts influenced by Bion, the colloquial/Freudian definition of "dream" (a conscious experience occurring while asleep) coexists with use of the term "dream" to denote the mental function that generates unconscious meaning from raw emotional experience. It is possible for a patient to have a dream in the colloquial sense, but not to be "dreaming" in the Bionian sense. Conversely, dreaming in a Bionian sense can occur while asleep or while

awake (â€œwaking dream thoughtâ€). When the dreaming function is working, everything that the patient says during the session may be heard as a waking dream, narrating the patientâ€™s here-and-now emotional experience of the session and the transference. We will consider the patientâ€™s dream (colloquially defined) and the rest of the session (the waking dream) with these ideas in mind.

NO. 4

A JUNGIAN PERSPECTIVE ON THE PATIENT'S DREAM

Speaker: Barbara Zabriskie, Ph.D.

SUMMARY:

In a Jungian approach, as in contemporary emotions research, dreams emerge from the experience of an individual as a mind-body continuum. Stimulated by charged emotions arising from a psycho-physical self, they employ narratives, images, and personifications to represent and symbolize unmetabolized affects and states of mind. Integration of the issues emerging from dreams can enhance the dreamer's capacity to calibrate feelings and projections. Dreams focus attention on unconscious dynamics which complement or compensate daytime consciousness, called the â€œremembered present" by the neuroscientist Gerald Edelman. In an analytic process, when patient and clinician engage a dream together, the insights often augment, amend, and relativize embedded attitudes. References to similar images in mythologies and religions place dreams in a historical and generational perspective.

21ST CENTURY PSYCHIATRY AT THE INTERFACE OF GENETICS, NEUROBIOLOGY AND CLINICAL SCIENCE

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

Discussant: Paul Summergrad, M.D.

SUMMARY:

This presidential symposium focuses on the future of psychiatry, namely how the remarkable recent advances in neuroscience are currently, and will in the future, being utilized to both elucidate the pathophysiology of the major psychiatric disorders and develop novel treatments.

Charles B. Nemeroff (University of Miami) will describe the burgeoning data base on the long term neurobiological consequences of child abuse and neglect and how these untoward early life stressors interact with genetic polymorphisms and induce epigenetic alterations that result in increased vulnerability to mood and anxiety disorders. The resistant endophenotype is relatively treatment resistant and will require novel strategies based upon its unique pathophysiology.

Daniel Weinberger (Lieber Institute and Johns Hopkins University) will describe the complex mechanisms recently described by which genetic variations produce cellular alterations and ultimately changes in CNS circuits that underlie vulnerability to schizophrenia. More specifically, the pioneering work on epistasis, gene x gene interactions, in this process as an explanation for the results of recent GWAS studies will be explained.

David Rubinow (University of North Carolina) will focus on the critical role of gonadal steroids and the hypothalamic-pituitary-gonadal axis in the etiology of mood disorders in women and the treatment implications of these findings.

Karl Deisseroth (Stanford University) will describe his groundbreaking findings using novel high resolution optical methods to identify and measure the activity of behaviorally relevant neural circuits and determine their role in neuropsychiatric disorders. Both preclinical and post mortem tissue findings will be presented.

Finally APA President, Paul Summergrad (Tufts University) will serve as the symposium discussant.

NO. 1

PARADISE LOST: THE PERSISTENT BIOLOGICAL AND PSYCHIATRIC CONSEQUENCES OF CHILD ABUSE AND NEGLECT

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

SUMMARY:

Brain imaging, neuroendocrine and neurotransmitter studies have revealed the many long-term biological consequences of child abuse and neglect. These changes underlie the increased vulnerability to mood and anxiety disorders in adulthood. Our group and others have demonstrated a number of long term neurobiological consequences of child abuse and neglect including structural and

functional brain imaging changes, neuroendocrine and immune alterations. In particular, alterations in the hypothalamic-pituitary-adrenal (HPA) axis, the major mediator of the mammalian stress response, contribute to the long standing effects of early life trauma. However, not all exposed individuals demonstrate altered HPA axis physiology, suggesting that genetic variations influence the psychiatric consequences of trauma exposure. Variants in the genes encoding the CRF R1 receptor, FKBP5, PAC1, oxytocin receptor, and others interact with adverse early environmental factors to predict risk for stress-related psychiatric disorders. Epigenetic mechanisms have now been shown to play a seminal role in mediating the effects of early life stress. These studies have suggested new molecular targets for drug development, biological risk factors, and predictors of treatment response. Patients with a history of child abuse and neglect exhibit a more severe disease course in terms of earlier age of onset and symptom severity, and exhibit a poorer treatment response to both (see file for complete abstract)

NO. 2 THE SIMPLE TRUTH ABOUT THE GENETIC COMPLEXITY OF SCHIZOPHRENIA

Speaker: Daniel R. Weinberger, M.D.

SUMMARY:

The past decade of genetic studies of patients with schizophrenia have generated enormous datasets with potentially profound insights about the causative mechanisms of illness at a very basic cellular level. This has led to a rethinking of many of the traditional concepts about psychiatric illness. In a nutshell, we can conclude the following from this generation of work. Complex behaviors are the result of multiple factors that interact biologically. Genes are the first objective clues to the causative mechanisms of psychiatric disorders. Across world populations, individual genes by themselves account for very small increments in risk. A small percentage of cases with the diagnosis of schizophrenia have a simpler genetic etiology. There are many developmental pathways to what we call schizophrenia. Many genes implicated in risk for schizophrenia based on single locus and epistatic interactions show predictable associations at the level of cortical

function in normal subjects. The genetics of psychiatric illness is the game changer both in understanding mechanisms and in finding therapeutic targets based on causation, not phenomenology. This presentation will review the scientific basis for these conclusions.

NO. 3 ILLUMINATING NEURAL CIRCUITRY

Speaker: Karl Deisseroth, M.D., Ph.D.

SUMMARY:

This talk will address optical tools for precise, high-resolution investigation of intact biological systems, and application of these tools to study the neural circuit underpinnings of adaptive and maladaptive behavior. Over the past decade our laboratory has created and developed both optogenetics (a technology for precisely controlling millisecond-scale activity patterns in specific cell types using microbial opsin genes and fiberoptic-based neural interfaces) and CLARITY (a technology to optically resolve high-resolution structural and molecular detail within intact tissues without disassembly). Most recently in optogenetics, our team has developed strategies for targeting microbial opsins and light to meet the challenging constraints of the freely-behaving mammal, engineered a panel of microbial opsin genes spanning a range of optical and kinetic properties, built high-speed behavioral and neural activity-readout tools compatible with real-time optogenetic control, disseminated the tools to thousands of investigators, and applied these optogenetic tools to develop circuit-based insight into anxiety, depression, and motivated behaviors. Distinct from optogenetics, our CLARITY technology can be used to transform intact biological tissue into a hybrid form in which components are removed and replaced with exogenous elements, resulting in a transparent tissue-hydrogel that both preserves, and makes accessible, structural and molecular information for

NO. 4 EVERYTHING YOU NEVER WANTED TO KNOW ABOUT SEX: THIS IS YOUR BRAIN ON STEROIDS

Speaker: David R. Rubinow, M.D.

SUMMARY:

The survival of our species (or any mammalian species) is dependent on the ability of reproductive steroids to generate behavioral states by acting centrally to integrate a wide array of peripheral actions, perceptions, and behaviors. The importance of this capacity is such that reproductive steroids also powerfully modulate many non-reproductive behavioral states and play a role in affective disturbances linked to changes in reproductive endocrine function. In addition to regulating virtually every system implicated in depression “ both activationally and organizationally “ reproductive steroids reveal the exquisite context-dependency of biology/physiology, thus providing critical insights into what is arguably the most important question in psychiatry, namely why do different individuals respond differently to the same stimulus. Mechanisms underlying the context-creating and context-dependent effects of reproductive steroids help explain processes fundamental to our understanding of psychiatric disorders, including sensitization, signal amplification, response programming, differential sensitivity and pharmacodynamics, susceptibility, and network (gene and neural) regulation. These mechanisms further demystify both the therapeutic and adverse behavioral effects of reproductive steroids.

THE PRACTICE OF CHILD AND ADOLESCENT PSYCHIATRY IN THE 21ST CENTURY

Chair: Paramjit T. Joshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the differences between pediatric and adult integrated care systems; 2) Identify ways to improve and enhance mental health care for all youth in diverse populations; 3) Identify the future challenges, opportunities, and changes in the practice of child and adolescent psychiatry.

SUMMARY:

A rapidly evolving knowledge-base and overwhelming financial challenges place child and adolescent psychiatry at a critical juncture that will surely shape its future. Major barriers exist in accessing children’s mental health care, healthcare delivery systems are in a constant state of change due to healthcare reform and

mental health parity, and federal research money is declining while we’re experiencing exponential growth in developmental neuroscience, developmental psychology, and developmental psychopathology. In addition, healthcare providers experience significant challenges in evaluating and treating youth in diverse populations. This symposium addresses these and other opportunities and challenges in children’s mental health with a focus on models for continuing to improve and expand upon the care of children and adolescents with mental illnesses.

NO. 1 INTEGRATED CARE: UNIQUE ASPECTS OF CHILD MENTAL HEALTH

Speaker: Gregory K. Fritz, M.D.

SUMMARY:

Three major forces are behind the inexorable movement toward integrated care: health care reform, mental health parity and existing major barriers to children’s access to mental health care. Developmental differences, the epidemiology of pediatric illness, and financial issues unique to the pediatric population differentiate child and adult integrated care systems. The AACAP has taken these factors into account in developing a “best principles” model for integrating child psychiatry into the pediatric health home. A number of barriers to instituting effective integrated care still exist, and fundamental changes in the US healthcare system are essential to broadly implement this fundamental change in service delivery. However, examples of effective pilot programs provide evidence of feasibility and substantial benefit.

NO. 2 WORKING WITH DIVERSE POPULATIONS: HIV, SEXUAL, ETHNIC, AND RACIAL MINORITY YOUTH

Speaker: Warren Y.K. Ng, M.D.

SUMMARY:

As we look towards the future of child and adolescent psychiatry, there are lessons learned in providing mental health services to diverse and often underserved populations. Youth who are HIV positive, sexual, ethnic, or racial minorities, face specific challenges and experience disparities in accessing and utilizing

mental health services. The psychiatrist must understand and navigate the complex family and parental issues since the youth are minors. Creating an empowering treatment alliance with the youth and facilitating an effective support network is critical. The role of stigma with mental health issues is compounded by the additional stigmas specific to the underserved population. Youth born with HIV or acquired afterwards encounter HIV stigma in addition to the complexities of medical treatment, family involvement, disclosure, and consent for care. Sexual minority youth who are lesbian, gay, bisexual, or transgender may be concerned about confidentiality, alliance, and acceptance. Ethnic and racial minority youth and their families experience wider systemic barriers such as socioeconomic differences, racism, educational inequities, and decreased access to care. It is important that we learn from our diversity, especially our underserved populations, in order to improve and enhance mental health care for all youth.

NO. 3 CHILDREN'S MENTAL HEALTH: A CALL TO ACTION

Speaker: Paramjit T. Joshi, M.D.

SUMMARY:

We need to shift our dialogue about children's mental health and think differently. In the decade to come, we will experience continued population growth and an increasing need for mental health care and wellbeing of our children and their families globally. We are certainly at the cusp of great change in our health care system that begs the questions "what will the delivery of mental health services look like in the near future, will the treatments be evidence-based, how much will they cost and will our patient's get better, and how will these outcomes be measured? Children's mental health problems have been called "the major chronic diseases of childhood. We cannot underestimate the magnitude of two forces that have come to bear on us and the change they will bring over the next few decades. The first is the rapidly rising cost of health care and the second the increasing pace and momentum of scientific discovery. A large majority of mental illnesses seen in adults have their origins in childhood. This presentation will focus on how we need to

seize all opportunities to improve and advocate for health care for millions of children.

NO. 4 THE FUTURE OF CHILD AND ADOLESCENT PSYCHIATRY TRAINING AND RESEARCH

Speaker: Bennett L. Leventhal, M.D.

SUMMARY:

As for all of academic medicine, change has been hard and swift for child and adolescent psychiatry (CAP). Declining Federal dollars for training and research have had a tremendous impact on career development. Similarly, reimbursement for clinical services, even with the ACA, makes it difficult for academic medical centers to meet clinical demands for evidence-based care, even if they can recruit skilled practitioners. In all settings, especially primary care, demand for child and adolescent psychiatrists has never been higher while the resources may have reached the nadir. This comes at a time of exponential growth in developmental neuroscience, developmental psychology, and developmental psychopathology, as well as broad concerns about burgeoning numbers of individuals affected by childhood onset psychiatric disorders. A rapidly evolving knowledge-base and overwhelming financial challenges place child and adolescent psychiatry at a critical juncture that will surely shape its future if not determine its survival. These challenges and opportunities will demand unprecedented creativity, flexibility, and tenacity for child and adolescent psychiatry as well as a clear understanding of the evolving policies and other exigencies related this "new era" of support for patient care, research, and clinical training. Critical, strategic actions will be necessary to preserve and advance the field.

MAY 19, 2015

TALKING ABOUT THE BRAIN WITH PATIENTS: SCIENCE, METAPHOR, AND COMMUNICATION

Chairs: Adrienne L. Bentman, M.D., Richard F. Summers, M.D.

Discussant: Christopher K. Varley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the use of neuroscience concepts in several common treatment modalities; 2) Describe the elements one should consider when introducing such concepts in treatment; 3) Participate in a case discussion using the concepts learned.

SUMMARY:

Practice Gap:

The National Neuroscience Curriculum Initiative (NNCI), an educational collaborative sponsored by the APA Committee on Medical Education and Life-long Learning and the American Association of Directors of Psychiatric Residency Training intends to provide an accessible, comprehensible, and practical online neuroscience curriculum to psychiatrists and others in the field. This will allow us to consider the best ways to present this information to our patients, family members, and medical colleagues. This Symposium address some initial ideas regarding how best to accomplish this.

Abstract:

Advances in neuroscience offer psychiatrists the opportunity to understand behavior, emotions, and the illnesses we treat in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Beyond learning the core elements of the functioning of our organ - the brain, remains the discovery of how we will integrate this knowledge into the care of our patients, and more importantly, into our conversations with patients, their family members, and our colleagues in other medical fields. Last year, the AADPRT-APA Symposium introduced audience members to the content of the NNCI and to the ways in which members could use the content to teach themselves and their students about brain function. This year program director/clinician-educators will discuss the use of cognitive neuroscience concepts in their work with patients, family members, and primary care colleagues. We have organized this discussion by treatment modality and relationship. We will address issues of appropriateness, timing, office tools, and "meeting the patient where they are". And we will address the ways in which timing, attunement, and the language of metaphor sometimes speaks best for the science. Lastly, audience and panel members will have the chance to participate in a case discussion using

the concepts learned. The case presentation will include illustrative video clips. The audience will participate in a discussion of the case along with members of the panel.

NO. 1

TALKING THE BRAIN WITH PARENTS

Speaker: Adrienne L. Bentman, M.D.

SUMMARY:

Parents wish for healthy children who are spared a painful youth and grow to adulthood engaged in life and supportive relationships and able to live on their own. Psychiatric illness challenges this parental wish and often derails their child's developmental trajectory along with other family members. Now that we, like our medical peers, have a brain model to plunk on our desks; when, where, how, and with whom should it be shared? How does knowing the neuroscience facilitate the alliance, enhance adherence, and assist the patient and family in charting a new course for the future? These questions will be addressed in the context of common scenarios psychiatrists confront.

NO. 2

NEUROSCIENCE AND COGNITIVE-BEHAVIOR THERAPY: INTEGRATING KNOWLEDGE AND PRACTICE

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

SUMMARY:

After a brief review of key research findings that illustrate the effects of cognitive-behavior therapy on the brain, methods are described for using neuroscience concepts in the practice of cognitive-behavior therapy (CBT). Opportunities for influencing the delivery of CBT with neuroscience concepts include: 1) enrichment of case conceptualizations and treatment plans; 2) enhancement of psychoeducational and normalizing processes of treatment; 4) instillation of hope; and 5) improvement of adherence to both pharmacotherapy and psychotherapy. Clinical examples and patient materials will highlight the usefulness of this approach in practice.

NO. 3

TALKING "THE BRAIN" IN COMBINED TREATMENT

Speaker: Art Walaszek, M.D.

SUMMARY:

Our patients come to us seeking relief from emotional suffering, and they bring with them varied ideas about what is causing that suffering and what will bring relief. Psychotherapy and pharmacotherapy can seem so different from each other that it may surprise patients that these treatments are complementary, that they act in overlapping ways, and that they reinforce each other. After all, why would an antidepressant be effective for depression that seems due entirely to life's stressors, and why would cognitive-behavioral therapy be effective for depression that seems have arisen out of the blue without a precipitant?

A modern neuroscience approach, as taught in the NNCI model, can help us answer these questions for patients and explain to them why combined psychotherapy and pharmacotherapy is the treatment of choice in many situations. This session will discuss this approach, including the models of (a) psychotherapy as a "top-down" modulator of limbic circuitry and psychotropic medications as a "bottom-up" regulator of emotional functioning, and (b) failure of neuroplasticity as a model of mental illness and enhancement of neuroplasticity as a final common pathway for both psychotherapy and medications. These models also help us explain why other approaches, such as exercise, may be effective elements of combined treatment.

NO. 4 TALKING THE BRAIN IN PSYCHODYNAMIC PSYCHOTHERAPY

Speaker: Richard F. Summers, M.D.

SUMMARY:

The psychodynamic model posits that earlier painful life experiences result in later repeated subjective experiences, perceptual distortions and out-of-date behavioral responses. The contemporary psychodynamic therapist recognizes that this process takes place in the brain as well as the mind, and supports the notions of associational networks, a lifelong attachment system, and trauma as a reflection of processes understandable from both perspectives. Psychodynamic therapy is seen as a process of "top down" change that involves selective brain plasticity. In addition to the traditional psychodynamic frame of

treatment that focuses on intra-psychic conflict and maladaptive responses to important relationships and lifecycle stress, a there is a new opportunity for psychodynamic therapy to address difficulties with adaptation to temperament and the experience of psychiatric illness.

NO. 5 TALKING 'THE BRAIN' WITH OUR MEDICAL COLLEAGUES

Speaker: Deborah Cowley, M.D.

SUMMARY:

In their approach to psychiatry and psychiatric patients, our medical colleagues range from being engaged and skilled to lacking confidence, knowledge, or interest. Our jobs as consultants are to meet them where they are, forge effective collaborations, and, in their language, facilitate the care their patients and families need. This experience often feels like that of a cross-cultural interpreter. Neuroscience, the "physiology" of the mind/brain, provides us with an architecture and language we can share and use as a bridge toward a better understanding of the interface of medicine and psychiatry. This session will address the ways in which discussions of neuroscience can facilitate relationships with our primary care colleagues and mental health care for their patients. By highlighting neuroscientific underpinnings of psychiatric disorders and insecure attachment, our discussions may also help combat misconceptions about mental illness, reduce stigma, and help our colleagues better understand and provide mental health care to patients in primary care settings. Common scenarios will be used to illustrate how, when, and where this is useful, and when it is not.

FRONTAL-SUBCORTICAL NETWORKS AND NEUROPSYCHIATRIC CONCEPTS FOR GENERAL PSYCHIATRISTS

Chairs: Sheldon Benjamin, M.D., David Silbersweig, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide several clinical examples of the importance of neuropsychiatry knowledge to general psychiatry practice ; 2) Describe what is meant by prefrontal / executive

function and prefrontal-limbic-subcortical circuits; 3) List several syndromes seen by psychiatrists in the setting of prefrontal dysfunction, including disorders of motivation, traumatic brain injury, and movement disorders.

SUMMARY:

General psychiatrists are increasingly called upon to evaluate and treat neuropsychiatric disorders. The inclusion of milestones in clinical neuroscience for general psychiatry trainees by the Accreditation Council on Graduate Medical Education (ACGME) is one indicator of the importance of neuropsychiatric education for general psychiatrists. Another indicator is the enhanced role psychiatrists will play in Accountable Care Organizations if they can manage the complex differential diagnosis and treatment of patients with neuropsychiatric disorders, whose care can otherwise be quite costly.

Neuropsychiatric training may be acquired by combined or dual neurology-psychiatry residency training, by fellowship training following general psychiatry or neurology training, or by specialization during general psychiatry or neurology residency. The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5 areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social neuroscience.

After presenting a review of prefrontal/executive function and prefrontal-limbic-subcortical circuits, three families of disorders at the interface of psychiatry and neurology that commonly present to psychiatrists will be reviewed: disorders of motivation, traumatic brain injury, and psychiatric comorbidities of extrapyramidal disorders. Each of these families of disorders impacts prefrontal-subcortical circuits of importance to psychiatrists. In all of them, knowledge of the relevant neuroanatomy, pathophysiology, and bedside neuropsychiatric examination leads to better understanding of the patient and increased treatment sophistication. These disorders also embody the aforementioned clinical neuroscience milestones.

This presidential symposium is presented by the American Neuropsychiatric Association (ANPA), an education, advocacy and sub-specialty group for psychiatrists, neurologists, neuropsychologists and clinical neuroscientists who share interests in brain-behavior relationships.

NO. 1 INTRODUCTION TO CLINICAL NEUROSCIENCE EDUCATION FOR PSYCHIATRISTS

Speaker: Sheldon Benjamin, M.D.

SUMMARY:

The ACGME clinical neuroscience milestones, implemented in July 2014 as a guide for general psychiatry training, may also serve as a guide to competent neuropsychiatry practice for general psychiatrists. They require demonstration of knowledge, skills, and attitudes in 5 areas: neurodiagnostic testing, neuropsychological testing, neuropsychiatric co-morbidity, neurobiology of psychiatric disorders, and applied social and emotional neuroscience. The recent development of these milestones combined with the increased value to accountable care organizations of psychiatrists competent to manage complex neuropsychiatric presentations make neuropsychiatric knowledge. This presentation will include an overview of the clinical neuroscience milestones, a review of neuropsychiatry training pathways, and an introduction to the symposium theme.

NO. 2 A USERS GUIDE TO THE FRONTAL LOBES: WHY PREFRONTAL EXECUTIVE FUNCTION MATTERS

Speaker: Sheldon Benjamin, M.D.

SUMMARY:

Psychiatrists have often looked to their neuropsychology colleagues for testing and interpretation of executive deficits. Yet prefrontal and executive function are major determinants of success in rehabilitation from any psychiatric or neuropsychiatric disorder, so psychiatrists should be expert in this area. After providing simple explanations of prefrontal and executive function and frontal-subcortical circuits, psychiatric and neuropsychiatric

disorders that may involve dysfunction in these circuits will be considered. Prefrontal syndromes with predominantly dorsolateral, orbitofrontal, and cingulate dysfunction will be reviewed. Finally, a few easy to use bedside tests of prefrontal/executive function will be presented with an emphasis on real-world behavioral correlates.

NO. 3 FRONTO-LIMBIC-SUBCORTICAL DISORDERS OF MOTIVATION

Speaker: David Silbersweig, M.D.

SUMMARY:

Neuropsychiatric disorders of motivation offer insights ranging from the clinical (e.g. diagnosis, treatment) to the philosophical (e.g. free will). The frontal-limbic-subcortical brain circuitry underlying goal directed behavior will be reviewed. Examples of related disorders and syndromes will be discussed. These include Tourette's Syndrome, OCD, anhedonia, apathy, akinetic mutism, and impulsivity. These considerations will be integrated into a neuropsychiatric model and approach that transcends neurology-psychiatry distinctions.

NO. 4 NEUROANATOMY AND NEURAL CIRCUITRY OF NEUROBEHAVIORAL CHANGES AFTER TRAUMATIC BRAIN INJURY

Speaker: Thomas W. McAllister, M.D.

SUMMARY:

Traumatic brain injury (TBI) represents the quintessential neuropsychiatric paradigm: it is difficult to appreciate what an individual with TBI and their family experience without understanding the brain regions impacted by biomechanical trauma, and it is equally critical to understand the effect of injury-related neurobehavioral sequelae on outcome after TBI. The neurobehavioral effects of TBI include changes in cognition, changes in personality, and increased risk of developing a host of psychiatric disorders. These neurobehavioral sequelae follow logically from the typical profile of injury associated with TBI. Several cortical regions including frontal cortex, temporal cortex, and hippocampus are particularly vulnerable to TBI. Furthermore, sub-cortical

white matter, particularly in frontal regions and the corpus callosum, are often damaged. Catecholaminergic, cholinergic, and serotonergic systems are vulnerable to disruption acutely and chronically in TBI. These brain regions and neurotransmitter systems are critical components of key frontal subcortical circuits that modulate complex human emotional expression and behavior. This profile of structural and neurochemical injury plays a direct role in the common neurobehavioral sequelae associated with TBI.

NO. 5 TREATING PARKINSON'S DISEASE AND OTHER NEUROPSYCHIATRIC DISORDERS: THE ADVANTAGES OF COMBINED TRAINING IN NEUROLOGY AND PSYCHIATRY

Speaker: John F. Sullivan, M.D.

SUMMARY:

One historical distinction between neurologic and psychiatric pathology is the ability of "neurologic" illness to be more clearly localized neuroanatomically. Advances in our understanding of brain function, catalyzed by evolving imaging technology, have demonstrated that psychiatric illnesses and symptoms do have neuroanatomic correlates, but may be better localized to networks rather than to discrete neural structures. Parkinson disease, long considered primarily a movement disorder and purely "neurologic," is now accepted as a neuropsychiatric disorder with hallmark psychiatric and cognitive symptoms that emerge and evolve in parallel with the motor symptoms. Awareness of meso-cortical and meso-limbic dopaminergic pathways, as well as the role of the basal ganglia in multiple frontal-subcortical networks, is helpful to understand, predict, and manage the non-motor symptoms of Parkinson Disease and related disorders. Combined training in neurology and psychiatry is invaluable in treating neuropsychiatric disorders, providing a thorough grounding and familiarity with the natural history, diagnostic tools, and treatments used by clinicians in both fields to assess and care for these patients.

SCIENTIFIC AND CLINICAL REPORTS

MAY 16, 2015

STUDIES IN GERIATRIC PSYCHIATRY AND DEMENTIA

NO. 1

ATTITUDES TOWARD DEMENTIA, AWARENESS OF DEMENTIA SERVICES, AND IMPACT OF A SHORT FILM ON DEMENTIA STIGMA IN A CHINESE-AMERICAN COMMUNITY

Speaker: Benjamin K.P. Woo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the severity of stigma toward dementia among Asian Americans, using the Chinese American community as an example; 2) Assess the awareness of dementia services in the Los Angeles Chinese community; and 3) Evaluate the usefulness of a culturally sensitive short film on stigma toward dementia.

SUMMARY:

Stigma surrounding dementia continues to plague ethnic minorities and serves as a major impediment to early detection and management of the disease. The Chinese language has no medical term for Alzheimer's diseases, instead describing the associated symptoms as chi dai with chi translating to "confused" and dai meaning "catatonic." These cultural misconceptions are alarming considering that Asian Americans are the fastest growing minority group in the older population. The purpose of this study is to determine the prevalence of stigma toward dementia and to assess the levels of awareness of dementia services in the Chinese American community. Subsequently, as part of this study, we have also developed a culturally sensitive short film to modify public stigma. Methods: 150 Chinese Americans were surveyed using a 15 question, yes/no format questionnaire in Chinese to assess their attitudes toward dementia. Higher stigma scores identified respondents who perceived that those with dementia suffered greater social, vocational, and intellectual impairment. Awareness of dementia services in the community was also measured.

Prior to viewing a short film to target public stigma towards dementia, another 90 Chinese Americans were asked to fill out the stigma survey. Results: Of the 150 respondents, 94 (62%) were females. Seventy-four (49%) of the participants had immigrated to the US for more than 20 years, and 62 (41%) were high school graduates. Forty-nine (32%) of the participants were elderly, and 27 (18%) of respondents endorsed a family history of dementia. However, only twenty (13%) of respondents felt aware of services for dementia patients in their community. The average dementia stigma score was 6.8. 80 (89%) of the ninety viewers found the short film to be useful to target public stigma. Comparing the group (n=17) who found the short film to be extremely helpful versus the group (n=73) who found the short film to be either useful or not useful, the group who benefited the most from the short film had a higher baseline of stigma toward dementia (7.3 vs. 6.0, $t=2.02$, $df=88$, $p=0.047$). Conclusions: These findings indicate that public stigma still pervades in the Chinese American community. Not only that, majority of respondents were not aware of dementia services, indirectly contributing to under-utilization of such services by the Chinese community. Nevertheless, this study has shown that creative, innovative, culturally sensitive short film can be a useful way to target public stigma towards dementia.

NO. 2

INCREASING USAGE OF SEDATIVE ANTIDEPRESSANTS IN LONG-TERM CARE HOMES AMONG ELDERLY WITH DEMENTIA: A POPULATION-BASED TIME-SERIES ANALYSIS

Speaker: Akshya Vasudev, M.B.B.S., M.D.

Co-Author(s): Salimah Z. Shariff, B.Math., Ph.D., Kuan Liu, M.Math., Amer M. Burhan, M.B.ChB, F.R.C.P.C., Nathan Herrmann, M.D., F.R.C.P.C., Sean Leonard, Muhammad Mamdani, Pharm.D., M.A., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize the trend in usage of sedative antidepressants in patients with dementia in long-term care; 2) To learn about changes in usage of other psychotropics including benzodiazepines, antipsychotics, cognitive enhancers & anti-convulsants; 3) To appreciate extent of psychotropic

polypharmacy in this vulnerable population; and
4) To appreciate projection patterns of sedative antidepressants versus comparators till 2017

SUMMARY:

Objective: To examine temporal changes in the prevalence of use of sedative antidepressants (mirtazapine, trazodone and tricyclics) and psychotropic polypharmacy among older adults with dementia living in long-term care homes.

Design: A population-based cross-sectional time-series analysis using linked administrative databases. The study timeframe was divided into 37 intervals of 3 months (quarters) each starting from January 1, 2004 to March 31, 2013. Results were forecasted to March 31, 2017. **Setting:** Ontario, Canada **Participants:** For each quarter, older adults living in a long-term care home with a documented diagnosis of dementia within 5 years prior to the start of the quarter were identified. **Main outcome measures:** Prevalence rates of sedative antidepressants versus comparator agents.

Results: The study population increased by 21% from n= 49,251 in the first quarter of 2004 to n= 59,785 by 2013. The prevalence of use of sedative antidepressant in the long-term care setting increased from 17% in 2004 to 31% by 2013 ($p < 0.0001$) and is projected to increase to 37% (95% CI 35.6% to 37.9%) by 2017. Benzodiazepine use prevalence decreased from 28% to 17% ($p < 0.0001$) with a projected rate of 8% (95% CI 3.1% to 12.9%) in 2017. Atypical antipsychotic use decreased from 38% to 34% ($p < 0.0001$) during the same period and is projected to reach 31% (95% CI 24.9% to 37.2%) in 2017. We observed a significant increase in proportion of patients on two or more psychotropics (44% to 51%, $p < 0.0001$) as well as those on two or more groups of psychotropics (43% to 50%, $p < 0.0001$) from 2004 to 2013. **Conclusions:** We observed an increase in use of sedative antidepressants in patients with dementia in the long-term care setting even though evidence supporting this trend remains weak and is contentious.

NO. 3

SELF-PERCEIVED NEED FOR MENTAL HEALTH CARE AND SUCCESSFUL TREATMENT OF DEPRESSIVE SYMPTOMS IN THE ELDERLY:

FINDINGS FROM AN IMPLEMENTATION STUDY

Speaker: Eric Van Exel, M.D., Ph.D.

Co-Author(s): Van Beljouw IMJ, Ms, Van Marwijk HWJ, MD, PhD, Beekman ATF, MD, PhD, Comijs H, PhD, Heerings M, Ms, van't Veer-Tazelaar PJ, PhD, Baur V, PhD, Verhaak, PFM, PhD, Laurant, MHG, PhD, Stek, ML MD, PhD, Van Exel E MD, PhD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use perceived need for mental health care as predictor on outcome after treatment of (sub)clinical depression; 2) Identify other needs, rather than need for mental health care in patients with (sub)clinical depression; and 3) Determine if absence of perceived need for mental health care is a reason to withhold treatment.

SUMMARY:

Background: The burden of depression and subclinical depression in older persons is high, contributing to important health problems in terms of morbidity, mortality and use of healthcare. Most depressed older persons remain undiagnosed and untreated while several randomized controlled trials in primary care show that (sub)clinical depression is eminently treatable. However, not all persons receiving evidence based treatments benefit from them. We hypothesize that a lack of self-perceived need for mental health care in subjects eligible to receive treatment for (sub)clinical depression predicts treatment outcomes. We combined a quantitative and qualitative approach to unravel the effect of self-perceived need for mental health care on outcome after treatment. **Method:** In this clinical implementation trial, aimed at improving screening (n=9660) and treatment of (sub)clinical depression, 256 persons of 65 years and older with depressive symptoms at baseline were recruited from 18 general practices and a home care organization in the Netherlands. The Perceived need for Care Questionnaire (PNCQ) was used in quantitative analysis to determine presence or absence of a self-perceived need for mental health care in all subjects. Qualitative results were based on in-depth interviews with a subsample of 26 (sub)clinically depressed persons and focused on their motivation for accepting or declining the treatment program, perspectives on self-

perceived needs for care and ambiguity about self-perceived needs. Results: Evidence-based treatment reduced depressive symptoms in older persons with a baseline self-perceived need for care (Wald=21.95, df=8, $p=0.01$), but symptoms remained stable among those without (Wald=12.293, df=8, $p=0.139$). The qualitative interviews showed that 1) persons with a self-perceived need for care more often experienced their depressive symptoms as burdensome, perceived more loneliness and were more intrinsically motivated to participate in treatment compared to those without a self-perceived need for care; 2) all persons expressed a need for care during the qualitative interviews, which was mainly related to perceiving a need for contact with others. 3) Finally, those with a self-perceived need for care were less ambiguous about their self-perceived needs. Conclusion: Assessing self-perceived need for mental health care is important to determine whether subjects with (sub)clinical depression can be successfully treated. This implies that the effectiveness of large scale implementation of mental health care programs can be considerably enhanced when self-perceived need of mental health care of eligible subjects is taken into account

NO. 4 ALTERED DEFAULT MODE NETWORK CONNECTIVITY IN PATIENTS WITH LATE-LIFE DEPRESSION

Speaker: Helen Lavretsky, M.D.

*Co-Author(s): Harris A Eyre, M.B.B.S. Hons.,
Helen Lavretsky, M.D., M.S.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of the pregenual anterior cingulate cortex in late-life depression; 2) Recognize the importance of functional Magnetic Resonance Imaging in understanding the pathophysiology of late-life depression; and 3) Appreciate the significance of functional deficiencies in late-life depression.

SUMMARY:

Background: This study was designed to map the pathophysiology of resting state functional connectivity in elderly participants with depression. Methods: Ten, older adults with depression (age 60 years and older) and 18

age-, sex-, and race-similar healthy controls were studied. Brain connectivity during resting state was assessed with functional magnetic resonance imaging (fMRI) data using independent component analysis (ICA), as implemented in MELODIC (Multivariate Exploratory Linear Decomposition into Independent Components), part of the FMRIB Software Library (FSL). Demographic and clinical measurements were assessed by standardized interviews. Results: Diagnostic groups were similar for age, education, cardiovascular risk factors (CVRF), and cumulative illness rating scales (CIRS). Compared with control participants, patients reported higher depressive symptoms as measured with the Hamilton Depression Rating Scale (HAMD), $t(1, 25) = 10.75$, $p < 0.001$, controls (mean $\hat{A} \pm$ SD): $4.24 \hat{A} \pm 3.38$, patients: $18.4 \hat{A} \pm 3.17$; the Geriatric Depression Scale (GDS), $t(1, 24) = 2.73$, $p = 0.012$, controls: $10.56 \hat{A} \pm 7.68$, patients: $18.70 \hat{A} \pm 6.88$. Patients also showed greater apathy measured with the Apathy Evaluation Scale (AES), $t(1,23) = 4.06$, $p < 0.001$, controls: $43.00 \hat{A} \pm 8.45$, patients: $29.0 \hat{A} \pm 7.92$; and resilience measured with the Connor-Davison Resilience Scale (CD-RISC), $t(1, 25) = 3.27$, $p = 0.003$, controls: $71.00 \hat{A} \pm 10.87$, patients: $56.3 \hat{A} \pm 11.94$ Table 1). Of the resting state networks identified across subjects, one resting state network showed regional hypoconnectivity in the depression group relative to the controls, ($p < 0.05$, Threshold-Free Cluster Enhancement (TFCE) corrected). Results remain significant both with and without including age, sex, and education as covariates in the statistical model. Specifically, the connectivity of the pregenual anterior cingulate cortex (pregenual ACC, $X=2$, $Y=38$, $Z=-4$, maximum $p = 0.016$) differentiated the depression participants from the controls group in the default mode network (DMN, Figure 1). However, associations between functional connectivity in this region and clinical measures remained below the threshold of significance in the depression group. Conclusion: Elderly depression participants showed lower DMN connectivity during resting state, which suggest cerebral functional deficiency in late life depression. The diminished function of the pregenual ACC in default mode network illustrates a fragile interface, which may be identified as a key malleable area to pharmacological intervention for late life depression.

BIOLOGICAL PSYCHIATRY

NO. 1

INFLAMMATORY AND IMMUNOLOGIC CYTOKINES: RELATIONSHIPS WITH HURRICANE EXPOSURE, ETHNICITY, GENDER AND PSYCHIATRIC DIAGNOSES

Speaker: Phebe M. Tucker, M.D.

Co-Author(s): Pascal Nitiema, M.D., M.S.C., M.P.H.,

Qaiser Khan, M.D., M.P.H.

Betty Pfefferbaum, M.D., J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the roles of pro-inflammatory Interleukin-6 and immunologic Interleukin-2 in health and mental health; 2) Understand research on differences in IL-2 and IL-6 among patients with PTSD, depression and other mental disorders; 3) Compare IL-2 and IL-6 in relocated hurricane survivors and demographically matched controls, considering ethnicity, gender, trauma exposure and psychiatric disorders; and 4) Discuss health and mental health implications of our findings related to cytokines in participants studied

SUMMARY:

Background: Inflammatory and immunologic cytokines have been of increased interest as markers for stress responses, mental disorders and general health. We examined relocated hurricane survivors and controls to assess relationships of Interleukin-2 (immunologic) and Interleukin-6 (pro-inflammatory) with hurricane exposure, demographic variables and psychiatric diagnoses. Methods: Forty hurricane survivors relocated to Oklahoma and 40 demographically (frequency) matched Oklahoma controls, predominantly African American (n=70, 87.5%), were assessed for psychiatric diagnosis (SCID-IV) and serum IL-2 and IL-6. Pearson chi-square tests compared diagnoses for both groups. Mean levels of IL-2 and IL-6 were log-transformed to meet the assumption of normality required for conducting parametric tests. Student t-test for independent samples compared the mean of log-transformed IL-2 and IL-6 values across demographics and morbidities. Linear regression models with logarithmic

transformation of the dependent variable compared cytokine levels in survivor and control groups after controlling for demographics and psychiatric diagnoses. Significance was set at $p < 0.05$. Results: Relocated Katrina survivors had higher proportions of current and lifetime PTSD, current MDD and current psychiatric diagnosis than controls. Bivariate analyses found the mean IL-2 level to be significantly higher in African American participants than other ethnicities (8 Caucasians, 1 Indian, 1 Asian). The mean IL-6 level was higher in females than in males and in participants with lifetime PTSD and any current psychiatric diagnosis. Neither current diagnosis of PTSD or MDD, nor exposure to Katrina were associated with IL-2 or IL-6 levels. A multivariable linear regression model adjusting for demographics and current psychiatric disorder also found IL-2 levels to be significantly higher in African Americans compared to other ethnicities and in respondents diagnosed with a psychiatric disorder. IL-2 levels were also found to slightly decrease with age. IL-6 levels were higher in females than males, and in respondents with lifetime PTSD and a psychiatric diagnosis. Conclusion: Results suggest that IL-2 was influenced by African American ethnicity and by the presence of mental illness. IL-6 was influenced by female gender and by the presence of lifetime PTSD and current mental health diagnosis. Thus, immunologic and pro-inflammatory cytokines studied were influenced by demographic variables and non-specifically by the presence of any mental disorder, with pro-inflammatory IL-6 also associated with lifetime PTSD. Implications of IL-2 differences are discussed for this participant group with unique ethnic composition, considering recent genetic and medical literature, as well as possible long-term impact of interleukin differences on health and mental health.

NO. 2

GENOMEWIDE ASSOCIATION STUDY IMPLICATES PROTEIN KINASE N2 AS A RISK FACTOR IN PERSISTENT DRUG ABUSE IN INTRAVENOUS DRUG USERS

Speaker: Shaocheng Wang, M.D., Ph.D.

Co-Author(s): Greg D. Kirk, M.D., Ph.D.

Shruti H. Mehta, Ph.D.

Brion S. Maher, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how to identify the individuals with specific external behavior phenomenon from a longitudinal cohort, using latent class growth analysis (LCGA); 2) Understand the principal of how to apply genome wide association analysis in psychiatric disorders; and 3) understand the general principal of how to interpret the results from genome wide association studies (GWAS).

SUMMARY:

Background: We performed a genome-wide association study (GWAS) to identify risk variants for continuously defined intravenous drug use in a prospective cohort ascertained for drug injection. **Methods:** The sample comprised 1228 individuals from the AIDS Linked to the Intravenous Experience (ALIVE) cohort with available genome-wide SNP data (Affymetrix 6.0). Using the semi-annual report from the ALIVE participants over thirteen years, we used latent class growth models to divide the population into two groups: persistent drug use and cessation. The median number of follow up visit is nineteen. Prior to GWAS, we performed several procedures for quality control. We removed individuals with low genotyping rate (less than 10%). We excluded SNPs with minor allele frequency (MAF) less than 0.08 and with more than 10% missing genotyping rate or Hardy-Weinberg test p-value less than 0.0001. Population stratification was accounted for by Multidimensional Scaling (MDS). After frequency and genotyping pruning, 712,405 SNPs remained. Latent class growth model was performed using Mplus. After filtering, there were 700 cases and 482 controls. Genome-Wide Association Study was performed using PLINK and Haploview. **Results:** Three associations were found with p-value < 1×10^{-6} . Two are on chromosome 2 (rs6749634, Odds ratio [OR] =0.53, p= 1.755×10^{-7} ; rs12711921, OR =0.58, p= 4.858×10^{-7}) and one is on chromosome 10 (rs11255655, OR =0.51, p= 7.367×10^{-7}). The above three loci are not located in any gene. In addition, significant associations were also found on chromosome 1 (rs7522512, OR =1.629, p= 9.737×10^{-6} ; rs6684950, OR =1.666, p= 9.858×10^{-6}) mapped to the protein kinase N2 (PKN2), chromosome 5 (rs7731348, OR =0.60, p= 5.264×10^{-6}) mapped to the G protein-coupled receptor 98 (GPR98), and chromosome 13 (rs2793763, OR =0.52, p= 86.223×10^{-6}) mapped to the citrate lyase beta like (CLYBL).

Conclusions: According to past research, no phenotype associations with the above SNPs (rs6749634, rs12711921, and rs11255655) or the above genes (PKN2, GRP98, and CLYBL) have been reported to our knowledge; moreover, these genes' in vivo function is yet unknown. Further research is needed confirm associations between these SNPs and intravenous drug use.

NO. 3

ASSOCIATION OF BRAIN-DERIVED NEUROTROPHIC FACTOR POLYMORPHISMS, TRAUMATIC STRESS, MILD TRAUMATIC BRAIN INJURY, AND COMBAT EXPOSURE WITH POSTTRAUMATIC STRESS DISORDER IN U.S. SOLDIERS RETURNING FROM DEPLOYMENT

Speaker: Michael Dretsch, Ph.D.

Co-Author(s): Kathy Williams, M.A., Tanja Emmerich, M.S., Gogce Crynen-Kayihan, Ph.D., Fiona Crawford, Ph.D., Grant Iverson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify significant genetic, environmental, and psychological predictors of PTSD in deployed military service members; 2) be familiar with screening instruments with sensitivity to deployment related PTSD; 3) recognize the need for interventions within the deployment cycle that might reduce the risk of PTSD; and 4) recognize that deployment related PTSD is multifaceted and can be attributed to a combination of genetic and environmental factors.

SUMMARY:

Importance: In addition to experiencing traumatic events while deployed in a combat environment, there are other factors that contribute to the development of posttraumatic stress disorder (PTSD) in military service members. **Objective:** To explore the contribution of genetics, childhood experiences, prior trauma, pre-deployment psychological health and cognitive functioning, and deployment factors to the development of posttraumatic stress associated with combat. **Design:** Longitudinal study, 12 month deployment, with pre- and post-deployment assessments. **Setting:** Participants were assessed while at a mobilization site and within 30 days of

deploying to Iraq or Afghanistan. The post-deployment assessment occurred within 30 days from returning stateside. Participants: Active-duty U.S. Army soldiers from two different combat brigades (N = 458) volunteered to be enrolled into the study. Both pre- and post-deployment data on 231 of the 458 soldiers were collected and analyzed.

Exposure: All participants were exposed to a deployment environment for 12 months. Participants were assessed for the level of combat exposure, injury, sleep, and trauma experienced while deployed. Main Outcome Measures: Pre- and post-deployment assessments included a battery of psychological health, medical history, and demographic questionnaires; neurocognitive tests (CNS-Vital Signs[®]); and blood-serum for specific genetic polymorphisms of the D2 dopamine receptor (DRD2), apolipoprotein (ApoE), and brain derived neurotrophic factor (BDNF). Results: Pre-deployment PTSD scores, greater combat exposure and concussion while deployed, and the brain-derived neurotrophic factor (BDNF) Val66Met genotype accounted for nearly 30% of the variance of post-deployment PTSD scores ($R^2 = .28$, $p < .001$, 95% CI [1.6, 1.7]). Conclusions and Relevance: These findings suggest pre-deployment traumatic stress and gene X environmental factors have a significant contribution to the development of combat-related PTSD in military service members.

NO. 4 ELEVATED CHOLESTEROL AND TRIGLYCERIDES ARE ASSOCIATED WITH BETTER COGNITIVE FUNCTIONING IN SCHIZOPHRENIA DATA FROM THE CATIE STUDY

*Speaker: Henry A. Nasrallah, M.D.
Co-Author(s): Thomas J. Blom, MS*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the serious cognitive deficits in schizophrenia 2) Discuss the relationship of metabolic parameters on cognition in schizophrenia 3) Recognize the association of hyperlipidemia with better cognitive performance in the CATIE schizophrenia cohort and its possible implication in the treatment of schizophrenia

SUMMARY:

Background: Neurocognitive impairment is a core feature of schizophrenia and its treatment remains a major challenge and unmet need. The second generation antipsychotics (SGA) are often associated with metabolic dysregulation such as weight gain, dyslipidemia and hyperglycemia, which are regarded as serious cardiovascular risk factors. However, there are reports suggesting that antipsychotic-induced hypercholesterolemia may be associated with cognitive improvement. We examined this relationship using the large CATIE study database. Methods: The sample size was N=1460 with an age range of 18-67 and a mean of 40 years. We used the Composite Neurocognitive Score used in the CATIE to statistically examine the relationship between high total cholesterol, high triglyceride levels and low HDL levels, with neurocognition. Triglyceride levels were examined only on subjects with fasting lipids (N=731). Results: Using analysis of variance with demographics and anticholinergic medication use as covariates, we found 1) High total cholesterol was associated with significantly better neurocognitive score ($p = 0.002$) than those with low total cholesterol levels, 2) The high triglyceride group had significantly better cognitive score ($p = .02$) than the low triglyceride group, 3) Subjects with low HDL had significantly worse cognition score ($p = .04$) than the high HDL group. Discussion: The implications of these findings for improved cognition with hyperlipidemia, which may increase cardiovascular risk, will be discussed. Given other reports of improved positive symptoms with weight gain, the important question of whether metabolic dysregulation, which may increase cardiovascular risk, represent a double edged sword in the treatment of schizophrenia, will be addressed

SUICIDE: EPIDEMIOLOGY, RISK, COMPETENCY, AND HISTORY OF PREVENTION TECHNIQUES

NO. 1 COMPLETED SUICIDES: PSYCHIATRIC DIAGNOSES AND FREQUENCY OF PREVIOUS ATTEMPTS

Speakers: Nisha Ramsinghani, D.O., Hoyle Leigh, M.D.
Co-Author(s): Hoyle Leigh, M.D., Ronna Mallios Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that a thorough assessment of prior suicidal behavior as it relates to an individual's diagnosis can improve patient care and potentially prevent lethality; 2) Recognize that completed suicide occurs across most psychiatric diagnosis as well as in persons without a psychiatric diagnosis; 3) Understand that although patients with borderline personality disorder may have many unsuccessful suicide attempts, some will eventually complete suicide.

SUMMARY:

Introduction: Some 90% of those who complete suicide are reported to suffer from a psychiatric illness. Little to no published data exist concerning the frequency of suicide attempts prior to completion for specific psychiatric diagnoses. Our clinical observations suggested that the number of suicide attempts vary depending on the psychiatric diagnoses. We hypothesized that the number of previous suicide attempts in completed suicides will also vary among different psychiatric disorders
Methods: All subjects in this study were completed suicides the information of which was obtained from the Fresno County Coroner's Office for the period of 2010-2013 and were confirmed as having been patients at a community hospital. Each patient's age, sex, race, and means of suicide were noted along with his or her psychiatric diagnosis and the number of prior suicide attempts. Data were inputted into SPSS statistical package and analyzed utilizing chi square and t tests.
Results:

206 completed suicides who had been patients at Community Regional Medical Center were evaluated. 177 patients had no prior suicide attempts and only 29 patients had 1 or more. 25.8% of female patients had 1 or more priors while only 9% of males had 1 or more < p= .004>. There were no statistically significant differences in race or age. Of the psychiatric diagnoses, 100% with borderline personality disorder had priors while only 34.8% without borderline personality disorder had at least one

prior suicide attempts. 60.7% with a substance use disorder had priors while only 24.4% without a SUD had prior suicide attempts. Of the 206 suicides, 64.6% had no established psychiatric diagnosis, 21.8% had a diagnosis of Major Depressive Disorder, 3.9 % had Bipolar Disorder, 2.4% had Schizophrenia, 1.9% had Borderline Personality Disorder, 1.9% had PTSD, 14.1% had a SUD, 4.9% had General Anxiety Disorder, and 3.9% had another psychiatric diagnosis. Of the manner in which suicide was completed, 41.3% were by gunshot, 24.8% were by hanging. and 11.2% were by drug overdose. Conclusion:

There is a significant increase in the number of suicide attempts prior to completion in patients who have borderline personality disorder or a substance use disorder. In fact, every completed suicide who had borderline personality diagnosis had at least one previous suicide attempt. Also women significantly have a greater number of suicide attempts when compared to men prior to completion. Major Depressive Disorder appeared to be the most frequent diagnoses among suicide completers and percentage of suicide completion via gunshot was far greater than other means of suicide. Surprisingly, in our study, a majority (64.6%) of completed suicides had no established psychiatric diagnosis. Our results imply that better detection of mental illness and treatment of at-risk patients may prevent completed suicides, and that repeated suicide attempts is a serious indicator of eventual successful suicide.

NO. 2

THE VISN 22 HIGH RISK FOR SUICIDE OPIOID DASHBOARD: AN INFORMATION TECHNOLOGY SOLUTION TO MONITOR SUICIDE RISK IN VETERANS PRESCRIBED HIGH-DOSE OPIOID MEDICATIONS

Speaker: Peter Hauser, M.D.

Co-Author(s): Jennifer Kryskalla, Pharm.D., Shira Kern, M.A., David Gray, Pharm.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the increasing use of opioid medications to treat chronic pain in Veterans and Military personnel; 2) Recognize the relationship between opioid

medication use and various risk factors for suicide in Veterans and Military personnel; 3) Recognize the increased risk of intentional or accidental overdose in Veterans and Military personnel who are prescribed opioid medications; 4) Identify information technology methods to quantify risk for suicide among Veterans and Military personnel who are prescribed opioid medications; and 5) Identify methods from electronic medical records to mitigate risk for suicide in Veterans and Military personnel who are prescribed opioid medications.

SUMMARY:

Background: Within the military population, the number of opioid prescriptions nearly quadrupled between 2001 and 2009 to almost 3.8 million, leading to greater rates of accidental or intentional overdose and death. As of 2009, one third of suicides among army personnel involved prescription drugs; the most misused class of medication was opioids. Greater risk of overdose and death have been linked to opioid prescription dosage and frequency, history of suicide attempts or self-harm behavior, history of depression or posttraumatic stress disorder (PTSD), a history of substance and/or alcohol abuse, and within the context of opioid medication use, the concurrent use of other central nervous system depressants; specifically benzodiazepines. The purpose of the current study is to demonstrate the efficacy of dashboard technology in assessing prospectively high-risk factors for opioid overdose. Dashboard technology allows providers who prescribe opioids to calculate morphine equivalent daily dose (MEDD), get a concise summary of opioid and other medications and assess Veterans' risk factors for overdose on an individual basis.

Methodology: The VISN 22 High Risk for Suicide Opioid dashboard incorporates various common risk factors for overdose or suicide with opioid prescribing information in a user friendly format. The initial goal of dashboard implementation was to decrease MEDD of > 200 mg to <5% of all Veterans prescribed opioids at each VISN 22 facility. One month later, a second category of Veterans (those with > 120 mg but < 199 mg MEDD) was added and the initial MEDD > 200 mg target of < 5% was decreased to < 3% to encourage additional progress.

Results: . Eight months into implementation, four of the five sites reached the initial target of <5% and two sites reached the <3% target. There was a 17% decrease in Veterans with total daily morphine equivalents > 200 mg (January 2013; 1,137 vs August 2013; 940- a decrease of 197 Veterans). From March 2013 to August 2013, VISN 22 also saw a 12% decrease in the number of Veterans prescribed > 120 mg MEDD but < 199 MEDD (March 2013; 2,295 vs August 2013; 2,013- a decrease of 277 Veterans). There were further reductions in the number of Veterans receiving > 120 mg but < 199 mg MEDD (August 2013; 2,018 vs July 2014; 1,189- a decrease of 829 Veterans) and Veterans receiving > 200 mg MEDD (August 2013; 940 vs July 2014; 836- a decrease of 104 Veterans). Conclusions: Health care providers are ultimately responsible for monitoring risk factors that may increase overdose and death. The VISN 22 High Risk for Suicide Opioid dashboard is a tool that allows providers to identify and prioritize Veterans who are at high risk for overdose on an individual basis. Initial data collected suggest that the dashboard has decreased the risk of negative consequences associated with opioid medication use.

NO. 3

LAST WILLS AND TESTAMENTS IN SUICIDE NOTES IN TORONTO: A NOVEL ISSUE WITH IMPLICATIONS FOR TESTAMENTARY CAPACITY

Speaker: Mark Sinyor, M.D.

Co-Author(s): Ayal Schaffer MD, FRCPC, Ian Hull, Carmelle Peisah MBBS (Hons), MD, FRANZP, Kenneth Shulman MD, FRCPC

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how frequently handwritten and unwitnessed ("holograph") wills are present in suicide notes; 2) Identify demographic and clinical features associated with people who leave "holograph" wills; and 3) Recognize how these wills help us to understanding the state of mind of suicide victims in their final moments and the implications for testamentary capacity.

SUMMARY:

Objective: To determine how frequently a last will and testament is included in suicide notes and whether, in such instances, factors are

present that may affect a person's testamentary capacity. Method: Of 1,565 suicide deaths in Toronto from 2003-2009, we identified 285 cases where suicide notes were left and were present in coroner charts. These notes were examined for will content. Charts were further examined to determine the presence of depression, psychotic illness, dementia and intoxication at the time of death. Results: Of the 285 suicide notes that were available for review, 59 (20.7%) were found to have a will attached and/or will content bequeathing the person's estate or portions thereof embedded within the suicide note. The mean age of those leaving wills was 50.2 years (range 22 to 86 years). Of those who left a will, 35 (59.3%) were reported to have suffered from depression and 8 (13.6%) suffered from another major mood or psychotic disorder. There were no cases of dementia detected. Nineteen had toxicology performed postmortem with 15 of 19 having alcohol, a sedative hypnotic/benzodiazepine, an opioid and/or a recreational drug in their body at death. Conclusions: A substantial minority of people leaving suicide notes also leave wills, a novel finding in the psychiatric literature. The observed high rates of mental illness and substance use around the time of death have important clinical implications for understanding the mindset of people who die from suicide and hence also legal implications regarding testamentary capacity.

NO. 4 SUICIDE PREVENTION: A CENTENNIAL REVIEW

Speaker: Roger Peele, M.D.

Co-Author(s): Raymond Crowel, Psy.D

Maryam Ravzavi, MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the degree to which knowledge in preventing suicide has changed over the past hundred years; 2) At the conclusion of this session, the participant should be able to state what knowledge has been gained over the past century as to suicide; 3) At the conclusion of this session, the participant should be able to describe the changes in foci of an Annual APA Meeting in 1915 in comparison to one in 2015.

SUMMARY:

In 1915, Tom Williams, M.D., wrote in his seminal paper THE PREVENTION OF SUICIDE [1]:

"The problem we have to study is one of preventive medicine, and concerns thousands of suicides due to distress of mind, the result of psycho-sociological conditions, before which, to judge by their great increase, society shows a helplessness which, in view of present psychopathological knowledge, is reprehensible." Can we conclude the same in 2015? Over the past century, has there been any progress on preventing suicides? Are we still "helpless"? Is the situation still "reprehensible"? A review of the two hundred and twenty seven articles on suicide and the five hundred and eighty nine other articles [e.g., on depression] related to suicide published in the American Journal of Psychiatry and its predecessors over the past hundred years finds 47% were published in the last decade. This review of our growth of knowledge as to epidemiology, genetics, epigenetics, neuropathology, psychiatric diagnoses, somatic diagnoses, clinical assessment, rating scales, as well as treatment finds many impressive advances in our understanding of suicide. Even so, this review finds the sense of "helplessness," stated a century ago, as to preventing suicides, still prevails. 1] Williams TA: The Prevention of Suicide. Am J Psychiatry. 1915; 71[3]:559-571.

TOPICS IN PSYCHIATRIC EDUCATION AND TRAINING

NO. 1 THE EPIDEMIC OF RESIDENT PHYSICIAN BURNOUT: CONTRIBUTORS AND POTENTIAL INTERVENTIONS TO TAKE CARE OF OUR OWN

Speaker: Emily Holmes, M.D., M.P.H.

Co-Author(s): Emily Holmes, M.D., M.P.H., AnnaMarie Connolly, M.D., Robert Hamer, Ph.D., Kenan Penaskovic, M.D., David Rubinow, M.D., Clark Denniston, M.D., and Samantha Meltzer-Brody, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Quantify rates of burnout among resident physicians across a wide range of specialties and among psychiatry residents specifically; 2) Predict which residents are most

likely to experience burnout ;3) Recognize contributors to burnout ;4) Identify strategies to alleviate burnout; and 5) Recognize differences between psychiatry residents and other residents in terms of identified contributors to burnout and proposed interventions to alleviate burnout.

SUMMARY:

Background and Objective: Burnout and depression are significant problems among resident physicians, with rates of burnout ranging from 60-76% and rates of depression as high as 50%. Residents who are burned out are more likely to self-report that they have provided suboptimal care and have made medical errors. This study surveyed residents to better understand which factors most contribute to burnout and which interventions may be most helpful for relieving burnout. We hypothesized that there would be significant differences between the contributors and interventions identified by psychiatry residents compared with other resident physicians.

Methods: Residents from all specialties at the University of North Carolina were asked to complete voluntary, IRB approved, electronic surveys from May-June of 2014. The surveys assessed for current symptoms of burnout and depression in residents and sought to identify contributing factors and potential interventions to address burnout. The resident survey included the validated Maslach Burnout Inventory (MBI) and the Patient Health Questionnaire (PHQ-9). The surveys were administered using Qualtrics software and analyzed using SAS software. Descriptive statistics (frequencies and percentages for categorical variables, means and standard deviations for numerical variables) were calculated. Categorical variables were analyzed using Fisher Exact tests, while continuous variables were analyzed using correlations, t tests, or ANOVA, depending on the hypothesis. No corrections for multiple comparisons were performed so results should be considered exploratory.

Results: The survey was completed by 308 residents. Of these respondents 36% were male, 61% were female, and 3% preferred not to answer. Approximately 70% of the residents met criteria for burnout. Surgical specialties had higher rates of burnout than did non-surgical specialties (86% vs. 64%, $p<0.001$), and 76% of psychiatry residents experienced burnout. Residents who

experienced burnout were more likely to be depressed ($p<0.001$). Psychiatry residents were more likely than other residents to report that time spent on electronic medical records, feeling under-appreciated, and difficulty with patients contributed to burnout ($p=0.04$, $p=0.02$, and $p=0.001$, respectively). Psychiatry residents were also more likely to report that training on how to deal with difficult patients would be a helpful intervention to address burnout ($p<0.001$). Compared with other residents, psychiatry residents had similar scores on the emotional exhaustion and depersonalization scales of the MBI; however, psychiatry residents had higher levels of personal accomplishment ($p=0.005$).

Conclusions: There are very few studies assessing burnout with large samples of residents across different specialties. To our knowledge, none of these studies identify contributors to or interventions for burnout. Rates of burnout vary by specialty but are high among all residents,

NO. 2

DEVELOPING A DIVERSIFIED PSYCHIATRIC WORKFORCE FOR THE 21ST CENTURY: RESEARCH AND POLICY CONSIDERATIONS

Speaker: Bernhard T. Baune, M.D., Ph.D.

Co-Author(s): Harris A Eyre, M.B.B.S., Helen Lavretsky, M.S., M.D., Gary Small, M.D., Bernhard T Baune, M.D., Ph.D., Steven Moylan, B.M.B.S., M.P.H., Art Waloszek, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the emerging challenges in psychiatry; 2) Recognize the importance of non-clinical skill diversification in psychiatric training; 3) Identify the challenges with non-clinical skill diversification in the setting of projected workforce shortages and clinical skill development; and 4) Identify strategies to monitor push and pull factors towards non-clinical diversification in psychiatry.

SUMMARY:

Background: Our communities face several significant mental health issues: Populations are aging; the burden of cognitive aging and depression is increasing; the pipeline for new drugs is modest; mental illnesses related to

cardio-metabolic disorders (e.g. diabetes, heart disease) are on the rise; numerous communities lack access to proper clinical care; and psychiatry is not keeping pace with cutting-edge information tech and biomedical advances. Emerging solutions to these challenges will rely on an appropriately trained psychiatric workforce with a range of clinical and non-clinical knowledge and skills. Therefore, fostering greater educational and workforce investment in broader non-clinical skills is critical. These fields may include research, public health, administration, management and leadership, economics, law, innovation and entrepreneurship, business, technology and informatics, media, engineering, financial services, politics and government, and social services.

Methods: Using a literature review of peer-reviewed research and policy documentation, this presentation will explore a research and policy approach to investigating the non-clinical interests, education and involvement of psychiatry trainees and fellows. There will be an emphasis on the US setting. **Results:** Careful research and policy consideration on career diversification in psychiatry is greatly needed. The Institute of Medicine [1], the Royal College of Physicians and Surgeons of Canada [2] and other major organizations [3, 4] have emphasized the need for broader non-clinical skills of doctors. A number of factors may influence the interest and engagement of medical students and psychiatry residents in non-clinical activities, however these are incompletely understood. The content and nature of medical school curricula will influence exposure to non-clinical activities (e.g. bio-innovation and leadership workshops). The number of residency positions for graduates may influence whether residents can take up full-time or resort to part-time clinical roles. The supply and demand of clinical psychiatric care is most critical to broadening non-clinical skills and activities e.g. if the demand for patient care is too great, then doctors spending more time away from patient care in non-clinical endeavors may be inappropriate. Health Resources and Services Administration data [5] suggests by 2020, the US may see a shortfall of more than 4 000 psychiatrists by 2020. The content and nature of the working environment may influence involvement in non-clinical activities e.g. poor work-life balance and clinical working environment, as well as positive

mentoring and engaging educational programs may also attract residents and fellows towards non-clinical areas.

Conclusion: Clearly non-clinical skill diversification is critical for a fit-for-purpose psychiatric workforce, however it must not compromise the quality of patient care and physician clinical skill development.

NO. 3 QUEER, QUEERING, AND QUESTIONING: DIGITAL NARRATIVES FOR HEALTH CARE EDUCATION

Speaker: Tara La Rose, M.S.W., Ph.D.

Co-Author(s): Albina Veltman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the health care disparities, stigma and discrimination experienced by LGBTQ individuals; 2) Recognize digital media technology as an important tool in healthcare education; 3) Identify various ways of integrating LGBTQ health issues into health education; 4) Explore an innovative curriculum delivery model; and 5) Recognize the importance of narrative based research methods in health care research.

SUMMARY:

There is a growing body of literature that describes the health disparities, stigma and discrimination often experienced by LGBTQ individuals. Lack of training, limited medical knowledge and scant access to relevant information are contributors to healthcare barriers experienced by queer patients.

There is a clear need for additional attention to LGBTQ healthcare education evidenced by the Association of American Medical Colleges (2007) recommendation to expand the scope of educational activities in this area. Unfortunately, many medical schools have not yet embraced these recommendations. A recent survey of Deans of medical education in 150 North American universities found that 70% of respondents rated their school's LGBTQ-specific curriculum as "fair" or below. Additional research suggests there is a positive correlation between medical students' knowledge of the issues affecting queer patients and exposure to this population; affirming attitudes towards queer patients are developed on the basis of patient interactions and through LGBTQ-related

curriculum. Digital media technology is proving to be a powerful tool in medical education; one that may help to resolve some of the current challenges described in the research.

Our project draws on the experiences of 3 key informant groups as resources for developing LGBTQ health education digital curriculum materials: 1) healthcare providers who currently champion care for queer individuals; 2) practitioners who may be understood as "allies, having expressed an interest in expanding their skills in providing care to LGBTQ individuals (but who have not yet focused on this work), and 3) queer-identified people as they access health services. Through "storying circles" (semi-structured group interviews), participants were encouraged to develop and share narratives about LGBTQ healthcare encounters. Qualitative data was collected from these circles using digital video and audio recording. Analysis of this data was used to elucidate and synthesize relevant themes such as challenges and successes, needed resources, and barriers to effective care, using digital narrative research techniques to inform the process. This material was used to create short digital narrative texts or "vignettes". Together, the texts will become a virtual library of e-learning materials for inclusion in the undergraduate medical school as well as the postgraduate psychiatry program at McMaster University. These texts will also be made available to allied healthcare programs (eg. nursing, social work, OT/PT) and continuing medical education activities within McMaster University, Trent University, and at other postsecondary institutions as well as in the community at large. This presentation will focus on the themes elucidated during the process of creating the digital narrative texts about LGBTQ health. Practical suggestions on how to best integrate LGBTQ health issues into health education curricula will be discussed.

NO. 4 WHAT IS PSYCHODYNAMIC SUPERVISION?

Speaker: Howard E. Book, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the "reflective space" and the skill of "reflecting" from a psychodynamic perspective; 2) List the elements that make up the skill of "containment"; and 3) Describe the link between

the patient's use of projective identification and the resident's opportunity to empathize.

SUMMARY:

Psychodynamic supervision refers to a particular psychodynamic stance and interventions undertaken by the supervisor that facilitates the resident's "particularly beginning residents" feeling "safe enough" in both the therapeutic and supervisory relationships to tolerate, contain, and make use of anxieties stirred up by the experiences of both learning the art of psychotherapy, and of enduring the process of being supervised. These anxieties reflect the resident's experience of being used by his/her patient as a repository for that patient's disavowed, unacceptable self and other representations, and/or troublesome affects, all of which are key to that patient's difficulties. These anxieties may also express persecutory anxieties inherent to the supervisory experience, since the supervisor also has an evaluative reporting role concerning the resident's competency as a psychotherapist. As well, anxieties experienced in the supervisory relationship may also reflect a parallel process by which unarticulated concerns arising in the therapeutic relationship between the resident and his/her patient are silently recreated within the supervisory relationship. The capacity to feel "safe enough" in psychotherapeutic and supervisory situations occurs through the supervisor's facilitating the resident's developing what has been termed "negative capabilities." These key counterintuitive capabilities are capacities to: tolerate not knowing, embrace feelings of anxiety and confusion, resist the temptation for premature closure, and avoid the internal push into action. It is the development of these skills that promotes the resident's ability to both create a "reflective space" and to develop the foundational skill of "reflecting," a skill on which psychodynamic psychotherapy is based. This paper will outline the psychodynamic supervisor's role in promoting the resident's growth and development in the above areas through: i) taking a "supervisory history" from the resident in the service of his/her learning style;

ii) promoting a supervisory alliance; iii) modulating the resident's anxiety through appropriate interventions along the Supportive/Expressive continuum; iv) promoting

the resident's capacity for reflecting in the service of his/her developing the psychotherapeutic skills of containment, beta functioning, mentalizing, and empathizing â€” all central to the practice of psychodynamic psychotherapy. This presentation will illustrate these capabilities and capacities with clinical vignettes distilled from the psychodynamic supervision of beginning residents.

MAY 17, 2015

ISSUES IN THE CARE OF MILITARY PERSONNEL AND VETERANS

NO. 1

BRIEF INTERVENTIONS TO PREVENT SUICIDE ATTEMPTS IN MILITARY PERSONNEL

Speakers: Craig J. Bryan, Psy.D., M. David Rudd, Ph.D.

Co-Author(s): Craig J. Bryan, PsyD, ABPP, M. David Rudd, PhD, ABPP, Tracy A. Clemans, PsyD, Evelyn Wertenberger, PhD, LCSW, Bruce Leeson, PhD, Kenneth Delano, PhD, Erin Wilkinson, PsyD, Jill Breitbart, PsyD, ABPP, Travis O. Bruce, MD, Kim Arne, LCSW, Sean Williams, LCSW, Jim Mintz, PhD, Stacey Young-McCaughan, PhD, RN, Alan Peterson, PhD, ABPP

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the three phases of brief cognitive behavioral therapy to prevent suicide attempts; 2) Describe the crisis response plan; and 3) Assist suicidal patients in identifying their reasons for living.

SUMMARY:

The current presentation will present the outcomes of two military-funded randomized controlled trials testing the efficacy of brief psychological interventions to prevent suicide attempts: brief cognitive behavioral therapy (BCBT) and the crisis response plan (CRP). BCBT for suicidal military personnel is a 12-session modification of a previously tested and empirically supported approach to treating suicidality (Rudd et al., 1996; Rudd, Joiner, & Rajab, 2004). A range of behavioral, cognitive, and exposure-based techniques are employed in a hierarchical, sequential manner that begins

with emotion regulation skills training, transitions to cognitive restructuring of cognitions and beliefs that contribute to suicide attempts, and finally a relapse prevention task that is comprised of imaginal rehearsal of acquired problems solving and emotion regulation skills. Emotion regulation is the primary treatment target, not psychiatric diagnosis. Participants were 152 active duty soldiers discharged from inpatient psychiatric hospitals. Eligible participants were randomized to either BCBT or treatment as usual (TAU). Results indicate Soldiers receiving BCBT were significantly less likely to make a suicide attempt during the two-year follow-up than Soldiers in TAU (14% vs. 36%; HR=.40, $p=.034$), suggesting a 60% decline in suicide attempts. Soldiers in BCBT also showed larger declines in suicidal ideation, hopelessness, depression, and posttraumatic stress symptoms than Soldiers in TAU, and were less likely to be medically discharged from the military (27% vs. 42%; OR=.51, $p=.064$).

The CRP (also known as a "safety plan") is a commonly-used intervention for the short-term management of suicide risk. The CRP is designed to target deficiencies in problem solving that contribute to suicidal behaviors by enhancing the suicidal individual's awareness of emerging emotional crises, and then outlining appropriate responses to these crises other than suicide. The CRP was originally developed for use within the context of suicide-focused psychotherapies but it is now commonly used in emergency settings as a single-session intervention. Its effectiveness in such settings is therefore as-yet unknown. Three versions of the CRP are being compared: treatment as usual (TAU, $n=19$) entails a no-suicide contract and professional support resources; the crisis response plan (CRP, $n=18$) identifies self-management skills and social supports; the enhanced CRP (E-CRP, $n=17$) also identifies Soldiers' reasons for living. Participants are 54 Soldiers with acute suicide ideation who are enrolled in an RCT comparing the three crisis interventions. Preliminary data indicate significant group pre-post differences in depression ($F(2,50)=7.16, p=.002$), agitation ($F(2,50)=7.35, p=.002$), urge to kill oneself ($F(2,50)=4.61, p=.015$), and anxiety ($F(2,50)=5.16, p=.009$). Immediate declines in negative emotions were significantly larger for the CRP and E-CRP conditions than for TAU.

**NO. 2
FINDINGS AND PATHS FORWARD FROM
THE STUDY "COGNITIVE PROCESSING
THERAPY FOR VETERANS DUALY
DIAGNOSED WITH POSTTRAUMATIC
STRESS DISORDER (PTSD) AND
SUBSTANCE USE DISORDERS"**

Speaker: Laura A. Bajor, D.O., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the challenges inherent to providing Cognitive Processing Therapy to individuals with co-occurring substance use disorders, e.g. problems with memory and executive function; 2) Learn best practices for meeting such challenges as revealed by this study, e.g. treating substance use as an avoidance behavior, simplifying instructions, and emphasizing repetition of past material; and 3) Learn about study findings that hint at best paths forward, e.g. subjects taking prazosin completed CPT at a significantly higher rate and with more symptom relief than those not on the drug.

SUMMARY:

Background: Providers have been historically reticent to conduct trauma-focused therapy with individuals dually diagnosed with posttraumatic stress disorder and substance use disorders. This has created a defacto barrier to treatment for individuals who use substances to cope with PTSD symptoms and who are thus unlikely to maintain sobriety until their PTSD triggers and symptoms are adequately addressed. We initiated this open design study to test the feasibility of providing Cognitive Processing Therapy, an evidence based treatment for PTSD, to veterans sober 90 days or less. Methods: We recruited dually diagnosed veterans from three residential treatment programs, all sober 90 days or less. Subjects underwent a 12-session course of CPT. Outcome measures included the PTSD Checklist, the Clinician Administered PTSD Scale, the Beck Depression Index, and days to relapse. Results: Twenty-two dually diagnosed veterans were consented, found eligible, and began CPT. Fourteen completed all twelve sessions while eight completed at least one but less than twelve sessions. Completers were significantly more likely to have dependent

children ($p < .02$) and to be taking the drug prazosin ($p < .03$) during treatment. Reduction in PCL and CAPS scores was significantly higher for completers than for non-completers ($p < .005$ and $p < .01$ respectively). Neither group demonstrated significant reduction in BDI score, and there was no significant difference between groups in mean days to relapse. Conclusions: Findings from this study indicate that treatment of individuals dually diagnosed with PTSD and substance use disorders may in fact be feasible during early sobriety. The association between use of prazosin and higher rates of treatment completion and symptom reduction is a novel finding with potential to be clinically relevant, while the significance of being the parent of a dependent child may be linked to increased motivation to complete treatment, although it is an immutable factor and therefore of less clinical interest. Since this was an open study with a relatively small number of participants, general feasibility and the positive influence of prazosin bear further investigation via randomized controlled trials adequately powered to test these results.

**NO. 3
COMPARING THE DSM-IV AND DSM-5
PTSD CRITERIA IN SOLDIERS EXPOSED
TO COMBAT: PROBLEMS WITH THE
NEW DEFINITION AND CLINICAL
IMPLICATIONS**

Speaker: Charles Hoge, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Characterize the differences between *DSM-IV-TR* and *DSM-5* PTSD definitions; 2) Identify the key clinical implications and concerns with using the new *DSM-5* PTSD definition in military personnel and veterans; and 3) Formulate strategies for managing discordant diagnoses, including subthreshold PTSD.

SUMMARY:

The new *DSM-5* definition of PTSD was published in the middle of 2013, replacing criteria that had been used to diagnosis PTSD for more than 25 years. There are numerous questions related to how this new definition will affect prevalence and whether it will be more or less useful in the clinical evaluation and treatment of service members and veterans

than the original one. In addition, there are extensive efforts to screen for PTSD throughout the DoD and VA, but screening tools are all based on the original definition. Head-to-head comparisons of *DSM-IV* and *DSM-5* criteria are lacking. Studies have mostly relied on extrapolations or modifications of *DSM-IV* instruments or internet surveys, and involved non-representative convenience samples (e.g. research registries, college students). We conducted a head-to-head comparison of the symptom criteria in 1,822 Soldiers from one infantry brigade in November 2013, including Soldiers who had previously deployed to Iraq or Afghanistan. Surveys contained both the *DSM-IV* and *DSM-5* versions of the PTSD checklist (PCL-S and PCL-5), with identical instructions. The survey process protected anonymity and controlled for potential order effects, with half of Soldiers receiving the PCL-S first followed by the PCL-5, and the other half receiving these measures in opposite order. Results showed that approximately the same percent of Soldiers met screening criteria for PTSD according to the two definitions (12-13%), and the PCL-5 showed equivalent psychometric properties to the PCL-S. However, the symptom criteria for the two PTSD definitions did not identify the same individuals. Among Soldiers who met symptom criteria according to *DSM-IV*, 30% did not meet the new definition, and a corresponding number only met the definition according to *DSM-5*. The new C-criterion was the most common reason for discordance. The *DSM-5* definition did not appear to have greater clinical utility than the previous one, based on a similar level of overlap with depression, other mental health problems, and functional impairment. These findings, as well as findings from several other studies, raise several important clinical concerns, including whether the old definition should be retained until further research is conducted, and what diagnostic codes/labels should be applied in discordant cases and in other cases involving significant sub-threshold symptoms. There are particular concerns for military personnel with the new structure in *DSM-5* whereby adjustment disorder and PTSD are considered to be on the same continuum in the Trauma- and Stressor-Related Disorders Chapter. This talk will include a literature review of the topic and a detailed discussion of the clinical implications.

NO. 4

EFFECT OF LIVE MUSIC ON THE EMOTIONAL STATE OF PATIENTS AND STAFF AT A MILITARY TREATMENT FACILITY (MTF)

Speaker: Micah Sickel, M.D., Ph.D.

*Co-Author(s): Micah J. Sickel, M.D., Ph.D.,
Tricia Kwiatkowski, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how a performing arts program can be integrated into a hospital setting; 2) Understand how live music performed in a hospital setting can affect the emotional state of listeners; and 3) Understand the unique needs of patients and staff at a military treatment facility (MTF)

SUMMARY:

Music, live and recorded, is known to improve the mood of those listening to it. Music in a hospital setting may be one way in which mood could be uplifted for both patients and staff. Military treatment facilities, or military hospitals, are unique hospital settings. It is unknown if live music within this setting would be uplifting to both patients and staff. This research seeks to better understand the effect of live music presented as part of the performing arts series, Stages of Healing, at Walter Reed National Military Medical Center. Surveys were handed out to all those who were attending the performances. These performances were in common areas of the hospitals, the lobbies, and were attended by patients, patient families, staff, and visitors. The attendees were a cross section of the above groups and included active duty service members who were both patients and employees, retirees who are patients and/or employees, family members of active duty service members and retired service members, and civilian and contract employees who have no service connection. Audience members were given surveys and were asked a number of questions including whether they felt the performance decreased their overall stress level as well as asked them how they felt before and after the performance. They were also asked how long they remained at the performance. Data were analyzed from several of these performances from the past 2013-2014 performing arts series season.

INTEGRATED CARE: SOME TOOLS OF THE TRADE

NO. 1

PATIENT SATISFACTION WITH SHARED MEDICAL APPOINTMENTS FOR WOMEN WITH DEPRESSION USING THE PATIENT SATISFACTION QUESTIONNAIRE-18 (PSQ-18)

Speaker: Lilian Gonsalves, M.D.

Co-Author(s): Jerilyn Hagan Sowell, M.S.N., C.N.S., Adele Viguera, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about Shared Medical Appointments (SMAs), an efficient method of delivering quality care to patients; 2) Recognize that Patient Satisfaction with SMAs is high; and 3) Identify characteristics of SMAs that make it a satisfactory treatment modality for patients.

SUMMARY:

Purpose: Shared Medical Appointments (SMAs), also known as group visits, have become a useful vehicle in providing easier access to the physician and increased efficiency. The purpose of this paper is to assess patient satisfaction in women with depression who attended the SMA using the Patient Satisfaction Questionnaire -18 (PSQ-18) Methodology: In 2003, the Department of Psychiatry and Psychology at the Cleveland Clinic created a 90 minute group appointment for medication management. All participants are women with a diagnosis of depression and/or anxiety. No standardized patient satisfaction questionnaire exists for SMAs in mental health. Therefore, from January, 2014 through June 2014, the PSQ -18, a validated questionnaire, was given to those participants who had attended at least one SMA. Eighty (80) patients completed and returned the questionnaire. Satisfaction scores in domains pertinent to our patients were compiled, excluding those more suited for the medical surgical patient. Results: Overall, patients were satisfied and confident with the treatment they received in the group. 80% of the patients agreed that the provider spent enough time with them while 75% agreed that the provider was attentive to what the patient was telling them. The majority of patients also

noted :a) they did not find it hard to get an appointment right away (64%), b) did not feel the doctors "hurried too much when they treated me" (77%), nor c) did the patients feel the doctors treat them in an impersonal way (84%). Conclusion: SMAs provide satisfactory care with a high level of patient confidence in the care received.

NO. 2

INTEGRATING PEER STAFF INTO MEDICATION MANAGEMENT VISITS TO SUPPORT RECOVERY

Speaker: Rachael Steimnitz, M.P.H.

Co-Author(s): Rachael Steimnitz, M.P.H., Elizabeth Austin, M.P.H., Florence LaGamma, M.S., Edith Kealey, Ph.D., Molly Finnerty M.D., Abbey Hoffman, M.S., Erica Vandewal, M.S., Daisy S. Ng-Mak, Ph.D. and Krithika Rajagopalan, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand what peer mental health services are and the evidence base for using peers in recovery; 2) Be aware of the common challenges psychiatrists and other clinicians experience when implementing new peer roles in the outpatient setting; 3) Understand the critical factors necessary to support clinicians in the implementation of peer roles, including hiring, supervision, and integration with broader clinical team; and 4) Identify effective strategies to support clinical teams struggling to integrate peer work into service delivery.

SUMMARY:

Background: Peer support is identified by SAMHSA as one of ten components of recovery oriented services. However, recent studies suggest incorporating peer staff in to case management teams and other mental health settings can present challenges. The purpose of the study was to identify organizational and administrative themes related to incorporating peer staff into psychiatric medication management visits. Methods: CommonGround, a web-based application that promotes peer-supported shared decision-making around psychotropic medication decisions, was adapted by the New York State Office of Mental Health (MyPSYCKES program). MyPSYCKES was implemented in 12 mental health clinics

and participating sites were required to hire at least one peer to support the program. Clients use the application in the waiting room with the assistance of peer staff before each medication appointment. Peer staff responsibilities include administrative and operational duties related to application use as well as interacting with clients and clinical team members to support treatment and recovery. Initial and follow up site visits (minimum of two) were conducted at each clinic during the first year of implementation and included observation of implementation meetings, key informant interviews, and observation/interviews with peers working with clients on the MyPSYCKES program. We conducted a content analysis of site notes to identify themes related to implementing the program. Results: Currently across the 12 sites, 23 peer staff support MyPSYCKES and 2,727 individuals have used the program before a medication visit. Most sites hired multiple new peer staff, and most peers held part time positions. Several sites had never employed peers and most had never employed peers in a position that required close integration with psychiatrists, medical records, and clinical teams. Themes that emerged during the first year of implementation included: 1) difficulties hiring peers and onboarding new peer staff, 2) structuring supervision for peer staff, 3) integrating peers into clinical service delivery and 4) helping other staff adapt to the new peer role. Discussion: The incorporation of peer roles into psychiatric services is a valuable step towards recovery driven models of care. Although previous studies identified the lack of a clear integrated clinical role for peer staff, one benefit of the MyPSYCKES program is that it gives peer staff a specific role with defined responsibilities. However, physicians and other clinic staff needed ongoing support during initial implementation that focused on the value and practice of peer supported treatment. Implementing programs that integrate peers into psychiatric practice requires systematic evaluation of and planning for potential administrative and clinical issues in order to realize the promise of such programs.

NO. 3 INTERACTIVE TOOLS TO ASSESS COMMON MENTAL ILLNESSES IN PRIMARY CARE

Speaker: Farah Ahmad, M.B.B.S., M.P.H., Ph.D.

*Co-Author(s): Kwame McKenzie, M.D.,
FRCPsych, Meb Rashid, M.D., CCFP, FCFP,
Manuela Ferrari, Ph.D., Yogendra Shakya,
Ph.D., Cliff Ledwos, M.A., Liane Ginsburg,
Ph.D.,*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify barriers to discuss common mental illnesses in primary care; 2) Learn about potential of interactive ehealth screening; 3) Gain knowledge about rates of depression, anxiety, and PTSD; 4) Understand mental health needs of patients served by community health centers; and 5) Discuss application of related screening guidelines in community health centers.

SUMMARY:

Evidence reveals that common mental illnesses remain under-detected in primary care settings. Patients and providers report several communication barriers. Our team has developed an Interactive Computer-assisted Screening Survey (iCAS) to address such communication barriers. The iCAS is completed by patients in their waiting and the program generates reports for patients and providers at the point of care. We have conducted a pilot randomized controlled trial with a partnering Community Health Centers (CHCs), Access Alliance in Toronto. The data for the full trial is under analysis. The purpose of this report is present results on the prevalence of depression, anxiety and posttraumatic stress gathered from 74 patients who completed the iCAS tool in English or Spanish. The high rates found for these conditions call for attention by policy makers and practitioners. The implementation of related screening guidelines should also be evaluated according to the needs of patients served by the CHCs.

NO. 4 UNDERSTANDING SPLIT-TREATMENT FROM THE PATIENTS' PERSPECTIVES: DO THEIR THERAPISTS AND PSYCHOPHARMACOLOGISTS ACTUALLY COMMUNICATE? DOES IT MATTER?

*Speakers: Thomas Kalman, M.D., M.S., Rachel
L. Levine Baruch, M.A.*

*Co-Author(s): Thomas P. Kalman, M.S., M.D.,
Rachel Levine Baruch, M.S.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define "Split-Care". Understand reasons for its development and prevalence and discuss advantages and disadvantages of Split-Care compared to one professional providing both therapy and medication; 2) Describe the results of surveys of therapists and prescribers assessing communication between professionals participating in split-care, and understand the significance of these prior findings; and 3) Learn the results of new research involving split-care recipients. New data on provider communication will be presented as well as data on the impact of this on patient satisfaction with treatment.

SUMMARY:

The provision of psychotherapy and psychotropic medication by two different professionals (split-care) has become prevalent in U.S. mental health care delivery, as more Americans receive prescriptions and psychiatrists provide less psychotherapy. Prior studies of psychotherapists and psychopharmacologists (presented at 2010 and 2012 APA annual meetings) have documented that for over 20% of split-care patients no communication has taken place between the two treatment providers, despite such communication being a recommended principle of optimal care. This paper supplements the prior surveys of the two professional groups with the first such survey of split-care patients themselves. Subjects and Methods: A 20-item questionnaire posted on SurveyMonkey was accessed by 503 split-care patients through Mechanical Turk, an online crowd-sourcing Web Site increasingly being used in Social Science research. These anonymously completed questionnaires provide data about patients' split-care experiences, including the professional disciplines of their two providers, the nature of any relationship between providers, whether or not communication between providers had occurred, and the impact of such communication on patients' satisfaction with treatment. RESULTS: Eighty percent of respondents were in psychotherapy with a psychologist, with 49% receiving their prescriptions from a primary care physician and 51% from a psychiatrist. Of respondents who were aware of whether or not their two

providers had communicated, 30% reported that no communication had occurred. Similarly, 30% and 36% of respondents reported never having been asked by their psychotherapist or psychopharmacologist, respectively, for permission to speak to the other professional. Patients for whom no communication had taken place between providers were significantly less satisfied with treatment than those whose providers had been in communication. CONCLUSIONS: This study confirms the high frequency of non-communication between providers in split-care arrangements. Also corroborated is the extensive prescribing by non-psychiatrists for many patients in split-care. The negative relationship between patient satisfaction and provider non-communication has great implications for treatment compliance and outcome, reinforcing the importance of communication between professionals engaged in this therapeutic arrangement. Implications of these findings for new Integrated Care models will also be discussed.

SCHIZOPHRENIA AND PSYCHOSIS

NO. 1

GLYCINE REUPTAKE INHIBITORS IN THE TREATMENT OF NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Speaker: Rejish K. Thomas, M.D.

Co-Author(s): Glen Baker, PhD, DSc., FCAHS, Serdar Dursun, PhD, MD, FRCPC, Kam Dhami, PhD, Pierre S. Chue, MD, FRCPC, FRCPsych

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define negative symptoms of schizophrenia and know the prevalence in the world; and 2) Recognize the pharmacology of glycine reuptake inhibitors and the mechanism of action to treat negative symptoms of schizophrenia on a molecular level; and 3) Recognize the advances and shortcomings of glycine reuptake inhibitor research to date; and 4) Identify the limits of psychiatric research to date and steps future research must take to address the unmet need of treatment for negative symptoms of schizophrenia.

SUMMARY:

Negative symptoms persist in over one quarter of patients with schizophrenia and are detrimental to prognosis, functionality and

quality of life. Currently, there are no adequate treatments for primary negative symptoms. However, enhancing N-methyl-D-aspartate receptor hypofunctioning with glycine reuptake inhibitors has garnered a lot of optimism as a potential new treatment. Trials of sarcosine-derivatives have yielded mixed results and potential severe side effects have halted progress to larger studies. Non- sarcosine derivatives such as bitopertin have proven to be less toxic and have shown success in phase II trials. Unfortunately, phase III trials of bitopertin to date have not met primary endpoints and a void in effective treatment options for negative symptoms persists. Further research to improve psychiatric study design, discover clinical biomarkers and build on early successes of other potential pharmacologic molecules is required. Keywords: bitopertin, sarcosine, glycine reuptake inhibitors, schizophrenia

NO. 2

ITI-007 FOR THE TREATMENT OF SCHIZOPHRENIA: SAFETY AND TOLERABILITY ANALYSES FROM THE RANDOMIZED ITI-007-005 TRIAL

Speakers: Kimberly E. Vanover, Ph.D., Sharon Mates, Ph.D., Robert E. Davis, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the mechanism of action of the investigational new drug ITI-007; 2) Summarize the key efficacy findings of ITI-007 from the randomized ITI-007-005 clinical trial; and 3) Summarize the key safety findings of ITI-007 from the randomized ITI-007-005 clinical trial.

SUMMARY:

BACKGROUND: ITI-007 is an investigational new chemical entity in development for the treatment of schizophrenia and other neuropsychiatric indications. ITI-007 is a potent serotonin 5-HT_{2A} receptor antagonist with wide separation between its affinity for 5-HT_{2A} receptors vs other neuropharmacological targets. As the dose is increased, ITI-007 engages dopamine D₂ receptors as a pre-synaptic partial agonist and post-synaptic antagonist, indirectly enhances glutamatergic neurotransmission by increasing the phosphorylation of mesolimbic GluN_{2B} subunits of N-methyl-D-aspartate (NMDA) channels, and

inhibits serotonin reuptake. At therapeutic doses, ITI-007 shows little or no engagement of targets associated with antipsychotic adverse events including muscarinic, histaminergic and adrenergic receptors. Moreover, its unique action at D₂ receptors predicts low propensity for motor adverse events. In the ITI-007-005 trial, ITI-007 was safe and well tolerated and a dose of 60 mg demonstrated antipsychotic efficacy in patients with acute schizophrenia as measured by improvement in the total Positive and Negative Syndrome Scale (PANSS) ($p=0.017$). 60 mg ITI-007 also demonstrated differentiation in key secondary endpoints including the PANSS positive and negative subscales and a subgroup analysis in patients with schizophrenia and co-morbid depression at baseline. Additional safety data from the ITI-007-005 trial are presented to better characterize the safety and tolerability profile of ITI-007. **METHODS:** Patients with an acutely exacerbated episode of schizophrenia were randomized to receive 60 mg ITI-007, 120 mg ITI-007, 4 mg risperidone or placebo in a 1:1:1:1 ratio. Blood was collected to evaluate metabolic, prolactin and other safety parameters. Motor function was evaluated using Simpson-Angus Scale (SAS), Barnes Akathisia Rating Scale (BARS), and Abnormal Involuntary Movement Scale (AIMS). Twelve-lead electrocardiograms and vital signs were measured around the time of peak and trough plasma levels. **RESULTS:** ITI-007 was well tolerated and the most frequent adverse event was sedation (13% for placebo, 17% for ITI-007 60 mg, 32.5% for ITI-007 120 mg and 21% for risperidone 4 mg). ITI-007 at both doses showed a favorable side effect profile compared to risperidone. For example, ITI-007 demonstrated a favorable metabolic profile on blood glucose levels, insulin, cholesterol and triglycerides. ITI-007 did not increase prolactin and did not worsen motor function. ITI-007 did not show sustained increased in heart rate, QT interval prolongation or other cardiovascular signals. There was no increase in suicidal ideation or behavior with ITI-007. There were no serious adverse events related to ITI-007. **DISCUSSION:** ITI-007 (60 mg) demonstrated antipsychotic efficacy in patients with acute schizophrenia. ITI-007 (60 and 120 mg) was safe and well tolerated. ITI-007 represents a new approach to the treatment of schizophrenia and affective disorders.

NO. 3 THIRTY-DAY HOSPITAL READMISSION FOR MEDICAID ENROLLEES WITH SCHIZOPHRENIA: THE ROLE OF PATIENT COMORBIDITY AND LOCAL HEALTH CARE SYSTEMS

Speaker: Alisa B. Busch, M.D., M.S.

*Co-Author(s): Arnold M. Epstein, M.D., M.A.,
Thomas G. McGuire, Ph.D., Sharon-Lise T.
Normand, Ph.D., Richard G. Frank, Ph.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the association between co-occurring substance use disorders and psychiatric (mental health and substance use disorder) 30-day readmission for individuals with schizophrenia in Medicaid; 2) Understand the association between co-occurring medical disorders and psychiatric 30-day readmission for individuals with schizophrenia in Medicaid; and 3) Understand the association between county-level rates of achieving post-hospital community follow-up within 7-days and psychiatric 30-day readmission for individuals with schizophrenia in Medicaid.

SUMMARY:

Objective: To examine the relationship between 30-day mental health/substance use disorder (MH/SUD) hospital readmission for persons with schizophrenia, and patient characteristics, hospital utilization, and community treatment quality and capacity. Method: Observational study of schizophrenia-diagnosed enrollees having ≥1 MH/SUD hospitalization in 2005 from 18 state Medicaid programs (N=28,083). Regression models examined the relationship between 30-day MH/SUD hospital readmission, enrollee characteristics (demographic and comorbidity) and county-level indicators for: 1) quality of care (antipsychotic and MH/SUD visit continuity, MH/SUD visit within 7-days post-hospitalization); 2) MH/SUD hospitalization (length of stay, admission rates); and 3) treatment capacity (e.g., population-based estimates of outpatient providers/clinics). Results: Fifty-one percent of the study population had a co-occurring substance use disorder; nearly 47% had a co-occurring chronic general medical condition. Enrollee comorbidity was associated with higher predicted probability of 30-day MH/SUD

readmission, particularly for enrollees with substance use disorders (Predicted Probability [95%CI]=23.9%[21.5%-26.3%]) versus without (14.7%[13.9%-15.4%]). Individuals with co-occurring chronic medical conditions also had a higher predicted probability of 30-day readmission, in a dose-response manner (e.g., ≥3: 25.1%[22.1%-28.2%] versus none: 17.7%[16.3%-19.1%]). Higher county rate of MH/SUD visits within 7-days post-hospitalization was associated with lower readmission for individual enrollees (e.g., for county rates of 7-day follow up of 55% versus 85%, readmission predicted probability =16.1%[15.8%-16.4%] versus 13.3%[12.9%-13.6%]). In contrast, higher county rate of MH/SUD hospitalization was associated with higher readmission probability for individual enrollees (e.g., for county admission rates 10% versus 30%, readmission predicted probability for an individual =11.3%[11.0%-11.6%] versus 16.7%[16.4%-17.0%]). Conclusions: Efforts to reduce 30-day MH/SUD readmissions should focus on co-occurring substance use disorders and medical care coordination, also factors that contribute to hospitalization in general and improving transitions to community care. These findings highlight an opportunity for Medicaid policy to influence improved access to substance use disorder treatment and post-discharge community MH/SUD follow-up, as well as improved coordination with general medical care.

NO. 4 KILLER CULT MEMBERS AND THE INSANITY PLEA: EXPLORING THE LINE BETWEEN BELIEF AND DELUSION

Speaker: Brian J. Holoyda, M.D., M.P.H.

Co-Author(s): William Newman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define a cult and distinguish it from other charismatic groups; 2) Delineate the history of psychiatric testimony in cult litigation; 3) Describe the use of the not guilty by reason of insanity (NGRI) plea by cult members who commit murder; 4) Explain how cult murder litigation has helped define the line between delusion and belief; and 5) Identify practical concerns for forensic examiners evaluating cult members who commit murder.

SUMMARY:

Cults are charismatic groups defined by members' adherence to a set of beliefs and teachings that differ from mainstream religions. Cult beliefs may appear unusual or bizarre to those outside of the organization, which can make it difficult for an outsider to know whether or not a belief is cult-related or delusional. In accordance with these beliefs or at the behest of a charismatic leader some cult members may participate in violent crimes like murder and later attempt to plead not guilty by reason of insanity (NGRI). It is therefore necessary for forensic experts evaluating cult members to understand how the court has responded to cult members and their beliefs when pleading NGRI for murder. Based on a review of extant case law, cult member defendants have not yet successfully plead NGRI on the basis of cult involvement despite receiving a broad array of psychiatric diagnoses that could qualify for such a defense. With the reintroduction of cult involvement in the *DSM-5* criteria for Other Specified Dissociative Disorder, however, there may be a resurgence of dissociative-type diagnoses in future cult-related cases, both criminal and civil.

INTEGRATED CARE ACROSS CLINICAL SETTINGS

NO. 1 IDENTIFYING UNDIAGNOSED PEDIATRIC MENTAL ILLNESS IN THE EMERGENCY DEPARTMENT

*Speaker: Leslie Zun, M.B.A., M.D.
Co-Author(s): LaVonne Downey, PhD.
Trena Burke*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify unsuspected psychiatric illness in pediatric patients who present to the emergency department (ED) with non-psychiatric related complaints; 2) Learn about Pediatric MINI test; and 3) Understand the importance of screening for mental illness in the emergency department.

SUMMARY:

Objective: The objective of this study was to identify unsuspected psychiatric illness in pediatric patients who present to the emergency department (ED) with non-

psychiatric related complaints. A comparison of the test results and ED MD assessments were then compared. Methods: All consenting and stable pediatric patients who presented to the ED with non-psychiatric complaints were given the Pediatric MINI International Neuropsychiatric Interview. It was administered by trained research fellows to the patient prior to their being seen by the physician. Prior to the patient's departure from the ED, the research fellow notified the emergency physician of the results of the MINI interview. Results: A total of 140 patients were enrolled in the study. The majority of patients 79% tested negative of all undiagnosed mental illnesses. The top diagnoses were as follows: attention deficit disorder (8%), separation anxiety (7%), and depression (6%). Of all those patients who tested positive for an undiagnosed mental illness only 2% were diagnosed by the ED attending. Conclusions: This study identified that the ED is a good place to identify undiagnosed mental health illnesses was confirmed. The use of an independent test such as the MINI was also shown to be useful to identify undetected mental health illnesses.

NO. 2 ENGAGEMENT IN A REMOTELY-DELIVERED BEHAVIORAL HEALTH INTERVENTION REDUCES DEPRESSION, STRESS, AND ANXIETY IN MEDICALLY HIGH-RISK POPULATIONS

*Speakers: Reena L. Pande, M.D., M.Sc., Aimee Peters, L.C.S.W., Patrick L. Kerr, Ph.D.
Co-Author(s): Aimee Peters, LCSW, Reena Pande, MD, MSc, and Patrick Kerr, PhD*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate the beneficial impact of a remotely delivered behavioral health intervention; 2) Identify the need for innovative approaches to treat individuals with co-existent behavioral and medical issues; and 3) Understand the potential impact of a behavioral health intervention in impact medical high-risk populations.

SUMMARY:

Objective: The dramatic rise in health care expenditures calls for innovative and scalable

strategies to achieve measurable, near-term improvements in behavioral health. Where behavioral health issues accompany medical disease, inadequate identification and treatment of co-existent behavioral health issues can lead to significantly poorer outcomes, increased medical resource utilization, and substantially greater cost of care. We evaluated the impact of a remotely-delivered behavioral health intervention targeted toward high-intensity medical populations, such as cardiovascular disease, diabetes, and chronic pain.

Methods: We performed a retrospective, observational cohort study of consecutive recent graduates of AbilTo's condition-specific behavioral health intervention, an 8-week, 16-session program delivered remotely by phone or video by a therapist with expertise in cognitive behavioral therapy and a behavioral health coach. The validated depression, anxiety, and stress scale (DASS-21) was used to evaluate behavioral health outcomes. **Results:** Four hundred ten consecutive recent AbilTo graduates were included in the analysis, including participants from AbilTo's core depression and anxiety program (n=138) and condition-specific programs focused on cardiovascular disease (n=108), diabetes (n=120), and chronic pain (n=44). Mean age was 55.1 \pm 9 years and 58% were female. Preferred mode of care delivery was by secure video in 23% and by phone in 77%. We found significant reductions in depression, anxiety, and stress across all programs. Amongst individuals with DASS scores above clinical threshold, depression score declined from a mean 19.8 \pm 8.2 to 7.9 \pm 7.9 with average absolute reduction of -12.0 \pm 9.6 ($p < 0.001$) resulting in an average percent reduction of 59%. Anxiety scores were decreased from 16.0 \pm 6.9 to 8.6 \pm 7.2 with average absolute reduction of -7.3 \pm 8.3 ($p < 0.001$). Similarly, stress scores decreased from 24.3 \pm 6.5 to 13.5 \pm 8.4 with average absolute reduction of -10.8 \pm 9.9 ($p < 0.001$). Results were comparable across all program subgroups and were no different based on mode of care delivery. **Conclusions:** Successful participation in a remotely-delivered behavioral health intervention can significantly improve depression, stress, and anxiety including a population with medical co-morbidities such as cardiac disease, diabetes, and chronic pain. A restored focus on finding innovative strategies to tackle barriers to behavior change in

individuals with co-morbid medical and behavioral health issues is imperative. Future studies to evaluate the impact these improvements in behavioral health may have on medical outcomes and total cost of care are needed to understand the potential population health impact of these findings.

NO. 3

A PHYSICIAN-HEALTH PLAN COLLABORATIVE SOLUTION FOR ACHIEVING PRIMARY CARE MENTAL HEALTH INTEGRATION

Speaker: Judith A. Feld, M.D.

Co-Author(s): Aubrey Balcom, MBA, Jay Swarthout, LMHC

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the different models of behavioral health integration; 2) Understand the cultural, educational, operational and reimbursement challenges and opportunities with integrating behavioral health professionals in the primary care arena; and 3) Appreciate the need to tailor integration interventions and change management approaches to unique practice demographics and culture.

SUMMARY:

Integrating behavioral health competencies within the primary care setting has become a widely accepted healthcare delivery imperative in order to improve healthcare quality, patient experience of care and affordability. Approximately half of all patients in primary care present with psychiatric co-morbidities, and 60% of psychiatric illnesses are treated in primary care. There are numerous national models of collaborative care, notably the IMPACT model for managing depression in older adults as well as the DIAMOND initiative in Minnesota, a multi-stakeholder collaborative program for the treatment of depression in primary care. Despite these successful initiatives demonstrating improved patient experience and outcomes and lower total costs for healthcare, significant barriers to implementing these models remain. These barriers include reimbursement constraints in fee-for-service, stigma, fragmentation and medical training and culture. This pilot program has been developed to address these barriers

and demonstrate the value (improved access, quality of care and provider/patient satisfaction) and sustainability (cost savings) of behavioral health integration in both pediatric and adult primary care practice. Independent Health, a community-based not-for-profit health plan in Western New York, has partnered with 29 community-based primary care practices to transform healthcare delivery through resource support, medical management innovation and a shared savings reimbursement model. As part of this collaboration, ten of these primary care practices (urban, suburban and rural) are participating in a two-year program that embeds hired licensed mental health counselors as primary behavioral health care consultants working as employees in the primary care team. This program is funded through a collaboration of Independent Health, two prominent community foundations and the participating primary care practices. Components of the program include training mental health providers to work in a primary care setting, as well as training the primary care team in collaborating with their new team members. Psychiatric consultation supports the practices as well. The program supports all primary care populations, is payer-agnostic, has a strong community focus, customizes practice interventions, and is built on a sustainable business model. Program metrics include improvement in markers of targeted chronic health conditions, improvement in functional capacity for patients with mental health and substance use disorders, as well as the cost impact of the intervention through analyzing data on level of care utilization and total cost of care. Preliminary findings from this program will be presented as well as lessons learned in building an integrated infrastructure in diverse, non-integrated practice settings.

NO. 4 INTEGRATING MENTAL HEALTH AND PRIMARY MEDICAL CARE FOR HOMELESS VETERANS IN A COMMUNITY SETTING

Speaker: Theddeus Iheanacho, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the complexities of treating homeless adults with severe mental illness and co-morbid chronic

medical disorders; 2) Identify effective strategies for improving access to primary medical care for homeless adults with severe mental illness and substance use disorder who are often high end users of emergency care; and 3) Identify clinical and patient centered outcomes that can measure successful implementation of any intervention for this cohort of patients.

SUMMARY:

The primary goal of our intervention was to deliver high-quality, accessible, integrated primary medical care services for Veterans in Connecticut struggling with mental illness and homelessness. The integrated service was characterized by high staff/Veteran ratios to allow for intensity of services, case and care management, and specialized care delivery. Co-location and integration of primary medical services with community-based mental health services and supported housing services for homeless Veterans represents a shift towards a patient-centered approach to holistic care. To provide integrated primary medical care services with mental health clinicians and housing case-managers, To provide primary medical services at the right place at the right time with a goal to reduce emergency room use for low-acuity medical and psychiatric care and prevent avoidable hospitalization, To provide accessible primary medical care services with a fixed-site, fixed-time open access model and remove traditional barriers to access To collect data on clinic processes and patient outcomes to serve as research platform for continued care improvements and innovation regarding care delivery Program Description: The Integrated Clinic started accepting patients in October 2012. Since then it has provided community-based, integrated primary medical care for over 200 Veterans experiencing mental illness and homelessness. Almost 100% of homeless Veterans served through our program have a *DSM* defined mental disorder. Our Integrated Clinic implemented a hybrid open access scheduling, which is a combination of scheduled visits and open slots for urgent same-day walk-in visits. The model allows for flexibility for Veterans who have difficulty accessing traditional models of primary care on time and regularly use the Emergency Rooms for their non-emergent care needs. It blends the ideas of open access of the emergency room with the continuity of care of traditional primary care. We also developed and implemented a

Veteran-focused, holistic, integrated care plan with the Critical Time Intervention (CTI) team and the Housing and Urban Development-VA supported housing (HUD-VASH) case managers. Both are time-limited intensive clinical case management program for Veterans with severe mental illness experiencing homelessness. They offer intensive case management in the areas of psychiatric rehabilitation, medication management, money management, substance abuse treatment and social support groups. Outcomes: 1. Net Change in ER use since Enrollment (6 months pre/post): -47.2% (108->57, compared to -19.7% nationally). 2. Net Change in Hospitalizations since Enrollment (6 months pre/post): -55.9% (34->15, compared to -29.5% nationally). 3. Treatment Adherence: 87% compared to 40% nationally. 4. Successful Transition to Routine Outpatient Care: 87% compared to 48% nationally. 5. Drop Out Rate from Treatment: 10% compared to 22% nationally.

MAY 18, 2015

SUICIDE: POSSIBLE COMORBIDITIES AND ENGAGING SURVIVORS

NO. 1 MARKED IMPACT ON SUICIDAL IDEATION AND SUICIDOLOGY IN A MILITARY POPULATION FOLLOWING A CERVICAL SYMPATHETIC BLOCKADE

Speaker: Eugene Lipov, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the sympathetic system impact on PTSD; 2) Discuss the sympathetic system blockade on PTSD; and 3) Discuss the sympathetic system blockade on suicidal ideation and suicidality.

SUMMARY:

INTRODUCTION: Studies suggest a single stellate ganglion block (SGB) procedure may provide long-term (i.e., months) symptomatic relief for those suffering from post-traumatic stress disorder (PTSD). The total number of patients treated with SGB for PTSD in the literature are over 200 with success rates of treatment of PTSD being over 70%. A recent

publication discussed the effect of SGB on a patient with severe PTSD that had suicidal ideation over 2 years. This patient was treated with SGB and became non suicidal in 2 days following the procedure (Dr Alino , Tripler Hospital , 2012) . Similar results have been observed in our clinic . The association of PTSD and suicides have reported in the past .The focus of this report is the summary of the available information in the use of SGB for treatment of PTSD with associated suicidal ideation .The SGB has unique advantages in the treatment of PTSD and associated symptoms do to the rapid time to clinical effect , under 30 minutes , as well as very high compliance rate with the therapy . The neurophysiologic rationale for why this might occur remains unknown, though changes in sympathetic/parasympathetic tone and neurohumoral factors have been postulated in our privies publications. **METHODS:** All patients discussed underwent a single right-sided stellate ganglion block using 7cc of local anesthetic under fluoroscopic guidance. Subject's PTSD symptoms were assessed using the PTSD Check List - Military (PCL -M). The data was collected as to the suicidal ideation when available . Cases Patient #1 (Dr Alino) The patient was a 35 year old male with 8 years' time in service (Army) as a truck driver. He had two deployments to Iraq 2004-2005 and 2007-2008. During this time the patient also reports psychological disturbance from seeing burning / dismembered bodies. He was admitted to the inpatient psychiatric ward 4 times between 22 MAR 2009 and 15 NOV 2010 for suicidality in the context of ETOH intoxication and PTSD symptoms. During the patient's final say on the TAMC psychiatric inpatient ward, he screened 80 or 85 on his PCL-M. Two days post-procedure he was discharged from the ward, his PCL-M having dropped to 18, and his suicidal ideation having completely resolved. Patient #2 (Dr Lipov) Patient #3 (Dr Lipov) **DISCUSSION:** It appears that SGB seems to significantly improve PTSD symptoms as well as significantly reduce or eliminate suicidal ideation in patients with severe PTSD . Further work is needed to identify optimal subjects for this treatment approach and to understand the mechanisms involved that can produce such a rapid, dramatic and long-term change in psychological health for PTSD patients with suicidal ideation.

NO. 2

DISORDERED SLEEP AND STRESS AMONG PRIVATE HIGH SCHOOL STUDENTS: INDEPENDENT AND COMBINED EFFECTS ON SUICIDE RISK

Speaker: Stephen Woolley, D.Sc.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss associations between sleep problems and the risk of suicidal ideation and attempts among private high school students; 2) Identify evidence that student risk of suicidality associated with sleep problems may in part be explained by stress and social factors; and 3) Discuss modifications of sleep-related suicide risk associated with availability of peer/adult support, parental interactions, academic pressure, feelings of security, and risky behaviors.

SUMMARY:

OBJECTIVE: To examine the role of sleep and stress in both suicidal ideation (SI) and attempts (SAs) among high school students and identify student-perceived sources of support. **METHODS:** Students completed (2012-4) the online Independent School Health Check Survey which asks about SI, SA, sleep, stressors, and sources of support. 38 covariates were identified as potential confounders of SI/SA associations with 1) difficulty falling/staying asleep (SLP) or 2) sleep problems interfering in daily activities (ACTIV). Logistic regression summarized the analysis (odds ratios, ORs). **RESULTS:** Students were ages 10-19 (n=12,709), 54% female; 65% white, 14% Asian, 6% Hispanic/Latino, 6% black; 95% hetero-, 2% homo-, 3% bi-sexual. SAs were made by 3%. Previous night's sleep was <5 hours for 10%; 17% reported SLP, 24% ACTIV and 42% "dissatisfaction" with sleep. Among SI students, 55% told no one about SI: telling friends (43%) was twice as likely as telling parents. SA (vs SI only) students were 2-3X more likely to tell adults about SI. Examining sleep, SLP (ORs 3.4 & 4.1) and ACTIV (ORs 2.6 & 2.9) were significantly associated with SI and SA. Among covariates, supportive people, seeking help, and positive feelings (e.g., school connection) were associated with reduced risk

of SI and SA. Loneliness was associated with elevated risk. Unexpected was that lack of academic pressure was associated with elevated risk of SI/SA. Physical violence (witnessing/victim of bullying, forced to have sex [FORCED], abused by boy/girlfriend, fighting) was strongly associated with SI/SA (ORs 2-11). "Risky behaviors" were associated with SI (ORs >1-6) and more strongly with SA (ORs 2-11). Individually controlling covariates, sleep-SI/SA remained significant but in some cases the OR was reduced up to 50% (e.g., controlling for stress-related FORCED). Sleep-SI/SA ORs varied by presence/absence of some covariates (e.g., ACTIV-SA differed 32% for those happy vs unhappy with friends). Sleep-related problems with daily activity (ACTIV) were associated with a doubling of the risk of SI (OR=2.1) after controlling covariates including demographics, sexual orientation, school performance, teased, feeling unsafe, alcohol, loneliness, not liking self, seeing bullying. Controlling for additional stress factors hypothesized to affect sleep resulted in a reduced but still significant association (OR=1.4). Similarly, ACTIV and SA were associated (OR=2.7) and remained so (OR=1.3) after controlling stress factors affecting sleep: modeling other sleep-SI/SA associations yielded similar results. **CONCLUSIONS:** As in previous student studies, sleep quality and stress had independent associations with SI/SA. Presence of support did not explain these associations. Results suggested that sleep may affect risk of SI/SA independent of as well as interacting with stress. Future studies of sleep and SI/SA risk are needed to assess separate and combined roles of sleep and stress.

NO. 3

CAUSES AND OUTCOMES OF ACETAMINOPHEN OVERDOSES: THE MAYO CLINIC EXPERIENCE, 2004-2010

Speaker: Nuria J. Thusius, M.D.

Co-Author(s): J. M. Bostwick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the potential complication of hepatotoxicity related to acetaminophen (Tylenol); 2) Describe demographic and clinical characteristics of patients presenting with both intentional and unintentional self-poisoning with

acetaminophen-containing medications; 3) Report findings from a large study of acetaminophen overdose patients with respect to comorbid mental and addictive illness, liver transplantation and death; and 4) Reinforce the dangers of unintentional overdose in pain patients.

SUMMARY:

Background: In the U.S., acetaminophen, the ubiquitous over-the-counter analgesic and antipyretic, is the most common self-poisoning agent, the top reason for emergency department visits from overdose, and a leading cause of fatal hepatotoxicity. Rates of unintended hepatic injury from acetaminophen used for pain management have recently risen. **Methods:** Retrospective analysis of a cohort of 207 patients >18 years treated at a tertiary medical center for excessive acetaminophen exposure, either from deliberate overdose or inadvertent self-poisoning. Data was analyzed with JUMP statistical program. Basic demographics were gathered along with data about treatment location (emergency department, general medical unit, psychiatry unit, or intensive care units including liver transplant unit); overdose intentionality; identities and number of tablets taken; acetaminophen serum concentration; liver function tests; history of mental health or addictive disorders; previous suicide attempts; and current alcohol use. Outcomes including medical complications, transfer to liver transplant unit, listing for liver transplant; actual transplant; and mortality were recorded. Liver injury associated with the number of acetaminophen-containing medications and comorbid alcoholism was assessed, as well as deceased and transplanted patients' clinical and demographic characteristics and long-term trends after liver transplant. **Results:** Both intentional and unintentional acetaminophen overdoses occurred in a background of psychiatric disorder or alcohol/drug dependence, most commonly of major depression (52%) or active alcohol dependence (42%). Half the overdoses -- 71% in patients with pain disorders -- were unintentional. Alcohol complicated both intentional (21%) and unintentional (13%) overdoses with toxicity requiring hospitalization or even liver transplantation more common in alcohol-using patients (p value 0.0169 by Fishers exact test and 0.014 by Pearson). When alcohol was

involved, generally less amount of acetaminophen tablets was tended to be taken (p value <0.0001 by Pearson). 65% of patients received acetylcysteine. Only 33% received acetylcysteine within 8 hours of overdose (26% within 24 hours), however, in most cases, overdose outcomes were still benign: Five patients (3%) were listed for liver transplant, three (2%) were transplanted and two (1%) died without receiving a new liver. In long-term follow-up, transplanted patients had low rates of self-injurious/destructive behaviors and non-compliance. **Conclusion:** The vast majority of patients did not require transplant. Patients with alcohol use disorders and late N-acetylcysteine administration were more likely to require liver transplant unit hospitalization. A high proportion of overdoses were unintentional, including two of three transplanted patients. The three patients receiving transplants did well on long-term follow-up with suspension of self-destructive and noncompliant behaviors.

NO. 4

LIVED LOST LIVES: A SCIENCE/ARTS RESEARCH COLLABORATIVE: ENGAGING BEREAVED FAMILIES, THE PUBLIC AND POLICY MAKERS WITH YOUNG-ADULT SUICIDE

Speakers: Kevin M. Malone, M.D., Seamus G. McGuinness, Ph.D., Anne Sheridan

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Gain a deeper understanding of suicide using inter-disciplinary science / arts methods; 2) Identify novel methods for acquiring new knowledge in relation to suicide; 3) Evaluate feedback from public participants and policy makers who engaged in the Lived Lives Public manifestation; 4) Explore the cross-community / cross-cultural transformation potential of Lived Lives for portraying the universality dimension of suicide in a global society; and 5) Move with research-to-public platform of Lived Lives towards sustained engagement with local Suicide Prevention policy makers.

SUMMARY:

Young adult suicide death constitutes a significant public health problem in many countries, cultures and communities. The associated mantle of stigma is a recognized

obstacle in suicide intervention and prevention, and the frequent inclination is to "look away". Stigma also impacts prevention implementation efforts by policy makers. An alternative strategy may be to "look toward", and to deepen the gaze into the "body and mind, heart and soul" of the problem and its effects on society to create a new collective understanding of suicide and its aftermath together with communities and their policy makers. We established a science / arts collaborative in a novel suicide research initiative that looked toward suicide-bereaved families to engage with them around the lived lives of 104 loved ones they had lost to suicide. 36 of these suicide deaths were aged under 21 years. Engagement with families was an essential step towards subsequently engaging with communities. The methods included a combined Psycho-biographic and Visual Arts Autopsy not previously described. Dissemination of results and findings have included "Lived Lives", a dynamic Arts installation initiative which has been placed for defined periods in public spaces in several urban and rural communities in Ireland, including Donegal as a pilot approach, mediated by the Artist and scientist, and facilitated by local suicide prevention policy makers. Public feedback from hundreds of attendees was simple and profound, with no adverse effects reported. Bereavement counselling support was made available throughout. Policy makers significantly advanced local prevention implementation initiatives in consultation and collaboration with the scientist, the artist and community. The statutory and voluntary feedback indicates that our approach has provided a new and sensitive model for public engagement with the problem of suicide that dismantles stigma, acknowledges bereavement and grief, and restores dignity and humanity to lives lost to suicide, which can facilitate change, and support for new local suicide prevention policy initiatives. We propose that such an approach may have universality potential that will resonate across cultures and communities and contribute profoundly to local suicide prevention action. The co-presenters from science / arts and policy will present the journey of the project in words, and images from the private and intimate stories with suicide bereaved families through to "Lived Lost Lives" presented in the public domain. We include feedback from statutory agencies and community voices,

including 120 16-18 year olds, whose reflections include: "I had thought about doing it, but would never do it now after seeing the wife (terrible) pain of the families left behind....teenagers don't think about their families missing them, they think about their friends...wife (terrible) sad" (16 year old participant, Lived Lost Lives, Letterkenny Arts Centre, Nov 2013).

PSYCHOSOMATIC AND CONSULTATIVE PSYCHIATRY

NO. 1 POSTTRAUMATIC STRESS DISORDER IS ASSOCIATED WITH IMPAIRED CORONARY DISTENSIBILITY AND PREDICTS MAJOR ADVERSE CARDIOVASCULAR EVENTS

Speaker: Naser Ahmadi, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Impaired coronary distensibility index is an endothelial dependent process and is associated with vulnerable plaque composition and cardiovascular mortality; 2) Posttraumatic stress disorder is independently associated with impaired coronary distensibility index; 3) Posttraumatic stress disorder is independently associated with impaired coronary distensibility index and predicts the major adverse cardiovascular events; and 4) Measures of coronary distensibility index can identify Posttraumatic stress disorder individuals at risk for major adverse cardiovascular events.

SUMMARY:

Background: Impaired coronary distensibility index (CDI) is an endothelial dependent process and is associated with vulnerable plaque composition and cardiovascular mortality. We recently reported that PTSD is independently associated with impaired CDI. This study investigates the relation of impaired CDI and PTSD with major adverse cardiovascular events (MACE). Hypothesis: There is a significant association between PTSD and impaired CDI with MACE. Methods: This study is consist of 246 subjects (aged 63±10 years, 12% women) with (n=50) and without (n=196) PTSD underwent computed tomography angiography (CTA) and their CDI were assessed. Subjects

were followed for the median of 50 months. CDI in left anterior descending artery (LAD) was defined as: [(Early diastole - mid diastole lumen cross section area (CSA))/ (lumen CSA in mid diastole x central pulse pressure) x 1000]. Major-adverse-cardiac-event (MACE) was defined as myocardial-infarction or cardiovascular-death. Survival regression was employed to assess the relation of impaired CDI and PTSD with MACE. Results: CDI was significantly lower in PTSD (3.4 ± 1.4) as compared to no-PTSD subjects (4.8 ± 1.5) ($p=0.01$). After adjustment for risk factors, the relative risk of MACE was 56% higher in those with PTSD as compared with those without PTSD ($P=0.001$). Similarly, the relative risk of MACE was 95% higher with unit decrease in CDI ($p=0.001$). Regression analyses revealed significant linkage between PTSD and impaired CDI with increased risk of MACE. After adjustment for age, gender, conventional risk factors, and CTA diagnosed CAD, the relative risk of MACE was 234% higher in each unit decrease in CDI & presence of PTSD as compared to those without PTSD ($p=0.001$). Conclusion: PTSD is independently associated with impaired CDI and predicts the major adverse cardiovascular events. Our findings suggest that measures of CDI can identify PTSD individuals at risk for MACE.

NO. 2 REDUCING PSYCHIATRIC SYMPTOM SEVERITY IN PATIENTS WITH EPILEPSY AND NON-EPILEPTIC SEIZURES

Speaker: Jasper J. Chen, M.B.A., M.D., M.P.H., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the extent of psychiatric comorbidity, and comorbid depression in particular, in patients with epilepsy and patients with non-epileptic seizures; 2) Treat severe symptoms of comorbid depression in patients with epilepsy and patients with non-epileptic seizures; 3) Identify the benefits of co-locating psychiatric services within epilepsy and neurology clinics in order to both reduce psychiatric symptom severity and better coordinate mental health care.

SUMMARY:

Rationale: Patients with epilepsy (PWE) and patients with non-epileptic seizures (PWNES) constitute particularly vulnerable patient populations and have high rates of psychiatric comorbidities. This potentially decreases quality of life and increases health care utilization and expenditures. However, lack of access to care or concern of stigma may preclude referral to outpatient psychiatric clinics. Furthermore, the optimal treatment of NES includes longitudinal psychiatric management. No published literature has assessed the impact of co-located psychiatric services within outpatient epilepsy clinics. We therefore evaluated the co-location of psychiatric services within a level 4 epilepsy center. Methods: From July 2013 to June 2014, a psychiatrist was co-located in the Dartmouth-Hitchcock Epilepsy Center outpatient clinic one afternoon per week (0.1 FTE) to provide medication management and time-limited structural psychotherapeutic interventions to all patients that scored greater than 15 on the Neurological Disorders Depression Inventory for Epilepsy (NDDI-E) and who agreed to the referral. Psychiatric symptom severity was assessed at baseline and follow-up visits using validated scales including NDDI-E, Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and cognitive subscale items from Quality of Life in Epilepsy-31 (QOLIE-31) scores. Results: Forty-three patients (18 male; 25 female) were referred to the clinic over a one-year period; 27 (64.3%) were seen in follow-up with a median of 3 follow-up visits (range 1 to 7). 37% of patients had NES exclusive of epilepsy, and 11% of patients had a dual diagnosis of epilepsy and NES. Psychiatric symptom severity decreased in 84%, with PHQ-9 and GAD-7 scores improving significantly from baseline (4.6 ± 0.4 SD improvement in PHQ-9 and 4.0 ± 0.4 SD improvement in GAD-7, p -values <0.001). NDDI-E and QOLIE-31 cognitive sub-item scores at their most recent visit were significantly improved as compared to nadir scores (3.3 ± 0.6 SD improvement in NDDI-E and 1.5 ± 0.2 SD improvement in QOLIE-31, p -values <0.001). These results are moreover clinically significant-defined as improvement by 4-5 points on PHQ-9 and GAD-7 instruments-and are correlated with an overall improvement as measured by NDDI-E and cognitive subscale QOLIE-31 items. Conclusion: A co-located psychiatrist demonstrated a reduction in psychiatric symptoms of PWE and PWNES, as

well as an improvement in psychiatric access and streamlining of their care. Epileptologists were able to dedicate more time to managing epilepsy as opposed to psychiatric comorbidities. As integrated models of collaborative and co-located care are becoming more widespread, mental health care providers located in outpatient neurology clinics may provide significant benefit for both patients and providers.

Key words: embedded, co-located, psychiatry, quality improvement.

NO. 3 PROACTIVE CONSULTATIONS IN A GENERAL HOSPITAL USING THE CEDARS-SINAI PSYCHIATRIC CONSULTATION IDENTIFICATION SCORE (CS-PCI)

Speaker: Waguih W. IsHak, M.D.

Co-Author(s): Bret Becker, MD, Rebecca Hedrick, MD, Anna Solt, MD, Enrique Lopez, Psy.D., Hussah Al-Kharafi, Ph.D. Candidate, Katherine Smith, Ph.D. Candidate, Michael Peterson, LCSW, Linda Parisi, RN, and Itai Danovitch, MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The participants will become familiar with the Proactive Consultation Model; 2) The participants will gain skills in identifying high-risk psychiatric patients in medical/surgical settings using Practice Guidelines; and 3) The participants will acquire knowledge about the benefits and challenges of the Cedars-Sinai Psychiatric Consultation Identification (CS-PCI) scoring system.

SUMMARY:

Background: Findings from the RWJF Report on Mental Disorders and Medical Comorbidity, IOM Report on Health and Behavior, APM Guidelines, show that Comorbidity between medical and mental conditions is highly prevalent, associated with higher costs, and results in worse health outcomes. Despite their impact on medical outcomes, underlying mental conditions are under-recognized and often go unaddressed. Collaborative care approaches within the medical setting have been found to be clinically helpful and cost-effective. Methods:

The Psychiatric Consultation Identification (PCI) score was developed at Cedars-Sinai Medical Center (CSMC) to systematically and proactively identify medical-surgical inpatients with significant underlying mental conditions. The CS-PCI score is used to screen hospitalized patients with medical conditions who might benefit from a psychiatric consultation. With this instrument we strive to improve the overall detection of psychiatric comorbidity that interferes with effective medical/surgical management. Results: The CS-PCI score is based on 40 risk factors adapted from APM Practice Guidelines. Clinical research personnel under supervision of a C/L psychiatrist screen new patients admitted to the hospitalist service for clinical problems and identify high-risk patients through review of recent medical notes using the CS-PCI score. Patient evaluations from the medical record are designed to take less than 5 minutes. When a high-risk patient is identified, the C/L psychiatrist will communicate with the attending physician to determine what further steps are in the best interest of the patient, which may or may not include a consult from psychiatry. Future implementation of the model includes training members of the medical team (social worker or physician assistant) to apply the CS-PCI to guide activating consults. Conclusion: The CS-PCI scoring method is an innovative tool to rapidly evaluate and identify high-risk patients in the medical setting that may benefit from a psychiatric consultation. Embedding psychiatric services in the medical settings is an established collaborative care strategy that has been shown to be both clinically and cost-effective.

NO. 4 THE VISN 22 EVIDENCED-BASED PSYCHOTHERAPY TELEMENTAL HEALTH CENTER AND REGIONAL PILOT: SUCCESSES AND CHALLENGES

Speaker: Peter Hauser, M.D.

Co-Author(s): Kathryn Williams, Ph.D.; Shira Kern, M.A.; Steven Thorp, Ph.D., Martin Paulus, M.D., Niles Shah, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) identify the necessary steps required to set up, implement and maintain a regional Telemental health program

for Veterans; 2) recognize the various challenges that providers and Veterans encounter when utilizing Telemental health modalities; 3) identify methods to mitigate these challenges in order to provide seamless Telemental health services to Veterans with Mental Health care needs; and 4) recognize the benefits of Telemental health as a modality of treatment for Veterans with PTSD.

SUMMARY:

Background: Telemental Health (TMH) refers to the use of secure communication technologies to facilitate timely access to mental health care for Veterans in rural or remote locations. TMH can be used to make diagnoses, manage care, perform checkups and provide longer term follow up care, among other uses such as individual and group psychotherapy, psycho-education, cognitive testing and general psychiatric care. Also, TMH is advantageous to those for whom traveling can be a financial burden or a trigger for PTSD symptomology.

Methodology: In 2011 the Veterans Health Administration (VHA) funded additional mental health staff therapists for each Veteran Integrated Service Network (VISN- 21 VISNs across USA) to provide evidence-based psychotherapy (EBP) via TMH. Also, 3 VISNs (including VISN 22) were provided resources to create regional EBP TMH pilots that serve Veterans across multiple VISNs. The implementation of the VISN 22 Regional EBP TMH pilot involved negotiating various logistic, administrative, educational and security issues across facilities and VISNs in the western United States. Prior to providing TMH services across facilities, potential remote sites were identified, Memorandums of Understanding (MOUs) written and signed, CPRS (electronic medical records) access provided to TMH providers, TMH clinics built, electronic inter-facility consults developed, and TMH technology tested. Clinical issues included educating referring providers about inclusion and exclusion criteria, developing a written emergency plan at remote sites available to TMH providers, and developing a written procedure for treatment protocols and communication of clinical information. The VISN 22 EBP TMH pilot collected clinical information, mileage not driven by Veterans who receive TMH services and travel dollars saved, no show rates, and Veteran, TMH and referring provider satisfaction. Results: In Fiscal Year 2013 (FY13)

the VISN 22 TMH EBP regional pilot provided 1643 individual EBP sessions to 233 unique Veterans (of these, 143 EBP sessions were provided In-Home to 42 Veterans) in 10 clinics located across 3 west coast VISNs. Over 200,000 travel miles were not driven (estimated savings- \$83,000). The no-show rate averaged 8-10% (varied by remote clinic), which was less than the facility average of 13.5%. In-Home TMH no show rates were 2%. In the 1st two quarters of FY 14 1,941 individual EBP sessions were provided to 504 unique Veterans. Conclusions: While TMH is becoming widely available, its use is limited in healthcare systems due to lack of knowledge, education, logistical guidance, and technical training. Significant time and resources must be devoted for successful implementation. The results of the VISN 22 EBP TMH Regional Pilot suggest that EBP via TMH can be provided successfully from a single location to numerous clinics (and In-Home) across a broad geographic area with favorable no-show rates.

POSTTRAUMATIC STRESS DISORDER AND ABUSE

NO. 1 THE STARTS SCREENING TOOL: ADVANCING CULTURALLY- APPROPRIATE TRAUMA SCREENINGS FOR YOUNG MEN OF COLOR EXPOSED TO VIOLENCE

Speakers: Nicky MacCallum, Linnea Ashley, M.P.H.

Co-Author(s): Linnea Ashley, M.P.H., Anne Marks, M.P.P., Vincent Chong, M.D., M.S., Randi Smith, M.D., M.P.H., Henrissa Bassey, M.P.H., Gregory P. Victorino, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss young men of colors recommendations for improving quality, culturally informed treatments for trauma and PTSD; 2) Identify best practices for treating clients who have trauma symptoms stemming from traumatic injury or violence; and 3) Define the principles of trauma-informed care with special attention to boys and men of color.

SUMMARY:

Early exposure to violent injury has deleterious short and long term effects on an individual's

physical, emotional, and social wellbeing that may significantly decrease an individual's quality of life and reduce opportunities for educational and economic success. Young men of color are disproportionately impacted by violence, both as victims of violent injury and as witnesses to traumatic injury. Moreover, young men of color residing in urban neighborhoods with high levels of violence are at a heightened risk of detrimental health outcomes following traumatic injury. However, in spite of the acute impact of violence on young men of color, there is a dearth of research detailing culturally informed recommendations for psychiatric trauma treatments - perpetuating a system in which trauma services are not informed by the population that they are designed to help.

To ameliorate this incongruence and identify trauma symptoms that we believe to be undiagnosed in young men of color, we designed a mixed-methods research study, conducted four focus groups, and conducted interviews with 69 men of color, ages 18-30. Participants were asked to: share how they access supports and services and identify their trauma needs, and provide recommendations for eliminating barriers that prevent individuals from accessing trauma services. We utilized the results of the aforementioned focus groups and interviews to develop Screening Tool for Awareness and Relief of Trauma Symptoms (STARTS) - a trauma assessment tool. STARTS screening questions were selected based on trauma symptoms that can be mitigated by brief interventions. STARTS contains the following interventions aimed at reducing trauma symptoms: trauma psycho-education, breathing exercises, sleep and health education, sensory grounding exercises, muscle relaxation exercises, hand massage, and creating a "self-care plan." Study participants trialed each STARTS intervention and provided feedback regarding STARTS' effectiveness and cultural appropriateness. Participants responded positively to STARTS, stating that the tool diminished certain symptoms and increased their interest in, and general willingness to use, intervention tools. Following the recommendations of those interviewed, we adapted some of STARTS' tools to be more understandable. This report will inform the current body of psychiatric research by sharing young men of color's insights, lessons learned, and recommendations for developing quality, culturally informed trauma treatments.

NO. 2

THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS' POSTTRAUMATIC STRESS DISORDER GUIDELINES REVIEW

Speaker: Malcolm Hopwood, M.B.B.S., M.D.

Co-Author(s): Professor Alexander McFarlane, Professor Warwick Middleton, Professor Maurice Eisenbruch, Dr Brian White, Dr John Collier, Dr Man-Pui Eddie So, Dr Deborah Julie Wearne, Dr Bradley Ng, Mr Graham Roper, Ms Janne McMahon, Mr Norm Wotherspoon, Mr Patrick Hardwick

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the utility of clinical practice guidelines in the treatment of PTSD; 2) Identify some of the major strengths associated with the guidelines and how to identify an appropriate one to use; 3) Identify some of the major weaknesses associated with the various guidelines; and 4) Learn how to select an appropriate clinical practice guideline for use in the treatment of PTSD.

SUMMARY:

The Royal Australia and New Zealand College of Psychiatry (RANZCP) has recently released a review of clinical practice guidelines on post-traumatic stress disorder (PTSD). Guidelines were selected from Australasian and international mental health organizations for review, including the American Psychiatric Association's 'Psychiatric evaluation of adults' and 'Guidelines Watch', as well as the UK's National Institute for Clinical Excellence's 'The management of PTSD in adults and children in primary and secondary care' and the 'Management of anxiety disorder: Clinical practice guidelines' published in the Canadian Journal of Psychiatry. The RANZCP elected to undertake a review of existing guidelines, rather than risk duplication by creating new ones. An expert panel was convened, including psychiatric specialists, and consumer and carer representatives. The Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument was used to allocate a ranking to each guideline. A recent National Health and Wellbeing Survey identified that PTSD is the most common psychiatric disorder in Australia, affecting 6.4% of the population. PTSD can

often have high levels of associated impairment and disability that can adversely affect consumers into the long term. Given its prevalence and seriousness, identifying and using good clinical practice guidelines for the treatment of PTSD is important. The RANZCP's review has shown up some of the strengths and limitations in the guidelines available internationally. The strengths include identifying effective treatments, discussed with relative consistency across all guidelines. These include Cognitive Behavioral Therapy, Rapid Eye Movement Desensitization Therapy and the use of medications. The limitations of the guidelines are somewhat numerous. They include that the more straightforward PTSD cases tend to be the ones that end up engaging in trials, meaning that there is a dearth of research into more complex presentations. Research into the interactions of medications and psychotherapy is another area that requires more work. Finally, the instances of co-morbidities alongside PTSD are very high, including major depression, substance misuse and anxiety disorder. The complexity of the interactions between these requires more investigation. The panel concluded that all of the guidelines reviewed have utility and are appropriate for use. Guidelines are often context-specific, so it may be useful to consider where the guideline was researched and published and the location when selecting one for use. Ultimately, having a clinically rigorous review of guidelines provides practitioners and consumers with a template with which to judge whether proper treatment is being given or received in consultations.

NO. 3

THE ASSOCIATION BETWEEN CHILD MALTREATMENT AND ADULT MENTAL HEALTH PROBLEMS IN A LARGE BIRTH COHORT: MORE COMPLEX THAN RETROSPECTIVE DATA SUGGEST

Speaker: Steve Kisely, M.D., Ph.D.

Co-Author(s): Ryan Mills, M.B., M.P.H., Jake Najman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance of various forms of child abuse to subsequent psychiatric problems in early adulthood; 2) Appreciate there is a disparity in both the incidence of child sexual abuse when

measured by self-report, and government agency notification, as well as in later psychological outcomes; 3) Understand that many patients with agency reported sexual abuse will not disclose this at psychiatric interview while, on the other hand, unreported abuse may lead to worse outcomes; and 4) Appreciate that the interaction between childhood abuse and adult mental health problems is probably more complex than has been suggested by retrospective data hitherto and requires further research.

SUMMARY:

Background: Retrospective studies have shown a high association between child abuse and subsequent psychiatric morbidity. Prospective studies are rarer. This was a prospective record-linkage analysis to examine whether notified and/or substantiated child maltreatment is associated with adverse psychological outcomes in early adulthood. In the case of sexual abuse, an additional aim was to whether there were any differences in outcomes depending on whether it as by retrospective self-report or prospective government agency notification. **Methods:** The participants were 3778 mother and child pairs enrolled in a population-based birth cohort study in Brisbane, Australia. Exposure to suspected child maltreatment was measured by linkage with state child protection agency data. The primary outcomes were the internalizing and externalizing scales of the Youth Self Report (YSR) and the Centre for Epidemiological Studies-Depression scales (CES-D) at approximately 21 years of age. **Results:** There were child abuse notifications on 286 participants. After adjustment for potential confounders, notified maltreatment was significantly associated with both internalizing and externalizing behaviour, as well as depression at 21. The strongest effect was for physical and emotional abuse and the outcome with the strongest association was externalising. The proportion of respondents with a history of agency notification of suspected child sexual abuse was only 2.5%, of whom just over half also self-reported. Self-reported child sexual abuse was associated with significantly higher internalizing, externalizing, depression and PTSD scores after adjustment for suspected socio-demographic confounders. However, none of these associations were found when examining the

agency-notified cases. Conclusions: Child abuse including neglect and emotional abuse has serious adverse effects on early adult mental health. The picture is more complicated in childhood sexual abuse with a disparity between the incidence of child sexual abuse when measured by retrospective self-report, and notifications to government agencies during childhood. In addition, adverse psychological outcomes were seen in the self-report group, but not the agency-documented cases. One possibility is that sexual abuse was under-reported to authorities in Queensland and that when un-notified, the abuse was more severe and/or prolonged. Another is recall bias. The interaction between childhood abuse and adult mental health problems is probably more complex than has been suggested by retrospective data hitherto and requires further research.

NO. 4

"DON'T TELL, DON'T HEAL:" SEXUAL VIOLENCE AGAINST MEN IN A SAMPLE OF ASYLUM-SEEKERS: A REPORT FROM BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE

Speaker: Kristina Jones, M.D.

Co-Author(s): Amy Jocelyne PhD

Brian MacMillan MSc

Asher Aladjem MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn rates of PTSD in Asylum-seeking men who report sexual assault; 2) Learn that sexual violence against men is common in conflict and post-conflict countries; 3) Understand culturally relevant interventions for male survivors of sexual assault; and 4) Gain awareness of African Asylum seekers and their psychiatric presentations.

SUMMARY:

The use of sexual violence as a weapon of war has been widely documented. However, the frequency and impact on male survivors of war trauma has not yet received substantial attention in the literature. Therefore, the aim of this study was to examine rates of sexual violence among men in a treatment seeking sample, and corresponding rates of posttraumatic stress disorder (PTSD). Our hypothesis was that men who reported past

histories of sexual violence would be more likely to report higher levels of PTSD symptoms than those who did not report a history of sexual assault. The Bellevue/NYU (New York University) Program for Survivors of Torture assists individuals and families from all over the world who are seeking asylum in the United States in the context of political, ethnic, or religious persecution and torture. The program provides comprehensive medical, mental health, and social services to asylum seekers and refugees. Our database includes 3,191 patients, of these, 1,931 are male. The total number of males reporting sexual assault was 186/1,931 yielding a prevalence estimate of 9.6%. Among a subset of 96 men from only African countries (including Congo, Cote D'Ivoire, Guinea), the reported rate of sexual violence was almost 51%. In terms of posttraumatic stress reactions, 59% of African males who endorsed sexual violence met criteria for PTSD, whereas only 33% of males who did not report sexual abuse met criteria for PTSD. This contrasts with the rate of PTSD in the entire sample of 36.7 percent with or without sexual assault. The findings from the current study highlight that sexual violence among male asylum seekers has important psychological ramifications that need to be addressed during the provision of care. Moreover, the legal, cultural and religious barriers to discussing sexual assault as part of the recovery from torture and trauma will be discussed.

PERSONALITY DISORDERS

NO. 1

A RANDOMIZED CONTROLLED TRIAL OF INTERNET-BASED PSYCHOEDUCATION FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Speaker: Mary C. Zanarini, Ed.D.

Co-Author(s): Michelle M. Wedig, Ph.D., Lindsey C. Conkey, M.A., Garrett Fitzmaurice, Sc.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize that teaching patients about BPD using the internet can improve their symptoms; 2) Recognize that teaching patients about BPD using the internet can improve their psychosocial functioning; and

3) Recognize that teaching patients about BPD using the internet is a low cost but effective form of early treatment for BPD.

SUMMARY:

Objective: The purpose of this study was to determine the efficacy of an internet-based psychoeducational program for patients with borderline personality disorder (BPD). **Method:** Half of 80 women between the ages of 18-30 meeting rigorous criteria for BPD were randomized to a trial of internet-based psychoeducational and half were not. All subjects took a series of assessments online for the 12 weeks of the acute phase of this trial. **Results:** Those subjects randomized to psychoeducation were found to have a significantly greater decline in five of the nine symptoms of BPD: intense anger, affective instability, serious identity disturbance, self-harm/suicide threats or attempts, and general impulsivity. They were also found to have a significantly greater improvement in their overall psychosocial functioning. In addition, 78 of the 80 subjects completed all 12 weeks of online assessments. **Conclusion:** Internet-based psychoeducation seems to be an efficacious form of early treatment for BPD.

NO. 2

ONLINE DIALECTICAL BEHAVIORAL THERAPY (DBT) IS EFFECTIVE IN IMPROVING SYMPTOMS IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Speaker: Nazanin Alavi, M.D.

Co-Author(s): Margo Rivera, Ph.D, Karen Gagnon, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand role of DBT in treating borderline personality disorder; 2) Understand the barriers to receiving psychotherapy in people with borderline personality symptoms; and 3) Understand the advantages of online DBT.

SUMMARY:

Introduction: Borderline personality disorder (BPD) is a common psychiatric disorder. Although Dialectical Behavioral Therapy (DBT) has been proven effective in the treatment of this disorder, many patients are resistant to

participating in group psychotherapy, a core aspect of DBT. With Internet use ever rising, offering the skills-building aspect of DBT online can provide an alternative treatment. **Method:** Participants applying for treatment were offered the opportunity to choose between the online format or live sessions of the Managing Powerful Emotions Group. In each of the 15 sessions of both groups, patients were provided with information about distress tolerance or emotion regulation skills, homework assignments, homework sheets, and feedback regarding the previous week's homework from the group therapist. Participants were assessed by using a self-assessment questionnaire and Difficulties in Emotion Regulation Scale (DERS). **Results:** The DERS scores among live and online groups were not significantly different before treatment. Statistical analysis showed that both online and live DBT significantly reduced DERS scores in all six categories, there was significant change in functioning and level of symptomatology in both groups after 15 weeks of treatment, and there was no significant differences in the changes in the scores in the live and online groups. **Conclusion:** Despite the proven efficacy of psychotherapy, there are some barriers, including resistance to participating in live sessions, long wait-lists, and transportation challenges. Delivering online psychotherapy might provide alternative treatment. This is the first study that has examined online DBT in the treatment of borderline personality disorder.

NO. 3

A COMPARATIVE STUDY OF THE PSYCHOSOCIAL MORBIDITY ASSOCIATED WITH BIPOLAR DISORDER AND BORDERLINE PERSONALITY DISORDER IN PSYCHIATRIC OUTPATIENTS

Speaker: Mark Zimmerman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recognize that few studies have directly compared the level of psychosocial morbidity associated with bipolar disorder and borderline personality disorder; 2) learn that the level of impairment associated with borderline personality disorder was as

great, or greater, than that experienced by patients with bipolar disorder; and 3) Learn that suicide attempts are more frequent in patients with borderline personality disorder than bipolar disorder.

SUMMARY:

Objectives: The morbidity associated with bipolar disorder is, in part, responsible for repeated calls for improved detection and recognition. No such commentary exists for improved detection of borderline personality disorder. Clinical experience suggests that borderline personality disorder is as disabling as bipolar disorder; however, no studies have directly compared the two disorders. For this reason we undertook the current analysis from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project comparing psychosocial morbidity in patients with bipolar disorder and borderline personality disorder. **Methods:** Patients were interviewed with semi-structured interviews. We compared 307 patients with DSM-IV borderline personality disorder but without bipolar disorder and 236 patients with bipolar disorder but without borderline personality disorder. **Results:** The patients with borderline personality disorder less frequently graduated college, were diagnosed with more comorbid disorders, more frequently had a history of substance use disorders, reported more suicidal ideation at the time of the evaluation, more frequently had attempted suicide, reported poorer social functioning and were rated lower on the Global Assessment of Functioning. There was no difference between the two patient groups in history of psychiatric hospitalization or time missed from work during the past five years. **Conclusions:** The level of psychosocial morbidity associated with borderline personality disorder was as great, or greater, than that experienced by patients with bipolar disorder. From a public health perspective, efforts to improve the detection and treatment of borderline personality disorder might be as important as efforts to improve the recognition and treatment of bipolar disorder.

MAY 19, 2015

PSYCHIATRY ACROSS CULTURES

NO. 1

A RANDOMIZED CLINICAL TRIAL OF MINDFULNESS-BASED COGNITIVE THERAPY FOR TREATMENT-RESISTANT DEPRESSION AND FUNCTIONAL MAGNETIC RESONANCE IMAGING

Speaker: Stuart J. Eisendrath, M.D.

Co-Author(s): Stuart J. Eisendrath, M.D., Daniel H. Mathalon, Ph.D, Erin P. Gillung, M.A., Kevin L. Delucchi, Ph.D, Mitchell D. Feldman, M.D., Zindel V. Segal, Ph.D

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the characteristics of treatment-resistant depression (TRD) to make appropriate diagnoses; 2) Know about Mindfulness-Based Cognitive Therapy options for TRD patients; and 3) Conceptualize potential brain mechanisms associated with MBCT training.

SUMMARY:

Introduction: Mindfulness-Based Cognitive Therapy (MBCT) is an effective treatment for relapse prevention, yet its efficacy for treatment-resistant depression (TRD) has not been examined in a randomized clinical trial (RCT). **Objective:** The objective of this single-blind RCT was to determine the efficacy of MBCT as an augmentative treatment to standard pharmacotherapy treatment-as-usual (TAU) for adults, age 18 and older, diagnosed with TRD in comparison to an active comparator condition. **Design:** 173 adults with DSM-IV diagnosis of major depressive disorder and who failed to respond to stand pharmacotherapy were recruited through the community and outpatient psychiatry and general medicine clinics, and were enrolled in the study, conducted at the University of California, San Francisco. Participants were randomized into 8-week group treatment with either MBCT or the Health-Enhancement Program (HEP), the comparator condition comprised of physical fitness, music therapy and nutritional education. A subgroup of 87 patients completed a pre-and post-intervention fMRI emotional working memory (WM) task to investigate MBCT effects on the brain dorsal executive control and ventral affective processing areas. **Primary Outcome:** Change in depressive symptoms was evaluated using the primary outcome measure, the 17-item Hamilton Depression Rating Scale (HAM-D).

Depression severity from pre-to post-treatment was measured by percent reduction in total scores, treatment response (scores $\geq 50\%$ decrease from baseline) and remission (post-treatment scores ≥ 7). Secondary outcomes included: anxiety levels, functional status, and overall quality of life satisfaction. fMRI data pre- and post-treatment investigated dorsal executive control area activations and ventral affective processing area activations. Results: Our findings showed that at the end of 8 week treatment, a significantly greater number of patients achieved response in the MBCT condition (30.3%) than in the HEP condition (15.3%; $p = .03$ in multivariate model). The mean percent reduction was also greater in the MBCT condition (36.6% versus 25.3%; $p = .01$ in the multivariate model). In these models state anxiety was related to the response rate and percent reduction. Perceived stress, anxiety and presence of personality disorder were moderators of effects. Although numerically superior for MBCT, there were no significant differences found for the rates of remission (22.4% versus 13.9%; $p = .15$) and mean level of total score of depression severity ($p = .09$). fMRI analysis demonstrated that 1) relative to the control, MBCT enhanced DLPFC activation and reduced ventrolateral prefrontal recruitment during WM performance and; 2) improved depression symptoms in association with enhanced regulation of amygdala activity during WM performance.

NO. 2 NEUROCOGNITIVE PREDICTORS OF RESPONSE IN TREATMENT-RESISTANT DEPRESSION WITH DEEP BRAIN STIMULATION (DBS) THERAPY

Speaker: Shane J. McInerney, M.B., M.D., M.Sc.

Co-Author(s): Heather Mc Neely, Ph.D., Joe Geraci, Ph.D., Peter Giacobbe, M.D. M.Sc. FRCPC, Sakina J Rizvi, Ph.D. Candidate, Anna Cyriac, H.BSc., Helen Mayberg, M.D. FRCPC, Andres M Lozano, M.D. Ph.D. FRCSC, Sidney H Kennedy, M.D. FRCPC

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Awareness of Deep Brain Stimulation (DBS) as a treatment modality for Treatment Resistant Depression (TRD); 2) Recognise that Subcallosal Cingulate Gyrus

(SCG) DBS has no known deleterious effects on cognition; and 3) Identification of psychomotor speed as a possible predictive variable for SCG DBS treatment response

SUMMARY:

Objective: Deep Brain Stimulation (DBS) is a neurosurgical intervention with demonstrated effectiveness for Treatment Resistant Depression (TRD) but longitudinal cognitive data remains limited. The objective of this study is to examine neurocognitive performance, pre-surgery and after 12 months of Subcallosal Cingulate Gyrus (SCG) DBS stimulation with an emphasis on identifying baseline cognitive predictors of treatment response to DBS.

Method: This was an open-label trial of SCG DBS surgery for TRD (N=20). All patients met criteria for TRD and were in a current major depressive episode (MDE) with a minimum score of 20 on the 17 item Hamilton Rating Scale for Depression (HRSD-17). Changes in mood were evaluated using the HRSD-17. A standardized neuropsychological battery assessing a range of neurocognitive abilities was administered at baseline and repeated at follow up. **Results:** There was a significant reduction in HDRS-17 scores from baseline to follow up and 55% (n=11) of patients were responders. At baseline there was impairment ($Z = -1$ SD below the mean) in information processing speed, executive functioning while psychomotor speed, motor dexterity, verbal memory, phonemic fluency and visual speeded attention were within 1SD below the mean. Overall, paired t tests revealed significant improvements ($P \leq 0.05$) in executive functions and approached significance on verbal learning, psychomotor speed and motor dexterity. There was no deterioration in cognitive function at the follow up period relative to baseline. The Finger Tap Test, a measure of psychomotor processing speed predicted treatment response and was independent of improvement in mood. Phonemic fluency was the only neuropsychological test that was correlated with mood, $r(13) = -0.63$, $p < 0.01$. **Conclusions:** SCG DBS had no deleterious effects on cognition over the 12 month follow up period. Psychomotor speed may be a useful baseline predictor of response to SCG DBS treatment.

NO. 3

ADDRESSING DEPRESSION AND PAIN TOGETHER: THE "ADAPT" CLINICAL TRIAL FOR OLDER ADULTS WITH DEPRESSION AND CHRONIC LOW BACK PAIN

Speaker: Jordan F. Karp, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the scientific, clinical, and systems-based rationales for treating depression and low back pain as linked conditions; 2) Describe the epidemiology and treatment options for comorbid depression and chronic low back pain in older adults; 3) Understand the efficacy of combination high-dose venlafaxine and Problem Solving Therapy for older adults with depression and chronic low back pain; and 4) Know how to take a high quality pain history that may inform concomitant psychiatric care and improve communication with other medical and rehabilitation specialties.

SUMMARY:

Among older adults, both depressive disorders and chronic low back pain (CLBP) are common, frequently comorbid, and associated with substantial disability. Treatment with combination pharmacotherapy and psychotherapy is often required for patients with difficult to treat depression and CLBP, especially when they are comorbid. The primary question addressed by this 2-phase RCT (funded by NIA) is to answer: What is the value of combination treatment with high-dose venlafaxine (VEN) plus a symptom-specific and age-appropriate intervention called Problem Solving Therapy for Depression and Pain (PST-DP) for older adults living with depression and CLBP when primary pharmacotherapy with low-dose venlafaxine and supportive management (VEN/SM) has led to partial or non-response? Step 1 is 6 weeks and consists of open treatment with lower-dose (150 mg/day) VEN/SM. Response is defined as a Patient Health Questionnaire score of ≤ 5 AND at least a 30% improvement on the Pain Numeric Rating Scale. Step 1 non-responders progress to step 2, a randomized controlled trial comparing 1) high-dose VEN/SM (300 mg/day) and 2) high-dose VEN/PST-DP (300 mg/day). Step 2 is 10 visits over 14 weeks. VEN/PST-DP treats depression and CLBP by: 1) building upon antidepressant gains achieved with low

dose VEN/SM, 2) improving self-efficacy to reduce learned helplessness, and 3) activating participants via activity scheduling. VEN/SM involves: 1) education about the chronicity of depression and CLBP, 2) an emphasis on adherence, and 3) management of side effects and suicide risk. We will recruit 250 subjects into step 1. 150 non-responders will be randomized in step 2 to detect an effect size of at least 0.30 between groups. Our primary hypotheses are that more subjects randomized to VEN/PST-DP will respond and experience less back-related disability compared to subjects randomized to VEN/SM. Survival analysis will be used to compare response rates and time to response for the treatment conditions. Improvement in both depression and pain intensity as criteria for response is novel and adds to the public health significance and innovation. After completion of step 2, all treatment responders are assessed for 12 months, to compare treatment durability. Since self-efficacy has been shown to predict treatment outcomes for both depression and pain, we hypothesize that for subjects assigned to receive treatment with VEN/PST-DP, self-efficacy will mediate treatment response. Recruitment will end 8/31/14, and we are on target to meet our recruitment goals.

NO. 4

THE 12-ITEM WHODAS 2.0 DISABILITY QUESTIONNAIRE HAS GOOD SENSITIVITY AMONG INDIVIDUALS WITH RECENT HISTORY OF DEPRESSION AND/OR SUICIDAL IDEATION

Speaker: Venkat Bhat, M.D.

Co-Author(s): Aihua Liu, 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) To understand the structure of the 12 item WHODAS 2.0 disability questionnaire, the Total scores and Individual items; 2) To recognize that Total Scores on the 5-minute, 12 Item WHODAS 2.0 Questionnaire is significantly different among individuals with recent history of Depression and/or suicidal ideation; 3) To identify the differences among individual disability items on the 12 items among individuals with recent history of Depression and/or suicidal ideation.

SUMMARY:

Introduction: *DSM-5* has adopted the 36 item WHODAS 2.0 questionnaire as a measure of disability to replace the GAF (Global Assessment of Functioning) scale. While the 36 item WHODAS 2.0 questionnaire takes 20 minutes to administer, the 12 item version takes 5 minutes to administer, and accounts for 81% of the variance with the more detailed 36 item version. The 12 item version gives a global score and has ratings on individual items. This study aimed to examine if the global scores are significantly different among individuals with recent history of Major Depressive Disorder (MDD) and/or suicidal ideation (SI), and to identify the nature of differences among each of the 12 items. Methods: The ongoing Epidemiological Catchment Area (ECA) Study at the Douglas Institute in Montreal administered a battery of questionnaires to about 2800 subjects who were a random representative sample. Mental disorders were identified with the Canadian Community Health Survey (CCHS 1.2) version of the Composite International Diagnostic Interview, including Major Depression and Suicidal ideation. The 12 item WHODAS 2.0 questionnaire was also administered by a trained interviewer and gives global and individual item scores with a focus on symptoms during the last 30 days. This study compared 4 groups of subjects on the global scores and individual item scores for the following during the last 12 months: a) MDD and SI (n=45) b) MDD but no SI (n=128) c) SI but no MDD (n=52) d) no MDD or SI (2071). Results: Univariate ANOVA analysis was significant ($p < 0.05$). This was followed by group comparison using the Tukey's test which suggested significant differences in the global scores among subjects with MDD and/or SI as compared to subjects with no MDD or SI. Subjects with MDD and SI had the highest global disability scores followed by subjects with MDD but no SI followed by subjects with only SI. Differences were seen in the distribution profile on each of the individual 12 questions among the four categories, and subjects with MDD and SI reported notable difficulties with maintaining friendships and managing day-to-day work/school. Conclusion: The 12 item WHODAS 2.0 questionnaire is able to capture global and individual differences in disability among subjects reporting MDD and/or SI during the last 12 months. Further, the disability scores

correspond with expected severity of MDD. The WHODAS 2.0 questionnaire examines disability during the last 30 days and sensitivity would have been higher if the depression symptoms were examined in the last 30 days (rather than last 12 months). Further studies are needed in larger samples to identify specific differences among subjects with MDD and/or SI and establish clinical utility.

PSYCHOPHARMACOLOGY

NO. 1 IMPROVING ANTIPSYCHOTIC PHARMACOTHERAPY VIA EDUCATIONAL OUTREACH TO PRESCRIBERS ACROSS A STATE MENTAL HEALTH SYSTEM

Speaker: Mary Brunette, M.D.

Co-Author(s): Nino Dzabisechvilli, Ph.D., Alex DeNesnera, M.D., Haiyi Xie, Ph.D., Stephen Bartels, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the range of cardiometabolic risk related to antipsychotic medications; 2) List risk factors for early cardiovascular mortality among people with schizophrenia and other severe mental illnesses; 3) Describe interventions to improve physician practices across organizations or service; and 4) Recognize the benefits and limitations of educational outreach for improving prescribing practices.

SUMMARY:

Antipsychotic medications are an important strategy to improve illness management among people with mental illnesses, but they can cause cardiometabolic side effects that may contribute to weight gain, hyperlipidemia and the development of diabetes and heart diseases. Since people with severe mental illnesses die prematurely of cardiovascular disease, finding ways to help prescribers minimize the risk of developing these diseases is an important goal. Little research has assessed whether educational outreach (also termed academic detailing for evidence-based prescribing) can improve prescribing for people with complex severe mental illnesses in community mental health settings. We conducted a statewide intervention using four

group sessions of educational outreach with additional audit and feedback for antipsychotic pharmacotherapy across a state community mental health system. Methods: With segmented regression analysis of interrupted time series, we evaluated five-year prescribing trends in Medicaid pharmacy claims for antipsychotics (high risk agents and low risk agents), with interaction terms for the effect of intervention and important moderators. Results: The final models showed that the post intervention trend for high risk antipsychotic utilization decreased among people with schizophrenia and bipolar disorder relative to people with other diagnoses ($\hat{\rho}^2$ -0.0107; p = 0.04) relative to those with other diagnoses, indicating the educational intervention impacted high risk antipsychotic prescribing significantly, depending upon patient's diagnosis. The post-intervention trend for low risk antipsychotic utilization increased among those who had no psychiatric hospital admissions compared to pre-intervention period ($\hat{\rho}^2$ = 0.0146, and p = 0.0197); and use of low risk agents decreased among those who had at least one psychiatric hospitalization ($\hat{\rho}^2$ = -0.0171, and p = 0.0076) relative to those without; indicating the educational intervention impacted low risk antipsychotic prescribing significantly depending upon patients' severity of illness. Overall use of high risk agents also differed by age of the patient. Conclusion: This study suggests that educational outreach with audit and feedback may improve quality of antipsychotic prescribing relative to cardiometabolic risk, but type and severity of mental illness also appear to be considerations driving the types of medications utilized by prescribers in community mental health.

NO. 2 GENETIC AND CLINICAL DETERMINANTS OF WEIGHT GAIN AND/OR METABOLIC SYNDROME IN A LARGE PSYCHIATRIC SAMPLE TREATED WITH PSYCHOTROPIC DRUGS

Speaker: Chin B. Eap, Ph.D.

Co-Author(s): Frederik Vandenberghe, Pharm.D., M.Sc., Nuria Saigi Morgui, Pharm.D., M.Sc., Aurélie Delacrétaz, M.Sc., Lina Quteineh, M.D., Ph.D., Armin von Gunten, M.Phil., M.D., Philippe Conus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize psychotropic drug-induced weight gain and metabolic complications; 2) Plan clinical measures to monitor psychotropic drug-induced weight gain and metabolic complications; and 3) Comprehend the promises and pitfalls of genetic tests for predicting psychotropic drug-induced weight gain.

SUMMARY:

Weight gain and obesity are important health problems associated with psychiatric disorders and/or with psychotropic drug treatments. This may have major clinical consequences considering that obesity can lead to the development of other components of the metabolic syndrome such as dyslipidemia, hypertension and type 2 diabetes, which may ultimately lead to the development of cardiovascular diseases, reducing patients' quality of life and increasing mortality in psychiatric populations. Since 2007 a study is ongoing at the Department of Psychiatry at the Lausanne University Hospital (Switzerland), investigating the clinical and genetic determinants of weight gain and/or other features of the metabolic syndrome induced by psychotropic drugs. The study has been approved by local ethics committees and presently over 1200 patients have been included, with informed consents. Clinical variables (retrospective and/or prospective) are recorded and an extensive genotyping is performed. In particular data obtained from a subset of the overall one year longitudinal study including 351 psychiatric patients, with metabolic parameters monitored (baseline, one, three, six, nine, 12 months) and with compliance ascertained will be presented. Prevalence of metabolic syndrome and obesity were 22% and 17%, respectively at baseline, and 32% and 24% after one year. Early detection of patients who have a higher risk of developing an important WG during psychotropic treatment is of major clinical relevance. Analyses indicate that an early weight gain >5% after a period of one month is the best predictor for important long term weight gain (≈15% after three months, ≈20% after 12 months). This analysis identifies most patients (97% for three months, 93% for 12 months) who had weight gain <5% after one month as continuing to have a moderate weight gain after 3 and 12 months

(Vandenberghe, Gholam-Rezaee et al., submitted).

Gene candidate analysis showed several new genetic polymorphisms to be significantly associated with weight gain and/or other metabolic features. Results on CRT1 (Choong et al., JAMA Psychiatry, 2013; 70(10):1011-19) as well as on other novel gene candidates will be discussed. Finally, an extensive genotyping of all included patients for genes significantly associated with BMI and weight gain in genome wide association studies in the general population and/or in psychiatric patients was performed. The influence of genetic risk scores built from over 30 genes will be presented, showing differences over 5 BMI units between carriers of the highest and the lowest genetic scores in psychiatric patients treated with psychotropic drugs. Finally, results will also be shown on how the combined use of a fast increase (i.e. >5% in one month) of weight following psychotropic drug prescription and of selected genetic factors, can increase the predictive power of an early detection of high risk patients for an important weight gain during long term drug treatment.

NO. 3

N-ACETYL-CYSTEINE AUGMENTATION LOWERS CLOZAPINE DOSE AS EFFICACY IS MAINTAINED AND ADVERSE EFFECTS AND OBSESSIVE SYMPTOMS ARE DIMINISHED: A CASE REPORT

Speaker: Richard H. McCarthy, C.M., M.D., Ph.D.

Co-Author(s): Swapnil Gupta, M.B., B.S., MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Employ N-Acetylcysteine (NAC) to augment and extend clozapine's efficacy; 2) Employ NAC to minimize clozapine's adverse effects; 3) identify potential further benefits NAC offers to control of violence, addictive and obsessive behaviors; 4) recognize how severe obsessions limits clozapine response; and 5) engage patients to use this "Stigma free" medication.

SUMMARY:

N-acetylcysteine (NAC), the acetyl derivative of the amino acid cysteine is an FDA approved drug used in acetaminophen overdose and as a

mucolytic agent. It is available over the counter (OTC) as a supplement. Cysteine is a sulfur containing nonessential amino acid that is involved in critical bodily functions. Cysteine availability is the rate-limiting step in glutathione synthesis. Cysteine and glutathione, the primary antioxidants in humans, play critical roles in cellular defenses against oxidative stress as free radical scavengers and detoxifying agents. Their role is crucial in maintaining structural and functional integrity of cell membranes. Cysteine is brought into nerve and glial cells by a cysteine/glutamate antiport that contributes to glutamate modulation in the brain. Thus, cysteine plays a role in glutathione deficiency, oxidative stress and glutamate modulation, pathophysiological processes that are significant in multiple psychiatric disorders. NAC has been used successfully in treating pathological gambling, trichotillomania, nicotine, cocaine, cannabis use/abuse, compulsive behaviors, bipolar disorder, depression, schizophrenia and violence. Used orally NAC has minimal adverse effects, rarely exceeding those of placebo. The FDA approved pharmaceutical grade NAC is prohibitively expensive. OTC NAC preparations are inexpensive and perceived as a vitamin pill. Therefore it is a stigma free addition to treatment. Patient acceptance is quite high. The risk benefit ratio for NAC use is low. There is minimal risk and reasonable potential for improvement with a medication patients readily accept. There are no literature reports specifically describing NAC augmentation of clozapine but the rate of participation by clozapine patients in NAC trials is so high that any improvements found could not have been achieved without a positive response in clozapine patients.

This presentation focuses on the treatment of an early onset schizoaffective disorder patient who responded positively only to clozapine. Significant adverse effects viz., sedation, and severe clozapine induced obsessive compulsive symptoms limited his response. The OCD symptoms were refractory to standard treatments. NAC was added in. Both OCD and schizoaffective symptoms improved. This set in motion a process of down tapering clozapine from 600 mgs to 100 mgs a day over a two year period. Dose related adverse effects decreased with no loss of antipsychotic efficacy. Concurrent with clozapine dose reduction there were decrements in OCD and sedation and

cognitive function improved. He was able to function more independently in school, and consistently made the Dean's List as a full time student at a competitive University. This patient's dramatic response will be discussed as well as other less dramatic but equally significant responses to NAC seen in other patients treated since that time. A common pathway is a reduction in violence and impulsive and compulsive behavior.

NO. 4 SEROTONIN SYNDROME REVISITED: HOW RELIABLE ARE OUR CURRENT DIAGNOSTIC CRITERIA?

Speaker: Ursula Werneke

Co-Author(s): Michael Ott, MD; Fariba Jamshidi, MD

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose serotonin syndrome with greater confidence; 2) Recognize the limitations of the diagnostic criteria systems for serotonin syndrome; 3) Understand the relationship between the various diagnostic criteria systems in use; and 4) Identify rhabdomyolysis as a symptom of severe serotonin syndrome.

SUMMARY:

Background: The diagnosis of serotonin syndrome remains challenging. But unless recognized in good time, it can potentially become life threatening. There are three competing though partly overlapping systems of diagnostic criteria. Whereas the Sternbach (SC) and Radomski criteria (RC) draw on neuromuscular, cognitive and autonomous symptoms, the Hunter classification (HC) focuses nearly exclusively on neuromuscular symptoms such as clonus in its various forms, hyperreflexia and tremor. The HC are purported to be more sensitive and specific than the other two systems; a claim based on the review of 2222 cases of overdoses with serotonergic drugs. We do not know how well HC perform in cases, where serotonin toxicity is caused as an adverse effect or a drug interaction but not as a result of an overdose. To test the performance of all three diagnostic criteria, we conducted a systematic review of all cases of serotonin syndrome since 2004 when HC came into use. Method: We searched PubMed and Web of

Science for cases using the terms "serotonin syndrome" and "serotonin toxicity". We included all cases of adult patients that fulfilled at least one of the three diagnostic systems. We calculated the overall agreement between the different diagnostic systems and estimated agreement beyond chance using Cohen's kappa. Then, we explored how many severe cases would be missed by HC using rhabdomyolysis and treatment in an intensive care unit (ICU) as a proxies for severity. Results: We identified 331 eligible cases. Of these, only 14% presented to psychiatric services. The overwhelming majority was seen by somatic specialties. 44% of cases met all three diagnostic systems, 27% both RC and SC, 17% SC only, 6% both HC and SC, 3% HC only, 1% both HC and RC and 1% RC only. The overall agreement between HC and SC was 52%, between HC and RC 62% and between SC and RC 75%. The kappa values were -0.03, 0.22 and 0,19 indicating no agreement beyond chance between HC and SC and poor agreement beyond chance between HC and RC and SC and RC. There were 47 (14%) cases of rhabdomyolysis. Of these, 38% of cases would have been missed exclusively relying on HC. There were 108 (33%) cases that required treatment in ICU. Again 40% of these would have been missed adhering strictly to HC. Discussion: Serotonin syndrome is strongly associated with psychiatric medications, yet only a small minority of cases presents to psychiatric services. Physicians and psychiatrists alike need an open mind to serotonin syndrome as a differential diagnosis, when presented with patients who rapidly physically and mentally deteriorate with no apparent explanation. This remains difficult because current diagnostic criteria poorly agree with each other and there is no objective gold standard for the diagnosis. Conclusion: Too strict adherence to one diagnostic criteria set increases the risk of overlooking not only of mild but also severe cases of serotonin toxicity.

SUBSTANCE USE AND MISUSE: ILLICIT DRUGS AND PRESCRIBED MEDICATIONS

NO. 1 INITIAL RESPONSE AS A PREDICTOR OF 12-WEEK BUPRENORPHINE- NALOXONE TREATMENT RESPONSE IN

A PRESCRIPTION OPIOID-DEPENDENT POPULATION

Speaker: Roger D. Weiss, M.D.

Co-Author(s): Katherine A. McDermott, B.A., Margaret L. Griffin, Ph.D., E. Yvette Hilario, B.S., David A. Fiellin, M.D., Garrett M. Fitzmaurice, Sc.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the role of buprenorphine in the treatment of prescription opioid dependence; 2) Understand the need to identify predictors of success as early as possible in the treatment process; and 3) Understand the value of assessing response to buprenorphine at 2 weeks in the treatment of prescription opioid dependence.

SUMMARY:

Objective: Initial medication response has been shown to predict treatment outcome across a variety of substance use disorders, but no studies have examined the predictive power of initial response to buprenorphine-naloxone in the treatment of prescription opioid dependence. We therefore conducted a secondary analysis of data from the Prescription Opioid Addiction Treatment Study to determine whether initial response to buprenorphine-naloxone predicted 12-week treatment outcome in a prescription opioid-dependent population. Method: Using data from a multi-site, randomized controlled trial of buprenorphine-naloxone plus counseling for DSM-IV prescription opioid dependence, we conducted a secondary analysis to investigate the relationship between initial medication response and 12-week treatment outcome to establish how soon the efficacy of buprenorphine-naloxone could be predicted. Outcomes were determined from the Substance Use Report, a self-report measure of substance use, and confirmatory urinalysis. Predictive values were calculated to determine the importance of abstinence vs. use at various time points within the first month of treatment (week 1, weeks 1-2, 1-3, or 1-4) in predicting successful vs. unsuccessful treatment outcome (based on abstinence or near-abstinence from opioids) in the last 4 weeks of buprenorphine-naloxone treatment (weeks 9-12). Results: Outcome was best predicted by medication response after two weeks of treatment. Two weeks of initial abstinence was moderately predictive of

treatment success (positive predictive value = 71%), while opioid use in both of the first two weeks was strongly predictive of unsuccessful treatment outcome (negative predictive value (NPV) = 84%), especially when successful outcome was defined as total abstinence from opioids in weeks 9-12 (NPV = 94%). Conclusion: Evaluating prescription opioid-dependent patients after two weeks of buprenorphine-naloxone treatment may help determine the likelihood of successful outcome at completion of the current treatment regimen.

NO. 2 HEROIN IS MOST EFFECTIVE TREATMENT FOR IMPROVING RETENTION AMONG OPIOID- DEPENDENT PATIENTS, BUT ARE WE READY FOR IT?

Speaker: Brittany B. Dennis, B.A.

Co-Author(s): Ashley Bonner, MSc., Leen Naji, BHSc., Monica Bawor, BSc., Anuja Bhalerao, Arnav Agarwal, BHSc., Joshua Kong, BSc, MSc., Michael Varenbut, M.D., Jeff Daiter, M.D., Carolyn Plater, BScN., Guillaume Pare, M.D., MSc., David C. Marsh, M.D., Andrew Worster, M.D., Dipika Desai, MSc., Joseph Beyne, PhD., Zainab Samaan, MBChB, PhD., and Lehana Thabane, PhD.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Rank the appropriate treatments for patients with opioid dependence using hierarchical estimates provided from the first multiple treatment comparison of opioid substitution therapy; 2) Interpret results from complex investigations utilizing novel network meta-analysis methodologies; 3) Identify the important features of trials contributing to high risk of bias, with a specific focus on trial eligibility criteria such as exclusion of patients on psychotropic medication; 4) Recognize the variability of definitions for response to opioid substitution therapy and the impact outcome selection will have on study findings; and 5) Acknowledge the critical implications of providing heroin as a treatment for opioid dependence.

SUMMARY:

Background: The risk for serious comorbidities such as HIV, hepatitis, and cardiac disease is high among patients with opioid use disorder

(OUD) and without treatment OUD can incur a substantial increase in mortality. The use of opioid substitution treatment (OST) for patients with addiction is controversial, and in some countries it is prohibited. The emergence of multiple OSTs renders traditional meta-analysis of direct evidence from randomized trials inadequate to provide hierarchical estimates of the best available treatment. Utilizing systematic review methods, we provide the first network meta-analysis to combine evidence from all trials examining OST to determine the most effective treatment for increasing patient retention. Methods: We combined the direct and indirect evidence of 16 interventions using network meta-analysis methods to determine the most effective OST for patient retention. We identified the direct evidence using an electronic search performed in Medline, EMBASE, PubMed, PsycINFO, Web of Science, Cochrane Library, Cochrane Clinical Trials Registry, World Health Organization International Clinical Trials Registry Platform Search Portal, and the National Institutes for Health Clinical Trials Registry. Randomized trials (RCTs) examining the effectiveness of any OST through the measurement of patient retention or substance abuse behavior were eligible for inclusion. The primary outcome was patient retention as measured by the number of participants remaining in the treatment, attending clinical visits, and receiving medication at the end of the study. Findings: The electronic screening led to the identification of 6077 articles of which we identified 28 RCTs providing results for treatment retention across 16 interventions with a combined sample of 2128 participants. In comparison to all other OSTs, heroin consistently ranked highest for increasing the odds of treatment retention, where heroin was found to increase the odds of remaining in treatment by 3.5-38.6 times when compared to high dose buprenorphine, high dose IV heroin + methadone, high dose methadone, high dose naltrexone, low dose buprenorphine, low dose methadone, low dose naltrexone implant, low dose oral naltrexone, low dose Suboxone, and placebo. High dose methadone was found to increase the odds of remaining in treatment by 10.54 and 10.92 times when compared to low dose naltrexone and placebo respectively. While all other treatments were inferior to heroin in high treatment retention, most interventions were shown to be more effective than placebo. Conclusion: Findings from the first multiple

treatment comparison and network meta-analysis of opioid substitution treatment suggest heroin assisted therapy is most effective for retaining patients on treatment. The results are formed from the evidence of 28 opioid substitution treatment trials, all of which suffer from a high risk of bias in their design.

NO. 3

OPIOID ADDICTION RESULTING FROM LEGITIMATE MEDICAL PRESCRIPTIONS

Speaker: Christopher Chiodo, M.D.

Co-Author(s): Michael Penna, B.A., Jeremy Smith, M.D., Eric Bluman, M.D., Ph.D., Joji Suzuki, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the substantial role that doctors and legitimate prescriptions play in the etiology of opioid addiction; 2) Understand that a legitimate prescription was the initial opioid exposure in 80% of patients over 30 years of age; and 3) Appreciate that the legitimate prescriptions associated with opioid addiction were most commonly written to treat musculoskeletal, dental, or nerve pain.

SUMMARY:

Background: In recent years there has been a dramatic increase in opioid consumption, misuse and overdose deaths in the United States. The estimated annual medical cost of prescription opioid abuse is over \$72 billion. Recent research has attempted to better understand the opioid epidemic and to design new strategies to combat it. The objective of this study was to determine where opioid addicted patients receive their initial opioid exposure, and specifically what percentage of those addictions arise from legitimate medical prescriptions. Methods: Fifty patients receiving treatment for opioid addiction at the Brigham and Women's Faulkner Hospital were anonymously surveyed. Patients were asked to identify the type and source of the opioids they used at three time points: 1) when they were first exposed to opioids; 2) when they first considered themselves addicted; and; 3) later during their addiction. Additional questions were related to heroin use, comorbid psychiatric disorders, and the nature of the disorder that the initial opioids were prescribed for. Results: Thirty-two males and 18 females completed the

study. The average age was 40 years (range, 19 to 59). The reported initial exposure was from a doctor in 29 patients (58%), a friend or family member in 14 patients (28%), and from a dealer or 'other' in seven patients (14%). When the data were stratified by age, the initial opioid exposure was from a doctor in 80% of patients over age 30, as compared to 7% in patients 19-30 years of age. Of those subjects whose first exposure was from a legitimate prescription, the nature of the condition most commonly being treated was musculoskeletal pain (45%) followed by dental (14%) and nerve pain (10%). There were no significant differences in sources of initial exposure when data were stratified by comorbid psychiatric diagnoses or concurrent substance use. Thirty-six patients (72%) also reported a history of heroin use. Of these patients, 17 (47%) reported that their initial exposure was from a legitimate prescription. Discussion: These findings emphasize the substantial role doctors play in the opioid epidemic. A legitimate prescription for opioid analgesics may often be the first step on the pathway to addiction. When compared to a similar study performed in the same metropolitan area several years ago, our data suggest that the percentage of addicted patients initially receiving an opioid prescription for a legitimate medical condition has nearly doubled.

NO. 4 MEDIATION AND MODERATION OF RELIGION SUBSTANCE ABUSE RELATIONSHIPS BY GENOTYPE

Speaker: Rachel E. Dew, M.D., M.H.Sc.

*Co-Author(s): Bernard Fuemmeler, Ph.D.,
Harold Koenig, M.D. M.H.Sc.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Summarize research on relationships of religious variables with substance use and abuse; 2) Describe previous findings on mediation and moderation of religion/health relationships by genetic factors; and 3) Describe current study findings on mediation and moderation of religion/substance abuse relationships by specific candidate genes.

SUMMARY:

Background: The negative correlation between substance abuse and religiosity is well established. This important relationship is often cited as a mechanism through which religiosity affects general health. Previous literature on substance abuse has indicated significant relationships of substance abuse disorders with candidate genes related to transmission and metabolism of such neurotransmitters as dopamine and serotonin. Additionally, several studies have uncovered genetic underpinnings to personal religiosity. However, little investigation has been made of how these three phenomena may interact. The current report details a secondary data analysis of religiosity, substance abuse, and genetics. Methods: Data were drawn from the National Longitudinal Study of Adolescent Health (Add Health), which surveyed a sample of over 15000 subjects from age 12 to age 38. Four waves of data were collected. At Wave IV, genotyping was performed for major candidate genes previously correlated with mental health: the serotonin transporter promoter region (5HTTLPR), dopamine transporter (DAT1), dopamine receptor subtype 4 (DRD4), and monoamine oxidase A (MAOA). For this analysis genotypes were dichotomized according to observed activity levels, in accordance with previous literature. Religious variables (religious attendance, importance of religion, and frequency of prayer) were modeled across Waves I-IV using growth mixture modeling. The growth parameters were regressed on substance use outcomes at Wave IV. To these models, genotypes were individually added to assess for possible mediation relationships. In order to test for moderation of religion/health relationships by genotype, subgroup analyses were performed using dichotomous groupings of genetic polymorphisms based on previous literature and theory. Results:

Evidence of mediation of the relationship of several religious variables to substance abuse outcomes was apparent for 5HT and DAT. DAT1 mediated the relationship of religious attendance with binge drinking. Multiple relationships of religious importance and frequency of personal prayer to substance abuse outcome at Wave IV lost statistical significance when controlled for genotype at 5HTTLPR. Analysis of possible moderation relationships found substantial variation in significance of religious variables to substance use outcomes among genotype subsets. More

variation was observed in analyses of religious importance and frequency of prayer than those measuring attendance at religious services. Conclusions: This analysis indicates that religiosity may relate to substance abuse in part through a correlation with genes, and that substantial variation in religion/substance use relationships may be observed based on genotype. Improved understanding of how religion relates to substance abuse will allow researchers to better apply this observed finding to prevention and treatment efforts.

DEPRESSION: TREATMENT AND RESISTANCE AND FUNCTIONALITY

NO. 1 TRAINING AND EDUCATION RECOMMENDATIONS FOR PRIMARY CARE PHYSICIANS IN METRO AND URBAN COMMUNITIES IN INDIA: FINDINGS OF A NEEDS ASSESSMENT FROM INDIA

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To find out competency of family physicians for suicide prevention; 2) To review ways in which deficiencies can be minimize; and 3) To examine merit education and training for suicide prevention.

SUMMARY:

Introduction: Suicide is a major public health problem which is becoming increasingly difficult to prevent in view of newer risk factors and vulnerable groups e.g. academic pressures, economic transition, farmers suicide. One of the obvious barrier is lack of human resource and level of education and skills amongst primary care physicians. This this paper we present some of the recommendations based upon our research about needs assessment of primary care physicians carried out in Mumbai, Maysore and Ahmedabad. Methods: Data was collected using a combination of qualitative and quantitative strategies such as environmental scans, focus groups, and gap analysis.

Participants for this study were recruited from healthcare professionals in primary care and community clinics, Results: A total of 144 primary care health professionals (physicians = 26%; primary care workers = 74%) completed the questionnaire. . The majority of healthcare professionals (64%) received no formal training in suicide prevention during their degree program, nor did they acquire it later. 63% of the participants do not ask about suicidal ideation. Their level of confidence and competence for identification and intervention was only moderate and agreed with requirements of more education.

These finding are clear arguments to develop curriculum for formal trailing and for continued professional development with specific focus on suicide prevention, Training needs to be part of teaching in general medical surgical, ER specialties in Post graduate teaching conclusion: Innovative models of education for family physicians and medical students are necessary for suicide prevention.

NO. 2 PATTERN OF PSYCHIATRIC ILLNESS AMONG WOMEN ATTENDING A PRIVATE PSYCHIATRIC CONSULTATION SERVICE IN A RURAL AREA OF BANGLADESH

Speaker: M.M. J. Uddin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the pattern of psychiatric illness among women attending private psychiatric consultation service in a rural area of Bangladesh; 2) Make a diagnosis of the women attending the psychiatrists in their private chamber; and 3) See the socio-demographic variables of the women attending the private psychiatric consultation service.

SUMMARY:

Mental health problem is a major public health issue globally as well as developing country like Bangladesh. Among 160 million population most of them are living in the rural area of Bangladesh and about 50% of them are women. In our society most of the female patients don't come to the hospital or any private chamber of psychiatrists for their treatment. They mostly depend on treatment practiced by the traditional healers. The present

study was aimed to assess the pattern of psychiatric illness among women attending private psychiatric consultation service in a rural area of Bangladesh.

This descriptive cross sectional study was done among the female attending the private psychiatric consultation service in Tangail (a district of Bangladesh) from January 2013 to June 2014 in the weekend (Friday) chamber of the authors. All the new patients who were attended the psychiatrists were included in the study. Any duplication was excluded. Socio-demographic data were collected through a semi-structured questionnaire developed by the authors and psychiatric diagnoses were made following DSM-IV-TR diagnostic criteria. Total 1173 female patients were found during the study period. Most of them (68%) belonged to 20 years to 40 years age group. Among the respondents most of them were housewife (62%) of lower class family. Most common psychiatric diagnosis were found major depressive disorder (19%), pain disorder (16%), somatization disorder (12%), schizophrenia (8%), obsessive compulsive disorder (8%), bipolar mood disorder (6%), conversion disorder (4%), adjustment disorder (4%), post partum psychosis and personality disorder each was 3%. Rest 17% were diagnosed as phobic disorder, substance related disorders, generalized anxiety disorder, dementia and epilepsy.

The result of the study indicates that further expansion of psychiatric services in the community with special emphasis for their proper identification and management is needed. Policy makers and planners should give attention in this regards.

NO. 3 BRIEF CULTURALLY-ADAPTED COGNITIVE BEHAVIORAL THERAPY FOR DEPRESSION: A RANDOMIZED CONTROLLED TRIAL FROM PAKISTAN

Speaker: Farooq Naeem, M.B.B.S., M.Sc., Ph.D.

Co-Author(s): Muhammad Irfan, Tariq Munshi, Saeed Farooq, Nusrat Husain, Muhammad Ayub

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become aware of issues related to cultural adaptation of CBT for

depression in Pakistan; 2) Learn of barriers and strengths while working with this client group; 3) Become aware of findings from the first RCT of CBT for depression from South Asia.

SUMMARY:

High rates of depression have been reported from Pakistan. Psychological interventions are an important part of treatment of depression. These interventions are underpinned by the Western values and need adapting to the cultural and religious needs of clients from Non Western cultures. There is limited evidence of psychological interventions from Low and Middle Income Countries (LMIC). We culturally adapted and tested efficacy of brief Culturally adapted CBT (CaCBT) for depression delivered by psychology graduates using a manual compared with treatment as usual (TAU). Participants with a diagnosis of depression, attending psychiatry departments of three teaching hospitals in Lahore, Pakistan, were included in the study. We screened a total of 280 clients and randomly allocated 137 of them to CaCBT plus Treatment As Usual (TAU) [Treatment group] or to TAU alone [Control group]. Assessments were completed at baseline, at 3 months and at 9 months after baseline. Reduction in depression score (Hospital Anxiety and Depression-Depression Subscale) at 3 months was primary outcome measure. The secondary outcome measures included anxiety scores (Hospital Anxiety and Depression-Anxiety Subscale), somatic symptoms (Bradford Somatic Inventory), disability (Brief Disability Questionnaire) and satisfaction with the treatment. Participants in Treatment group showed statistically significant improvement in depression, anxiety, somatic symptoms and disability. This effect was sustained at 9 months after baseline (Except for disability). Participants in Treatment group also reported higher satisfaction with treatment compared with those in Control group. Brief CaCBT can be effective in improving depressive symptoms, when compared with treatment as usual. This is the first report of a trial of Culturally adapted CBT from South Asia and further studies are needed to generalize these findings.

NO. 4

CULTURE AND PSYCHOTHERAPY: A PSYCHOSOCIAL FRAMEWORK FOR ANALYSIS

Speaker: Constantine D. Della, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the significance of the impact of culture on psychotherapy; 2) Identify the cultural factors that inform the practice of psychotherapy; and 3) Integrate the cultural factors that are important in the areas of psychotherapy training, service delivery, and research.

SUMMARY:

Culture possesses multiple functions in psychotherapeutic processes: (1) it creates specific sources of stress, (2) it provides specific modes of coping with distress, (3) it governs social responses to distress and disability, (4) it defines the symptoms of distress and psychopathology, (5) it determines the interpretation of symptoms and their subsequent biological, psychological, and social impacts, (6) it guides help-seeking and the response to treatment, and (7) it shapes the meaning of the illness experience. Psychotherapy, therefore, involves processes that are informed by the patient's culture. Indigenous psychotherapies could be found in many societies and they may be used alone or in conjunction with Western modalities of treatment. In the Philippines, psychotherapists largely employ Western models of psychotherapy. This paper describes some indigenous healing rituals and discusses the psychosocial framework that lends efficacy in the treatment modalities for psychological problems. Furthermore, this paper also aims to integrate this framework into the current practice of psychotherapy in the Philippines and provide recommendations vis-a-vis training, service, and research in the field of psychotherapy.

MAY 20, 2015

MOOD DISORDERS

NO. 1

ARE ANTIDEPRESSANTS ASSOCIATED WITH INCREASED RISK OF POOR

OUTCOME IN PATIENTS WITH BIPOLAR DISORDER?

Speaker: John W. Goethe, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Compare and contrast medication variables associated with risk of readmission in patients with bipolar disorder; 2) Discuss the role of antidepressants in the pharmacotherapy of bipolar disorder based upon current guidelines; and 3) Compare and contrast the benefits of mood stabilizers in patients with bipolar mania versus bipolar depression and bipolar II.

SUMMARY:

Background: Recent guidelines recommend that antidepressants (AD) not be used in bipolar patients (BP) without a co-prescribed mood stabilizer (MS), especially in patients with symptoms of mania. **Hypotheses:** Risk of readmission (RA) in patients with a current episode of BP mania (BPM) or BP mixed (BPMx) is significantly greater in those (1) on AD without MS (AD-MS) vs. AD with MS (AD+MS) and (2) on AD-MS vs. all other medications.

Methods: The study sample was 4931 consecutive inpatient discharges (1/2000-6/2013) with a BP clinical diagnosis (1397 BPM, 1017 BPMx, 1799 BP depressed (BPD), 718 BP II). Readmissions were identified at 1, 3, 6 and 12 months post discharge. Logistic regression was used to identify other potentially relevant variables after including demographics and stepwise selected medications associated with RA; the regressions were repeated for each BP subtype. RA risks were compared for AD-MS vs. AD+MS in each of the 4 BP subtypes and at each of the 4 time points using Mantel-Haenszel chi-square analyses. RA was also compared in patients treated with AD plus antipsychotics (AD+AP) vs. AD+MS. Length of stay (LOS), GAF at discharge and other measures of service utilization/outcome were examined using similar analyses. **Results:** 13% of the sample was readmitted within one month, 35% within 12 months. Consistent with the hypothesis for the sample as a whole, RA risk was increased in those on AD-MS at 1, 3, 6 and 12 months, controlling for subtype and other medications (ORs^{1.2-1.8}). AD-MS was also associated

with increased RA in the regressions specific to each BP subtype [for BPM ORs \approx 2.5 at 3 and 12 months and for BPD OR=1.5 at 1 month. In bivariate analyses AD-MS compared to all other treatments was associated with increased RA risk in BPM at 3, 6 and 12 months (ORs \approx 2.4) and in BPMx, but only at 3 and 6 months and with lower risks (ORs \approx 1.7); in contrast, AD+MS compared to all other treatments was associated with reduced RA risk in BPM at 1, 3 and 6 months (ORs \approx 0.7) and in BPMx and BPD at 1, 3, 6 and 12 months (ORs \approx 0.6). Also of interest was that AD+AP compared to AD+MS was associated with increased RA in BPM (e.g., OR=5.1 at 12 months) and in each of the other BP subtypes at most time points (ORs \approx 2.0-2.8). Also consistent with the hypothesis was the association of AD-MS with longer LOS in BPMx (OR=1.7); this association was found in BPD (OR=2.2) and BP II (OR=2.7) as well. Discussion: Readmission (RA) was common in this sample; the findings support the hypothesis that AD-MS in BPM and BPMx is associated with increased risk of RA. These data generally support current guidelines about AD use in BP and provide additional information: co-prescribed mood stabilizers may reduce RA in BPD as well as BPM, and the increased RA risk associated with AD appears to continue for at least 12 months after AD exposure. Further research is needed.

NO. 2 CANNABIS WITHDRAWAL IN ADULTS WITH DEPRESSION OR BIPOLAR DISORDER

*Speaker: David A. Gorelick, M.D., Ph.D.
Co-Author(s): Douglas L. Boggs, Pharm.D.,
Deanna L. Kelly, Pharm.D., Fang Liu, M.S.,
Jared A. Linthicum, M.S., Hailey E. Turner, M.S.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize common cannabis withdrawal symptoms in people with mood disorders; 2) Diagnose a cannabis withdrawal syndrome by *DSM-5* criteria; and 3) Identify the role of cannabis withdrawal in promoting use of psychoactive substances.

SUMMARY:

Background: Cannabis use is prevalent among adults with mood disorders, but we are not

aware of any studies of cannabis withdrawal in this population.

Methods: We collected data about cannabis use patterns and the experience of cannabis withdrawal from 58 adults (two-thirds men, three-quarters African-American) with current mood disorder (27 bipolar, 31 major depression) using the Marijuana Quit Questionnaire, a 176-item, semi-structured questionnaire. The index quit attempt was their "most difficult" (self-defined) cannabis quit attempt without formal treatment while not in a controlled environment. Among participants whose quit attempt began after the onset of their mood disorder (mood disorder group), we compared those with bipolar disorder (n=18) with those with depression (n=16), using chi-square test for categorical and Wilcoxon test for continuous variables. Five participants with quit attempt and mood disorder onset within the same year were excluded from analyses.

Results: The index quit attempt lasted 14.8 [27.8] months (median 2.5 months, range 1 day-10 years). 71% of participants experienced a cannabis withdrawal syndrome (*DSM-5* criteria). The most frequently reported withdrawal symptoms were increased cannabis craving (76%), irritability (74%), boredom (65%), depression (62%), anxiety (62%), and restlessness (62%). The number of withdrawal symptoms per participant was positively correlated with greater frequency and amount of cannabis use. Withdrawal symptoms often prompted actions to relieve them, including increased use of alcohol (44%), tobacco (50%), and cannabis (39%). Participants with bipolar disorder were more likely than those with depression to be using tobacco regularly at the start of their quit attempt (100% vs. 56%, p=.006), to increase tobacco use during the attempt (72% vs. 25%, p=.01), and to be taking lithium (39% vs. 0%, p=.02). Otherwise, there were no significant group differences in withdrawal characteristics. There were few significant differences between the combined mood disorder group (n=34) and those with quit attempt before onset of their mood disorder (n=19).

Conclusions: These findings suggest that cannabis withdrawal syndrome is common among adults with mood disorders and is experienced similarly to other individuals with mental illness (e.g., schizophrenia) and people without serious psychiatric comorbidity. As in other populations, cannabis withdrawal may

serve as negative reinforcement for relapse during a quit attempt and prompt increased use of other psychoactive substances; thus, it warrants clinical attention. Acknowledgements: Funded by the Intramural Research Program, National Institutes of Health, National Institute on Drug Abuse (NIDA) (Gorelick) and NIDA Residential Research Support Services Contract HHSN271200599091CADB (N01DA-5-9909; Kelly, PI).

NO. 3 ROLE OF BOTULINUM TOXIN IN DEPRESSION: A SYSTEMIC REVIEW AND META-ANALYSIS

Speaker: Ajay Parsaik, M.D., M.S.

Co-Author(s): Ajay K Parsaik MD MS, Sonia S Mascarenhas, Aqeel Hashmi MD, Larry J. Prokop, Vineeth John MD MBA, Olaoluwa Okusaga MD MScPHR, Balwinder Singh MD MS

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To consolidate the evidence for botulinum toxin A efficacy in depression.

SUMMARY:

Objective: To consolidate the evidence for botulinum toxin A efficacy in depression. Methods: We searched MEDLINE, EMBASE, Cochrane and Scopus through May 5, 2014, for studies evaluating the botulinum toxin A efficacy in depression. Only randomized controlled trials (RCTs) were included in the meta-analysis. A pooled mean difference in primary depression score, and pooled odds ratio (OR) for response and remission rate with 95% confidence interval (CI) was estimated using the random-effects model. Heterogeneity was assessed using Cochran's Q test and I² statistic. Results: Of the 639 retrieved articles, 5 studies enrolling 194 subjects (age 49 ± 9.6 years) were included in the systematic review; while 3 RCTs enrolling 134 subjects were included in the meta-analysis. Meta-analysis showed significant decreased in mean primary depression score among botulinum toxin A compared to placebo (-9.80, 95% CI -12.90, -6.69) with modest heterogeneity between the studies (Cochran's Q test, I² = 70). Response and remission rate was 8.27 and 4.6 times (respectively) higher among botulinum toxin A compared to placebo with

zero heterogeneity between the studies. Two studies excluded from the meta-analysis also showed significant decrease in primary depression score after receiving botulinum toxin A. Few subjects had minor side effects, which were similar between two groups. Conclusion: This study suggests that botulinum toxin A causes significant improvement in depressive symptoms and is a safe adjunctive treatment for depression. Future trials evaluating the antidepressant per se effect of botulinum toxin A, and further elucidating the underlying antidepressant mechanism of botulinum toxin A are needed.

NO. 4 PREDICTIVE VALUES OF SCREENING QUESTIONS FOR LIFETIME AND PAST- 12-MONTHS DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER

Speaker: Venkat Bhat, M.D.

Co-Author(s): Aihua Liu, Ph.D., Jean Caron, Ph.D., Gustavo Turecki, Ph.D

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To understand the predictive values of the two screening questions for Major Depressive Disorder for lifetime and past 12 month diagnoses; 2) To appreciate epidemiological and numeric perspectives in the depression diagnosis algorithm from the screening questions to final diagnosis; and 3) To recognize the nature of symptom distribution when subjects meet or fail to meet the final list of 9 symptoms of Major Depressive Disorder

SUMMARY:

Introduction: The sensitivity, specificity and predictive values of the two screening questions (first is being sad, empty or distressed, second is being discouraged) have been examined in various contexts and comorbidities for diagnosis of Major Depressive Episode (MDE). However, the predictive values of the two screening questions have not been studied in the context of last 12 month and lifetime diagnosis of Major Depressive Disorder (MDD). Further, this predictive value has not been examined in a population that is random and representative, and in the context of the nature of final distribution of individual symptoms. This

study aimed to examine predictive values and symptom distribution by examining the algorithmic flow of numbers from the screening questions to final diagnosis of MDE during the last 12 months and lifetime. Methods: The Montreal Epidemiological Catchment Area Study (ECA) is a longitudinal project currently underway at the Douglas Institute. 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); 1823 agreed to be re-interviewed two years later (T2). Mental disorders were identified with the Canadian Community Health Survey (CCHS 1.2) version of the Composite International Diagnostic Interview. This study specifically examined the MDD algorithm in the context of last 12 month and lifetime MDD diagnosis. Further, the symptom distribution was studied in the context of lifetime diagnosis of depression. Results: For lifetime MDD diagnosis among 2433 subjects, 1401 answered affirmatively for the first screening question and among the remaining 1032 subjects, 145 answered affirmatively for the second screening question. For the first screening question, 550 subjects had a final diagnosis of MDD (PPV-0.39) and for the second question, 22 subjects had a final MDD diagnosis. For the last 12 months MDD diagnosis among 1823 patients, 143 subjects had a final MDD diagnosis among 473 who answered affirmatively to the first question (PPV-0.30), and 4 had a final MDD diagnosis among 77 who answered affirmatively to the second question. Among patients with lifetime MDD diagnosis, feelings of worthlessness and psychomotor symptoms were the least frequently reported symptoms. In addition, most people who reported episodes of being sad, empty or distressed, also reported being discouraged in the detailed symptom review. Conclusion: The important finding is that most of the final diagnosis of MDD (both with lifetime and last 12 month) is captured by the first screening question and there is then a significantly lower yield for the second question, and this is because of the high correlation in the symptoms covered by the two screening questions. The study is from a representative population and suggests that worthlessness and psychomotor symptoms are the least prevalent among subjects with final lifetime diagnosis.

CHILD AND ADOLESCENT AND HOSPITAL PSYCHIATRY

NO. 1

IMPACT OF A MENTAL HEALTH CURRICULUM FOR HIGH SCHOOL STUDENTS ON KNOWLEDGE, ATTITUDES, AND HELP-SEEKING EFFICACY: A RANDOMIZED CONTROLLED TRIAL

Speaker: Robert P. Milin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the meaning of mental health literacy and will acquire knowledge of its effectiveness to date in youth; 2) Determine the effectiveness of a mental health educational curriculum for youth on change in knowledge, stigma and help seeking attitudes in youth; and 3) Propose a generalizable and evidence-based school curriculum to provide mental health literacy to youth in high schools.

SUMMARY:

Introduction: Effective strategies for mental health (MH) awareness are needed for youth who are at highest risk for developing mental illness. Expectations of stigma prevent youth from seeking help and accessing MH services. Researchers have not adequately examined the effectiveness of school-based MH educational programs. Methods: Randomized controlled trial of 25 secondary schools in Ottawa included 534 adolescents (mean age=15.6). Schools were randomized into one of three arms: control (n=172), curriculum (n=200) and curriculum + follow-up eLearning (n=162). The mental health educational curriculum (MHEC) was implemented in grades 11/12 Healthy Living course, replacing the existing mental health component. Control students received the Healthy Living Course, as usual. Teachers received training on the curriculum for implementation into their classrooms. A research assistant administered pre and post questionnaires to all groups. For the purpose of pre/post analysis, both curriculum groups were combined, as there were no group differences in those receiving the curriculum. Results: Within the curriculum group, there were significant increases in mental health

knowledge, $t(262) = 4.17$; $p = .00$ (Cohen's $d = 0.27$), positive attitudes toward mental illness, $t(155) = 1.13$; $p = .26$ (Cohen's $d = 0.18$), and help-seeking efficacy, $t(307) = 2.62$; $p = .01$ (Cohen's $d = 0.13$). Small effect sizes were found across all three measures. Findings indicated there were no differences from pre to post in the control group across any dependent variable. In the sub-group analysis, University streamed students in the curriculum group significantly increased their mental health knowledge from Pre ($M=8.50$; $SD = 2.16$) to Post ($M = 9.52$; $SD = 2.24$), $t(149) = 5.73$; $p = .00$. Cohen's d was 0.46, indicating a medium effect size. These students also reported a significant increase in their attitudes toward mental illness from Pre ($M=20.74$; $SD = 2.47$) to Post ($M = 21.50$; $SD = 2.57$), $t(172) = 3.83$; $p = .00$. Cohen's d was 0.30, indicating a medium effect size. Finally, these students reported a significant increase in their help-seeking efficacy from Pre ($M=9.69$; $SD = 2.47$) to Post ($M = 10.12$; $SD = 22.29$), $t(178) = 2.55$; $p = .01$. Cohen's d was 0.18, indicating a small effect size. There were no significant differences for any dependent variables when examining students in the Community College stream curriculum group, nor were there any differences in the University or Community College control groups. Conclusion: This is the first RCT showing the effectiveness of a MHEC for youth. Students experienced improvements in knowledge, stigma reduction and increased help-seeking self-efficacy. University streamed students were favoured in this study. Further adaptations to the curriculum may be required for community college streamed students. This curriculum delivery model supports the general applicability of mental health literacy.

NO. 2

THE PROJECT QUIXOTE: THE PSYCHOSOCIAL CARE CENTER FOR "STREET CHILDREN" AND STRATEGIES OF "CRACKLAND" APPROACH

Speaker: Ligia Florio, M.D.

Co-Author(s): Mauricio Diamant, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate the social reality of the users of crack; 2) Reveal the strategies of approximation; and 3) Discuss treatment options and segments.

SUMMARY:

The Projeto Quixote is a Civil Society Organization connected to the Federal University of Sao Paulo (UNIFESP), which has operated since 1996. Its mission is to transform the stories of children, adolescents, and families in situations of high social risk through integrated clinical and social care. Projeto Quixote uses art, education, and culture as its tools to approach and get closer to children and youth. Projeto Quixote Work Nowadays. Today, Projeto Quixote has two headquarters: a central location in Vila Mariana, where most of its activities take place, and smaller location in República Square, in the center of Sao Paulo, which focuses on outreach programs for children and adolescents living on the streets. To achieve its mission, Projeto Quixote is divided in two sectors: Assistance: project teams use recreational activities to build bonds with the youth, creating an atmosphere of trust where each child or adolescent's needs can be voiced, and seen to by a multidisciplinary team. This work is done through Quixote's five assistance programs: Educational: encompasses the different workshops that Quixote provides, such as arts, graffiti, break, computers, sports, craftwork, video, etc.; Clinic: provides assistance in psychology, psychiatry, pediatrics, educational psychology and social work. Through this program, Quixote has become renowned in the field of drug abuse and mental health. It also runs the Cuidar (Care) Project, which focuses on victims of sexual violence and abuse; Workplace Education: prepares youths for adulthood, training them to be professionals and entrepreneurs through projects like Quixote Jovem (Youth from Quixote), which provide basic skills for the labor market, such as communication, citizenship, computer skills, and entrepreneurial projects. Also includes the Agencia Quixote Spray Arte, a project that helps generate income through graffiti. The final phase of this project is the insertion of the youth in the labor market, through our partners (e.g., PwC); Family Care: provides psychosocial care, discussion groups among families, and income generation through the production and sale of craft items; Urban Refugees (children and youths living on the streets): approaches children and adolescents living on the streets in the region of Caronia, headquartered downtown in Sao Paulo, with the objective to return them to their home

communities. Teaching and Research: systematizes and disseminates the knowledge gained from Quixote's daily activities. Offers courses, supervision, and consulting for managers, educators, and technicians from social networks throughout Brazil. Works to use research to support public policies for children and youth at social risk.

NO. 3 SIX CORE STRATEGIES IN REDUCING RESTRAINTS AND SECLUSIONS IN INPATIENT CHILD AND ADOLESCENT SETTINGS

Speaker: Muhammad W. Azeem, M.D.

Co-Author(s): Bhagya Reddy, MD, Marianne Wudarsky, MD, Ph.D, Michelle Sarofin, LCSW, Frank Gregory, Ph.D., Linda Carabetta, RN, Denise Wyrick, LCSW.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the traumatic impact of restraints and seclusions on children and youth; 2) Learn about six core strategies to reduce restraints and seclusions in inpatient child and adolescent setting; and 3) Recognize the importance of providing trauma informed care to children and adolescents in inpatient setting.

SUMMARY:

Restraints and seclusions are utilized in child and adolescent psychiatric treatment venues such as inpatient hospital units, residential programs, schools and juvenile justice settings, as means of managing aggressive and self-injurious behaviors. These procedures can be considered by youth as aversive and traumatizing, and in worst case scenarios, deaths have been reported. In most recent years, various regulatory agencies and professional groups have recommended these restrictive interventions only be used in most extreme circumstances, that is when children and youths pose imminent risk of harm to themselves or others. There are limited studies looking at various programs targeted to reducing restraints and seclusions in inpatient child and adolescent settings.

Albert J. Solnit Children's Center has 52 hospital psychiatric beds for youth. The

adolescents admitted to the hospital come from tertiary care hospitals and emergency departments across the state and have failed inpatient stabilization, medication trials and various psychotherapeutic treatments. The adolescents usually present with severe aggression or / and self-injurious behaviors and often required multiple restraints and seclusions before admission to Solnit Center. A large number of youths has experienced repetitive and/or chronic trauma. There has been a marked reduction in the frequency of restraint and seclusion utilization at Solnit Center using six core strategies developed by National Association of State Mental Health Program Directors (NASMHPD). These strategies are based on trauma informed and strength based care, and rooted in primary prevention principles (Azeem et al., 2011). Mechanical restraints are probably the most traumatizing intervention occurring in inpatient settings. With restraint reduction and trauma informed care initiatives, mechanical restraints decreased by 100 % from 485 in 2005 to "zero" in 2013 at Solnit, for two years running, in 2012 and 2013. Physical restraints decreased by 87% from 3033 in 2005 to 394 in 2013 and seclusions decreased by 67% from 1150 in 2005 to 385 in 2013. The mechanical restraint beds once used at this facility were deconstructed and a symbolic "Healing Bench" was fabricated from the wood of the mechanical restraint beds. The strategies which were implemented at the facility to reduce restraints and seclusions included: 1) leadership towards organizational change, 2) use of data to inform practice, 3) youth and family involvement, 4) workforce development, 5) use of restraint and seclusion prevention and reduction tools, and 6) vigorous debriefing techniques. Reference:

Azeem, Muhammad W, Aujla, Akashdeep, Ramerth, Michelle, Binsfeld, Gary, Jones, Robert B (2011). Effectiveness of Six Core Strategies Based on Trauma Informed Care in Reducing Seclusions and Restraints at a Child and Adolescent Psychiatric Hospital.

Journal of Child & Adolescent Psychiatric Nursing; 24:11-15.

NO. 4 STATEWIDE HOSPITAL QUALITY IMPROVEMENT COLLABORATIVE FOR REDUCING PSYCHIATRIC 30-DAY

READMISSIONS: STRATEGIES USED BY HIGH-PERFORMING HOSPITALS

Speakers: Kate M. Sherman, L.C.S.W., M.S.W., Molly Finnerty, M.D.

Co-Author(s): Edith Kealey, Ph.D., Alison Burke, B.S.W., J.D., Erica Van De Wal, M.A., Steering Committee of the NYS Readmissions Quality Collaborative

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the prevalence of behavioral health readmission; 2) Identify clinical and pharmacological interventions that may contribute to decreased readmissions; and 3) Identify discharge process improvements and systems changes that promote improved engagement in aftercare and contribute to decreased readmissions.

SUMMARY:

BACKGROUND: Inpatient readmissions are a critical focus for healthcare providers and payers. In 2011, there were 3.3 million 30-day readmissions in the US, costing \$41.3 billion; and among Medicaid enrollees age 18-64, behavioral health conditions top the list of index hospitalization diagnoses (AHRQ, SB #172). Most current national efforts to address readmissions focus on medical conditions. To fill this gap, the NYS Office of Mental Health (OMH) and the Greater NY Hospital Association led a two-year Quality Improvement Collaborative with 40 hospital psychiatry departments, focused on reducing behavioral health inpatient readmissions. This study examined strategies used by high-performing departments of psychiatry with marked reductions in 30-day psychiatric readmissions. **Methods:** The quality collaborative engaged 40 hospitals from 6/12-6/14. Join point regression analyses were used to identify hospitals with statistically significant improvement or a strong trend toward improvement on multiple project outcome measures. Site visits were conducted with 10 high performing hospitals. Research staff conducted semi-structured interviews with hospital project teams, to identify promising practices for reducing behavioral health readmissions. Qualitative analysis involved identification of themes and documentation of detailed examples of how hospitals operationalized strategies for change. **Findings:** High performing hospitals used multiple synergistic strategies for reducing psychiatric

readmissions, including 1) Emergency Department interventions, 2) enhancing discharge planning, 3) medication-related strategies, 4) addressing concrete needs and potential barriers to care after discharge, 5) counseling interventions for clients and families, 6) improved communication and collaboration between inpatient and outpatient services, 7) active follow-up post discharge, and 8) leadership that fostered a culture of innovation. All successful hospitals actively engaged staff across settings in reducing readmissions. For example, Emergency Department staff identified potential behavioral health readmissions, called for in-person evaluation by the inpatient team, and increased their capacity to develop safe outpatient alternatives to admission. Outpatient clinicians participated in "warm hand-offs," visiting inpatients whom they would be treating post discharge. Collaboration was facilitated by cross-departmental meetings and use of health information technology. **Conclusions:** Reducing behavioral health readmissions requires a set of mutually reinforcing interventions spanning clinical practice, discharge processes and systems of care. Heightened collaboration across the continuum of care to provide active support during care transitions is critical to success.

TREATMENT STRATEGIES IN PSYCHIATRY AND NEUROPSYCHIATRY

NO. 1

COGNITIVE AND BEHAVIORAL IMPROVEMENT AFTER PROLONGED TREATMENT WITH ZOPICLONE IN NEUROCOGNITIVE DISORDERS AND ELECTROENCEPHALOGRAPH ABNORMALITIES

Speaker: Alfonso Ceccherini-Nelli, M.D.

Co-Author(s): Lisa Burback, M.D., Karthikeyan Ganapathy, M.D., George Vozar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify neurocognitive disorders who may respond to zopiclone/zolpidem; 2) Become aware of clinical effects of zopiclone in a case series of neurocognitive disorders; and 3) Acquire new information about possible mechanisms of action of selective GABA agonists in brain damaged patients.

SUMMARY:

Background: Zolpidem, a selective GABA agonist at the GABA(A)-alpha1-receptor subunit, may restore consciousness and other cognitive functions in a minority of brain damaged subjects. The response to zolpidem may be predicted by baseline resting electroencephalography (EEG) tracings with a high amplitude and low frequency oscillatory peaks of about 6-10 Hz over frontocentral regions. Methods: five consecutive patients with different neurocognitive disorders and baseline EEG dysrhythmias were treated open label with zopiclone, another selective GABA(A) receptor agonist. Results: In this case series, we describe remarkable improvement of cognition, motricity and problematic behavior after zopiclone administration.

Conclusions: These preliminary clinical findings and the significant body of research, implicating GABAergic mechanisms in the pathophysiology of an heterogeneous group of neurocognitive disorders, warrant further investigation of zopiclone and other selective GABA agonists.

NO. 2

A SYSTEMATIC REVIEW AND META-ANALYSIS OF ACTIVE VERSUS SHAM DEEP BRAIN STIMULATION FOR OBSESSIVE-COMPULSIVE AND DEPRESSIVE DISORDERS

Speaker: Steve Kisely, M.D., Ph.D.

Co-Author(s): Katherine Hall, B.S, Dan Siskind M.B., M.P.H, Ph.D., Julianne Frater, M.B., Sarah Olsen M.B. B.S., David Crompton, M.B.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand methodological issues in the application of randomized controlled trials to the evaluation of deep brain stimulation; 2) Appreciate the current evidence-base for deep brain stimulation in the treatment of psychiatric disorders; and 3) Understand issues in obtaining informed consent for the procedure.

SUMMARY:

Background: Deep brain stimulation (DBS) is increasingly being applied to psychiatric disorders such as obsessive-compulsive disorders, major depression and anorexia nervosa. Double-blind, randomized controlled

trials of active versus sham treatment have been limited to very small numbers the largest single study to date had only 16 subjects. We undertook a systematic review and meta-analysis on the effectiveness of DBS in psychiatric conditions. Method: A systematic literature search for double-blind, randomized controlled trials of active versus sham treatment for obsessive-compulsive and depressive disorders using PubMed/Medline and EMBASE up till April 2013. Where possible we combined results from studies in a meta-analysis. We assessed differences in final values between the active and sham treatments for parallel-group studies and compared the results of paired analyses in changes from baseline score for cross-over designs. Results: Five studies met inclusion criteria, all of which were of obsessive-compulsive disorder. 44 subjects provided data for the meta-analysis. The main outcome was a reduction in obsessive symptoms measured by the Yale Brown Obsessive Compulsive Scale. Patients on active, as opposed to sham, treatment had a significantly lower mean score (MD 8.93; 95% CI, -13.35 to 5.76; $P < 0.001$), representing partial remission. There was also a statistically significant difference between active and sham treatments for two studies using the Hamilton Rating Scale for Depression (MD 7.89; 95% CI, -13.86 to 1.91; $P = 0.01$). However, a third of patients experienced significant adverse effects ($n = 16$). Conclusions: There have been previous meta-analyses of the effect of DBS on disorders such as Parkinson's disease, dystonia and chronic pain but this is the first meta-analysis of the procedure in psychiatric conditions. DBS shows promise for treatment-resistant obsessive-compulsive disorder but there are insufficient randomized controlled data for other psychiatric conditions. It therefore remains an experimental treatment for severe, medically-refractory conditions till further data are available.

NO. 3

EFFICACIOUS ULTRA-LONG-TERM TREATMENT OF PANIC DISORDER WITH CLONAZEPAM OR PAROXETINE MIGHT NOT PREVENT RELAPSE AFTER DRUG WITHDRAWAL

Speaker: Antonio E. Nardi, M.D., Ph.D.

Co-Author(s): Marina D Mochcovitch, M.D., Tathiana Baczynski, M.D., Silvia Hoirsch-Clapauch, M.D., Rafael C Freire, M.D., Ph.D., Sergio Machado, Ph.D., Adriana C Silva, Ph.D., Roman Amrein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Analyze the similarities and differences of acute, long-term and withdrawal phase treatment with clonazepam, paroxetine, and their combination; 2) Describe the main adverse events during treatment phase and withdrawal phase with clonazepam, paroxetine, and their combination; 3) Discuss the advantage and problems of a long-term treatment for panic disorder and the selection of patients who could benefit of it; 4) Recognize the main symptoms of panic disorder recurrence after drug withdrawal and discuss the options for restart the treatment; and 5) Describe a schedule for slowing tapering clonazepam and paroxetine off after a long-term treatment.

SUMMARY:

OBJECTIVE: To describe the clinical and therapeutic features of 120 panic disorder (PD) patients treated for 3 years with clonazepam, paroxetine, or clonazepam + paroxetine and their follow-up for 6 years after the treatment. **METHOD:** A prospective open study with 120 PD patients randomized 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. Tapered withdrawal of the treatment 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. Assessments were done every three months or at least once a year. **RESULTS:** 94 patients completed 3 years treatment. All were free of panic attacks since at least one year before undergoing 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. No serious or severe AE or withdrawal symptoms were observed but PA/month, CGI S,

and HAMA worsened slightly and the rate adverse events increased slightly during the withdrawal period compared to the treatment period, being still much lower compared to pretreatment conditions. Assessments were annual in 66 patients and performed at 5 or 6 years in the remaining 28 patients. In annually studied patients the relapse rates were similar after the 3 treatments with a marginal advantage of clonazepam over the combination ($p=0.0035$) and paroxetine ($p=0.08$, exact Fisher) at the first year after drug withdrawal. Cumulative relapses rate were 41%, 77%, and 94% at years 1, 4, and 6, but relapse therapy with either clonazepam or paroxetine was successful in nearly all cases. 90% of the annually followed patients were during the 6 years of follow up in average in remission (partial: 54%, full: 36%); 73% were PA free, 91% had a CGI-S score of 1, and 39% HAMA scores of 510; 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 510, with 39% needing PD treatment. **CONCLUSION:** PD is a chronic disorder, with many patients relapsing despite being asymptomatic at least one year after 3 years treatment. However, response to the restarted treatment was excellent at any time during the 6-year follow-up. Paroxetine and clonazepam were associated with similar long-term prognoses but clonazepam was better tolerated.

NO. 4

A PILOT STUDY TO DETERMINE THE SAFETY AND EFFICACY OF H-COIL TRANSCRANIAL MAGNETIC STIMULATION IN ANOREXIA NERVOSA

Speaker: Yuliya Knyahnytska

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand no evidence-based treatments for severe anorexia nervosa exist; 2) Know insula has been found to play a significant role in perceptions, mood, anxiety, and obsession; and 3) Know No technology

before could reach deep areas of the brain, such as insula.

SUMMARY:

Recently, there have been advances in understanding the neurobiology of Anorexia Nervosa (AN). Brain areas, such as dorsomedial and dorsolateral prefrontal cortex have been shown to play an important role in AN. However, current research points to deeper prefrontal and subcortical areas as being implicated in eating disorders. Functional MRI studies have shown that when emaciated and malnourished individuals are shown pictures of food they display abnormal activity in the insula and orbitofrontal cortex (OFC) as well as medial temporal, parietal and anterior cingulate cortex. Moreover, a recently conducted meta-analysis points to deep prefrontal (subcallosal and cingulate gyrus) as well as subcortical areas (thalamus and insula) as possibly playing a role in the pathophysiology of AN. Up to this point, TMS has had functional capacity to stimulate only the superficial cortical regions of the brain. The new Hcoiled coil (Hcoil) was developed to activate deeper regions of the brain, which may have superior therapeutic utility in AN as magnetic fields can reach areas purported to be involved in its pathophysiology. A recently completed RCT for major depression demonstrated that deep rTMS yielded higher remission rates compared to superficial rTMS revealing potential to be more effective than superficial rTMS for AN as well. In addition, the Hcoil deep rTMS is likely more effective and generalizable than superficial rTMS as it does not require sophisticated neuronavigation. We propose to conduct a pilot study to investigate the efficacy and safety of the H-coil deep rTMS targeting the insula for patients with treatment resistant anorexia nervosa (TrAN). This non-blinded, prospective, 12-week pilot study investigates rTMS treatment in 12 outpatients with treatment resistant AN(TrAN). Currently 3 females with TrAN restricting subtype are enrolled in this treatment trial. Their age ranges from 20 to 38 years, mean BMI is 15.9. They have completed a number of psychological and cognitive instruments. 67% had been diagnosed with depression, 66.7% generalized anxiety disorder, and 33.3% had past history of substance abuse. All subjects receive prefrontal deep rTMS 5 times per week for 6 weeks, for a total of 30 sessions as a part of an active treatment phase, followed by a

maintenance phase with two sessions weekly for 6 weeks. The safety and efficacy of this new form of rTMS will be presented.

A SAMPLING OF THE VARIOUS TOPICS THAT PSYCHIATRY ENCOMPASSES

NO. 1

NEXTGENU.ORG: DEMOCRATIZING PSYCHIATRIC AND OTHER HEALTH SCIENCES EDUCATION WITH THE WORLD'S FIRST PORTAL TO FREE, ACCREDITED HIGHER EDUCATION

Speaker: Randall F. White, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain how the current worldwide shortage of mental health and other health care workers can be improved by use of current technology; 2) Use NextGenU.org to teach their trainees, or to create their own globally available courses; and 3) Identify common barriers to higher education & how NextGenU.org mixed educational method of online learning, peer and mentored activities is a portal to accessible, free, accredited higher education.

SUMMARY:

Background: NextGenU is the world's first portal to free, accredited, higher education -- it's been called the world's first free university (we're for credit, for free, unlike any other organization). NextGenU partners with leading universities, professional societies, and government organizations including Grand Challenges Canada, the American College of Preventive Medicine, U.S. CDC, NATO Science for Peace, and the World Health Organization. Methods: Starting with a focus in the health sciences, particularly in addiction medicine and other psychiatry-related topics, NextGenU's accredited courses span from college-level pre-health sciences and community health worker trainings through medical and public health graduate training, residency programs, and continuing medical education. The courses are competency-based, and include online knowledge transfer, a web-based global peer community of practice, and local, skills-based mentorships. Our accredited partners, North American universities that are outstanding in

each particular course topic, give learners credit for this training (or institutions can adopt them and use them with their students), all for the first time ever cost-free, and also advertisement-free, barrier-free, and carbon-free. Founded in 2001, we globally launched our first full course in March 2012, Emergency Medicine (EM) for Senior Medical Students, in partnership with Emory University's WHO Center for Injury Control, the International Federation of EM, and the Society of Academic EM. The course was required for the graduating Classes of 2013 at University of Missouri (UM) and the U.S. Uniformed Services University of the Health Sciences (USUHS). Control groups were the Class of 2012 at USUHS, and the Class of 2013 nationally. Results: We now have over 2,400 registered users in 116 countries, and over 130 trainings in development. USUHS NextGenUsers averaged 80.3% (n=167, 95% CI [79.3%-81.3%]) vs. USUHS control students' averaging 80.9% (n=163, 95% CI [79.9%-81.9%], p=0.4) on the Society of Academic EM exam, vs. the national comparison population's averaging 71.4% (n=415, 95% CI [70.6%-72.2%]; p<0.0001). NextGenUsers at U of Missouri averaged 71.2% (+/-5.7 SD, n=35, 95% CI [69.3%-73.1%]) on the SAEM exam vs. 71.4% nationally (p=0.8). Both EM Clerkship Directors reported that students appreciated the low barriers to using these asynchronous, competency-based, site-agnostic trainings. We are currently testing our trainings in addiction medicine in Kenya, and will report on those data as well. Discussion/Conclusions: This new educational tool is helping to bring high-quality health sciences education to the world, and has the potential (because of their concentration in this area) to particularly quickly amplify training in psychiatry.

NO. 2 ANOREXIA AND THE ENDOCANNABINOID SYSTEM: REPORT OF A CASE WITH 33 YEARS OF CANNABIS TREATMENT

Speaker: Denis J. Petro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Report of a case involving 33 years of successful management using cannabis as medicine. Support for efficacy

includes 2 episodes involving symptom return requiring hospitalization off treatment; 2) Review of the endocannabinoid system in the brain with emphasis on the role of the insula in anorexic and bulimic patients; 3) Presentation of findings from research demonstration the endocannabinoid receptor activity in anorexia nervosa and involvement of this system in integration of gustatory information; and 4) Discussion of the role of the insula in integration sensory experiences as associated with eating including sensation, emotions and satiety.

SUMMARY:

Anorexia and the Endocannabinoid System- Report of a Patient with 33 years of Cannabis Treatment

A 50-year-old male with a 40-year history of an eating disorder was seen in neurology consultation. The patient developed an eating disorder in the third grade. Medical evaluation by an endocrinologist was negative and the child was placed on the anabolic steroid, Anavar (oxandrolone). After 2 years of treatment including improved appetite and body weight, the steroid was discontinued due to headaches and liver "scarring" considered to be drug related. Symptoms of anorexia returned and late in adolescence, the patient began using cannabis to improve appetite. He continued cannabis use as an adult until age 40 when he discontinued cannabis due to an employment physical including drug testing. He lost 22 pounds in the following month and required hospitalization due to weight loss, decreased appetite and abdominal pain. An extensive hospital workup failed to find a cause for the symptoms. CT scan of the abdomen revealed multiple liver lesions similar to the "scarring" reported three decades previously. Screening for drugs of abuse was negative and the patient was discharged. A second episode of weight loss (12 pounds in 10 days) while not on cannabis required a second hospitalization at age 50 again with a negative workup. On discharge he regained the weight with use of cannabis. Cannabis has been used as an appetite stimulant in cachexia associated with cancer or AIDS or to treat the nausea and vomiting due to chemotherapy. Trials of the psychoactive cannabinoid Delta-9 tetrahydrocannabinol (THC) were conducted in the 1980s with limited evidence for efficacy in short-term treatment of primary anorexia nervosa. More recently, research using ligand

binding at CB1 receptors and positron emission tomography, or PET, imaging of the brain have been used to determine changes in endocannabinoid receptors and the densities in anorexic or bulimic patients compared with healthy patients. In a study of 16 bulimic female patients and 14 anorexia nervosa patients along with 19 age-matched females, total CB1 receptor availability was increased compared with controls and CB1 receptor availability was increased in the insula in both anorexic and bulimic subjects vs. the control group. The authors (Gerard N, et al. *Biol. Psychiatry* 2011 Oct 15;70(8):777-84) suggest that CB1 receptor up regulation in anorexia nervosa is a long-term compensation for an underactive endocannabinoid system in anorexia and provides evidence for involvement of this system in the integration of gustatory information in reward and emotion processing. The case of a 50-year-old male with a 40-year history of anorexia can be characterized as an N-of-1 trial of cannabis with documentation of at least 2 episodes of symptom return associated with cannabis abstinence for non-medical reasons. With 33 years of cannabis exposure, no emergent side effects, or dose escalation.

NO. 3 PHYSICIAN-ASSISTED SUICIDE AND THE PROFESSIONAL ROLE OF PSYCHIATRISTS. A MEDICAL ETHICAL ANALYSIS

Speaker: Jochen Vollmann, M.D., Ph.D.

Co-Author(s): Jakov Gather, M.D., M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify cases of physician assisted suicide (PAS) versus other end of life practices; 2) Recognize situations and requests of PAS in patients with mental disorders; 3) Identify the ethical and legal aspects of PAS; 4) Reflect and discuss the professional role of psychiatrists in PAS; and 5) Identify and express an ethical informed personal position on PAS.

SUMMARY:

Introduction: Physician-assisted suicide (PAS) is currently the subject of controversial discussion in many countries, albeit only a few of them have legalized this end-of-life practice under

certain conditions. For the main part, the patients who ask for assistance in suicide suffer from incurable physical diseases. However, in some cases suicide of patients who additionally or solely suffer from mental disorders is also assisted. Objectives: The aim of this contribution is to describe potential roles of the psychiatrists in the context of PAS and to formulate ethical arguments for or against the respective involvement of psychiatrists in PAS. Results: Some authors argue that psychiatrists, invoking the social responsibility for suicide prevention, should strictly reject any involvement in PAS and offer a psychiatric treatment to patients with suicide plans. Others see the role of the psychiatrists in assessing the patients' competence, which constitutes a fundamental prerequisite for PAS from an ethical point of view. Moreover, others deem a medical prescription of a lethal drug and the assistance in suicide by psychiatrists for ethically acceptable under certain conditions. Conclusion: We argue that psychiatrists are particularly well-suited to differentiate autonomous and non-autonomous suicide plans based on their expertise in the field of suicidology and in competence assessment. From an ethical point of view, the involvement of psychiatrists can contribute to quality assurance of a legalized practice of PAS, benefit the patient autonomy at the end of life and minimize risks of abuse.

NO. 4 TAI CHI TREATMENT FOR DEPRESSED CHINESE-AMERICANS: A RANDOMIZED TRIAL

Speaker: Albert Yeung, M.D.

Co-Author(s): Albert Yeung, M.D., Sc.D., Run Feng, B.A., M.P.H., Daniel Ju Hyung Kim, B.A., Peter Wayne, Ph.D., Gloria Yeh, M.D., M.P.H., Lee EK, Ph.D., John W. Denninger, M.D., Ph.D., Herbert Benson, M.D., Gregory L. Fricchione, M.D., Maurizio Fava, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Introduction of tai chi, a mind-body tradition originated in China; 2) Learn whether tai chi is feasible, safe, and effective for treating Chinese Americans with major depressive disorder; and 3) Learn potential and implications of using tai chi for treatment of major depressive disorder.

SUMMARY:

Background: This pilot study examined the feasibility, safety, and efficacy of using tai chi for treating major depressive disorder (MDD). **Methods:** Sixty-seven Chinese Americans with MDD were randomized into 12 weeks' of tai chi intervention, education program, or waitlist. The key outcome measurement was the 17-item Hamilton Rating Scale for Depression (HAM-D17); Positive response was defined as a decrease of 50% or more on the HAM-D17, and remission was defined HAM-D17 \leq 7. Intent-to-treat analyses with last observations carried forward were performed. **Results:** Participants (N=67) were 71% female, mean age 54 (\pm 13). 77% of participants completed the intervention and the post-treatment assessment; no serious adverse events were reported. The response rates were 41%, 57%, and 71% and remission rates were 35%, 43%, and 65% for the waitlisted group, education group, and the tai chi intervention group respectively. Compared to the waitlisted group, the tai chi group showed improved response (odds ratio [OR] 2.51 [95% CI, 1.11-5.70]), and a trend of improved remission (OR 2.02 [95% CI, 0.94-4.40]) after adjusting for age, gender, and baseline HAM-D17 score. **Conclusion:** This study demonstrated that tai chi intervention was feasible, safe, and improved treatment response of Chinese American patients with MDD. **Key Words:** Depression, Chinese, Tai Chi, Mind-Body Intervention, Clinical Trial Target Audience(s): Psychiatrists, Psychologists, Social Workers, Primary Care Practitioners, Trainees, Mind Body Medicine Researchers.

SEMINARS

MAY 16, 2015

AN UPDATE ON THE MANAGEMENT OF PSYCHIATRIC DISORDERS IN PREGNANT AND POSTPARTUM WOMEN

*Directors: Shaila Misri, M.D., Deirdre Ryan, M.B.
Faculty: Barbara Shulman, M.D., 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 increased awareness of clinical manifestations of perinatal psychiatric disorders; 2) Implement appropriate treatment options with pharmacological and non-pharmacological modalities; 3) Be cognizant of the impact of perinatal mental illness on the well-being of the family.

SUMMARY:

This seminar provides a comprehensive, in-depth overview of psychiatric disorders in pregnancy and postpartum. This includes research and treatment updates in: Major depression, anxiety disorders (generalized anxiety disorder, panic disorder, and obsessive compulsive disorder), post-traumatic stress disorder, eating disorders, and psychotic disorders in perinatal women. In addition, mother-baby attachment issues and paternal depression are described. Controversy in perinatal pharmacotherapy and non-pharmacological treatments including psychotherapies, light therapy, infant massage, and alternative therapies are discussed. Management of women with bipolar I and II disorders and schizophrenia during pregnancy and the postpartum will be covered in detail. Interaction with the audience is encouraged for management of complex patient presentation. This seminar is designed to update the audience on the cutting edge knowledge in this subspecialty.

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.

MAY 17, 2015

TRAINING PRACTITIONERS TO USE A PSYCHOPATHOLOGY CLINICAL RATING SCALE

*Director: Ahmed Aboraya, Dr.P.H., M.D.
Faculty: Daniel Elswick, M.D., Henry A. Nasrallah, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reliably assess the psychological symptoms of the main adult psychiatric disorders (anxiety, panic, depression, bipolar, schizophrenia, alcohol, drug, attention-deficit/hyperactivity disorders).; 2) Learn the nine principles for creating reliable psychological dimensions and how to create psychological dimensions for the main adult

psychiatric disorders.; 3) Learn and apply the "bottom first then top (BFTT)" approach to psychiatric diagnosis.; 4) Use the Standard for Clinicians' Interview in Psychiatry (SCIP) to create a descriptive psychopathology database.

SUMMARY:

Background: Measurement-based psychiatric assessment is routinely used in research and clinical trials but is infrequently used by mental health practitioners, including psychiatrists. Psychiatry residents and mental health professionals are lacking training on descriptive psychopathology and clinical scales in the US and worldwide (1, 2). One of the impediments to teaching clinical scales is the lack of a diagnostic interview designed for clinicians to use in clinical settings. This impediment was removed by the development of the Standard for Clinicians' Interview in Psychiatry (SCIP) as a clinician-administered diagnostic interview (3, 4). The SCIP reliably measures 150 symptoms and signs of adult psychiatric disorders. The absence of reliable measurement of symptoms was the main limiting factor in creating reliable dimensions in the past (5). The SCIP's reliable symptoms and signs result in 14 reliable SCIP dimensions (anxiety, posttraumatic stress, depression, mania, hallucinations, Schneider first-rank symptoms, delusions, disorganized thoughts, disorganized behavior, negative symptoms, alcohol addiction, drug addiction, attention problems and hyperactivity). The SCIP's symptoms, signs and dimensions are the teaching materials for this course. The SCIP instruction manual (36 pages) and the five SCIP modules for anxiety, mood, psychotic, substance use, and attention-deficit/hyperactivity disorders will be distributed to participants.

Course Content Summary:

1. Participants will learn about the scope of descriptive psychopathology and use of clinical scales in psychiatric assessment.
2. Participants will learn about the three approaches to psychiatric diagnoses: the "top-down" approach, the "bottom-up" approach and the "bottom first then top (BFTT)" approach.
3. Participants will be required to read the SCIP instruction manual and five SCIP modules for anxiety, mood, psychotic, substance use, and attention-deficit/hyperactivity disorders.
4. The SCIP's three phases of psychiatric assessment (interview, etiological search , and

disorder classification) will be demonstrated and a video of a SCIP interview (35 minutes) will show the process.

5. Participants will practice creating a psychopathology database by watching the videotape of a SCIP interview. The compatibility of the SCIP with the DSM and ICD systems will be discussed.

6. Participants will learn about the nine SCIP principles for creating reliable dimensions.

7. Participants will practice creating depression and mania dimensions from the videotape interview.

8. We will discuss the use of the SCIP database to create a descriptive psychopathology map (DPM) for patients with mental illness and how it is related to the Research Domain Criteria (RDoC) (6).

RISK ASSESSMENT FOR VIOLENCE

Director: Phillip Resnick, M.D.

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

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

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) Understand the neurological support for the use of narrative hypnosis, where appropriate, as an adjunct treatment for acute and chronic pain; 2) Use at least three techniques of hypnosis in the safe reduction of chronic pain; 3) Recognize populations for which hypnosis has (and has not) been shown by evidence to be useful in the treatment of chronic or acute pain.

SUMMARY:

Hypnosis is an effective therapy for pain management and most recently has been studied as a useful therapy in both elders in pediatric pain conditions. Its efficacy is based in neuroscience involving the functions of the default mode of the brain and the experience of flow. The artful use of language activates semantic networks, which can be therapeutic for the patient. The techniques of hypnosis rely upon the ways in which the brain processes language for comprehension and response. We review some of the most recent and robust evidence for its usefulness for a variety of conditions, across the life span. While neuroscience based, this course focuses upon learning how to do hypnosis so that participants can gain sufficient skills to practice at home. We aim to provide a sufficient variety of techniques so that even experienced practitioners of hypnosis can gain new tools to aid in their practice.

MAY 18, 2015

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 8 videotape segments from actual trials and mock trials. Participants will see examples of powerful and powerless testimony in response to the same questions. Mistakes commonly made by witnesses will be demonstrated. Slides of proper and improper courtroom clothing will be shown. Handouts include lists of suggestions for witnesses in depositions, 15 trick questions by attorneys, and over 50 suggestions for attorneys cross-examining psychiatrists.

PRIMARY CARE SKILLS FOR PSYCHIATRISTS

Directors: Erik Vanderlip, M.D., M.P.H., Lori Raney, M.D.

Faculty: Robert M. McCarron, D.O., Martha Ward

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Review the causes of excess mortality in the SMI population and discuss lifestyle modifications that are useful; 2) Understand the current state of the art in treating diabetes, hypertension, dyslipidemias, smoking cessation and obesity; 3) Develop skills in understanding the use of treatment algorithms for prevalent chronic illnesses in the SMI population; 4) Explore the use of a primary care consultant to assist in treatment of patients if prescribing desired; 5) Discuss the rationale

for psychiatrist management of chronic physical conditions with emphasis on liability and scope of practice concerns.

SUMMARY:

Patients with mental illness, including those with serious mental illness (SMI), experience disproportionately high rates of tobacco use, obesity, hypertension, hyperlipidemia and disturbances in glucose metabolism. This is often partially the result of treatment with psychiatric medications. This population suffers from suboptimal access to quality medical care, lower rates of screening for common medical conditions and suboptimal treatment of known medical disorders such as hypertension, hyperlipidemia and nicotine dependence. Poor exercise habits, sedentary lifestyles and poor dietary choices also contribute to excessive morbidity. As a result, mortality in those with mental illness is significantly increased relative to the general population, and there is evidence that this gap in mortality is growing over the past decades. Because of their unique background as physicians, psychiatrists have a particularly important role in the clinical care, advocacy and teaching related to improving the medical care of their patients. As part of the broader medical neighborhood of specialist and primary care providers, psychiatrists may have a role in the principal care management and care coordination of some of their clients because of the chronicity and severity of their illnesses, similar to other medical specialists (nephrologists caring for patients on dialysis, or oncologists caring for patients with cancer). There is a growing need to provide educational opportunities to psychiatrists regarding the evaluation and management of the leading cardiovascular risk factors for their clients. This course provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors which contribute heavily to the primary cause of death of most persons suffering with SMI.

NEUROANATOMY OF EMOTIONS

Director: Ricardo M. 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 neuroanatomical-emotional correlates in autism; 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.

WHY IS SEX IMPORTANT? A SEMINAR ON THE IMPEDIMENTS TO ADULT LOVE

Director: Stephen B. Levine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Articulate and communicate to patients the reasons why sex nurtures and sustains intimate adult relationships; 2) Translate for patients how some of their behavioral patterns impair their partner's ability to feel and express love for them; 3) Recognize and begin treatment for the iconic psychopathologies of love.

SUMMARY:

Psychiatry generally avoids discussing love directly in its residency training and continuing education offerings. As a result psychiatrists are now greatly underrepresented among professionals with expertise in the treatment of sexual and relationship problems. This seminar will reintroduce love to the audience by presenting the nurture systems within long term relationships, nine meanings of love, five skills that sustain satisfying connections and five practical dimensions to assess the state of one's love for a partner. These concepts are particularly useful to therapists attempting to help those deliberating what to do about their recurrent relationship unhappiness. The seminar will look beyond many patients' complaints of anxiety and depression to their possible sources in their disappointments in love and sex. DSM-5 pathologies will be reintroduced as impediments to loving that either interfere with courtship success, the partner's ability to feel love for the patient or the patient's ability to express love for the partner. Beyond DSM-5, four iconic processes that destroy the nurture systems-- Love/lust split, Jealousy, Sexual Addiction, and Infidelity--will be presented. Major emphasis will be placed on therapist tools to help patients coping with infidelity. The dynamics of forgiveness will be presented prior to a general discussion period.

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; 2) Write better malpractice opinion reports; 3) Be a more effective expert witness in depositions.

SUMMARY:

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

Principles of writing malpractice reports will be explicated. The differences in plaintiff and defense expert reports will be explored. For example, defense reports are only expected to address deviations from the standard of care identified by plaintiff's experts. In preparing for expert witness depositions, participants will be advised about what to remove from their file, the importance of not volunteering anything, and that nothing is "off the record." Handouts will include suggestions for discovery depositions. Each participant will write an opinion about an actual inpatient suicide malpractice case. Participants will defend their opinions in mock cross-examination.

MAY 19, 2015

CURRENT PROCEDURAL TERMINOLOGY CODING AND DOCUMENTATION

Directors: Ronald Burd, M.D., Jeremy S. Musher, M.D.

Faculty: Junji Takeshita, M.D., Allan A. Anderson, M.D., Gregory G. Harris, M.D., M.P.H., David Nace, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) 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; 2) To familiarize attendees with the most up-to-date AMA/CMS guidelines for documenting the services/procedures provided to their patients; 3) To impart a basic understanding of appropriate use of E/M codes.

SUMMARY:

This course is for both clinicians (psychiatrists, psychologists, social workers) and office personnel who either provide mental health services or bill patients for such services using "Current Procedural Terminology (CPT) codes, copyrighted by the American Medical Association. The course will provide an overview of the CPT codes used most frequently by psychiatrists, with an emphasis on the use of evaluation and management (E/M) codes now required when providing evaluation and management of patients with or without psychotherapy and how to document for those codes based on the CMS E/M documentation guidelines. It will explain the use of the add-on codes for psychotherapy, and interactive psychotherapy. 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.

THE CULTURAL FORMULATION INTERVIEW ILLUSTRATED: HOW TO APPROACH CULTURALLY-APPROPRIATE ASSESSMENT USING DSM-5- A HANDS-ON COURSE WITH VIDEO EXAMPLES

Directors: Russell F. Lim, M.D., M.Ed., Francis G. Lu, M.D.

Faculty: Roberto Lewis-Fernandez, M.A., 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 first six supplementary modules to evaluate for cultural identity, explanatory models, age related issues, religion, immigration, & the clinician-patient relationship.; 3) be familiar with the use of the

second six supplementary modules to evaluate for level of functioning, psychosocial stressors, social network, coping and help seeking, and care givers.; 4) 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.

WOMEN IN PSYCHIATRY: CAREER LADDER, ACADEMICS, ADVOCACY AND PERSONAL LIFE. OPPORTUNITIES AND CHALLENGES.

Director: Isabel Schuermeyer, M.D.

Faculty: Margo C. Funk, M.A., M.D., Karen Jacobs, D.O., Tatiana Falcone, M.D., Kathleen S. Franco, M.D., M.S.

associate residency director and specific subspecialty program directors.

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) Learn ways to effectively negotiate, network and seek mentoring; 3) Identify ways of managing outside pressures (such as motherhood), despite working in a high pressured field.

SUMMARY:

Despite psychiatry being one of the more attractive fields for women to enter after medical school, there are still challenges that women face. For example, leadership positions remain primarily held by men and pay inequality continues to be an issue faced in most work places. Evidence suggest that in practice, the scientific efforts of women are not as well recognized as the ones for men and is referred to as "the Matilda Effect". Within advocacy groups and professional organizations men are often in positions of power. While these trends are very slowly changing, there are many things women can do to increase our representation.

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.

The goal of this course is to describe the many of the challenges that women in psychiatry face and the opportunities that women have to further their careers. Interactive exercises will be used to teach participants and topics for this will include negotiation, effective networking, "when to say no", mentoring and how to negotiate the "juggling act" that many women psychiatrists face. The course instructors have succeeded in many of the common challenges and include a medical school dean, past president of the state chapter of the APA, an

SYMPOSIA

MAY 16, 2015

DRUGS, DRINKING, AND DISORDERED EATING: MANAGING PSYCHIATRIC COMPLICATIONS ASSOCIATED WITH BARIATRIC SURGERY

Chair: Sanjeev Sockalingam, M.D.

Discussant: Raed Hawa, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) 1. Identify risk factors and early signs of problem alcohol use and severe disordered eating related to massive weight loss.; 2) 2. Use tools and an approach to managing complex substance use and eating psychopathology after bariatric surgery; 3) 3. Describe an approach to monitoring and managing complications related to massive weight loss using psychotherapeutic and psychopharmacological treatments.

SUMMARY:

With the obesity epidemic reaching epic proportions in North America and high prevalence of obesity in psychiatric patient populations, psychiatrists are now considered integral to the management of severe obesity in hospital and community based settings. Psychosomatic medicine clinicians are in a unique position to provide much needed multi-modal psychosocial approach to individuals suffering from severe obesity due to their skills in managing complex psychiatric and obesity-related medical co-morbidities.

Despite the established benefits of bariatric surgery for most obese patients, medication absorption, alcohol use disorders and eating disorders have been identified as potentially serious addictive and mental health complications after bariatric surgery. Due to the surgical procedure, post-operative medication management can be challenging due to changes in medication absorption through various post-operative phases. These changes can de-stabilize psychiatric illness, which is prevalent in nearly 70% of bariatric surgery patients, and may compromise physical and mental quality of life.

In addition, changes in the metabolism of alcohol after bariatric surgery can result in some patients developing alcohol use disorders.

Problematic alcohol use can be difficult to manage due to impact on weight, coping and nutritional and medical sequelae. Furthermore, cases of severe eating psychopathology emerging after bariatric surgery, such as anorexia nervosa and other eating disorders, have also been identified in the literature and can result in serious impairment for patients and their families.

The following symposium will focus on psychiatric approaches to managing these challenging psychosocial issues after bariatric surgery. Dr. Sockalingam will provide a review of alcohol use and bariatric surgery, including new insights from animal based models and implications for clinical care. Dr. Hawa will review the evolving psychopharmacological evidence for managing psychiatric illness post-surgery and will share evidence-informed protocols by clinicians. Dr. Wnuk will present data on eating disorder symptoms and psychopathology after bariatric surgery and preliminary data in a mindfulness intervention for these patients. Dr. WB Zhang will present on a systematic review of online and smartphone applications and tools to assist psychiatrists with managing psychiatric and behavioural challenges in this population. Lastly, Dr. Cassin will present data on the effect of a brief motivational interviewing protocol for bariatric surgery patients. Participants will receive resources, including manuals and evidence-informed protocols, and will learn via illustrative case discussions to enhance psychiatrist comfort in managing these challenging "3 D's" in bariatric surgery after care.

NO. 1

NEW INSIGHTS INTO ALCOHOL USE DISORDERS AFTER BARIATRIC SURGERY

Speaker: Sanjeev Sockalingam, M.D.

SUMMARY:

The phenomenon of "cross-addiction" has emerged as a concern in bariatric surgery and weight loss. Studies suggest that approximately 1 in 3 people who pursue bariatric surgery have a history of alcohol use disorders and suggest that there is a significant increase in alcohol use disorder symptoms approximately 2 years after surgery. Possible factors placing people at higher risk of developing alcohol use disorders after surgery

are younger age at time of surgery, having a roux-en-y gastric bypass, male gender, and consuming >2 drinks per week before surgery. Several neurobiological mechanisms may be responsible for this increased risk of alcohol misuse after bariatric surgery. Patient engagement, ongoing education and long-term support for bariatric surgery patients are essential to minimizing the negative effects of alcohol and to improving patients'™ post-surgery quality of life and weight loss. Data from a bariatric centre of excellence on alcohol prevalence rates and evidence-based screening protocols to minimize alcohol risks with bariatric surgery will be discussed. Interventions, such as groups for at-risk individuals, will also be situated within the current evidence.

References:

1. Heinberg LJ et al. Alcohol and bariatric surgery: review and suggested recommendations for assessment and management. *Surg Obes Relat Dis.* 2012;8:357-363.
2. Wee CC et al. High-risk alcohol use after weight loss surgery. *Surg Obes Relat Dis.* 2014

NO. 2 PSYCHOPHARMACOLOGY IN SEVERE OBESITY: SURGERY AND BEYOND

Speaker: Raed Hawa, M.D.

SUMMARY:

Depression and obesity are highly comorbid and appear to have a reciprocal relationship. Unsurprisingly given this data, many bariatric surgery candidates take antidepressant medication. One recent multi-site study reported that 35% of their large cohort of patients presenting for bariatric surgery were taking medication for depression on baseline assessment. Given the established effect of gastric bypass surgery on drug absorption in general, it is imperative that physicians managing bariatric surgery patients are aware of possible complications associated with impaired psychiatric medication absorption and are comfortable managing these complications. The following presentation will review the current evidence for psychopharmacology with massive weight loss. Data from a two separate case series will demonstrate the role of evidence-informed protocols for lithium and for antidepressants during the peri-operative period. Lastly, evidence on potential complications associated with psychotropics

post-surgery, such as SSRI discontinuation syndrome, will be reviewed.

References:

1. Bingham K, Hawa R, Sockalingam S. SSRI Discontinuation Syndrome Following Bariatric Surgery: A Case Report and Focused Literature Review. *Psychosomatics* 2014 (in press).
2. Padwal R, et al. A systematic review of drug absorption following bariatric surgery and its theoretical implications. *Obes Rev* 2010;11:41-50.

NO. 3 DISORDERED EATING AFTER BARIATRIC SURGERY: DETECTION AND TREATMENT

Speaker: Susan M. Wnuk, Ph.D.

SUMMARY:

Bariatric surgery has been performed in greater numbers in recent years, and along with benefits to quality of life and physical and mental health outcomes, clinicians and researchers have noted the troubling occurrence of eating disorders in post-surgery patients. Eating disorders can be as severe in this population as in other populations, but they can escape clinical detection. When eating disorders occur post-surgery, the age of onset tends to be considerably older than in the typical patient with an eating disorder. In addition, behaviours such as food restriction and concern about body weight and shape, which can be indicative of an eating disorder, are common in bariatric surgery patients without eating disorders. Therefore, determining when these behaviours are indicative of psychopathology can be difficult. The published literature on this topic 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. Finally, preliminary data from a mindful eating group intervention for post-surgery patients with disordered eating will be summarized.

NO. 4 SMARTPHONE APPS AND ONLINE PSYCHOSOCIAL RESOURCES FOR WEIGHT LOSS: THE PSYCHIATRIST'S TOOLKIT

Speaker: Melvyn W.B. Zhang, M.B.B.S.

SUMMARY:

Psychosocial interventions are not routinely offered in bariatric surgery programs, even though it is known that there are numerous underlying psychological factors that could contribute both to the development and maintenance of obesity. With the advancement of technologies, the objective of the current study will be to look into the effectiveness of newer modalities of technology. The following presentation will review available apps for bariatric psychosocial management. A description of the an online CBT web portal and smartphone application developed using HTML5 technologies and programmed using "jQuery" developmental toolkit will be presented. We will present data from a systematic review on outcomes related to this app demonstrating symptom improvement, specifically depression and eating psychopathology, and usability. Conclusions and recommendations for the use of online and smartphone applications for weight loss will be discussed, including future modifications and clinical limitations.

**NO. 5
MOTIVATIONAL INTERVIEWING FOR
MASSIVE WEIGHT LOSS: OFFICE-
BASED INTERVENTIONS**

Speaker: Stephanie E. Cassin, Ph.D.

SUMMARY:

Patients who undergo bariatric surgery lose an average of 60% to 70% of their excess body weight within the first 2 to 3 years. Patients are typically taught behavioural strategies to maintain their weight loss, such as stimulus control and self-monitoring food consumption. However, motivation for maintaining behavioural changes tends to dwindle over time, and 20 to 50% of patients begin to regain their weight within the first 1 ½ to 2 years following surgery. Motivational interviewing (MI) is a client-centered, directive method for enhancing intrinsic motivation for behavioural change. Meta-analytic reviews have demonstrated that very brief MI interventions are efficacious in improving health-related behaviours. This symposium presentation will focus on a pilot study recently conducted by our group designed to integrate MI into aftercare for bariatric surgery patients. We will discuss the

rationale for applying MI in bariatric surgery populations and provide an overview of the treatment protocol.

**MULTIPLE SCLEROSIS AND MENTAL
HEALTH: AN INTERDISCIPLINARY CARE
MODEL**

Chair: Laura Safar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the demographic and clinical characteristics, access and use of health services with emphasis on mental health services, and outcomes, of patients with multiple sclerosis (MS) in the US; 2) Describe the elements of a comprehensive and interdisciplinary approach to the management of multiple sclerosis, with emphasis on the management of psychiatric symptoms; 3) Conduct a comprehensive psychosocial assessment of patients with Multiple Sclerosis and psychiatric symptoms and generate a clinically meaningful formulation, differential diagnosis, and plan of care ; 4) Implement evidence-based treatment recommendations for patients with multiple sclerosis and psychiatric symptoms, including psychopharmacologic and psychotherapeutic approaches; 5) Understand the cognitive deficits commonly found in MS and their functional impact; conduct office-based cognitive assessment; state the criteria for referral to cognitive testing and rehabilitation; .

SUMMARY:

Multiple Sclerosis (MS) is a chronic inflammatory and immune-mediated disease of the Central Nervous System. It can be considered a paradigm of neuropsychiatric illness, with highly prevalent psychiatric symptoms including mood and anxiety disorders and cognitive deficits.

Expert guidelines recommend an interdisciplinary approach to the treatment of MS, with mental health providers working closely with neurologists and other health professionals in the assessment and management of these patients.

The distribution of services for patients with MS in different areas of the United States is varied, and access to specialized care may be challenging. The utilization of creative variations

of an ideal inter-disciplinary team may help address these patients' needs.

Psychiatric and cognitive symptoms in MS are often under-recognized and undertreated. Their physiopathology is often secondary to the interplay of biological, environmental and psychological elements. The clinical phenomenology of psychiatric symptoms in MS has elements in common with those of primary psychiatric illness but also differences. Furthermore, the neurological illness modifies the expression of emotional processes.

The identification and treatment of cognitive and psychiatric symptoms in patients with MS may improve adherence to MS treatment and favorably impact this illness prognosis. It may alleviate the suffering of these patients and the quality of life of patients with MS and their families.

This symposium is designed to improve participants' knowledge about the assessment and management of cognitive and psychiatric symptoms in MS. We will discuss the epidemiology of MS with emphasis on its neuropsychiatric manifestations and access to care. We will describe the components of an interdisciplinary approach to the assessment and management of these patients. We will discuss the pathophysiology and phenomenology of psychiatric and cognitive symptoms in MS; the elements of a comprehensive assessment, including office-based neuropsychiatric, cognitive, and psychosocial assessment and more specialized neuropsychological testing. We will present the current evidence for different treatment modalities including psychopharmacological and psychological treatment, as well as cognitive rehabilitation, and discuss specific aspects of the biological, psychological and cognitive rehabilitation treatment in detail.

Learners will benefit from detailed lectures with inclusion of case vignettes presentations, and question-and-answer sessions. Learners will have ample opportunities to present their clinical questions to integrate the presented information.

We expect that participants from this symposium will increase their knowledge base and subsequently implement improvements in their practices when caring for patients with multiple sclerosis and neuropsychiatric symptoms.

NO. 1

MULTIPLE SCLEROSIS (MS) SERVICES AND ACCESS TO CARE: BUILDING AN INTERDISCIPLINARY TEAM

Speaker: Sarah L. Minden, M.D.

SUMMARY:

The wide range of symptoms, high prevalence of emotional and cognitive disorders, and progressive nature of MS require that treatment should be multi-faceted and well-coordinated, including the integration of mental health and other specialized medical providers. Unfortunately, the majority of people with MS do not obtain specialized and integrated care. We will discuss the prevalence of mood and affective disorders; report on the American Academy of Neurology's recently published "Evidence-based Guideline: Assessment and management of psychiatric disorders in individuals with multiple sclerosis"; and provide an overview of the current status of availability and access to mental health care in the US. We will address obstacles to care at the system, provider, and patient and family levels and explore alternative models of care, such as the use of tele-consultations and "virtual"™ interdisciplinary teams.

NO. 2 NEUROPSYCHIATRIC ASSESSMENT AND MANAGEMENT IN MULTIPLE SCLEROSIS

Speaker: Laura Safar, M.D.

SUMMARY:

Individuals with Multiple Sclerosis (MS) present a high prevalence of psychiatric symptoms and disorders including depression, anxiety, irritability, bipolar disorder, alcohol and substance use, increased suicide risk, and cognitive difficulties. The phenomenology of neuropsychiatric symptoms may be different than in primary psychiatric illness due to the contribution from MS symptoms such as fatigue and sleep disturbances. We will discuss the prevalence and presentation of psychiatric disorders in MS and the use of scales that have been validated in MS to aid in diagnosis and in monitoring response to treatment. We will describe the elements of a comprehensive treatment plan including treatment of MS with disease modifying drugs; psychopharmacology and evidence for the efficacy of different agents in MS; treatment of comorbid MS symptoms

such as fatigue and pain; evidence for different psychotherapeutic and for cognitive rehabilitation approaches.

**NO. 3
COGNITIVE DEFICITS IN MS:
ASSESSMENT AND REHABILITATION
THERAPIES**

Speaker: Lindsay Barker, Ph.D.

SUMMARY:

The prevalence of cognitive dysfunction in MS ranges from 45 to 65% and can be seen at various stages of illness including early in the course. Cognitive dysfunction is a major cause of disability in this population. We will discuss the pattern of cognitive impairment typically seen in MS including attention, speed of processing, executive function, and memory encoding and retrieval. The purpose and use of formal neuropsychological evaluation will be discussed to assess cognitive dysfunction and the impact of other comorbidities (depression, anxiety, fatigue) as well as to help guide treatment recommendations. We will discuss a comprehensive treatment approach including: Treatment of comorbid disorders (such as depression, fatigue, and insomnia) which may also affect cognition; cognitive rehabilitation evidence and tools; and helpful strategies for patients to better manage and compensate for their cognitive symptoms.

**NO. 4
PSYCHOSOCIAL ADAPTATION IN MS**

Speaker: David Rintell, Ed.D.

SUMMARY:

The overall treatment goal in MS can be articulated broadly as the prevention and reduction of disability. If we define disability as impairment in one's ability to engage in activities and relationships, psychosocial factors need to be taken into account. Clinicians who work with people with MS and their families have long observed that disability is determined not only by inflammatory disease activity, but also by psychosocial functioning. One patient may have limited use of limbs or impairment in mobility, but she works full time, engages with family members, and maintains important social connections, while another patient with minimal CNS damage may be confined to home and lives a constrained, limited life. One marker of

those patients who remain active and productive is that they have more effectively adapted to life with MS. The presenter will summarize what is known about adaptation to MS, and propose and describe a phase model of adaptation to life with MS.

**NO. 5
AN EIGHT-YEAR TELEPHONE SUPPORT
GROUP FOR HOMEBOUND PEOPLE
WITH MULTIPLE SCLEROSIS**

Speaker: Audrey H. Cecil, M.S.W.

SUMMARY:

An exploration of the dynamics of a long-term telephone support group for individuals with multiple sclerosis (MS). MS is a progressive neurological disease that frequently affects mobility and engenders isolation. All of the participants in this group are physically disabled by their disease. The mobility challenges of this population led to the idea of using conference call technology as a treatment modality. Incorporating theory from neurobiology research, this presentation will chronicle the implementation the group and offer observations about the interplay between individual self-esteem, group participation, and the use of technology in mental health treatment.

**CAN BETTER UNDERSTANDING OF THE
MECHANISMS UNDERLYING
OBSESSIVE COMPULSIVE DISORDER
IMPACT ON TREATMENT?**

Chair: Margaret A. Richter, M.D.

Discussant: H. Blair Simpson, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outline current OCD first-line treatments and anticipated treatment outcomes.; 2) Identify cognitive and personality features associated with patients with OCD and appreciate how they are relevant for treatment.; 3) Describe neurocognitive findings in OCD and appreciate how they may impact on treatment outcome.; 4) Understand the current neurobiological models and neuroimaging findings of OCD.; 5) Appreciate the potential role of brain and liver genes in treatment outcomes in OCD. .

SUMMARY:

OCD is a severe neuropsychiatric disorder with significant phenotypic heterogeneity, and a typically chronic course of illness. Current first-line treatments remain cognitive-behavioral therapy (CBT), and pharmacological treatment with SSRIs. However response to both treatment modalities is quite limited; CBT typically results in clinically significant benefit in approximately 75% of patients, while in medication studies only 40-60% will achieve at least a 35% reduction in symptom severity. Moreover only 20-25% attain remission with either modality. Thus achieving better treatment outcomes is a major priority. In this symposium, the presenters will examine potential mechanisms underlying OCD illness which may impact treatment outcome, including clinical correlates, personality and cognitive markers, the role of neurocognitive function from the perspective of habit formation, and the possible utility of neuroimaging and neurogenetics in guiding treatment. Dr. Richter will begin with current evidence-based treatment for OCD, and a review of the outcome data. She will describe clinical factors which appear to correlate with treatment response. New data will be presented, allowing comparison and contrasting of these potential clinical correlates of treatment outcome in individuals receiving pharmacotherapy or CBT, followed by discussion of how these factors might be incorporated in clinical decisions regarding treatment. Dr. Rector will discuss the increasing importance placed on the role of cognitive and personality factors in the development and maintenance of OCD. Data examining personality and cognitive mediators of treatment outcome in CBT from naturalistic and randomized controlled trials will be presented. Findings will focus on the independent effects of dimensions of the five factor model and obsessive beliefs. Dr. Fineberg will discuss the habit hypothesis of OCD, implicating dysfunction in brain systems regulating control of habits and of purposeful goal-directed action. Data from a recent functional neuroimaging study will be presented, in which OCD subjects demonstrated increased habitual response correlating with caudate hyperactivity. Dr. van den Heuvel will review the role of fronto-striatal and limbic circuits in OCD. She will then discuss how imaging data may be used to guide treatment in the near future, and potentially help to develop innovative treatment

strategies. Last, Dr. Zai will review current knowledge regarding pharmacogenetics in OCD. Data will be presented from a recent study examining novel genetic variants in a number of OCD candidate genes. She will then discuss the growing importance of understanding the role of genetic factors in medication response and tolerability. At the conclusion of this symposium, Dr. Simpson will lead a discussion on development of a rubric synthesizing potential markers of response that could be used by clinicians in the near future.

NO. 1 CLINICAL CORRELATES OF TREATMENT OUTCOME IN OCD

Speaker: Margaret A. Richter, M.D.

SUMMARY:

The current evidence-based first-line treatments for OCD consist of pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs), and cognitive-behavioral therapy (CBT). However despite decades of research, treatment outcome with these modalities remain limited. Existing data for potential clinical correlates of treatment response point to illness duration and severity, predominant OCD symptoms, and comorbidity, but little efforts have been made to explore these factors differentially in samples receiving each of the two major treatment modalities. In this presentation, the treatment outcome literature will be summarized. New data will be presented on two groups of well-characterized OCD subjects: a sample of 249 OCD subjects for whom retrospective drug response information was systematically collected, and a parallel data set comprising 127 patients who received CBT. Potential clinical predictive factors associated with response in these two populations will be reviewed and contrasted. This presentation will end with suggestions regarding how these clinical factors may be used to inform discussions between clinicians and patients when determining on an individualized course of treatment.

NO. 2 THE EXAMINATION OF FIVE- FACTOR MODEL PERSONALITY TRAITS AND COGNITIVE DIMENSIONS IN COGNITIVE BEHAVIORAL THERAPY TREATMENT FOR OCD

Speaker: Neil Rector, Ph.D.

SUMMARY:

There has been considerable cross-sectional examination of OCD-related cognitive and personality vulnerabilities in non-clinical, epidemiological and clinical populations. However, the extent to which these factors can be reduced and moderate/mediate clinical response in first-line CBT treatment for OCD has been examined less thoroughly. The aim of this talk is: 1) to examine the role of OCD-specific cognitive vulnerabilities in moderating and mediating treatment outcomes in exposure response prevention and integrated CBT for OCD in a large-scale, randomized controlled trial (N =127), and 2) to examine a broader range of cognitive and personality variables and their relationship to clinical outcomes in a large-scale naturalistic CBT for OCD service (N = 170). The results of the study are discussed in relation to the higher-order and lower-order psychological modelling of OCD and potential refinements to manual-based CBT to optimally target underlying vulnerabilities.

NO. 3 UNDERSTANDING THE ROLE OF HABIT IN OCD

Speaker: Naomi A. Fineberg, M.B.B.S.

SUMMARY:

The habit hypothesis of OCD implicates dysfunction in brain systems regulating the control of habits and of purposeful goal-directed action. Habits are stimulus-driven behaviours that may arise from failure in goal-directed control. In OCD it is unclear which of these two systems drives the exaggerated tendency to perform habits, which have been observed regardless of whether they are working to gain reward or avoid punishment. Two studies in OCD found deficits in goal-directed behaviour during trial-by-trial learning, suggesting excess habit could arise as a result of disturbance in the goal-directed system. A recent study investigated the neural correlates of excess habit in 37 OCD patients and 33 controls, who learned to avoid shock during fMRI scanning. We observed increased habitual responding in the OCD group, which was associated with hyperactivity in the caudate. Activation correlated with increased urge to perform habits. The OCD group also showed

increased medial orbitofrontal cortex activation, though this did not correlate with habit formation.

The caudate nucleus represents a key region implicated in the pathophysiology of OCD as well as the execution of goal-directed behaviour. These results suggest the habit formation biases result from impairment in this system, rather than a build-up of habits.

NO. 4 BRAIN CIRCUIT STRUCTURE AND FUNCTION IN OCD

Speaker: Odile A. van den Heuvel, M.D., Ph.D.

SUMMARY:

Three decades of neuroimaging research resulted in consistent disease models of OCD. These models involve the limbic circuit (crucial for emotional processing, fear conditioning and extinction learning), and the ventral "motivational" and dorsal "cognitive control" frontal-striatal circuits. More recent studies also show important roles for the cerebellum and fronto-parietal connections. The involvement of the brain circuit depends on the state, the symptom profile, the disease stage, the presence of co-morbid disorders, the genetic vulnerability and the compensatory mechanisms. I will present some recent brain imaging results (structural and functional MRI) and some theoretical concepts on the involvement of the limbic circuit and the role of anxiety in the clinical phenotype of the obsessive-compulsive and related disorders (from the anxious end of the spectrum to the impulsive end). I will also propose some neurodevelopmental ideas on how early symptoms develop into compulsive behaviours during disease course. Moreover, I will touch upon the role of impaired cognitive failure (including response inhibition), involving the connections between limbic and frontal-striatal brain circuits. I will discuss how we might use brain correlates to guide personalized medicine and to develop innovative treatment strategies.

NO. 5 PHARMACOGENETIC MARKERS OF TREATMENT RESPONSE IN OCD

Speaker: Gwyneth Zai, M.D., M.Sc.

SUMMARY:

Obsessive-compulsive disorder (OCD) is a chronic neuropsychiatric disorder with high genetic influence. Serotonin reuptake inhibitors (SRIs) antidepressants are widely accepted as the first-line pharmacological treatment of OCD, however, approximately 50% of OCD patients show poor response. Personalized medicine utilizing genetic testing has recently received much attention given that the variability of antidepressant response and adverse effects are partly due to an individual's genetic variations. This has led to increasing research to investigate the role of specific genetic factors on antidepressant response and utility of testing in the clinical realm. In this session, we will review the most recent findings in the pharmacogenetics of OCD. We will also report on a recent study of 32 single nucleotide polymorphisms across 14 OCD candidate genes and their regulatory regions in 222 OCD patients with retrospective response data using a custom-made 32-SNP QuantStudio Flex Real-Time PCR System chip. Individuals were grouped into those who improved following an adequate trial of SRI(s) as compared with those who reported "minimal" improvement, "no change", or "worsening". Interesting associations ($P < 0.05$) were detected for serotonin genes 5HT2A and 5HT1B in SSRI/SRI response. These variants may be clinically useful in predicting treatment resistance versus response in OCD.

SHAME: THE MISSING FACTOR IN CONCEPTUALIZING AND TREATING BORDERLINE PERSONALITY DISORDER: SHAME'S POWERFUL IMPACT ON THE LIVES OF THOSE WITH BORDERLINE PERSONALITY DISORDER (BPD)

Chair: Valerie Porr, M.A.

Discussant: Antonia New, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Raise awareness in clinicians and researchers of the important role played by shame in triggering anger, avoidance, withdrawal and other negative reactions in the lives of people with BPD.; 2) Highlight the need for more in depth understanding and research on the role of shame in BPD so as to develop more effective treatments that address the experience of shame and its consequences.; 3)

Demonstrate to clinicians various methodology to address shame in the treatment of those with BPD; 4) Learn about a research based new method of addressing shame using CBT-DBT techniques; 5) Understand the devastating effect of shame on people living with BPD.

SUMMARY:

Shame is a central emotion in BPD that has been overlooked in the conceptualization of BPD despite its' relationship to self-injurious behavior, chronic suicidality and its' association with self-esteem, quality of life, and angry-hostile feelings. Shame plays a major role in a person with BPD's negative self-image and is frequently used by patients to describe their acute feelings of pain about themselves and the reasons they avoid engaging in life tasks. Very little research has focused on the impact of shame on the person's sense of self, behaviors and reactions. How the person with BPD maladaptively responds to feelings of shame, how they have learned to cope with shame and how this affects their current mental distress has not been studied sufficiently to bring relief to those with BPD. The puzzling cluster of symptoms seen in BPD may be seen as the expression of and defenses against the painful emotion of shame. Shame-proneness has been found to be related to anger arousal and the tendency to externalize attributions for one's own behavior by blaming others and not taking responsibility for one's behavior. Rumination, particularly anger rumination, has been demonstrated to occur in response to shame, to escalate anger and to predict BPD symptoms. (Peters, J.) Shame leads to keeping secrets, to self-concealment, to lying and "bullshitting" (Mentalization: Bateman and Fonegy) and to fragmentation of the sense of self. Internalizing shame, how one experiences oneself, is as a threat from within, an internal feedback of threat leading to arousal of the threat protection system (Gilbert) Externalizing shame is shame from without, is sensitivity to negative feelings and thoughts about the self in the minds of others as in rejection sensitivity. The relationship between shame-proneness and BPD features has important implications for treatment. Therapy is enhanced by helping the patient with BPD to see how it causes them to use maladaptive methods to attempt to "work around" rather than "work through" their shame. Data will be presented demonstrating an evidence based CBT treatment for Shame in a

self-acceptance group therapy and how shame is dealt with clinically in Transference Focused Therapy, in psychoeducation programs utilizing the TARA Method, and the impact of the experience of SHAME on a young woman with BPD will be discussed

**NO. 1
CUTTING TO THE CORE OF BPD- TARA
METHOD TECHNIQUES FOR COPING
WITH SHAME IN THE FAMILY**

Speaker: Valerie Porr, M.A.

SUMMARY:

Feelings of shame seems to be the common denominator of most BPD responses and are a frequent trigger of BPD escalations. Conducting TARA Method Family Psychoeducation Programs over twenty years reveals that shame is often the trigger to emotional shifts and misperceptions. The shame reaction of people with BPD to perceived negative evaluations such as judgment, criticism, or blame, and general misinterpretation of social situations is baffling to family members, especially because it triggers extreme escalations or volatile reactions to what appears to them as a benign situation. Differentiating shame responses from guilt responses is essential to improving family relationships so that compassion for their emotional pain can develop. Most adults have no frame of reference for evaluating shame responses. Raising awareness of their loved one's proclivity to shame responses leads to understanding the perfectionism, rigidity, and self-invalidation their loved ones with BPD feel and to accepting and validating the painful self-concept of "badness" they constantly experience. Shame is an impediment to thinking clearly as it exaggerates ambiguity and overwhelms cognitive ability in the moment. The TARA Method teaches families to validate and normalize shame responses, to reduce ambiguity by clarifying intentions, to recognize physiological shame responses such as downcast eyes, shoulders

**NO. 2
DEVELOPMENT OF AN EVIDENCE-
BASED, COGNITIVE-BEHAVIORAL
TREATMENT FOR SHAME: SELF-
ACCEPTANCE GROUP THERAPY**

Speaker: Michelle Schoenleber, Ph.D.

SUMMARY:

The need for empirically validated treatments for shame has been widely noted, with emerging evidence suggesting cognitive-behavioral treatments may be especially helpful in reducing shame (e.g., Resick et al., 2002; Rizvi & Linehan, 2005). The present research examines the utility of Self-Acceptance Group Therapy (SAGT), a cognitive-behavioral treatment designed specifically to target shame. SAGT is an 8-week intervention involving psychoeducation and training in the use of cognitive and behavioral skills for enhancing shame resilience and coping. Findings from an open trial will be presented (anticipated N=50). Eligible outpatients are those reporting elevated shame and who have an individual mental health provider; outpatients were excluded if experiencing current mania or psychosis. To date, 24 outpatients have enrolled in the study, with 7 currently receiving SAGT along with their ongoing treatment-as-usual. Preliminary data from the additional 4 outpatients who have completed pre- and post-treatment assessments indicate that SAGT improves self-acceptance (pre M=66.00; post M=77.25) on the Self-Compassion Scale (Neff, 2003), reduces trait shame (pre M=69.00; post M=64.75) on the Experiences of Shame Scale (Andrews et al., 2002) and reduces the severity of borderline personality symptoms (pre M=42.50; post M=25.00) on the Borderline Evaluation of Severity over Time (Pfohl & Blum, 1997).

**NO. 3
TREATING SHAME WITH
TRANSFERENCE FOCUSED THERAPY
METHADODOLOGY**

Speaker: Peter Freed, M.D.

SUMMARY:

Shame ,A Transference Focused Therapist, will discuss the emphasis on shame based experiences in TFP treatment and techniques implemented for shame management. Shame plays a major role in the lives of patients with BPD. Patients are ashamed of their failures (in school, work and relationships), ashamed of their outbursts, ashamed of how their lives are going. This shame can be big picture (as when one is "ashamed to be me") and little picture (as when one is ashamed of their writing and avoids handing in a term paper for fear of a bad grade).

The problem is that when shame is given in to, rather than confronted, patients can enter "shame spirals" in which avoidance of challenges that could induce shame leads them to procrastinate, do half-assed jobs, miss deadlines, break agreements, and otherwise fall short of meeting their obligations to themselves and others. This triggers more shame. As such, shame management has become an important part of modern psychotherapy for borderline conditions. Patients need to anticipate shame-inducing events and "head them off at the pass," while learning to expose shame to the light of day whenever episodes crop up. Shame thrives on darkness and secrecy, and learning to confront it openly, with one's head held high, is the key to shame management.

NO. 4 SHAME FROM THE INSIDE OUT: HOW SHAME IS EXPERIENCED WHEN COPING WITH BPD

Speaker: Kristie Tse, B.A.

SUMMARY:

A young woman with BPD will discuss her experiences with the feelings of shame and will describe how she attempts to cope with this painful emotion. She will also discuss the role of shame in the lives of BPD participants in a TARA survey. Shame is the topic that comes up most often at a TARA psychoeducational program for people with BPD called "Living with BPD". At these meetings the courageous people with BPD share their devastating shame experiences and describe how profoundly shame affects their lives, leading to feeling incompetent, like a bad person, not deserving anything good. Shame is an impediment to whatever someone with BPD is doing. Shame responses are intensified by any situation or interaction that seems ambiguous. Clarifying intentions, a technique used in metallization based therapy, can reduce ambiguity and help decrease the feeling of shame. The feeling of shame seems to turn off cognitive circuits in the brain and worsens ambiguity. Any sense of rejection will also trigger feelings of shame. The presenter will talk about the impact and intensity of interactions or situations that seem ambiguous and how this effects her ability to regulate her emotions. When the spotlight of shame takes over, the response is often to attack others, to diminish someone else to feel

better about one's self, to avoid or withdraw or to attack oneself as in non-suicidal self injury.

THE ROLE OF ADDICTIONS IN THE HIV TREATMENT CASCADE

Chair: Lawrence M. McGlynn, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the state of HIV treatment in the USA and possible reasons for the significant number of untreated individuals; 2) Identify changes in the brain reward pathways due to HIV/AIDS, and the implications for individuals using substances; 3) Understand the current epidemiology, diagnosis and treatment of opioid, alcohol, and amphetamine use disorders in the context of HIV/AIDS.; 4) Understand and utilize motivational interviewing for HIV-positive individuals and those at risk of acquiring HIV .

SUMMARY:

HIV treatment in the United States has enjoyed tremendous success, due in large part to the efficacy of antiretroviral medications. By 2015, it is estimated that 50% of those living with the virus will be over the age of 50, a statistic that would not have been possible if not for the availability of medications. More than 1 million individuals in the U.S. are living with HIV/AIDS, however it is estimated that only 28% of those infected with the virus are being successfully treated with antiretroviral medications. Twenty percent of those with HIV have not been tested or are unaware of their infection. These figures have been referred to as the HIV Treatment Cascade. Multiple factors may play a role in the data, including fear, access to care, mental illness, and stigma. The role of substances in the HIV Treatment Cascade is understood to be significant.

In this symposium, experts in HIV and addictions will present updates on the role of substances in the HIV Treatment Cascade. A review of the current understanding of the addiction circuitry in the context of HIV will set the stage for discussions on alcohol, heroin, and methamphetamine and their role in the current HIV epidemic. Treatment of these substance use disorders in HIV/AIDS will be presented, as well as possible drug-drug and drug-disease interactions. Finally, the use of motivational interviewing and its utility in the HIV

Treatment Cascade will be presented, along with a illustrative demonstration.

**NO. 1
THE ADDICTION CIRCUITRY IN
HIV/AIDS**

Speaker: Harinder Rai, B.A.

SUMMARY:

The use of substances and infection with HIV have a clear association but may remain treated as separate problems. HIV causes multiple and sometimes poorly-defined neuropsychiatric changes but evidence implicates its effects on the prefrontal cortex, a region which regulates many higher order cognitive functions—including the addiction pathway. In this presentation, a revised version of the addiction circuit will be discussed, including recent evidence of the effect specific substances may have along this circuitry. This presentation will also propose an updated clinical approach based on recent advances in the neurobiology of addiction and of the effects of HIV on the brain.

**NO. 2
ALCOHOL USE DISORDERS AND HIV**

Speaker: Yelizaveta I. Sher, M.D.

SUMMARY:

The effects of alcohol include impairment of judgment and reduction of inhibitions. The role of heroin and methamphetamine in the HIV epidemic have been the focus of multiple studies, however alcohol may elude the scrutiny of providers attempting to identify HIV risk factors in their patients. This presentation will examine the epidemiology and effects of alcohol in the transmission of HIV. The speaker will also discuss treatment of alcohol use disorders in those with HIV/AIDS.

**NO. 3
HEROIN USE AND HIV/AIDS: AN
UPDATE**

Speaker: Rusty Baik

SUMMARY:

Early in the HIV/AIDS epidemic, risk factors for acquiring the virus became evident. Individuals using intravenous drugs, notably heroin, suffered significant morbidity and mortality due to the virus. Today, methamphetamine has

been identified as a major contributor to the current epidemic. Heroin use, however, has continued to exist in certain segments of the US population, and may have experienced a surge in some communities. This presentation will review the history and effects of heroin use and its role in HIV transmission. Health disparities and risk factors will also be discussed, and well as neuropsychiatric considerations.

**NO. 4
THE ROLE OF METHAMPHETAMINE
AND PARTY DRUGS IN THE HIV/AIDS
TREATMENT CASCADE**

Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:

Men who have sex with men continues to be a significant demographic in the current HIV/AIDS epidemic. The use of stimulants is frequently cited as a key risk factor in the transmission of HIV. Many at risk of acquiring HIV are not being tested for the virus. In this presentation, a review of the effects of methamphetamine and party drugs will be discussed, and their role in the transmission and treatment of HIV. Possible reasons for avoidance of testing will also be addressed.

**NO. 5
THE ROLE OF MOTIVATIONAL
INTERVIEWING IN THE HIV TREATMENT
CASCADE**

Speaker: Antoine Douaihy, M.D.

**ADVANCES IN MEDICATIONS
DEVELOPMENT TO TREAT ALCOHOL
USE DISORDER AND CO-OCCURRING
PSYCHIATRIC DISORDERS**

Chair: Raye Z. Litten, Ph.D.

Discussant: Raye Z. Litten, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know promising medications to treat alcohol use disorder and co-occurring psychiatric disorders; 2) know how effective screening models can be developed and implemented to advance the development of new medications; 3) Specify high-priority research questions that will better inform clinical practice.

SUMMARY:

Alcohol use disorder (AUD) is among the most prevalent mental health disorders found in the world today. More than 76 million worldwide are estimated to have a diagnosable AUD. Moreover, AUD frequently co-occurs with other psychiatric disorders, resulting in an increased risk for suicide, relapse to drinking, violence, and overall poor response to treatment. Unfortunately, there is little evidence-based research to guide clinical care for this population. In this symposium, presentations will be delivered on a variety of topics detailing the advancements made in medications development. The first presentation will focus on strategies in streamlining the drug development process for more efficiency and increasing the predictability through utilization of human laboratory paradigms as screening models for candidate compounds. The second presentation will feature results of the NIAAA Clinical Investigations Group (NCIG) multi-site clinical trial assessing varenicline for alcohol dependence. The third presentation will focus on the most recent advances in pharmacotherapies and psychosocial interventions specifically designed to address AUD and bipolar comorbidity, including recent results of a clinical trial using a combination of valproate and naltrexone. Finally, new advances in medications development will be presented in treating patients with schizophrenia and comorbid AUD. Specifically, new strategies for drug development will be presented, exploring a combination of targets across translational studies. During the discussion session, high-priority research questions will be identified and addressed. Although significant progress has been made in medications development to treat AUD and psychiatric comorbidity, more work remains if we are to provide more effective guidelines for the treatment community.

**NO. 1
MEDICATIONS DEVELOPMENT FOR
ALCOHOL USE DISORDER: WHY
HUMAN LABORATORY MODELS ARE A
GOOD IDEA**

Speaker: Raye Z. Litten, Ph.D.

SUMMARY:

The process of drug development continues to be challenging. The cost of developing a successful new compound is now in the range

of \$3.7 to \$12 billion dollars from discovery to launch. Only one in 10 new Central Nervous System (CNS) compounds entering Phase 1 reach the market-place and only 46% of CNS candidates succeed in pivotal Phase 3 trials (compared with 66% for all other compounds). In an effort to improve the success rate, and subsequently save time and money, animal and human laboratory paradigms are being developed and validated as screening models. Predictive screening models can help make informative "Go/No-Go" decisions on whether or not to conduct long, costly clinical trials on candidate compounds. In this presentation, various human laboratory paradigms and their associated dependent measures that are the most sensitive in predicting clinical success will be identified. Approaches will be presented to validate these paradigms as potential screening models.

NO. 2**A DOUBLE-BLIND, PLACEBO-
CONTROLLED TRIAL ASSESSING THE
EFFICACY AND SAFETY OF
VARENICLINE TARTRATE FOR
ALCOHOL DEPENDENCE**

Speaker: Daniel E. Falk, Ph.D.

SUMMARY:

Converging lines of data suggest that nicotinic acetylene receptors play a significant role in the rewarding effects of both nicotine and alcohol dependence, indicating a promising molecular target for the treatment of both disorders. Several preclinical studies found varenicline, a $\alpha 4\beta 2$ nicotinic acetylene partial agonist, effective in reducing drinking in rodents and baboons. In a human laboratory study and small clinical trials, varenicline reduced alcohol consumption and craving in heavy drinking smokers. The present study is the first multi-site study designed to assess the efficacy and safety of varenicline for the treatment of alcohol dependence in smokers and non-smokers. Two hundred patients meeting DSM-IV criteria for alcohol dependence were recruited across 5 clinical sites. Patients received double-blind varenicline (2 mg daily) or matched placebo and a computerized behavioral intervention. Compared to the placebo group, the varenicline group had significantly fewer days of heavy drinking and reduced craving for alcohol. The average treatment effect on alcohol use was

similar for smokers and non-smokers. Varenicline was well tolerated by both smokers and non-smokers with few unexpected adverse events. Challenges for further development and approval of varenicline for alcohol dependence will be discussed.

NO. 3 TREATMENT OF ALCOHOL USE DISORDER WITH CO-OCCURRING BIPOLAR DISORDER: EFFICACY AND PREDICTION OF TREATMENT RESPONSE

Speaker: Ihasan M. Salloum, M.D.

SUMMARY:

Alcohol use disorder (AUD) is highly comorbid with bipolar disorder and this comorbidity is associated with significant risk for suicide, lack of treatment response, and poor outcome. Despite a modest increase in studies addressing this comorbid condition, experimental interventions have been ineffective in most patients, leaving a significant unmet treatment need for this population. The aim of this presentation is to review most recent advances in the pharmacotherapies and psychosocial interventions specifically designed to address AUD and bipolar disorder comorbidity. Paradigms used in clinical trials to address this comorbidity include using a single agent versus using combined agents. Results from controlled trials will be discussed including the results of specific combination of medications capitalizing on complementary mechanisms of action to improve alcohol outcome. Furthermore, this presentation will discuss predictors of treatment response in this population including exploratory analyses aimed at identifying potential markers using proteomic analyses. Implications for future research on emerging treatment strategies will also be explored.

NO. 4 ALCOHOL USE DISORDER AND SCHIZOPHRENIA: APPROACHES TO PHARMACOLOGIC INTERVENTIONS

Speaker: Alan I. Green, M.D.

SUMMARY:

Alcohol use disorder (AUD) as well as other substance use disorders are common in patients with schizophrenia and lead to a poor

outcome in these patients with increased symptoms, relapses, violence, and poor overall response to treatment. Most of the antipsychotic medications that are used in schizophrenia do not appear to decrease alcohol or other substance use in these patients. However, emerging but still preliminary data suggest that the atypical antipsychotic medication clozapine may be different it appears to decrease alcohol or other substance use. Given the toxicity of clozapine, however, its use is limited to those patients with schizophrenia whose psychotic symptoms are resistant to treatment with other agents. Thus, there is a need to develop other alternative pharmacologic strategies for treatment of these patients. Reports of the use of naltrexone and disulfiram in patients with schizophrenia and AUD will be reviewed. Moreover, human neuroimaging studies, as well as animal studies, will be discussed that provide potential leads toward new medication development for the treatment of AUD in schizophrenia.

MEANING AND DIGNITY IN END-OF- LIFE CARE: PSYCHOTHERAPEUTIC INNOVATIONS

Chair: Harvey M. Chochinov, M.D., Ph.D.

Discussant: Melyn Leszcz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the psychological, existential and spiritual challenges facing patients with life threatening and life limiting conditions.; 2) Understand the basic principles underlying several novel psychotherapeutic approaches for patients nearing death.; 3) Be familiar with empirical data regarding novel psychotherapeutic modalities in palliative end-of-life care.

SUMMARY:

Patients with advanced and end stage illness face a variety of psychological, existential and spiritual challenges. Over the past decade, a number of novel psychotherapeutic approaches have been developed, specifically designed to address the needs of this vulnerable group of patients. Those interventions that have been subject to the most rigorous evaluations, and are beginning to enter into clinical practice, include Meaning-Centered Psychotherapy, Managing Cancer and Living Meaningfully

(CALM) and Dignity Therapy. The founders of each of these novel therapies will discuss their work, providing an overview of, 1) the empirical and/or theoretical basis underpinning their approach; 2) the core features and principles that define this work; and 3) the evidentiary basis for these novel psychotherapies. Each of these innovative psychotherapies will be illustrated by way of case examples, demonstrating how the application of these approaches plays out in clinical practice.

**NO. 1
DIGNITY THERAPY: EVIDENCE AND PRACTICE IN PALLIATIVE CARE**

Speaker: Harvey M. Chochinov, M.D., Ph.D.

SUMMARY:

Dignity Therapy is a brief, individual psychotherapy, designed for application within the setting of palliative and end-of-life care. It has been studied in several countries worldwide, with an accumulating body of evidence demonstrating its ability to enhance end-of-life experience. This presentation will provide an overview of the empirical basis for Dignity Therapy—including the model of dignity in the terminally ill—and a survey of published data reporting the outcomes from various clinical trials. Case material will be used to illustrate key issues and to demonstrate core principles of Dignity Therapy.

**NO. 2
MANAGING CANCER AND LIVING MEANINGFULLY: FROM THE PRACTICAL TO THE PROFOUND**

Speaker: Gary Rodin, M.D.

SUMMARY:

Managing Cancer and Living Meaningfully (CALM) is a brief individual supportive expressive therapy for patients with metastatic cancer. It provides reflective space for such individuals to address concerns related to four overarching domains: symptom control and treatment decisions, attachment security, values and the sense of meaning and mortality. The goals are to relieve distress, to support mentalization, and to allow individuals to sustain a "double awareness" of the possibilities for living while also facing impending mortality. Clinician trials have

demonstrated reductions in depression and death anxiety and growth in spiritual well-being as a result of the intervention. Large randomized controlled trials are now underway in Canada and Europe and international workshops are held several times yearly to train health professionals in the delivery of this intervention.

**NO. 3
MEANING-CENTERED PSYCHOTHERAPY IN ADVANCED CANCER PATIENTS**

Speaker: William Breitbart, M.D.

SUMMARY:

Meaning-Centered Psychotherapy (MCP) is a novel intervention designed to help advanced cancer patients improve their quality of life, and diminish despair through the enhancement of a sense of meaning in life. MCP is an adaptation of Victor Frankl's logotherapy, designed specifically for cancer patients who are facing the end of life. Breitbart and colleagues at Memorial Sloan-Kettering Cancer Center developed and tested MCP in two formats: Meaning Centered Group psychotherapy (MCGP) and Individual Meaning Centered Psychotherapy (IMCP). Both MCGP and IMCP have been tested in pilot as well as larger Randomized controlled trials, funded by the National Cancer Institute. IMCP is a 7 session intervention, and MCGP is an 8 session intervention. Both MCP interventions involve sessions that are partly didactic and partly experiential. The focus of MCP is to help patients be aware of the importance of maintaining a sense of meaning in life and to make the four main sources of meaning in life (Experiential, Creative, Attitudinal, and Historical) more available to utilize with intention. Both IMCP and MCGP have been demonstrated in RCTs to significantly enhance Meaning and quality of life, and to significantly reduce hopelessness, anxiety, depression, desire for hastened death and symptom burden distress. In this symposium, the basic elements of MCP as well as the content of each session will be reviewed. The results of RCTs showing efficacy will also be presented.

EVIDENCE-BASED PSYCHOPHARMACOLOGY ALGORITHMS TO GUIDE CLINICAL

DECISIONS FOR TREATING BIPOLAR DISORDER

*Chairs: Dana Wang, M.D., David N. Osser, M.D.
Discussant: R.H. Belmaker, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Apply the evidence-based best psychopharmacology for bipolar depression and mania in daily clinical practice.; 2) Prescribe effectively in special populations of bipolar patients with co-morbidities.; 3) Use the medications with the best efficacy for treatment resistant individuals.

SUMMARY:

Some existing practice guidelines for the psychopharmacology of bipolar disorder are out of date. Others have been criticized for insufficient focus on negative data on medications recommended, lack of clear pathways for maintenance treatment, and missing coverage of common patient scenarios. The American Psychiatric Association guideline was last published in 2002 and the latest Texas Medication Algorithm Project product was from 2007. As one of the groups producing up-to-date and clinically useful heuristics to guide practice, the Psychopharmacology Algorithm Project at the Harvard South Shore Program has been publishing a series of new algorithms. The latest updates of the bipolar algorithms are being distributed as part of the 8th edition (2014) of the model curriculum for psychopharmacology of the American Society of Clinical Psychopharmacology. The method may be summarized as follows. Authors review previous algorithms and guidelines, key studies, and new data. In constructing the decision trees, preference in the early nodes is given to treatments that are effective for acute episodes but also produce the best results in maintenance studies, and have favorable side effect profiles. In later nodes, where more treatment-resistant patients are addressed, the emphasis shifts to options with the strongest efficacy as the primary consideration. Conclusions reached on the sequencing of choices are opinion-based distillations of large amounts of evidence that vary in quality and are subject to conflicting interpretation. The rigorous, blinded peer review process is an essential part of the validation of the algorithms. If the reasoning, based on the authors' interpretations of the pertinent evidence, was

plausible to reviewers then it is retained. Otherwise, adjustments are made to achieve consensus. The advantage of using an algorithm-informed approach to clinical care is not only to supplement current shortcomings of treatment guidelines, but also to minimize clinical error due to lack of knowledge of the pertinent evidence. Algorithms help avoid use of unproven or harmful medications, reduce bias in clinical judgment, and (especially important in the era of the Affordable Care Act) increase efficiency of care in time and cost. The format of the symposium will involve one hour of focus on each of the algorithms for bipolar depression and bipolar mania. Each algorithm has subdivisions for mixed presentations, and there are discussions of important comorbidities and other considerations that change the basic algorithms. An international expert who was not involved in the creation of these algorithms will comment critically on key issues. 30 minutes will be left for interaction of the presenters with the audience. The audience will walk away with actionable treatment strategies to better manage bipolar disorder in day-to-day practice. The website that has these algorithms and others is available for free consultations at www.psychopharm.mobi.

NO. 1 BIPOLAR DEPRESSION ALGORITHM PART 1: INTRODUCTION AND DISCUSSION OF IMPORTANT COMORBIDITY AND INITIAL TREATMENT OPTIONS

Speaker: Dana Wang, M.D.

SUMMARY:

The method of algorithm development will be described. Key principles in the early nodes are that treatments should be effective for the acute episode, prevent future episodes while not inducing mania, and be reasonably safe. Also, the process of peer review leading to the current version will be described. The purposes and use of the algorithms will be summarized. Then a brief overview of the full, basic bipolar depression algorithm is presented to highlight its key features. The algorithm begins with a diagnostic evaluation. This includes consideration of common psychiatric comorbidities such as substance use disorders, anxiety disorders, attention deficit hyperactivity disorder, posttraumatic stress disorder, various

medical conditions, and special populations including women with childbearing potential, pregnancy, treatment resistant bipolar depression and patients with mixed features will be addressed. Any of these could change some aspect of the algorithm. At the beginning, ECT is a 1st line option for patients in need of urgent treatment. Lithium is the first-line pharmacotherapy. There are now three choices for second line: lamotrigine and quetiapine from the previous version of this algorithm, and lurasidone has been added. If psychotic symptoms are present, lamotrigine is less favored.

NO. 2 BIPOLAR DEPRESSION PART 2: TREATMENT - RESISTANCE, THE ROLES OF ANTIDEPRESSANTS, TREATMENT COMBINATIONS, AND LESS EVIDENCED OPTIONS

Speaker: Arash Ansari, M.D.

SUMMARY:

After sequential trials from among the options of lithium, lamotrigine, quetiapine, and lurasidone (one or more might be avoided due to side effect considerations), the next step considers valproate, which has a small evidence base for bipolar depression, or an antidepressant (bupropion and SSRIs preferred) added to a mood stabilizer. The role of antidepressants will be discussed at some length, considering the 2013 consensus guidelines from the International Society for Bipolar Disorders Task Force report. Also a key report in 2014 that addresses the question of the combination of antidepressants and mood stabilizers will be presented. Olanzapine monotherapy (approved in Japan but not the U.S.) and olanzapine/fluoxetine (FDA-approved) are considered later in the algorithm due to the metabolic risks of olanzapine. In mixed and rapid cycling cases, continue to avoid antidepressants: taper and discontinue them if present. Combinations of the above options are considered in the event of partial response. The session concludes with some comments on the limitations of this bipolar depression algorithm and some speculations about changes that might occur in the future.

NO. 3

BIPOLAR MANIA ALGORITHM PART 1: INTRODUCTION AND DISCUSSION OF IMPORTANT COMORBIDITY, AND INITIAL TREATMENT OPTIONS.

Speaker: David N. Osser, M.D.

SUMMARY:

Three main goals in choosing treatment for an acute manic episode include 1) effectiveness for the current episode, 2) ability of the treatment to prevent relapses to depression, and 3) minimizing short and long-term side effects. After accurate diagnosis, managing contributing medical causes including substance misuse, discontinuing antidepressants, and considering the patient's child-bearing potential, different algorithms for mixed and non-mixed mania are proposed. Patients with mixed mania may be treated first with a second generation antipsychotic (SGA) of which the first choice is quetiapine because of its greater efficacy for depressive episodes in bipolar disorder. Valproate, and then lithium or carbamazepine may be added for unsatisfactory control of symptoms. For non-mixed mania, lithium is the first-line recommendation. An SGA can be added, and again quetiapine is favored, but if quetiapine is unacceptable, risperidone is the next choice. If quetiapine is ineffective, consider using a different SGA from among those with the strongest efficacy in mania, such as risperidone or olanzapine.

NO. 4 BIPOLAR MANIA PART 2: FURTHER EXPLANATION OF THE ROLES OF HALOPERIDOL, OLANZAPINE, AND VALPROATE IN THIS ALGORITHM: TREATMENT-RESISTANT MANIA

Speaker: Othman Mohammad, M.D.

SUMMARY:

In this algorithm, olanzapine is not considered a first-line second generation antipsychotic (SGA) due to its side effects, but it could be second-line. Valproate is not one of the early choices for non-mixed mania because of unfavorable efficacy when compared to lithium and SGAs. Haloperidol is avoided in the early phases because of low ability to prevent shift to depression and high tardive dyskinesia risk, but it can be used briefly (in combination with lorazepam) for agitation requiring parenteral treatment. If the mania, whether mixed or non-

mixed is refractory to the three initial treatments proposed, and the diagnosis is confirmed, then depending on what has already been tried, consider carbamazepine, haloperidol, olanzapine, risperidone, and valproate as first-tier, aripiprazole, ziprasidone, and asenapine as second-tier, and clozapine as third-tier. The merits and disadvantages of each of these will be discussed. Electroconvulsive therapy may be considered at any point in the algorithm if there is a history of positive response or intolerance of medications. If the results are still unsatisfactory after trying one of the above options, select another. The presentation concludes with mention of some new options for the treatment of mania that require further research.

NOVEL PHILOSOPHIES IN MENTAL HEALTH EDUCATION

Chairs: Zainab Jabur, M.D., M.P.H., Norman Sartorius, M.A., M.D.

Discussant: Simon C. Wessley, M.D., M.H.Sc.

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 have increased knowledge about new teaching methods and emphasis in mental health.; 2) At the completion of this session participants will be able to have a better understanding of overall aims of simulation training, the history and development of the training modality.; 3) At the completion of this session participants will be able to have a better understanding of overall aims of integrated clerkships in medical school & patient focused learning.; 4) At the completion of this session participants will be able to have a better understanding of courses that focus on nontechnical skills and biases to improve clinical skills such as risk assessments.

SUMMARY:

This symposium will define and explore several new directions in the philosophy of mental health education. It aims to stimulate a discussion about the shifting paradigms in educational focus. Over the last several decades, there has been a strong push to move away from classic didactic teaching to more interactive and patient focused methods. These include, among others, the use of the patient narrative to teach about the patient experience

and illness and patient trajectory focused programs in medical schools. In addition, there has also been a movement towards learning in a safer environment, both for the patient as well as the learner, while still retaining the real life experiential component. This is the main objective of simulation training. Finally, the development of courses that focus on nontechnical skills such as decision making and bias rather than classical medical subjects have also been shown to improve clinical skills. The piloting of one course will be presented in detail. The symposium will review these methods and philosophies and discuss their impact on the quality of mental health education. Professor Norman Sartorius will chair the panel of presenters from King's College London, Instituto Superior de Medicina, and Harvard Medical School, and facilitate the interactive question and answer sessions. Professor Sir Simon Wessley, President of the Royal College of Psychiatrists, will be the discussant.

NO. 1

SIMULATION TRAINING, WHERE WE'VE COME FROM, WHERE WE ARE, AND WHERE WE'RE GOING.

Speaker: Sean Cross, M.B.B.S.

SUMMARY:

In medical and surgical specialties, high-fidelity simulation with structured debriefing is widely used, but so far this has not been widely applied to psychiatry. The use of simulation in mental health is a relatively new use of this teaching modality. Our center has designed and delivered a program of simulation-based interventions to multi-disciplinary mental health professionals, using a combination of high and low fidelity simulation approaches, including mannequins, actors, and props. The courses address different aspects of clinical care for psychiatric patients, including, among others: clinical skills, including history taking, risk assessments, and formulation and treatment planning; acute medical care for psychiatric patients; legal tribunals and coroner's courts; de-escalation of agitated patients; Simulated patient presentations and group debriefing enable the inter-professional, cross-disciplinary team to learn together and from each other in scenarios that are as realistic as

possible. We believe it makes sense to train people together, when they are expected to deliver care together. We are also developing unique models of debriefing that are suited to mental health simulation.

In the last two years, our center has trained more than 300 staff members in more than 10 newly developed courses. Our initial evaluation data shows statistically significant increase in knowledge, confidence, and awareness in different psychiatric subject matters.

**NO. 2
MOCK BEHAVIORAL CODES: CASE SIMULATION TO TEACH 4TH YEAR MEDICAL STUDENTS HOW TO APPROACH AND CONTAIN ANGRY, AGITATED AND POTENTIALLY VIOLENT PATIENTS**

Speaker: Argyro Caminis, M.D., M.P.H.

SUMMARY:

One of the most stressful aspects of clinical practice involves the management of angry, agitated and potentially violent patients, even more so without sufficient training to know how to intervene in ways that maintain safety for all involved, are therapeutic, and can help to de-escalate potentially out of control situations. We piloted a project with the specific objectives of: 1) using "mock codes" as a model, to implement a case-based simulation to teach senior medical students assessment and management of angry and agitated patients; 2) to understand the need for, desire for, and feasibility of teaching this topic in a medical school curriculum; 3) to identify core curricular content for such a simulation.

The intervention was a three and a half hour workshop, made up of 20-25 students each, that took place twice during a two-week internship preparation course for fourth year Harvard Medical students. One workshop. Each workshop consisted of an overview lecture, breakout into small groups led by clinician-educators to role-play of an angry patient scenario and an agitated patient scenario, and concluded with role-play and large group discussion. Students were asked to complete an anonymous survey before and after the workshops. Results showed that training in the management of agitated patients, including topics such as psychological challenges, risk assessment, development of differential and

intervention options is needed, desired, and feasible in medical school.

**NO. 3
LONGITUDINAL INTEGRATED CLERKSHIP: A YEAR-LONG THIRD-YEAR MEDICAL SCHOOL EXPERIENCE IN THE ACUTE PSYCHIATRIC SERVICES AND OUTPATIENT CLINICS**

Speaker: Lior Givon, M.D., Ph.D.

SUMMARY:

The Harvard Medical School Cambridge Integrated Clerkship (CIC) was launched in 2004 as part of the Harvard Medical School curriculum reform efforts. The CIC is a pilot effort that replaces the third year traditional clerkship curriculum with a "continuity of care" curriculum. Each year, 12 medical students are organized into teams, which has a cohort of patients. Patients are selected by faculty (with patient consent) and represent a spectrum of patients across disciplines and specialties.

Students follow the patients longitudinally through all phases of diagnosis and treatment, all services, through any hospitalizations, and including follow-up after discharge. Cases are assigned in an order that is likely to provide an ascending level of academic and patient care challenge.

The program is intended to emphasize whole patient care, and to promote ideals of professionalism and connection with patients. Students get an understanding of how psychiatric issues can affect physical health and vice versa. Early results show that compared with students not in the program, these students report an increased feeling of connection with patients, greater self-awareness, and a greater responsibility for their own learning. Students on the program also perform slightly better on NBME shelf exams and retain the information longer, suggesting there are no major gaps in content knowledge.

**NO. 4
CURIOSITY AND SIMULATION: A MENTAL HEALTH APPROACH FOR FIRST-YEAR MEDICINE STUDENTS**

Speaker: Victor H.O. Otani, M.D.

SUMMARY:

Psychiatric disorders have always attracted the curiosity of the general population and medical

students are no exception to that. Literature and movies, for example, have been successfully exploring this interest. Even though only a minority of medical students will choose psychiatry as a speciality, the spirit of inquiry which most of them have could help reduce the prejudice and the knowledge gap that psychiatry seems to have when compared to other specialities by the end of the graduation course. We used a trained actor to simulate a scenario of a psychotic patient who was supposed to be interviewed by a first-year student of Medicine in his anamnesis practice. Fifteen students volunteered for this pilot. When facing a situation in which the student felt uncomfortable, he could pause the simulation and ask for a supervisor consultation before resuming it. The pilot group found the simulation a very interesting practice which improved their confidence and their interest in mental health.

NO. 5 EXPLORING THE NONTECHNICAL SKILL OF PERSONAL AND COGNITIVE BIAS TO IMPROVE CLINICAL SKILLS, INCLUDING RISK ASSESSMENTS

Speaker: Zainab Jabur, M.D., M.P.H.

SUMMARY:

“The simplest approach to improving doctors’ decision making is to educate them about the existence of the biases” (Bornstein, B. H. & Emler, A. C. (2001)). When assessing a patient, clinicians should balance the potential costs & benefits of several possible courses of action. However, in spite of increasing emphasis on evidence based practice guidelines, it does not appear that clinicians use the same processes in their work with patients.

Many different factors contribute to variability in clinical practice. We developed a course to address this subjectivity & bias. We piloted 5 courses with participants from multidisciplinary backgrounds. The courses focused on 6 clinical scenarios: 3 psychiatric cases of increasing difficulty, each followed by 1 clinical decision pathway which is made by the group. During the case & discussion, participants were asked to be aware of initial impressions when presented with the clinical case & make treatment decisions before & after a group discussion. The discussion was directed around

fact gathering & processing of personal experiences of the patients, brainstorming around treatment decisions, exploring pros & cons to potential decisions, & exploring factors, including bias, affecting decisions & clinical actions. There is neither inter-patient nor inter-treater consistency in practice with treatment decisions around symptomology & current risk assessment; decisions appear to be more closely linked to perceptions about patient, i.e. bias.

PERSONALIZED MEDICINE IN MOOD AND ANXIETY DISORDERS: THE FUTURE IS BRIGHT

Chairs: Charles B. Nemeroff, M.D., Ph.D., Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The role of child abuse and neglect in the risk for mood and anxiety disorders; 2) The role of genetics and epigenetics in the risk for the development of mood and anxiety disorders and in their response to treatment; 3) The role of brain imaging as a tool to predict treatment response in depression.

SUMMARY:

In the past three decades, we have witnessed remarkable advances in the diagnosis and treatment of several major medical disorders by virtue of being able to match individual patients to optimal treatments. The most often cited examples of this strategy are infectious disease, certain cancers, and more recently cardiovascular disease. Indeed, the dramatic increase in survival rates for infectious disease was, in large part, due to the ability to identify the causative bacterium and conduct antibiotic drug sensitivity testing in individual patients. In the case of breast cancer, five year survival rates have dramatically improved, not only due to increased detection, but in part due to identification of individual receptor and genomic characteristics of the individual patient’s cancer, e.g. estrogen receptor positive, HER2 positive, BRCA 1 and 2 positive mutations, etc. These same principles are now being applied to central nervous system (CNS) disorders including the major psychiatric disorders. Personalized medicine in psychiatry is generally comprised of two major components:

prediction of disease vulnerability and prediction of treatment response which can broadly be divided into prediction of side effects (tolerability) and prediction of therapeutic efficacy. This symposium focuses on both of these facets of personalized medicine including the role of genetics and epigenetics, brain imaging, and early life trauma in risk for and treatment response in mood and anxiety disorders.

**NO. 1
CHILD ABUSE AND NEGLECT PREDICT
DISEASE VULNERABILITY AND
TREATMENT RESPONSE:
NEUROBIOLOGICAL MECHANISMS**

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

SUMMARY:

One factor which has received considerable attention in terms of both increased risk and poor response to treatment is early life adverse events including child abuse and neglect. This literature has virtually exploded in the last decade with a multitude of independent studies unequivocally demonstrating that not only does child abuse and neglect markedly increase risk for depression, bipolar disorder, and post-traumatic stress disorder (PTSD) and result in a much more severe clinical course by a multitude of measures (early onset, increased risk for suicide) but it is also associated with a poorer response to treatment, both pharmacotherapy and psychotherapy. Early life trauma is associated with both structural and functional brain imaging alterations that may be trauma-type specific, e.g. sexual abuse versus emotional abuse/neglect. Interestingly, much work has demonstrated genetic polymorphisms that mediate vulnerability to mood and anxiety disorders in victims of child abuse and certain of these gene variants, e.g. FKBP5, also impact upon treatment response. Taken together, there is overwhelming evidence that depression in patients with a history of child abuse and neglect represents a distinct endophenotype.

**NO. 2
UNDERSTANDING GENETIC AND
EPIGENETIC RISK FACTORS THAT
DIFFERENTIATE RISK AND RESILIENCE
IN THE AFTERMATH OF CHILD ABUSE
AND NEGLECT**

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

Child abuse and neglect lead to long-lasting alterations across a number of stress related pathways, increasing vulnerability to disease, including posttraumatic stress disorder (PTSD) and depression. I will review previous genetic association studies indicating that these effects may be mediated by gene x environment interactions involving two critical genes in the HPA axis, CRHR1 and FKBP5. I will then review 2 new large hypotheses-neutral studies to understand gene pathways involved at the epigenetic and genetic levels. We aimed to elucidate the impact of different early environment on disease-related genome-wide gene expression and DNA methylation in peripheral blood. We found that non-overlapping biological pathways are affected in the two PTSD groups (with vs. without childhood trauma). Interesting we found that changes in DNA methylation have a much greater impact in the child-abuse group. Finally, I will present recent, unpublished data using gene x environment analyses at the whole genome level in a cohort of >6000 traumatized subjects, examining the effects of child maltreatment on the development of PTSD and depression risk. Together these findings lead to the hypothesis that high levels of early life trauma lead to disease through the developmental interaction of genetic variants with neural circuits that regulate emotion.

**NO. 3
A PERSONALIZED MEDICINE
APPROACH TO PSYCHOTIC MAJOR
DEPRESSION**

Speaker: Alan F. Schatzberg, M.D.

SUMMARY:

In recent years, considerable data have emerged that excessive activity of the Hypothalamic Pituitary Adrenal (HPA) Axis is a common feature in patients with major depression with psychotic features. The Axis includes several hormones that regulate the synthesis and release of glucocorticoids, including central corticotropin releasing hormone (CRH) and its receptors and binding proteins, adrenocorticotropin hormone (ACTH) from the pituitary, and cortisol released from the adrenal. The Axis is a closed loop system with cortisol feeding back to inhibit synthesis and

release of CRH and ACTH at the level of the brain and the pituitary. CRH is also active in regions of the brain outside of the feedback loop (e.g., the amygdala). In this talk, we review recent findings from our group and others in this area. We first present on HPA Axis dysregulation in the disorder, followed by the neurocognitive deficits and functional brain imaging observed and their relationship to cortisol overactivity, and then explore whether variation for genes that control the HPA Axis may also play roles in conferring risk for the disorder. These data point to possible development of a personalized approach to diagnosis and treatment.

**NO. 4
EVERYDAY FUNCTIONING IN MOOD
DISORDERS: TREATMENT
IMPLICATIONS OF VARIABILITY IN
OUTCOMES**

Speaker: Philip Harvey, Ph.D.

SUMMARY:

Neuropsychiatric conditions, including mood disorders, are among the world's most disabling disorders. Both major depression and bipolar illness are among the top 10 causes of disability indexed by reduced everyday functioning. The traditional conceptualizations of the causes of disability were focused on symptoms, but do not consider the fact that rates of everyday disability in patients in individuals whose symptoms respond to treatment are about 50% in bipolar disorder and 25% in major depression. As a result, differentiation between patients whose reduced everyday functioning is due to nonresponsive symptoms versus other causes is critical and treatments must be aimed at the cause of disability and not delivered generically at all patients. This presentation will differentiate between disability associated with treatment resistance and disability caused by cognitive deficits and related functional skills and will provide scientifically valid and clinically useful information about treatments for disability of these two different origins. Characteristics of disability in mood disorders, similarities to other related conditions such as PTSD and schizophrenia, and the course of impairments will be presented. Information from large-scale studies of disability in mood disorder, including

those with a focus on genomics, will be used to highlight these distinctions.

**NO. 5
PRECISION MEDICINE: THE EVOLVING
ROLE FOR IMAGING IN OPTIMIZING
TREATMENT FOR DEPRESSION**

Speaker: Helen S. Mayberg, M.D.

SUMMARY:

Though treatments are highly effective in some individuals, there is no reliable method to match patients to their best option. Therefore, a long term goal is to develop a clinically viable algorithm that selects the best treatment and avoids ineffective ones, while also identifying patients that require alternatives to standard first-line interventions. Towards this goal, this presentation presents findings from a series of positron emission tomography and magnetic resonance imaging studies examining baseline patterns predictive of differential response to different treatments. FDG PET and complementary resting-state fMRI imaging biosignatures have been defined that stratify patients into two distinct subtypes predictive of likely remission to escitalopram or cognitive behavioral therapy as well as identify those patients who will fail combined treatment. Parallel studies in known treatment resistant patients further identify additional structural and functional imaging patterns providing additional evidence of biologically distinct depression subtypes with relevance to treatment selection and optimization at all stages of illness.

**NO. 6
INSIGHTS INTO NOVEL EARLY
INTERVENTIONS FROM NONHUMAN
PRIMATE TRANSLATIONAL STUDIES OF
ANXIOUS TEMPERAMENT**

Speaker: Ned Kalin, M.D.

SUMMARY:

Anxiety and depressive disorders commonly present early in life. Therefore, an opportunity exists for early identification and intervention prior to the long-term sequelae of these disorders. Studies demonstrate that childhood anxious temperament (AT) is the phenotype most predictive of the later development of anxiety and depression. We characterized AT in developing rhesus monkeys and discovered the altered neural circuitry that underlies AT (the

central nucleus of the amygdala (Ce), anterior hippocampus, prefrontal cortex and periaqueductal gray). We also characterized phenotypic variation in relation to AT demonstrating common and selective neural substrates that underlie different symptomatic presentations of AT. Heritability analyses demonstrate that AT is approximately 35 % heritable and we we found differential heritability of the AT neural circuit. This suggests the possibility of selectively targeting different components of the neural circuit some of which are more genetically determined while others are more influenced by environment. To investigate molecular mechanisms, we performed genome wide transcriptome analyses that demonstrate a reduction in Ce neuroplasticity gene expression in individuals with extreme AT. These data provide the foundation for the development of novel early individualized treatment strategies aimed at the prevention of the later development of severe psychopathology.

THE EMERGING FIELD OF COMPUTATIONAL PSYCHIATRY

Chairs: Tobias Nolte, M.D., Read Montague, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Attendees will get an introduction to what Computational Psychiatry (CP) is about and what heuristic principles govern it.; 2) They will recognize the potential this approach can have to reconceptualize diagnostic entities and extend current nosology of psychopathologies beyond the DSM.; ; 3) Attendees will be updated with latest findings from a large-scale CP study on Borderline Personality Disorder. They will understand how computationally derived deficits in mentalizing characterize B.

SUMMARY:

Computational ideas pervade many areas of science and have an integrative explanatory role in neuroscience and cognitive science. However, computational depictions of cognitive function have had surprisingly little impact on the way we assess mental illness because diseases of the mind have not been systematically conceptualized in computational terms. Here, we outline goals and nascent

efforts in the new field of computational psychiatry, discuss future directions and expectations with regards to re-conceptualizing the current psychopathology nosology and introduce a paradigm shift for using computational models to map mechanisms of dysfunction onto biological accounts of altered brain functioning. Lastly, we will support such an approach with first empirical findings from a large-scale study of personality disorders.

NO. 1 THE EMERGING FIELD OF COMPUTATIONAL PSYCHIATRY

Speaker: Read Montague, Ph.D.

SUMMARY:

Computational ideas pervade many areas of science and have an integrative explanatory role in neuroscience and cognitive science. However, computational depictions of cognitive function have had surprisingly little impact on the way we assess mental illness because diseases of the mind have not been systematically conceptualized in computational terms. Here, we outline goals and nascent efforts in the new field of computational psychiatry, which seeks to characterize mental dysfunction in terms of aberrant computations over multiple scales. We highlight early efforts in this area that employ reinforcement learning and game theoretic frameworks to elucidate decision-making in health and disease. Looking forward, we emphasize a need for theory development and large-scale computational phenotyping in human subjects.

NO. 2 A COMPUTATIONAL FRAMEWORK FOR PSYCHOPATHOLOGY

Speaker: Peter Fonagy, Ph.D.

SUMMARY:

The presentation will briefly cover the controversy surrounding phenomenologically based polythetic dichotomous categorisation of mental disorder and the challenges in making valid neuro-biological links between pleiotropic disorders and unique pathophysiology. The argument will be advanced that mental disorders are not amenable to simple neuro-biological explanation because they represent a failure of function without necessary damage to neural substrate and higher order processes

can intervene between neuro-biological vulnerability and pathophysiological manifestations. The domain of psychiatry is a contribution to identifying the neurobiological underpinnings of mental disorder through delineating brain circuit malfunctions, distinguishing it from neurology, which is concerned with identifiable lesions. Disorders of brain circuits are best captured functionally in terms of computational models. As much of cognitive processing is inherently content (semantics) dependent, computational psychiatry needs to quantitatively map the functioning of content-specific cognitive sub-systems to address content domain dependent processes. Genetic influences on behaviour are content dependent because selection pressures conserve content specific cognitive sub-systems.

NO. 3

A COMPUTATIONAL PSYCHIATRY APPROACH TO MENTALIZING DEFICITS IN BORDERLINE PERSONALITY DISORDER

Speaker: Tobias Nolte, M.D.

SUMMARY:

In this talk we will expand upon the notion that computationally derived paradigms can provide an novel inroad into our understanding of psychopathology. We will present new data from a large scale study on personality disorders currently being undertaken by Read Montague's lab in both the US and the UK. Preliminary results will shed light on specific deficits in mentalizing as postulated in the Mentalization-based developmental framework accounting for disease mechanisms in BPD. Specifically, we will present data on failures of mentalizing two person interactions and highlight clinical implications for treatment and aspects of the therapeutic relationship, namely the importance of epistemic trust when modifying generative models of self and others.

PSYCHIATRIC CONSULTATION TO THE ARMY PATIENT-CENTERED MEDICAL HOME (PCMH)

Chair: Charles S. Milliken, M.D.

EDUCATIONAL OBJECTIVE:

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

of the Army/DoD's Patient Centered Medical Home including its robust mental health components; 2) Be able to discuss the opportunities for psychiatric consultation within the PCMH; 3) Be able to discuss the opportunities available for alcohol misuse identification, intervention, and consultation, particularly in the context of available referral to confidential alcohol treatment.

SUMMARY:

DoD and the Army have adopted the Patient Centered Medical Home model of providing primary care. As configured by DoD it has a robust mental health component. This presentation reviews this new model as adopted by DoD and particularly the Army. It reviews data and presents DoD data supporting a robust mental health in primary care approach. The Army model extends mental health screening to include alcohol screening. Confidential alcohol treatment for Soldiers is necessary if that is to be effective; data from an Army pilot are presented. Alcohol Screening and Brief Intervention creates opportunities for the consulting psychiatrist which are discussed. The model also extends the role of the consulting psychiatrist in the Army's previous RESPECT-MIL program; opportunities for an Embedded Behavioral Health psychiatrist in consulting to the Soldier Centered Medical Home are reviewed.

NO. 1

SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT AND PHARMACOLOGIC CONSULTATION TO THE PCMH

Speaker: John R. Magera, M.D.

SUMMARY:

Alcohol Screening, Brief Intervention, Referral, and Treatment has over 30 randomized controlled trials supporting its efficacy. The Patient Centered Medical Home provides a platform well suited for implementing SBIRT within DoD Primary Care settings. Key findings supporting the implementation of SBIRT within DoD's PCMH are reviewed. Because the MTF specialty addiction services do not see dependents and retirees, these are an often under recognized and underserved population in our clinics. Civilian SBIRT trials have pioneered the use of psychopharmacological

interventions by primary care providers. The presentation review principles of SBIRT and pharmacologic agents that the consulting psychiatrist may find most suited to use by primary care.

NO. 2 CONSULTING TO PRIMARY CARE CLINICS

Speaker: Shannon Ford, M.D.

SUMMARY:

The presenter has served as a psychiatrist to one of the Army's Embedded BH units. These units provide BH support to a defined unit of AD Soldiers. Under the Army's PCMH Operation Order and implementation plan, the EBH psychiatrist would also consult to that unit's primary care support, the Solider Centered Medical Home as an External Behavioral Health Consultant. This represents a shift from a previous consulting psychiatrist under the Army's RESPECT-MIL model. Opportunities and challenges presented by this model are discussed based on grassroot experiences, interviews with other active duty colleagues, and from experiences consulting to Internal Medicine/Geriatric Medicine clinics in the medical center setting.

NO. 3 CONFIDENTIAL ALCOHOL TREATMENT FOR SOLDIERS: A NECESSITY FOR EFFECTIVE PRIMARY CARE ALCOHOL SCREENING AND BRIEF INTERVENTION

Speaker: Charles S. Milliken, M.D.

SUMMARY:

Data is reviewed which show that combat exposures are associated with increased alcohol misuse in addition to depression and posttraumatic stress disorder. Alcohol complicates these other conditions and complicates their treatment. Being able to address alcohol problems is important, but alcohol treatment, even for those without alcohol incidents, has not been traditionally been afforded the same privacy protections as other mental health problems within DoD. Data show that Soldiers with alcohol problems get referred at a much lower rate than those with mental health problems. If early alcohol intervention is to be successful, 'safe' treatment must be available. Data from a pilot of are

presented. Army but not DoD-wide policy has subsequently been changed to allow for confidential alcohol treatment.

BETWEEN TEMPERAMENT AND MENTAL DISORDERS: ASSESSING THE CONTINUUM

Chair: Irina Trofimova, M.Sc., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) learn latest development and models in temperament research and its links to mental illness; 2) recognize the links between temperament traits and dispositions for psychiatric disorders; 3) to compare neurophysiological imbalances underlying temperament and psychiatric disorders.

SUMMARY:

The objectives of this symposium are to review the theories, measurement and findings related to temperament research (biologically based individual differences), as well as to compare it to psychiatric disorders. Temperament and mental illnesses are considered to be varying degrees of the same continuum of imbalance in the neurophysiological regulation of behavior. The symposium will start with an historic and theoretical review of the approaches and models used in the study of temperament as well as neuro-chemical systems implicated in its traits. The other contributions will present specific findings in regards to the links between mood disorders and temperament, personality and temperament. The relationships between psychopathology, psychophysiology, and temperament will be discussed.

NO. 1 COUPLING OF TEMPERAMENT TRAITS WITH DEPRESSION IN DIFFERENT AGE GROUPS

Speaker: William Sulis, M.D., Ph.D.

SUMMARY:

Temperament and depression have both been linked to neurotransmitter imbalances in neurophysiological systems of behavioural regulation, though with different degrees of such imbalance. Aging has also been linked to neurochemical changes within regulatory systems, however few studies have investigated age specifics related to depression and

temperament traits. This study investigated the coupling of sex, age and temperament with major depression (MD) (using four age groups of adult samples (17-24, 25-45, 46-65, 66-84 year old) and the Structure of Temperament Questionnaire (STQ-77) consisting of 12 scales. The results showed that patients with MD reported significant changes in 9 or 12 traits: motor endurance, social-verbal endurance, intellectual endurance, motor tempo, self confidence, plasticity, sensation seeking all decreased, while impulsivity and neuroticism increased. Other sex- and age-related effects are reported. The results are discussed from the perspective of the neurochemical Functional Ensemble of Temperament model and the action of opioid receptors.

NO. 2 PSYCHOPHYSIOLOGY OF TEMPERAMENT TRAITS AND ITS LINKS TO MENTAL ILLNESS

Speaker: Irina Trofimova, M.Sc., Ph.D.

SUMMARY:

This presentation reviews over 40 theories and models of temperament based on the Western European, Eastern European and North-American traditions. Temperament is viewed here as biologically based individual differences with main links to endocrinal-limbic regulation and to the morphology of the nervous system. Findings in psychophysiology, neuropsychology, personality theory and personality disorders are compared to the traits described as temperament according to various approaches. The presentation summarizes over 200 overlapping entries of temperament characteristics and underlines six key insights, which emerged within psychology during the 20th century, concerning 12 biologically based components of behavioural regulation. The final list of 12 temperament traits is analysed from a functional perspective, which considers the development of the structure of adult temperament as a result of certain functional properties of the tasks and activities of adult humans. The contribution of neurochemical systems regulating temperament traits is compared to its contribution of mental disorders.

NO. 3

COMPARISON OF MEASURES OF TEMPERAMENT AND PERSONALITY DISORDERS

Speaker: Julie Christiansen, M.Sc.

SUMMARY:

Temperament and mental illnesses are considered to be varied degrees of the same continuum of imbalance in the neurophysiological regulation of behaviour. Temperament traits were linked to specific patterns in the relationships between neurotransmitters and activation of certain brain structures. Similar links were found between neurotransmitters, brain structures, and personality disorders. This presentation reports a study using the Structure of Temperament Questionnaire (STQ-77) and the Personality Assessment Inventory (PAI) applied to three age groups of adult samples. Samples were taken from general and clinical populations in Southern Ontario, Canada. The results showed that the scales of PAI measuring depression correlated significantly with a lower physical endurance, low tempo, high impulsivity, and low plasticity, as measured by the STQ-77. The PAI scales measuring anxiety related disorders correlated highly with the scale of neuroticism as measured by the STQ-77. These results indicate the benefits of measurement of temperament within the scope of clinical practice.

NO. 4 COUPLING OF TEMPERAMENT TRAITS WITH ANXIETY IN DIFFERENT AGE GROUPS

Speaker: William Sulis, M.D., Ph.D.

SUMMARY:

Temperament and anxiety have both been linked to neurotransmitter imbalances in neurophysiological systems of behavioural regulation, though with different degrees of such imbalance. Aging has also been linked to neurochemical changes within regulatory systems, however few studies have investigated age specifics related to anxiety and temperament traits. This study investigated the coupling of sex, age and temperament with generalized anxiety disorder (GAD) (using three age groups of adult samples (17-24, 25-45, 46-65 year old) and the Structure of Temperament Questionnaire (STQ-77) consisting of 12 scales.

The results showed that patients with GAD had significantly lower Social-verbal Endurance, Mental Endurance, Plasticity, and higher Impulsivity than healthy individuals. GAD was associated with significantly higher Neuroticism and lower Self-Confidence in women than in men. Other sex- and age-related effects are reported. The results are discussed from the perspective of the neurochemical Functional Ensemble of Temperament model and the action of opioid receptors.

PSYCHIATRIC/PSYCHOLOGICAL INPUT INTO NATIONAL PLANS TO COUNTER-TERRORISM

Chairs: Zebulon Taintor, M.D., Jerrold Post, M.D.

Discussant: Zebulon Taintor, M.D.

EDUCATIONAL OBJECTIVE:

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

- 1) describe psychiatric/psychological elements of national counter terrorism plans in Australia, Canada, Great Britain, Pakistan, and the United States;
- 2) describe proposed psychiatric/psychological components of national counter terrorism plans in English-speaking countries;
- 3) list some roles psychiatrists might play in counter terrorism.

SUMMARY:

Recommendations on psychological aspects of terrorism were made by the 9/11 Commission, but have had increased attention as hundreds of educated citizens of developed, Western democracies have been recruited into terrorist groups, surprising those who knew them as they grew up. National plans to counter terrorism have to consider how their citizens become radicalized, what paths lead to violent extremism, and ways of preventing more youths going the same way. This symposium will present what psychiatric/psychological thinking has been incorporated into the counterterrorism programs of Australia, Canada, Great Britain, Pakistan, and the United States. While all share a common language and similar democratic institutions, national contexts and circumstances differ. The plans will be described according to the public health principles of prevention, early detection and treatment (deradicalization) and tertiary prevention (isolation and rehabilitation). They seek to apply a wide range of research on social

forces, groups, gangs, criminality, spirituality, identity, and a host of other factors. For example, recent research on social media shows that groups may become isolated and self-reinforcing, so the challenge is not only to come up with messages that counter terrorism, but also how to get through to groups that might benefit from them. Several plans depend on developing community resilience. Nations sponsor varying amounts of research into possibly relevant biological factors. Rating scales, guidelines on diagnosis, treatment and safety have been adapted from forensic psychiatry/psychology.

Deradicalization philosophies and programs have taken different forms in the five countries, with varying support and success. For each country, the presentation will include:

- 1) How is the threat of terrorism seen in the country? What are trends, priorities?
- 2) What is the strategy/plan? Level of support? What assumptions are made about the path(s) to violent extremism? What communities are seen as at risk for producing violent extremists?
- 3) How have assumptions such as "radical incubators" held up?
- 4) Since early detection involves data collection and surveillance, what civil liberties issues have emerged?
- 5) What roles are assigned to which agencies for prevention, development of community resilience, deradicalization, and maintenance of public safety?
- 6) What deradicalization programs have emerged? How is success evaluated?
- 7) What academic centers have merged/been funded?
- 8) What areas of international cooperation have emerged? The Australian presentation will include comments about Indonesian and Philippine programs.
- 9) What roles are carried out by which religious leaders/institutions?
- 10) What changes are planned for educational curricula?
- 11) What is planned for citizens returning from fighting abroad? What will be voluntary or "mandatory" (as proposed in Britain)?
- 12) What future activities are planned? What funding is available?

NO. 1

CANADA'S COUNTER TERRORISM PLAN IS DEVELOPING PSYCHOLOGICAL COMPONENTS

Speaker: Howard E. Book, M.D.

SUMMARY:

Canada's national antiterrorism plan is the responsibility of Public Safety Canada and is available for all to see (<http://www.publicsafety.gc.ca/cnt/rsrscs/pblctn/s/rsinc-gnst-trrrsm/index-eng.aspx>). Its strengths are on police and disaster preparedness. Its four components are Prevent, Detect, Deny, Respond. Although multiple partners are listed, Health Canada's role is biological, and there is no mental of collaboration with mental health, psychology, or psychiatry. However, the effort is drawing more attention and offers of collaboration as jihadist Canadians are found fighting in Iraq and Syria. Particularly impressive is the case of John Maguire, a blond, blue-eyed, ex-business student in Ottawa whose change of life course has astonished all who knew him. So the issue of pathways to terrorism, cognitive distortions, a general "How did he get that way?" mood is moving Canadians to consider psychological dimensions of countering terrorism. Government will likely follow. So far no new legislation or programs for returning jihadists.

NO. 2

AUSTRALIA'S COUNTER-TERRORISM PLAN LACKS PSYCHOLOGICAL ANTI-TERRORISM MEASURES

Speakers: Peter Parry, M.B.B.S., Clarke Jones, Ph.D.

SUMMARY:

Australia's national plan for countering terrorism has been developed by the National Counter Terrorism Committee. The third edition was published in 2012 (<http://www.nationalsecurity.gov.au/MediaandPublications/Publications/Documents/national-counter-terrorism-plan-2012.pdf>). Its four points are preparedness, prevention, response, and recovery. The only psychological mention is for victims of terrorist acts. But Australia is beginning to consider deradicalization programs and to involve mental health professionals in its plans.

NO. 3

A PSYCHIATRIC PERSPECTIVE ON U.K. APPROACHES TO COUNTER-TERRORISM

Speaker: Rachel Jenkins, M.D.

SUMMARY:

CONTEST, the UK's counterterrorism strategy was developed by the Home Office in 2003 and first publicly published in 2006. Revisions followed in 2009 and 2011, with annual implementation reports in 2010 and 2013. Its "4Ps": Prevention, Pursue, Protect, and Prepare, follow public health principles. Primary prevention is evident in Prevent activities, concentrated on communities at risk for developing violent extremists, secondary prevention in early identification of individuals who might benefit from the CHANNEL program. Tertiary prevention is seen in a major revision of the programme, with proposed legislation submitted by the government, with significant support from the opposition, on 3 September 2014. The final form of the legislation and its implementation will determine new dimensions of the UK strategy. Mandatory deradicalization is the plan for those returning jihadists or those otherwise on the list of persons at risk. The prime minister has urged attention to "UK Values", definitions and implementation at the programme level to be worked out. A current US-UK difference with practical and psychological consequences is whether passports and citizenship should be taken from returning fighters. A court order placing a person under the Terrorism Prevention and Investigation Measure would include mandatory deradicalization. The government currently operates the Al Furqan program in prisons using imams and the Healthy Identities program using psychotherapists to identify in

NO. 4

PSYCHOLOGICAL INPUT INTO PAKISTAN'S COUNTER-TERRORISM EFFORTS

Speakers: Feriha Peracha, Ph.D., Khalid A. Mufti, M.D.

SUMMARY:

Pakistan has had a National Counterterrorism Authority created by parliamentary legislation in the Ministry of Interior and a succession of anti-terrorism laws. However, while the national sentiment against terrorism in the abstract is

well established, there are tensions among various centers of power, some who regard certain groups as nonterrorists (legitimate political groups) and feel differences can be settled by negotiating with those groups, others who regard those same groups as terrorists but still favor negotiations, and those who are against negotiating with any entity that uses terrorist methods. Some groups are regarded as terrorists, but still is always some question as to how issues have been resolved with an ongoing tension between those who wish to negotiate with the groups that others regard as terrorists. The Pakistan Taliban is a prime example, in that the present government has appointed negotiating teams, talks have taken place, and cease-fires have been declared. However, as this is written the army is engaged in clearing North Waziristan of terrorists.

Deradicalization programmes are carried out by imams in prisons for adult men. Techniques have been adapted from programmes used in prisons in Indonesia, Malaysia, and Saudi Arabia. There are ongoing efforts to identify communities in which radicalization is promoted, such as in Karachi, south Punjab, KPK province, etc. Efforts to promote civil society have been hampered by threats against, and assa

NO. 5 PSYCHOLOGICAL DIMENSIONS OF THE U.S. COUNTER-TERRORISM PLAN

Speaker: Jerrold Post, M.D.

SUMMARY:

The US planning process has paid attention to psychological dimensions from the initial recommendations of the 9/11 Commission. Activities have included funding literature reviews, counter terrorism academic programs, NGOs and government services.

THE WAR ON WOMEN

Chairs: Gail E. Robinson, M.D., Gisele Apter, M.D., Ph.D.

Discussant: Carol C. Nadelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe legal obstacles to reproduction rights ; 2) Understand how legislation and societal practices impose difficulties on women's lives internationally and

in North America; 3) Treat women who have been raped that avoid blaming the victim; 4) Recognize public health measures tht can protect women's rights.

SUMMARY:

Women in Europe and North America often feel smug about the freedom they have in contrast to women in other societies, especially in low income countries, around the world. However, the last decades have seen the undermining of reproductive rights, the constant distortion of scientific data, and persistent sociological and cultural bias. It was thought that longstanding inequities that affect women's health and wellbeing would gradually disappear. Instead, women still cannot get equal pay for equal work and there is an increasing feminization of poverty. Exposure to trauma is commonly linked to negative mental health. History of trauma and abuse of women are common around the world. Women are still more likely to get sexually assaulted, beaten or murdered by an intimate or former intimate partner. Date rape on campus has become epidemic. When they are victims of assault, they are likely to get blamed for precipitating or allowing it and the aggressors are excused. Attacks against reproductive rights have sprung up in numerous states with laws and restrictions putting obstacles in the way of women seeking abortion under the false pretense that women will be at risk of an "abortion trauma syndrome", a syndrome that does not exist in any textbook or study. Companies will pay for Viagra prescriptions but refuse to pay for contraceptives. While adequate screening, assessment and management of mental health disorders during the peripartum is still in dire need of major public health investment, instead attempts are made to defund women's health care services. as well, women continue to disappear from history. Talented women composers, writers and even psychiatrists are forgotten. The effects of these restrictions on women's mental health and wellbeing will be discussed.

NO. 1 PERIPARTUM MENTAL HEALTH: ACCESS AND CARE ARE STILL AN ISSUE

Speaker: Gisele Apter, M.D., Ph.D.

SUMMARY:

When will care for women during the peripartum be on top of our agenda? Data on mental health disorders during the peripartum is now plentiful. It shows that, during pregnancy and postpartum, women more frequently from psychiatric disorders and mental health issues than at any other time during their life. The physiological stress of pregnancy and preparing for a newborn is a challenge for many women. Pre-existing mental health disorders are not miraculously cured during pregnancy, the risk of a psychiatric episode is heightened during the immediate postpartum. Since most women are concerned about their offspring's well-being, it seems essential to offer good physical and mental health care in order to address the needs of mothers and infants. However, women with depression are less likely to seek care resulting in fewer prenatal visits and, therefore, endangering both their own health and the pregnancy. Current data show that depression itself is probably increases the risk for the fetus and the newborn. All major maternal issues, including a past history of abuse, are know to have consequences to the mother-infant interaction and, through dysregulated interactive configurations, heighten the risk for disorganized attachment, itself a fertile soil for future major psychiatric problems. Different programs offering rapid, non-stigmatizing, expert maternal and mother-infant care during pregnancy and postpartum will be presented.

NO. 2 UNDERSTANDING THE SOCIAL DETERMINANTS OF WOMEN'S MENTAL HEALTH

Speaker: Helen Herrman, M.B.B.S., M.D.

SUMMARY:

The impact of social determinants on women's mental health is becoming clearer worldwide. Poverty, violence at home, the work of women as family caregivers, stress at work, the multiple roles and burdens of women, and unequal access to health care all affect women's mental health and the health of their families. Violence against women and children and the consequences for mental health are among the most serious concerns. These factors are now recognized as the key to a long-established observation: that women compared with men have a greater burden of ill-health from depression. Depression makes a large

contribution to ill-health in women, and depression in mothers affects the health and development of their children. Clinically there is a need to assess and treat mental health problems in girls and women of all ages and work with them to support recovery. This requires access to care through primary health, mother, child, and reproductive health settings, and gender-sensitive approaches to care at all levels. Beyond the health system, social and gender policies informed by human rights obligations have clear relevance for local, national and international strategies that can reduce risk factors and promote women's mental health.

NO. 3 ABORTION AND OUR PATIENTS: SCIENCE IN CLINICAL CARE

Speaker: Nada L. Stotland, M.D., M.P.H.

SUMMARY:

Attitudes towards abortion are an excellent example of psychodynamic "vertical split". Many people are opposed to abortion in the abstract but desperately seek abortion when pregnancy occurs in circumstances which they find incompatible with successful parenting. In the Unites States, 1/3 of women have abortions during their lives; among them are our patients. This presentation will review the evidence about the relationship between abortion and psychiatry - abortion does not cause psychiatric illness - and discusses how to help patients deal with decisions, experiences, and feelings about problem pregnancies.

NO. 4 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, current culture tends to blame the victim. 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. In fact, the majority of women do not report to the police. Reasons for not reporting include: shame; guilt; fear of the assailant returning; fear of not being believed; or fear of the whole court process. 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. 5 THE DISAPPEARANCE OF WOMEN

Speaker: Malkah T. Notman, M.D.

SUMMARY:

That women are discriminated against and are the objects of control, hostility and lack of freedom is obvious in religious extremist societies. In the developed world, particularly in the west, women have made many gains. In professional and business contexts it may seem that women have equal opportunities and that the war on women no longer exists. The reproductive situations are clear examples of continuing limitations. However the "war on women" continues in more subtle ways in relation to women's leadership and in deeper attitudes concerning equality. Talented women have often disappeared from history. It might seem as if there were never any women composers or artists. As an example of disappearance, this presentation will examine several situations in psychiatry and psychoanalysis where several women leaders in one generation were followed by an absence of women (in psychoanalytic society) and where women are subtly undermined by prevailing attitudes. These will be described and discussed.

IMPROVING THE EFFECTIVENESS OF COGNITIVE BEHAVIORAL THERAPY (CBT) ACROSS CULTURES

Chair: Muhammad Irfan, M.B.B.S., M.S.

Discussant: Farooq Naeem, M.B.B.S., M.Sc., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the conclusion of this session participants will be able to recognize social origins of psychiatric illnesses and its relevance in developing psychological interventions.; ; 2) At the conclusion of this session participants will be able to recognize and understand themes related to CBT and the need to culturally adapt CBT especially in ethnic minority communities.; ; 3) At the conclusion of this session participants will be able to identify necessary steps to culturally adapt CBT.; ; 4) At the conclusion of this session participants will be able to identify cultural assumptions underlying CBT and ACT and their implications on clinical adaptation and application in diverse populations.

SUMMARY:

Cognitive Behaviour Therapy (CBT) has a strong evidence base and is recommended by the National Institute of Health and Clinical Excellence (NICE) in the UK and by the American Psychiatric Association (APA) in the US for a variety of emotional and mental health problems. However, it has been suggested that CBT is underpinned by specific cultural values and for it to be effective for clients from diverse backgrounds it should be culturally adapted. It has been suggested that cultures are different in core values, for example; Individualism-Communalism, Cognitivism-Emotionalism, Free will-Determinism and Materialism-Spiritualism. Therapists working with ethnic minority clients in the US have developed guidelines for adaptation of therapy. Most of these guidelines are based on theoretical grounds or personal experiences. These guidelines were not the direct outcome of research to address cultural issues. The literature describing guidance for cognitive therapists is limited. Recently our international group have used various methods to adapt CBT for clients from various backgrounds including African, Caribbean, Chinese, Bangladeshi and Pakistani. In this symposium we will describe our experience of adaptation of CBT and outcome of RCTs to evaluate these culturally adapted therapies.

NO. 1

DEVELOPING A MODEL FOR CULTURAL ADAPTATION OF CBT FOR ENGLISH SPEAKING CARIBBEAN ORIGIN GROUP

Speaker: Kwame J. McKenzie, M.D.

SUMMARY:

Reports have shown that culturally adapting CBT can make it more accessible and acceptable to specific diverse populations. Our study aimed to develop a model for cultural adaptation that could be used for Canadian racialised populations and specifically to adapt CBT for English Speaking Caribbean origin group in Toronto. A literature review was used to identify areas of a standard CBT manual which may need cultural adaptation. This was used to develop the questions for focus groups of community members. Feedback from the focus groups was used to adapt the manual and a further focus group of practitioners was undertaken to check that the changes that were made were practical with regards to delivering CBT. Changes in the level of personal disclosure, homework, timing of sessions and content of the examples were suggested. The therapists found the culturally adapted CBT easy to use and felt it offered them license to be more flexible in their practice. They believed it to be an improvement on existing manuals for this group. Feedback from the patients was similarly positive. Culturally adapted CBT was found to be an acceptable alternative to standard manuals in this qualitative study and no problems were found in implementation.

Authors: Kwame Mckenzie and Akwatu Khenti

NO. 2

CULTURAL ISSUES ON THE USE OF CBT AND ACCEPTANCE AND COMMITMENT THERAPY (ACT)

Speaker: Kenneth Fung, M.D., M.S.

SUMMARY:

There is increasing recognition that cultural issues need to be addressed in order to enhance the effectiveness of psychotherapy for diverse populations. Evidence-based therapies, such as Cognitive Behavior Therapy (CBT), need to be culturally adapted for different populations while maintaining its core therapeutic aims. At the same, there has also been an expansion and incorporation of other cultural practices, such as mindfulness, into the family of CBT, such as 3rd-wave interventions like Acceptance and Commitment Therapy (ACT). ACT is based philosophically on Functional Contextualism and is the clinical

application of Relation Frame Theory. Its core therapeutic processes include: Acceptance, Defusion, Present Moment, Self-as-context, Values, and Committed Action. In addition to the obvious incorporation of the concept of mindfulness, its principles are culturally consistent with Asian philosophies and thought, such as that of Buddhism. This presentation will examine: (i) the philosophical and cultural differences between the two psychological interventions, traditional CBT and ACT; (ii) the cultural considerations of each in adapting them for diverse groups; and (iii) the experience of integrating the use of CBT and ACT together for diverse groups, including in the Chinese and Portuguese clinical populations.

Author: Kenneth Fung and Monica Scalco

NO. 3

CULTURAL ADAPTATION OF CBT: PROCESS, METHODS AND FINDING

Speaker: Farooq Naeem, M.B.B.S., M.Sc., Ph.D.

SUMMARY:

We adapted CBT for Pakistani clients in Manchester, Southampton and in Pakistan. A mixed method approach was used. A series of qualitative studies were conducted which involved interviews and focus groups with clients, their carers, mental health professionals and managers. The results of these studies were used to develop guidelines that were used to culturally adapt CBT. We found that in order to effectively work with clients from South Asian Muslims (SAM) background, therapists need to consider and develop three fundamental areas of cultural competence; (1) Awareness of relevant cultural issues and preparation for therapy; (2) Assessment and engagement and, (3) Adjustments in therapy techniques. Awareness of cultural issues in turn includes awareness of cultural and religious issues, capacity and circumstances of both the individual and the system and cognitions and beliefs. Overall, findings from, developing culturally sensitive CBT project suggest that minor adjustments in therapy are required in order to work with clients from this group. So far 8 RCTs have been conducted in Pakistan and the UK of culturally adapted CBT. This presentation will focus on methodology and process of adaptation and outcome of the qualitative studies which guided adaptation of CBT.

NO. 4
CULTURAL ADAPTATION OF CBT FOR PSYCHOTIC DISORDERS

Speaker: Shanaya Rathod, M.D.

SUMMARY:

Cognitive Behaviour Therapy (CBT) is the most widely recommended psychological therapy for psychotic disorders (e.g. NICE 2014). However, explanations used in CBT are based on Western concepts and illness models. There has been little attention given to modifying the therapeutic framework and practice of therapy (Williams et al, 2006) to incorporate an understanding of diverse ethnic, cultural and religious contexts (Rathod et al, 2008). Theory, interpretation and practice of CBT in multi-ethnic client groups needs to be adapted to the growing literature on cross-cultural counselling and the ethical and practical concerns surrounding competency and training of psychotherapists working with these clients (Pedersen, 2003). Dissemination of cognitive therapy across widely diverse cultures is increasingly occurring. The evidence to support this is explored as are problems associated with using therapy that is not culturally adapted.

NO. 5
DEPRESSED BRITISH SOUTH ASIAN MOTHERS "VOICES WITHIN THE FOUR WALLS": A MIXED-METHODS STUDY

Speaker: Nusrat Husain, D.P.H., M.B.B.S., M.D., M.P.H.

SUMMARY:

British south Asians are one of the largest ethnic minority groups living in the UK. High rates of depression have been reported in these women. Previous literature has neglected British south Asian women's experiences of postnatal depression. Current guidelines suggest a need for tailored maternity services to improve access to care for women from ethnic minorities. This mixed methods study looks at British south Asian women's explanatory models to explain postnatal depression, their preferred treatment and the development and pilot testing of a culturally adapted group psychological intervention. The most commonly reported factors contributing to the persistence of depression were marital disharmony, lack of support, and financial difficulties. Past help

received was primarily antidepressants which were not welcomed. Several other factors which often lead to difficulties in engagement were identified including stigma of mental illness, different cultural beliefs, lack of trust in mental health services and a lack of awareness of services available. The mothers found the culturally adapted group CBT intervention to be acceptable and many reported benefits such as higher overall wellbeing. The participants expressed their satisfaction with the culturally adapted intervention and felt an overall positive change in their attitudes, behaviour and confidence level.

Authors: Husain N, Lovell K, Khan S, Rahman A, Chaudhry N, Waheed W, Bhojani I, Atif N, Chaudhry N

NO. 6
EVALUATION OF CULTURALLY ADAPTED CBT (CACBT) THROUGH RANDOMIZED CONTROLLED TRIALS IN PAKISTAN: DEVELOPING THE EVIDENCE BASE

Speaker: Muhammad Irfan, M.B.B.S., M.S.

SUMMARY:

The cultural adaptation of CBT involved a series of qualitative studies in Pakistan and the results were utilized in the selection of culturally equivalent terminology. We conducted randomized controlled trials to evaluate culturally adapted CBT and this presentation will focus on these RCTs. In the first RCT, CaCBT was evaluated in primary care for patients with depression. This culturally adapted CBT was then used to develop self-help manual. A multicentre RCT was conducted to test the effectiveness of this self-help manual. We also conducted RCTs for CaCBT in Psychosis. Recently a RCT of brief CaCBT was conducted in patients attending secondary care. The publication of these results will pave the path for wider acceptance of psychological therapies in general and CBT in particular, in Pakistan.

IMPLEMENTATION OF COORDINATED SPECIALTY CARE FOR FIRST-EPISEDE PSYCHOSIS IN U.S. COMMUNITY MENTAL HEALTH CLINICS

Chairs: Mary Brunette, M.D., Piper Meyer-Kalos, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the elements of the NAVIGATE model of coordinated specialty care for people with first episode psychosis; 2) List 3 facilitators and 3 barriers to implementing coordinated specialty care for people with first episode psychosis; 3) Describe strategies for engaging and working with families of patients with first episode psychosis; 4) Identify 5 cardiometabolic conditions and risk factors in patients with first episode psychosis; 5) Recognize the cost effectiveness of coordinated specialty care for people with first episode psychosis.

SUMMARY:

Schizophrenia occurs in approximately 1% of the adult population and can be the most disabling of psychiatric disorders, accounting for one-third of all spending for mental health treatment in the U.S.. Additional indirect costs arise from family caregiving, unemployment, criminal justice involvement, physical and emotional distress, and premature mortality. Providing high quality coordinated specialty care immediately after the illness begins promises to improve outcomes and reduce disability. Ideal care for young people with first episode psychosis (FEP) includes Medication Management, Individual Resiliency Training, Family Intervention and Supported Employment and Education (SEE). Researchers of the RAISE-ETP study developed a team-based, manual-driven care model with these components called NAVIGATE, and randomized 36 community clinics across 21 states to provide NAVIGATE or to continue community treatment as usual. In this symposium, (one of two submitted to describe the recently completed research on this model), researchers will present topics relevant to implementing NAVIGATE and other coordinated specialty care for people with FEP in typical U.S. mental health treatment settings. Presenters will focus on the aspects of care that are key for young people with FEP and the organizations and systems aiming to improve care for this population.

Dr. Brunette will discuss implementation strategies. She will describe the NAVIGATE model of coordinated specialty care for people with first episode psychosis, review findings from a qualitative analysis of capacity within the study's community mental health centers,

describe an array of funding strategies for NAVIGATE, and discuss ensuring access for Supported Employment and Education. Dr. Meyer-Kalos will describe the Individual Resiliency Training (IRT) intervention. She will discuss the types of training and supervision clinicians need to deliver this intervention, and the assessment of fidelity to the service delivery model to ensure high quality service delivery. Dr. Glynn will describe the family intervention model and present data on the engagement of families in this model of care. Dr. Correll will present data on the physical health status of the 404 people with FEP who entered the RAISE-ETP study. He will discuss the need to address cardiometabolic risk in this vulnerable population and the coordination of physical and mental health care for this group. Dr. Rosenheck will describe the cost effectiveness of delivering coordinated specialty care for FEP, presenting analyses estimating the cost effectiveness of NAVIGATE among 404 FEP participants over two years. The group will discuss the promise of implementing coordinated specialty care for people with FEP and the ways in which American mental health providers, clinics, mental health authorities and payors can adopt such care.

NO. 1 FACILITATORS AND BARRIERS TO IMPLEMENTATION OF COORDINATED SPECIALTY CARE IN U.S. COMMUNITY MENTAL HEALTH CLINICS

Speaker: Mary Brunette, M.D.

SUMMARY:

Coordinated specialty care such as NAVIGATE for young people with first episode psychosis (FEP) includes medication management, individual recovery counseling, family intervention and supported employment/education (SEE). In this model, a team provides the services and coordinates care via team meetings and supervision. In the RAISE-ETP study, 17 community clinics across the U.S. were randomly assigned to implement NAVIGATE. Qualitative analysis of baseline clinic characteristics identified four dimensions relevant to implementation and demonstrated variation within them: communications, organization, staffing, and service array. Overall, the clinics were adequately staffed and organized to provide NAVIGATE. Two key

areas of variation in capacity posed potential implementation challenges. In organization, some clinics relied solely on Medicaid rehabilitation funding and were not prepared to obtain reimbursement from private insurances or to find sources of support for care for uninsured patients with FEP. In service array, some clinics had limited ability to provide SEE. This key service facilitates rapid job searches or school enrollment to help people find competitive employment or to enter school. SEE workers then provide practical support for managing illness symptoms during work or school. Not all state Medicaid programs include this effective intervention and private insurances do not cover it, limiting access

**NO. 2
INDIVIDUAL RESILIENCY TRAINING IN
NAVIGATE: TRAINING, SUPERVISION,
AND FIDELITY ASSESSMENT TO
SUPPORT IMPLEMENTATION**

Speaker: Piper Meyer-Kalos, Ph.D.

SUMMARY:

Individualized Resiliency Training (IRT) is a modular, cognitive-behaviorally-based individual intervention for persons recovering from a first episode of psychosis. Its primary aims are to promote recovery by identifying client strengths and resiliency factors, enhance illness self-management and symptom coping, teach skills to facilitate functional recovery, and to help persons achieve and maintain personal goals and wellness. IRT is composed of seven standard modules, as well as seven (optional) individualized modules. The implementation and dissemination of IRT included a comprehensive plan to ensure fidelity and high quality service delivery. In this symposium, we will provide an overview of the IRT implementation plan including a model for training, consultation, and individual clinician fidelity monitoring for the standard and the individualized modules. We will review the coordination of training across the sites and the measures to assess competency and complete the certification process. Data will be presented on the qualifications of the IRT clinicians trained, fidelity monitoring, and IRT certification.

**NO. 3
THE ROLE OF THE FAMILY
INTERVENTION IN NAVIGATE**

Speaker: Shirley Glynn, Ph.D.

SUMMARY:

The Recovery After an Initial Schizophrenia Episode (RAISE) project is an NIMH-funded 34 site randomized controlled trial evaluating the benefits of participation in a multicomponent pharmacological and psychosocial intervention, NAVIGATE, on clinical and functional outcomes after a first psychotic episode. One key NAVIGATE psychosocial component is a comprehensive individual family program including engagement, assessment, illness education, follow-up, and skills-training customized to participant need. The intervention is grounded in a resilience framework and much of the content reinforces the individual resiliency training offered to individuals in NAVIGATE. This presentation will provide an overview and rationale for this family intervention, as well as a description of key components. Data on uptake and participant characteristics will also be presented. Particular attention will be paid to highlighting clinical issues which emerged in conducting the NAVIGATE family intervention and require attention when working with early psychosis in families, including the impact of divorce and blended families of origin on engagement, family members who use illicit substances with the consumer, relatives who are highly ambivalent or hostile towards use of the consumer's antipsychotic medication, and role strain and distress in conjugal partners of individuals experiencing an initial psychotic episode.

**NO. 4
RISK FACTORS FOR MEDICAL
COMORBIDITIES AT THE ONSET OF
PSYCHOSIS: RELEVANCE FOR
IMPROVED CARE DELIVERY IN
PATIENTS DIAGNOSED WITH
SCHIZOPHRENIA**

Speaker: Christoph U. Correll, M.D.

SUMMARY:

Individuals with schizophrenia have high cardiovascular morbidity and premature mortality. However, risk status and moderators/mediators in the earliest illness stages are less clear. We assessed cardiometabolic risk in first-episode schizophrenia-spectrum disorders (FES) and its

relationship to illness duration, and antipsychotic treatment duration and type, using baseline results of the NIMH-funded Recovery After an Initial Schizophrenia Episode (RAISE) study. Patients aged 15-40 years FES and <6 months lifetime antipsychotic treatment were assessed at 34 community mental health facilities. Pre-baseline antipsychotic treatment was based on community clinician's/patient's decision. In 394/404 subjects with cardiometabolic data (age=23.6±5.0 years) with 47.3±46.1 days of antipsychotic treatment, 49.3% were obese/overweight (23.1%/26.2%), 50.8% smoked, 46.3% had dyslipidemia, 39.9% had pre-hypertension, 10.0% had hypertension, and 13.2% had metabolic syndrome. Prediabetes (glucose-based=4.0%, HbA1C-based=15.4%) and diabetes (glucose-based=3.0%, HbA1C-based=2.9%) were less frequent. Total psychiatric illness duration correlated significantly with higher body composition markers, whereas antipsychotic treatment duration correlated significantly with higher metabolic variables. Olanzapine was associated with higher triglycerides, insulin and insulin resistance, whereas quetiapine was associated with higher triglyceride/HDL-cholesterol levels. These data underscore that prevention

NO. 5 COST-EFFECTIVENESS OF COORDINATED SPECIALTY CARE FOR PEOPLE WITH FIRST-EPISEDE PSYCHOSIS

Speaker: Robert Rosenheck, M.D.

SUMMARY:

No randomized trial has examined the cost-effectiveness of early intervention programs for first episode psychosis over an extended period of time. The NIMH RAISE-ETP (Early Treatment Program) used a cluster randomized trial to evaluate an Coordinated Specialty Care designed to significantly improve the functional outcome and quality of life of people in their first episode of psychosis. Monthly data were gathered through patient interviews on the use of inpatient, residential and outpatient psychiatric, rehabilitative and medical service use and all psychotropic and non-psychotropic medications. Costs of services were estimated using administrative data from Medicaid, VA and private sector claims data bases as well as

from published estimates, and adjusted for inflation to July 1, 2014. Medication costs were estimated using Federal Supply Schedule and Medicaid prices. Services were multiplied by unit costs and summed to estimate total costs for each patient, for each of 24 months. Costs of training for RAISE-ETP patients were distributed among patients at sites randomly assigned to receive the intensive intervention. Quality of Life was assessed with the QOLI and QALYs were assessed on the basis of Positive and Negative Syndrome Scale (PANSS) subscales and side effects using the algorithm developed by Lenert et al., (2004).

DEVELOPMENT, IMPLEMENTATION, AND EFFICACY OF INNOVATIVE BEHAVIORAL ACTIVATION PROGRAMS: EXPERIENCES FROM TWO ACUTE PSYCHIATRIC INPATIENT UNITS

Chairs: Marlene Taube-Schiff, Ph.D., Jackie K. Gollan, Ph.D.

Discussant: Christopher Martell, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the milieu-based BAC framework and how it can be applied in an acute psychiatric inpatient setting; 2) Identify challenges encountered when developing and rolling out a new framework of intervention on an inpatient psychiatric unit; 3) Identify ways in which a BAC framework could be applied to participants' own settings in terms of staff training, feasibility of implementation and research ideas.

SUMMARY:

Patient engagement in the therapeutic milieu on an inpatient unit is an essential ingredient to both recovery and discharge. Behavioral Activation (BA) is a structured, evidence-based intervention found to help psychiatric patients modify avoidance behavior and engage with their environment (Dimidjian et al, 2011). However, a limited amount of research exists to guide mental health professionals on the implementation of behavioral activation interventions within acute inpatient psychiatric units where patients with heterogeneous psychiatric illness reside. Recently, Dr. Jackie Gollan and her colleagues developed Behavioral Activation Communication (BAC), which is an approach that allows for medical staff to

become trained to educate patients regarding the principles and techniques of behavioral activation during their hospitalization. The goal of this symposium is to describe the development, feasibility, implementation, and evidence found for use of this evidence-based milieu approach on two separate psychiatric inpatient units – Northwestern Memorial Hospital (NMH) in Chicago, Illinois and University Health Network, Toronto General Hospital (UHN-TGH), Toronto, Canada. Symposium content will be based on research and training programs conducted by presenters, which will be situated in an up-to-date review of the literature. We will have four presentations during this symposium: Dr. Gollan from NMH will describe the use of behavioral activation as a treatment strategy and milieu culture in the treatment of an acute mentally ill population. She will present program data on the successful implementation and comparative effectiveness of the BAC program. Dr. Marlene Taube-Schiff will describe the adaptation of the BAC program to the acute psychiatric inpatient unit at UHN-TGH, providing an overview of the staff training, challenges, research developments and lessons learned from the implementation of this program. Jenna McLeod will describe the group programming at UHN-TGH and the rollout and research of BAC groups on the general psychiatric unit at UHN-TGH. Dr. Anna Skorzewska will describe the innovative implementation of BAC within a Psychiatric Intensive Care Unit. Dr. Christopher Martell, who has written, consulted and spoken internationally about the development and implementation of Behavior Activation Therapy, will serve as discussant to comment on dissemination challenges with BA and how a BA-based milieu approach can offer a framework for understanding and altering motivation mechanisms underlying acute psychiatric disorders.

**NO. 1
BEHAVIORAL ACTIVATION
COMMUNICATION (BAC) PROGRAM
FOR ACUTE PSYCHIATRIC INPATIENTS:
MODEL, TECHNIQUES AND
EFFECTIVENESS**

Speaker: Jackie K. Gollan, Ph.D.

SUMMARY:

This presentation focuses on the model, principals, and effectiveness data for the Behavioral Activation Communication (BAC) milieu approach for acutely ill psychiatric inpatients. Data suggest that compared with a Milieu as Usual approach (MAU), inpatients in the BAC milieu demonstrated significantly greater change in self-reported positive affect and significantly greater change in behaviors that reflected engagement in the treatment modalities and the milieu. Patients with severe depression residing on the BAC unit showed significant differences in the degree of change of positive affect (twice the improvement) compared to equally severely depressed patients on the TAU unit. Negative affect and avoidance were significantly reduced on both units with no difference by unit. Finally, inpatient approach behaviors and positive affect are predictors of clinical change from admission to discharge on both units. These are the first data to demonstrate that an evidence-based social milieu using Behavioral Activation Communication can significantly increase positive affect, reduce patient avoidance, and decrease depression compared to treatment as usual among severely ill adults with psychiatric disorders.

**NO. 2
ADAPTATION OF BAC TO UNIVERSITY
HEALTH NETWORK-TORONTO
GENERAL HOSPITAL: DEVELOPMENT,
FEASIBILITY, TRAINING AND
RESEARCH DEVELOPMENTS**

Speaker: Marlene Taube-Schiff, Ph.D.

SUMMARY:

This presentation will outline the adaptation and application of the BAC model at UHN-TGH. The psychiatric inpatient unit at the TGH consists of operationally connected programs, including general psychiatry, psychiatric intensive care and geriatric psychiatry. These programs provide interdisciplinary interventions for patients presenting with diagnosis of serious mental illness, including psychotic disorders; mood disorders; psychiatric illness secondary to other medical conditions; and substance use disorders. Treatment to assist in recovery consists of medication review and modification, mood stabilization, risk management, and group programming. Given the success of BAC to engage patients and enhance positive affect

(Gollan et al. 2013), our team implemented a BAC framework within our inpatient unit. During this presentation, we will guide participants through the beginning stages of setting up a BA program including planning and implementation phases, encountered challenges, staff training and research developments. We will describe evaluation tools employed to ensure the effectiveness of this program, provide initial feedback from staff experiences during rollout as well as preliminary data on the effectiveness of this intervention on our unit.

**NO. 3
IMPLEMENTATION OF BAC ON A
GENERAL PSYCHIATRY INPATIENT
UNIT: FEASIBILITY, INTEGRATION AND
STAFF IMPRESSIONS**

Speaker: Jenna McLeod, C.T.R.S.

SUMMARY:

On our unit we offer groups that are skills based, activity based as well as staff-patient community outings. Examples of these include cognitive behavioural therapy, expressive arts, and coping skills. During this presentation we will outline the group programming offered on the inpatient unit at UHN-TGH and how BAC has become integrated into this model. The implementation of our BAC group modules has allowed for small groups of patients to engage in BAC on a daily basis. We will present preliminary results from a qualitative study that will provide an overview of staff impressions regarding: BAC training received; barriers and enablers to program implementation, as well as staff satisfaction. Self-report measures from patients will also be presented focusing on the impact of BA on levels of approach, avoidance and boredom. These results will speak to the feasibility of adapting the BAC milieu approach to our unit, steps taken in order to modify the intervention for this particular group of patients as well as overall staff reactions encountered and any resulting modifications.

**NO. 4
INNOVATIVE BAC PROGRAMMING
WITHIN A SPECIALIZED PSYCHIATRIC
INTENSIVE CARE UNIT**

Speaker: Anna Skorzevska, M.D.

SUMMARY:

This presentation will provide an overview of the existing milieu (before and after BA rollout) within our highly specialized six-bed Psychiatric Intensive Care Unit (PICU). No published research exists on the use of BA within a Psychiatric Intensive Care Unit (PICU). We will present our modified BAC protocol, specifically designed and implemented for patients that reside within this setting of our inpatient unit. This has involved implementation of both sensory-based and recreation-based activities for patients to be carried out on a daily schedule. These activities are chosen in accordance with our newly developed recreation and leisure product policy. Interim data will be presented highlighting enablers and barriers to carrying out these activities from patients and staff; as well as self-report and staff-observed measures.

**THE EVOLUTION OF MATHEMATICAL
PSYCHIATRY: IMPLICATIONS FOR
BRIDGING DSM-5 AND RESEARCH
DOMAIN CRITERIAS (RDOCS) USING
BEHAVIORAL GAME THEORY**

Chair: Lawrence Amsel, M.D.

Discussant: Andrew J. Gerber, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Session participants will be able to demonstrate knowledge of behavioral assumptions that underlie economic theory and that may also be applicable to understanding pathologic behaviors. ; 2) Session participants will be able to demonstrate knowledge of traditional decision tree models used to capture motivational states that inform individual decisions and strategic decisions.; 3) Session participants will be able to demonstrate knowledge of the research progress in integrating neuro-economic models into psychiatric theory and practice. .

SUMMARY:

Psychiatric research appears to be at a crisis point as illustrated by the schism between the APA's new DSM-5, and the RDoCs research program championed by the NIMH. In the past few decades analogous dilemmas in the Social Sciences have been, at least in part, bridged by Behavioral Economics (BE), which includes Behavioral Game Theory (BGT). BE is an interdisciplinary approach that combines the

mathematical rigor of economic modeling, with the empirical methodology of social psychology. While this approach has revolutionized research in the Social Sciences, Psychiatry had been slow to integrate it. For example, in 2003 Amsel organized the first APA symposium on applications of Decision Science (DS) and Game Theory (GT) to psychiatric research through mathematical modeling (MM), an approach termed Mathematical Psychiatry (MP). Although the symposium participants (Amsel, Weber, Bechara, Rogers, Lenert) described cutting edge theoretical and empirical research, in 2003 this approach seemed marginal to psychiatric research. However, over the last decade Psychiatry has seen an explosion of interest in BE, with thousands of research articles incorporating economic-style tasks (often in conjunction with brain imaging), and with scores of theoretical articles on mathematical and computational modeling of psychopathology no longer raising eyebrows. Simultaneously, entirely new interdisciplinary fields relevant to psychiatric research have emerged, e.g. Neuroeconomics, and Computational Psychiatry. In this symposium we will first give a brief historical review of the field's progress. Second, we will present current research (empirical and theoretical) by active leaders in the field. Third, we will look ahead at the implications of this work for future research. In the first talk, Amsel will review some of the history of MP, and also present a new model of OCD as a self-signaling game; this model borrows a standard formalization in GT to explain pathologic behavior. Rogers describes current work on the relation of serotonin activity in individual brains and GT models of resource allocation, one of the most pertinent private-public policy issues of our time. Jollant describes his work using DS to isolate vulnerabilities that contribute to the risk of suicidal behaviors. Griffith uses an innovative GT model to bridge contemporary theories of complicated grief with Freud's model as posited in Mourning and Melancholia. Ainslie, one of the founders of the DS/ GT approach in psychiatry, describes innovative modeling of intrapersonal bargaining between successive motivational states within an individual that may explain addiction, anorexia nervosa, and OCPD. Gerber, will be our discussant and will also address the role that fMRI plays in this work. In conclusion, we will discuss how Behavioral Game Theory can help bridge the perspectives

of DSM-V and RDoCs, and point forward, toward a mathematically rigorous, yet clinically relevant, psychiatric research program.

**NO. 1
BRIDGING DSM-5 AND RDOCS USING
BEHAVIORAL GAME THEORY:
MODELING OBSESSIVE-COMPULSIVE
DISORDER AS A SIGNALING GAME**

Speaker: Lawrence Amsel, M.D.

SUMMARY:

The thesis of the talk is that mathematical modeling drawing on Decision Science and Behavioral Game Theory (DS/BGT) may serve to bridge the schism between the APA's new DSM-5, and the contrasting RDoCs research program championed by NIMH. The goal of these models is to move psychiatric research toward a more rigorous mathematical foundation, while focusing on clinical applicability. In this paper we hope to demonstrate that a mathematical model of repetition compulsion (RC) improves on existing models of this psychopathology, and has valuable clinical implications. Building on work by Mijović-Prelec and Prelec (M-P&P, 2010), we postulate a model in which there are two salient outcomes in the mind of the OCD subject during repeated checking: the utility of the potential material gain or loss, and the utility of gaining information about oneself. Thus, seemingly irrational action choices, such as repeated checking, may actually serve a valuable self-signaling function. Even behaviors considered pathological may have a rationally definable structure (Becker, 1988) and this gives us new clues to improve our treatment approaches. Using this example, the talk will also illustrate how mathematical and theoretical DS/BGT models in psychiatry have evolved and matured in the decade since Amsel's 2003 APA symposium. We will close by contextualizing and introducing the work of the other presenters.

**NO. 2
ADAPTING GAME THEORY TO MODEL
RESOURCE MANAGEMENT
BEHAVIORS: CLINICAL IMPLICATIONS**

Speaker: Robert Rogers, Ph.D.

SUMMARY:

Psychiatric illnesses frequently involve disrupted inter-personal relationships and social isolation, which are important predictors of relapse and poor clinical outcomes. By contrast, sustained involvement with social groups tends to be associated with better outcomes. In the 2003 APA symposium Amsel (2003) and Rogers (2003) discussed the application of Decision and Game Theoretic models and tasks to the study of psychopathology, and over the last decade these models have had an expanded influence on psychiatric research. Continuing on these themes, we have recently adapted game-theoretic models to explore how serotonin activity mediates the way that individuals work with others to achieve a group-based objective, namely the preservation of valuable, but depletable resources for the longer-term. Diminished serotonin activity is associated with aggressive resource-harvesting behaviours and disrupted use of the social norms that constrain resource usage (Bilderbeck et al., 2014). Here, we describe clinical extensions of this research, suggesting that individuals who are vulnerable to depression exhibit broad problems managing resources, both as part of social groups and as individuals. Our results can inform the understanding of the neurobiological and clinical aspects of social exchanges within groups. In addition, they offer ways to model the difficulties patients face when trying to manage social and financial resources to stay well.

NO. 3 DECISION-MAKING AND SUICIDAL BEHAVIOR

Speaker: Fabrice Jollant, M.D., Ph.D.

SUMMARY:

The risk of suicidal behavior requires specific vulnerabilities beyond acute mental disorders, e.g. depression or schizophrenia. These vulnerabilities could explain why 50% of schizophrenic patients never attempt suicide, and over 90% will not actually die by suicide. In recent years, interest in the neurocognitive basis of vulnerability to suicidal behaviour has increased. In the 2003 APA symposium, Amsel proposed a theoretical model of suicidal behaviors based on Decision Science and Game Theory (Amsel, 2003). And over the last decade empirical studies of decision-making (DM) have demonstrated that poor DM is an informative neurocognitive marker, as it is seen

more frequently in patients who have attempted suicide than in those who have not. Recent results from a meta-analysis support these findings (Richard-Devantoy, 2014). Moreover, relatives of suicide completers also displayed riskier DM in a gambling paradigm, suggesting some form of heritability. The investigation of correlates to impaired DM in suicide attempters revealed that it was 1) correlated with more interpersonal difficulties 2) associated with genetic factors previously associated with the risk of suicidal acts 3) related to dysfunction of the orbitofrontal cortex, and 4) independent of working memory, attention or cognitive inhibition deficits. Recent studies using transcranial magnetic stimulation (rTMS) or lithium shed light on potential ways to improve decision-making (Halcomb et al., 2013).

NO. 4 MODELING THE GRIEF PROCESS USING GAME THEORY AND INFORMATION PROCESSING

Speaker: Erica Griffith, B.S.

SUMMARY:

In Mourning and Melancholia (MM), Freud proposed a model of normal grieving that involved decathecting individual memories of the deceased until the totality of the loss had been integrated. In contrast, contemporary studies of complicated grief (CG) have taken a cognitive behavioral (CBT) approach. In a 2003 APA symposium, Amsel discussed the application of Decision Science (DS) and Game Theoretic (GT) models to the study of psychopathology. Here we propose a two-player GT model of the normal grief process in which the individuals are modeled (analogized) by two corporations with multiple, mutually beneficial contracts. The grief process is modeled by the strategic response of the surviving corporation (SC) after the collapse of the partner corporation (PC). We show, that under appropriate conditions, the best response to the totally lost relationship would entail the independent restructuring of each contract, a process structurally similar to serial exposure to individual, episodic memories that allows for a de-coupling of negative valence from these memories and re-valuation of expectancy in similar future experiences. The GT model thus captures the common formal elements of both Freud's model and contemporary theories.

Consistent with the existing empirical literature on CG, this model implies that CG may arise from a failure to decompose the relationship into manageable episodic memories (contracts) or from incapacity to manage the habituation /transformation process.

NO. 5 INTERTEMPORAL BARGAINING IN SELF-CONTROL

Speaker: George Ainslie, M.D.

SUMMARY:

Ainslie introduced Decision Science and Game Theory to psychiatric research (Picoeconomics 1992). These ideas were further developed and introduced to the APA in a 2003 symposium by Amsel et al. (Amsel, 2003). A decade later there is considerable evidence that people share an inborn mammalian tendency to devalue future events according to a hyperbolic function that represents the preference for smaller imminent payoffs over greater but delayed rewards. This leads to a state of limited warfare “ or Game Theoretic competition -- between a person’s successive motivational states, seen as separate agents. For instance, they may wish to be sober in the long run, but to get drunk today. As demonstrated by recent research, an effective form of self-control is to bundle the current choice with similar future choices by interpreting it as a test case for future choices. This device has many of the properties of the iterated prisoner’s dilemma, a Game Theory model. It reduces incentives for impulsivity but also has undesirable effects: increased impact of lapses (as in the abstinence violation effect); a consequent incentive to repress or deny lapses; and a tendency to evaluate choices for their potential precedent setting effects, rather than as experiences in the here-and-now (leading to compulsiveness). The role that intertemporal bargaining models now play in addictions, impulse disorders, anorexia nervosa, and OCPD will be discussed.

ALCOHOL USE DISORDERS AND PTSD: NEW FINDINGS, NEW CHALLENGES

Chair: Anita Bechtholt, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the nature and

course of PTSD symptoms and their co-occurrence with alcohol use disorders; 2) Understand the major behavior and pharmacological interventions for co-occurring PTSD and alcohol use disorders; 3) Know the neurological and genetic underpinnings of PTSD and alcohol use disorders.

SUMMARY:

There is little doubt that alcohol use disorder (AUD) and Posttraumatic Stress Disorder (PTSD) co-occur across a variety of patient populations. Epidemiological studies show that between 25-40 percent of those seeking treatment of for alcohol use disorder (AUD) meet criteria for current PTSD. Researchers and clinicians have highlighted the potentially cyclical nature of this co-morbidity: persons with PTSD may use alcohol to self-medicate or manage their PTSD symptoms. This reduction in PTSD symptoms may, in turn, serves to reinforce inappropriate alcohol consumption, which then may lead to alcohol problems and the maintenance of PTSD symptomatology. The purpose of this symposium is to highlight recent NIAAA-funded research on understanding the neurological and behavioral underpinnings of PTSD and breaking the cycle of PTSD and alcohol use disorder (AUD). Dr. Kathleen Brady will focus on the link between early childhood trauma and the development of alcohol dependence and recent research on pharmacological and behavioral treatment s tailored to victims of childhood trauma. Then, Dr. Murray Raskind will address the treatment of PTSD and alcohol use disorders among combat veterans. The potential for using a generically available CNS-active alpha-1 adrenoreceptor antagonist (prazosin) will be discussed and recent results from a pilot study and placebo controlled trail will be presented. Dr. Kerry Ressler will address co-morbid PTSD and alcohol use disorders from a translational research perspective. He will synthesize findings from Finding from a series of both animal and human studies focused on the intersection of fear / stress and appetitive / addictive disorders, along with the shared risk factors of childhood trauma, emotion

dysregulation, prefrontal-amygdala dyscontrol, and genetic mechanisms. The relative contribution of each of these factors in dysregulated stress responses characteristics of PTSD and alcohol use disorders will be discussed. Finally, Dr. Lisa Najavits will present an update on a well-established, multimodal behavioral intervention for PTSD-Seeking Safety. Seeking Safety focuses on helping patients learn coping skills to attain greater safety in their lives. Data will be presented on combining Seeking Safety with pharmacotherapy and the use of mobile phone applications as adjuncts to the core behavioral intervention.

**NO. 1
NEW DEVELOPMENTS IN THE
TREATMENT OF CO-OCCURRING PTSD
AND ALCOHOL USE DISORDERS**

Speaker: Kathleen Brady, M.D., Ph.D.

SUMMARY:

Post-Traumatic Stress Disorder (PTSD) and Alcohol Use Disorders commonly co-occur. There is accumulating evidence to suggest that individuals who experience high levels of early life adversity are at particular risk for the development of alcohol use disorders. There is also a great deal of evidence suggesting that PTSD and early life trauma can predict poor treatment outcome in traditional addictions treatment settings. Because of these findings, a number of investigations in recent years have focused on both pharmacotherapeutic and psychotherapeutic treatment of co-occurring PTSD and substance use disorders. In this presentation, the connection between early life trauma and the development of alcohol dependence will be explored. In addition, results from recent trials exploring treatments tailored for individuals with co-occurring PTSD and alcohol dependence will be reviewed.

**NO. 2
THE ALPHA-1 ADRENORECEPTOR
ANTAGONIST PRAZOSIN FOR ALCOHOL
USE DISORDER IN COMBAT VETERANS
(AND CIVILIANS) WITH PTSD**

Speaker: Murray A. Raskind, M.D.

SUMMARY:

Alcohol use disorder is commonly comorbid with PTSD. Some combat Veterans use alcohol as 'selfmedication' to suppress briefly PTSD sleep disturbance, trauma nightmares and daytime hyperarousal symptoms. Both PTSD and the alcohol withdrawal symptoms often contribute to development of dependence involve increased noradrenergic activity. We employed the generically available CNS-active alpha-1 adrenoreceptor antagonist prazosin as a rational approach to treating PTSD with comorbid alcohol dependence by lowering the CNS response to released norepinephrine. Results: Study 1.Both combat Veterans have remained abstinent from alcohol consumption for 19 years, PTSD symptoms have been substantially reduced, and suicidal ideation disappeared during prazosin maintenance treatment. Prazosin was well tolerated. Study 2. There was a significantly greater reduction in alcohol consumption in the prazosin group than the placebo group; there was no difference in PTSD symptom reduction between groups. Conclusions: CNS alpha 1 AR antagonism with prazosin appears to be effective for alcohol use disorder comorbid with PTSD. Efficacy in combat trauma PTSD may be a function of reduced need to selfmedicate PTSD symptoms with alcohol. Prazosin efficacy for alcohol use disorder appears to be independent of effects on PTSD.

**NO. 3
UPDATE ON TRANSLATIONAL
RESEARCH: NEUROBIOLOGY OF
APPETITIVE AND AVERSIVE BEHAVIORS
IN MICE AND ALCOHOL USE
DISORDERS AND PTSD IN HUMANS**

Speaker: Kerry Ressler, M.D., Ph.D.

SUMMARY:

Traumatic experience has been linked to substance and alcohol use disorders, as well as Posttraumatic Stress Disorder and other comorbid mood-related psychopathology. We have focused on the intersection of fear / stress and appetitive / addictive disorders, along with the shared risk factors of childhood trauma, emotion dysregulation, prefrontal-amygdala dyscontrol, and genetic mechanisms which may underlie dysregulated stress responses. I will review recent animal studies demonstrating that

BDNF-mediated plasticity within prefrontal cortex and amygdala is involved in appetitive and aversive behavior. I will then review epidemiological data from a highly at-risk inner city population (N>8000), demonstrating the high levels of comorbidity. Finally, we report results from a genome-wide association study (GWAS) of problematic alcohol use as measured by the Alcohol Use Disorders Identification Test. Results indicate a genome-wide significant association between total AUDIT score and a single nucleotide polymorphism upstream of the gene, SCLT1 [N=1036, p=2.61E-10-8], which also replicated in a meta-analysis of two independent cohorts (N=1394, p=0.0004). This SNP also associated with SCLT1 gene expression and cortical-cerebellar functional connectivity measured via functional magnetic resonance imaging. Overall these data suggest that translational neurobiological and genetic approaches may help to understand risk and suggest future interventions for stress-related comorbidity.

NO. 4

AN UPDATE ON THE SEEKING SAFETY MODEL: EMPIRICAL AND CLINICAL DEVELOPMENTS

Speaker: Lisa Najavits, Ph.D.

SUMMARY:

Seeking Safety is an evidence-based behavioral therapy designed for co-occurring PTSD and substance abuse. The focus of Seeking Safety is to help patients learn coping skills to attain greater safety in their lives. Examples of Seeking Safety topics are, Asking for Help, Creating Meaning, Setting Boundaries in Relationships, Taking Good Care of Yourself, Healing from Anger, Compassion, Honesty, and Healthy Relationships. Seeking Safety is a present-focused model that has been widely implemented with numerous populations, including men, women, homeless, criminal justice, adolescents, veterans and military, and seriously mentally ill. This presentation will describe the model briefly, and offer a summary of new findings and clinical expansions. New empirical findings include a study of Seeking Safety plus sertraline medication versus Seeking Safety plus placebo; peer-led Seeking Safety; Seeking Safety for gambling disorder; and a Department of Defense study. Clinical

developments include a phone app for transition-age youth; an HIV guide; a guide for seriously mentally ill; online training for clinicians; an online option for facilitating training; and translations into 8 languages. We will discuss how such developments arose in relation to the broader field of PTSD/substance abuse comorbidity and trauma-informed care.

REDUCE DURATION OF UNTREATED PSYCHOSIS (DUP) AND THEN TREAT WELL

Chair: S. Charles Schulz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the comprehensive program developed in the RAISE grant to approach First Episode Psychosis.; 2) Discuss the strategies for evaluation of the young patients with an initial psychotic episode.; 3) Review the initial medication approaches to the first episode of psychosis and the next steps for non-responders.

SUMMARY:

There has been substantial focus on identifying and treating patients with a first episode of psychosis for a quarter of a century. Meta-analytic studies have demonstrated that the longer Duration of Untreated Psychosis (DUP) exists the poorer is the outcome of the illness. Other studies have shown that with earlier engagement with the first episode patient there is less severe symptomatology. However, around the world there are significant differences in the length of time of onset of psychosis to the initiation of treatment. This leads to new goals to reduce DUP in a constructive way. Further, there are now programs which have studied and described effective initial treatments from initiating medication, starting cognitive behavior therapy, engaging parents in psychoeducation, and helping with occupational therapy. This symposium will describe a range of approaches from early intervention into the evaluations, how to start treatments, how other countries have advanced the programs, and even how to assist the young patients if initial response is not adequate. To begin the Symposium, Dr. John Kane will describe the plan and current results of the RAISE study – a multi-center trial that

structured and then examined a range of approaches for the First Episode patients. This large study included a broad range of both academic and community settings that leads to excellent application. An important topic in beginning treatment of the First Episode patients is the initial evaluation of the young patients and objective measures of their status. Dr. Oliver Freudenreich has developed an excellent standard approach to this topic and has formatted how the evaluations lead to diminishing treatment delays. There is great concern about the length of DUP in the US and it is very interesting how other countries have originated a way to make the public aware of the illness. Dr Brian O'Donoghue will discuss the strategies in two countries, Australia and Ireland, aimed at reducing the DUP. This will include the roll-out of the EPPIC model of Early Intervention for psychosis services across Australia and also innovative public education campaigns about psychosis in Ireland, such as a play about psychosis and a storyline in a popular TV soap opera. To conclude the symposium, Dr. Robert Zipursky will describe findings from a Canadian First Episode program which reviews the standardized steps through treatment and will also discuss the approaches to the young patients who do not respond to the initial interventions. In conclusion, reducing the DUP is a highly important step in the treatment of young people with serious psychiatric illness. These presentations which include approaches from other countries will inform the attendees to the reduction of DUP and the important steps in treating.

**NO. 1
HIGH-QUALITY PSYCHIATRIC CARE TO
REDUCE TIME OF ACTIVE PSYCHOSIS**

Speaker: Oliver Freudenreich, M.D.

SUMMARY:

High-quality psychiatric care that is stage-based, effective and safe is necessary for the optimal treatment of patients with psychosis. Secondary prevention is possible when treatment is instituted and appropriately stepped-up (including the early use of clozapine) in the face of poor response. This presentation describes how a comprehensive initial assessment in patients with suspected or established psychosis at presentation allows for longitudinal treatment planning that minimizes

treatment delays and aims to keep short the time a patient remains psychotic.

**NO. 2
RECOVERY AFTER AN INITIAL
SCHIZOPHRENIA EPISODE: EARLY
TREATMENT PROGRAM**

Speaker: John M. Kane, M.D.

SUMMARY:

Schizophrenia is associated with enormous personal suffering and disability. Although a number of innovative first episode programs have been implemented, there are remarkably few prospective, randomized, controlled trials comparing a multimodal team approach to usual care. Such a study has never been conducted in the U.S. in real world community clinics under extant reimbursement constraints. The aims of the NIMH-funded RAISE Early Treatment Program are to develop a comprehensive intervention designed to promote symptomatic and functional recovery, be capable of being delivered in real world settings utilizing current funding mechanisms and to assess the clinical effectiveness of the intervention as compared to usual care in real world community treatment settings. Patients 15-40 years old with a first episode of schizophrenia; schizoaffective disorder; schizophreniform disorder, psychotic disorder NOS, or brief psychotic disorder and no more than six months of antipsychotic medications were eligible. Patients are followed for a minimum of two years, with major assessments conducted by blinded, centralized raters using live, two-way video. We selected 34 clinical sites in 21 states and utilized cluster randomization to assign 17 to the experimental treatment and 17 to usual care. Enrollment began in July, 2009 and ended in July 2011 with 404 subjects. Results will be presented.

**NO. 3
THE REDUCTION OF THE DURATION OF
UNTREATED PSYCHOSIS IN AUSTRALIA
AND IRELAND**

Speaker: Brian O'Donoghue

SUMMARY:

The duration of untreated psychosis (DUP) comprises two components, help-seeking delays and health system delays. This presentation will discuss the strategies

employed in two countries, Australia and Ireland, aimed at reducing the DUP in psychotic disorders. Throughout Australia, the headspace Youth Early Psychosis Program (hYEPP) will deliver the EPPIC model of early intervention for psychosis services to young people experiencing a first psychotic episode and their families. These specialized psychosis services will be embedded within headspace centres, which provide mental health and primary care services in a non-stigmatizing, youth-focused setting. To reduce help-seeking delays, the Community Development team within Orygen Youth Health undertakes educational campaigns directed at community, education and health organizations to encourage the early referral of young people developing a psychotic disorder. In Ireland, in addition to the planned roll-out of early intervention services, innovative public education campaigns have been undertaken by the DETECT early intervention service to raise awareness of psychosis in the general public. These campaigns consisted of working with the script writers of a national television soap opera to introduce a realistic portrayal of schizophrenia and commissioning a play that has toured nationally, "One Man Many Voices"™, which portrays a character experiencing auditory hallucinations.

NO. 4 RECOVERY IN SCHIZOPHRENIA: WHAT'S DUP GOT TO DO WITH IT?

Speaker: Robert Zipursky, M.D.

SUMMARY:

Schizophrenia is a highly treatable illness with the large majority of patients achieving remission of their psychotic symptoms following their first episode of psychosis. Rates of recovery, however, remain relatively low and underscore the challenge of returning to a full level of functioning in the community following a psychotic illness. There has been much interest in the possibility that protracted periods of untreated psychosis may contribute to the difficulties experienced in functioning. Duration of untreated psychosis (DUP) has been proposed as a critical modifiable determinant of recovery. It has been difficult to exclude the possibility that DUP is a risk marker for illnesses with more insidious onset and poorer outcomes. This presentation will address the question of whether DUP should be understood as a modifiable determinant of treatment response

and recovery. Comprehensive approaches to treatment of the first episode of schizophrenia and intensive efforts at preventing relapse will be discussed as essential components of optimal treatment.

SOCIETY UNFAIR, SOCIETY UNWELL: ADDRESSING THE SOCIAL DETERMINANTS OF MENTAL HEALTH

Chairs: Ruth Shim, M.D., M.P.H., Michael T. Compton, M.D., M.P.H.

Discussant: David A. Pollack, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) describe the concept of the social determinants of mental health; 2) list common social determinants of mental health that providers encounter in their practice; 3) consider activities that providers can engage in to improve mental health in communities by addressing the social determinants of mental health.

SUMMARY:

This symposium will introduce and define the concept of the social determinants of mental health (the conditions in which people are born, grow, live, work, and age that impact our mental health). These determinants are shaped by the multilevel distribution of money, power, and resources in our society, and are responsible for many of the health inequalities that exist within and between countries. Simply put, society plays a prominent role in creating and shaping poor mental health and mental illnesses, and, as such, society is also in a position to improve mental health and reduce the risk for mental illness. Furthermore, in order to consider a prevention approach in psychiatry, we must move beyond the traditional concepts of proximal risk factors, and more toward the "fundamental causes of disease," also referred to as "the causes of the causes." This symposium will briefly touch on the many social determinants that are impacting our society, but will focus in and provide a more detailed analysis of three determinants of particular interest: food insecurity, income inequality, and adverse features of the built environment. This symposium will present important concepts, including social justice, public health approaches to treating mental illnesses, and the impact of public policies and social norms on

mental health. The clinician's role in addressing the social determinants of mental health through policies, politics, and governance strategies will be discussed.

**NO. 1
AN INTRODUCTION TO THE SOCIAL DETERMINANTS OF MENTAL HEALTH**

Speaker: Ruth Shim, M.D., M.P.H.

SUMMARY:

This presentation will define and describe the concept of the social determinants of mental health, using a framework developed by the Symposium Co-Chairs. It will discuss important concepts related to the social determinants of mental, and emphasize the connection to social justice. The importance of public policy in taking action to address the social determinants of mental health will be discussed.

**NO. 2
FOOD INSECURITY AS A SOCIAL DETERMINANT OF MENTAL HEALTH**

Speaker: Michael T. Compton, M.D., M.P.H.

SUMMARY:

This presentation will present an overview of the effects of hunger, food insecurity, poor dietary quality, and nutritional deficiency and their adverse effects on mental well-being. Associations between food insecurity and the obesity epidemic will be discussed. Tested and effective policy interventions that support good nutrition across the lifespan, beginning in utero (maternal nutrition) will be articulated.

**NO. 3
POVERTY AND INCOME INEQUALITY AS SOCIAL DETERMINANTS OF MENTAL HEALTH**

Speaker: Marc W. Manseau, M.D., M.P.H.

SUMMARY:

This presentation will focus on poverty as a macro-level risk factor for poor mental health and will address issues of individual-level and area-level poverty. Specific topics to be discussed will include the "poverty tax," income inequality, and relative deprivation, as well as the widening gap between the rich and poor, and the child poverty epidemic in the United States. Relevant policy implications

(including social protective systems and redistributive welfare systems) will be discussed.

**NO. 4
ADVERSE FEATURES OF THE BUILT ENVIRONMENT AS SOCIAL DETERMINANTS OF MENTAL HEALTH**

Speaker: Lynn Todman, Ph.D.

SUMMARY:

This presentation will discuss the quality of the built environment, and how neighborhoods, urban environments, green spaces, and exposures represent social determinants of mental health. Furthermore, the impact of public transportation systems and rural development will be discussed. Policy solutions and issues related to urban planning will be addressed.

THE PLACE OF BENZODIAZEPINES IN TREATMENT OF ANXIETY DISORDERS: ARE WE IGNORING THE EVIDENCE?

Chair: Edward K. Silberman, M.D.

Discussant: Edward K. Silberman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List three factors influencing the diagnostic trend away from anxiety disorders to mood disorders; 2) Define the terms drug abuse, drug misuse, addiction, and physiologic dependence; 3) Summarize the evidence about abuse liability of benzodiazepines in general psychiatric populations and those with a history of substance abuse; 4) List five guidelines for safe and effective prescription of benzodiazepines.

SUMMARY:

When benzodiazepine anxiolytics were first marketed they were viewed as liability-free successors to barbiturates and widely prescribed, often for vague indications. Now they are commonly viewed as drugs with high liability to abuse and misuse and prescribed reluctantly, if at all, by many psychiatrists and primary care physicians. This symposium examines the causes of this transition and reviews the actual evidence base for abuse and misuse of benzodiazepines vs. their therapeutic benefit. Individual presentations will review: (1) Aspects of psychiatric culture, general American culture, and business culture that have

contributed to a bias against diagnosing anxiety disorders; (2) The evidence base for abuse and misuse potential of benzodiazepines in general psychiatric populations; (3) The evidence base for benefits vs. liabilities of benzodiazepine treatment for patients with histories of substance abuse; (4) The influence of perceived legal and regulatory liability on anxiolytic prescribing practices. Following the presentation, the Discussant will propose evidence-based guidelines for use of benzodiazepines in anxiety disorders.

NO. 1 HOW AN AGE OF ANXIETY BECAME AN AGE OF DEPRESSION

Speaker: Allan V. Horwitz, Ph.D.

SUMMARY:

During the 1950s and 1960s anxiety was the emblematic mental health problem in the U.S., while depression was considered to be a rare condition. One of the most puzzling phenomena regarding mental health treatment, research, and policy is why depression has become the central component of the stress tradition since that time, although epidemiological surveys show that anxiety is still the most widespread condition in the community. Several factors led to the rise of depressive and fall of anxiety diagnoses during the past half century. First, the association of anxiety with diffuse and amorphous conceptions of "stress" and "neuroses" became incompatible with professional norms demanding diagnostic specificity. At the same time, the contrasting nosologies of anxiety and depression in the DSM III led major depressive disorder to encompass a far greater range of patients than any particular anxiety disorder. In addition, the agenda of the emergent field of biological psychiatry could be more closely tied to depression than to anxiety, which was associated with psychoanalytic theories. Finally, when a new class of anti-depressant drugs emerged in the late 1980s, it made more sense to market them as anti-depressants than as anxiolytics, although they are prescribed for both depression and anxiety.

NO. 2 ABUSE POTENTIAL OF BENZODIAZEPINES: WHAT IS THE EVIDENCE?

Speaker: Richard Balon, M.D.

SUMMARY:

There has been a continuing public perception that benzodiazepines are widely abused and have a high abuse potential. This presentation reviews the literature on this topic. The evidence suggests that (1) benzodiazepines are not over-used, (2) long-term use or dependence is a relatively limited clinical phenomenon, (3) individuals using benzodiazepines rarely demonstrate tolerance to anxiolytic action or escalate the dose, (4) most prescriptions for benzodiazepines are for 6 months or less, (5) only a small proportion of patients in drug abuse treatment facilities list benzodiazepines as their primary drug problem; rather, they are used in the context of alcohol or poly-substance abuse, (6) patients with chronic medical and/or psychiatric illnesses, patients with chronic dysphoria, patients with personality disorders, and those with chronic sleep difficulties may be at higher risk for misuse or abuse.

NO. 3 BENZODIAZEPINE PRESCRIPTION FOR PATIENTS WITH SUBSTANCE ABUSE: IS IT EVER APPROPRIATE?

Speaker: Domenic A. Ciraulo, M.D.

SUMMARY:

It is a common conception among psychiatrists that a history of substance abuse is an absolute contra-indication to prescription of benzodiazepines, because such patients would invariably abuse these medications, or their use would trigger a relapse of abuse of other substances. In fact, the evidence base presents a much more nuanced picture of the risks and benefits of prescribing benzodiazepines to patients with prior substance abuse. This talk will review the pre-clinical literature on euphoriant and reinforcing properties of benzodiazepines as well as the literature defining risks and benefits in clinical populations of patients recovering from substance abuse. Areas of relatively higher vs. lower risk will be described, and guidelines for prescribing will be proposed.

NO. 4 FEAR-DRIVEN RELUCTANCE TO PRESCRIBE BENZODIAZEPINES AND THE PERCEIVED STANDARD OF CARE

Speaker: Kenneth Weiss, M.D.

SUMMARY:

Despite decades of subsequent clinical practice and research on the safety and efficacy of benzodiazepines in anxiety disorders, many practitioners avoid this class of medications. The avoidance is sufficiently prevalent to stigmatize prescribers, who are concerned they might negligently expose patients to an iatrogenic substance use disorder. This fear-driven dynamic is fueled by prescribers' and consumers' fear of addiction, fear of misuse and diversion, the ascendance of SSRIs as treatments of choice for anxiety, and perceived preventive risk management of malpractice claims. As a result, common practice is to use benzodiazepines sparingly or as a last resort. But is this the legal standard of care? In this presentation, participants will address the evolving standards of care for anxiety and related disorders in relation to medical malpractice case law and the evolving regulatory environment. Standard-of-care considerations will also be discussed in the context of treatment algorithms, competing products, documentation, and off-label prescribing. Data will be derived from retrospective analyses of New York and other states' regulation of benzodiazepine prescribing and from court decisions on the duty of prescribers to patients.

PHYSICAL HEALTH IN BIPOLAR DISORDER: SCIENTIFIC, CLINICAL, AND PUBLIC HEALTH IMPLICATIONS

Chair: Benjamin Goldstein, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To discuss clinical evidence of increased oxidative stress and evidence of impaired mitochondrial function in patients with mood disorders and schizophrenia; 2) To discuss the role of metabolic inflammatory disturbances in pathogenesis of bipolar disorder; 3) To consider how the heart-bipolar link may inform monitoring, treatment, and stigma-reduction in adolescent bipolar disorder; 4) To understand the multiple and longitudinal relationships between bipolar disorder and specific medical conditions.

SUMMARY:

Over the past 15 years, a robust evidence base has emerged regarding the excessive burden of physical illness and mortality among people with bipolar disorder. Excessive medical burden is observed internationally, and preceded the advent of second generation antipsychotics. Multiple factors contribute, including excessive smoking, the stress of mood symptoms, sedentary lifestyle, sleep disruption, and certain medications. In addition, there is accumulating evidence regarding shared pathophysiologic mechanisms such as inflammation and oxidative stress. Excessive medical burden is observed across the lifespan, including elderly, middle-age adults, and youth. Importantly, problems with physical health have been repeatedly linked with a more pernicious course and outcome of bipolar disorder. Alongside growing recognition of the importance of physical health in bipolar disorder, there has been burgeoning interest in biomarker discovery strategies and treatment approaches that relate directly to physical health. Indeed, there has been a recent move toward conceptualizing bipolar disorder as a systemic illness that affects multiple organ systems despite being defined by mood symptoms. The concept of staging is beginning to take shape in bipolar disorder, with the hope that this will inform prognosis, assessment, and treatment. Given the impact of physical health on brain structure and function, there is growing consensus that physical health will play an important role in bringing the concept of staging in bipolar disorder to the point that it affects clinical decision making. In summary, at each level of analysis, including subcellular factors, systems and circuits, clinical course, and treatment, there is abundant evidence that brain and body are intricately and meaningfully linked in bipolar disorder. Nonetheless, there are knowledge gaps that have thus far prevented the field from fully exploiting brain-body perspectives for the benefit of patients and society. This symposium seeks to highlight the current state of knowledge across each of the above levels of analysis, and to provide attendees with an up-to-date, authoritative, and translational perspective on the topic of physical health in bipolar disorder. The presenters are each thought leaders in their respective areas, and will bring together expertise and cutting-edge findings relating to biomarker discovery, vascular underpinnings of bipolar disorder,

novel therapeutic approaches targeting brain-body links, and disease staging in bipolar disorder. We believe that our symposium exemplifies the theme of this meeting, "Psychiatry: Integrating Body and Mind, Heart and Soul", and that our symposium will convey to attendees the tremendous promise and relevance of this type of integration.

**NO. 1
OXIDATIVE STRESS IN BIPOLAR
DISORDER AND OTHER PSYCHIATRIC
ILLNESSES**

Speaker: Ana Andreazza, Ph.D.

SUMMARY:

There is increasing evidence that oxidative stress may play a role in psychiatric illnesses. In recent years, sophisticated clinical measures are unveiling links of oxidative stress markers with disease domains. In addition, preclinical work is converging in identifying oxidative stress as a key element in pathophysiological states in diverse animal models. Dr. Andreazza will overview these issues, presenting unpublished data that are moving the field forward in identifying oxidative stress as a pathophysiological mechanism in these disorders. She will first discuss clinical evidence of increased oxidative stress and evidence of impaired mitochondrial function in patients with mood disorders and schizophrenia, then Dr. Andreazza will discuss the link between peripheral measures of oxidative stress and white matter abnormalities in the same disorders. Overall, Dr. Andreazza will highlight oxidative stress as a cellular process possibly involved in the expression of behavioral traits characteristic of psychiatric disorders.

**NO. 2
ADOLESCENT BIPOLAR DISORDER AS
A VASCULAR DISEASE**

Speaker: Benjamin Goldstein, M.D., Ph.D.

SUMMARY:

Bipolar disorder is a leading cause of disability and morbidity among adolescents world-wide. Moreover, bipolar disorder among adolescents is associated with an even greater symptomatic burden than adult bipolar disorder. Nonetheless, to date there are no clinically applicable biomarkers that can be used in the assessment or treatment of adolescents with

bipolar disorder. There is growing evidence that, similar to adults, bipolar disorder among adolescents is associated with elevated cardiovascular risk. As such, pursuing vascular biomarkers may be fruitful. Compared to studies of adults, confounded by decades of the allostatic load of bipolar disorder (exposure to symptoms and their associated physiological strain), studies of adolescents may enhance signal detection. This presentation will elaborate recent findings regarding vascular biomarkers among adolescents with bipolar disorder, including vascular imaging, cerebral blood flow, and inflammatory markers. The presentation will put forth the hypothesis that bipolar disorder among adolescents is in part a vascular disease, and will demonstrate potential applications of this concept to biomarker discovery and novel treatment approaches. Finally, the presentation will consider the potential benefits on stigma reduction of positioning bipolar disorder as a systemic vascular illness.

**NO. 3
METABOLIC-INFLAMMATORY
DISTURBANCE IN BIPOLAR DISORDER:
IMPLICATIONS FOR DISEASE
PATHOGENESIS AND COGNITIVE
IMPAIRMENT**

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Convergent evidence implicates disturbances in metabolic - inflammatory systems a salient to the pathogenesis of bipolar disorder, the progression of illness, cognitive dysfunction, medical comorbidity and premature mortality. Disturbances in metabolic inflammatory systems are not only a convergent pathogenetic substrate but also represent both cause and consequence of the disorder. The mechanistic role of metabolic inflammatory disturbances in bipolar disorder provides the basis for hypothesizing that multimodality approaches capable of modulating the system may not only be symptom suppressing but also disease modifying along the illness trajectory. This presentation will succinctly review disturbances in metabolic inflammatory systems in bipolar disorder and discuss implications for domain - specific psychopathology e.g. cognitive dysfunction and present results and rationale

for recent studies with minocycline and infliximab.

NO. 4 STAGING IN BIPOLAR DISORDER AND ITS RELATIONSHIP TO PHYSICAL HEALTH

Speaker: David J. Kupfer, M.D.

SUMMARY:

The incorporation of physical health issues is essential if we are to advance our treatment of bipolar disorder. Recently, efforts have been made to establish a staging model for bipolar disorder (BD) similar to the strategies used in oncology and cardiovascular disease. Several of us have proposed a staging model for BD which includes aspects of genetics and neuroimaging findings.

Support in favor of or rejection of a staging model of BD will require the inclusion of other biologic measures related to the concept that BD is a multisystem disorder and involves other medical disorders. A staging model for a chronic disorder that does not deal with the probabilities that these chronic disorders represent a multisystem may miss the most vital aspects of the staging components. For example, at what stage should we incorporate the tracking of inflammatory markers or ascertain specific risk factors for various medical diseases including diabetes, asthma, and other chronic illnesses. Finally, as all of the previous points imply, a staging approach to BD explicitly points to the need for targeted stage-appropriate interventions.

MINDFULNESS: IN THE BRAIN AND IN CLINICAL PRACTICE

Chair: Frank Sommers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with research based evidence for brain changes including the neural mechanisms of Mindfulness Training (MT), and who are most and least likely to benefit.; 2) Learn about the clinical application of time limited MT in a group format setting, and in office based practice.; 3) Become acquainted with and inspired by the well established, pioneering, interprofessional Applied Mindfulness Meditation (AMM-MIND) Program at the University of Toronto.

SUMMARY:

While mindfulness is an ancient practise, its resurgence maybe a natural reaction to the pace of modern life that many of us, patients and healers, find ourselves in. Further, as we embrace the laudable maturational and therapeutic goal of self regulation, mindfulness training can provide widely acceptable paths toward reaching such a goal. Accumulating evidence is providing reassurance that diverse mindfulness training approaches are highly effective in achieving therapeutic progress in a variety of mental health problems, and indeed may have the potential to strengthen coping skills and life enjoyment in everyone.

In this clinically focused session we will explore evidence for neural mechanisms of Mindfulness Training (MT) - its mode of changing the brain and clarify who are the most and least likely to benefit from MT, including a comparison with progressive muscle relaxation and cognitive behavioral therapy.

Research results will be presented on the outcome of a group Mindfulness Based Stress Reduction (MBSR) program, and the therapeutic factors that lead to participants' sustained improvement on follow up, compared to controls. The standardized MBSR group format of this 8 week program will provide an adaptable model for clinicians in a variety of settings.

Another application of MT will be in the realm of treatment of psycho-sexual dysfunctions. This program has been using MT as its core therapeutic modality over the past 40 years. The Mindfulness concepts of learning to be Present Centered (PC) and Process Absorbed (PA) and their consequent positive application on the Autonomic Nervous System have proven to be life changing practises for both single men and women, as well as couples, who have learned to generalize the mindfulness skills acquired in the course of their brief, directive treatment program to many other aspects of their lives in very effective, life affirming ways.

Finally we will review the innovative Applied Mindfulness Meditation Program (AMM-MIND) at the University of Toronto. This well established program, with 45 faculty, trains health science and other professionals, e.g. chaplains, police, and corporate world, ways to apply and integrate mindfulness and mindfulness meditation into daily life. This integrative practice can lead to improved self

and co-regulation, attentional skills, and reduced errors, while promoting health, wellness and resiliency.

**NO. 1
NEURAL MECHANISMS OF
MINDFULNESS TRAINING - HOW DOES
IT CHANGE THE BRAIN AND WHOM
CAN IT HELP?**

Speaker: Norman A. S. Farb, Ph.D.

SUMMARY:

In a time when clinical applications of mindfulness training (MT) are rapidly growing in popularity, we are just beginning to understand the many mechanisms underlying its efficacy. This presentation will summarize the major research findings cognitive neuroscience has to offer on how MT works, revealing mechanisms for novel sensory integration and reduced reliance on prior conceptual knowledge about the self and others. Based on the neuroscience data, the review will attempt to “reverse-engineer”™ case studies of people who are most and least likely to benefit from mindfulness interventions, providing a tractable translation of this growing research literature into clinical practice recommendations. A comparison of MT’s strengths and weakness relative to progressive muscle relaxation therapy and cognitive behavioral therapy will be provided.

**NO. 2
IDENTIFYING THERAPEUTIC FACTORS
IN AN EIGHT-WEEK (30-HOUR)
MINDFULNESS-BASED-STRESS
REDUCTION PROGRAM**

Speaker: Katalin J. Margittai, M.D.

SUMMARY:

Since their introduction into mainstream medical practice, time-limited, mindfulness-based group therapies have proven effective in reducing the subjective levels of stress, pain, anxiety and depression in participants. Using a standard 30-hour MBSR group format, we monitored 140 patients at baseline, at completion of the program (8 weeks), at one month follow-up (12 weeks), and again at one year (60 weeks). Clinically relevant symptoms were assessed using self-report questionnaires (Beck Depression Inventory, Beck Anxiety Inventory, Perceived Stress Scale, Visual Analogue Pain Scale), and the acquisition of

mindfulness skills was assessed using the Toronto Mindfulness Scale (TMS - curiosity and decentering) and the Mindful Attention Awareness Scale (MAAS - capacity to be in the moment). Forty-five control subjects were sequentially recruited from the waitlist, and from an outpatient psychiatric practice. Statistical analysis of the data was performed using the SPSS software package.

The results included subjects improving more than controls, their improvement being sustained over time, and clinical improvements directly correlated with gains in mindfulness skills.

**NO. 3
MINDFULNESS IN LOVE AND LOVE
MAKING**

Speaker: Frank Sommers, M.D.

SUMMARY:

Neuroendocrine and neuroimaging studies provide evidence for the utility of Mindfulness Training (MT) in a wide variety of mental health afflictions. This presentation arises from experience with MT as a core therapeutic tool, along with autonomic nervous system re-training, in 7,651 sessions with single women and men, and couples. An innovative part in this version of MT has been the integration of video as an adjunct therapeutic modality. This approach is particularly useful in conveying cognitive and affective content in a way that overcomes language, and cultural barriers with a wide variety of patients. The generalizability of this mode of MT to patients' lives beyond the intimate relationship has enhanced its receptivity and provided gratifyingly positive therapeutic results, over many years.

**NO. 4
EVERY MOMENT IS AN OPPORTUNITY
TO PRACTICE (OTP): INTEGRATING
MINDFULNESS AND MINDFULNESS
MEDITATION**

Speaker: Michele C. G. Chaban, D.Phil., M.S.W., Ph.D.

SUMMARY:

The Applied Mindfulness Meditation Program (AMM-MIND) at the University Toronto is a community of practice, built on phenomenological options and practice possibilities, encouraging participants to

integrate and apply mindfulness and mindfulness meditation into every moment of life. The intent of integrative practice would be to enhance self-regulation, co-regulation, attentional skills, and reduce error, as well as help promote health, wellness and resiliency. Teaching inter-professionals how to integrate practice for over a decade, and drawing from the practice experience of over 45 faculty in the AMM-MIND program, participants learn how to begin anew with a life both on and off the cushion of mindfulness meditation, making it an integral part of self. This approach explores strategies for the integration of Mindfulness and Mindfulness Meditation (M,MM) into one's life which includes but is largely beyond the traditions of seated practice.

COMPULSIVITY AS A NEW TRANS-DIAGNOSTIC RESEARCH DOMAIN FOR THE RDOC

Chair: Michael Van Ameringen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To understand the evidence supporting compulsivity as a new trans-diagnostic research domain; 2) To recognize the neurocognitive mechanisms and neural correlates of compulsivity; 3) To understand the potential risk genes and the role of the oxytocin/vasopressin system and the immune-inflammation system in OCDS; 4) To review the use of medications and the potential use of dTMS in the treatment of compulsive behaviours.

SUMMARY:

There has been a recent focus on identifying endophenotypes and moving towards dimensionality in order to better capture individual vulnerability to psychopathology and the high rate of comorbidity of psychiatric disorders. Endophenotypes (intermediate phenotypes) have the potential to measure objective trait markers that are either simpler to assess than complex phenotypic behavioral diseases or may represent constructs more closely aligned with the biological underpinnings of psychiatric disorders. Compulsivity refers to a tendency to perform unpleasantly repetitive actions in a habitual or stereotyped fashion in order to prevent a perceived negative consequence, leading to

functional impairment. Compulsivity represents behaviors common to numerous conditions. A 'compulsivity continuum' has been hypothesized, with the prototypical disorder of compulsive behavior being Obsessive Compulsive Disorder (OCD), and comprises a group of disorders, also referred to as 'OCD spectrum' disorders (OCDS), which includes, Body Dysmorphic Disorder, Trichotillomania, Tourette's syndrome, Eating disorders, Autistic Disorder, 'behavioral addictions' (e.g. Gambling, Sex Addiction) Substance Abuse and Binge Drinking. The research domain criteria (RDoC) classification purposes new ways of classifying psychopathology based on dimensions of observable behavior and neurobiological measures (from genes to neural circuits to behaviors), cutting across disorders as traditionally defined. We propose that Compulsivity be considered a new RDoC domain. In this symposium we will selectively review new developments in the investigation of compulsivity in order to advance our understanding of the pathophysiology of compulsive disorders by examining: 1) the contribution of neurocognitive mechanisms involved in vulnerability to compulsivity and the neural correlates of excess habits under fMRI scanning, 2) the role of the oxytocin/vasopressin system and the immune-inflammatory system in modulating the repetitive behavior domain in OCDS, 3) the potential risk genes for OCDS, 4) the evidenced base use of medications for compulsive behaviors, and 5) the results of Transcranial Magnetic Stimulation (dTMS) treatment, targeting the Anterior Cingulate Cortex in OCD.

NO. 1

COGNITION AS A TREATMENT TARGET IN OBSESSIVE-COMPULSIVE DISORDERS (OCD)

Speaker: Naomi A. Fineberg, M.B.B.S.

SUMMARY:

Patients with OCD are significantly impaired in a broad range of cognitive tasks. A better understanding of the neuropsychological basis for these deficits may guide treatment's allocation and advance treatment development. Accumulating evidence suggests neurocognitive mechanisms mediating behavioural inhibition (motor inhibition, reversal learning, set-shifting) and habit learning may

contribute toward vulnerability to compulsive activity. In OCD, distributed network perturbation appears focussed around the orbitofrontal cortex (OFC), caudate, putamen and associated neuro-circuitry. A recent study investigated the neural correlates of excess habit in 37 OCD patients and 33 controls, who learned to avoid shock during fMRI scanning. Increased habitual responding in the OCD group was associated with caudate hyperactivity. Activation correlated with increased urge to perform habits. The caudate represents a key region implicated in the execution of goal-directed behaviour. These results suggest the habit formation biases result from impairment in this system, rather than a build-up of habits. The OCD group also showed increased medial OFC activation, though this did not correlate with habit formation. Glutamate is the major excitatory neurotransmitter within this neuro-circuitry. Preliminary data suggesting a therapeutic role for glutamate receptor modulators supports their further investigation as therapeutic agents in obsessive-compulsive disorders.

NO. 2 OXYTOCIN/VASOPRESSIN AND IMMUNE-INFLAMMATORY INTERVENTIONS FOR THE REPETITIVE BEHAVIOR DOMAIN IN AUTISM AND OBSESSIVE-COMPULSIVE SPECTRUM DISORDERS

Speaker: Eric Hollander, M.D.

SUMMARY:

We present a series of studies that examine the role of the oxytocin/vasopressin and the immune-inflammatory system in modulating the repetitive behavior domain in ASD and OCSD. Oxytocin/vasopressin play a role in modulating social cognition and self-stimulatory behaviors. Interventions to enhance oxytocin or block V1a receptor signaling may modulate these domains. High-functioning adults with autism participated in a multi-center, randomized, double-blind, placebo-controlled, cross-over study of the effects of novel V1a receptor antagonist RG7713. The V1a antagonist showed evidence of anxiolysis; effects on eyetracking and RMET as modest effect sizes. There were large negative effect sizes of the V1a antagonist vs. placebo on the social cognition ASR measure Lust and Fearful

subscales. Olfaction and drug x phase effects influenced social cognition measures. Immune-inflammatory mechanisms may play a role in both animals and humans in modulating the repetitive behavior domain. The helminth *Trichura Suis Ova* decreases proinflammatory cytokines, increases anti-inflammatory cytokines, and has been used to treat auto-immune condition. Studies in adult ASD patients showed improvement in rigidity, craving for sameness and restricted interests. Also, studies modulating core body temperature in childhood ASD demonstrated improvement in measures of the repetitive behavior domain. New outcome measures may assess change in this domain across various OCSD, in line with goals of RDOCS.

NO. 3 THE USE OF COMPULSIVITY AS A PHENOTYPE IN GENETIC STUDIES OF OCD

Speaker: Margaret A. Richter, M.D.

SUMMARY:

Understanding of the genetic basis of obsessive-compulsive disorder (OCD) is expected to grow dramatically in the near future with emergence of genome-wide association studies based on large pooled subject samples from international collaborative groups. To date these and candidate gene studies have focused on the illness as phenotype, based on DSM criteria. However there is evidence to support genetic exploration of a compulsivity phenotype common to OCD & Related Disorders. Further, there is a need to explore other potentially more meaningful "compulsivity"™ subphenotypes that might be shared across broader diagnostic domains, within and beyond OCD. In this presentation, the literature regarding potential risk genes across the OCD-related disorders such as hoarding disorder, body dysmorphic disorder and trichotillomania will be reviewed. New data will be presented from the Toronto OCD genetics workgroup in a well-characterized sample of 560 subjects with OCD, exploring OCD-related putative risk genes in relation to other potential compulsivity phenotypes, utilizing scores from the Obsessive Beliefs Questionnaire and the Personality Disorders Questionnaire. Differences observed regarding risk association from previously reported association results based on OCD

diagnosis will be discussed from the perspective of potential utility of broader constructs of compulsivity in future genetic studies.

NO. 4 PHARMACOLOGICAL TREATMENT OF COMPULSIVITY ACROSS DISORDERS

Speaker: Jon Grant, M.D.

SUMMARY:

This presentation will discuss the evidence-based use of medications for compulsive behaviors. By focusing on compulsive aspects of several psychiatric disorders, such as obsessive compulsive disorder, trichotillomania, skin picking, and gambling disorder, the presentation will discuss what is known about the response to various pharmacological agents and similarities and differences between disorders.

Learning objectives: people attending the presentation will 1) understand evidence-based pharmacological approaches to compulsivity; 2) how response may differ across compulsive behaviors; and 3) what cognitive aspects of the behavior may predict treatment response.

NO. 5 DTMS IN OCD-STATE OF THE ART

Speaker: Lior Carmi, M.Psy.

SUMMARY:

Enhanced Error Related Negativity (ERN) signal following performance of a mistake characterizes OCD patients, correlates with OC symptom severity and located to the anterior-cingulate-cortex (ACC). It is yet to be determined whether this 'Over monitoring' dysfunction is due to over-reaction to punishment cues (i.e., I was mistaken), or to a constant cognitive bias towards erroneous content (i.e., this is correct/wrong). Targeting this hyper activation via Deep TMS may influence symptom severity.

Method: 31 OCD patients and 25 healthy controls went through EEG measurements of an arithmetic task (awareness of erroneous content) and Stroop task (eliciting ERN). The OCD group was treated with five weeks of double blind dTMS treatment simultaneously administered with symptom provocation and targeting the ACC. Results: OCD showed higher activation in low frequency bands compared to

healthy control after merely identifying wrong solutions { $F(2, 32) = 5.23$ ($p < 0.01$), $p.e = 0.24$ }. The active dTMS group improved significantly in YBOCS score compared to placebo (28% vs. 6% reduction), { $t(93) = -2.29$ ($p = 0.0243$)}. Conclusions: Over-monitoring condition is expressed in OCD upon observing an erroneous content and not only when an error is committed. Moreover, positive results with dTMS treatment towards the ACC suggest that it may be used as a therapeutic intervention in OCD.

TRAINING EXPERIENCES IN PSYCHIATRY: THEN, NOW AND HOW TO CREATE THE BEST FUTURE

*Chairs: Andrea M. Brownridge, J.D., M.D.,
M.H.A., Stacia E. Mills, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the various types of biases minority group members have confronted historically while examining the societal implications of marginalization; 2) Define and identify microaggressions while recognizing the psychological costs to both the victims and perpetrators; 3) Appreciate the personal steps each individual can take to redress microaggressions in mental health care.

SUMMARY:

We have all taken history lessons in our lives. Learning history is imperative to shaping the future. It helps us to not repeat the past and to honor those that came before us. What we often forget is that although history is factual, every historical tale is told from someone's perspective. In this symposium, we will discuss the history of psychiatry from a less often heard perspective and use these historical lessons to compare how far we have come today. However, it is not enough just to note the differences between yesterday and today as we still have many changes and improvements to make within our own training programs. As such, we will discuss ways to take action in order to move the right direction and achieve our goals. Today's speakers will share the less often heard perspective of minority groups and their training experiences in psychiatry. At the closing, discussant Dr. Ranna Parekh will share strategies to combat prejudice at the workplace in order to minimize the impact

microaggressions have on one's emotional well-being.

**NO. 1
INTRODUCTION TO TRAINING
EXPERIENCES IN PSYCHIATRY: THEN,
NOW AND HOW TO CREATE THE BEST
FUTURE**

Speaker: Stacia E. Mills, M.D.

SUMMARY:

The primary aim of this symposium is to survey the progress that minorities in psychiatric training have made in the last 50 years.

**NO. 2
PAVING THE WAY: A LOOK INTO THE
HISTORY OF PSYCHIATRIC TRAINING
PROGRAMS**

Speaker: Frank Clark, M.D.

SUMMARY:

Appreciating history is imperative to shaping the future as it helps us to avoid missteps of the past. It permits us to celebrate those that paved a smoother road for us, and be inspired to continue their works based on our own experiences with dignity violations and microaggressions.

**NO. 3
ARE WE THERE YET: CURRENT
PERSPECTIVES OF RESIDENTS AND
FELLOWS IN TRAINING**

Speakers: Tiffani Bell, M.D., D. Anton Bland, M.D., Roberto Montenegro, M.D., Ph.D.

SUMMARY:

Early career psychiatrists who recently completed training as well residents and fellows approaching the end of training will recount a personal experience of microaggressions during residency. At the conclusion of this presentation, it will be clear that although things have improved from the late 1960s through 1980s, we still have many improvements to be made if we are to become a truly great specialty.

**NO. 4
BUILDING THE ROAD WE ENVISION:
TOOLS TO ADDRESS THE PROBLEMS
OF THE PAST AND PRESENT**

Speaker: Ranna Parekh, M.D., M.P.H.

SUMMARY:

Microaggressions are the brief and commonplace daily verbal, behavioral, and environmental indignities that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group. First coined by Dr. Chester Pierce in the 1970s, "racial microaggressions" refer to the subtle and often automatic "put-downs" and insults directed toward Black Americans. Today, microaggressions are played out daily in our communities, classrooms, courtrooms, and exam rooms and surely almost every person has either been the target of a microaggression or unintentionally perpetrated one against another. Under the guidance of psychiatrist-author, Dr. Ranna Parekh, the audience will be introduced to strategies to combat prejudice at the workplace in order to minimize the impact microaggressions have on one's emotional well-being.

**PREPARING RESIDENTS FOR WAR:
HOW MILITARY GRADUATE MEDICAL
EDUCATION PREPARES EARLY
CAREER PSYCHIATRISTS FOR
OVERSEAS DEPLOYMENTS**

Chair: Vincent F. Capaldi II, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how military training programs prepare residents for deployment; 2) Contrast and compare differences and similarities among the military services in training and; utilization of new psychiatrists; 3) Describe the resources available to new psychiatrists in the deployed setting.

SUMMARY:

During the conflicts in Iraq and Afghanistan, new military psychiatrists are often deployed within a year of completing residency. This symposium will address some of the unique treatment and environmental challenges these new psychiatrists may face while deployed. Each speaker was deployed to Afghanistan within one year of graduating from a military psychiatric residency. The speakers

will describe the challenges of deployment, the resources that are available to psychiatrists in the deployed setting, and recommendations for training improvements in the future.

**NO. 1
APPROACHING THE BREECH:
MEASURES FOR PREPARING
RESIDENTS FOR DEPLOYMENT**

Speaker: Hanna Zembrzuska, M.D.

SUMMARY:

While military residency programs offer training and resources in preparation for deployment, understanding of some unique features of the environment require first-hand experience. This presentation will address the various training opportunities that military residents are provided in preparation for eventual overseas deployment to a combat zone. We will highlight the role of didactic training, practical exercises, and centralized military training for Combat Operational Stress Control and Traumatic Event Management. Recommendations on improving training techniques and opportunities will be explored.

**NO. 2
NAVY COMBAT PSYCHIATRY AFTER
RESIDENCY: THE EXPERIENCE OF AN
EARLY CAREER PSYCHIATRIST
EMBEDDED WITH THE U.S. MARINE
CORPS**

Speaker: Dennis A. White, M.D.

SUMMARY:

Early career military psychiatrists often deploy in support of operational missions soon after graduation from residency training. The presenters share personal and professional experiences specific to their military branch of service. Cases treated during an embedded United States Marine Corps Operational Stress Control and Readiness (OSCAR) psychiatrist's deployment to Helmand Province, Afghanistan, during 2012-2013 are reviewed. Approximately 500 primarily mental health encounters were made during a six month deployment. OSCAR providers are tasked with an additional mission of outreach and education on topics related to combat stress and Traumatic Brain Injury. OSCAR providers conducted 24 missions to forward operating bases. OSCAR psychiatrists often

travel in close proximity to combat operations and assist with trauma care in a forward environment as well. Forward mental health care is effective in preventing psychiatric casualties, destigmatization, and further coordination of care. Resources for early career psychiatrist deploying in support of the United States Marine Corps include chain of command support, doctrinal materials published under the OSCAR and Combat Operational Stress Control (COSC) programs, and military specific training received in residency. Additional knowledge in the areas of trauma care provision, consultation psychiatry, and an understanding of the operational environment is recommended.

**NO. 3
RESOURCES FOR EARLY CAREER
PSYCHIATRISTS IN COMBAT**

Speaker: Vincent F. Capaldi II, M.D.

SUMMARY:

While there are many resources available to a new psychiatrist downrange, there is usually very little guidance on how to access and use them. This presentation will highlight the various resources available for early career psychiatrist. It will also present the experience of an early career psychiatrist operating within a Combat Operational Stress Control unit in Afghanistan. He will provide a perspective on how the training provided during residency and the support provided in theater made the transition from resident to senior mental health officer a seamless transition.

**SPIRITUALITY AND RELIGION IN
GLOBAL MENTAL HEALTH**

Chair: Wai Lun Alan Fung, M.D., Sc.D.

Discussant: Melyn Leszcz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the role of spirituality and religion on mental health in such countries as Brazil, Canada, China, India, Pakistan, the United Kingdom, as well as globally.; 2) identify the role of major faith traditions, such as Christianity (including specific forms such as Spiritism), Hinduism, Islam and Judaism, in global mental health.; 3) recognize the role of different professionals (e.g.

spiritual care professionals, psychiatrists, family physicians, other mental health workers) in the interface of spirituality and mental health. .

SUMMARY:

The Mental Health and Faith Community Partnership was recently launched in the United States by the American Psychiatric Association (APA) - with the goal of enhancing mental health through the promotion of collaborations between mental health and spiritual care professionals. To our best knowledge, such a partnership is the first of its kind worldwide to be initiated at the national level. Nonetheless, spirituality/religion is relevant to mental health and mental disorders beyond the United States - and indeed globally.

This symposium gathers together speakers from different countries to explore the interface between spirituality/religion and mental health in such countries as Brazil, Canada, China, India, Pakistan, the United Kingdom, as well as globally.

The Chair, Dr. Alan Fung, is to date the only Steering Committee member of the APA Mental Health and Faith Community Partnership from outside the United States. He will provide a general overview of the relevance of spirituality/religion in global mental health.

Prof. Alexander Moreira-Almeida, a psychiatrist from Brazil, will then present on the role of Spiritism - a spiritualist philosophy widely accepted in Brazil with strong influences on mental health field - on mental health diagnoses and treatments, as well as the integration of spiritual approaches to psychiatric treatment in Brazil.

Prof. Unaiza Niaz, a psychiatrist from Pakistan, will then present on the role of Islamic practices & spirituality in the treatment of Pakistani psychiatric patients - especially on the development of resilience in psychotrauma.

Prof. Dinesh Bhugra, President of the World Psychiatric Association (2014-2017), is a psychiatrist from the United Kingdom originally from India. He will present on the role of Hinduism on mental health in different countries: India, the United Kingdom, and worldwide. He will also discuss about endeavors on the interface of spirituality/religion and mental health by the World Psychiatric Association.

Dr. Tat-Ying Wong, a family physician focusing on mental health practice, will present on his extensive efforts in addressing mental health

needs in China as well as the Chinese population in Canada through the delivery of mental health psycho-education in a spiritual context. This has been specifically designed to address the issue of the scarcity of culturally-sensitive mental health manpower and services. Prof. Victor Shepherd, a Christian pastor, theologian and Professor Ordinarius of the University of Oxford, will present on his experience in working with the severely mental ill over three decades, as well as efforts in promoting mental health of his congregations through collaborations with mental health professionals.

The discussant, Prof. Moly Leszcz, a psychiatrist and Interim Department Chair of Psychiatry at the University of Toronto, will provide general discussion on the topic with the use of Judaism as an illustration.

NO. 1

SPIRITISM AND MENTAL HEALTH: THEORY AND PRACTICE

Speaker: Alexander Moreira-Almeida, M.D., Ph.D.

SUMMARY:

Spiritism is a spiritualist philosophy developed in France in 19th Century that is widely accepted in Brazil and influences mental health field, especially through its perspective on mental disorders, spiritually integrated treatments, and dozens of spiritist psychiatric hospitals that seek to integrate conventional medical treatment with complementary spiritual therapy. This presentation reviews Spiritism's views on mental disorders and discusses spiritist psychiatric hospitals, especially their use of spiritual practices, their operating structure, health professionals involved, modalities of care, and institutional difficulties in integrating spiritual practices with conventional treatment.

References:

Moreira-Almeida A, Lotufo Neto F. Spiritist views of mental disorders in Brazil. *Transcult Psychiatry*. 2005; 42(4):570-95.

Lucchetti G, Aguiar PR, Braghetta CC, Vallada CP, Moreira-Almeida A, Vallada H. Spiritist psychiatric hospitals in Brazil: integration of conventional psychiatric treatment and spiritual complementary therapy. *Cult Med Psychiatry*. 2012; 36(1):124-35.

Learning objectives:

- i) To understand the approach developed by Spiritism to mental health
- ii) To recognize existing forms of integration of spiritual approaches to psychiatric treatment

**NO. 2
ISLAMIC PERSPECTIVE IN THE
PSYCHIATRIC PRACTICE IN PAKISTAN**

Speaker: Unaiza Niaz, M.D.

SUMMARY:

In this presentation the role of Islamic practices & spirituality in the treatment of Pakistani psychiatric patients will be presented. Pakistan is a developing moderate Islamic country, with rich cultural background. Faith and religion has always been a part of the lives of average Pakistani. The author has observed the development of resilience, in the traumatic stress in the survivors of terrorist attacks, drone attacks and quick recovery the psychiatric illnesses in the large number of Afghan refugees and IIDPâ€™S, with regular observance of religious practices.

Learning Objectives:

- i) To recognize faith and religion as vital factors in developing resilience in psychotrauma, in the believers.
- ii) To enhance the awareness of psychiatrists globally of how encouraging patients in distress to continue their religious practices could hasten recovery and ensure better prognosis.

**NO. 3
HINDUISM AND PRINCIPLES OF
MENTAL HEALTH**

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

SUMMARY:

The presenter will describe the role of Hinduism on mental health in different countries: India, the United Kingdom, and worldwide. He will also discuss about endeavors on the interface of spirituality/religion and mental health by the World Psychiatric Association.

**NO. 4
EXPANDING THE REACH AND
MULTIPLYING THE IMPACT OF MENTAL
HEALTH PREVENTION AND
INTERVENTION WHERE RESOURCES
ARE SCARCE: EMPOWERING FAITH
COMMUNITIES TO DELIVER MENTAL**

**HEALTH PSYCHOEDUCATION IN A
SPIRITUAL CONTEXT**

Speaker: Tat-Ying Wong, M.D.

SUMMARY:

In many local and overseas communities, culture and language sensitive mental health resources are extremely scarce. For example, in the Greater Toronto Area, with a Chinese population of over 537,000, there are only 16 Chinese speaking psychiatrists, representing only 28% of the recommended ratio of psychiatrist to population of 1:8400 by the Canadian Psychiatric Association. In Hong Kong, the ratio of psychiatrist to population is even worse at 1:44,200. One solution to this ongoing manpower crisis is to expand the reach and impact of mental health prevention and intervention by empowering faith communities to deliver mental health psycho-education in a spiritual context. Preliminary outcome data for such partnerships documenting the effectiveness of this psycho educational model will be presented.

Learning objectives:

- i) to recognize the benefits of empowering faith communities in delivering mental health psycho education in a spiritual context
- ii) to understand how to build and utilize partnerships with local faith communities to expand the reach and multiply the impact of mental health prevention and intervention using case studies of partnerships with local and oversea Chinese faith communities.

**NO. 5
PSYCH AND SPIRIT: THE ROLE OF
FAITH COMMUNITIES IN THE
TREATMENT OF MENTAL ILLNESS**

Speaker: Victor Shepherd, Ph.D.

SUMMARY:

While the Christian community-in-general in no way claims an expertise or medical sophistication that only those trained in psychiatry can provide, it remains the case that frequently a pastor, who has ready access to people's homes and therefore to their unguarded, undisguised self-presentation (readier access than anyone else in our society), is the first non-family member to notice and identify aberrant behaviour and concomitant suffering. For this reason the pastor has a special place in moving family-members past

the pseudo-secrecy and false shame surrounding the sufferer's illness. Similarly the pastor has immediate opportunity to make an appropriate referral.

The Christian community, suitably sensitized and informed by an alert pastor, is uniquely poised to provide care and support to the sufferer throughout treatment/institutionalization, and also to assist family-members and friends who are frequently under-equipped to understand the genesis, nature and prognosis of the illness and under-resourced in coping with their own stress. In all of this the Christian community can defuse the stigmas that pertain to mental illness and disavow the false spiritualizing that is often brought to bear on psychiatric disorders.

LEARNING OBJECTIVES:

- i) the need to facilitate co-operation between congregation and experts in mental health.
- ii) how to equip congregants to assist helpfully yet non-intrusively those suffering from mental illness.

THE NATIONAL INTREPID CENTER OF EXCELLENCE (NICOE) RESEARCH UPDATE AND MODEL OF CARE FOR TRAUMATIC BRAIN INJURY AND PSYCHOLOGICAL HEALTH CONDITIONS

Chairs: Geoffrey Grammer, M.D., Elspeth C. Ritchie, M.D., M.P.H.

Discussants: Robert L. Koffman, M.D., M.P.H., Thomas DeGraba, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe clinical considerations for evaluation and treatment of service members with combat related traumatic brain injury (TBI) with psychological health (PH) co-morbidity.; 2) Assess the novel clinical model at the National Intrepid Center of Excellence (NICoE) and business models that reflect productivity.; 3) Present the research infrastructure and strategic research plan at the NICoE, with consideration of the first three years research findings, and describe its influence on clinical care delivery.; 4) Present the latest research findings from the National Intrepid Center of Excellence, in order to more precisely identify and treat specific neural injury patterns in TBI and PH conditions.

SUMMARY:

The U.S. 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 comprehensively evaluate and treat 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 sequela, in order to advance novel diagnostic and treatment strategies. At the end of the presentations the Chairman will lead a discussion with the audience on these issues.

NO. 1

CARE OF PATIENTS WITH MILD TRAUMATIC BRAIN INJURY AND CO-MORBID PSYCHOLOGICAL HEALTH CONDITIONS

Speaker: James Kelly, M.D.

SUMMARY:

Over ten years of war and repeated combat exposure of the U.S. military force has resulted in a significant number of service members with subsequent medical morbidity. Advances of vehicle armor, body armor, field medicine, and advanced trauma care has been essential at improving mortality rates, but also has resulted in survivors of combat trauma who now must contend with traumatic brain injury and co-morbid psychological health conditions. Recognizing the medical need, both civilian and military resources have been allocated to discovering diagnostic techniques and optimal treatments to enhance self-efficacy, personal recovery, social and family reintegration, and maximize the long-term trajectory of recovery. Collaborating with the academic and sports concussion community has been essential in advancing this area of medicine.

NO. 2

THE ROLE OF THE NICOE'S INTEGRATED PRACTICE UNIT MODEL

WITHIN THE MILITARY HEALTH SYSTEM PATHWAY OF CARE

Speaker: Sara M. Kass, 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 paradigm 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. All aspects of the NICoE, including the facility design, patient matriculation, clinical flow, and provider interface have been designed to enhance communication and care delivery. The NICoE model integrates with the broader Military Health System pathway of care to address care needs of patients while limiting redundancy of resources. Productivity measurements must incorporate contemporary business models of health care and provide consideration to indirect yield from training and education, and research.

NO. 3 NICOE RESEARCH INFRASTRUCTURE AND STRATEGIC RESEARCH PLAN

Speaker: Geoffrey Grammer, M.D.

SUMMARY:

The National Intrepid Center of Excellence (NICoE) is four week, integrative, patient centered, interdisciplinary care program for patients with mild to moderate Traumatic Brain Injury and co-morbid psychological health conditions. During the course of care, patients are offered the opportunity to participate in research protocols that produce 2000 clinical and 41,000 imaging data elements. A robust bioinformatics system allows for acquisition, storage, and analysis while minimizing impact on clinical care and productivity. Results from the past three years since the NICoE's inception has led to modifications of hypothesis and a new research strategic vision for defining different pathophysiologic states that make up this heterogeneous group. Using advanced

physiologic assessment, clinical care can be tailored to each individual based on their pathophysiologic categorization and theoretical treatments to restore physiologic or neurologic disturbance, rather than fixed approaches for broad diagnostic categories. Using a model of "focused empiricism" we hope to identify and enhance those therapies that support recovery while simultaneously demonstrating and discontinuing those modalities which fail to produce favorable results.

NO. 4 RESEARCH FINDINGS UPDATE FROM THE NICOE

Speaker: Thomas DeGraba, M.D.

SUMMARY:

Patients who attend the National Intrepid Center of Excellence (NICoE) four week integrative, interdisciplinary, patient centered care program are offered opportunities to participate in a variety of research programs that strive to better characterize the disease state, establish biologic correlates of wellness, and determine long term outcomes. Utilization of advanced technology including MRI, PET, EEG, magnetoencephalopathy (MEG), transcranial doppler, physiologic assessment, comprehensive autonomic evaluation, and polysomnography will provide more precise quantitative characterization of the injured brain. When combined with exquisitely detailed data elements from standardized interdisciplinary evaluation, profiles have emerged that coalesce around discrete subpopulations. The latest data that defines these populations and their pathophysiologic correlates will be presented, including potential biomarkers for PTSD and mTBI.

MAY 17, 2015

VARIABLES IN HOW SUICIDE IMPACTS TREATING PROFESSIONALS: LEVEL OF TRAINING, TYPE OF SUICIDE, NOTORIETY OF THE VICTIM, AND THREAT OF MALPRACTICE SUIT

Chairs: Kenneth R. Silk, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To appreciate that the

level of training of the professional can influence the impact of suicide on the professional; 2) To appreciate that the level notoriety (and public knowledge) of the patient professional can influence the impact of suicide on the professional; 3) To suggest ways in which supervisors and other senior clinicians can provide support for junior clinicians after a patient suicide; 4) To present how the very real threat of a malpractice suit can complicate the professional's processing of a patient suicide.

SUMMARY:

Suicide of a patient is a very disturbing and complicated event for the treating professional. As we attempt to improve on our understanding as to how professional process suicide as well as try to develop programs and interventions that can help these professional through the event, we must realize that there are a number of variables that come into play when considering the impact of a suicide on the professional treating the patient. Some of these variables which are listed below will be discussed in this symposium. These include (1) the level of training the professional has had such as a resident or other trainee, fellow, young psychiatrist just getting started in independent clinical work (2) the overall clinical experience that professional has had as well as prior exposure to a patient suicide (3) whether the suicide is a public event such as recent suicides involving actors and (4) whether there is a genuine threat of a malpractice suit in response to the suicide. The symposium will present and discuss all of these topics and will solicit input from the audience as to their own experiences with suicide of their own patients as well as suggestions as to how we can support better our peer professionals.

NO. 1

THE AFTERMATH OF SUICIDE FOR THE TREATING PROFESSIONAL

Speaker: Michael F. Myers, M.D.

SUMMARY:

Suicides occur in clinical practice despite best efforts at risk assessment and treatment. It is estimated that fifty per cent of psychiatrists can expect to have at least one patient die by suicide, an experience that may be one of the most difficult professional times in their careers. Losing a patient to suicide is considered an

occupational hazard of treating mentally ill patients. I will discuss: the psychological reactions to patient suicide, including the myriad variables that characterize the physician-patient relationship; reactions of family and friends to the loss of a loved one to suicide (the survivors's™ experience); psychiatric morbidity in family members after death by suicide; the clinician's™ roles and responsibilities after suicide, including outreach to survivors; and self-care after losing a patient to suicide.

NO. 2

PERSPECTIVE OF THE PSYCHIATRIST-IN-TRAINING

Speaker: Rachel Caravella, M.D.

SUMMARY:

This portion of the presentation will focus on the impact of a patient suicide on psychiatry trainees. It will review typical reactions of individual trainees and a residency group. Considerations regarding recommendations for individual ways to cope will be presented. The presentation will also include suggestions for questions that trainees may pose to their supervisors and describe considerations for family interactions. A brief case example will be presented of how one program utilized various interventions to support and educate their trainees after a patient suicide. Highlighted interventions will include: (1) a readily available, online, training module on patient suicide; (2) response protocol for chief residents; (3) constructive, non-critical case review with faculty and residents together; (4) easily accessible list of faculty members willing to discuss personal experiences of patient suicide; and (4) open processing of the event with residency classes.

NO. 3

ALWAYS EXPECT THE UNEXPECTED

Speaker: Philip R. Muskin, M.D.

SUMMARY:

A patient's™ suicide has an impact on the psychiatrist that can be devastating and long lasting. When treating patients who are medically ill, and when the psychiatric symptoms appear to stem directly from the medical illness and/or treatment, there may be confusion regarding the patient's™ risk for

suicide. This presentation will detail the case of a patient who became hypomanic when treated with steroids, developed behavioral issues that interfered with his work, and was medically admitted. He recovered fully, was discharged, returned to work successfully, and committed suicide the evening of a family meeting. The impact of his suicide on his family and on his psychiatrist will be discussed.

NO. 4 PATIENT SUICIDE AND THE THREAT OF MALPRACTICE

Speaker: Kenneth R. Silk, M.D.

SUMMARY:

The threat of a malpractice suit can confound how a professional deals with the suicide of a patient. Often the treating professional has some sense of whether litigation might occur, though hopefully there are more "false positives" when we fear a suit but it does not materialize. This ability to anticipate future litigation is probably most dependent on the interactions the professional had with the family during treatment of the patient, what the patient relayed during treatment as to how family and friends felt about the treatment or the nature of the contacts with the victim's friends and family members in the period closely following the suicide. Processing a patient suicide is complicated, but threat of litigation impedes the professional's access to experience the loss more completely. Sharing the pain and empathy of the loss with the family can become blocked or attenuated. Threat of litigation complicates the professional's emotions leading to moments of rage, fear, defensiveness, and anger at the family effectively hindering a more thorough working through of the loss and grief. The professional may distance him/herself from the loss and the accompanying self-doubt. Emotions relating to the suicide become walled off, and the experience and its accompanying affect is then isolated. Reaction to the suicide remains "unprocessed" and one is unable to use the event and one's reaction to it to understand further oneself as a professional and as a human being.

NO. 5 A VIEW FROM THE WINGS: TREATING THE FAMOUS AND INFAMOUS

Speaker: Susan L. Donner, M.D.

SUMMARY:

Well-known patients and their families in psychiatric and therapeutic treatment present a number of challenges to their mental health practitioners. This talk will address potential pressures and conflicts experienced by the professional that may arise in the course of treatment and impact outcome. Topics will include the "specialness" of the patient, temptations to deviate from standard guidelines, threat of media exposure, potential transference and countertransference phenomena.

NO. 6 SUICIDE AND THE COMMUNITY

Speaker: Robert Michels, M.D.

SUMMARY:

Suicide is a dramatic event. It has an impact on all who are touched by it—family, friends and neighbors of the victim, doctors, therapists and caretakers, and the community at large. When the victim is socially prominent the impact on the latter may be immense, and have secondary repercussions that influence the experience of the family, friends and caretakers. It may also influence public attitudes toward suicide, psychiatric patients, mental illness, psychiatric treatment, and resources to provide treatment for those in need. The psychiatric profession, and the media play a major role in shaping that impact, and have a social and ethical responsibility to study it.

OPTIMIZING TREATMENT OF COMPLICATED GRIEF: RESULTS OF A MULTICENTER CLINICAL TRIAL

Chair: M. Katherine Shear, M.D.

Discussants: Michael First, M.D., Charles F. Reynolds III, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To describe the clinical presentation of complicated grief and to compare performance of several diagnostic criteria sets for CG in a clinical sample.; 2) To learn about pharmacotherapy for complicated grief and its effectiveness.; 3) To understand the principles and procedures used in psychotherapy for CG.

SUMMARY:

Sixty million people die every year worldwide leaving at least 2-3 times that number struggling with acute grief. For many people bereavement is like an earthquake disrupting the foundation of their lives. Remarkably, most people adapt to very sad and devastating loss with deepened empathy and restored potential for joy and satisfaction in life. Acute grief is reshaped and integrated. However sometimes people don't adapt. We have now learned that the progress of grief can be derailed by complicating thoughts, behaviors, dysregulated emotions or toxic social responses. The result is prolonged acute grief, an impairing condition associated with elevated rates of suicidality, sleep disturbance, interpersonal problems and substance use disorders as well as increased rates of cardiovascular disease and cancer.

Close relationships are central in the lives of most people, and losing a loved one can be devastating. Bereavement is qualitatively different from other life events in that intense emotions and disruption of daily life activities is expected and socially sanctioned. Social expectations for grief are often ritualized and vary across cultures. These unique qualities of bereavement have led to wariness among writers of diagnostic criteria and a policy to avoid psychiatric diagnosis in bereaved people. Correspondingly there has been insufficient clinical attention to grief related problems. Presenters in this symposium have been instrumental in drawing attention to situations in which bereaved people do need to be diagnosed and treated. Presenters have played a central role in describing complicated grief, identifying and testing diagnostic criteria, and developing and testing treatment for this debilitating condition, also called prolonged grief disorder.

The purpose of this symposium is to present state of the art information about complicated grief, an under-recognized and under-treated syndrome and up-to-date information about pharmacotherapy, psychotherapy and their combination. We provide an in-depth discussion of the clinical syndrome, discuss the current status of DSM 5 and ICD 11 diagnostic criteria and summarize where this work is headed. Symposium presenters have conducted the largest clinical trials in the world targeting complicated grief and will present both pharmacotherapy and psychotherapy results from recently completed NIMH-funded

trials. In addition, presenters will discuss rationale and procedures for pharmacotherapy of CG and outline the principles, strategies and procedures used in complicated grief treatment.

NO. 1**COMPLICATED GRIEF: CLINICAL AND DIAGNOSTIC CONSIDERATIONS**

Speaker: Sidney Zisook, M.D.

SUMMARY:

Considered one of life's most challenging losses, bereavement shares many features of other, non-bereavement types of loss. However, bereavement also has some unique features: it is almost always painful and disruptive, generally datable, and always irreversible. A universal response to bereavement, grief begins in an initial, "acute grief" form, a bitter but generally transient phenomenon which moves to "integrated grief," a less burdensome, but timeless, form of grief. The hallmark features of integrated grief are the ability of the bereaved to accept the reality and meaning of the death, return to life, function, re-experience pleasure, and seek the companionship and love of others.

However, for some individuals, in certain circumstances, the transition from the initial, acute grief response to integrated grief does not occur. Instead, maladaptive thoughts, feelings, or behaviors derail the mourning process and the bereaved person gets stuck, indefinitely, in prolonged, acute grief, a condition we call "Complicated Grief" (CG). Despite CG's prevalence, chronicity, profound impact on quality of life and function, comorbidity with other psychiatric and general medical conditions, and even associated suicide risk, many individuals go undiagnosed by clinicians. This presentation will describe risk factors, clinical features, and differential diagnostic considerations, all illuminated by clinical illustrations.

NO. 2**DIAGNOSTIC PERFORMANCE OF SEVERAL PROPOSED CRITERIA SETS FOR COMPLICATED GRIEF**

Speaker: Christine Mauro, Ph.D.

SUMMARY:

Several criteria sets for Complicated Grief (CG) have been published, including a criteria set by

Prigerson et al. in 2009 and Shear et al. in 2011. CG was also added to DSM-5 as Persistent Complex Bereavement Disorder under Section III, "Emerging Measures and Models." A comparison of each of these three criteria sets on the same study sample has yet to be done.

We collected a sample of confirmed CG cases (n=178) and a sample of controls (n=80). Cases had an ICG>30, functional impairment due to their grief, and a CG diagnosis made by an expert. Participants completed the Structured Clinical Interview for CG (SCI-CG), a new clinician administered structured interview. The SCI-CG, a 33-item "SCID-like" instrument, was designed to assess the presence of any of the CG symptoms included in the three published criteria sets for CG. Prior instrument validation established the SCI-CG has good internal consistency (alpha= 0.76), test-retest reliability (ICC= 0.68), and inter-rater reliability (ICC = 0.95).

Using this data, the diagnostic performance of the proposed criteria sets were evaluated. Preliminary analysis on the CG cases showed the Prigerson and DSM-5 sets had lower sensitivities than the Shear set (56.2%, 67.5%, 99.4% respectively). Specificity results are forthcoming.

NO. 3 IS THERE A ROLE FOR PHARMACOTHERAPY IN THE TREATMENT OF COMPLICATED GRIEF? AVAILABLE DATA AND RESULTS OF A RANDOMIZED CONTROLLED TRIAL OF CITALOPRAM

Speaker: Naomi Simon, M.D.

SUMMARY:

Complicated Grief is a common and impairing condition and despite the lack of a formal recognition in the DSM nomenclature until recently, clinicians are faced with the management of patients with severe and impairing persistent grief in practice. While randomized controlled data support the efficacy of Complicated Grief Psychotherapy for CG, much less has been known about pharmacotherapy, despite the common use of such agents in clinical practice. There is thus a critical need to develop an evidence base to understand whether psychiatric medications have a safe and effective role or not in the treatment of CG to guide clinical practice. This

presentation will review previously published case series and open label trials (5 reports combined totaling n=50 participants with CG) providing preliminary signals that antidepressants but not benzodiazepines may be effective for CG. The remainder of the presentation will present the rationale, design and results of the first large well powered randomized clinical trial of any medication, in this case the SSRI citalopram compared to a pill placebo, in a large well characterized sample of adults with CG.

NO. 4 PSYCHOTHERAPY FOR COMPLICATED GRIEF: AN EVIDENCE-BASED APPROACH

Speaker: M. Katherine Shear, M.D.

SUMMARY:

Complicated grief is a recently recognized syndrome which can be conceptualized as a condition in which healing after bereavement is complicated by maladaptive thoughts or dysfunctional behaviors that prolong acute grief. Our research group pioneered a proven efficacious treatment called Complicated Grief Treatment (CGT). Two large single site studies and a multicenter study have provided data supporting the efficacy of this approach. Our earlier study showed that CGT was more effective than Interpersonal Psychotherapy (IPT) in bereaved adults with complicated grief. In a recently completed large single site study among older adults (n=151, mean (SD) age = 66.1 (8.9), 18.5% males), CGT had twice as large of a response rate as an active comparison, IPT (71% versus 32% respectively) confirming these results. In addition there have been a handful of pilot studies showing efficacy of this general approach or of a somewhat different one. This presentation will provide an overview of CGT, its treatment approach and core procedures, as well as present supporting empirical data including results from our latest ongoing multisite study, the data collection of which will be completed by October 2014. Other psychotherapy approaches will also be discussed in light of these results.

AFTERWAR: HEALING THE MORAL WOUNDS OF OUR SOLDIERS

Chairs: Nancy Sherman, Ph.D., Stephen N. Xenakis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognizing the complexity of moral injuries due to war; 2) Identifying a range of posttraumatic symptoms far wider than fear responsiveness; 3) Identifying structures crucial for military/civilian engagement and homecomings that are positive and healing ; 4) Discuss ways the psychiatric profession can better engage with homecoming veterans who may have limited insurance funds for therapeutic care.

SUMMARY:

2.6 million soldiers are currently returning home from war, the greatest number since Vietnam. With an increase in suicides and post-traumatic stress, the military has embraced measures such as resilience training and positive psychology to heal mind as well as body. But the moral dimensions of psychological injuries “guilt, shame, feeling responsible for doing wrong or being wronged” still elude much treatment, especially if it is based narrowly on deconditioning of fear responses. What is the nature of the moral war within and how can clinicians help treat moral injuries? In what ways are the injuries not always well thought of as pathological, but rather are a matter of sorting through the hard problems of when a war is just, when conduct is just, and when military interventions ameliorate rather than worsen conflict zones? How can civilians, through public and therapeutic engagement, help heal the afterwar soldiers endure? How can they contribute to a good homecoming?

NO. 1 TREATING MORAL INJURY IN WAR VETERANS

Speaker: Victoria Bruner, L.C.S.W.

NO. 2 THE AFTERWAR: HEALING THE MORAL WOUNDS OF OUR SOLDIERS

Speaker: Nancy Sherman, Ph.D.

SUMMARY:

This session will explore the nature of soldiers’ moral injury and moral healing in the aftermath of war. I focus on the role of specific emotions that signal moral injury, such as guilt, shame, and resentment. But I also

explore positive emotions and attitudes, such as trust, self-empathy, forgiveness, and hope. I argue that all these emotions constitute important ways in which we hold self and others to account for actions, omissions, and aspirations. That idea that we hold ourselves and others to account is key to recognizing what is at the heart of moral disappointment, shame, resentment, and guilt, but key, also, to understanding how we reach out to self and others for healing through reassurance, compassion, and empathy. Exploring emotions like these is no easy task for stoic soldiers bent on action and “mission accomplished.” But it is also not easy for civilians who typically bear some ill-defined contributory responsibility for the wars their citizen-soldiers fight. Public engagement in homecoming involves exploring these feelings of accountability on both sides. This session will explore the psychological and moral dimensions of that engagement.

NO. 3 DEPARTMENT OF DEFENSE AND VETERANS ADMINISTRATION PROTOCOLS FOR TREATING VETERANS WITH TRAUMATIC BRAIN INJURY AND POSTTRAUMATIC STRESS DISORDER

Speaker: Stephen N. Xenakis, M.D.

SUMMARY:

In this presentation, the following questions will be discussed: How are the DOD and Veterans Administration responding to spikes in suicide among military members? What are the protocols for treating Traumatic Brain Injury and PTSD? How has military and civilian leadership sought to destigmatize PTSD? What are new, promising protocols for integrative psychological and health care of the returning veteran? What recommendations are being made to the DOD on neurobehavioral conditions and medical management of active service members and veterans?

NO. 4 REPORT FROM THE GROUND ON PSYCHOLOGICAL TRAUMA COGNITIVE PROCESSING THERAPY

Speaker: Joshua Mantz, B.S.

SUMMARY:

On April 21, 2007 CAPT Josh Mantz died in Baghdad and came back to life after flatlining for 15 minutes, long past the time doctors routinely mark as the cutoff point for lifesaving measures, given the damage likely to the brain without vital signs. Not only did Josh survive, but he returned to his unit five months later to resume his platoon command. Yet despite the remarkable revival and media tour as the resilience poster boy for the DoD, Josh emotionally crashed four years later. "It's the moral injury over time that really kills people." Soldiers lose their identity. They don't understand who they are anymore. And most people don't appreciate the awful weight of that moral injury." Josh Mantz returned home from leading troops downrange, and went on to lead troops in a warrior resilience battalion at Fort Riley, Kansas. He developed novel techniques for breaking down the stoic resistance of his soldiers. The experience helped him reflect on his own struggles in processing the long shadows of a complex war fought in and amongst civilians, some of whom were ambiguously allied with the enemy. Working so closely with soldiers who suffer intense moral injuries took a severe toll on his own mental and physical health. And so one question to explore in this session is: Just what kinds of sacrifices do we owe others, whether on the battlefield or in the clinic?

HEALING THE BROKEN BOUGH: UPDATE ON THE DIAGNOSIS, PREVENTION AND TREATMENT OF FETAL ALCOHOL SPECTRUM DISORDERS (FASD)

Chair: Kenneth Warren, Ph.D.

Discussant: Edward Riley, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common characteristics of individuals with a history of prenatal alcohol exposure, including how these characteristics differ from key features of other neurodevelopmental disorders.; 2) Demonstrate knowledge of latest developments in the screening and diagnosis of fetal alcohol spectrum disorders.; 3) Be familiar with current research on promising interventions for individuals with FASD.

SUMMARY:

Kenneth Warren, PhD, Deputy Director NIAAA, will provide an introduction to describe fetal alcohol syndrome (FAS) and the broader spectrum that has been referred to as fetal alcohol spectrum disorders (FASD), as well as the new APA DSM 5 category of neurobehavioral disorder: prenatal alcohol exposed (ND-PAE). The history of this neurobehavioral disorder will be discussed, including the reasons underlying the delay in its identification until the last quarter of the 20th century. Also to be addressed are the research and clinical challenges that remain. Elizabeth Sowell, PhD will discuss results from longitudinal brain imaging studies demonstrating that brain structure and function are different in children and youth prenatally exposed to alcohol compared to unexposed children and youth, and that the effects of prenatal alcohol exposure persist into adolescence. Understanding how brain maturation evolves in children and youth with PAE is important to understand both the long-term impact of drinking during pregnancy and to evaluate possible interventions and treatments to determine which are most effective. Findings from brain imaging studies to date suggest that early identification and treatment of children with prenatal alcohol exposure may make the biggest difference, and may improve the outcomes for these children and their families. Peter Hammond, PhD will discuss links between prenatal alcohol exposure, facial dysmorphism, and cognitive impairment in FASD using novel morphometric analysis of 3d facial photos and MRI images of the brain. The face and brain develop in close harmony and so facial form often heralds atypical development associated with genetic anomaly and teratogenic exposure. Sarah Mattson, PhD will discuss the development and use of a neurobehavioral profile(s) of FASD in the diagnosis of alcohol-affected children. Data from a multi-site collaborative study on FASD (Collaborative Initiative on FASD) will be described, further characterizing the broad array of neurobehavioral deficits that may be associated with heavy prenatal alcohol exposure. Julie Kable, PhD will provide a critical review of progress towards validating the proposed diagnostic criteria for neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE), including establishing reliability in making the diagnosis and validating

the relative contribution of each of the proposed symptoms in identifying the severity of ND-PAE. Her presentation will also address recent improvements in access to mental health care and services and specific treatment strategies found to facilitate adaptation and adjustment.

**NO. 1
OVERVIEW OF FETAL ALCOHOL
SPECTRUM DISORDERS**

Speaker: Kenneth Warren, Ph.D.

SUMMARY:

The overview will provide an introduction to describe fetal alcohol syndrome (FAS) and the broader spectrum that has been referred to as fetal alcohol spectrum disorders (FASD), as well as the new APA DSM 5 category of neurobehavioral disorder: prenatal alcohol exposed (ND-PAE). The history of this neurobehavioral disorder will be discussed, including the reasons underlying the delay in its identification until the last quarter of the 20th century. Also to be addressed are the research and clinical challenges that remain.

**NO. 2
BRAIN DEVELOPMENT IN CHILDREN
AND ADOLESCENTS WITH PRENATAL
ALCOHOL EXPOSURE**

Speaker: Elizabeth R. Sowell, Ph.D.

SUMMARY:

Children and adolescents whose mothers drank heavily during pregnancy can demonstrate a variety of behavioral and intellectual difficulties, and may also have facial abnormalities. Research shows that brain structure and function are different in children and youth prenatally exposed to alcohol compared to unexposed children and youth, demonstrating a brain basis for the observed behavioral and intellectual difficulties. Understanding how brain maturation happens in children and youth with prenatal alcohol exposure is important to understand both the long term impact of drinking during pregnancy, and to evaluate possible interventions and treatments to determine which are most effective.

Results from longitudinal brain imaging studies will be discussed, supporting the conclusion that the effects of prenatal alcohol exposure persist into adolescence and alter the development of both brain structure and

function. This suggests that early identification and treatment of children with prenatal alcohol exposure may make the biggest difference, and may improve the outcomes for these children and their families.

**NO. 3
FACIAL CLUES TO THE EFFECTS OF
PRENATAL ALCOHOL EXPOSURE ON
BRAIN AND BEHAVIOR**

Speaker: Peter Hammond, Ph.D.

SUMMARY:

The face and brain develop in close harmony and so facial form often heralds atypical development associated with genetic anomaly and teratogenic exposure. The talk will demonstrate links between prenatal alcohol exposure, facial dysmorphism and cognitive impairment using novel morphometric analysis of 3d facial photos and MRI images of the brain.

**NO. 4
DEVELOPING A NEUROBEHAVIORAL
PROFILE OF FASD**

Speaker: Sarah N. Mattson, Ph.D.

SUMMARY:

Heavy prenatal alcohol exposure is associated with a broad array of neurobehavioral deficits. These deficits can be used as a basis for diagnostic labels included under the umbrella of fetal alcohol spectrum disorders (FASD). Possible labels under this umbrella include fetal alcohol syndrome (FAS), alcohol-related birth defects, alcohol-related neurodevelopmental disorder (ARND), and neurobehavioral disorder associated with prenatal alcohol exposure (ND-PAE), which was included in the DSM 5 under "conditions for further study". ARND and ND-PAE are based on neurobehavioral findings and do not require any of the physical features required for the FAS diagnosis. This presentation will focus on the development and use of a neurobehavioral profile(s) of FASD in the diagnosis of alcohol-affected children. Data from a multi-site collaborative study on FASD (CIFASD) will be described.

**NO. 5
NEUROBEHAVIORAL DISORDER
ASSOCIATED WITH PRENATAL
ALCOHOL EXPOSURE: RELIABILITY**

AND VALIDITY OF DIAGNOSTIC CRITERIA AND INTERVENTIONS FOR FASD

Speaker: Julie Kable, Ph.D.

SUMMARY:

In the DSM 5 Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) was proposed to encompass the range of neurodevelopmental disabilities that can be associated with prenatal alcohol exposure (PAE). The development of ND-PAE as a mental health diagnosis is an important step in the appropriate identification and treatment of individuals with a lifetime of behavioral and mental health problems associated with PAE, but additional research is needed to validate the proposed diagnostic criteria. This includes establishing reliability in making the diagnosis and validating the relative contribution of each of the proposed symptoms in identifying the severity of ND-PAE. The proposed presentation will provide a critical review of the progress towards meeting these goals, with a focus on analyses that are using two existing cohorts: the Collaborative Initiative on Fetal Alcohol Spectrum Disorders (CIFASD) and the Collaboration on FASD Prevalence (COFASP). Within each cohort, the frequency of symptoms within domains and convergence of domains will be compared among individuals with a history of PAE and those without a history of PAE. In addition, improvements in access to mental health care and services and specific treatment strategies that have been found to facilitate adaptation and adjustment will be discussed.

THE POTENTIAL OF BIOMARKERS TO ASSIST IN CLINICAL CARE OF SCHIZOPHRENIA

Chair: S. Charles Schulz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the potential of biomarkers to advance clinical treatment, and the results of brain imaging studies that predict treatment response; 2) Understand the results of studies measuring proteomics, then using these results for diagnosis; 3) Know the use of genetic findings and the relationship to response to medication treatment.

SUMMARY:

In the review of the use of biomarkers in the diagnosis and treatment plan for many medical illnesses, there is substantial advancement to make specific assessments and clear treatment plans. For example, the field is aware of the publication of genetic markers leading to specific breast cancer interventions. Further, examination of imaging and other biomarkers contribute substantially to treatment plans and prognosis. Psychiatry has mostly focused on a descriptive diagnosis and then utilization treatments based on group studies. More recently, investigators have been advancing biomarker research and the results are showing substantial potential to clarify diagnosis, to determine which treatments may be the most significant, and the course of disorders such as the Prodrome. In this symposium, the presenters will address the use of brain imaging, proteomics, genetics, and combinations of markers to address diagnosis and treatment.

The first speaker in the symposium, Sir Robin Murray, will describe the use of brain imaging in diagnostic assessment and the more recent findings of MRI cortical measures and response to treatment. The recent treatment response research not only can assist the clinical approach for clinicians, but can substantially reduce lengthy periods of non-response.

This presentation will be followed by the report by Dr. Sabine Bohn who has contributed significant findings in the field of proteomics to the field of psychiatry and specifically to schizophrenia. The work of proteomics to diagnosis in the early phase of illness is an important step to lead to appropriate intervention.

Dr. Anil Malhotra has applied research in genetics to the practical areas of pharmacological treatment. He will describe the relationship between genetic factors and treatment resistance in schizophrenia.

To conclude the symposium, Dr. Tyrone Cannon will report on the recent biomarker research in the area of the Prodrome. Because of the controversy during the work on DSM5 about this area of psychiatry his recent research may assist the clinicians in the field to address progression of prodrome symptoms and steps for intervention.

In conclusion, the potential for biomarkers to assist clinicians in the field of schizophrenia has made substantial advances. These

presentations describe a broad range of measures and the potential for practical application.

**NO. 1
EFFICACY OF BIOMARKERS IN
PREDICTING OUTCOME OF FIRST
EPISODE PSYCHOSIS**

Speaker: Robin Murray, M.D.

**NO. 2
THE POTENTIAL OF PROTEOMICS
BIOMARKER STUDIES FOR
PSYCHIATRIC DISORDERS**

Speaker: Sabine Bahn, M.D., Ph.D.

SUMMARY:

Biomarkers are defined as “measurable characteristics that reflect physiological, pharmacological, or disease processes. Suitable platforms for biomarker discovery include genomic, transcriptomic, proteomic, metabolomic and imaging analyses. However, most biomarkers used in clinical studies are based on proteomic applications as the majority of current drug targets are proteins, such as G protein-coupled receptors, ion channels, enzymes and components of hormone signalling pathways. Furthermore, linking the results of biomarker studies using protein-protein interaction approaches can assist in systems biology approaches and could lead to hypothesis generation and identification of new drug targets.

**NO. 3
PHARMACOGENETICS: USING GENETIC
INFORMATION TO ENHANCE
TREATMENT**

Speaker: Anil Malhotra, M.D.

SUMMARY:

Pharmacogenetics (and pharmacogenomics) offers the prospect of the identification of readily accessible biological predictors of psychotropic drug response, may provide novel information about the molecular substrates of drug efficacy, and guide new drug development strategies for the treatment of psychiatric disorders. In this presentation, we will review basic methodological concerns encountered in psychiatric pharmacogenetic studies. These include design issues, power considerations,

appropriate outcome measures, and specific issues pertaining to candidate gene and genome-wide association (GWAS) studies. These issues will be discussed in the context of pharmacogenetic studies of antipsychotic drug response “ including data implicating the dopamine D2 receptor gene in antipsychotic drug efficacy, as well as results suggesting that genetic factors in key molecular pathways may be highly predictive of common adverse events associated with the second generation antipsychotic drugs. The implication of these developments for the state of the art treatment of psychiatric disorders will be discussed.

**NO. 4
BIOMARKERS OF VULNERABILITY AND
PROGRESSION IN THE PSYCHOSIS
PRODROME**

Speaker: Tyrone D. Cannon, Ph.D.

**NO. 5
BIOMARKERS OF VULNERABILITY AND
PROGRESSION IN THE PSYCHOSIS
PRODROME**

Speaker: Diana Perkins, M.D., M.P.H.

**BRIEF THERAPY: PRACTICAL CLINICAL
PEARLS**

Chair: Mantosh Dewan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the common factors that are essential for all successful patient encounters. ; 2) Incorporate basic elements of cognitive therapy in the treatment of patients with depression; 3) Practice basics of cognitive-behavioral therapy for the treatment of trauma; 4) Include specific techniques to improve adherence and prevent patients from dropping out.

SUMMARY:

Brief therapies are the norm today. Two of the most effective, evidence based brief therapies for two of the most common conditions seen by psychiatrists are presented: cognitive therapy for depression and exposure therapy for trauma. Both presentations emphasize the practical, salient elements of these brief therapies that practitioners can readily incorporate in their clinical work. Extensive video vignettes illustrate these points. Two

other critical aspects of brief therapy are addressed. First, evidence for the necessity of common factors for successful outcomes in all treatments- psychotherapy as well as psychopharmacology- are presented. Lastly, strategies for prevention of premature termination of therapy, a common problem in practice, are detailed. Sufficient time is protected to enable this to be an interactive experience.

NO. 1 CONTRIBUTION OF COMMON VERSUS SPECIFIC FACTORS (THERAPY OR MEDICATION) TO SUCCESSFUL OUTCOME

Speaker: Mantosh Dewan, M.D.

SUMMARY:

All successful interventions require a strong foundation of common factors. This is even true for psychopharmacological treatments. Additional contribution from specific interventions build on this common platform to produce optimal results. This presentation identifies these necessary common factors and presents estimates of the relative power of the common versus specific factors.

NO. 2 COGNITIVE THERAPY FOR DEPRESSION

Speaker: Judith Beck, Ph.D.

SUMMARY:

Since 1977, Cognitive Behavior Therapy (CBT) has been shown to be an effective form of treatment for depression in dozens of randomized controlled trials for patients across the lifespan with mild, moderate, and severe major depression, atypical depression, and treatment resistant depression. In addition, a number of studies have demonstrated that patients treated with CBT have generally half the relapse rate compared to those treated with medication.

CBT for depression is usually present-focused, goal-oriented, structured, and time-sensitive and teaches patients skills to modify their depressed thinking and behavior in order to bring about enduring change in their mood. CBT is highly collaborative and requires a strong therapeutic alliance. Both therapists and patients are quite active. Treatment is based on

a cognitive conceptualization of the individual patient and needs to be varied to meet the preferences and needs of the patient. In addition to cognitive and behavioral techniques, strategies from many other psychotherapeutic modalities - such as dialectical behavior therapy, acceptance and commitment therapy, Gestalt Therapy, compassion therapy, psychodynamic psychotherapy, motivational interviewing, mindfulness meditation, and positive psychology - may be incorporated into treatment, especially in cases of complicated and long-standing depression, and used within the context of the cognitive model.

NO. 3 EXPOSURE THERAPY FOR A RAPE SURVIVOR WITH POSTTRAUMATIC STRESS DISORDER

Speaker: Seth J. Gillihan, Ph.D.

SUMMARY:

This presentation will briefly review the revised diagnostic criteria for PTSD from DSM-5; describe how the therapeutic techniques that comprise exposure therapy for PTSD address the processes that seem to maintain the disorder; and summarize the evidence base supporting the use of this treatment. It will also include brief video clips of Dr. Edna B. Foa, a pioneer in trauma treatment and the developer of prolonged exposure therapy, demonstrating the key techniques of the treatment.

NO. 4 PREMATURE PSYCHOTHERAPY TERMINATION

Speaker: Roger P. Greenberg, Ph.D.

SUMMARY:

This is an overview of what is known about psychotherapy dropout based on a number of articles and book co-authored by the presenter. Basic questions addressed include: What is premature therapy termination? How is it defined? and How big a problem is it? A number of factors possibly related to premature termination are also discussed. These include: Does the diagnosis affect the probability of dropping out? Does the therapist's theoretical orientation make a difference? Is the therapist's level of experience related to dropout? Given the magnitude of the problem, what things can a therapist do that have been shown to make a

difference and improve the likelihood of a positive outcome?

QUALITY IMPROVEMENT INITIATIVES: INTERNATIONAL PERSPECTIVES

Chairs: John S. McIntyre, M.D., Wolfgang Gaebel, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify four quality improvement projects organized by the World Psychiatric Association.; 2) Identify three risk factors that lead to restraint deaths in the child and adolescent population.; 3) Identify the impact of certain pathways of care in the treatment of depression, anxiety and somatoform disorders.; 4) Understand the key elements in the implementation of quality improvement initiatives in routine mental healthcare.

SUMMARY:

This Symposium, organized by the World Psychiatric Association's Section on Quality Assurance, focuses on quality improvement initiatives in the United States and Germany. One presentation focuses projects conducted by the WPA with its 137 member societies in 118 countries. Projects that include work on stigma, depression in primary care, treatment of comorbid depression and diabetes and practice guidelines will be described. A presentation from Germany analyses the patterns of care and treatment patterns received by patients with depression, anxiety and somatoform disorders and the differential effect of such pathways on critical events such as sick leave, early retirement and mortality. A second presentation from Germany describes the implementation of quality improvement initiatives in routine mental healthcare. For the treatment of depression and schizophrenia four sets of trans-sectional quality improvement data from nine hospitals and outpatient facilities will be compared to results of other countries. A fourth presentation focuses on a U.S. study of deaths secondary to the use of restraints and presents details on nine such patients under the age of 18. Finally there will be a presentation on the Wisconsin Health Information Organization which is a unique public-private database and one of the most comprehensive claims data base available. Its use to evaluate variation and

improve the quality of psychiatric care in Wisconsin will be described.

NO. 1 ROLE OF WORLD PSYCHIATRIC ASSOCIATION IN PROMOTING QUALITY IMPROVEMENT INITIATIVES

Speaker: John S. McIntyre, M.D.

SUMMARY:

The World Psychiatric Association with 137 member societies in 118 different countries and representing more than 200,000 psychiatrists is uniquely positioned to have a major impact on promoting quality improvement efforts in the delivery of high quality psychiatric care throughout the world. WPA, in joint efforts with national psychiatric associations, has focused on a number of quality improvement projects including work on stigma, depression in primary care, treatment of comorbid depression and diabetes, barriers to care and practice guidelines.

This presentation will focus on specific QI initiatives. Barriers to the increased international implementation of these initiatives will be outlined and an agenda for overcoming these barriers proposed.

WPA, joining with national psychiatric societies, can greatly aid in the implementation of quality initiatives internationally which will improve the quality of care for persons with mental illnesses.

NO. 2 SECONDARY DATA ANALYSIS IN QUALITY ASSURANCE: PATHWAYS OF CARE IN DEPRESSION, ANXIETY AND SOMATOFORM DISORDERS

Speaker: Wolfgang Gaebel, M.D., Ph.D.

SUMMARY:

Depression, somatoform and anxiety disorders are among the most frequent mental disorders in Germany. Different sectors and disciplines participate in mental healthcare of patients with mental disorders, but there is a lack of empirical evidence of the quality of care in different settings and of the quality of outcomes in different settings. There is evidence from several studies that patients with depression, anxiety and somatoform disorders use the healthcare system intensively. Using routine data provided by statutory health insurance providers and the German Pension Fund, we

analyzed the pathways of care and treatment patterns over time (medication/psychotherapy) of patients with these mental disorders, and the differential effects of such pathways on critical events like sick leave, early retirement and mortality. A pathway is defined here as the pattern of mental healthcare utilization over time. Initial results of the analysis will be presented and discussed, and will include analyses of both mental and general healthcare utilization across different disciplines. The analysis aims at developing recommendations for optimal treatment and interdisciplinary collaboration

NO. 3 IMPLEMENTATION OF QUALITY INDICATORS IN ROUTINE MENTAL HEALTH CARE

Speaker: Birgit Janssen, Ph.D.

SUMMARY:

Quality Indicators that are valid and feasible can measure the quality of care and thus have the potential to effectively improve healthcare. However implementation of quality indicator tools in routine mental health care in Europe is challenging. One reason for this is the sectoral structure of the health care system in many of the European countries.

The German Association for Psychiatry, Psychotherapy and Psychosomatics (DGPPN) has developed four sets of trans-sectoral Quality Indicators (QI) that are specifically designed for relevant mental disorders with a high prevalence in inpatient and outpatient mental health care (depression and schizophrenia). As an example, the implementation of the QIs in routine health care of nine psychiatric hospitals and outpatient facilities in Northrhine-Westfalia will be presented and compared to results of other countries. The potential benefits for improving treatment quality by implementation of QIs in routine mental health care will be discussed.

NO. 4 RESTRAINT-RELATED DEATHS IN CHILDREN AND ADOLESCENTS

Speaker: J. Richard Ciccone, M.D.

SUMMARY:

There has been little research to date that has focused on deaths as a result of restraints in the

child and adolescent population. Equip for Equality and the National Disabilities Rights Network, supported by multiple grants, studied deaths that resulted from restraints in various treatment settings for all age ranges. State patient advocacy organizations provided information about these deaths, including all available records. A Data Collection Form was created to guide data review and provide consistent, quantifiable results. Fifteen states provided a total of 61 records that met criteria for inclusion in the original study. This follow-up study focuses on the nine cases of restraint related death that involved individuals younger than 18. Descriptive vignettes will be presented and the quantifiable data analyzed to assess risk factors that contributed to these deaths. Comparisons will be made to determine what, if any, differences exist in outcomes between youth and adult populations. We hope to identify lessons that can be applied to both psychiatric and nonpsychiatric child and adolescent populations and future directions for research.

NO. 5 USE OF AN ALL-PAYERS CLAIM DATABASE TO IMPROVE QUALITY OF PSYCHIATRIC CARE IN WISCONSIN

Speaker: Jerry Halverson, M.D.

SUMMARY:

Wisconsin Health Information Organization (WHIO) is an all-payers claims database that has been used in Wisconsin to help track healthcare treatment and utilization trends in the state. WHIO is a unique public-private partnership between the state, providers, insurers and employers. WHIO has been a model for many other states that are currently attempting to put a similar program in place. WHIO is one of the most comprehensive claims databases available and represents the care given to over 80 % of the population of the state representing over 300 million health claims. Through use of the database, providers in the state have been able to work with various other stakeholders (the state as well as employers) to evaluate variation and improve quality of care delivered. This presentation will discuss the use of the WHIO all-payers claim database and how it has been used to evaluate for variation and improve quality of psychiatric care in the state of Wisconsin. We will discuss

utilization trends for psychiatric care including specific diagnoses and treatments and discuss how this type of data can be used to improve quality of care in the state.

AN UPDATE ON NEUROCOGNITIVE DISORDERS FOR THE GENERAL PSYCHIATRIST

Chairs: Andrea Iaconi, D.Phil., M.D., David Gold, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To consider challenges faced in the assessment and diagnosis of neurocognitive disorders within a psychiatric practice.; 2) To understand the complex interplay between psychiatric disorders including depression and bipolar disorder, their treatments, and cognitive decline in later life.; 3) To develop an approach to the diagnosis of neurocognitive disorders in older adults presenting in psychiatric practice.

SUMMARY:

The prevalence of dementia is on the rise, in step with an aging population, and memory complaints are a common concern in older adults. Psychiatrists are well-placed to monitor their patients for the development of cognitive impairments. Unfortunately, they face the challenge of considerable overlap between symptoms of neurocognitive and psychiatric disorders, in addition to the complicating factor of psychotropic medication-induced changes in cognition. This symposium will focus on several aspects of neurocognitive disorders in the general psychiatric practice. Dr. Gallagher will present a review of the significance of cognitive dysfunction in late-life depression. Dr. Fischer will explore the challenge of diagnosis when symptoms of neurocognitive disorders masquerade as primary psychiatric disorders. Dr. Iaconi will then conclude by exploring the relationship between psychotropic medications and cognitive impairment and will present an approach to the diagnosis and management of neurocognitive disorders in general psychiatric practice.

NO. 1 DEPRESSION AND COGNITIVE DECLINE IN LATER LIFE: CAUSE, CONSEQUENCE OR COMORBIDITY?

Speaker: Damien Gallagher

SUMMARY:

Epidemiological evidence indicates that there is a complex interplay between depression and cognitive decline in later life. In particular, both a recent and remote history of depression have been linked to increased risk of cognitive decline in later life. Conversely, cognitive decline and functional impairment are potent predictors of both new onset depression and persistence of depression once established. In the absence of dementia there are frequently subtle deficits in executive control functions in depressed older adults. The depression with executive dysfunction syndrome describes a prevalent subtype of depression in later life which is associated with a distinct clinical presentation, longitudinal course and pattern of medical comorbidities. We discuss how recognition of cognitive dysfunction in this context has several important implications for clinical care. Firstly, the presence of comorbid cognitive dysfunction should automatically trigger a search for underlying aetiological factors and management of medical comorbidities. There is also evidence that responsiveness to standard therapeutic approaches may be diminished in certain instances and there are additional considerations which should be taken into account when choosing treatment. Finally we discuss the importance of early intervention and how novel therapeutic approaches should be evaluated in terms of their impact both upon depression and associated cognitive outcomes.

NO. 2 DEMENTIA PRESENTING WITH PSYCHIATRIC SYMPTOMS

Speaker: Corinne E. Fischer, M.D.

SUMMARY:

There are many different subtypes of dementia that can present with psychiatric symptoms, although the overlap is much more marked with some disorders in comparison to others. In some instances the overlap may lead to a delay in diagnosis and the application of inappropriate treatments, thus having important implications for patient management. Two relatively common dementia subtypes that may frequently present with a prominent psychiatric presentation are frontal-temporal dementia (FTD) and dementia

with lewy bodies (DLB). Patients with FTD typically undergo a marked change in personality in the early stages of the disease, resulting in extreme apathy or conversely impulsivity, disinhibition and socially inappropriate behavior. It may be hard to distinguish these symptoms from other psychiatric disorders such as major depression or bipolar disorder, where you may see similar changes in personality. Similarly, patients who have DLB may often present with prominent psychotic symptoms, including delusions and visual hallucinations, early on in the course of the disease. Distinguishing features that should lead to an increased index of suspicion include the presence of a movement disorder (parkinsonism) and fluctuating cognitive symptoms. Patients with more conventional dementia diagnoses, including Alzheimer's Disease (AD) and Vascular Dementia (VD), may occasionally present with psychiatric symptoms at initial presentation, although this is more rare.

NO. 3

AN APPROACH TO DIAGNOSING AND MANAGING COGNITIVE IMPAIRMENT IN PSYCHIATRIC PRACTICE: COGNITIVE EFFECTS OF PSYCHIATRIC ILLNESS AND PSYCHOTROPIC MEDICATIONS

Speaker: Andrea Iaconi, D.Phil., M.D.

SUMMARY:

Psychiatrists have an under-recognized but important role in the prevention, diagnosis and management of dementia. The psychiatric patient population is at high risk for the development of neurocognitive disorders. Individuals with bipolar disorder and schizophrenia present with cognitive dysfunction throughout the life span, and are at increased risk of cognitive decline as they age. Depression is also a known risk factor for dementia. This presentation aims to provide an evidence-based approach to the assessment of neurocognitive disorders in older adults in a general psychiatric practice and to the management of mild dementia. The use of appropriate tools for neuropsychological and functional assessment can help guide diagnosis and management strategies. There are many potentially reversible causes of cognitive impairment, including medications, medical illness and substance misuse, which can be considered and investigated. Most psychotropic

medications, including antipsychotics, benzodiazepines, anticonvulsants, lithium, and antidepressants with anticholinergic properties, have significant effects on cognitive function. Dose adjustment or switching of these medications in older adults may help to optimize cognitive function. From the perspective of psychiatric management of mild dementia, the value of certain psychotherapies and the use of cholinesterase inhibitors will be explored.

ADVANCES IN THE NEUROBIOLOGY OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Chair: Joseph Biederman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about new neuroimaging research documenting separate networks subserving working memory and ADHD.; 2) Learn about the differential pharmacological effects of stimulants on working memory and ADHD symptoms.; 3) Understand the association between dopamine 4 receptor dysfunction and working memory; 4) Understand abnormalities in the fear circuitry in non-traumatized young adults with ADHD. .

SUMMARY:

Prevailing neuropsychological models of ADHD propose that it arises from deficits in executive functions, but accumulating clinical evidence suggests a dissociation between ADHD and executive dysfunctions. Dr Biederman's study examined whether ADHD and executive dysfunction are neurobiologically dissociated by examining clinical status and brain function during a parametric n-back working memory experiment in well-characterized, longitudinally followed participants who had been diagnosed with or without ADHD in childhood. Dr Thomas Spencer will present evidence from clinical trials of stimulants in ADHD, further supporting the dissociation between ADHD and WM deficits. In this study, Cohen's d estimates for the Cambridge Neuropsychological Test Automated Battery spatial working memory measures differed significantly by 1.8 standard deviations ($t = -10.8$, $df = 70$, $p < 0.001$) and 1.9 standard deviations ($t = -11.1$, $df = 70$, $p < 0.001$) for the strategy and total between errors subcategories respectively. Confidence intervals did not

overlap with those of the Adult ADHD Investigator Symptom Rating Scale (AISRS). Dr. Bhide will present results from preclinical studies documenting in a prenatal nicotine exposed rodent model of ADHD that although oral methylphenidate produced significant improvements in working memory, selective D4 receptor agonist produced significantly more pronounced improvements than methylphenidate. Dr. Andrea Spencer's study aimed to identify neural biomarkers of biologic vulnerability to PTSD in ADHD by studying fear extinction deficiency as measured by skin conductance response (SCR) and functional magnetic resonance imaging (fMRI). Non-traumatized never-medicated ADHD subjects showed robustly lesser activation compared to controls in the vmPFC during late extinction, similar to findings reported in PTSD subjects. ADHD subjects also had lesser activation in brain structures that mediate fear extinction learning. Results indicate altered patterns of brain activation in extinction and impaired fear extinction recall in adults with ADHD, which is similar to findings in PTSD and may suggest an underlying vulnerability.

NO. 1 DISSOCIATION OF WORKING MEMORY AND ADHD IN THE BRAIN

Speaker: Joseph Biederman, M.D.

SUMMARY:

This study examined whether ADHD and executive dysfunction are neurobiologically dissociated by examining clinical status and brain function during a parametric n-back working memory experiment in well-characterized, longitudinally followed participants who had been diagnosed with or without ADHD in childhood. Spatial working memory status was independent of whether ADHD participants were currently diagnosed with ADHD (persistent) or had remitted from their diagnosis in adulthood. During scanned performance on the n-back task, ADHD participants with impaired spatial working memory performed worse than controls and ADHD participants with unimpaired spatial working memory, whose performance did not differ from one another. Both the controls and the ADHD participants with unimpaired spatial working memory exhibited significant linearly increasing activation as a function of working-memory load in dorsolateral prefrontal cortex,

intraparietal sulcus, and cerebellum, and these activations did not differ significantly between these groups. In contrast, ADHD participants with impaired spatial working memory exhibited significant hypoactivation in the same regions of the left hemisphere. These findings point to a neurobiological dissociation between ADHD and executive dysfunctions that often accompany ADHD.

NO. 2 EVIDENCE OF A PHARMACOLOGICAL DISSOCIATION BETWEEN THE ROBUST EFFECTS OF METHYLPHENIDATE ON ADHD SYMPTOMS AND WEAKER EFFECTS ON WORKING MEMORY

Speaker: Thomas Spencer, M.D.

SUMMARY:

Working memory (WM) deficits often co-occur with, but do not define, attention deficit hyperactivity disorder (ADHD). Preclinical and neuroimaging studies show that ADHD and WM deficits are dissociated at the level of individual dopamine receptor function. We hypothesized that there would also be a pharmacological dissociation of the effects of stimulants on ADHD and WM. ADHD subjects were derived from three prospective clinical trials involving treatment with OROS methylphenidate in adolescents and adults with DSM-IV ADHD. Cohen's d was used to evaluate effect size between baseline and week 6 for all assessments. Cohen's d estimates for the Cambridge Neuropsychological Test Automated Battery spatial working memory measures differed significantly by 1.8 standard deviations ($p < 0.001$) and 1.9 standard deviations ($p < 0.001$) for the strategy and total between errors subcategories respectively. Confidence intervals did not overlap with those of the Adult ADHD Investigator Symptom Rating Scale (AISRS). A similar effect was observed for changes in AISRS and the Behavior Rating Inventory of Executive Function working memory scale where the Cohen's d estimates differed significantly by 1.1 standard deviations ($p = 0.015$) and confidence intervals did not overlap. These findings provide further evidence for the dissociation between ADHD and WM deficits.

NO. 3

WORKING MEMORY DEFICITS AND TRANSGENERATIONAL TRANSMISSION OF ADHD PHENOTYPE IN A PRENATAL NICOTINE EXPOSURE MOUSE MODEL

Speaker: Pradeep G. Bhide, Ph.D.

SUMMARY:

Prenatal nicotine exposure mouse model is an ecologically valid ADHD model with striking face-, construct- and predictive validity. In this model, we found significant decreases in cingulate cortex volume; frontal cortical dopamine content, dopamine D2 and D4 receptor activity, and significant increase in kappa and mu opioid receptor activities. Behavioral analysis showed increased locomotor activity and deficits in working memory. Oral methylphenidate administration resulted in increased frontal cortical dopamine content, increased dopamine D4 receptor activity and decreased locomotor activity. Although oral methylphenidate produced significant improvements in working memory, selective D4 receptor agonist produced significantly more pronounced improvements than methylphenidate. When the prenatally nicotine exposed mice were bred with drug naïve partners, the resulting generations showed increased locomotor activity. The trans-generational transmission occurred via the female but not the male line of founders. Thus, the prenatal nicotine exposure mouse model has provided significant novel insights into the neurobiology of ADHD.

NO. 4

A FUNCTIONAL MAGNETIC RESONANCE IMAGING STUDY OF VULNERABILITY FOR POSTTRAUMATIC STRESS DISORDER IN NON-TRAUMATIZED, MEDICATION NAIVE ADULTS WITH ADHD

Speaker: Andrea Spencer, M.D.

SUMMARY:

Background: Clinical and preclinical data have shown an association between posttraumatic stress disorder (PTSD) and attention deficit hyperactivity disorder (ADHD). Objective: To identify neural biomarkers of biologic vulnerability to PTSD in ADHD by studying fear extinction deficiency as measured by skin conductance response (SCR) and functional

magnetic resonance imaging (fMRI). Method: 19 medication-naive adults with ADHD and no trauma exposure and 21 historical controls underwent a 2-day visual fear conditioning and extinction neuroimaging paradigm in a 3-T fMRI scanner. Day 1 included conditioning and extinction training, and day 2 included extinction recall testing. Magnitude of fear response was measured with SCR data. Results: ADHD subjects showed robustly lesser activation compared to controls in the vmPFC during late extinction, similar to findings reported in PTSD subjects. ADHD subjects also had lesser activation in brain structures that mediate fear extinction learning. ADHD subjects showed a trend toward increased SCR response during extinction recall and greater activation in the cerebellum, suggesting impaired extinction retention as in PTSD subjects. Conclusions: Results indicate some altered patterns of brain activation in extinction and impaired fear extinction recall in adults with ADHD, which is similar to findings in PTSD and may suggest an underlying vulnerability.

THE RELEVANCE OF CIRCADIAN RHYTHM DISTURBANCES AND TREATMENT TO PSYCHIATRIC PRACTICE

Chairs: Richard S. Schwartz, M.D., Jacqueline Olds, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the disorders and sub-clinical presentations characterized by circadian rhythm disruption and/or retinal sub-sensitivity to environmental light cues. ; 2) Recognize the role that individual differences in light sensitivity can play in vulnerability to circadian rhythm disruptions.; 3) Understand light as it affects circadian rhythms and learn how to compare the effectiveness of different light sources for affecting the circadian system.; 4) Identify lighting devices and systems characteristics that will help clinicians recommend more effective light delivery for improving circadian sleep disorders; 5) Describe the role of circadian disruption in delirium including recent evidence using light treatment and melatonergic agents for delirium prevention and treatment.

SUMMARY:

Circadian rhythm disruption plays a critical role in mood disorders and other psychiatric conditions. Despite the presence of empirically-supported treatments, circadian interventions remain underappreciated and underutilized. Their efficacy extends beyond seasonal affective disorder (SAD) and includes non-seasonal depression and sleep disorders. New evidence has begun to define roles for circadian interventions in delirium and dementia as well. This class of interventions may offer rapid symptom relief while being inexpensive and remarkably safe.

Clinical Epidemiology: We begin with an overview of common disorders characterized by circadian rhythm disruption, as well as sub-clinical behavioral and physiological consequences.

Etiology: The pathophysiology of circadian rhythm disruption will be presented, including major depression (seasonal affective disorder [SAD] and non-seasonal depression), delirium, circadian rhythm sleep disorders, and dementia. The emerging role of individual differences in sensitivity to environmental light levels and the consequences for etiological models will be discussed.

Interventions: A practical overview of circadian interventions will discuss the empirical foundation of light treatment dosing and prescribing. Field studies characterizing light exposures in various populations will be presented with attention to what constitutes effective light for the circadian system and the neurobiological mechanism of action of light treatment.

Light Treatment: Light treatment is a first-line treatment for SAD that traditionally involves 30 minutes of 10,000 lux full-spectrum white light or 2 h of 2,500 lux at the cornea. A non-rod, non-cone class of retinal photoreceptors-the melanopsin-containing intrinsically photosensitive retinal ganglion cells-serve as the primary means of converting light into neural signals for the circadian system. This discovery has opened up opportunities for the use of biologically-informed light spectra and lower levels of light for treatment. Recent studies have shown that light can also be used to treat non-seasonal depression (post-partum and bipolar depression), sleep disorders, post-traumatic stress disorder, delirium, and dementia. The use of a tailored light treatment to treat or prevent delirium and to improve sleep and behavior in Alzheimer's disease patients will be

presented, including challenges associated with delivering light therapy to acute medical inpatients and Alzheimer's disease patients.

Additional Interventions: Two other leading circadian interventions are wake therapy and melatonergic agents. Where it is difficult to ensure adequate light exposure (e.g. medical inpatient settings), melatonin and its agonist ramelteon have been used to prevent or treat delirium with exciting preliminary results.

Dissemination & Implementation: Suggestions for broader implementation of chronobiological treatments and their incorporation into multiple practice settings will be discussed.

NO. 1 INDIVIDUAL DIFFERENCES IN LIGHT SENSITIVITY

Speaker: Kathryn A. Roecklein, Ph.D.

SUMMARY:

During shorter, darker winter days, up to 2% of the population develops seasonal affective disorder (SAD). However, the biological underpinnings of such individual differences in sensitivity to light have not been well understood. A pre-existing retinal subsensitivity to light may trigger SAD in vulnerable individuals under low wintertime light conditions. The main aim of this study was to assess the activity of the retinal light input pathway in SAD and controls in summer and winter. Retinal responses to light can be measured using the post-illumination pupil response (PIPR) that assesses melanopsin-containing cellular responses in the non-visual light input pathway. Data indicate that the PIPR in SAD is lower compared to controls, in winter but not summer. This suggests a failure to up-regulate melanopsin-specific retinal responding in months of shorter day length, which may contribute to the pathophysiology of SAD. More broadly, such individual differences in retinal sensitivity may explain vulnerability to other Circadian Rhythm Disorders and could potentially predict treatment disposition.

NO. 2 CIRCADIAN DISRUPTION IN DELIRIUM: THE ROLE OF LIGHT, MELATONIN, AND RAMELTEON

Speaker: Mark Oldham, M.D.

SUMMARY:

Acute medical and surgical illness are closely associated with circadian disruption, and virtually all patients exhibit sleep-wake cycle disturbances by the time of syndromal delirium onset. Studies among the critically ill and post-surgical cohorts support a model of serial circadian rhythm degradation. Delirium presents with a diminished amplitude of circadian variation and often exhibits a phase delay. Even acute changes in circadian rhythmicity contributes to delirium, impaired immunity, autonomic dysfunction, and abnormalities in endocrine signaling. Not only is delirium characterized by chronodisruption, but recent trials of bright light, melatonin, and the melatonin agonist ramelteon have found that these may prevent, postpone, or treat delirium. All six published trials that included light therapy (LT) for delirium have yielded positive results—four of which have been randomized pilot studies. All but one of the intervention studies using melatonin among acute medical and surgical illness have reported positive results including improved sleep, earlier successful post-surgical extubation, and lower delirium incidence. Further data in support of melatonin's use is derived from unpublished data presented at critical care poster sessions. Finally, one randomized trial found that ramelteon, when administered nightly to aged medical inpatients, remarkably reduced incidence of delirium—3% versus 32%.

NO. 3 DEFINING AND MEASURING CIRCADIAN LIGHT

Speaker: Mark S. Rea, Ph.D.

SUMMARY:

Light is formally defined as optical radiation incident on the retina that evokes a visual sensation in humans. The current definition of light does not directly relate to its effects on the human circadian system. Since retinal light (and dark) exposures regulate the human circadian system and since disruption of the circadian system has broad implications for health and well-being, it is becoming increasingly important to develop a new definition of circadian light. It is now well accepted that the lighting characteristics (intensity, spectrum, timing, duration) affecting the visual system are different than those affecting the circadian system and these differences will be discussed. A definition of circadian light will be proposed

and discussed, including a discussion of a model of human circadian phototransduction that can be used to estimate circadian effectiveness of various light sources at various light levels. Using this model, calculations of the effectiveness of different light sources at activating the circadian system were compared and will be presented. Measurement devices and techniques will also be discussed.

NO. 4 APPLICATIONS AND PRACTICAL SPECIFICATIONS FOR LIGHT TREATMENT

Speaker: Mariana Figueiro, Ph.D.

SUMMARY:

Light treatment has shown great promise as a non-pharmacological treatment in helping those suffering from circadian sleep disorders. However, both positive and negative results have been reported in the literature. These contradictory data may result from 1) reduced compliance due to practicality of getting light or glare generated by the device or 2) lack of accurate measurement of light stimulus. This presentation will discuss pros and cons of various lighting devices and techniques (e.g., light boxes, light masks, ambient lighting, light goggles, blue-enriched light) and present some field data on personal light exposures in various populations. It will also discuss lighting interventions designed to shift circadian phase in the field and present data on a tailored light treatment designed to improve sleep and behavior in Alzheimer's disease and related dementia patients. Finally, a light exposure and avoidance system designed to increase effectiveness of the light treatment in the field will be presented.

INTEGRATION OF SPIRITUALITY IN HEALTH CARE: RESEARCH AND CLINICAL REPORTS

Chair: Alexander Moreira-Almeida, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of spirituality for clinical practice and research on mental health; 2) Identify different modalities of integration of spirituality in clinical care and the evidence available for their effectiveness; 3) Take a spiritual history and integrate

patients' spirituality in a comprehensive clinical approach; 4) Recognize different research strategies that have been used and what clinical aspects of spirituality are in greater need of rigorous research.

SUMMARY:

Despite a large number of studies on the relationship between religiosity/spirituality (R/S) and health, some areas have been poorly explored, especially the impact of spiritual and spiritually integrated treatments and the development of clinical applications of the currently available epidemiologic data about the interconnection between R/S and health. This symposium presents research evidence and practical examples on the integration of R/S into health care. The first speaker presents a systematic review and meta-analysis of spiritual intervention's effect on physical and mental health. The second reviews evidence available and presents practical guidelines for the integration of R/S into mental health care. The third presenter discusses clinical implications of R/S for the treatment of depression. The last two speakers, based on research and clinical experience, discuss patients' interests and practical examples of spiritually integrated psychotherapy.

NO. 1

CONTROLLED CLINICAL TRIALS FOR SPIRITUAL AND RELIGIOUS INTERVENTIONS: A SYSTEMATIC REVIEW AND META-ANALYSIS

Speaker: Homero Vallada, M.D., Ph.D.

SUMMARY:

The presentation will discuss randomized clinical trials on spiritual and/or religious interventions in physical and mental health in different groups, through a systematic review and meta-analysis. The purpose of this work was: (1) to evaluate the efficacy of spiritual/religious interventions as complementary therapy; (2) to conduct a descriptive analysis of intervention models and their goals, and (3) to identify the methodological quality of clinical trials. Seven different databases were selected and the study was conducted in two phases: (a) phase 1: reading the title and the abstracts, (b) phase 2: reading the remaining articles. 4751 papers were identified and 4367 were excluded (phase 1).

Of the remaining 162 studies, 123 were again excluded (phase 2), which left 39 remaining articles. Regardless of the population studied, the 38 out of these 39 reports showed positive or neutral results with the use of spiritual/religious interventions. The main results were: decrease of symptoms of depression, anxiety, alcohol consumption, overweight, stress, improved quality of life, increased adherence to medical treatments and satisfaction with the protocols discussed. The meta-analysis showed statistically significant effect of the intervention for anxiety ($p = <0.0001$), but not for depression or quality of life.

NO. 2

CLINICAL IMPLICATIONS OF SPIRITUALITY TO MENTAL HEALTH: REVIEW OF EVIDENCE AND PRACTICAL GUIDELINES

Speaker: Alexander Moreira-Almeida, M.D., Ph.D.

SUMMARY:

Despite empirical evidence of a relationship between religiosity/spirituality (R/S) and mental health and recommendations by professional associations that these research findings be integrated into clinical practice, application of this knowledge in the clinic remains a challenge. This presentation reviews the current state of the evidence and provides evidence-based guidelines for spiritual assessment and for integration of R/S into mental health treatment. We performed PubMed searches of relevant terms yielded 1,109 papers. We selected empirical studies and reviews that addressed assessment of R/S in clinical practice. The most widely acknowledged and agreed-upon application of R/S to clinical practice is the need to take a spiritual history (SH), which may improve patient compliance, satisfaction with care, and health outcomes. We found 25 instruments for SH collection, several of which were validated and of good clinical utility. This presentation provides practical guidelines for spiritual assessment and integration thereof into mental health treatment, as well as suggestions for future research on the topic.

NO. 3

INTEREST IN SPIRITUALLY INTEGRATED PSYCHOTHERAPY

AMONG ACUTE PSYCHIATRIC PATIENTS

Speaker: David H. Rosmarin, Ph.D.

SUMMARY:

Objective: Spiritually integrated psychotherapy (SIP) increasingly common, though systematic assessment of interest in such treatments has not yet been assessed among acute psychiatric patients.

Methods: We conducted a survey with 253 acute psychiatric patients (99% response rate) at a private psychiatric hospital in Eastern Massachusetts, USA.

Results: More than half (58.2%) of patients reported "fairly" or greater interest in SIP and 17.4% reported "very much" interest. Neither demographic nor clinical factors were significant predictors except that current depression predicted greater interest. Religious affiliation and general spiritual/religious involvement were associated with more interest, however many affiliated patients reported low/no interest (42%), and conversely many unaffiliated patients reported "fairly" or greater interest (37%).

Conclusions: Many acute psychiatric patients report interest in integrating spirituality into their mental health care. Specific assessment of interest in SIP should be routine in clinical care, irrespective of patients' levels of religious involvement.

NO. 4 DEPRESSION AND SPIRITUALITY: CLINICAL IMPLICATIONS

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 view of human experience as having emotional, and existential 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. Case examples will illustrate this framework.

NO. 5 SPIRITUALITY GROUPS WITH THE CHRONICALLY MENTALLY ILL

Speaker: Nancy Kehoe, Ph.D.

SUMMARY:

Although the exploration of religion and spirituality has become more mainstream in psychiatric work, discussing these areas with those who suffer with serious mental illness is still approached with more hesitation because of the association between mental illness and religion. One only has to look on YouTube to see how religious beliefs continue to be pathologized.

The focus for this presentation will be on spirituality groups in a day treatment program. The experience, of both the clients and the staff, is that the discussion of religion and spirituality, rather than being a problem, is a strong binding force in the community as it fosters understanding, compassion and acceptance.

Two groups will be described, one a discussion group on spiritual beliefs and the second a mindfulness group. Both groups are open to all in the community regardless of diagnosis. Guidelines for the groups will be offered and some illustrations of the group work.

PRIMARY CARE AND ASSERTIVE COMMUNITY TREATMENT (ACT) TEAMS: NEW FRONTIERS IN TEAM-BASED CHRONIC ILLNESS MANAGEMENT

Chairs: Erik Vanderlip, M.D., M.P.H., Maria Monroe-DeVita, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify similarities between the ACT model of care delivery and chronic illness care models, such as the Patient-Centered Medical Home.; 2) Articulate the rationale for delivering better primary care and chronic illness management to populations with Serious Mental Illness.; 3) Recognize the spectrum of primary care integration available for ACT interventions, and the degree to which ACT teams already engage in primary care.; 4) Compare several possible models of primary care and chronic illness management currently under study.; 5) Adapt potentially effective

intervention models to local communities and clinics in need of integrated care services for those with SMI.

SUMMARY:

Assertive Community Treatment (ACT) has been recognized as an evidence-based practice, delivering interdisciplinary services and proactive engagement for individuals suffering with serious mental illness (SMI) since its inception in the 1980s. Over three decades, the ACT model has incorporated new elements of effective interventions including supported employment and dual-disorder treatment, matching skillsets of the workforce to the complex needs of the individuals it serves. ACT is intended to provide the totality of clinical and case management needs within the team, and in many ways is similar to the primary care notion of the Patient-Centered Medical Home (PCMH) for those with SMI.

For over a decade, it has been well documented that those with SMI die prematurely, sometimes by as much as 25 years. The leading cause of death is cardiovascular disease, and it is estimated that as much as 60% of this excess mortality is access to quality primary care services and chronic disease management. Because of their structure and function, ACT teams are uniquely suited to manage complex chronic illnesses, but have traditionally been reluctant to manage physical illness because of lack of knowledge, liability concerns, time and resources.

Many states have been recognizing the value of ACT to deliver cost-effective interventions for adults with SMI, allowing them the freedom of living independently in the community. Consequently, states such as Minnesota, Georgia and Oregon have supported the relatively recent implementation of widespread ACT networks, while other states have mandated that ACT be a covered service in their Medicaid behavioral health contracts. There are estimated to be as many as 1,000 ACT teams nationally, functioning in various capacities, in nearly every state.

This symposium will highlight several innovative national approaches to ACT integration of primary care services. At the conclusion of the program, there will be time for audience engagement and discussion facilitating comparisons between interventions and a shared understanding of the rationale behind blending primary care services and ACT

models. Communicating the experience of early adopters will help to inform more widespread dissemination, collaboration and study of new ACT models that could effectively shorten the mortality gap of those with SMI over time.

NO. 1

THE MINNESOTA APPROACH TO INTEGRATED CARE: INTEGRATED ILLNESS MANAGEMENT AND RECOVERY ON ACT TEAMS

Speakers: Piper Meyer, Ph.D., Lynette Studer, M.S.S.W., Steve Harker, M.D.

SUMMARY:

The interdisciplinary approach of an ACT team offers a resource rich structure to deliver an integrated approach to treatment for persons with SMI. As part of an ongoing initiative to address modifiable health risk factors for persons with SMI, Minnesota has increased awareness and monitoring of a subset of health risk factors. More recently, a pilot group of ACT teams have been trained in an intervention for integrated mental and physical health care. Integrated Illness Management and Recovery (I-IMR) is a medical illness self-management intervention developed to address chronic mental and physical health conditions for persons with SMI. In I-IMR, persons learn self-management tools to manage both chronic mental health and medical disorders. In this presentation, we will describe the implementation and training of I-IMR on ACT teams. We will address the adaptations necessary to implement an integrated intervention on an ACT team and present results from a pilot study with 10 ACT teams trained in I-IMR. We will discuss current training needs of ACT practitioners and summarize both practitioner and consumer outcomes associated with the implementation of I-IMR. In addition, we will present some data that relates to parallel county and state initiatives to improve physical health within ACT.

NO. 2

EMBEDDED PRIMARY CARE WITHIN ASSERTIVE COMMUNITY TREATMENT: IMPLEMENTATION AND OUTCOMES IN L.A. COUNTY

Speaker: Benjamin Henwood, L.C.S.W., M.S.W., Ph.D.

SUMMARY:

Assertive community treatment (ACT) is a team-based service delivery approach for individuals with complex health and social needs. Although multiple disciplines are represented within ACT, primary care has typically been absent. This presentation describes the development of an integrated ACT model (I-ACT) in which primary care is embedded within an existing ACT team and its use within a large-scale policy experiment being conducted by the Los Angeles County Department of Mental Health. Findings from the implementation and outcomes evaluation of 5 programs that combined supportive housing, assertive community treatment (ACT), and primary care through this policy experiment will be presented. Discussion will include both the success and challenges of the model, as well as its potential for increasing healthcare access and reducing health disparities for an underserved, vulnerable population.

NO. 3**FROM THE EYES OF THE PACT STAFF: BARRIERS AND FACILITATORS TO EFFECTIVE PHYSICAL HEALTH MANAGEMENT**

Speaker: Maria Monroe-DeVita, Ph.D.

SUMMARY:

This presentation will highlight the results of a focus group with Washington State PACT leaders held in February, 2014 as part of a statewide symposium for ACT and integrated care. The medical staff and ACT team leaders provided candid feedback on the extensive barriers to implementing primary care within ACT, including scope of practice and medico-legal issues, education and staff knowledge/oversight, reimbursement and time pressures. The focus will then shift to ideas cultivated by the teams to overcome those barriers and the resources needed to facilitate primary care integration on ACT. Discussion will center on statewide initiatives and current opportunities being pursued to facilitate teams delivering better primary care services to their clients.

NO. 4**SOONER OR LATER: THE OKLAHOMA ADOPTION OF HEALTH HOMES AND ACT INTEGRATION**

Speaker: Erik Vanderlip, M.D., M.P.H.

SUMMARY:

This presentation will focus on comparing and contrasting prior models of ACT integration with Primary care with recent developments in Health Home funding in Oklahoma. It will outline the progress in implementing Health Homes within Oklahoma ACT teams, and discuss several alternate models of ACT integration that vary by region, local primary care resources, and population density. The presentation will then shift to discussing common threads in ACT integration across innovative programs throughout the nation, identifying promising themes and shared struggles.

PERINATAL MENTAL HEALTH: EVALUATION AND TREATMENT CONSIDERATIONS FOR THE GENERAL PSYCHIATRIST

Chairs: Elizabeth Fitelson, M.D., Lucy Hutner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Interpret new findings in the area of perinatal mental health in the context of the existing knowledge base in order to use the scientific literature to inform clinical treatment decisions. ; 2) Diagnose, assess, and communicate with patients about the clinical course, morbidity, and treatment options for affective and anxiety disorders in the perinatal period.; 3) Identify perinatal women with high-risk substance use and substance abuse, gain basic tools for communicating with patients about this behavior and possible treatments in the perinatal period. ; 4) Recognize the psychological, physiologic, and psychiatric consequences of infertility and its treatments for women. .

SUMMARY:

Most women will experience at least one pregnancy in their lifetimes; approximately half of all pregnancies in the US each year are unplanned. Nevertheless, psychiatrists who treat women of childbearing age often find themselves at a loss to make appropriate

recommendations when their patients become, or plan to become, pregnant. Many patients struggle with issues related to infertility, and psychiatrists must contend with the psychological and psychiatric consequences for their patients and families. Treatment decisions, particularly around pharmacologic interventions in pregnancy, ideally should involve careful and collaborative assessment of the risks of both illness and treatment on a case by case basis, utilizing the most up to date information. However, it can be difficult to interpret the most recent studies without the context of the extensive and growing literature in this field, particularly when patients are influenced by coverage in the lay press that may be inaccurate or distorted. This symposium will cover psychiatric issues related to infertility and its treatments, as well as assessment and treatment options for perinatal women with affective, anxiety, and substance use disorders.

**NO. 1
ANTIDEPRESSANTS IN PREGNANCY:
KNOWLEDGE TRANSFER AND
TRANSLATION OF SCIENTIFIC
EVIDENCE**

Speaker: Adrienne Einarson, R.N.

SUMMARY:

All of the methods used for examining the safety of antidepressants in pregnancy have some deficiencies in methodology, thus reinforcing the need for accurate interpretations when discussing results. In addition, dissemination in both the scientific and lay press, has been selective and therefore potentially biased. Consequently, this lack of clarity may impede the transfer of evidence-based information to women requiring an antidepressant during pregnancy, thus impacting decision-making regarding treatment.

**NO. 2
APPROACH TO SUBSTANCE USE
DISORDERS IN THE PERINATAL PERIOD**

Speaker: Shabnam Shakibaie Smith, M.D.

SUMMARY:

Misuse and abuse of substances in pregnancy and lactation is a common yet ignored phenomenon, which carries high risks for the health of both the mother and the future child. Shame and stigma associated with this

behavior can make it more difficult for women to ask for help and therefore not receive the care they need. It is crucial for mental health and other clinicians caring for pregnant and postpartum women to be aware of the prevalence and risks of substance use in pregnancy, how to screen patients effectively, and how to initiate treatment or facilitate referral when appropriate. This talk will provide education, practical guidance, and resources for mental health clinicians on how to approach substance use disorders in the perinatal period.

**NO. 3
PSYCHIATRIC AND PSYCHOLOGICAL
EFFECTS OF INFERTILITY AND
INFERTILITY TREATMENTS**

Speaker: Lucy Hutner, M.D.

SUMMARY:

Infertility and its treatments are risk factors for depression and anxiety in women, even when the outcome is a healthy pregnancy and baby. Women with mood and anxiety disorders at baseline may face even greater morbidity when going through the psychological and biological stresses of repeated cycles of hormonal interventions associated with assisted reproductive technologies (ART). This talk will review risk factors for psychiatric comorbidity in women with infertility, common ART interventions and their psychiatric sequelae, and treatment options for mood and anxiety symptoms in this population.

**NO. 4
BIPOLAR DISORDER IN THE PERINATAL
PATIENT: BALANCING THE RISKS OF
ILLNESS AND TREATMENT**

Speaker: Elizabeth Fitelson, M.D.

SUMMARY:

Women with Bipolar Disorder face significant risks of mood instability and its consequences in pregnancy and the postpartum. However, many mood stabilizing medications also carry risks for adverse pregnancy outcomes and for the future child. This presentation will provide an overview of these risks, in order to assist clinical decision-making for mental health clinicians working with pregnant women (or women of childbearing age) with Bipolar illness.

NO. 5

ANXIETY DISORDERS IN PREGNANCY: WHAT EVERY CLINICIAN NEEDS TO KNOW

Speaker: Lauren M. Osborne, M.D.

SUMMARY:

Anxiety and depression are common disorders in pregnancy and the postpartum period, affecting 10-20% of women worldwide. While there is a vast literature on effects of and treatment for depression in pregnancy, there is a smaller but growing literature about the effects, etiology, and treatment of anxiety, which is just as prevalent and can carry high morbidity for both mother and fetus. This presentation will offer an overview of: 1) the etiology of anxiety in pregnancy; 2) the effect of untreated prenatal anxiety on the fetus; and 3) pharmacologic and non-pharmacologic options for the treatment of anxiety in pregnancy

NO. 6 TREATMENT OF DEPRESSION IN PERINATAL WOMEN

Speaker: Laura Miller, M.D.

SUMMARY:

Depression is widely described as the most common complication of childbirth. This presentation will focus on the treatment of depressive disorders in pregnancy and postpartum. The focus will be on the data examining the risks and benefits of specific antidepressants in the perinatal period, as well as a summary of the risks of untreated depression in this population.

ON-CALL UPDATE: SKILLS IN ACUTE CARE PSYCHIATRY

Chair: Jodi Lofchy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Engage in a collaborative discussion regarding medical stability of psychiatric referrals; 2) Conduct a risk assessment in the emergency department for suicidality; 3) Identify an approach to managing the agitated patient; 4) Identify the key risk factors for premature discharge and best practices in the informed discharge process.

SUMMARY:

This session will provide an overview of the skills and knowledge required to take call in the hospital setting. Topics will include emergency risk assessment, determination of medical stability in psychiatric referrals and the management of the agitated patient. Staff on call are often asked to assess inpatients requesting discharge. We will include a review of the key considerations in assessing risk in admitted patients as well as the latest recommendations regarding Informed Discharge and the obligations of the discharging physician. Participants will have opportunities to engage in interactive clinical decision making exercises, and develop specific strategies for effective communication with emergency colleagues and multidisciplinary team members. This session will include identified Best Practices in Acute Care Psychiatry and a model will be provided to guide the psychiatrist on call in the hospital setting.

NO. 1 ON - CALL RISK ASSESSMENT: SUICIDE

Speaker: Jodi Lofchy, M.D.

SUMMARY:

Suicide risk assessment in the emergency department will be reviewed with particular attention to the unique challenges inherent to the on call system. At times psychiatrists are in the position of reviewing cases from off site while working with members of a multidisciplinary team and need to determine patient disposition without a direct assessment. This session will provide a review of the high-risk patient in the ED with emphasis on the need for appropriate documentation.

NO. 2 ASSESSING MEDICAL STABILITY IN PSYCHIATRIC EMERGENCIES

Speaker: David Kocerginski, M.D.

SUMMARY:

This presentation will provide an overview of the assessment process for determining medical stability in patients seen within an emergency department with psychiatric symptoms. Controversies surrounding definitions of medical clearance/medical stability which often lead to tensions between departments of

emergency medicine and psychiatric programs will be explored. Common challenges facing the on call psychiatrist will be highlighted. The use of protocols in defining criteria for medical stability and improving communication between departments will also be reviewed.

NO. 3 MANAGING THE AGITATED PATIENT ON-CALL

Speaker: Anna Skorzewska, M.D.

SUMMARY:

Aggression or agitation is one of the most frequent reasons for being paged when covering a psychiatric unit on-call. Managing the situation is often difficult because you must assess the situation very quickly and make decisions, often knowing very little of the patient and his or her circumstances. This part of the workshop will cover how to gather information quickly, determine what information is relevant and make safe and appropriate management decisions. It will also cover an approach to psychopharmacological management of the patient in an agitated state.

NO. 4 MANAGING COMMON INPATIENT ISSUES

Speaker: Andrea Waddell, M.D., M.Ed.

SUMMARY:

The on-call psychiatrist is typically responsible for following up on treatment plans created by the inpatient clinical team and dealing with issues that arise during the on-call period. This session will focus on approaches to common issues arising on-call including managing common complaints (poor sleep, pain, constipation etc.) and premature discharge. Psychiatric patients are 9 times more likely than other patients to leave hospital against medical advice. We will review best practices in managing premature discharge including patient assessment, patient education and clinical documentation.

CHILDHOOD PRECURSORS OF BORDERLINE PERSONALITY DISORDER (BPD)

Chair: Joel Paris, M.D.

Discussant: Andrew M. Chanen, M.B.B.S., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To review the latest research on the childhood precursors of BPD.; 2) To report on research concerning children and adolescents at risk for BPD; 3) To report on biological factors and the risk for BPD.

SUMMARY:

Personality disorders develop over the life course but can usually be diagnosed during adolescence. There is also evidence that some of their features are identifiable before puberty. This symposium will present findings concerning early identification of borderline personality disorder (BPD) that shed light on etiology, and that could be applicable for primary prevention. These clinically important issues are illuminated by the research to be presented at this symposium.

Reference:

Sharp, C., Tackett, J. eds. (2014): Handbook of Borderline Personality Disorder in Children and Adolescents. New York, Springer

NO. 1 WHY ARE CHILDHOOD PRECURSORS IMPORTANT?

Speaker: Joel Paris, M.D.

SUMMARY:

Many major mental disorders, including psychoses, mood disorders, and substance use disorders, are now known to begin early in development. This research strategy has also been applied to personality disorders. The childhood precursors of antisocial personality are long established. Recent research has shown that children and adolescents at risk for borderline personality disorder can also be identified.

This presentation will focus on what early precursors can tell us about the etiology of personality disorders. Applying a multidimensional biopsychosocial model, temperamental abnormalities should appear early in development, and psychosocial risk factors should also be present at an early stage. However risk factors in developmental psychopathology show both equifinality and multifinality. One unanswered question is why

some children with risk factors develop serious disorders, while others remain relatively resilient. Another concerns recent data suggesting that children with high plasticity show a greater likelihood for disorder, but also have an increased capacity to become high functioning adults.

Referenes:

1) Belsky, J. & Pluess, M. (2009). The nature (and nurture?) of plasticity in early human development. *Perspectives in Psychological Science*, 4, 345-351

2) Cicchetti D., & Rogosch, F.A. (2002). A developmental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology* 70,6-20

NO. 2 HYPERMENTALIZING IN ADOLESCENT BPD COMPARED TO PSYCHIATRIC AND HEALTHY CONTROLS: INTRODUCING A NEW MEASURE

Speaker: Carla Sharp, Ph.D.

SUMMARY:

Interpersonal difficulties are a widely accepted characteristic of borderline personality disorder (BPD). Research examining the social-cognitive deficits underlying these problems has resulted in mixed findings. Previously, we have provided a reconciliation of mixed findings by developing a hypermentalizing model for BPD (Sharp, 2014). We have demonstrated the presence of hypermentalizing in adolescence (Sharp et al., 2011, 2013) using the Movie Assessment for Social Cognition (MASC; Dziobek et al., 2006). However, the MASC is an experimental task and currently no self-report measure of hypermentalizing exist. Moreover, hypermentalizing has not been studied in healthy adolescents. It is therefore unclear how the previous BPD-hypermentalizing link should be interpreted in the context of typical adolescence. In this study, we introduce a newly developed measure of hypermentalizing for use in adolescence. We compare hypermentalizing across three samples of 12-17 year old girls: 35 BPD, 50 non-BPD psychiatric controls, and 80 healthy controls. Results demonstrated significant differences in overall hypermentalizing such that borderline adolescents evidenced significantly higher means, followed by psychiatric controls, and finally healthy controls. Differences were most

pronounced for hypermentalizing in the context of parent relationships (compared to best friend or romantic partner).

NO. 3 HEIGHTENED NEGATIVE EMOTIONAL REACTIVITY AS A MARKER OF STRESS SENSITIVITY IN THE DEVELOPMENT OF BPD SYMPTOMS

Speaker: Stephanie Stepp, Ph.D.

SUMMARY:

Negative emotionality is a distinguishing feature of borderline personality disorder (BPD). However, this person-level vulnerability has not been examined as a marker of stress sensitivity implicated in the development of this disorder. The current study utilized a multi-method approach to examine the interplay between negative emotional reactivity (NER) and stressful life events (SLEs) on the development of BPD symptoms across three years (ages 16-18) in a diverse, at-risk sample of adolescent girls (N=113). A latent variable of NER was created from an intensive multi-method assessment at age 16: (1) self-report, (2) negative emotion ratings to stressors from ecological momentary assessments across one week, and (3) observer-rated negative affectivity during a mother-daughter laboratory conflict discussion task. Prospective assessments of SLEs (family poverty, single parent household, difficult life circumstances, trauma, and sexual abuse) were collected from age 5 to 16.

Results from multilevel models demonstrated a significant interaction between NER and SLEs, such that girls with heightened NER who experienced SLEs were at increased risk for BPD symptoms. Additionally, NER and exposure to sexual abuse significantly predicted increases in BPD symptoms over time. These findings highlight NER as a marker of stress sensitivity ultimately increasing risk for the development of BPD symptoms.

NO. 4 THE ASSOCIATION BETWEEN BPD IN ADOLESCENTS, CHILDHOOD ADVERSITY, AND CHILDHOOD PROTECTIVE EXPERIENCES

Speaker: Mary C. Zanarini, Ed.D.

SUMMARY:

Objective: The first purpose of this study was to compare the levels of childhood adversity and protective childhood experiences 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 best set of 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 and protective childhood experiences. Results: Adolescents with BPD reported significantly higher levels of both childhood abuse and neglect than comparison subjects. They also reported significantly lower levels of protective childhood experiences: positive relationships with others, childhood competence, and parental competence. In multivariate analyses, four variables reflecting childhood adversity and protective childhood experiences increased the risk of BPD in adolescents: a higher level of abuse and neglect as well as a lower level of positive relationships and childhood competence. Conclusions: Taken together, the results of this study suggest that BPD in adolescents is associated with a higher level of childhood adversity and a lower level of childhood protective experiences.

REAL - LIFE CONSEQUENCES TO PATIENTS AND FAMILIES OF MISDIAGNOSIS, MISUNDERSTANDING, MISTREATMENT AND STIGMATIZATION OF BORDERLINE PERSONALITY DISORDER (BPD)

Chairs: Valerie Porr, M.A., Mark Zimmerman, M.D.

Discussant: John M. Oldham, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Highlight the enormous extent of over/misdiagnosis, mistreatment and stigmatization of BPD in the mental health system and the resulting negative consequences on patients and their families.; 2) Acknowledge need to recognize importance of improving differentiation of diagnosis between BPD and other disorders in children, adolescents and adults to avoid

over/misdiagnosis and improve outcome; 3) Stress the need to use assessment instruments and/or structured interviews when diagnosing to avoid invalid, incorrect diagnoses leading to iatrogenic treatment; 4) Highlight the iatrogenic effect of misdiagnosis and mistreatment of BPD in terms of emotional and physical toll on family and enormous financial burden it creates. Emphasize the harm due to stigma; 5) Recognize the enormous emotional and physical consequences and grief the person experiences due to misdiagnosis and mistreatment, separate and apart from the consequences of having BPD.

SUMMARY:

Presently those with BPD face a treatment crisis. 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 underlies major public health problems including substance abuse, alcoholism, domestic violence, impulse control disorders leading to high rates of incarceration and highest use of mental health services such as emergency room visits and inpatient hospitalizations. Additionally suicide attempters and completers amongst veterans show a high prevalence of BPD. Rampant professional stigma against BPD patients, who are seen as patients to be "avoided", "treatment refractory," "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. Misdiagnosis is the usual experience for patients resulting in wasted years of treatment resulting in hopelessness and chaos and crisis in families along with enormous expenditures for iatrogenic treatment. The need for utilization of assessment with validated diagnostic instruments to rule out or diagnose BPD, BiPolar, ADHD, substance abuse and other comorbid diagnoses as well as to diagnosis children and adolescents at the time symptoms appear will be discussed. The consequences of failing to diagnose will be highlighted. The need for clinical education in evidence based BPD treatments, training, and supervision as well as patient and family psychoeducation as an aid to improving outcome will be discussed. Results of a TARA on-line survey will be presented.

NO. 1

IS RESEARCH ON BPD UNDERFUNDED BY THE NATIONAL INSTITUTES OF HEALTH?

Speaker: Mark Zimmerman, M.D.

SUMMARY:

The relationship between bipolar disorder and borderline personality disorder (BPD) generates intense interest. Both patients with bipolar disorder and BPD are frequently hospitalized, chronically unemployed, abuse substances, attempt and commit suicide. However, one significant difference between the two disorders is that patients with BPD are often viewed negatively by mental health professionals. We examined whether this negative bias against BPD might be reflected in the level of research funding on the disorder. We searched the National Institute of Health (NIH) Research Portfolio Online Portfolio Reporting Tool (RePORT) for the past 25 years and compared the number of grants funded and the total amount of funding for BPD and bipolar disorder. The yearly mean number of grants receiving funding was significantly higher for bipolar disorder than for BPD. Results were the same when focusing on newly funded grants. For every year since 1990 more grants were funded for bipolar disorder than BPD. Summed across all 25 years, the level of funding for bipolar disorder was more than 10 times greater than the level of funding for BPD (\$622 million vs. \$55 million). These findings suggest that the level of NIH research funding for BPD is not commensurate with the level of psychosocial morbidity, mortality, and health expenditures associated with the disorder.

NO. 2

BPD PUBLIC HEALTH AND TREATMENT CRISIS: GLOBAL CONSEQUENCES OF MISDIAGNOSIS, MISTREATMENT AND STIGMATIZATION OF BPD

Speaker: Valerie Porr, M.A.

SUMMARY:

For nearly two decades TARA has operated a National BPD Helpline providing thousands of callers with information and referrals to BPD evidence based clinicians.. We have interviewed and collected data from callers including age, age of symptom onset, professional diagnosis, at what age; has family diagnosed, prior diagnoses, history of treatment, number of hospitalizations or suicide attempts. We are

aware of available programs, openings and wait lists in the community. TARA's Helpline, a BPD national pulse, a window into the treatment and diagnosis experience of callers across the country reveals a severe lack of services in most communities, the long length of time between initial awareness of symptoms and eventual BPD diagnosis, the difficulties faced in finding appropriate BPD treatment, and the professional stigma patients and families experience when seeking help. Although TARA Data indicates onset seems to occur in childhood to early adolescence, clinicians fail to diagnose those under 18, delaying implementing effective treatment. Onset during these crucial years without diagnosis or appropriate treatment leads to significant interruptions in normal academic and social development and adoption of maladaptive, harmful coping behaviors. Disparities in research, clinical trials, publications and research financing for BPD will be presented along with suggestions for improving treatment outcome.

NO. 3

EVALUATING EXPERIENCES OF 300 PARTICIPANTS WITH DIAGNOSIS AND TREATMENT OF BPD: RESULTS OF A TARA ON-LINE SURVEY

Speaker: Kristie Tse, B.A.

SUMMARY:

TARA for Borderline Personality Disorder is a nonprofit organization that provides psycho-education to families and people with BPD and operates a national helpline. TARA conducted an on-line survey of 300 people titled: Evaluating your experiences with Diagnosis and Treatment of Borderline Personality Disorder. TARA developed this survey in response to observations garnered from calls to our national helpline and information obtained from our family classes that indicated that appropriate diagnosis and treatment is a major stumbling block towards getting help. The TARA survey aimed to collect data on quality of experiences when people searched for an accurate diagnosis and appropriate treatment of their problems and consequences to the individuals when they failed to get the help they needed. The data quantifies the experiences of those with BPD and demonstrates the need to improve diagnosis and availability of evidence based treatments for BPD as well as advocacy

for widespread availability of these treatments in the community and increases in BPD research funding.

NO. 4

BPD, THE FAMILY AND PSYCHIATRY

Speaker: Eric Manheimer, M.D.

SUMMARY:

A parent of a young woman eventually diagnosed with borderline personality disorder (BPD) will describe his family's journey through the mental health system. Starting in early childhood AT AGEW ? 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, hospitalizations, emergency room visits, psychopharmacology and the lack of coordination and communication between providers will be explored. The financial and emotional costs to the family of each new diagnosis and how each relapse, crisis impacted all of them will be described. The inability of the psychiatric community to diagnose and communicate effectively treatment options for BPD caused alienation, isolation, anger, demoralization, and hopelessness. Coping with BPD affected their relationship with another child and put enormous stress on relationships. 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.

INTRODUCING THE STRUCTURED CLINICAL INTERVIEW FOR DSM-5 " CLINICIAN VERSION (SCID-5-CV)

Chair: Michael First, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) demonstrate knowledge of the basic advantages of using a structured diagnostic interview in clinical practice. Educational, and forensic settings ; 2) demonstrate knowledge of the diagnostic coverage, structure, and basic conventions of the SCID-5-CV; 3) understand how to administer the SCID-5-CV to diagnosis a patient with a mood and anxiety disorder .

SUMMARY:

Each revision of the DSM has introduced new and increased complexity to the challenges facing psychiatric clinicians who must evaluate and diagnose psychopathology in their patients in order to provide appropriate treatments. Clinicians today must be prepared to recognize an ever-wider range of symptoms and syndromes. A comprehensive but semi-structured diagnostic interview guide, originally developed to improve diagnostic reliability and diagnostic accuracy in research studies, can help guide clinicians and students as they strive to master the range of disorders included in the DSM-5.

The Structured Clinical Interview for DSM-Clinician Version (SCID-CV), which was first published in 1996 as an adaptation for clinicians of the widely used Structured Clinical Interview for DSM " Research Version, has been updated for DSM-5 (SCID-5-CV) and is being released at the Annual Meeting. The SCID-5-CV is organized into diagnostic modules and assesses current and lifetime mood disorders, psychotic disorders, panic disorder, and PTSD, and current substance use disorder, social anxiety disorder, generalized anxiety disorder, OCD, ADHD, and Adjustment Disorders. Screening questions are also provided to screen for an additional 17 disorders, including Eating, Sleep-wake, Obsessive-Compulsive and Related Disorders and Somatic Symptom Disorders. The SCID-CV begins with an open-ended Overview, which offers the patient the opportunity to describe the presenting problem in his or her own words. The bulk of the SCID consists of a sequence of interview questions that are designed to approximate the differential diagnostic process of an experienced clinician. Although specific structured questions are provided to help elicit diagnostic information, the ratings in the SCID-CV reflect the presence or absence of the DSM-5 diagnostic criteria. Consequently, in most cases the patient will need to elaborate or provide specific examples in order to make a valid diagnostic rating.

This symposium offers the participant a comprehensive introduction to the SCID-CV, divided into four segments. The first segment provides an orientation to the basic structure and diagnostic conventions in the SCID-CV. The second and third segments offer a brief "tour" of the SCID-CV sections for Mood and Psychotic Disorders and the sections for

Substance Use and Anxiety Disorders. The final segment brings the SCID-CV to life and consists of a mock SCID-CV interview of a "patient" with a Mood and Anxiety Disorder, accompanied by commentary designed to illustrate the major points made during the first three segments of this symposium.

NO. 1
INTRODUCTION TO SCID-CV
Speaker: Michael First, M.D.

SUMMARY:

This presentation provides a brief overview of structured diagnostic interviewing in general and then focuses on the history of the development of the SCID. The diagnostic coverage and modular structure of the SCID-CV will then be reviewed, as well as the basic SCID conventions such as layout and formatting, how to rate the diagnostic criteria, and the rules for skip-out instructions and asking questions. The segment concludes with a discussion of the open-ended Overview section, accompanied by a brief video clip of that section being administered.

NO. 2
DIAGNOSING MOOD AND PSYCHOTIC DISORDERS USING THE SCID-CV
Speaker: Janet B.W. Williams, Ph.D.

SUMMARY:

An overview of the decision tree following the DSM-5 rules for making differential diagnoses of mood and psychotic disorders will be presented. The way this is operationalized in the SCID-5-CV will be discussed and participants will be walked through the process of administering the corresponding modules of the SCID-5-CV. The segment concludes with a brief video clip of those sections being administered.

NO. 3
DIAGNOSING SUBSTANCE USE AND ANXIETY DISORDERS USING THE SCID-CV
Speaker: Rhonda Karg, Ph.D.

SUMMARY:

This presentation offers a brief overview of the SCID-CV sections for Substance Use and

Anxiety Disorders, to include a review of the diagnostic criteria and suggestions for improving the assessment of these disorders. The segment concludes with a brief video clip of that section being administered.

COMPREHENSIVE HIV
NEUROPSYCHIATRY UPDATE
Chair: Karl Goodkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand current medical and treatment approaches for the HIV/AIDS patient.; 2) Understand the pathophysiology of neurocognitive decline in HIV patient populations. ; 3) Understand the diagnostic and treatment approaches to HIV-associated neurocognitive disorders (HAND). ; 4) Describe psychopharmacological treatment (including drug interactions) for neurocognitive impairment and disorder as well as other psychiatric illnesses occurring in HIV/AIDS. ; 5) Identify at least two clinical issues that arise in the diagnosis and treatment of HIV neurocognitive disorder and the implications for decisions about treatment.

SUMMARY:

Advances in the treatment of the human immunodeficiency virus (HIV) have dramatically improved survival rates over the past 10 years. As life expectancy increases, however, more and more clinicians are likely to encounter neuropsychiatric manifestations of HIV disease. Some patients present may with cognitive deficits due to an HIV triggered neurotoxic cascade in the central nervous system, while others might present with a spectrum of psychiatric disorders during the course of their illness. These disorders can adversely influence the progression of HIV disease, lead to noncompliance with prescribed medication and treatment and, if missed, can lead to irreversible damage. As quality of life becomes a more central consideration in the management of HIV as a chronic illness, better awareness of these neuropsychiatric manifestations is paramount. During this symposium participants will receive an up-to-date medical review (including the most recent advances in antiretroviral therapy), discuss the assessment and diagnosis of neuropsychiatric disorders, and identify the

most current and effective psychopharmacologic treatment options.

**NO. 1
MEDICAL UPDATE**

Speaker: Marshall Forstein, M.D.

SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. 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. 2
NEUROCOGNITIVE DECLINE IN
HIV/AIDS**

Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:

Diagnosis and treatment of HIV infection have led to undisputable successes and, as a result, patients are living longer. However, neurocognitive decline may present itself, or persist, in an otherwise healthy HIV-positive individual. Inflammation, comorbidities, and iatrogenic sources may contribute to the pathology. In this presentation, the various processes leading to impaired neurocognitive functioning in those with HIV/AIDS will be discussed, as well as practical and theoretical treatments.

**NO. 3
PSYCHOPHARMACOLOGICAL
TREATMENTS IN HIV PATIENTS**

Speaker: Stephen J. Ferrando, M.D.

SUMMARY:

The current psychopharmacology for HIV/AIDS recognizes particular drug interactions between HIV medications and psychiatric drugs. HIV-infected patients have high rates of psychiatric disorders, including substance use disorders. Identification and effective management of these disorders can improve quality of life and help to ensure medical treatment adherence. Drug interactions and side effects, however, may complicate the psychopharmacological treatment of this populations. During this session faculty will review the indications and precautions to consider when prescribing psychoactive drugs to HIV patients with mental health complications.

**NO. 4
DISCUSSING HIV COGNITIVE
DISORDER WITH PATIENTS: GIVING
THE DIAGNOSIS AND THE
IMPLICATIONS FOR PSYCHIATRIC
CARE**

Speaker: Marshall Forstein, M.D.

SUMMARY:

The decline of cognitive functions can be devastating for any patient, but particularly for a patient already managing a serious disease such as HIV/AIDS and living longer due to the tremendous impact of antiretroviral medications. In spite of excellence adherence to medications and treatment, neurocognitive deficits can develop and frighten patients who had become hopeful they would lead more normal lives with current treatments. This presentation will discuss strategies for giving a diagnosis of HIV cognitive impairment and working with the impact of the diagnosis and treatment decisions in the context of an ongoing psychotherapeutic relationship. Depending on the patient's awareness of the risk factors, the personality structure and coping mechanisms available to the patient, clinicians must be prepared to provide a space for the emotional trauma and beliefs of the patient to unfold. Strategies and techniques for eliciting perceptions of risk, accepting the facts and incorporating the potential problems associated with decreased cognitive function will be discussed. At the end of the presentation participants will be able to identify at least two

clinical issues that arise in the diagnosis and treatment of HIV neurocognitive disorder and understand their implications for decisions about treatment.

NO. 5 DIAGNOSIS AND CLINICAL MONITORING OF HAND

Speaker: Karl Goodkin, M.D., Ph.D.

SUMMARY:

HIV-associated neurocognitive disorders (HAND) can impact attention, working memory, speed of processing, problem solving and executive function. The neurocognitive complications of HAND include poor performance on tests of movement and coordination, attention and concentration, mental flexibility and reaction time—any of which can interfere with daily functioning and impact quality of life. While there has been a reduction in the incidence of HAND since the onset of new treatments, the prevalence continues at high rates. Moreover, failure to identify cognitive deficits in the HIV-positive population may directly influence successful management of the disease. Unfortunately, screening for HAND is not routine in HIV medical care despite recommendations in HIV treatment guidelines. Also, many providers lack expertise to adequately assess and/or monitor patients'™ symptoms. In this session participants will learn how to assess, diagnosis, and monitor HAND, review the advantages and limitations of available screening instruments (including neuroimaging), and how to rule out other possible causes of symptoms or overlapping symptoms with different etiologies.

THE SCHIZOPHRENIA SYNDROME IN 2015: NEW FACTS AND EMERGING INSIGHTS

Chairs: Henry A. Nasrallah, M.D., Rajiv Tandon, M.D.

Discussant: Carol A. Tamminga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the emerging complex genetics of schizophrenia; 2) Discuss the breakthroughs in pathophysiologic mechanisms of schizophrenia; 3) Explain the biologic and clinical heterogeneity of schizophrenia; 4) Review the current and

evolving therapeutic approaches to schizophrenia.

SUMMARY:

Accelerating Genetic Discoveries

Anil K. Malhotra

The identification of causative genes for complex disorders such as schizophrenia has been challenging. Early linkage studies were predicated on single or oligogenic models of illness; more recent candidate gene and genome-wide association studies (GWAS) assumed multiple genes of modest effect. Although both strategies yielded intriguing results, the majority of the heritability of psychiatric disorders remains unexplained.

Recent developments, however, suggest that gene identification may be more tractable. First, studies of copy number variants have identified replicable results implicating relatively circumscribed regions of the genome in schizophrenia and, more recently, bipolar disorder. Second, a landmark large-scale GWAS mega “analysis has detected 108 loci influencing risk for schizophrenia, including a locus near the dopamine D2 receptor gene. Third, both approaches have suggested shared genetic factors that influence risk across psychiatric disorders, therefore providing new impetus for reconsideration of our diagnostic system. Finally, pharmacogenetic work supports this notion, with data suggesting alleles that predispose to side effects of treatment that do not respect diagnostic boundaries and, in some cases, have common effects across drugs of a specific class.

Taken together, these data provide evidence that specific genetic factors may play an important role in multiple aspects of psychiatric disorders, and pave the way for development of new treatment targets for schizophrenia and related disorders. Moreover, the impetus towards personalized treatment will be bolstered by these data, and suggest near-term strategies to improve the outcome of these disabling disorders.

NO. 1 ACCELERATING GENETIC DISCOVERIES IN SCHIZOPHRENIA

Speaker: Anil Malhotra, M.D.

SUMMARY:

The identification of causative genes for complex disorders such as schizophrenia has been challenging. Early linkage studies were predicated on single or oligogenic models of illness; more recent candidate gene and genome-wide association studies (GWAS) assumed multiple genes of modest effect. Although both strategies yielded intriguing results, the majority of the heritability of psychiatric disorders remains unexplained.

Recent developments, however, suggest that gene identification may be more tractable. First, studies of copy number variants have identified replicable results implicating relatively circumscribed regions of the genome in schizophrenia and, more recently, bipolar disorder. Second, a landmark large-scale GWAS mega-analysis has detected 108 loci influencing risk for schizophrenia, including a locus near the dopamine D2 receptor gene. Third, both approaches have suggested shared genetic factors that influence risk across psychiatric disorders, therefore providing new impetus for reconsideration of our diagnostic system. Finally, pharmacogenetic work supports this notion, with data suggesting alleles that predispose to side effects of treatment that do not respect diagnostic boundaries and, in some cases, have common effects across drugs of a specific class.

Taken together, these data provide evidence that specific genetic factors may play an important role in multiple aspects of psychiatric disorders, and pave the way for development of new treatment targets.

NO. 2 OF PATHOPHYSIOLOGY OF SCHIZOPHRENIA: EMERGING INSIGHTS

Speaker: Matcheri Keshavan, M.D.

SUMMARY:

Despite the substantial phenotypic, pathophysiological and etiological heterogeneity of schizophrenia, technological limitations, and the less than ideal animal models, considerable progress has been made in characterizing the neurobiological substrate of schizophrenia. I will review the advances in this area that have stemmed from neuroimaging, electrophysiological and neuropathological approaches. Several neurobiological alterations in domains of brain structure, function, and neurochemistry have been characterized that may reflect diverse pathophysiological

pathways from the genome to the phenotype.

One view of schizophrenia I will expand on is that of a neurodevelopmental imbalance in excitatory/inhibitory neural systems leading to impaired neural plasticity. Diminished neuroplasticity might account for the cognitive deficits and negative symptoms, while aberrant hyperplasticity and metaplastic processes might account for the observed psychotic symptoms and affect dysregulation. While none of the observed abnormalities in schizophrenia are likely to support diagnostic distinctions based on current symptom-based classification, many can serve as potential footholds for elucidating causal genes, and as therapeutic targets for novel drug discovery. The accumulating facts on the neurobiology of schizophrenia calls for novel integrative model(s) that may generate new, testable models and predictions.

NO. 3 ADVANCES IN DIAGNOSIS AND PHENOMENOLOGY

Speaker: Rajiv Tandon, M.D.

SUMMARY:

Despite changing definitions of schizophrenia over the past century and inability to delineate a biological core, the construct of schizophrenia still conveys useful information: (i) patients diagnosed as having schizophrenia have real disease- they experience both suffering and disability; (ii) a diagnosis of schizophrenia suggests a distinctive clinical profile- long-term course; admixture of positive, negative, and cognitive symptoms; likelihood of benefit from antipsychotic treatment; and (iii) schizophrenia satisfies criteria for a valid diagnostic entity better than almost any other psychiatric diagnosis. On the other hand, the concept of schizophrenia has serious shortcomings. First, it is not a single disease entity- it has multiple etiological factors and pathophysiological mechanisms. Second, its clinical manifestations are so diverse that its extreme variability has been considered by some to be a core feature. Third, its boundaries are ill-defined and not clearly demarcated from other clinical entities. Several revisions in DSM -5 and ICD-11 address these limitations. Instead of traditional schizophrenia subtypes, heterogeneity is explained by illness dimensions. Better delineation from schizoaffective disorder and

definition of attenuated psychosis syndrome are two additional key changes. The relationship of the DSM-5 approach to the RDoC method will be critically examined and the path ahead will be summarized.

NO. 4 BEYOND DOPAMINE: THE EVOLVING THERAPEUTICS OF SCHIZOPHRENIA AND ITS VARIOUS SYMPTOM DOMAINS

Speaker: Henry A. Nasrallah, M.D.

SUMMARY:

The pharmacotherapy of the schizophrenia syndrome has witnessed minimal changes over the past 6 decades. Medications with Dopamine D2 receptor antagonism remain the only approved treatments for schizophrenia, with efficacy only for the positive symptoms [in about 60-70% of patients]. No treatment has yet been developed for the disabling negative symptoms and cognitive deficits. In addition, growing literature have focused on the potential deleterious effects of antipsychotics on brain tissue, but the bulk of the evidence points to neurotoxicity of haloperidol.

But the field is not at a standstill. The glutamate model of schizophrenia [hypofunctioning of the NMDA receptor based on PCP psychosis] is being intensely pursued as a potential avenue for new drug development. GABA deficits in schizophrenia also serves as a model for alternative pharmacotherapy. The neuro-inflammation and oxidative stress that have been documented during psychotic episodes are opening new vistas for anti-inflammatory and anti-oxidant drugs as adjunctive therapies. Targeted psychosocial interventions starting in the prodrome and the first episode show promising results. Cognitive remediation has emerged as a viable intervention until a cognitive enhancing agent is discovered. Drug development is focusing on negative symptoms and cognitive deficits, with several agents being assessed at this time. Finally, genetic advances will eventually unravel the pathophysiologies of the various subtypes of

SPACES, GENES, INDUCED PLURIPOTENT STEM CELLS (IPSCS) AND NEUROCIRCUITS: HOW NOVEL APPROACHES ARE INFORMING OUR UNDERSTANDING OF ETIOLOGY AND CLINICAL PHENOTYPE IN PSYCHIATRY

Chairs: Ruth O'Hara, Ph.D., Joachim Hallmayer, M.D.

Discussant: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recognize and understand some of the most innovative approaches to identifying the cellular and clinical phenotypes of psychiatric illness.; 2) understand how findings from studies of genetic, iPSC and neuroimaging can be translated into meaningful clinical phenotypes.; 3) understand how a how research involving multi-level approaches from cellular models to dimensional assessments can be integrated into an enhanced understanding of psychiatric etiologies.

SUMMARY:

The goal of this symposium is to describe how some of the most cutting-edge approaches in psychiatric research today are increasing our knowledge of the etiology of mental health disorders and helping us refine and redefine our clinical phenotypes. The research presented covers the spectrum from recent advances in characterizing the genetic basis of mental illness, to novel cellular models of psychiatric disorders using iPSCs, to new approaches for revealing the brain circuits subserving psychiatric symptoms to the use of RDoC derived dimensional approaches to clinical phenotyping. Specifically, Dr. Pasca will present on the recent innovative work of his group which resulted in generating a functional laminated human cortex from human pluripotent stem cells. He will present on how this cellular model has the potential to revolutionize our understanding of the etiological basis of psychiatric disorders. Dr. Etkin will speak to the substantial advances his group has made in characterizing the neurocircuits impacted in psychiatric disorders, describing new methods for direct and non-invasive probing and manipulation of circuits and insights that this brings for the development of new circuit-targeting therapeutics. Based on data from her ongoing longitudinal investigations, Dr. O'Hara will present on models integrating dimensional neurocognitive and neuropsychiatric measures that refine our clinical phenotypes, speaking also to the impact of developmental processes and stage of lifespan. Finally, drawing on data and models from his own work, Dr. Hallmayer will illustrate how research involving multi-level

integration, from in vitro cell studies to imaging, clinical and cognitive assessments in living subjects, can connect specific cellular and structural defects with symptoms in patients, thus revolutionizing the way we understand mental illness.

**NO. 1
IPSCS: A REVOLUTION IN
UNDERSTANDING PSYCHIATRIC
DISORDERS**

Speaker: Pasca Sergiu, M.D.

SUMMARY:

Dr. Pasca will present on the use of neurons derived from induced pluripotent stem cells (iPSC) to model neuropsychiatric disorders. Specifically, Dr Pasca will show how penetrant genetic events associated with neurodevelopmental disorders provide a window into the cellular and molecular pathogenesis of psychiatric disease in patient derived neurons, while avoiding the challenges raised by the high degree of genetic heterogeneity underlining complex mental disorders. Further, he will present on the recent work of his group to enhance our understanding of human brain development and maldevelopment using a novel approach for generating from human pluripotent stem cells a functional laminated human cortex.

**NO. 2
NEURAL CIRCUITS AS SUBSTRATES OF
MENTAL ILLNESS AND TARGETS FOR
THERAPEUTICS**

Speaker: Amit Etkin, M.D., Ph.D.

SUMMARY:

Over the past two decades, neuroimaging studies have identified a set of commonly-observed changes in distributed brain systems underlying cognition, emotion and mood, amongst others. Establishment of these potential circuit-level biomarkers of key core mental processes, which may be perturbed in different ways across psychiatric disorders, has created the challenge of how to use these insights 1) to understand the nature of neural circuit deficits one or multiple psychiatric disorders, and 2) to directly guide the development of novel circuit-based therapeutics. Dr. Etkin will discuss the most recent findings from his laboratory aimed at

defining the neural circuit abnormalities associated with psychiatric disorders as a whole, as well as specific changes associated with anxiety, depression, and post-traumatic stress disorder. He will then describe new methods for direct and non-invasive probing and manipulation of circuits and insights that this brings for the development of new circuit-targeting therapeutics. Together, these data suggest that we are now on the brink of innovation in "rational" circuit-based diagnostics and treatments for mental illness, thus going beyond the dominant psychotherapeutic and psychopharmacological tools currently available.

**NO. 3
NEUROCOGNITIVE DIMENSIONS AND
NEUROCIRCUITS SUBSERVING
PSYCHIATRIC DISORDERS: A
DEVELOPMENTAL PERSPECTIVE**

Speaker: Ruth O'Hara, Ph.D.

SUMMARY:

The neurocognitive dimensions of psychiatric disorders have become increasingly important for understanding their development, maintenance and treatment and increasingly salient as related to the NIH Research Domain Criteria (RDoC). This presentation will focus on the role of neurocognitive dimensions of two of the most common psychiatric issues across the lifespan, depressive and anxiety symptoms. Specifically, spanning from adolescence to late life, Dr. Oâ€™Hara will present preliminary work from her multiple ongoing longitudinal investigations of over 200 individuals across the lifespan with fully characterized neurocognitive and neuropsychiatric symptoms, as well as well-defined neurocircuitry. In addition to observing that specific neurocircuits map onto clinically relevant affective phenotypes, the data also indicate that age is a highly significant moderator of the relationship of neurocognitive dimensions to the spectrum of affective processing. These findings underscore how considering developmental or lifespan stage is critical to understanding the role of cognitive dimensions in affective symptoms.

**NO. 4
INTEGRATING GENES, IPSCS AND
NEUROCIRCUITS INTO A CLEARER
UNDERSTANDING OF THE ETIOLOGY**

AND CLINICAL PHENOTYPES IN PSYCHIATRIC DISORDERS

Speaker: Joachim Hallmayer, M.D.

SUMMARY:

Drawing on his findings from his ongoing NIH supported work to identify the cellular and molecular mechanisms underlying neuropsychiatric phenotypes in patients with defined genetic disorders, including 22q11 deletion syndrome (22q11DS), Timothy Syndrome and PMD, Dr. Hallmayer's presentation will speak to the challenges and gains inherent to integrating multi-modal information into a meaningful understanding of the etiology of psychiatric disorders and an increased characterization of the clinical and therapeutic relevance for the psychiatric disorder under investigation.

CHALLENGES AND OPPORTUNITIES FOR GLOBAL MENTAL HEALTH

Chair: Samuel O. Okpaku, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) familiarize themselves with the history of global mental health.; 2) the epidemiological issues of global mental health.; 3) treatment needs and gaps in services.; 4) opportunities for training and research.; 5) opportunities for service delivery and intervention.

SUMMARY:

Low and Middle income countries account for about 80% of the world's population of 6.7 billion. Worldwide it is estimated that 450 million people are affected with mental, neuropsychiatric and neurological disorders. 25% of individuals will suffer the above conditions in their life time. Mental and neurological and neuropsychiatric conditions contribute 14% of the global burden of disease of non-communicable diseases. Furthermore it is estimated that by 2030 unipolar disorder will rank as the 2nd leading cause of death and by 2040 the number of individuals living with dementia will increase to about 81.1 million persons. The above data have implications for many low and middle income countries that are low resourced and lack capacity to deal with associated suffering. There are also implications for the rich nations. Many of these nations have

framed their foreign policies and health policies against a background of health and national security, economics in addition to humanitarian factors. The Millennium Development Fund and the Treaty of the Social Determinants of Health have contributed to an International vision of health promotion and equity with emphasis on Low and Middle Income countries. So have the WHO and other UN agencies, the World Bank and the IMF. In addition there are various bilateral, regional and multilateral and faith based activities in this area. At the same time the portfolio of health is expanding to include issues related to human rights, violence and climate change.

The symposium will attempt to highlight the Challenges and Opportunities of Global Mental Health. There will be an overview of the burden of illness, the treatment needs, gaps and disparities, Examples of innovative training and research programs as well as examples of innovative service delivery systems from developing countries. It will be shown that global mental health activities, have considerable opportunities for mutual and bilateral benefits. The rich and poor countries can benefit. We are all in this together.

NO. 1

TASK SHIFTING AND SHARING OPPORTUNITIES AND CAVEATS- PERSPECTIVES OF STAKEHOLDERS IN A WEST AFRICAN NATION

Speaker: Vincent Agyapong, M.D.

SUMMARY:

Recent years have seen growing interest in the effectiveness of task shifting as a strategy for addressing expanding health care challenges in settings with shortages of qualified health personnel. In Ghana, task-shifting has been practiced within the mental health care delivery system for several decades due to the absence of adequate numbers of trained psychiatrists. With a population of almost 25 million people, the West African nation Ghana has only 18 trained psychiatrists (with just 12 in active public sector service) who practice mainly in the southern half of the country. Four of the ten regions of Ghana have no psychiatrist and in these regions, mental health delivery, if available, is provided primarily by Community Mental Health Nurses, Community Mental Health Officers and Clinical Psychiatry Officers

who serve as gate keepers of mental health for large sections of the Ghanaian population. This study sought to generate new knowledge on the impact and challenges associated with task shifting on the West African nation's mental health delivery system from the perspectives of stakeholders. We evaluate proposals from stakeholders including psychiatrists, community mental health workers, senior policy makers and policy coordinators on how to overcome the challenges posed by task shifting.

NO. 2

AM I MY BROTHER'S KEEPER

Speaker: Samuel O. Okpaku, M.D., Ph.D.

SUMMARY:

Global health and global mental health are shifts in paradigm that are in response to the globalization process. Meanwhile, there is a shift in the definition and portfolio of health to include for example human rights and climate change. Many rich nations are beginning to include health policies within their foreign policies.

This presentation will give a history of global mental health. It will present a definition of global mental health along 5 criteria. This definition as will be useful for research and scholarship.

The presentation will highlight what some of the rich countries are contributing to global health, and what more they can do. It will also highlight the reciprocal benefits not only in terms of cultural and friendship benefits, but also potential education, research, and training benefits. It will define global mental health as the range of activities concerned with health that meets five principal criteria: universal and transuniversal criterion; public health criterion; stakeholder's criterion; problem ownership criterion; and team criterion. This definition distinguishes it from community mental health and it allows for us likely to facilitate scholarship and research. Global mental health like the overarching process of globalization is not without any criticism. There is a vocal group that challenges the westernization and over medicalization of mental health. The role of such group as a watch dog will also be presented.

NO. 3

GLOBAL MENTAL HEALTH: IS IT POSSIBLE?

Speaker: Clare Pain, M.D.

SUMMARY:

There are significant hazards in both the theory and practice of Global Mental Health as noted by key contributors to the field e.g. Derek Summerfield and Suman Fernando. If according with the WHO, depression accounts for the biggest global burden of all diseases, is depression similar enough to HIV or TB to generalize its identification and treatment in and between all the countries in the world? Does the idea and practice of Global Mental Health inevitably involve the imposition of western bio-models of mental illnesses onto contexts too various to make sense? Given the huge differences in such underlying concepts as the definition of the self, considerations of health and illness, the expression of mental distress and wellness and the nature of help, are our evidence based treatments of antidepressants and psychotherapies useful or even feasible universally? Can they possibly benefit the social distress of impoverished people in low income countries?

This paper will explore possible compromises that take into consideration these extremely important questions, and which might constructively address the huge gap in mental health services and need in low income countries. Clinical examples drawn from both Canadian refugees and the University of Toronto/Addis Ababa University collaboration will illustrate some possibilities e.g. Reverse innovation, task shifting, educational scale up, western and traditional mental health collaborations.

NO. 4

BRINGING UBUNTU BACK FROM SOUTHERN AFRICA

Speaker: Mary Kay Smith, M.D.

SUMMARY:

It is often assumed that international health education experiences contribute to improved cultural competence, acquisition of knowledge, and development of new skills in medical students, residents, and other health professions students. When these experiences involve the delivery of care in countries with limited health care resources, the narrative often turns to the clinical services provided to communities in need, and while these future

health care professionals may return home with more nuanced perspectives regarding access to care and population health, opportunities to learn about local philosophies and traditions are frequently missed.

This presentation will examine how a medical educator was invited to Southern Africa to teach faith leaders about mental illnesses, HIV infection, and neglected tropical diseases, and learned the concept of Ubuntu in the process. The author will discuss how she used this focus on interconnectedness as the organizing principle in collaborating with academic and community-based partners in developing and implementing a health care workforce development initiative. She will explain how lessons learned from faith and community leaders in Zambia and D.R. Congo were utilized to bring health professions students and individuals with limited access to health care together to start promoting health and wellness in their local community.

NO. 5 THE BURDEN AND TREATMENT GAP OF MENTAL ILLNESS

Speaker: Robert Kohn, M.D.

SUMMARY:

Well-designed epidemiological studies that provide information on prevalence of mental illness and utilization of mental health services exist. The WHO Atlas and the WHO-AIMS provides information on mental health resources and services for many countries. Using data from the Americas as an example, the burden of disease for neuropsychiatric disorders accounts for 15.5% of all DALYs and 38.2% of all YLDs. Yet in Latin America the average mental health care budget is only 2.25% of the total budget, with 83% going to long term care mental hospitals. For severe and moderate disorders among adults with affective disorders, anxiety disorders and substance use disorders, the median treatment gap is estimated to be 73.5% for the Americas, 47.2% for North America, and 77.9% for Latin America. For all disorders regardless of severity the treatment gap in the Americas is 78.1%. The treatment gap in the United States for schizophrenia is 42.0%. However, for Latin America and the Caribbean the treatment gap is 56.4%. The median treatment gap for the Americas for children and adolescents is 63.8% and 52.6% for severe disorders. Barriers to care continue to need to

be bridged, and are one of the main obstacles to reducing the treatment gap.

ANTI-LESBIAN GAY BISEXUAL TRANSGENDER (LGBT) DISCRIMINATION ABROAD AND ASYLUM-SEEKING AT HOME: THE PSYCHIATRIST'S ROLE

Chair: Amir Ahuja, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the anti-LGBT legislation and discrimination that exists in Uganda and Iran (and in other parts of the world) today.; 2) Explain the effects that legal discrimination in Uganda and Iran has on access to mental health care for LGBT people, and what can be done about it.; 3) Explain the effects that legal discrimination has on the mental health of LGBT people, resulting in depression, substance use, and PTSD, and leading LGBT people to seek asylum.; 4) Identify the tenuous situation of LGBT people seeking asylum and the psychiatrist's role in facilitating the LGBT-related asylum cases throughout the world.; 5) Appreciate and embrace the role that psychiatrists play in advocating for sexual and gender minorities abroad and at home.

SUMMARY:

Psychiatrists are only beginning to scratch the surface in regards to the devastating effects that social discrimination has on various minority groups. This is especially true for sexual and gender (SOGI) minorities, often referred to as the lesbian, gay, bisexual and transgender (LGBT) population. In this case, there are many instances of discrimination being codified in law, both in North America and abroad, which intensifies these effects on mental health. Domestically, some work has been done to define these effects. For example, the Family Acceptance Project identified that LGBT youth and young adults who are rejected by their families for their LGBT status are 8 times more likely to commit suicide, 3 times more likely to use illegal drugs and 3 times more likely to acquire HIV. This is one of the first wide scale studies down on this topic, and little research has been done with adults who are rejected by society, even in North America.

There is a particular dearth of information in International Psychiatry in regards to this phenomenon. In certain areas of the world, particularly Africa and the Middle East, this is particularly salient as there are many anti-gay laws there which codify discrimination and embolden society to reject SOGI minorities. In a recent report from the Sexual Minorities Uganda (SMUG) organization, they document that anti-gay attacks in Uganda have increased 10 times over since the passage of the infamous Anti-Gay Law there, which punishes gay activity or promotion of gay activity with life imprisonment. This has led to blackmailing of LGBT Ugandans and state-backed harassment including rapes, robberies and murders. In this presentation, a psychiatrist and journalist published in the Guardian and New England Journal of Medicine, Miriam Shuchman, MD, will share her views as a psychiatrist from the ground in Africa. A prominent Ugandan gay activist, John Wambere, will discuss his difficulties since the laws passage and the uncertainty as he applies for asylum. (The law has been retracted but is in the process of being reinstated now).

In Iran, a similar situation exists. Iranian psychiatrist Shervin Shadianloo will discuss his experiences in Iran and in Canada fighting for those still in that country and facing death for their SOGI minority status. He will be joined by Arsham, a gay Iranian seeking asylum in Canada now.

All of this leads us to what our role as psychiatrists can be in these situations. We can document the atrocities like Dr Shuchman. We can advocate for those still in danger like Dr Shadianloo. We can also assist in asylum cases, and Dr Joanne Ahola from Columbia University will discuss this, as she has done much work in this area.

Finally, the incoming WPA President, Dinesh Bhugra, will be our discussant as he has also done much work in the area of asylum-seekers who are LGBT.

Overall, this is a vital life-and-death issue that exists throughout the world and we are uniquely equipped to help.

NO. 1 A PSYCHIATRIST'S VIEW OF INTERNATIONAL ANTI-GAY POLICIES

Speaker: Miriam Shuchman, M.D.

SUMMARY:

As a psychiatrist and reporter, I bring a unique perspective to this situation. In multiple reports from Africa, I have seen first-hand the lack of health care access that pervades the continent. Once you add the anti-gay laws and attitudes on top of that, there is extreme lack of HIV care for many LGBT people, as well as a complete lack of LGBT-sensitive care throughout the whole continent (and many other places in the world). In addition, mental health is barely addressed at all throughout Africa, and many people in the LGBT communities in homophobic countries are in desperate need of mental healthcare. There is widespread substance use, PTSD, and depression amongst this community and no one to support them, which is a dangerous situation. I will discuss how psychiatrist's can play a role as reporters and advocates to bring more awareness to this issue and help increase access to care abroad.

NO. 2 MY EXPERIENCES IN UGANDA AND AS AN ASYLUM-SEEKER

Speaker: John A. Wambere

SUMMARY:

Uganda's population is estimated at 38 million, and its estimated about 2-3% are the sexual Minorities (Lesbians Gays Bisexual Trans Intersex and Queers). This population is faced with discriminatory laws and persecution because of who they are. Access to health services is more or less nonexistent for these people. In addition, they are faced with stigma for a multitude of reasons, such as being LGBT, HIV status, and same sex behaviors. Not only is there no support from the state in terms of protections from discrimination and mistreatment, but there is actually further persecution from the state. This has left LGBT people in Uganda with few outlets and resources to deal with a constantly hostile environment.

In this talk, I discuss my own experiences as an out gay man in Uganda, and as a gay activist fighting for better visibility and better access to care. Many of my friends have been beaten and robbed, and my home was robbed several times in the wake of the anti-gay legislation that was sponsored by the Ugandan government. As a result of these and other violent acts, many of us have had to seek asylum, and that is where my journey has led me. I will discuss the difficulties of seeking asylum, being isolated

from friends and family back home, and still trying to fight discrimination from abroad.

NO. 3

A VIEW FROM IRAN: DISCRIMINATION AT HOME AND MENTAL HEALTH NEEDS OF ASYLUM SEEKERS

Speaker: Shervin Shadianloo, M.D.

SUMMARY:

Background: There is very little if any study done about LGBT mental health issues in Iran that are known or published. The topic is sensitive in the country and mostly understood with assumptions made through news and media random case reporting of LGBT issues in Iran. There are LGBT asylum seekers from Iran primarily to the western countries based on the legal limitations for LGBT in Iran. In this talk, I will discuss these issues and discuss a study I am conducting to further assess the situation. I will be joined by an asylum-seeker from Iran to share a personal viewpoint.

The purpose of the study is to look into LGBT asylum seekers in regards to their mental health, which will cover the ones already left. To examine the condition in Iran, the attitude of mental health practitioners will be surveyed.

Method: two separate questionnaire will be sent for the two topics. The first one to the LGBT asylum seekers either already in the process of seeking in a host country or the ones already reached their destination. This questionnaire will include demographic, length of process and previous or current mental health symptoms including affective, anxiety, trauma, PTSD and substance use. The second questionnaire will be sent to variety of mental health workers ranging between psychiatrist to counselors. In this questionnaire, after demographic, their knowledge and attitude towards LGBT and their needs will be asked.

NO. 4

BE AN EXPERT WITNESS IN LGBTI ASYLUM CASES AT HOME

Speaker: Joanne Ahola, M.D.

SUMMARY:

Persecution based on sexual orientation or gender identity (SOGI) or interest conditions is the basis for a growing number of asylum claims and these cases 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 cumulative trauma in asylum seekers, and working with applicants who have not met legal filing deadlines because of a "freezing" of development living in repressive conditions. Homosexuality is criminalized in 76 countries...asylum is real possibility in only a few, including the U.S. and Canada. Goals include understanding the critical role played by the mental health professional in providing clinical evaluations and written and oral testimony.

WITHDRAWN INTEGRATING DIALECTICAL BEHAVIORAL THERAPY, MENTALIZATION-BASED TREATMENT, AND GENERAL PSYCHIATRIC MANAGEMENT USING AN INTERPERSONAL FOCUS

Chairs: Lois W. Choi-Kain, M.D., M.Ed., Brandon Unruh, M.D.

Discussants: Anthony Bateman, M.D., Shelley McMain, Ph.D.

INTENSIVE SHORT-TERM DYNAMIC PSYCHOTHERAPY(ISTDP): EVIDENCE, THEORY, AND TECHNIQUE

Chairs: Jeffrey Katzman, M.D., Patricia Coughlin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the evidence supporting the use of Intensive Short Term Dynamic Psychotherapy with multiple patient groups; 2) Identify the theory behind the methodology used in Intensive Short Term Dynamic Psychotherapy from a psychodynamic and attachment point of view; 3) Learn and apply the techniques of Intensive Short Term Dynamic Psychotherapy to current patients and understand potential avenues for further information and training.

SUMMARY:

Intensive Short Term Dynamic Psychotherapy (ISTDP) has emerged as a highly efficacious treatment paradigm for patients with a wide variety of diagnoses. Evidence points to its

value in working with patients with difficulty with affect regulation, anxiety, somatization, and self destructive character defenses. What's more, unlike the characterization of long term psychodynamic psychotherapy or psychoanalysis, patients can benefit from a very brief intervention. In fact, evidence points to sustained therapeutic value for patients following just one session.

This symposium will review the evidence pointing to the therapeutic efficacy of this paradigm. The program will then review the specific theoretical basis of the paradigm, using various media to add to the understanding of this paradigm. Participants will watch film clips demonstrating specific components of this theory. They will also have the opportunity to practice specific points made through a role play exercise. Following a description of the theoretical basis of this paradigm, specific techniques will be identified used by the ISTDP practitioner. Films of actual therapeutic work will then be used to demonstrate specific components of this theory including developing an intrapsychic focus, using the triangles of person and conflict, applying pressure to facilitate the experience of affect of working through of defense, identification of channels of anxiety, and unlocking of unconscious memories through this process. A presentation of follow up to the patients presented will also be shared.

NO. 1 ISTDP- EVIDENCE, THEORY, AND TECHNIQUE

Speaker: Jeffrey Katzman, M.D.

SUMMARY:

Intensive Short Term Dynamic Psychotherapy has emerged as an evidence based psychotherapy with wide utility. Evidence points to its tremendous cost savings, use for patients with multiple diagnoses, and even for the long term benefit of one session. In this presentation, evidence supporting this intervention will be presented, along with a description of the underlying theoretical base and specific techniques involved. These concepts will be amplified with film brief film clips from the films *Extremely Loud and Incredibly Close*.

NO. 2

ISTDP: THE EXPERIENCE OF TRAINING DURING A GENERAL RESIDENCY PROGRAM

Speaker: Brandon Yarns, M.D.

SUMMARY:

A fourth year resident will share his experience with training in Intensive Short Term Dynamic Psychotherapy over the course of a residency training program. Of specific note, he will describe how it has complemented and extended the traditional psychodynamic curriculum in the program, the utility of learning specific techniques, the value of videotaped supervision, the integration of this experience based on the patient in question, and the overall contribution of learning this paradigm on the residency training experience.

NO. 3

ISTDP: EXAMPLES FROM VIDEOTAPED PATIENT EXAMPLES

Speaker: Patricia Coughlin, Ph.D.

SUMMARY:

Intensive Short Term Dynamic Psychotherapy has a long history of using videotape for review and supervision of case material to facilitate future interventions. Videotape case examples will be presented by a leading clinician in the field of Intensive Short Term Dynamic Psychotherapy. Dr. Coughlin is the author of two books, multiple articles, and is an internationally recognized trainer in ISTDP, working in multiple countries and institutions over the course of the year. Cases presented will focus on specific examples of this paradigm, including the critical importance of identifying a specific problem with the client to facilitate the therapeutic alliance. Cases will also highlight the development of an internal focus, the use of the triangles of person and conflict, and a demonstration of unlocking from the unconscious amidst the experience of affect. The critical importance of a psychodynamic formulation will be demonstrated through observation of patient material. Dr. Coughlin will also comment on potential resources for those interested in further exploration of this paradigm.

MAY 18, 2015

TELEPSYCHIATRY'S EVIDENCE BASE SHOWS EFFECTIVENESS: NEW MODELS (ASYNCHRONOUS), MORE PSYCHOTHERAPY, AND INNOVATIONS WITH SPECIAL POPULATIONS

Chairs: Donald M. Hilty, M.D., Terry Rabinowitz, D.D.S., M.D.

Discussant: Donald M. Hilty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the evidence base of telepsychiatry and how it applies to populations and reaching new settings; 2) Apply principles, approaches and knowledge to clinical practice with patients using telepsychiatry or other forms of technology.; 3) Modify assessment, triage, and treatment of patients based on technology or setting in order to have successful clinical, program and practice outcomes.; .

SUMMARY:

Telepsychiatry (TP) or telemental health (TMH) is entering its third "real" or significant decade of research/evaluation. Clinical approaches, models, and protocols are well-established; training of residents and students is in progress. Methods. The effectiveness of TP (i.e., TMH; videoconferencing or synchronous TP (STP); asynchronous TP (ATP)) is based on whether it successfully achieves equal or superior objectives than in-person care " while considering the perspective of the patient, provider, program, community, and society as a whole. Satisfaction, feasibility and clinical outcome assessment is well at-hand. Results. TP is effective for diagnosis and assessment across many populations, for disorders in many settings (emergency, home health), and is comparable to in-person care. Adjustments may be necessary for regular assessment, examination, and treatments are better known (e.g., VS or PE at distant site; accessories for play with children). Adult clinical guidelines and child/adolescent practice parameters/minimal standards/guidelines are in place. Innovative models of care (i.e., collaborative care, asynchronous have equally positive outcomes. The psychotherapy evidence base needs additional data. Conclusions. TP is effective, increases access to care, and needs more research on specific disorders,

psychotherapies, culture and diversity, and costs.

Effectiveness of telepsychiatry (TP) or telemental health (TMH) was evaluated in a review of the literature in 2013 (totaling 755 articles) leading to 70 actual studies (Hilty et al 2013). TP is effective for diagnosis and assessment across many populations (adult, child/adolescent, geriatric and ethnic), for disorders in many settings (emergency, home health), and is comparable to in-person care.

Members might wonder, "Who can be treated with TP?" Populations with differences in age (i.e., child/adolescent, geriatric), culture and diversity, and non-outpatient settings (e.g., emergency, juvenile hall, nursing homes)? Adult clinical guidelines and child/adolescent practice parameters/minimal standards/guidelines are in place (Yellowlees et al 2009; AACAP 2008; Hilty 2014).

Members might wonder, "How to apply TP to regular practice, what model to use, or how to adjust regular practice to TP?" For example, child and adolescent psychiatry clinicians contend with additional disorders (e.g., autism/learning/cognitive disorders) and more often include family and systems work. Second, types of providers vary more widely in terms of trainin (e.g., child and adolescent psychiatry or PhD programs in psychology) and types of treatment (e.g., high intensity, short vs. long duration). Finally, some patient populations require providers to extrapolate knowledge and skills from usual settings to medical, corrections/juvenile hall, and school settings " this requires particularly insightful judgment and perhaps additional skill sets (e.g., consultation-liaison or psychosomatic medicine).

NO. 1

EFFECTIVENESS OF TELEPSYCHIATRY: FEASIBILITY AND OUTCOMES FOR SYNCHRONOUS/VIDEO (STP), ASYNCHRONOUS/STORE AND FORWARD (ATP), AND OTHER MODELS

Speaker: Donald M. Hilty, M.D.

SUMMARY:

Effectiveness of telepsychiatry (TP) is determined on the basis of clinical parameters, the beneficial effects of a program or policy under optimal conditions of delivery, and other data under more real-world conditions. A key component of effectiveness is feasibility and/or

replicability or adaptation to other settings (also known as dissemination). Clinical research trials usually assess effectiveness compared to in-person service, preferably with a design that is randomized. A review of 755 articles shows that TP is effective for diagnosis and assessment across many populations (adult, child/adolescent, geriatric and ethnic), for disorders in many settings (emergency, home health), and is comparable to in-person care.

References:

1. Hilty DM, Marks SL, Urness D, et al. Clinical and educational applications of telepsychiatry: a review. *Can J Psychiat* 2004;49(1):12-23
2. Hilty DM, Shoemaker EZ, Myers KK, et al. A preliminary clinical guideline on telemental health for care of children and adolescents. *J Child Adol Psychopharm*, in press.

NO. 2 VIEWS AND MISCONCEPTIONS OF TELEPSYCHIATRY: A SURVEY OF PSYCHIATRY FELLOWS, RESIDENTS AND TRAINING DIRECTORS

Speaker: Cesar Cruz, M.D.

NO. 3 SPECIAL CONSIDERATIONS FOR PSYCHOLOGICAL EVALUATIONS, FORMAL ASSESSMENTS (E.G., COGNITIVE TESTING), THERAPIES (E.G., CBT), AND OTHER PSYCHOLOGICAL TREATMENTS

Speaker: Carolyn Turvey, Ph.D.

SUMMARY:

The evidence-base of telepsychotherapy is starting to develop. A recent review shows preliminary positives in terms of developing the therapeutic alliance, doing psychological assessments and neuropsychological testing. Additional findings show comparative outcomes for therapies like CBT to in-person care. Finally, work is being done with individual/marriage/family/ counseling in child/adolescent, adult and other patients; this crosses the field of psychiatry, psychology, cognitive testing fields, other social sciences (Myers and Turvey 2013).

References:

6. Morland LA, Hynes AK, Mackintosh MA, et al. Group cognitive processing therapy delivered to veterans via telehealth: a pilot cohort. *J Trauma Stress* 2011;24(4):465-469
7. Myers KM, Turvey C. *Telemental Health: Clinical, Technical And Administrative Foundations For Evidence-Based Practice*. Elsevier, NY, NY, 2013.

NO. 4 HOW TO ADAPT CLINICAL APPROACHES AND TELEPSYCHIATRY TO CHILD, ADOLESCENT, AND FAMILY WORK - CONSIDERATIONS BASED ON TREATMENTS AND SETTINGS

Speaker: Erica Shoemaker, M.D.

SUMMARY:

has been shown (Morland et al 2011; Myers et al 2007) and it has been hypothesized that this approach may be better for some disorders, such as autism-spectrum patients, than in-person care. Treatment modalities like play therapy require site- and technology-based improvisation (e.g., remote site room design, position of camera, camera options like zoom/control/tracking) (Hilty et al 2014).

References:

8. AACAP Practice Parameter for Telepsychiatry with Children and Adolescents. *J Am Acad Child Adol Psychiatr* 2007;47(12):1468-1483.
9. Myers KM, Valentine JM, Melzer. Feasibility, acceptability, and sustainability of telepsychiatry for children and adolescents. *Psych Serv* 2007;58:1493-1496.

NO. 5 SPECIAL POPULATIONS AND MODELS: TP TO THE NURSING HOME, ISSUES WITH CULTURE AND DIVERSITY AND MODELS

Speaker: Terry Rabinowitz, D.D.S., M.D.

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 impact of increased marijuana potency and availability and the subsequent need for improved treatments and become aware of treatment trials of pharmacological and psychological approaches; 5) Understand major empirically supported behavioral treatments for substance use disorders, potential for combining behavioral and pharmacologic approaches, and obstacles in delivering these treatments.

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, along with a recent rise in heroin use (e.g., in New York City, the heroin overdose death rate is the highest that it has been since 2003). In addition, cocaine use remains endemic, methamphetamine use has decreased, marijuana has higher potency and greater availability, and marijuana use has 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 MISUSE
OF PRESCRIPTION STIMULANTS AND
SEDATIVE-HYPNOTICS**

Speaker: John J. Mariani, M.D.

SUMMARY:

Despite extensive clinical experience, concerns about over-prescribing, 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 DEPENDENCE: ROLE FOR
OPIOID AGONISTS AND ANTAGONISTS**

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

SUMMARY:

Prescription opioid abuse has reached epidemic proportions in the U.S. Clinicians face the significant challenge of maintaining therapeutic access to opioids for legitimate analgesic use while minimizing the potential for opioid abuse and diversion. Addiction in pain patients is often more difficult to identify than in illicit substance users. Screening and risk stratification, universal precautions, identification of aberrant behaviors, and adherence monitoring techniques will be considered. We will discuss treatment options for patients with opioid dependence and chronic pain, including abuse-deterrent 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 MEDICATION TO TREAT PROBLEMATIC NON-PRESCRIPTION STIMULANT USE

Speaker: Adam Bisaga, M.D.

SUMMARY:

Problematic use of cocaine and amphetamine-type stimulants remains a severe health concern, with no commonly accepted pharmacotherapies. Most recently, strategies to enhance rather than block the dopaminergic neurotransmission have proven effective to induce abstinence in stimulant-using individuals. Medications such as d-amphetamine and methylphenidate are the most promising, with modafinil and bupropion found helpful in a subset of patients. Practical and safety concerns involved in prescribing psychostimulant medications to stimulant users will be discussed. Other pharmacological strategies, such as medications that enhance GABAergic neurotransmission (e.g., topiramate) or naltrexone can also be beneficial, particularly to help in maintaining abstinence. A recent trial showed a combination of d-amphetamine and topiramate to be effective in producing abstinence in heavy cocaine users. 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 CHOOSING TREATMENT FOR CANNABIS USE DISORDERS

Speaker: Frances R. Levin, M.D.

SUMMARY:

Cannabis is the most widely used illicit drug in the United States, with 10% of users ending up dependent. Underlying psychopathology increases this risk, and, in others, marijuana use may increase risk of depression and psychosis. Heavy chronic cannabis use can lead to a characteristic withdrawal syndrome, especially with current THC levels averaging 7-10%. Such symptoms may hinder 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.

NO. 5 COMBINING MEDICATION AND PSYCHOSOCIAL INTERVENTIONS IN THE TREATMENT OF SUBSTANCE USE DISORDERS

Speaker: Edward V. Nunes, M.D.

SUMMARY:

Several types of psychosocial-behavioral interventions, including cognitive-behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-step facilitation), have been studied for use either alone or in combination with medications for treatment of substance use disorders. Such interventions have served as 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.

THE WIDENING SCOPE OF GROUP THERAPY FOR TREATING COMPLEX PATIENTS

Chair: Jan Malat, M.D.

Discussant: Melyn Leszcz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) 1. Identify common challenges running groups for complex patients; 2) 2. Describe specific group interventions for each patient population; 3) 3. Understand the role of common therapeutic factors in running groups for complex patients; 4) 4. Describe best group practices for complex patients; ; .

SUMMARY:

Group therapy practice and research has expanded significantly over the last decade to treat a wider range of more complex and unstable patients. There has been a growing trend to integrate and combine different group treatment models and approaches to enhance effectiveness. This symposium focuses on integrative group approaches that apply best practices for: 1) groups for co-occurring disorders (addiction and mental illness), 2) groups for PTSD and addiction, 3) groups for suicidal patients; 4) groups for the geriatric population; and 5) groups for patients with medical problems. Presenters will describe best practices in addition to examples of how they elicit a number of common group therapeutic factors such as cohesion, altruism and universality in combination with more specific techniques adapted for the different patient populations.

NO. 1

I'M NOT ALONE: A GROUP FOR PEOPLE WITH RECURRENT SUICIDE ATTEMPTS

Speaker: Yvonne Bergmans, M.S.W.

SUMMARY:

People with recurrent suicide attempts often find themselves excluded from group participation due to perceptions of risk, fear and stigma. Clients might even ask the question, "what's the point? I just want to die." In the face of nihilism, affective dysregulation and difficulties keeping oneself safe, unique adaptations of group therapy are required. Conference participants will be introduced to the group intervention, A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (PISA) . The facilitators discuss techniques used to develop cohesion, universality, hope and altruism in this type of group. Data will be presented to participants discussing the therapeutic factors, as identified by group

participants, relevant to their group experience. Finally, facilitators discuss key ingredients to enable the delivery of PISA groups, such as the role of group supervision for facilitators.

NO. 2

I'M NOT ALONE: A GROUP FOR PEOPLE WITH RECURRENT SUICIDE ATTEMPTS

Speaker: Nadiya Sunderji, M.D.

SUMMARY:

People with recurrent suicide attempts often find themselves excluded from group participation due to perceptions of risk, fear and stigma. Clients might even ask the question, "what's the point? I just want to die." In the face of nihilism, affective dysregulation and difficulties keeping oneself safe, unique adaptations of group therapy are required. Conference participants will be introduced to the group intervention, A Psychosocial/Psychoeducational Intervention for People with Recurrent Suicide Attempts (PISA) . The facilitators discuss techniques used to develop cohesion, universality, hope and altruism in this type of group. Data will be presented to participants discussing the therapeutic factors, as identified by group participants, relevant to their group experience. Finally, facilitators discuss key ingredients to enable the delivery of PISA groups, such as the role of group supervision for facilitators.

NO. 3

CHAOS VERSUS COHESION: CHALLENGES RUNNING GROUPS FOR CONCURRENT DISORDERS

Speaker: Jan Malat, M.D.

SUMMARY:

Treating concurrent disorders in a group setting poses several challenges including: 1) managing crises 2) addressing multiple symptoms 3) balancing containing and supportive interventions versus activating and challenging interventions 4) working with cognitive and skills deficits 5) managing supersensitivity 6) addressing shame and hopelessness in response to chronic symptoms and frequent relapses 7) helping patients reduce fragmented care within the treatment system. This workshop will focus on a variety of integrative group therapy approaches which help patients: understand the links between addiction and

mental illness, develop healthier attachments, increase self care, improve relations with caregivers, improve affect regulation and reduce shame

**NO. 4
FINDING A VOICE IN TRAUMA AND
ADDICTION: RUNNING A STAGE TWO
TRAUMA AND ADDICTION GROUP**

Speaker: Pamela A. Stewart, M.D.

SUMMARY:

The treatment of trauma has historically been organized in three stages of recovery. However, it is more difficult to assess the stage of recovery when patients are struggling with co-occurring disorders. This has been further complicated by the harm-reduction model where abstinence is not required which further challenges the clinician in staging trauma. This presentation will focus on clinical challenges and dilemmas facilitating a Stage-Two Trauma and Substance-Use Group. It will describe how working with co-occurring disorders has influenced our assessment of Stage-Two trauma work both in individual and group therapy.

**NO. 5
REMEMBERING THE FORGOTTEN:
PSYCHOTHERAPY GROUPS FOR
GERIATRIC PATIENTS**

Speaker: Ken Schwartz, M.D.

SUMMARY:

The current and projected growth of the elderly population is extraordinary. Group therapy is considered to be an effective treatment to help deal with the many losses associated with aging and/or medical or depressive illness. However, it remains underutilized as clinicians remain unaware of its benefits and the unique techniques required to work with this special population in both outpatient community settings and long-term care homes. In this presentation, an integrated group therapy that incorporates interpersonal, psychodynamic, developmental, cognitive-behavioural and existential approaches is described. Technical and countertransference challenges, along with clinical material, to illustrate common themes and therapeutic factors, are described.

NO. 6

**KIDNEY DISEASE AS A MENTAL
DISORDER: GROUP THERAPY
EXPERIENCES WITH PATIENTS
SUFFERING FROM CHRONIC KIDNEY
DISEASE**

Speaker: Marta Novak, M.D., Ph.D.

SUMMARY:

Chronic kidney disease (CKD) is a progressive, life-threatening condition. At the last stage of CKD, end-stage kidney disease (ESKD) is present, when renal replacement therapies (dialysis or transplantation) are needed. Living with CKD and ESKD significantly impairs the person's quality of life and shortens life expectancy. Both dialysis and transplantation are posing significant challenges for the patients, families and caregivers to cope with everyday life as well as facing existential issues. Depression, anxiety, trauma, feelings of hopelessness and demoralization is often experienced by the patients and their family members. Group therapy can be a very valuable source of support in the unique and complex challenges our patients face.

The presentation will review how we should adapt our group work to treat complex medically ill patients using flexible, integrative approaches including psycho-education (about the disease, its particular treatments and mental health issues), interpersonal and supportive elements as well as existential approaches.

We will discuss both how common therapeutic factors work in groups of patients with CKD/ESKD as well as the specific considerations in this patient group.

UPDATES IN NEUROPSYCHIATRY

Chairs: Yelizaveta I. Sher, M.D., Jos  R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize symptomology of posterior reversible encephalopathy syndrome and appreciate the pathophysiology behind it.; 2) To diagnose and treat post-stroke depression.; 3) To appreciate neuropsychiatric complications of hepatitis C and its treatments; 4) To recognize and treat neuropsychiatric complications of multiple sclerosis.; 5) To identify neuropsychiatric presentations of chronic fatigue syndrome.

SUMMARY:

Updates in Neuropsychiatry, similarly to prior years, will review most pertinent and interesting topics in neuropsychiatry not uncommonly seen by Psychosomatic Medicine specialists. Topics this year will include posterior reversible encephalopathy syndrome, neuropsychiatric complications of multiple sclerosis, neuropsychiatric complications of hepatitis C and its treatments, post-stroke depression, and chronic fatigue syndrome.

Posterior reversible encephalopathy syndrome (PRES) has a variety of associated neuropsychiatric signs and symptoms and is an important entity on differential for delirium. Pathophysiology includes break down in autoregulation and blood-brain barrier leading to cerebral edema. In this presentation, Dr. Sher will discuss presentations and pathophysiology of PRES with the goal of increasing the awareness of psychiatrists of this important phenomenon.

Multiple sclerosis (MS) has a range of neuropsychiatric conditions such as fatigue, cognitive dysfunction, and pseudobulbar affect, and depression. In fact, depression is co-morbid in 50% of patients with MS, the highest rate among the neurologically afflicted adults. Dr. Garcia will discuss the epidemiology, diagnosis, significance, and treatment of such conditions.

Hepatitis C is a blood-borne disease affecting upwards of 200 million people worldwide. Although liver disease is the classic presentation, other systems may also be involved. Neuropsychiatric complications in the acutely and chronically infected may include disorders of cognition and mood. Until recently, treatment for hepatitis C has depended on the co-administration of various forms of interferon which also may contribute to changes in mental status, including high rates of depression leading to discontinuation. Newer interferon-free treatments are now available. In this presentation, a clinical update on the CNS pathology of hepatitis C will be discussed, as well as diagnosis and the latest treatments.

Post-stroke depression afflicts at least 30 per cent of the stroke survivors due to both organic deficits and psychosocial circumstances. In this part of the symposium, Dr. Ament will review the epidemiology, causality, and treatments.

The two central symptoms of chronic fatigue syndrome (CFS) are severe, disabling fatigue

and cognitive impairment, also known as 'brain fog.' To date, neuroimaging and neuropsychological studies have produced mixed results when trying to locate the structural changes responsible for these two cardinal symptoms. However, EEG data suggests that symptoms experienced by CFS patients may originate within the thalamo-cortical circuit dysfunction and may assist in the understanding of the syndrome's etiology and a way to prevent or treat this condition. In his presentation, Dr. Maldonado will discuss neuropsychiatric presentations of CFS as well as most recent EEG data describing possible underlying pathophysiology.

NO. 1 POSTERIOR REVERSIBLE ENCEPHALOPATHY SYNDROME

Speaker: Yelizaveta I. Sher, M.D.

SUMMARY:

Posterior reversible encephalopathy syndrome (PRES) has a variety of associated neuropsychiatric signs and symptoms and is an important entity on differential for delirium. Pathophysiology includes break down in autoregulation and blood-brain barrier leading to cerebral edema. In this presentation, Dr. Sher will discuss presentations and pathophysiology of PRES with the goal of increasing the awareness of psychiatrists of this important phenomenon.

NO. 2 NEUROPSYCHIATRIC COMPLICATIONS OF MULTIPLE SCLEROSIS

Speaker: Renee M. Garcia, M.D.

SUMMARY:

Multiple sclerosis (MS) has a range of neuropsychiatric conditions such as fatigue, cognitive dysfunction, and pseudobulbar affect, and depression. In fact, depression is co-morbid in 50% of patients with MS, the highest rate among the neurologically afflicted adults. Dr. Garcia will discuss the epidemiology, diagnosis, significance, and treatment of such conditions.

NO. 3 NEUROPSYCHIATRIC ASPECTS OF HEPATITIS C AND ITS TREATMENTS

Speaker: Lawrence M. McGlynn, M.D.

SUMMARY:

Hepatitis C is a blood-borne disease affecting upwards of 200 million people worldwide. Although liver disease is the classic presentation, other systems may also be involved. Neuropsychiatric complications in the acutely and chronically infected may include disorders of cognition and mood. Until recently, treatment for hepatitis C has depended on the co-administration of various forms of interferon which also may contribute to changes in mental status, including high rates of depression leading to discontinuation. Newer interferon-free treatments are now available. In this presentation, a clinical update on the CNS pathology of hepatitis C will be discussed, as well as diagnosis and the latest treatments.

NO. 4**UPDATES IN NEUROPSYCHIATRY**

Speaker: Andrea Ament, M.D.

SUMMARY:

Updates in Neuropsychiatry, similarly to prior years, will review most pertinent and interesting topics in neuropsychiatry not uncommonly seen by Psychosomatic Medicine specialists. Post-stroke depression afflicts at least 30 per cent of the stroke survivors. In this part of the symposium, Dr. Ament will review the epidemiology, causality, and treatments.

NO. 5**ELECTROPHYSIOLOGIC CORRELATES IN CHRONIC FATIGUE SYNDROME**

Speaker: JosÁ© R. Maldonado, M.D.

SUMMARY:

The two central symptoms of chronic fatigue syndrome (CFS) are severe, disabling fatigue and cognitive impairment, also known as 'brain fog.' To date, neuroimaging and neuropsychological studies have produced mixed results when trying to locate the structural changes responsible for these two cardinal symptoms. However, EEG data suggests that symptoms experienced by CFS patients may originate within the thalamo-cortical circuit dysfunction and may assist in the understanding of the syndrome's etiology and a way to prevent or treat this condition. In his presentation, Dr. Maldonado will discuss

neuropsychiatric presentations of CFS as well as most recent EEG data describing possible underlying pathophysiology.

A COMPREHENSIVE REVIEW: DEMENTIAS, BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIAS (BPSD) AND INAPPROPRIATE SEXUAL BEHAVIORS IN DEMENTIA (ISBD)

Chair: Rajesh R. Tampi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the different types of dementias; 2) Define behavioral and psychological symptoms of dementias; 3) Describe the epidemiology, neurobiology, assessment and management of behavioral and psychological symptoms of dementias; 4) Define inappropriate sexual behaviors in dementias; 5) Discuss the epidemiology, neurobiology, assessment and management of inappropriate sexual behaviors in dementias .

SUMMARY:

Dementias are the most common neurodegenerative conditions in humans. As we age, the incidence and prevalence of dementias increases. Currently in the United States, there are over 5 million individuals with dementias. This number is projected to rise to over 11 million over the next thirty years. Despite emerging data on various important aspects of dementia, the diagnosis and management of these disorders is not standardized. Also, the data on the management dementias is still limited with none of the pharmacotherapeutic agents available showing any long term benefits. Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD.

However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. Inappropriate Sexual Behaviors in Dementias (ISBD) are a group of behavioral symptoms that are not uncommon in individuals with dementias and cause significant distress to everyone involved. There is emerging data on the epidemiology, neurobiology, assessments and treatments for ISBD. In this symposium, we will discuss the epidemiology, neurobiology, assessment and management of individuals with dementias, BPSD and ISBD. We will also provide an evidence based guideline to assess and manage these individuals. Finally, we will elaborate on the recent controversies in the treatment of individuals with dementias, BPSD and ISBD.

**NO. 1
DEMENTIAS: AN UPDATE**

Speaker: Kristina Zdanys, M.D.

SUMMARY:

Dementias are the most common neurodegenerative conditions in human beings. As we age, the incidence and prevalence of dementias increase. Currently in the United States, there are over 5 million individuals with dementias. This number is projected to rise to over 11 million over the next thirty years. Despite emerging data on various important aspects of dementia, the diagnosis and management of these disorders is not standardized. The data on the management of dementias is still limited with none of the pharmacotherapeutic agents available in the market showing any longer term benefits. In this symposium, we will discuss the epidemiology, neurobiology, assessment and management of individuals with Dementias.

**NO. 2
BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: DEFINITION, EPIDEMIOLOGY AND NEUROBIOLOGY**

Speaker: Rabeea Mansoor, M.D.

SUMMARY:

Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result

from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological treatment modalities for BPSD. However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. In this part of the symposium, we will discuss the definition, epidemiology and neurobiology of individuals with BPSD.

**NO. 3
SEXUALITY AND AGING**

Speaker: Anil K. Bachu, M.D.

SUMMARY:

Sexuality in late life can be impacted by many variables including the loss of one's partner, the loss of privacy and medical and psychiatric comorbidities seen in older adults. In this symposium, we will first provide an overview of the biological and psychosocial factors impacting sexuality in the late life.

**NO. 4
BEHAVIORAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA AND INAPPROPRIATE SEXUAL BEHAVIORS IN DEMENTIA**

Speaker: Rajesh R. Tampi, M.D.

SUMMARY:

Behavioral and Psychological Symptoms of Dementia (BPSD) refers to a group of non-cognitive symptoms and behaviors that occur commonly in patients with dementia. They result from a complex interplay between various biological, psychological and social factors involved in the disease process. BPSD is associated with increased caregiver burden, institutionalization, a more rapid decline in cognition and function and overall poorer quality of life. It also adds to the direct and indirect costs of caring for patients with dementia. Available data indicate efficacy for some non-pharmacological and pharmacological

treatment modalities for BPSD. However, recently the use of psychotropic medications for the treatment of BPSD has generated controversy due to increased recognition of their serious adverse effects. Inappropriate Sexual Behaviors in Dementias (ISBD) are a group of behavioral symptoms that are not uncommon in individuals with dementias and cause significant distress to everyone involved. There is emerging data on the epidemiology, neurobiology, assessments and treatments for ISBD. In this symposium, we will discuss the assessment and management of individuals with BPSD and the epidemiology, neurobiology assessment and management of individuals with ISBD. We will also provide an evidence based guideline to assess and manage these individuals. Finally, we will elaborate on the recent controversies in the treatment of individuals with BPSD and ISBD.

THE BIOLOGICAL AND SYMPTOM RELATIONSHIPS BETWEEN THE PERSONALITY DISORDERS AND THE ANXIETY, MOOD AND PSYCHOTIC DISORDERS

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 how biological markers may be able to distinguish those personality disorders which represent independent disorders from those that are variants of normal personality.; 2) Identify the common and different categorical and dimensional aspects of bipolar disorder and borderline personality disorder.; 3) Recognize how the interactions of personality pathology and the anxiety disorders may affect the measurement of personality and the outcome of treated anxiety disorders.; 4) Recognize common associations between the psychotic disorders and the personality disorders.

SUMMARY:

The field of psychiatry has long been interested in the relationship of personality and psychopathology. At various times there have been different hypotheses about the relationship of the two, including a continuum theory, common etiologic factors for separate disorders and independent disorders which

nonetheless influenced each other. This symposium returns to this topic and examines it from several different perspectives. There will be a presentation on the biological processes that may be common to both personality psychopathology and what used to be called the Axis I disorders. Personality disorders that appear to be related to biomarkers will be discussed. There will be a presentation of how bipolar disorder and borderline disorder are similar and different from dimensional and categorical perspectives. Another presentation will examine the relationship between the anxiety disorders and personality pathology. Included in that talk will be comorbidity, how personality disorders affect outcome of anxiety disorders and the relationship between Social Anxiety Disorder and Avoidant Personality Disorder. Finally, the relationship of the psychotic disorders to the personality disorders will be discussed. We hope to provide a reasonable empirical update on this area, although we may raise as many questions as we answer.

NO. 1

BORDERLINE PERSONALITY DISORDER AND BIPOLAR DISORDER- DIMENSIONALLY SIMILAR AND CATEGORICALLY DIFFERENT.

Speaker: Terence A. Ketter, M.D.

SUMMARY:

There is a lack of consensus regarding the extent to which borderline personality disorder (BPD) and bipolar disorder (BD) are dimensionally similar versus categorically different. Categorical BPD-BD approaches seek to support the distinctiveness of BPD (a putatively primarily psychologically/experientially-driven entity) compared to BD (a putatively primarily biological/genetically-driven entity), citing differential histories of childhood sexual abuse, parasuicidal behavior, BD in family members, and pharmacotherapy responses, while noting BPD-BD comorbidity limitations, including approximately 85% of BPD and BD not being comorbid with one another, BPD having more comorbidity with unipolar major depressive disorder than with BD, and BD possibly having more comorbidity with personality disorders other than BPD. The dimensional BPD-BD approach seeks to extend the bipolar spectrum

concept from a relationship between BD and affective temperaments to one between BD and personality disorders, supported by the need for personality disorders to be formulated as variants of normal personality rather than categorical disease entities, congruity with the National Institute of Mental Health Research Domain Criteria (RDoC) approach, and symptomatic overlap (e.g., mood lability and impulsivity). Without doubt, further research is needed to address how to move forward from the current dimensional versus categorical BPD-BD relationship impasse.

NO. 2 OVERLAP OF PSYCHOTIC SYMPTOMS AND PERSONALITY PATHOLOGY

Speaker: Rona Hu, M.D.

SUMMARY:

How does a savvy psychiatrist deal with psychotic symptoms in patients who appear to have personality disorders? Symptoms of paranoid personality disorder overlap considerably with those of schizophrenia, and the same can be said, to a lesser extent, in schizotypal and schizoid patients. People with antisocial personality disorder can evince behaviors misattributed to psychosis and vice versa, sometimes with profound legal implications, especially if violence is involved. Borderline personality disorder can also include psychotic symptoms, and of course an existing personality disorder is not protective against later developing a primary psychotic disorder. Add the complexities of comorbid substance use and/or mood symptoms and these issues challenge our diagnostic understanding and our compassion. Research on the relationship between psychotic disorders and personality disorders includes genetics, neuroimaging and phenomenologic studies and can inform our understanding and treatment of these patients. We will discuss cases and provide practical recommendations.

NO. 3 OVERLAP BETWEEN SYNDROMAL PSYCHIATRIC DISORDERS AND PERSONALITY DISORDERS IN BIOMARKERS

Speaker: M. Mercedes Perez-Rodriguez, M.D., Ph.D.

NO. 4 EMPIRICAL EVIDENCE ON THE RELATIONSHIP OF THE ANXIETY DISORDERS AND PERSONALITY PATHOLOGY

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

SUMMARY:

The anxiety disorders have long been associated with the personality disorders. At one time an anxiety disorder was considered a "neurosis" and the equivalent of a personality disorder. Although that idea has been discarded, more recent empirical research has confirmed relationships between the anxiety and personality disorders. Covered in this presentation will be: frequency of co-occurrence of the anxiety and personality disorders (comorbidity); the effect of anxiety disorders on the measurement of personality pathology; the effect of personality pathology on the treatment outcome of anxiety disorders; and the relationship of Social Anxiety Disorder to Avoidant Personality Disorder. A clinician's view will be taken as to what these anxiety and personality disorders mean to the average treating clinician.

PSYCHOSIS AND DIABETES: CHALLENGES AND STRATEGIES FOR SUCCESSFUL CO-MANAGEMENT

Chairs: Niall P. Boyce, M.B., Lydia Chwastiak, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the increased risk of diabetes in their patients with psychosis and what contributes to this risk.; 2) Recognize that diabetes is underdiagnosed in this population and understand ways to improve both the diagnosis and treatment of diabetes in psychosis, closing the "treatment gap"™.; 3) Understand the mechanisms by which antipsychotic drugs impair glucose and lipid metabolism, increase inflammation and increase risk for cardiometabolic risk. ; 4) Understand the evidence supporting behavioral, medical and surgical interventions for the prevention and treatment of diabetes in patients with psychosis. ; 5) Understand the potential effectiveness of collaborative care models and behavioral health homes for managing this comorbidity.

SUMMARY:

This symposium will review the association of psychotic disorders, including schizophrenia and schizoaffective disorder, with diabetes. The prevalence of diabetes is higher in individuals with psychotic illness compared to the general population. We will examine risk factors for diabetes in psychosis, both general (age, obesity, hyperlipidemia, hypertension, lack of physical activity, race) and those unique to individuals with psychotic disorder and serious mental illness (social determinants of health such as poverty and stress, medications, genetics). The session will discuss potential lessons for patients and clinicians for improving diagnosis and treatment of diabetes in psychosis. A key problem is that diabetes is underdiagnosed in individuals with psychotic disorders, possibly due to lack of routine medical care in patients with mental illness and/or to lack of metabolic monitoring for patients on atypical antipsychotics. We will review how individuals with psychotic disorders show variable access of diabetes services, depending on the healthcare system, highlight gaps in both access to treatment and our knowledge of who is receiving treatment, then suggest policy changes that could improve diabetes care for persons with psychotic disorders.

Medical morbidity associated with severe mental illness remains the domain least improved by recent treatment advances, at least in part due to unhealthy lifestyles, medication side effects and inadequate medical care. Additionally, there is evidence that some of the atypical antipsychotic agents are associated with insulin resistance, hyperlipidemia, weight gain- all increasing the risk for diabetes and cardiovascular disease. This presentation will discuss the mechanisms by which antipsychotic drugs impair glucose and lipid metabolism, increase inflammation and increase risk for cardiometabolic risk. Other environmental and behavioral factors such as diet, exercise and smoking will be discussed. This presentation will highlight specific drugs and their role in increasing risk for diabetes. Strategies and novel approaches to reduce the impact of the antipsychotic agents and cardiometabolic risk will also be discussed.

Finally, we will consider strategies for the prevention and treatment of diabetes in patients with psychosis, covering behavioral, medical and surgical interventions. Lifestyle modification interventions target healthy diet and physical activity: we will review their effectiveness among patients with psychosis, and explore the barriers to implementation in community mental health settings. We will also examine the evidence for diabetes self-care interventions in this population. We will examine the challenges to effective pharmacologic treatment of psychotic disorders in the setting of comorbid diabetes, and the indications for switching from medications with high metabolic liability to those with lower liability, and the use of metformin.

**NO. 1
EPIDEMIOLOGY OF DIABETES IN PSYCHOSIS**

Speaker: Martha Craig-Ward, M.D.

SUMMARY:

This presentation will review the global association of psychotic disorders, including schizophrenia and schizoaffective disorder, with diabetes. The prevalence of diabetes is higher in individuals with psychotic illness compared to the general population, although estimating the true prevalence is challenging, since diabetes is underdiagnosed in those with psychotic disorders. We will examine the risk factors for diabetes in psychosis, both those common to the general population (age, obesity, hyperlipidemia, hypertension, lack of physical activity, race) and those unique to individuals with psychotic disorder and serious mental illness (social determinants of health such as poverty and stress, medications, particularly certain antipsychotics, genetics). The session will discuss potential lessons for patients and clinicians for improving diagnosis and treatment of diabetes in psychosis.

**NO. 2
CLOSING THE TREATMENT GAP FOR DIABETES IN PSYCHOSIS**

Speaker: Benjamin Druss, M.D.

SUMMARY:

Reasons will be discussed for the diabetes "treatment gap" that exists for individuals with psychotic disorders compared to the

general population. Diabetes is underdiagnosed in individuals with psychotic disorders, possibly due to lack of routine medical care in patients with mental illness and/or to lack of metabolic monitoring for patients on atypical antipsychotics. The presentation will review how individuals with psychotic disorders show variable access of diabetes services, depending on the healthcare system and highlight gaps in both access to treatment and our knowledge of who is receiving treatment. Persons with psychotic disorders receive lower quality of care for diabetes: a situation that needs to be redressed. The presentation will close with a look at areas for opportunities for policy changes.

NO. 3 PATHWAYS TO CARDIOMETABOLIC DISEASE IN PSYCHOSIS

Speaker: David Henderson, M.D.

SUMMARY:

High rates of medical morbidity and excess mortality have long been associated with chronic mental illness, particularly schizophrenia. Medical morbidity remains the domain least improved by recent treatment advances, at least in part due to unhealthy lifestyles, medication side effects and inadequate medical care. Additionally, there is evidence that some of the atypical antipsychotic agents are associated with insulin resistance, hyperlipidemia, weight gain- all increasing the risk for diabetes and cardiovascular disease. This presentation will discuss the mechanisms by which antipsychotic drugs impair glucose and lipid metabolism, increase inflammation and increase risk for cardiometabolic risk. Other environmental and behavioral factors such as diet, exercise and smoking will be discussed. This presentation will highlight specific drugs and their role in increasing risk for diabetes. Strategies and novel approaches to reduce the impact of the antipsychotic agents and cardiometabolic risk will also be discussed.

NO. 4 CLINICAL MANAGEMENT OF DIABETES AND PSYCHOSIS

Speaker: Lydia Chwastiak, M.D., M.P.H.

SUMMARY:

This presentation will consider strategies for the prevention and treatment of diabetes in patients with psychosis. The evidence supporting behavioral, medical and surgical interventions will be reviewed. First, lifestyle modification interventions that target healthy diet and physical activity to prevent diabetes or complications will be considered. We will review the effectiveness of such interventions among patients with psychosis, and explore the barriers to implementation in community mental health settings. We will also examine the evidence for diabetes self-care interventions (including smoking cessation) in this population. Second, we will examine the challenges to effective pharmacologic treatment of psychotic disorders in the setting of comorbid diabetes, and the indications for switching from medications with high metabolic liability to those with lower liability, and the use of metformin. Pharmacologic treatment of diabetes will also be discussed, including management of cardiovascular risk factors, and barriers to appropriate treatment intensification. The impact of depression and neurocognitive impairment on both medical and behavioral treatment will be considered. Third, we will consider the role for bariatric surgery to prevent or treat diabetes in this population. Finally, we will explore the potential effectiveness of collaborative care models and behavioral health homes for managing this co-morbidity.

IMPLEMENTATION AND EVIDENCE: COLLABORATIVE PRIMARY CARE FOR POSTTRAUMATIC STRESS DISORDER AND DEPRESSION IN THE U.S. MILITARY

Chairs: Charles C. Engel, M.D., M.P.H., Harold Pincus, M.D.

Discussant: Harold Pincus, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the advantages of collaborative care for anxiety, depression and other psychiatric conditions. ; 2) List features of and rationale for the STEPS-UP collaborative care intervention.; 3) Describe the impact of STEPS-UP collaborative care on mental health outcomes. ; 4) Discuss patient, mental health specialist, and primary care clinician impressions of STEPS-UP and control care.

SUMMARY:

Research has found that service members return from deployments to war with high rates of PTSD, depression, and other behavioral health problems, and that most do not receive adequate mental health services for their problems due to stigma and other issues. Collaborative primary care may improve their care and associated outcomes. This symposium will consist of a series of presentations on recent US military efforts to implement and evaluate collaborative care models for PTSD and Depression. Several presentations will describe the results of a recently completed randomized effectiveness trial of collaborative primary care for US service members. The trial compared a scalable, centrally managed program of collaborative primary care versus optimized usual care. This design of this trial, unprecedented in a military health system, will be described as well as clinical and qualitative outcomes will be presented.

**NO. 1
PATIENT AND PROVIDER
PERSPECTIVES OF COLLABORATIVE
PRIMARY CARE IN THE U.S. MILITARY
HEALTH SYSTEM**

Speaker: Terri Tanielian, M.A.

SUMMARY:

Within a large randomized controlled trial for enhancing treatment of PTSD and depression in military primary care clinics, we conducted a substudy to understand participants'™ perspectives on the intervention and their experiences with the military mental health system. We present data from 36 randomly-selected patients interviewed 3 times each (across 9 months), representing the two different interventions under study and six different military installations. All patients who participated were screened into the study based on the presence of significant depression and/or PTSD symptoms, and followed in the interventions for up to a year post-screening. We also present data from 38 health care providers, including nurse care facilitators, primary care providers, and behavioral health providers. Interviews were coded in ATLAS-ti. In this presentation, we focus on barriers to mental health care and the intervention elements that were used to help participants overcome those barriers. We found barriers

similar to those found in the civilian population (e.g., logistical barriers and wait-lists; difficulty communicating across providers, etc.) as well as those that appear to be unique to the military (e.g., discouragement from the chain of command, challenges engaging soldiers in behavioral health care). Some elements of the intervention in STEPS-UP had low uptake, whereas other elements were more popular, and participants'™ explanations for these choices will be described.

**NO. 2
RANDOMIZED EFFECTIVENESS TRIAL
OF COLLABORATIVE CARE IN THE U.S.
MILITARY: EFFECTS ON PTSD,
DEPRESSION, FUNCTIONING, AND
SERVICE USE**

Speaker: Michael C. Freed, Ph.D.

SUMMARY:

We present the main outcomes from the STEPS-UP Trial, a large randomized effectiveness trial of collaborative care for PTSD and depression in the US military health system. Six hundred sixty six service members meeting clinical criteria for PTSD, Depression or both were randomized to either optimized usual primary care (n=332), a form of collaborative care widely implemented in the US Army health system since 2007, or to the STEPS-UP collaborative care intervention (n=334), described in detail in the previous presentation. Follow-up rates were over 85% and consistent across the treatment groups. Intention to treat analyses revealed statistically and clinically significant improvements in PTSD, depression and somatic symptom, suicidal ideation, mental health functioning, and somatic symptom severity. Data relating to impact of intervention on mental health and general medical service use will also be presented. These results point to the importance of several intervention elements: central implementation coordination, measurement-based care, active patient engagement using care managers, and the use of automated decision support for determining when and for whom to intensify treatment. Implications for primary care interventions to improve mental health care are addressed.

**NO. 3
COLLABORATIVE CARE FOR ANXIETY
AND DEPRESSION: AN OPPORTUNITY**

FOR THE U.S. MILITARY HEALTH SYSTEM

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

SUMMARY:

High rates of PTSD and depression are related to the U.S. military conflicts in Iraq and Afghanistan. Often, those affected have not sought care due to barriers and stigma. Evidence shows that specific primary care enhancements consistently improve clinical outcomes for patients with anxiety, depression, suicidal ideation, chronic pain, and a range of other psychiatric disorders common among service members and veterans. Economic analyses suggest that collaborative care-related improvements can reduce service-delivery silos, extend the reach of psychiatric care, and improve patient engagement at an acceptable health system cost. Dr. Unutzer will provide a short overview of collaborative care for anxiety and depression and discuss why collaborative care may be particularly suited for use in health settings offering medical care to service members, veterans, and their families.

NO. 4 SCALABLE, CENTRALLY IMPLEMENTED COLLABORATIVE PRIMARY CARE TREATMENT PACKAGE FOR PTSD AND DEPRESSION IN THE U.S. MILITARY

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

SUMMARY:

We describe the design of the STEPS-UP Trial, a 6 installation (18 primary care clinic) randomized effectiveness trial comparing collaborative care models for PTSD and depression in U.S. military health system. Soldiers with PTSD, depression or both and referred by their primary care provider were randomly assigned to one of two treatment arms for 12 months. Research assessments were completed in both groups at baseline, 3-, 6-, and 12-month follow-up time points. Participants assigned to the control arm received collaborative care as widely disseminated in U.S. Army clinics beginning in 2007 (RESPECT-Mil). Those assigned to the STEPS-UP care received a second generation collaborative care intervention relying on a systems-based central implementation model, measurement-based care featuring use real time registries to step up care for treatment

resistant patients, and care managers trained in patient engagement strategies. Other intervention and research design features are described. STEPS-UP Trial and intervention will serve as a model for future evidence-based military and VA health system change.

INTERPERSONAL PSYCHOTHERAPY IN 2015: LOOKING BACK AND FORGING AHEAD

Chair: Holly Swartz, M.D.

Discussant: Ellen Frank, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role of interpersonal psychotherapy in improving patient outcomes across mood and anxiety disorders; 2) Identify new psychotherapeutic approaches to managing mood and anxiety disorders; 3) Evaluate recent advances in IPT research and practice.

SUMMARY:

In 2015, psychotherapy is at a crossroads. Economic and social forces have converged to preferentially emphasize the role of pharmacotherapy in the management of psychiatric illnesses, often at the expense of psychotherapy. And yet, data continues to accrue showing that evidence based psychotherapies are effective treatments for a range of psychiatric disorders including depression, anxiety, and eating disorders. Many patients prefer psychotherapy to pharmacotherapy, and for several common psychiatric disorders, psychotherapy is at least as efficacious as pharmacotherapy.

The current symposium highlights new developments in Interpersonal Psychotherapy (IPT), a time-limited, focused psychotherapy that is currently included in expert consensus treatment guidelines for the treatment of depression, eating disorders and bipolar disorder. Presentations will include an overview of IPT studies over the past 40 years, a discussion of a very brief form of IPT for use in primary care settings, exciting new findings showing a role for IPT in the treatment of PTSD, an exploration of the process of change in IPT sessions, and preliminary experience with a website to train clinicians in an adaptation of IPT for bipolar disorder. Presenters include internationally recognized experts in IPT,

including one of the original developers of the treatment (Myrna Weissman, Ph.D.). This symposium will build the case that IPT remains an important and compelling treatment option for a range of psychiatric disorders in 2015.

**NO. 1
INTERPERSONAL COUNSELING (IPC)
FOR DEPRESSION IN PRIMARY CARE**

Speaker: Myrna M. Weissman, Ph.D.

SUMMARY:

With the implementation of the Affordable Care Act in the United States, there is increasing interest in patient-centered, cost-effective models of care that expand access to mental health services for diverse populations. To meet the mental health care needs of the newly insured individuals will require expanding access to evidence-based, though currently underutilized, approaches to the primary care management of depression. Primary care will continue to be a major source of screening and treatment of depression, especially for patients with low incomes because of its high prevalence, substantial morbidity, and adverse effects on management of chronic medical conditions.

Interpersonal Counseling (IPC), a brief patient-centered approach to managing depression, lowers the burden on primary care physicians by locating a mental health worker within the primary care setting. IPC derives directly from interpersonal psychotherapy (IPT), an evidence based psychotherapy developed by Klerman and Weissman with numerous efficacy studies, translations, and adaptations for cross-cultural use. This presentation describes the rationale for using IPC in primary care, and summarizes its development and evidence of efficacy

**NO. 2
SUDDEN GAINS IN COGNITIVE
THERAPY AND INTERPERSONAL
PSYCHOTHERAPY FOR ADULT
DEPRESSION**

Speaker: Frenk Peeters, M.D., Ph.D.

SUMMARY:

Objective: We examined the rates, baseline predictors and clinical impact of sudden gains in a randomized comparison of individual Cognitive Therapy (CT) and Interpersonal Psychotherapy (IPT) for adult depression.

Method: Patients were 117 depressed outpatients who received 16-20 sessions of either CT or IPT. Session-by-session symptom severity was assessed using the Beck Depression Inventory-II. Our primary analyses examined sudden gains using the original criteria as defined by Tang & DeRubeis (1999). In a series of secondary analyses, we examined whether the duration of the between-session interval at which sudden gains were recorded affected the results obtained.

Results: There were significantly more patients with sudden gains in CT (42.2%) as compared to IPT (24.5%). There were no differences with regard to the magnitude and timing of the sudden gains. In both treatments, sudden gains were predicted by baseline quality of life score and absence of axis-I comorbidity, and those with sudden gains reported lower levels of depression severity at post-treatment and 5 months FU. The duration of the between-session interval did not influence the results.

Conclusions: The current study indicates differences in occurrence of sudden gains in two treatment modalities that overall showed similar results, which might reflect different mechanisms of change.

**NO. 3
WEB-BASED TRAINING FOR
CLINICIANS TO EXTEND THE REACH OF
INTERPERSONAL AND SOCIAL RHYTHM
THERAPY**

Speaker: Holly Swartz, M.D.

SUMMARY:

Background: Despite demonstrated efficacy of evidence-based psychotherapies (EBPs) for many psychiatric disorders, availability of these treatments in routine practice settings is limited. Barriers to dissemination include limited capacity to train a large workforce in EBPs.

Methods: In the context of conducting a randomized trial to compare methods for EBP implementation in community settings, we developed a website to train clinicians in Interpersonal and Social Rhythm Therapy (IPSRT), an adaptation of Interpersonal Psychotherapy with demonstrated efficacy for bipolar disorder. At the end of the research study, the website was opened to the public as a free online training resource. The website requires visitors to register to gain access to the training. This presentation will describe the

content of the website (www.ipsrt.org) and website usage data.

Results: The website went live on 2/7/14. Over a four and a half month period, the IPRST website had 466 unique visitors. Seventy-two percent of visitors were female. Visitors resided in 31 different countries, although the majority was from the United States (65%). Fifteen percent of visitors were M.D.s. Visitors reported intent to use IPSRT in wide range of settings from private practice to the classroom to working with the uninsured.

Conclusions: There is a high level of interest in online IPSRT training. Web-based training may help to disseminate EBPs.

NO. 4 INTERPERSONAL PSYCHOTHERAPY FOR PTSD

Speaker: John C. Markowitz, M.D.

SUMMARY:

Exposure to trauma reminders has been considered imperative in psychotherapy for posttraumatic stress disorder (PTSD). Following promising pilot research, we tested interpersonal psychotherapy (IPT) as non-exposure-based, non-cognitive behavioral PTSD treatment.

This randomized, fourteen-week trial compared IPT; Prolonged Exposure (PE), an exposure-based exemplar; and Relaxation Therapy (RT), an active control psychotherapy, in 110 unmedicated patients having DSM-IV chronic PTSD and Clinician-Administered PTSD Scale (CAPS) score >50. We hypothesized no more than minimal IPT inferiority (CAPS difference <12.5 points) to PE.

All therapies had large within-group pre/post effect sizes ($d=1.32-1.88$). Attrition: IPT 15%, PE 29%, RT 34% (n.s.). Response rates (>30% CAPS improvement): IPT 63%, PE 47%, RT 38% (n.s.). IPT and PE CAPS outcome differed by 5.5 points (n.s.); the null hypothesis of more than minimal IPT inferiority was rejected ($p=0.035$). PE patients with comorbid MDD dropped out nine times more than non-depressed PE patients.

This first controlled study of IPT for PTSD demonstrated non-inferiority to "gold standard" exposure-based treatment. IPT had (non-significantly) lower attrition and higher response than PE. Contradicting a near clinical dogma, PTSD treatment may not require cognitive behavioral exposure to trauma

reminders. As differential therapeutics, patients with comorbid MDD may fare better in IPT than PE.

NO. 5 FORTY YEARS OF INTERPERSONAL PSYCHOTHERAPY

Speaker: Paula Ravitz, M.D.

SUMMARY:

OBJECTIVE: The first controlled Interpersonal Psychotherapy (IPT; Weissman, Markowitz, & Klerman, 2007) study for depression was published 40 years ago, and since then, new applications of the model have emerged, informed and driven by research and public health needs. This 40-year review and historiography synthesizes an overview of peer-reviewed published research on the outcomes, applications, processes, evolution and dissemination of IPT.

METHODS: Using a systematic step-wise review methodology, the authors identified all English language papers in the research databases of Web of Science, Embase, Medline and Psych Info. These included RCTs, controlled studies, pilot studies, outcome and process research, protocols, adaptations, reviews, overviews, discussion papers, editorials, and case reports. We examined trends over time within the larger contexts of major social, mental health, and psychotherapeutic theoretical developments.

RESULTS: The number of IPT publications has increased exponentially since its genesis establishing the effectiveness of this treatment model. This presentation will review the 40-year history of IPT and include discussion of implications for future developments and dissemination.

UNDERSTANDING BORDERLINE PERSONALITY DISORDER (BPD): THIRTY-FIVE YEARS OF PROGRESS THROUGH EMPIRICAL RESEARCH

Chairs: Kenneth R. Silk, M.D., Perry Hoffman, Ph.D.

Discussant: John G. Gunderson, M.D.

EDUCATIONAL OBJECTIVE:

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

course of borderline personality disorder is much more positive than thought 35 years ago; 2) Appreciate that there are a number of empirically supported effective psychotherapies for the treatment of borderline personality disorder; 3) Have increased knowledge of factors that increase the risk of suicidal behavior in borderline personality disorder; 4) Understand how to limit excessive pharmacologic treatment and polypharmacy in the treatment of these patients.

SUMMARY:

Borderline Personality Disorder (BPD) remains poorly understood by many mental health professionals. Pre-conceived notions about diagnosis, treatment, management, and course of this often thought of as perplexing disorder abound and contribute to marginal treatment and stigma while newer and more promising data are often not known by many clinicians. The National Education Association for Borderline Personality Disorder (NEA.BPD), a not-for-profit non-commercial organization, has provided information primarily to consumers since 2001. NEA.BPD is currently developing brief on-line tutorials presented by experts in BPD to familiarize treatment providers with the most current information about BPD. This symposium presents five segments that will be placed on the NEA.BPD website while informing the audience of the advances in diagnosis, treatment, management, and course of this disorder over the past 25 years. (1) Dr. Paris introduces the symposium and presents an overview of BPD. (2) Dr. Black reviews the different RCT-supported effective psychosocial treatments. (3) Dr. Silk presents an overview of psychopharmacologic interventions. (4) Dr. Soloff presents issues related to the identification and management of suicide risk, and (5) Dr. Zanarini discusses the course of the disorder. (6) Dr. Gunderson is the discussant. In sum this symposium presents not only a broad overview of BPD but also will ask the audience via an online link to provide NEA.BPD feedback as to the relevance of these presentations as appropriate web resources. Via expanded availability of updated knowledge of BPD, providers hopefully may view the disorder in a more positive light while utilizing the management and intervention strategies that have been shown currently to be most effective in BPD.

NO. 1

BASIC FACTS ABOUT BPD

Speaker: Joel Paris, M.D.

SUMMARY:

To set the stage, we review facts about Borderline Personality Disorder (BPD). (1) Diagnosis: BPD is characterized by emotional dysregulation (also called affective instability), a wide range of impulsive behaviors, highly unstable interpersonal relationships, as well as some micropsychotic symptoms. Some of its most characteristic features are chronic suicidality and self-harm. BPD can be differentiated from major depression and bipolar disorders by its symptoms as well as its early onset and later chronicity. (2) Prevalence: BPD is common in clinical practice. Epidemiological studies suggest a community prevalence of at least 1% (higher if one defines BPD more broadly). (3) Etiology: The causes of BPD are complex; many are still unknown. BPD seems to develop from a set of heritable temperamental variations, amplified by psychosocial stressors, most particularly childhood adversities. (4) Course: BPD often has childhood precursors. Its first clinical presentation is commonly in adolescence. It usually creates most problems in young adulthood, but often improves by age 30-40. By middle age most cases no longer meet diagnostic criteria, so prognosis is fairly good. Although 10% will commit suicide, the vast majority choose to go on living. (5) Treatment: BPD has a reputation as a therapeutic challenge, but a large body of research reveals that specialized forms of psychotherapy are often effective. In contrast, psychopharmacological interventions have limited value.

NO. 2

THE LONG-TERM COURSE OF BPD

Speaker: Mary C. Zanarini, Ed.D.

SUMMARY:

Many clinicians still believe that borderline personality disorder (BPD) is a chronic condition with a poor symptomatic prognosis. In the 1990s, NIMH funded two prospective studies of the long-term course of BPD—the McLean Study of Adult Development (MSAD) and the Collaborative Longitudinal Personality Disorders Study (CLPS). Both of these studies have found that BPD has a good prognosis

symptomatically. More specifically, remissions are very common and likely to be sustained in nature and thus, recurrences are relatively rare. These studies have also found that suicide is substantially less common than predicted by the results of four large-scale, follow-back studies conducted in the 1980s. Areas with a more guarded prognosis for some borderline patients are psychosocial functioning and physical health.

NO. 3 LONGITUDINAL PERSPECTIVES ON SUICIDAL BEHAVIOR IN BPD

Speaker: Paul H. Soloff, M.D.

SUMMARY:

BPD is defined, in part, by recurrent suicidal and self-injurious behaviors. For a large majority of patients, these symptoms remit over time; however, 3%-10% die by suicide. Acute stressors such as adverse life events, depression, and substance use precipitate attempts in BPD, while vulnerability factors such as impulsivity, negative affectivity, and poor psychosocial function increase suicide risk across many years. No risk factors are specific to BPD; however, some are closely related to core borderline pathology (e.g. childhood abuse, affective instability, impulsive-aggression.) Predictors change over time. Acute stressors such as MDD are predictive in the short term, while poor psychosocial function predicts attempts over many years. Some risk factors are modifiable, others not. (e.g. A biologic diathesis to suicide is suggested by family history, and biomarkers associated with suicidal behavior.) For some attempters, lethality increases with recurrent attempts, and is associated with illness severity and poor psychosocial function. High lethality attempts and suicide, are associated with older age, illness severity, prior attempts, impulsive-aggression (e.g. co-morbid ASPD), greater intent to die, and low SES. Current treatments focus on acute stressors and self-injurious behaviors for short term relief. Focusing treatment efforts on social and vocational rehabilitation may offer longer term benefit

NO. 4 PHARMACOLOGIC TREATMENT OF BPD

Speaker: Kenneth R. Silk, M.D.

SUMMARY:

While we have multiple evidence based psychotherapies for BPD, we have meager evidence for pharmacologic effectiveness in BPD. While the APA Guidelines (2001) put a heavy emphasis on treatment with SSRIs, more recent studies suggest that use of antipsychotic medication and mood stabilizers probably have a larger role (with a stronger data base) in pharmacologic treatment than do the SSRIs. Nonetheless, this shift in the classes of medications prescribed has taken place with very little supporting evidence. Guidelines from the APA, from the UK, and from New Zealand and Australia uniformly agree that medication treatment is ancillary to psychotherapeutic treatment, yet they cannot agree upon which, if any, medication or medication class should be used in this ancillary capacity. Empirical studies of specific medications in BPD suffer from small numbers of subjects studied, and across study disagreements as to (a) target outcomes, (b) measures to quantify specific outcomes, and (c) which specific medication to study as representative of a medication class. Meta-analyses and systematic reviews come to different conclusions even when they are essentially reviewing the same studies. This lack of specificity can lead to polypharmacy and confusion in the mind of the treating physician as to how to guide and manage the pharmacological treatment in these patients. Recommendations as to how to prescribe more rationally to patients with BPD will be put forth.

NO. 5 EVIDENCE-BASED PSYCHOTHERAPIES FOR TREATMENT IN BPD

Speaker: Donald Black, M.D.

SUMMARY:

A broad range of psychotherapies has been developed for the treatment of borderline personality disorder (BPD), including individual and group treatment programs. In the past 25 years many of these treatments have garnered empirical support. The data are consistent in showing that patients who engage in one of these programs have measureable improvements in mood, impulsiveness, and symptoms specific to BPD such as mood dysregulation, cognitive problems (e.g., overvalued ideas, depersonalization, and nonpsychotic paranoia), identity issues, and

disturbed relationships. With some programs, improvements include reductions in some health care utilization measures, and suicidal acts and self-harm. The best known program is dialectical behavior therapy; other programs include mentalization therapy, cognitive behavioral therapy, schema-focused therapy, transference-focused psychotherapy, Systems Training for Emotional Predictability and Problem Solving, and general psychiatric management. Each program has a role in the treatment armamentarium for BPD, although research provides little guidance about which program is best suited to a particular patient. The presenter will compare and contrast the programs, including the empirical data base supportive of each program. Barriers to their implementation will be discussed including cost, training, and maintaining fidelity to the model. Treatment guidelines will be reviewed including the NICE and Cochrane reviews.

PSYCHIATRIC CARE IN ADOLESCENT OBESITY: INTEGRATED APPROACHES TO CHALLENGING TRANSITIONS AND ONGOING PSYCHOSOCIAL STRESSORS

Chairs: Sanjeev Sockalingam, M.D., Marlene Taube-Schiff, Ph.D.

Discussant: Sanjeev Sockalingam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe psychosocial and emotional stressors often observed in adolescents experiencing chronic obesity and the impact of these stressors on their overall well-being.; 2) Identify developmental and behavioural issues that arise for young adults at the time of care transition from a paediatric to adult healthcare setting and how these issues impact transfer of care.; 3) Describe transition initiatives that can be implemented in order to aid transfer of care for obese adolescents who are receiving interventions for obesity management.

SUMMARY:

The World Health Organization has declared obesity a global epidemic. The rates of obesity among youth (15-25 years) have risen over the last 3-4 decades. Research has shown that youth experience greater difficulty coping with medication compliance, making lifestyle changes, and adhering to healthy living

practices compared to other age groups. Such reduced self-care is linked with significant physical and mental health complications and, therefore, researchers and providers are highlighting the need for increased attention to this patient population. Currently, there is a paucity of research to inform clinicians of best practice for youth when they turn 18 years old and approach transition of obesity management from pediatric to adult health care settings. Adolescents with chronic medical illnesses have been evaluated regarding perceptions of the transition process. Common requests include: meeting the adult team prior to transfer; increased availability of evening and/or weekend appointments; and opportunities to meet youth with similar medical issues. However, psychiatric and psychological care of young adults has not traditionally attended to transition needs. This symposium will focus on the implementation of programs of care for adolescents/young adults within two different obesity management programs – the Toronto Western Hospital, Bariatric Surgery Program (TWH-BSP) in Toronto, Canada and the Karolinska Institutet (KI), Adolescent Obesity Treatment Program, in Stockholm, Sweden. Dr. Erik Hemmingsson will present data on the psychosocial and emotional stressors within their youth population and share recently published findings on how these factors interact to trigger weight gain and obesity, through such mechanisms as stress, inflammation and reduced metabolism. A holistic treatment approach for adolescents/young adults will be suggested. Dr. Marlene Taube-Schiff will review behavioural and adherence issues in young adults and the impact of psychosocial and development factors on the transfer of care process. Dr. Marlene Taube-Schiff will also present the transition program developed at the TWH-BSP and share preliminary data on transition experiences of bariatric patients that have transferred their care from a pediatric setting. Ms. Kastanais will provide summarize the impact of behavioural and medication adherence issues for young adults when transfer of care occurs. This will be drawn from the chronic medical disease literature and placed in the context of risks for bariatric surgery patients. Dr. Reynisdottir will conclude with an overview of the KI program and share experiences of treating obese adolescents and the transition towards bariatric surgical interventions. She will also present data

regarding psychiatric comorbidities from their cohort of obese adolescents. Dr. Sanjeev Sockalingam will facilitate and moderate case discussions that will be used to generate discussion and to apply symposium context to real world scenarios.

**NO. 1
IMPACT OF BEHAVIORAL AND
MEDICATION ADHERENCE ISSUES FOR
OBESE YOUTH TRANSFERRED TO AN
ADULT-CENTERED BARIATRIC
SURGERY CENTER**

Speaker: Patti Kastanias, M.Sc., R.N.

SUMMARY:

For the treatment of obesity, bariatric surgery is currently the only treatment recommendation for sustained weight loss in individuals with previously unsuccessful weight loss attempts. With the exponential increase in childhood and youth obesity rates worldwide, morbidity and mortality risk from comorbid conditions such as diabetes, hypertension, metabolic syndrome and sleep apnea are also on the rise. At the same time, research has shown that youth experience greater difficulty with behavioural and medication adherence compared to other age groups. At the time of transfer of care to an adult-centered facility, this difficulty is heightened. What is the psychological and medical impact of non-adherence to treatment? Literature from other chronic medical conditions (e.g. cystic fibrosis, HIV, organ transplant, congenital heart disease and sickle cell disease) reports serious health risks associated with this including depression, disease progression, organ rejection, increased health care utilization, use of "unnecessary" and more potent and/or toxic drugs, and, ultimately, failure of treatment. This talk will look at this evidence as a context for examining risks for obese youth transferred to our Bariatric Surgery Center of Excellence for follow-up care and/or bariatric surgery.

**NO. 2
CHALLENGING TREATMENT DECISIONS
IN PRESENCE OF PSYCHOSOCIAL
STRESS AND PSYCHIATRIC
COMORBIDITY: EXPERIENCES FROM A
YOUTH-CENTERED OBESITY PROGRAM**

Speaker: Signy Reynisdottir, M.D., Ph.D.

SUMMARY:

Adolescents are particularly challenging in terms of obesity treatment. Pediatric programs are increasingly targeting the whole family, an approach that rarely suits the adolescent, who is also unlikely to be sufficiently mature for structured adult care, which generally results in poor adherence and unsatisfactory treatment outcomes. We describe here an adolescent-tailored obesity treatment program that aims to facilitate transition and meet the specific needs of 16-25 year-olds. Data from the first five years of running the specialized adolescent program reveal a high proportion of psychiatric illness (>40%) and psychosocial stress among patients, low treatment adherence, and unsatisfactory treatment results. Bariatric surgery can therefore be an important treatment option provided there is comprehensive pre- and postoperative care from a multidisciplinary team including psychiatric and psychological support. The optimal timing of surgical intervention will be discussed, particularly the balance between the patient's maturity and psychosocial situation, against the possible gains in health and quality of life.

**NO. 3
BEHAVIORAL AND ADHERENCE ISSUES
IN YOUNG ADULTS: CHALLENGES FOR
ADULT HEALTH CARE PROVIDERS:
DEVELOPMENT OF TRANSITION
PROGRAMS IN OBESITY MANAGEMENT**

Speaker: Marlene Taube-Schiff, Ph.D.

SUMMARY:

Youth experience several changes in terms of physical and psychological development. These changes often result in greater difficulty coping with medication compliance, making lifestyle changes, and adhering to healthy living practices compared to other age groups. Such reduced self-care is linked with significant physical and mental health complications. Importantly, eighteen years old is the time of transfer from pediatric to adult healthcare settings. Research has found that a variety of transition initiatives are helpful to implement to support this transfer their care, however, little research has been done with respect to transition issues and obesity management. In this presentation, Dr. Marlene Taube-Schiff will

review up-to-date literature on the challenges experienced by adult health care providers during transfer of care. She will outline the implementation of a transition program at the TWH-BSP highlighting both challenges encountered and lessons learned. In addition, preliminary qualitative data will be presented illustrating patient experiences that have transferred their care from our partner pediatric program as well as the experiences of young adults that initiate obesity management within our adult healthcare setting. We will describe similarities and differences between these two populations in the context of development issues and a chronic medical illness model.

NO. 4 THE PROMINENT ROLE OF PSYCHOSOCIAL AND EMOTIONAL DISTRESS IN OBESITY DEVELOPMENT AND THE NEED FOR A HOLISTIC TREATMENT APPROACH

Speaker: Erik Hemmingsson, Ph.D.

SUMMARY:

Given the robust association between low socioeconomic status and obesity, combined with new insights into how socioeconomic disadvantage adversely affects psychosocial and emotional factors, stress, inflammation and metabolism, a new causal model of weight gain and obesity is proposed. At particular risk are children growing up in a disharmonious family environment, mainly caused by parental socioeconomic disadvantage, where they are exposed to parental frustrations, relationship discord, a lack of support and cohesion, negative belief systems, unmet emotional needs, and general insecurity. Without adequate resilience, such experiences increase the risk of psychological and emotional distress, including low self-esteem and self-worth, negative emotions, negative self-belief, powerlessness, depression, anxiety, insecurity, and a heightened sensitivity to stress. These inner disturbances eventually cause a psychoemotional overload, triggering a cascade of weight gain-inducing effects including maladaptive coping strategies such as eating to suppress negative emotions, chronic stress, appetite up-regulation, low-grade inflammation, and possibly reduced basal metabolism. Over time, this causes obesity, circular causality and further weight gain. The high presence of these

psychosocial and emotional distress factors in people with obesity present a very clear challenge for clinicians, and emphasizes the need for a holistic treatment approach, especially in adolescents.

BETRAYED BY THE BODY: PTSD IN MEDICAL POPULATIONS

Chair: Gary Rodin, M.D.

Discussant: Gary Rodin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the causes of posttraumatic stress disorders in medical populations.; 2) Be aware of the clinical manifestations of posttraumatic stress disorders in patients with medical illness and injury.; 3) Gain knowledge of prevention and treatment of acute stress disorder and PTSD in medical populations.; 4) Recognize the impact of posttraumatic stress disorders on physical health and mortality.

SUMMARY:

The onset of a life-threatening medical illness may be one of the most common and distressing events that humans face, although its immediate impact has been much less studied than that associated with other traumatic circumstances. Such trauma has unique and typical characteristics, including that it arises from within the body, rather than from outside it, that it may be chronic and repetitive, and that it may be initiated by the delivery of bad news by a health care provider. Complications or progression of the disease may also trigger the onset or recurrence of traumatic stress symptoms, as may the sometimes terrifying experience of the medical treatment or its side-effects. In some cases, posttraumatic stress disorder (PTSD) antedates or contributes to the onset of the medical illness and to its comorbidity with traumatic stress disorders. Intervention studies in such populations have only recently been initiated, although the predictable occurrence of traumatic stress symptoms in medically ill populations provides a unique opportunity for preventive and therapeutic interventions to prevent or alleviate these symptoms.

This symposium will present new research findings regarding the biological, psychological, and social risk factors and the clinical

manifestations of traumatic stress in medically ill and injured populations. These include adults diagnosed with acute leukemia, medically ill patients who have survived treatment in an intensive care unit, and children who have suffered from burns and other injuries. New research findings will also be presented from another high risk population demonstrating the impact of PTSD on physical health, as well as on the risk of physical injury, suicide or homicide. These findings highlight the urgent need to intervene to prevent and treat traumatic stress in medical and other high risk populations. The implications of these findings for medical education and health care delivery and for the integration of psychiatric care and psychotherapeutic interventions in medical settings will be considered.

**NO. 1
THE TRAUMA FROM WITHIN:
PREDICTORS, PREVALENCE, AND
PALLIATION OF TRAUMATIC STRESS
SYMPTOMS IN ACUTE LEUKEMIA**

Speaker: Peter Fitzgerald, M.D.

SUMMARY:

The diagnosis of acute leukemia (AL) is a life-altering event that dramatically imposes the threat of physical suffering and mortality due to the illness and intensive treatment. Affected patients describe feeling abducted by this disease, taken out of their ordinary lives into an urgent hospitalization with an uncertain outcome. We have shown that clinically significant traumatic stress symptoms occur in 1/3 of newly diagnosed AL patients, and persist in approximately 20%. This prevalence is higher than that reported after major physical trauma and is associated in AL with physical distress, less satisfaction with communication with medical caregivers, lower perceived social support, and less attachment security. Further, the traumatic stress associated with AL may be less likely than that following discrete trauma to resolve spontaneously due to the ongoing and repetitive nature of the stressors. The predictable nature of the traumatic stress in AL and its adverse effects requires that preventive and therapeutic interventions be instituted. We therefore developed an Emotion and Symptom-focused intervention (EAS) that is tailored to address the psychological and physical distress associated with the diagnosis and treatment of

AL. Data will be presented from a randomized controlled trial of EAS that is now underway.

**NO. 2
POSTTRAUMATIC STRESS
PHENOMENA IN CRITICAL
ILLNESS/INTENSIVE CARE SURVIVORS**

Speaker: Oscar J. Bienvenu, M.D., Ph.D.

SUMMARY:

As more patients are surviving critical illnesses, the focus has shifted to long-term sequelae. Survivors often have substantial posttraumatic stress disorder (PTSD) phenomena, as well as other anxiety and depressive phenomena, cognitive impairment, and weakness. Results from recent systematic reviews and meta-analyses suggest that at least 20% of critical illness survivors have clinically significant PTSD symptoms or meet diagnostic criteria for PTSD. Intensive care unit (ICU) benzodiazepine doses and post-ICU memories of frightening delirious experiences have been associated with post-ICU PTSD, though causal mechanisms are unclear. Conversely, results from several studies suggest that stress doses of corticosteroids in-ICU may prevent PTSD. Investigators in a number of controlled studies have shown that an effective prevention and early intervention tool is an ICU diary. ICU diaries are written by clinicians (especially nurses) and family members to help patients fill in memory gaps with authentic autobiographical information; they are written in non-clinical language and may include photographs. Diaries appear to help patients process bewildering and frightening experiences, though the mechanism explaining their efficacy remains unclear. The growing population of critical illness/intensive care survivors deserves our attention.

**NO. 3
A COMPLEX SYSTEMS APPROACH TO
IDENTIFY RISK FACTORS FOR PTSD IN
CHILDREN WITH INJURIES AND BURNS**

Speaker: Glenn Saxe, M.D.

SUMMARY:

Background: This presentation applies a novel computational approach to identify risk factors for PTSD in children with burns and other injuries. PTSD emerges and is sustained within a complex system of variables that span molecular, cellular, neurologic, developmental,

and social levels of organization. Complete understandings will require knowledge about the properties of the complex system in which PTSD is embedded; and about the causal relations between the variables that constitute the system's components. We detail a computational approach to enable both causal and complex systems-level inference in a unified analysis. Methods: Our validation study was conducted with a data set on risk factors for PTSD in 163 injured children. Using the framework of local causal graph and Markov Boundary algorithms, the possible causal association between each pair of variables was examined and a Causal Network, produced. The Causal Network was examined for its adaptive properties, and searched for variables that disproportionately contributed to these properties. Results: An adaptive causal network of 110 variables and 166 bivariate relations was identified. The variables that most contributed to its adaptive properties were CRHR1 gene, FKPB5 gene, age, socioeconomic status, and acute anxiety. Modeling the removal of these variables dramatically diminished its adaptive properties.

NO. 4 PTSD RELATED HEALTH RISKS AND MORTALITY AMONG VIETNAM VETERANS

Speaker: Charles R. Marmar, M.D.

SUMMARY:

Data will be presented from a two wave (1986-88 and 2011-13) 40 year longitudinal study of adverse health and mortality risks associated with warzone PTSD in a nationally representative study of Vietnam veterans. Among veterans living today warzone PTSD was associated with increased rates of cardiovascular, neurological, genitourinary and musculoskeletal diseases. Between the first wave (average age early forties) and the second (average age mid sixties) we estimated 1,324,930 deaths occurred. The leading causes of death were neoplasms (30.0%; 95% CI: 21.6%–38.4) and heart disease (18.5%; 95% CI: 11.4%–25.6). Injuries/poisoning and communicable diseases accounted for 10.3% (95% CI: 1.3%–19.3) and 6.1% (95% CI: 1.4%–10.8) of population deaths, respectively. PTSD at the time of the first wave was associated with a doubling of risk of death, after

controlling for demographic variables (HR = 2.25; 95% CI: 1.29%–3.92). After adjusting for demographics PTSD at the time of the first wave was strongly associated with external causes of death (i.e., injuries, poisoning, suicide, and homicide) adjustments for demographics (HR = 14.36; 95% CI: 3.13%–65.79) and cancer related deaths (HR = 2.98; 95% CI: 1.41%–6.30), but surprisingly not with deaths from heart disease.

LGBT AND DIFFERENCES OF SEX DEVELOPMENT PATIENT CARE COMPETENCIES: TAKING PSYCHIATRY INTO THE NEXT ERA OF SEX, SEXUALITY, AND GENDER SENSITIVE CARE

Chair: Scott F. Leibowitz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how improving competency-based medical education on gender, sex, and sexuality applies to the behavioral health needs of LGBT and DSD-affected populations.; 2) Understand the importance of specifying competencies and educational milestones on gender, sex, and sexuality in psychiatry residency training.; 3) Describe potential opportunities to integrate teaching about gender, sex, and sexuality in psychiatric training and clinical practice.; 4) Discuss the relevance of institutional climate and faculty education to developing clinical competence with gender, sex, and sexuality issues.

SUMMARY:

Psychiatry residency training has historically lacked in its inclusion of issues related to sex, sexuality, and gender. Additionally, the healthcare disparities faced by individuals whose anatomies and identities are within the societal minority in these realms are well documented. Institutional climate has been shown to significantly impact the training of future physicians with respect to these issues.

In the last sixty years, the field of psychiatry has evolved in its conceptualization of individuals with variant expressions and identities along the sex, sexuality, and gender spectra. Over several decades, the DSM has gone from initially classifying homosexuality as psychopathology, conflating gender identity and

sexual orientation, to removing homosexuality as a disorder, and then subsequently including diagnoses that pathologized individuals with gender-identity variants. More recently, the DSM5 has moved away from pathologizing the identity of these individuals, but rather captures the experience associated with these identities by changing the diagnosis from "Gender Identity Disorder" to "Gender Dysphoria." For populations who already experience societal stigma at disproportionately higher rates, it is clear why their relationship with psychiatrists—who represent a discipline that has only recently begun to depathologize all identity variants—would require extra sensitivity and trust building measures.

Competency-based medical education is a process that begins in medical school and provides a framework to support effective learning for the development of knowledge, skills, attitudes, and behaviors necessary for clinical practice. Achieving and assessing competence is a developmental process that extends into post-medical graduate education. The Association of American Medical Colleges (AAMC) created an advisory committee in 2012 to promote LGBT health equality through advancement of medical education on sex, sexuality, and gender issues. The committee has developed a set of 30 competencies specific to these populations and mapped them to the pre-existing framework of competency-based medical education. Additionally, the committee has authored a monograph that describes how to: (1) integrate these competencies into existing medical curricula; (2) promote the necessary institutional climate change across levels of experience, including faculty and administrators; and (3) assess the achievement of physician competence in these areas.

This symposium will provide an overview of the project, discuss its relevance to behavioral health, and promote understanding of integration of the competencies into psychiatry training and enhancing institutional climate. Presenters include the AAMC manager of the project, and four members of the committee. They include a senior faculty psychiatrist, junior faculty psychiatrist, junior child and adolescent psychiatrist, and a medical student entering psychiatry residency next year.

NO. 1

OVERVIEW OF THE AAMC LGBT/DSD-AFFECTED PATIENT CARE ADVISORY PROJECT AND COMPETENCIES

Speaker: Tiffani St.Cloud

SUMMARY:

The Association of American Medical Colleges is dedicated to providing our member institutions the resources they need to deliver high quality care to all patient populations. A 2005-2006 study of medical school curricula and climate conducted by the AAMC Organization of Student Representatives and AAMC Group on Student Affairs revealed that the majority of medical school students did not feel that the curricula afforded them the skills required to provide appropriate care to patients of diverse sexual orientations and gender identities. In response to this data, in 2007, the AAMC released a report on improving the medical school culture, climate, and curriculum. The objectives in this report outlined concrete steps to move academic medicine's care for and education about people of diverse sexual orientations and gender identities. In 2012 the AAMC convened the LGBT and DSD-Affected Patient Care Advisory Committee to make the recommendations in this report a reality.

In this presentation, the lead program management specialist for the Diversity Policy and Programs at the AAMC will provide an overview of: (1) the complete AAMC recommendations; (2) the committees actions to date; and (3) planned future projects

NO. 2

LGBT AND DSD-AFFECTED PATIENT CARE COMPETENCIES: RELEVANCE TO BEHAVIORAL HEALTH

Speaker: Andres F. Sciolla, M.D.

SUMMARY:

Marked increased risk for mental disorders, e.g., depressive and anxiety disorders, are among the most serious health disparities documented in LGBT individuals as compared to their heterosexual peers. The preponderance of evidence suggests that these disparities are the result of stigma at the structural (e.g., banning same-sex marriage), interpersonal (e.g., hate crimes) and intraindividual (e.g., internalized homophobia) levels. For too long, psychiatrists contributed to these disparities by pathologizing and attempting to change gender

identity/expression and sexual orientation at variance with heteronormative expectations. Prejudice cloaked in scientific language eventually gave way to organized psychiatry championing the de-pathologizing of those identities and behaviors, and the denunciation of so-called “reparative therapies”. This presentation will engage the audience in applying the Competencies to several clinical vignettes to illustrate how they can help psychiatrists and mental health practitioners provide compassionate and effective care to LGBT and DSD-affected patients and their families across the lifespan. Additionally, the presentation will integrate the well-established bio-psycho-social approach in psychiatry, as well as emerging research that is beginning to characterize resilience in the face of trauma and adversity in these groups.

**NO. 3
BRIDGING THE LGBT AND DSD-
AFFECTED PATIENT CARE
COMPETENCIES FROM MEDICAL
SCHOOL INTO PSYCHIATRY
RESIDENCY TRAINING**

Speaker: Kristen Eckstrand, M.D., Ph.D.

SUMMARY:

To reduce health disparities that harm individuals who may be LGBT and/or born with DSD, a comprehensive educational approach is necessary. With respect to LGBT and DSD-affected communities, medical education serves to (a) increase healthcare professionals’ awareness and knowledge of health risk and resiliency, (b) train students to provide high-quality, patient-centered care, and (c) inspire students to be advocates for the health of patients.

While the competencies released by the AAMC LGBT and DSD-Affected Patient Care Advisory Committee target undergraduate medical education (UME), their structure utilizes the framework of the Accreditation Council for Graduate Medical Education (ACGME). Rigorous assessment of these competencies in the UME setting can provide direction and motivation for continuous learning and improvement. Further, these competencies set a high bar for medical students and, based on current research on the knowledge, skills, and attitudes of medical students, GME will be

essential for trainees to master the competencies necessary to provide comprehensive and sensitive medical care to LGBT and DSD-affected patients. By discussing the competencies and using developmental milestones across the learning trajectory, this session discusses how the AAMC competencies can be extended and applied to Psychiatry residency training.

**NO. 4
INTEGRATING THE COMPETENCIES BY
MODALITY: GUIDANCE FOR
COLLABORATIVE EFFORTS AMONG
RESIDENTS, FACULTY, AND
ADMINISTRATORS**

Speaker: Scott F. Leibowitz, M.D.

SUMMARY:

Competency based medical education begins in the undergraduate medical education setting, however mastering the competencies often extends into residency training. For psychiatry residents, understanding the behavioral health needs of LGBT, gender nonconforming, and/or DSD-affected individuals is markedly important considering many of the health disparities they face fall in the psychiatric domain. Faculty and administrators are also key players in ensuring that educational modalities sufficiently address issues related to gender, sex development, and sexuality.

Integrating the competencies in graduate medical education does not require a massive reorganization of training curricula. Many of the competencies require universal changes to all patient-physician interactions that should be addressed during pre-existing training activities. Other competencies may require the psychiatrist to have specific knowledge or display specific practices related to sex anatomy, sexuality, and gender that might require the inclusion of a case-based learning activity or specific seminar on these issues. This talk will discuss the integration of these competencies into the education of psychiatry trainees and faculty alike.

**NO. 5
ENHANCING INSTITUTIONAL CLIMATE
AND ASSESSMENT TO PROMOTE SEX,
SEXUALITY, AND GENDER
COMPETENCE**

Speaker: Brian Hurley, M.B.A., M.D.

SUMMARY:

Curricula focused on lesbian gay bisexual and transgender (LGBT) and differences of sex development (DSD) content are taught in institutional climates with varying degrees of student, faculty, and staff diversity, implicit biases and stigmas, and cultural strengths that shape the hidden curriculum experienced by learners. Hidden curriculum is the set of implicit norms, values, and regulations within the process of training that the students are expected to assume and embrace in order to function effectively in a professional role, and can include both undesirable cultural attitudes as well as positive and affirming attributes. There are no validated instruments assessing the entirety of a school's climate and hidden curriculum, but proxy measures examining institutional efforts on education, establishment of policies against mistreatment, promotion of equality, and cultivating a welcoming patient care environment are useful for this purpose. Existing curricular databases, various AAMC surveys, and the Human Rights Campaign Foundation's Healthcare Equality Index can serve as proxy measures of an institution's climate. Enhancing institutional climate and strengthening the hidden curriculum requires interventions guided by ongoing assessments, and is a critical endeavor that supports effective implementation of LGBT and DSD-related curricula.

FROM NEURON TO NEIGHBORHOOD: AN UPDATE ON CONTEMPORARY MODELS FOR DISEASE PATHOGENESIS, CLINICAL CHARACTERIZATION, AND TREATMENT OF BIPOLAR DISORDER

Chairs: Roger S. McIntyre, M.D., Natalie L. Rasgon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To provide an accessible, coherent, comprehensive, and clinically relevant understanding of prevailing pathogenetic models in bipolar disorder; 2) stratification in bipolar disorder .

SUMMARY:

During the past two decades substantial progress has been made in our understanding

of the pathophysiology and pathogenesis of bipolar disorder. Moreover, bipolar disorder has been fundamentally reconceptualised as a neuroprogressive disorder that pursues a developmental trajectory. Efforts are underway to stage bipolar disorder and identify biomarkers/biosignatures that can assist in patient stratification with the ultimate goal of personalize and precision management. Contemporaneous with the foregoing efforts has been refinement in the phenomenology of bipolar disorder with a particular emphasis on domain-specific psychopathology and a better appreciation of age, gender, cultural and social influences. Scientific development in bipolar disorder are providing a platform for novel approaches to treating and modifying the course of bipolar disorder.

This collection of presentations will provide the participants with an update on contemporary models of disease pathogenesis, the implications of refining and measuring domain specific psychopathology e.g. cognitive impairment, agitation, mixed/anxiety specifier, the influence of gender and metabolic comorbidity e.g. diabetes obesity. The presentations are not only intended to be synthetic of extant scientific data but are also intended to be clinically relevant underscoring the importance of considering gender influences, measurement based care, identifying and modifying traditional and emerging risk factors for diabetes and obesity and the implications of medical comorbidity management in altering the trajectory of bipolar disorder

NO. 1 BRIDGING THE RESEARCH DOMAIN CRITERIA TO BIPOLAR DISORDER: UNDERSTANDING THE ROLE OF INFLAMMATION/METABOLISM IN NEUROCIRCUIT ASYNCHRONY

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Bipolar Disorder is a severe brain disorder associated with alterations in neurocircuits that sub serves emotional processing, emotional regulation, and reward behaviour. Alterations in the structure, function, reciprocity and chemical composition of implicated neurocircuits represent a convergent final pathway of risk and resiliency factors. Available evidence suggests

To discuss new insights regarding the phenomenology and implications

that alterations in immunoinflammatory and metabolic processes are positive, and consequential of altered neurocircuits. This presentation will provide an accessible understanding of the contemporary pathogenetic model in bipolar disorder and underscore implications for new drug discovery and clinical practice, the implications of medical comorbidity e.g. obesity on brain neurocircuits will also be reviewed.

Learning Objectives: To review contemporary pathogenetic models in bipolar disorder, 2) to discuss the implications of inflammatory and metabolic, and oxidative factors in the staging of bipolar disorder and its management.

NO. 2 INSULIN RESISTANCE OR TYPE 2 DIABETES MELLITUS: MODIFIABLE RISK FACTORS FOR BRAIN ALTERATIONS IN BIPOLAR DISORDERS

Speaker: Tomas Hajek, D.Phil., Psy.D.

SUMMARY:

Type 2 diabetes mellitus (T2DM) damages the brain and frequently co-occurs with bipolar disorders (BD). Studying patients with both T2DM and BD could help identify preventable risk factors for neuroimaging changes in BD. We Acquired magnetic resonance imaging and spectroscopy from 33 BD subjects with impaired glucose metabolism (19 with insulin resistance/glucose intolerance (IR/GI), 14 with T2DM), 15 euglycemic BD participants and 11 euglycemic, nonpsychiatric controls. The BD patients with IR, GI or T2DM had significantly lower NAA, creatine levels and hippocampal volumes than the euglycemic BD participants or euglycemic, nonpsychiatric controls ($F(3,55)=4.57$, $p=0.006$; $F(3,55)=2.92$, $p=0.04$, corrected $p<0.02$ respectively). The NAA correlated with Global Assessment of Functioning ($r(46)=0.28$, $p=0.05$). Age was significantly more negatively associated with hippocampal volumes in BD subjects with IR/GI/T2DM than in the euglycemic BD participants ($F(2, 44)=9.96$, $p=0.0003$). This is the first study demonstrating that T2DM or even prediabetes may be risk factors for brain alterations in BD. These findings raise the possibility that improving diabetes care among BD subjects and intervening already at the level of prediabetes could slow brain aging in BD. This could also prove beneficial for impaired

psychosocial functioning, which was associated with some of the neuroimaging alterations.

NO. 3 IRRITABILITY, ANXIETY, AND MIXED DEPRESSION IN BIPOLAR DISORDER

Speaker: Terence A. Ketter, M.D.

SUMMARY:

Irritability is a core criterion for acute hypo/mania but also commonly occurs in acute MDEs. Consequently, DSM-5 considered irritability an "overlapping" symptom of mood elevation and depression, and (along w/ psychomotor agitation and distractibility) not counting towards the 3 "non-overlapping" mood elevation symptoms needed for mixed depression (MDE w/ mixed features). BD outpatients were assessed w/ the STEP-BD Affective Disorders Evaluation. Prevalence and clinical correlates of baseline irritability and mixed depression were assessed. Among 501 patients w/ BDI or BDII, 301 (60%) had any baseline current irritability, and those w/ compared to w/o any current irritability had significantly higher rates of any current anxiety 77% vs. 43%, depression 64% vs. 38%, and mood elevation 45% vs. 17% as well as Hx of anxiety disorder 75% vs. 54%. This pattern of associations of current irritability w/ current anxiety and Hx of anxiety disorder was also evident in patients w/ a current MDE and patients who were currently euthymic. Among 142 patients w/ a current MDE, only approx 10% had DSM-5 (≥3 threshold-level non-overlapping mood elevation symptoms) mixed depression, whereas approx 30% had "Benazzi" (≥3 threshold-level overlapping/non-overlapping mood elevation symptoms) mixed depression. "Benazzi" mixed compared to pure depression, was associated w/ threshold-level irritability in approx 90% vs. 40%, distractibility in approx 80% vs. 30%, and psychomotor agitation in 50% vs 5%

NO. 4 DIFFERENTIAL EFFECTS OF WEIGHT VERSUS INSULIN RESISTANCE IN PATIENTS WITH DEPRESSIVE DISORDERS

Speaker: Natalie L. Rasgon, M.D., Ph.D.

SUMMARY:

Background: Major depressive disorder and DM2 share numerous pathophysiological characteristics that suggest bidirectional links between CNS and endocrine homeostasis. Patients with DM2 have a high incidence of depression, and, patients with depression are at increased risk of developing DM2 due to behaviors leading to obesity.

Methods: Subjects included men and women ages 19-71 (N=58) with a history of BP or MDD. All subjects underwent an IST, SSPG, and neurocognitive testing. Because DM2 is associated with deficits in executive functions, attention, and global functioning we postulated that changes in these domains might be seen with IR. Therefore, we tested the following cognitive measures: WASI, BVRT, WAIS, DKEFS Color-Word Test and Trail Making Test 4.

Results: Differential effects on cognition were found in relation to SSPG and BMI within age groups. Higher SSPG was associated with worse cognitive flexibility in the group <45 years higher SSPG ($t=4.24$, $p=.004$) as measured by the D-KEFS Trails 4 time score, whereas higher BMI was associated with worse estimate of global intelligence in the group >45 years ($t=-2.20$, $p=.04$).

Conclusions: The negative impact of IR in younger adults with depression raises concerns regarding the long-term impact on cognition in younger adults with IR and depression. Overweight and obesity in older adults with history of depression appear to have further negative impacts on cognition similar to deficits seen in patients with DM2.

TRAUMA AND RESILIENCE IN LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) POPULATIONS

Chairs: Laura Erickson-Schroth, M.D., Rebecca Hopkinson, M.D.

Discussant: Omar Fattal, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the reasons that LGBT people are likely to have different experiences of trauma than other populations.; 2) Identify some of the ways in which trauma manifests in psychiatric illness in LGBT populations.; 3) Suggest possible treatment modalities that take into account the unique experiences of LGBT survivors of trauma.

SUMMARY:

Numerous studies have demonstrated that lesbian, gay, bisexual, and transgender (LGBT) people are targets of discrimination and violence more often than non-LGBT people. However, their unique experiences of trauma, psychiatric outcomes, resilience factors, and possible treatment modalities are not well understood. This symposium will present data from five studies, each of which addresses one or more of these areas. A case control study through the Bellevue/NYU Program for Survivors of Torture demonstrates that LGBT survivors of torture, when compared with non-LGBT survivors of torture have younger onset of trauma, more sexual trauma, and more trauma by family members. A discussion of the dynamics of group therapy with lesbian and gay survivors of torture through the same program reveals many of the psychological consequences of trauma in this group, as well as successful treatment strategies. Members of the Lucy Wicks HIV and LGBT Psychiatry clinic at Columbia University also attempt to make meaning of the unique needs of LGBT people with trauma histories, and explore possible treatment modalities. The Columbia University LGBT Initiative presents a literature review on resilience in transgender populations. Finally, researchers at New York University present the findings in a new longitudinal study of transgender youth, suicidality, and resilience. Each of the presentations contributes to our knowledge of trauma and resilience in LGBT populations, and provides opportunities for audience members to engage with researchers in this area.

NO. 1 SUICIDE RISK AND RESILIENCY AMONG TRANS YOUTH

Speakers: John Frank, B.A., Arnold H. Grossman, Ph.D.

SUMMARY:

Among trans* youth, resilience to suicide is associated with self-esteem, personal mastery, and social support (Grossman et al., 2011). Risk factors for suicide ideation include parental abuse, discrimination and victimization related to gender identity, and exposure to violence (Grossman & Augelli, 2007; Haas et al., 2014). Thwarted belongingness and perceived burdensomeness have also been proposed as

risk factors for suicide ideation (Joiner, 2005), but have not been tested among trans* youth. The current study explored 1) the relative impact of thwarted belongingness, perceived burdensomeness, victimization, parental physical and psychological abuse, and exposure to pain on suicide ideation and 2) the relative impact of self-esteem, personal mastery, and social support from teachers, parents, classmates and a close friend on resilience to suicide among 129 trans* youth (aged 15-21) in three US cities. In a step-wise regression on suicide ideation, perceived burdensomeness and parental psychological abuse were included in the final model ($R^2 = .36$, $F(2, 105) = 29.79$ $p < .001$) from the risk factors. In a step-wise regression on resilience to suicide, self-esteem and teacher support were included from the protective factors ($R^2 = .38$, $F(2,120) = 35.93$ $p < .001$). Implications for practice and research will be discussed.

NO. 2 FORCED MIGRANTS PERSECUTED FOR PERCEIVED LGBT IDENTITY

Speakers: Rebecca Hopkinson, M.D., Eva Keatley, B.Sc.

SUMMARY:

Forced migrants are a unique population, particularly those who have endured persecution for their perceived sexual orientation or gender identity. A number of health, social service, and legal organizations dedicate significant resources towards assisting this group, yet little data exist about the specific experiences and needs of forced migrants persecuted due to perceived lesbian, gay, bisexual or transgender (LGBT) status. In the current study, data are reported regarding demographics, persecution histories, and mental health of treatment-seeking survivors of torture persecuted due to perceived LGBT identity. In order to explore how persecution and symptoms may differ for clients perceived as LGBT, clients persecuted due to perceived LGBT identity (N=35) were compared to survivors of torture from the same countries that were persecuted for other reasons, such as their religious, political or ethnic affiliations (N=35). The perceived-LGBT group had a higher incidence of sexual violence ($\bar{M} \pm 12.6$, $p < .01$), persecutions occurring during childhood ($\bar{M} \pm 4.4$, $p = .04$), persecution by family members ($\bar{M} \pm 16.6$, $p < .01$), and suicidal ideation

($\bar{M} \pm 6.63$, $p = .01$). Understanding the type of persecution experiences and how these influence mental health outcomes is an essential step towards designing and delivering effective treatments.

NO. 3 RESILIENCE IN TRANSGENDER POPULATIONS

Speakers: Laura Erickson-Schroth, M.D., Elizabeth Glaeser, B.A.

SUMMARY:

A number of studies have explored experiences of stigma and discrimination in transgender populations. A burgeoning field is also examining the ways in which resilience factors can contribute to improving the lives of transgender individuals despite the adversity they face. Studies of resilience in transgender populations have employed varied methodologies, including qualitative and quantitative analyses, online and in-person measures, and individual, as well as group, processing. Researchers have considered adverse events to include experiences of internal or external stigma, subtle or blatant discrimination, as well as simply living life as a transgender person. Outcome measures have included self-esteem, mental distress, depression, anxiety, and suicidality. Resilience factors in existing studies of transgender populations can be divided into internal and environmental factors. Some factors line up with previous research on resilience in other populations, especially lesbian, gay, and bisexual populations, and some appear to be unique to transgender communities. Further research is necessary to develop an improved understanding of resilience factors in transgender populations, especially those factors that are modifiable by health or social interventions.

NO. 4 TREATING LGBT PATIENTS WITH COMPLEX TRAUMA

Speaker: Joan E. Storey, L.C.S.W., Ph.D.

SUMMARY:

Several cases from a LGBT and HIV specialized mental health clinic at Columbia Presbyterian Hospital will be presented and discussed. Inner-city LGBT patients usually do not live in strong

LGBT affirmative neighborhoods and many report being victimized due to their gender and or sexual orientation by family, teachers, social service staff and their neighbors. Inner-city LGBT patients are affected by HIV/AIDS, substance abuse and violence (termed the SAVA Syndemic). We will focus on the ways patients intertwining experiences of stigma, internalized homophobia, and SAVA influences the course of therapy. It has been our experience that initially patients do not perceive their treatment as helpful, due to their pervasive sense that anyone they interact with could potentially harm them. They can be erratic, can "mis-hear" what is said to them, and at times may be very confrontational with the therapist and clinic staff. These reactions are viewed as expectable responses given their life experiences. If special attention is paid to developing the alliance, patients can use therapy as a catalyst for decreasing dangerous behavioral patterns and to developing healthier relationships. Lastly, we will discuss how this informs both clinic structure and the treatment modalities used with this population.

NO. 5 GROUP PSYCHOTHERAPY WITH LESBIAN AND GAY ASYLUM SEEKERS

Speakers: Melba J. Sullivan, Ph.D., Kelly J. Kleinert, M.D.

SUMMARY:

As federal and state legislation progressively protects the rights of lesbian and gay Americans, the number of lesbian and gay survivors of trauma and torture from around the world seeking refuge in the United States will increase. Given these historic shifts, it is imperative that mental health professionals provide services that address the needs of survivors of homophobic persecution. This presentation describes the development and implementation of a group treatment for lesbian and gay forced migrants in a large urban hospital. The providers'™ integrative approach to treatment draws on an understanding of the impact of traumatic experiences that begin in childhood and are perpetrated by family, community, and society across a lifetime. The group's™ goals are to facilitate safety, rebuild lives, promote adaptive coping skills, reduce symptoms, and support adjustment. Suggestions for future treatment

and research to address lesbian and gay mental health and well-being will be discussed.

NOVEL PSYCHOPHARMACOLOGICAL THERAPIES FOR PSYCHIATRIC DISORDERS: MDMA AND PSILOCYBIN

Chairs: Michael C. Mithoefer, M.D., Timothy D. Brewerton, M.D.

Discussant: Timothy D. Brewerton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand and discuss past and current research into the therapeutic use of psychedelic compounds and MDMA in psychotherapy; 2) Know and understand the history of MDMA and psilocybin in psychotherapy; 3) Evaluate the risks and benefits of MDMA-assisted and psilocybin-assisted psychotherapy; 4) Understand the scientific, social, legal and cultural context of research on MDMA-assisted and psilocybin-assisted psychotherapy.

SUMMARY:

Researchers and clinicians continue to seek means to enhance the effectiveness of psychotherapy. This can be done by promoting transformative experiences, enhancing therapeutic alliance and enhancing tolerance for emotionally intense material. Between 1943 and 1973 more than 1000 papers appeared in the scientific literature discussing the therapeutic use of the classic psychedelic compounds LSD and psilocybin; however most of this research was discontinued because of restrictive government regulations, including the designation of classic psychedelics as Schedule I compounds with no accepted medical safety and medical use. Subsequently, published case reports described use of methylenedioxymethamphetamine (MDMA) as a catalyst to psychotherapy. This use stopped in 1985 when MDMA was placed in Schedule I before any controlled trials were done. After a hiatus of over 20 years, there has been a resurgence in research with MDMA and psilocybin in Phase II clinical trials in the US and other countries. Evidence is accumulating that MDMA and psilocybin can enhance therapeutic outcomes. Healthy volunteers report increased emotional empathy and tolerance of upsetting memories after MDMA administration, and they report transformative (mystical-type)

experiences and enduring positive mood and behavior change after psilocybin. Randomized, controlled trials of MDMA-assisted psychotherapy in people with PTSD found significant reduction in symptoms lasting over 12 months. Promising preliminary data from a trial comparing three doses of MDMA in military veterans, firefighters and police officers with PTSD suggests lasting benefits from MDMA-assisted psychotherapy in this population. Research is underway on MDMA as a treatment for social anxiety in people on the autism spectrum. A randomized, double-blind trial of psilocybin in people with a life-threatening cancer diagnosis showed significant decreases in symptoms of anxiety and depression. In an open-label pilot study, psilocybin-facilitated treatment of tobacco smoking cessation resulted in success rates substantially higher than other smoking cessation therapies. Similarly, a pilot study of psilocybin-assisted treatment for alcohol dependence demonstrated clinical improvement following psilocybin administration, with the degree of improvement predicted by the self-reported intensity of the psilocybin experience. This symposium will present and discuss the methods and results of these clinical trials and provide an overview of completed and ongoing research in the US, Canada, Switzerland and Israel. These recent studies, together with historical data, clearly demonstrate that classic psychedelics and MDMA can be safely administered under appropriate medical supervision. The encouraging results of these studies provide a strong rationale for further investigation of their use as adjuncts to the psychotherapeutic process

**NO. 1
PSILOCYBIN, MYSTICAL-TYPE
EXPERIENCES, AND THE TREATMENT
OF SYMPTOMS OF ANXIETY AND
DEPRESSION IN PATIENTS WITH A
LIFE-THREATENING CANCER
DIAGNOSIS**

Speaker: Roland Griffiths, Ph.D.

SUMMARY:

Recent studies in healthy volunteers showed that psilocybin administration under supportive conditions occasioned mystical-type transformative experiences producing enduring positive changes in attitude, mood, and

behavior. A recent pilot study suggested that a moderately-low psilocybin dose reduced anxiety and depression symptoms in cancer patients. In this double-blind study, patients with a life-threatening cancer diagnosis who had symptoms of anxiety or depression received a low (1 or 3mg/70kg) or high (22 or 30mg/70kg) dose of psilocybin in counterbalanced order with 1 month between sessions. For this preliminary analysis, we compared first session results between the low (n=24) and high (n=25) dose groups. On session days, the high dose group showed substantially greater effects including perceptual changes, mystical-type subjective experiences, and labile mood. At the 4-week follow-up the high dose group showed significantly lower anxiety (STAI Trait Anxiety, HAM-A) and depression (BDI, HAM-D) compared to the low dose group. These participants attributed significantly greater positive changes in attitudes about life/self, positive social effects, and positive behavior changes to the experience, and a higher percentage reported the experience to be among the 5 most personally meaningful of their lives (56% vs. 17%). These results suggest psilocybin has efficacy in treating psychologically distressed cancer patients.

**NO. 2
PSILOCYBIN-ASSISTED TREATMENT
FOR ALCOHOL DEPENDENCE**

Speaker: Michael P. Bogenschutz, M.D.

SUMMARY:

Several lines of evidence suggest that classic hallucinogens can have clinically relevant effects in alcohol and drug addiction. We conducted a proof-of-concept study of psilocybin-assisted treatment alcohol dependence. Ten volunteers with DSM-IV alcohol dependence received 12 weekly outpatient therapy sessions as well as receiving psilocybin (0.3-0.4 mg/kg PO) in supervised medication sessions at weeks 4 and 8 (Seven participants received the second session). Subjective effects of psilocybin were qualitatively similar to those described in other populations, but varied considerably in intensity among individuals. Drinking did not decrease significantly during the first 4 weeks of psychosocial treatment, but decreased significantly during weeks 5-12 of treatment, following the first psilocybin session ($p < 0.05$). Gains were largely maintained at 24- and 36-

week follow-ups. Significant improvements in craving, self-efficacy, motivation, and consequences of drinking were also noted. The intensity of self-reported psilocybin effects during the week 4 session strongly predicted change in drinking during weeks 5-8 ($r = 0.76$ to $r = 0.89$) and also predicted decreases in craving and increases in abstinence self-efficacy during week 5. There were no significant treatment-related adverse events. These preliminary findings provide a strong rationale for controlled trials to investigate efficacy and mechanisms.

NO. 3 MDMA TREATMENT OF SOCIAL ANXIETY IN ADULTS ON THE AUTISM SPECTRUM

Speaker: Charles S. Grob, M.D.

SUMMARY:

Adults on the autism spectrum are at higher risk of psychological disorders, including social anxiety. In studies of healthy volunteers, MDMA increases prosocial behaviors and reduces distress in response to simulated social rejection and in the face of distressing memories. MDMA-assisted psychotherapy has also been demonstrated to reduce PTSD symptoms. Narratives, surveys and interviews have found increased comfort in social situations in adults on the autism spectrum after self-administration of ecstasy (material represented as MDMA). An FDA-approved double-blind, placebo-controlled research study of MDMA in 12 adult subjects on the autism spectrum with social anxiety is currently being conducted at Harbor-UCLA Medical Center and the Los Angeles BioMedical Research Institute. We hypothesize that two sessions with moderate-dose MDMA will reduce social anxiety in adult subjects on the autism spectrum, as measured by the Liebowitz Social Anxiety Scale (LSAS). Mood, perceived stress, - interpersonal reactivity and identifying emotions in others are also being assessed. Additionally, MDMA is a monoamine releaser that elevates levels of the neurohormone oxytocin. Potential mechanisms involving neurohormone secretion, including oxytocin, will be measured at baseline, during peak drug effects, and at follow-up.

NO. 4

PSILOCYBIN AS AN ADJUNCT TO TOBACCO SMOKING CESSATION TREATMENT

Speaker: Matthew W. Johnson, Ph.D.

SUMMARY:

Despite promising early findings on the therapeutic use of psychedelics in addiction treatment, rigorous follow up has not been conducted. We have conducted an open-label pilot study administering moderate (20mg/70kg) and high (30mg/70kg) doses of psilocybin within a structured 15-week treatment protocol to determine the safety and feasibility of the classic psychedelic psilocybin as an adjunct to tobacco smoking cessation treatment. Participants were 15 psychiatrically healthy nicotine-dependent smokers (10 males; mean age of 51 years), with a mean of 6 previous lifetime quit attempts, and smoking a mean of 19 cigarettes per day for a mean of 31 years. Biological indicators and self-report of recent smoking demonstrated that 12 of 15 participants (80%) showed seven-day point prevalence abstinence at 6-month follow-up. This observed smoking cessation rate substantially exceeds rates commonly reported for other behavioral and/or pharmacological therapies (typically <35%). Although the open-label design does not allow for definitive conclusions regarding the efficacy of psilocybin, these findings suggest psilocybin to be a safe and potentially efficacious adjunct to smoking cessation treatment. These results warrant renewed interest in psychedelic-facilitated treatment of addiction.

NO. 5 MDMA-ASSISTED PSYCHOTHERAPY: A PROMISING TREATMENT FOR POSTTRAUMATIC STRESS DISORDER

Speaker: Michael C. Mithoefer, M.D.

SUMMARY:

Psychopharmacology and established psychotherapeutic methods for treating posttraumatic stress disorder (PTSD) are ineffective for a significant percentage of patients. A drug that could catalyze psychotherapy in treatment resistant patients could aid in addressing this serious public health problem. The first completed Phase II clinical trial of MDMA-assisted psychotherapy in 20 subjects with treatment resistant, mostly

crime related PTSD demonstrated an 83% clinical response compared to 25% in the group receiving the same psychotherapy with inactive placebo. Neuropsychological assessment before and after treatment was unchanged in both groups. A long-term follow-up of this cohort 45 months later showed sustained benefit in at least 74% of subjects. A smaller study in Switzerland showed a similar effect size. Preliminary data from an ongoing study of MDMA-assisted psychotherapy in US military veterans, firefighters and police officers, and another ongoing US study at a separate site are producing encouraging results. Other MDMA/PTSD studies are ongoing in Canada and Israel. There have been no unexpected drug-related serious adverse events in five clinical trials. Multicenter Phase III trials are planned to further test the safety and effectiveness supported by this promising Phase II data.

FACING DEATH IN RESEARCH AND CLINICAL CARE

Chair: Alexander Moreira-Almeida, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the importance of experiences related to death for clinical practice and research; 2) Be more comfortable to investigate and to discuss experiences related to death; 3) Identify when experiences related to death are relevant to clinical care; 4) Differentiate when healthy experiences related to death from psychotic or dissociative disorders; 5) Integrate positively, during treatment, healthy experiences related to death in patients' life.

SUMMARY:

This interdisciplinary international symposium integrates philosophical, neuroimaging, epidemiological, personality, and clinical studies to discuss clinical and research approaches to experiences related to death. First, the symposium presents empirical data on how personality dimensions impacts coping with death, indicating the importance of self-transcendence in addition to self-directedness and Cooperativeness. Then, the empirical and philosophical investigations of spiritual experiences related to death performed by William James are presented as a model of rigorous and open-minded approach. The third

presentation summarizes data from recent studies investigating anomalous experiences related to the experience of the departed (mediumship). It covers the differential diagnosis between mediumship and psychotic/dissociative disorders, neurofunctional correlates, and explorations regarding the origins, the sources, of mediumistic experiences. Finally, the last speaker, discusses clinical examples to help the clinician use such reported experiences to promote healing for their patients.

NO. 1 SELF-TRANSCENDENCE AND ADAPTATION TO ULTIMATE SITUATIONS: CLINICAL AND RESEARCH FINDINGS

Speaker: C. Robert Cloninger, M.D., Ph.D.

SUMMARY:

Death is one type of situation that we are ultimately helpless to control or avoid. Ultimate situations like suffering, death, guilt, wonder, and uncertainty provoke a person to reflect on the nature and meaning of their existence and to develop in Self-transcendence [1]. For example, facing the mystery of death can lead to acceptance of the limits of intellectual knowledge, allowing open-minded scientific investigation as well as faith.

Clinically the way we approach ultimate situations can help us to develop in well-being by increasing Self-transcendence. Studies in diverse cultures show that people who are Self-transcendent as well as Self-directed and Cooperative are healthier, happier, and more fulfilled than others [2]. People who are Self-directed and Cooperative, but not Self-transcendent, may be healthy but they are less ready to cope with ultimate situations like death and suffering. They strive to cope in materialistic ways and are likely to try to deny the reality or value of anything they cannot measure objectively, control personally, or view as an extension of their self-interests. As a result, most discussions about ultimate phenomena with people who are highly resistant to a transcendent perspective elicit strong emotional responses that are not scientific (i.e., dogmatic and closed-minded).

1. Jaspers K: The Way to Wisdom: An Introduction to Philosophy. New Haven: Yale University press; 1954.

2. Cloninger CR: What makes people healthy, happy, and fulfill

NO. 2

WILLIAM JAMES AND SCIENTIFIC INVESTIGATION OF SPIRITUAL EXPERIENCES RELATED TO DEATH

Speaker: Alexandre Sech Jr., M.A.

SUMMARY:

Traditional textbooks on the history of psychiatry and psychology fail to recognize William James's empirical investigations on psychic phenomena, namely on spiritual experiences related to death, as a legitimate effort to understand the human mind. The purpose of this talk is to offer evidence of his views regarding the exploration of those phenomena as well as the radical, yet alternative, solutions that James advanced to overcome theoretical and methodological hindrances. Through an analysis of his writings, it is argued that his psychological and philosophical works converge in psychical research revealing the outline of a science of mind capable of encompassing spiritual experiences related to death as part of human experience and, therefore, subject to scientific scrutiny.

Sech Junior A, de Freitas Araujo S, Moreira-Almeida A. William James and psychical research: towards a radical science of mind. *Hist Psychiatry*. 2013 Mar;24(1):62-78.

NO. 3

ANOMALOUS EXPERIENCES RELATED TO THE EXPERIENCE OF THE DEPARTED (MEDIUMSHIP) - CLINICAL AND RESEARCH IMPLICATIONS

Speaker: Alexander Moreira-Almeida, M.D., Ph.D.

SUMMARY:

Mediumship can be defined as an experience in which an individual purports to be in communication with, or under the control of, the personality of a deceased. Mediumistic experiences are phenomena widespread throughout human history, expressed as oracles, prophets, and shamans, and being part of the Greek, Roman, and Judeo-Christian roots of Western society, as well as of Tibetan Buddhism and Hinduism. The study of mediumship is important because it has

significant implications for our understanding of the nature of the mind and for clinical care. In the 19th century, studies on mediumship phenomena were vital to the development of theories on dissociation and the subliminal mind. In the last decades, there has been a renewed interest in the study of spiritual experiences such as mediumship, mainly in their relationship with mental health. This paper will present data from recent studies investigating differential diagnosis between mediumship and psychotic/dissociative disorders, neurofunctional correlates, and explorations regarding the origins, the sources, of mediumistic experiences. Evidence indicates that most mediumistic experience is not pathological, and may even be related to better mental health, have specific patterns of brain activation and suggest non-reductionist views of mind.

Moreira-Almeida, A. Research on mediumship and the Mind-brain relationship. In: Moreira-Almeida & Santana Santos (Org.). *Exploring Frontiers of the Mind-Brain Relationship*. Springer, 2012.

NO. 4

HELPING THE CLINICIAN BE PREPARED FOR ANOMALOUS EXPERIENCES DURING TREATMENT OF TRAUMATIC LOSS

Speaker: James Lomax, M.D.

SUMMARY:

Post death experience of "communications" from the lost other are common in bereavement (Sormanti, 1997), but management of these events is not a routine part of the education of mental health professionals. While not well studied, post death communications seem even more common after traumatic loss. One form of such communication Theriomorphism (experiencing human or divine spirit in animal form) has historically been incorporated into many religious traditions but at the current time is rarely spoken about in Western cultures. The presentation will include clinical examples and a brief conceptual framework to help the clinician use such reported experiences to promote healing at vulnerable times for their patients.

Sormanti M, Aug J : Parental Bereavement : Spiritual Connections with Deceased Children. *Amm J Orthopsychiatry* 1997;6; 460-469

THE MENTAL HEALTH AND FAITH COMMUNITY PARTNERSHIP: WHERE SHOULD WE GO FROM HERE?

Chair: John R. Peteet, M.D.

Discussant: Annelle Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand ways to more effectively address mental health needs within religious communities through collaboration between mental health and spiritual care providers; 2) recognize effective ways to educate clinicians about the place of spiritual resources in the recovery of their patients; 3) identify opportunities at the local and national level to implement lessons learned from a diversity of models of cooperation.

SUMMARY:

Many individuals with emotional struggles turn first to clergy, only to feel stigmatized by psychiatric conditions. Conversely, many individuals in mental health treatment search for spiritual answers to existential concerns in areas such as identity, hope, meaning, forgiveness and connection. Recognizing the longstanding divisions between mental health and spiritual care providers, last year in Washington, DC the APA leadership convened a broadly representative Steering Committee for an unprecedented Mental Health and Faith Community Partnership. Its principal aims were to establish an ongoing dialogue between psychiatrists and clergy leaders of faith communities; and to identify or develop resources which can equip mental health and faith communities to deal better with their shared concerns. Building on this and subsequent discussions at the 2014 IPS annual meeting, this session explores how insights gained from diverse sources communities can inform the best practices which that will have sustained impact. The first presenter Abraham Nussbaum will describe Walking Together, the first meeting of which recruited an interdisciplinary roster of presenters to describe historical instances of care for the mentally ill by Christian communities and to help contemporary communities of particular faith to consider their responsibilities for walking with the mentally ill. Nancy Kehoe, a clinical psychologist and Catholic nun, will describe a variety of ways she has used to educate mental

health professionals about the clinical relevance of faith in practice. Psychiatrist Alan Fung will describe lessons learned from working at the faith/mental health interface in the Asian community in Toronto, as well as discuss potential implications of the Mental Health and Faith Community Partnership for Canada and the training of mental health and spiritual care professionals. Tatiana Falcone, a child and adolescent psychiatrist at the Cleveland Clinic who has been active in research in ways to reduce stigma among minority communities and has helped educate local clergy on mental health issues will discuss the implications of her work at both levels. Finally, Craig Rennebohm, who has pioneered a national interfaith mental health ministry organization will discuss the challenges of enlisting psychiatry as an ally in the spiritual and religious life, the emerging network of interfaith mental health collaborations, and what is at the core of the dialogue between psychiatrists and clergy. Discussant Annelle Primm will review the role of the APA in supporting practical next steps in this important initiative.

NO. 1 THE WALKING TOGETHER CONFERENCE AND INITIATIVE

Speaker: Abraham M. Nussbaum, M.D.

SUMMARY:

Faith communities are often on the front line in supporting people with mental illness, and people with mental illness are present in every faith community. The presence in, and treatment of, people with mental illness in faith communities has been neglected in the literature. The Walking Together initiative engaged an audience of mental health practitioners, clergy and faith leaders, laypeople, theologians, church historians, people with mental illness, and social sector leaders to discuss particular instances in which Christian faith communities do (and do not) care for persons with mental illness. We recruited an interdisciplinary roster of presenters to describe and critically engage particular instances of care of the mentally ill in Christian history. They engaged topics as various as fifteenth-century Spanish priest Joan-Gilabert JofrÃ©'s founding of the first psychiatric hospital; the centuries-old practice of sheltering mentally ill pilgrims in Geel, Belgium; the founding of the Mennonite Mental Health Services in postwar America; and

contemporary efforts to address the high rates of depression among African-American pastors. Walking Together fosters conversations about the care of persons with mental illness by encouraging particular communities to consider their responsibilities to persons with mental illness and to imagine new ways to walk with them.

NO. 2 PSYCHIATRY AND THE EXPLORATION OF FAITH

Speaker: Nancy Kehoe, Ph.D.

SUMMARY:

During the Age of Enlightenment the disciplines of philosophy, medicine and religion diverged. Philosophers have since generally tended to the mind, doctors to the body and religious professionals to the soul. Within psychiatry, Freud's view of religion as a defense or as a symptom of a deeper disorder has consciously or unconsciously reinforced the idea that faith should be ignored or analyzed in relation to the patient's pathology. Recently, however, appreciation has grown for the need to consider human beings more holistically, including the role of their beliefs and practices in treatment either as resources important to their healing, or as sources of internal conflict.

This presentation considers a variety of ways to help psychiatrists explore a person's belief system and to collaborate with religious professionals in order to treat patients more holistically. These include sharing information about the experience of individuals with major mental illness in spirituality groups, demonstrating spiritually sensitive interviews, writing for lay and professional audiences, and using Youtube videos.

NO. 3 MENTAL HEALTH AND FAITH COMMUNITY PARTNERSHIP: AN ASIAN CANADIAN PERSPECTIVE

Speaker: Wai Lun Alan Fung, M.D., Sc.D.

SUMMARY:

The presenter will discuss his perspective on the Mental Health and Faith Community Partnership as a Chinese Canadian and to date, the only Steering Committee member from outside the United States. He will describe his professional endeavors in the interface between

spirituality/religion and psychiatry in Canada including those for the general population as a whole (e.g. the Toronto Mental Health and Spiritual Care Symposium, the Working Group for the Promotion of Mental Health in Faith Communities, etc.), as well as those specifically for the East/Southeast Asian communities in Canada utilizing an Interprofessional Collaborations & Education (IPC/IPE) framework. Moreover, he will discuss potential initiatives in this interface to be launched in Canada, inspired by the APA Mental Health and Faith Community Partnership. Furthermore, he will briefly explore some potential implications of this partnership for addressing the educational needs of both mental health and spiritual care professionals in training.

NO. 4 PROJECT COPE- AN INNOVATIVE STRATEGY ENGAGING THE CLERGY TO IMPROVE MENTAL HEALTH IN THE COMMUNITY

Speaker: Tatiana Falcone, M.D.

SUMMARY:

Communities of faith are perhaps one of the first accessed by mental health patients when in need for support. Research suggests that religion and spirituality have an important healing effect for patients and families. During 3 years Project COPE, aimed to engage the community to do psychoeducation about mental health issues for patients and families. A coalition between mental health providers, patients, family, advocacy organizations (NAMI) and different churches was created to engage the community in the 4 session psychoeducation seminars, 48 classes was given, and 24 of them were in local churches. Each one of the members of the coalition participated in some training to improve their knowledge of mental health. The priest and pastors in the church encouraged their members to participate in the mental health screening and seminar, 2200 mental health screenings were done in 3 years. Historically important barriers and stigma have driven the faith community and psychiatry apart, in the last ten years important steps have been taken to breach this barriers. The faith leaders are frequently in position to offer substantial help to individuals with acute mental health needs, Clergy is frequently positioned in a gatekeeper

role that can be very helpful breaking stigma and bringing patients support. The collaboration proved to be very effective at the local level, to engage the community.

NO. 5 PSYCHIATRY AS A RESOURCE IN FAITH COMMUNITIES

Speaker: William C. Rennebohm, D.Min.

SUMMARY:

Spirituality has been located in the field of psychiatry through APA working groups, residency curricula, research and the continued revision of the DSM. The Pathways National Training Initiative has organized a parallel effort, introducing the concerns and resources of psychiatry to clergy and congregations through a growing network of local multi-faith mental health training collaboratives. The core curriculum focuses on the role of clergy in providing spiritual care with individuals facing a psychiatric illness, the role of congregations as centers of mental health education and the service of congregational members as "companions," supportive of recovery. Examples from St. Louis, Chicago, Denver and Los Angeles illustrate the range of cooperation and shared care fostered by the training collaborative model. A twenty-five year dialogue between a chaplain and a psychiatrist in Seattle offers insight into common concerns key language and basic concepts at the heart of the Mental Health Training Collaborative (MHTC) model.

YOUTH INTERRUPTED: ALCOHOL USE DISORDERS AND ADOLESCENTS

Chair: Robert Huebner, Ph.D.

Discussant: Aaron White, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the unique vulnerabilities of adolescents to the short- and long-term effects of alcohol; 2) Recognize the signs of alcohol use disorders in adolescents and how to screen for such disorders; 3) Identify the roles that alcohol plays in sexual assaults involving adolescents .

SUMMARY:

Adolescence is a time of increased risk-taking combined with immature decision-making and

poor self-control, leading to high rates of morbidity and mortality. Alcohol and other drug use commonly begins during adolescence at a time when the frontal lobes, charged with decision making and impulse control, are still developing. Excessive drinking during the teen years can lead to both short- and long-term consequences. Acute consumption contributes to sexual assaults, overdoses, injuries and death. The earlier one starts drinking the greater the odds of developing an alcohol use disorder down the road. The heightened vulnerability of adolescents to the deleterious effects of alcohol pose difficult challenges for those in the treatment and prevention fields. Much remains unknown regarding the reasons for the increased susceptibility of adolescents to alcohol-related harms, how to detect alcohol problems in this age group and what to do about it. This symposium will cover a spectrum of issues relevant to adolescent alcohol use. Andrey Ryabinin will discuss translational findings on the effects of social isolation on alcohol consumption in mice with an eye toward helping attendees understand the contributions of socialization to alcohol consumption in adolescent animals. Marisa Silveri will present data on the neurochemistry involved in the developmental effects of binge alcohol consumption during adolescence. Sharon Levy will discuss brief interventions in adolescents and demonstrate the use of an NIAAA youth alcohol screening tool that can be incorporated into outpatient psychiatry care. Sandra Brown will discuss ways in which insights from adolescent neurocognitive and social development can inform effective interventions for dissuading or reducing alcohol use among youth. Finally, Antonia Abbey will explore the roles that alcohol plays in sexual assaults involving college students. Collectively, these presentations will help attendees understand the state of the knowledge regarding the impact of alcohol, both short- and long-term, on adolescents and their brains.

NO. 1 MODELING EFFECTS OF SOCIAL ISOLATION ON ALCOHOL DRINKING IN ADOLESCENT MICE

Speaker: Andrey Ryabinin, Ph.D.

SUMMARY:

Social isolation is often accompanied by increased alcohol use among adolescents. To investigate whether such isolation predicts increased alcohol consumption we modeled effects of social isolation in adolescent mice. Males and females of four strains of mice known to differ in affiliative behaviors were tested using a 2-bottle choice procedure with ascending concentrations of saccharine (S) - sweetened ethanol (E). Isolate-housed (IH) mice consumed more E+S than socially housed (SH) mice, and this effect of isolation persisted in a majority of the groups when the bottles were switched to 10E-only. This effect demonstrated E-specificity, as the E+S only group regulated their voluntary drinking differently than the S-only group. Subsequent circadian analysis of drinking patterns revealed that SH and IH mice exhibited similar rates of this behavior during their peak time of consumption. However, IH mice exhibited higher levels of consummatory behaviors further into the dark phase, exhibiting a pronounced bout of 10E+0.2S drinking ~8.5h into the dark phase. Collectively our results demonstrate that social isolation increases voluntary E+S drinking in adolescent mice and that this effect of social housing is attributable to aberrant temporal drinking patterns in IH mice that may model alcohol consumption in alcohol-addicted socially-isolated adolescents. Supported by: NIH Grants AA019793, AA10760 and MH096475

**NO. 2
ADOLESCENCE AND EMERGING
ADULTHOOD: DEVELOPMENT, GABA &
ALCOHOL USE**

Speaker: Marisa Silveri, Ph.D.

SUMMARY:

Advanced neuroimaging techniques are providing important opportunities to non-invasively characterize the development of the adolescent brain. In particular, studies utilizing magnetic resonance (MR) technologies have helped identify important neurobiological milestones in brain development that, when examined in the context of cognitive and emotional maturation, ultimately allow for the successful navigation of the second decade of life. The frontal lobe is the last region of the brain to undergo major remodeling, a process that occurs late in adolescence and extends into the early twenties, or emerging adulthood.

Frontal lobe refinement, including maturation of the gamma-amino-butyric-acid (GABA) inhibitory neural system, permits necessary developmental improvements in cognitive control and reduced impulsivity. To this end, neurochemical developmental changes and alterations associated with binge alcohol consumption within the critical period of adolescence may confer heightened vulnerability for problematic alcohol use that often accompanies this age span.

**NO. 3
ALCOHOL SCREENING AND BRIEF
INTERVENTION: USING THE NIAAA
YOUTH ALCOHOL SCREENING GUIDE
IN OUTPATIENT PSYCHIATRY**

Speaker: Sharon Levy, M.P.H., Ph.D.

SUMMARY:

Teens with mental health disorders are more likely to use alcohol and develop substance use disorders than their peers. Outpatient psychiatry care is a logical place to screen and administer brief alcohol interventions to prevent, delay or decrease use. In order to do so effectively clinicians need efficient tools and effective intervention strategies for adolescents at varying risk levels. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has developed an empirically-derived alcohol screening tool and clinician guide to meet these needs. The objectives of this presentation are 1) to briefly review the literature on adolescent brief intervention, 2) demonstrate the use of the NIAAA youth alcohol screening tool and 3) to demonstrate practical brief interventions that can be incorporated into outpatient psychiatry care.

**NO. 4
USING DEVELOPMENT TO INFORM
ADOLESCENT ALCOHOL
INTERVENTION**

Speaker: Sandra Brown, Ph.D.

SUMMARY:

This presentation focuses on core developmental and alcohol involvement transitions of adolescents. Fundamentally, social, neurological and neurocognitive development during adolescence create a framework from which to evaluate the etiology, progression, impact and remission of heavy

alcohol involvement. Long term use trajectories from youth exhibiting alcohol problems will be used to articulate alcohol and drug impact in key areas of functioning and describe common challenges youth face as well as avenues of their success. These empirical findings have given direction to new developmentally informed approaches to early intervention. One such model of early intervention, currently being tested in three cities, will be presented along with intervention process analyses relevant to treatment design, implementation and dissemination. These findings will be used to demonstrate how neurocognitive and social factors can inform effective addiction interventions for youth.

**NO. 5
ALCOHOL'S ROLE IN SEXUAL ASSAULT
ON COLLEGE CAMPUSES: WHAT IS
THE EVIDENCE AND WHAT RESEARCH
IS STILL NEEDED?**

Speaker: Antonia Abbey, Ph.D.

SUMMARY:

Numerous studies have documented high rates of sexual assault on college campuses. This presentation reviews the findings from experimental and survey research that examines alcohol consumption as a risk factor for perpetration and victimization. The findings are described within the context of a theoretical model that takes into account pharmacological and psychological mechanisms. Gaps in our current knowledge and next steps in the NIAAA research agenda for alcohol and sexual assault are identified.

**ADVANCES IN THERAPEUTIC
INTERVENTIONS IN GERIATRIC
PSYCHIATRY**

Chair: Helen Lavretsky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about recent advances in the treatment of geriatric unipolar depression; 2) Gain knowledge on approaches that may help overcome some of the challenges in managing care for older people with bipolar disorder; 3) Be aware of: recent trials on drug and nondrug interventions for Alzheimer's disease and recent successes in treating neuropsychiatric symptoms in dementia; 4)

Understand the efficacy of novel neuromodulation techniques in geriatric psychiatry; 5) Have a better understanding of medical complexity as a key correlate of health outcomes among older people with mood disorders.

SUMMARY:

The elderly are the fastest growing segment of the global population with the number of people age 60 or older having doubled since 1980 and the number of people age 80 or older expected to increase more than 4-fold (to 395 million) by the year 2050.

This symposium on the recent Advances in Therapeutic Interventions in Geriatric Psychiatry will provide an in-depth discussion of recent therapeutic advances in the treatment of geriatric mood disorders and dementing illnesses using pharmacological, neuromodulation, lifestyle and psychosocial interventions. Current approaches to diagnosing and treating major late-life mental disorders will be discussed and include late-life unipolar depression, bipolar disorders, cognitive decline and Alzheimer's disease, and dementia with behavioral disturbances. The role of comorbid medical and cognitive conditions in treatment response will be discussed. The basic mechanisms and biomarkers of treatment response in late-life neuropsychiatric disorders will be discussed. The Symposium will target broad audience of clinicians, researchers and trainees at various levels of training in psychiatry. Participants will gain familiarity with the applications of translational neuroscience research and understand the effect of aging on treatment response in late-life neuropsychiatric disorders.

**NO. 1
LATE-LIFE BIPOLAR DISORDER:
EMERGING RESEARCH AND
COMPLEXITIES OF CARE**

Speaker: Martha Sajatovic, M.D.

SUMMARY:

Despite growing number of older adults with bipolar disorder, until recently, research on treatments for older adults with bipolar disorder (BD) has received little attention. Older adults are especially likely to experience adverse drug effects as a result of their multiple chronic diseases, use of multiple concomitant

medications, and the pharmacokinetic and pharmacodynamic changes that accompany aging. The complex medical comorbidity seen in BD elders supports the notion that BD is a multi-system and progressive disorder.

Lithium, anticonvulsant compounds and atypical antipsychotic medications are effective and widely utilized pharmacologic treatments in mixed age populations with BD. However, data specific to geriatric BD populations is quite limited. There is considerable controversy regarding usefulness and tolerability of lithium in older adults, although a multi-site study funded by the NIMH compared use of lithium vs. divalproex sodium in geriatric Type I BD mania. Secondary analyses from controlled clinical trials have suggested a beneficial role for the novel anticonvulsant lamotrigine in later-life BD, and preliminary data encourage use of select atypical antipsychotic drugs. Tolerability concerns with foundational treatments for geriatric patients with BD differ from younger populations, and drug titration and targeted maximum doses are likely to require modification. Epidemiologic and prospective treatment trials are needed to validate the available data.

NO. 2 THOUGHTS, TRIALS AND TRIBULATIONS: AN UPDATE ON TREATMENT OF DEMENTIA

Speaker: Krista L. Lanctot, Ph.D.

SUMMARY:

Treatment of major neurocognitive disorders (NCD) such as Alzheimer's disease (AD) is an active area of research. Recent treatment trials for AD have targeted amyloid-beta peptide (A β) in brain tissues and hyperphosphorylation of microtubule-associated Tau protein in neurons in an effort to discover agents with disease-modifying effects. To date, no interventions have shown efficacy and safety in AD. Lifestyle interventions such as exercise and cognitive training and interventions based on noninvasive stimulation techniques such as repetitive transcranial stimulation (rTMS) and transcranial direct current stimulation (tDCS), have also been explored. Two trials for of neuropsychiatric symptoms (NPS) have provided preliminary evidence suggesting efficacy in those with AD. The CitAD trial, which evaluated citalopram for agitation in patients

with AD, found the addition of citalopram compared with placebo in those receiving a psychosocial intervention significantly reduced agitation and caregiver distress. The ADMET trial found the addition of methylphenidate compared with placebo in those receiving a psychosocial interventions decreased apathy. While no disease modifying effects have not been demonstrated in AD, there is hope that earlier intervention may modify disease progression. Modification of amyloid-related cascades are now being considered as possible interventions in the prodrome. Despite challenges, earlier interventions are likely to impact these diseases.

NO. 3 NEUROMODULATION IN THE TREATMENT OF GERIATRIC PSYCHIATRIC DISORDERS

Speaker: William M. McDonald, M.D.

SUMMARY:

Geriatric patients are often refractory to pharmacological treatments for mood disorders and dementia. Electroconvulsive therapy (ECT) is clearly effective in late life depression and new research demonstrates that ECT is effective in dementia with severe agitation. Novel treatments such as magnetic stimulation therapy (MST) have the potential to provide benefits comparable to ECT without the risks of cognitive problems and could be particularly beneficial in the elderly. Transcranial magnetic stimulation (TMS) has also has demonstrated efficacy in depression and has few cognitive side effects. TMS has the potential to provide effective treatment for depression without the risks associated with anesthesia and ECT related cognitive problems. Other novel neuromodulation techniques including transcranial direct current stimulation and deep brain stimulation may also have important applications in geriatric psychiatry.

NO. 4 ADVANCES IN THE TREATMENT OF LATE LIFE UNIPOLAR DEPRESSION.

Speaker: Helen Lavretsky, M.D.

SUMMARY:

Nearly two-thirds of elderly patients treated for depression fail to achieve symptomatic remission and functional recovery with first-line

pharmacotherapy. New strategies are needed to improve clinical outcomes of geriatric depression. In this presentation, the results of the recent trials involving combination and augmentation treatment strategies to improve clinical outcomes of late life unipolar depression will be reviewed, including the use of atypical antipsychotics, stimulants, cognitive enhancers and cognitive remediation techniques, psychotherapies, as well as lifestyle interventions such as exercise, and the use of the complementary and alternative medicine techniques like Tai Chi, meditation, and yoga, herbal and nutritional supplements.

EVIDENCE-BASED SPECIALTY TREATMENTS FOR OBSESSIVE COMPULSIVE DISORDER (OCD) AND RELATED DISORDERS: UPDATES AND ISSUES ON DISSEMINATION OF EXPERTISE

Chair: Debbie Sookman, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify evidence-based pharmacotherapy for OCD and Related Disorders; ; 2) Identify evidence-based specialty cognitive behavior therapy for OCD and Related Disorders; 3) Recognize the need and proposed strategies for dissemination of specialty expertise with OCD and Related Disorders.

SUMMARY:

Obsessive Compulsive Disorder (OCD) and Related Disorders are a group of highly disabling conditions classified together in DSM-5. These disorders are associated with substantial distress, psychosocial dysfunction, and high burden to families and society. A significant difficulty in this field is that although evidence-based treatments are available these are not accessible to many sufferers, contributing to chronicity of illness, intransigence of symptoms, and high but often ineffective health care utilization. Related disorders include Body Dysmorphic Disorder (BDD), Trichotillomania, Excoriation Disorder, and Hoarding Disorder. Evidence-based treatment for these psychiatric disorders is a specialized field. The presenters will discuss specialty treatments and also address issues related to dissemination of expertise. Dr. Katharine Phillips will summarize DSM-5

classification rationale and treatment implications. Dr. Phillips will then discuss efficacious cognitive-behavioral and pharmacotherapy approaches tailored to BDD's unique symptoms that are common but often overlooked in clinical practice. Treatment approaches to foster engagement and to improve insight as well as strategies for highly suicidal patients will be described. Dr. Debbie Sookman will discuss specialized cognitive behavior therapy (CBT) for heterogeneous OCD subtype characteristics such as phenomenology and appraisal of thoughts, intolerance of distress (e.g., anxiety, uncertainty, sense of incompleteness), risk aversion, and cognitive and behavioral rituals. Specific protocols designed to improve collaboration, to enhance learning, and to promote resilience during cognitive therapy, behavioral experiments, and exposure and response prevention for OCD will be described and illustrated. Dr. Naomi Fineberg will present current pharmacotherapy for OCD, augmenting strategies, and somatic treatments for severe and enduring cases. Dr. Fineberg will discuss reasons response to first line CBT or pharmacotherapy may produce only partial response, strategies to protect against relapse, and the need for highly specialized services for OCD and related disorders. Dr. Peggy Richter will outline indications for and limitations of pharmacotherapy for Trichotillomania, Excoriation Disorder, and Hoarding Disorder. Specifically adapted CBT approaches for these disorders will be described with discussion of rationale for delivery by clinicians with disorder specific expertise. The presenters will propose strategies for dissemination of specialty expertise in this field. Substantial time will be allocated to discussion among the presenters and with the audience.

NO. 1 UPDATE ON PHARMACOTHERAPY AND COGNITIVE BEHAVIORAL THERAPY FOR BODY DYSMORPHIC DISORDER (BDD)

Speaker: Katharine A. Phillips, M.D.

SUMMARY:

Dr. Katharine Phillips, who chaired the DSM-5 Workgroup on Obsessive-Compulsive Spectrum Disorders, will first briefly summarize the classification of Obsessive-Compulsive and

Related Disorders in DSM-5, the rationale for the addition of this new chapter to DSM-5, and treatment implications. She will then focus on evidence-based treatment of BDD. Individuals with BDD typically have poor or absent insight (believing that they really do look ugly or deformed), and thus many patients are reluctant to accept psychiatric treatment; instead, many receive cosmetic treatment (such as surgery or dermatologic treatment), which appears to be ineffective in virtually all cases. Thus, it is important to use approaches such as psycho-education and motivational interviewing, and to establish a good therapeutic alliance, to engage patients in treatment. Dr. Phillips will discuss these approaches. She will then review efficacious pharmacologic treatments for BDD and will also present recently analyzed data from the first relapse-prevention pharmacotherapy study in BDD. She will also describe evidence-based CBT that is tailored to BDD's unique symptoms, which she and her colleagues developed. Strategies for more highly suicidal patients with BDD will also be described.

**NO. 2
SPECIALTY COGNITIVE BEHAVIOR
THERAPY FOR OCD**

Speaker: Debbie Sookman, Ph.D.

SUMMARY:

Dr. Debbie Sookman will discuss updates in evidence based specialized cognitive behavior therapy (CBT) for heterogeneous OCD subtype characteristics. These include phenomenology and appraisal of thoughts, intolerance of distress (e.g., anxiety, uncertainty, sense of threat or incompleteness), risk aversion, and cognitive and behavioral rituals. Specific protocols designed to improve collaboration, to enhance learning, and to promote resilience during cognitive therapy, behavioral experiments, and exposure and response prevention for OCD will be described and illustrated. The goal of specialty treatments for OCD is sustained symptom remission and normalized psychosocial functioning and quality of life for as many patients as possible. Strategies for intervention and patient-related factors that may be related to treatment resistance will be described. Processes to optimize dissemination of specialty expertise will be discussed.

**NO. 3
OPTIMIZING PHARMACOTHERAPY FOR
OCD: NEW TREATMENTS AND
SERVICES**

Speaker: Naomi A. Fineberg, M.B.B.S.

SUMMARY:

OCD, as encountered in the psychiatry clinic, tends to pursue a chronic relapsing course. Moreover, first line treatment with CBT or SSRI usually only produces a partial response and more effective treatment strategies are sought. For treatment-responders, long-term treatment is known to protect against relapse and is often required. Combining SSRI with CBT or with adjunctive low dose antipsychotic represent two potentially effective methods for SSRI-resistant disorder. Novel pharmacological compounds with potential efficacy in OCD are under investigation, including drugs acting to modulate glutamate neurotransmission. Cognitive remediation therapy may improve cognitive flexibility and enhance treatment-outcomes. Highly Specialized Services are helpful for the most severe and enduring cases. For these individuals, experimental somatic treatments involving neuro-modulation or ablative neurosurgery may also be considered. Treatments and services will be discussed.

**NO. 4
TREATING THE OCD-RELATED
DISORDERS: THE NEED FOR SPECIFIC
DISORDER-BASED STRATEGIES**

Speaker: Margaret A. Richter, M.D.

SUMMARY:

With the advent of DSM-5, there is increasing recognition of the need for effective treatment for the OCD-Related Disorders. These disorders, comprising Hoarding Disorder (HD), Trichotillomania (TTM), Excoriation Disorder (EC), and Body Dysmorphic Disorder (BDD), were previously seen as relatively rare, and in some cases did not have established diagnostic criteria, limiting research into clinically effective treatment. There has been a tendency for clinicians to assume that these disorders can be treated with medications or cognitive-behavioral strategies developed for OCD, however available data suggests that distinct modifications are needed to achieve optimal outcomes. In this presentation, pharmacological and psychological treatment

will be reviewed for HD, TTM and EC. This will be followed by a synthesis and evidence-based recommendations for disorder-specific drug treatment. As pharmacotherapy typically results in more limited gains than can be achieved with CBT for these conditions, emphasis will be on CBT. Protocols have been developed for TTM /EC, focusing on habit reversal (i.e. awareness training, behavioral analysis, competing response) with cognitive restructuring, while for HD core elements include targeting of acquiring, discarding, hoarding beliefs, and development of organizational strategies. Last there will be some discussion of strategies for specific problems encountered in treatment with these discrete populations.

TREATING PSYCHIATRIC DISORDERS DURING PREGNANCY

Chair: Donna Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Treat unipolar depression in pregnant women using up to the date evidence for safety and efficacy; 2) Treat bipolar disorder in pregnant women using up to the date evidence for safety and efficacy ; 3) Treat schizophrenia in pregnant women using up to date evidence for safety and efficacy; 4) Treat substance abuse in pregnant women using up to date evidence for safety and efficacy.

SUMMARY:

Psychiatric disorders can occur during pregnancy leading to questions about optimal treatment that is safe for the mother and her fetus. Frequent publications on this topic sometimes leave both pregnant women and their health care providers confused and sometimes alarmed due to contradictory findings. This symposium will provide the latest evidence-based guidance on the optimal management of unipolar depression (Dr Stewart), bipolar disorder (Dr Rondon), schizophrenia (Dr Vigod) and substance abuse (DR Buckley) during pregnancy. Both pharmacologic and nonpharmacologic treatments will be discussed by some of the leading experts in this field.

NO. 1

THE TREATMENT OF UNIPOLAR DEPRESSION DURING PREGNANCY

Speaker: Donna Stewart, M.D.

SUMMARY:

Unipolar depression during pregnancy is a common and treatable mental disorder that affects more than 12% of pregnant women. Treatment may include evidence-based psychotherapy, antidepressant medication, a combination of both or ECT. It is important to remember that untreated depression itself can cause maternal and fetal morbidity, so nontreatment is not without risk. Data from randomized controlled trials of psychotherapies and antidepressants during pregnancy are very limited but observational data of mothers and newborns suggest that evidence-based psychotherapies, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, many tricyclic antidepressants and ECT are relatively safe. This presentation will review the evidence for efficacy and safety of the major treatments of depression during pregnancy and conclude with clinical guidance for best practice in view of the current, and rapidly changing, evidence.

NO. 2

MANAGEMENT OF WOMEN WITH BIPOLAR DISORDER DURING PREGNANCY

Speaker: Marta B. Rondon, M.D.

SUMMARY:

This presentation will offer evidence-based guidelines for treatment of bipolar disorder (BD) during pregnancy. The known risk of teratogenicity and perinatal complications resulting from common mood stabilizing agents (lithium, carbamazepine and valproate) will be discussed. The relative risk of a bipolar episode is uncertain but discontinuation of medication increases the risk of relapse postpartum. Bipolar episodes during pregnancy increase the risk of obstetric complications, preterm birth and small for gestational age (SGA) infants. Continued use of lithium during pregnancy helps to reduce relapse, and recommencing it immediately after delivery reduces recurrences. Although lithium carries a small risk of cardiac teratogenicity, other anticonvulsants, cause more teratogenicity and neonatal problems. Conventional nonsedative antipsychotics are relatively safe and useful when mood stabilizers are discontinued. There is limited information on

newer antipsychotics. Antidepressants may cause SGA infants, teratogenicity and neonatal toxicity, including persistent neonatal pulmonary hypertension, but using them during pregnancy may decrease the risk of a depressive episode. Clinicians should present current evidence and negotiate with the patient and her family the management of symptoms, considering their reproductive wishes, and balancing the risks of medication and the consequences of having a recurrent episode.

NO. 3 WOMEN WITH SCHIZOPHRENIA DURING PREGNANCY AND POSTPARTUM

Speaker: Simone Vigod, M.D.

SUMMARY:

About 50% of women with schizophrenia become mothers, and birth rates have increased in recent years with advent of newer fertility-sparing antipsychotic medications and shift from institutionalization to community-based care. Unfortunately, women with schizophrenia are uniquely vulnerable during pregnancy and postpartum. Biological and psychosocial shifts occur during pregnancy and with childbirth that may worsen illness/trigger relapse. Social and economic resource disadvantages may also impact on mental health and parenting ability. Women with schizophrenia also demonstrate significant resilience as mothers. With appropriate supports, many women have successful parenting experiences. Population-based research from our group has focused on pregnancy outcomes among women with schizophrenia, including the impact of antipsychotic drug treatment on both maternal and fetal health. During this presentation, we will discuss: (1) Trends in birth rates among women with schizophrenia between 1996 and 2009; (2) Challenges faced by women with schizophrenia and their families during pregnancy and postpartum; (3) Evidence for health care interventions whose goal is to support women with schizophrenia and their families during pregnancy and postpartum; and (4) Benefits, harms and current treatment recommendations for antipsychotic drug treatment in pregnancy and lactation.

NO. 4

TREATING SUBSTANCE USE DISORDERS DURING PREGNANCY AND POSTPARTUM

Speaker: Leslie Buckley, M.D., M.P.H.

SUMMARY:

Although there is clear evidence for teratogenic effects, the use of substances during pregnancy remains prevalent in the population. In addition to being the most common preventable cause of intellectual developmental disorder, substance use during pregnancy is also associated with uterine growth problems, obstetrical complications, neonatal withdrawal syndromes and other long-term developmental effects. Optimal detection and treatment of substance use issues in pregnant women requires a comprehensive and non-judgmental approach. Informing women of the impact of substance use on the developing fetus is of utmost importance and screening tools which are specific for pregnant women can be used. Improvement in maternal and fetal outcomes is possible through supporting and treating women unable to abstain from harmful use. It is essential to understand the underlying dynamics involved for each woman and provide appropriate intervention available to assist her in achieving her treatment goals. Health care is sometimes linked with child protective services, a relationship that can at times add a layer of complexity to substance use treatment. During this presentation we will discuss: epidemiology of substance use in pregnancy; neonatal consequences of in-utero exposure; and screening and treatment interventions for substance use in pregnancy.

POSITIVE PSYCHIATRY ACROSS THE LIFESPAN

Chairs: Dilip V. Jeste, M.D., Samantha Boardman, M.D., M.Psy.

Discussant: Richard F. Summers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the characteristics of positive psychosocial traits such as resilience, optimism, and social engagement across the lifespan; 2) Learn the application of psychotherapeutic interventions in regular clinical practice that focus on enhancing patients'™ well-being; 3) Use

techniques to teach the concepts of Positive Psychiatry to trainees and colleagues.

SUMMARY:

Psychiatry is typically defined as a branch of medicine focused on diagnosis and treatment of mental illnesses. This conceptualization needs to be expanded to include understanding and promoting well-being through assessment and interventions involving positive psychosocial attributes in people who suffer from or are at high risk of developing mental or physical illnesses. These concepts incorporated in Positive Psychiatry date back at least to the beginning of the 19th century, and were popularized by the recent Positive Psychology movement; yet, they largely remain outside the mainstream psychiatry. There are four main components of Positive Psychiatry: (I) Positive mental health outcomes (e.g., well-being), (II) Positive Psycho-Social Factors (PPSFs) comprised of psychological traits (resilience and hardiness, optimism, personal mastery and coping self-efficacy, social engagement, spirituality and religiosity, and wisdom - including compassion) and environmental factors (family dynamics, social support, and other environmental determinants of general healthcare), (III) Biology of Positive Psychiatry constructs, and (IV) Positive Psychiatry Interventions including preventive ones.

This symposium will make recommendations for research, clinical practice, and training in Positive Psychiatry from childhood through late life. Empirical data will be presented to suggest that positive traits may be improved through psychosocial and behavioral interventions. As a branch of medicine, rooted in biology, clinicians and researchers are well poised to provide major contributions to the positive mental health movement, thereby impacting the overall healthcare. The speakers include experts in different arenas including child psychiatry, geriatric psychiatry, and psychology, and reflect broad experience in research, teaching, and clinical practice. They also reflect geographical diversity and include various levels of seniority from a Fellow to senior professors.

NO. 1

POSITIVE PSYCHIATRY OF LATE LIFE

Speaker: Dilip V. Jeste, M.D.

SUMMARY:

We are conducting longitudinal psycho-bio-social studies of nearly 2,000 randomly selected community-dwelling adults as well as adults with serious illnesses including schizophrenia, HIV and AIDS, and cancer. We find a paradox of aging across the board – i.e., higher well-being and better psychosocial functioning despite worsening physical health. The strongest predictors of well-being are resilience and absence of depression rather than demographics, physical health, cognitive functioning, or severity of illness. Even in a serious mental illness such as schizophrenia, happiness may be an attainable goal for a sizable proportion of patients. Strategies for promoting successful aging among people with major illnesses and disabilities will be presented. The traditional conceptualization of old age as a period of progressive decline needs to change. Aging can have a positive effect on mental as well as physical health if appropriate physical, cognitive, and psychosocial stimulation is provided.

NO. 2

POSTIVE CHILD PSYCHIATRY; APPLICATION FOR PRACTICE AND EDUCATION

Speaker: David Rettew, M.D.

SUMMARY:

Accumulating research demonstrates that most symptoms of child psychopathology exist dimensionally with no clear boundaries between wellness and illness. Furthermore, there is strong evidence that improvements in domains of wellness such as exercise, nutrition, positive parenting, and sleep can have positive benefits for youth struggling with or at risk for psychiatric disorders. Yet despite this new understanding, the incorporation of wellness and health promotion strategies in typical child psychiatry practice and education remains slow. This presentation will describe a clinical model, called the Vermont Family Based Approach, that strives to assess key aspects of wellness in families of children presenting for evaluation and then to integrate them in the overall treatment plan. Such an approach provides for a number of new pathways for improvement beyond the traditional methods of psychotherapy and medication. The teaching of these principles to the next generation of psychiatrists in medical school, residency, and

fellowship will also be outlined. The cumulative goal of these efforts is to reclaim psychiatrists as experts in true mental health rather than simply mental illness.

NO. 3 NEUROPLASTICITY OF ADULTHOOD

Speaker: Jennifer R. Gatchel, M.D., Ph.D.

SUMMARY:

One of the fundamental principles of the brain is its ability to change in response to a variety of experiences and stimuli, including not only novel experiences but also insults or injury. Moreover, the adult brain retains the capacity of structural and functional neuroplasticity throughout development and aging. Over the past several decades, our understanding of the how the brain is shaped by experience has grown rapidly. This session will provide an overview of the proposed mechanisms underlying adult neuroplasticity including both synaptic reorganization and neurogenesis. The qualitative and quantitative differences in neuroplasticity across the lifespan will be discussed. Finally, we will discuss both enhancing and attenuating factors of neuroplasticity, with a focus on how we might best harness this process in positive psychiatry.

NO. 4 POSITIVE PSYCHOTHERAPEUTIC AND BEHAVIORAL INTERVENTIONS

Speaker: Piper Meyer, Ph.D.

NO. 5 POSITIVE PSYCHIATRY IN CLINICAL PRACTICE

Speaker: Samantha Boardman, M.D., M.Psy.

SUMMARY:

Well-being and positive functioning are core elements of mental health. Research in the field of Positive Psychology enhances our understanding of the full range of human experience and how to achieve optimal functioning. Using the "tools" of positive psychology, psychiatrists can expand their range of treatment options and better engage patients in the treatment process. A more comprehensive approach to mental health that considers the illness and also the possibility of wellness that recognizes symptoms and also sees potential can be achieved by integrating

positive psychology into a psychiatrist's clinical practice.

VALUE IN MENTAL HEALTH CARE: WHAT DOES IT MEAN, AND WHO DECIDES?

Chairs: Robert P. Roca, M.D., M.P.H., Benjamin Liptzin, M.D.

Discussant: Steven Sharfstein, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) define the meaning of the concept of value as it pertains to healthcare; 2) identify various outcomes that may be used in determining the value of services; 3) discuss methods by which costs may be reduced without compromising outcomes.

SUMMARY:

The concept of "value" is increasingly part of the conversation about healthcare services. In general, value is a function of benefit and cost; the greater the benefit per unit of cost, the greater the value. And in general, the judge of value is the party that receives the goods or services, i.e., the "customer". Discussing value in healthcare is complicated by the fact that we serve different "customers", each of whom has a different take on benefit and cost. From the perspective of patients, high-value care may be that which helps them feel and function better at low out-of-pocket cost. From the perspective of the hospital or program administrator, high-value care may be that which achieves quality goals set by accrediting bodies, regulators, and payers "resulting perhaps in higher reimbursement" at low cost to the institution. From the perspective of the self-insured employer, high value care may be that which maximizes the productivity of the workforce at low cost to the employer. From the point of view of an entire society, high-value care may be that which achieves the "triple aim" of good population health and good patient experience at lowest cost to society. While this analysis is very complicated in general healthcare, it is even more complicated in mental healthcare, in part because of the complexity of defining and measuring benefit, particularly in terms of outcomes. In this symposium we will consider the meaning of value in mental healthcare from the perspectives of patients, of clinical

administrators, and of payers. We will review the state-of-the-art of outcomes measurement and other methods of evaluating benefit in mental healthcare. We will examine the potential impact of new models of reimbursement on the value proposition of psychiatric services provided in hospitals and in organized systems of care (e.g., ACO's) and what this means for psychiatrists and other mental health professionals. We will discuss approaches to lowering costs while preserving benefit – and thus enhancing value - by eliminating "non-value-added" activities. And we will hear the perspective of those whom we serve. As complicated as this discussion is, it is vital that psychiatrists understand the methods by which the value of our work is evaluated by different stakeholders so that we can engage with them to ensure that we have the right role in the changing world of mental healthcare and that our patients receive the high-value services they deserve.

NO. 1
VALUE: MEDICINE'S HOLY GRAIL?

Speaker: Robert P. Roca, M.D., M.P.H.

SUMMARY:

High-value health care – great outcomes at low cost – might be considered medicine’s – Holy Grail. But value is very difficult to measure – in medicine in general and psychiatry in particular – because of lack of consensus about outcomes, the complexity of measuring costs, and the involvement of stakeholders (patients, payers, etc) with different and potentially conflicting goals. One of the most comprehensive frameworks for value measurement in healthcare (Porter, NEJM 2010; 363) states that value – should be defined around the (patient) . . . and the creation of value for patients should determine the rewards for all other actors in the system. Yet even this impressive analysis has been criticized for failing to take into account the true needs of patients, and it does not even broach the question of how to apply this model to improving the value of mental healthcare services. This presentation will review the Porter model, consider its applicability to the services we provide to persons with mental illnesses, review the first fruits of value measurement efforts in a psychiatric health system, and consider next steps. These

efforts are vital if we are to improve the work we do with our patients and survive in the emerging world of – value-based reimbursement.

NO. 2
VALUE: PERSPECTIVES ON OUTCOMES AND COSTS

Speaker: Benjamin Liptzin, M.D.

SUMMARY:

"Value is the combination of outcomes divided by costs. In trying to put a value on outcomes there may be different perspectives from the point of view of patients, their family, their employer and their health insurer. With respect to patients outcomes can acutely result in symptom reduction, partial or full remission and then relapse or the absence of it within a 6 or 12 month period. That symptom reduction should also come with minimal or no side effects (e.g. metabolic syndrome). For the patient and/or family direct costs can include visit costs and prescription costs as well as the indirect costs of time lost from work or other meaningful activities. For an employer the treatment costs can include the costs to their health insurance plan (if self insured). Other costs may include lost productivity to the employer from missed days or "presenteeism" i.e. showing up for working but being less productive. Employers may also have costs for short- or long-term disability as well as the costs of losing a valuable employee and the costs of replacing them. A health insurer will bear the costs of short term treatment, relapses, and the costs of other associated medical conditions that may get worse in the absence of adequate treatment.

NO. 3
MEASURING OUTCOMES USING STANDARDIZED TOOLS: WHY IT'S IMPORTANT AND HOW TO DO IT

Speaker: Henry Harbin, M.D.

SUMMARY:

There is a clear need to establish the value of MHSUD (Mental Health and Substance Use Disorders) services. Given the recent expansion of funding for MHSUD treatments with the federal parity bill and the ACA, as well as funding increases in the VA and DOD, payers are asking about the cost effectiveness and

quality of all types of treatments. Several large effectiveness trials funded by NIMH (e.g., STAR-D, CATIE) demonstrated that in large scale implementations of common evidenced based treatments in real world settings, the outcomes of treatment were disappointing. Unfortunately the specialty MHSUD system only rarely measures clinical results using standardized, validated and quantitative outcome instruments like the PHQ-9, so there is no way for a third party (e.g., payer or employer) to know if there has been clinical success on an individual or population basis. This presentation will discuss how the MHSUD field can remedy this problem by setting a standard that quantifiable outcome measures should be used in all clinical settings and by providing technical assistance to providers on how best to select and use these tools. The presentation will also consider how outpatient providers can seek reimbursement for using these tools just as internists get reimbursement for tests used to track outcomes for diabetes.

NO. 4

VALUE: WHAT MATTERS TO THE PEOPLE WE TREAT?

Speaker: Dinah Miller, M.D.

SUMMARY:

Why do patients come to see psychiatrists? What are they looking for, how do they measure that, and what is it worth to them? In a system, these questions get operationalized with an assortment of rating scales, treatment plans with measurable goals, CPT codes that define value by the minute depending on what occurs in the session, and one of 259 measures of physician quality reporting for Medicare providers. From the perspective of the person receiving care, these are likely not the things that really matter. This session will address the following questions:

Why do people come for psychiatric care?

What do they value in the experience of treatment?

How do we measure whether they are receiving what they came for?

Can it be operationalized?

From the patient's perspective, does the time spent quantifying our work add to the value of treatment, or does it detract from it?

And finally, does success always mean that the patient values the treatment?

NO. 5

ELIMINATE WASTE, IMPROVE VALUE

Speaker: Sunil Khushalani, M.D.

SUMMARY:

"The eye cannot see what the mind does not know." - Anonymous.

When one learns to recognize waste, one can see that it is ubiquitous in any system. The bedrock of the Lean performance improvement methodology is the identification and elimination of waste in all processes under study. Each wasted step eliminated within a process has the potential to improve value.

Lean classifies waste into eight types. When stakeholders are sensitized to recognizing waste and taught to cultivate a mindset and skill-set to eliminate waste continuously, it has the potential to have a robust impact on the enhancement of value. This is a vital skill for practitioners and organizations to inculcate, so that they can facilitate the design of a truly patient-centered system.

How to improve value by systematically eliminating waste is illustrated through the application of Lean methodology in a large psychiatric health system. One will hear about a collaboration between two hospitals to reduce transfers of psychiatric inpatients to the ER; a project to improve the timeliness and length of discharge summaries to after care providers and lastly a project to reduce amount of and redundancy in documentation by mental health workers.

EARLY LIFE ADVERSITIES AND PHYSICIANS' RESILIENCE AND RISK FOR NEGATIVE PROFESSIONAL OUTCOMES

Chairs: Andres F. Sciolla, M.D., Alistair J.R. Finlayson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify one preventive educational tool and one screening instrument for professional boundary violations.; 2) Discuss the evidence linking childhood maltreatment and neglect to adult insecure attachment style and dysfunctional thinking patterns or beliefs.; 3) Apply information derived from the Childhood Trauma Questionnaire to the assessment and remediation of physicians referred for boundary violations.

SUMMARY:

A staggering body of research has documented a myriad of deleterious consequences of adverse childhood experiences (ACEs), including depression, anxiety, substance abuse and suicide. Studies in medical students, residents and physicians have documented a substantial increased risk for burnout, depression and suicide, as compared to the general population. Although systematic research on the prevalence of ACEs among physicians is scarce, it is possible that adverse early experiences increase the risk for negative health and professional outcomes. Aside from negative mental health outcomes, professional boundary violations represent another potential negative professional outcome stemming from ACEs, given consistent findings from studies in arenas related to the regulation of patient-physician boundaries, such as emotion and behavior regulation, empathy, and intimacy. This symposium brings together specialists from two institutions: 1) the Center for Professional Health at Vanderbilt University; and 2) the Physician Assessment and Clinical Education (PACE) Program at the University of California. These well-established programs have years of expertise in the psychological assessment and remediation of physicians with various problematic behaviors, including professional boundaries violations. Working independently until now, both groups converged on the unique role of ACEs on physicians' resilience and risk for negative health and professional outcomes. A theoretical model based on an extensive literature review will serve as an overarching, unifying theme for five individual presentations and discussions. These individual discussions include: 1) Physicians Sanctioned for Boundary Violations: Risk and Resiliency; 2) Early Childhood Maltreatment: a Risk Factor for Physician Boundary Violations?; 3) Maladaptive beliefs and insecure attachment as possible mediators between childhood maltreatment and physician professional boundary violations; 4) Comprehensive Evaluation of Physician Sexual Boundary Violators; and (5) Attachment and belief system findings in physician sexual boundary violators. Besides Q&A from the audience at the end of each presentation, the symposium will feature a highly dynamic discussion between the audience and the panel of presenters. The discussion will highlight

therapeutic and self-care strategies to promote mindful awareness, resilience and post-traumatic growth among physicians with histories of ACEs. Together, these strategies may address not only the risk for professional boundary violations, but other negative health and professional outcomes as well. Eventually, since many of those strategies do not solely target the psychological and behavioral sequelae of ACEs, these strategies should influence the undergraduate and postgraduate medical education curricula and should be promoted among all at-risk medical trainees. Moreover, to bring about sustained change, the prevailing emphasis on individual resources and resiliency

NO. 1 EARLY CHILDHOOD MALTREATMENT: A RISK FACTOR FOR PHYSICIAN BOUNDARY VIOLATIONS?

Speaker: Kai MacDonald, M.D.

SUMMARY:

Objective:

The assessment and remediation of boundary-challenged healthcare professionals is enhanced through examination of individual risk factors. One of these risk factors—also implicated in myriad other relational and psychiatric outcomes, is early childhood maltreatment. As part of a CME professional boundaries course, we assessed childhood trauma in 150 attendees (mostly physicians).

Methods:

We administered the Childhood Trauma Questionnaire (CTQ) to 150 healthcare professionals (mostly physicians) attending a CME course on professional boundaries. As part of an analysis of a smaller data set, correlations and relationships among self- and expert ratings and between different risk factors were examined.

Results:

In our smaller data set (100 participants), one-fifth of participants reported moderate to severe childhood emotional abuse; nearly half reported moderate to severe emotional neglect. Twenty-nine percent reported other adverse childhood experiences not captured by the CTQ (i.e. bullying). In the smaller data set, childhood maltreatment was correlated with attachment anxiety and avoidance and predicted expert-

rated insecure attachment and maladaptive beliefs.

Conclusions:

Our findings support a potential link between childhood adversity and boundary difficulties, partly mediated by insecure attachment and early maladaptive beliefs.

NO. 2 PHYSICIANS SANCTIONED FOR BOUNDARY VIOLATIONS: RISK AND RESILIENCY

Speaker: William H. Swiggart, M.S.

SUMMARY:

This presentation will review data from a professional development course for physicians who were sanctioned for sexual violations, sexual impropriety, and or sexual harassment in the workplace. Possible risk factors related to family of origin structure, childhood trauma, and educational deficits will be explored. A boundary violation screening instrument will be presented in an experiential exercise. The importance of self-care and resiliency will be discussed with specific protective factors that promote wellness. The importance of preventive education will be addressed. Participants should become acquainted with the scope of boundary violations, pre-violation behaviors or risk factors, preventive educational tools, one screening instrument, and behaviors that improve resiliency and wellness.

NO. 3 ATTACHMENT AND BELIEF SYSTEM FINDINGS IN PHYSICIAN SEXUAL BOUNDARY VIOLATORS

Speaker: Ron E. Neufeld, B.A., B.S.

SUMMARY:

Objectives: Adverse childhood experiences may play a role in boundary violations by physicians. Limited data exists on the psychological mechanism linking childhood adversities to adult professional behavior. This presentation will compare and contrast findings from comprehensive evaluations and transformative educational experiences with physicians who violate sexual boundaries.

Methods: Data from physician Genograms, FACES, Flooding and ACE questionnaires, along with psychometric evaluation results will be described in relation to categories of

boundary violation, diagnosis and recommendations in physicians referred for comprehensive evaluation and those attending transformational educational experiences.

Conclusions: Overall, our findings appear to support a theoretical model featuring insecure attachment and maladaptive beliefs mediating the association between childhood trauma and professional boundaries difficulties

NO. 4 MALADAPTIVE BELIEFS AND INSECURE ATTACHMENT AS POSSIBLE MEDIATORS BETWEEN CHILDHOOD MALTREATMENT AND PHYSICIAN PROFESSIONAL BOUNDARY VIOLATIONS

Speaker: Andres F. Sciolla, M.D.

SUMMARY:

Objective:

Adverse childhood experiences may play a role in boundary violations by physicians. Limited data exists on the psychological mechanism(s) linking childhood adversities to adult professional behavior. As part of a CME course for referred healthcare professionals, we assessed attachment style and dysfunctional thinking patterns (early maladaptive schemas) in 150 attendees.

Methods:

We administered the Experiences in Close Relationships-Revised questionnaire and the Young Schema Questionnaire to 150 healthcare professionals (mostly physicians) attending a CME course on professional boundaries. Experts assessed the attachment style of participants, based on the narrative qualities of structured autobiographies. Data on the Childhood Trauma Questionnaire are reported separately.

Results:

Contrary to our expectations, in a smaller, previously-published data set (100 participants) the average attachment anxiety and attachment avoidance were low, and more than half of participants were rated secure by experts. The most commonly endorsed early maladaptive schemas in our sample were Self-Sacrifice, Unrelenting Standards and Entitlement. The overall pattern of elevated schemas correlated with the Childhood Trauma Questionnaire score.

Conclusions:

Overall, our findings support a theoretical model featuring insecure attachment and maladaptive beliefs as mediators for the association between childhood trauma and professional boundaries difficulties.

NO. 5 PHYSICIANS WHO CROSS SEXUAL BOUNDARIES

Speaker: Alistair J.R. Finlayson, M.D.

SUMMARY:

We will discuss data from comprehensive evaluations of physicians who cross sexual boundaries, including psychometrics, interviews, and questionnaires, comparing frequencies of adverse childhood events, genogram findings and other descriptive measures of family of origin experiences to the complaints about their sexual behavior.

MAY 19, 2015

FACTORS THAT ENHANCE RESILIENCE IN AT-RISK GROUPS THAT HAVE EXPERIENCED FAMILY VIOLENCE (FV)

Chair: Donna Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and enhance those factors that assist patients with severe medical illness to improve their resilience and enhance their mental health; 2) Identify factors in women with unwanted pregnancies that can be used in treatment to assist them to become more resilient; 3) Recognize factors that assist immigrant women from Asia who have suffered domestic violence that can be used in counselling to enhance their resilience and mental health; 4) Recognize factors that enhance resilience in prisoners, drug treatment program patients and other services, so these can be used in treatment to improve mental health outcomes.

SUMMARY:

Resilience is a dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain or regain their mental health despite exposure to adversity. This symposium will present information on the factors that have been found

to increase resilience in several groups which have experienced adversity such as a severe physical illness (Dr Stewart), unwanted pregnancies (Dr Rondon), Asian immigrant who have experienced FV (Dr Ahmad) and diverse groups (e.g., prisoners, substance abuse program patients) who have experienced FV (Dr Herrman). By more fully understanding the factors that enhance resilience, psychiatrists can more effectively help their patients to optimize resilience and move toward better mental health.

NO. 1 A SYSTEMATIC REVIEW OF RESILIENCE IN THE PHYSICALLY ILL

Speaker: Donna Stewart, M.D.

SUMMARY:

Resilience is the capacity of individuals to maintain, or regain, their mental health in the face of significant adversity, including physical illness. We conducted a systematic review of resilience and related concepts in the physically ill to determine factors associated with predicting or promoting resilience. An electronic search of PsychInfo, Medline, and CINAHL databases between 1950 and March 2014 was performed. A total of 6535 articles were retrieved and 206 articles met inclusion criteria. Psychological factors associated with resilience were self-efficacy, self-esteem, internal locus of control, optimism, mastery, hardiness, hope, self-empowerment, acceptance of illness, and determination. Social support was highly predictive of, and associated with, resilience. Coping strategies such as positive cognitive appraisal, spirituality, active coping, and mastery were also associated with resilience. Resilience factors directly salient to physical illness such as self-care, adherence to treatment, health related quality of life, illness perception, pain perception, exercise adherence, and physical outcomes were also found. These findings need to be considered and, when appropriate, incorporated into the psychological and psychiatric care of physically ill individuals.

NO. 2 MENTAL HEALTH AND RESILIENCE IN WOMEN FACING UNWANTED PREGNANCY

Speaker: Marta B. Rondon, M.D.

SUMMARY:

Reproductive health problems have been identified as a major cause of emotional distress and poor mental health for women. One of the relevant risk factors is unwanted pregnancy. International literature shows that abortion is followed, in general, by a decrease in previously high levels of anxiety. We examined whether mental health and resilience was enhanced by the experience of therapeutic termination of pregnancy (TOP) in women with a history of gender-based violence, problems with alcohol or drugs, or personal/family history of suicide, attempted suicide and depressive disorders. 50 women with unwanted pregnancy who scored 9 or higher in the PHQ-9 completed the Connor-Davidson Resilience Scale (CD-RISC) before undergoing therapeutic termination of pregnancy (T1) and six months after the procedure (T2). The scores on PHQ were lower and on RISC were higher in women at T2. Women undergoing therapeutic TOP see their mental health as better and their resilience enhanced. Access to a legal procedure in a health setting, with available counseling may be a factor in improving the capacity of these women to face substantial stressors without suffering adverse mental health outcomes.

NO. 3 RESILIENCE AND RESOURCES AMONG SOUTH ASIAN IMMIGRANT WOMEN AS SURVIVORS OF PARTNER VIOLENCE

Speaker: Farah Ahmad, M.B.B.S., M.P.H., Ph.D.

SUMMARY:

This study explored resilience among South Asian (SA) immigrant women who were survivors of intimate partner violence (IPV). Eleven women participated in in-depth interviews. Thematic analysis was conducted using constant comparison. We identified five crosscutting themes: resources before and after the turning-point (i.e. decision to confront violence), transformations in self, modification of social networks, and being an immigrant. Women drew upon their individual cognitive abilities, social support, and professional assistance to move beyond victimization. All women modified their social networks purposefully. The changes in individual-self included an increased sense of autonomy, positive outlook, and keeping busy. The

changes in collective-self occurred as women developed a stronger feeling of belonging to their adopted country. This hybrid identity created a loop of reciprocity and a desire to contribute to their community. Women were cognizant of their surmountable challenges as immigrants. SA immigrant women IPV survivors sought multiple resources at micro, meso and macro levels, signifying the need for socio-ecological approaches in programs and policies along with inter-sectoral coordination to foster resilience. Although our sample size was small and included only South Asian women, the factors identified by our participants may be helpful in treating other abused women immigrants who have experienced IPV.

NO. 4 PROMOTING RESILIENCE IN INDIVIDUALS AFFECTED BY CHILD MALTREATMENT AND INTIMATE PARTNER VIOLENCE

Speaker: Helen Herrman, M.B.B.S., M.D.

SUMMARY:

Child maltreatment (CM) and intimate partner violence (IPV) are among the main risk factors for mental disorders worldwide. Practitioners and policymakers also need to understand how best to support throughout the lifespan those affected. This presentation aims to review the factors contributing to resilience and evidence about effective means to promote resilience in individuals with experience of violence.

One definition of resilience is: "A dynamic process in which psychological, social, environmental and biological factors interact to enable an individual at any stage of life to develop, maintain or regain their mental health despite exposure to adversity"™. We will describe a systematic review of studies on the effectiveness of interventions in various settings to promote resilience in those with experience of CM and IPV. Twenty studies of complex and simple interventions for resilience in community, welfare, employment, prison, and substance abuse and mental illness service settings will be described.

Evaluation is needed of collaborations between health and non-health sectors to reduce exposure to adversity, improve resilience and promote mental health.

SEIZURE THERAPY FOR DEPRESSION: TEACHING AN 'OLD DOG' SOME 'NEW TRICKS'

Chairs: Sarah H. Lisanby, M.D., Matthew V. Rudorfer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) define the parameters that determine the dose of electroconvulsive therapy; 2) discuss the risks and benefits of modern ECT dosing in severe depression, including electrode placement and stimulus parameters.; 3) identify new approaches using magnetic stimulation to improve the tolerability of seizure therapy.

SUMMARY:

Electroconvulsive Therapy (ECT) is our oldest somatic therapy in psychiatry still in clinical use today, but modern ECT bears little resemblance to the form originally practiced 7 decades ago. Today, advances in technique and dosage have resulted in improved safety and tolerability, while preserving its unparalleled efficacy in treating among our most severely ill patients in psychiatry. This panel reviews the latest developments, demonstrating that this old technology has been transformed through advancements in dosing, devices, and innovations to improve its focality and precision. Dr. Angel Peterchev, a pioneer in brain stimulation technology and an electrical engineer with expertise in power electronics, will define the parameters that describe the "dose" of electricity, and present the fundamentals of approaches to optimize the dose in terms of its spatial and temporal components. Dr. Mustafa Husain, expert in clinical neuromodulation and a leading researcher in clinical trials with various forms of brain stimulation, will present new results from multi-center trials on the safety and efficacy of ultrabrief pulse right unilateral ECT in geriatric depression, including the latest results from the Consortium for Research on ECT (CORE) and the Prolonging Remission in Depressed Elders (PRIDE) NIMH sponsored trials. Dr. Lisanby, whose translational research led to the development of magnetic seizure therapy (MST) will present how this novel approach to inducing seizures was developed and share insights gleaned from preclinical and early stage clinical trials with this novel technology. She will also

present the latest results from the NIMH sponsored "Rational Design of Electrical and Magnetic Seizure Therapies" study. Finally, Dr. Jeff Daskalakis, leading expert in transcranial magnetic stimulation (TMS), will present his new results on the comparative efficacy of MST and ECT, including new leads regarding biomarkers of response that may be useful in patient selection. Together, the speakers will provide a comprehensive view of the latest enhancements and improvements on this therapy which remains a gold standard for severely depressed and suicidal patients. An 'old dog' really can learn some 'new tricks.'

NO. 1 DOSE FOR SEIZURE THERAPY: DEFINITIONS AND IMPLICATIONS FOR PRACTICE

Speaker: Angel Peterchev, Ph.D.

SUMMARY:

This presentation will provide the fundamentals necessary to understand the parameters that define the dosage of electrical and magnetic stimulation. Focus will be placed on electroconvulsive therapy (ECT) and magnetic seizure therapy (MST), but the concepts also apply to subconvulsive forms of electrical and magnetic stimulation as well.

NO. 2 SAFETY AND EFFICACY OF RIGHT UNILATERAL ULTRABRIEF PULSE ELECTROCONVULSIVE THERAPY IN DEPRESSED SENIORS: NEW INSIGHTS FROM THE PROLONGING REMISSION IN DEPRESSED ELDERLY TRIAL

Speaker: Mustafa M. Husain, M.D.

SUMMARY:

Through a series of large, multi-center randomized controlled trials, important insights have been learned regarding the factors that affect clinical outcomes with ECT. Those factors include electrode placement, pulse width, and dosage relative to seizure threshold, among others. While evidence supports the enhanced safety and superior memory outcomes with ultrabrief pulse width and right unilateral electrode placement, the efficacy of those innovations in severely depressed seniors was not known. This presentation will show

newly available data from the NIMH sponsored Prolonging Remission in Depressed Elders (PRIDE) trial demonstrating safety and efficacy of this form of ECT in severely depressed seniors. Implications for practice will be discussed.

NO. 3

TRANSLATIONAL DEVELOPMENT OF MAGNETIC SEIZURE THERAPY (MST): IMPROVING THE SAFETY AND FOCALITY OF SEIZURE THERAPY

Speaker: Sarah H. Lisanby, M.D.

SUMMARY:

In ECT, electricity must be passed through the scalp and skull to induce the seizure. This approach has inherent limitations to focality that can be effectively overcome by using magnetic stimulation to induce the seizure. Magnetic fields pass through tissue without impedance, permitting better control over the electric field induced in the brain. Magnetic seizure therapy (MST) was developed by Dr. Lisanby's team to provide more precision over the induced electric field, and thereby improve the safety and precision of seizure therapy. Results to date demonstrate that MST can induce seizures with substantially weaker and more focal electric fields in the brain, and significantly reduce the cognitive side effects. This presentation will include the latest results from the NIMH sponsored "Rational Design of Electrical and Magnetic Seizure Therapies" study. It will also review the latest results from the Stanley Medical Research Foundation sponsored multi-center trial on the antidepressant efficacy of MST compared with ECT.

NO. 4

SAFETY AND EFFICACY OF MAGNETIC SEIZURE THERAPY

Speaker: Z.J. Daskalakis, M.D.

SUMMARY:

Magnetic seizure therapy (MST) is a novel approach to improve the safety of ECT, but further information is needed to define its feasibility, safety and efficacy. The results of the antidepressant efficacy and safety of MST versus ECT will be presented. This presentation will also review aspects of dosage with MST, including the effect of stimulation frequency.

Finally, new data on putative biomarkers that predict antidepressant response will be reviewed. Using transcranial magnetic stimulation (TMS)-induced evoked potential measures associated with cortical inhibition, new data on response predictors which may also shed light on mechanism of action will be presented.

NOWHERE TO GO: THE CRISIS OF PSYCHIATRIC PATIENTS BOARDING IN EMERGENCY DEPARTMENTS

Chairs: Yad M. Jabbarpour, M.D., Marvin Swartz, M.D.

Discussant: Steven Sharfstein, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to explain the definition of boarding and the impact on patients, healthcare provider satisfaction, and quality of care and safety.; 2) Participants will be able to discuss patient flow as it applies to psychiatric patients boarding in emergency departments.; 3) Participants will be able to identify potential solutions to decrease boarding and improve patient flow at the level of the clinician, emergency department, and psychiatric services delivery system.

SUMMARY:

Psychiatric boarding, defined as behavioral health patients' waiting emergency rooms, hallways or other areas for inpatient beds, is a serious and ubiquitous problem in the U.S. and other countries. Boarding is recognized as a major cause of emergency department (ED) crowding and ambulance diversions, having a significant impact on health care providers, patient satisfaction, health care costs and clinical outcomes for both psychiatric and "non-psychiatric" patients. According to the Agency for Healthcare Research and Quality (AHRQ), mental illness and/or substance use disorders are related to one out of every eight ED cases in the U.S. This burden extrapolates into nearly twelve million visits to hospital ED's in a year. The psychiatric emergency population represents a high risk group for patient safety concerns, including those at risk for self-harm, including suicide, those at risk for aggression, and the negative outcome of an elopement. Co-occurring substance use disorders, including intoxication, withdrawal and

associated behaviors, also places this population at high safety risk. If a patient requires psychiatric hospitalization, neither beds nor community mental health safety net resources may be readily available. With no bed, the associated consequence may include the emergency custody order expiring and the person walking out of the emergency department or the patient being boarded in the ED for days until a bed is found. Some address this patient flow problem as an emergency department and hospital issue; others identify the lack of community resources and psychiatric beds; others formulate boarding as a symptom of a larger illness of a fragmented and underfunded mental health system. Accreditation organizations and other oversight agencies, including AHRQ, The Joint Commission (TJC), and the Centers for Medicare & Medicaid Services (CMS) assess that patient flow in emergency departments is an issue, especially in regard to the behavioral health population. The perspectives of emergency medicine, emergency psychiatry, accreditation organizations and mental health system structure will be discussed, including potential solutions for clinicians, administrators and mental health system architects.

NO. 1 RISKS TO PATIENT SAFETY AND QUALITY OF CARE FROM BOARDING OF PSYCHIATRIC PATIENTS IN EMERGENCY DEPARTMENTS

Speaker: Anne C. Bauer, M.D.

SUMMARY:

Because excessively long stays for patients in EDs present higher risks to patient safety and the quality of care for these individuals, The Joint Commission has been concerned about boarding of psychiatric patients and others for many years. Since 2005, The Joint Commission has required its accredited healthcare organizations to identify "patient flow" problems because these are areas where care can be compromised. The "patient flow" standards were revised in 2012 based on national data and concerned feedback from accredited organizations and stakeholders, to increase the requirements so that collected data and set goals will guide the mitigation of factors associated with boarding on patients. Furthermore, recognizing that the causes of

boarding psychiatric patients go beyond the reach of the EDs as well as the hospitals, The Joint Commission set a new element of performance, which went into effect January 1, 2014, requiring hospital leaders to coordinate care for psychiatric patients in their EDs with other providers, county and state authorities. In addition to standards, The Joint Commission has other "levers" to support patient safety and quality of care by its accredited facilities. This presentation will detail these activities along with some of the creative solutions to the problem of ED boarding that accredited health care organizations have developed.

NO. 2 THE LEGAL CHALLENGES AND RESPONSES TO SHORTAGES OF BEDS FOR EMERGENCY PSYCHIATRIC EVALUATION

Speaker: Richard J. Bonnie, J.D.

SUMMARY:

Emergency Departments (EDs) around the nation have been challenged with triaging psychiatric patients in need of emergency psychiatric hospitalization. However, finding suitable psychiatric beds in a timely manner has been difficult, resulting in either patients being "boarded" indefinitely in EDs, placed in "medical" beds, held in jails, or released prematurely from emergency custody to the community. What role should the law play in responding to these problems? Recent experiences in the states of Washington and Virginia will be reviewed.

NO. 3 WHY IS THERE A PSYCHIATRIC BED SHORTAGE?

Speaker: Marvin Swartz, M.D.

SUMMARY:

The recent and mounting crisis of patient boarding in emergency departments raises the question of the origin of psychiatric bed shortages. This presentation will discuss the history and dynamics of state hospital, public and private psychiatric beds supply. The rise and fall of the state hospital as the primary locus of treatment in the public sector, the effect of the enactment Medicaid and Medicare and the rise and contraction of general hospital

and free-standing psychiatric hospitals will be discussed. The lack of comprehensive federal mental health parity legislation prior to 2008 and potential for correction under the Wellstone and Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) will also be discussed.

**NO. 4
DEALING WITH PSYCHIATRIC
BOARDERS IN THE EMERGENCY
DEPARTMENT: AN EMERGENCY
PHYSICIAN'S PERSPECTIVE**

Speaker: Leslie Zun, M.B.A., M.D.

SUMMARY:

The number of psychiatric patients presenting to emergency department has increased substantially in the last few years at the same time the resources for psychiatrist patients for inpatient and outpatient resources has decreased. These factors had lead to the dilemma of long delays in the deposition of psychiatric patients who may wait hours to days with little or no treatment or intervention. The purpose of this discussion is to understand the demands and resources for psychiatric patients in the emergency department, to explore patient care alternatives and to learn if the patient needs to be admitted. This talk will deal with examining options for care prior to the patients' arrival in the ED, using admission criteria, beginning medications and providing ED interventions.

**INTERACTING WITH DEMANDING,
SUICIDAL AND AGGRESSIVE PATIENTS:
AVOIDING INTERPERSONAL CRASH
AND COMBUSTION**

Chair: Diana Kljenak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List different factors contributing to difficulty in interactions between the patient and clinician; 2) Compare and contrast countertransference feelings that suicidal, demanding and aggressive patients invoke in clinicians; 3) Formulate strategy to manage suicidal, demanding and aggressive patients.

SUMMARY:

The assessment and management of suicidal, demanding, angry and aggressive patient often

present unique clinical challenges. Strong countertransference reactions can lead to blaming the patient and labeling the patient as "difficult". This symposium will provide clinicians with an overview and discussion of different factors which contribute to difficulty in interactions between the patient and clinician. The principles of management of suicidal and demanding patients will be outlined. The session will conclude with the review of risk factors for violence and principles of management of aggressive patients. The audience will have the opportunity to reflect on their countertransference reactions during these "difficult" clinician-patient interactions.

**NO. 1
INTERACTING WITH SUICIDAL
PATIENTS**

Speaker: Yvonne Bergmans, M.S.W.

SUMMARY:

The assessment and management of patients experiencing suicide attempts or ideation often present unique clinical challenges. Strong countertransference reactions can lead to blaming the patient and labeling the patient as "difficult" The session will open with an overview of factors which contribute to difficulty in interactions between the patient and clinician. The principles of management of suicidal patients will be then outlined. The audience will have the opportunity to reflect on their countertransference reactions to suicidal patients.

**NO. 2
INTERACTING WITH DEMANDING
PATIENTS**

Speaker: Shelley McMMain, Ph.D.

SUMMARY:

The assessment and management of demanding patients often present unique clinical challenges. Strong countertransference reactions can lead to blaming the patient and labeling the patient as "difficult" The session will open with an overview of factors which contribute to difficulty in interactions between the patient and clinician. The principles of management of demanding patients will be then outlined. The audience will have the opportunity to reflect on their countertransference reactions to demanding patients.

NO. 3 INTERACTING WITH AGGRESSIVE PATIENTS

Speaker: Jodi Lofchy, M.D.

SUMMARY:

The assessment and management of angry and aggressive patients often present unique clinical challenges. The encounters with such patients often are complicated by strong countertransference reactions and are often labeled as difficult. The session will open with an overview of different factors contributing to difficulty in interactions between the patient and psychiatrist. The risk factors for violence and principles of management of aggressive patients will be then outlined. The audience will have the opportunity to reflect on their countertransference reactions to angry patients.

MAINTENANCE OF CERTIFICATION (MOC): WHY IT EXISTS, WHAT IT IS ABOUT, AND HOW YOU CAN DO IT

Chair: Philip R. Muskin, 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)

NO. 1 AMERICAN BOARD OF MEDICAL SPECIALTIES 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. The 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 AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY 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 PROVIDES EVERYTHING YOU NEED TO MAKE MOC EASY FOR YOU

Speaker: Tristan Gorrindo, 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.

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

MOC: WHAT SHOULD I DO?

Speaker: Margo D. Lauterbach, M.D.

SUMMARY:

The ABPN's Maintenance of Certification program is required to maintain certification in psychiatry and subspecialties. The ABPN Folio is one tool available to record and track MOC progress. There are numerous ABPN approved activities to choose from for CME, self-assessment, and Improvement in Medical Practice (PIP). These opportunities in MOC are worth reviewing in detail for Diplomats to assist them with the MOC process.

Objectives:

To (1) navigate the most pertinent ABPN websites relevant to MOC, (2) highlight the ABPN Folio system (3) showcase the different ABPN approved activities in detail.

Methods: The ABPN website and Folio system is rich with information that was combed for details and collected in a way that can be presented in a lecture format and live tutorial.

Results: Over 100 ABPN approved products exist for ABPN Diplomates to choose from for MOC. Each varies with respect to topic, characteristics, credits, cost and other factors.

Conclusion: Navigating the process of MOC can be de-mystified for Diplomates by presenting the ABPN approved activities in detail, how to choose activities, and how to record what is completed via Folio to keep organized.

ATTACHMENT AND CHRONIC ILLNESS: CHALLENGING CASES ACROSS THE LIFESPAN

Chairs: Janna Gordon-Elliott, M.D., Susan Samuels, M.D.

Discussant: Robert Maunder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) demonstrate knowledge of the fundamentals of Attachment Theory, as it relates to infant attachment and adult attachment styles; 2) demonstrate knowledge of how disturbed attachment styles can develop as a consequence of living with chronic illness and can negatively impact the course of medical illness; 3) demonstrate knowledge of management strategies for engaging and working with medically ill individuals with

maladaptive attachment styles and behaviors; 4) utilize these management strategies in clinical settings with the purpose of not only engaging patients but also mitigating the negative effects that abnormal attachment behaviors can have on the course of medical illness through improving patients'™ participation in self-care, cooperation with their medical providers, and coping with the stress of illness; 5) teach medical providers about attachment style and how to better manage patients based on this understanding.

SUMMARY:

Mental health practitioners, whether consultation-liaison (C-L) psychiatrists in a large teaching hospital, general adult or child/adolescent psychiatrists, or community clinicians in other settings, are often consulted by medical colleagues to aid in the treatment of patients facing the stressors of chronic medical illness. Common quandaries presented to the psychiatric provider include treatment non-adherence, and help-rejecting, demanding or manipulative behavior. The individual's response to living with, and managing, chronic disease, is related to numerous intrapsychic, interpersonal, and external factors, and reflects the sum of the patient's life experience. Attachment style and behaviors can significantly affect how one copes with and manages medical illness. Reciprocally, the stressors of chronic disease, especially early in life, can shape an individual's attachment style. Furthermore, pathology in attachment can serve as a paradigm for thinking about problematic behavior in a patient that is impacting the illness and treatment.

Attachment style, generally established in early childhood, is defined as an interpersonal trait that encompasses the type of bond one shared with caregivers as a result of caregivers' levels of sensitivity and responsiveness to the child's needs. This attachment style may manifest in the individual's interactions with caregivers later in life, perhaps the clinicians providing care during a hospitalization or exacerbation of a chronic medical illness. Infant attachment theory has been extrapolated to develop a model of adult attachment. Pathological styles of attachment can negatively impact one's psychological adjustment to illness, interaction with caregivers, and ability to appropriately navigate medical care; the ways in which this occurs varies according to age and life stage, in

turn reflecting the particular challenges and expectations of that developmental phase.

Problematic patient behavior can tax or bewilder the most even-minded clinician. Having a lens to observe and understand such behaviors, such as attachment theory, can help the clinician devise a working model for what is going awry and steps to address it, thus improving the quality of care. With knowledge of pathological attachment styles, the clinician might address the problem by enhancing family structure (for a child), augmenting the patient's sense of autonomy while maintaining boundaries (in a young adult), or attending to the adult patient's relationship to the medical team to enhance cooperation and adherence with medical care.

Through case-based discussions, we will explore the interplay between attachment styles and chronic medical illness, including challenging issues that may arise during the course of medical care. We will specifically examine these issues at three different stages of life: the child/young adolescent, the older adolescent/emerging adult, and the middle-aged adult.

NO. 1 INTRODUCTION

Speaker: Janna Gordon-Elliott, M.D.

SUMMARY:

Drs. Janna Gordon-Elliott and Samuels will provide an introduction to the symposium. They will present the impetus for creating this series of talks, drawing from their experiences working with medically ill patients, from children to the elderly. They have observed how common it is that the problems prompting a psychiatric consultation can be understood as being rooted in the patients'™ maladaptive attachment styles and behaviors, often triggered or worsened by the medical illness, the hospitalization, or the patient-provider dynamic. From their perspective working with children and adults, they will discuss how a developmental approach to understanding patients'™ emotions and behaviors in the setting of medical illness, can be particularly useful on a general C-L service, and as a tool for teaching psychiatry trainees. Drs. Gordon-Elliott and Samuels will briefly introduce Attachment Theory, including models of infant attachment and adult attachment. They will provide introductions for the three speakers.

**NO. 2
ATTACHMENT AND MEDICAL ILLNESS
IN THE CHILD AND YOUNG
ADOLESCENT**

Speaker: Gabrielle H. Silver, M.D.

SUMMARY:

Dr. Silver will begin her talk with a brief illustrative case, drawn from her work with children and adolescents admitted to the general hospital. Dr. Silver will then go on to discuss the unique developmental effects of living with medical illness on youngsters, and how stages of development, in turn, impact the course of medical illness. She will highlight the ways in which attachment styles and behaviors are shaped by illness – be it through disruptions in routine and socialization, loss of usual boundaries of the child’s body, and altered dependency needs. She will review how problematic attachment behavior can affect the youngster and his or her family system coping with illness and their relationship with health care providers. Specific suggestions will be provided that may help to address behavior that is having a negative impact on the child’s health, including family-based interventions that are based on what is known about the child and family’s attachment style.

**NO. 3
ATTACHMENT AND MEDICAL ILLNESS
IN THE LATE ADOLESCENT AND
YOUNG ADULT: THE EMERGING ADULT**

Speaker: Jennifer Tanner, Ph.D.

SUMMARY:

Dr. Tanner will begin her talk with a brief illustrative case, based on her clinical experience working with individuals in late adolescence and young adulthood, a stage of life that is being referred to as “emerging adulthood”. Dr. Tanner will introduce a theoretical framework for understanding the emerging adult in his or her psychological and social context by reviewing the particular tasks, opportunities and trials that the emerging adult experiences. Individuals with chronic illness who are passing from childhood to adulthood face unique challenges, including transitioning their care from pediatrics to adult medicine and taking on responsibility for self-care.

Problematic attachment styles will be activated in response to such stressors, leading to maladaptive behaviors with substantial negative consequences on health and quality of life. Dr. Tanner will discuss ways to identify abnormal attachment style and behavior in the medically ill emerging adult and to develop interventions that may help the individual better manage this fraught period.

**NO. 4
ATTACHMENT AND MEDICAL ILLNESS
IN THE ADULT OF MIDDLE AGE**

Speaker: Francine Cournos, M.D.

SUMMARY:

Dr. Cournos will open her talk with a brief illustrative case, taken from her work with adults living with chronic medical illness. Dr. Cournos will draw from her clinical experience and research involving patients with HIV disease to discuss how dysfunctional attachment style and behavior interact with and influence the course of medical illness. Life experiences and psychological and psychiatric factors will affect the course of an individual’s disease, and even the incidence of the disease (e.g., risk taking behavior and its association with the development and progression of HIV disease). Conversely, living with chronic illness will affect personality, functioning, and mental health throughout adulthood. Dr. Cournos will present material from her own research to support her discussion. She will offer insights into how understanding of attachment models can help the health provider to facilitate improved quality of care and quality of life in patients living with medical illness.

**PERSONALITY AND PERSONALITY
DISORDERS: UNRESOLVED PUZZLES**

Chair: John F. Clarkin, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the neurobiological underpinnings of pathology as it arises in adolescence.; 2) Describe a conceptual framework within which to understand personality and its disorders.; 3) Identify the theoretical efforts to integrate biological, intrapsychic, and behavioral aspects of personality pathology.

SUMMARY:

The empirical investigation of different facets of personality pathology has exploded since the description of the disorders in DSM-III in 1980. However, as evidenced by the disagreements and controversy surrounding the recommendations of the work group on personality disorders leading up to DSM-5, there are major limitations in the theoretical understanding of the nature of personality pathology, an understanding that is required to integrate the growing amount of empirical information from genetics, neuroscience, social cognition, intrapsychic experience, and interpersonal behavior as they relate to personality pathology.

In this panel, four internationally recognized experts in personality development and its pathology will examine central issues. Human imaging and animal studies provide data on the interactions between environment and brain development in the adolescent period that could lead to deficits in emotion regulation. A general framework for understanding both the central features of personality disorder and individual differences will be presented. In addition, a consideration will be made of genetic dispositions that may incline some individuals to less open and trusting social communication, leaving them vulnerable to social challenges. Finally, it will be postulated that for the field of personality disorders to advance in both clinical assessment and treatment, there must be an integration of neurobiological determinants and their intrapsychic and symbolic determinants.

NO. 1

THE ADOLESCENT BRAIN AND THE EMERGENCE AND PEAK OF PSYCHOPATHOLOGY

Speaker: BJ Casey, Ph.D.

SUMMARY:

Adolescence is a period of heightened emotionality and increased risk for mental illness, affecting as many as 1 in 5. This article reviews recent human imaging and animal studies that demarcate adolescent specific changes in brain and behavior that may help to explain this period of increased risk for psychopathology. We highlight adolescence as a sensitive period when: 1) the environment has particularly strong influences on brain and

behavior; and 2) normative changes in brain development can lead to an imbalance between rapidly changing limbic circuitry and relatively slower developing prefrontal circuitry. This imbalance can be exacerbated by both genetic and environmental influences leading to less capacity to regulate emotions and higher risk for psychopathology. We discuss these findings in the context of understanding who may be at greatest risk for psychopathology and when and how to best treat symptoms of emotional dysregulation.

NO. 2

THE NATURE AND SCOPE OF DISORDERED PERSONALITY

Speaker: John Livesley, M.D., Ph.D.

SUMMARY:

Over the last three decades, personality disorder has been established as an important area of clinical research and practice. Research has increased exponentially. However, less progress has been made in establishing a science of personality disorder. The problem is the field lacks a coherent conceptual model to integrate empirical findings and organize clinical intervention. This presentation examines the nature and scope of a clinically useful framework for conceptualizing personality disorder. Drawing on an idea expressed by Henry Murray, it is suggested that to treat personality disorder clinicians need to know how a patient is like all other patients with personality disorder, like some other patients, and like no other patient. That is, we need a conceptual framework that incorporates an understanding of the general features of personality disorder and individual differences in clinical presentations while also providing ways to represent the enormous heterogeneity and individuality in clinical cases. A conceptual approach to these requirements will be discussed based on ideas from normal personality science and evolutionary psychiatry.

NO. 3

RIGIDITY AS THE KEY DEFICIT AS WE LABEL PERSONALITY DISORDER

Speaker: Peter Fonagy, Ph.D.

SUMMARY:

Personality Disorder has been a troublesome concept because of its roots in the poorly defined polymorphous construct of

personality. All agree on the social definition is essential at the current state of knowledge but the mechanisms by which social processes act to generate this disorder have remained obscure. This paper aims to advance the debate moving away from the notion of deficit to the notion of adaptation. It is argued that certain adaptations to social environments to which some individuals may be genetically disposed makes them less open to social communication, experience less trust in key interpersonal domains, and as a consequence appear to others as relatively inaccessible to influence. They may be labelled "rigid" or "hard to reach" and the social challenges which ensue exacerbate their difficulties with communication. Search for a uniquely intrapsychic or biological understanding of personality disorder has yielded limited progress. We hope that an extension of the construct into the domain of communication and intergenerational knowledge transmission will advance the integration of social and biological constructs in this domain.

NO. 4 CONTROVERSIES IN THE CLASSIFICATION OF PERSONALITY DISORDERS

Speaker: Otto F. Kernberg, M.D.

SUMMARY:

This presentation will explore the apparent dilemma of dimensional in contrast to categorical criteria for classification of personality disorders. It will start from a proposed definition of personality and personality disorders, followed by an examination of the basic functions and corresponding underlying structures of the normal personality, and the common features of all personality disorders. The fundamental structure of identity, and its components, that is, the concepts of self and the concept of significant others, is the essential structure involved in normal and abnormal personalities. Underlying neurobiological determinants and their intrapsychic, symbolic or existential determinants will be outlined. A major conclusion of this presentation will be the proposal that both organized integration of neurobiological structures and functions, and organized integration of symbolic "existential structures and functions are involved in the

development of the personality, and in the corresponding psychopathology. The major inadequacy of most present classifications of personality disorders transcends the categorical "dimensional alternative: it resides in the systematic neglect of the symbolic "existential level of organization of psychic experience and its intricate interaction with the primary, neurobiological one.

IMPACT OF UNRECOGNIZED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER ON TREATMENT OF ANXIETY AND DEPRESSIVE DISORDERS

Chair: Thomas E. Brown, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) 1. Understand incidence of undetected ADHD in patients diagnosed with anxiety disorder and/or depression.; 2) 2. Explain why clinicians often do not recognize underlying ADHD in patients diagnosed with anxiety disorder and/or depression due to misunderstandings of ADHD.; 3) 3. Identify clinical indicators of ADHD in patients with anxiety and/or depressive disorders.; 4) 4. Describe various clinical strategies for management of anxiety disorders or depression with underlying ADHD.

SUMMARY:

Many adults diagnosed with anxiety and/or depressive disorders also have an underlying ADHD. In the national comorbidity study this overlap was found in 22.6% of adults diagnosed with Dysthymia, 9.4% with MDD, 19% of patients with Agoraphobia, 14% with Social Anxiety Disorder (SAD), and 11.9% with Generalized Anxiety Disorder. When ADHD is present in such cases, but not recognized, treatment is likely to be compromised. The initial presentation of this symposium will describe an updated understanding of ADHD and its impact upon self-management of anxiety and depression. Following presentations will use data and videos collected from mood and anxiety disorder clinics to demonstrate the frequency of unrecognized ADHD in anxiety and depressive patients and will offer clinical strategies for assessment and treatment.

NO. 1

IMPLICATIONS OF NEW UNDERSTANDINGS OF ADHD FOR TREATMENT OF ANXIETY AND DEPRESSION

Speaker: Thomas E. Brown, Ph.D.

SUMMARY:

ADHD is now understood as a complex developmental impairment of the management system of the brain, its executive functions (EF). This presentation will describe these chronic EF problems with 1) organizing, prioritizing and activating to work; 2) focusing, sustaining and shifting attention to tasks; 3) regulating alertness, sustaining effort, and processing speed; 4) managing frustration and modulating emotions; 5) utilizing working memory and accessing recall; and 6) monitoring and self-regulating action.

These cognitive functions are impaired for everyone sometimes; those with ADHD simply suffer more severe and chronic impairments of these functions much of the time, but not always.

All those with ADHD tend to have some specific activities in which they suffer no impairment in these functions which are often quite problematic for them. This situational variability of ADHD symptoms is one of the most puzzling features of ADHD.

The presentation will also describe why impairments of ADHD often overlap with other disorders such as anxiety and depression in ways that are not qualitative and categorical, but quantitative and dimensional, often confusing diagnostic assessments.

Recent research has highlighted that emotion plays a significant role in ADHD. Executive functions are often disrupted by "bottom up" pressures of emotions while ADHD symptoms often impair "top down" management and responsiveness to emotions. This presentation will describe mechanisms of these processes

NO. 2 INCIDENCE AND INTERVENTIONS FOR PATIENTS WITH DEPRESSIVE DISORDER AND UNDERLYING ADHD

Speaker: Martin A. Katzman, M.D.

SUMMARY:

ADHD is often found in patients with Dysthymia or Major Depressive Disorder (MDD). Recent

research has investigated potentially predictive factors in the detection of ADHD in this patient population. This section of the symposium will demonstrate strategies for early and accurate detection of ADHD in patients presenting with depressive symptoms. The implications of the overlapping symptoms on cognitive function will be reviewed, highlighting negative impairments to executive functioning, memory, and maladaptive cognitions. Case studies will be utilized to gain further insight into detection and appropriate treatment management. A multidimensional approach for clinicians will be discussed in order to achieve optimal patient outcome.

NO. 3 INCIDENCE AND INTERVENTIONS FOR PATIENTS WITH ANXIETY DISORDERS AND UNDERLYING ADHD

Speaker: Larry J. Klassen, M.D.

SUMMARY:

Due to the overlapping symptoms in anxiety disorders and ADHD, it is essential to develop clinical and diagnostic techniques for early and accurate detection. Treatment strategies for comorbid ADHD and anxiety disorders are prevalent in the scientific literature, however ADHD is still often undetected or misdiagnosed in those presenting with anxiety disorders. In this section, the clinical challenges that exist for clinicians in detection of these disorders, specifically in regards to determining the origin of each disorder, will be discussed. The use of case studies and videos will provide clinicians with effective skills in detecting these disorders in order to develop appropriate treatment for these patients. Furthermore, the pharmacological management of comorbid ADHD and anxiety disorders will be described, highlighting challenges that may arise for clinicians.

INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH FOR MANAGING MEMORY DISORDERS

Chair: Lewis Mehl-Madrona, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1. diagnose mild cognitive impairment (minor neurocognitive disorder) from major cognitive disorder and from depression. ;

2) identify at least three interventions that can reduce the rate of cognitive decline.; 3) treat cognitive impairment as part of a multi-disciplinary team in a group medical visit format.; 4) recognize at least five elements of group psychotherapy that are operative in group medical visits for cognitive impairment.; 5) describe osteopathic neuromuscular medicine and explain how it can be a part of geriatric psychiatry consultation and treatment as well as ongoing group medical visits in the primary care setting.

SUMMARY:

Neurocognitive disorders (minor or major) have been a pessimistic area of psychiatry. While medications are not helpful in delaying progression to minor neurocognitive disorder (MiND) or from MiND to major neurocognitive disorder (MaND), a variety of interventions have shown helpful in a number of clinical trials, born out by several meta-analyses. These interventions consists of exercise, diet (Japanese, Mediterranean, low carbohydrate and sugar), cognitive stimulation/enhancement, and movement/balance exercise, such as t'ai chi, chi gong, and yoga. We describe an innovative, collaborative model for care for individuals with MiND and MaND that consists of weekly group medical visits involving behavioral health clinicians (psychiatrist, psychologist, behavioral specialist), primary care provider (PA, NP, or MD/DO), and nurse. Within this format in which patients and caregivers/spouses can come weekly if desired, education can take place, along with socialization (a significant factor in preventing disease progression), cognitive stimulation and enhancement exercises, collaborative problem solving, balance/breathing/stretching exercises, and time for reflection. With 12 patients per group for two hours, these visits are cost effective and have been found to be pleasurable for patients and clinicians and in our research, result in actual behavior change and in reduction of progression toward further memory impairment and toward MaND for those with MiND. We show how osteopathic neuromuscular medicine with its emphasis on mind and body can add to these efforts and can be further used in a geriatric psychiatry context in the nursing home for reduction of agitation and aggression, improvement of sleep, and reduction of reportable events. We conclude with recommendations for implementation of

collaborative, group medical visits, inclusive of mental health and medical practitioners, and suggest ways in which these efforts can be evaluated. We emphasize the elements of successful group therapy developed by Yalom that are equally operative in successful group medical visits, though more implicit and implied than in group psychotherapy.

NO. 1 EVIDENCE-BASED PRACTICES TO IMPROVE MEMORY OR REDUCE THE RATE OF DECLINE

Speaker: Lewis Mehl-Madrona, M.D., Ph.D.

SUMMARY:

In this presentation we present the results of our and others' meta-analyses on practices that delay the onset of minor neurocognitive disorder, delay the progression from minor to major, and sometimes improve cognitive function. Multiple studies agree that medications do not delay progression, but that lifestyle factors do. Exercise has been found to be the most robust preventive agent for decline or diagnosis. Diet is also important. A Japanese diet low in rice, the Mediterranean diet, and other high vegetable, low carbohydrate, low sugar diets have been found to be helpful in preventing decline. Diets high in vegetables and fruits and low in carbohydrates, sugars, and processed foods have been associated with delayed onset of cognitive impairment. Supplement studies have been largely disappointing, though there has been recent support for vitamin E in its mixed tocopherols form and in conjunction with vitamin C. Criticism of micronutrient studies have been levied at their use of single agents when multiple deficiencies probably coexist. Studies have shown that malnourishment runs high in geriatric populations, especially sarcopenic obesity, and that poor nutrition is association with poor outcome. Multiple reviews indicate the value of cognitive enhancement and cognitive stimulation. Studies suggest that group medical visits composed of behavioral health practitioners, primary care practitioner, and a support nurse work best to implement behavior change.

NO. 2

RESULTS OF IMPLEMENTING GROUP MEDICAL VISITS WITH BEHAVIORAL HEALTH INTO PRIMARY CARE

Speaker: Barbara Mainguy, M.A., M.F.A.

SUMMARY:

We present the process and the results of implementing group medical visits into an academic primary care clinic. Our initial opposition came from physicians' ideas that nothing could be done to prevent cognitive decline or that only medications were effective. Other researchers have noticed this as a worldwide systemic bias in contemporary health care. We began with an educational program for practitioners even as we implemented a group medical visit for patients and their spouses or caregivers. The leaders consisted of a family physician, a behavioral health specialist, and a nurse. Group members were assessed pre- and post-intervention for cognitive function (using the Montreal Cognitive Assessment Scale), for balance, using a stand on one leg for 5 seconds test, for depression (using the geriatric depression scale), and for quality of life (using elicited narratives). Dietary changes were reviewed. Within each group visit, history was obtained through a check-in process in which participants reported changes and significant events since their last visit. Following this movement, balance, and breathing exercises were taught. Then came cognitive stimulation and enhancement exercises, followed by education about diet, cooking, and support for lifestyle change. The group ended with general discussion. Throughout, a nurse took members one by one for vital signs and any necessary physical assessments. Group improved cognitive function, socialization, and balance.

NO. 3 INTEGRATING BEHAVIORAL HEALTH, LIFESTYLE MANAGEMENT, AND GENERAL MEDICINE IN A PRIMARY CARE SETTING

Speaker: Michael Ross, D.O.

SUMMARY:

Conventional geriatric medicine and psychiatry is performed through consultations with instructions for implementations of recommendations. Previous research has suggested that these recommendations are

rarely implemented. We compared conventional consultations with a hands-on approach in which patients and caregivers freely interact with geriatric care providers from primary care, behavioral health, and other disciplines, in a group medical care context. Instead of consultation, geriatric providers trained medical support staff to perform cognitive testing and entered into visits in the primary care clinic to provide assistance and expertise. Data was collected on patient and family satisfaction, implementation of recommended procedures, and overall outcome. We found quicker entrance into collaborative care and the development of ongoing relationships with patients and their families that were collaborative with the primary care providers in a group medical care context. Lifestyle changes conducive to delaying the rate of memory loss and the progression toward dementia were much more likely to happen in the less formal, group medical care context. Patients were more likely to exercise, to move their diet in the direction of the Mediterranean diet (shown to slow the rate of cognitive decline), and to perform cognitive stimulation and enhancement exercises (also associated with reduction in the rate of decline) in collaborative group care instead of treatment as usual.

NO. 4 THE ROLE OF OSTEOPATHIC MEDICINE IN PREVENTING FRAILTY AND MEMORY DECLINE

Speaker: Magili Chapman-Quinn, D.O.

SUMMARY:

Osteopathic medicine has existed parallel to allopathic medicine for over 100 years. In Maine, because the only medical school in the state is osteopathic and for other reasons, osteopathic medicine has flourished. Within this context, osteopathic medicine has developed approaches to preserve strength, balance, gait, fitness, resilience, and memory, believing that all of these are related. This presentation reviews the theory of osteopathic medicine and why body fitness would be associated with memory preservation, explaining the empirical findings that exercise reduces the rate of cognitive decline. We will review ways in which osteopathic medicine is used to prevent memory loss, through both

direct and indirect means. Demonstrations will be presented of techniques utilized through craniosacral therapy and more comprehensive approaches. These techniques relate both to Pribram's theory of holographic memory and the Hameroff-Penrose theory of consciousness, the implications of which we will review. A case series of patients with frailty and memory problems will be presented in which improvement exceeds statistical expectations ($p < 0.001$) using the chi-square test. The final part of the presentation will consist of demonstrations of the osteopathic techniques utilized.

NO. 5 INTEGRATING NEUROMUSCULAR MEDICINE INTO GERIATRIC GROUP VISITS AND NURSING HOME CARE

Speaker: Josephine Conte, D.O.

SUMMARY:

Neuromuscular medicine is an important aspect of osteopathic medical practice which sometimes differentiates it from allopathic medical practice. With the academic program at Maine Dartmouth Family Medicine Residency, osteopathic physicians and allopathic physicians work side-by-side and manual medicine has become a respected intervention. In this presentation, we explore how osteopathic therapies can be integrated into group medical visits within a primary care setting and present evidence that the addition of these modalities provides added benefit over exercise, diet, cognitive stimulation/enhancement, and socialization. Additionally, we present evidence that osteopathic therapies can be used in a nursing home setting to improve sleep, reduce use of psychoactive medications (especially antipsychotics) while reducing agitation and aggression, and reduce incidence of critical incidents (falls, ED visits, staff reports of agitation/aggression/physical contact). We present the philosophy of osteopathic neuromuscular medicine and show how it interacts with other systems of care and can be integrated into a geriatric psychiatric consultation in a nursing home setting and into integrated behavioral health/primary care care in an outpatient clinic setting.

"I HAVE YOUR BACK!": MEANINGFUL ACTION TO ADDRESS VICARIOUS TRAUMA IN THE WORKPLACE

Chair: Gertie Quitangon, M.D.

Discussant: Charles R. Figley, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To increase understanding of the concept of vicarious trauma (VT) in clinicians and the disruptions in trauma-focused schemas of safety, trust, control, esteem, and intimacy.; 2) To illustrate how VT can manifest in clinicians who work with three distinct populations: survivors of military, civilian and disaster trauma.; 3) To identify evidence-informed practices for clinicians, training directors, supervisors and managers in the evaluation and management of VT in the workplace.; 4) To highlight the role of leadership in organizations in building worker resilience and promoting psychological health and safety in the workplace.

SUMMARY:

In the empathic engagement with trauma victims, mental health clinicians are exposed to repeated details of traumatic memories and reactions that can negatively alter fundamental beliefs about the world, self and others, referred to as vicarious trauma (McCann & Pearlman, 1990). The impact of working with trauma victims can present as disruptions in trauma-focused schemas of safety, trust, control, esteem, and intimacy. Empathic engagement is a basic therapeutic process inherent in most job descriptions for clinicians and when the work itself becomes an occupational hazard, meaningful action can be taken in the workplace to reduce the job risk and promote the psychological health and safety of clinicians. Self-care strategies, trauma-informed supervision, active caseload management, education and training on vicarious trauma (VT) and other evidence-informed approaches derived from models of integrated worker health promotion and safety programs can prevent VT and generate positive individual outcomes such as vicarious resilience and professional growth, and organizational outcomes such as employee satisfaction, recruitment and retention, absence reduction, and productivity. We present a theoretical rationale for VT and a framework for practitioners, training directors, supervisors and

managers to systematically evaluate and manage VT in mental health clinicians in three scenarios “ work with victims of military, civilian and disaster trauma.

NO. 1

A CASE PRESENTATION ON VICARIOUS TRAUMA FROM WORK WITH A 9/11 FIRST RESPONDER

Speaker: Mark R. Evces, Ph.D.

SUMMARY:

An overview of current theoretical and empirical data on vicarious trauma (VT) will be presented and compared and contrasted with other work-impact concepts such as burnout, compassion fatigue and secondary traumatic stress. The presenter will reflect on his experience of working with a 9/11 first responder. A vignette will be used to illustrate and discuss VT with an emphasis on disruptions in trauma-focused schemas of safety, trust, control, esteem, and intimacy as theorized by McCann & Pearlman (1990). Individual risk and protective factors will be explored and a framework for the systematic assessment and management of VT will be presented. Specific evidence-informed strategies in addressing VT and promoting worker resilience on both individual and organizational levels will be discussed.

NO. 2

A CASE PRESENTATION ON VICARIOUS TRAUMA FROM WORK WITH DELAYED-ONSET POSTTRAUMATIC STRESS DISORDER AFTER A TRAUMATIC BIRTH

Speaker: Danielle A. Kaplan, Ph.D.

SUMMARY:

The presenter will reflect on her experience of working with a patient with delayed-onset PTSD after a traumatic birth. A vignette will be used to illustrate and discuss VT with an emphasis on disruptions in trauma-focused schemas safety, trust, control, esteem, and intimacy as theorized by McCann & Pearlman (1990). Individual risk and protective factors will be explored and a framework for the systematic assessment and management of VT will be presented. Specific evidence-informed strategies in addressing VT and promoting worker resilience on both individual and organizational levels will be discussed.

NO. 3

A CASE PRESENTATION ON VICARIOUS TRAUMA FROM WORK WITH A SURVIVOR OF MILITARY TRAUMA

Speaker: Charles Nelson, Ph.D.

SUMMARY:

The presenter will reflect on his experience of working with a survivor of military trauma. A vignette will be used to illustrate and discuss VT with an emphasis on disruptions in trauma-focused schemas of safety, trust, control, esteem, and intimacy as theorized by McCann & Pearlman (1990). Individual risk and protective factors will be explored and a framework for the systematic assessment and management of VT will be presented. Specific evidence-informed strategies in addressing VT and promoting worker resilience on both individual and organizational levels will be discussed.

NO. 4

A CASE PRESENTATION ON VICARIOUS TRAUMA FROM WORK WITH A BOSTON MARATHON BOMBING VICTIM

Speaker: April J. Naturale, Ph.D.

SUMMARY:

The presenter will reflect on her experience of working with a Boston Marathon bombing victim. A vignette will be used to illustrate and discuss VT with an emphasis on disruptions in trauma-focused schemas of safety, trust, control, esteem, and intimacy as theorized by McCann & Pearlman (1990). Individual risk and protective factors will be explored and a framework for the systematic assessment and management of VT will be presented. Specific evidence-informed strategies in addressing VT and promoting worker resilience on both individual and organizational levels will be discussed.

ADDICTIONS: EPIDEMIOLOGY AND TREATMENT IN FRANCE AND IN THE UNITED STATES: 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 how the epidemiology of drug abuse differs in France

and the United States.; 2) Understand how the pharmacological treatment of drug abuse differs in France and the United States.; 3) Understand the screening and treatment of drug abuse in primary care in the US and co-morbidity of substance abuse and mental in France.

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 Addictions: Epidemiology and treatment in France and in the United States: 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. Florence Vorspan (FR) will begin by presenting the epidemiology of drug use and abuse in France. He will be followed by Dr. David McDuff (US) who will speak about Alcohol and other drug misuse by American collegiate and professional athletes.

Then Dr Renaud De Beaurepaire (FR) will talk about the pharmacological treatments of substance abuse in France and Dr. Bankole Johnson (US) will discuss Personalized Medicine Treatment for Alcohol Use Disorders.

Finally, Dr. Francois Petitjean, Diona Diaconescu & David Birman (FR) will discuss alcohol and mental illness: cause or consequence and Dr. David Oslin (US) will present on the screening and treatment of substance abuse disorders in primary care in the US.

There will be ample time for questions and answers.

NO. 1 ADDICTIONS IN FRANCE: AN EPIDEMIOLOGICAL OVERVIEW

Speaker: Florence Vorspan, M.D., Ph.D.

SUMMARY:

Introduction: France is a country with an ancestral tradition of wine and alcohol making, and a more recent and weaker history of tobacco producing. The country is also characterized by a strong social welfare system, with universal medical coverage and easy access to doctors and drug prescription. At the

same time, France evolves in European and global economy, so that new drugs or new addictive behaviour emerge.

Methods: We will provide an overview of current epidemiology of addictions in France using a systematic review of published epidemiological studies, regular surveys and grey literature. Available data on addictive compounds use, dependence and morbidity will be described. New trends will be discussed.

Results: Tobacco smoking and alcohol drinking are still the main addictions in France. E-cigarettes sells are rising and the product is fashionable. Baclofen has received in 2014 a temporary license as a treatment of alcohol dependence from the regulatory agency. Sedatives dependence is becoming a major health concern. Cannabis use remains high but stable in youngsters, and the end of the legal ban is in debate. Heroin dependence is still mainly treated by Buprenorphine despite a recent rise in the number of Methadone-maintained patients. Cocaine and stimulants use increase, but the number of patients in treatment is still lower than in other countries. Gambling is more studied than it used to be.

Discussion: Epidemiological data and trends will be discussed.

NO. 2 BACLOFEN FOR THE TREATMENT OF ALCOHOL DEPENDENCE

Speaker: Renaud de Beaurepaire, M.D.

SUMMARY:

Alcohol dependence is a major public health problem, with lifetime prevalence estimates of 7 to 12.5% in Western countries. Baclofen has recently emerged as a treatment of major interest for alcohol dependence. Baclofen suppresses craving, inducing a state of indifference towards alcohol. Studies using low doses (30-60mg daily) have provided conflicting results, while baclofen effectiveness appears to be much more consistent when doses are individually tailored, many individuals responding only to high doses. However, baclofen has many potentially dangerous side effects, and the maximal dose of baclofen that may be used is a matter of discussion. In the present paper, baclofen clinical trials will be reviewed, and the question of the doses in relation to effectiveness and side effects will be discussed. A guide for the prescription of baclofen will be presented.

NO. 3
ALCOHOL AND OTHER DRUG MISUSE
BY AMERICAN COLLEGIATE AND
PROFESSIONAL ATHLETES

Speaker: David R. McDuff, M.D.

SUMMARY:

American athletes at higher competitive levels in general use/misuse alcohol and other drugs (AODs) for similar reasons as non-athletes (socialize, relax, fit in, raise confidence, reduce stress, escape problems, relieve boredom, sleep, reduce negative emotions, relieve cravings, maintain a substance use disorder). Athletes however, additionally use AODs and performance enhancing drugs (PEDs) to accelerate injury recovery, manage acute and chronic pain, reduce weight and/or body fat, and boost performance by raising intensity/aggression, increasing muscle mass/power, improving endurance/oxygenation, enhancing focus/concentration, & increasing wakefulness/energy, etc. Despite these additional reasons for using AODs/PEDs, epidemiological surveys at collegiate levels and urine surveillance testing and AOD treatment data at professional levels indicate that elite athletes use less alcohol and drugs of abuse and have lower rates of most substance use disorders than matched non-athlete samples especially in season. In contrast and as expected, elite US athletes have higher rates of use/disorders of typical PEDS (stimulants including nicotine & caffeine, anabolic steroids & other mass building agents) and likely have higher use/disorder rates for opioid pain, ADD and sleep medications and off-season binge drinking. This presentation will review patterns and prevalence of AODs and PEDs in US athletes and briefly describe screening, brief intervention, treatment, and prevention,

NO. 4
PERSONALIZED MEDICINE TREATMENT
FOR ALCOHOL USE DISORDERS IN THE
U.S.

Speaker: Bankole Johnson, M.D.

SUMMARY:

Over 20 years of research has identified the serotonin-3 receptor system to be critical to the expression of the rewarding effects and abuse liability of alcohol. Effects of the serotonin-3

receptor are modulated by genetic differences at that receptor and by molecular variants at the serotonin transporter, which gates about 60% of serotonin function. Through biochemical/laboratory experiments in humans, we found that genetic differences at the Serotonin transporter are associated with variation in alcohol preference and drinking. Furthermore, we tested whether variation at the Serotonin transporter and receptor predicts treatment response to ondansetron with a phase II clinical trial of 285 alcohol-dependent individuals, randomized by genetic difference at the Serotonin transporter. We discovered that the serotonin-3 receptor blocker, ondansetron, was efficacious treatment for alcohol dependence among those with selective genetic variation at either/both of the serotonin-3 receptor and serotonin transporter. This finding offers the possibility of pre-screening individuals with alcohol use disorder by these selective serotonergic genotypes, subsequently allowing low-dose ondansetron as a treatment agent and opening up personalized medicine treatment for alcohol use disorder.

NO. 5
ALCOHOL AND MENTAL DISORDERS:
CAUSE OR CONSEQUENCE?

Speaker: Francois Petitjean, M.D.

SUMMARY:

Clinical and epidemiological studies have shown that the frequency of occurrence of co-morbid mental disorders in individuals who use alcohol or other psychoactive substances can be high (Baldacchino et al., 2009; Kessler et al., 2005). While mental disorders are risk factors for substance use disorders, the presence of a substance use disorder may affect the occurrence of mental disorders. Among those with a mental health disorder, data from clinical samples indicate that between a third and a half will meet the criteria for another mental or substance use disorder at some point in their lives (Hall et al., 2009) Diagnosing co-morbidity in substance users is often complicated by symptom overlap, symptom fluctuations, and the limitations of the assessment methods, among other methodological issues.

Among substance users, the most common mental disorders are personality disorders, anxiety and mood disorders. This presentation will look at the cause/consequence relation between alcohol use or abuse and mental

disorders, from a clinical point of view and from a research approach. Epidemiological data will be reviewed as well as biological hypotheses and therapeutic strategies will be discussed

Reference: Baldacchino, A., Groussard-Escaffre, N., Clancy, C., Lack, C., Sieroslavska, K. et al. (2009), "Epidemiological issues in comorbidity: lessons learnt from a pan-European ISADORA project, Mental Health and Substance Use: Dual Diagnosis 2 (2), pp. 88-100.

NO. 6 SCREENING AND TREATMENT OF SUBSTANCE ABUSE DISORDERS IN PRIMARY CARE IN THE U.S.

Speaker: David Oslin, M.D.

SUMMARY:

Alcohol dependence (DSM-5 = alcohol use disorder (AUD)) is the fourth leading cause of disability worldwide, yet no more than 15% of individuals with an AUD are actively engaged in treatment. Primary care is a key venue for the identification of patients with an AUD and the delivery of initial interventions. Indeed, the vast majority of screening and new case identification occurs within primary care. Alcohol Care Management (ACM) is a program that was developed to enhance the use of pharmacotherapy for AUDs in primary care settings using medication management counseling as the therapeutic background. We recently completed a 26-week single-blind, randomized clinical trial of ACM in 3 VA Medical Centers. Subjects were assigned to treatment in ACM versus referral to standard care in a specialty outpatient addiction treatment program. ACM focused on the use of pharmacotherapy (naltrexone) and counseling and was delivered in-person or by telephone in weekly sessions within primary care by a trained behavioral health provider (psychologist, nurse or social worker). A total of 163 alcohol-dependent subjects were randomized, and over 60% of them had a history of specialty care for addiction. Subjects in the ACM condition were significantly more likely to engage in treatment over the 26 weeks (OR=5.36, 95% CI = (2.99, 9.59)) and were more than twice as likely to abstain from heavy drinking in any given month (OR =2.16; 1.27-3.66).

ADMINISTRATIVE PSYCHIATRY: A WORLDWIDE PERSPECTIVE

Chair: Victor J.A. Buwalda, M.D., Ph.D.

Discussant: Sy A. Saeed, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) The participants will gain insight in what Administrative Psychiatry is about and its added value for the (early career) psychiatrist. ; 2) The participants will learn about the changing environment of psychiatry and the skills needed to fulfil important administrative roles in psychiatry today. ; 3) The participants will learn about the leadership, leadership roles and leadership qualities for practicing psychiatrists. ; 4) The participants will gain insight the does and don'ts of an MBA and will learn about the added value of an MBA. ; 5) The participants will learn about a worldwide questionnaire on Administrative Psychiatry and understand the aim of this international survey on Administrative Psychiatry.

SUMMARY:

Sperry (1997) acknowledged the Outcome revolution as a new paradigm to improve the clinical care process. Administrative Psychiatry systematically examines the interaction between the content and policy of the treatment process and the strategic choices arising from this interaction. In this regard, psychiatric administrators recognize that treatment and care of the psychiatric patient are central to the formulation of policies and the achievement of treatment objectives. Psychiatric Administration enables professionals in mental health care to act primarily in the interest of the patient and to develop a strategic approach on three levels:

1. micro level: organization of the clinical care process
2. meso level: operation of governing boards and directors of mental health institutions
3. macro level: management of global mental health initiatives.

Psychiatrists are the leading professionals on these three levels. Because of their thorough medical and specialist training they can understand all aspects of the treatment process. To fulfill their leadership roles they need to be trained in the organization of the process, the formulation of policies and strategies.

In this symposium the principles of Administrative Psychiatry are presented and the

support Administrative Psychiatry can offer psychiatrists in different leadership roles. The differences and similarities of Administrative Psychiatry in various countries throughout the world will be addressed and a proposal for a worldwide survey will be presented.

NO. 1 WHAT IS ADMINISTRATIVE PSYCHIATRY ABOUT?

Speaker: Victor J.A. Buwalda, M.D., Ph.D.

SUMMARY:

It is strange that there is still an Administrative Association for Psychiatrists: there has never been an association for Administrative Surgeons or Internists. Even though it is a peculiarity in the medical field, there remains a need for an association for Administrative Psychiatry. What does the Association for Administrative Psychiatry stand for and why should psychiatrists and early career psychiatrists become a member? Administrative Psychiatry is about leadership and leadership roles. It is about advocacy to put Psychiatry on the political agenda; it is about facilitating psychiatrists to do their jobs right and about empowerment of their patients. In this presentation the development of Administrative Psychiatry in The Netherlands and worldwide is discussed as well the motivation for becoming an Administrative Psychiatrist. The use and development of devices to enrich Administrative Psychiatry will also be considered

NO. 2 LEADERSHIP, MANAGEMENT AND ADMINISTRATIVE ISSUES

Speaker: Julian Beezhold, M.D.

SUMMARY:

Leadership, management and administrative issues tend to receive relatively little time and attention during our psychiatric training, yet they impact on every psychiatrist and are often the factor that determines whether or not one's working life is fulfilling and rewarding. This presentation takes a broad overview of leadership, management and administrative issues involving psychiatrists around the world. Findings from the research literature will be reviewed and highlighted. This will include aspects related to the residency/specialist training of psychiatrists. It will also draw on

lessons from other fields and the extensive literature on this topic relating to business settings.

From this introduction the presentation will then focus on two themes, namely that of leadership and leadership qualities and also on some practical tips and strategies that may be useful to many practicing psychiatrists.

NO. 3 THE BENEFITS OF AN MASTER'S IN BUSINESS ADMINISTRATION

Speaker: Geetha Jayaram, M.B.A., M.B.B.S., M.D.

SUMMARY:

Globally, especially within developed economies, there is a growing trend of doctors undertaking formalized business and management training to equip themselves for the wider challenges of healthcare delivery. Whilst many undertake competency-specific training in leadership, project management, healthcare finance, etc., a small proportion go the full hog and undertake a formalized Masters program such as a Masters in Business Administration.

Who should do an MBA? Whilst the authors believe that all doctors would benefit from some management and leadership training, they are not of the view that all doctors should do an MBA. The MBA is a massive commitment in terms of time, money, emotional and opportunity costs, and therefore only those aspiring to start their own services, run their organizations at the very top as general managers (CEOs) or those looking to change functions (within or outside industry) such as healthcare management consulting, investment banking etc. should consider this seriously.

Others would be better off with a leadership or similar skill-based course in project management, leadership, finance etc. that would allow them to take on leadership roles such as clinical director within an organization.

The major benefits of the MBA include: (1) enhanced and diverse skill acquisition, (2) building a diverse network and (3) attitudinal development. In this presentation the above-mentioned issues are discussed.

NO. 4

A PROPOSAL FOR A WORLDWIDE SURVEY ON ADMINISTRATIVE PSYCHIATRY

Speaker: Victor J.A. Buwalda, M.D., Ph.D.

SUMMARY:

Worldwide there are differences in how private practices are organized. In this presentation a worldwide questionnaire developed at the last WPA congress in Madrid will be shown to the participants. The aim of the questionnaire is to study the administrative needs and desires of psychiatrists in different parts of the world. The use of IT and outcome measures during treatment are also the subject of the questionnaire. It is the intention to discuss and prepare the questionnaire for an international mailing and receive comments on the items presented.

CONTEMPORARY CLINICAL AND RESEARCH APPLICATIONS OF THE DSM-5 ALTERNATIVE MODEL OF PERSONALITY DISORDERS

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) Identify personality disorders in clinical practice; 2) Recognize advantages of conceptualizing personality disorders in terms of the DSM-5 alternative model; 3) Understand recent developments in research on the DSM-5 alternative model of personality disorders.

SUMMARY:

The DSM-5 includes an alternative hybrid model of personality disorders (PDs), encompassing both dimensional and categorical features, in addition to the categorical model of personality disorders that was also included in DSM-IV. The DSM-5 alternative model is gaining traction in both research and clinical settings because it solves problems with the DSM-IV approach to personality disorders, such as excessive comorbidity and heterogeneity within putatively coherent categories. This symposium focuses on recent research and clinical aspects of the DSM-5 alternative PD model. Dr. Skodol, chair of the DSM-5 personality and personality disorders workgroup, will provide an overview

of the model and its clinical application. Dr. First will describe recent collaborative efforts aimed at developing a clinical interview for the DSM-5 alternative model (the SCID-AMPD). Dr. Simms will focus on his research on the alternative model in clinical samples, with an eye toward how parts of the model intersect in conceptualizing complex PD presentations. Dr. Krueger will describe recent research aimed at linking the dimensional domains of personality pathology in the alternative model with brain networks identified through fMRI data on functional connectivity. The discussant will be Dr. Oldham, a past APA president, who will focus on directions for the model going forward (e.g., in future revisions of the DSM).

NO. 1 DISTINGUISHING BETWEEN PERSONALITY DISORDER STYLE AND SEVERITY: CONCEPTUAL AND PSYCHOMETRIC CONSIDERATIONS

Speaker: Leonard J. Simms, Ph.D.

SUMMARY:

It is both clinically and conceptually appealing to make a distinction between personality disorder (PD) severity and style. In particular, it has become common to note that simply exhibiting elevated PD traits is not sufficient to warrant a PD diagnosis. To that end, formal attempts to distinguish PD severity and style appear in Section III of the recent DSM-5 revision to the PD criteria, as well as in the draft criteria for PD in the ongoing revisions to the International Classification of Diseases (ICD). Despite the intuitive and conceptual appeal of distinguishing severity from style, making such a distinction has proven to be phenotypically difficult. In this presentation, I will explore the severity/style distinction both conceptually and using data from our ongoing Computerized Adaptive Test for PD (CAT-PD) studies. In particular, I will (a) evaluate the extent to which the Section III system permits a meaningful psychometric distinction between severity and style, and (b) discuss these results in the context of existing and novel alternatives for defining PD. Implications for PD research and clinical work will be discussed.

NO. 2 LINKING NEURAL INTRINSIC CONNECTIVITY NETWORKS (ICNS)

WITH DSM-5 PATHOLOGICAL PERSONALITY DOMAINS

Speaker: Robert F. Krueger, Ph.D.

SUMMARY:

DSM-5 contains an Alternative Model of Personality Disorders (PDs), and one key feature of this model is dimensional domains of pathological personality. Specifically, these domains encompass tendencies to experience diverse negative affects, to be detached from other people, to act antagonistically toward others, to be disinhibited, and to have psychotic experiences. These five areas of personality variation are maladaptive extremes of the well replicated Five Factor Model (FFM) of general personality. A dimensional model of this sort is likely to facilitate efforts to understand the neurobiology of psychopathology because large groups of persons can be studied and characterized both in terms of neural systems, and in terms multiple dimensions encompassing clinically relevant personality problems. This approach circumvents problems inherent in trying to assign participants to categories that are accompanied by high comorbidity rates and heterogeneity of presentation within putatively coherent categories. Here, we report on potential neural correlates of DSM-5 pathological personality domains in N=244 community-dwelling research participants. Participants were scanned in a 3T fMRI scanner at rest, and data from this resting state scan were used to derive intrinsic connectivity networks (ICNs) through independent components analysis. Patterns of association linking non-artifactual ICNs with domains of pathological personality were subsequently derived.

NO. 3 THE DEVELOPMENT OF THE STRUCTURED CLINICAL INTERVIEW FOR DSM-5 ALTERNATIVE MODEL FOR PERSONALITY DISORDERS

Speaker: Michael First, M.D.

SUMMARY:

This presentation describes the development of the SCID-AMPD, a structured clinical interview corresponding to the various elements of the DSM-5 Alternative Model for Personality Disorder. In order to provide maximum flexibility to researchers and clinicians who are

interesting in assessing research subjects (or patients) according to the alternative model, three separate modules have been created to cover the various aspects of the model. Module I assesses the Levels of Personality Functioning Scale, a 5 point severity scale corresponding to the four domains of personality functioning included in the model (Identity, Self-direction, Empathy, Intimacy). Module II provides ratings for the 25 individual facets, combining them to provide dimensional ratings for the five DSM-5 trait domains (negative affectivity, detachment, antagonism, disinhibition, psychoticism). Module III provides a structured interview for the hybrid categorical/dimensional model, starting first with ratings for the "criterion A" items (i.e., ratings for the disorder-specific personality functioning domains), then continuing with trait ratings that cover both the disorder-specific traits as well as ratings for the general traits in order to allow for a diagnosis of Personality Disorder Trait Specified for cases in which the criteria are not met for any of the six personality categories.

NO. 4 PERSONALITY DISORDER CLASSIFICATION: STUCK IN NEUTRAL, HOW TO MOVE FORWARD?

Speaker: Andrew Skodol, M.D.

SUMMARY:

An Alternative DSM-5 Model for Personality Disorders was published in Sect. III of DSM-5, while the identical categories and criteria from DSM-IV for the personality disorders (PDs) are in Sect. II. Given strong shifts from categorical diagnoses toward dimensional representations in psychiatry, how did the PDs end up stuck in neutral with the flawed DSM-IV model perpetuated? This presentation reviews factors that influenced the development of the new model and data to encourage and facilitate its use by clinicians. These include recognizing 1) a dimensional structure for psychopathology for which personality may be foundational; 2) a consensus on the structure of normal and abnormal personality; 3) the clinical significance of personality; 4) PD-specific severity required to establish disorder; 5) disruption, discontinuity, and perceived clinical utility of the Alternative Model may not be problems; and 6) a way forward involving collaborative research

on neurobiological and psychosocial processes, treatment planning, and outcomes.

GENDER DYSPHORIA AND TREATMENT IN MINORS: LEGAL AND ETHICAL CONSIDERATIONS

Chairs: Erik R. Frost, M.D., Philip J. Candilis, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize ethical dilemmas when performing informed consent of a minor; 2) Describe treatment options for gender dysphoria; 3) Identify clinical factors which might impair competency to consent to treatment; 4) Recognize exceptions to competency standards for minors; 5) Understand the required disclosures for gender dysphoria treatment options.

SUMMARY:

Case Presentation: A 16 year old Caucasian female presents to outpatient child psychiatry clinic complaining of gender dysphoria and depressive symptoms, requesting evaluation to be "cleared" for hormone replacement therapy and ultimately gender reassignment surgery. Discussion: Informed consent typically has three requirements 1) the disclosure of treatment-relevant information to patients by clinicians, 2) that the patients' decision must be voluntary, and 3) that the patient must be competent to make the treatment decision (Grisso & Applebaum, 1998). The first portion of this workshop will discuss unique considerations regarding capacity evaluations of a minor. For instance, the law related to the treatment of minors generally presumes that they are incompetent to consent though there are some exceptions (Grisso, 2003). Furthermore, courts' decisions about competence are influenced by the consequences of the treatment decision (Grisso & Applebaum, 1993). In the case of gender reassignment surgery, the consequences of the treatment decision are generally irreversible and thus require special considerations. The second portion of the workshop will focus on the disclosure element of a competency evaluation for the treatment of gender dysphoria. Generally, the law requires that patients must be informed of five things: 1. The nature of the disorder for which treatment is

being proposed. 2. The nature of the proposed treatment. 3. The benefits associated with the treatment as well as the likelihood of their occurrence. 4. The risks and discomforts associated with the treatment and their likelihood. 5. The alternative treatments available (including no treatment), as well as their risks and benefits (Natanson v. Kline, 1960). Gender reassignment usually consists of a diagnostic phase (mostly supported by a mental health professional), followed by hormonal therapy (through an endocrinologist), a real-life experience, and at the end the gender reassignment surgery itself (Monstrey, 2011). This portion of the workshop will emphasize the relevant disclosures listed above specifically as they relate to the process of gender reassignment.

NO. 1 CASE PRESENTATION

Speaker: Erik R. Frost, M.D.

SUMMARY:

Presentation and discussion of relevant case, including discussion of differential diagnosis, results of psychological testing, and treatment course.

NO. 2 COMPETENCY EVALUATIONS IN MINORS

Speaker: Philip J. Candilis, M.D.

SUMMARY:

A discussion of the legal components included in a competency evaluation, with special consideration towards minors seeking treatment of gender dysphoria.

NO. 3 DISCLOSURE ELEMENTS AND DISCUSSION IN THE TREATMENT OF GENDER DYSPHORIA

Speaker: Ricky D. Malone, M.D.

SUMMARY:

A discussion of treatment options for gender dysphoria, including how they relate to a competency evaluation with special consideration to the ethical dilemma of treatment in a minor.

MOBILE MENTAL HEALTH APPS: WHAT CLINICIANS NEED TO KNOW

Chair: Michael Van Ameringen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) 1) To obtain an overview of how mental health apps can be used in clinical practice; 2) 2) To review the advantages and disadvantages of using mental health apps; 3) 3) To review the evidence based literature on mental health apps; 4) 4)

SUMMARY:

The widespread adoption and use of mobile technologies is opening new and innovative ways to improve health and healthcare delivery. Mobile Health (mHealth) is the term used to describe the practice of medicine and public health that is supported by mobile devices. The healthcare software application (app) industry is generating hundreds of new apps each month with most designed for use on mobile devices. It is estimated that, by the end of 2015, about half a trillion apps will have been downloaded. Over half of smartphone users use their mobile device to search for health information, with 20% of them having a health related app. The most popular of these are related to weight, diet and exercise, with 6% of mHealth apps focusing on mental health outcomes. In spite of new FDA regulations, most mental health apps will not be regulated, largely leaving the review and certification of apps to the marketplace. Most available reviews of mHealth apps have largely focused on personal impressions, rather than evidence-based, unbiased assessments of clinical performance and data security. Many apps have been developed by reputable organizations so users may be confident in app accuracy, purpose and adherence to treatment guidelines, however there are very few published validation studies. Consumer acceptability of mHealth has typically been rated as good, although there is little data on how much individuals actually use their mHealth apps. This symposium will provide an overview of the use of mental health apps. The evidence-based literature for mental-health apps will be reviewed. The advantages and disadvantages of using Apps in clinical practice will be discussed with a focus on the safety and security of mHealth apps. Strategies for integrating apps into clinical practice will be reviewed. As well

some of the more popular mental health apps will be demonstrated.

NO. 1 MENTAL HEALTH APPS: WHERE TO START?

Speaker: Michael Van Ameringen, M.D.

SUMMARY:

There has been an explosion in the development and use of mobile health (mhealth) apps that are widely used by consumers. By 2018, it is estimated that more than 14 billion Smartphone and tablet users will have downloaded mhealth applications. However with the rapid developments in this field, it has been hard for clinicians to keep abreast of these advances. Mental health apps can provide psycho-education, clinical assessment, tracking of symptoms and physiological variables and self-help or therapist-assisted treatment. Many apps have been developed by reputable organizations (Mayo Clinic, VA's National Centre for PTSD, etc.) making users confident in the app's accuracy, purpose and adherence to treatment guidelines, there are few published validation studies. This presentation will 1) provide a broad overview of the use of mental health apps, 2) review the evidence-based literature for the use of mental health apps, 3) examine the potential advantages of using mental health apps and 4) look at the potential use of mental health apps in the future.

NO. 2 APPS: SAFETY, PRIVACY AND ETHICAL ISSUES

Speaker: Simon A. Rego, Psy.D.

SUMMARY:

We are in the midst of the mobile revolution, spurred by both the advances in mobile technology and the widespread adoption of that technology. The speed with which mobile devices have been embraced exceeds that of any previous technology. While there are numerous advantages to using this technology, there are also many significant issues that still need to be addressed when it comes to using them – especially within the healthcare industry. This portion of the talk will address several of these key issues, including: data security and privacy, licensure and jurisdiction, safety and liability, and efficacy/effectiveness.

**NO. 3
PRACTICAL APPLICATIONS OF MENTAL
HEALTH APPS**

Speaker: Michelle A. Blackmore, Ph.D.

SUMMARY:

Technology-based solutions to enhance client engagement and delivery of health care are a primary focus of recent health care reform efforts. Within mental health care, clinicians are increasingly using mobile technologies such as mhealth apps to augment clinical interventions in a more personalized, timely, transportable, and cost-effective manner. Indeed, there are now countless mhealth apps available for smart phones that target a range of mental health issues, and such apps can assist greatly in improving the generalization and saliency of therapeutic interventions outside of session. When determining whether mhealth apps might be useful in your own clinical practice, the challenge is figuring out where to begin. How can you incorporate these apps into your clinical practice, and how do you choose the appropriate apps for your clients? This portion of the symposium will review a sampling of the more popular mhealth apps that can be used to enhance self-monitoring, thought tracking, behavioral activation, exposure work, and coaching, as well as self-assessment and psychoeducation. A review of mhealth apps based on empirically-supported treatment principles will be provided, as well as demonstrated for the audience.

**NO. 4
MENTAL HEALTH PROFESSIONALS'
ATTITUDES TOWARDS THE USE OF
MENTAL HEALTH MOBILE
APPLICATIONS (APPS) IN CLINICAL
PRACTICE**

Speaker: Keren Grosman Kaplan, M.D.

**OUTCOME ASSESSMENTS, THE NEW
GENERATION, AND THE CHALLENGES
OF THE IMPLEMENTATION**

*Chairs: Victor J.A. Buwalda, M.D., Ph.D.,
William Narrow, M.D., M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outcome measurements

these days is more and more common but not automatically part of the clinical care process. This symposium aims to give participants insight into the challenges and benefits of outcome measurement in psychiatry and addiction. . ; 2) The participant will learn about the different possibilities of this model and its implementation in daily clinical practice; 3) The participant will also get an overview of the differences between the US and The Netherlands. .

SUMMARY:

Almost two decades have elapsed since the announcement of an "outcomes revolution" by Sperry (1997), yet outcomes measurement is still not fully integrated into routine psychiatric practice despite its usefulness in determining whether effective and economically responsible healthcare has been delivered. Outcome measurement makes quality, access and cost visible by using standardized measurement instruments. Outcome monitoring uses those instruments to assess these key metrics at pre-determined points in the processes of care. Outcome management involves collection of data on individuals, populations and services to continuously improve performance.

Unfortunately, at present, outcome measurement and monitoring is not automatically used in daily clinical practice. Clinicians, organizations, government bodies, insurers and other stakeholders throughout the world are trying resolutely to promote their use (Trauer et al., 2010; Buwalda et al. 2011, 2013). In this workshop/symposium American and Dutch researchers in the field of psychiatry and addiction will present new strategies in using outcome measures in routine clinical practice.

First, a project studying the entire process of validating and implementing outcome measures will be presented (Buwalda, Ph.D. thesis (2013). Measurement instruments were implemented in a psychiatric outpatient clinic for anxiety and mood disorders. The three quality domains defined by Donabedian (1988), structure, process and outcomes, were the frame. The validity of outcome monitoring measures was evaluated, and the implementation of the outcome measures, with feedback on the treatment results to both clinicians and patients was studied in daily clinical practice.

Secondly, three presentations representing different projects of implementation and the hurdles to overcome in the field of psychiatry

and addiction will be discussed. The last presentation concerns dimensional assessments in DSM-5 in the US.

NO. 1 ROUTINE OUTCOME MONITORING (ROM) IN DUTCH PSYCHIATRY: MEASUREMENT INSTRUMENTS, IMPLEMENTATION AND OUTCOME

Speaker: Victor J.A. Buwalda, M.D., Ph.D.

SUMMARY:

This presentation is about the study on the entire process of validating and implementing of Outcome Measures in routine clinical practice in an psychiatric outpatient clinic for anxiety and mood disorders. The three quality domains defined by Donabedian (1988): structure, process and outcomes, formed the framework. The study presented here consists of two parts. The first evaluated the validity of the Outcome Monitoring measures: are these measurement instruments capable of demonstrating insight into the treatment process? The second study considered the implementation of the outcome measures, where feedback concerning treatment results was offered to both clinicians and patients; it also examined their attitudes to the use of Outcome Measurement instruments in daily clinical practice (Buwalda, PhD thesis (2013).

Important factors to influence the implementation process are attitude, professional autonomy, organizational factors, the constantly changing health care environment and pressures caused by insurers and governmental bodies.

NO. 2 USE OF OUTCOME MEASUREMENTS IN CLINICAL PRACTICE: HOW SPECIFIC SHOULD ONE BE?

Speaker: M. Annet Nugter, Ph.D.

SUMMARY:

Outcome measurement may be used in clinical practice as feedback to the professional on the progress of the patient. Examples are the feedback systems of Michael Lambert and Scott Miller and their research groups. Other countries such as the United Kingdom use outcome measurement as part of the national performance measurement.

It has been shown that the use of outcome assessments in individual treatment is effective for patients who do not improve or who improve less than expected (e.g. Knaup et al., 2009). Signals of lack of improvement alerts the professional and helps him to think about the accuracy of his diagnosis, the chosen interventions, or general factors that influence the course of treatment (the occurrence of life events, the patient-professional working alliance, the patient's support system).

Research has also shown that the professional's attitude towards receiving feedback from outcome assessments and towards the relevance of the instruments are crucial factors in the acceptance and use of this feedback information (De Jong et al., 2012; Van Dijk et al., 2013). Instruments such as the Outcome Questionnaire or the Health of the Nation Outcome Scales are often regarded as too general to be useful in treatment.

In this presentation outcomes of general and more specific measurements taken from several patient groups will be compared and discussed with the participants.

NO. 3 ROM IN ADDICTION CARE IN THE NETHERLANDS

Speaker: Gerdien H. de Weert-van Oene, Ph.D.

SUMMARY:

Between 2000 and 2011 three nationwide outcome monitoring projects were conducted in The Netherlands: in Lifestyle Training programs, at inpatient motivational centers and dual diagnosis clinics. In 2011 an Expert Committee offered advice for the implementation of ROM in the field of addiction care. Contrary to the above-mentioned projects, this ROM was to be implemented separately from special programs or settings, throughout the whole treatment. One of the major challenges for the committee was to identify outcome measures suitable for addiction care. These were found in four domains: addiction, symptomatology, limitations in daily functioning and quality of life. Client satisfaction was added later. These days insurance companies require the implementation of ROM to account for performance. However, the implementation of monitoring is hampered by this obligatory character of ROM.

In this contribution the main principles of Dutch ROM in the field of addiction care are

discussed, as well as strengths and weaknesses in the implementation process. A number of outcome results are presented.

NO. 4 USE AND OUTCOMES OF ROM FOR PATIENTS UNDERGOING SHORT-TERM TREATMENT IN A LARGE URBAN INSTITUTION

Speaker: Stasja Draisma, Psy.D.

SUMMARY:

GGZ InGeest is a large mental health hospital (2,300 staff members and 30,250 patients currently undergoing treatment) with a catchment area for patients in the Amsterdam region. The majority of patients is treated for mood and anxiety disorders in short term care. For the last few years ROM has been implemented during treatment for approximately forty percent of the patients. Changes in symptoms are assessed with symptom check lists such as the BSI. In the presentation, we will compare the change in symptoms for in- and outpatients in short term care for mood and anxiety disorders. To what extent are ROM questionnaires applied; is this sample representative for the patient population; and what kind and magnitude of change are obtained during short term treatment? What differences are found between various groups of patients (e.g. in- or outpatients, diagnoses, treatment duration/history). An impression of the way in which ROM outcomes are used and appreciated by caregivers of the institution will be presented.

NO. 5 DIMENSIONAL ASSESSMENTS IN DSM- 5

Speaker: William Narrow, M.D., M.P.H.

SUMMARY:

One of the major goals of DSM-5 development was to expand the diagnostic assessment to include not only categorical disorders, but also dimensional assessments of symptoms, disability, and personality traits. Such an assessment is important in that it has the potential for increased clinical utility and diagnostic accuracy, improved care, and enhanced patient satisfaction. The DSM-5 includes, in Section 3 and online, measures for the assessment of cross-cutting symptoms,

severity of diagnosis, personality traits, and disability. These measures were tested in the DSM-5 field trials in children, adolescents, and adults, and were demonstrated to have good reliability and feasibility in this clinical research context. The next step for these measures is to conduct more research on their effect on quality of care and the best methods to disseminate and implement them in routine practices. In this presentation the background of the dimensional measures in DSM-5, and how a new diagnostic assessment could be advantageous for both research and clinical practice, will be covered.

BORDERLINE PERSONALITY DISORDER (BPD) AND COMORBID DISORDERS: WHEN TO PRIORITIZE TREATMENTS FOR EACH

Chair: John G. Gunderson, M.D.

Discussant: Anthony Bateman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) distinguish when the treatment of co-occurring disorders take precedence over treatment of BPD ; 2) know when treatment of BPD takes precedence over treatment of co-occurring disorders; 3) know that once manic episodes are remitted, BPD remains as a serious illness requiring its own treatment; 4) differentiate these forms of PTSD that make treating BPD unfeasible and possibly harmful; 5) restrict the prescription of anti-depressants when MDD co-occurs with BPD.

SUMMARY:

Borderline personality disorder usually co-occurs with bipolar disorder (about 25%), substance abuse disorders (about 35%), PTSD (about 30%), major depressive disorder (about 50%), and anxiety disorders (about 40%). Clinicians must decide whether and when to treat them concurrently or when to give one or the other of these disorders priority. This symposium will offer informed and practical clinical guidelines as to how to make these decisions.

NO. 1 BPD AND BIPOLAR DISORDER

Speaker: Mark Zimmerman, M.D.

SUMMARY:

Both bipolar disorder and borderline personality disorder (BPD) are serious mental health disorders resulting in significant psychosocial morbidity, reduced health related quality of life, and excess mortality. A comprehensive review of the comorbidity between BPD and bipolar disorder: found that approximately 10% of patients with BPD had bipolar I disorder and another 10% had bipolar II disorder. Likewise, approximately 20% of bipolar II patients were diagnosed with BPD, though only 10% of bipolar I patients were diagnosed with BPD. In this presentation I will review studies of the impact of BPD on the treatment of bipolar disorder and the studies of the impact of bipolar disorder on the treatment of BPD. In addition, I will review which treatments have been found to be effective for both disorders and which treatments have been found to be effective for only 1 of these 2 disorders. Cases will be described of patients with both BPD and bipolar disorder and how treatment was sequenced and prioritized. Finally, based on the available empirical evidence and clinical experience a framework for treatment prioritization will be presented.

NO. 2 POSTTRAUMATIC STRESS DISORDER AND BPD

Speaker: Judith L. Herman, M.D.

SUMMARY:

Most people suffering from borderline personality disorder report a history of childhood trauma: physical abuse, sexual abuse, and/or witnessing domestic violence. Prolonged and repeated trauma in childhood is indicative of disrupted parental care and consequent insecure attachment. The disturbances in affect regulation, toxic shame, and self-loathing that are hallmarks of BPD can be understood as developmental sequelae of trauma and disrupted attachment in childhood. This paper will suggest that trauma-informed psychotherapy is a useful foundation for treatment, whether or not the patient meets diagnostic criteria for full-blown concurrent PTSD. A basic understanding of the developmental impact of childhood trauma helps the patient make sense of herself (a.k.a. mentalize) and relieves shame. Within this basic framework, however, the focus of treatment can be modified, depending on the patient's

chief complaints and stage of recovery. Case examples will be offered as illustrations.

NO. 3 BPD AND MAJOR DEPRESSIVE DISORDER

Speaker: John G. Gunderson, M.D.

SUMMARY:

These disorders commonly co-occur (~ 50%) and most frequently treatment begins with the "more treatable" disorder, i.e., MDD. This presentation will describe why this strategy is not helpful and usually harmful. Reasons to treat BPD first and make MDD secondary include: a) when BPD remits, MDD's remission follows, b) antidepressants are specifically the least useful type of medication for MDD when BPD is present, c) emphasis on medications undermines the message of taking control over one's life necessary for successful treatment of BPD, and d) the failure of antidepressant medications causes despair and hopelessness, and unnecessarily prolongs the depression.

NO. 4 BPD AND ANXIETY DISORDERS

Speaker: Alex S. Keuroghlian, M.D.

SUMMARY:

Anxiety disorders occur in about 25 to 50 percent of BPD patients. This paper will review the available evidence about their interaction and then suggest that because BPD has a strongly negative effect on the course of GAD and social phobia, it needs to be prioritized in treatment planning. In contrast, BPD has little interaction with the course of OCD or panic disorder and these need to be treated like independent disorders. Why the different anxiety disorders interact differently with BPD will be discussed.

NO. 5 BPD AND SUBSTANCE ABUSE

Speaker: Joel Paris, M.D.

SUMMARY:

Substance abuse is one of the most common comorbidities related to the diagnosis of BPD. A large body of research shows that the presence of severe substance abuse interferes with treatment, and predicts a poorer outcome,

including death by suicide. Severe substance abuse, which seriously interferes with functioning, may be a contra-indication for the prescription of specialized forms of psychotherapy that have been shown to be effective in BPD. In these cases, interventions to bring the use of substances under control can precede the application of evidence-based psychological treatment.

In contrast, mild to moderate levels of substance abuse, in which large areas of functioning are unaffected, can be considered to be "part of the territory" of BPD, and are not a contra-indication. Research shows that most patients with BPD decrease their level of substance abuse as they recover over time. While there are few clinical trials that directly address this comorbidity, treatment may be effective in reducing lower levels of these symptoms.

ACADEMIC PSYCHIATRY 101: A TOOLKIT FOR EDUCATORS

Chair: Sarah B. Johnson, M.D.

EDUCATIONAL OBJECTIVE:

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

- 1) 1. Understand job opportunities in academic Psychiatry and what to ask for when negotiating for jobs in learning institutions;
- 2) 2. Become familiar with basic skills necessary to work in academics, including preparing and presenting lectures, utilizing technology in education, giving feedback to students and writing letters of recommendation.;
- 3) 3. Have an opportunity to discuss questions and concerns about the future of academic medicine with distinguished educators.

SUMMARY:

Navigating the world of academic Psychiatry can be a daunting task. Many people graduate from residency feeling ill-prepared to embark on a career in academics. Little formal training may be available in some institutions and formal mentorship programs can be difficult to find. The goal of this symposium is to provide an overview of academic Psychiatry and guide Early Career (or those considering a career change or needing a refresher) psychiatrists through today's complex world of medical education. From negotiating your first job to preparing a lecture, to giving feedback to learners, this symposium will provide tools

necessary to serve as effective educators. All presenters are leaders in the Association of Academic Psychiatry at various stages of their careers, with proven track records as educators.

Part 1. Introduction and Pearls and Pitfalls of Negotiating Your First Job

This section will address the process of job negotiation, as well as provide an overview of careers available in Psychiatry. Subspecialties, funding sources, basics of contracts and negotiation skills will be explored. Participants will have the opportunity to ask questions and will understand factors that can contribute to overall job satisfaction in academics at the conclusion of this part of the presentation.

Part 2. Educator Bootcamp 101

This part of the presentation will include mini-presentations on key skills required in education. Distinguished educators will share their experiences and offer instruction on topics including teaching methods, preparing lectures, technology in education, mentorship, writing letters of recommendation and giving feedback to learners. Issues such as boundaries and professionalism will also be discussed. Audience participation and interaction will be included throughout the presentation.

Part 3. The Future of Academic Psychiatry

The conclusion of this presentation will include a panel discussion of current issues in academic Psychiatry. Funding sources, changes in education driven by LCME and ACGME accrediting bodies and the impact of healthcare reform on academic Psychiatry will be included. Discussion will include how to preserve the educational mission in times of budget stress and best practices for dealing with institutional conflicts that arise during times of system stress.

NO. 1

PART 1. INTRODUCTION AND PEARLS AND PITFALLS OF NEGOTIATING YOUR FIRST JOB

Speaker: John Luo, M.D.

SUMMARY:

This section will address the process of job negotiation, as well as provide an overview of careers available in Psychiatry. Subspecialties, funding sources, basics of contracts and negotiation skills will be explored. Participants will have the opportunity to ask questions and

will understand factors that can contribute to overall job satisfaction in academics at the conclusion of this part of the presentation.

NO. 2 EDUCATOR BOOTCAMP 101

Speaker: Joan M. Anzia, M.D.

SUMMARY:

This part of the presentation will include mini-presentations on key skills required in educations. Distinguished educators will share their experiences and offer instruction on topics including teaching methods, preparing lectures, technology in education, mentorship, writing letters of recommendation and giving feedback to learners. Issues such as boundaries and professionalism will also be discussed. Audience participation and interaction will be included throughout the presentation.

NO. 3 THE FUTURE OF ACADEMIC PSYCHIATRY

Speaker: Robert Boland, M.D.

SUMMARY:

The conclusion of this presentation will include a panel discussion of current issues in academic Psychiatry. Funding sources, changes in education driven by LCME and ACGME accrediting bodies and the impact of healthcare reform on academic Psychiatry will be included. Discussion will include how to preserve the educational mission in times of budget stress and best practices for dealing with institutional conflicts that arise during times of system stress.

DISSOCIATIVE SUBTYPE OF POSTTRAUMATIC STRESS DISORDER (PTSD): NEURAL, EPIGENETIC AND CLINICAL ASPECTS

Chair: David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define and discuss the new dissociative subtype of PTSD In the DSM-5.; 2) Identify trauma history and symptom profiles that distinguish the hyperarousal from the dissociative subtype of PTSD.; 3) Identify epigenetic differences between hyperarousal

and dissociative PTSD ; 4) Identify emotion regulation deficits in PTSD.; 5) Discuss treatment implications of the dissociative vs. hyperarousal subtype of PTSD.

SUMMARY:

We propose a panel on neural correlates of dissociation involving new data on a novel diagnostic category in the DSM-5: the dissociative subtype of PTSD. The data presented include epigenetic developmental precursors of dissociation, neuroimaging of brain mechanisms underlying dissociation, and implications of these developments for treatments that differ from standard care for trauma-related disorders. Dr. Spiegel as Chair would provide an overview of dissociative disorders, novel diagnostic categories in DSM-5, and treatment implications of the findings to be presented. Dr. Vermetten will discuss latent class analysis studies and epidemiological data that have informed us about the clinical endophenotype of the dissociative subtype across PTSD studies, and discusses the importance of identifying this subgroup in biological studies. The subtype has been identified in 15-30% of PTSD populations, characterized by suicidality as well as early life trauma histories. Dr. Yehuda will present epigenetic and neuroimaging evidence regarding biomarkers of dissociation in PTSD among OIF/OEF combat veterans. Epigenetic data among 174 OIF/OEF combat veterans with PTSD show that methylation of the NR3C1 glucocorticoid receptor gene is lower and gene expression higher (enhanced GR sensitivity), while in those with high dissociation, GR methylation is higher and gene expression is lower. Dr. Lanius will present novel fMRI data on trauma-related brain mechanisms of dissociation. The new biological profile of this subtype involves emotional over-modulation by mPFC that impacts peripheral and central processing of affect, in contrast to the limbic activation and frontal inhibition typical of hyperarousal forms of PTSD. These results imply distinct connectivity patterns underlying unique PTSD symptom dimensions and suggest biomarkers for PTSD and its dissociative subtype involving specific brain regions. Dr. Spiegel will discuss therapeutic implications using new fMRI data on brain regions associated with hypnotizability and the hypnotic state. They suggest that structured management of dissociation using hypnosis can

modulate the PFC-limbic imbalance seen in the dissociative subtype of PTSD. These findings link epidemiological, clinical, epigenetic, and neuroimaging data and carry implications for differences in treatment of those with the dissociative subtype of PTSD.

NO. 1 DISTINCT INTRINSIC CONNECTIVITY PATTERNS OF PTSD HYPERAROUSAL

Speaker: Ruth A. Lanius, M.D., Ph.D.

SUMMARY:

Background Posttraumatic stress disorder (PTSD) is a multidimensional disorder including distinct symptom clusters. The objective of this study was to examine the degree to which resting intrinsic connectivity of the default mode (DMN)-, central executive (CEN)-, and salience network (SN) was associated with severity of re-experiencing (RE), avoidance/numbing (A/N), hyperarousal, and depersonalisation/derealisation (DP/DR) symptoms.

Methods Using an independent component analysis (ICA) of resting-state functional MRI data from 21 PTSD participants, a multivariate analysis of covariance was performed to determine functional connectivity in relation to PTSD symptoms.

Results Hyperarousal symptoms were associated with significantly decreased connectivity of posterior insula/superior temporal gyrus within the salience network (peak MNI: -44, -8, 0, $t = -4.2512$, $k = 40$). DP/DR symptoms were associated with a decoupling of perigenual anterior cingulate/ventromedial prefrontal cortex within dorsal DMN (peak MNI: 8, 40, -4; $t = -3.8501$; $k = 15$). Their severity was associated with altered functional connectivity of dorsal and ventral DMN components as well as between dorsal DMN and CEN. No significant associations were observed for RE or A/N symptoms.

Conclusions Intrinsic connectivity network alterations in PTSD underlie hyperarousal and DP/DR PTSD symptoms. These findings may aid in the identification of possible biomarkers for PTSD and its newly defined dissociative subtype.

NO. 2 DEVELOPMENT OF A DSM-5 BASED CLINICIAN ADMINISTERED

DISSOCIATIVE SUBTYPE SCALE TO PTSD

Speaker: Eric Vermetten, M.D., Ph.D.

SUMMARY:

Background: Thus far latent class analysis studies have informed us about the representation of the clinical phenotype of the dissociative subtype of PTSD. These have underscored the importance of identifying this subgroup in clinical studies. The subtype is typically identified in 15-30% of studied populations, often characterized by comorbidities as well as early life trauma histories. Method: There is an urgency for a proper clinical scale, that is based on DSM5 typology and that can be used in clinical as well biological studies. Results: This presentation will focus on a scale that is can be added to the CAPS and can be used to assess the subtype, and serves to monitor treatment response. This is important in the phase-oriented treatment planning. Conclusions: Results from earlier analyses as well as first results in various populations will be presented.

NO. 3 EMERGING BIOLOGICAL EVIDENCE FOR THE DISSOCIATIVE SUBTYPE

Speaker: Rachel Yehuda, Ph.D.

SUMMARY:

Background: The creation of a new dissociative sub-type of PTSD in DSM-5 has rekindled discussions of whether symptoms such as dissociative amnesia, depersonalization or derealization reflect amplifiers of PTSD, or represent a distinct biological phenotype.

Methods: Two data sets were analyzed to determine biological correlates of dissociation. In the first, white matter abnormalities in PTSD were examined with diffusion tensor imaging tractography in 20 combat veterans with and without PTSD. In a second, 50 combat veterans with PTSD were evaluated for genome-wide methylation and were compared with 50 combat veterans without PTSD.

Results: Lower mean diffusivity and increased fractional anisotropy was observed in combat veterans with PTSD showing high dissociation in the cingulum bundle. Furthermore, depersonalization/derealization and dissociative amnesia were highly associated with greater connectivity ($r = -.523$, $p = .108$ and $r = -.475$,

$p=.02$, respectively). For the DNA methylation subgroups bi-clustering analyses, two distinct clusters were observed that were found, following pathway analyses, to associate with peritraumatic dissociation. Subsequently, the entire sample could be correctly classified by the genes responsible for the clustering.

Conclusions Greater connectivity in the cingulum bundle in high dissociators support the idea that dissociative symptoms may have a distinct neural and structural correlates. The methylation data revealed a unique molecular (epigen

NO. 4 BRAIN REGIONS INVOLVED IN HYPNOSIS AND DISSOCIATION: THERAPEUTIC IMPLICATIONS

Speaker: David Spiegel, M.D.

SUMMARY:

Background Hypnosis has proven clinical utility in treating PTSD and dissociation.

Methods In the first fMRI study we compared 12 highs and 12 lows on the Hypnotic Induction Profile (HIP) at rest. In the second we compared 36 highs and 21 lows consistently high or low on the HIP and the Harvard Group Scale (HGSHS) in and out of hypnosis.

Results 1) Resting state analysis revealed significantly greater functional connectivity between the left dorsolateral prefrontal cortex and the dorsal anterior cingulate cortex among highs compared to lows ($p=.01$). 2) During hypnosis high hypnotizables exhibited reduced regional fractional amplitude of BOLD signal in the dACC and left superior frontal gyrus during hypnosis relative to rest (TFCE) $p < .05$. Highs also displayed significantly greater connectivity between right DLPFC and both left and right insula during hypnosis compared to rest at $p < .05$. Connectivity between left DLPFC and core default mode regions, including posterior cingulate cortex (PCC) and contralateral inferior parietal lobule (IPL) were significantly negatively correlated with hypnotic experience ($p < .05$).

Conclusions These changes underlie the focused attention and enhanced somatic control that characterizes hypnosis. They provide a mechanism underlying psychotherapy involving structured exposure to traumatic memories coupled with somatic control: frontal control of insula and default mode regions, with

better regulation of emotion, cognition, and memory.

EDUCATING PSYCHIATRISTS FOR WORK IN INTEGRATED CARE: FOCUS ON INTERDISCIPLINARY COLLABORATION

*Chairs: Deborah Cowley, M.D., Lori Raney, M.D.
Discussant: Jurgen Unutzer, M.D., M.P.H.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify challenges in teaching psychiatry residents and psychiatrists to work with other disciplines in integrated care settings; 2) Discuss core competencies needed to work as a psychiatrist consultant in integrated care settings with team members of different disciplines; 3) Describe models, rotations, and curricula currently available to teach psychiatrists to work collaboratively in integrated care settings.

SUMMARY:

Of people in the United States with mental disorders, most do not seek care. Of those who do, only one in eight sees a psychiatrist, and the majority consult primary care physicians. Rates of psychiatric disorders in primary care settings are high, at about 25% of employed and 50% of Medicaid patients. Anxiety and depression increase utilization and costs in primary care settings. Unfortunately, even when psychiatric disorders are recognized in primary care patients, there are significant barriers to referring them for mental health care. These include a lack of psychiatrists and other mental health providers and the stigma of psychiatric referral and treatment. Recognition of this unmet need for mental health care has led to efforts to integrate such care into primary care settings. Integrated care models, such as collaborative care, significantly improve access, outcomes, function, and patient satisfaction. With the advent of patient-centered medical homes and accountable care organizations (ACOs), there is increasing interest in implementing integrated care models. In addition, the excess mortality of psychiatric patients, especially the chronically and seriously mentally ill, from medical causes has led to efforts to integrate primary medical care into mental health settings such as community mental health centers. This symposium

addresses the educational needs of psychiatrists interested in working in integrated care. Such work requires competencies in interdisciplinary teamwork, education and supervision of other team members, effective communication and coordination of care, and working within the "culture" of primary care. Four presentations will discuss a national survey of how psychiatry residency programs are currently beginning to educate residents about integrated care, the role and needed skills of the consulting psychiatrist within a collaborative care team, education of psychiatry and family medicine trainees and practitioners in integrated care in Canada, and a curriculum to train PCPs to work in mental health settings. A panel of primary care medical and psychology providers will discuss what they need and want in a psychiatrist consultant and the needs of their own trainees for education regarding psychiatric disorders and behavioral problems.

**NO. 1
HOW PSYCHIATRY RESIDENCY
PROGRAMS ARE EDUCATING THEIR
RESIDENTS IN INTEGRATED CARE:
NATIONAL SURVEY RESULTS AND
RECOMMENDATIONS FOR EDUCATORS**

Speaker: Claudia L. Reardon, M.D.

SUMMARY:

Education in integrated care is increasingly important during psychiatry residency. The new Accreditation Council for Graduate Medical Education (ACGME) Psychiatry Milestones require that residents be able, by the time of graduation, to provide integrated care for psychiatric patients through collaboration with other physicians. In 2014, the American Association of Directors of Psychiatric Residency Training (AADPRT) Integrated Care Task Force undertook a survey of all general and child and adolescent psychiatry residency training directors to ascertain program strategies for educating their trainees in integrated care. In this presentation, the Chair of this task force will describe the results of this national survey, including types and venues of integrated care rotations offered, when in the course of residency they are offered, how supervision is provided, how rotations are funded, and how didactics are organized. Based on themes that emerged from the survey, she will make recommendations for ways in

which programs can start or optimize their own integrated care education for residents.

**NO. 2
EDUCATIONAL NEEDS OF THE
INTEGRATED CARE CONSULTING
PSYCHIATRIST**

Speaker: Anna Ratzliff, M.D., Ph.D.

SUMMARY:

There is now a strong evidence-base for providing mental health care for patients with common disorders such as depression or anxiety in primary care using integrated care models. In these models, such as Collaborative Care, a psychiatric consultant works closely with a team, including primary care providers and behavioral health providers, using a shared workflow to provide mental health care in a primary care setting using chronic illness care principles such as measurement based treatment to target and population-based approaches. With the increased implementation of integrated care models, psychiatrists'™ educational needs will also need to evolve. The educational needs of the psychiatric consultant and the consulting psychiatrist perspective on the training needs of the typical integrated team members (consulting psychiatrist, primary care providers and behavioral health professionals) will be reviewed.

**NO. 3
COLLABORATIVE MENTAL HEALTH
CARE IN CANADA: PSYCHIATRY-
FAMILY MEDICINE PARTNERSHIPS**

Speaker: Nick Kates, M.B.B.S.

SUMMARY:

Over the past 15 years, there has been increasing interest in Canada in collaborative partnerships between primary care and mental health providers, including integrating mental health services into primary care settings. The Canadian Psychiatric Association and the College of Family Physicians of Canada have collaborated since 1997 in making recommendations about shared mental health care. These have included recommendations for academic centers and continuing education departments about how to prepare learners and practicing physicians in both disciplines to work together in collaborative interprofessional

partnerships, both in delivering direct patient care and at a systems level, designing and evaluating integrated care programs. This presentation will focus on what psychiatrists need to learn to effectively collaborate with family physicians and how psychiatry and family medicine residents are trained to work in integrated care settings in Canada.

**NO. 4
TRAINING PRIMARY CARE PROVIDERS
TO WORK EFFECTIVELY IN THE
COMMUNITY MENTAL HEALTH CENTER
ENVIRONMENT**

Speaker: Lori Raney, M.D.

SUMMARY:

The range of integrating primary care and behavioral health includes bringing medical services to the population of patients with serious mental illness (SMI) who are dying prematurely due to preventable causes. Many locations across the country, including the 100+ site SAMHSA/HRSA Primary Care Behavioral Health Initiative (PBHCI) have been bringing primary care providers (PCPs) in or near public mental health settings to provide this care in close proximity to where the patients are most willing to be seen. Even with the convenience of this closeness of services, several workforce issues have emerged in these settings and a recent study by RAND has shown major issues with recruiting and retaining PCPs to work in these environments. We have learned in the primary care setting that a subset of psychiatrists make the best consultants with proper training, and we are now recognizing that the same is true of PCPs working in public mental health settings. This presentation will describe a curriculum developed through the Center for Integrated Health Solutions that psychiatrists and PCPs can use to educate newly recruited medical staff to increase the chances of successful partnerships in these settings.

**NO. 5
PANEL DISCUSSION: INTEGRATED
CARE EDUCATION: A
MULTIDISCIPLINARY PERSPECTIVE**

Speaker: Kari A. Stephens, Ph.D.

SUMMARY:

This panel discussion will include the perspectives of a pediatrician, a family physician, and a psychologist, all of whom are educators with an interest and/or experience in integrated care and in teaching trainees and practitioners how to work in these settings. The panel will discuss issues for collaboration with psychiatrists, including what makes a psychiatrist a valuable collaborator and partner, what psychiatrists can learn to work effectively with their discipline in integrated care settings, and how psychiatrists can help to educate trainees and practitioners in other specialties and disciplines about mental health and collaborative mental health care.

**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.

Discussant: Frederick K. Goodwin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) identify and critique recent studies of antidepressants, antipsychotics, anticonvulsants, and lithium in bipolar disorder; ; 2) critique and apply data from the above studies to clinical practice; 3) recognize proposed changes in DSM -5 in bipolar disorders, evidence for and against such changes, and the impact on their practice.

SUMMARY:

In this symposium, the audience will receive updates on the most latest studies, critiqued objectively and interpreted clinically, on treatments for bipolar disorder, provided by leading experts. Presenters will cover antidepressants, antipsychotics, anticonvulsants, and lithium, as well as recent changes in DSM -5. Analyses will be critical, and will delineate strengths and weaknesses in studies and data, and will help the audience understand studies from the last few years, and integrate that knowledge with prior studies and their prior clinical experience. Panel and audience interaction and discussion will allow for the airing of multiple perspectives and approaches. Data from new analyses or studies in the last 2-3 years will be emphasized and presented, in addition to key studies from prior years.

**NO. 1
ANTICONVULSANTS IN BIPOLAR
DISORDERS**

Speaker: Terence A. Ketter, M.D.

SUMMARY:

United States Food & Drug Administration (US FDA) approved treatments for bipolar disorder (BD) include lithium & antipsychotics for acute mania and BD maintenance. Of approximately 30 US FDA approved anticonvulsants, only 3 have BD indications (valproate & carbamazepine for acute mania, lamotrigine for maintenance), with efficacy similar to other approved agents and tolerability similar to lithium and superior to antipsychotics. In this presentation, I will review recent RCTs of new & emerging anticonvulsants in BD and comorbid conditions. These data will be analyzed and put in the context of clinical practice to help understand the potential clinical utility of some of these agents for BD.

**NO. 2
REVIEW OF EFFICACY DATA WITH
NEUROLEPTICS IN BIPOLAR
DEPRESSION AND MIXED STATES**

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

During the past decade, there has been a significant increase in the number of pharmacological treatment options for bipolar depression and recurrence prevention. The increased availability of treatment provides treatment alternatives as well as the impetus to define what comprises an "antidepressant" and "mood stabilizer" in bipolar disorder (BD). This presentation will examine recent randomized studies with antipsychotic agents in the treatment of acute bipolar depression and in maintenance treatment. These recent studies will be analyzed and discussed in terms of their relevance for up-to-date algorithms of treatment for this life-long disorder. Harms, especially metabolic syndrome, will be analyzed. Evidence regarding three new agents marketed in the last few years, with limited metabolic syndrome risks, will be examined. The use of antipsychotics in mixed states of bipolar illness will be especially emphasized.

NO. 3

**ANTIDEPRESSANTS IN BIPOLAR
DISORDER: AN UPDATE**

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

In this presentation, I will review recent randomized clinical trials (RCTs) on antidepressants in bipolar disorder. In particular, I will present and review RCTs from the NIMH-sponsored STEP study in both acute and maintenance treatment of bipolar depression. I will also present the first analysis of a new RCT on citalopram versus placebo, added to mood stabilizers, for acute and maintenance treatment of bipolar depression. This study will be the first placebo-controlled RCT of a modern antidepressant in maintenance treatment of bipolar disorder type I. Other recent RCTs, especially of type II bipolar disorder, will also be presented and analyzed. The audience will learn about the most recent and most valid studies of this topic. New data from a Scandinavian cohort on risk of antidepressant-induced mania will also be presented.

**NO. 4
EFFICACY AND EFFECTIVENESS: HOW
THE NEWEST TRIALS CAN INFORM
CURRENT PRESCRIBING OF LITHIUM
FOR BIPOLAR DISORDER**

Speaker: Michael J. Ostacher, M.D., M.P.H.

SUMMARY:

Lithium is a well-established treatment for bipolar disorder, yet lithium prescribing is declining in clinical practice. Several practical clinical trials studied the use of lithium in clinical practice. BALANCE, a randomized, open-label study maintenance study of bipolar I disorder that compared combination treatment with divalproex sodium plus lithium to monotherapy with either drug, and used a novel design with an active run-in phase prior to randomization. LiTMUS, a randomized, open-label study of subacute patients with bipolar I disorder, compared a strategy using moderate dose lithium added to optimized pharmacological treatment to a strategy using optimized pharmacological treatment without lithium. The six-month long Clinical and Health Outcomes Initiative in Comparative Effectiveness for Bipolar Disorder (CHOICE) compared a strategy using lithium added to care to one using

quetiapine. The results of these effectiveness studies will be discussed relative to the existing efficacy data for lithium in bipolar disorder, with its implications for the clinician trying to manage bipolar disorder in the era of anticonvulsants and atypical antipsychotics. Recent meta-analytic data on randomized efficacy of lithium in suicide prevention will be presented. New analyses from a Scandinavian cohort of lithium risks for long-term renal impairment will be provided.

TREATMENT-RESISTANT DEPRESSION IN LATE-LIFE: RESULTS OF THE INCOMPLETE RESPONSE IN LATE LIFE DEPRESSION: GETTING TO REMISSION RANDOMIZED PLACEBO-CONTROLLED TRIAL

Chairs: Benoit Mulsant, M.D., Eric Lenze, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) describe the epidemiology and current pharmacotherapy options for treatment-resistant depression in late life.; 2) describe the efficacy of aripiprazole augmentation for the pharmacotherapy of treatment-resistant depression in late life.; 3) describe the tolerability of aripiprazole augmentation for the pharmacotherapy of treatment-resistant depression in late life.; 4) identify potential future directions for the pharmacotherapy of treatment-resistant depression in late life.

SUMMARY:

This symposium will present the results of a randomized placebo-controlled trial titled "Incomplete Response in Late-Life Depression: Getting to Remission" (IRL-GREY). This trial was funded by the National Institute of Mental Health (NIMH) to assess the efficacy and tolerability of the atypical antipsychotic aripiprazole used as an augmentation to the serotonin-norepinephrine reuptake inhibitor venlafaxine extended release (XR).

Treatment-resistant major depression is a common and life-threatening psychiatric disorder in older persons. There is scarce available evidence on the efficacy or tolerability of pharmacotherapy for treatment-resistant depression in older adults, as almost all of the treatment trials upon which consensus

guidelines are based derive from studies conducted in mixed age or young adult samples.

From 2009 to 2014, 446 patients age 60 years old and older who presented with a non-psychotic major depressive episode were recruited at three academic sites (Pittsburgh, St Louis, and Toronto). Participants who did not remit during a 12 -14-week lead-in phase of open-label venlafaxine XR (up to 300 mg/day) were considered to be treatment resistant and randomized to augmentation with aripiprazole or placebo in a 12-week phase. Those whose depression remitted during this augmentation phase were kept on blinded augmentation medication (aripiprazole or placebo) for an additional 12-week continuation phase to examine stability of remission and longer-term tolerability. Of 466 participants treated with venlafaxine XR, 181 completed the lead-in phase as nonremitters and were then randomized to the addition of aripiprazole or placebo. Aripiprazole was associated with a higher rate of remission and shorter time to remission, with a number needed to treat (NNT) = 6. Aripiprazole was well tolerated, with no changes relative to placebo in emergence of akathisia or abnormal involuntary movements, fasting blood sugar, cholesterol, or QTc interval. However, aripiprazole was associated with weight gain relative to placebo.

This study is unique in using a placebo-controlled design to assess the efficacy of an atypical antipsychotic in a large sample (N=181) of older adults with prospectively-defined treatment-resistant depression, and in examining the motor, metabolic, and cardiac effects of aripiprazole in this group.

The four presentations will (1) review the epidemiology and current evidence-based treatment options for treatment-resistant late-life depression; (2) present the design of and efficacy results of the IRL-GREY study; (3) describe the safety and tolerability results of the IRL-GREY study; (4) discuss current options and future directions for the pharmacotherapy of logic treatment of treatment-resistant depression in late-life.

NO. 1 EPIDEMIOLOGY AND CURRENT EVIDENCE-BASED TREATMENT OPTIONS FOR TREATMENT-RESISTANT DEPRESSION IN LATE LIFE

Speaker: Daniel M. Blumberger, M.D.

SUMMARY:

When distinguished from inadequate treatment, and misdiagnosis, treatment resistant depression can be defined as failure to achieve remission with at least one antidepressant medication trial of adequate dose and duration. Rates of treatment resistance in randomized controlled trials of SSRIs and SNRIs in late-life depression range from 50-80%. There is a paucity of data to guide the pharmacotherapy of treatment-resistant depression in late life. STAR*D included only a small number of older subjects, and industry-funded phase-3 trials of aripiprazole and quetiapine excluded adults aged >65. The two published geriatric randomized controlled trials suffer from small sample size, short duration, and inclusion of subjects with psychosis. Several open studies have assessed various pharmacologic strategies including open studies of switching from an SSRI to nortriptyline, venlafaxine, or duloxetine; lithium, bupropion, or nortriptyline augmentation of an SSRI. A significant proportion (i.e., 40-50%) of SSRI nonresponders remit with these strategies. The switch to a SNRI appears to be as effective as, and more easy to implement than, augmentation strategies. However, many patients do not respond to or tolerate these strategies or have a brittle response. Additional studies are needed to address the problem of treatment-resistant depression in late life.

NO. 2

THE IRL-GREY CLINICAL TRIAL OF ARIPIPRAZOLE AUGMENTATION FOR TREATMENT-RESISTANT DEPRESSION IN LATE LIFE: TOLERABILITY AND SAFETY

Speaker: Benoit Mulsant, M.D.

SUMMARY:

Several concerns exist regarding the use of antipsychotic medications in older adults, including neurological side effects, cardiometabolic effects (e.g., weight gain and adiposity, insulin resistance, and hyperlipidemia), and cardiovascular effects potentially leading to a mortality risk. These concerns mostly stems from placebo-controlled trials conducted in older patients with dementia and there is virtually no controlled data

regarding the safety and tolerability of antipsychotic medications in older patients with mood disorders.

In the IRL-Grey study, individuals (N=181) who were randomized to the addition of aripiprazole or placebo, were assessed using a battery of physiological markers and measures. They included: (1) validated measures of akathisia, parkinsonism, and tardive dyskinesia; (2) fasting insulin, glucose, and lipids to measure cardiometabolic consequences of aripiprazole (3) DEXA scans to measure adiposity (4) EKG, pulse, and blood pressure; (5) systematic assessments of somatic symptoms to assess for adverse effects. The results of these assessments will be presented.

NO. 3

THE IRL-GREY CLINICAL TRIAL OF ARIPIPRAZOLE AUGMENTATION FOR TREATMENT-RESISTANT DEPRESSION IN LATE LIFE: EFFICACY RESULTS

Speaker: Eric Lenze, M.D.

SUMMARY:

From 2009-2014, three academic sites in Pittsburgh, St Louis, and Toronto conducted an NIMH-funded clinical trial, the main goals of which were to test the efficacy and tolerability of aripiprazole augmentation when added to venlafaxine extended-release (XR) in individuals who did not achieve remission from depression when treated with venlafaxine XR monotherapy. We started 468 individuals aged 60+, in a 12-14 week lead-in phase during which they received venlafaxine XR at doses as high as 300mg daily. One-hundred eight one participants who did not achieve remission (defined as a score of 10 or lower on the Montgomery-Asberg Depression Rating Scale during at least two consecutive assessments) were randomized to the addition of aripiprazole or placebo. In this 12-week augmentation phase, study medication was started at 2 mg daily and titrated as needed and tolerated up to 15 mg daily. Remission and response rates, time to remission, and trajectory of symptomatic improvement will be presented.

NO. 4

FUTURE DIRECTIONS FOR THE PHARMACOTHERAPY OF TREATMENT-RESISTANT DEPRESSION IN LATE LIFE:

THE ROLE OF THE OPIOID SYSTEM AND OPIOID AGENTS

Speaker: Jordan F. Karp, M.D.

SUMMARY:

When monoaminergic antidepressants are ineffective at eliciting a full response for older patients with TRD, augmentation pharmacotherapy using medications with a unique mechanism of action and rapid onset may offer relief. Modulation of the opiate system may be a novel treatment approach for TRD. It is established that opiate receptor subtypes modulate regulation of serotonin in the mammalian midbrain, raphe, and forebrain. Indeed, the periaqueductal grey matter, an area rich in opiate receptors, receives projections from the amygdala, frontal cortex, and locus coeruleus, suggesting reciprocal modulation of the opiate and monoaminergic systems. Owing to the observed euphoric, tranquilizing, and anti-anxiety actions of opioids, a functional deficiency of endogenous opioids has been postulated to underlie the pathogenesis of endogenous depression. This is supported by observations of mood improvement in mid-life patients treated with cyclazocine (a mixed agonist/antagonist opioid), beta-endorphin infusions, and a synthetic enkephalin analogue. Buprenorphine is a partial agonist at μ -receptors, an antagonist of kappa (κ) receptors, and also displays affinity for delta (δ) opiate receptors. Buprenorphine has a favorable safety profile with low risk of respiratory depression, and the pharmacokinetics are not affected by advanced age. We will discuss the role of the opioid system in late-life depression and the potential role of opioid agents in its treatment.

GLOBAL MENTAL HEALTH

Chairs: Dilip V. Jeste, M.D., Anne E. Becker, M.D., Ph.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn about the global burden of serious mental illnesses and substance use disorders; 2) Understand pragmatic ways of meeting mental healthcare challenges in underserved populations; 3) Be able to use psychosocial interventions to promote well-being across the lifespan.

SUMMARY:

As the world is getting smaller, global psychiatry is becoming increasingly more important. With an incredibly accelerated development of technology, transportation, and communication, traditional national and cultural barriers are breaking down. In their place are emerging new models of cultural integration and disintegration. This symposium will review several major areas of interest both for American psychiatry and for international psychiatry. The considerable health and social burdens imposed by mental disorders are well documented; yet, there exist major deficiencies in closing the resource and treatment gaps in delivery of optimal mental healthcare. These problems are particularly striking in some segments of population. For example, one critical global challenge is the rapidly changing demographics with dramatic increases in the numbers and proportions of older adults, yet the necessary geriatrics-trained workforce is shrinking. The adolescent mental health burden is disproportionately high in low- and middle-income countries, making it difficult to respond to mental health needs among these vulnerable youth. Prevalence of substance use and addiction is increasing at an alarming rate, particularly in Africa. The data on suicides are inconsistent and often unreliable, and suicide prevention efforts are sadly lacking in many parts of the world. On the positive side, there is a growing awareness of the need to treat mental illnesses, and new strategies are being developed and tested in several parts of the world. These include health system strengthening, promoting successful aging through enhanced opportunities for physical activities and psychosocial support, and leveraging scarce resources with task shifting and task sharing. Empirical data will be presented on innovative and commonsense approaches to promoting well-being across the lifespan. The speakers will summarize decades-long work in several different continents. The Discussant, who is the President of the World Psychiatric Association, will weave the four presentations into common themes, and illustrate ways of dealing with the challenges in global mental health and healthcare in an organized manner. There will be plenty of time for discussion from the floor.

NO. 1

GERIATRIC PSYCHIATRY ACROSS THE GLOBE: BAD NEWS AND GOOD NEWS

Speaker: Dilip V. Jeste, M.D.

SUMMARY:

Today there are 550 million people in the world older than 65 years; in 2040, there will be 1.4 billion. This seismic demographic shift will be felt most strongly in geriatric psychiatry. There will be a notable increase in prevalence of mental illnesses among aging Baby Boomer. Yet, paradoxically, the geriatric mental health workforce is shrinking, due to the economics of geriatric healthcare as well as rampant ageism. However, empirical data paint a brighter picture of the course of psychopathology and disability among older mentally ill people than the traditional conceptualization suggests. Thus, a proportion of older persons with serious mental illnesses experience sustained remission, the predictors of which include social support and early initiation of treatment. In recent years, neuroscience research has clearly demonstrated neuroplasticity of adulthood, with continued brain growth and development. These positive outcomes are related mainly to positive psychological attributes such as optimism, resilience, and social engagement, along with physical, cognitive, and psychosocial stimulation. Positive Old Age Psychiatry can develop into a core component of the overall healthcare system aimed at promoting successful ageing, and helping convert the so-called silver tsunami into a golden wave of well functioning seniors.

NO. 2

EXPANDING YOUTH MENTAL HEALTH CARE ACCESS IN LOW- AND MIDDLE-INCOME COUNTRIES: LESSONS FROM SCHOOL-BASED STUDIES IN FIJI AND HAITI

Speaker: Anne E. Becker, M.D., Ph.D.

SUMMARY:

The enormous global health and social burdens imposed by mental disorders are well-documented and widely recognized, and yet progress in closing the resource and treatment gaps characterizing mental health care delivery in low resource regions has been both too little and too slow. The adolescent mental health burden, moreover, is disproportionately high in low- and middle-income countries (LMICs),

where extraordinary challenges beset efforts to respond to mental health needs among vulnerable youth. Key strategies proposed to close the treatment gap in LMICs include health system strengthening and leveraging of scarce resources for more substantive impact. Among these, task shifting holds great promise, but the potential benefits of task sharing with educators have not yet been fully tapped. For example, engagement of teachers as navigators for youth in need of mental health services might be one avenue for improving their access to available care. In this presentation, findings from two school-based studies on youth mental health in LMICs—Fiji and Haiti—will be discussed to illustrate innovative and commonsense approaches to circumventing some of the numerous cultural and social structural barriers to mental health care.

NO. 3

ADDICTIONS PSYCHIATRY IN AFRICA

Speaker: Solomon Rataemane, M.D.

SUMMARY:

Addiction to alcohol and drugs is a major concern in Africa today. This is due to a number of factors such as poverty, low literacy rates, and co-morbidity with chronic illnesses such as HIV/AIDS. The common substances of abuse include alcohol, cannabis, cocaine, heroin, methamphetamines, and inhalants such as glue, benzene and petrol. There is also a mixture of cannabis with other substances but mainly with psycho-stimulants such as methamphetamines, and cathinone. These combinations are given different local names in various countries. The commonest combination in South Africa is cannabis and heroin to which other substances may be added. This presentation explores trends in use of different substances with emphasis on Eastern and Southern Africa. Concerns regarding harm reduction in substance abuse will also be discussed in the context of policy development in substance abuse including current evidence based approaches to reduce dependence on these substances. Can we significantly reduce addiction to alcohol and drugs?

NO. 4

RETHINKING GLOBAL SUICIDES

Speaker: Michael R. Phillips, M.D., M.P.H.

SUMMARY:

The recent release of the WHO's first report on global suicides, 'Preventing suicide: A global imperative', highlights the huge variability in the pattern and trajectory of suicide globally; the very low quality of the available data on suicide, suicide methods, and attempted suicide; and the surprising large drop in suicide rates in almost all regions of the world over the last decade. It also showed that globally the male-to-female suicide ratio is about 1.6:1 (not 3:1 as is commonly reported in high-income countries), that the most common method of suicide is pesticide ingestion (not hanging or firearms), and that the prevalence and treatment rates for mental illnesses appear to have little effect on the constantly changing rates of suicide both within and between countries. This presentation will discuss the results from the report, summarize the 'take home messages' from the report, and consider what different types of countries need to do next to understand and prevent this important public health problem.

POLYVAGAL THEORY, OXYTOCIN, BONDING, AND MIND-BODY METHODS TO BALANCE THE AUTONOMIC NERVOUS SYSTEM AND RESTORE CONNECTEDNESS

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the role of the vagal nerves in social communication and affiliative behavior; 2) Discuss the evidence for activation of the parasympathetic nervous system by specific voluntarily regulated breathing practices; 3) Recognize clinical indications for the use of specific mind-body practices in the treatment of psychiatric and stress-related conditions; 4) Summarize the roles of oxytocin and vasopressin relevant to social behavior.

SUMMARY:

A reciprocal relationship is evolving between neuroscience and mind-body practice. Information from neuroanatomic, neuroimaging, and neurohormonal studies advance our ability to develop neurophysiological models and refine mind-body approaches leading to more

rapidly effective treatments for a wide range of psychological and physical conditions. Conversely, clinical studies and observations of patient responses yield valuable clues to guide research efforts. Voluntarily regulated breathing practices (VRBPs) can be used as noninvasive probes to study autonomic and neuroendocrine response to peripheral stimuli and to test new approaches to treatment resistant conditions. VRBPs are well-suited to research because respirations can be paced, counted, voluntarily modified, and objectively monitored. The Polyvagal Theory will be described to explain the neurobiological mechanisms that mediate affiliative behavior. Polyvagal Theory provides a new perspective expanding our understanding of normal and atypical behavior, mental health, and psychiatric disorders. Polyvagal Theory, by incorporating both phylogenetic and developmental perspectives, explains how the autonomic nervous system forms the neural "platform" upon which social behavior and the development of trusting relationships are based. The theory explains how reactions to danger and life threat and experiences of abuse and trauma may retune our nervous system to respond to friends, caregivers, and therapists as if they were threats or predators. The theory may help practitioners distinguish the contextual features that trigger defense from those that are calming and support spontaneous social engagement.

Complex roles of oxytocin and vasopressin will be discussed relevant to social behavior and her perspective on the state of research on neurohormones involved in bonding and other social behaviors. She will describe our current understanding of the biochemistry of social bond formation, and the implications of social bonds for anxiety, emotional regulation and other aspects of healing and restoration. It is now well established, based primarily on research in socially-monogamous mammals, that oxytocin and vasopressin play an essential role in the selective social behaviors associated with social bond formation. The same hormones regulate social bonding also play a critical role in the hypothalamic-pituitary-adrenal axis and the management of challenges including inflammation.

There will be review of clinical studies of voluntarily regulated breathing practices for anxiety, caregiver stress, depression, PTSD, mass disasters, schizophrenia, and inflammatory bowel disease. She will present a

clinical cases of disconnection due to PTSD and subsequent reconnection with a brief mind-body intervention that illustrates and raises questions related to the neurophysiological mechanisms that may underlie research findings and clinical responses to mind-body practices.

**NO. 1
CONNECTEDNESS AS A BIOLOGICAL
IMPERATIVE: UNDERSTANDING
BONDING THROUGH THE LENS OF THE
POLYVAGAL THEORY**

Speaker: Stephen Porges, Ph.D.

SUMMARY:

Dr. Porges will describe the Polyvagal Theory to explain the neurobiological mechanisms that mediate affiliative behavior. Polyvagal Theory provides a new perspective expanding our understanding of normal and atypical behavior, mental health, and psychiatric disorders. Polyvagal Theory, by incorporating both phylogenetic and developmental perspectives, explains how the autonomic nervous system forms the neural “platform” upon which social behavior and the development of trusting relationships are based. The theory explains how reactions to danger and life threat and experiences of abuse and trauma may retune our nervous system to respond to friends, caregivers, and therapists as if they were threats or predators. The theory may help practitioners distinguish the contextual features that trigger defense from those that are calming and support spontaneous social engagement.

**NO. 2
OXYTOCIN AND VASOPRESSIN: THE
STATE OF RESEARCH ON SOCIAL
BONDING**

Speaker: C. Sue Carter, Ph.D.

SUMMARY:

Dr. Carter will describe our current understanding of the biochemistry of social bond formation, and the implications of social bonds for anxiety, emotional regulation and other aspects of healing and restoration. It is now well established, based primarily on research in socially-monogamous mammals, that oxytocin and vasopressin play an essential role in the selective social behaviors associated with social bond formation. The same hormones that regulate social bonding also play a critical

role in the hypothalamic-pituitary-adrenal axis and the management of challenges including inflammation. In addition, she will describe the gender-specific, developmental effects of behavioral and epigenetic consequences of oxytocin during the birth process and early life, with implications for sociality across the life-cycle.

**NO. 3
MOVEMENT AND BREATHING
PRACTICES: RESEARCH, CLINICAL
APPLICATIONS, AND
NEUROPHYSIOLOGICAL MODELS**

Speaker: Patricia L. Gerbarg, M.D.

SUMMARY:

Review of research evidence, clinical studies, and case presentations. clinical cases of disconnection due to PTSD and subsequent reconnection and restoration of the experience of bonding using a mind-body intervention will illustrate and raises questions related to neurophysiological mechanisms Discussion of neurophysiological models that may explain research findings and clinical observations. Clinical applications of movement and breathing practices in treatment of psychiatric disorders with a focus on disorders of disconnection related to PTSD. Risks and contraindications.

**NO. 4
BREATH-BODY-MIND EXPERIENTIAL**

Speaker: Richard P. Brown, M.D.

SUMMARY:

Dr. Brown will lead participants through movement and breathing practices used in Breath-Body-Mind workshops that can be easily integrated with other treatment modalities and adapted to numerous treatment settings. These will illustrate the potential role of neurovisceral integration for self-care, stress reduction and treatment of psychiatric and stress-related medical conditions. This experiential component includes simple movement coordinated with breath, Coherent Breathing, Breath Moving, Ha Breath, Body Scan, and brief group process. Participants will experience some of the effects of these practices on their physical, mental, emotional, and relational state.

APA ASSEMBLY AS APA MEMBERS' VOICE AND CENTER OF PLANNING FOR THEIR PROFESSIONAL FUTURE

Chairs: Rodrigo A. Munoz, M.D., Roger Peele, M.D.

Discussants: Brian Crowley, M.D., Harold Eist, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase awareness of Assembly's activities in behalf of APA members; 2) Propose ideas to improve communications with District Branches and individual members; 3) Explore ideas that permit Assembly to better integrate members' needs with APA policies.

SUMMARY:

The APA Assembly is elected directly by the APA members. It has a history of responding to their requests, problems, interests and ever changing interactions with insurance companies and government agencies.. The Assembly has often started initiatives that protect our patients and permit a more rational allocation of resources for care.

This presentation will examine the history of the Assembly and some of the actions it has successfully got implemented by the APA. We have to go now into the future to debate the best measures that will permit the Assembly to retain and enhance its participation in the future of American psychiatry.

NO. 1 THE EVOLUTION OF THE APA ASSEMBLY 1953-2003

Speaker: John S. McIntyre, M.D.

SUMMARY:

This presentation will review the history of the Assembly over its first 50 years. The development of District Branches and then Areas and the relationship of the Assembly and the Board of Trustees will be described. The pivotal Key Conference and the referendum to have the Assembly become the policy making body of the Association will be outlined. The establishment of representation of Minority and Underrepresented Groups, Members-in-Training and Early Career Psychiatrists will be discussed. A comparison of the APA Assembly and the AMA House of Delegates will be

presented. Key leaders of the APA Assembly during its initial 50 years will be identified.

NO. 2 IS THERE A ROLE FOR THE ASSEMBLY IN THE 21ST CENTURY?

Speaker: Jenny I. Boyer, M.D.

SUMMARY:

The Assembly of the American Psychiatric Association was created to provide, at the national level, representation for local members of the APA and those with special interests through District/State Branches and Allied [Psychiatric] Organizations. The Assembly, as a sitting body, through its seven Area Councils and Committees develops Action Papers which puts forth, on an affirmative vote, the policies and positions of the membership it represents to the Board of Trustees [BOT]. The BOT then makes a determination, based on APA organizational positions, procedures and fiscal considerations, as to whether the approved Action Papers will be implemented and how they will be supervised/managed. The Assembly cannot over rule the actions of the BOT. The Assembly does not directly control the executive/management staff of the APA. This presentation will examine the practical value of the Assembly, as it is currently constructed, and render suggestions for altering its mandate.

NO. 3 THE ASSEMBLY COMES OF AGE

Speaker: Roger Peele, M.D.

SUMMARY:

For its first two decades, the American Psychiatric Association [APA] was much like Great Britain's House of Lords, considering and debating issues, but having limited impact on the governance of the APA. In addition to the leadership of Warren Williams and his allies in the Assembly was the work of Oscar Legault, of the Washington Psychiatric Society [WPS]. Almost immediately after becoming a Member of the Assembly in 1974, the APA Board of Trustees [BOT] voted 16-0 to become part of a class action suit against Saint Elizabeths [DC]. On several grounds, WPS objected to the APA being part of that law suit. Legault took that concern to the APA Assembly, and persuaded the Assembly to ask the APA BOT to reverse its decision, something the Assembly had never

done before. The Board then took another vote, 8-8, so the decision still held, but Assembly was beginning to sense some power. In 1979, Legault developed a referendum that would have changed the APA Constitution to where the Assembly would have powers like the AMA's House of Delegates. While the motion failed, 1980, because it needed a 2/3 vote, the fact that the majority voted in favor carried a message to APA leaders. Over the past 34 years, the Assembly's power has varied a little depending on whether the Assembly's Speaker views her or his role as representing the Assembly or representing the BOT. Regardless, except for budget issues, it has been rare that the APA has moved in directions not approved by the Assembly.

TRAUMATIC BRAIN INJURY (TBI) AND MENTAL HEALTH COMORBIDITIES IN THE U.S. MILITARY: LESSONS LEARNED FROM WAR

Chairs: David A. Williamson, M.D., Louis French, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the clinical presentations of mild, moderate, and severe TBI, their long term trajectories, and their prognosis; ; 2) Describe the elements of assessment of Traumatic Brain Injury patients including the contributions of multidisciplinary team members; 3) Recognize the myriad presentations of complex partial seizures ; 4) Diagnose and treat the wide spectrum of neuropsychiatric complications of Traumatic Brain Injury and mental health co-morbidities in trauma patients; 5) Describe factors associated with poor outcome after concussion.

SUMMARY:

Traumatic Brain Injury (TBI) has been described as the signature injury of the wars in Afghanistan and Iraq. TBI is a spectrum of conditions ranging from mild concussion through to severe injuries with profound neurological deficits. Each category of patient has unique characteristics and challenges. The Military healthcare system has developed and refined a multidisciplinary behavioral health team role in the assessment and treatment of TBI patients. The symposium, delivered by

practitioners at the primary National Military Trauma Center, will describe the yield in lessons learned from more than ten years of clinical practice and research in wartime. The military experience has important implications for civilian models of TBI care. Behavioral health providers have an important role in the acute (trauma) phase of care, during rehabilitation, and also over the longer term trajectory of care of TBI patients after their return to family and community.

Research in military populations identifies factors that predict poor outcomes in concussion and mild TBI. Experience with moderate and severely injured TBI populations shows high rates of neuropsychiatric complications including mood disorders, cognitive disorders, behavioral disturbances, and seizures. Complex partial seizures present special challenges as many patients present with syndromes that mimic psychiatric disorders. Iatrogenic (polypharmacy-related) complications can worsen psychiatric presentations disrupting cognition, behavior, and mood. Psychiatric consultants can guide surgeons and intensivists to minimize these avoidable complications of trauma patient treatment.

Over the longer term, the behavioral health team can assist rehabilitation specialists to work with patients with cognitive, behavioral and emotional disturbances and are well placed to help families adapt to the changes in relationships, including intimate ones, that occur after TBI. Mood disorders, a common late complication of TBI, can jeopardize rehabilitation and family viability and present serious safety challenges in patients who have impaired impulse control.

The presenters will review strategies developed to assess and intervene early in the trajectory of care of TBI patients, to anticipate and mitigate the challenges of disordered brain function in clinical and domestic environments, and to optimize outcomes for TBI patients through early recognition of neuropsychiatric complications.

NO. 1 MILD TBI AND CO-MORBIDITIES IN MILITARY POPULATIONS

Speaker: Louis French, Psy.D.

SUMMARY:

Recent military conflicts in Iraq and Afghanistan have focused much attention on traumatic brain injury (TBI) and explosive blast as an injury mechanism. The majority of these brain injuries have been mild (also known as concussion). Data suggest that during deployment as many as 20% or more may have suffered a concussion. Those with TBI during deployment are more likely to report post-injury and post-deployment somatic and/or neuropsychiatric symptoms than those without such an injury history. While the evidence for primary blast effects (effects of the blast "wave" itself) upon the central nervous system is limited, there are a number of aspects of blast induced brain injury that may be different from more "atypical" injury mechanisms such as motor vehicle accidents or falls. These include high rates of sensory impairment, pain issues, and polytrauma. In addition, the emotional context in which the injury occurred must also be considered in understanding the clinical presentation of these patients. Successful treatment of these individuals must utilize a multidisciplinary approach focused on the varied conditions that occur in those injured. This lecture will describe important issues in the assessment of those with mild TBI and provide a framework for assessment and treatment.

NO. 2
MULTIDISCIPLINARY TBI SCREENING
IN A MILITARY TRAUMA CENTER

Speaker: Wendy A. Law, Ph.D.

SUMMARY:

The lecture will discuss the structure of a multidisciplinary TBI Consult Service and the process of TBI screening in trauma patients at WRNMMC. This service is an automatic consultation for all Military Service Members medically evacuated to WRNMMC for injuries sustained in OIF/OEF/OND operations. Because most patients medevacated from theater evidence blast-related polytrauma injuries requiring urgent medical attention immediately after injury, possible effects from non-penetrating TBI often go unrecognized until explicitly assessed in the medical setting. The TBI team holds discussion rounds reviewing patients' injury histories prior to conducting direct clinical patient assessment rounds to determine TBI status and factors potentially impacting patients' medical care and

recovery (e.g., problems with sleep, emotional regulation, cognition). Recommendations for managing neurobehavioral difficulties or disorders of consciousness are provided to the Trauma team to prevent TBI complications impeding medical care. Early implementation of neuropsychological screening can help inform disposition and rehabilitation planning for discharge considerations after stabilization of the patient's medical status. This lecture will describe the operation of TBI consult service and benefits of early screening to long-term outcome.

NO. 3
OVERVIEW OF NEUROPSYCHIATRIC
COMPLICATIONS OF TBI IN MILITARY
POPULATIONS; LESSONS LEARNED

Speaker: David A. Williamson, M.D.

SUMMARY:

Traumatic Brain Injury (TBI) is present in more than 35% of combat wounded and has been labelled the signature injury of the wars in Afghanistan and Iraq. The presentation will review lessons learned in the assessment and treatment of TBI by the Neuropsychiatry/TBI Unit at Walter Reed, which has been embedded within the team of Trauma Clinicians at the U.S. Military's Primary Trauma Center. The presentation will review common neuropsychiatric complications of TBI, focusing on moderate and severe injuries, including mood disorders, psychosis, delirium, behavioral disorders, and cognitive disorders. In addition many patients have co-morbid PTSD, adjustment issues, and survivor guilt. To respond to these challenges the military has evolved a multidisciplinary team approach that begins intervention during trauma care and continues through rehabilitation and the return to community phases of care. Experience has revealed a changing pattern of clinical challenges over time in TBI patients that yield a robust role for behavioral health intervention throughout the entire trajectory of care. Case vignettes will highlight common clinical themes. The lessons learned from the U.S. Military healthcare experience have important implications for civilian TBI care, and the role of behavioral health providers.

NO. 4

COMPLEX PARTIAL SEIZURES PRESENTING WITH PSYCHIATRIC SYMPTOMS IN TBI PATIENTS

Speaker: Adam L. Hunzeker, M.D.

SUMMARY:

Seizures are a common complication of penetrating brain injury. The clinical presentation of Complex Partial Seizures can mimic many forms of psychiatric illness including psychosis, delirium, mood disorders, behavioral disorders, and aphasia/thought disorder. The lecture will review a series of cases from the inpatient Traumatic Brain Injury Program at Walter Reed illustrating the wide-ranging presentation. Approaches to patient assessment will be discussed as well as treatment strategies.

TWO-YEAR RESULTS OF A COMPREHENSIVE CARE MODEL IN FIRST EPISODE SCHIZOPHRENIA: THE RECOVERY AFTER AN INITIAL SCHIZOPHRENIA EPISODE EARLY TREATMENT PROGRAM (RAISE ETP)

Chairs: John M. Kane, M.D., Robert K. Heinssen, Ph.D.

Discussant: Robert K. Heinssen, 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 discuss the essential ingredients of a comprehensive care model for first episode schizophrenia.; 2) At the completion of this session participants will be able to identify critical characteristics of first episode patients (and families) that distinguish them; 3) The participants will be familiar with the potential advantages of a comprehensive, team-based multidisciplinary approach to treating first episode patients and their families in terms of a variety .

SUMMARY:

The National Institute of Mental Health (NIMH) issued a Request for Proposals entitled "Recovery After an Initial Schizophrenia Episode (RAISE)" in November 2007. The goal of the NIMH initiative is to change the trajectory and prognosis of first episode psychosis (FEP). The premise is that by combining state-of-the-art pharmacologic and psychosocial treatments in

a patient-centric fashion and having them delivered by a well-trained and coordinated, multidisciplinary team, the functional outcome and quality of life for first episode patients treated in the community can be significantly improved. The specified aims of RAISE are, first, to develop a comprehensive and integrated intervention designed to: promote symptomatic recovery; minimize disability; maximize social academic and vocational functioning; be capable of being delivered in real world settings utilizing current funding mechanisms, and, second, to assess the overall clinical impact and cost effectiveness of the intervention as compared to currently prevailing treatment approaches and to conduct the comparison in non-academic, real world community treatment settings in the U.S

We developed a treatment model (NAVIGATE) and training program based on extensive literature review and expert consultation. Our primary aim is to compare the experimental intervention to "usual care" on quality of life. Secondary aims include comparisons on remission, recovery and cost effectiveness. Patients 15-40 years old with a first episode of schizophrenia; schizoaffective disorder; schizophreniform disorder, psychotic disorder NOS, or brief psychotic disorder according to DSM IV and no more than six months of antipsychotic medications were eligible. Patients are followed for a minimum of two years, with major assessments conducted by blinded, centralized raters using live, two-way video. We selected 34 clinical sites in 21 states and utilized cluster randomization to assign 17 to the experimental treatment-NAVIGATE and 17 to usual care. Enrollment began in July, 2009 and ended in July 2011 with 404 subjects.

Bob Heinssen will present NIMH's perspective on the funding and conduct of this trial. Nina Schooler will present the overall design and management of the project. Delbert Robinson will present the pharmacologic treatment model and the computerized decision support system that were implemented at the NAVIGATE sites. Kim Mueser will present the psychosocial treatment model and its implementation at the experimental sites. John Kane will present the overall results of the trial, with emphasis on quality of life, psychopathology and recovery. Another symposium submission by Mary Brunette will focus on other aspects of this project, including medical co-morbidity, cost effectiveness, training, etc.

NO. 1
THE RAISE-ETP STUDY DESIGN AND IMPLEMENTATION MODEL

Speaker: Nina R. Schooler, Ph.D.

SUMMARY:

The National Institute of Mental Health (NIMH) mandate to evaluate an integrated intervention for the treatment of first-episode psychosis (FEP) that could be delivered in non-academic community treatment settings in the United States drove the design and conduct of the RAISE-ETP study. Thirty-four sites in 21 states were selected that did not have formal FEP programs but were willing to create such a program and to provide team-based care. Sites, rather than individual patients, were randomly assigned to provide either the integrated treatment or usual care, limiting training of intervention teams to half of the sites and avoiding the risk that a novel intervention will influence treatment of those not assigned to it. Further, participants did not have to agree to random treatment allocation. All sites received training in recruitment, engagement and retention of FEP patients. Those sites randomized to the integrated intervention, NAVIGATE, then received training and ongoing consultation and support in providing treatment. Because the study was conducted at sites without trained clinical research assessors, clinical assessments were completed by centralized clinical assessors using live two-way video. Assessors were masked to site and study design. Details regarding research implementation and study conduct will be presented.

NO. 2
OVERVIEW AND IMPLEMENTATION OF THE RAISE-ETP STUDY PSYCHOSOCIAL TREATMENT MODEL: THE NAVIGATE PROGRAM

Speaker: Kim T. Mueser, Ph.D.

SUMMARY:

The NAVIGATE program was developed based on a review of common services provided in effective first episode psychosis treatment programs developed abroad, and tailored to the context of the U.S. Healthcare system. NAVIGATE is a multidisciplinary program, typically staffed by five members who work

collaboratively with each other, the client, and family to provide individualized pharmacological treatment and three psychosocial programs. The three psychosocial components include: the Family Program (aimed at developing a collaborative relationship with family members, providing information about psychosis and treatment, and harnessing support for the client), Individual Resiliency Training (an individual psychotherapeutic approach aimed at enhancing clients'™ wellness and personal resiliency, providing information about psychosis and its treatment, improving illness self-management, and facilitating progress towards social and health goals), and Supported Employment and Education (aimed at helping clients identify or develop personally meaningful goals related to education or competitive employment, and pursuing those goals). All of the psychosocial treatment providers from NAVIGATE teams at the 17 sites randomized to NAVIGATE participated in an initial live three-day training, followed up with regular expert phone consultations, fidelity monitoring, and booster trainings. The psychosocial programs will be described, as well as results from the fidelity evaluations for each progr

NO. 3
ASSISTING PRESCRIBERS EFFORTS TO OPTIMIZE PHARMACOTHERAPY FOR FIRST- EPISODE SCHIZOPHRENIA

Speaker: Delbert Robinson, M.D.

SUMMARY:

Most prescribers see few patients with first episode schizophrenia and few community clinicians have the time to keep abreast of research findings about the specialized treatment needs of this patient subgroup. Compared with medication treatment for multi-episode patients, the suggested sequence and optimal dosing of medications differs for first episode patients. Core requirements for NAVIGATE medication treatment were that it 1) incorporated research findings about the specialized medication approaches needed for patients with early phase schizophrenia-spectrum disorders and 2) be tailored to individual needs and preferences. Medication treatment used COMPASS, a computer clinical decision making tool using a measurement-based care approach that was developed for

NAVIGATE and was available to NAVIGATE prescribers and patients on a secure website. COMPASS facilitated patient -prescriber communication through direct patient input of information about symptoms, side effects, treatment preferences and other issues into the system. These data then guided prescribers in their sessions with patients. COMPASS also provided guidance about evidence-based medication strategies that informed patient -prescriber decision making about medication treatment. Data on patient use of COMPASS and of the effect of COMPASS on medication prescription will be presented at the meeting.

NO. 4 RAISE ETP:NAVIGATE VERSUS USUAL CARE- TWO-YEAR OUTCOMES

Speaker: John M. Kane, M.D.

SUMMARY:

Objective: The premise of the NIMH RAISE-ETP (Early Treatment Program) is to combine state-of-the-art pharmacologic and psychosocial treatments delivered by a well-trained, multidisciplinary team, in order to significantly improve the functional outcome and quality of life for first episode psychosis patients. The study is being conducted in non-academic (‘‘real world’’) treatment settings, using primarily extant reimbursement mechanisms.

Method: Our primary aim is to compare the experimental intervention to ‘‘usual care’’ on quality of life. Secondary aims include comparisons on remission, recovery and cost effectiveness. Patients 15-40 years old with a first episode of schizophrenia; schizoaffective disorder; schizophreniform disorder, psychotic disorder NOS, or brief psychotic disorder and no more than six months of antipsychotic medications were eligible. Patients are followed for a minimum of two years, with major assessments conducted by blinded, centralized raters using live, two-way video. We selected 34 clinical sites in 21 states and utilized cluster randomization to assign 17 to the experimental treatment and 17 to usual care. Enrollment began in July, 2009 and ended in July 2011 with 404 subjects.

Results: We will present outcome data comparing quality of life, remission and recovery in those patients receiving the enhanced intervention (NAVIGATE) and those receiving usual care.

ENHANCING CAPACITY TO ADDRESS MENTAL HEALTH NEEDS OF VETERANS AND THEIR FAMILIES: THE WELCOME BACK VETERANS (WVB) INITIATIVE

Chairs: Marcia Valenstein, M.D., Terri Tanielian, M.A.

Discussant: John F. Greden, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common reintegration issues and mental health symptoms among returning veterans; 2) Describe innovative approaches to meeting the needs of returning veterans that have been developed by six universities and that can be implemented in communities; 3) Explore the potential for partnerships and employing innovative strategies for assisting veterans in their own home communities.

SUMMARY:

Veterans returning from the conflicts in Afghanistan and Iraq have high levels of mental health symptoms, and many report interpersonal difficulties following deployments. Community support may be important in mitigating symptoms, and treatment may be needed when symptoms persist.

The Welcome Back Veterans Initiative is funded by the McCormick Foundation in partnership with Major League Baseball and aims to meet the mental health needs of returning veterans and their families. During 2011-2013, six sites were funded under the Initiative and worked collectively to expand capacity, improve access, and deliver quality treatment to veterans around the nation.

Presentations will describe a variety of initiatives initiated under the WBV umbrella to reach out and serve returning veterans including: innovative strategies to screen and connect Veterans to treatment resources using websites; training of community providers in military culture; veteran peer outreach initiatives; innovative platforms to disseminate family-centered psychological health services through in-home Tele-health and smartphone applications; and community/university based inter-disciplinary approaches to veterans with military sexual trauma.

We will provide an overview of the guiding conceptual framework within the Initiative,

describe the breadth of activities conducted under the initiative, review the impact of the Initiative programs, and highlight lessons learned and implications for other community based programs serving veterans.

Symposium attendees will learn about common reintegration issues and mental health symptoms among returning veterans, innovative approaches to meeting the needs of these veterans, and explore the potential for employing these strategies in their own home communities.

NO. 1

WBV SOUTHEAST INITIATIVE: BRAVE HEART'S OUTREACH AND PARTNERSHIP WITH STAR BEHAVIORAL HEALTH PROVIDERS

Speaker: Barbara Rothbaum, Ph.D.

SUMMARY:

BraveHeart: Welcome Back Veterans Southeast Initiative is a partnership between Emory University School of Medicine and the Atlanta Braves. BraveHeart is an outreach, education and resource program for OEF/OIF/OND Veterans and their Families dealing with PTSD. BraveHeart offers a comprehensive, confidential website in which Veterans and Families can access information about PTSD, locate treatment resources, and utilize the SimCoach, an interactive avatar that can screen for PTSD symptoms.

To address the needs of our Veterans, we have formed a partnership with the Georgia National Guard, Georgia Department of Behavioral Health & Developmental Disabilities, Center for Deployment Psychology, and the Military Family Research Institute at Purdue University to pilot the Star Behavioral Health Providers (SBHP) in Georgia. The SBHP program will provide training to behavioral health providers in military-specific culture and disseminate empirically-supported treatments that focus on the needs of military families. The program will offer an online registry of these specially trained providers to serve as a resource for Veterans and their Families in Georgia.

NO. 2

VALENSTEIN: BUDDY-TO-BUDDY: A PEER OUTREACH PROGRAM FOR NATIONAL GUARD SOLDIERS

Speaker: Marcia Valenstein, M.D.

SUMMARY:

Peer outreach is one strategy for increasing support, reducing stigma, and facilitating appropriate connections to resources for returning National Guard (NG) Soldiers. Supported by WBV, The Michigan Army NG and its University/VA partners developed an innovative peer outreach program, the BuddytoBuddy (B2B) program. A formative evaluation of B2B was conducted as was an assessment of whether B2B was associated with treatment initiation and outcomes. Data were collected through surveys and qualitative interviews. A total of 2922 surveys were returned (53% response rate). Semi-structured interviews were completed with 78 Soldiers and 5 Buddies purposively drawn from units with substantial and lower levels of B2B implementation. Surveys indicated high rates of MH symptoms. Non-commissioned officers were more likely to interact with Buddies than junior enlisted Soldiers. Fully 70% of Soldiers with PTSD symptoms received MH treatment in last year. Higher levels of PTSD symptoms were associated with higher levels of first-tier Buddies. Qualitative data suggested more positive evaluations of leadership, leadership support, and regular Buddy attendance at drill weekends was key for program uptake. There was a high degree of commitment to continuation of B2B.

NO. 3

OVERCOMING BARRIERS TO CARE FOR RETURNING VETERANS WITH POSTTRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY WITH A VETERAN OUTREACH TEAM

Speaker: Naomi Simon, M.D.

SUMMARY:

The Red Sox Foundation and the Massachusetts General Hospital Home Base Program (HBP) was established to address gaps in clinical care, education and research for OEF/OIF/OND veterans and their families affected by PTSD, traumatic brain injury and deployment related stress. To help overcome barriers to care, we established a team of veteran and family outreach coordinators with former having served in Iraq or Afghanistan. Veteran outreach roles include: (i) peer support, including the initial phone intake coordinator,

and an assigned contact for each veteran entering care; (ii) participation in outreach and education to the community to educate about PTSD and TBI, and guidance of affected veterans and families into care; and (iii) training and feedback about military culture and systems to HBP civilian clinicians in support of clinical care, research and educational efforts. Initial data suggest high rates of acceptance and completion of initial clinical evaluation with phone assessment and scheduling by a fellow veteran (over 90%), and the utility of flexible outreach approaches for reaching patients who miss appointments. Additional qualitative and quantitative data illustrating the utility of this outreach approach including the use of social media, outreach to families, and integration of clinical support will be presented.

**NO. 4
LESTER UCLA WELCOME BACK
VETERANS FAMILY RESILIENCE
CENTER: INNOVATIONS IN FAMILY
CENTERED BEHAVIORAL HEALTH CARE
FOR VETERANS**

Speaker: Patricia Lester, M.D.

SUMMARY:

Many factors limit veteran and civilian systems of care in meeting the needs of veterans/service members and their families: 1) lack of training in evidence-based practices; 2) barriers to care access, and 3) VHA statutes constraining work with non-Veteran relatives. Enhancing capacity in civilian/VHA systems is critical to support the reintegration of veterans/service members and their families. The UCLA Welcome Back Veterans Family Resilience Center (WBVFC) utilizes an ecological framework to catalyze transformation within care systems to meet the needs of veterans and their families. Through the development of public-private partnerships, such as with the California National Guard, Greater Los Angeles VHA, and Star Behavioral Health Program, we have increased the availability a continuum of family-centered services customized to the needs of veteran families facing reintegration, and psychological and physical injuries. We have recently created a UCLA Training Institute to more systematically support these collaborations. This presentation will describe these efforts, as well as research evaluating innovative platforms to disseminate family-centered psychological health services

through in-home Tele-health, mobile applications and web-based programming. The WBVFC is a prototype for how academic centers can partner with other systems of care to promote access to high quality family-centered behavioral health services to Veterans.

**NO. 5
TREATMENT OF MILITARY SEXUAL
TRAUMA OUTSIDE OF THE VETERANS
ADMINISTRATION SYSTEM -
CHALLENGES AND OPPORTUNITIES**

Speaker: Nirranjan Karnik, M.D., Ph.D.

SUMMARY:

Military sexual trauma (MST) is an area of growing recognition and clinical focus. Based on data from 2010, MST appears to impact at least 400,000 women and about 200,000 men from the population of over 22 million veterans. By some estimates over 800,000 women may have experienced MST. A significant portion of veterans suffering from MST prefer to obtain services outside of the Veterans Administration System. Some of this is driven by the stigma surrounding MST, and also due to the military triggers inherent within any VA setting. The presentation of MST can vary remarkably across the psychosomatic spectrum. Some veterans present with classical PTSD symptoms while others present with a constellation of physical and psychological symptoms. MST can impact not only daily functioning but can also have long-term consequences on the veteran's ability to build and maintain relationships. This presentation will review the current research on MST, present clinical experiences in caring for these veterans, and review a model of interdisciplinary care that can be used by clinics outside of the VA system.

MAY 20, 2015

**CARING FOR CLERGY AND RELIGIOUS
PROFESSIONALS: PSYCHIATRIC,
VOCATIONAL, AND FAMILY
CONSIDERATIONS**

Chair: Mary L. Dell, D.Min., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) recognize the importance of good mental and physical health of clergy,

their unique stresses, and the importance of healthy clergy to the mental health of the communities they serve.; 2) discuss concerns inherent to children of religious professionals, including unique stresses and their contributions to psychiatric conditions in childhood, adolescence, and adulthood.; 3) Participants will define common diagnostic challenges leading to clergy evaluation; 4) Participants will be able to describe how a biopsychosocial and spiritual formulation can be applied and used in the assessment and treatment of a particular adjustment stress.; 5) discuss special issues of male and female clergy, and concerns particular to early, mid, late career and retired clergy and implication for mental health and psychiatric care.

SUMMARY:

There are 350,000 religious congregations in America, with 118 million individuals visiting a house of worship weekly. Serving these are over 600,000 clergy, not including retirees, and hospital, prison, and military chaplains.

Clergy mental health is important for two reasons: 1) 600,000 plus individuals is a sizable patient population, even greater when considering dependents; 2) clergy are in regular contact with 118 million individuals. This symposium will discuss unique aspects of the vocational lives of religious professionals that influence their psychiatric health, and thus the thousands of individuals they influence on a regular basis.

Clergy fill many personal and public duties, have unclear job descriptions, and no privacy. They are on the front lines for serious mental illness, face difficult management decisions, and have both time and financial limits that impact family relations. Despite the availability of support clergy and clergy family members often do not seek help. Research on both faith and adult development will be shared, showing how a systemic support network can provide clergy support through healthcare, educational, and crisis intervention. Data will be in the form of case examples of the support services at predictable points in a minister's career.

Psychiatrists are often asked to evaluate clergy at key milestones such as entrance into a discernment process, seminary, or before ordination. At times, clergy face personal and professional crises that may warrant referral for further psychiatric evaluation. Dr. Crisp-Han will present her team's experiences in evaluating

clergy from different faith traditions over many years. Factors leading to evaluation, such as personal stressors, professional disappointments, clergy burnout, mood and anxiety disorders, substance use, boundary violations will be discussed. Diagnostic findings and recommendations regarding treatment, education and prevention will be shared.

Clergy children have unique stresses and family dynamics due to the public vocations of their parents. They feel expectations to be perfect in behavior, academics, and personal relationships. Clergy devote themselves to others, leaving no time for their own children. Clergy kids often endure financial stress and numerous moves. Some grow to resent their parents and even religion itself. Assessment and treatment approaches for working with clergy offspring will be discussed.

Clergy view their professional as a calling, not a job. They are vulnerable to biopsychosocial and spiritual stressors all people face at retirement - perhaps more so because their identity has been entwined with their vocational lives. "Clinical stories" of clergy at or anticipating retirement can illustrate how a comprehensive formulation aids identifying these transitional challenges. Helping clergy-patients to recover the joy of their calling and reintegrate their identities for their remaining life will be emphasized.

NO. 1

PROFESSIONAL SUPPORT OF CLERGY: ATTENDING TO PHYSICAL, DEVELOPMENTAL, SPIRITUAL ARENAS IN A MINISTER'S LIFE

Speaker: Mark Biddle, Ph.D.

SUMMARY:

Clergy are asked to fill a range of personal and public duties, live with little if no privacy, and are given a range of unclear job expectations. As a result ministers face a relationship problems across a wide range of frequency and severity. Ministers are often asked for moral advice, often a first line support and referral for serious mental illness, face difficult management decisions, and have both time and financial limits that impact family relations. Despite the availability of support clergy and clergy family members often do not seek help. This presentation will draw on the research on both faith and adult development showing how

a systemic support network successfully provided clergy support through healthcare, educational, and crisis intervention. Data will be in the form of case examples of the support services provided at predictable points in a minister's career.

NO. 2 PROFESSIONAL ASSESSMENT OF CLERGY: FITNESS FOR DUTY AND PSYCHOLOGICAL HEALTH

Speaker: Holly Crisp-Han, M.D.

SUMMARY:

Clergy from various faith traditions face numerous pressures. At times, clergy are challenged with personal and professional crises that may warrant referral for further psychiatric evaluation or professional assessment. Dr. Crisp-Han will present her team's experiences in evaluating clergy from different faith traditions over many years. This portion of the symposium will present common factors leading to evaluation, such as personal stressors, relationship losses, professional disappointments, clergy burnout, mood and anxiety disorders, substance use, boundary violations, and conflict with broader systemic forces.

Data regarding diagnostic outcomes and findings of our team's evaluations will be discussed, as well as recommendations regarding treatment, education and prevention.

NO. 3 CLERGY KIDS: LIVING IN THE POST MODERN FISHBOWL

Speaker: Mary L. Dell, D.Min., M.D.

SUMMARY:

Children of clergy and other religious professionals have unique psychosocial stresses and family dynamics due to the very public vocations of their clergy parents. As most major world faith traditions hold their professional religious to be public examples of morality and right, ethical living, the children of religious leaders can feel significant societal, family, and even personal expectations to be perfect in behavior, academics, personal relationships, and other endeavors. Their parents give significant amounts time, emotional and physical energy to serving others outside the home, often leaving them little time

and energy for their own children. Clergy kids often have to move at times in their lives that are disruptive to their healthy social and academic development, and must live on relatively low household incomes. Some clergy children then grow to resent the religious organizations their parents lead and even all forms of religion and spirituality. This talk will examine these concerns in depth, and discuss assessment and treatment approaches for clinicians working with offspring of clergy and religious professionals.

NO. 4 LETTING GO AND RECOVERY OF LOVES AT THE END OF A CALLING

Speaker: James Lomax, M.D.

SUMMARY:

Leaders of Faith Communities, like many physicians, tend to see their professional life as a calling, not a job. Also like physicians, these individuals are vulnerable to the spectrum of biopsychosocial and spiritual stressors all people face at retirement with some additional power because their identity has been intimately involved with their vocational life. This portion of the symposium will consist of "clinical stories" of clergy at or anticipating retirement and illustrate how a comprehensive formulation allows the clinician to identify and address such challenges at each of conceptual level. Helping our patients to "recover the lost loves" of their calling in order to "reweave them into the tapestry" of their remaining life will be emphasized.

Objective 4: Participants will be able to describe how a biopsychosocial and spiritual formulation can be applied and used in the assessment and treatment of a particular adjustment stress.

THE ATHLETE, CIVILIAN, AND SOLDIER WITH TRAUMATIC BRAIN INJURY (TBI): WHAT THEY SHARE AND HOW THEY DIFFER

Chair: Michele T. Pato, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand cause and effect of Traumatic Brain Injury (TBI) in these three groups, (the soldier, the civilian, and the athlete) ; 2) Differentiate neurocognitive features

of mild TBI vs. moderate/severe TBI; 3) Compare and contrast the clinical course between single vs. repetitive TBI; 4) Discuss potential biomarkers for both diagnosis and monitoring of progress post-injury.

SUMMARY:

The need to establish uniform criteria for diagnosing Traumatic Brain Injury (TBI) is critical to developing meaningful research protocols and ultimately effective treatments (immediate post injury and long term). TBI occurs in a number of settings: 1) accidents involving head trauma 2) 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. Despite continuing research funding and public interest, the diagnosis and treatment of TBI remains both controversial and challenging. Despite four international consensus conferences led by the recognized experts in the field they have not been able to define a gold standard for diagnosis or treatment. Mild and often repetitive TBI, is often seen in athletic and military settings, and commonly occurs without loss of consciousness. This symposium will review the current knowledge comparing severe TBI with mild TBI in various patient populations. Special emphasis will be placed on the most recent findings in diagnosis and treatment issues unique to each population.

NO. 1 TBI AND ISSUES OF COMORBIDITY AND TREATMENT

Speaker: Michele T. Pato, M.D.

SUMMARY:

These presentations will review the symptoms of single and multiple traumatic brain injury in general and discuss specific instruments for assessment both neurobiological and psychological. Functional imaging has given more specific knowledge and understanding of the variable impact of TBI on the brain and even have allowed for longitudinal analysis of effects. In Dr. Pato's discussion of treatment issues there will be emphasis on comorbidity including anxiety disorders, depression, cognitive impairment and memory loss, and substance

abuse. The other presenters will emphasize the immediate treatment issues and some of the differences in comorbidity between those in athletics and military service.

NO. 2 POTENTIAL RISK FACTORS RELATED TO TYPES OF TBI AND TREATMENT ISSUES

Speaker: David Baron, D.O., M.Ed.

SUMMARY:

There are significant risk factors for sports TBI from participation in a contact/collision sport. Though even non-contact sport can result in TBI. The presenter will discuss a number of interventions have been identified that lower the risk. However, using equipment that lowers risk may give athletes a false sense of confidence and lead them to play with greater reckless abandon. We will discuss a number of important treatment issues including the immediate TBI decision to rest and stay out of the game. Returning to play too soon, sometimes immediately, is likely the single biggest risk factor for Second Impact Syndrome (SIS) in the world of sports. Heat exposure during the event and even genetics may play roles in determining risk for concussion.

NO. 3 DIFFERENCE AND SIMILARITIES IN RISK AND OUTCOME FOR TBI SUFFERED BY THOSE IN THE MILITARY

Speaker: Patricia I. Ordorica, M.D.

NEURODEVELOPMENTAL DISORDER ASSOCIATED WITH PRENATAL ALCOHOL EXPOSURE (ND-PAE): SOCIETY'S PREVENTABLE MENTAL HEALTH EPIDEMIC

Chair: Susan D. Rich, M.D., M.P.H.

Discussant: Roger Peele, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize prenatal alcohol exposure as the leading preventable cause of intellectual disability and neuropsychiatric issues in the Western World, affecting 2-6% of school aged children in the US.; 2) To diagnose Neurodevelopmental Disorder associated with Prenatal Alcohol

Exposure, distinct from other DSM-5 conditions (e.g., neurodevelopmental, mood/anxiety, externalizing, thought disorders).; 3) To use a 4-domain model for evaluation and treatment planning (i.e., social/communication, neurocognitive, peripheral nervous system, mood regulation/autonomic arousal) of affected individuals.; 4) To prevent prenatal alcohol exposure among patients in a variety of practice settings using strategies of preconception health awareness and contraceptive promotion for alcohol consumers.; 5) To recognize the need for prevention, diagnosis, clinical trials, treatment, vocational services and long term housing for Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure. .

SUMMARY:

An estimated 2-6% of school-aged children have Neurodevelopmental Disorder associated with Prenatal Alcohol Exposure (ND-PAE), exceeding rates of autistic disorders, Down's Syndrome, spina bifida and cerebral palsy. In the style of biological mimicry, ND-PAE masquerades as a variety of neuropsychiatric conditions, masking the hidden etiology "prenatal exposure to our social drug of choice: alcohol.

ND-PAE is caused by neuroteratogenic effects of alcohol (e.g., on neuronal migration, apoptosis, neurotransmitter systems, endocrine function, development of central and peripheral neurons). ND-PAE can occur as early as the first few weeks post conception "before most women know they are pregnant. These "functional birth defects" manifest in 4 domains: neurocognitive issues, mood dysregulation and autonomic arousal, peripheral nervous system/neurologic impairment, and social/communication deficits, contributing to limitations in adaptive functioning (i.e., poor conceptual, social, and practical performance). Resultant deficits in consequential thinking, problem solving, flexibility, gullibility, self-regulation, executive functions, social skills, and speech/language processes leave affected individuals vulnerable to school failure, relationship difficulties, peer pressure, victimization and crime. These individuals often have difficulty with academic and job performance, mental health and substance abuse problems, homelessness, and difficulty with the law. Yet school systems, psychiatric hospitals, outpatient mental health clinics, substance abuse services programs, homeless

shelters, court systems, and correctional facilities neither recognize nor treat individuals with ND-PAE.

Presenters will discuss the epidemiology, science, and current state of research into this misunderstood condition, shedding light on the need for primary prevention (contraception and preconception health for alcohol users), clinical trials, multidisciplinary treatment, vocational supports, and housing programs for affected individuals. A case discussion with a patient will highlight the plight of individuals with ND-PAE, underscoring the need for appropriate academic, vocational, psychiatric, and housing programs and the role that trained psychiatrists can play in diagnosis, treatment, and prevention.

NO. 1

EXPOSURE TO ETHANOL DURING EARLY GESTATION: BRAIN, BEHAVIOR, AND GENETIC SUSCEPTIBILITY IN A MOUSE MODEL OF FETAL ALCOHOL SPECTRUM DISORDERS

Speaker: Scott E. Parnell, Ph.D.

SUMMARY:

Ethanol exposure during pregnancy results in a wide spectrum of anatomical and behavioral abnormalities, making diagnoses of FASD difficult. Some of this variation in ethanol's teratogenicity results from differences in the developmental stage-specific timing of exposure. Recent research has shown that a single ethanol exposure during early pregnancy induces significant long-term, stage-dependent alterations in mouse brains. These ethanol-exposed offspring also exhibit unique, stage-specific behavioral differences. Complicating the stage-specific effects of ethanol, increasing evidence has implicated genetic factors that confer a predisposition to ethanol-induced birth defects. Mutations involving the Shh signaling pathway result in developmental disorders that phenocopy gestational ethanol exposure. Mice that are haploinsufficient for either Shh (+/-) or the downstream transcriptional regulator Gli2 (+/-) develop normally, but when exposed to ethanol, they develop more severe dysmorphologies than their wild-type littermates. These data, along with other genetic studies, suggest that the Shh pathway or genes involving primary cilia (organelles that transduce

the Shh signaling pathways) underlie some of the variations in genetic susceptibility in FASD. Identification of stage-specific patterns of anatomical and behavioral alterations, along with susceptibility genes will improve prevention and diagnosis and enhance potential intervention and ameliorative measures.

NO. 2

BETTER SAFE THAN SORRY - ALCOHOL AND UNPROTECTED SEX DON'T MIX!

Speaker: Sydnie Butin

SUMMARY:

Up to 50% of U.S. pregnancies are unplanned and 1 in 8 childbearing age women binge drink, leaving an epidemic number of pregnancies at risk of unintentional prenatal alcohol exposure (PAE). The Centers for Disease Control and Prevention has launched a Preconception Health and Health Care initiative to intervene in this global crisis. Preconception health promotion is the concept of informing reproductive age men and women about the reproductive health impact of lifestyle behaviors and environmental chemicals before conception in order to reduce the impact of teratogens on offspring. The Better Safe than Sorry (BSTS) campaign is a preconception and contraceptive awareness program developed by high school and college students in collaboration with a child/adolescent and adult psychiatrist to prevent PAE using social media and a blog (www.bettersafethansorryproject.wordpress.com). This primary prevention strategy (similar to promoting condom use for HIV/AIDS prevention) is a brief intervention in the inpatient, clinical practice and community settings. Psychiatrists are well-positioned to prevent PAE by promoting preconception awareness, pregnancy planning and contraceptive use in reproductive age alcohol consumers.

NO. 3

BASIC SCIENCE STRATEGIES FOR STUDYING ND-PAE: THE TIPPING POINT FOR A PARADIGM SHIFT TO PREVENTION AND TREATMENT

Speaker: Sarah E. Cavanaugh, Ph.D.

SUMMARY:

Given the limited success of historical social strategies for eliminating alcohol-exposed

pregnancies, much of the fetal alcohol syndrome (FAS)-related research effort is focused on understanding the mechanisms of alcohol induced damage, with hopes of ultimately preventing or treating it. Many basic science studies use animal models of FAS, typically rodents and sheep. This presentation will provide an overview of the common models of FAS, what they are being used to accomplish, limitations inherent in the models, and alternative methods. An overview of the need for clinical trials prevention and treatment protocols will be outlined to guide future population-based research initiatives in humans to prevent and treat Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure (ND-PAE).

NO. 4

THE HIDDEN COST OF ND-PAE

Speaker: Susan D. Rich, M.D., M.P.H.

SUMMARY:

Neurodevelopmental Disorder Associated with Prenatal Alcohol Exposure (ND-PAE) is a prevalent yet underestimated and misunderstood condition in outpatient clinics, inpatient units, adoption and foster care systems, and juvenile detention centers. As the leading known and preventable cause of intellectual disability, costs exceed \$6 billion each year for full Fetal Alcohol Syndrome alone. Associated deficits predispose affected individuals to a lifetime of academic failure, joblessness, parenting failure, homelessness, and incarceration.

This presentation reviews the DSM-5 diagnostic criteria for ND-PAE, outlines societal costs of unrecognized and untreated ND-PAE, discusses a 4-domain treatment planning model, and proposes alternatives to institutionalization and incarceration for affected individuals. Early accurate diagnosis and intervention services during early childhood can improve academic, social, and daily life skills. Identification prior to adulthood can facilitate transitional planning, supportive housing or group home placement when necessary. Child/adolescent, adult, addiction, and forensic psychiatrists are well positioned to better assess, diagnose and treat individuals with ND-PAE. Self-sustaining residential communities can potentially provide vocational supports, safe housing, and socialization for young adults transitioning from high school will help reduce

societal costs due to incarceration rates and/or institutionalization.

TWITR (TELEMEDICINE WELLNESS, INTERVENTION, TRIAGE, AND REFERRAL): A PILOT PROJECT TO PROMOTE SCHOOL SAFETY

Chair: Manish R. Aligeti, M.D., M.H.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of mental illness in children and adolescents on the criminal justice system.; 2) Understand the importance of school-based psychiatric intervention to screen high-risk students and utilize available local resources.; 3) Recognize different parameters that can be measured to evaluate the impact of school-based interventions.; 4) Emphasize the role of collaborating the education system and mental healthcare system to improve the quality of care in this population. ; 5) To replicate the model nationwide, considering and addressing the professional, legal, logistical and social limitations.

SUMMARY:

According to the Federal Bureau of Investigation's Uniform Crime Report, in 2010 juveniles accounted for 13.5% of all violent crime arrests and 22.5% of all property crime arrests. Almost 70% of the two million children and adolescents arrested each year have mental illness and of these, at least 20% have serious illness making them vulnerable to commit suicide and violent crimes [1]. Nearly 100 million dollars are spent by juvenile detention facilities each year to house offenders who are waiting for mental health services, adding a huge financial burden on the society [2]. There are few studies indicating the importance of school-based interventions in identifying and treating mental health disorders in this age group [3]. Such interventions will not only reduce the prevalence of mental health problems but will also aim at decreasing the overall criminal behaviors associated with untreated mental illness.

Telemedicine Wellness, Intervention, Triage and Referral Project (TWITR) is a unique school-based project catering to the mental health needs of children and adolescents in the rural areas of West Texas. This project is funded by

the State of Texas Office of the Governor's Criminal Justice Department to promote school safety by providing psychiatric assessment and referral services to students. As a part of this project, Licensed Professional Counselor's (LPC) screen students who are referred by school counselors from Lubbock and surrounding school districts. Reasons for referral include imminent risk of harm to self/others, declining grades, aggressive behaviors, and truancy. After screening, these students are triaged during weekly meetings with child and adolescent psychiatry team to discuss appropriate treatment plan. Those requiring outpatient psychiatric evaluations are seen through telemedicine clinic. Some of the other referrals, based on severity of their presentation include; inpatient treatment centers, legal system, substance recovery centers, outpatient counseling centers, etc. The LPCs' also conduct mental health-training seminars for school nurses, counselors, and educators.

In this symposium, along with presenting the model of the TWITR project, we will present its success story from the year 2013-2014 by comparing various academic outcome measures from before and after the intervention. In its inception year, this project impacted nearly 200,000 students, either directly or indirectly, from Lubbock and its surrounding counties. Such a project can have huge implications on population that is both underserved and at high risk for mortality and morbidity from psychiatric disorders. Our ultimate goal is to have a positive impact on communities that can potentially help bridge a gap of needs and services, by developing a protocol of providing mental health care, effective in Texas and nationwide.

References: Will be provided during the symposium.

NO. 1

TWITR PROJECT: INTRODUCTION

Speaker: Deepti Vats, M.D.

SUMMARY:

TWITR project: Introduction

A thorough literature review on how mental illnesses in children and adolescents affect the criminal justice system will be presented in the introduction. Complete overview of the Telemedicine Wellness, Intervention, Triage, and

Referral (TWITR) project will be also provided in this section. All the steps in devising the model, including budgeting, school agreements and contracts, legal aspects, timeline, and role of health care providers will be discussed. Complete description of the school referral and screening process along with various clinical instruments that were used. A discussion on optimal utilization and incorporation of the available community resources into the TWITR project will also be done here.

NO. 2 TWITR PROJECT: A SUCCESS STORY

Speaker: Ankit A. Parmar, M.D., M.H.A.

SUMMARY:

During the TWITR project's first year, August 2013 to May 2014, school counselors referred a total of 75 students from six independent school districts of West Texas area. Of these 75 students, 61 were screened by Licensed Professional Counselors (LPC) using the following instruments; Child Mania Rating Scale, Mood and Feeling Questionnaire, Screen for Child Anxiety Related Disorders, Vanderbilt ADHD Assessment Scale, and Suicidal Ideations Questionnaire. These students were then staffed during weekly treatment meetings with child and adolescent psychiatry team. Various disposition referrals were made based on the severity of these students' clinical presentation. Six students were admitted to inpatient psychiatric units, six were arrested, and 25 were evaluated at the outpatient telepsychiatry clinic. The rest were referred to substance abuse treatment centers, outpatient counseling centers, and primary care providers with case specific recommendations. In this section, we will discuss the baseline demographic and clinical characteristics, results of the screening instruments, and changes in the academic functional outcomes, such as grade point averages, truancy, and disciplinary reports. Positive impact of the TWITR project on these parameters will be provided here.

NO. 3 TWITR PROJECT: CHALLENGES AND TRAINING

Speaker: Manish R. Aligeti, M.D., M.H.A.

SUMMARY:

The success of the incipient year led to the extension of the TWITR project for two additional school years (August 2014 - May 2016). In this session, preliminary findings from the current year will be compared to the previous year. Several professional, legal, logistical and social challenges that were faced during the first year of the project were addressed and incorporated in formulating the project for the next year. A thorough discussion of these challenges will be done here. In addition, two parameters measuring social characteristics of students; Children's Loneliness Questionnaire and Hopelessness Scale Children, were also included to strengthen the evaluation process, will be discussed. Training seminars held to educate school nurses, counselors, and educators will also be discussed during this session.

BODY-FOCUSED BEHAVIORS UNDERSTANDING, TREATMENT **REPETITIVE NEW BETTER**

Chairs: Margaret A. Richter, M.D., Mark Sinyor, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose the BFRBs and appreciate their heavy burden on sufferers.; 2) Understand current evidence for the genetic underpinnings of the BFRBs.; 3) Identify neurocognitive and personality features associated with patients with BFRBs and appreciate how they are relevant for treatment.; 4) Understand psychotherapy options for BFRBs including the Comprehensive Behavioral (ComB) model of treatment and the evidence for it.; 5) Use evidence based strategies to treat the BFRBs with medication.

SUMMARY:

The Body Focused Repetitive Behaviors (BFRBs) which include Trichotillomania (TTM, Hair-Pulling Disorder), Excoriation (Skin-Picking) Disorder and nail biting, have been described as the third most prevalent category of mental illness after anxiety and mood disorders. However advances in understanding and treatment have lagged. Formal recognition of these conditions in the DSM-5 has now spurred renewed interest by researchers and clinicians. This symposium will provide an overview of our

most up-to-date understanding of how BFRBs arise, including their genetic basis and neurocognitive/personality features associated with them. We will then explore the latest evidence for their treatment including studies of pharmacotherapy and psychotherapy. Dr. Jon Grant will begin the symposium with an introduction of these conditions, and present on neurocognitive and neurobiological findings that have emerged in the literature in recent years. He will then build on this base of understanding to discuss the roles of both traditional psychopharmacological options and newer emerging alternatives such as N-acetylcysteine and inositol. The genetic underpinnings of these conditions will then be introduced by Dr. David Pauls. He will review existing family, genetic and heritability data and present the largest genetic study of trichotillomania conducted to date. This will be followed by a presentation by Dr. Neil Rector who will review theories of personality vulnerability factors for OCD & Related Disorders to date. He will then introduce new data specifically related to differences in specific personality facets/traits which may underlie the BFRBs. Last, Dr. Mark Sinyor will review the existing literature regarding psychotherapy for this group of conditions, and introduce a widely-used comprehensive model of cognitive-behavioral treatment. He will then present new data from an ongoing pilot study delivering this treatment in group form. By the conclusion of this symposium attendees will appreciate recent developments in this field, and understand emerging evidence-based treatment options which can be applied in their patients.

**NO. 1
USING NEUROBIOLOGY TO IMPROVE
MEDICATION TREATMENT OF BFRBS**

Speaker: Jon Grant, M.D.

SUMMARY:

Trichotillomania and Skin Picking Disorder are relatively common and often-disabling but they usually go unrecognized in clinical practice. Over the last 10 years, there has been a growing body of research on the cognitive and neurobiological underpinnings of trichotillomania and skin picking disorder. In addition, pharmacological treatment has been ongoing for the past 20 years for these disorders. Recently, the field of medication treatment has been using what is known about

the biology of these disorders to refine our treatment approach. This presentation will review the neurocognitive and neurobiological findings in trichotillomania and skin picking disorder, will also emphasize recent research findings on effective pharmacologic treatments, and will offer practical advice on how to successfully treat patients with these often difficult-to-treat disorders.

**NO. 2
THE FAMILIALITY OF HAIR PULLING
AND ITS RELATION TO OTHER MOOD
AND ANXIETY DISORDERS**

Speaker: David L. Pauls, Ph.D.

SUMMARY:

Until recently very little was known about the familiarity of hair pulling (HP). Furthermore, its relation to other obsessive-compulsive (OC) spectrum disorders was also unclear. While many clinic studies have reported an apparent relation to skin picking, obsessive-compulsive disorder (OCD) and other mood and anxiety disorders, a direct examination of its relation to these conditions has not been done. Family studies are ideal to examine both the familial aggregation of HP and its familial relation to other mood and anxiety disorders. Recently the first case-controlled family study of HP was reported. The results of this research and other related studies will be presented and the findings will be discussed.

**NO. 3
THE EXAMINATION OF FIVE-FACTOR
MODEL PERSONALITY TRAITS AND
COGNITIVE DIMENSIONS IN CBT
TREATMENT RESPONSE FOR DSM-5
TRICHOTILLOMANIA, EXCORIATION,
AND HOARDING DISORDER**

Speaker: Neil Rector, Ph.D.

SUMMARY:

There has been considerable cross-sectional examination of OCD-related cognitive and personality vulnerabilities in non-clinical, epidemiological and clinical populations. The extent to which these factors can be reduced and moderate/mediate clinical response in first-line CBT treatment has been examined less thoroughly. Further, however, there has been very little examination of these cognitive and

personality vulnerabilities in the DSM-5 OCD spectrum conditions, including trichotillomania, excoriation disorder and hoarding disorder. The aim of this talk is to explore the nature of cognitive and personality vulnerability in the DSM-5 spectrum conditions and the extent to which these factors can be successfully reduced with manual-based CBT treatments. The results indicated that while CBT treatment effects for the three OCD Related Disorders were large (dâ€™s range from 0.79 to .89 on primary symptom measures), the corresponding impact on personality dimensions was minimal with FFM stability estimates ranging from 0.77 to 0.92 depending on the FFM dimension. This pattern differs significantly from the personality changes and correlates with symptom improvement in OCD. The overlap and distinction between OCD and the Related Disorders in terms of cognitive and personality vulnerabilities, and the extent to which CBT successfully targets these factors, will be discussed.

**NO. 4
PSYCHOTHERAPY FOR
TRICHOTILLOMANIA: A PILOT STUDY
OF THE COMPREHENSIVE BEHAVIORAL
(COMB) MODEL APPLIED IN A GROUP
SETTING**

Speaker: Mark Sinyor, M.D.

SUMMARY:

Background: A growing body of evidence suggests that several psychotherapeutic modalities including habit reversal therapy and acceptance and commitment therapy are effective in treating the BFRBs. It has been argued that an enhanced version of habit reversal therapy involving a comprehensive behavioral (ComB) approach are of benefit, but this strategy and psychotherapies for trichotillomania in general have limited evidence in a group format.

Method: In an ongoing pilot study, 24 patients with trichotillomania completed 9 weekly structured cognitive behavioral therapy sessions using a manualized version of ComB with a one month follow-up. Baseline characteristics and outcome measures (hairs pulled, BDI) were monitored.

Results: Ninety-two percent of patients were female (mean age 33.4+/-9.2 years) with the most common comorbid diagnoses being MDD

(58%), substance use disorders (20%), social phobia (18%) and OCD (13%). There was a significant difference in the number of hairs pulled in pre- (M=394.3,SD=473.3) and post- (M=105.9,SD=162.9) treatment; $t(23)=3.39, p = 0.003$ as well as BDI scores pre- (M=20.9,SD=14.7) and post- (M=14.8,SD=13.9) treatment; $t(11)=3.47, p=.005$.

Conclusion: Group CBT using the ComB model appears to be effective in reducing hair pulling and depressive symptoms in some patients. Further work needs to be done to replicate these results in larger samples.

**TERRORISM IN PAKISTAN - A
BEHAVIORAL SCIENCES PERSPECTIVE**

Chairs: Mir N. Mazhar, M.D., Tariq Munshi, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to understand the behavioral sciences perspective of terrorism in Pakistan; 2) Participants will be able to understand the interplay of historical, geopolitical, anthropological and psychosocial factors and forces in terrorism; 3) Participants will be able to understand the controversial issues linked to terrorism.

SUMMARY:

Pakistan is a classic example of a country caught in an ongoing war against terrorism, where the state, its people, its neighbors, allies and friends have had diverse and often conflicting views on the subject. Surprisingly, Pakistan is considered to be both a frontline nation in the international war against terrorism and at the same time a sponsor of international terrorism. More than a decade after its active involvement in an all-out war against terrorism, it finds its allies as well as its own government entering into a dialogue with the terrorist organizations to find a palatable solution. It can be argued that Pakistan has gained worldwide attention for "terrorism" and its role in the "war against terrorism". The region is well placed geopolitically for economic successes but has been plagued by terrorism in various shapes and forms. This symposium reviews the behavioral sciences perspectives of terrorism in Pakistan and attempts to explain terrorism in this part of the world as a complex interplay of historical, geopolitical, anthropological and psychosocial factors and forces. Drawing from

theories by Western scholars to explain the behavioral and cognitive underpinnings of a terrorist mind, the symposium highlights the peculiarities of similar operatives at individual and group levels. Thorny issues related to the ethical and human right dimensions of the topic are visited from the unique perspective of a society challenged by schisms and divergence of opinions at individual, family, and community levels. It is attempted to minimize the political descriptions, although this cannot be avoided entirely, because of the nature of terrorism. At this important juncture in history, the aim is to look at terrorism in Pakistan from the perspective of the behavioral sciences so as to take into account an interplay of diverse factors that have contributed to unprecedented suffering by the nation at the hands of terrorists. The symposium also takes into account the country's unique and advantageous geopolitical status, which has resulted in a peculiar anthropological experience through its use as a corridor used for thousands of year by Greeks, Arabs, Mongols, Turks, Afghans, and Iranians to reach India's capital, Delhi, the seat of power in the subcontinent. The psychological, social, and religious vulnerabilities of the people of Pakistan, which may predispose this country to both contributing to, and becoming a victim of terrorism is also considered from a unique perspective.

NO. 1 TERRORISM IN PAKISTAN CONTROVERSIES

Speaker: Fareed A. Minhas, M.R.C.

NO. 2 EVOLUTION OF TERRORISM IN PAKISTAN

Speaker: Mowadat H. Rana, M.R.C.

SUMMARY:

It is believed that successive governments in Pakistan looked ignored the terrorist groups who made roads into the society to become a "subculture". In the meantime, the evangelical schools working with young men and women alike provided a perfect cover for them to be converted to a militant way of life by representatives of terrorist groups. The regular recruitment of young men from across the country to be used as suicide bombers and jihadi fighters was not once denounced by the

religious leaders and leaders of political parties. From the late 1990s onwards, the callousness and pathological nature of "a belle indifference" shown by mainstream society set in, leading to a partial paralysis of civic life and the state machinery. While the majority of the population is still committed to liberalism, progress, democracy, a pluralistic world view, tolerance, and peace, there is an ever-growing, deep intrusion of reactionary, fundamentalist, and pagan thinking in some sections of Pakistani society. A deeper understanding of how these macroscopic changes have influenced the psyche and social lives of the vulnerable population falling prey to terrorism is in order.

NO. 3 TERRORISM IN PAKISTAN PSYCHOSOCIAL PERSPECTIVE

Speaker: Tariq Hassan, M.B.B.S.

SUMMARY:

To understand the "psychology" of a terrorist in Pakistan or otherwise, one must try to understand how they view their own conduct and why. They view their own actions as rational and purposeful, driven in response to their own perception of social, political, religious, and other realities. But dismissing terrorists as "mad", "evil" or "aliens" is perhaps reassuring as it distances us from them and their motives. The thinking that "I am good and right" and "You are bad and wrong" prevails in the mind of a terrorist in any part of the world. These beliefs distance them from their victims, and probably make it easier for them to kill their opponents with apparently little or no sense of remorse or guilt. This mindset was a common finding among the majority of terrorists who were captured and taken into custody from various parts of Pakistan and interviewed while in confinement. The concept of themselves being "good" and their victims "bad" emerges from a range of religious, ideological, social, and cultural factors. Related to this idea is the concept of revenge, renown, and reaction in the pursuit of terrorism.

NO. 4 TERRORISM IN PAKISTAN RELIGIOUS PERSPECTIVE

Speaker: Asad T. Nizami

SUMMARY:

The 21st century has witnessed a revival of religious fundamentalism that runs counter to the previous perception that secularization, although erratic, is irreversible. The concept that the rise of modern society and the decay of religion are two sides of the same coin has unfortunately proved to be wrong. The concept of "Islamist martyrdom" and its abuse were highlighted at the conclusion of the Swat operation against terrorism in Pakistan in 2009. A number of adolescents who were to be "future suicide bombers" in Pakistan were taken into custody and, before their release into the community, were psychologically profiled. Their narratives described the recipe for "making a suicide bomber in six weeks." All the adolescents were recruited by the cleric of the madrassa they attended for their daily Koranic recitation. Some clerics in Pakistan have made attempts to separate Islam from terrorism. Nonetheless, there still remain to be found better answers to the question as to why some individuals favor only the jihad version of Islam when there are alternative ways of pursuing and interpreting the Islamic faith.

IMPROVING ENGAGEMENT OF ETHNIC AND RACIAL MINORITIES THROUGH INTEGRATED CARE: INNOVATIVE APPROACHES FROM THE FIELD

Chairs: Justin Chen, M.D., M.P.H., Albert Yeung, M.D.

Discussant: Laurence J. Kirmayer, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the challenges of adapting existing mental health care resources for diverse populations in the U.S. and abroad; 2) Identify at least two innovative approaches to improving engagement of ethnic and racial minorities in mental health care in the U.S. and abroad; 3) Discuss how integrated care can be used to improve engagement of minority patients in a variety of settings.

SUMMARY:

Ever since the landmark 1999 Surgeon General's Report on Mental Health found that "striking disparities in access, quality, and availability of mental health services exist for racial and ethnic minority Americans," a flurry of

research has attempted to characterize the specific barriers to mental health treatment that exist in the U.S. for minority populations, and to propose interventions that might help overcome these barriers. Nonetheless, recent reviews have found that disparities in access to and quality of mental health care persist, due to a wide variety of logistical, historical, and sociocultural factors. As the diversity of the U.S. population continues to increase, with Caucasians projected to become a minority race as early as 2042, it is clear that innovative approaches will be required to bridge these persistent mental health treatment gaps for large segments of the populace. In this symposium, five clinician-researchers will discuss their experiences in attempting to engage Latino and Asian patients in mental health care treatment through integrated approaches, both in the U.S. and abroad. The advent of novel technologies such as telepsychiatry, as well as the use of group-based and stepped-care approaches will be discussed. Opportunities and challenges will be highlighted. While Collaborative Care involving integration of behavioral health screening and management into primary care is a central theme, not all the interventions utilize such an approach. Additionally, the importance of bidirectional learning will be stressed, including the idea that understanding and flexibly engaging with culturally determined illness beliefs are crucial when attempting to design mental health services for diverse populations.

NO. 1

EFFECTIVENESS OF TELEPSYCHIATRY-BASED CULTURALLY SENSITIVE COLLABORATIVE TREATMENT FOR DEPRESSED CHINESE-AMERICAN IMMIGRANTS

Speaker: Albert Yeung, M.D.

SUMMARY:

Chinese Americans with Major Depressive Disorder (MDD) frequently have difficulty accessing culturally sensitive care. This presentation will report the results of a trial to evaluate the effectiveness of a telepsychiatry-based culturally sensitive collaborative treatment (T-CSCT) to improve outcomes for depressed Chinese American immigrants in primary care settings. Participants were identified via primary care practices and

randomized to receive either T-CSCT or treatment as usual (TAU) for six months. T-CSCT involves cultural consultation via videoconference and care management. The primary outcome measure was the 17-item Hamilton Rating Scale for Depression (HAM-D-17). Positive response was defined as a >50% decrease in HAM-D-17 score, and remission as HAM-D-17 ≤ 7 . Secondary outcomes were the Clinical Global Impression-Severity (CGI-S) and Improvement (CGI-I) scales, and the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). Outcomes were analyzed using multivariate logistic regression and multivariate analysis of covariance. Participants (n=190) were 63% female, with a mean age of 50 years (± 14.5). T-CSCT improved treatment response and remission by HAM-D-17, and improved HAM-D-17, CGI-S, CGI-I and Q-LES-Q measurements. In conclusion, T-CSCT is effective in improving treatment outcomes of Chinese immigrants with MDD. It offers a platform for providing culturally sensitive care to underserved immigrant populations without requiring physical proximity.

NO. 2 IMPACT OF A CULTURALLY FOCUSED PSYCHIATRIC CONSULTATION ON DEPRESSIVE SYMPTOMS AMONG LATINOS IN PRIMARY CARE

Speaker: Nhi-Ha Trinh, M.D., M.P.H.

SUMMARY:

Depressed Latino Americans are less likely to seek mental health services than depressed Caucasian Americans. To improve patient engagement in mental health care, we implemented a culturally focused psychiatric (CFP) consultation service in primary care settings. In this talk, we present results of a study on the adaptation and implementation of the CFP intervention to engage and improve symptoms in depressed Latino Americans. The two-visit intervention used culturally adapted clinical assessments and toolkits in English or Spanish. Acceptability was evaluated using a treatment satisfaction scale at six-month follow-up and in-depth semi-structured interviews at the end of the program. Depressive symptoms were measured at baseline and six-month follow-up using the Quick Inventory of Depression Scale, Self-Rated (QIDS-SR). Participants

(N=118) were primarily monolingual Spanish speakers (64%). Participants reported that the program met their expectations, providers were culturally sensitive, and recommendations were culturally sensitive. Participation in the CFP intervention predicted lower depressive symptoms at follow-up (unstandardized beta = -3.09 , $p=0.008$), independent of baseline depressive symptoms, clinic site, age, gender, and employment status. In conclusion, results suggest that the CFP program was found acceptable to a group of depressed Latino American primary care patients, whose depressive symptoms improved from the short-term consultation.

NO. 3 A GROUP INTERVENTION FOR DIABETES TREATMENT ADHERENCE AND DEPRESSION IN HISPANICS

Speaker: Trina Chang, M.D., M.P.H.

SUMMARY:

Diabetes and depression appear to have a bidirectional relationship, with each disorder associated with an elevated risk of developing the other. Furthermore, by lowering treatment adherence, depression may worsen diabetes outcomes. These problems may be compounded in minority populations that face stigma and socioeconomic barriers to chronic disease diagnosis and management. This presentation describes a study for evaluating feasibility and preliminary effectiveness data for a psychotherapy-based group intervention promoting better illness management for Spanish-speaking patients with Type 2 diabetes. The PRISM-D intervention (PRoblem-solving, Information, Support and Motivation in Diabetes) includes 12 weekly group visits, with two visits each for six topics covered. The first visit for each topic focuses on eliciting problems and support from participants (using elements of motivational interviewing) and correcting misinformation. In the second visit, participants learn a form of Problem Solving Treatment, modified to include motivational enhancement. Outcomes include measures of diabetes self-care behaviors, depression, diabetes-related distress, and hemoglobin A1C. Quantitative and qualitative results of a pilot group will be presented. If this intervention proves feasible and effective, it may provide a way to improve outcomes of two prevalent and costly chronic

illnesses that often co-occur and may involve special management concerns in minority populations.

**NO. 4
COLLABORATIVE CARE TREATMENT
FOR DEPRESSION IN PREGNANCY IN
SÃO PAULO, BRAZIL**

Speaker: Hsiang Huang, M.D., M.P.H.

SUMMARY:

Depression during pregnancy is a global health problem and has direct consequences for the affected woman and her children and family. In low- and middle-income countries, depression during pregnancy is highly prevalent, and usually unrecognized and untreated. Dr. Huang will describe the current primary care system in Brazil and present one way in which integrated mental health interventions in primary care can potentially provide comprehensive depression care for low-income depressed pregnant women. PROGRAVIDA is a randomized controlled trial for pregnant women with depression attending prenatal care in 12 primary care units with Family Health Program, covering an area of 400,000 inhabitants in São Paulo, Brazil. The intervention is a stepped care program delivered using a team approach (which includes the primary care provider, nurse, nursing assistants, and mental health consultants). In the intervention arm, nursing assistants utilize problem solving techniques to help women in their homes, while those with severe depressive symptoms are referred to the primary care provider and are assessed for the need of antidepressants. Depressed women in the control group receive usual care. Dr. Huang will then describe how this approach to depression care for pregnant women might be applied to primary care settings in the US.

**NO. 5
A GROUP-BASED STRESS
MANAGEMENT INTERVENTION FOR
DEPRESSED CHINESE IMMIGRANT
PATIENTS AT SOUTH COVE
COMMUNITY HEALTH CENTER**

Speaker: Justin Chen, M.D., M.P.H.

SUMMARY:

Individuals of Chinese descent make up the largest subgroup of Asians in the U.S. and also have among the lowest rates of mental health

service utilization of any racial/ethnic group. Of the many barriers contributing to this underutilization of mental health care, stigma and a lack of culturally appropriate services are among the most significant. This presentation will describe an innovative approach to engaging this vulnerable and underserved population that attempts to flexibly bridge different culturally based conceptualizations of depressive symptoms in a primary care population. This intervention utilizes an 8-week, group-based approach led by bilingual, bicultural social workers at a community health center in Boston's Chinatown. Each session encompasses three core components: 1) a psychoeducation/didactic portion, 2) an open-ended but thematically organized facilitated discussion, and 3) a practical skills-based section drawing from elements of cognitive behavioral therapy, mindfulness, and traditional Eastern philosophies such as Taoism and Buddhism. Dr. Chen will discuss how the structure and content of the intervention will be shaped by qualitative focus groups conducted among current patients at the clinic, and how stigmatizing or overly medicalized terminology will be avoided in order to improve engagement. Challenges and opportunities in the implementation of the program will be discussed, along with preliminary results and future directions for innovation.

**TRANSLATING THE RAPIDLY
EXPANDING BASIC AND CLINICAL
KNOWLEDGE BASE OF CANNABINOID
MEDICINE INTO THE HOLISTIC
TREATMENT OF NEUROPSYCHIATRIC
DISORDERS**

Chair: David G. Ostrow, M.D., Ph.D.

Discussant: Phillipe Lucas, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand existing evidence that specific MC constituents might be useful parts of integrative holistic healthcare.; 2) Know the specific barriers for psychiatrists and researchers in translating current laboratory and observational studies into treatment guidelines; 3) Understand how to overcome those barriers through collaborative patient community-caregiver-academic and industry researcher-government agency efforts for policy and priority changes?; 4) Discuss how to develop

cannabinoid therapeutics as part of integrative wellness healthcare rather than as an alternative/exclusionary system.

SUMMARY:

It has been almost 55 years since Dr. Lester Grinspoon's book, *Marihuana Reconsidered*, was published, wherein he predicted that cannabis would be legalized for adults within a decade. The resulting debate was so furious and chaotic that Dr. Grinspoon himself admitted that he had overlooked the irrationality of attitudes and opinions about illicit drugs strongly held by users and non-users alike. Adding to the conflicting and often self-contradictory attempts to control the use of cannabis while unbiased scientific evidence could be accumulated has been the exceptional nature of its classification as a Schedule I narcotic and restrictions on its availability for any studies that sought evidence for its potential therapeutic applications. Even now, as the majority of US citizens are living in States with Medicinal Cannabis Programs and all Canadian Provinces have regulated Medical Cannabis Programs, there are unresolved conflicts between the Federal prohibition of cannabis use, including the requirement for universal drug testing under the Drug Free Workplace provisions of the War on Drugs. Because heavy cannabis use, especially if initiated among adolescents and young adults, does arguably have the potential for dependence, acute psychotic reactions and reduced cognitive and intellectual functioning, psychiatrists have been among those medical specialties most wary of its legalization and acceptance into clinical practice. This Symposium has been designed to provide an update on the state of Cannabinoid Medicine research and practice and a forum for consideration of the optimal conditions necessary to translate those findings into a holistic framework for the treatment of a variety of neuropsychiatric disorders. It will begin with a simplified explanation of the human endocannabinoid system and how it is thought to interact with other NT systems, neurotransmission modulators and signaling systems, and cellular metabolic processes that might underly MC's wide range of therapeutic effects in the clinical and and laboratory studies that the other presentations will describe. Finally, the Discussant will review the history of medical cannabis programs in North America

and the exciting possibilities now that companies interested in developing, testing and marketing new strains of cannabis for new healthcare applications are entering into the field.

NO. 1

TRANSLATING CANNABINOID SCIENCE INTO INTEGRATIVE AND HOLISTIC WELLNESS ORIENTED MEDICINE

Speaker: David G. Ostrow, M.D., Ph.D.

SUMMARY:

With the majority of Americans (and all Canadians) now living in States with Medicinal Cannabis Programs and legalization of recreational cannabis use by adults following closely behind, it is time to address the huge gaps in medical and residency education and training to include the known and potential therapeutic uses of cannabinoid-based therapeutics. While the science of the human endocannabinoid system has long been known from the pioneering work of Mechoulam and followers, the actual mechanisms by which the endocannabinoid system interacts with other neurotransmitter and modulator systems and how exogenous phytocannabinoids work in regulating specific CNS and peripheral signaling and homeostatic processes are the subject of much current research. This presentation will summarize what is known about these interactions between endocannabinoid receptors and signaling that may underly the translation of exogenous phytocannabinoid-based therapies into treatments for mood disorders, pain, HIV infection and disease progression, cancer, epilepsy and other neuropsychiatric conditions that will be discussed by the remaining presenters. The case for integrating cannabinoid therapeutics into holistic and wellness oriented medicine for optimal results, rather than its development as a separate exclusive alternative therapy, will be made based on the multitude of potential applications and overlap with modern psychiatric practice.

NO. 2

CANNABIS FOR THERAPEUTIC PURPOSES IN A MENTAL HEALTH FRAMEWORK: FROM THE HUMAN ENDOCANNABINOID SYSTEM TO PUBLIC HEALTH

Speaker: Zach Walsh, Ph.D.

**NO. 3
THE INTEGRATION OF CANNABIS-
BASED THERAPIES INTO THE
NEUROPSYCHIATRIC ASPECTS OF
HIV/AIDS AND OTHER BRAIN
SYNDROMES**

Speaker: Karl Goodkin, M.D., Ph.D.

SUMMARY:

Cannabis contains more than 120 different cannabinoid molecules. While THC is the main psychoactive cannabinoid, cannabidiol (CBD) has anti-anxiety, anti-psychotic, analgesic, anti-epileptic, anti-spasmodic, anti-emetic, and anti-diabetic properties. Cannabinol (CBN) augments the effects of THC and is analgesic and aids sleep. Medical cannabis (MC) has been used with HIV/AIDS patients since the beginning for appetite stimulation, insomnia, and pain. Research on long-term health effects of MC on AIDS-related morbidity/mortality in patients on HAART is variable, and largely related to adherence. Some studies show a preference for *C. indica* for pain, agitation, sleep, non-migraine headaches, glaucoma, neuropathy, spasticity, seizures, and joint pain, but CBD concentrations of *C. indica* grown for MC ranges from 0-low. Toxic effects can include severe anxiety, paranoia and dyspnea and may be a neurodevelopmental concern in teenagers. Conversely, THC was recently found to interact with Al^2 peptide, inhibiting aggregation and lowering both total GSK-3 β levels and phosphorylated GSK-3 β levels in a dose-dependent fashion, suggesting utility in HIV-associated neurocognitive disorders. Finally, the rate of fatal overdoses from prescription opioids more than quadrupled between 1999-2010 in the US, and MC use could offset this trend. Once we know what cannabinoids ameliorate specific symptoms, their integration into existing therapies can accelerate.

**NO. 4
CANNABINOIDS IN ACUTE AND
CHRONIC HIV: INSIGHTS FROM BASIC
RESEARCH AND TRAJECTORY
MODELING**

Speaker: Dana Gabuzda, M.D.

SUMMARY:

Laboratory and animal studies of (endo)cannabinoids suggest these molecules have protective effects against mood, anxiety, and inflammatory disorders, and "buffering" effects that protect against psychological and physiological stresses. HIV causes immune dysregulation, inflammation, and oxidative stress, while biopsychosocial factors increase vulnerability to anxiety, psychological distress, and depression. Anti-inflammatory, appetite-stimulating, anti-anxiety, anti-depressant, and anti-nociceptive effects of cannabinoids may ameliorate HIV-related comorbidities, including inflammatory conditions, weight loss, depression, and pain. Using the Multicenter AIDS Cohort Study dataset, we characterized trajectories of men with/without heavy marijuana use pre-/post-seroconversion (n=85). These studies showed no effects of heavy marijuana use in seroconverters compared to non-users matched for age, race, education, smoking, and alcohol use on virological and immunological markers up to 5 years post-seroconversion, nor differences in long-term outcomes, such as cardiovascular events, disease progression, and all-cause mortality. Trajectory analysis of CES-D scores in HIV+ men showed weak associations between daily marijuana use and lower CES-D scores among men over age 50. Current knowledge of (endo)cannabinoids in HIV, including in vitro studies and non-human primates, suggest beneficial effects for several HIV-related symptoms and comorbidities and directions for future research.

**NO. 5
CANNABIS, BRAIN CANCER, AND
REDEFINING CLINICAL TRIALS WITH
BOTANICAL MEDICINES**

Speaker: Jahan P. Marcu, Ph.D.

SUMMARY:

Active ingredients in the Cannabis plant have been shown to have notable anti-cancer properties. Regulations that allow the standardization of medical Cannabis will allow clinical trials to be conducted with diverse preparations of Cannabis. Regulation is becoming mandatory in some States that allow medicinal cannabis, but not necessarily in States that are legalizing recreational cannabis. The producers, manufacturers, dispensaries,

and laboratories involved in this “industry” can operate legally in those states but function without any Federal regulation or oversight as long as Cannabis is included in Schedule I of the narcotic code. Due to increasing concerns over the need to standardize medicinal cannabis preparations, the American Herbal Product Association (AHPA) has created industry guidelines on manufacturing, producing, dispensing, and laboratory operation standards and published these in the Cannabis monograph of the American Herbal Pharmacopeia (AHP). The work of AHPA/AHP lays the foundation for a certification body called Patient Focused Certification (PFC). These guidelines are being incorporated into state level regulations as mandatory product safety standards in new state programs. The results of the first round of PFC auditing will be presented, along with recommendations for additional research on the impact of such regulations on patients, facilities, government, universities, and neighborhoods.

**TRAUMA-CENTERED
PSYCHOTHERAPY: APPLYING
EVIDENCE-BASED TECHNIQUES
WITHIN A PSYCHOTHERAPEUTIC
FRAME**

Chair: Hadar Lubin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Apply at least three trauma-centered techniques within their psychotherapy practice; 2) Know the four basic principles of trauma-centered psychotherapy; 3) List the most common forms of avoidance and methods of addressing avoidance in conducting a trauma inquiry.

SUMMARY:

This symposium will present a model of intensive trauma-centered inquiry in a psychotherapeutic frame. Recent developments in the trauma treatment field have emphasized relatively brief, manualized methodologies based exposure or cognitive restructuring. For the physician in psychotherapeutic practice, often with clients who are seen over a substantial period of time, it has been unclear how to integrate these advances within a psychotherapy frame. We will articulate a number of linking principles

between evidence-based work and psychotherapy and then present a model for applying these techniques effectively.

**NO. 1
PRINCIPLES OF TRAUMA-CENTERED
PSYCHOTHERAPY**

Speaker: Hadar Lubin, M.D.

SUMMARY:

Dr. Lubin will review the basic axioms and principles of trauma-centered psychotherapy, which include the central roles of fear, avoidance, and relational structures in trauma schemas, as well as the importance of immediacy, engagement, and emotionality in delivering services. Once a trauma-centered frame has been established with the patient, the therapist must proceed with confidence, focus, and consistency in conducting the trauma inquiry.

**NO. 2
CONDUCTING AN INTENSIVE,
DETAILED TRAUMA INQUIRY**

Speaker: David R. Johnson, M.D.

SUMMARY:

This presentation will describe the common attempts by the patient to avoid revealing details of their traumatic experiences and the specific techniques that can be effective in respectfully countering this avoidance and reaching the points of strong affect held within the patient’s trauma schemas. Having a clear sense of the aim of the inquiry is critical. Managing the disruptions in the therapeutic alliance that often occur when working with traumatized patients, and the specific techniques used in turning these disruptions into opportunities for growth will be described.

**NO. 3
CLINICAL EXAMPLES OF TRAUMA-
CENTERED PSYCHOTHERAPY WITH
EXTREMELY CHALLENGING PATIENTS**

Speaker: Christine Mayor

SUMMARY:

This presentation will focus on clinical examples of engagement with the extremely challenging patients, including highly disassociated patients, young traumatized children, patients

with co-morbid borderline personality disorder, and angry, litigious patients. In each of these cases, the usual therapeutic alliance is broken or severely disrupted, requiring special techniques in sustaining the therapeutic effort and avoiding entangling the therapist in unhelpful and conflictual interactions.

DSM AND PSYCHIATRIC DIAGNOSIS: PAST, PRESENT, FUTURE

Chair: S. Nassir Ghaemi, M.D., M.P.H.

Discussant: Paul McHugh, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the historical process of the development of major current psychiatric diagnoses in DSM-III; 2) Recognize the changes and lack of change in the evolution of DSM revisions in the fourth and fifth editions; 3) Identify rationales and arguments for and against different approaches to revising DSM editions; 4) Appreciate the basic philosophy and way of thinking behind the basic DSM organization, and rationales for and against that approach; 5) Recognize potential future changes in psychiatric diagnosis driven by genetics and other research.

SUMMARY:

In this symposium, prominent historians of psychiatry who have published the main histories of DSM will present their historical research, including original material from the APA archives and from oral histories with leaders involved in DSM-III, IV, and 5. Also, leaders involved in the three major revisions of DSM will provide their personal experience and perspective on the evolution of those nosologies. The DSM process as applied to psychiatric diagnosis will thus be analyzed historically and critiqued conceptually and its strengths and limitations will be discussed. Future alternatives, such as the impact of genomics, will be evaluated based on this careful analysis of the history and evolution of DSM revisions since 1980. Most presenters have decades of experience in the field, and thus provide both academic specialization and personal experience to their discussions.

NO. 1

DSM-5 IN THE CONTEXT OF THE HISTORY OF PSYCHIATRY: PLUSES AND MINUSES

Speaker: Edward Shorter, Ph.D.

SUMMARY:

DSM-5 is a reminder that, although psychiatry has made great progress in sorting out the classification of diseases, it still has a ways to go. On the plus side, DSM-5 recognizes catatonia as a distinct disease entity; it is no longer a "subtype" of schizophrenia. On the minus side, several sturdy diagnoses from psychiatry's nosological history have not been honored: mixed anxiety-depression, which is the commonest form of either depression or anxiety, needs to be reinserted. Melancholia needs to regain its status as a distinct mood disorder, and not a "specifier." Major depression is a highly heterogeneous category, and psychiatry's traditional "two depressions" need to be revived. "Schizophrenia" remains in DSM-5 a distinct entity, while the time is long past for it to be broken into separate diseases. Finally, the fragmentation of anxiety continues in a series of micro-diagnoses that possess neither a distinctive psychopathology nor a distinctive response to treatment. The history of psychiatry offers examples of the failure of diagnosis in such entities as "hysteria." But much that is good in the field's diagnostic past deserves to be restored.

NO. 2

THE 1980 REVOLUTION IN AMERICAN PSYCHIATRY: NEED FOR BETTER DIAGNOSIS OR RESPONDING TO OUTSIDE THREATS?

Speaker: Hannah Decker, Ph.D.

SUMMARY:

The recent introduction of DSM-5, newly organized but still unchanged in many ways, demands a historical look at its origins. By 1970, it was clear that American psychiatry faced a crisis. This paper will discuss the many factors that seemed to make it imperative to restore confidence in the nation's psychiatrists. The Board of Trustees of the APA concluded in 1973 that one way to deal with the perilous situation was to revise DSM-II, even though it had appeared only five years previously. Robert Spitzer was chosen to be

the new editor and was instructed to form a Task Force to begin work. One of his challenges was to solve the abysmal state of accurate diagnosis in psychiatry. In this regard, the Task Force relied on a system of operational (diagnostic) criteria that, unbeknownst to them, had originated in a radical proposal to reform the acquisition of knowledge by a Harvard physicist in 1927. Since DSM-5 continues to rely on many aspects of the diagnostic system of DSM-III, the paper will conclude with a discussion of both the constructive and troubling aspects of DSM-III.

NO. 3 DSM REVISIONS IN THE CONTEXT OF MEDICINE, CULTURE, AND SCIENCE

Speaker: S. Nassir Ghaemi, M.D., M.P.H.

SUMMARY:

Since the major revision of DSM-III in 1980, the DSM system of nosology has been central to psychiatric practice and research. In this historical and conceptual analysis, we will review the basic thinking that underlies DSM revisions. The change in DSM-III from prior thinking will be analyzed, and then the continuation of the basic DSM system in the 4th and 5th revisions will be described. The bases for making changes in DSM revisions, or not making changes, will be analyzed from both historical and scientific perspectives. The influence of scientific factors versus non-scientific factors will be assessed based on historical evidence and based on examples from the scientific literature. How much and what kinds of scientific evidence have provided a basis for DSM revision, and their interaction with cultural factors, will be explored based on historical changes in the third to fifth editions. The Oslerian tradition of medicine, of clinical syndromes correlating with pathophysiology and/or etiology, will be considered as an approach to diagnosis that has not been followed well in the DSM-III through 5 tradition. Strengths and weaknesses of both approaches - the Oslerian medical model versus DSM approaches - will be analyzed. The impact of the DSM system on psychiatric research, both as benefit and drawback, will be assessed. Whether future genetics can or will alter DSM-based nosology will be discussed.

NO. 4

DSM-5: ITS PAST AND FUTURE

Speaker: Jan Fawcett, M.D.

SUMMARY:

All of the DSMs™ have been in some way based on Oslerian medicine, with signs and symptoms that seemed to aggregate as psychopathologic syndromes. Since a major purpose of diagnosis is to guide treatment, it has become increasingly clear that even DSM-5, the most recent edition, is very modest in its ability to guide and predict treatment response. Cancer treatment is leading the development of personalized medicine. This change will be discussed in terms of the application of psychopharmacologic treatment, particularly of treatment resistant mood disorders, with off-label medications such as pramipexole, minocycline, or low dose Naltrexone. This leads us to consider whether psychiatric syndromes, such as major depression conceptualized from the viewpoint of personalized medicine may actually be found made up of many overlapping pathological mechanisms. This would explain the limited results in the current treatment of mood disorders and the need to administer a range of medications to successfully address these disorders. Measures which predict response in subcategories of patients such as those with elevated C reactive protein predicting response to infliximab or nortriptyline over escitalopram, may find specific markers for response that improve the value of treatment studies beyond the double blind, random assignment, placebo controlled studies, thus illustrating the value of personalized medicine.

BEYOND INFLAMMATION: DIVERSE IMMUNE AND METABOLIC DYSFUNCTIONS IN CLINICAL DEPRESSION

Chairs: Bernhard T. Baune, M.D., Ph.D., Roger S. McIntyre, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will learn about a novel phase-specific model of immune dysfunction in clinical depression.; 2) Participants will learn about the neurobiological role of chemokines in depression.; 3) Participants will learn about inflammation-metabolic interactions in depression.; 4) Participants will learn about immune markers

related to mood, cognitive function and antidepressant treatment response in geriatric depression and adolescents with bipolar disorder.; 5) Participants will learn about effects of sleep disturbance on inflammation and depression risk and about effective behavioural interventions.

SUMMARY:

The purpose of this symposium is to present novel findings on the broader role of the immune system in depression and to discuss the potential of immune-based treatment implications. Firstly, three basic science orientated presentations will demonstrate a novel dynamic phase-specific model of immune dysfunction in clinical depression (B. Baune), will present novel findings on the neurobiology of chemokines including a meta-analysis on the role of chemokines in depression (H. Eyre), and will broaden the spectrum on the inflammation-metabolic interactions in depression (R. McIntyre). On key translational and clinical aspects of these scientific foundations, the symposium will present novel data on immune markers related to antidepressant treatment response during geriatric depression (H. Lavretsky), it will highlight the effects of sleep disturbance on inflammation and depression risk and discuss the potential of behavioural interventions that target sleep disturbance (M. Irwin) and data on inflammation as a putative biomarker of mood and cognition among adolescents with bipolar disorder (B. Goldstein) will be presented. Overall, the symposium extends the broader scientific foundations of immune dysfunction and it highlights the translational impact of immune dysfunction in depression treatment.

NO. 1

A DYNAMIC PHASE-SPECIFIC MODEL OF IMMUNE DYSFUNCTION IN CLINICAL DEPRESSION

Speaker: Bernhard T. Baune, M.D., Ph.D.

SUMMARY:

Immune dysfunction and pro-inflammatory states in particular have been implicated in the aetiology and pathogenesis of depression. While the onset of an episode and certain symptoms of depression appear well explained by this inflammatory model, the underpinnings of the episodic and progressive nature, as well

as relapse and remission status in depression is not well understood. In this presentation, results are presented on additional immune factors beyond pro- and anti-inflammatory cytokines that may effectively contribute to the neurobiology and the complex course of clinical depression. Considering neurobiological effects of immunomodulatory factors such as T cells, macrophages, microglia and astrocytes relevant to depression, the presentation will demonstrate a neuroimmune model of clinical depression underpinned by dynamic immunomodulatory processes. Such a dynamic neuroimmune model of clinical phases of depression will be presented in an attempt to adequately explain depression-like behaviours in pre-clinical models and the dynamic nature of depression in clinical populations during the course of the illness (acute vs remitted vs recurrent / progressive). Finally, based on this dynamic nature of the immune model of depression, implications for immunomodulatory treatments of depression depending on the clinical and corresponding immunological phases are presented.

NO. 2

NEUROBIOLOGY OF CHEMOKINES: MECHANISTIC STUDIES AND A CLINICAL META-ANALYSIS IN MAJOR DEPRESSION

Speaker: Bernhard T. Baune, M.D., Ph.D.

SUMMARY:

Our understanding of the immunology of depression is evolving. So far research has primarily focused on inflammatory processes and biomarkers relevant to depression. A recent systematic review by this group reveals that chemokines exert numerous neurobiological effects in addition to their classical chemotactic functions relevant to the pathophysiology of depression. Indeed, chemokines are implicated in various mechanisms and pathways in depression depression such as pre- and post-synaptic modulation of traditional neurotransmitter systems, regulation of the neuroendocrine axes, control of blood-brain barrier permeability, neuroprotective effects and regulation of axon sprouting and elongation. This presentation will demonstrate mechanistic evidence on the role of chemokines in transgenic mouse models of CXCR5 while CCR6 and CCR7 receptors. Specifically, it will

be shown that CXCR5 is involved in the maturation of neural cells and the proliferation of neurons in the hippocampal dentate gyrus, that CCR6 and CCR7 receptors play a role in cognition and learning behavior and that CCR7 is involved in mediating social behaviour and stress response following maternal separation. In addition, this presentation will evaluate the use of chemokines as biomarkers in depression based on a meta-analysis of human clinical studies. Overall, the presented findings suggest that chemokines are potentially useful as clinical biomarkers and therapeutic targets in depression.

**NO. 3
UNDERSTANDING IMMUNE-
INFLAMMATORY MECHANISMS
RELEVANT TO THE TREATMENT AND
PREVENTION OF BRAIN DISORDERS**

Speaker: Roger S. McIntyre, M.D.

SUMMARY:

Psychiatric drug development and discovery requires a fundamental shift towards novel targets with methodologies that are robust and scalable. It is amply documented that individuals with mood disorders are differentially affected by concurrent medical disorders that share in common with mood disorders convergent pathophysiology. The convergent molecular and neural substrates for brain disorders and metabolic/inflammatory comorbidity provide the impetus to prioritize the prevention and treatment of chronic medical disorders in individuals with brain disorders. The presentation will review viable and evidence-based convergent molecular underpinnings for brain and metabolic/inflammatory conditions. Implications for brain disorder pathogenesis, progression of illness, and treatment will also be discussed. Implications for novel treatments primarily targeting metabolic and inflammatory processes pharmacologically and behaviourally will also be discussed. The objectives of this presentation are to review common metabolic and inflammatory comorbidity in individuals with mood disorders and its implication for phenomenology notable cognitive dysfunction and to discuss novel pharmacological and non-pharmacological approaches to the treatment that target metabolic and inflammatory systems.

NO. 4

**ANTI-INFLAMMATORY AND
ANTIDEPRESSANT EFFECTS IN OLDER
ADULTS WITH CHRONIC STRESS AND
MOOD DISORDERS**

Speaker: Helen Lavretsky, M.D.

SUMMARY:

Nearly two-thirds of elderly patients treated for depression fail to achieve symptomatic remission and functional recovery with first-line pharmacotherapy. Treatment resistance could be in part due to increased inflammation. New strategies are needed to improve clinical outcomes of geriatric and caregiver depression. I will review the results of our recent studies that used antidepressant drugs and mind-body interventions linking clinical response to the change in the immune and inflammatory biomarkers in the context of interventions for dementia caregiver stress and late-life mood disorders. The studies of novel antidepressants and the use of Tai Chi and yoga and meditation in aging populations will be reviewed. The effects on the pro-inflammatory marker, C-reactive protein, the activity of immune cell telomerase and nuclear factor-kappa B as well gene expression analyses will be provided and linked to change in the measures of mood, stress, and cognition, and neuroimaging biomarkers. Both the use of antidepressant drugs and complementary use of mind-body interventions may provide additional improvement of clinical outcomes in treatment and prevention of chronic stress via several putative mechanisms of increased telomerase levels, downregulation of gene expression in NFkappaB signaling pathways resulting in decreased inflammation, and "brain fitness effect" associated with cognitive improvement.

**NO. 5
SLEEP DISTURBANCE AND
INFLAMMATION RECIPROCALLY
CONTRIBUTE TO DEPRESSION:
IMPLICATIONS FOR THE TREATMENT
AND PREVENTION OF DEPRESSION IN
OLDER ADULTS**

Speaker: Michael Irwin, M.D.

SUMMARY:

Sleep disturbance and inflammation independently predict depression risk in older adults, but the reciprocal contributions of these

biobehavioral mechanisms to depression are not known. It will be shown that sleep disturbance is prospectively associated with a 5-fold increased risk of depression, and a 16-fold increased risk of depression recurrence in older adults (n=419) two years later. Additionally, data will be shown that sleep disturbance leads to an activation of systemic-, cellular-, and genomic markers of inflammation. Such activation of inflammatory signaling leads to depressed mood and anhedonia, which are mediated by activation of the dorsal anterior cingulate cortex and reduced activity of the ventral striatum, respectively. Importantly, sleep disturbance moderates inflammation-induced depression; experimentally induced inflammation leads to depression among those who have sleep disturbance, but not in those who report minimal sleep complaints. Finally, it will be shown results in older adults insomnia (n=123) that insomnia remission is coupled with improvement in depressive symptoms and a reversal of cellular inflammation, reduced expression of genes encoding pro-inflammatory mediators, and decreases in high risk C (>3 mg/dl) maintained during 1-yr follow-up. Together, these findings support the need for further research to evaluate the efficacy of interventions to sleep and/or inflammatory mechanisms, with the potential to prevent depression in older adults.

NO. 6 INFLAMMATION AS A PUTATIVE BIOMARKER OF MOOD AND COGNITION AMONG ADOLESCENTS WITH BIPOLAR DISORDER

Speaker: Benjamin Goldstein, M.D., Ph.D.

SUMMARY:

Objective: Inflammation has been associated with depressive and hypo/manic symptoms among adolescents and adults with bipolar disorder (BP). Inflammation is also salient to cognitive dysfunction. This presentation integrates inflammation, cognition, and mood among adolescents with and without BP.

Method: Subjects were 25 adolescents (13-21 years) with BP and 11 controls. Blood levels of high-sensitivity c-reactive protein (hsCRP) were measured. Extended versions of the KSADS mania (MRS) and depression (DEP-P) sections examined mood symptoms. Sixteen BP adolescents and 11 controls also completed an

automated neurocognitive battery. Anticipated sample size at the time of presentation will be N=30/group.

Result: Mean hsCRP was higher among BP adolescents vs. controls (2.68 vs. 0.50, $p=0.054$). Within the BP group, hsCRP levels were associated with DEP-P scores ($r=0.38$, $p=0.064$). hsCRP levels were associated with percent errors on the intra-extradimensional (IED) subtest among adolescents with BP ($r=0.70$, $p=0.005$), but not among controls ($r=0.19$, $p=0.572$).

Conclusion: These findings suggest that inflammation may be relevant both to mood symptoms and to executive dysfunction among BP adolescents. Larger studies on this topic are warranted, as are studies examining the impact of anti-inflammatory pharmacological and behavioral interventions on mood and cognition in adolescent BP.

IT'S ABOUT TIME! IMPROVING PHYSICAL HEALTH OUTCOMES IN YOUNG PEOPLE PRESCRIBED ANTIPSYCHOTIC MEDICATIONS

Chairs: Phillip B. Ward, B.Sc., Ph.D., David Shiers

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the need for regular monitoring of key physical health indicators in patients commenced on anti-psychotic medications; 2) Describe the trajectory of weight gain and metabolic abnormalities in patients commencing anti-psychotic medications; 3) Understand the potential of lifestyle and life skills interventions for attenuating weight gain in people commencing anti-psychotic medication.

SUMMARY:

Many people experiencing psychosis face a future restricted not only by mental illness but also by poor physical health. Despite twenty years of advances in understanding the nature of psychosis and its treatments, those affected still lose up to 15-20 years of life. Higher rates of obesity, cardiovascular disease (CVD) and diabetes contribute to a widening health gap and these physical health co-morbidities are now the most frequent cause of premature death for people with psychosis, being more common than suicide. This symposium will

highlight the current evidence for cardiometabolic complications arising in the early stages of treatment with antipsychotic medications. Increased rates of tobacco use, inactivity, poor nutrition, weight gain and cardiometabolic disturbance are evident soon after antipsychotic treatment initiation, especially in those experiencing first episode psychosis. In an effort to address these issues, the Healthy Active Lives (HeAL) declaration (www.iphys.org.au) argues that it is time to discard the traditional Cartesian dualism in favor of a far more holistic body & mind approach, commenced from the onset of treatment with antipsychotic medications. Routine antipsychotic adverse effect monitoring and smoking cessation interventions are needed from the earliest phases of treatment as part of multi-disciplinary care for young people prescribed antipsychotic medications.

**NO. 1
ANTIPSYCHOTIC-RELATED RISK FOR
WEIGHT GAIN AND METABOLIC
ABNORMALITIES DURING
DEVELOPMENT**

Speaker: Christoph U. Correll, M.D.

SUMMARY:

Obesity and related cardiovascular disorders are among the most pressing pandemics of modern times. While the prevalence of these general medical conditions has been growing in developed and developing countries, patients with severe psychiatric disorders are even more afflicted by them, shortening their life expectancy by 25-30 years. This premature mortality is predominantly related to higher prevalence rates of obesity, metabolic syndrome, diabetes and cardiovascular illness and death in the psychiatrically ill compared to the general population.

Antipsychotic related weight gain and metabolic abnormalities contribute to the premature mortality in people with severe mental disorders, representing targets for preventable risk accumulation. Research suggests that the risk for antipsychotic-related weight gain as well as weight-unrelated, dose dependent metabolic adverse effects compared to the general population is particularly enhanced in younger patients treated with antipsychotics.

This presentation will summarize recent data on the cardiometabolic risk accumulation in youth

receiving antipsychotics as well as ways to counter these adverse effects with potentially serious long-term consequences. Particular emphasis will be placed on the effect of development for the development of antipsychotic related cardiometabolic adverse effects, including more distal and difficult to study risk estimates for diabetes mellitus.

**NO. 2
YOUNG PEOPLE WITH
SCHIZOPHRENIA: A HIGH-RISK GROUP
FOR DIABETES: OPPORTUNITIES FOR
PREVENTION AND EARLY
INTERVENTION FROM AN
ENDOCRINOLOGICAL PERSPECTIVE**

Speaker: Katherine Samaras, M.B.B.S., Ph.D.

SUMMARY:

Severe mental illness carries a 20-year shortfall in life expectancy due to premature physical illnesses, such as diabetes and cardiovascular disease. An alarming 3-fold increased risk of incident diabetes has been documented in young people prescribed antipsychotics. All clinicians should be concerned about the preventable physical disease burden in people with severe mental illness. It appears that diabetes risk is increased within the first year of antipsychotic initiation, either rapidly inducing diabetes or clinically unmasking previously undetected diabetes or pre-diabetes. Antidepressant therapy and mood stabilizers are also associated with risk for weight gain and diabetes. The mechanisms by which these medications increase risk for diabetes, obesity and cardiac disease will be discussed. Models for physical health screening, monitoring and early intervention are being developed and refined in many settings around the world. Such models, we will argue, should be components of standard care, instigated at antipsychotic initiation. New standards of care for physical health monitoring and intervention in severe mental illness have led to a growing international consensus on the need for regular cardiometabolic screening and for early intervention to prevent diminution of physical health, most recently summarized in the HeAL Declaration (Healthy Active Lives), which focused specifically on Keeping The Body In Mind In Youth With Psychosis.

NO. 3

RESULTS FROM THE NATIONAL INSTITUTE OF MENTAL HEALTH-FUNDED METABOLIC EFFECTS OF ANTIPSYCHOTICS IN CHILDREN STUDY

Speaker: John W. Newcomer, M.D.

SUMMARY:

Antipsychotic prescription rates in children are higher in the US compared to other countries, largely driven by off-label use for disruptive behavior. The randomized, NIMH-funded Metabolic Effects of Antipsychotics in Children study (MEAC) characterized the metabolic effects of 12 weeks of antipsychotic treatment using gold-standard techniques in children with disruptive behaviors.

Antipsychotic-naïve youth (age 6-18) with clinically significant aggression/irritability in the setting of one or more DSM-IV disruptive behavior disorders were randomized to 12 weeks of treatment with aripiprazole, olanzapine or risperidone. During 12 weeks of exposure, differential effects of treatment were observed on measures of adiposity and other endpoints. Specifically, time by treatment condition effects were detected on DEXA %fat ($p < 0.0001$). Antipsychotic-induced increases in adiposity were associated with adverse changes in insulin sensitivity measured for adipose ($p = 0.028$) and hepatic ($p = 0.095$) tissue. Importantly, treatment resulted in marked improvement in Aberrant Behavior Checklist irritability/aggression subscale scores ($p < 0.0001$).

Randomized clinical trials that incorporate adaptive or practical design elements to enhance generalizability to real-world practice can increase understanding of treatment safety and tolerability, inform risk mitigation, and contribute to the understanding of the overall risks and benefits of treatment.

NO. 4 EARLY LIFESTYLE INTERVENTION ATTENUATES ANTIPSYCHOTIC-INDUCED WEIGHT GAIN IN FIRST-EPIISODE PSYCHOSIS

Speaker: Jackie Curtis, M.D.

SUMMARY:

Youth with first episode psychosis (FEP) receiving antipsychotic (AP) medications are at risk of obesity and metabolic syndrome. AP initiation induces rapid deterioration in

metabolic health, with up to 77% experiencing clinically significant ($>7\%$) weight-gain within 12 months. We aimed to determine whether a multidisciplinary, 12-week intervention could attenuate weight gain. Young people with FEP aged 15-25 were enrolled in the "Keeping the Body in Mind"™ Program, including weekly individualized dietetic monitoring and education and group education, and individualized exercise prescriptions by an exercise physiologist, utilizing a supervised on-site gym. Controls were youth with FEP from another service that did not offer lifestyle interventions. 16 participants (56% females, mean age 20.0 \pm 2.3) years) completed the intervention, and data were obtained from 12 controls (8% female, mean age 21.7 \pm 2.0). Weight gain was substantially lower in the intervention group compared to controls (1.8kgs \pm 3.0 versus 7.8kgs \pm 4.7, $p < 0.001$). Waist circumference did not increase significantly in the intervention group, whilst waist circumference increased significantly for controls (0.1cm \pm 4.0 versus 7.1cm \pm 3.6, $p < 0.001$). BP, lipids or glucose did not change significantly for either group. Multidisciplinary early lifestyle interventions can attenuate antipsychotic induced weight gain, and may be an important means of achieving one of the key HeAL targets.

LOST IN TRANSITION: IMPROVING SAFETY, QUALITY, AND RECOVERY THROUGH TRANSITIONS OF CARE

Chair: Yad M. Jabbarpour, M.D.

Discussant: Ken Duckworth, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the impact of transition of care (TOC) on safety and recovery; 2) Formulate models of transition of care to support decreasing readmissions, decreasing suicide risk and supporting a culture of safety and recovery; 3) Integrate TOC best practices into their psychiatric services.

SUMMARY:

Transition of Care (TOC) represents a movement of a patient from one setting of service to another. These transitions are critical steps for patients. Safety and recovery can be compromised on multiple levels as individuals navigate these complex transitions "whether

it be discharge from a hospital, departure from an emergency department or transfers across organizations within an integrated system. Failure modes exist that can impact relapse, readmission, public safety, suicide risk, aggression risk, risk of involvement with the legal system and the person's recovery. Several strategies are now being implemented and assessed across the country to help mitigate these risk areas and support the success of the patient, family and clinicians. Healthcare and Patient Safety organizations are beginning to provide more attention and resources to support clinicians, patients, families and systems of care to improve continuity of care services. These organizations include The Joint Commission, Centers for Medicare & Medicaid Services (CMS), American Geriatric Society and (Agency for Healthcare Research and Quality (AHRQ). Best and promising practices may include follow-up soon after discharge, assertive outreach (e.g., contact within 24 hours), hand-off communication, integrated care, health information technology clinical decision support, Assertive Community Treatment (ACT), peer support "bridgers," self-management skill building, crisis plans/WRAP (Wellness Recovery Action Plan) implementation and supporting a culture of safety. Several transition of care models exist – especially in the medical field. Domains targeted may include i) information transfer, ii) patient & caregiver preparation, iii) self-management support, and iv) empowerment to assert preferences.

NO. 1 KEY CHALLENGES ACROSS THE HEALTH CARE CONTINUUM AND FOUNDATIONS FOR SUCCESS

Speaker: Tracy Collander, L.C.S.W.

SUMMARY:

In 2012, The Joint Commission began a three-year initiative to define methods for achieving improvement in the effectiveness of patient transitions between health care organizations, in order to support the continuation of safe, high quality care for patients in all settings. As a part of this initiative, the root causes of ineffective transitions of care were identified as well as the seven foundations that must be present in order to assure safe and effective transitions from one health care setting to another. This

presentation will highlight the common challenges identified in transitions of care for behavioral health care providers and will provide an overview of the seven foundations that support safe, effective transitions of care. Examples of measures used by The Joint Commission to assess safe and effective transitions of care will be reviewed along with examples of effective approaches used by behavioral health care providers.

NO. 2 ROUTINE DISCHARGE PLANNING ON BEHAVIORAL HEALTH INPATIENT UNITS: WHAT'S HAPPENING, AND DOES IT WORK?

Speaker: Thomas E. Smith, M.D.

SUMMARY:

Inpatient discharge planning practices believed to improve transitions include communication with outpatient providers, scheduling timely aftercare appointments, and forwarding discharge summaries to outpatient providers. These practices represent a standard of care, but studies of general medical/surgical discharges indicate that hospital providers complete them for fewer than 50% of discharges. In addition, little is known about how often behavioral health inpatient providers complete these practices and whether the practices significantly impact patients' attendance at behavioral health aftercare services. The author reports data from a statewide assessment of care coordination needs and provider discharge planning practices for Medicaid patients hospitalized on behavioral health units. Preliminary analyses of over 17,000 discharges indicated that inpatient providers completed at least one of the 3 identified practices for the majority of discharges. Analyses confirmed significant associations between providers completing discharge planning practices and patients attending behavioral health aftercare services. Further analyses will identify patient subgroups that did not benefit from these practices and likely required more intensive care transition interventions. Research that determines when and for whom specific discharge planning practices are effective will allow providers to better align scarce resources to maximize quality care for a highly vulnerable population.

**NO. 3
BRIDGING THE GAPS AND
CONNECTING THE PHYSICAL AND
PSYCHIATRIC HEALTH DOMAINS: A
RECOVERY-ORIENTED PEER
PERSPECTIVE**

Speaker: Lisa Halpern, M.P.P.

SUMMARY:

From the recovery-oriented peer perspective, Transition of Care (TOC) processes provide opportunities to assist recovery for the persons we serve. People with lived experience of a psychiatric condition (PLE) can minimize disruptions across TOC settings and help mitigate conditions leading to readmission to hospitals by assisting people cycling through an emergency room and working as their advocates in a hospital to improve quality of care. Peers work as bridgers coordinating care for someone dealing with a complex transition, whether coming out of a hospital or changing treatment plans, and also work as navigators linking the physical and psychiatric health domains. PLE help clarify the individual's recovery goals with an Assertive Community Treatment team and play a vital role in helping to support someone in creating a Wellness Recovery Action Plan. PLE also facilitate family and community support. The transition period between care settings is a vulnerable time for the people we serve; PLE are qualified to help them by providing insight, a "has been there" approach, communication skills and empathy.

**NO. 4
THE ROLE OF COLLABORATIVE CARE
IN IMPROVING PATIENT TRACKING
AND FOLLOW-UP**

Speaker: Lori Raney, M.D.

SUMMARY:

Collaborative care models are centered on a set of core principles that provide a population-based approach to managing the care of individuals with medical and behavioral health conditions. A solid evidence base of over 80 randomized controlled trials demonstrates this approach can be used to reach the basic tenets of the Triple Aim: improving care at a lower cost and with greater patient satisfaction with the care provided. Systematic tracking and follow-up utilizing registries with an aim of

changing treatment for nonresponders or those lost to care provides a safety net approach that can be useful in a variety of ways including tracking transitions of care to and from intensive medical and psychiatric care. This presentation will provide an overview of the Collaborative Care model, its Core Principles and roles of the various team members. Discussion of the use of registries to guide care decisions will be included.

Learning Objectives

1. Describe the 5 Core Principles of Effective Collaborative Care and how they provide a safeguard during the provision of care; 2) Discuss how registries can be used to track baseline and treatment response as well as monitor decisions to intensify treatment; and 3) Understand basic concepts of population-based care and the role of the psychiatrist on the Collaborative Care team

**INTEGRATING MENTAL HEALTH AND
PRIMARY CARE SERVICES:
EXPERIENCES IN THREE COUNTRIES**

Chair: Javier I. Escobar, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To discuss international models for integrating mental health into primary care services in three countries and describe how they will improve patient care.; 2) To outline particular accomplishments challenges in each of the three countries.; 3) To inform the ongoing ACA developments in the United States.

SUMMARY:

Primary care has been called de "defacto" mental health system. Given the coexistence of physical and mental disorders and the availability of a similar and effective model (chronic care model) for management of these disorders, integration of care is highly desirable. This symposium brings together primary care physicians and psychiatrists from 4 different countries who will present on: The Medical Home Model being developed in the United States in parallel with the Affordable Care Act (Obama Care) and the opportunities it provides for integrated care; Current efforts for integration of care in two Latin American countries, Chile and Colombia; How mental health/primary care services have been

integrated in Spain, a country with a highly developed health care system. The discussion will highlight problems and promises in this area and list specific recommendations toward successful integration of care. There will be a particular focus on Hispanic populations both in the United States and abroad.

**NO. 1
MEDICAL HOME MODEL, AN AVENUE
FOR EFFECTIVE MENTAL HEALTH
PROGRAMS**

Speaker: Alfred Tallia, M.D.

SUMMARY:

The medical home model is gaining relevance in the United States in the age of the ACA. Given the fragmentation of care, this should be an ideal way to deliver mental health services to a large segment of the population. This presentation will provide a review of the medical home model in the United States and will discuss ways to effectively insert mental health care within that model.

**NO. 2
INTEGRATION OF MENTAL HEALTH
AND PRIMARY CARE: THE EXPERIENCE
IN COLOMBIA**

Speaker: Hernan G. Rincon-Hoyos, M.D., M.P.H.

SUMMARY:

Introduction: The integration of physical and mental health care is highly desirable in primary care. Objectives: to respond the question: up to what levels are ready all actors of the Colombian Health System to integrate mental health into the primary care of chronic diseases? Methods: we are both, reviewing: (1) Colombian laws supporting the physical and mental primary health integration of care; (2) Colombian history of primary physical and mental health care; and (3) some demonstrative institutional cases; and also (4) interviewing decision makers at government and private sectors. Results (Preliminary): Colombian law and government support the integration of physical and mental health care and the interest seem to be growing among all actors. There still are some barriers that need to be addressed like a long standing academic tradition of primary physical and mental health care running independently. In addition, people's disaffiliation

or mobility within the health system, family members affiliated to different health providers and some ways of payment to providers seem to be disincentives for the continuity of comprehensive health promotion and prevention programs. Conclusion: we preliminarily concluded although the law and Colombian Ministry of Health are supporting to move forward, cultural, academic and system factors are still barriers to the widespread **integration of care.**

**NO. 3
INTEGRATION OF TREATMENT OF
DEPRESSION IN WOMEN IN THE
PRIMARY CARE LEVEL IN CHILE**

Speaker: Graciela Rojas, M.D.

SUMMARY:

Chile, a middle-income country, has around 17 million inhabitants. The national public health system provides services to 72.2% of the population. Since the 1990's, there has been an implementation of a psychiatry reform that has emphasized the development of a mental health component in primary care. Two RCT have demonstrated the effectiveness of depression program in primary care clinics. The results of these trials contributed to the National Program for the Detection, Diagnosis and Treatment of Depression that started in 2001 in primary care clinics. A maternal mental health component was also introduced, establishing a universal screening protocol for postpartum depression (PPD) and guaranteeing the availability of effective treatment. However, there is a huge treatment gap for PPD. A mixed methods study was carried out to describe and analyze possible barriers to service use and treatment access for PPD in mothers presenting for a well-child check up at six primary care centers in Santiago, Chile. Mothers rejected psychotherapy (51.8%) and medications (66.1%). Barriers to services described were ideas of motherhood, stigma about PPD, and perception of lack of treatment efficacy. A clear screening procedure and a trust relationship with healthcare workers were mentioned as facilitators.

Chile has a successful experience by integrating mental health in primary care but there are still barriers to overcome.

INNOVATING AND SUPPORTING DEMENTIA CARE ACROSS THE SETTING CONTINUUM

Chairs: Ron Keren, M.D., Lesley Wiesenfeld, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will be able to describe the clinical/safety challenges in providing medical/surgical care to patients with co-morbid dementia; identify best practice strategies to respond to care gaps.; 2) To consider the impact of shifting perspectives on the use of psychotropic agents for dementia care in the long-term care setting and current barriers to further change.; ; 3) To appreciate the role psychiatrists can play in the management of the behavioral and psychological symptoms of home-bound patients with dementia.; 4) Participants will appreciate the challenges facing families and substitute decision-makers in making end-of-life medical decisions on behalf of patients with severe dementia.

SUMMARY:

Innovating and Supporting Dementia Care Across the Setting Continuum

Dementia, a leading cause of morbidity in the aging population, causes profound disabilities in cognition, day-to-day functioning and behavior. With the aging of the boomer population, the worldwide prevalence of dementia is expected to increase twofold in the next 20 years. By the year 2050 it is estimated that 115 million people will have dementia. Subsequently, the demand for psychiatric expertise in the treatment of patients with cognitive and behavioral symptoms in various health care settings is on the rise.

Because of their advanced age, individuals with dementia are often burdened with numerous medical comorbidities, which can lead to acute care admissions and early placement into long-term care homes. In these settings, challenging behaviors such as resistance to personal care, physical aggression, agitation, impulsivity, wandering and aberrant vocalizations, profoundly impact on caregiving and safety of these and other patients, as well as the staff providing their care. Furthermore, the capacity for patients with severe dementia to make medical decisions in these settings is invariably

compromised. Distressed families are often confronted with making urgent treatment decisions regarding life-threatening medical illnesses without fully understanding the impact of these decisions in the face of frailty and severe dementia or knowledge of the previously expressed or unexpressed wishes of their loved ones.

Psychiatrists, in particular, play a crucial role in the management of the behavioral aspects of dementia and supporting families and substitute decision makers to make treatment decisions. With the advancement of telemedicine and innovative outreach models, psychiatrists also play an increasingly important role in the management of patients with dementia who, because of complex medical problems and frailty, are homebound or hard to access/serve. This symposium will explore the roles and challenges for psychiatrists in the management of dementia across various settings; acute care, long-term care/nursing homes and homebound individuals. It will focus on the task of managing challenging behaviors in these settings and on the communication with families and substitute decision makers on critical end-of-life medical decisions.

We will review the practice-informing literature at the interface of geriatric Consultation-Liaison psychiatry, the treatment of the behavioral and psychiatric symptoms of dementia in patients admitted to medical and surgical wards as well as long-term care homes and in the community. We will review a variety of evidence-based approaches for minimizing the inappropriate use of psychotropic medications in long-term care. We will explore a model of urban tele medicine and describe a process for communicating with families and substitute decision-makers on end-of-life decision-making.

NO. 1

SAFE PATIENTS/SAFE STAFF: GERIATRIC PSYCHIATRY C/L INNOVATIONS TO OPTIMIZE THE CARE OF HOSPITALIZED ELDERLY WITH COMORBID DEMENTIA

Speaker: Lesley Wiesenfeld, M.D.

SUMMARY:

The prevalence of co-morbid dementia in patients admitted to the general hospital setting is growing, with consequent increased demands for psychogeriatric support for these

vulnerable patients. When patients with dementia-associated behavioural symptoms such as physical agitation, resistance-to-care, wandering and impulsivity require general hospital admission for concurrent medical or surgical illnesses, behavioural symptoms may emerge or worsen under the stress of illness, invasive/intrusive care, and unfamiliar surroundings and care providers, rendering it challenging to deliver safe, effective patient-care. Consequently, the care of hospitalized patients with dementia with BPSD (behavioural and psychological symptoms of dementia) has been identified by front-line clinicians and health-care system leaders as needing attention, innovation and adaptation of best practices, to optimize outcomes.

This presentation will review the practice-informing literature at the interface of Geriatric Consultation-Liaison psychiatry, BPSD treatment and patient and staff safety. Practice innovations targeting support of patients with BPSD admitted to medical and surgical wards will be reviewed including the benefits of adopting proactive models of care, adapting dementia-specific non-pharmacologic interventions for the general hospital, and implementing standardized care plans. Outcomes data from implementation of a hospital-wide, proactive dementia care program will be shared.

NO. 2 REACHING THE HOMEBOUND POPULATION: HOME VISITS AND TELEMEDICINE OUTREACH FOR COGNITIVELY IMPAIRED FRAIL ELDERLY AND THEIR CARE PROVIDERS

Speaker: Sarah Colman, M.D.

SUMMARY:

A substantial proportion of older people living at home have complex health problems that render them frail and homebound. Many suffer from some degree of cognitive impairment. These individuals are poorly served by predominantly office based primary care delivery models. Caregivers are often family members who need to manage both medical comorbidity and the behavioural and psychological symptoms of dementia (BPSD), including agitation, aberrant motor behavior, anxiety, irritability, depression, apathy,

disinhibition, psychosis, and sleep or appetite changes.

Home-based primary care services have been shown to reduce mortality, admissions to long-term facilities, emergency room visits, and functional decline, and to improve patient quality of life and caregiver satisfaction. As well, supporting the caregiver in this dyadic relationship has evidence for improving quality of life for both the dementia sufferer and care provider.

This presentation will explore two models of the model of psychiatric outreach to the homebound dementia population. The first is a collaborative program in which a psychiatrist is affiliated with a home visiting primary care team. The second is an urban telemedicine program. Specific ways to support family members dealing with BPSD will be discussed.

NO. 3

TO MEDICATE OR NOT TO MEDICATE: CONTROVERSIES AND CULTURAL SHIFTS IN THE MANAGEMENT OF THE BEHAVIORAL SYMPTOMS OF DEMENTIA IN LONG-TERM CARE

Speaker: Andrea Iaconi, D.Phil., M.D.

SUMMARY:

The use psychotropic medication to manage behavioural symptoms in long-term care has a troubled history. Their widespread use as a chemical restraint, legislated restrictions in their use, evidence of their limited efficacy and significant risks, and the over-medication of residents of long-term care, have all brought psychotropic medications into the limelight, presenting a challenge to those who provide psychiatric care in this setting.

This presentation begins by describing trends over time in psychotropic prescribing practices in long-term care and the scientific evidence and cultural shifts that have driven these changes. Recent data on prescribing patterns in Ontario long-term care homes is contrasted to current evidence-based guidelines for the use of psychotropic medication in dementia. I explore factors that influence psychotropic prescribing, beyond the behavioural symptoms themselves, including factors specific to the long-term care setting. This includes a discussion of competing interests that must be balanced including the patient's quality of life, their autonomy, their family's concerns,

their physical safety and the physical safety of co-residents and staff. Finally, I review a variety of evidence-based approaches for minimizing inappropriate use of psychotropic medication in long-term care.

NO. 4 THE DILEMMA OF END-OF-LIFE DECISION MAKING IN SEVERE DEMENTIA

Speaker: Ron Keren, M.D.

SUMMARY:

Patients and families are generally aware of the cognitive decline and behavioral changes associated with dementia, however, many do not appreciate that dementia is a terminal illness. Unlike other medical conditions such as cancer where death can be reasonably well predicted, the prediction of death, in patients with dementia, is much more difficult. For this, and other reasons, advanced care planning and end-of-life discussions are often overlooked whilst caring for individuals with dementia.

Families and substitute decision makers of patients with severe dementia often struggle in making health care decisions: as a result patients in the severe stage of dementia may undergo intrusive and aggressive treatments in contrast to their previous wishes. These treatments may cause them unnecessary pain, decline in function and loss of dignity. Tube feedings, for example, frequently involve restraining patients to avoid their removal and have not been shown to prolong life.

In this session I will review the challenges of end-of-life decision-making in patients with severe dementia and describe a process for communicating with families and substitute decision-makers about this issue that has been used on a geriatric psychiatry inpatient unit for patients with severe dementia and responsive behaviors at the Toronto Rehabilitation Institute.

IMPLEMENTING MENTAL HEALTH INTERVENTIONS IN LOW-INCOME CONTEXTS: STRATEGIES, STAGES, AND SUPPORTS FROM IMPLEMENTATION TO SCALE

Chairs: Sean A. Kidd, Ph.D., Kwame J. McKenzie, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) After the completion of this session participants will be able to articulate key strategies pertaining to the implementation of mental health interventions in low income contexts.; 2) After the completion of this session participants will be able to identify research strategies relevant to such interventions. ; 3) After the completion of this session participants will be able to understand how a global strategy to support mental health innovation such as Grand Challenges Canada operates. .

SUMMARY:

Access to effective mental health treatments and professionals represents a pervasive and persistent problem in low income contexts. This is a significant concern internationally with 15% of the global burden of disease attributable to neuropsychiatric conditions and 85% of the world's population residing in low and middle income countries. Developing sustainable approaches to decrease the treatment gap is the aim of Grand Challenges Canada (GCC). To this end GCC identifies emerging leaders in global health, offers funds to innovators to prove that their intervention works and offers competitive grants focusing on scaling up interventions.

The goals of this symposium are to describe key strategies for developing, scaling, and sustaining mental health interventions in low income contexts and to articulate how GCC provides a structure for supporting this work at a global level.

To illustrate the stages of implementation of interventions and the research models that attend them, three GCC-funded projects will be presented. Of these three projects, two are based out of Kenya and involve a collaboration between Canadian institutions and the University of Nairobi. These include an early stage proof of concept project and a large scaling project. The third is a multiple case study project that is examining the implementation methods of internationally recognized leaders in mental health intervention in low income contexts.

The proof of concept project that will be presented is entitled "Community REcovery Achieved Through Entrepreneurism (CREATE): A new paradigm for recovery from serious mental illness in low resource settings." This study examines how community-based social

businesses coupled with focused psychosocial rehabilitation supports in the form of a low cost Toolkit might operate in low income contexts to support employment and recovery. The scaling project is entitled "The Kenya Integrated Intervention Model for Dialogue and Screening to Promote Children's Mental Wellbeing (KIDS)," which is examining how mental health issues can be prevented in rural Africa. It will also push for early detection, and employ appropriate evidence-based management which is affordable, accessible and appropriate. This work will reach over 5000 children in schools in rural areas and is being rigorously evaluated. From these two projects, at very different stages of development, key points of implementation and impact will be highlighted as will the research models supporting this work. The third study, which is international in scope, uses the framework of 'social entrepreneurship' to identify approaches across geographic contexts and sectors that are having major impacts despite striking resource limitations and other forms of adversity. Broadening the lens across multiple interventions, this part of the symposium will address common strategies and the evidence supporting them.

NO. 1

CREATE: A NEW PARADIGM FOR RECOVERY FROM SERIOUS MENTAL ILLNESS IN LOW-RESOURCE SETTINGS

Speakers: Arlene MacDougall, M.D., David M. Ndetei, M.D., Ph.D.

SUMMARY:

People with serious mental illness (PWSMI) living in low income contexts often lack access to opportunities for meaningful employment and psychosocial rehabilitation (PSR) services. To address this gap, we are developing and evaluating "CREATE": a new paradigm of recovery that couples social businesses with focused PSR practices and peer supports in Machakos, Kenya. Social businesses are commercially-viable and locally-informed businesses that provide training and real employment opportunities for PWSMI in their community. Research suggests social business employment leads to reduced symptoms and health services utilization, and improved employment outcomes and psychological well-being. To support employee functioning, we are

piloting a low-cost Toolkit of PSR best practices that can be used by local community health workers and PWSMI themselves. CREATE looks to identify opportunities to partner with local service organizations, leverage local markets and create sustainable community enterprises to build local capacity for PSR. Proof of concept will be demonstrated through indicators of business sustainability and impact employment, income, quality of life, symptoms, mental health self-management, family burden and stigma using a mixed methods approach. The overarching objective is to build a CREATE network spanning different settings within and outside of Kenya, and organized around & supported by regional hubs.

NO. 2

KIDS: A WHOLE-SCHOOL APPROACH TO IMPROVING MENTAL HEALTH IN A LOW-INCOME COUNTRY

Speakers: Kwame J. McKenzie, M.D., David M. Ndetei, M.D., Ph.D.

SUMMARY:

Funded by Grand Challenges Canada, KIDS is an innovative whole school approach to improving mental health in two areas of Kenya. Reaching 5000 children in both urban and rural schools, KIDS has developed peer to peer clubs, parent clubs and education for teachers in an attempt to improve mental health literacy. Schools are then linked to primary care services.

Baseline assessment of mental health and service utilization was carried out before the intervention and 1 year later. Assessment tools were culturally adapted to ensure that the captured the rates of mental health problems and stigma.

In this presentation the baseline data on the rates of mental health problems in schools and some early data on the outcome of the intervention will be presented.

NO. 3

UNPACKING SOCIAL IMPACT: EXAMINING THE SCALABILITY OF TOP-TIER SOCIAL INNOVATORS IN MENTAL HEALTH

Speaker: Sean A. Kidd, Ph.D.

SUMMARY:

Access to effective mental health treatments and professionals represents a pervasive and persistent problem in low income countries. However, in the very settings where harsh political, social, and economic conditions would seem to represent a total impasse, one can find compelling local examples of social innovation. There can be found individuals, social entrepreneurs, who move forward innovative solutions to major social problems. This study focuses on the question: Can a core, common set of implementation and program delivery characteristics be identified in the work of social entrepreneurs making inroads in mental health equity in low income countries? This information was collected via 5 in-depth case studies with social entrepreneurs addressing mental health across 3 continents. The findings led to the development of a cross-cutting model for advancing low-cost and sustainable mental health interventions in adverse contexts.

WHAT ARE PSYCHIATRIC SYSTEMS DOING TO IMPROVE? UTILIZING PERFORMANCE IMPROVEMENT METHODS TO ADVANCE PSYCHIATRIC CARE

Chair: Sunil Khushalani, M.D.

Discussant: Steven Sharfstein, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the impact of utilizing performance improvement methods in psychiatry; 2) Learn how one can incorporate learning about performance improvement methods into psychiatric education; 3) Recognize the potential of these performance improvement methods to the field of psychiatry.

SUMMARY:

The US health care system is well on its way to consuming a fifth of our gross domestic product (GDP) by 2020. Health care outcomes in the US are not in keeping with this level of expenditure. There is no doubt that health care systems will have to become safer, espouse higher quality and become more cost effective. Change is not optional anymore. We can either actively seek out change, or it will be thrust upon us where time works against health organizations. There is no better time than now to start advocating for the changing of our care systems from the inside. If we can do that soon, then we can

maintain control of how we change our systems, such that we can implement systems that better focus on the customer and at a pace with which we are comfortable.

One can utilize the vast amounts of experience from fields outside the world of medicine in adopting modern performance improvement methods. This culture of performance improvement and these methodologies are gradually finding their way into the field of medicine, with very promising results. We would like to share some examples of these approaches and demonstrate how they can be adopted and integrated into psychiatric organizations. We would also like to share an example of how learning about performance improvement has been integrated into residency education. Incorporating the richness of these performance improvement methods can be a timely and crucial catalyst for such a necessary transformation of psychiatric care to occur.

NO. 1 LEAN BEHAVIORAL HEALTH: THE KINGS COUNTY HOSPITAL STORY

Speaker: Joseph P. Merlino, M.D., M.P.A.

SUMMARY:

An overview of the use of lean in manufacturing, health care, and now in mental health care is presented. How this methodology was successfully implemented at one of the largest mental health centers in the country following an internationally publicized tragedy is presented. Various case examples are presented from various clinical services across the behavioral healthcare continuum.

NO. 2 LEAN TECHNIQUES IN SUPPORT OF INTEGRATION AND ACCESS: PREPARING FOR NECESSARY CARE DELIVERY SYSTEM REDESIGN

Speaker: Jill Bowen, Ph.D.

SUMMARY:

Kings County Hospital Behavioral Health Services has utilized the Lean approach to program improvement developed by the Toyota Production System to successfully transform a system in distress. As we face the realities of a changing health care environment and prepare for the necessary redesign of our care delivery systems, the lean approach is again proving

invaluable in providing tools to support these improvements. Access to care in Behavioral Health ambulatory services and integration of behavioral health and medical care are two essential components necessary for success. Rapid Improvement Events (RIEs) and Daily Management System (DMS) are Lean approaches that have been employed to address the need to increase Behavioral Health Primary Care Clinic (BHPCC) billable visits by reducing no show rates, increasing the number of patients who receive full integrated mental health and medical care in the BHPCC, and improving patient flow. Quality of care improvements are impacted by working to improve on-time starts, ensuring collaboration of care for those who receive their mental health and medical care in two separate clinics, and ensuring access to ambulatory mental health care for those in need.

**NO. 3
TEACHING HIGH-VALUE CARE AND
ENGAGING RESIDENTS IN QUALITY
IMPROVEMENT STRATEGIES**

Speaker: Melissa Arbuckle, M.D., Ph.D.

SUMMARY:

The escalating cost of healthcare in the United States has been described as an unsustainable crisis. Unfortunately, high costs are not necessarily linked to high value as programs struggle to address issues of patient safety and quality improvement. In the face of these challenges, it has become increasingly urgent to integrate training in resource management, patient safety and quality improvement within medical education. Unfortunately, these concepts are not easily taught through traditional educational formats used within residency training and many clinical educators have virtually no formal training in these concepts. Within this symposium we will discuss various approaches to teaching these complex concepts through classroom exercises, case based discussions, and resident led quality improvement initiatives. Group discussion will focus on some of the challenges and strategies for implementing change within mental health care systems and residency training programs. Symposium participants will learn potential ways to integrate these new concepts into their training programs and to develop strategies to engage residents and

faculty in the process of developing competency in high-value care.

**NO. 4
THE ROLE OF AN INDUSTRIAL
ENGINEER IN A PSYCHIATRIC SETTING**

Speaker: Antonio DePaolo, Ph.D.

SUMMARY:

At first glance, the title of an Industrial Engineer does not seem to fit into anything outside of manufacturing, However, trained Industrial Engineers have made their way into healthcare, education, government, and more recently into the world of psychiatry and behavioral health. An Industrial Engineer provides a systems view of business processes by utilizing their skillset to identify waste, develop improvement opportunities, and facilitate the implementation of improvement through a variety of systems-based methodologies. The methodologies discussed within this symposium will include Strategy Deployment, Value Stream Mapping, and Lean Six Sigma to provide an overarching framework on achieving improved customer value.

**NO. 5
CREATING A CULTURE OF
IMPROVEMENT AT A LARGE
PSYCHIATRIC HEALTH SYSTEM**

Speaker: Sunil Khushalani, M.D.

SUMMARY:

What does it take to create a culture of improvement in a large organization? Sheppard Pratt Health System, a large non-profit psychiatric health system decided to adopt Lean, a performance improvement methodology that promotes continuous improvement. It adopted a vision to create a health system where problems are embraced as opportunities for improvement and where everyone is motivated, trained, and empowered to spot and solve problems, all with the goal of making Sheppard Pratt a constantly improving place to receive services and work.

There has been a multi-pronged approach to attempt this transformation. Rapid process improvement events, daily huddles, and a multi-week lean problem course are all methods used to incrementally involve a growing percentage of the work force. One can hear an overview of this effort with some examples which

demonstrate improved satisfaction, quality, safety, delivery while lowering costs. More importantly, this approach is changing the paradigm to a newer “Sheppard Way”™ of dealing with difficult problems. Anyone who experiences recurrent or persistent problems can take ownership of solving such problems. There are numerous examples of a “let-us-try-and-fix-it”™ attitude emerging at multiple levels of the organization.

EVERYTHING YOU NEEDED TO KNOW ABOUT PERITRANSPLANT, PSYCHOSOCIAL, AND NEUROPSYCHIATRIC ISSUES AFFECTING OUTCOME

Chairs: Yelizaveta I. Sher, M.D., Jos  R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize pre-transplant psychosocial risk factors affecting post-transplant outcomes; 2) To perform systematic evaluation for solid transplant psychosocial candidacy, using Stanford Integrated Psychosocial Evaluation for Transplantation (SIPAT) tool; 3) To recognize and treat post-transplant neuropsychiatric complications, including delirium, demoralization, mood and anxiety disorders; 4) To appreciate unique neuropsychiatric challenges associated with artificial heart technologies (Ventricular Assistive Device (VAD), Implantable Cardioverter Defibrillator (ICD), artificial heart).

SUMMARY:

Psychosocial and neuropsychiatric issues are common among transplant recipients, both before and after transplantation. Similarly, psychosocial factors may significantly affect post-transplant outcomes and better assessment tools are needed in order to improve outcomes. This symposium will cover important pre- and post-transplant psychosocial and neuropsychiatric issues and complications, including the pre-transplant psychosocial evaluation process.

Studies have demonstrated the importance of psychosocial factors to the ultimate success of transplanted organs. Dr. Garcia will discuss pre-transplant psychosocial factors affecting post-

transplant psychosocial and medical outcomes in cardiothoracic transplantation (e.g., psychiatric comorbidities, substance abuse, adherence with medical care, support system). The Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT) is a new systematic way to assess psychosocial candidacy for transplantation. In the original study, the tool demonstrated excellent inter-rater reliability and correlation with post-transplant outcomes (Maldonado et al. *Psychosomatics* 2012; 53:123-132). New findings demonstrate that SIPAT scores significantly correlate with the probability of poor medical and psychosocial outcomes. Dr. Ament will review published and new research findings supporting the use of this tool.

Dr. Sher will discuss neuropsychiatric syndromes (e.g., delirium, demoralization, depression, anxiety) common among transplant recipients, especially focused on our recent findings among lung transplant patients, including unique pharmacodynamics effects of psychotropic agents associated with worsened outcome, morbidity and mortality.

Finally, Dr. Maldonado will discuss special neuropsychiatric issues of patients undergoing ventricular assistive device (VAD) and total artificial heart (TAH) implantation as a bridge to transplant. This technology is associated with its own unique challenges, such as high rate of embolic events leading to cognitive deficits post-transplant. We will review the available data on the neuropsychiatric sequelae of VAD/TAH technologies, with a particular analysis of the experience at Stanford University Medical Center TAH Program from the time of its approval in 6/2013 to present.

NO. 1 PRETRANSPLANT PSYCHOSOCIAL RISK FACTORS

Speaker: Renee M. Garcia, M.D.

SUMMARY:

Psychosocial and neuropsychiatric issues are common among transplant recipients, both before and after transplantation. Similarly, psychosocial factors may significantly affect post-transplant outcomes and better assessment tools are needed in order to improve outcomes. This symposium will cover important pre- and post-transplant psychosocial and neuropsychiatric issues and

complications, including the pre-transplant psychosocial evaluation process.

Studies have demonstrated the importance of psychosocial factors to the ultimate success of transplanted organs. Dr. Garcia will discuss pre-transplant psychosocial factors affecting post-transplant psychosocial and medical outcomes in cardiothoracic transplantation (e.g., psychiatric comorbidities, substance abuse, adherence with medical care, support system).

**NO. 2
EVERYTHING YOU NEEDED TO KNOW
ABOUT PERITRANSPLANT,
PSYCHOSOCIAL, AND
NEUROPSYCHIATRIC ISSUES
AFFECTING OUTCOME**

Speaker: Andrea Ament, M.D.

SUMMARY:

The Stanford Integrated Psychosocial Assessment for Transplantation (SIPAT) is a new systematic way to assess psychosocial candidacy for transplantation. In the original study, the tool demonstrated excellent inter-rater reliability and correlation with post-transplant outcomes (Maldonado et al. *Psychosomatics* 2012; 53:123-132). New findings demonstrate that SIPAT scores significantly correlate with the probability of poor medical and psychosocial outcomes. Dr. Ament will review published and new research findings supporting the use of this tool.

**NO. 3
POSTTRANSPLANT
NEUROPSYCHIATRIC COMPLICATIONS**

Speaker: Yelizaveta I. Sher, M.D.

SUMMARY:

Dr. Sher will discuss neuropsychiatric syndromes (e.g., delirium, demoralization, depression, anxiety) common among transplant recipients, especially focused on our recent findings among lung transplant patients, including unique pharmacodynamics effects of psychotropic agents associated with worsened outcome, morbidity and mortality.

**NO. 4
SPECIAL NEUROPSYCHIATRIC ISSUES
ASSOCIATED WITH ARTIFICIAL HEART
TECHNOLOGIES**

Speaker: Jos  R. Maldonado, M.D.

SUMMARY:

Finally, Dr. Maldonado will discuss special neuropsychiatric issues of patients undergoing ventricular assistive device (VAD) and total artificial heart (TAH) implantation as a bridge to transplant. This technology is associated with its own unique challenges, such as high rate of embolic events leading to cognitive deficits post-transplant. We will review the available data on the neuropsychiatric sequelae of VAD/TAH technologies, with a particular analysis of the experience at Stanford University Medical Center TAH Program from the time of its approval in 6/2013 to present.

**PATIENT SUICIDE IN RESIDENCY
TRAINING: THE RIPPLE EFFECT**

*Chairs: Deepa Ujwal, M.D., Sidney Zisook, M.D.
Discussants: Christina Mangurian, M.D., James 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 include presentations from 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 LOSING A PATIENT TO SUICIDE: THE RIPPLE EFFECT

Speaker: Michael F. Myers, M.D.

SUMMARY:

In this brief presentation, I will summarize my own personal and professional experience with suicide. This also includes insights gleaned from treating psychiatrists who have come to therapy as a result of losing a patient or family member to suicide. Suicide does not exist in a vacuum. It affects a lot of people. When a resident loses a patient to suicide, many individuals in the medical setting are affected: fellow residents, medical students, supervising faculty, other mental health professionals involved in the treatment, training directors, deans of postgraduate education and other administrators of the facility. I will discuss how stigma derails open communication and suggest ways in which everyone can pull together.

NO. 2 INVESTIGATING THE USE OF "COLLATERAL DAMAGES" TO ENHANCE PATIENT SUICIDE CURRICULA DURING RESIDENCY TRAINING

Speaker: Deepak Prabhakar, M.D., M.P.H.

SUMMARY:

This presentation will discuss results from a resident-education research project that investigated the efficacy of a new patient suicide curriculum. The curriculum 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 research related evaluations. These results were compared to assess both knowledge and attitudes resulting from this educational program. Participants reported increased awareness of the common feelings physicians and trainees often experience after a patient suicide, available support systems, required documentation and the role played by

risk management. This patient suicide educational program increased awareness of issues related to patient suicide and shows promise as a useful and long-overdue educational program in residency training

NO. 3 EMOTIONAL AND COGNITIVE RESPONSES OF CLINICIANS TO PATIENT SUICIDE

Speaker: Joan M. Anzia, M.D.

SUMMARY:

This section will explore both senior clinician's and trainee's responses to a patient suicide, using video interviews of people at both stages of career. Two brief video interviews will be followed by a review of emotional and cognitive responses to this event, and facilitated group discussion.

NO. 4 EXPERIENCING PATIENT SUICIDE AS A PSYCHIATRY INTERN

Speaker: Daphne C. Ferrer, M.D.

SUMMARY:

Patient suicide, though anticipated to occur at some point in our careers as psychiatrists, is a difficult experience. When it occurs as early as intern year of residency training, this is a unique experience in itself. My experience was with a 38yo male with bipolar disorder, alcohol use disorder, PTSD by history, borderline and dependent personality features, multiple prior psych hospitalizations admitted for threatening suicide in the setting of alcohol intoxication, medication non-compliance, and recent life crisis (recent break-up with girlfriend). After a few weeks stay in the hospital, was discharged to a former employer's home (who coincidentally was the father of another pt on the unit), with the plan to follow up at intensive outpatient program--at the time, pt was not interested in getting help for alcohol use. One month post-hospitalization, pt was found dead by suspected suicide by overdose in the basement of his former employer's home by employer's wife. This presentation will illustrate the impact this experience has made on myself as a mental health provider and how it will continue to shape me in my journey as a psychiatrist.

NO. 5 IMPACT OF PATIENT SUICIDE DURING RESIDENCY TRAINING

Speaker: Alexis A. Seegan, M.D.

SUMMARY:

As part of this symposium, I will discuss my personal experience with a patient committing suicide while on the inpatient psychiatry unit, and in dealing with the aftermath of this patient's suicide. During my intern year, I cared for a talented and vibrant young woman who struggled with depression and borderline personality disorder, and she ended up committing suicide while an inpatient on the acute psychiatric unit. After her suicide, I experienced a tremendous sense of guilt and responsibility for her death, and grappled with the idea that even the hospital could not keep a person safe from themselves. I had been in close contact with the patient's family during her hospitalization, and grieved alongside them after her suicide. The family invited me to her memorial service, which was a very meaningful experience that helped me to process my grief. Now, as a third-year resident, I still consider her suicide to be influential on how I practice psychiatry and know that it was one of the formative events in my residency training.

NO. 6 A RESIDENT'S PERSPECTIVE ON PATIENT SUICIDE

Speaker: Brenda Bye, D.O.

SUMMARY:

I propose to share my personal experience of patient suicide. I took care of a severely ill young man during my third year. Despite my best efforts and judgments, he suicided several months into our care. I was shocked and numb. I looked for errors and clues hoping to find a rational explanation. My supervisor asked "You're not blaming yourself are you?" but that was not it. My fantasy was destroyed. Working hard could not save everyone and I felt powerless in the face of such an awesome truth.

Over the next month, I sat through a painful case review, where the pulled the case was pulled to miniscule pieces with the same sad conclusion, "we did our best." I went

about my days pretending nothing had happened and spent my evenings worrying about my patients. "Who would be next?" It was really only through seeking supervision and challenging my illusion of control over patient's lives that I have begun processing this. I can admit that six months later suicidal patients make me anxious in a way that did not exist before. I wish that I could reclaim my own innocent optimism.

MINERAL-VITAMIN COMBINATIONS AS PRIMARY TREATMENT OF PSYCHIATRIC SYMPTOMS

Chairs: Charles Popper, M.D., Barbara L. Gracious, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the biological rationale for the effectiveness of broad-spectrum mineral-vitamin supplementation in treating psychiatric symptoms and modifying brain functions.; 2) Identify specific symptoms and brain functions, such as impulsivity, anxiety, mood, and cognition, that have been found to improve with broad-spectrum micronutrient treatment in RCTs.; 3) Treat or prevent certain psychiatric symptoms using broad-spectrum micronutrients, understanding the strengths and limitations of the evidence database.; 4) Avoid relative contraindications and utilize appropriate precautions that must be exercised for safe use of these interventions.; 5) Recognize the potential public health benefit of using multinutrients in stressful situations such as natural disasters.

SUMMARY:

Minerals and vitamins are involved in virtually every biologic process, so micronutrient deficiencies have broad effects throughout the body and brain. Micronutrient insufficiencies are present in most people, even in "well fed" populations. Some single nutrients (EPA/DHA, folate, B12; perhaps chromium, vitamin D, and zinc) have clinical value for certain psychiatric indications, but none are powerful enough to constitute monotherapies. In contrast, micronutrient formulations containing a broad spectrum of minerals and vitamins appear effective in randomized controlled trials (RCTs) as potent treatments of aggressive and disordered conduct, ADHD, mood disorders,

and anxiety/stress. Three RCTs showed reduced violence and major misconduct in incarcerated offenders, and one RCT found reduced aggressive and disordered conduct in school children. In adults with ADHD, a RCT found reduced hyperactivity/impulsivity (ES 0.46±0.67), inattention (ES 0.33±0.62), and CGI (ES 0.53±0.57), with a response rate of 64%. In youth with ADHD, the best estimate of response rate is 63-76%. For mood disorders, a RCT on adults with depressive symptoms (MADRS ≥ 20) and comorbid ADHD showed an effect size for broad-spectrum micronutrients similar to standard antidepressants (ES 0.41), and open-label data suggest sustained mood improvement lasting at least 4 years. Open-label data also suggest possible effectiveness in OCD, autism, and substance abuse. Improved response to major stress in healthy adults has been found in several RCTs, including reduction of anxiety and other post-traumatic symptoms following natural disasters, with one study finding sustained improvements one year later. Cognitive benefits have been noted in non-psychiatric populations: 1) a meta-analysis found improved academic performance in healthy school children (ES 0.44), 2) a meta-analysis showed improved free-recall memory in healthy adults (ES 0.32), and 3) a large multi-year RCT found slowing of age-related decline in executive functioning and verbal memory. Adverse effects of broad-spectrum micronutrient treatments appear markedly fewer and milder than with conventional treatment. By providing a full range of micronutrients, physiological functioning can be pervasively optimized, resulting in enhanced mental functioning in humans and neurotrophism, neuronal development, and neuroprotection in animals. Biological mechanisms and population data on nutritional inadequacies will be presented, and clinical advisories and medical cautions are offered. Unlike interventions employing single minerals or single vitamins, or multi-mineral/vitamin supplementation with 2-5 ingredients, these broad-spectrum micronutrient approaches appear comparable in efficacy to conventional psychopharmacological treatments with much fewer side effects and well sustained effectiveness. These treatments deserve additional research and, based on current data, appear valid for application now in some clinical situations.

NO. 1

SCIENTIFIC RATIONALE FOR BROAD-SPECTRUM MICRONUTRIENT TREATMENTS OF BRAIN FUNCTION

Speaker: Charles Popper, M.D.

SUMMARY:

Minerals and vitamins are involved in every physiological process as cofactors for most enzymes, regulators of transcription factors (altering DNA methylation), modifiers of membrane fluidity and function, and components of receptors, transporters, ion channels, and pump mechanisms. Numerous factors contribute to micronutrient insufficiencies in humans, including genetics, exercise, stress, aging, and soil depletion. Most Americans have suboptimal micronutrient status, which can increase the severity of medical disorders and, more subtly, contribute to subclinical syndromes related to physiological underperformance. Increased micronutrient intake has been shown to counter suboptimal functioning resulting from genetic variants in enzyme structure and from oxidative damage to nuclear DNA and mitochondria (associated with metabolic and inflammatory changes, neuronal decay, and accelerated aging). Animal studies show neurotrophic effects of broad-spectrum micronutrients on rat brain structure and function following cortical lesions. To optimize physiological functioning across the full range of biological processes, a complete complement of minerals and vitamins must be present at sufficient levels: Correction of just a few micronutrient insufficiencies (as in prior RCTs in psychiatry) will not pervasively optimize biological and brain functioning. A change in approach from single-nutrient supplementation to broad-spectrum interventions makes more biological and clinical sense.

NO. 2 TREATMENT OF AGGRESSION, MOOD, ATTENTION-DEFICIT/HYPERACTIVITY DISORDER, AND ADDICTIONS WITH MULTINUTRIENT FORMULAS: THE EVIDENCE TO DATE

Speaker: Julia J. Rucklidge, Ph.D.

SUMMARY:

Multi-ingredient micronutrient approaches to treating psychiatric symptoms appear promising. Four RCTs have shown superiority of

nutrients over placebo in reducing offending behaviours (28-47% reduction) in incarcerated adults and antisocial youth. Two randomized controlled trials (RCT) showed benefits of micronutrients for reducing clinical depression compared to placebo, with a medium effect size (0.41) in the more rigorous study. Other RCTs have examined mood changes in healthy or medically ill populations (8 positive, 6 negative), making it difficult to generalize to psychiatric samples. Bipolar disorder treated in six open-label (OL) trials have all shown benefit with large effect sizes (>0.8), but controlled studies are needed. In ADHD, most trials (2 RCTs, 3 OL) have shown benefits of micronutrients (ES 0.33-1.88) with one negative trial using doses likely too low to effect change. A one-year follow-up of an RCT of adults with ADHD showed that those staying on micronutrients displayed greater improvement in ADHD and mood symptoms than those who switched to medications or discontinued micronutrients. For addictions, one RCT and three OL trials showed micronutrients diminish alcohol and opiate withdrawal symptoms, reduce relapse rates, and improve psychological functioning. A pilot RCT showed benefits of multinutrients in assisting people with quitting smoking.

NO. 3 TREATMENT OF ANXIETY AND STRESS WITH MULTINUTRIENT FORMULAS

Speaker: Bonnie J. Kaplan, Ph.D.

SUMMARY:

Current data suggest that a portion of the anxiety and stress in humans may be due to nutrient insufficiency. Although frank nutrient deficiency syndromes are now rare in the developed world, the majority of North Americans are suboptimally nourished. At least 5 RCTs show amelioration of anxiety and stress as a result of micronutrient treatment with broad-spectrum formulas (>30 minerals and vitamins) as well as B-complex formulas (5-10 nutrients). These benefits have been shown both in clinical samples and in the general population. In addition, several studies have documented powerful mental health benefits of micronutrient treatment of depression and anxiety following earthquakes and floods. When natural disasters strike, one of the expectable immediate consequences is reduced ability to obtain and prepare nutritious food. Hence, at such times when anxiety and stress are

elevated, and the nutrition needed to maximize mental health may be in short supply, micronutrient supplementation during disasters may become a sensible public health measure for reducing post-traumatic symptoms. Randomized trials following the Christchurch earthquakes were recently replicated in a randomized trial in people suffering the southern Alberta flood. Effect sizes were generally large (1.28 – 2.18) for both broad spectrum and B-complex formulas.

NO. 4 CLINICAL APPROACH TO USE OF MULTINUTRIENT FORMULAS: PRIORITIZING SAFETY

Speaker: Barbara L. Gracious, M.D.

SUMMARY:

Clinical interventions using multinutrient supplements requires diligence and care. Specific products must be evaluated to verify that individual ingredients are bioavailable and doses do not pose toxicity risks. Concepts commonly used in safety assessments of individual dietary nutrients, including daily recommended intake (DRI) and tolerable upper intake levels (UL), will be reviewed. For multinutrient products, controlled data on safety and tolerability across a range of doses are needed in humans for each specific micronutrient product. Adverse effect data will be presented from clinical studies of the multi-micronutrient products described in this symposium; the available controlled studies appear to demonstrate good short-term tolerance and safety, with few side effects or laboratory changes. Effects of multinutrient supplementation on serum nutrient levels will be described. Similar to drug interactions of conventional pharmacological agents, drug-nutrient interactions are plentiful and can be problematic; these will be discussed together with strategies for safe clinical use of multinutrient products in combination with conventional agents. Strict and relative contraindications related to physical disorders and to dietary and lifestyle factors will be surveyed. In general, clinicians need to be cautious and knowledgeable about the complex pharmacological effects of multimicronutrient treatments, especially when used in combination with any CNS-active medication.

INTIMATE PARTNER VIOLENCE (IPV) AND MENTAL HEALTH

Chair: Donna Stewart, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify children who have experienced child maltreatment or witnessed intimate partner violence; 2) Recognize and treat or refer adult patients who have experienced intimate partner violence; 3) Recognize, treat or refer victims of sexual violence; 4) Understand the health sector responsibilities in the WHO Guidelines on intimate partner violence/sexual violence.

SUMMARY:

Intimate partner violence (IPV) is a global public health problem that has serious detrimental effects on physical and mental health. While IPV may affect either sex, women are more likely to be seriously injured or killed. Children in the family may be victims of maltreatment or may suffer psychological damage as a result of witnessing parental IPV. Depression, anxiety, PTSD and substance abuse are common mental health sequelae for adults and children.

This symposium will include presentations on IPV and Children (Dr MacMillan), IPV in Adults (Dr Wathen), Sexual Violence (SV) (Dr Vigod) and Adherence to the New WHO Guidelines on IPV and SV using the Latin American and Caribbean Region as one example of the challenges faced in the health care sector (Dr Stewart). All the speakers are experts on these topics and have recently contributed to national or international position papers, academic papers or clinical guidelines.

NO. 1 IPV IN ADULTS

Speaker: Nadine Wathen, Ph.D.

SUMMARY:

The term intimate partner violence (IPV) describes physical, sexual or psychological harm by a current or former partner or spouse. IPV is essentially a violation of human rights and a preventable exposure associated with serious consequences. IPV must be addressed through social, educational and legal policies. This presentation will provide an overview of 1) the epidemiology of IPV, including prevalence and risk factors; 2) associated health impairments,

with a focus on mental health; and 3) the evidence for the effectiveness of various healthcare interventions that address primary, secondary and tertiary prevention of IPV, including identification, assessment, documentation, and treatment. The paper will provide recommendations for IPV-specific best practices in psychiatry and present opportunities for further education and research in this area.

NO. 2 SEXUAL VIOLENCE IN INTIMATE PARTNERS

Speaker: Simone Vigod, M.D.

SUMMARY:

Sexual violence is any sexual act that is perpetrated against someone's will. It can encompass a range of offenses, including a completed nonconsensual sex act (e.g., rape), an attempted nonconsensual sex act, abusive sexual contact (e.g., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment). Sexual violence can occur within an intimate partner violence (IPV) setting when the victim does not consent, is unable to consent or refuses to allow the act.

In some countries, more than half of reported acts of sexual violence occur within an intimate partner relationship, particularly for women. Younger women are at high risk, and case identification improves when clinicians directly ask about the possibility of sexual violence. Acute management involves attention to safety as well as physical and reproductive health consequences. Initial psychological intervention should be individual, supportive, non-judgmental, confidential and educational in nature about the effects of sexual violence. Long term psychological management needs will be determined by past history, symptoms, coping mechanisms, vulnerabilities, and resilience of the individual patient.

This presentation will review key aspects of sexual violence within an IPV setting: (1) definitions and consequences; (2) prevalence and risk factors; and (3) recommendations for acute management.

NO. 3 NATIONAL CLINICAL/POLICY GUIDELINES ON IPV AND SEXUAL

VIOLENCE AGAINST WOMEN IN LATIN AMERICA AND CARIBBEAN PAN-AMERICAN HEALTH ORGANIZATION MEMBER COUNTRIES

Speaker: Donna Stewart, M.D.

SUMMARY:

LAC countries have some of the highest rates of IPV in the world. This presentation will discuss baseline levels of adherence and gaps in LAC countries to 2013 WHO Guidelines on Responding to IPV and SV against Women. We conducted a Survey Monkey Questionnaire, sent emails to PAHO focal points, conducted web searches, reviewed the UN Women web site and personal contacts. All policy and clinical topics were entered into a matrix by recommendations in WHO Guidelines. National policies (15/27) and guidelines (12/27) were obtained from English, Portuguese or Spanish speaking countries. Multiple sectors were involved. Fewer than 50% of these countries had policies or guidelines on IPV/SV and those that did had many gaps. Gaps on mental health problems and training of practitioners were prominent. Information for patients regarding symptoms and services was inadequate. Other WHO recommendations that were deficient in LAC countries will be presented. All countries should develop and implement IPV/SV clinical and policy guidelines that adhere to the 2013 WHO Guidelines and further training, services, monitoring and evaluation are needed especially relating to mental health aspects.

NO. 4 CHILDREN'S EXPOSURE TO IPV

Speaker: Harriet MacMillan, M.D.

SUMMARY:

Children's exposure to IPV is increasingly understood to be a type of child maltreatment associated with a level of impairment that is similar to other types of abuse and neglect in childhood. This presentation will provide an overview of the effects of children's exposure to IPV and discuss approaches to assessment.

Children's exposure to IPV formed the basis for a recent review by us and was also addressed within the World Health Organization Guidelines for responding to IPV and sexual violence against women. An evidence-based

summary of information from these two reviews will be provided.

Learning about children's exposure to IPV and understanding ways to include questions about such exposure as part of history-taking is essential for psychiatrists. It is important that children undergoing assessment for emotional and behavioural problems be asked about IPV in a way that is developmentally appropriate and safe.

Awareness of the impact of IPV on children and the approach to considering such exposure is important for all mental health professionals working with children and adolescents. Developing skills to ask about IPV exposure in a way that does not put children or women at risk is essential in addressing emotional and behavioural problems in children.

CHEATING, PERSONALITY DISORDERS AND SPORTS PSYCHIATRY

Chairs: Thomas Newmark, M.D., Ira Glick, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose and treat personality disorders in athletes involved in cheating behavior; 2) Recognize cheating behavior in college athletes and ethical issues to address; 3) Identify the psychological motivations that lead an athlete to cheat using banned substances; 4) Understand how cheating and unethical behavior alter our view of sports and athletes and the role of the sports psychiatrist.;

SUMMARY:

Cheating in sports has occurred from ancient Olympics until today. The psychology of winning at any cost to gain fame, extreme financial incentives, and success leads athletes to cheat by using PEDs (Performance Enhancing Drugs). Many athletes feel the need to cheat with PEDs to be highly competitive. This despite the risks to their health and being caught. Cheating also impacts the integrity and ethics in sports and undermines the value of fair play. Recent events in Major League Baseball, cycling, and track and field highlight the issue of cheating with PEDs. For example, an athlete may suffer from a personality/character disorder with narcissism and be more prone to cheat with PEDs. The psychiatrist who is sensitive to individual and team dynamics can recognize, diagnose and treat these issues.

The presenters will discuss the role of treatment and prevention at all competitive levels. A historical perspective of cheating in sports will be cited including other forms of cheating such as a team throwing a game. The impact of cheating on the athlete, fan, and society will be addressed. The psychiatrist can have a role in addressing these issues on an individual, team and societal level as sports culture often mirrors societal norms.

NO. 1 PSYCHOLOGY OF INFAMOUS SPORTS SCANDALS IN HISTORY

Speaker: Thomas Newmark, M.D.

SUMMARY:

Sports scandals are usually motivated to gain fame and fortune. Sports scandals will be discussed and can take the form of the use of Banned substance (PEDs) ; Betting; Bribery; and Battery. Examples will be presented such as cyclist Lance Armstrong and PEDs; baseball player Pete Rose and gambling; Ice skater Tanya Harding and the assault on Nancy Kerrigan incident and the Chicago White Sox (Black Sox) throwing the Baseball World Series. Underlying motivations will be discussed. Other examples of individual and team Scandals will be presented.

NO. 2 CHEATING, PERSONALITY ISSUES, AND THE ROLE OF THE SPORTS PSYCHIATRIST ON THE COLLEGE LEVEL

Speaker: Eric D. Morse, M.D.

SUMMARY:

Cheating is often part of college sports on and off the field. From faking injuries to slow down the game to intentionally hurting an opponent, certain personality constructs make it easier for student athletes to cheat. Off the field, cheating academically may help student athletes remain eligible with the NCAA to compete. Financial opportunities to play professionally may lead student athletes to compromise their ethics. Pressure to perform may lead to taking performance enhancing drugs or doping. The Sports Psychiatrist can consult with athletes who have been caught cheating. Our role may be to educate and prevent, assist athletes not to cheat again, or help with the consequential

stress of being caught and dealing with a suspension, ban, career termination, and resulting loss of identity. Sports Psychiatrists are asked to assist with medical red shirts for mental health reasons or medical drops of courses to keep student athletes eligible. We are sometimes asked to cheat - to come up with a helpful diagnosis, therapeutic use exemption request, prescribe a medication that an student athlete has already tested positive for, etc. Pressure to be a "team player" may come from the student athlete, parents, Sports Medicine, coaches, or administration. When a Sports Psychiatrist recognizes cheating, what obligations does she or he have?

NO. 3 PSYCHODYNAMIC DIAGNOSIS AND TREATMENT OF ATHLETES WITH PERSONALITY DISORDERS WHO CHEAT

Speaker: Dan Begel, M.D.

SUMMARY:

Athletes with personality disorders such as narcissistic, borderline or antisocial personalities are at higher risk of cheating behavior. Understanding the deeper motivations of such athletes can drive the treatment. It is important to explore childhood and family and cultural dynamics to develop a treatment plan. This is often not examined in depth. Treatment strategies will be offered.

NO. 4 CAN WE TREAT THE CHEAT?

Speaker: Ira Glick, M.D.

SUMMARY:

Treatment of the athlete that cheats is challenging. After making an accurate diagnosis often of a personality Dis there are a few treatment options. CBT, Family therapy, Dynamic therapy and Supportive therapy are tools to use. Often the elite athlete may feel a sense of entitlement that needs to be addressed. The VIP athlete presents unique challenges to be aware of including issues of transference and countertransference. The role of the Sports Psychiatrist/ team Psychiatrist will be discussed.

THE CHILD REFUGEE CRISIS ON THE U.S. BORDER: MENTAL HEALTH FACTORS AND CONSEQUENCES

Chair: Andres J. Pumariega, M.D.

Discussants: Pedro Ruiz, M.D., Andres J. Pumariega, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outline the scope of the child refugee crisis along the US Mexico border and the mental health consequences for the children involved ; 2) Review the responses from governmental and non-governmental entities responding to this crisis in two communities along the border. ; 3) Learn from the response to previous US child refugee crises, especially what psychiatrists and US psychiatry in general can do to assist in facing this crisis; 4) Understand the negative responses by the host culture to these child refugees in the current sociocultural context and how psychiatrists and US Psychiatry can address them. .

SUMMARY:

The surge of unaccompanied minors entering the U.S. through the U.S.-Mexico border from Latin America, primarily from Mexico and Central America (primarily Guatemala, El Salvador and Honduras), has increased dramatically during the past fiscal year (FY 13-14) as compared to the prior fiscal year (FY 12-13) according to the analysis or recently released government data conducted by the Pew Research Center. While the number of children apprehended in the earlier year was nearly 39,000, this number has increased to more than 57,000 in the first nine months of the latter year. Although the majority of these children and youth are adolescents, the younger children population has increased substantially during the past year. A large portion of these children, especially those from Central America, have reportedly fled chaotic communities wracked by violence and threats of such perpetrated by gangs and drug cartels. Corruption in State and local governments of these nations has allegedly compromised safety and most basic services. At the same time, the United States has faced a tide of undocumented immigration from Mexico and Central America, which now totals approximately 12 million undocumented

immigrants and close to 1 million attempting to enter annually. The latter influx has been viewed through different lenses politically and in terms of policy than those of refugees from nations in formal armed conflict involving the U.S. These latter immigrants are primarily viewed as economic migrants and have been met with vociferous opposition by many and refusal to offer paths for normalization. However, a recent sub-group of unaccompanied minors from Central America has raised even sharper political and social divisions, and presents significant challenges for the provision of social services and immigration services. These children have been sent fleeing violence and terrorism related to drug trafficking in many Central American nations, and are highly vulnerable to immigration-related trauma as well as trauma from the raging conflicts in their homelands. Furthermore, their emigration was possibly prompted by the actions of grown-up Central American refugee children, who in response to the trauma they faced in the 1980's, turned to gang warfare in the U.S. that eventually were deported back to their home nations. This symposium attempts to examine the various aspects of this emerging refugee crisis along our borders, examining various perspectives: the mental health and social services implications of the current crisis, the historical and generational roots of this crisis in the Central American child refugees crisis of the 1980's, the lessons learned from prior child refugee crises (Pedro Pan of the 1960's and Guantanamo of the 1990's), the psychological roots of the negative response by the host culture in the U.S., and how psychiatrists/ US psychiatry can contribute to the amelioration of the impact of this crisis and its eventual resolution

NO. 1
IMPACT OF THE CENTRAL AMERICAN REFUGEE CRISIS ON THE LOWER RIO GRANDE VALLEY REGION

Speaker: Francisco Fernandez, M.D.

SUMMARY:

The Lower Rio Grande Valley (LRGV) region of Texas has been a crossing point for undocumented immigrants for decades. It has also had a historical relationship with Mexico and grown in population and importance over the last 30 years. The LRGV has struggled with

growing needs for health and mental health services, and recently achieved approval for a new school of medicine to help address its health disparities. Now the LRGV has been additionally impacted by the Central American child refugee crisis. While the focus remains on medical clearance and disease prevention, mental health is less likely to receive medical attention let alone treatment. At entry, U.S. Health and Human Services provides a well-child exam, vaccinations against communicable diseases, screening for TB and mental health problems, and placement in quarantine or special facilities. The effects of collective violence and extreme poverty have an additive effect on the mental health of children crossing the border, especially those without their parents. Studies have shown that untreated mental health problems in refugee youth predict future violence and delinquencies. This presentation will focus on the response in the LRGV to the current crisis and the provision of coordinated assessments and urgent care to children at greatest mental health risk. The impact of this exodus on the LRGV further strains its limited resources, but the region has responded using its historical expertise with border issues.

NO. 2
THE CENTRAL AMERICAN CHILD REFUGEE CRISIS: SOUTHERN CALIFORNIA AND HISTORICAL PERSPECTIVES

Speaker: William Arroyo, M.D.

SUMMARY:

The often abrupt exodus by children and youth from Central American countries has involved a life-threatening trek through Mexico on their way to the U.S.-Mexican border, including exposure to multiple events of victimization, risk and trauma at the hands of an array of individuals who have been paid exorbitant sums of money and risky means of transportation. Detailed and harrowing stories of physical beatings, sexual victimization and severe injuries sustained en route to the U.S have been chronicled in the lay literature. The U.S. government agencies responsible for responding to this new population have been overwhelmed insofar as their capacity to provide appropriate services and are evidently less capable of providing developmentally

appropriate services. Although a large percentage of these apprehended children have been placed with relatives, many have not been. In Los Angeles County where there are at least 2000 of these children, there is a dearth of services including legal, health, mental health and other social services. On a more hopeful note, there is an emerging consortium of community and government agencies which are developing strategies to meet the needs of these children which includes identifying local funding resources. This presentation will not only include a discussion of the current needs and responses to traumatized Central American children currently, but also draw linkages between the historical refugee wave of the 1980s and the current exodus.

**NO. 3
PSYCHOLOGICAL ASPECTS OF THE
1960S PEDRO PAN EXODUS 1994
CUBAN BALSERO CRISIS: LESSONS
LEARNED**

Speaker: Eugenio Rothe, M.D.

SUMMARY:

In the 1960s an exodus of over 20,000 unaccompanied child refugees entered the U.S. from Cuba as a result of the Cuban Revolution. Though the families sending their children were typically of higher socioeconomic status and there was coordination by the Catholic Church in the US, there are still many mental health consequences as a result of various forms of traumatization amongst this group children and families involved. In the year 1994 the economy of the island of Cuba plunges into the Deepest Financial Crisis since 1959 communist takeover. Riots erupted and fearing the possibility of a civil war, the Cuban government invited all of those who were discontent to leave and this culminated with a massive exodus by sea to the U.S. in anything that would float. Many died at sea and others were intercepted by the U.S. Coast Guard and placed in refugee camps at the U.S. Naval Base at Guantanamo Bay. Of the refugees, 2,500 were children and adolescents who remained in the camps for up to a year prior to being admitted to the U.S. The author worked in the Guantanamo refugee camps as a medical volunteer and produced four research studies and six scientific publications describing the experience of the child and adolescent refugees in this exodus. He also has extensive

clinical experience working with the grown-up Pedro Pan refugees. The author will present the findings of the research and clinical experiences, and the lessons learned from treating these groups of child refugees.

**NO. 4
CAN SOCIAL PSYCHIATRY HELP
ADDRESS THE REACTION OF HOST
COUNTRIES TO IMMIGRANTS?**

Speaker: Kenneth Thompson, M.D.

SUMMARY:

The recent vociferous and at times outlandish rejection of the young migrants from Central America by some people in the United States highlights the need to understand and address the reactions of people in countries receiving immigrants. While it is easy to dismiss the very distressing aspects of these reactions as evidence of xenophobia, racism and sectarianism- which they often are- simply condemning them does little good toward ameliorating them. Further, simply rejecting these reactions as illegitimate masks the very real losses and concerns that inward migration causes host communities. Those reactions are based in part on a poor economy resulting from global competition for traditional industrial jobs, now facing the prospects of immigrants displacing them from available jobs in their homeland. Using recent examples from Pittsburgh, where there is an influx of Nepali Bhutanese refugees, this presentation will explore how an informed social psychiatrist might help to address the concerns of host countries about migrants and the process of settlement, with the goals of increasing cultural dialogue, mutual understanding and ongoing community problem solving.

**PHYSICAL EXAMINATION IN
PSYCHIATRIC PRACTICE**

Chairs: Priya Gopalan, M.D., Pierre Azzam, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify medical conditions that present with psychiatric symptoms ; 2) Apply the physical examination to specific psychiatric conditions that require attention to physical findings; 3) Recognize catatonia as a syndrome through use of physical examination findings ; 4) Conduct a

thorough bedside exam for neurocognitive disorders, which includes testing for cognitive dysfunction and focus on physical findings ; 5) Describe medical conditions that occur commonly in the psychiatric patient population that require attention by the general psychiatrist.

SUMMARY:

As compared to the general population, individuals with mental illness are at greater risk for medical morbidity and mortality and present more frequently with undiagnosed physical conditions. Because psychiatric features may herald medical illness, and individuals with mental illness tend less often to see general practitioners, psychiatrists must remain vigilant for physical signs and symptoms in their own practice. Moreover, psychiatric and medical pharmacotherapies can precipitate serious medical and psychiatric conditions, respectively; as such, psychiatrists are uniquely situated to prevent and identify iatrogenic complications.

The overlap between neurologic and psychiatric presentations showcases the diagnostic value inherent to physical examination. After a stroke that impacts frontal networks, for example, patients may experience psychomotor deficits that limit meaningful engagement with recovery efforts (e.g., amotivational syndromes) or alter the expression of emotion (e.g., pseudobulbar affect). Partial complex seizures from a mesial temporal focus may manifest with a predominance of auditory disturbances (e.g., hallucinations of church bells), fear (e.g., brief panic-like episodes), or atypical cognitive experiences (e.g., recurrent intrusive thoughts). In each of these cases, physical examination will typically highlight subtle findings “ gait ataxia, primitive reflexes, or echophenomena after frontal stroke, and automatisms in the setting of seizure “ to evidence neurologic insults that otherwise may be misidentified as "primary" psychiatric pathology.

In this symposium, we will highlight critical elements of the physical exam as they pertain to the general psychiatrist. We will begin with an overview of relevant aspects of the physical exam in psychiatric care, with a brief overview of medical and psychiatric disorders for which physical examination is prudent. We will then provide a detailed review of the syndrome of catatonia, for which examination is vital for diagnosis and guides appropriate management.

We will next turn attention to neuropsychiatric testing that can be used to screen for and diagnose neurocognitive impairments. We will conclude with a discussion on the medical care of psychiatric patients and discuss common medical comorbidities in psychiatric patient populations that require vigilance on the part of the general psychiatrist.

1. Physical Examination in Psychiatry: An Overview of Clinical Scenarios
2. Clinical Highlight: Catatonia and the Physical Exam
3. Neurocognitive Disorders: Neuropsychiatric Testing and the Bedside Exam
4. Medical Care of the Psychiatric Patient

NO. 1

PHYSICAL EXAMINATION IN PSYCHIATRY: AN OVERVIEW OF CLINICAL SCENARIOS

Speaker: Priya Gopalan, M.D.

SUMMARY:

Many conditions in medicine present with prominent psychiatric symptoms. For example, seizures, hypothyroidism, and lupus may present first with depression, psychosis, or mania; yet, physical examinations are not universally performed on psychiatric patients, with studies suggesting that over 40% of psychiatric inpatients do not receive a physical exam (Hodgson et al). Other conditions in psychiatry such as intoxication and withdrawal states, somatic symptoms disorders, and neurodegenerative conditions require attention to the exam, which in fact, may guide management of these conditions.

This section will provide an outline of the physical exam in psychiatry, with a discussion of areas of focus for the general psychiatrist. We will provide a broad overview of commonly encountered physical findings in intoxication and withdrawal states, endocrine and neurologic disorders, as well as somatic symptoms and other conditions. Guidelines will be provided to incorporate physical examination into a regular psychiatric evaluation and adapt it to various locations of practice.

NO. 2

CLINICAL HIGHLIGHT: CATATONIA AND THE PHYSICAL EXAM

Speaker: Pierre Azzam, M.D.

SUMMARY:

Proper identification of catatonia hinges on thorough physical examination. Recent changes in DSM-5 to the diagnostic criteria for catatonia highlight its many and unique signs. Those who expect catatonia to appear universally as stupor, mutism, and posturing are often surprised to discover that the syndrome is quite heterogeneous, with hyperkinetic features that often fluctuate with hypokinetic ones. The catatonic patient carries a broad differential diagnosis, from devastating structural neurologic injuries to selective behaviors. Physical examination becomes vital to recognizing a cluster of clinical indicators that point to catatonia, and that allow clinicians to swiftly manage the syndrome while identifying precipitating disease processes.

In this symposium, we will review the comprehensive physical examination for catatonia. We will highlight objective findings that are seen commonly among catatonic patients, focusing on the often-perplexing dichotomies that define the syndrome; e.g., negativism and oppositional paratonia (gegenhalten) versus automatic obedience and echophenomena; stupor and mutism versus purposeless agitation (excitement) and excessive redundant speech (verbigeration). We will cover the nuanced descriptors of catatonic signs, including differences between waxy flexibility and catalepsy and mannerisms and stereotypies, while reviewing the neural networks that underlie this fascinating syndrome.

NO. 3 NEUROCOGNITIVE DISORDERS: NEUROPSYCHIATRIC TESTING AND THE BEDSIDE EXAM

Speaker: Sarah Faeder, M.D., Ph.D.

SUMMARY:

Neurocognitive dysfunction is seen commonly in general psychiatric practice, including impairments to inhibition with attention-deficit hyperactivity disorder (ADHD), executive function with psychotic disorders, and concentration with depression. General medical and neurologic conditions often also generate disturbances to memory, orientation, planning, and attention. These may be transient in the case of delirium (e.g., disorientation after seizure) or persistent with major neurocognitive

disorders (e.g., HIV-associated dementia). Therefore, it is imperative that psychiatrists be comfortable with evaluating neurocognitive consequences for both psychiatric and physical illness.

Several instruments are available to assist clinicians with screening and diagnosing neurocognitive dysfunction. In this symposium, we will review validated instruments and common examination techniques, including the Montreal Cognitive Assessment (MoCA), Confusion Assessment Method (CAM), and Executive Interview (EXIT). Cognitive domains that are assessed by these tools will be discussed, along with their proper uses for diagnosis and treatment planning. We will focus attention on the manner in which specific aspects of these instruments may be used to assess for particular neurocognitive disorders; for example, use of measures that are more specific to attention, to distinguish delirium from frontal apathy syndromes and depression.

NO. 4 MEDICAL CARE OF THE PSYCHIATRIC PATIENT

Speaker: Neil Puri, M.D.

SUMMARY:

Psychiatrists providing care in longitudinal settings may find themselves as the only medical provider for patients with chronic psychiatric disorders. Patients with severe mental illness often face significant medical comorbidity and may suffer from elevated morbidity and mortality as a result. Practitioners caring for this population require a solid understanding of common medical comorbidities (such as diabetes, hypertension, and chronic obstructive pulmonary disease) and an ability to recognize these illnesses in their patient population. With this knowledge, general psychiatrists may refer their patients appropriately and assist in management of overall health and wellness.

We will provide an overview of medical comorbidities commonly encountered by the general psychiatrist across settings. Attention will be given to physical findings suggestive of undetected or undiagnosed medical disorders (such as diabetes), that may be incorporated into a regular psychiatric appointment. Updated guidelines for preventive care for these conditions will also be reviewed.

BRIDGING THE GAP BETWEEN INTIMATE PARTNER VIOLENCE (IPV) AND MENTAL HEALTH SERVICES

Chairs: Mayumi Okuda, M.D., Obianuju "Uju" J. Obi, M.D., M.P.H.

Discussant: Elizabeth Fitelson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Increase knowledge on the incidence of psychiatric disorders in victims of IPV; 2) Review emerging strategies that foster collaboration between domestic violence agencies and mental health services; 3) Identify areas in which there are barriers to fostering partnerships between domestic violence agencies and mental health services; 4) Explore the dynamics of interdisciplinary teamwork (i.e. law enforcement, social work, criminal justice, immigration, psychiatric services) in providing care to victims of IPV; 5) Describe a collaborative program that seeks to serve the mental health needs of victims and contribute to scientific knowledge that will allow for improved prevention of intimate and familial violence.

SUMMARY:

Intimate partner violence (IPV), which affects at least 20% of women, is a significant risk factor for depression and PTSD. Remarkably, there is a dearth of knowledge within the psychiatric community about how to handle, treat, and utilize resources for victims of violence. This symposium will provide an overview of the associations between IPV and psychopathology; explore the current state of collaborations between domestic violence service agencies and psychiatric treatment settings (including substance abuse); and describe a novel collaborative initiative between Columbia's psychiatry department and the New York City Family Justice Centers (FJCs), an initiative of the Mayor's Office to Combat Domestic Violence, which is bringing academic medicine to IPV intervention and IPV clinical needs into psychiatry's purview.

NO. 1 INCIDENCE OF PSYCHIATRIC DISORDERS IN VICTIMS OF IPV

Speaker: Mayumi Okuda, M.D.

SUMMARY:

Intimate Partner Violence (IPV) exacts a staggering toll on society. Although prior national studies have examined the prevalence and predictive value of psychiatric disorders for IPV victimization, their cross-sectional design has not allowed the estimation of the effects of IPV on the risk of incident or new onset psychiatric disorders. This study presents data from the largest nationally representative study in the U.S. (NESARC) which reports the 12-month incidence of psychiatric disorders in victims of IPV. The study found that approximately one-fifth of those victimized in the previous 12 months have a new onset psychiatric disorder, and that the risk of new onset was related to the frequency of acts of violence. IPV is associated not only with an increased risk of posttraumatic stress disorder, major depressive disorder and substance use disorders, as previously reported, but also with bipolar disorder, panic disorder, and generalized anxiety disorder.

NO. 2 COLLABORATIVE EFFORTS BETWEEN THE IPV COMMUNITY AND THE PSYCHIATRIC COMMUNITY

Speaker: Obianuju "Uju" J. Obi, M.D., M.P.H.

SUMMARY:

Individuals who experience intimate partner violence (IPV) are more likely to suffer from mental health problems compared to those who do not experience IPV. Given the high comorbidity between IPV and mental health disorders and the efforts to reform the healthcare field towards a medical home model, fostering collaborations between IPV agencies and psychiatric treatment services should be essential. However, IPV services and psychiatric services have unique histories that lead to distinct ways of service delivery and can lead to cultural barriers in working together. This presentation will identify novel strategies for partnership and explore the nuances of why such fields have been isolated.

NO. 3 IPV OUTCOMES IN WOMEN WITH POSTTRAUMATIC STRESS DISORDER AND SUBSTANCE USE: A SECONDARY ANALYSIS OF NATIONAL INSTITUTE ON DRUG ABUSE CLINICAL TRIALS

NETWORK WOMEN AND TRAUMA MULTISITE STUDY

Speaker: Denise Hien, Ph.D.

SUMMARY:

Despite known linkages between intimate partner violence (IPV), posttraumatic stress disorder (PTSD) and substance use disorders (SUD), research on the dual diagnosis of PTSD-SUD and its relationship to IPV is in an early stage. The current study is a secondary analysis of a larger NIDA Clinical Trials Network study exploring the effectiveness of two behavioral interventions for women with comorbid PTSD-SUD. Participants (n =288) were randomly assigned to Seeking Safety, a cognitive-behavioral treatment focused on trauma and substance abuse symptoms, or to Women's Health Education, a psychoeducational group. Participants who were abstinent at baseline were significantly less likely to experience IPV over the follow-up period, whereas participants living with someone with an alcohol problem were significantly more likely to experience IPV over follow-up. A significant interaction between treatment condition and baseline abstinence was found. Participants who were abstinent at baseline and in the Seeking Safety condition were significantly less likely to report IPV over follow-up. These findings indicate that an integrated treatment for PTSD and SUD was associated with significantly better IPV outcomes for a subset of individuals. Further research examining the intersection of PTSD, SUD and IPV and the impact of treatment on a range of outcomes is needed.

NO. 4

THE WOMEN'S RECOVERY GROUP: TAILORING GROUP THERAPY FOR WOMEN WITH SUBSTANCE USE DISORDERS

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

SUMMARY:

The Women's Recovery Group (WRG) is a relapse-prevention group designed to treat women with substance use disorders (SUD) who are heterogeneous with respect to specific substance of abuse, presence of co-occurring psychiatric disorders, trauma histories, and age/stage of life. It has gender-focused content and is delivered in single-gender format. Participants in the Stage II randomized

controlled trial, had significant reductions in mean days of substance use at end of group treatment and at the 6 month post-treatment follow-up. The WRG provides education, discussion of relapse prevention, and skills practices to help women identify the way in which clinically significant issues (e.g., domestic violence and abuse, reproductive health, and family and partner concerns) play a role in relapse risk, and to problem-solve managing these risks in the course of recovery. The WRG provides an effective single-gender, women-focused group therapy component of treatment that can be delivered in the context of mixed-gender outpatient, partial, or residential treatment. It is a replicable, manual-based group therapy for women with women-focused content that can be implemented in an open-enrollment format in a variety of clinical settings and may provide a component of treatment for women with interpersonal violence histories in treatment for SUD.

NO. 5

NEW YORK CITY FAMILY JUSTICE CENTERS OF THE MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE

Speaker: Margarita Guzman, J.D.

SUMMARY:

The Mayor's Office to Combat Domestic Violence (OCDV), established in 2001, oversees the citywide delivery of domestic violence services, develops policies and programs, and works with diverse communities to increase awareness of domestic violence. Among several initiatives, OCDV operates the New York City Family Justice Centers (FJCs) which provide comprehensive civil legal, counseling and supportive services for victims of domestic violence, elder abuse, and sex trafficking. Located in the Bronx, Brooklyn, Queens and Manhattan, the FJCs are supportive, non-judgmental environments that provide holistic services to victims of all ages, genders and sexual orientations, regardless of their immigration status. Key City agencies, community, social and civil legal service providers, and District Attorney's Offices are located on-site at the Centers to make it easier for victims to get help. Since the first FJC opened in 2005, the Centers have assisted over 110,000 clients. This year, from January 1 through September 7, 2014, over 12,000 clients

have been assisted. This presentation will describe the range of services provided by the New York City Family Justice Centers (FJCs), and a new initiative to provide psychiatric services on-site.

ESTABLISHMENT, MAINTENANCE, AND ASSESSMENT OF A CLINICAL TELEPSYCHIATRY PROGRAM IN AN ACADEMIC MEDICAL CENTER

Chairs: Joseph Pierri, M.D., Kenneth Nash, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify telepsychiatry as a practical solution to deliver psychiatric care to underserved areas.; 2) Understand how to establish a telepsychiatry clinic using established best practice guidelines.; 3) Identify potential tools for assessing patient and practitioner outcomes.; 4) Consider models for involvement of advanced psychiatry trainees in the practice of telepsychiatry.

SUMMARY:

There is a nationwide shortage of psychiatrists and this shortage is most pronounced in rural and underserved areas. To address this need in rural Pennsylvania, the Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center has collaborated with our medical assistance managed care affiliate to create a telepsychiatry program using innovative technologies to provide services to individuals with very limited access to psychiatric care. We established our telepsychiatry clinical service based on best practices recommended by the American Psychiatric Association, the American Telehealth Association, and the American Academy of Child and Adolescent Psychiatry. Using these guidelines, we developed a protocol for establishing a clinic, training psychiatrists, and providing ongoing patient care via videoconferencing. We have collaborated with our technology development team to evaluate and test several iterations of video teleconferencing technology overtime. Currently there are eight psychiatrists in our program who provide ongoing psychiatric care to eight different remote clinical sites. Our psychiatrists will have 4000 clinical encounters this year. We have collected data on how patients acclimate to telepsychiatry and on their

satisfaction with the care provided. We have also collected data on our psychiatrists' perception of the care they deliver. Both patients and psychiatrists rate their experiences positively. Our telepsychiatry program also incorporates advanced psychiatric residents as providers of care, as we anticipate that telepsychiatry will be an important means for delivery of psychiatric services in the future.

NO. 1 INITIATION OF A CLINICAL TELEPSYCHIATRY PROGRAM IN PENNSYLVANIA: THE SITUATION AND CHALLENGES

Speaker: Jack Cahalane, M.P.H., Ph.D.

SUMMARY:

There is a critical shortage of psychiatrists and especially child psychiatrists in most areas of rural Pennsylvania. Psychiatry tends to be an academically oriented profession with a frequent emphasis on research and teaching and as a result psychiatrists tend to gravitate to urban areas where they can pursue these interests at academic centers. In rural areas these shortages can be quite pronounced and there are some counties in Pennsylvania where there are no psychiatrists practicing and or residing. Where psychiatrists are available to provide services, they are typically trained in adult psychiatry. This leaves them in the position of being asked to provide services to adolescents and children even though they lack the requisite fellowship training in child psychiatry.

Telepsychiatry is a way to address this clinical need by providing psychiatric services from urban areas to consumers in rural areas via remote interactive video link. Teleconferencing technology has been readily available for some time but its use in providing psychiatric services has increased only gradually over the years. Practitioner preference for face to face, on site, contact as well as regulatory and third party reimbursement has hampered the adoption of this technological solution to the urban/rural disparity in psychiatrist availability.

NO. 2 A CLINICAL PARTNERSHIP WITH A MANAGED CARE ORGANIZATION

Speaker: James Schuster, M.B.A., M.D.

SUMMARY:

The project was undertaken by Western Psychiatric Institute and Clinic and Community Care

Behavioral Health Organization, a behavioral health managed care organization (MCO). The MCO

had substantial knowledge of the resources (or lack thereof) of the providers in the rural regions and saw it as part of their responsibility and duty to maintain a less regional and more statewide

approach to network access to behavioral health services. The MCO identified providers of ambulatory behavioral health services in rural areas who were reporting a shortage of trained psychiatrists. To maintain access to services consumers were frequently seen for intake appointments by a trained master's-prepared clinician who would develop a plan of care. This

usually included a combination of psychotherapeutic and pharmacologic interventions. The agency typically had the ability to begin the psychotherapeutic intervention but lacked the resources to

initiate pharmacologic interventions in a timely manner if at all. The consequences of this delay places a burden on individuals, families and the community as well contributes to an increase in the

utilization of emergency and inpatient psychiatric services. The telepsychiatry program addressed

these issues by providing access to a highly trained psychiatrist in a timely manner.

NO. 3 IMPLEMENTATION OF BEST PRACTICES IN SETTING UP A TELEPSYCHIATRY CLINIC

Speaker: Joseph Pierri, M.D.

SUMMARY:

Operational planning meetings took place prior to the initiation of psychiatric services via video link, and during these meetings a list of nineteen operational issues were identified and reviewed prior to initiation of services. A critical component in this project was the use of an on-site liaison at the local mental health center. The liaison was a mental health professional,

typically either a nurse or social worker and acted as the onsite champion for the patient's telepsychiatry experience. This individual's role was to be present with the consumers at the remote site during the telepsychiatry sessions. This is especially critical when children and adolescents are seen and is also important when the psychiatrist sees adults. The onsite liaison and the psychiatrist initiate a short meeting prior to the psychiatrist seeing patients that day. The telepsychiatry sessions are reserved in four-hour blocks and during these sessions the psychiatrist provides three hours of face-to-face sessions with one hour reserved for administrative time.

NO. 4 ASSESSING PATIENT AND PRACTITIONER EXPERIENCE

Speaker: Shabana Khan, M.D.

SUMMARY:

Provision of Telepsychiatric services is relatively new in Pennsylvania and our involvement with the Behavioral Health Special Interest Group of the American Telemedicine Association has informed the development of our telepsychiatry program. This project focused on assessing the overall level of satisfaction of the psychiatrist providing the service, measuring patient engagement with telepsychiatry, along with an examination of the process of adjustment to, and comfort with, this unique method of service provision. A questionnaire was administered to treating psychiatrist and to individuals receiving care after the first session and again after the third session with the psychiatrist to assess satisfaction with the delivery of care. Satisfaction can also be seen as a proxy variable for engagement, retention and positive clinical outcomes.

NO. 5 TELEPSYCHIATRY IN RESIDENCY TRAINING: LEARNING CLINICAL PRACTICE THROUGH THE GRAPHICAL USER INTERFACE

Speaker: Joseph T. Kelley Victor, M.D.

SUMMARY:

For the past several years, advanced general and child and adolescent psychiatric residents have provided direct care in the telepsychiatry clinic. We have created a training program

involving background reading, observation by experienced telepsychiatrists, and ongoing supervision. Residents also participate in the academic mission of the telepsychiatry service. Two residents will present their experiences as trainees, as well as present the data they have collected and analyzed as part of their experience. We will also present plans for the future development of the telepsychiatry training program.

FAITH AND MAJOR DEPRESSIVE DISORDER: DSM-5, THE CULTURAL FORMULATION INTERVIEW, AND TRADITION-BASED RESPONSES

Chair: Abraham M. Nussbaum, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To explore the modest inter-rater reliability of Major Depressive Disorder in the DSM-5 field trials and to appreciate how DSM-5's Cultural Formulation Interview (CFI) is a critical diagnostic tool. ; 2) To understand the particular needs and challenges of Muslims experiencing Major Depressive Disorder.; 3) To describe key elements of screening for depression (with the PHQ-9) and training clergy an evidence-based psychotherapy in African American churches.; 4) To recognize the currents in traditional Jewish thought and community life that may affect how Jews experiencing depression interact with the mental health care system.; 5) To articulate ways that American evangelical and fundamentalist Christian describe depression, as well as influential non-psychiatric treatment models such as "biblical counseling."

SUMMARY:

In the DSM-5 field trials, the criteria set for Major Depressive Disorder was found to have only 'questionable' inter-rater reliability. We will argue that this low reliability may be related to the complex and varied ways in which different cultural and religious communities understand, narrate, and treat depression. We will discuss how the DSM-5 Cultural Formulation Interview (CFI) renews attention to the ways psychiatric disorders are culturally experienced and expressed, and therefore serves as a needed complement for clinicians seeking to understand and treat depression among patients for whom faith is a central marker of

self-identity. To illustrate this, speakers will describe how depression is experienced and treated within four distinct North American cultural and religious contexts: traditional Jewish communities, evangelical and fundamentalist Christian communities, Muslim communities, and African American churches.

NO. 1 MENTAL ILLNESS NOT A SPIRITUAL WEAKNESS: DEPRESSION IN MUSLIM COMMUNITIES

Speaker: Farha Z. Abbasi, M.D.

SUMMARY:

The 1.57 billion Muslims constitute 23% of the world's population and serve as a majority in approximately 50 countries around the world. Muslims constitute an ethnically diverse and multicultural population with uniformity of religious beliefs. Muslims living in West are currently struggling with their identity, fighting isolation and acculturation. Biculturalism issues are leading to intergenerational conflict and domestic violence. Immigrants and refugees are suffering from trauma and displacement. Mental health stressors have been augmented by Islamophobia and negative image being perpetrated by media. The population relies heavily on local Islamic centers for support and resources. To a population where religion and spirituality are big resource of resilience and survival it is inevitable to turn to your local Imam/chaplain in moment of crises. Mental health illnesses are shrouded in stigma and silence. Never acknowledged and hardly treated. Mental health breakdown can easily become crises of faith and spirituality. The "faith blind" approach of western trained clinician can further discourage and alienate this vulnerable population. The disproportionate burden of growing needs of the community and scarce resources has further burdened local Islamic centers and Imams. It is vital to strengthen this community structure by training Imams in Mental health awareness. These Imams should also be assessed for compassionate fatigue and screened for their mental health needs.

NO. 2 EVIDENCE-BASED DEPRESSION CARE IN AFRICAN-AMERICAN CHURCHES

Speaker: Sidney Hankerson, M.B.A., M.D.

SUMMARY:

African American adults with major depressive disorder (MDD) are less likely to use mental health treatment than their white adult counterparts. Various factors contribute to racial disparity including, lack of access to care, distrust of providers, and stigma. Because clergy are regarded as trusted "gatekeepers," they are the primary conduit to mental health education and/or services for socioeconomically diverse African Americans. My funded NIMH Career Development Award (K23) is designed to investigate the feasibility and acceptability of utilizing a community-partnered participatory research (CPPR) approach to support clergy in implementing Interpersonal Counseling (IPC) in faith-based settings. IPC is a manualized, evidence-based depression intervention with demonstrated efficacy across racial/ethnic groups. It is directly derived from Interpersonal Psychotherapy (IPT), and can be effectively delivered by non-mental health professionals such as clergy. The intervention consists of 3-sessions within which the provider identifies depression, defines its interpersonal context, provides education and hope, suggests strategies for handling problems, and refers clients to a higher level of care, as needed.

NO. 3**"AND YOU SHALL REJOICE ON YOUR FESTIVAL AND BE ONLY JOYFUL": DEPRESSION IN TRADITIONAL JEWISH COMMUNITIES**

Speaker: Marta Herschkopf, M.D.

SUMMARY:

Some studies suggest a higher incidence of mood/anxiety disorders amongst traditional/Orthodox Jewish communities compared to the general population, members of such communities are often hesitant to seek out mental health services for a variety of reasons, including stigma, understanding their symptoms as part of a spiritual ailment, and concerns that treatment options would involve transgressing Jewish laws. Partnering with clergy or other community leaders is often helpful and at times essential to engaging such patients. These members of the community can serve not only as referral sources, but also as cultural brokers to help clinicians and patients

navigate concerns of what is or is not permissible according to Jewish law. This talk will explore discussions of depression, grief, and joy in traditional Jewish thought, as well as the barriers and resources available to help treat depression in modern traditional Jewish communities.

NO. 4**"WHEN SORROWS LIKE SEA BILLOWS ROLL": DEPRESSION IN EVANGELICAL AND FUNDAMENTALIST CHRISTIAN COMMUNITIES**

Speaker: Warren A. Kinghorn, M.D.

SUMMARY:

Over 25% of Americans self-identify as evangelical or fundamentalist Christians. For many participants in evangelical or fundamentalist Christian communities, faith and religious belief provide the central framework within which all of life is interpreted and lived. These communities, however, are quite diverse in their approaches to mental health and mental illness. While some evangelical and fundamentalist approaches to depression are highly critical of psychiatry and psychiatry's diagnostic language, insisting that depression be interpreted as a theological or spiritual problem, others are much more accommodating of the DSM and of modern psychiatric interventions. This presentation will feature a discussion of three important and diverse movements within evangelical and fundamentalist Christian communities: the "integrationist" movement, which is respectful of modern clinical psychology and seeks to integrate psychological concepts with Christian belief; the "Biblical counseling" movement, which rejects much of modern psychology and psychiatry and recommends that Christians receive counseling primarily from clergy; and the "health and wealth" teaching of proponents of the "prosperity gospel." Clinicians who wish to provide culturally sensitive care to depressed individuals from evangelical or fundamentalist communities need to be aware not only of these movements but also of the faith commitments and social contexts from which they emerge.

WOMEN'S ISSUES IN MINORITY AND UNDERREPRESENTED GROUPS

Chairs: Gail E. Robinson, M.D., Stephen A. McLeod-Bryant, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize issues women face in different minority groups; 2) Understand the consequences of domestic violence in the black population.; 3) Identify the additional struggles of LGBT women with mental illness. .

SUMMARY:

Women are part of any minority or underrepresented group. There are general issues that all women face as well as specific issues that may be relevant in different minority groups. Overall there is an increasing feminization of poverty. Women are more likely to be victims of domestic violence. Many inner city black women are struggling to raise children on their own. Native american women risk losing their status if they marry non-natives. Lesbian women dealing with mental illness may be underserved and discriminated against. Minority females of all ages may face obstacles to obtaining mental health care due to stigma, lack of resources or culturally insensitive programs. This symposium will provide an overview of these problems faced by women in general and specific groups of minority women

NO. 1

AFRICAN-AMERICAN WOMEN WITH HISTORY OF ABUSE AND INCARCERATION

Speaker: Rahn Bailey

SUMMARY:

According to the study "Black Women in the United States, 2014" released by the National Coalition on Black Civic Participation Black Women's Roundtable, "Black women are especially likely to be a victim of violence in America. In Fact, no woman is more likely to be murdered in America today than a Black woman. No woman is more likely to be raped than a Black woman. And no woman is more likely to be beaten, either by a stranger or by someone she loves and trusts than a Black woman. Black women remain more likely than any other group of women in America today to go to prison." It is estimated that 1 in 100 African American women are in prison. They are 3 times more likely to be imprisoned than their

white counterparts. Despite their sustained presence in prisons and jails, the voices of Black women are often excluded from discussions about criminal justice and correctional systems. Like black women under slavery, women in contemporary prisons are subjected to institutionalized sexual abuse. Racial stereotypes of black women as promiscuous, criminal and prone to violence make it more difficult for law and society to recognize their victimization and more likely that they will be scrutinized as sexual deviants and potential criminals. The attendees will receive an overview of the intriguing paradoxes of black inmates as mothers, as women with reproductive rights and as women in general.

NO. 2

FEMINIZATION OF POVERTY AND MENTAL HEALTH

Speaker: Ludmila De Faria, M.D.

SUMMARY:

Current census and epidemiologic data show that more women than men fall below the poverty line. This is true even in developed countries such as the United States. Poverty disproportionately affects women who are head of households or single parents. It increases stress and may pose a significant risk for women to develop a new and significant mental illness or experience a relapse, further impacting their ability to provide and care for their family. Mental illness contributes to low SES by imposing a barrier to access education and to maintain employment. It may also further alienate family and other support systems, thus perpetuating the cycle. Despite such robust data and the implications for the children being raised in these households, US healthcare policies have failed to address the issue. Current policies limit access to care, including family planning. Establishing programs targeting access to care and creating a safety net in the community for this vulnerable population would have an exponential effect, improving quality of life for mother, children and the community at large.

NO. 3

ENDURING NATIVE WOMEN

Speaker: Linda Nahulu, M.D.

SUMMARY:

Since post contact, the lives of the native, indigenous women of America have drastically changed. Despite the destruction of their traditional roles, the women try to fulfill their responsibilities to family, tribe, and nation. They are placed in the difficult, often distressing position of having to comply with multiple and conflicting social roles. The mental health effects and needs of these women have been, and continue to be, among the highest in the nation. This presentation serves as an introduction to the literature, individual perspectives, mental health issues, including limitations and barriers to access and treatment of this diverse population: American Indian, Alaska Native and Native Hawaiian women. Fundamental and essential to this dialogue is the role of traditional, cultural affiliation that each individual possesses.

**NO. 4
LESBIAN, GAY, BISEXUAL, AND
TRANSGENDER WOMEN**

Speaker: Mary E. Barber, M.D.

SUMMARY:

LGBT women become mothers in different ways, both before and after coming out. LGBT mothers encounter bias and discrimination on the basis of their sexual and gender identities, and LGBT mothers with mental health diagnoses face added burden of stigma related to mental illness. Case examples will illustrate issues that may arise for these mothers. Both LGBT mothers and their children can benefit from affirming treatment services and peer supports.

**NO. 5
WAYS THAT SCHOOL-BASED CLINICS
CAN ADDRESS MENTAL HEALTH
DISPARITIES FACED BY AFRICAN
AMERICAN TEENAGE GIRLS**

Speaker: Ulrick Vieux Jr., D.O., M.S.

SUMMARY:

It is estimated that at least 20% of children and adolescents have an identifiable mental health disorder yet only 20% of these receive any form of treatment. As an estimated 95% of American youths are enrolled in school, this venue is a logical point of entry into mental health services for young people. There is a tendency to define mental health strictly on the basis of mental

illness. As a result, the aim of policy makers has been to focus on emotional disturbance, violence and substance abuse without adequately examining the role of schools in the healthy development of social and emotional functioning. Child and adolescent psychiatrists can: work directly with educational staff to support children with emotional and behavioural needs; consult with social workers and teachers directly about challenging cases; communicate with community psychiatrists, therapists and parents about children's behaviours in school; provide crisis interventions, therapeutic and medication management services as the primary clinician. psychiatric services are greatly important to school environments and a child and adolescent psychiatrists can provide seminars to help staff, parents and the treatment team to better understand complex mental health issues; and act as advocates for the child and family. Attendees will get an understanding of the basic foundation of a school-based mental health program and how it can help diminish health disparities for African American females.

**NATIONAL ACTION ALLIANCE FOR
SUICIDE PREVENTION:
RECOMMENDATIONS FOR
PREVENTION FROM THE SUICIDE
ATTEMPT SURVIVORS TASK FORCE
REPORT**

Chair: Steve Daviss, M.D.

Discussant: Dinah Miller, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the Core Values most shared by suicide attempt survivors.; 2) List the Recommendations that were included in the National Action Alliance for Suicide Prevention Report, "The Way Forward," which seeks to prevent suicide by promoting national strategies.; 3) Explain the implementation of the National Strategy for Suicide Prevention and the framework for stakeholders to use when developing resources and initiatives to prevent suicide.

SUMMARY:

The stigma around suicide is often associated with whispers or silence, despite the fact that prevention of suicide is a national priority. The National Action Alliance for Suicide Prevention

convened a national task force of suicide attempt survivors last year, releasing a groundbreaking, federally funded report called The Way Forward. The goal of this report is to provide a framework for national, state, and local stakeholders to use when developing resources and initiatives to prevent suicide as part of the National Strategy for Suicide Prevention (NSSP).

This groundbreaking report identified eight Core Values and seven Recommendations that are helping to catalyze major changes in the national approach to suicide prevention and response. The speakers will discuss ways in which clinicians and others can bring the report's recommendations to life and open channels of communication and awareness around the topic of suicidal thinking.

Speakers include symposium chair, Steve Daviss, MD DFAPA, past president of the Maryland Psychiatric Society and co-author of the book, "Shrink Rap: Three Psychiatrists Explain Their Work;" and discussant, Dinah Miller, MD, co-author of "Shrink Rap" and author of the upcoming book, "Committed: The Battle Over Forced Psychiatric Care."

Presenters are listed in the Part B Presenters.

NO. 1 THE NATIONAL SUICIDE PREVENTION LIFELINE

Speaker: John Draper, Ph.D.

SUMMARY:

The Project Director for the National Suicide Prevention Lifeline will discuss his experiences with the Lifeline.

NO. 2 THE NATIONAL ACTION ALLIANCE SUICIDE ATTEMPT SURVIVOR TASK FORCE PRESENTS GUIDANCE FROM RESEARCH AND LIVED EXPERIENCE

Speaker: DeQuincy A. Lezine, Ph.D.

SUMMARY:

The National Action Alliance for Suicide Prevention's Suicide Attempt Survivor Task Force has created "The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience". To our knowledge, this resource is unprecedented in that it provides consensus recommendations for programs, practices, and policies guided by lived

experience, published research, and expert opinion. The presentation will briefly describe the background and development of the document, outline its key concepts and discuss recommendations that are most relevant to the psychiatric community. The Core Values for suicide prevention identified by the Task Force will be highlighted as they are vital to understanding what attempt survivors would find to be helpful. The presentation will also discuss concepts and recommendations from the six major areas that have been identified: Peer Inclusion; Family, Friends & Support Networks; Mental Health & Medical Care; Continuity of Care & Systems Linkages; Crisis & Emergency Care; and Community Outreach & Education.

NO. 3 WORKING WITH PEOPLE WHO HAVE BEEN SUICIDAL VIA SOCIAL MEDIA

Speaker: Dese'Rae L. Stage, B.S.

SUMMARY:

This presenter will discuss how social media and contact with real people who've been suicidal can be crucial in bringing this high-risk but long-neglected population into the conversation -- and without fear.

NO. 4 SOCIAL MEDIA AND SUICIDAL TALK

Speaker: Cara Anna, B.A.

SUMMARY:

The editor for the Talking about Suicide blog and the What Happens Now blog talks about how people with suicidal thoughts use social media.

WORKSHOPS

MAY 16, 2015

CHILDREN OF PSYCHIATRISTS

Chairs: Michelle Riba, M.D., Leah J. Dickstein, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) know about psychiatrists' children's experience growing up; 2) know about the challenges of parenting from other member psychiatrists; 3) share ways to improve our abilities to parent, as psychiatrists

SUMMARY:

This is an annual workshop in which children of psychiatrists discuss their experiences. The "children" are young, old, from countries throughout the world. Their stories are fascinating, rich and so instructive to our members. We care deeply about our children and the impact of our professions on their development. This workshop is always exciting and we come away appreciating how important it is to discuss the topic and receive feedback from our children.

MODELS OF MENTAL HEALTH COLLABORATION IN PEDIATRIC PRIMARY CARE

*Chairs: Shireen Cama, M.D., Barry Sarvet, M.D.
Speakers: Marian F. Earls, M.D., Katherine E. Grimes, M.D., M.P.H., Amy Cheung, M.D., M.Sc.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the need and potential role for collaborative care between primary care pediatrics and psychiatry; 2) Describe different models of mental health collaboration within primary care pediatrics; 3) Discuss the benefits and challenges of different collaborative models; 4) Consider each collaborative model's potential applicability in one's own community

SUMMARY:

Increasingly, pediatricians are being asked to evaluate and treat mental health problems faced by patients in primary care. Almost half of all

pediatric office visits address emotional, behavioral, psychosocial, developmental, and/or educational issues. The primary care environment is in many ways an ideal setting for delivering mental health interventions for youth. However, there are many challenges faced by pediatricians in these situations. Partnerships with psychiatrists and other mental health specialists can prove instrumental to ensuring that children and adolescents with psychiatric concerns are effectively identified, diagnosed and treated. This workshop aims to engender discussion about the emerging and evolving partnerships between pediatric primary care and psychiatry. Dr. Marian Earls will present an overview of the need for psychiatric collaboration within pediatric primary care from a pediatrician's perspective. Three models of mental health service delivery in a primary care setting will be discussed. Dr. Amy Cheung will discuss initiatives designed to enhance primary care practitioners' abilities to address mental health problems in their patients. Dr. Barry Sarvet will present data supporting a consultative model of care, using the Massachusetts Child Psychiatry Access Project (MCPAP) as an example. Dr. Katherine Grimes will discuss the integrative model of mental health delivery and its place within the medical home. Dr. Shireen Cama will then present a case study, and panelists will be asked to describe how that particular case could be addressed in the delivery model on which they are presenting. Similarities and differences between the models will be highlighted. Workshop participants will be asked to discuss their experience and opinions regarding each of the models and their thoughts on how mental health needs of children are being met in their own communities

EEG IN PSYCHIATRIC PRACTICE

Chairs: Oliver Pogarell, M.D., Nashaat N. Boutros, M.D.

Speakers: Oliver Pogarell, M.D., Nashaat 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 participants will have a complete grasp of the general indications and specific diagnostic uses of the clinical EEG. They will develop an understanding of how EEG can be useful in monitoring ECT and pharmacotherapy. Attendees should also be able to understand the limitations of EEG and broad categories of pathophysiology that produce EEG abnormalities.

USE OF SOCIAL MEDIA AND THE INTERNET TO EDUCATE THE MASSES: INCREASING AWARENESS AND DECREASING THE STIGMA OF PSYCHIATRY AMONGST MINORITY POPULATIONS

Chair: Wilsa M.S. Charles Malveaux, M.A., M.D.

Speakers: Jeffrey A. Borenstein, M.D., Racquel Reid, M.D., Chuan Mei Lee, M.D., Vandai Le, M.D., Tiffani Bell, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Illuminate the amount of access minority groups have to credible information about mental health via the internet and social media. 2) Identify the major themes minority groups discuss when addressing mental health, e.g. attitudes toward diagnosis, treatment, and media perception. 3) Describe the means various minority groups use to connect with other minorities about mental illness, stigma, and access to mental health.; 4) Elucidate the differences among specific ethnic minorities within the US in view of psychiatry especially as it pertains to social media.; 5) Explore ways psychiatrists can use social media and the internet to change the dialogue about psychiatry amongst minorities and break barriers.

SUMMARY:

The question of how social media and the Internet permeate daily life and impact the administration of mental health care in the United States has been of particular interest to researchers inside and outside of medicine in recent years. Increasingly over the past decade, more people have largely obtained their information about psychiatry or psychiatric services from the Internet. Social media, or Internet-based applications centered on user-generated shared content, has revolutionized the way people discuss mental illness, and studies have demonstrated how patients with severe mental illness are portrayed as dangerous. Furthermore, the possibility of media as a conduit for psychological trauma, especially after a national tragedy, has generated concern. Of particular interest is the impact on ethnic minorities of stigma toward mental illness. In many ethnic-minority communities, while the reasons behind stigma may vary, there is even more pressure from within minority communities, not to seek psychiatric care. Research demonstrates that while certain minority groups are at increased risk for mental health disorders due to acculturative stress and trauma, stigma

surrounding psychiatric care has been perpetuated by family members, friends, and other individuals in the community, with whom patients more easily come into contact via social media. While access to the Internet and social media has grown, there has been little research done on the ways individuals with mental illness use social media, nor have there been sufficient studies on how psychiatrists can incorporate these technologies in the education and treatment of their patients, and others in need.

This workshop first aims to identify the access of minorities to various forms of social media, how they tend to discuss mental health on these outlets, and the common themes regarding psychiatry and mental illness. It also seeks to identify the stigmas to pursuing mental health perceived by different ethnic minorities and how these views may vary based upon the type of platform used, e.g. Facebook, Tumblr, LinkedIn, MSN Messenger, and Twitter. Presenters will draw on cross-disciplinary examples from other areas of study, including sociological, epidemiological, marketing, and communications, and will integrate information on how other health professionals use these tools. The workshop will conclude with an educated discussion on specific ways that psychiatrists can effectively use social media and the Internet as a whole to change the dialogue about psychiatry amongst minorities, and break down barriers to mental health care.

Keywords: Social media and mental health; stigma of psychiatry; psychiatry in the media; information technology and psychiatry.

**NOTE: This workshop is endorsed by both the APA/SAMHSA Minority Fellows, and the APA Council on Communications.*

U.S. AND LOW- AND MIDDLE-INCOME COUNTRIES MODELS OF EDUCATION AND TRAINING ON GLOBAL MENTAL HEALTH

Chairs: Milton Wainberg, M.D., Bibhav Acharya, M.D.

Speakers: Donald R. Banik, D.O., M.P.H., Muhammad Irfan, M.B.B.S., M.S., Roy A. Kallivayalil, M.D., Carla Marienfeld, M.D.

EDUCATIONAL OBJECTIVE:

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

of global mental health (GMH) training for medical students, residents, fellows and general practitioners; 2) Learn cost-saving GMH training models in the US and low- and middle-income countries; 3) Recognize how these efforts contribute towards developing novel and feasible packages of care to reduce the global burden of mental illness; 4) Describe the impact of these GMH trainings within the institution who provide GMH training to their students and residents; and 5) Examine the ethical concerns associated with GMH training programs.

SUMMARY:

Global health education and training opportunities in medical, nursing and other health-related fields are common in undergraduate, graduate and post-graduate schools. With the grave concern of the high global burden of mental disorders together with the lack of resources in low and middle-income countries to provide mental health care and/or to train mental health providers, educators and researchers, global mental health education and training has become a clear priority. Diverse models of education and training on global mental health have been developed to help generate the teachers, providers and researchers that will lead the field of global mental health. These models or programs train: 1) local primary care providers and general practitioners to provide the needed care and train supervisors to maintain these programs; 2) local educators who will then train those that will provide care; 3) local researchers to develop local mental health research agendas; 4) US medical students, psychiatry residents and child psychiatry fellows to engage them in examples 1-3.

Our workshop will present examples of US and international-based efforts to promote global mental health education, training and research. The panel will discuss ethical considerations in training approaches focusing on clinical, research, and educational global mental health work done by US-based trainees in developing countries as models towards capacity development abroad.

MAINTENANCE OF CERTIFICATION # 4-PERFORMANCE IN PRACTICE: MAKING IT WORK IN YOUR PRACTICE

Chairs: Farifteh Duffy, Ph.D., Tristan Gorrindo, M.D.

Speakers: Farifteh Duffy, Ph.D., Margo D. Lauterbach, M.D., Tristan Gorrindo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize and learn about ABPN MOC program requirements including PART IV Performance in Practice (PIP) requirements for practice assessment; 2) Identify APA educational activities and products to support preparation for ABPN MOC requirement; and 3) Demonstrate acquired practical skills for practice assessment using the PIP, and implementing improvement(s) in clinical settings.

SUMMARY:

A major challenge for clinicians is the need to maintain expertise in the face of an ever-expanding evidence base. Traditional didactic approaches to education show limited success in changing practice and clinical practice guidelines can be hard to apply at the level of an individual patient or an organization. Consequently, there is still a substantial gap between recommended evidence-based practices and actual clinical care (IOM, 2001).

The American Board of Medical Specialties and the American Board of Psychiatry and Neurology require 4-part Maintenance of Certification to facilitate physician lifelong learning, competence, and practice improvement. The four parts include: professionalism and professional standing (Part I), lifelong learning and self-assessment (Part II), assessment of knowledge, judgment and skills (Part III), and improvement in medical practice (Part IV). In response to MOC requirements, American Psychiatric Association (APA) has developed a host of educational programs and products, including a number of Performance in Practice (PIP) clinical modules to facilitate Part IV physician practice assessment. The PIP clinical modules translate conceptual information from practice guidelines into practical steps, providing an active learning experience that supports integration of evidence-based best practices into clinical care. Psychiatrists are required to complete one PIP unit during a 10-year MOC program. Each PIP unit consists of clinical module (focus of this workshop), and feedback module. Each clinical module involves 3 stages:

STAGE A: is a baseline retrospective chart review of at least 5 patients in a specified

category. Delivered care is then compared to "published best practices, practice guidelines or peer-based standards" as outlined in each PIP clinical module

STAGE B: involves design and implementation of a clinical practice improvement plan

STAGE C: includes follow-up re-measurement via a second chart review of 5 patients in the same category within 24 months of fulfilling Stage A.

In addition to reviewing the three stages of PIP clinical module, this workshop will provide opportunity for questions and review of examples aimed at helping clinicians prepare for Maintenance of Certification (MOC) Part IV practice assessment requirements. Successful implementation of PIP modules in clinical practice could change the way in which new scientific information is adopted and disseminated by clinicians, thus lessening the current gap between evidence-based best practice and actual care.

EMPATHY: TO TEACH, TO LEARN, TO PRACTICE

Chairs: Adriana Foster, M.D., James Lomax, M.D.

Speaker: Dawnelle Schatte, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the implications of empathy training on physicians professional development; 2) Appraise available methods used to introduce empathic communication in medical training; and 3) Devise an approach to utilize empathy training or assessment in clinical or educational programs

SUMMARY:

Physician's empathy shortens the duration of the common cold and decreases diabetes complications. In psychiatry, therapist's empathy positively influences therapeutic alliance and treatment outcome. Patient narratives, communication skills training and experiential learning can effectively teach empathy. Reports abound showing that empathy decreases as the students and residents progress in their medical training, thus reinforcement of empathic skills is necessary throughout medical school, specialty training and further along, in clinical practice.

We present three approaches to teach and reinforce empathy: 1) an interaction with a

virtual patient with depression, followed by immediate feedback about the trainee's empathic response and an ensuing interview with a standardized patient; 2) the use of students' personal reflection on a difficult patient encounter with a drug-seeking patient; 3) a multi-targeted approach including live interviewing by senior faculty, empathy readings and recorded trainee interviews.

We will illustrate these approaches by presenting a range of students' responses to empathic opportunities in virtual patient scenarios and standardized patient interactions. We will show provocative stimuli which would be challenging for the resident to maintain an empathic stance. We will discuss trainees' responses to moments when they have a chance to identify with patients and implications of empathy on transference, self-disclosure and boundaries in the therapeutic encounter. We will address the implications of empathy training on psychiatrist's professional development. Finally, we will focus on the potential consequences of empathy training on physicians' job contentment and patients' satisfaction with the therapeutic relationship. All participants will be invited to share their insights about empathy in clinical practice and psychiatric education. We will invite volunteer workshop participants to discuss examples from their own practice and teaching, to illustrate empathy (or lack thereof) in patient encounters.

SECOND GENERATION COLLABORATIONS: CURING THE AILMENT OF POLITICS IN PSYCHIATRIC TREATMENT

Chair: Patrick Hendry, M.D.

Speakers: John P. Daly, M.D., Laysha Ostrow, Ph.D., Leah Harris, M.A., Liza Long, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe political and economic issues in attitudes toward psychiatric practices in the U.S.; 2) Identify common ground between different stakeholder groups for improving U.S. psychiatric care; 3) Discuss family member, practitioner, and patient perspectives on current controversies in patient care; and 4) Engage in collaborative advocacy strategies for a progressive agenda.

SUMMARY:

Families and patients in the U.S. often face difficulties in accessing mental health services, navigating complex service systems, making informed decisions about treatment options, and achieving health and recovery. In the wake of high profile mass shootings, media and public policy discussions have focused on the lack of timely access to and insufficient funding for psychiatric care and social services. Additional social problems that have been the subject of heightened public concern are the increasing trend of treating inmates with mental illness in prison, and lack of law enforcement training in appropriate responses to individuals with mental illness. Mental health advocates generally agree on the nature of the mental health care crisis in America, but rhetoric on political solutions has become increasingly polarized, with little to no cooperation between the factions. Some advocates are seeking to bridge these divides and evolve the public policy conversation using the principles of negotiation, conflict resolution, and dialectical thinking. The workshop, Second Generation Collaborations: Curing the Ailment of Politics in Psychiatric Treatment, will discuss issues of help-seeking and quality of care in the context of an emerging paradigm of collaboration among patient and family advocates, service providers, researchers, and other practitioners. Workshop panelists are young professionals in medical practice, public health research, and patient and family advocacy. John Daly, MD, is a psychiatry resident at University of Southern California, with an interest in child and adolescent psychiatry and women's health. Laysha Ostrow, PhD, is a postdoctoral fellow at University of California San Francisco conducting research on recovery-oriented mental health systems. Leah Harris, MA, is a consumer advocate and Director of the National Coalition for Mental Health Recovery in Washington, DC. Liza Long, MA is a family advocate and founding member of Treatment Before Tragedy, and the author of *The Price of Silence: A Mom's Perspective on Mental Illness* and the viral blog post "I am Adam Lanza's Mother." The workshop will be moderated by Patrick Hendry, Senior Director of Consumer Advocacy at Mental Health America, who has worked in Washington DC and nationally to advance collaboration among multiple stakeholders.

The panelists will discuss current controversies and concrete strategies to overcome

disciplinary and political differences in order to achieve our common objectives in modernizing the U.S. mental health care system. These strategies include addressing nationwide crises in homelessness, unemployment, incarceration, and violence. Discussion will provide diverse perspectives on the political, scientific, and practice agenda for the U.S. mental health care system and its role in building healthy communities and families. This workshop will suggest areas of common ground to advance political debate access to appropriate supports.

ADVOCACY 101: HOW TO SUCCESSFULLY ADVOCATE FOR YOUR PATIENTS AND YOUR PRACTICE

Chair: Jerry Halverson, M.D.

Speakers: Robert P. Cabaj, M.D., Jerry Halverson, M.D., Christina J. Arredondo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how physicians can affect legislative process; 2) identify an advocacy aim and set goals to help achieve the aim; 3) recognize key constituencies that may help or hinder the advocacy aim and have a plan to approach both; and 4) Identify examples of successful advocacy in mental health policy

SUMMARY:

Medical practice is becoming defined more and more by politics rather than what is right for patients. Politicians are increasingly interfering in the physician/ patient relationship. In order to meet the needs of our patients and our core professional values, the ability to advocate for our patients and our profession increasingly recognized as core competence for a successful physician. To be able to practice population medicine at all, the ability of physicians to be appointed to or to influence local, state and national public health agencies is crucial. Most physicians do not have training in how to successfully engage public officials. This workshop is presented by the APA's Council on Advocacy and Government Relations and the presenters will be veterans in this arena. The goal of this workshop is to give the practicing physician a "crash course" in advocacy. We will discuss how why physician advocacy is more important than ever in this era of healthcare reform. We will discuss how to set advocacy goals and then how to set about accomplishing them discussing issues such as

working with other groups inside and outside the house of medicine. We will give examples from different states of successfully accomplished advocacy. There will be ample time for discussion as well as a case example of an "advocacy goal" and how it was accomplished.

RESILIENCY'S ROLE IN FORCE HEALTH PROTECTION: DETERMINING THE EFFECTIVENESS OF INTERNATIONAL MILITARY EFFORTS

Chair: Christopher H. Warner, M.D.

Speakers: Stephanie Belanger, Ph.D., Carl A. Castro, Ph.D., Rakesh Jetly, M.D., Dennis McGurk, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the concept of resiliency, its benefits and limitations, and its impact on military behavioral health issues; 2) Discuss the effectiveness of two distinct military resiliency programs and understand how those programs can be drawn upon in future treatment; and 3) Identify potential strategies for decreasing stigma and improving access to behavioral health care for military service personnel and veterans

SUMMARY:

The past fourteen years has been marked by high operational tempo for both US military forces and their strategic partners. The consequences of repeated deployments to Iraq and Afghanistan coupled with the impact of combat exposure has presented military forces with significant challenges for both the servicemember and their families. While most military personnel and their families have coped well under these difficult circumstances, many perceive varying forms of stress and face some difficulty in coping with it at some point. To address this issue, an increasing number of efforts and strategies are being developed to promote and support psychological resilience to stress for service members and families. Psychological resilience is defined as the capacity to adapt successfully in the presence of risk and adversity. These efforts have not gone without criticism as there has been question about the effectiveness of resiliency development. This presentation will review two current military resilience systems: the United

States Army Comprehensive Soldier Fitness and the Canadian military's Road to Mental Readiness highlighting their differences and similarities of the programs. Researchers from both countries will present findings on the effectiveness of the programs and discuss the future implications for the programs and how they may continue to evolve within their respective military services.

CULTURAL PSYCHIATRY IN INTEGRATED CARE: THE ASIAN-AMERICAN/CANADIAN EXPERIENCE

Chair: Sharat P. Iyer, M.D., M.S.

Speakers: Sharat P. Iyer, M.D., M.S., Albert Yeung, M.D., Francis G. Lu, M.D., Russell F. Lim, M.D., M.Ed., Yu-Heng Guo, M.D., Kenneth Fung, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand concepts of integrated care, including evidence-based models of mental health care in integrated primary care settings; 2) Identify the key facets of the DSM-5 Outline for Cultural Formulation, and the challenges of providing culturally-focused mental health care in primary care settings; 3) Discuss the South Cove Culturally Sensitive Collaborative Treatment model and how it can be adapted to other settings and to serving people of other cultures; and 4) Explain the need for additional training for psychiatry residents to prepare them to serve as clinicians and leaders in culturally-focused integrated primary care settings

SUMMARY:

The purpose of this workshop is to foster a discussion about culturally-focused care in integrated care settings, with a specific focus on people of Asian origin. The goal will be to introduce core concepts of integrated care and cultural assessment, and to foster discussion on how to establish culturally-focused integrated care settings and how to better train psychiatrists to serve in these environments. Providing mental health care to ethnic minorities in North America faces numerous challenges. In the case of people of Asian origin, these challenges can include cultural stigma toward mental illness and mental health care, difficulty expressing psychological symptoms, and the fact that mental illnesses often present with

physical symptoms and signs rather than behavioral or psychological ones. For these reasons, integrated primary care settings can be an ideal venue to address mental health concerns in Asian-American and Asian-Canadian populations. Existing evidence-based models of integrated care provide population-based mental health treatment by using concepts of systematic measurement-based care, care management, and treatment algorithms. However, providing integrated care for ethnic minorities may introduce additional challenges. Appropriate mental health care should assess the impact of culture on the patient and provide care that is reflective of the patient's understanding of illness and the treatments desired. The DSM-5 Outline for Cultural Formulation provides an ideal model to ensure provision of culturally-sensitive care. However, it may be difficult in the fast-paced, measurement-based culture of primary care to fully understand how beliefs, culture and background affect presentation and potential avenues for treatment. The South Cove Community Health Center in Boston, MA has successfully established an integrated primary care setting using evidence-based collaborative care models. In the South Cove model, known as Culturally Sensitive Collaborative Treatment (CSCT), primary care patients of Asian origin are screened with a language-concordant depression screening instrument, and patients with elevated scores are contacted by telephone to schedule an assessment for major depressive disorder as well as cultural concepts of illness and treatment. Diagnosed patients are then provided with treatment and referred to telephone-based case management follow-up. Providers are also working on introducing telepsychiatry into this model. Well-trained psychiatrists will be needed to work in integrated culturally-focused primary care settings such as South Cove. Unfortunately, psychiatry residency programs in North America provide limited training in integrated care or on learning about the cultural formulation or culturally-focused work with ethnic minorities. Additional efforts will be needed to ensure graduating residents are sufficiently ready to serve as leaders in culturally-focused integrated care settings.

**SEXUAL ASSAULT RESPONSE
BEHAVIORS: SCIENTIFIC,**

PROCEDURAL, AND ETHICAL CHALLENGES

Chairs: David E. Johnson, M.D., Philip J. Candilis, M.D.

Speaker: Scott C. Moran, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the difficulties in prosecuting sexual assault crimes; 2) Understand similarities and differences between military and civilian systems for prosecuting sexual assault crimes; 3) Understand the social and cultural misperceptions about sexual assault victims and the meanings inherent to terminology that describes victim behavior; and 4) Understand ethical influences and dimensions of expert testimony on victim behavior.

SUMMARY:

Misconceptions surrounding the behavior of sexual assault victims impair reporting, investigation, and prosecution of sexual assault crimes. Greatly under-reported in both civilian and military settings, these behaviors are the focus of multiple efforts by the US military to improve reporting and prosecution of sexual assaults. Prosecution in the military often involves the use of psychiatric expert witnesses to explain the wide range of victim sexual assault behavior. The term "counterintuitive victim behavior" has arisen to describe this field of knowledge, raising a further concern for the stigmatization caused by the terminology itself. Results from national surveys, the literature, and the authors' own research will describe concepts and terms which may be more appropriate to this difficult social and legal assessment. This workshop explores these and other influences on expert testimony in military sexual assault cases, drawing lessons from Psychiatry's history of naming controversies and management of unsettled areas of science.

PROFESSIONALISM IN SOCIAL NETWORKING: DO'S AND DON'TS FOR PSYCHIATRISTS

Chair: Almari Ginory, D.O.

Speakers: Michelle Chaney, M.D., M.S., M.Sc., Wesley Hill, M.D.

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) Discussion of how to address patients on social networking sites; 4) Discuss real case examples of unprofessional content; and 5) Review of professional and local guidelines regarding social networking.

SUMMARY:

Social networking has become part of one's daily life. Words such as tweeting, blogging, posting, tagging, and selfies have become part of regular vernacular. Young physicians are training in a society where they are transitioning from social users of these sites to professional where patient's are sending them friend requests and searching for information. For more seasoned physicians, they are adjusting to this new technology and incorporating it into their business models. A simple Google search of a physician's name will grant a patient access to their health grades, reviews by other patients, publications, office website, social networking sites 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. Unfortunately, several physicians have made national headlines over information posted on social networking sites. Young physicians should be aware of potential pitfalls of patients have easy accessibility to physicians such as a suicide threat sent via Facebook message, text, or email. However, when used responsibly, these sites can also be beneficial professionally and personally. This is a difficult balance. The purpose of this workshop will be to provide education to residents and medical students about the specific guidelines as they relate to interfacing with social networking sites, in both personal and professional interactions. In previous workshops, there were over an hour of questions related to physician interactions with social networking sites. These questions will be incorporated into the presentation as there appears to be several gray areas that physicians struggle with. We will use real life examples to foster discussion with attendees. The goal will be to have an open forum where attendees can ask questions and discuss issues/concerns.

For residents, the goal will be to provide the education for them to return to their programs and modify policies.

ADMINISTRATIVE PSYCHIATRY IN THE U.S.: CURRENT PERSPECTIVES

Chairs: Geetha Jayaram, M.B.A., M.B.B.S., M.D., Victor J.A. Buwalda, M.D., Ph.D.

Speakers: Geetha Jayaram, M.B.A., M.B.B.S., M.D., Victor J.A. Buwalda, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To describe current administrative tasks of psychiatric leadership; 2) To compare global perspectives on leadership and administration; and 3) To understand pitfalls and hardships encountered in implementing administrative goals .

SUMMARY:

Psychiatric administration enables professionals in mental health care to act primarily in the interest of the patient and to develop a strategic approach on three levels:

1. micro level: organization of the clinical care process
2. meso level: operation of governing boards and directors of mental health institutions
3. macro level: management of global mental health initiatives

In the US, rising economic demands, new alignments and mergers dictate the pressing need for psychiatric leaders to be well versed with budgets, targeting revenues, regulatory demands, credentialing, quality of care, emergency needs, and patient complexities. Good leadership requires hard and 'soft' skills of management, a 360 degree self-assessment, cohesive teamwork clear vocalization of a mission, and alignment with top management. Balancing clinical and administrative needs can be difficult. Successful leadership is based on both task and people related skills and techniques. The American Association of Psychiatric Administrators enhances and promotes these skills.

ADVANCING PUBLIC SERVICE PSYCHIATRY TO MEET UNMET NEEDS: THE NATIONAL HEALTH SERVICE CORPS AND THE IDEA OF THE AMERICAN PSYCHIATRIC SERVICE CORPS

Chair: Kenneth Thompson, M.D.

Speakers: Robert J. Ronis, M.D., M.P.H., Annelle Primm, M.D., M.P.H., Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the elements of public service psychiatry; 2) Appreciate the capacity of the National Health Service Corps to address the health person shortages of the nation; and 3) Describe the ideas behind the concept of the American Psychiatric Service Corps.

SUMMARY:

American psychiatry is plagued by the maldistribution of psychiatrists across the country both in terms of geography and in terms of populations that are underserved. Rural Americans, poor Americans, ethnic and racial minorities, incarcerated Americans are among the people who may have great need for skilled psychiatric care but have often have very limited access to it. Those psychiatrists that serve these complex populations often do so with extremely limited resources and in isolation from the support of the profession. The same is even more true of international work. As a result, the desire of many psychiatrists to be of public service in this nation and elsewhere is overwhelmed by concern about the complexities and challenges of the work involved. This presentation will consider ways the profession might help shift this balance to favor the greater engagement of psychiatrists in public service. Presenters will describe the importance of the National Health Service Corps as a vehicle for promoting national service and outline various initiatives with in the APA that support public service. The concept of the "American Psychiatric Service Corps" will be proposed as a way to engage the profession in supporting and fostering public service community psychiatry.

PRESCRIBING FOOD: CAN DIET INTERVENTIONS REDUCE SYMPTOMS IN CHILDREN WITH MENTAL ILLNESS?

Chair: Douglas Russell, M.D.

Speakers: Judith Pentz, M.D., Drew Ramsey, M.D., Douglas Russell, M.D., Alice R. Mao, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand basic brain nutrition and how it can be achieved through diet; 2) Describe several prevalent dietary interventions for children with mood disorders, ADHD, and ASD; 3) Discuss the evidence base for these dietary interventions; and 4) Integrate this knowledge into a clinically applicable and evidence-based approach.

SUMMARY:

Every day, clinicians who work with children and adolescents are confronted with questions from parents about new, safe interventions for their children with mental illness. Given the rise of health food grocery chains, 'locavore' food culture, the explosion of nutritional and herbal supplementation products, and proliferation of health food blogs on the internet, it is no surprise that these questions are increasingly targeted toward diet. But what advice is good advice? For years, studies focused on diet interventions in mood disorders, ADHD, and autism have been largely heterogeneous, and the data mixed. As a result, many clinicians are hesitant to make definitive recommendations to their patients and families. With this workshop, we will attempt to clarify the growing evidence (positive and negative) for several common dietary interventions for specific conditions in order to help clinicians gain confidence discussing this important topic with their patients and patients' families. The workshop will include four representative panelists. Drew Ramsey, MD (Columbia University) has written extensively on food and brain nutrition, and will begin by discussing food and brain health in children. Judith Pentz, MD (University of New Mexico) will review the data on micronutrient interventions in mood disorders. Douglas Russell, MD (UCLA) will review the evidence for restriction diets and Omega-3 supplementation in ADHD. Finally, Alice Mao, MD (Baylor College) will discuss the evidence regarding gluten and casein free diets in Autism Spectrum Disorders. The workshop will conclude with audience discussion. The intended audience for this workshop includes clinicians working in adult and child and adolescent psychiatry, residents, medical students, those interested in

preventative psychiatry, and anyone interested in complementary and integrative medicine.

THE FUTURE OF MILITARY PSYCHIATRY: INTEGRATING ADVANCES AND LESSONS LEARNED ONTO THE BATTLEFIELD

Chair: Christopher H. Warner, M.D.

Speakers: Rakesh Jetly, M.D., Eric Vermetten, M.D., Ph.D., Monica Lovasz, M.D., Christopher Ivany, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Outline the key advances made in military behavioral health care over the past 15 years and their impact on future military policies and procedures; 2) Recognize the similarities and key differences between US and foreign military service behavioral healthcare; and 3) Identify potential challenges facing military behavioral healthcare in the coming decade and recommend potential interventions to improve the system of care.

SUMMARY:

Since World War I, military mental health providers have played an important role in military medical care. From the establishment of the principles of Forward Psychiatry, to the implementation of Combat Stress Control Teams, to the expansion of peacetime behavioral health care, to the ongoing challenges of identifying and treating service members with PTSD. The past fifteen years have been marked by significant expansion in capabilities both on the battlefield and the home front as well as an increased recognition by military leaders about the impact of poorly managed behavioral health issues. This has led to significant advances in the treatment of individual service members, the development of more established systems of care, and an increased level of understanding about topics such as resiliency, use of medications in a deployed environment, reducing the stigma of seeking behavioral health care, and the determination of biomarkers for diagnosing behavioral health conditions. These challenges and advances are not unique to the US military but rather have been an ongoing challenges for many of our military partners who have fought alongside US service members in Iraq and Afghanistan. This presentation will highlight the

key advances that have occurred in four unique systems of care: the US Army, the US Air Force, the Canadian Army, and the Dutch Army. Presenters will highlight the key advances and lessons learned and also discuss the way ahead for each of those services over the next decade.

HAND-OFFS IN PSYCHIATRY: A HAND TO IMPROVE TRANSITIONS OF CARE

Chairs: Mary Kimmel, M.D., Geetha Jayaram, M.B.A., M.B.B.S., M.D.

Speakers: Yad M. Jabbarpour, M.D., Sunil Khushalani, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand key points where hand-offs as part of Transitions of Care (TOC) occur and current problems with hand-offs; 2) Define important areas of communication and coordination 3) Identify performance improvement methodologies to evaluate current hand-off processes from the systems perspective; and 4) Utilize tools and processes to improve hand-off processes 5) Give input into guidelines for TOC and hand-offs to be used across psychiatry.

SUMMARY:

Background: The Joint Commission has currently a three-year initiative to define methods for achieving improvement in the transitions of patients between health care organizations, which provide for the continuation of safe, quality care for patients in all settings (The Joint Commission, 2012). Transitions of Care (TOC) refer to the movement of patients between health care practitioners, settings, and home. An important part of TOC is the hand-off process. A hand-off (HO) is defined as the transfer of role and responsibility from one person to another in a physical or mental process (Solet, 2005). HO occur in a number of settings, to and from outpatient treatment team to ED provider to inpatient treatment team; from an outgoing treatment team to an incoming treatment team; at shift change, and from provider to provider, including residents. HO have become more frequent with greater numbers of shift changes and with a health care system that has increased in complexity, involving a greater number of care providers involved in the care of each patient. Communication failures including omitted content and failure-prone communication

processes lead to uncertainty in decision-making regarding patient care which can result in inefficient, suboptimal care (Arora, 2005); an estimated 80% of serious medical errors involve miscommunication between caregivers when patients are transferred (Joint Commission Center for Transforming Healthcare, 2013). In addition, high-risk patients might be lost to follow-up during TOC (Picavage, 2012). There is considerable variation in the quality of content of HO (Solet, 2005). Recommendations: Medicine and Surgery have been developed models to improve HO through standardizing the transition process by utilizing mnemonics to help providers involved remember important steps. No uniform approach exists in Psychiatry. We need a structured approach to educating those involved in TOC. A systems view directing all stakeholders to map the current HO processes can help provide insight into the current process and identify sources of communication breakdown. A standardized approach to communicate about medications and the treatment plan is important. It is also important to continually evaluate and improve the HO processes. Specific to psychiatry, acuity in terms of suicide risk and aggression risk must be communicated during HO.

Conclusions: HO processes have become increasingly important to ensure patient safety and quality of patient care. A formalized approach should be applied to assess HO and to ensure a systems approach. There must be standardized protocol to ensure communication of suicide and aggression risk. Support should be given to institutions in order to help them evaluate and improve their HO processes. In addition, a national set of guidelines created for mental health HO would ensure the quality of TOC despite an increasingly complex health care system.

COERCIVE AND NONCOERCIVE ELEMENTS OF MANDATED OUTPATIENT TREATMENT: WHAT PROMOTES RECOVERY? A PRESENTATION, DEBATE AND DISCUSSION

Chair: Serena Y. Volpp, M.D., M.P.H.

Speakers: Louis F. Cuoco, D.S.W., L.C.S.W., Daniel Garza, M.D., Scott Soloway, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the demographic and clinical correlates of Assisted Outpatient Treatment (AOT) "removal" (involuntary transport of an individual with an AOT court order to a psychiatric emergency room); 2) Understand the concept and implementation of voluntary AOT agreements; and 3) Understand the potential role of both the coercive and non-coercive elements of AOT in promoting recovery.

SUMMARY:

With the proliferation of media reports about mass shootings in the past few years, court-mandated treatment has become a popular "solution" to the problem of violence in the public imagination. However Assisted Outpatient Treatment (AOT), also called outpatient civil commitment, involuntary outpatient commitment, or court mandated outpatient treatment remains a source of controversy in the mental health community. Perceptions of AOT range from an unduly coercive imposition of governmental power to a necessary first step for some individuals on their journey towards recovery. The New York City AOT program was established in 1999 and has coordinated care and treatment for thousands of consumers. This workshop using AOT program evaluation data from calendar year 2013, along with a de-identified case vignette, seeks to engender an informed discussion of this issue. It will compare and contrast the coercive and non-coercive elements of the AOT program in New York City which currently serves approximately 1400 individuals. Specifically, using program evaluation data we will briefly examine how the population that is "removed" compares demographically and diagnostically (especially around substance use disorders) with the AOT population as a whole. AOT legislation (Kendra's Law) allows for the involuntarily transport of an individual with an AOT court order to a psychiatric emergency room for evaluation when the treatment plan is not followed and it appears that hospitalization may be necessary. Further, we will examine how these variables correlate with the outcome of the removal. This will be followed by a brief presentation on "voluntary AOT agreements" (monitoring of the consumer and his/her providers without a judicial mandate), and its implementation over the history of AOT, with special reference to its use within the New York

City jurisdiction. These presentations will be followed by a brief debate based on a de-identified case vignette of a consumer currently on or recently graduated from AOT. The debate will focus on whether voluntary AOT has added value over court mandated AOT as an intermediate step towards consumers' autonomous control of their own recovery. Following these presentations there will be ample time for a facilitated audience discussion of both the material presented and the more general question of the role of coercive and non-coercive aspects of AOT in promoting recovery.

THE ROLE OF PEER SUPPORTS IN RECOVERY TO PRACTICE

Chairs: Stephany M. Bryan, Octavio N. Martinez Jr., M.D., M.P.H.

Speaker: Michele R. Guzmajn, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify at least three examples of the role of peer specialists and peer networks in supporting persons with mental health conditions or concerns; 2) Define at least three challenges and strategies to address and overcome barriers in an artificial treatment setting while utilizing peer specialists in a natural community setting; and 3) Identify at least three opportunities to advance peer supports across a variety of health care or social service settings while enhancing participants recovery knowledge, skills and attitudes.

SUMMARY:

During the past few years, the US healthcare systems have faced enormous, rapid and profound changes. The Mental Health Parity and Addiction Equity Act and mental health and substance use service benefits under the Patient Protection and Affordable Care Act are two significant drivers advancing the redesign and delivery of health care services with a focus in improved health care outcomes. As the country continues to grapple with the mental health care workforce challenges and shortages, the role of peers and peer support continues to gain significant momentum as a strategy to augment and support traditional as well as innovative health and mental health services. The Hogg Foundation will describe the role and benefit of utilizing peer support and

peer networks in adult mental health in-patient and community-based settings. By supporting the whole health needs, peer support and peer networks can increase Hope, Personal Responsibility, Education, Self-Advocacy, and Recovery, thus resulting in better health outcomes and increased consumer satisfaction. This presentation will also explore best practices of peer support and share some of the challenges in advancing peer support in mental health settings. The presenters will highlight peer programs located in both urban and rural communities and discuss elements of the peer certification process. From the experiences of this funder, common themes will be extrapolated, and discussion will be facilitated regarding key components of successful implementation of peer support and peer networks, a group exercise to process opportunities and challenges/considerations to launching a peer support or peer network project (approximately 15 minutes) and a report out from each of the groups and Q&A (approximately 15 minutes).

PSYCHOPHARMACOLOGY ALGORITHM FOR MANAGEMENT OF GENERALIZED ANXIETY DISORDER

Chairs: Harmony R. Abejuela, M.D., David N. Osser, M.D.

Speakers: Harmony R. Abejuela, M.D., David N. Osser, M.D., Robert D. Patterson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Diagnose generalized anxiety disorder (GAD) by the DSM-5 criteria; 2) Gain a greater understanding of the evidence-based literature supporting commonly-used first-line medications for GAD; 3) Increase awareness of psychopharmacological options available for management of treatment-resistant and treatment-intolerant GAD; 4) Be able to consider alternative approaches for GAD patients who have certain co-morbidities and be able to understand other features that would change the standard algorithm; and 5) Learn to access the GAD algorithm and other algorithms developed by the Psychopharmacology Algorithm Project at the Harvard South Shore Program on the internet.

SUMMARY:

This is a 2014 revision of previous algorithms for the psychopharmacology of generalized anxiety disorder (GAD) under the auspices of the Psychopharmacology Algorithm Project at the Harvard South Shore Program (HSS), which has recently published six algorithms for other disorders. Previous HSS GAD algorithms from 1999 and 2010 and associated references were re-evaluated. Newer studies and reviews published from 2008-2014 were obtained from PubMed and analyzed with focus on their potential to justify changes in the recommendations of previous algorithms. Exceptions to the main algorithm for special patient populations, such as women of childbearing potential and pregnant women, adolescents, the elderly, and those with common medical and psychiatric co-morbidities were considered. Efficacy and tolerability in both acute and maintenance treatment were the basis for prioritizing treatments. If efficacy, tolerability, and safety were comparable, then costs were considered. Selective serotonin reuptake inhibitors (SSRIs) are still the basic first-line medications for GAD. Early alternatives include duloxetine, buspirone, hydroxyzine, gabapentin/pregabalin, or bupropion. If response is inadequate, then the second recommendation is to try a different SSRI. Additional alternatives now include benzodiazepines, venlafaxine, agomelatine, or herbal remedies like kava. Bupropion is a possibility based on one small randomized clinical trial. Gabapentin may be considered (despite minimal evidence and the absence of efficacy evaluations) as it is very similar to pregabalin, which has undergone many clinical trials and has been approved in Europe for GAD, though it is not approved in the United States for this indication. However, though they are similar, gabapentin is not a scheduled drug, has a more favorable safety profile, and is more affordable than pregabalin. If there is an unsatisfactory response to the second SSRI, then the recommendation is to try a serotonin-norepinephrine reuptake inhibitor (SNRI). Other alternatives to SSRIs and SNRIs for treatment-resistant or treatment-intolerant patients include tricyclic antidepressants, second generation antipsychotics, and valproate. For patients with a validated partial response after an SSRI trial, the recommendation is to consider adding a medication that might augment the SSRI. For this purpose, hydroxyzine, gabapentin/pregabalin, or a benzodiazepine

might be considered. This revision of the GAD algorithm responds to issues raised by new treatments under development such as pregabalin and organizes the evidence systematically for practical clinical application. It differs from previous versions in proposing more alternatives to the usually recommended SSRIs and SNRIs in the event of inadequate response or unacceptable side effects.

FROM RICHES TO RAGS: THE VETERAN AND THE PUBLIC MENTAL HEALTH SYSTEM

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Harold S. Kudler, M.D.

Speakers: Maria Llorente, M.D., Elspeth C. Ritchie, M.D., M.P.H., Harold S. Kudler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ways to help the veteran avoid a decline in mental health functioning and socio-economic status; 2) Treat both PTSD and the many comorbid conditions (eg substance abuse, traumatic brain injury, homelessness); and 3) Assist the veteran who is in the criminal justice system re-integrate into society.

SUMMARY:

Veterans who return to school or work are struggling with difficulty staying focused and on task. When they fail in work or school they become at high risk for suicide. The suicide rate among service members and veterans continues at an unacceptable rate.

Many veterans do not go to the VA for treatment. Those who fall between those cracks may end up in the public state mental health system and/or correctional facilities. In most states the public mental health system has fragile if any connections with the military or VA. The presenters are: 1) the Chief Medical Officer for the Department of Mental Health in Washington DC; 2) The Chief of Psychiatry for the Washington DC VA; and 3) the Acting Chief Consultant for the VA. They are actively trying to integrate the DoD, VA, the public mental health system and the community. Many other states are doing the same, with the assistance of the Substance Abuse and Mental Health Services Administration (SAMSHA) Policy Academy focusing on best practices. Using Washington DC as an example, this lecture will focus on

priorities for veterans, including: 1) economic security; 2) reducing homelessness; 3) improved access to care; 4) enhancing the veteran's ability to stay in school; and 5) minimizing involvement with the criminal justice system. For suicide prevention efforts to be successful, a strategic and concerted effort is needed by all on the home front, including civilian mental health providers, churches, schools, the VA, state and federal agencies.

VIOLENCE TOWARD CARE PROVIDERS IN THE GENERAL HOSPITAL: STRATEGIES FOR ASSESSMENT, TREATMENT, SAFETY, AND RISK REDUCTION

Chairs: Rebecca W. Brendel, M.D., Teresa Rummans, M.D.

Speakers: Sean P. Heffernan, M.D., James R. Rundell, M.D., Lisa Seyfried, M.D., Rebecca W. Brendel, M.D., Teresa Rummans, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn to identify risk factors for violence and aggression in the general hospital; 2) Learn practical strategies for assessing, reducing, and managing violence and aggression by hospitalized patients; and 3) Understand clinical and legal considerations relevant to managing episodes of violence and/or aggression by patients in the general hospital.

SUMMARY:

Health care workers face a high rate of workplace violence. Although care providers frequently minimize or discount assaults by patients as illness-related and routine in the course of care, there are nonetheless risks of injury to both patients and staff. In addition, caring for assaultive patients is often resource intensive and may be associated with long length of stay and challenges for discharge. Especially when care providers perceive violence or assaultiveness by a patient as unmanageable, unending, and/ or intentional, there may be a desire to take legal action in hopes of effecting a solution to caring for a challenging patient. This workshop will use a case example as a departure point for a robust series of commentaries addressing the evidence base for assessing risk of violence and treatment/ reduction of violence, practical

strategies for managing the assaultive/ violent patient, and forensic considerations in managing the assaultive patient in medical and surgical settings. 1) Case Presentation: Dr. Heffernan will present the case of an assaultive patient to highlight the challenges of caring for patients with behavioral dysregulation and violence on a medical unit. Dr. Heffernan will present specific questions for comment and discussion by the remaining speakers during their presentations. 2) Understanding Violence and Aggression: The Evidence Base for Psychosomatic Medicine Practice, James Rundell MD. Dr. Rundell will present key findings of the recent APM Guideline and Evidence Based Medicine Subcommittee and EAPM Monograph on Violence and Aggression. The presentation will focus on assessing the status of the literature regarding correlates of aggression and violence with a focus on key factors raised by the case presentation. 3) medical-surgical floors at a large academic medical center over a one-year period. The discussion will include an analysis of demographic, situational, and clinical characteristics of perpetrators and their acts or threats of violence. Strategies for identifying patients with the highest likelihood of engaging in violence and mitigating risk will be presented. 4) Should We Call the Police? How to Manage the Assaultive Patient When Clinical Efforts Seem Inadequate, Rebecca Weintraub Brendel MD, JD. Dr. Brendel will discuss the factors that may contribute to staff seeking legal options for managing an assaultive/ violent patient. A practical framework for assessing if and when to contact law enforcement, as well as limitations of and alternatives to contacting authorities will be presented.

IMPROVING TREATMENT OUTCOMES: HOW CAN CLINICIANS IMPLEMENT IN THEIR PRACTICE A SYSTEMATIC APPROACH TO PHARMACOTHERAPY FOR LATE-LIFE DEPRESSION?

Chair: Benoit Mulsant, M.D.

Speakers: Zahinoor Ismail, M.D., Kiran Rabheru, M.D., Daniel M. Blumberger, M.D., Mark Rapoport, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess the efficacy and risks of various antidepressants and other

pharmacologic agents in the treatment of late-life depression; 2) appreciate the advantages of a systematic vs. an individual approach to the pharmacotherapy of late-life depression; and 3) identify the impediments to implementing a systematic approach to the pharmacotherapy of late-life depression.

SUMMARY:

Depression is the most prevalent treatable psychiatric disorder in late life. An increasing number of older persons are being treated for depression and pharmacotherapy with antidepressants is the main modality used by psychiatrists and by family physicians. More than 70 placebo-controlled trials and meta-analyses of these trials support the efficacy of these medications. Guidelines based on this body of evidence have been published and disseminated. However, up to half of older depressed patients do not receive adequate pharmacotherapy and most do not benefit from it. The effectiveness of an antidepressant depends more the way it is used than on the specific antidepressant being used. Strong evidence supports that better outcomes are achieved when their use is embedded in structured processes (e.g., algorithm, measurement-based care, care management) as opposed to attempting to individualize treatment.

In this workshop, the panelists will discuss the clinical relevance and applicability of the evidence supporting the benefits and the risks of antidepressant and other psychotropic medications in the treatment of late-life depression. They will focus on the relative merits of a systematic approach to the pharmacotherapy of late-life depression ("treatment algorithmic", "stepped care", "care pathways") vs. an individualized approach ("treatment as usual"). The workshop will be highly interactive: after very brief presentation setting the context, the audience will be invited to participate in these discussions and to share their success and challenges when treating older patients with depression. At the conclusion of the workshop, participants will have improved their ability to optimize outcomes of pharmacotherapy when treating patients with late-life depression.

Mulsant BH, Blumberger DM, Ismail Z, Rabheru K, Rapoport MJ. A Systematic Approach to Pharmacotherapy for Geriatric Major Depression.

Characteristics of Perpetrators of Violence Towards Care Providers or

EFFECTIVE AND SAFE USE OF PSYCH MOBILE APPS: CURRENT TRENDS AND THE FUTURE

Chairs: Steven Chan, M.B.A., M.D., Donald M. Hilty, M.D.

Speakers: Donald M. Hilty, M.D., Steven Chan, M.B.A., M.D., John Torous, M.D., John Luo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the prevalence and significance of mobile devices and apps as an adjunct and modality for psychiatric practice; 2) Name 10 different mobile apps useful for patient and provider; and 3) Distinguish effective and ineffective mobile apps based on security risks, privacy issues, and clinical efficacy considerations.

SUMMARY:

Thousands of smartphone and smartphone-augmented apps (e.g., fitness trackers, smartwatches) for mental health and psychiatric purposes exist, but clinicians have little guidance or tools to effectively evaluate them. These apps can assist with assessment (i.e., ecological 'snapshots' of behavior), decision-support, health promotion and treatment (e.g., monitoring and adherence). As of 2014, no set of self-certification standards has been approved or created by any medical society or governing body, including the American Psychiatric Association, American Psychology Association, National Alliance on Mental Illness, and the Substance Abuse and Mental Health Services Administration.

Technology offers new potentially better ways of assessing patients (e.g., bipolar mood changes). The technology to patients - and if included in assessment by clinicians in a standard way - allows clinicians to monitor patient condition on a daily basis; the literature suggests that most patients have smartphones and the prevalence will increase. Smartphones may facilitate self-report or other measures for mood, reminders for medication adherence, trigger self-CBT strategies to reduce negative thoughts, and provide alternative ideas when faced with the temptation to use substances. For complex patients with personality

dysfunction, there may be 'frame'-stabilizing interventions and DBT apps that facilitate well-being.

Use of psych mobile apps, though, has to be done with great care. Psychiatrists must be aware of the evolving standards of care when engaging in telepsychiatry, with the impact of technology on privacy, boundaries, and communication (e.g., what is best to say in person, by phone, by text or other means). In addition, HIPAA and other privacy issues particularly with recent 'cloud' violations - challenge our area. Another consideration is how social media projects psychiatrists professionally, personally and inadvertently (i.e., Facebook, Twitter). With technology in some cases evolving even faster than either legal or professional guidelines, psychiatrists must be up to date and well-informed regarding best practices for utilizing digital tools.

The APA, AMIA (American Medical Informatics Association), American Telemedicine Association (ATA) and others are moving to provide members with helpful guidance about smartphone apps targeting mental health and psychiatric issues. This workshop will focus on the prevalence of mobile devices and apps as an adjunct and modality for psychiatric practice, consider patient and provider issues, and ask questions for attendees to consider on clinical efficacy, security, privacy issues, and other management issues. It will discuss the latest psychiatric, informatics and technology research to help put the information in context.

HOW I CHOSE PSYCHIATRY: REFLECTIONS ON RECRUITMENT STRATEGIES FOR UNDERGRADUATE-LEVEL MEDICAL STUDENTS

Chairs: Lu Gao, Kien T. Dang, M.D.

Speakers: Kaitlin Baenziger, B.Sc., Melissa Sheehan, Jordan Bawks, B.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the rationale behind active recruitment of medical students into psychiatry; 2) Discuss factors that influence medical students decisions to pursue psychiatry as a career; and 3) Describe strategies for recruiting medical students into psychiatry.

SUMMARY:

Psychiatry is facing a decline in yearly program graduates, despite increasing demands for psychiatric services. From 2001-2008, the annual count of new graduates from American psychiatry programs fell 14% from 1,142 to 985 with a concurrent fall in the total number of programs from 186 to 181 (Faulkner et al, 2011). A 2009 survey of Canadian medical students revealed that just under 3% were interested in psychiatry at the time of entry into medical school (Scott et al, 2009). Faced with such numbers, it would be prudent for departments of psychiatry across Canada and the U.S. to re-examine and optimize strategies for recruiting medical students to pursue the discipline.

The goal of this workshop will be to re-affirm the rationale behind recruitment of medical students into psychiatry, to gain insight into medical student career decision processes, and develop effective recruitment practices in the context of various institutions of medical education. The strategy adopted at the University of Toronto will be presented and discussed by a faculty member of the Recruitment Committee. A panel of medical students, who had been actively involved in planning recruitment events for their peers, will discuss career exploration and decision making. In this workshop, participants will reflect upon their own specialty decision making process, and consider the factors that influence medical students to pursue psychiatry or another specialty. The group will discuss current strategies at their own medical schools for student recruitment, and share successes and obstacles. Finally, participants will brainstorm, discuss, and plan recruitment strategies that will be enacted at their home institutions.

LEARNING BY EXAMPLES: KEY COMPONENTS/DEVELOPMENTAL STEPS THAT LED TO SUSTAINABLE COLLABORATIVE CARE MODELS IN A U.S. SETTING VERSUS A CANADIAN SETTING

Chairs: Mark D. Williams, M.D., Nick Kates, M.B.B.S.

Speakers: Mark D. Williams, M.D., Nick Kates, M.B.B.S.

EDUCATIONAL OBJECTIVE:

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

behavioral care has evolved in our two systems, the forces that have shaped it and the current priorities /goals; 2) Describe the main components in system redesign that include the target population and stakeholders, the available evidence for workable models, measurement tools, and implementation models; 3) Compare similarities and differences in resource utilization between the two systems do you have the right people?; 4) List three of the main barriers to this type of work and examples of ways to work around these challenges; and 5) List examples of ideas that did not work in integrating behavioral health into primary care and reasons why.

SUMMARY:

The APA published the Milliman report (4/2014) that states that the effective integration of medical and behavioral care could save \$26-\$48 billion annually in general healthcare costs. This workshop will bring together two Psychiatrists with over a decade of experience in building integrative care models in two very different settings. We will compare and contrast what has succeeded and what hasn't worked in designing and implementing these models. We will highlight key lessons learnt that are applicable to similar projects in other communities and discuss the potential of these models for improving access, early detection, reducing costs and increasing the capacity of primary care, with many opportunities for audience interaction. This is meant to be a very practical course for those struggling with developing or sustaining an integrated care program in their work environment.

MAY 17, 2015

PROVIDING MENTAL HEALTH SERVICES IN AREAS WITH RESTRICTED HUMAN RIGHTS

Chairs: Obianuju "Uju" J. Obi, M.D., M.P.H., Héctor Colón-Rivera, M.D.

Speakers: Neil Leibowitz, J.D., M.D., Bipin Subedi, M.D., Makeda N. Jones-Jacques, M.D., Linda Piwowarczyk, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To recognize the growing need for adequate mental health services to those in prison systems and immigration

detention centers; 2) Identify the particular adverse effects of having and treating mental health disabilities; 3) Become aware of the psychodynamic implications of working with this population; and 4) Classify what policy strategies can be used to aid those with restricted rights.

SUMMARY:

The United States is unique in that it boasts one of the highest rates of detaining and imprisoning people. Studies have indicated that mental health disorders are highly correlated in areas where people have restricted rights such as in prisons and in refugee/immigrant detention sites. Additionally, these same institutions are also fraught with high levels of violence and trauma. Despite the elevated rates of mental health disorders and trauma that many have suffered and continue to suffer in these institutions, the treatment of psychiatric disorders tends to be limited. Not only is there a large knowledge gap in the psychiatric community on how persons with severe mental illness are managed within prison systems and within immigration detention facilities, mental health professionals who work in these environments are subjected to unique forms of psychodynamic situations that are different from those experienced in the general population. Furthermore, the restrictions placed on both the clients and clinicians lead to complex social dynamics and how care is effectively provided.

This workshop will present an overview of mental health care within prison facilities and immigration detention centers throughout the country. Presentations will be from experienced clinicians who have worked directly with these populations. They will identify key topics that are uniquely prevalent in these settings such as shortages of psychiatric services including bed availability, trauma history, the use of solitary confinement, sexual aggression, and issues working in interdisciplinary environments, among other topics. We will also explore the nuances of witnessed trauma by treating clinicians and how it influences diagnostic interpretation and countertransference issues including the clinician's ability to maintain neutrality and empathy.

PRIMARY CARE AND PSYCHIATRY IN THE MILITARY

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Brian Crowley, M.D.

Speaker: Brian Crowley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the characteristics of PTSD in combat veterans since 9/11; 2) Understand the pros and cons of delivering care for PTSD in the primary care setting; and 3) Learn the results of a large multisite randomized effectiveness trial of collaborative care for PTSD and depression in US Army soldiers attending primary care.

SUMMARY:

Background: Research has shown high rates of war-related trauma, Posttraumatic Stress Disorder (PTSD) and depression among US service members deployed to Iraq and Afghanistan. Often, service members do not seek needed treatment due to stigma and barriers to care. When treatment is delivered, it often fails to meet quality standards. Collaborative primary care can potentially address these issues and improve mental health outcomes.

Objective: To describe the design and baseline characteristics of a large multisite randomized effectiveness trial of collaborative care for PTSD and depression in US Army soldiers attending primary care. Methods: The STEPS-UP Trial (Stepped Enhancement of PTSD Services Using Primary Care) is a 6 installation randomized effectiveness trial involving 18 clinics providing primary care for US Army soldiers. Study rationale, design, enrollment and full baseline sample characteristics are described. Findings: A total of 2,592 soldiers attending primary care with PTSD, depression or both were recruited for the trial. Of those, 666 (26%) met eligibility criteria, received a baseline assessment, and were randomized to 12 months of optimized usual primary care versus optimized usual primary care plus STEPS-UP collaborative management. Reassessments were completed at 3-, 6-, and 12-months. Baseline characteristics were similar across the two intervention groups. Results should be available. Conclusions: The STEPS-UP Trial will be the first large scale randomized effectiveness trial completed in the US Military Health System, assessing the impact of a collaborative primary care approach on mental health outcomes. It offers important lessons for

assessing military health system change.
Keywords: PTSD, depression, collaborative care, primary care, military

CV BOOT CAMP

Chair: John Teshima, M.D., M.Ed.

Speakers: Marcy Verduin, M.D., Sarah B. Johnson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how to create a Curriculum Vitae (CV) that is effective for employment and/or academic promotions; 2) Receive feedback and critique on their current Curriculum Vitae (CV); and 3) Network with mentors in academic medicine.

SUMMARY:

A CV is a key document for any mental health professional. It summarizes and catalogues accomplishments and experiences so that any person can quickly appreciate the professional's suitability for employment, for administrative positions, for academic promotion, for prizes/awards, and any other decision that requires an evaluation of the professional's abilities. Although formats may vary in different settings, there are general approaches to make all CVs more effective as well as common pitfalls to avoid. This CV Boot Camp is an opportunity for you to bring a copy of your CV, either in hard copy or on a suitable electronic device (phones are too small) to be reviewed by a CV Mentor (a faculty member at an academic institutions). The CV Mentor will provide suggestions and feedback to help improve your CV for whatever purposes you anticipate you will need it.

AN INTRODUCTION TO NEUROIMAGING IN DEMENTIA

Chair: Vimal M. Aga, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the subtypes of dementia, and understand the critical role of neuroimaging in the diagnostic workup of dementia including problems with the generic neuroimaging reports in dementia patients; 2) Describe relevant neuroanatomy and basic MRI physics; order the standard brain MRI dementia protocol; and use standard rating scales to

interpret brain MRI studies in patients with dementia; 3) Identify the signature neuroimaging findings in the common dementia subtypes with the help of scans from real cases; 4) Develop a basic understanding of the role of functional neuroimaging in a memory clinic; and 5) Elucidate reimbursement issues related to neuroimaging in dementia.

SUMMARY:

Dementia is a clinical syndrome, and unlike the primary psychiatric syndromes, establishing a disease-specific diagnosis is now not only possible in most cases but is the standard of care in present-day memory clinics. There are many reasons for this. Reversible etiologies must be identified and treated. Even in the primary neurodegenerative dementias, a disease-specific diagnosis guides treatment of both cognitive and behavioral symptoms in all stages of the disease. Families are becoming increasingly aware of the various etiologies of dementia and routinely seek this information. Establishing a disease-specific diagnosis can also aid further genetic testing, if necessary, of the patient and, at times, of family members. Neuroimaging is a critical part of the diagnostic work-up of dementia. Use of neuroimaging techniques greatly increases the specificity of the clinical diagnostic criteria. Structural neuroimaging is recommended in all patients with a new diagnosis of dementia; in selected cases, functional imaging may also be necessary. The exclusionary approach, where brain imaging was used solely to rule out treatable brain pathology, has been replaced by the inclusionary approach, where brain imaging is now done mostly to rule in rather than rule out neurodegenerative diseases that lead to dementia. While newer neuroimaging techniques are still in the research domain, many others are now very much part of the standard clinic practice. The common dementias are known to have pathognomonic neuroimaging signatures, which are not usually noted by radiologists in the imaging report. Therefore, it is imperative for any clinician that works with dementia patients to have a thorough understanding of how to order appropriate brain scans and how to interpret them.

This practical workshop by a clinical psychiatrist will introduce the clinician to the use of structural brain imaging, primarily MRI, in patients with dementia, with examples from real

cases from the presenter's clinical practice. The use of FDG-PET scans to further differentiate between various dementias in selected cases, and the issue of reimbursement, will also be covered briefly. By the end of the workshop, the audience will be familiar with the use of neuroimaging techniques commonly used in the work-up of dementia, be able to identify the neuroimaging signatures of the common dementias, and be able to order and interpret relevant brain imaging studies in their own clinical practices. A working knowledge of basic human neuroanatomy will be helpful but is not essential to participate in this workshop.

BRIEF PRIMER TO ACCEPTANCE AND COMMITMENT THERAPY

Chairs: Kenneth Fung, M.D., M.S., Mateusz Zurowski, M.D., M.Sc.

Speakers: Kenneth Fung, M.D., M.S., Mateusz Zurowski, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Distinguish the underlying philosophical and theoretical assumptions behind traditional types of psychotherapies versus 'third wave' psychotherapies; 2) Describe the six core therapeutic components of Acceptance and Commitment Therapy (ACT); and 3) Incorporate some ACT strategies into clinical work when indicated.

SUMMARY:

Acceptance and Commitment Therapy (ACT) is a "third wave" psychological intervention with growing empirical support in research as well as growing interest among clinicians and the lay public. It is recognized by the US Substance Abuse and Mental Health Services (SAMHSA) as an empirically supported intervention. Like other "third wave" interventions such as Mindfulness Based Cognitive Therapy and Dialectical Behavioral Therapy, ACT includes elements of acceptance and mindfulness, and targets functional and contextual changes of mental phenomena rather than changes in their content, form, or frequency. It does not seek to change literal thought contents; rather, it changes our relation to thoughts and loosens the importance of thoughts in directing behavior. The core concept of ACT is that psychological suffering is frequently caused by thoughts and language constricting behavior.

ACT views pathology as psychological inflexibility that emerges from experiential avoidance, cognitive entanglement, attachment to fixed concepts about "self", loss of contact with the present, and the resulting failure to take needed behavioral steps in accordance with core values. ACT may be especially powerful for "stuck" patients who fail to respond to traditional CBT.

This workshop will familiarize the attendees with the basic philosophy and theory of ACT, namely Functional Contextualism and Relation Frame Theory. These concepts will be used to situate the basic tenets of ACT within the larger philosophy of psychotherapies, and will provide a foundation for ACT based interventions. The six core components of ACT will be presented. These include: Acceptance, Cognitive Defusion, Contact with the Present, Self-as-context, Values, and Committed Action. We will especially focus on three of these core processes to facilitate immediate basic clinical application. Defusion, contact with the present moment, and values will be elucidated in more detail, connecting their theoretical basis to experiential exercises and direct clinical work. Experiential exercises will be used to facilitate in session learning. Examples will be drawn from our experiences in adapting ACT for use with various populations including those with depression, anxiety, chronic pain, internalized stigma due to HIV and mental illness, parents with children with ASD, and psychosis.

PROMOTING MENTAL HEALTH OF REFUGEES AND IMMIGRANTS: NORTH AMERICAN AND GLOBAL PERSPECTIVES

Chairs: Aida Spahic-Mihajlovic, M.D., M.S., Rama Rao Gogineni, M.D.

Speakers: Morton Beiser, C.M., M.D., Khalid A. Mufti, M.D., Ali Mufti, M.B.B.S., Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Teach psychiatrists how to better address the concerns of host countries about migrants and the process of settlement; 2) Increase cultural dialogue, mutual understanding, and ongoing community problem solving; 3) Understand and address the reactions of people in countries receiving immigrants; 4) Understand how stressors and

an unwelcome host community can exacerbate an already difficult experience for migrants; and 5) Address particular difficulties that women will face and discuss ways of supporting children, including unaccompanied minors, in their resettlement.

SUMMARY:

Morton Beiser, MD in his work with Nigerian, Tamil, Ethiopian communities in Canada developed a curriculum about immigration, resettlement, identity and discrimination for elementary school children, high school students. He studied high suicide rates in Tamil immigrants, resiliency in refugees and immigrants. These are examples of issues that immigrants and refugees face in the host country, and what we, mental health workers can do to enhance our understanding of issues that they face and provide advocacy, research, and clinical services.

Recent conflicts in Iraq, Afghanistan, Syria, Kosovo and the genocide in Rwanda show the difficulties faced by international organizations in trying to protect civilians. In today's world there are about 25-50 million refugees and displaced people, and contributed to a tremendous increase in refugees. Today's global economy is contributing to a swell in emigration and immigration. The refugee experience confronts us with humanity at its most challenged-forcibly uprooted and in flight from violence, caught between countries, facing an uncertain future-but it also provides some of the most striking examples of human resilience. Refugees and immigrants represent a variety of cultures, races and nations. Both immigrants and refugees are vulnerable to develop an increase in medical and mental disabilities. Risk factors that may predispose refugees, asylum seekers and immigrants to psychiatric symptoms and disorders include: exposure to war, state-sponsored violence and oppression, internment in refugee camps, human trafficking, physical displacement outside one's home country, loss of family members and prolonged separation, the stress of adapting to a new culture, low socioeconomic status, and unemployment. Stressors include separation from family and community; an unwelcome host community; prolonged or severe suffering prior to exile; being elderly or adolescent; lacking knowledge of the host language and loss of socioeconomic status. Dr. Mufti's research shows in Afghan refugees in Pakistan show

70% PTSD or trauma related syndromes. Kosovan and Bosnian refugees manifest PTSD with hyper arousal and numbing. "New Pittsburghers" refugees from Bhutan, Nepal, Myanmar etc. developed similar symptom cluster and were helped by supportive resettlement efforts by psychiatry. The panel will also address particular difficulties that women will face, and discuss ways of supporting children, including unaccompanied minors.

TEACHING EGO DEFENSE MECHANISMS WITH MEDIA CLIPS

Chairs: Luis F. Ramirez, M.D., David J. Robinson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Definition of Ego Defense Mechanism; 2) Explain Freud's Theoretical Model for Ego Defense Mechanisms; 3) Describe 20 Common Defense Mechanisms in Personality Disorder Psychopathology; and 4) Identify Defense Mechanisms in Media Clips (movies and television shows).

SUMMARY:

Ego defense mechanisms are one of the cornerstones to understanding many types of psychotherapy, as well the psychodynamics of personality disorders. This topic is a difficult one to teach since the concepts are abstract and the standard definitions often seem convoluted to trainees. This workshop reviews Freud's model of psychological functioning, with an emphasis on the id, ego, and superego. Building on this, the theoretical framework of unconscious defense mechanisms is discussed. Approximately twenty of the most common ego defense mechanisms seen in personality disorders are defined and then further explained with illustrations. Once these mechanisms have been introduced, attendees are then shown media clips (from movies or television shows) that illustrate the ego defenses in real-world situations. Using audience reply technology, the attendees will vote on which mechanism(s) they saw portrayed, and explanatory answers are given. The quality of the portrayal is discussed and suggestions for other media sources is sought from the audience.

THE TEACHING OF PSYCHOTHERAPY INTERVENTIONS IN THE PSYCHIATRIC

EMERGENCY CENTER DURING RESIDENCY TRAINING

Chairs: Anu A. Matorin, M.D., Ye B. Du, M.D., M.P.H.

Speakers: Natalie C. Pon, M.D., Shirali S. Patel, M.D., Gary Bryan Fillette, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify unique educational opportunities in the ER setting that allow for integrated; 2) Utilize key clinical moments in the ER setting for the teaching of specific psychotherapeutic interventions; and 3) Stimulate educators to exchange ideas in order to develop creative and practical strategies that can be implemented throughout residency training.

SUMMARY:

The set of "Core Competencies" advocated by the American Council of Graduate Medical Education (ACGME) has had a major impact on graduate psychiatry training, with a renewed emphasis on training programs to demonstrate competency in the area of psychotherapy. However, current residents report concerns about the adequacy of the time and resources provided by their programs, level of departmental support and their own perceived self-competence. In order to achieve competency in psychotherapy it is ideal to introduce it as early as possible. In general, PGY-1 didactic series include lectures on interviewing and simple psychotherapeutic interventions. However, PGY-1 residents often struggle with implementing new psychotherapeutic skills in their clinical rotations, which typically involve inpatient and ER settings.

While the fast-paced, practical environment of the ER may appear to be an unusual setting in which to teach residents psychotherapy techniques, we argue that it actually offers a particularly rich opportunity for the teaching of psychotherapy. Several studies have demonstrated the effectiveness of using specific psychotherapeutic interventions in the ER setting to manage crises and prevent readmission through interventions borrowed from a range of modalities, including dialectical behavioral therapy, cognitive behavioral therapy, and psychodynamic psychotherapy. However, the value of the ER setting as a place for teaching these psychotherapy techniques to

residents has yet to be clearly described and examined. In this workshop, we will focus on resident case based presentations on the learning of psychotherapeutic interventions in our Psychiatry Emergency Center at Ben Taub Hospital, a Level 1 Trauma Center, which is a major teaching and clinical site for our PGY-1, PGY-2 and PGY-4 residents. Special focus will be given to the unique issues and challenges training programs face in this area. Additionally, we will address the role of supervision in achieving an optimal educational experience in psychotherapy during residency training.

MILITARY SEXUAL ASSAULT: ROOT CAUSES, PREVENTION EFFECTIVENESS, AND CHALLENGES IN TREATMENT

Chair: Christopher H. Warner, M.D.

Speakers: Carl A. Castro, Ph.D., Sara Kintzle, M.S.W., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the scope of the issue of military sexual trauma and its relationship to behavioral health conditions in the military; 2) Implement strategies for reducing barriers to reporting sexual assault; and 3) Understand the unique aspects of military culture that impact the issue of military sexual trauma and be able to develop mitigation strategies.

SUMMARY:

In May 2014, the US Department of Defense reported that there were 5,061 sex assault reports in the 2013 fiscal year. That represented a 50% increase from the same period the year before. While some argued that this increase was associated with an improving climate encouraging report of these events, others felt that this was still just a tip of the iceberg. More concerning was that an anonymous survey from 2012 found that nearly 26,000 service members said they were a victim of an incident of sexual assault or unwanted sexual contact but only a fraction actually filed a report.

This presentation will review the root causes which have been associated with military sexual trauma including history, gender stereotypes, cultural acceptance, entitlement, alcohol, rape myths, and organizational policies/procedures. Specific focus will be paid to unique aspects of

the military culture which may inadvertently foster sexual assault.

The results of a study on servicemember attitudes, beliefs, and behaviors will be reviewed highlighting potential areas for intervention and prevention strategies. Several key aspects include not only self report data on sexual misconduct exposure but also service member attitudes about leadership response, protection from assault, willingness to report, perceived barriers to reporting, and the relationship between those exposed to sexual trauma and those with military behavioral health issues. A review of prevention and intervention strategies incorporated throughout the military will be provided including an analysis of the strengths and weaknesses of each method and recommendations will be provided on the way ahead for both increasing the willingness to report and enhancing the protection of military service members.

BUT THEY'RE JUST KIDS! ASSESSING THE RISK OF VIOLENCE IN YOUTH

Chair: Sandra K. Antoniak, M.D.

Speaker: George David Annas, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how violence risk factors vary over the life span; 2) Appreciate the impact of developmental maturity on violence risk; 3) Perform an objective risk assessment using the guided clinical judgement risk assessment model; and 4) Utilize the outcome of an objective risk assessment to design and implement therapeutic interventions for at risk youth.

SUMMARY:

The United States incarcerates a higher percentage of its youth than any other country in the world. The daily census of incarcerated juveniles is 70,000, with 25,000 awaiting proceedings or disposition, and 62,000 in residential facilities. The majority of treatment and evaluation of these youths is conducted by psychiatrists who have not completed a child fellowship. The American Academy of Child and Adolescent Psychiatry has recommended that children and adolescents referred to correctional institutions and related facilities be evaluated for the risk of violence. Violence risk assessments of children and adolescents are more complex than those of adults because

predictors of violent behaviors vary by developmental stage and level of psychosocial maturity of the youth. Structured risk assessment tools, enhance objective risk assessment by providing a framework for careful evaluation of risk and protective factors in several domains.

A thorough risk assessment can assist treatment providers and judicial decision makers to design and implement therapeutic interventions for incarcerated youth and to provide for aftercare for youth, post-release. This workshop will provide participants an introduction to violence risk assessment of youth and the opportunity to participate in a simulated violence risk assessment and to present/discuss their conclusions with peers.

Reference #1 Fazel S. et al, A comparative study of violence risk assessment tools: a systemic review and metaregression analysis of 68 studies involving 25,980 participants. Clin Psych Rev: April (2011) 31(3): 499-513.
Reference #2 Catchpole, R. & Gretton, H. (2003). The Predictive Validity of Risk Assessment With Violent Young Offenders: A 1-Year Examination of Criminal Outcome. Criminal Justice & Behavior, 30(6), 688-708.

CULTURAL COMPETENCE IN DIVERSE CLINICAL SETTINGS

Chairs: Kenneth Fung, M.D., M.S., Lisa F. Andermann, M.D.

Speakers: Kenneth Fung, M.D., M.S., Lisa F. Andermann, M.D., Hung Tat Lo, M.B.B.S., Alpna Munshi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe concepts related to understanding Cultural Competence; 2) Identify key components of the Outline for Cultural Formulation and the Cultural Formulation Interview; and 3) Apply Cultural Formulation Interview (CFI) and other Cultural Competence tools in diverse clinical settings.

SUMMARY:

Cultural Competence (CC) is an essential requisite in delivering effective mental healthcare to diverse populations. The DSM5 has expanded its focus on cultural issues, and now includes the Cultural Formulation Interview (CFI). In this workshop, we will take a broad perspective to discuss and review the current concepts and approaches to Cultural

Competence (CC), including its core components, i.e. Attitudes, Knowledge, Skills, and Power. We will introduce various clinical tools that we have adapted or created from our experience in training CC over the years at the University of Toronto and in the community. These tools help cultivate a generic approach towards CC and are applicable for interviewing, diagnosis, formulation, and treatment. We will especially focus on Cultural Formulation and the CFI, as well as their adaptation and application in different clinical settings, from the emergency room to psychotherapy sessions. Participants will have an opportunity to engage in supervised role-plays to conduct culturally competent interviews. Participants will leave this course with a toolkit that will be contextually applicable to clinical practice.

USING THE CULTURAL FORMULATION INTERVIEW WITH REFUGEES

Chairs: Suni N. Jani, M.D., M.P.H., An Dinh, D.O., Sophia Banu, M.D.

Speakers: Ali A. Asghar-Ali, M.D., Asim Shah, M.D., An Dinh, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Use the cultural formulation interview to diagnose refugee patients with mental illnesses; 2) Be able to state special practice considerations for refugee patients; 3) Use the culturagram for treatment planning of refugees; and 4) Use the WHO DAS 2.0 to measure mental health outcomes in culturally diverse refugees.

SUMMARY:

Background: a. Refugees experience significant trauma through displacement but even after acceptance by a host country, they do not receive treatment for persisting symptoms of mental illness due to stigma, barriers to care, and acculturation difficulties. A validated and standardized psychiatric assessment and treatment model is needed to improve cultural competency of psychiatrists working with refugees to ensure quality care. II.

a. Creating a standardized practice model for the treatment of refugee patients

b. Training psychiatrists to use the DSM 5 Cultural Formulation Interview (CFI) and culturagram for diagnosis and treatment of refugee populations

c. Evaluating treatment progress in the culturagram through World Health Organization Disability Assessment Schedule 2.0 (WHO DAS 2.0) scores III. Proposition and Discussion:

a. Baylor College of Medicine psychiatrists use the CFI at The Clinic for International Trauma Survivors to diagnose a refugee in their cultural context and then map a treatment plan with the culturagram, a validated tool designed to plan interventions. This refugee treatment model's progress is evaluated by their WHO DAS 2.0 score to validate the improvement in health reflected by psychosocial parameters in the culturagram.

IV. Implications:

a. Utilizing the CFI and the culturagram in conjunction may improve diagnostic accuracy, therapeutic alliance, and organized treatment planning

b. This pilot model can be replicated by psychiatrists in a variety of settings.

OPPORTUNITIES FOR HEALTH CARE REFORM TO IMPACT FORENSIC SERVICES DELIVERY: THE NEW YORK EXPERIENCE

Chair: Neal Cohen, M.D.

Speakers: Merrill Rotter, M.D., Ann Marie T. Sullivan, M.D., Elizabeth Ford, M.D., Fred C. Osher, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the cutting edge clinical interventions for justice-involved clients; 2) Appreciate health care reform as opportunity for forensic health care redesign; and 3) Identify innovative program models for forensic service delivery and health care.

SUMMARY:

Weekly headlines raise concerns about individuals with mental illness and criminal justice involvement. Their overrepresentation in jails and prisons, their safety and treatment needs while incarcerated, and the risks they pose to themselves and others upon return to the community without adequate services are among the issues receiving ongoing attention as the result of high profile cases and advocacy litigation. For over two decades diversion programs focused on alternatives to incarceration for defendants with mental illness

Aims/Objectives:

and post-incarceration reentry initiatives have attempted to address this critical, undoubtedly underserved population. Research and practice confirm, however, that the success of such programs are dependent on the availability of appropriate services in the community. By increasing the opportunities for health care enrollment and sparking a redesign of the public mental health system, the Affordable Care Act (ACA) offers a unique opportunity to address the needs of this disenfranchised forensic population. In this workshop, we use the New York example to present how to take advantage of this opportunity for health care redesign, and implement innovative programming for this often misunderstood, shunned and underserved population. Following introductory remarks by the Chair, Dr. Neal Cohen, Dr. Merrill Rotter will review current perspectives on over-representation of justice-involved individuals with mental illness and describe the kinds of interventions necessary for both clinical and justice-related outcomes. Dr. Ann Sullivan, Commission of the NYS Office of Mental Health will then present the NYS model for Medicaid Redesign and how the changing health care landscape can address the needs of forensic populations. Elizabeth Ford, M.D. will discuss the NYC-based strategies for workforce training and program implementation, including pilot projects integrating health homes into diversion and community reentry. Finally, Dr. Fred Osher, Director of Health Systems and Services Policy at the Council of State Governments Justice Center, will reflect on the New York initiatives presented with particular emphasis on how they fit into the national landscape of health care reform and services for justice-involved individuals with mental illness. The workshop will begin and end with opportunities for audience members to discuss their experience with health care reform, its impact on forensic services and programs in which they provide care and/or consultation.

THE AMERICAN JOURNAL OF PSYCHIATRY RESIDENTS' JOURNAL: HOW TO GET INVOLVED

Chairs: Misty Richards, M.D., M.S., Robert Freedman, M.D.

Speakers: Rajiv Radhakrishnan, M.B.B.S., M.D., Tobias Wasser, M.D., Holly Peek, M.D., M.P.H., Kathleen M. Patchan, M.D., Ijeoma Chukwu, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) By the end of the workshop, participants should be able to identify the purpose of the Residents' Journal; 2) Participants should be able to identify ways to be involved in the Residents' Journal, such as authoring manuscripts, peer review and guest editing; and 3) Participants will be able to identify the different manuscript types which are accepted at the Residents' Journal and how to prepare such manuscripts.

SUMMARY:

The American Journal of Psychiatry Residents' Journal was founded in 2006 in an effort to get residents, fellows and medical students involved in the writing and editing process. The Residents' Journal has now grown into the largest Resident led Journal in Medicine. The Journal features between 5 and 7 papers per month, and has regular contributors from over 50 psychiatric residencies nationwide. The Residents' Journal continues to make changes on an annual basis in an attempt to provide residents with additional scholarly activities. This workshop will provide participants with knowledge about the Residents' Journal and demonstrates ways in which one can be involved and further strengthen their academic writing, peer review and editing skills.

WHY DID ALOIS ALZHEIMERS LOSE?

Chair: Jason Karlawish, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the historical trends that shaped our current approach to Alzheimer's disease; 2) Understand how the US Medicare system kept Alzheimer's disease hidden; and 3) Understand how cultural concepts of senility were only one reason why Alzheimer's remained hidden in the 20th century.

SUMMARY:

At the turn of the 20th century, Alois Alzheimer presented the case of an unusual disease of the cerebral cortex, and, soon after, his mentor Emile Kraepelin, in yet another edition of his internationally influential textbook of psychiatry, premiered Alzheimer's Disease. It was a signature case of clinical pathological correlation at a time when this approach to

discover and define disease had thoroughly enthralled medicine. And yet, it disappeared. For much of the 20th century, Dr. Alzheimer's disease of the cerebral cortex would remain true to his description: an unusual disease. Why, for much of the 20th century, was Alzheimer's disease forgotten? A common answer to this question was that age-related cortical disorders were categorized as part of normal, or even natural aging. This senility story is incomplete. There are at least four other inter-related and competing explanations. They include disciplinary engagements and disengagements. Alois Alzheimer was a psychiatrist who thought like a neurologist and practiced like a neuropathologist. He was, in a sense, caught between disciplines. A second explanation is that medicine of the 20th century was thoroughly disengaged from its 19th century progressivism and reformism. In western nations, especially the U.S., appeals to the rising problem of the number and costs of the elderly and their many disabilities can be found as early as 1960, but medicine did not listen. In the aftermath of national socialism and in the throes of a Cold War, medicine had no tolerance for disease as a social problem in need of societal reforms, but a problem of individuals in need of a thorough work up and treatment. The fee for service reimbursement, supported by a federal Medicare, sealed this into a lucrative business model. Finally, the brain was and still remains an elusive organ to measure. Unlike diseases such as cardiovascular disease, cerebral disorders have resisted easy measurement.

ADDRESSING THE SOCIAL DETERMINANTS OF LATINO MENTAL HEALTH

Chair: Carissa Caban-Aleman, M.D.

Speakers: Carissa Caban-Aleman, M.D., Guillermo Valdes, M.B.A., M.D., Elena F. Garcia Aracena, M.D., Helena Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Address the challenges and unique mental health needs of Hispanic/Latino populations 2) Recognize the social determinants of mental health that particularly contribute to the Hispanic/Latino population; 3) Understand the impact of particular historical and cultural variants on mental health and mental disorders; and 4)

Develop strategies for improving mental health care for Hispanic/Latino patients that address the social determinants of their illnesses.

SUMMARY:

The Social Determinants of Health have been well documented in recent years. However, there continues to be limited research on the impact of Social Determinants on Mental Health and how to connect the research to program development and implementation of models that actually address these determinants and cultural variables particularly for this population. This workshop attempts to examine the impact of various social determinants of mental health, not only on Hispanic/Latino Immigrants in the United States, but also in their countries of origins, and how these determinants become modified or transformed within the context of immigration. Latino immigrants have limited access to and utilization of health care services, in many cases by virtue of being foreign-born. In addition, the physical and mental health status of Latinos deteriorates once they immigrate to the United States. Lack of access to health care and health information may contribute to this decline in health status. Additional factors contributing to mental health care access barriers include: immigration status, lack of health insurance, low socioeconomic status, low English proficiency, and perceived discrimination. Disparities in mental healthcare are often seen when comparing African Americans to Caucasian populations; however, methodological limitations often make it difficult to determine the true role of neighborhood and environmental factors like poverty, unemployment, nutrition, discrimination, and chronic stress.

This workshop aims to have a discussion on how we can improve our role as psychiatrists by addressing, not only biopsychosocial factors, but also the social determinants that are key etiologic factors for our patients' psychiatric illnesses. We aim to highlight examples of strategies to improve access to and quality of mental health treatment among Latinos, and models, resources, and approaches in which systems-based practices and cultural humility may be used as strategies to reduce disparities in Latino mental health.

PEARLS OF PSYCHOSOMATIC MEDICINE: STUFF YOU REALLY WANT TO KNOW ABOUT DELIRIUM,

TORSADES, TREATMENT OF PREGNANT WOMEN, AND PROJECTIVE IDENTIFICATION

Chair: Philip R. Muskin, M.D.

Speakers: Joji Suzuki, M.D., Margo C. Funk, M.A., M.D., Christina L. Wichman, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be able to actualize the important role we play by promoting and implementing models of care that bring addiction treatment into medical settings; 2) Understand QTc prolongation issues relevant to the psychiatrist, including risk factors for Torsades de Pointes (TdP), QT-prolonging medications, approach to the delirious patient with prolonged-QTc; 3) Review the current evidence for using antidepressants, mood stabilizers, and antipsychotics in pregnancy and lactation; and 4) Understand how people who typically do not use those primitive defenses employ such defense mechanisms in frustrating if not exasperating consultations.

SUMMARY:

Psychosomatic Medicine (PsM) is a psychiatric subspecialty that crosses many disciplines. The daily concerns of practitioners of PsM are shared by many psychiatrists. This workshop will focus on four areas:

Addictions: Joji Suzuki will discuss the important role we play by promoting and implementing models of care that bring addiction treatment into medical settings. Given that less than 10% of patients with substance use disorders receive treatment in any given year, there is a critical need for innovative strategies to increase patient access to addiction treatment. Two models will be reviewed briefly to illustrate these approaches: 1) collaborative care management of opioid dependent patients in primary care, and 2) psychiatry consultation service to facilitate initiation of buprenorphine maintenance treatment in hospitalized opioid dependent patients.

QTc and Torsades: Margo Funk will highlight QTc prolongation issues relevant to the psychiatrist, including risk factors for Torsades de Pointes (TdP), QT-prolonging medications, approach to the delirious patient with prolonged-QTc, and TdP risk assessment in the patient with a pacemaker or implanted

cardioverter defibrillator. Basics of bedside ECG interpretation will be presented along with a typical clinical vignette encountered in treatment of patients in the hospital.

Psychiatric treatment of pregnant/nursing women: Christine Wichman will review the difficulty in trying to navigate the burgeoning literature on the topic of perinatal psychiatry can be frustrating due to an overabundance and often conflicting evidence. She will provide an overview of the current evidence for using antidepressants, mood stabilizers, and antipsychotics in pregnancy and lactation. **Projective Identification at the Bedside:** Philip Muskin will present how people who typically do not use those primitive defenses employ such defense mechanisms in frustrating if not exasperating consultations. Defenses more commonly seen in work with patients who have borderline personality disorder may pop up during psychiatric consultations on medical/surgical patients. A particularly problematic issue is the use of projective identification. The consultant may feel helpless, angry, or anxious without understanding why s/he is having those emotions. Similar to the understanding and interpretation of projective identification in psychotherapy, the experience can be illuminating for the psychiatrist and lead to a successful outcome for the consultation. The moment-to-moment interaction that results in projective identification will be illustrated using cases. How to "get to yes" with the consultee will be elucidated.

CURRENT PROCEDURAL TERMINOLOGY CODE SET: THE OLD, THE NEW, AND THE UGLY!

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 2013 CPT code changes; 2) Understand the new CPT codes for Applied Behavior Analysis; and 3) Identify the appropriate CPT codes (including documentation requirements) that optimally reflect actual clinical work, to optimize clinical billing and pass an audit.

SUMMARY:

The American Medical Association revised the current procedural terminology (CPT) codes used by mental health professionals who file claims for payment, for 2013 and beyond. Psychiatrists continue to struggle as to how to choose the appropriate CPT code that optimally reflects their clinical work. The confusion is especially apparent when billing a combination of evaluation and management (E/M) code along with add on code such as for psychotherapy or interactive services.

This workshop will focus on three areas of importance to the psychiatric community. 1. The Old: a quick revision of the 2013 current procedural terminology (CPT) codes. 2. The New: an introduction to the new CPT codes for Applied Behavior Analysis, that may be of particular interest to clinicians who treat children and adolescents.

3. The Ugly: a discussion of medical record audits by payers and documentation requirements to support billed CPT codes. This workshop is presented by managed care medical directors who use a specially designed auditing tool to review medical records submitted with the new CPT codes. They have also been actively involved in the review and discussion around the new CPT codes for Applied Behavior Analysis. By the completion of the workshop, clinicians should thoroughly understand both the documentation requirements that reflect their clinical work and be able to use new CPT codes with insight and ease. Additionally, they will understand and be able to use the new CPT codes for Applied Behavior Analysis.

COUNTIES AS PSYCHIATRIC SERVICE PROVIDERS

Chair: Marc D. Graff, M.D.

Speakers: Roger Peele, M.D., Jeffrey Geller, Leon Evans, Robert P. Cabaj, M.D., Roderick Shaner, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the range of services and service demands that counties handle. 2) Describe common difficulties in operating county level systems of care and learn current "best practices. 3) Learn how county leaders and other experts see the near-term health care challenges of the Affordable

Care Act, Meaningful Use, MHPAEA, transition to ICD-10, etc. 4) Identify and describe common political sticking points in county governments and their mental health systems and common financial issues.

SUMMARY:

While Federal and State roles in providing psychiatric services have received much attention over the years, relatively little attention has been paid to the Counties, even though the bulk of direct psychiatric services is often delivered at the County level, either by a single county or a consortium of counties. From Delaware's three counties to Texas' 254 counties, from a county of just 12 square miles to a county-equivalent of 323,440 square miles, and from a county total population of 82 residents to one of over 10,000,000 residents, counties vary widely.

County services and service demands vary widely, as well. About half of the counties in the United States do not have a single practicing psychiatrist. Other counties have a rich mixture of services and expertise, including mental health clinics and hospitals, primary care clinics, public health clinics, and consultation to courts, jails and schools. County governments can help or hinder the delivery of mental health care by budget provisions, policy planning and, at times micromanaging.

This Workshop will review some of the experiences and "lessons learned" from some senior leaders in County and State systems of care. It is expected that Workshop participants will add to and reflect on what is presented, sharing their own struggles and epiphanies. The Workshop will also explore ways in which APA could develop additional resources to help those who work at the County level.

MILD TRAUMATIC BRAIN INJURY: ASSESSMENT AND INITIAL MANAGEMENT WITH NEUROPHARMACOLOGY

Chairs: David B. FitzGerald, M.B.A., M.D., Josepha A. Cheong, M.D.

Speakers: David B. FitzGerald, M.B.A., 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; and

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.

PHYSICIAN HEALTH AND PHYSICIAN AS PATIENT

Chair: Glen O. Gabbard, M.D.
Speakers: Holly Crisp-Han, M.D., Gabrielle S. Hobday, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the common problems that physicians experience in the role of patient; 2) Recognize the typical countertransference problems that psychiatrists experience when treating a colleague; and 3) How to treat physicians who come to us in the role of patient.

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, and

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 problem. Moreover, the axiom that doctors often get the worst treatment may also apply. Common transferences and counter transferences will be illustrated as well

PSYCHIATRIC, ORTHOPEDIC, AND ETHICAL CONCERNS IN DELAYED AMPUTATIONS SUBSEQUENT TO TRAUMATIC INJURY IN A MILITARY SETTING

Chair: Edmund G. Howe III, J.D., M.D.
Speakers: Benjamin K. Potter, M.D., Harold J. Wain, Ph.D., Edmund G. Howe III, J.D., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the critical medical, physical, and emotional factors leading patients to request delayed elective amputations; 2) Identify potential confounding primary and secondary gain issues common among patients seeking delayed elective amputations; 3) Recognize core psychiatric concerns for pre-screening patients who request delayed amputations; 4) Recognize core conflicting ethical considerations involving patients' autonomy and beneficence when patients request elective amputations; and 5) Recognize how the ethical principle of Compensatory justice may apply to the question of when to perform elective amputations to service persons.

SUMMARY:

Major extremity trauma is a profound physical and psychosocial life-changing event. Most patients not sustaining overt traumatic amputation are candidates for limb salvage and are treated as such. However, despite ostensibly successful limb salvage via healing of soft tissues and fractures, some patients are plagued by persistent pain and/or unsatisfactory function and eventually seek

delayed amputation. During the recent conflicts in Iraq and Afghanistan, approximately 15-20% of all amputations have been performed in a delayed fashion more than 12 weeks from injury. Of these, a substantial proportion of patients have actively sought delayed amputation after healing of their injuries. As the military amputee centers of excellence have worked to improve amputee function and outcomes, we have become victims of our own success. Many limb salvage patients that, treated at other facilities, would have not even considered amputation witness the faster initial progress of their amputee counterparts and seek amputation as a relative shortcut to wellness and recovery. Still others return years following injury, or following non-combat related injuries, and pursue amputation for different reasons. The protocol for reviewing patients' requests for delayed or late amputations at the Walter Reed National Military Medical Center requires formal evaluation by at least two orthopedic surgeons and a psychiatrist, as well as a physical therapist, prosthetist, and peer-amputee. The psycho-social aspects of "elective" amputations are complex (though some patients feel they have no choice). These aspects include pain, depression, PTSD, anxiety, and real and/or perceived secondary gain. This workshop will enhance participants' capacity to understand the medical, psychiatric and ethical concerns that arise in these instances. Participants will also understand the psychopathology that can disrupt recovery and contribute to inappropriate choices for surgery. The ethical considerations of respecting these patients autonomy, on one hand, and of not doing harm or doing good, on the other, and the consideration of the principle of compensatory justice in the military also bear on these clinical decisions and will be discussed. Time will be allotted at the end of each presentation to ask questions and time will be allotted at the end of the presentations for further comments and discussion.

HELPING PATIENTS WHO DRINK TOO MUCH: USING THE NIAAA'S CLINICIAN'S GUIDE

Chair: Mike Fleming, M.D., M.P.H.

Speakers: Mike Fleming, M.D., M.P.H., Robert Huebner, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the use of the Clinician's guide and the specific relationship between alcohol consumption and the risk of alcohol-related problems; 2) Obtain increased knowledge and research supported guidance for screening, intervention, and treatment of alcohol related problems; and 3) Discuss NIAAA Clinician's Guide and how it can be implemented into a variety of different service settings.

SUMMARY:

This workshop will examine the research-based NIAAA Clinician's Guide and its application in a variety of treatment settings. The presentation will address the use of the guide, including screening and interventions, medication management support, alcohol counseling resources, and patient education. Implementation of the guide in different service settings will also be addressed.

DETECTION AND TREATMENT OF BULLYING-RELATED MORBIDITY: A PUBLIC HEALTH NEED

Chair: Jorge C. Srabstein, M.D.

Speaker: Jorge C. Srabstein, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know the multifaceted nature of bullying; 2) Understand the global ubiquitous prevalence of bullying across social settings and along the life span; 3) Advance the detection of morbidity associated with bullying in the clinical setting; 4) Consider the Syndrome of Maltreatment as a possible nosological entity in the diagnosis of bullying related morbidity; and 5) Support the prevention and treatment of physical and emotional morbidity related to bullying.

SUMMARY:

Background: There is evolving understanding that bullying is a multifaceted form of maltreatment, globally prevalent across social settings and along the lifespan. It is associated with a wide array of morbidity and linked to mortality risk due to suicide, homicide and accidental injuries. The American Psychiatric Association has developed a Position Statement to promote the prevention of bullying related morbidity. A Global Health Initiative for the Prevention of Bullying has been developed

to raise international medical awareness about the nature, ecology and morbidity of bullying and to advocate for its prevention, detection and treatment.

Objectives: At the end of this workshop the participants will be able to: 1) Know the multifaceted nature of bullying 2) Understand its global ubiquitous prevalence across social settings and along the life span 3) Detect morbidity associated with bullying in the clinical setting 4) Consider the Syndrome of Maltreatment as a possible nosological entity in the diagnosis of bullying related morbidity 5) along the lifespan and an exploration of the health problems related to it. Its framework will be provided by one or more clinical vignettes. Its findings and recommendations will be based on 10 years of clinical, research and advocacy efforts to prevent health problems related to this form of maltreatment. Conclusion: There is an urgent need for all health practitioners, especially psychiatrists, to be aware of the evolving understanding about the nature and ecology of bullying and detect, prevent and treat its related morbidity.

References 1. Srabstein J, Piazza T. Is there a syndrome of bullying? *Int J Adolesc Med Health.* 2011 Dec 9;24(1):91-6 <http://www.ncbi.nlm.nih.gov/pubmed/22909917>
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4. Global Health Initiative for the Prevention of Bullying, www.ghipb.org
5. Joint AACAP and APA Position Statement on Prevention of Bullying-Related Morbidity and Mortality [file:///C:/Users/SrabsJ/Downloads/ps2011_bullying%20\(6\).pdf](file:///C:/Users/SrabsJ/Downloads/ps2011_bullying%20(6).pdf)

DEVELOPING A CITYWIDE SYSTEM OF CARE IN ACUTE PSYCHIATRY: THE TORONTO MENTAL HEALTH AND ADDICTIONS ACUTE CARE ALLIANCE

Chair: Molyn Leszcz, M.D.

Speakers: Linda Young, Donald Wasylenki, M.D., Vicky Stergiopoulos, M.D., M.H.Sc., Paul V. Benassi, M.D., Nicole Kozloff, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Consider how a coordinated system of care can impact local acute psychiatric services; 2) Describe research findings that have emerged from the Alliance and how a coordinated system of care can support research initiatives; 3) Discuss the educational opportunities a coordinated system of care can provide for physical and mental health professionals in training; and 4) Imagine applying some of the features of the Alliance to the participant's home jurisdiction and consider what would and would not work.

SUMMARY:

Health system integration is critical in improving the effectiveness and efficiency of mental health services. The Toronto Mental Health and Addictions Acute Care Alliance is a partnership of the University of Toronto Department of Psychiatry and 7 University of Toronto-affiliated hospitals with acute inpatient psychiatric services. The Alliance was originally struck to coordinate emergency transfers and bedflow across member hospitals. In addition to this development, it has standardized documentation and other best practices, collected and interpreted data to improve system access to acute psychiatric services, and supported research initiatives that have resulted in improved clinical care, knowledge and training across member hospitals. It has engaged clinicians, trainees, researchers, administrators and policy makers who have worked collaboratively to advance the Alliance's initiatives. Molyn Leszcz, Vice Chair, University of Toronto Department of Psychiatry and Psychiatrist-in-Chief at Mount Sinai Hospital, will introduce the workshop and briefly describe the Alliance's history and evolution. Don Wasylenki, Medical Director of the Alliance, will describe the day-to-day practices of the Alliance and its impact on clinical care. Vicky Stergiopoulos, Psychiatrist-in-Chief at St. Michael's Hospital, will present the Alliance's research initiatives, including an intervention for the most frequent users of emergency services, and how these have translated into improved knowledge and care. Finally, Nicole Kozloff and Paul Benassi, the Alliance's resident

representatives, will discuss the Alliance's impact on training. Linda Young, Director Maternal, Newborn, Child Mental Health, Interprofessional Practice and Organizational Learning at Toronto East General Hospital will serve as a discussant. Presenters will then engage the audience in a discussion to explore the benefits and limitations of such an organization, and how the lessons learned by the Alliance might apply to participants' respective settings.

WOMEN PSYCHIATRISTS: ROADBLOCKS AND PATHWAYS TO SUCCESS

Chairs: Rashi Aggarwal, M.D., Petros Levounis, M.D.

Speakers: Donna M. Norris, M.D., Laura Roberts, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common challenges in the career paths of women psychiatrists; 2) Discuss societal and self-expectations that help or hamper women psychiatrists in their professional growth; and 3) Discuss potential solutions to professional challenges faced by women psychiatrists.

SUMMARY:

Women in psychiatry are more likely to enter academic careers today than they were in the past, but are less likely than men to stay in it. They are also less likely than men to rise to the highest ranks in the field. The number of women department chairs in psychiatry (12%) is higher than in departments like surgery (2%) but much lower than in departments like pediatrics (19%) and family medicine (18%). Psychiatry does have some female leadership the recent APA president being a woman however, the total proportion of female leaders is still low. Multiple reasons have been proposed to explain this shortage of women in academic and leadership roles. They include societal expectations being able to juggle a demanding academic or leadership role while being the primary caregiver for family. Further, there are not enough role models of women psychiatrists who successfully manage academic careers and/or leadership roles and family lives. In this workshop we will discuss many of the challenges faced by women psychiatrists in

developing professionally. We will also discuss the roles societal expectations and self-expectations play in the lives of professional women. We will have an open dialogue about personal experiences as they relate to these issues. We will offer potential solutions that woman psychiatrists can use to face and resolve these challenges successfully. We will address pathways to success in academic careers and in organized psychiatry. This workshop will be highly interactive. We will have a 30 minute presentation summarizing the challenges, their reasons and some solutions. This will be followed by an expert panel discussion on 3 topics:

1. Societal expectations from women psychiatrists
2. Self-expectations (Internalized Sexism)
3. Overcoming the obstacles.

The panel and audience will be encouraged to share their personal experiences as they relate to the above topics.

MAY 18, 2015

ETHICS OF CLINICAL REASONING

Chair: Nancy N. Potter, Ph.D.

Speakers: Mona Gupta, M.D., Ph.D., Nancy N. Potter, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become aware of different ways of knowing and how each contributes to diagnostic reasoning; 2) Identify strengths and weaknesses of each way of knowing; and 3) Identify ethical issues in relying on one form or another in the context of particular cases.

SUMMARY:

Although psychiatric diagnostic categories are based on operationalized criteria, diagnostic reasoning draws on several types of knowledge (e.g. tacit knowledge, empathic knowledge). These types of knowledge can support good diagnostic practice. However, diagnoses are not necessarily clearly correct or incorrect, therefore, diagnosis is oriented towards aiding patients rather than getting the right answer. The psychiatrist's diagnostic understanding of the patient should serve to improve her life. This introduces an ethical dimension to diagnostic reasoning. But the ethics of relying on one or another way of knowing in order to make diagnoses are not apparent. This workshop

explores the weight we give to different types of knowing in order to illuminate what should count as a better ethics of clinical reasoning. Leaders first present research on how psychiatrists reason toward diagnoses, after which they work with specific cases and draw on the audience to explore ethical issues.

A USER'S GUIDE TO THE FRONTAL LOBES: BEDSIDE ASSESSMENT OF FRONTAL EXECUTIVE FUNCTION

Chair: Sheldon Benjamin, M.D.

Speakers: Sheldon Benjamin, M.D., Margo D. Lauterbach, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand what is meant by prefrontal and executive function; 2) Recognize evidence of frontal/executive function in the patient interview and mental status examination; and 3) Learn to perform several simple bedside cognitive tasks for assessment of prefrontal/executive function.

SUMMARY:

Impairment of executive functions (anticipation, goal selection, planning, and monitoring along with underlying frontal functions of drive and sequencing) is a major cause of the failure of psychiatric patients to adapt to social, occupational and educational demands. Intact executive function is a predictor of success in rehabilitation. Cognitive neuroscientists are increasingly relating neuropsychiatric disorders to dysfunction in one of the known frontal-subcortical networks underlying the executive functions. Yet, psychiatrists typically leave assessment of executive function to our colleagues in neuropsychology. Information about executive function can be readily obtained from the neuropsychiatric history, behavioral observations and bedside cognitive status tasks in the standard mental status examination. By becoming aware of these clues and learning a few other simple bedside cognitive assessment tasks, psychiatrists can learn to estimate the level of executive dysfunction of their patients as part of their routine psychiatric examination. Following a brief introduction to prefrontal/executive function, a model for teaching bedside assessment of executive function will be presented using interactive demonstrations and

video. Demonstrations will be based on specific patient behaviors to be matched with appropriate mental status examination methods. Participants will learn how to correctly perform the tasks being demonstrated. Participants are encouraged to bring questions about executive function and mental status assessment tasks.

MEDICATIONS FOR THE TREATMENT OF ALCOHOL USE DISORDERS AND RELATED COMORBIDITIES: A BRIEF GUIDE

Chair: Domenic A. Ciraulo, M.D.

Speaker: Domenic A. Ciraulo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of the efficacy, and safety of the FDA approved medications for the treatment of alcohol use disorders; 2) Identify the steps involved in screening for alcohol use disorders and developing a medications-assisted treatment plan; and 3) Identify the special considerations in treating alcohol use disorder patients with psychiatric comorbidities.

SUMMARY:

Three oral medications (disulfiram, acamprosate, and naltrexone) and one injectable medication (extended-release injectable naltrexone) have been approved by the U.S. Food and Drug Administration (FDA) for the treatment of alcohol use disorders. This workshop will review the rationale for selecting each medication including the mechanism of action, dosing, efficacy and safety of each medication for the treatment of alcohol use disorders and related comorbidities. Steps in assessing the patient for risky alcohol use as well as developing and implementing a medication assisted treatment plan will be discussed. Topics will include steps involved in screening the patient for medication use; taking a relevant patient history; conducting a physical exam with a focus on evaluating neurocognitive function, sequelae of alcohol use, and looking for evidence of hepatic dysfunction. In addition to standard laboratory testing such as CBC, vitamin deficiencies, hepatic and renal testing, the use of newer biomarkers such as Carbohydrate-deficient transferrin (CDT), gamma-glutamyl

transpeptidase (GGT) and aminotransferase (AST) will be discussed. The role of recently developed, highly sensitive alcohol metabolites such as ethyl glucuronide (EtG) and phosphatidylethanol (PEth) will be also be reviewed. When a patient's initial assessment supports a diagnosis of Alcohol Use Disorder developing a comprehensive treatment plan becomes critical. Stages in this process involve setting goals with the patient for medication assisted treatment, establishing expectations by educating the patient as to how the medication works and what to expect from treatment will be discussed. A full disclosure about the medication and the reasons it was selected, including discussion of potential risks and benefits and the time to full effect should be included. The strategy of integrating pharmacologic and non-pharmacologic therapies and their relative merits will be discussed as well as the importance of maintaining close coordination between medication management and other aspects of addiction treatment when providers are separate.

Factors affecting the physician's choice of medication will be considered. In addition to factors specific to each medication, the clinician should consider the patient's (a) past experience with addiction medication; (b) beliefs and opinions as to which medications may be most helpful; (c) level of patient's motivation; (d) medical status and contraindications for each medications; and (e) history of medications adherence. The final topic to be discussed will be medication assisted treatment of patients with co-occurring psychiatric disorder.

FOOD AND THE BRAIN

Chairs: Emily Deans, M.D., Drew Ramsey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss up to date nutritional studies and their relationship with mental health; 2) Perform food assessments on their patients and recommend safe dietary changes; and 3) Understand the impact of whole foods and probiotics/fermented foods on the gut/brain axis.

SUMMARY:

In this workshop geared toward clinicians, we will review the latest available evidence linking

nutrition to mental health along with practical tips about addressing diet in your medical practice. The workshop will be composed of two sections including case examples and a question and answer period. 1) Animals, vegetables and minerals: the fundamentals of nutrition and psychopathology. We discuss both specific vitamins/minerals/fermented foods in addition to global dietary patterns and their links to mental illness. We will discuss how gut and brain health are linked. In addition we will address specialty diets (such as veganism, low carb, calorie restriction, post gastric bypass, etc.) and their clinical implications in the field. 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.

BLOGGING, LINKING, LIKING & FOLLOWING: A PSYCHIATRIST'S GUIDE FOR USING SOCIAL MEDIA AND BLOGGING FOR MENTAL HEALTH EDUCATION AND ADVOCACY

Chairs: Holly Peek, M.D., M.P.H., Clarice J. Kestenbaum, M.D.

Speakers: Eugene V. Beresin, M.D., Steve Schlozman, M.D., Lara J. Cox, M.D., Carlene MacMillan, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the benefits of utilizing social media and blogging for mental health education and advocacy; 2) Create an effective and professional online presence 3) Know how to network, make professional connections, and enter professional media markets; and 4) Understand and utilize effective social media communication techniques in order to educate the public, bring awareness to important mental health issues, and reduce stigma.

SUMMARY:

The public, more than ever, is receiving their health information from the internet. In fact, 82% of internet users look for health information online with mental health issues being one of the top health topics accessed (1). Furthermore, one-third of social media users are searching for health-related resources, such as watching

online videos, reading stories on a website or blog, or joining a health related group on a social networking site(2). The vast ability that the internet has to disseminate medical information demonstrates the importance of mental health professionals' engagement in online communication in order to educate the public about mental illness, bring awareness to important issues, reduce stigma, and advocate for patients. Despite the evidence, psychiatrists are often hesitant to engage in online communication, thus missing the opportunity to engage the public for mental health education and advocacy. This workshop will aim to teach psychiatrists the essential tools they will need to engage effectively and professionally with the public using online communication, specifically blogging and social media. This workshop will begin with a review of the evidence supporting the importance of mental health professionals having an online presence. Examples will be given to demonstrate how other mental health professionals have used their blogs and social media sites for mental health education and advocacy. Participants will then be introduced to the key concepts of creating a professional blog, including creating content, writing techniques for online publications, formats, and ways to connect with readers. Concepts of professional social media use for both the novice and experienced user will also be introduced, demonstrating to participants the various components and strategies of effective social media communication and maintaining professionalism. The workshop will conclude with a guided interactive session, where participants can practice putting into action the social media skills they learned to promote mental health education and advocacy. By the conclusion of this workshop, participants will be able to understand the benefits of blogging and social media as a way to connect with their patients as well as the general public. Participants should be inspired to utilize these techniques in order to educate the public, bring awareness to important mental health issues, reduce stigma, help the public navigate the complex mental healthcare system, and gain access to life-saving care. 1 Fox S, Jones S. The Social Life of Health Information. Pew Internet & American Life Project. 2011; www.pewinternet.org/Reports/2009/8-The-Social-Life-of-Health-Information/02-A-Shifting-Landscape/1-Americans-are-tapping-into-a-

widening-network-of-both-online-and-offline-sources.aspx.

2 Social Media "Likes" Healthcare. PwC Healthcare Institute. 2013; <http://pwchealth.com/cgi-local/hregister.cgi/reg/health-care-social-media-report.pdf>.

WHEN A PSYCHIATRIST LOSES A PARENT

Chair: William H. Sledge, M.D.

Speakers: Francine Cournos, M.D., Mohsin Ahmed, M.D., Ph.D., Richard F. Summers, 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; and 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 pg1 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.

RETHINKING THE LONG-TERM USE OF ANTIPSYCHOTICS IN SCHIZOPHRENIA: FOR EVERYONE, NO ONE OR SOME?

Chairs: Sandra Steingard, M.D., Carl Cohen, M.D.

Speakers: Joanna Moncrieff, M.B.B.S., M.D., Hugh Middleton, M.D., Sandra Steingard, M.D., Stephen R. Marder, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the distinction between a drug-centered vs. disease-centered theory of drug action; 2) Understand the implications of the placebo response; 3) Understand the implications of recent long-term outcome studies in individuals diagnosed with schizophrenia; and 4) Characterize a critical response to the ideas presented in the workshop.

SUMMARY:

Current psychiatric treatment guidelines include the recommendation for long term use of anti-psychotic drugs for persons diagnosed with schizophrenia. In recent years, data have emerged that challenges these assumptions. In this workshop, an international panel of psychiatrists from the Critical Psychiatry Network will examine these guidelines from several perspectives. This will be followed by a rebuttal from a psychopharmacologist and schizophrenia researcher. Dr. Moncrieff will discuss disease-centered and drug-centered theories of drug action and review the evidence for whether antipsychotics act by targeting an underlying abnormality (disease-centered model) or whether they act by producing an altered mental and physical state (drug-centered model). None of these models has been proven and other mechanisms have been suggested. The psychoactive and physical effects that are highlighted by the drug-centered model and their significance for psychiatric practice will be described. The speaker will discuss the pros and cons of using antipsychotics for the short-term and long-term treatment of psychosis and the balance of risks when using these drugs in other conditions such as bipolar disorder. Dr. Middleton will discuss the implications of the placebo effect. Conventional views of it tend to be limited to a one-dimensional concept that overlooks the many different ways in which a prescription's

meaning can influence its effects. A more sophisticated approach to "placebo" effects may help explain some of the more incomprehensible effects of psychiatric drugs. The presentation will draw upon recent reviews of placebo research. Dr. Steingard will return to an examination of the optimal long-term use of anti-psychotic drugs. These drugs are considered highly effective in reducing positive symptoms, their discontinuation is strongly correlated with high risk of relapse, and treatment guidelines recommend long-term maintenance. In tandem with increasingly shorter hospitalizations, treatment is focused on starting neuroleptics quickly with rapid dose escalation. This suggests that many individuals are prescribed higher doses than are required. This fact is made more urgent in light of recent data suggesting that chronic exposure to anti-psychotics may, at least for some, hinder full recovery. Dr. Steingard will examine this clinical dilemma and will present data from a chart review of her practice in which patients were actively engaged in shared decision making about tapering their drugs. Dr Marder, an internationally recognized expert on the pharmacological treatment and the care of persons with schizophrenia, will serve as a discussant and offer a rebuttal to the other speakers. Dr Cohen, an expert on aging and schizophrenia, will lead the interactive discussion between audience and presenters.

INTEGRATING PSYCHIATRISTS WITHIN PRIMARY CARE SETTINGS: PRACTICAL TIPS AND TOOLS

Chair: Nick Kates, M.B.B.S.

Speaker: Jon S. Davine, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the problems arising at the interface between mental health and primary care services; 2) Understand the importance and benefits of integrating mental health services within primary care; 3) Apply the principles underlying collaborative partnerships; 4) Employ specific tips to enable them to work effectively in primary care settings; and 5) Organize a primary care visit to include direct and indirect services.

SUMMARY:

The emergence of the patient-centred medical home (PCMH), one of whose goals is the better integration of mental health care with physical health care has served to highlight the importance of strong links between mental health and primary care services and the need to find ways of building collaborative partnerships. This workshop draws on experiences of a program in Hamilton, Ontario, Canada which has successfully integrated mental health counsellors and psychiatrists into the offices of what is now 150 physicians for over 20 years. It begins by summarising the role that primary care plays in delivering mental health care, the problems that exist in the relationship between the two disciplines and the key principles that should guide psychiatrists and other mental health clinicians when working collaboratively with family physicians. It then presents a vision for the roles that primary care and mental health services could play in a better integrated system and summarises changes that any mental health service can make to improve collaboration with family physicians. The workshop then focuses on the practical skills that will enable psychiatrists to function effectively within primary care settings, based on experiences in the Hamilton Program. It describes how the program works, the roles of the psychiatrist, mental health counsellor and family physicians and the principles that have guided the development of the service. It then reviews practical skills to assist any psychiatrist working in primary care. These include a) building the partnership, b) the possible roles that a psychiatrist can play, c) conducting a consultation, d) follow-up visits, e) effective charting, f) educational opportunities such partnerships present, g) ways to improve communication h) completing forms and correspondence i) telephone back-up in between visits j) novel ways of delivering care k) organising the day and, l) funding options. The workshop then discusses how the program is managed and co-ordinated, how it has increased the capacity of primary care providers to deliver mental health care and others lessons learnt. It discusses the potential that collaborative partnerships offer for early detection and intervention, and for building partnerships with community agencies. Finally it will present strategies and practical approaches for adapting and implementing these concepts in any community, and the entire workshop will

emphasise practical tips and tools that can be introduced by attendees into their own practice.

PHARMACOTHERAPY AND PSYCHOTHERAPY TREATMENT FOR POSTTRAUMATIC STRESS DISORDER: USING META-ANALYSES TO DETERMINE WHICH TREATMENTS ARE MOST EFFECTIVE

*Chairs: Daniel J. Lee, M.D., Charles Hoge, M.D.
Speakers: Daniel J. Lee, M.D., Jonathan P. Wolf, M.D., Charles Hoge, M.D., Carla W. Schnitzlein, D.O.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with current PTSD guidelines as well as differing methodologies used in interpreting existing data; 2) Understand significant limitations present in existing studies and challenges in comparing studies; and 3) Apply presented efficacy data for various pharmacotherapy and psychotherapy modalities in selection of appropriate treatments for patients.

SUMMARY:

Importance: Current posttraumatic stress disorder (PTSD) treatment guidelines are contradictory, or assume that antidepressant medications are generally equivalent to trauma-focused psychotherapies, despite the absence of well-controlled head-to-head comparisons. **Objective:** Comparison of effect sizes (against control and within-group) of randomized clinical trials (RCTs) involving antidepressants, adjunctive prazosin, trauma-focused psychotherapies (TFPs), stress inoculation training (SIT), and cognitive-behavioral therapy (CBT). **Data Sources:** Authors searched for RCTs, without language restriction, Medline (1900-June 2014), Embase (1860-June 2014), Cochrane Central Register of Controlled Trials, and PsycInfo (1806-June 2014). **Study Selection:** RCTs with 8 weeks of medication or 8 sessions of psychotherapy involving active control conditions, such as placebo, alternative medication, supportive psychotherapy, biofeedback, or relaxation training. **Clinician-Administered PTSD Scale (CAPS), Short PTSD Rating Interview (SPRINT), or PTSD Symptom Scale-Interview (PSS-I) were required outcome measures. 0.2% (40/17302) of initial hits were analyzed. Data Extraction and Synthesis:**

Independent review, data abstraction, and bias assessment using standardized forms, with disagreements resolved by consensus. Mean CAPS/SPRINT/PSS-I were grouped by conventional re-randomization and outcome measurement times (8-12 weeks, 15-24 weeks, 34+ weeks). Effect sizes were computed and analyzed using traditional meta-analysis techniques. Meta-analyses were completed for medication versus control, medication pre/post-treatment, psychotherapy versus control, and psychotherapy pre/post-treatment. Main Outcome(s) and Measure(s): Effect sizes derived from CAPS/SPRINT/PSS-I, which are standardized diagnostic interview scales that rate PTSD severity.

Results: Venlafaxine and SIT demonstrated initial large effect sizes with erosion of effect beyond 12 weeks. Sertraline, fluoxetine, and adjunctive prazosin demonstrated larger effect sizes beyond 12 weeks. TFPs tracked with best performing medications. CBT tracked with worst performing medications. Data suggested equivalence between sertraline, fluoxetine, adjunctive prazosin, and TFPs. Medication and psychotherapy studies were similar demographically, but substantially different in risk of biases. Conclusions and Relevance: In general, efficacy persisted long after psychotherapy completion, whereas continued medication use was necessary to achieve long-term benefit. Venlafaxine and SIT are less optimal for first-line use given erosion of effect beyond 12 weeks. Sertraline, fluoxetine, adjunctive prazosin, and TFPs appear to be stronger first-line treatments ahead of paroxetine, citalopram, bupropion, mirtazapine, brofaromine, and non-TFPs. Our findings contradict current guidelines. Guidelines may require revision.

THE CHALLENGE OF RECHALLENGE: A RATIONAL APPROACH TO TREATING SURVIVORS OF MAJOR ADVERSE EFFECTS OF CLOZAPINE

Chair: Peter Manu, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define the incidence and clinical features of life-threatening adverse effects of clozapine: agranulocytosis, myocarditis, diabetic ketoacidosis, gastrointestinal hypomotility, pancreatitis and

NMS; 2) Compare the risk of clozapine-related deaths with the benefits produced by the decrease in suicidal behavior and number of hospitalizations and the increase in quality of life; and 3) Learn when can patients with life-threatening adverse effects be rechallenged with clozapine.

SUMMARY:

Clozapine is widely prescribed for treatment-refractory patients with schizophrenia, but its use is limited by prescribers' concerns regarding potentially life-threatening adverse effects. These complications include neutropenia and agranulocytosis, myocarditis, diabetic ketoacidosis, venous thromboembolism, gastrointestinal hypomotility (adynamic ileus), pancreatitis, and neuroleptic malignant syndrome. Clinical and ethical challenges exist in managing schizophrenia in patients who had survived a life-threatening adverse drug reaction. A rational, scientific approach is limited by the absence of controlled studies of the outcomes of re-starting clozapine after a life-threatening adverse drug reaction. Systematic review of the cases reported in the literature during the interval 1972-2011 (Manu et al., 2012, Nielsen et al., 2013) indicate that a favorable outcome of rechallenge can be expected in patients who have recovered from neutropenia, neuroleptic malignant syndrome, venous thromboembolism, ileus and diabetic ketoacidosis, but not after agranulocytosis and myocarditis.

"I'LL SHOW YOU MINE, IF YOU SHOW ME YOURS:" THE IMPACT OF UNDERAGE SEXTING

Chair: Renee Sorrentino, M.D.

Speakers: Susan Hatters Friedman, M.D., Sara Moore, M.A.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Participants will become aware of the prevalence and research regarding underage sexting; 2) Participants will become familiar with the laws and legal implications of underage sexting; and 3) Participants will identify the ethical implications related to underage sexting and treatment challenges

SUMMARY:

Sexting generally refers to the act of sending sexually explicit electronic messages, primarily through the use of a cell phone. Sexting has gained media attention due to the number of teens who face legal charges after sending, receiving, storing, or disseminating nude pictures. Research regarding the prevalence among teenagers is unclear. A study conducted by The National Campaign to Prevent Teen and Unplanned Pregnancy and Cosmogirl.com found that 20% of teenagers sent naked or seminude images of themselves or posted them online. Another study found that approximately 9.6% of the youths surveyed reported they appeared in or received nude or nearly nude images (Mitchell et al., 2011). A more recent study found 28% of the sample reported sending naked pictures of themselves through text or email (Temple et al., 2012). The legal ramifications of underage sexting vary from a misdemeanor to felony criminal charges. Since 2009 at least 24 states have enacted legislations to address youth sexting and in 2012 at least 13 other states have introduced bills or resolutions (National Conference of State Legislatures, 2014). For those states that have yet to pass laws related to sexting individuals found guilty face potential prosecution under the state's or federal child pornography laws. Anyone convicted of a child pornography charge must also register as a sex offender including other potential consequences such as denial of college admission, ineligibility for student financial aid, and restrictions on employment and where one lives. Due to the difficulties in understanding the prevalence and characteristics of underage sexting and the discrepancies in the laws, clinicians must be aware of the ethical issues and treatment difficulties unique to this population. This workshop will review the research related to underage sexting, address the laws and legal issues and conclude with a discussion regarding the ethical implications and treatment challenges.

PUBLIC HEALTH APPROACHES TO CAMPUS MENTAL HEALTH IN CANADA AND THE U.S.: MCMASTER UNIVERSITY, CORNELL UNIVERSITY, AND THE JED FOUNDATION

Chairs: Catharine Munn, M.D., Leigh A. White, M.D.

Speakers: Victor Schwartz, M.D., Tim Marchell, M.P.H., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the public health approach to campus or post-secondary mental health, as applied in an American and a Canadian context; 2) Identify key components to two campus mental health strategies which can be considered, adopted or modified for use in the participant's institutions; 3) Identify resources which can be used to guide the development of a mental health strategy; and 4) Identify potential opportunities and challenges involved in developing a campus-wide mental health strategy.

SUMMARY:

Colleges and universities across North America and beyond are more aware and concerned about the mental health of their students than ever before. They are having to face the complexities of dealing with increasing numbers of students presenting with mental health issues and requesting accommodations for mental-health related disabilities. Frequently schools are looking to psychiatrists, other mental health professionals and administrators to not only help develop and provide services for students, but to create procedures and policies to address mental health concerns or, increasingly, comprehensive mental health strategies for their campuses. A public health approach to campus mental health has been adopted by some institutions, considering mental health promotion, prevention and intervention. Beginning in 2014, McMaster University in Ontario, Canada began to develop their Student Mental Health and Well-being Strategy. McMaster looked to many schools and institutions across North America and discovered the particular expertise among American colleagues at: Cornell University in Ithaca, NY, where they have been building on their public health approach to student mental health for 20 years, and to the JED Foundation, a not-for-profit foundation which has been providing leadership and resources in emotional health promotion and suicide prevention for college students for the past 12 years. In this workshop, McMaster University in Canada and Cornell University in the US will discuss the process of developing a mental health strategy for each institution, given that McMaster has

recently embarked on a more deliberate strategy to address student mental health and Cornell has been developing their approach for many years. McMaster and Cornell will describe key features of their approaches, and challenges encountered during the process, so that attendees can learn from these experiences. The JED Foundation will highlight some of their resources which can help to guide and organize the development of mental health strategies for other post-secondary institutions. Participants will have the opportunity to discuss the process of developing a mental health strategy in Canada and the U.S. and pose questions to all presenters.

MOOD DISORDERS IN NEUROLOGICAL ILLNESS

Chair: Laura Safar, M.D.

Speakers: Shreya Raj, M.D., John F. Sullivan, M.D., Gaston Baslet, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Utilize up-to-date diagnostic criteria and assessment methods to evaluate patients with mood symptoms and neurological illness; 2) Generate a clinically meaningful formulation and differential diagnosis for patients with mood symptoms in neurological illness, including pathophysiological and brain-behavior considerations; and 3) Implement evidence-based treatment recommendations for patients with mood disorders and neurological illness.

SUMMARY:

Mood disorders, and especially depression, are highly prevalent in neurological illnesses but are often under-recognized and undertreated. The relationship between mood disorders and neurological illness is complex in several aspects including pathophysiology, clinical presentation, and response to treatment. Mood symptoms may be the direct result of brain pathology, very much like other manifestations such as cognitive or motor disturbances. In other cases they may be a result of a more complex interplay of biological, environmental and psychological elements. In terms of their clinical presentation, neurological illness may produce signs and symptoms such as psychomotor retardation, apathy, concentration deficits, and sleep disorders which may make the diagnosis of a mood disorder challenging.

The identification and treatment of mood disorders in individuals with neurological illnesses may improve adherence to the treatment of the neurological illness and its prognosis.

This workshop is designed to improve participants' knowledge about the assessment and management of mood disorders in different neurological illnesses. It will include an overview of the general principles utilized in the assessment of neuropsychiatric disorders with discussion of the neuropsychiatric exam and efficient use of office cognitive testing, mood scales, and ancillary tests for a diagnostic work-up of complex cases. We will then discuss mood disorders in the context of specific neurological disorders such as dementia, cerebrovascular disease, Parkinson's disease and other movement disorders, multiple sclerosis, traumatic brain illness, and epilepsy. For these, we will briefly discuss epidemiology and pathophysiology, and focus on clinical presentation and evidence-based interventions.

Learners will benefit from a variety of educational formats, including lectures, case discussions, and question-and-answer sessions. Learners will have ample opportunities to present their clinical questions to integrate the presented information.

We expect that workshop participants will increase their knowledge base and subsequently implement improvements in their practices when caring for patients with neuropsychiatric complaints, specifically mood disorders in the context of neurological illness.

PSYCHIATRY IN THE COURTS: APA CONFRONTS LEGAL ISSUES OF CONCERN TO THE FIELD

Chair: Marvin Swartz, M.D.

Speakers: Paul S. Appelbaum, M.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the process and criteria by which APA decides to become involved as a friend of the court in major cases; 2) Appreciate the issues involved in challenges to the authority of medical boards; 3) Recognize the mental health-based arguments underlying opposition to bans on gay marriage; and 4) Discuss the challenges to physician speech and practice posed by bans on firearms discussion in physician-patient encounters

SUMMARY:

The Committee on Judicial Action reviews ongoing court cases of importance to psychiatrists and our patients, and makes recommendations regarding APA participation as amicus curiae (friend of the court). This workshop offers APA members the opportunity to hear about several major issues that the Committee has discussed over the past year, and to provide their input concerning APA's role in these cases. Three cases will be summarized and the issues they raise will be addressed: 1) *Wollschlaeger v. State of Florida* upholding the Florida law restricting physicians' ability to communicate with patients about gun safety. Wollschlaeger raises the question of how statutes may appropriately limit the types of inquiries physicians make of their patients in the conduct of medical care; 2) *North Carolina Board of Dentistry v. the FTCC* case challenging the conduct and authority of the NC Dental Board to regulate the practice of teeth whitening. This case raises questions of when such a Board is appropriately acting within its authority to regulate the practice of dentistry as opposed to acting primarily to protect its guild interests; 3) *Bostic v. Schaefer*, striking down Virginia's restrictions on same-sex marriage. 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.

"IT'S A WONDERFUL LIFE:" PSYCHIATRY IN CANADA

Chairs: Leslie H. Gise, M.D., Steven Sharfstein, M.D., M.P.A.

Speakers: Jon S. Davine, M.D., Randall F. White, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how the financing of Canadian health care differs from that in the US and affects mental health care. ; 2) Understand how psychiatrists are reimbursed in Canada as compared to the U.S.; and 3) Appreciate how a publicly funded universal health care system affects the practice of psychiatry.

SUMMARY:

Psychiatric care should be universal, accessible, high quality and affordable. How well are Canada and the US doing? Questions about Canadian mental health care include: How accessible is mental health care? Is there a shortage of psychiatrists? How much does the government intrude in psychiatric practice? How much psychotherapy do psychiatrists do? What is the relationship with primary care? Do students graduate with large debts? How many choose psychiatry? How is this determined? How much solo private practice by psychiatrists is there? How well does fee-for-service work? What paperwork is involved? How are reimbursement and fees set? What are typical incomes for psychiatrists? How stable is mental health funding and what is the tax burden? Are there drug formularies, how hard is it to override them and how much access is there to newer medications? A brief history of universal health care in Canada will be presented including the evolution of the Canada Health Act and how it affects the practice of psychiatry in Canada. Presentations by psychiatrists working in the provinces of British Columbia and Ontario will address a variety of issues including the advantages and disadvantages of the existing model, the quality of mental health care, referrals, waits, paperwork and reimbursement. Do patients have to be referred to a psychiatrist by a primary care doctor and how much psychiatric treatment do primary care doctors do? Do psychiatrists see only patients with severe mental illness or patients who need only psychotherapy? The system for delivering both acute and chronic mental health care in British Columbia will be described as well as a typical day for a psychiatrist in Ontario. Practice patterns and content will be addressed including the frequency and duration of visits, the flexibility to increase frequency and duration if necessary, and the average length of stay for a psychiatric patient in the hospital. The US federal health care law of 2010 has expanded coverage but millions lack coverage. Psychiatry is disproportionately affected and care is unaffordable for many. People with serious mental illness are especially vulnerable since they often have comorbid substance use disorders and medical illness. Access to care is limited by private insurers who aim to maximize profits. Hospitals, health systems and individual psychiatrists are scrambling to reorganize themselves to benefit from rapidly-changing incentives. People differ on what they think

about the quality of US health and mental health care. Some believe the US has "the best health care in the world", while US is ranked poorly by the OECD which represents 40 developed countries. US and Canadian psychiatrists will have an opportunity to dialogue on the issues of health care reform and psychiatric practice which are facing both countries.

PRACTICAL GUIDE TO PREPARING PSYCHIATRIC TRAINEES TO PRACTICE IN INTEGRATED PRIMARY CARE AND MENTAL HEALTH SETTINGS

Chairs: Rachel Robitz, M.D., Steve Koh, M.D., M.P.H.

Speakers: Robert M. McCarron, D.O., Jessica Thackaberry, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the benefits of training psychiatry residents to function in integrated medical and psychiatric care outpatient settings; 2) Compare a traditional psychiatric residency training setting to one which uses an integrated approach; and 3) Demonstrate a technique to train psychiatric residents to function within an integrated medical and psychiatric care outpatient setting.

SUMMARY:

The Patient Protection and Affordable Care Act (PPACA) is both encouraging the development of and providing funding for patient centered medical homes (PCMH). At this time millions of Americans receive healthcare through PCMHs (1). With this emphasis on healthcare delivery through PCMH, American healthcare is shifting towards a strong focus on integrated physical and mental health services within a primary care setting (2). Moreover, collaborative care models are being used more often because they have greater efficacy in treating some mental health conditions such as depression (3). As the systems which psychiatrists work within change it is also important that training of psychiatrists changes to best prepare them to work within these new systems.

One psychiatric residency training program has described its curriculum to train psychiatric residents to function as collaborators and consultants within primary care settings (4). However, apart from the literature describing this program, there is very little information

available about how to train developing psychiatrists to practice within an integrated medical and psychiatric care outpatient setting. This workshop aims to fill this gap by providing practical guidance on how to train developing psychiatrists in this emerging setting.

The practical guidance provided through this workshop will be demonstrated in a multimedia and interactive format for those interested in training residents to provide psychiatric care in integrative and collaborative settings. Participants will work through a case presented by video in both a traditional manner and then using an integrative approach. By comparing the two approaches through interactive discussion, participants will begin to understand the importance of training trainees to function in integrative outpatient settings and provide practical skills in how best to train psychiatry residents to function in these settings.

1. Klein DB, Laugesen MJ, Liu N. The Patient-centered medical home: A future standard for American health care? *Public Administration Review*, 2013; 73(s1): s82-s92.

2. Working Party Group on Integrated Behavioral Healthcare. The development of joint principles: integrating behavioral health care into the patient-centered medical home. *Ann Fam Med*, 2014; 12(2): 184-5.

3. Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Arch of Intern Med*, 2006; 166(21): 2314-2321.

4. Cowley DS, Katon W, Veith RC. Training psychiatry residents as consultants in primary care settings. *Academic Psychiatry*, 2000; 24(3): 124-132

A NOVEL EDUCATIONAL INTERVENTION TO INCREASE CLINICAL SCHOLARSHIP AMONG FACULTY AND TRAINEES

Chairs: Julie B. Penzner, M.D., Jimmy Avari

Speakers: Elizabeth Auchincloss, M.D., Dimitry Francois, M.D., Caitlin Snow, M.D., Janna Gordon-Elliott, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate a model of residency education and faculty career development in which scholarship is prioritized and academic progress is fostered; 2) Describe the role, function and identity of a clinical scholar; 3) Characterize scholarship- and

career-related knowledge gaps in a population of young academic psychiatrists, and elucidate a system for filling these gaps; and 4) Consider the role of mentorship and scholarship supervision in residency education and faculty career development.

SUMMARY:

In an era in which academic psychiatry is increasingly driven by managed care demands and shortened lengths of stay, and when emphasis has shifted from diagnosis and treatment toward patient safety and satisfaction, there is an evolving tension with traditional academic models. At risk with these changes is clinical scholarship. To address this, Weill Cornell Medical College introduced in 2013 the inaugural Clinical Scholars Institute.

This novel program aims to immerse early- to mid-level faculty into a process of socialization to research and academics, goal-setting and mentoring. Program evaluation data are being collected, including number and types of publications, mentorship collaborations and influence on academic productivity. Based on the success of the Institute for faculty, we have developed a similar Institute for residents, which will be presented in this workshop as well. The aim of this workshop is to introduce this model for clinical scholarship for faculty and trainees, with detailed discussion of the mechanisms of the Institute as well as program evaluation metrics and results.

Dissemination of the concept of such an Institute is vital to the academic life of young psychiatric faculty and trainees. The field of academic psychiatry has evolved into one increasingly divided between research-driven concepts on the one hand, divorced from their clinical applications on the other. However, a majority of researched findings have arisen from astute clinical observations; these intellectual products are qualitatively different from the usual findings of investigators, and can act in synergy with these research-driven products. Today, however, few clinicians are versed in understanding the research enough to rigorously apply it. Conversely, the clinical acumen of researchers atrophies with time away from patient care, limiting facility with hypothesis generating. Residents, as yet unformed as either clinicians or researchers, need training in both areas simultaneously, particularly as we face a future of medicine with increasing technical complexity. Therefore, such

a project as the Clinical Scholars Institute aims to synthesize the clinicians' expertise with the researchers' acumen, working towards a singular pursuit of scholarship in academic psychiatry.

This workshop offers a model for an innovative educational program with demonstrated efficacy in fostering scholarship among residents and junior faculty in the Weill Cornell Department of Psychiatry. Clinical scholarship maintains the health of the field and its academic institutions, particularly as the current cost-driven climate threatens to undermine academic progress, idea sharing and career-oriented self-examination.

CHANGES IN PSYCHIATRY AND CHANGING STYLES OF PRACTICE: VIEWS FROM SENIOR AND EARLY CAREER PSYCHIATRISTS

Chair: Malkah T. Notman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Familiarize participants with changes in psychiatry in the recent past and the implications of these changes for the options structure and styles of psychiatric practice; 2) Familiarize participants with challenges, dilemmas and risks of these changes; 3) Discuss possible approaches and solutions; and 4) Present differences in experience and views of early career psychiatrists and senior psychiatrists in relation to these changes.

SUMMARY:

Psychiatry is a changing field, historically and for each generation. These changes affect practice, both institutional and individual. We will discuss these changes 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, changing technology such as the internet and electronic medical records.

2. Changes in health care systems such as from fee for service to newer models. We will discuss the effect of the increased integration of psychiatry and primary care and the place of psychotherapy in this model.

3. Changes in career patterns such as from solo practice to group and institutional practice and from primarily psychotherapy to combined treatment or pharmacotherapy.

4. Changes in view about confidentiality and how one considers protecting confidentiality, including possible generational differences in acceptance of electronic medical records which can circulate within a large medical system.

Presenters are two senior psychiatrists and two early career psychiatrists. The two early career psychiatrists will discuss their views of current practice particularly insurance and confidentiality, and their experience moving from training to practice. Dr Raaven will discuss patient therapist boundaries in relation to the internet.

The two senior psychiatrists will describe the changes they have observed from a longer term perspective, the effects on their careers and practice and changes over the course of a career. They will make predictions about the future in relation to specific changes, such as Obamacare and changes in career patterns.

AN INTRODUCTION TO COMPLEMENTARY, ALTERNATIVE, AND INTEGRATIVE MEDICINE IN PSYCHIATRY

Chairs: Lila E. Massoumi, M.D., David London, M.D.

Speakers: Lila E. Massoumi, M.D., David London, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand what is meant by the terms Complementary & Alternative Medicine (CAM) and Integrative Medicine; 2) Understand the history and present status of CAM in the US within the government sector, academia, medical education, and the medical specialties; 3) Immediately implement several CAM treatments into clinical practice for which there is a strong evidence base.; and 4) Understand what resources are available to learn more about CAM in Psychiatry

SUMMARY:

Part I of this workshop defines "Complementary & Alternative Medicine", describes evolving terms including more recent, "Integrative

Medicine," and findings from the APA Task Force about the patterns of CAM use in psychiatric patients. The widespread use of CAM treatments perplexes many physicians. We address concerns of scientific implausibility, adulteration of products, liability, and vulnerable patients who may be misled. We review obstacles to research and the state of CAM in the U.S. within the government, academia, medical education, and other medical specialties. Part II reviews seven examples of CAM treatments easily incorporated into clinical practice: 1) Magnesium, one of several key micronutrients, helps maintain normal muscle and nerve function; deficiency can trigger agitation, anxiety, irritability, restless legs syndrome, sleep disorders, or depression. 2) A Mediterranean-style diet protects against depression. A low glycemic load diet improves symptoms of tension and depression in overweight individuals. 3) The herb Rhodiola rosea is effective in depression and fatigue. 4) The nutritional supplement S-adenosylmethionine, SAMe, is effective for depression, fibromyalgia, and can benefit dementia. Both rhodiola and SAMe are effective augmenting agents for antidepressants. 5) The gut-brain axis is more than a neural connection; gut microbiota influence brain function through neuroendocrine and immunological mechanisms. Research supports a role for probiotics in the treatment of affective disorders. Imaging studies of the brain show they improve functions in regions controlling central processing of emotion and sensation. 6) Voluntary regulated breathing techniques regulate mental and emotional states improving attention, memory, reaction time, and calmness and reducing symptoms of anxiety, depression, stress, insomnia, PTSD, OCD, ADD, and schizophrenia. 7) Mindfulness is nonjudgmental moment-by-moment awareness of sensations, thoughts, and emotions improving symptoms of anxiety, depression and stress.

Part III: The speakers draw on experiences within their private practices. Challenges to learning about CAM are acknowledged, and practical tips are provided including resources to learn more such as publications, professional organizations, online sites, and resources provided by the APA (including the "Integrative Medicine" track at the Annual Meeting, and the APA Caucus on CAM).

Lila Massoumi, MD, is Chair of the APA Caucus on CAM.

David London, MD, is Assistant Clinical Professor of Psychiatry at Yale University

PERSONAL EXPERIENCES OF PSYCHIATRISTS IN THE COMBAT ZONE

Chairs: Sebastian R. Schnellbacher, D.O., Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Jason I. Dailey, M.D., Kenneth E. Richter Jr., D.O., Anna Makela, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the challenges for military psychiatrists in a war zone; 2) Understand the basic principles of combat stress control; and 3) Recognize complexities of delivering behavioral health care in a deployed environment.

SUMMARY:

Recently, the United States Military has been at war longer than any time in our country's history. After 14 years of war, almost 3 million veterans have served in wars overseas. Military psychiatrists have deployed alongside these troops to Iraq, Afghanistan, and elsewhere. This unique workshop will draw upon the personal experiences of these individuals. Essential principles of combat stress control will be demonstrated and updated. Other issues that will be discussed include the complexities of balancing the needs of command and the Soldier, ethical issues around dual agency and confidentiality, balancing personal and professional relationships, and treating local nationals/detainees.

FOLLOW THE YELLOW BRICK ROAD: THE MCMASTER COMPETENCY-BASED FRAMEWORK FOR RESIDENCY TRAINING IN PSYCHIATRY

Chairs: Sheila C. Harms, M.D., Karen Saperson, M.B.B.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Provide a brief synthesis of the CBME research findings relevant to postgraduate psychiatry training; 2) Describe the process of developing a comprehensive CBME postgraduate training framework at McMaster University and identify the

component parts; 3) Highlight research findings from an educational survey exploring psychiatry residents experiences with supervisory practices at McMaster University and Stanford University, including its relevance to CBME education; and 4) Identify educational needs emerging from the above research and its application to CBME faculty development initiatives at McMaster University

SUMMARY:

The Royal College (RC) of Physicians and Surgeons of Canada has mandated a paradigm shift in Canadian postgraduate training programs from a time-based model to competency based medical education (CBME) starting in 2015. To facilitate this, a national initiative referred to as Competence by Design has been developed which introduces a CBME model of learning and assessment within residency training. Similarly, the Accreditation Council for Graduate Medical Education (ACGME) recently identified educational milestones as an essential component of training for U.S. psychiatry residents. In July, 2014, the Milestones Project was formally implemented, outlining the developmental goals that residents need to attain to meet core physician competencies. These emerging requirements highlight the need for an educational approach that focuses on demonstrable skills and abilities as outcomes measures. In response to these changes, American and Canadian psychiatry educators are challenged to develop new programs with methods of teaching and evaluation that reflect competencies/milestones. In Canada, CBME programs have been trialed in some surgical sub-specialties for years. In contrast, CBME in psychiatry is in the early stages and seemingly less well developed. The purpose of this interactive workshop is to present an integrated competency-based psychiatric training program being developed at McMaster University designed to meet educational needs across the continuum from undergraduate, post-graduate and faculty learners in psychiatry. A review of the program development process will be provided as well as an introduction to the McMaster CBME framework. Specifically, the components of the McMaster framework which will be discussed include a synthesis and critical review of the CBME literature in psychiatry, description of an educational research effort in collaboration with Stanford University to better

understand typical learning experiences for residents in the clinical setting, the use of these baseline research findings to inform CBME faculty development efforts, descriptions of ongoing faculty development efforts and innovative CBME implementation plans at McMaster University. Small and large group discussions will be used to engage participants in sharing their own experiences and to consider expansion of CBME initiatives in their settings.

DUAL DIAGNOSIS TREATMENT ON AN ASSERTIVE COMMUNITY TREATMENT TEAM: PSYCHIATRISTS AS GROUP LEADERS

Chairs: Ann Hackman, M.D., Curtis Adams, M.D.

Speakers: M. M. Naveen, M.D., Marissa Flaherty, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) understand the importance of evidence based dual diagnosis treatment in an Assertive Community Treatment setting; 2) identify benefits to psychiatric leadership in the provision of person centered dual diagnosis treatment to ACT consumers 3) describe the role of the ACT psychiatrist in leading dual diagnosis groups; and 4) identify ways in which psychiatric trainees can participate in ACT dual diagnosis treatment and added benefits which trainees bring to ACT consumers.

SUMMARY:

For more than 20 years psychiatrists, including psychiatric residents, on the University of Maryland's ACT team have led or co-led dual diagnosis groups. However although current ACT fidelity measures (DACTS and TMACT) mandate the presence of addictions counselor on the team, there is little in the literature regarding the role of the psychiatrist in dual diagnosis treatment for ACT clients. This workshop describes the experience of two attending psychiatrists with a combined total of more than 35 years of experience in running dual diagnosis groups with the University of Maryland's ACT team. The team is located in urban Baltimore and works with individuals in underserved areas. More than 65% of 105 adult clients treated by the team have co-

occurring substance use disorders; during the past year 41 individual clients have attended one or more dual diagnosis groups. Groups are open and have a limited number of rules and expectations. Groups use a stages of change model and utilize techniques including motivational interviewing to address challenges related to substance use and recovery as well as dealing with psychiatric symptoms, wellness, individual recovery goals, coping skills and meaningful activities. Psychiatrists group leaders are very familiar with major mental illnesses as well as substance related diagnosis, have added knowledge of pharmacology and in our setting are deeply committed to a person centered, recovery oriented approach to treatment. Groups frequently include resident psychiatrists who are expected to participate and often to prepare a topic and lead a group session; the presence of trainees is typically quite well received by clients and beneficial to the trainees.

The panel will briefly consider the literature around dual diagnosis treatment in an ACT setting, consider some of the unique challenges in this setting, describe our dual diagnosis groups and discuss the advantages of having a physician in the role of group leader. We will also focus on the role of psychiatric trainees in longstanding dual diagnosis groups and the added value which they bring to the process. Then, with the audience, we will consider dual diagnosis treatment in an ACT setting and psychiatrists' role in dual diagnosis treatment groups

HOW TO ADAPT IN-PERSON TO TELEPSYCHIATRIC PRACTICE FOR CLINICIANS AND RESIDENTS

Chairs: Donald M. Hilty, M.D., Allison Crawford

Speakers: Christopher Snowdy, M.D., Donald M. Hilty, M.D., Patrick T. O'Neill, M.D., John Teshima, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Know how to adjust in-person to telepsychiatric practice; 2) Adapt literal or concrete methods of assessment and treatment by looking at play options/accessories, social media examples and plant/room issues for child/adolescent pts; and 3) Deal with special issues by group

discussion (i.e., supervision, settings or others) depending on the attendees interests.

SUMMARY:

Telepsychiatry and technology are fast-changing clinical practice, resident education and how we communicate with patients. The ATA adult guidelines (Yellowlees et al 2009) review scope, clinical applications, and clinical/administrative/technical procedures for practice (assessment, treatments, cultural competency, populations and difficult settings.

Clinicians and residents need concrete examples of how to adapt in-person care to telepsychiatry. A new step toward a child guideline focuses on patient appropriateness, site locations, therapeutic space, technology, how to select a model of care, and risk management issues (Hilty et al 2014; e.g., room/plant, accessories for play, who is in the room). Furthermore, they need telepsychiatric 'competencies' and familiarity on how 'newer' trends (i.e., social media, and texting) affect 'older' issues like impact privacy, boundaries, and communication (e.g., again, child/adolescent psychiatry provides good examples as teens are 'hip').

The APA, AAP, AADPRT, AMIA (American Medical Informatics Association), American Telemedicine Association (ATA) - and this workshop - provide members with helpful guidance on adjusting in-person to telepsychiatric practice; how to adapt concrete treatment methods using child/adolescent care as an example; and issues related to supervision/education depending on the attendees' interests.

REFERENCES: 1. Hilty D.M., D. Ferrer, E.J. Callahan, ET AL: The effectiveness of telemental health: A 2013 review. TEL J E-HEALTH 2013 JUN;19(6):444-54

2. Hilty DM, Shoemaker EZ, Myers KM, et al. A preliminary clinical guideline on telemental health for care of children and adolescents. J Child Adol Psychopharm, in press.

3. Sunderji N, Crawford A, Jovanovic M. Telepsychiatry in Graduate Medical Education: A Narrative Review. Academic Psychiatry 2014 Aug 26

PROFESSIONALISM AND PHYSICIAN HEALTH: INTEGRATING ETHICS AND SELF-CARE

Chairs: Philip J. Candilis, M.D., Richard Martinez, M.D.

Speakers: Philip J. Candilis, M.D., Edmund G. Howe III, J.D., M.D., Richard Martinez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate knowledge of specific habits and skills of professional practice that support both physician health and medical professionalism; 2) Identify strategies for resolving ethical dilemmas at the intersection of multiple obligations or agencies; and 3) Recognize the vulnerabilities of medical work that require integration of resilience and professional competency.

SUMMARY:

New challenges to professionalism in psychiatry arise from the emotional exhaustion, disengagement, and diminished productivity of physician burn-out. Recent studies are clear that burn-out affects all physicians from students and residents to mid-career and senior practitioners. Yet it remains unclear how best to maintain health and professionalism across the career path. Models of professionalism that emphasize self-reflection, sensitivity to vulnerability, honesty, and integrity (in the sense of wholeness or intactness) may be the ideal manner for underscoring physician health and maintaining a medical professionalism that meets aspirational goals. This presentation will identify and describe the considerable overlap between professional ethics and physician health, as well as the related skills and habits of resilience and professional ethics that define the ethical practitioner.

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) To implement standard components of the session structure; 2) To elicit and evaluate key cognitions; and 3) To 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 disorders 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.

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; and 4) Participate in a case-based discussion that illustrates the challenges and options while being on this 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. This presentation was given during the 2014 Annual Meeting. Due to overflowing attendance the Scientific Program Committee has asked that it be presented again in Toronto, Canada as an encore presentation.

UPDATE FROM THE COUNCIL ON PSYCHIATRY AND THE LAW

Chair: Steven Hoge, M.B.A., M.D.

Speakers: Paul S. Appelbaum, M.D., Li-Wen Lee, M.D., Marvin Swartz, M.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the different kinds of policy documents produced by the APA (such as Position Statements and Resource Documents) and understand the procedures for their review and approval; 2) Understand the issues related to the legal regulation of professional licensure and how questions about mental health history may be asked in an appropriate, non-discriminatory fashion; 3) Understand the current policy debate regarding involuntary outpatient commitment and how recent research literature may affect the direction of APA policy; 4) Understand emerging issues related to patients having online access to their psychiatric records and proposed APA policy; and 5) Understand the current issues related to sex predator commitment laws and participate in discussion of revision of the APA policy.

SUMMARY:

This workshop will provide members with an overview of the process by which the Council on Psychiatry and Law develops APA policy documents, such as Position Statements and Resource Documents. The goal of the workshop is to provide members an update on recent and ongoing issues that the Council is addressing. This workshop will provide the members with an opportunity to provide feedback to the Council regarding a range of important areas. Dr. Hoge will provide an overview of the process. Dr. Appelbaum will discuss recent litigation regarding the mental health history inquiries made of those applying for professional licensure and how those questions may run afoul of the ADA. Dr. Lee will discuss emerging issues related to online access of mental health records by patients, appropriate restrictions on access consistent

with HIPAA and professional ethics. A proposed Position Statement will be presented. Dr. Swartz will discuss the Council's work on an update of an APA document regarding mandatory outpatient treatment, also known as involuntary outpatient commitment. Outpatient commitment is a vigorously contested issue and recent data and developments may affect APA policy. Dr. Zonana will review developments in sex predator commitment since the APA Task Force Report, now more than 15 years old. In each area, the Council will elicit feedback from members regarding the important policy issues. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

PROFESSIONAL BOUNDARIES IN THE ERA OF THE INTERNET

Chairs: Glen O. Gabbard, M.D., Gabrielle S. Hobday, M.D.

Speakers: Glen O. Gabbard, M.D., Gabrielle S. Hobday, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) How to implement current professional ethics codes relevant to Internet communication in mental health settings; 2) How to identify privacy issues inherent in placing information about oneself on the Internet; and 3) How to approach dilemmas involving the Googling of a patient.

SUMMARY:

The sea change in the society leading to communication by email, texting, and social media has created a host of complexities for psychiatrists and other mental health professionals. Moreover, the private life of the practitioner has been shattered by the availability of extensive information on the Internet. Patients routinely Google their doctor before making an appointment and often discover "Rate Your Doctor" websites that may have information that is false or at least out of context. Professionals receive invitations to be "Facebook friends" as well. The converse is also occurring where practitioners have access to the opportunity to google or initiate contact with patients through electronic means. A discussion of the potential risks or possible benefits of these types of interactions will be discussed. The actual practice is running way ahead of case law and ethics codes. So while

the answers to many of the situations posed may not be entirely clear, what is evident is that we are in the midst of a new era of boundary problems which are complicated dilemmas for the clinician. In this workshop we will present many clinical vignettes and have the audience vote on answers using the Audience Response System (ARS) so we can see how the assembled group of clinicians regard the use of the Internet in a variety of boundary situations. We also will encourage the members of the audience to bring in cases of their own. Finally, we will briefly survey how the major medical and mental health organizations are developing ethics codes in the face of all this uncertainty.

A RESIDENT'S GUIDE TO BORDERLINE PERSONALITY DISORDER: FROM THE EXPERTS (PART 1 OF 2)

Chair: Brian Palmer, M.D., M.P.H.

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

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

This is a repeat of three workshops held in New Orleans in 2010, Philadelphia in 2012, San Francisco in 2013, and New York in 2014. 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 (features) 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 (follow) 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.

EVALUATING DISABILITY IN YOUR PATIENT: THE LONG, WINDING ROAD INVOLVING THERAPEUTIC PROCESS, EMPLOYERS, AND EMPLOYEES

Chairs: Paul Pender, Psy.D., R.Scott Benson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn the ways to distinguish psychosocial issues from mental health conditions and how to discuss these distinctions with patients; 2) Identify resources to develop sound return to work recommendations to include job adjustments that are compliant with job protection and medical leave laws; and 3) Identify common return to work recommendations for mental

health conditions and how to engage both patient and employer for success.

SUMMARY:

According to the National Institute of Mental Health (NIMH), psychiatric disorders were the leading cause of disability in the US and Canada for individuals aged 14-44 (Levin, 2013). It would be assumed then that most mental health professionals can expect to be confronted with requests from patients to provide documentation to support a disability claim. In fact at the psychiatric residency level, 97% of junior and senior residents in psychiatry had completed at least one evaluation (Christopher, Bolan, Recupero, & Phillips, 2010) yet training has been quite sparse.

While there has sometimes been a call for "forensic assessments" where a physician is "called on to provide an expert opinion regarding the presence of any psychiatric diagnoses and functional impairments (Williams & Crouser, 2014), this is often impractical. A patient may be asking for just a few days off or may need documentation for their claim of FMLA benefits. In order to help their patients, psychiatrists should expect to communicate with others who can support a treatment plan. As a result, psychiatrists whether they want to or not sometimes find themselves involved in matters beyond the typical doctor-patient relationship.

In order to work more collaboratively with employers, this presentation will highlight the distinction between behavioral health disability that results from a psychiatric condition from a "psychosocial issue" such as workplace dissatisfaction and/or interpersonal concerns. Following Warren's (2013) thinking concerning psychosocial issues and Gold's (2013) view of "work capacity" (balance between work supply and work demand), we will highlight the often complex interplay between psychiatric assessment and treatment when support for a disability claim has been requested. We will present an orientation for psychiatrists of common employer resources to assist them when working with patients who may require time off from work. Finally we will explore more in-depth the interplay between patients' emotional distress about a workplace situation and how to better assess the extent that the impairment in functioning is more related to "psychosocial issues" vs. a true mental health condition. Examples will highlight different

scenarios and suggest strategies that support the doctor-patient relationship and the progress of treatment.

MORALE AND MENTAL HEALTH IN VIETNAM, HIGHLIGHTS FROM U.S. ARMY PSYCHIATRY IN THE VIETNAM WAR: NEW CHALLENGES IN EXTENDED COUNTERINSURGENCY WARFARE

Chairs: Norman M. Camp, 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) Appreciate the morale and mental health crisis that developed in Vietnam, despite the diminishing combat intensity, as the war lengthened and the American public became increasingly opposed; 2) Appreciate the historically unique collection of bio\psycho\social risk factors affecting successive cohorts of regular soldiers who were sent to fight insurgent/guerrillas in Vietnam; 3) Appreciate the patterns of management and treatment for psychiatric conditions and behavior problems --including the forward treatment doctrine --utilized by Army psychiatry in Vietnam; and 4) Understand the powerful but sometimes unapparent ethical contradictions that surrounded psychiatric treatment decisions in Vietnam.

SUMMARY:

America fought a ground war in Vietnam (1965-1973) as part of a multinational force committed to what ultimately proved to be a futile effort to oppose a takeover of the Republic of South Vietnam by communist forces from their neighbor to the north. This outcome is despite the commitment of a large and technologically superior U.S. force, and despite great effort and sacrifice on the battlefield. Against all expectations it evolved into a big, protracted, bloody, mostly guerrilla war, which provoked intense media scrutiny and political controversy. This in turn fueled great social upheaval in the United States--an American nightmare that threatened its most basic institutions, including the U.S. military. In the end, the enemy proved to be more resourceful and resilient and outlasted the will of the American people. The Vietnam War proved to be extremely costly to the U.S. in terms of casualties--including psychiatric casualties--and the loss of American

resources and international prestige. In the second half of the war (1969-1973) troops in Vietnam expressed in every way short of collective mutiny, including a wide array of individual and group psychosocial pathologies, their inability or unwillingness to accept the risks of combat, acknowledge military authority, or tolerate the hardships of an assignment in Vietnam. Matters became substantially worse in 1970 when a heroin epidemic quickly spread among the lower ranks--an unprecedented problem that seriously undermined soldier health, morale, and military preparedness. Regrettably, and quite surprising considering the four decades that have passed since the end of hostilities, there has been no official history written by the U.S. Army (75-80% of forces in Vietnam) about psychiatric problems in Vietnam, nor has there been a systematic study of what went wrong. Furthermore, sufficient archival material does not exist that could serve as a data base for analysis. The Army evidently lost, abandoned, or destroyed documentation that could have served as primary source material. This information could prove especially worthwhile considering that in many regards Vietnam appears to have presaged the type of American wars that have arisen so far in the Twenty-first Century and which may become more common in the future. It was with these features in mind that the presenter set out to create US Army Psychiatry in the Vietnam War. The methodology utilized was that of assembling and synthesizing information drawn from a wide variety of sources--published and unpublished--to document the successes and failures of the deployed Army psychiatrists and allied mental health and medical personnel. This approach was augmented by findings from the author's 1982 survey of the veteran psychiatrists who served with the Army in Vietnam. This symposium will review highlights from this recent publication.

LESSONS FROM THE FRONT: APPLYING COMBAT STRESS CONTROL TECHNIQUES TO EVERYDAY PSYCHIATRIC PRACTICE IN AMERICA

Chair: Steven Pflanz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the management of combat stress casualties; 2) Discuss the

approach to deciding when and when not to recommend a military member be returned to duty, disarmed or medically evacuated; and 3) Effectively formulate withdrawal from work and return to work recommendations for patients and employers.

SUMMARY:

Militaries of various nations have observed over the last century that evacuating psychiatric casualties out of theater paradoxically leads to worse outcomes in terms of chronic disability than returning personnel to the front lines when possible & appropriate. Similarly, occupational psychiatrists have observed that once a patient leaves work or goes on disability, the prognosis for return to work is grim. Even so, most psychiatrists don't recognize withdrawal from work as a psychiatric emergency. The military uses the concepts of PIES (proximity-immediacy-expectancy-simplicity) or BICEPS (brevity-immediacy-centrality-expectancy-proximity-simplicity) to manage combat stress casualties in the war zone. The presenter will describe his experiences commanding a Combat Stress Control unit in Afghanistan and managing combat stress and psychiatric casualties in that war zone. The approach to decisions about return to duty, disarming patients, and medical evacuation from theater will be reviewed. The overwhelming majority of patients were, in fact, returned to duty and very few were disarmed or evacuated. The presenter will then translate these concepts to decisions about withdrawal from work and return to work in outpatient psychiatric practice. Work is a core developmental role for most adults and preserving work function is a vital task of psychiatric care. Withdrawal from work, even for brief periods, should never be considered lightly. Using the military's past century of experience managing combat stress, the presenter will help attendees develop a framework for making such decisions and lead an audience discussion of the relevance (or lack thereof) of combat stress control techniques to routine workplace psychiatry.

SKILLS IN EXTREME NEGOTIATION WITHIN THE WORK ENVIRONMENT

Chairs: Ari E. Zaretsky, M.D., Sanjeev Sockalingam, M.D.

Speaker: Susan Lieff, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe eight strategies for effective negotiation; 2) Reflect on and recognize their own conflict styles and the advantages and disadvantages of these particular repertoires of dealing with conflict; and 3) Integrate effective strategies of negotiation and conflict management into their current careers and workplace.

SUMMARY:

Conflict is inherent in all human interaction but presents in very specific scenarios in the contemporary psychiatric work environment. Many times conflict cannot be fully resolved but at all times must be managed to ensure that the risks and damages associated with conflict can be mitigated and the positive aspects of conflict can be safely realized. The damaging aspects of conflict are often related to the deployment of maladaptive negotiation strategies, however, few graduates of psychiatry residency programs are formally taught the art and science of negotiation and conflict management. In this workshop, participants will review the recent research on interpersonal communication, conflict styles and effective strategies to negotiate under stressful circumstances. The emphasis of this workshop will be on acquiring practical skills through practice and role-play in a number of different but very common scenarios that psychiatrists might encounter early in their work career.

DEVELOPMENT AND IMPLEMENTATION OF INTERPROFESSIONAL AND INTEGRATED CLINICAL TREATMENT AND TRAINING PROGRAMS AT A VA MEDICAL CENTER

Chairs: Rebecca J. Pate, M.D., Shaguffa Jabeen, M.D.

Speakers: Jennifer Bean, Pharm.D., Erin Patel, Psy.D., Clarence G. White Jr., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the four core competencies of interprofessional care and discuss how these can be applied to clinical and educational programs; 2) Describe how to develop interprofessional clinics within their organization, especially within VA healthcare settings; and 3) Develop an interprofessional

didactic learning series that addresses the learning and team-building needs of their clinical staff and trainees. 4) Identify innovative interprofessional clinical practice areas that can be developed at their medical center. 5) Create grids among three or more disciplines and create shared medical appointments which account for workload and billing concerns. .

SUMMARY:

Implementation of the Behavioral Health Interdisciplinary Programs (BHIP) in Veterans Affairs (VA) hospitals has stimulated innovation and team building. The objectives of the BHIP model are to promote effective communication, improve health care outcomes by providing a Veteran-centered, recovery-oriented approach and to reduce costs and errors. Not only has implementation of the BHIP model met the objectives of coordinated, collaborative and comprehensive team based care , but Interprofessional clinical training has also been greatly enhanced for trainees in Psychiatry, Psychology and Pharmacy. Within the VA, integration of clinical care across disciplines has been evolving since the placement of mental health (MH) services directly into medical services. Primary Care Mental Health Integration (PCMHI) connects mind and body to heart and soul. In these Primary Care clinics, Veterans are able to receive MH services by either their PCP in coordination with a MH consultant or by an embedded MH professional. Following this initial evaluation, Veterans are referred to general or specialty MH clinics to address crises or exacerbations of symptoms if indicated. The integration of medical and MH services has been well received by Veterans, as they are able to receive all their healthcare services in one location.

BHIPs are the next step in the continuum for integrated mental health care by Psychiatry, Psychology, and Pharmacy. At Tennessee Valley Healthcare System (TVHS), the first BHIP has been developed as a trainee staffed clinic for Veterans with complex clinical presentations. It has improved graduate trainee education and Veteran satisfaction. Interprofessional (IP) collaboration among residents from Psychiatry, Psychology, and Pharmacy has enhanced care delivery. Specific outcomes within the BHIP are being tracked, including mental health re-hospitalizations, ER visits, clinical appointment attendance, adherence to treatment, and utilization of

evidence-based medication management and psychotherapy. This workshop will also discuss the following: continuity of care and training, didactics development, management of quality and safety issues, and program evaluation processes and outcomes. Additionally, future plans for the development of diagnoses specific BHIPs and the integration of Telehealth will be discussed.

UPDATE ON SYNTHETIC CANNABINOIDS

Chairs: George Loeffler, M.D., Adriana de Julio, M.D.

Speakers: Eileen Delaney, Ph.D., Adriana de Julio, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize population trends in synthetic cannabinoid use, including among the active duty military population; 2) Explore motivation for synthetic cannabinoid use; 3) Identify outcomes in the first known study of synthetic cannabinoids in a residential substance abuse treatment center. Of particular interest is that this is an active duty US military population; 4) Identify potential neuropsychiatric sequelae of synthetic cannabinoid use as related to toxicology, receptor targets, half-life, and metabolism; and 5) Treat the synthetic cannabinoid withdrawal syndrome. Learn about the positive neuropsychiatric uses of cannabidiol

SUMMARY:

Synthetic Cannabinoids (SC's) are designer drugs that mimic the effects of cannabis. This talk will address the epidemiology of SC use, recent results from the first in-depth examination of SC use at an (active duty US military) residential substance abuse treatment center, and the neuropsychiatry of SC.

International Trends in SC Use: Though SC's have been recreationally used since 2004, use patterns and motivation for use remain unclear. We address these questions drawing from a variety of international sources, most notably surveys of substance use in the general population and online surveys of SC users. The overall prevalence of SC use is significantly less than natural cannabis. The majority of those who use SC do so only a few times. They tend to be males in their late teens and early twenties. The primary motivation for use is curiosity. Of the small subset using SC's

longitudinally, the vast majority also use natural cannabis and tend to use natural cannabis much more heavily. Somewhat surprisingly, use in the active duty population appears to be significantly lower than in the general population. SC Use in a Residential Substance Abuse Treatment Center: We present the findings of a retrospective record review examining SC use, related psychiatric symptoms, and treatment outcomes at a residential substance abuse treatment center for active duty service members. Fourteen percent of patients entering the treatment center during an 18-month period tested positive for SC via a urine drug test. These cases were matched with controls. Preliminary analyses show that upon entering treatment, SC users were less likely to have a PTSD diagnosis, while no other differences on psychiatric diagnoses were found. Regarding substance-related disorders, SC users were less likely to be diagnosed with alcohol-related disorders but more likely to be diagnosed with amphetamine-, cannabis-, and hallucinogen-related disorders compared to non-SC users. Further results about differences in treatment outcomes will also be provided as well as overall conclusions and clinical implications. Update on the Neuropsychiatry of SC: Unlike marijuana (9-THC), a partial agonist at cannabinoid receptors, SC is a full agonist. SC binds with higher affinity than 9-THC. This distinct toxicology profile and lack of cannabidiol as compared to 9-THC may offer some insight to the suspected greater potential for seizures, psychosis, and prolonged anxiogenic effects during withdrawal. The chemical mechanisms that increase levels of anxiety have been studied in the rodent model. Evidence suggests SC increases noradrenergic activity by increasing the firing rate of locus coeruleus neurons causing anxiogenic-like responses. This response, termed SC withdrawal, can last up to 8 days. However, SC withdrawal remains poorly understood. There are also emerging clinical uses of cannabidiols for epilepsy and neuropsychiatric conditions that physicians should be aware of.

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: Chandrika Balgobin, D.O., Vanessa Torres Llenza, M.D., Stephanie Cho, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discern psychiatric disorders whose symptoms and presentation may mimic medical/physical disorders; 2) Discern medical disorders whose symptoms and presentation may mimic psychiatric disorders; 3) Recognize approaches to diagnose and manage psychiatric disorders that mimic medical disorders in their presentation; and 4) Recognize 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 work-ups 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.

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; and 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.

PTSD IN PSYCHIATRISTS: A HIDDEN EPIDEMIC

Chair: Arthur Lazarus, M.B.A., M.D.

Speakers: Steven Moffic, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the types of clinically-related traumatic events that can cause PTSD in psychiatrists; 2) Understand the role of shame and humiliation in the genesis of PTSD symptoms; 3) Recognize the potentially harmful effects of subclinical PTSD on physician wellness; and 4) Advocate for effective prevention and treatment programs tailored specifically to psychiatrists, psychiatric residents and other physicians.

SUMMARY:

PTSD is under-recognized in physicians even though it may be more prevalent in physicians than in the general population in the United States. Psychiatrists, in particular, may be predisposed to PTSD because of their repeated exposure to violent or suicidal patients and high patient-related stress in general. Other potentially traumatizing events, such as malpractice litigation and medical errors resulting in serious adverse outcomes, may cause PTSD. Medical students and residents are also at high risk to develop PTSD related to clinical training. In addition, psychiatrists who are "second victims" in the sense that they are indirectly exposed to trauma may develop PTSD. PTSD affects the well-being of psychiatrists and their ability to care for patients. Traumatized physicians may, in fact, unwittingly and iatrogenically cause PTSD in their patients due to impaired and non-empathic behavior. Because physicians with PTSD often suffer in silence, there needs to be an appreciation of the role of shame and humiliation in developing PTSD symptoms. In the course of helping others, psychiatrists may deny that they are vulnerable to the same risks as their patients. The cumulative effect of work-

related stress could result in subclinical PTSD manifested by burnout, substance abuse, relationship problems, depression or even death. The workshop leader and panelists have either experienced traumatic events related to clinical practice or are specialists in physician health. They each bring their own unique perspectives to this workshop, and their presentations will include several brief clinical vignettes. Not infrequently, patients meet diagnostic criteria for one or more other DSM-5 diagnoses (especially mood and substance-related disorders), necessitating an assessment and treatment plan that demands rigor and a comprehensive biopsychosocial vision. At least one-third of the workshop will be protected for discussion and interaction with the attendees. Workshop participants will be encouraged to discuss disguised clinical cases from their practices as well as their own personal stories of trauma, symptoms, and treatment experiences. The steps considered prerequisite for recovery will be explored, including the challenges associated with implementing effective treatment and support programs.

BEHAVIORAL HEALTH SERVICES WITHIN AN IMMIGRANT COMMUNITY: A POPULATION HEALTH PERSPECTIVE FROM A STUDENT-RUN FREE CLINIC

Chair: Andres Barkil-Oteo, M.D., M.Sc.

Speakers: Natalie Lastra, Hannah Raila, M.S., Juan G. Rodriguez, Michelle A. Silva, Psy.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the concept of psychoeducation and its role in mental health promotion and prevention of mental illness; 2) Define the role of a supervised graduate student as facilitator of a psychoeducation intervention; and 3) Understand some of the challenges and strategies for delivering behavioral health interventions within a medical student run primary care clinic

SUMMARY:

The HAVEN Free Clinic Behavioral Health (BH) Program for Depression is an American Psychiatric Association-funded initiative (A Helping Hands grant) in which supervised graduate students provide mental health services to uninsured, largely undocumented, Spanish-speaking immigrants. In alignment with

the World Health Organization Mental Health GAP guidelines,¹ this program provides first-line services including: 1) psychoeducation, 2) reduction of psychosocial stressors, and 3) modified behavioral activation exercises to patients with mild-to-moderate depression. To address the lack of specialist mental health providers available to the immigrant community, these services are provided by Yale University graduate student volunteers trained and supervised by an interdisciplinary team of psychiatrists and psychologists. The BH Program provides this population with free services grounded in a population mental health approach that focuses on the promotion of mental health and prevention of mental illnesses.² In the BH Program, Spanish-speaking health professional and public health student volunteers administer an individualized psychoeducational curriculum that is delivered one-on-one and is based on the Promotora [community health worker] manual developed at the University of California, Berkeley. This psychoeducation curriculum targets common acculturative stressors associated with the Latino/a immigrant experience in the United States.³ In addition, graduate student facilitators promote patient behaviors (e.g. exercise, reactivation of social networks) that are associated with psychological health. Finally, volunteers in the Social Services department at HAVEN target psychosocial stressors by connecting patients with community resources ranging from English classes to legal services. To prepare students to participate in the program, psychologists and psychiatrists train student volunteers in the principles of motivational interviewing and common strategies for engagement, population health, quality improvement methods, and psychoeducation. The immigrant community of Fair Haven, CT has limited access to mental health services because of barriers within the health care system, as well as a national shortage of primary care providers. This shortage is projected to worsen in the coming years.⁴ Through graduate student involvement, the BH Program for Depression serves as a model for rational task shifting,⁵ expanding access to mental health services to undocumented immigrants, and increasing student interest in community mental health. Within this workshop we will discuss the details of the BH project. Group discussion will focus on some of the challenges and strategies for

implementing similar projects within a student-run clinic. Workshop participants will identify potential ways to overcome difficulties of implementation and to develop strategies to engage students and faculty in the process of designing and delivering BH services.

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

Chair: Brian Palmer, M.D., M.P.H.

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

EDUCATIONAL OBJECTIVE:

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

SUMMARY:

This is a repeat of prior workshops held in New Orleans in 2010, Philadelphia in 2012, San Francisco in 2013, and New York in 2014. Those resident-only workshops were very successful, with high levels of attendance and engagement (over 100 attendees at each session). 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 (features) 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 (follow) 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.

TRANSITIONING FROM SERVICEMEMBER TO VETERAN: IMPACT, ASSISTANCE, AND A WAY AHEAD

Chair: Christopher H. Warner, M.D.

Speakers: Carl A. Castro, Ph.D., Charles Hoge, M.D., Loree K. Sutton, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the key tenets of military transition theory and recognize the implications upon their veteran patient population; 2) Develop an increased understanding of the military culture and have an increased level of competence in interacting with this unique cultural group; 3) Identify veterans who are struggling with issues of military transition, even long after their service is complete; and 4) Provide strategies, treatments, and refer to resources to assist in military transition.

SUMMARY:

Since the U.S. went to war in Afghanistan in 2001 and Iraq in 2003, more than 2.5 million

members of the Army, Navy, Marines, Air Force, Coast Guard and related Reserve and National Guard units have deployed to those countries with over one third completing multiple tours, and nearly 50,000 completing five tours of duty in these combat zones. It is estimated that 7-20% of the service members and veterans who deployed to those countries are suffering from behavioral health conditions. As such, significant focus including efforts in identifying symptoms early, reducing stigma to seek assistance, and development and expansion of evidence based treatments for these conditions have been a focus of research efforts in the last decade. Yet, little attention or research has focused on an enduring military stressor, the transition from military to civilian life. This key transition that every service member will face produces changes in relationships, assumptions, work context and personal and social identity.

This presentation will discuss the military transition theory including the three interacting and overlapping phases (approaching, managing, and assessing) and will describe individual, interpersonal, community, and military organizational factors that impact the military transition process. Discussions will focus on concepts of burdensomeness and belongingness with efforts outlining individual tasks that transitioning service members can do (Dr. Charles Hoge author of the book *Once a Warrior Always a Warrior*) and community resources and assistance which may be available for this process (BG(ret) Loree Sutton, Chief of Veterans Affairs for New York City). Consideration will be given to how this transition and the successful ability to navigate it may impact key areas such as veteran suicides, willingness to continue care, and elder care of veterans. It will conclude with a discussion on future initiatives for both while these service members are in uniform and once they transition back to civilian life that can assist in this process and help identify veterans who are struggling with transition and assist in developing a sense of community belongingness.

COMPUTER-ASSISTED COGNITIVE BEHAVIOR THERAPY FOR DEPRESSION

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

Speakers: Jesse H. Wright, M.D., Ph.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify advantages and disadvantages of computer-assisted cognitive-behavior therapy (CCBT) for depression; 2) Describe evidence base for the effectiveness of CCBT; and 3) Detail methods of using CCBT in clinical practice.

SUMMARY:

Computer-assisted cognitive-behavior therapy (CCBT) for depression is emerging as an effective method of delivering evidence-based treatment to more people at lower cost than traditional CBT. This workshop details advantages and disadvantages of CCBT, reviews research on the efficacy of this form of treatment for depression, illustrates several computer programs for CCBT in current use, and describes methods of integrating CCBT into clinical practice. The proposed method features ways to enhance the efforts of clinicians and move toward a hybrid method of clinician + technology for treatment delivery. Workshop participants will discuss implementation of CCBT in clinical practice and opportunities for future development of computer technology for psychotherapy.

Educational Methods:

- 1) Interactive illustration of CCBT for depression
- 2) Illustration of three programs for CCBT for depression
- 3) Interactive discussion with participants

INTRODUCTION TO MEDIA WRITING: A HANDS-ON, INTERACTIVE EXPERIENCE FOR PSYCHIATRY TRAINEES AND EARLY CAREER PSYCHIATRISTS

Chairs: Smita Das, M.D., M.P.H., Ph.D., Desiree Shapiro, M.D.

Speakers: Deborah L. Cabaniss, M.D., Lloyd I. Sederer, M.D., Drew Ramsey, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Appreciate the importance and value of communicating mental health information to the public ; 2) Learn the basics of becoming involved in media writing (including increased awareness about potential writing opportunities and media outlets); 3) Develop basic writing skills to efficiently/effectively deliver a message (practice writing, receive real time feedback from peers/experts, examining

strengths/weaknesses in samples); and 4) Encourage involvement in written media efforts, including APA sponsored projects. .

SUMMARY:

In the age of social media and instantaneous reporting, mental health-related news rapidly reaches the public. Unfortunately, this information is occasionally presented with bias or added stigma, sending unsound messages to large audiences. It is important for leaders in psychiatry to deliver factual and responsible mental health messages in print media such as opinion editorials, blogs, twitter, and other written formats in order to promote accurate reporting, increase awareness of mental health issues, and reduce stigmatization/discrimination of mental illness. Many young and early career psychiatrists, the future leaders of the mental health, have no formal training in creating engaging and effective media writing. The goal of this workshop will be to increase confidence in and awareness of psychiatry's involvement in disseminating mental health information, both effectively and responsibly. The APA Leadership Fellows (Bibhav Acharya, MD; Smita Das, MD, PhD, MPH; R. Scott Johnson, MD, JD; Ayana Jordan, MD; Brent Nelson, MD; & Desiree Shapiro, MD) will present an interactive workshop on written communications put forth by psychiatrists for the general public. This interactive workshop will highlight the value of communicating mental health information to the public in an effective and efficient manner via media writing outlets such as press releases, opinion editorial pieces, tweets, and blog entries. Experts in the field will teach the basics of media writing, including how to get involved and how to create a message. There will also be an experiential activity with live feedback from peers and experts. Finally there will be a handout of "pearls" or "dos and dont's" collected from experienced mental health writers. We have invited guest speakers from Columbia's esteemed media writing course, Deborah Cabaniss, MD, Lloyd Sederer, MD, and Drew Ramsey, MD, to present significant information and facilitate the live writing activity. The speakers will introduce the session by discussing the basics of media writing including getting involved, creating a message, writing effectively, and engaging the appropriate media outlets. Following this, there will be an interactive component led by the speakers and the APL Fellows. Using a hypothetical breaking

mental health news story, attendees will break into groups to construct the opening and subsequent opening of an editorial, the title and opening of a blog entry, and various tweets. To conclude, the group will review the pieces written during the break-out sessions. Our experts will then provide feedback and answer questions from the audience. In addition to increasing writing interest and skills amongst the attendees, we hope to further APA endeavors in media. Many APA figures use twitter effectively to disseminate information, and the APA publishes a "Healthy Minds" blog. We hope to inspire such activity in these efforts. This workshop is meant to be highly interactive.

PRACTICING IN THE NINTH DECADE: OPPORTUNITIES AND ISSUES

Chairs: Roger Peele, M.D., Herbert Pardes, M.D.

Speakers: Leah J. Dickstein, M.A., M.D., Norman A. Clemens, M.D., Brian Crowley, M.D., Alan A. Stone, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe the advantages of having octogenarian psychiatrists as part of American medicine; 2) Describe some of the issues that arise when practicing in one's ninth decade; and 3) Describe some of the personal advantages to continuing to work in their ninth decade

SUMMARY:

Given the experience that octogenarian psychiatrists bring to teaching, administrative work, and clinical care, and given the general shortage of psychiatrists, it is important qualitatively and quantitatively that octogenarian psychiatrists be part of American medicine. Some octogenarians even find that they practice with greater effectiveness than they did decades earlier

In addition to helping make the shortage of psychiatrists a little less dire, there is general evidence that working in later in life correlates with better physical and mental health. This Workshop consists of seven competent and willing octogenarian psychiatrists still active as teachers, administrators or clinicians, who will reflect on their present work, its pluses and minuses, and very much welcome discussion of the pros and cons of active practice in their ninth decade.

DON'T GET HIT: HOW TO MANAGE THE AGITATED SOLDIER OR PATIENT

*Chairs: Sebastian R. Schnellbacher, D.O.,
Wendi M. Waits, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the signs and symptoms of an agitated patient; 2) Employ basic principles of de-escalation; and 3) Understand the distinctive elements of agitation in a military environment.

SUMMARY:

Anger and agitation are very common in the medical environment. Almost half of all health care professionals have experienced violence during their careers. Several mental health conditions (including psychosis, mania, personality disorders and substance use) are a significant risk factor for increased violent behavior. Because of these reasons, psychiatrists need to be prepared to identify and deescalate an agitated patient at a moment's notice. Anger and agitation can also manifest themselves uniquely in a military environment, and familiarization with these patterns can help avoid negative outcomes. This presentation will focus on the differential diagnosis and common patterns of anger and suggest effective preventive and de-escalating management strategies.

PSYCHIATRIC INTERVENTIONS IN PALLIATIVE OR END-STAGE CANCER

*Chair: Antolin Trinidad, M.D., Ph.D.
Speaker: Cheryl Person, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify psychopharmacological aspects relevant to palliative or end-stage cancer; 2) Recognize psychiatric assessments and psychotherapeutic interventions unique to the patient with end stage cancer; and 3) Recognize specific psychiatric aspects of the dying process in cancer that can be appreciated in a case presentation.

SUMMARY:

The psychiatric assessment and continuing management of the patient in the palliative

phases of cancer or those who have end stage malignant diseases are unique in many ways - the shortness of their lifespan, the presence of associated symptoms like pain and delirium, and the need to constantly collaborate/liaison with oncologists and other non-psychiatric medical teams are examples of issues that the clinician need to consider in depth. This workshop will present an update on psychopharmacology in palliative oncology (including an update on drug-drug interactions) as well as review essential psychotherapeutic facets relevant to palliation and the dying patient. Two extended case studies will be presented that will highlight these issues.

FROM TEMPERAMENT TO PSYCHIATRIC ILLNESS: NEUROPSYCHOLOGY OF UNDERLYING SYSTEMS

*Chair: Irina Trofimova, M.Sc., Ph.D.
Speakers: William Sulis, M.D., Ph.D., Julie Christiansen, M.Sc.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the links between temperament traits and dispositions for psychiatric disorders; 2) Diagnose temperament traits using a compact screening temperament test; and 3) Reason in regards to underlying neurophysiological imbalances underlying psychiatric disorders .

SUMMARY:

Temperament and mental illnesses are considered to be varying degrees of the same continuum of imbalance in the neurophysiological regulation of behavior. Temperament traits were linked to specific patterns in the relationships between neurotransmitters and activation of certain brain structures. Similar links were found between neurotransmitters, brain structures, and personality disorders. This workshop reviews about 40 existing models of temperament summarizing them in an integrated 12-trait model. Neurochemical correlates for each trait are reviewed and compared against symptoms of psychiatric illnesses. Participants will be offered an introduction and practice with a brief screening test of temperament, the Structure of Temperament Questionnaire (STQ-77), assessing the 12 temperament traits in clinical and healthy populations. Main approaches to the interpretation of temperament profiles in the

context of psychiatric practice will be discussed.

THE EVIDENCE-BASED PSYCHOTHERAPIST: USING THEORIES AND TECHNIQUES FROM ATTACHMENT, TRAUMA AND MENTALIZING TO IMPROVE OUTCOMES

Chairs: Paula Ravitz, M.D., Robert Maunder, M.D.

Speakers: Melyn Leszcz, M.D., Clare Pain, M.D., Jon J. Hunter, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand critical factors related to the effective establishment and maintenance of the therapeutic alliance; 2) Utilize clinical approaches that reduce the risk of therapeutic impasses and negative outcomes in psychotherapy; and 3) Delineate how attachment-based formulation, mentalizing, countertransference, and taking account of trauma, can be used to improve psychotherapy outcomes.

SUMMARY:

What predicts psychotherapy outcomes? The evidence suggests that the greatest impact is due to factors that are common to all models of psychotherapy. These include a strong therapeutic alliance, empathy and collecting client feedback, consensus about goals, collaboration, positive regard, therapist genuineness, and a therapist's ability to adapt to his or her patient and to manage the tensions and strong emotions that arise in therapy (Norcross & Lambert, 2011; Norcross & Wampold, 2011). To optimally apply these common factors, the therapist needs to understand a patient's relational world, to mentalize, and, in turn, to communicate meaningfully. Research has established that there is much more that distinguishes effective from ineffective therapists than that which distinguishes the effectiveness of different models of therapy (Barth et al., 2013). The best psychotherapists afford their patients twice the likelihood of improvement and half the likelihood of deteriorating compared to less effective therapists (Baldwin & Imel, 2013), whereas the difference in effectiveness between different models of therapy is much less pronounced.

Therefore, the central focus of this workshop, on improving psychotherapy effectiveness, is to guide clinicians on how best to use ourselves as therapeutic agents - emphasizing the evidence-based psychotherapist over evidence-based psychotherapies (Leszcz, Pain, Hunter, Maunder & Ravitz. in press).

This workshop aims to help psychiatrists to expand their clinical repertoire and improve outcomes through application of an integrative, relationally-informed approach. Foci will include the therapeutic alliance, attachment, countertransference, interpersonal dynamics, mentalizing principles and the impact of trauma in clinical presentations. The format of the workshop features a combination of didactic, interactive presentations, with filmed simulations that demonstrate applied principles to practice with standardized patients.

MAY 19, 2015

THE INTERDISCIPLINARY TEAM AND ROLE OF THE PSYCHIATRIST IN DEEP BRAIN STIMULATION

Chair: Sarah M. Fayad, M.D.

Speakers: Sarah M. Fayad, M.D., Herbert Ward, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Clinicians will identify the FDA approved indications for DBS and experimental uses of DBS and will understand the role of the interdisciplinary team; 2) Clinicians will identify psychiatric symptoms which may be a barrier to successful DBS; 3) Clinicians will learn which rating scales are commonly employed in assessing patients for DBS; and 4) Clinicians will identify treatment strategies for managing patients following DBS.

SUMMARY:

Deep Brain Stimulation (DBS) 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 (HDE) from the Food and Drug Administration (FDA) for use in carefully selected cases of obsessive compulsive disorder (OCD). 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 or interdisciplinary approach for screening and then also follow DBS subjects pre- and post-operatively. This team can involve follow-up typically involves 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 success 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 (DDS) 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 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 the treatment in the postoperative period.

BREAKING DOWN BARRIERS TO CARE: STIGMA AND OTHER OBSTACLES

Chair: Michelle Wu, M.D.

Speakers: John V. Campo, M.D., Eugene V. Beresin, M.D., Gordon Strauss, M.D., Patricia Lester, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the impact of stigma on preventing access to psychiatric care; 2) Identify methods that can be utilized in primary care settings to help close the mental health treatment gap and to promote positive strengths; 3) Identify outreach strategies that are being utilized to help college students obtain psychiatric care and maintain mental well-being; 4) Recognize importance of public education in reducing stigma and raising psychiatric awareness; and 5) Integrate this knowledge into proposing measures to reduce psychiatric stigma in their own practice and institutions.

SUMMARY:

Stigma against people with mental illness continues to be a major barrier to treatment. Public stigma leads to social undesirability, internalization of negative feelings, and self-stigma.¹ Studies have demonstrated that decreasing stigma in the community will reduce self-stigma. Public health campaigns can improve mental health literacy which will lead to change in attitudes towards the mentally ill.³ Other studies have shown that interventions which enhance coping skills, such as improving self-esteem, empowerment, and help-seeking behavior may be more beneficial than interventions that purely attempt to alter the stigmatizing beliefs and attitudes of the individual. 2. This workshop reviews the current state of mental health stigma, issues related to stigma preventing access to psychiatric care, specific strategies and programs that are currently being implemented in varied settings to provide mental health education to combat stigma, and provides participants to consider how they might implement these strategies in their own settings. Eugene Beresin, MD will review historical issues related to stigma, along with successful public education campaigns in

the UK, Australia, and New Zealand. He will discuss his work at the Clay Center for Young Healthy Minds at Massachusetts General Hospital, which educates parents and caregivers about mental health and well-being. Gordon Strauss, MD will address stigma in college mental health and the outreach efforts at the University of Louisville to teach and reinforce the variety of ways that college students can access care through orientations with resident advisors, career counselors, and within the Greek system. Jessica Jeffrey, MD and Michelle Wu, MD will present a behavioral health screening tool currently used at UCLA in a primary care setting. A psychometrically validated behavioral health measures questionnaire identifies areas of increased symptoms, and includes strength-based measures to identify areas of positive functioning. Besides connecting patients to appropriate providers, patients are then provided with a clearer picture of treatment progress and are encouraged to develop areas of strength to promote and reinforce personalized education and positive coping. John Campo, MD will review all these key subjects and lead a discussion inspiring workshop participants to examine what they can do in their practice and institutions to join the fight against psychiatric stigma. References:1. Latalova K, Kamaradova D, Prasko J. Perspectives on perceived stigma and self-stigma in adult male patients with depression. *Neuropsychiatric Disease and Treatment*. 2014;10: 1399-14052. Mittal D, Sullivan G, Chekuri L, Allee E, Corrigan PW. Empirical studies of self-stigma reduction strategies: a critical review of the literature. *Psychiatric Services*. 2012 Oct; 63(10): 974-813. Dyduch A, Grzywa A. Stigma and related factors based on mental illness stigma. *Pol Merkur Lekarski*. 2009 Mar;26(153):263-7

PSYCHIATRY OF PANDEMICS: MENTAL HEALTH ASPECTS OF PANDEMIC OUTBREAKS OF INFECTIOUS DISEASES

Chair: Damir Huremovic, M.D., M.P.P.

Speakers: Nyapati R. Rao, M.D., M.S., Robert Martin, M.D., Shabneet Hira-Brar, M.D., Amarpreet Singh, M.D., Hisbay Ali, M.D., Rajvee Vora, M.D., M.S.

EDUCATIONAL OBJECTIVE:

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

mental health aspects of infectious disease epidemics at both individual and public health level; 2) Identify unique mental health issues associated with rapid outbreaks of serious infections (e.g. Ebola hemorrhagic fever, SARS); 3) Manage mental health aspects of a serious infectious disease outbreak on inpatient and outpatient services; and 4) Manage public mental health aspects of an infectious disease outbreak at a local community level.

SUMMARY:

Catastrophic pandemics have been occurring at regular intervals throughout human history, with the last one (Spanish flu pandemic of 1918) taking place nearly a century ago. In the decades that followed, contemporary psychiatry has given such events little consideration. Modern-day mental health resources and research have largely been focused on infectious diseases that impose significant public health burden on the society (e.g. HIV or Hepatitis C). With their steady and predictable epidemiology, such diseases allow for studious and systematic approach. A rapidly spreading outbreak of an infectious disease, on the other hand, leaves little time to fully comprehend mental health aspects of that illness, yet its social impact may be immense. Recent developments, including a current outbreak of Ebola hemorrhagic fever and, in recent past, SARS, have again drawn global attention to such pandemics, stirring up anxiety and unease across continents. When such events occur, mental health response is by default undertaken as a mental health response to a disaster. While the approach of disaster psychiatry is applicable to organizing and providing mental health response to epidemic outbreaks, there are some crucial idiosyncrasies in pandemic mental health worth serious consideration: 1) Unlike most disasters, pandemic outbreaks have predictable epidemiological models that allow reasonable time for planning and preparation as the pandemic progresses; 2) Health workers in pandemic outbreaks are both at increased risk for infection and traumatized by caring for infected patients, with rates of PTSD among healthcare personnel reaching 20 percent, as was the case during the 2003 SARS outbreak. 3) Quarantine, for centuries routinely practiced method of infection control, has received surprisingly little attention in psychiatric literature. Nevertheless, prolonged isolation and separation from families and their

community can have profound effect on individuals even if they are not directly affected by the disease⁴) Psychiatric sequelae of surviving the illness, its complications, and complications associated with treatment may warrant sustained mental health focus and attention⁵) Managing concerns, fears, and misconceptions at local community and broader public level becomes as important as treating individual patients. 6) Healthcare facilities may transform from points of care to nodes of transmission, further jeopardizing public trust in healthcare system and its ability to respond to the outbreak. This workshop examines the unique elements of pandemic outbreaks to be considered when formulating a mental health response and explores additional modalities of supplementing and strengthening that response. Planning for mental health response at various levels will be outlined. A panel of seasoned clinicians with frontline experience of practicing psychiatry across the globe will present. Ample time is allocated for Q&A and participant discussion.

INTERACTIVE TRAINING AND DISSEMINATION OF TOBACCO CESSATION IN PSYCHIATRY: AN RX FOR CHANGE

Chair: Smita Das, M.D., M.P.H., Ph.D.

Speakers: Smita Das, M.D., M.P.H., Ph.D., Andrew J. Saxon, M.D., Douglas Ziedonis, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Explain the relevance and importance of tobacco cessation treatment in psychiatric settings; 2) Review smoking+mental illness epidemiology, medication interactions, nicotine, dual diagnosis and withdrawal symptoms; 3) Provide brief skills for clinicians using behavioral techniques for smoking cessation, including the 5 A's and increase knowledge of pharmacologic cessation aids and their use in psychiatric settings; and 4) Be able to access RxforChange, a web based curriculum to disseminate tobacco treatment training for health care professionals, including specific training for psychiatric settings.

SUMMARY:

Smoking and smoking related mortality/morbidity continue to

disproportionately affect those with mental illness. Among individuals with mental illness, smoking prevalence is 2 to 4 times that of the general population. Smokers with mental illness and addictive disorders purchase nearly half of cigarettes sold in the United States. Smoking is important to psychiatric practice for a variety of reasons such as use or withdrawal effects on behavior/mood, association with future suicide attempts and psychotropic drug level changes. Treating smoking is one of the most important activities a clinician can do in terms of lives saved, quality of life, and cost efficacy. The APA recommends that psychiatrists assess the smoking status of all patients, including readiness to quit, level of nicotine dependence, previous quit history, and provide explicit advice to motivate patients to stop smoking. In a recent national AAMC survey of physicians, psychiatrists, as compared to other doctors, were least likely to participate in cessation activities and most likely to feel that there were greater priorities in care and that smoking cessation would worsen other symptoms. Only half of US psychiatry residency programs provide training for treating tobacco while 89% of program directors have interest in a model tobacco treatment training curriculum. "Rx For Change" is a mental health focused tobacco treatment training program informed by a comprehensive literature review, consultation with an expert advisory group, interviews with psychiatry residency training faculty, and focus groups with psychiatry residents. Rx for Change emphasizes a Transtheoretical Model of change-stage tailored approach with other evidence-based tobacco treatments such as are nicotine replacement, bupropion, varenicline, nortriptyline, clonidine, and psychosocial therapies (integrating 5 A's-to ask all patients about tobacco use, advise to quit, assess readiness, assist, and arrange follow-up). The 4 hour training when included in curriculum for psychiatry residents is associated with improvements in knowledge, attitudes, confidence, and counseling behaviors. This workshop will offer abbreviated psychiatry focused tobacco cessation training with a secondary goal to provide a resource to attendees to use at their sites. Rx for Change is available online via <http://rxforchange.ucsf.edu> at no cost and offers a packaged training tool for improving treatment of tobacco use in psychiatric care. After the training participants receive material from the website that can be

accessed later. An expert panel will close the session with an interactive question and answer opportunity. We hope that APA attendees who participate in the workshop, as leaders at their institution, disseminate the training. Dissemination of an evidence-based tobacco treatment curriculum has the potential of dramatically increasing the proportion of smokers with mental illness who receive assistance with quitting.

MORAL DILEMMAS, MENTAL HEALTH, AND ETHICAL CONDUCT ON THE BATTLEFIELD: THE NATO APPROACH

Chair: Christopher H. Warner, M.D.

Speakers: Rakesh Jetly, M.D., Eric Vermetten, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the context in which moral decisions are made in military operations; 2) Understand the relationship between unethical battlefield behaviors and mental health symptoms; and 3) Provide recommendations on actions leaders can take to promote awareness of and interventions for mental health issues associated with moral decisions.

SUMMARY:

Military operations often involve difficult decisions that affect the well-being of the decision-makers, their subordinates and peers, their adversaries and civilians impacted by the conflict. These decisions exist throughout the full-spectrum of military operations (e.g. peacekeeping, peacemaking, humanitarian, and combat) and are often the most difficult that soldiers will face. The difficulty stems from the fact that these decisions require the service member to choose between mission success, civilian safety and force protection. Currently there are no NATO-wide, standardized education or training packages to help make these decisions or deal with the potential impact of the decisions on service member mental health. Moral dilemmas require the reconciliation of conflicting values and obligations. These decisions may create psychological distress associated with what are called moral injuries (Maguen & Litz) such as grief, shame, guilt. In some cases, moral dilemmas contribute to mental health problems

such as PTSD, depression and anxiety. Additionally, the underlying presence of psychological distress may negatively influence soldiers' attitudes towards following the laws of armed conflict and rules of engagement. This can lead to decision-making resulting in misconduct and other unethical behaviors. Military operations involve moral decision-making at every level (strategic through tactical) and these decisions have important implications. First, the consequences of a single bad decision can erode local, national, international and host nation support thereby derailing the strategic mission and putting troops at risk. Second, attention to the interplay between moral decision-making and mental health is a crucial component of leaders' responsibility for their soldiers. This demands leadership initiatives (e.g., education and ethics training, after action reviews, counseling, reintegration programs) that mitigate the threat to the mission and soldier well-being.

This presentation will highlight the four year efforts of a multi-national group of military behavioral health experts and leaders in developing guidance on what leaders can do to establish a positive ethical climate and the related improved mental health in military medical units and standardized training in support of that guidance.

HIGH ANXIETY IN THE RESIDENT CLINIC: CHALLENGES FOR THERAPISTS-IN-TRAINING

Chairs: Joan M. Anzia, M.D., John Manring, M.D.

Speakers: Priyanthy Weerasekera, M.D., M.Ed., Megan Pirigyj, M.D., Kara Brown, 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 participants in exploring at least three different difficult situations in the early stages of therapy; and 3) Make maximal use of psychotherapy supervision to address early therapy challenges.

SUMMARY:

Beginning resident psychotherapists enter clinical practice with a wealth of information gleaned from textbooks, didactics and

supervision. Challenges initially arise in implementing and applying this information to real-life patients, and residents may often find themselves in situations in which they feel underprepared. In addition, the early period of psychotherapy is critical to building a therapeutic alliance; residents may feel that altering the frame of therapy to support complex, challenging patients may be beneficial in establishing rapport, only to learn later that damage has occurred. This workshop will examine common scenarios that emerge in psychotherapy and prove challenging to the beginning psychotherapist. Examples include the erotic transference (The Seductive Patient), difficulty engaging the reluctant patient (The Silent Patient), and gift-giver (The Generous Patient). 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 patients, 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.

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., Laura Roberts, M.A., 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; and 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? Do you want to yelp?

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 small 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, speculation about future developments, 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.

WORKING WITH THE GENDER-VARIANT CLIENT/CLIENTS WITH GENDER DYSPHORIA

Chair: David Baker-Hargrove, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Assess and confirm a diagnosis of gender dysphoria in appropriate patients; 2) Understand common terms and cultural language in the transgender/transsexual community; 3) Identify the emotional, physical, and mental health challenges typically present in patients with gender dysphoria; 4) Understand the role and responsibilities of the mental health professional in the medical treatment of patients with gender dysphoria; and 5) Utilize modalities to treat patients with gender dysphoria.

SUMMARY:

The unique needs of transgender/transsexual clients present an emerging field in physical and mental health today. Mental health professionals can benefit clients by being ready and equipped to provide needed services in a culturally competent and sensitive manner that promotes growth and healing. This seminar will

cover the identification, assessment, and diagnosis of gender dysphoria; commonly used terms and cultural language; and the emotional, mental health, and physical challenges that exist within the transgender/transsexual community and psychological and medical treatment modalities for these patients.

WHEN HEART AND MIND CONFLICT: HELPING COGNITIVELY IMPAIRED COLLEAGUES TRANSITION OUT OF CLINICAL PRACTICE BUT PRESERVE THEIR PERSONAL INTEGRITY

Chairs: Sheila Hafter-Gray, M.D., Paul Wick, M.D.

Speakers: Nada L. Stotland, M.D., M.P.H., James Lomax, M.D., Luis T. Sanchez, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Differentiate age-related cognitive changes that do not affect competence from those that make a colleague unsafe to work with patients ; 2) Delineate emotional challenges in leaving practice and design alternative strategies to help colleagues meet them; 3) Delineate steps one may take when a cognitively challenged colleague declines to retire; 4) Determine when referring a senior colleague to a Physicians' Health Committee is appropriate; 5) Balance conflicting ethical requirements as we plan late stages of our individual careers.

SUMMARY:

Weiss v Walsh [324 F. Supp. 75 (S.D.N.Y. 1971)] made it nearly impossible to require a professional individual to retire from practice because of age alone; and since then advances in health care make it possible for psychiatrists to practice well into their 80s or even 90s. We now must cope with colleagues whose cognitive decline may have made them incompetent, but who continue in practice. There is a good body of evidence on which to base determinations of incompetence; but encouraging colleagues to retire from practice is emotionally fraught, primarily because of the tight imbrication of practice and self identify. After reviewing the evidence on cognitive decline, we will turn to narrative-based explorations of the psychosocial issues and their management. The primary task is to transition to a new developmental stage in

which one maintains personal integrity though one is no longer engaged in direct patient care. What are the factors that may make it difficult for psychiatrists to take this step, and how may we, as individuals and as a professional organization, help colleagues successfully do this? When incompetence is accompanied by personality changes, what interventions may be useful? What procedures have medical organizations developed to deal with cognitively impaired physicians whose patients may be at risk? What are the ethical issues we all confront if we determine to practice until we die?

Disclaimer: The opinions or assertions contained in her presentation are the private views of Dr. Hafter Gray and are not to be construed as official or as reflecting the views or policies of the the Uniformed Services University, the Department of Defense or any of its affiliated organizations, or the United States Government.

PRACTICAL STRATEGIES TO DECREASE COGNITIVE BIAS IN THE DIAGNOSIS OF MEDICAL CONDITIONS MIMICKING PSYCHIATRIC DISORDERS

Chairs: Adam L. Hunzeker, M.D., Rohul Amin, M.D.

Speakers: Rohul Amin, M.D., Adam L. Hunzeker, M.D., Vincent F. Capaldi II, M.D., Jarred A. Hagan, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify personal clinical decision making processes and cognitive biases; 2) Recognize the cost and morbidity/mortality associated with thought error in healthcare; 3) Describe the difference between fast and slow thinking processes; 4) Explain the contribution of heuristics to the diagnostic process; and 5) Demonstrate the use of cognitive forcing strategies to reduce cognitive bias using real-world clinical vignettes

SUMMARY:

Introduction: Diagnostic ambiguity is commonplace in psychiatric practice. With limited etiological understanding behind the illnesses that we treat, it can be a daunting task to diagnostically approach a complex patient. The nexus between a medical and psychiatric illness is fraught with diagnostic pitfalls. Incorrect treatments and diagnosis can be

costly and dangerous. Evidence suggests a great majority of diagnostic errors stem from "thought errors" that lead to morbidity and mortality as well as medico-legal actions against physicians. Data has shown, however, that through education, physicians can decrease diagnostic thought errors and improve clinical outcomes. The aim of this workshop is to help learners identify and recognize the contribution of their cognitive biases in clinical decision making. With the improved insight into these processes, we aim to have the learners demonstrate strategies using small groups and real-world cases to reduce thought errors and ultimately become better diagnosticians. The participants will be able to use the cases provided for training at their institutions. A bibliography with other useful references and an easy reference pocket card will be included for further advancement of the learned skills. 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. The small groups would permit demonstration of skills needed to reduce diagnostic errors. 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. Through education and learned skills in this workshop, the contributions of cognitive bias can be lessened thus enabling physicians to approach complicated patients more effectively.

DIAGNOSING, DISCLOSING, AND DOCUMENTING BORDERLINE PERSONALITY DISORDER: CLINICAL AND ETHICAL DIMENSIONS

Chairs: Dominic Sisti, Ph.D., John G. Gunderson, M.D.

Speakers: Andrea G. Segal, M.S., Andrew M. Siegel, M.A., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify reasons psychiatrists do not disclose the diagnosis of borderline personality disorder to patients.; 2)

Examine practices related to documenting borderline personality disorder.; 3) Critique disclosure and documentation lapses using ethical theories.

SUMMARY:

Borderline Personality Disorder (BPD) is a valid and reliable diagnosis with effective treatments. However, data suggest many patients remain unaware they carry the diagnosis, even when they are actively engaged in outpatient psychiatric treatment. The presenters will first review results from a survey conducted at the 2014 APA Annual Meeting revealing that 60% of respondents have failed to disclose a diagnosis of BPD to their patients, and a substantial number said they avoid transparent documentation of BPD. The findings highlight the need for further research to identify specific reasons why psychiatrists are sometimes hesitant to be fully open about the diagnosis of BPD, so that educational interventions about the importance of diagnostic transparency may be designed and deployed. Second, the ethical issues related to diagnostic transparency will be addressed. Finally, the ramifications of lapses in diagnostic disclosure and documentation will be discussed in the context of integrated care.

SOCIAL MEDIA: THE GOOD, THE BAD, AND THE UGLY

Chair: John Luo, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the permanence and pervasiveness of social media content and its impact on privacy; 2) Address the boundaries of beneficence and harm with social media in medicine; and 3) Utilize good practices for preserving privacy online.

SUMMARY:

Social media is well-known and utilized by both the public and professionals. It's potential for outreach and knowledge dissemination are tremendous with regards to health information as well as social causes, in addition to keeping your friends updated with your activities. The line in the sand keeps being washed out and redrawn with regards to how social media is used in medicine. Opinions change over time as to what is considered appropriate professional behavior online. With the lower

threshold for posting information, privacy is being constantly undermined and has become a rare commodity. Invasion of privacy has a tremendous downside to one's professional reputation online. This workshop will provide an overview of the major social media sites with regards to how they are used in healthcare, as well as demonstrate the various ways privacy has been eroded. Tools and strategies to preserve privacy and maintain the boundary with professional reputation online will be reviewed.

ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

Chairs: Richard D. Milone, M.D., Richard K. Harding, M.D.

Speakers: Mark S. Komrad, M.D., William Arroyo, M.D., Stephen C. Scheiber, M.D., Claire Zilber, M.D., Elissa P. Benedek, M.D., Wade C. Myers, 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; and 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.

QIGONG FOR MENTAL HEALTH

Chair: Colleen T. Loehr, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand scientific research about qigong interventions in treating depression, anxiety, and other mental health problems; 2) Practice qigong exercises to increase vitality, mental clarity, and overall well-being; and 3) Teach simple qigong exercises to patients.

SUMMARY:

Qigong is an ancient healing art from China that is having increasing relevance to mental health care. This workshop will review recent meta-analyses of randomized controlled trials on qigong interventions in treating depression, anxiety, post-traumatic stress disorder, and other mental health problems. Medical schools, psychiatric hospitals, and outpatient clinics that offer qigong classes will be described. The presenter will discuss personal experiences of teaching qigong exercises to staff and patients at a psychiatric hospital. Participants will also learn and practice qigong exercises during this active workshop. Participants can expect to experience increased vitality and clarity of mind from engaging in qigong exercises taught during this workshop. Participants will be able to teach patients simple qigong exercises to improve overall well-being.

WHOSE COMMUNICATION PROBLEM? OBSTACLES TO RECOVERY IN PERSONS WITH INTELLECTUAL DISABILITY AND PSYCHIATRIC DISORDERS

Chairs: Robert J. Pary, M.D., Janice L. Forster, M.D.

Speakers: Janice L. Forster, M.D., Jeffrey I. Bennett, M.D., Stephen Ruedrich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the challenges of systems of care on assessment of acute psychiatric emergencies in individuals with ID; 2) Describe the strategies to overcome inadequate or misleading data when evaluating and treating persons with ID with psychiatric disorders on an acute unit; 3) Review the challenges and modifications needed when utilizing Telepsychiatry to consult on persons with ID; and 4) Discuss the possible effects of childhood sexual abuse on post-surgical recovery as an adult.

SUMMARY:

Persons with intellectual disability (ID) not only face the usual barriers to recovery that most people confront as they recover from an acute psychiatric episode, there are often additional stresses because of communication difficulties or difficulties in abstract reasoning. While communication problems in persons with ID have been well described, less attention has been given to the communication challenges from those who provide supports or treatment. This is especially true when important aspects of their past are either not considered or ignored. This presentation will utilize case presentations to illustrate several aspects of how the recovery persons with intellectual disability from physical and/or psychiatric illnesses can often be complicated by miscommunication among caregivers and health professionals. The seminar will also recommend several strategies in how persons with intellectual disability can (re)gain control over health and daily functioning.

PSYCHOTHERAPY UPDATE 2015: PROMOTING EVIDENCE-BASED PRACTICE

*Chairs: Priyanthy Weerasekera, M.D., M.Ed.,
John Manning, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Determine indications and contraindications to the different psychotherapies; 2) Understand the different individual patient variables that predict outcome; 3) Become familiar with how to form a therapeutic alliance with their patient; and 4) Learn evidence-based teaching methods for learning psychotherapy.

SUMMARY:

The last few decades have witnessed significant advances in psychotherapy research. This research has demonstrated that there are evidence-based psychotherapies for patients with psychiatric disorders, that the therapeutic alliance is a key variable in outcome, and that individual variables help tailor treatments to patients. Of the evidence-based therapies studied to date, cognitive-behavioural, interpersonal, psychodynamic, experiential, couple, family and group, target specific

psychiatric disorders or problems that commonly accompany these conditions. Level 1 evidence (that is meta-analyses or double-blind controlled trials) exists for most of these therapies across a variety of conditions. The therapeutic alliance has also been found to predict outcome early in treatment independent of therapy type, and is related to therapist skill and attributes, and to patient variables. Individual variables such as attachment styles and personality traits have also been shown to differentially predict response to treatment, indicating that not all patients with the same disorder respond similarly to the same psychotherapy.

The purpose of this workshop is to provide a psychotherapy update for the practising psychiatrist, who is not familiar with the extensive literature in this area. By reviewing this literature the clinician will become familiar with the current indications and contraindications of the various psychotherapies for patients with psychiatric disorders. How research informs practice will also be closely examined with clinical case examples. References will be provided as well as resources to assist the clinician to keep up with this challenging and exciting area. The most up to date literature (up to 2015) will be reviewed.

TO TREAT OR NOT TO TREAT: IS THAT THE QUESTION? THE EVALUATION AND TREATMENT OF MOOD DISORDERS IN CASE EXAMPLES OF PREGNANT WOMEN

Chair: Kara E. Driscoll, M.D.

*Speakers: Katherine L. Wisner, M.D., M.S., Kara
Brown, M.D., Marley Doyle, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the barriers to the identification and treatment of mood disorders during pregnancy; 2) Engage the patient in discussion and decision-making regarding her treatment; and 3) Deliver evidence-based psychiatric care to this vulnerable and important population.

SUMMARY:

Women are particularly vulnerable to the occurrence of mood episodes during the childbearing years. In spite of this, identification

of mood disturbance is often delayed and under-treated during pregnancy, particularly as compared to non-pregnant women. As a result, there is a risk of relapse of prior illness or unnecessary prolongation of the identification and treatment of new illness during pregnancy which impacts both mother and her child. Many mental health practitioners and patients feel overwhelmed by the decision-making involved in the care of a pregnant woman with mood disturbance.

This workshop is designed to 1) highlight and address some of the barriers to identification and treatment of mood disorders during pregnancy and 2) facilitate better care of the pregnant patient. Attendees will participate in discussion of case examples of pregnant women with mood disorders, focusing on evaluation, treatment options, and common dilemmas. The workshop leaders and attendees will collaborate in creating an individual treatment plan for each patient. The workshop will highlight common screening tools, risks of treatment versus no treatment, possible exposures during pregnancy, and potential for relapse in those with a history of mood disorders. Workshop leaders and participants will also discuss issues of medication monitoring and dose adjustments secondary to pregnancy metabolism and as well as planning for the postpartum period. Finally, the participants will practice skills for engaging the patient in a discussion about treatment and fostering patient participation in the decision-making. Workshop presenters will incorporate current evidence available for the treatment of mood disorders during pregnancy. At the end of this workshop, the participants will have increased comfort with the individualized evaluation, identification, and treatment of mood disorders in pregnant women.

MEFLOQUINE INTOXICATION IN CLINICAL AND FORENSIC PSYCHIATRY

Chairs: Remington L. Nevin, M.D., M.P.H., Elspeth C. Ritchie, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe key neuropsychiatric features of mefloquine intoxication and its chronic sequelae, including those highlighted in the 2013 boxed warning for the drug; 2) Identify critical considerations in the clinical diagnosis and management of

mefloquine intoxication; and 3) Recognize the relevance of mefloquine intoxication and its chronic sequelae in psychosomatic medicine and forensic psychiatry, particularly among military service members and veterans.

SUMMARY:

Mefloquine (previously marketed as Lariam) is a quinoline derivative antimalarial originally developed by the U.S. military that has recently been recognized as having significant intoxicating and neurotoxic potential. A new boxed warning, added in 2013, warns of chronic psychiatric effects "reported to continue for months or years" after use of the drug, including "anxiety, paranoia, and depression to hallucinations and psychotic behavior", and neurological effects including "dizziness or vertigo, tinnitus, and loss of balance". The chronic neuropsychiatric effects of mefloquine toxicity highlighted in the 2013 boxed warning may have significant relevance in psychosomatic medicine and forensic psychiatry, and may readily complicate and confound diagnosis of conditions frequently comorbid with military service and deployment, including posttraumatic stress disorder and traumatic brain injury. In this case-based workshop, the history of mefloquine's use, particularly within military populations, is discussed, and the key neuropsychiatric features of mefloquine intoxication and its chronic sequelae are described. Through vignettes and case presentations, critical considerations are introduced to aid the psychiatrist in the clinical diagnosis and management of mefloquine intoxication, including recommendations for appropriate pharmacologic management, laboratory and radiological testing, and additional specialist referrals. Forensic issues including the potential role of mefloquine intoxication in cases of violence and suicide are then considered.

PRE-EXPOSURE PROPHYLAXIS FOR HIV: THE SCIENCE, PSYCHOLOGY, AND IMPLICATIONS FOR CLINICAL PRACTICE

Chair: Marshall Forstein, M.D.

Speakers: David Goldenberg, M.D., Kenneth Ashley, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define PrEP [pre-exposure prophylaxis] and the ARTs [antiretroviral treatments] that are currently available for PrEP; 2) Identify populations at risk for HIV that might benefit from PrEP; 3) Formulate a clinical situation in which PrEP might be appropriate and safe.; 4) Identify two potential adverse outcomes of population use of PrEP; and 5) Identify at least two co- occurring conditions in which PrEP might be problematic.

SUMMARY:

HIV continues to be a worldwide epidemic. In the United States, approximately 50,000 new infections occur yearly, with the major incidence in MSM's (men who have sex with men) Men of color are disproportionately infected, and young men continue to participate in unprotected sex in spite of having knowledge about the use of condoms. The advent of multi drug treatment for HIV that has increased health and longevity among those infected has had the effect of decreasing the sense of fear and anxiety about acquiring HIV as a life threatening disease. Young people who have not experienced the scourge of HIV in their peer communities often believe that if they get infected they " simply need to take medication". Based on a few studies in the US and in Africa, antiretroviral medication has been shown to effectively block infection by HIV if taken daily [pre-exposure prophylaxis-PrEP]. Studies vary in the effectiveness for preventing HIV from 42% to 92%. Given the enormous impact of HIV on at risk populations both the CDC and the World Health Organization recommend PrEP for "high risk" individuals who are serologically tested to be HIV negative. These population based recommendations do not adequately assess the impact of PrEP on individuals with regards to psychological readiness, capacity for adequate adherence to daily dosing, and potential for increasing risk taking behavior. Antiretroviral therapy for people infected with HIV that suppresses viral replication has already been shown to have a significant impact on reducing the transmission of HIV from HIV infected to non-infected. Concerns have been voiced about spending resources on PrEP rather than on treatment for those already infected, especially in resource poor nations. This Workshop will present a few brief presentations on the science of PrEP, the translation of the research into clinical practice, the psychotherapeutic and

psychosocial issues, and the ethical implications of using costly medications in healthy people. The long term unintended consequences will be discussed as social, political, intrapsychic and public health issues. The following questions will be raised in brief presentations: 1-How effective is PrEP when used in the clinical setting compared to research protocols? What variables in the protocols might not be present in the clinical setting? 2-What social, psychological and financial issues must be considered from applying research findings to a specific clinical situation?

3- How will the use of PrEP affect decision making and risk taking among a variety of MSM's? 4-How will resources applied to PrEP affect the access to care and treatment for people infected with HIV?

5-How should psychiatrists and mental health clinicians incorporate PrEP into an ongoing treatment for high-risk individuals? What countertransference issues might arise?

I WISH I LEARNED THAT IN RESIDENCY: PREPARING FUTURE PSYCHIATRISTS FOR THE FUTURE OF PSYCHIATRY

Chairs: Sharat P. Iyer, M.D., M.S., Matthew D. Erlich, M.D.

Speakers: Sharat P. Iyer, M.D., M.S., Matthew D. Erlich, M.D., Andres Barkil-Oteo, M.D., M.Sc., Barney R. 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 how recent structural and economic changes within the behavioral health service delivery system impacts new psychiatrists entering the field; 2) Learn how to discuss direct and indirect health care costs with consumers; 3) Comprehend concepts of quality measurement and improvement, and how adoption of performance metrics and incentives will affect psychiatrists; 4) Understand how to train future psychiatrists to work in integrated settings with licensed and para-professional colleagues, including consumer providers; and 5) Recognize how to safely use mobile apps and social media to improve clinical care and advocacy.

SUMMARY:

Newly graduating psychiatry residents and fellows face a rapidly transforming field with unparalleled challenges and unique opportunities. These changes are shifting the locus of psychiatric care into integrated primary care settings, where the chronic disease mortality gap for people with mental illnesses can be addressed, but where the role of the psychiatrist is increasingly uncertain. Changes to the health care delivery system and financing are shifting priorities in mental health care and are leaving consumers increasingly burdened by out-of-pocket expenses. The expansion of the non-physician mental health workforce (e.g., peer providers and other para-professionals) will challenge the role of the future psychiatrist. Proficiency in recovery-oriented practices, accountability, quality measurement and improvement, patient-centered care, and enhanced use of technology will be essential to the psychiatrist in the office and beyond. Residency programs are at the front line of workforce development, and will need to meet the demands of newly emerging delivery systems. They need to transform medical students into effective clinical psychiatrists, adept team leaders, and integrated practitioners. On the whole, current four-year residency programs in psychiatry do not emphasize how to manage managed care, how psychiatrists' services are accountable and counted in terms of costs or outcomes of care, how to integrate with other professional and para-professional providers, how to discuss costs of care with consumers, and how to incorporate technology, especially social media, as an effective tool of practice and advocacy. Psychiatrists entering the field today therefore need to add skills to their repertoire in order to be the psychiatrists of tomorrow. A better understanding of the novel health care delivery systems introduced by the Affordable Care Act, such as accountable care organizations and Medicaid health homes, is critical. Future psychiatrists will need to know how to navigate quality measurement and performance incentives in order to ensure their clinical and economic effectiveness. They will need to integrate with other providers, work in increasingly diverse delivery systems, and engage consumers about the immediate and real costs of care, in order to improve adherence, clinical outcomes, recovery and hope. Moreover, the 21st century psychiatrist will increasingly use mobile technology and

social media in their personal and professional lives, and will need to know how to do this safely and successfully. This workshop will introduce Resident-Fellow and Early Career Psychiatrist members to the tools and skills they will need to be effective psychiatrists of the future, and will also serve as a forum for discussion about the future of psychiatry for APA members across the spectrum of experience in the field.

NO POSTER? NO PUBLICATION? NO PROBLEM. A STEP-BY-STEP GUIDE TO GET YOU STARTED IN THE SCHOLARLY ACTIVITY PROCESS

Chair: Rashmi Aggarwal, M.D.

Speakers: Nicole Guanci, M.D., M. Pilar Trelles, M.D., Cristina Montalvo, M.B.B.S., M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To help participants identify barriers to productivity in the scholarly activity process; 2) To provide concrete steps towards choosing a topic for an abstract; and 3) To provide guidelines for undertaking a literature search and to give specific 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 lack the necessary skills for 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 a combined 23 poster abstracts at the APA's Institute for Psychiatric Services and annual meeting during the 2013-2014 academic year. This is in comparison to a previous precedent of only a few 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.

VARIETIES OF RELIGION AND SPIRITUALITY: WHAT SHOULD CLINICIANS KNOW?

Chairs: Chris Winfrey, M.D., Rama Rao Gogineni, M.D.

Speakers: John R. Peteet, M.D., Shridhar Sharma, D.P.M., M.B.B.S., M.D., Driss Moussaoui, M.D., Steven Moffic, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Define spirituality and, religion, and appreciate the importance of their relationship with mental health; 2) Understand

how increased cultural competency among physicians will enhance their effectiveness in diagnosing, treating, and addressing spirituality and religious concerns as a barrier, facilitator; 3) Grasp the phenomenological and epidemiological manifestations of religions and spirituality in clinical practice; 4) Understand the religious and spiritual impact of mental illness in a variety of different contexts; and 5) Acquire practical tips for training clinicians and setting milestones amongst residents and faculty for assessing their progress.

SUMMARY:

Religion & spirituality and science & psychiatry share a long and complex history. For scientists, consciousness and thought are entirely physical products of our brain created by the electrical and chemical changes in the neurons. Empiricism in science and earlier psychoanalytic writings contributed to a split between religion, spirituality, and psychiatry (Peteet). It is also suggested that there is a difference between spirituality and religion. However, there is an intimate relationship between spirituality, religion, and mental Health. Spirituality has a deep psychobiological basis, a reality that needs to be understood. However, different religions of the world have somewhat varying views of faith, spirituality that contribute not only to the practice of their ethno-cultural life, but also influence their acceptance of science of psychiatry, it's practice and treatments. Many patients desire to discuss or incorporate religious/spiritual beliefs in their care but often raise concern about how health care providers would accept their beliefs (Stanley et al). In twelve steps program, spirituality is widely valued, and in palliative medicine, spirituality is included in their care. However, religion and spirituality (R/S) is not widely accepted in psychiatry. Many patients have described their beliefs of religion and spirituality as conducive to their mental health. It is important to understand the ways in which individuals appeal to religion and spirituality when under stress, and the ways that R/S can contribute to mental health. For example, a telephone survey of over 2000 African-American correlated religious social support with several positive health behaviors although negative interactions in their faith community correlated with increased binge drinking (Debnam et al). Greater attention is now being paid to the religious experience of individuals, rather than

to the doctrines set out by institutions, so that the quality of the experience, and the resultant functional outcomes can help to distinguish these from pathology. The presenters and discussant in this session will comment from their diverse experiences on the implications of R/S for clinical practice, DSM-V, and the changing face of the relationship between mental health, psychiatry, and religion and spirituality. They come from America, Africa, south Asia, and the Middle East, and represent Judaism, Christianity, Buddhism, Hinduism, and Islam. Discussion will focus on finding a common message regarding how better to impact policy and strengthen relationships between R/S and mental health communities. Religion and culture are often inextricably woven; both must be considered when we try to understand people's beliefs and practices. Attempting treatment without understanding the spiritual/religious/cultural context of the patient is likely to prove unempathic and ineffectual.

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; and 3) facilitate permanent changes in eating.

SUMMARY:

A growing body of research demonstrates that cognitive behavioral techniques are an important part of a weight loss and maintenance program, in addition to exercise and changes in eating (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.

WEEDING THROUGH THE HYPE: UNDERSTANDING ADOLESCENT CANNABIS USE

Chairs: Kara Bagot, M.D., Sharon L. Hirsch, M.D.

Speakers: Sharon L. Hirsch, M.D., Gabrielle Shapiro, M.D., Christian Hopfer, M.D., Ara Anspikian, M.D., Christopher J. Hammond, M.D., Kara Bagot, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the various forms of cannabis being used by adolescents, the methods of use and outcomes of use; 2) Understand how the adolescent neurodevelopmental phase impacts adolescents use of cannabis and vice versa; 3) Learn screening interventions to identify at-risk and cannabis abusing youth; and 4) Recognize the challenges of practicing in an environment of increasing legalization.

SUMMARY:

Cannabis is the most widely used substance in the world, especially among adolescents. This is of concern given the increased susceptibility in developing brains to substance exposure. Past-year prevalence of cannabis use in youth aged 12-17 years is estimated to be 13.4%, with greater than 25% meeting criteria for Cannabis Use Disorder. Given the conceivable increase in marijuana availability to youth, and decreased perception of harm, via medical marijuana and pro-legalization legislation, the

association between early cannabis use and psychosocial, medical and psychiatric outcomes is an important public health issue. Bottom up affective and motivational processes (including reward processing) mature around the time of puberty leading to strong temptation and approach motivation in adolescents. However, top down processes mature gradually into young adulthood such that adolescents have greater difficulty inhibiting behaviors in the context of salient stimuli and lack of positive and structured supports. Frequent consequences of cannabis use include substance dependence, motor vehicle accidents, cognitive impairment, respiratory problems and onset of psychosis, especially in those individuals with a high baseline clinical risk. Use characteristics such as onset, frequency and duration have been shown to be associated with health-related outcomes. Research demonstrates that with increased legalization of cannabis, prevalence of cannabis abuse among adolescents will increase. Additionally, those who have already initiated use are more likely to use more frequently. Identifying successful screening and treatment interventions is essential for prevention and cessation of cannabis use and prevention of associated deleterious health outcomes.

YOU BE THE NEUROLOGIST: DIAGNOSIS AND TREATMENT OF MILD TRAUMATIC BRAIN INJURY IN A CASE STUDY FORMAT

Chairs: David B. FitzGerald, M.B.A., M.D., Josepha A. Cheong, M.D.

Speakers: David B. FitzGerald, M.B.A., 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; and 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.

MEDICAL COMPLICATIONS OF ANOREXIA NERVOSA AND BULIMIA AND THEIR EVIDENCE-BASED TREATMENTS: CASE-BASED REVIEWS

Chair: Philip S. Mehler, M.D.

Speaker: Philip S. Mehler, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the medical complications associated with anorexia nervosa ; 2) Recognize the medical complications associated with bulimia nervosa; 3) Become familiar with the treatments that are utilized for patients with anorexia and bulimia to maximize their chances of a successful recovery; 4) Understand the crucial role of the multidisciplinary teams in the medical care of patients with anorexia nervosa and bulimia; and 5) Recognize the potential adverse events that may be associated with weight restoration and "detoxing" from purging behaviors.

SUMMARY:

This workshop will address the medical complications of anorexia nervosa and bulimia and the most effective treatment methods. There are many serious medical complications associated with anorexia nervosa and bulimia which directly impact the ability to achieve an overall successful outcome. It is critical that mental health professionals are familiar with the medical complications associated with anorexia nervosa and bulimia, regardless of its duration or severity. Clinical vignettes will be presented to elucidate the salient teaching points. The workshop will be structured as a

comprehensive, case-based, salient body system by body system review of these medical complications with clear delineation of those which are associated with anorexia nervosa versus those associated with bulimia. In addition, an extensive amount of time will be devoted to reviewing the evidence-based therapeutic options for these medical complications including insights about safe nutritional rehabilitation and weight restoration.

BODY DYSMORPHIC DISORDER: CLINICAL FEATURES, NEUROBIOLOGY, AND TREATMENT

Chair: Katharine A. Phillips, M.D.

Speakers: 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) Diagnose body dysmorphic disorder based on new DSM-5 criteria; 2) Identify genetic and environmental/sociocultural factors, as well as visual processing abnormalities, that may contribute to the development and maintenance of BDD; and 3) Effectively treat body dysmorphic disorder with pharmacotherapy and identify effective approaches and resources for treating body dysmorphic disorder with cognitive behavioral therapy.

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, a tendency to experience obsessive thoughts and compulsive behaviors, evolutionary and cultural influences regarding physical appearance, and visual perceptual abnormalities. Some of these factors may be etiologic whereas others may contribute to the maintenance of BDD symptoms. Dr. Phillips will review BDD's key clinical features and will discuss evidence-based treatment approaches, both pharmacologic and psychosocial, as well as how to engage patients in treatment. Dr. Feusner will discuss findings that may be relevant to this disorder's etiology and maintenance, both biological and psychosocial, with a focus on abnormalities in visual processing. This will lead to an interactive session in which audience members can ask questions and discuss their cases. 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 the workshop will also focus on. We have given this workshop at the annual meeting for the past two years; we propose to give it again because it has been so well attended, and because participants were very interested in the topic and had many cases to discuss.

MORAL TREATMENT IN PSYCHIATRY: REFLECTION ON EUROPEAN ROOTS AND THE INFLUENCE OF MORAL THERAPY ON EARLY AMERICAN PSYCHIATRY

Chairs: David Roby, M.D., Louis C. Charland, Ph.D.

Speakers: Louis C. Charland, Ph.D., David Roby, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Introduce history of Moral

treatment in England and America; 2) Discuss ethical and clinical aspects of moral treatment; and 3) Discuss ethical and clinical legacy of moral treatment in America.

SUMMARY:

While one might argue "You know moral treatment when you see it," the inception of moral treatment emerged in Europe over several centuries. Each location had its own unique history, context, principles and practice. Collectively, all of these institutions contrasted starkly with the harsh and repressive norms of treatment which preceded them. The authors will summarize briefly four prominent European institutions in Spain, Italy, France and England. They will focus in much greater detail on the York Retreat which was founded in 1792 by William Tuke in conjunction with local Quakers. Lastly, the influence of the York Retreat on several early American psychiatric institutions will be explored. In particular Friends Hospital, New York Hospital, the Hartford Retreat and Sheppard Pratt will be examined with attention to both the early and long term influence of moral treatment. In 1791, William Tuke and fellow York Quakers were aghast by the deplorable treatment received by Hannah Mills, an unfortunate 24 year old Quaker who succumbed to an acute illness in several weeks. When local Quakers attempted to visit her, they were turned away, being told she was unfit to receive visitors. While Quakers lamented her fate, they also felt some visitation might have afforded her some solace. They resolved to create a Quaker institution to provide more compassionate care. The resolution came to fruition in 1796 when the York Retreat admitted its first patients. Recognition of this innovative treatment was galvanized in 1813 when Samuel Tuke, grandson of founder William Tuke published a 220 page account describing in great detail the York Retreat. Samuel Tuke would continue as a staunch advocate for improved care both in England and around the world. The York Retreat remains open to this day, and continues to embrace innovative strategies. While moral treatment is complimented by many modalities of psychiatric care, it continues to be a powerful humanistic and compassionate principle.

THE MANY FACES OF NARCISSISM

Chair: Glen O. Gabbard, M.D.

Speaker: Holly Crisp-Han, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify true narcissistic personality disorder; 2) Recognize the cultural variants of narcissism that stop short of being personality disorders; and 3) Treat the different variants of pathological narcissism that appear in practice.

SUMMARY:

Narcissism is a widely used word in psychiatry but one that lacks specificity. It is used to describe persons who are selfish, to represent the opposite of altruism, to disparage those who may be successful and self-confident who inspire envy in others, to denote a specific DSM 5 personality disorder, and to characterize an entire generation-i.e., the "Millenials". The latter usage of the term blurs the distinction between cultural trends and individual psychopathology, much like Lasch's "culture of narcissism" did in the 1970s. Narcissism may also be confused with the everyday phenomenon of healthy self-interest. In this workshop we will explore these diverse ways of using the word, and we will survey the research on narcissistic personality disorder, suggesting that there are relevant subgroups that are not clearly depicted in the DSM 5 criteria. We will also seek to identify individual characteristics that help clinicians diagnose people with pathological narcissism or true narcissistic personality disorder. Finally, we will discuss the treatment implications of the distinctions that we clarifying.

ARTS-BASED WORKSHOP: "WILDERNESS," AN AWARD-WINNING, 10-MINUTE FILM ABOUT A MOTHER'S STRUGGLE TO SEEK MENTAL HEALTH CARE FOR HER SON

Chair: Suzanne M. Archie, M.D.

Speakers: Jill Dennison, B.A., Alexandra Douglas, M.D., Elizabeth M. Ward, R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To highlight the struggles of families as they enter the mental healthcare system.; 2) To disseminate knowledge from families, as users of the system, to healthcare providers.; 3) To empower healthcare providers to make changes in their practice and the

system that may help connect patients and their families to care; 4) To share stories and experiences that help connect families and healthcare providers in a way that supports young people experiencing a first episode of psychosis; and 5) To develop strategies that help to make treatments more engaging and accessible for young patients and their families.

SUMMARY:

In order to transform the healthcare system so that it is more accessible, it is important to actually view the system from the perspective of young people and their families. Research has shown that the arts are a powerful medium for translating poignant human experiences into stories that depict an aspect of reality that can connect, move, and enlighten audiences.

In this workshop, the attendees will be drawn into the story of a mother who is trying to find help for her son following a first episode of psychosis. *Wilderness* is a film that helps the audience to discover a mother's journey through the system. It won the Remi Platinum award for Best Drama in the Short Film category at the 2012 Worldfest-Houston International Film Festival.

This film will be used to introduce and explore in depth the various barriers and obstacles that families face as they attempt to navigate the mental healthcare system. We will explore specific issues family may face and the ways that healthcare providers, healthcare institutions, and the general public can remove some of these barriers in order to help facilitate access. This workshop aims to reveal universal truths about the implications of our system and to explore how healthcare providers can improve the stories of families struggling to support and give care to their ill relatives. The results of a thematically analyzed transcription of a focus group about *Wilderness* involving 10 mental healthcare providers and two family members will be presented. Some of the themes identified include the need to better address the concerns of families through family education and support and to include them as partners in care.

Reference:

Gerson R and Corcoran C. Qualitative Research with Families of First Episode and Prodromal Patients. Eds. Boydell KM and Ferguson HB. *Hearing Voices: Qualitative Inquiry in Early Psychosis*. Wilfrid Laurier University Press, 2012: 45-58.

YOU RE READY TO PRACTICE...NOW WHAT?

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

Speakers: Kristen Lambert, J.D., M.S.W., Moira K. Wertheimer, B.S.N., J.D., R.N.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Have a general understanding of issues when forming a new practice, joining an existing partnership or beginning as an independent contractor; 2) Appreciate the importance of evaluating issues prior to joining or forming a practice such as: contracts, employment status, compensation, exclusivity provisions, and insurance coverage; 3) Have an understanding of record retention guidelines/regulations: who owns the records and the importance of office policies reflecting same.; 4) Understand the importance of policies regarding standard documentation, risks involved with EMR and written documentation; and 5) Recognize the importance of supervision of trainees, office staff and related malpractice issues.

SUMMARY:

There are a number of risk management and legal considerations when entering practice after residency, fellowship, as an early career psychiatrist or if considering a change after years of practicing psychiatry. Options for employment may include: opening a solo office, forming a partnership or joining a group practice as an independent contractor or employee. This session will provide an overview of issues to consider within each of these options, will identify risk management strategies and will explore topics such as medical record retention/release, acting in a supervisory capacity, office compliance system, and will discuss contractual considerations with a new or existing partnership.

MULTIMEDIA INTERACTIVE TEACHING METHODS IN PSYCHIATRIC EDUCATION, ENABLING DEEPER LEVELS OF LEARNING: AN INTERNATIONAL PERSPECTIVE

Chairs: Raja Natarajan, M.B.B.S., Manikam Thiru

Speakers: Raja Natarajan, M.B.B.S., Manikam Thiru, Janet Young, B.A., O.T., Michael Crook

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify ways in which multi-media techniques can be used to enhance psychiatric education at under-graduate and post-graduate levels; 2) Identify how media-based forum theatre techniques can be used to enhance psychiatric team development and education; 3) Identify how interactive on-line teaching can be used to enhance distance learning using constructivist methodology; and 4) Consider how interactive multi-media techniques can be used to enhance their own fields of psychiatric education.

SUMMARY:

Within psychiatry training, a change in teaching and learning methodology is endorsed by the World Psychiatry Association (WPA), who promote a move towards more interactive methods of teaching and away from didactic methodology. Evidence suggests that using constructivist, experiential methods for teaching, creates deeper levels of learning, with increased engagement of students and greater application of knowledge and learning in the context of clinical practice.

The presenting team have developed a range of teaching methods using multi-media techniques to increase accessibility of learning in many settings - small group learning, the lecture format, psychiatric team development, on-line interactive learning, team telephone teaching. Techniques, including the use of filmed 'patient' behaviour, simulated psychiatric consultations, commercial film clips, patient monologues, audio clips, on-line learning platforms and film in forum theatre, have been used to aid the construction of deeper levels of learning through reflection, to embed clinical and communication theory into practice and to stimulate engagement in psychiatric education.

The psychiatry training team from the UK have used interactive multi-media techniques in the UK and overseas – Egypt, Singapore, Hong Kong, Malta and India - and have delivered individual training on-line with psychiatrists across continents – Australia, India, Africa. With the increased availability of multi-media and on-line facilities world-wide, the opportunity to integrate media tools into teaching is on the increase. In areas of the world where teaching

resources are limited, the use of media to enhance learning is a viable way to encourage constructivist learning, as promoted by the WPA. The session will highlight at one such project, where multi-media techniques were used in large scale under-graduate psychiatry lectures at SRM University Medical College Hospital, Chennai.

This workshop will use experiential learning to enable participants to experience how multi-media techniques can be applied within psychiatric education, and to foster the sharing of good practice.

WOMEN OF A CERTAIN AGE SHARE SURPRISING SPECIAL EXPERIENCES

Chairs: Leah J. Dickstein, M.A., M.D., Elissa P. Benedek, M.D.

Speakers: Carol C. Nadelson, M.D., Esther Roberts, M.D., Malkah T. Notman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Reconsider their current & future personal & professional life plans, depending upon current opportunities & ages, which they had never before perceived as possible; 2) Dedicate more individual time to making previously perceived unreachable goals, now potential realities, especially depending upon their personal health status & that of their significant others; and 3) Incorporate lessons learned today about lengths of personal life & careers into their current & future teaching opportunities to students, trainees and individual pts.

SUMMARY:

In the second decade of the twenty-first century, increasing life span has become a normal reality for increasing groups, especially for educated women. Invited women colleagues of a certain age will reveal & comment on unexpected personal & professional experiences never before deemed possible or probable, and their reactions to these occurrences.

Sufficient discussion time will enable audience members to comment, pose questions, and perhaps seek & receive unexpected recommendations for their own current &/or potential future years.

**CURRENT PROCEDURAL
TERMINOLOGY CODING AND
DOCUMENTATION UPDATE**

Chair: Ronald Burd, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Be aware of changes to CPT coding in the past year; 2) Provide understanding of documentation of E/M coding; and 3) Respond to attendees specific questions about CPT coding issues.

SUMMARY:

The goals of the workshop are to inform practitioners about changes in the RBRVS Medicare physician reimbursement system, modifications in CPT coding and current issues associated with documentation guidelines. This year's workshop will focus on 1) updating participants as to current issues related to CPT coding 2) a review of current Medicare reimbursement issues and concerns, and 3) discussion of documentation guidelines for psychiatric services as well as the evaluation and management service codes. Time will be reserved for questions and comments by the participants about the above topics as well as issues and problems faced by the participants in their own practices.

**PSYCHIATRISTS WHO HAVE SURVIVED
THE SUICIDE DEATH OF A LOVED ONE:
THEIR INSIGHTS**

Chair: Michael F. Myers, M.D.

Speakers: Akshay Lohitsa, M.D., Anna Halperin Rosen, M.D., Karen K. Miday, M.D., Morisa Schiff-Mayer, M.D., Edward Rynearson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Become familiar with how the suicide death of a loved one affects individuals, including psychiatrists; 2) Know what bereaved psychiatrists can teach us about this very unique loss; and 3) Learn how we can help grieving psychiatrists when they consult us.

SUMMARY:

According to the Centers for Disease Control and Prevention, there were 39,518 deaths by suicide in the United States in 2011 (the most recent year for which we have data). It is

estimated that each suicide ultimately affects at least six people, many of whom are surviving family members. For some survivors, losing a loved member of one's family while growing up may inform their decision to study medicine and perhaps psychiatry. But others may not become a survivor until they are already studying or practicing psychiatry. This workshop is an extension of a standing room only workshop presented at APA 2013. Five psychiatrists who have been bereaved by the suicide death of a family member will enlighten us with their personal and courageous stories. Dr Akshay Lohitsa is a PGY4 resident at Weill Cornell Medical College in NYC. He lost his brother to suicide during his first year of training. With the aid of brief video feeds of his brother when he was young, he will discuss his loss and its impact on his becoming a psychiatrist. Dr Anna Halperin Rosen, a fellow in child psychiatry, lost her brother, Anthony Halperin, a fourth year medical student to suicide in April 2011. She will discuss the difficulty of identifying risk factors in highly functioning people and the impact that a family member's suicide can have on a survivor who works as a mental health professional. Dr Karen Miday will discuss the challenge of reconciling the Hippocratic Oath ("First, do no harm") with her physician son's death by suicide in June 2012. She will also discuss the very troubling, and often unspoken, element of shame, especially when substance use is a contributing factor. Dr Morisa Schiff-Mayer lost her mother to suicide. She will discuss the underground emotion of anger associated with surviving the suicide of a loved one, in particular its confusing aspects for the survivor and his/her family, friends and associates. Dr Ted Rynearson, clinician and researcher and author of "Retelling Violent Death" lost his wife to suicide in 1974. He will recount his memories of meeting with his wife's psychiatrist after her death and discuss ways in which clinicians can best help patients trying to cope with traumatic loss. Audience members are invited to engage with the speakers in their quest to understand this very difficult and painful loss.

**ABERRANT OPIOID-TAKING
BEHAVIOR/ABERRANT OPIOID-
PRESCRIBING BEHAVIOR: TWO SIDES
OF THE SAME COIN**

Chairs: Kenneth M. Certa, M.D., William Jangro, D.O.

Speakers: Mitchell J. Cohen, M.D., Christopher R. Martin, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe models for the understanding of chronic pain, and the role of opioids in its treatment; 2) List warning signs of problematic opioid use; 3) describe patterns of behavior in prescribers which can abet opioid addiction; and 4) Describe mechanisms to limit potential for aberrant prescription drug use, in both patient and prescriber.

SUMMARY:

Aberrant opioid taking behavior has become a topic of increasing clinical interest. Although much has been written on the topic, multiple factors prevent physicians from adequately assessing for it. Psychiatrists are often asked to assess whether a patient is abusing his or her medications. On the flip side, other than in cases of illegal "pill mills", aberrant opioid prescribing behavior receives much less attention. Just as aberrant opioid taking exists on a continuum, we observe that the same holds true with opioid prescribing. Whether directly embedded in an interdisciplinary pain medicine practice, consulting on medical/surgical floors, or providing outpatient consultation to pain specialist colleagues, psychiatrists have a unique and important role to play screening for "high risk" patients while at the same time educating colleagues on issues that may be unconsciously influencing their prescribing practices.

The purpose of this workshop is to first give a brief overview of modern bio/psycho/social models of pain as an experience. This perspective is contrasted with traditional models where chronic pain is seen as a disease. Next, we will review select literature on aberrant opioid taking behaviors, discuss methods of assessing and treating "high risk" patients with chronic pain. Finally, we will present a series of cases that illustrate a continuum of aberrant prescribing behaviors.

Dr. Cohen will provide an overview of pain medicine and of the role psychiatrists play in this interdisciplinary subspecialty.

Drs. Cohen and Jangro will discuss how to assess for aberrant opioid taking behavior in the context of chronic pain, and how to make clinically sound, ethical decisions when choosing whether to treat a patient with comorbid pain and opioid addiction.

Dr. Jangro will propose a model to assess for aberrant opioid prescribing behavior on a continuum that includes thoughtful-, helpless-, disinterested-, and drug dealing- prescriber. He will describe traits of the thoughtful opioid prescriber.

Drs. Certa and Martin will discuss aberrant opioid prescribing behavior and present cases we have encountered in our C/L services and outpatient pain medicine program. These cases illustrate our model of problematic opiate prescribing practices.

"Helpless" prescriber: becomes overly- involved with the patient; unable to cope with the patient's distress; may unconsciously use opioids to medicate away psychosocial stressors.

"Disinterested" prescriber: too focused on the patient's complaints; fails to see the "big picture;" signs of addiction are ignored; gets irritated when colleagues try to discuss concerns about prescribing behavior.

"Drug Dealing" prescriber: prescribes only for financial gain; illegal; no clinical justification; no concern for public's well-being.

PSYCHIATRIC INNOVATIONS OF 21ST CENTURY COMBAT: HOW EXTENDED COMBAT IMPROVED OUR ABILITY TO EFFECTIVELY TREAT VETERANS

Chairs: David M. Oliver, M.D., Elspeth C. Ritchie, M.D., M.P.H.

Speakers: Paul S. Hammer, B.S., M.D., Jeffrey Millegan, M.D., M.P.H., David M. Oliver, M.D., Andrew Mortimer, D.O.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the transformation of military philosophy toward seeking psychological care; 2) Understand the development of resilience and the operational stress continuum in military veterans; 3) Understand how extended combat led to improved medical informatics and telemedicine on the battlefield; and 4) Understand the development of psychological therapies for combat PTSD.

SUMMARY:

Extended combat leads to increased research and development in multiple areas or industry, logistics, information technology, and psychological health. Extended 21st century combat in Central Asia has contributed to positive developments in the treatment, understanding and assessment of psychological health of combat veterans. Specifically it contributed to changes in military philosophy towards mental illness, led to development of evidence based therapies, and vastly improved medical informatics on the battlefield which as a whole contributed to decreased stigma, improved willingness to seek care, and better access to IT tools to provide effective, safe psychological health care.

CAPT Paul Hammer, former Director of Defense Center of Excellence for Psychological Health and Traumatic Brain Injury and current Commanding Officer of the US Navy Medical Informatics command, reports on the transformation of military philosophy to one that shunned and avoided mental health support to one that recognizes and endorses the value of close psychological support. He addresses the ascendance of "COMBAT/OPERATIONAL STRESS CONTROL" to a military priority and the expansion of military psychological health efforts.

CDR Jeffrey Millegan addresses the role of resiliency as it applies to psychiatric patients and military members. He reports on the use of complimentary and alternative approaches to enhance resiliency, improve work effectiveness and recovery from psychological injury. He will address the mind body medicine concept and discuss its use during pre-deployment training.

CAPT David Oliver reports on the success of telemedicine in Central Asia and on other platforms which stems from the increase in bandwidth and IT capabilities. Along with CAPT Hammer, he discusses the other IT advances which allow instant access to health records from miles away and how that improves the provision of care.

The panel discusses improvements in evidence based therapies which occurred due to the public exposure to combat related mental illness. The proliferation of manualized therapies for treating PTSD have led improved use of evidence based psychotherapy.

CIVIL COMMITMENT: ASSESSMENT OF STATUTES OF AREA 7 STATES AND NATIVE SOVEREIGN NATIONS

Chairs: Monica Taylor-Desir, M.D., M.P.H., Roland Segal, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the indications for involuntary commitment; 2) Recognize the differences between civil commitment statutes of different states and native sovereign nations.; 3) Identify barriers that indigenous communities face when seeking involuntary psychiatric care; and 4) Develop strategies for improving involuntary commitment processes in their local communities.

SUMMARY:

There are over 560 federally recognized tribes in the United States. Canada has over 600 First Nations Communities which represent more than 50 nations or cultural groups and 50 Aboriginal languages. Native Americans who reside on reservation land are not subject to their state of local jurisdiction but are under their own tribal jurisdiction. There is a dearth of tribally operated inpatient hospitals for the mentally ill which presents a major barrier in seeking involuntary hospitalization for those Native American persons who are a danger to themselves or others. Civil commitment of people who suffer from mental illness and present a danger to self or other people is not a new topic. However, jurisdictions codify the process differently and there is great variation in the process, time frame, duration and type of involuntary treatment. This workshop will examine the statutes of the American Psychiatric Association Area 7 states (Alaska, Arizona, Hawaii, Idaho, Nevada, Oregon, New Mexico, Washington, Montana, Colorado and West Canada) and review the differences as well similarities between these jurisdictions.

In 2005-2009 the highest suicide rate in America was in Native American males with 27.61 suicides per 100,000 persons (CDC, 2014). Native Americans have the highest rate of suicide but have the most difficulty receiving psychiatric care. During this workshop we will examine a southwestern native sovereign nation that has developed a mental health code, the tribe's history of an intergovernmental agreement to assist their community members

in securing mental health care and the continued barriers they face. We hope to generate a discussion on the role of psychiatrists and mental health professionals advocating for their patients and collaborating with colleagues to secure the psychiatric care needed for individuals in their communities.

MOOD, ART, AND POLITICS: ABRAHAM LINCOLN, VINCENT VAN GOGH AND SYLVIA PLATH - RESILIENCE AND CREATIVITY IN THE FACE OF GREAT ODDS

Chair: John P. O'Reardon, M.D.

Speakers: John P. O'Reardon, M.D., Michelle Landy, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the links between psychopathology and artistic achievement; 2) Identify the role that mood disorders have played in the lives of major figures in the worlds of politics, art and poetry; and 3) Appreciate that mood disorders are double edged in being a spur to creativity as well unleashing destructive forces in the mind.

SUMMARY:

In this workshop we will examine the lives of two great artists and that of a deeply beloved politician, Abraham Lincoln, to some the "Father of the Nation". Through a detailed examination of their life stories we will attempt to understand their psychology to ascertain what role psychopathology played in driving their consummate achievements. As we will find out together such psychopathology as reflected in their severe mood disorders was at times a spur to greatness but did not ultimately define who they were as people or artists. Indeed at various times in their lives mood disorders were a profound obstacle to the execution of their innate gifts and creativity. Creativity and exquisite achievement are not restricted to artists of the word (Sylvia Plath) or of the canvas (Van Gogh) but also politicians who must become the masters of both words & ideas. Abraham Lincoln embodies the highest achievement in politics & government. He ended slavery and kept the Union together despite the tide of secession and tremendous losses in the war. On the poetic side Sylvia

Plath put forth a tremendous creative output in a very short period of time before her life was cruelly cut short by her own hand. Plath illustrates that a mood disorder can fracture a life. Finally we will examine the life of Van Gogh who also produced an enormous rich output in a short career. Like Plath he had to struggle against inner demons all his life to prevent an ultimate fracture of his life, a goal he was not able to achieve in the end.

THE CHALLENGES AND POTENTIAL SOLUTIONS OF TEACHING RESIDENTS EVIDENCE-BASED ASSESSMENT AND MANAGEMENT OF VIOLENCE WITHIN INPATIENT PSYCHIATRY SETTINGS

Chairs: Keith A. Hermanstynne, M.D., M.P.H., Christina Mangurian, M.D.

Speakers: Paul S. Appelbaum, M.D., Marvin Swartz, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify pharmacotherapy and behavioral strategies that can be effective in managing violence on the inpatient unit; 2) Describe challenges in teaching residents effective violence management strategies during residency training; and 3) Discuss results of a pilot program using a structured assessment tool coupled with evidence-based interventions to reduce patient violence.

SUMMARY:

Residency trainees in the inpatient psychiatry setting often face the challenge of working with patients with both a history of serious mental illness and a past or present history of violent behavior. While there have been several articles published on the utility of violence risk assessments, it can be difficult to implement structured assessments on inpatient settings. In addition, there are more research articles that focus on pharmacotherapy strategies that can reduce violent behavior in the mentally ill in comparison to evidence-based suggestions that describe effective behavioral strategies. This combination of factors can make it especially challenging to train residents how to effectively assess and manage patients with a past history of violent behavior on the inpatient unit.

Our workshop will examine existing research on pharmacotherapy and behavioral interventions that can reduce the risk of violence in psychiatric inpatients with a history of serious mental illness. We will then discuss the challenges in teaching psychiatric residents about violence risk assessment and management strategies that can be useful on the inpatient unit. Finally, we will review the results of a pilot program at a county inpatient psychiatry unit staffed by resident trainees that used a subset of the HCR-20 coupled with evidence-based interventions to reduce patient violence.

INTEGRATED AND COLLABORATIVE TRAINING FOR PSYCHIATRISTS AND NURSE PRACTITIONERS: MEETING THE NEEDS OF UNDERSERVED PATIENT POPULATIONS

Chair: Laura F. Marrone, M.D.

Speakers: Lawrence Malak, M.D., Steve Koh, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn more about the training and history of psychiatric nurse practice.; 2) Learn how clinical training for nurse practice in psychiatry can be integrated into traditional psychiatry clinical training programs; 3) Discern potential barriers and challenges in implementing a nurse practice clinical training program within general residency programs; and 4) Learn about potential future directions in collaborative model between psychiatry and nurse practice.

SUMMARY:

As a potential collaborator in the mental health provider market, it is important to establish a working relationship between psychiatry and psychiatric nurse practice (NP). This is especially true in psychiatrically underserved patient populations such as Geriatric Psychiatry due to the current lack of sufficient providers and resources to meet mental health treatment needs (1). As the psychiatric NPs' role expands, psychiatrists may need to take on a collaborative, clinical educator role in their development as the implementation of collaborative models increases.

The demand for more providers treating patients with unmet mental health needs creates opportunities to integrate nurse practitioners and other multidisciplinary trainees into psychiatric training sites. Some institutions are additionally developing curricula and models to teach integrated, multi-disciplinary team-based clinical practices to create a collaborative model (2). Preliminary trials examining collaborative care modes have been piloted in primary care settings, but studies examining collaborative models in mental health and psychiatry sub-specialty settings are needed (3). At University of California, San Diego (UCSD), we developed a novel clinical rotation for NP students at a psychiatric clinic with a traditional outpatient psychiatry residency training model. In San Diego, two new Advanced Psychiatric NP training programs have started in the last 5 years to begin to address the growing need for access to psychiatric treatment. The University of San Diego began training with community partnerships but no affiliation with the UCSD until 2013 when an effort to collaborate and train NP students alongside psychiatric residents was initiated. This partnership highlighted the culture change needed within a traditional outpatient mental health training clinic and presents an interesting opportunity to define the role of the psychiatric NP within a treatment team of trainees from different disciplines.

The session will give overview of psychiatric NP programs and provide comparisons with general residency clinical training. It will highlight cultural and perceptual challenges in co-training, present potential ways to improve on and impact clinical training, and promote discussion regarding the development of best practices in collaborative learning environments.

1. Kaas, Merrie J., Beattie, Elizabeth. Geropsychiatric Nursing Practice in the United States: Present Trends and Future Directions. *Journal of the American Psychiatric Nurses Assoc*, 2006; 12(3), 142-155.

2. ParÃ©, Line, et al. "Training in interprofessional collaboration: Pedagogic innovation in family medicine units." *Can Fam Physician*. 2012 April; 58(4): e203â€“e209.

3. Vedel, Isabelle, et al. "Diffusion of a collaborative care model in primary care: A longitudinal qualitative study." *BMC Fam Pract*.

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TRANSGENDER CARE IN THE BIBLE BELT: CHALLENGES OF FAMILY AND SOCIETAL NONACCEPTANCE

*Chairs: Daena L. Petersen, M.A., M.D., M.P.H.,
McLeod F. Gwynette, M.D.*

*Speakers: Dan H. Karasic, M.D., Nathaniel
Sharon, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Realize the impact regional religious and social cultures can have on transgender self-identity and family acceptance; 2) Recognize the psychological challenges facing transgender adolescents and young adults in non-accepting environments.; 3) Know the important role puberty blocking drugs and hormones perform in the treatment of transgender youth; and 4) Understand potential social and interpersonal impacts on the family system when a youth comes out as transgender.

SUMMARY:

Transgender adolescents and young adults face significant psychological and biological challenges, beyond the developmentally typical "search for identity" characteristic of this age group. The transgender patient is often engaged in a simultaneous struggle for both self-acceptance and the acceptance of loved ones. Rates of suicide, HIV, and homelessness are elevated in the transgender population, possibly reflecting this internal struggle.

The family's response to the transgender patient's disclosure can positively or negatively affect the patient's coping ability at a time when they are most in need of support. Many family members feel confused and angry as a result of a loved one's transgender disclosure, often leading to conflict both amongst the family and within the transgender patient. Parents may undergo a grieving process as they sense the "loss" of the child they anticipated would assume natal-assigned gender norms and fulfill traditional gender expectations.

The family's religious background may be a complicating factor, as transgender patients often feel judged or ostracized by religious organizations. Family members may feel that their desire to unconditionally love and support

their child lies in direct opposition to their own lifelong values and religious beliefs.

This workshop will comprise two case reports, followed by lively discussion amongst the presenters and the audience. The first case will be a fourteen-year-old female-to-male (FtM) transgender patient (presented by Dr. Petersen) who faces tremendous family conflict and difficult medical choices regarding the onset of puberty. The second case (presented by Dr. Gwynette) involves an eighteen-year-old male-to-female (MtF) transgender patient with Autism Spectrum Disorder (ASD), a condition of disproportionately high prevalence in transgender patients.

Dr. Karasic, a leader in the field of transgender mental health, and Dr. Sharon, a child and adolescent psychiatrist with experience caring for transgender youth in rural regions, will discuss each case. The discussants will explore principles of culturally competent transgender care, focusing on the complex family and psychological challenges facing transgender adolescents and young adults, including how best to support transgender patients and their families in resource-poor communities.

THE ROLE OF THE PSYCHIATRIST IN TREATING COLLEGE STUDENTS: HISTORICAL PERSPECTIVES, CHALLENGES, AND CURRENT INNOVATIONS

Chair: Amy Poon, M.D.

*Speakers: Leigh A. White, M.D., Nora
Feldpausch, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the increased demand for college psychiatric services and the current prevalence of mental illness in this population, and identify possible reasons for this increase; 2) Appreciate the different models of psychiatric care for college students, including innovative models for delivery of care; 3) Exchange challenges and experiences encountered in the treatment of college students, and reflect and learn from these exchanges; and 4) Understand the need for integration and advocacy of mental health resources for students, and be motivated to take an active role in promoting these back in their own practices.

SUMMARY:

As the demand for psychiatric services grows among college campuses, there is a need to re-examine how services are provided. This workshop will benefit any psychiatrist that treats college students, including private practice. We will review the literature, including the most recent prevalence data of mental illness in the college population. We will also review the historical organization of college mental health centers, and how this affects the structure of college mental health services today. We will present examples of health care delivery systems and current models of care, which tend to vary widely across college campuses.

This will be an interactive workshop, where we will take several breaks to promote discussion among participants. With the vast differences in delivery of health services among college campuses, this workshop provides an opportunity to promote dialogue between institutions, exchange ideas, learn from the experiences of other college campuses, and potentially take innovative ideas back to our own practice and institutions.

We will focus on current challenges that all college mental health providers face, including privacy laws, ethical challenges, risks of suicide and violence, family involvement, and barriers to integration of care. We will provide opportunity for participants to discuss these with each other, including potential solutions to these challenges.

We will spend the last part of the workshop reviewing current innovations in college mental health. This will include a presentation of integrated care teams, a novel model for the care of students. We will also look at partnerships with the administration of college campuses, and the importance of advocacy for students with mental illness, especially the need for resources.

Pedrelli P et al. College students: mental health problems and treatment considerations. *Acad Psychiatry*. 2014 Aug 21 [Epub ahead of print] PMID: 25142250

Shuchman M. Falling through the cracks--Virginia Tech and the restructuring of college mental health services. *N Engl J Med*. 2007 Jul 12;357(2):105-10.

MAY 20, 2015

TACKLING FINANCIAL HEALTH AT A COMMUNITY MENTAL HEALTH CENTER

Chair: Michael Sernyak, M.D.

Speakers: Annie Harper, Ph.D., Michael Rowe, Ph.D., Marc I. Rosen, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize how financial problems including low or insecure incomes and struggles with financial management may be affecting client's lives, general well-being, and mental health; 2) Identify existing options to support clients with their financial problems, and assess the strengths and weakness of these existing options; and 3) Identify alternative ways to help clients with their financial problems, and develop strategies for their implementation.

SUMMARY:

This presentation will explore how a large urban mental health center, the Connecticut Mental Health Center (CMHC) is addressing its clients' financial health-their ability to meet basic needs, plan for the future, and live a meaningful life without constant anxiety about making ends meet. Financial wellness has been identified by SAMHSA as one of the eight dimensions of wellness critical to enabling people with mental illness to achieve recovery and social inclusion. Currently, the most common option for low-income people with mental illness who are receiving social security income and who struggle with money is to be assigned a representative payee, who receives the person's income, pays key bills, and disburses the remaining cash to the client. CMHC also offers a money management program in which a money manager, who interacts regularly with clinical staff, manages money for a small group of designated clients who have difficulty coping with their finances. Research at CMHC has also led to the development of procedures for mental health providers at all levels to provide money management-based counseling. These include a money management-based treatment for people who use disability payments to buy drugs or alcohol, a detailed clinical assessment to determine when someone is not capable of managing their own funds and evidence for when representative payee assignment is effective.

We have also begun to explore options for clients who face financial difficulties but do not require, or accept, losing control over their own finances. Working with an anthropologist who brings ethnographic and qualitative expertise to our work, we have conducted a series of focus groups and in-depth individual interviews with CMHC clients and staff. We found that many clients struggle with their finances, expend significant energy on coping strategies, feel stigmatized by both their illness and their poverty, and lack access to information and services that could help them use their income more effectively. Many are either un-banked or under-banked, and most use costly non-bank services such as check-cashers. In partnership with CMHC clients and staff, we are designing a range of services to help clients meet their varied financial needs and goals in ways that clients will see as supportive and empowering rather than punitive. Working within a framework of 'citizenship-oriented care,' and drawing on the broader field of microfinance for people living in poverty, we will support clients in managing their resources to achieve fulfilling social relationships, responsibilities and valued roles. Services will include one-on-one financial counseling, group-based financial management training, support for gaining access to mainstream financial tools and services, and budgeting and saving support groups. Peer support staff will be the primary providers of services. Initial findings from this work will be included in the conference presentation.

THE ROLE OF PSYCHIATRY IN ACQUIRED BRAIN INJURY TREATMENT

Chair: David A. Williamson, M.D.

Speakers: Gary Goldberg, M.D., Kathleen T. Bechtold, Ph.D., David A. Williamson, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the role of Psychiatry in treating Acquired Brain Injury Complications as part of an Interdisciplinary healthcare team; 2) Diagnose the evolving pattern of common Psychiatric complications of Acquired Brain Injury throughout the long term trajectory of care; 3) Describe special considerations for pharmacological management of mood disorders in Acquired Brain Injury; and 4) Recognize the roles of multidisciplinary mental health team members in comprehensively managing ABI.

SUMMARY:

Acquired Brain Injury (ABI) includes all types of traumatic brain injuries and also brain injuries caused after birth by ischemia, hypoxia, surgical resection, and infection/inflammation. Regardless of etiology, afflicted patients present with common functional deficits correlating with damage to specific brain structures. Patients with ABI typically present in the acute phase to non-psychiatric specialists such as Emergency Physicians, Intensivists, and Neurologists or Neurosurgeons. In the subacute phase of care many patients are managed in a rehabilitation medicine setting with a Psychiatrist coordinating a team of neurorehabilitation sub-specialists. Many patients are returned to the community after extensive medical and rehabilitation treatment without having contact with a Psychiatrist.

However ABI may produce profound changes in emotional regulation, cognitive/executive function, and behavior; studies show high rates of mood disorder and other syndromes familiar to Psychiatry. ABI patients are sensitive to medication side effects and polypharmacy, or narcotics, prescribed by other specialists may induce changes in mental state or behavior. These morbidities derail the rehabilitation and recovery of ABI patients by corrupting interactions with providers and family members, by undermining motivation and degrading functional capacity, and sometimes creating unsafe behavior. Such adverse outcomes can frequently precipitate a crisis before a referral to Psychiatry is prompted.

The panel includes clinicians spanning the trajectory of care of ABI patients from an acute trauma hospital setting, through to an inpatient rehabilitation hospital, and on to outpatient care. The participants will present the arguments for robust psychiatric involvement in ABI treatment from the acute phase onwards. The most advanced and sophisticated domains of human brain function mediate social skills, communication, pragmatics, and communion between people; these relational competencies are degraded in complex and debilitating ways by ABI.

Recognizing that many psychiatrists asked to evaluate such patients may have no specific training in Rehabilitation Medicine, Neuropsychiatry, or ABI care, nonetheless the panel will discuss the valuable roles of General Psychiatrists to assess and treat complications

of ABI and support families throughout the long trajectory of care and recovery.

The participants also collectively have experience in both a Military/Veterans Administration setting and in a civilian managed care setting. The discussion will include a review of contrasts and similarities in the role of Psychiatry between the two systems, with suggestions for best practices.

INTERPERSONAL PSYCHOTHERAPY (IPT) FOR POSTPARTUM DEPRESSION

Chairs: Paula Ravitz, M.D., Sophie Grigoriadis, M.A., M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify and treat postpartum depression; 2) Use phase- and focus-specific therapeutic guidelines of IPT adapted for treatment of post-partum depression; and 3) Apply an IPT-PPD adherence checklist as an aide-memoire to structure treatment.

SUMMARY:

Postpartum depression is highly prevalent, in up to 15 % of women during the first year following delivery. It adversely affects mothers, their children and families, thus there is a critical need for it to be detected and treated. Medication can be helpful, however many lactating mothers prefer to avoid medication entering breast milk and prefer a talking therapy. Moreover, epidemiological studies and meta-analyses of predictive studies consistently highlight the importance of etiological psychosocial variables for postpartum depression, especially marital conflict and a lack of social support both of which are addressed in Interpersonal Psychotherapy (IPT; Klerman, Weissman & Markowitz). IPT is a well validated, evidence-supported post-partum depression treatment that is grounded in interpersonal and attachment theories (Sullivan, 1953; Bowlby, 1969).

IPT for postpartum depression uses a manualized, 12-session format in which the treatment goals are symptomatic relief and alleviation of interpersonal problems related to role transitions, marital conflicts, interpersonal sensitivity or losses. Therapeutic processes attend to close relationships, communication and social supports in the context of a life transition that is rife with changes and challenges that activate the attachment system.

IPT offers clear guidelines for helping mothers to engage with social supports and manage the role transition with its many demands and opportunities, thus leading to the alleviation of depressive symptoms.

This didactic, interactive workshop presents the therapeutic guidelines, with clinical case examples of IPT for postpartum depression, based on the manualized adaptation of IPT for postpartum depression (Stuart and Robertson, 2003). Modification for telephone provision, based on our accrued experience from an RCT with 240 postpartum depressed mothers, half of whom received IPT (PI: CL Dennis) will also be reviewed. Practical adherence checklists developed for the trial will be presented to aid clinicians to deliver the treatment with fidelity

INTEGRATING MENTAL HEALTH AND PRIMARY CARE: THE CANADIAN EXPERIENCE

Chairs: Nick Kates, M.B.B.S., Roger C. Bland, C.M., M.B.

Speakers: Nick Kates, M.B.B.S., Rivian Weinerman, M.D., Nadiya Sunderji, M.D., Francine Lemire, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the various components of the Canadian strategy to improve collaboration; 2) Appreciate the importance of support and direction from National Organisations for the strategy; 3) Utilise specific approaches to increasing the capacity of primary care to manage depression; and 4) Recognise the importance of training psychiatry residents to practice in collaborative models .

SUMMARY:

Recent evidence from the US and other countries has highlighted that more effective collaboration between mental health and primary care services (integrated care) can lead to better outcomes, improved access to services, more cost-efficient services and greater user and provider satisfaction. With the emergence of the Patient Centred Medical Home and Accountable Care Organisations, better collaboration becomes even more important.

In Canada, for the last 18 years the Canadian Psychiatric Association and the College of Family Physicians of Canada have been working together to promote and support collaborative mental health care across Canada and develop a comprehensive strategy that includes changes any mental health service can make to work more closely with primary care, the integration of mental health services within primary care settings, training of psychiatry and family medicine residents in collaborative practice, educational programs aimed at increasing family physicians skills and comfort in managing common mental health problems, and support for these activities at the local, provincial and national level. This workshop presents four aspects of this collaboration and the impact each has had on improving care and outcomes for patients. The first presentation looks at a clinical program in Hamilton, Ontario that has successfully integrated mental health and addiction services into the offices of 150 family physicians in a city of 500,000 people. The second discusses a province wide initiative in British Columbia to increase family physician skills and the capacity of primary care in managing individuals with depression, a project that has now been successfully exported to another province. In 2011 a mandatory two months rotation in a collaborative mental health care project was introduced for all psychiatry residents and the third presentation looks at the challenges Canada's 16 residency programs have faced in implementing this requirement, and the efforts to address these challenges (e.g. a national consensus on core competencies). The final presentation summarizes the partnership between two national organizations - the Canadian Psychiatric Association and the College of Family Physicians of Canada – who have shared a common vision and the ways in which the partnership has both promoted and supported collaboration, including the preparation of a joint position paper on collaborative care in 1997, updated in 2011 which laid the foundation and guiding principles for collaborative practice. The workshop will be interactive with opportunities for participants to share their experiences in these four areas and will highlight how the four aspects (collaborative clinical care, increasing capacity of primary care, training psychiatrists, and support at the organizational / systems level support and reinforce each other and have contributed to significant changes in the

working partnership between psychiatrists and family physicians.

A TRANSLATIONAL RESEARCH APPROACH TO THE RESPONSIBLE CONDUCT OF RESEARCH

Chairs: Dominic Sisti, Ph.D., Donald S. Kornfeld, M.D.

Speakers: Mark S. Davis, Ph.D., Brian C. Martinson, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Teach the different motivations for misconduct within the research hierarchy and suggest ways to minimize misconduct.; 2) Identify and describe several complementary perspectives that have been proposed to understand undesirable research-related behavior.; 3) Identify at least one validated measure of organizational climate that can be used to assess the research-integrity climates of academic institutions.; and 4) Identify steps their organizations can take to address specific etiological factors in research misconduct and related maladaptive practices.;

SUMMARY:

The research on research integrity has now evolved to the point where it can and should be translated into policy and practice. Findings to date point to a wide variety of factors operating on different levels. This presentation will begin with an overview of what we know about the etiology of research misconduct, focusing on personality, situational stressors, organizational practices, cultural differences, and the reward system of academe. Several competing narratives about undesirable research-related behavior will be examined, and recent concerns about reproducibility issues in science will be considered. This will lead the discussion toward what specific policies and practices individuals and organizations might take to help prevent and control research misconduct and other detrimental research practices.

DO SAME-SEX MARRIAGES DIFFER FROM STRAIGHT MARRIAGES?

Chair: Scott Haltzman, M.D.

Speaker: Scott Haltzman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize barriers to marriage by gay and lesbian individuals in the US and worldwide; 2) Identify main styles of conflict among married individuals, and how the approach to conflict differs, on average, between gay and straight partners; and 3) Describe the unique risks of infidelity in heterosexual and homosexual men and assess the role of "open marriage" or polyamory in the therapeutic encounter. .

SUMMARY:

As of August, 2014, 19 states/districts in the US have legalized same-sex marriage, and 20 states have banned them. Across the world 16 other countries recognize same-sex marriages. According to the Census Bureau there were 646,000 same-sex-couple households in 2010, (115,064 of them with children) in the US. The Pew Research Center (2013) estimated that there were more than 71,100 same-sex marriages nationwide since the practice was first legalized in Massachusetts in 2004. (Lesbian marriages account for three-fifths of all the marriages.)

While over 90 percent of heterosexuals state they wish to marry, 52 percent of all LGBT individuals express a wish to have the same opportunity. But what does that opportunity bring?

Prior to the legalization of same-sex marriage, studies already found evidence of difference in dyadic styles between heterosexual and homosexual relationships. For instance, compared to heterosexual couples, same-sexed couples use more humor and affection when confronted with relationship stress; they demonstrate fewer controlling or hostile emotions; they are less likely to view conflict as a personal attack; and they show lower levels of physiologic arousal during conflict.

Because of the relative novel phenomenon of gay and lesbian marriage, we still know very little about how same-sex marriages differ from heterosexual marriages. For instance, the models for what marriage "should" look like-as defined by centuries of heterosexual tradition-are not likely to be accepted by the LGBT community. Because of the lack of societal norms the limits and boundaries of gay and lesbian marriage, homosexual couples have the both the opportunity and angst of defining for

themselves what coupledness means. In pioneering the social "norms" of a committed relationship, for example, the culture of monogamy is not highly entrenched in gay dyads (particularly among men). One frequently cited report from 30 years ago showed that, compared to straight couples, lesbian pairs have fewer outside partners, whereas coupled gay males have more partners and seek more variety. More recent data from the San Francisco area showed that among gay men who were in committed relationships, 45 percent stated they agreed to be monogamous, and 47 percent wished to have open sexual options.

Data will also be explored about whether same-sex marriages differ in their duration and quality. Heterosexual marriages have not fared well since the late 1960s, with the peak divorce rate at 50 percent by 1980. While the heterosexual divorce rate had declined in past decades (explained in part by the decline in marriages) we have yet to collect data on the divorce rate among same-sex marriages-an issue complicated by the fact that states that don't recognize same-sex marriages refuse to grant divorces.

INTEGRATIVE MEDICINE: COMPREHENSIVE PATIENT RECOVERY AT BOTH THE NATIONAL INTREPID CENTER OF EXCELLENCE AND FORT BELVOIR ADDICTIONS TREATMENT CENTER

*Chairs: Robert L. Koffman, M.D., M.P.H.,
Frances I. Stewart, M.D.*

*Speakers: Melissa S. Walker, M.A., Rick Yount,
B.S., M.S., Roger Duda, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Describe how complementary medicine is incorporated into military health facilities and utilized in various treatments to include combat-related traumatic injury complicated by psychological comorbidity as well as substance use disorders; 2) Present the use of Art Therapy as a tool for the externalization and processing of traumatic experiences; 3) Understand the application of canine assisted therapy in affect regulation, social readjustment, and enhanced coping behaviors; and 4) Consider how the use of

acupuncture as a modality for patient engagement, pain control, and improved sleep fits into a model of interdisciplinary care.

SUMMARY:

In over a decade of war, repeated and sustained deployments have created significant physical, emotional, and psychiatric morbidity. Novel approaches demonstrating the utility of Integrative Medicine techniques are practiced in the care of our Wounded Warriors both at the National Intrepid Center of Excellence and at the Fort Belvoir Community Hospital Addictions Medicine Department. The Military is treating the whole person, both the body and spirit, through many modalities, to include reiki, meditation, acupuncture, and nutrition.

FORENSIC PRIMER FOR COMMUNITY PSYCHIATRISTS

Chair: Cathleen A. Cerny, M.D.

Speakers: Cathleen A. Cerny, M.D., Megan Testa, M.D., Delaney Smith, M.D., Susan Hatters Friedman, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify why knowledge of forensic psychiatry is important for community providers, knowledge gaps observed in many community providers and the benefits of closing those gaps; 2) Educate community providers on up-to-date forensic issues that impact their practice and best-practices for dealing with these situations; and 3) Highlight times where a more formal consult from a forensic colleague is warranted and ways to obtain such consults.

SUMMARY:

All four authors are trained forensic psychiatrists who currently work in or have worked in community settings including community mental health centers, state hospitals, jails, diversion programs and county mental health boards. Through personal experience, they have come to realize that the typical community mental health professional has limited knowledge of forensic psychiatry topics that have a direct bearing on their day-to-day practice. The knowledge deficit can impact clinical care, understanding of the various systems community patients interact with and the providers' own comfort levels with complex patients. The authors will discuss key forensic

topic areas for community psychiatrists including risk assessment, mental health courts and diversion programs, dual role conflicts and malpractice risks (with special attention to pregnant patients), inpatient and outpatient commitment, treatment consent and guardianship. The authors will include real life cases to enliven the topic.

BEING A PART OF THE SOLUTION: A SYSTEMATIC, EFFECTIVE, AND CUSTOMIZED WAY TO REDUCE AGGRESSION, SECLUSIONS, AND RESTRAINTS

Chair: Sunil Khushalani, M.D.

Speakers: Steven Sharfstein, M.D., M.P.A., Robert P. Roca, M.D., M.P.H., Antonio DePaolo, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the importance and challenges of reducing Seclusion and Restraint interventions in today's psychiatric context; 2) Describe a few traditional approaches to reducing Seclusion and Restraint interventions to manage aggressive patients; and 3) Learn about some innovative applications of performance improvement methods to reduce Seclusion and Restraint interventions.

SUMMARY:

Seclusion and restraint use are controversial interventions. Their use is usually justified as a last-resort safety measure needed to protect staff and patients against assaultive patients when other measures have failed, but they carry the potential of physical and psychological harm to both the patients and staff. They provide no therapeutic benefit to the patients; some even describe them as evidence of treatment failure. Accreditation standards and guidelines have been created to assist in a nationwide effort to curtail the use of such interventions. Over the years, a variety of strategies has been used to accomplish this goal. Models such as 6CS, or Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint, have been implemented and studied in a variety of psychiatric settings. 6CS is a part of SAMHSA's National Registry of Evidence-Based Programs and Practices. A multi-site review of this evidence-based model states,

"With a broad range of stakeholders increasingly engaged in efforts to transform the mental health system to support recovery, consumer autonomy, and social integration, the persistence of these coercive practices remains a troubling anomaly." Although regulations require that seclusion and restraints are only employed when all other measures have failed, there is considerable variation amongst providers and settings in how and how often these interventions are carried out. The challenge of reducing them is complicated by the fact that each setting and patient population is unique. As a result of this, a reduction strategy that works in one setting may not work elsewhere. At our institution, we have been using Lean performance improvement methods to help improve quality and safety. Some of our staff members have utilized this approach to tackle the challenge of reducing seclusion and restraints as a bottom-up approach instead of being driven as a top-down approach. We have found that this bottom-up approach is very successful in engaging direct-care staff. The Lean methodology has many advantages. It taps into the staff's latent potential to come up with efficient and innovative solutions to a myriad of chronic and vexing problems. As this methodology has continuous improvement and measurement as its tenets, we believe that it is well positioned to gain further ground in this difficult challenge of reducing seclusion and restraints in a variety of settings. It works because it respectfully taps into the experience of those who are closest to the process. They are at a unique vantage point from which they can introduce successful and sustainable solutions. We would like to share some tools for reducing the use of seclusion and restraints and the results of our institution's implementation of this methodology. In our opinion, this methodology is not only complementary to many existing strategies, but is also a very robust method for creating a better and safer health care system.

INTEGRATING CARE: PRACTICAL STEPS IN IMPLEMENTING A PRIMARY CARE CLINIC AT A COMMUNITY MENTAL HEALTH CENTER

Chairs: Aniyizhai Annamalai, M.D., Jeanne Steiner

Speakers: Jeanne Steiner, Robert A. Cole, M.H.S., Michael Sernyak, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand the principles in developing an integrated primary and behavioral health program for seriously mentally ill patients; 2) Recognize the challenges in building an integrated program between a primary care and a behavioral health agency; and 3) Identify strategies to successfully implement an integrated program at a community mental health center.

SUMMARY:

Untreated and undiagnosed medical conditions among persons with serious mental illness contribute to an average life expectancy that is 25 years shorter than persons without such an illness. Poor access to primary healthcare services is a major contributing factor. In recent years, approaches to integration that bring medical providers into behavioral health settings are gaining momentum.

In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched a Primary and Behavioral Health Care Integration program (PBHCI) to promote the development of integrated health care services. Over the past five years, 100 grantee organizations have received funding through this mechanism. Although each grantee has a unique approach to integration, the basic requirements are the same—assessment and referral for the prevention and treatment of general medical illnesses, development of data registries to track primary care outcomes, integrated care management to follow-up with primary care services, and providing illness prevention and wellness support services.

These co-located models of care show promise of improved medical and behavioral health outcomes, as well as access to and engagement in care. However, there are many challenges in successful implementation of these programs. Some of these challenges are forming a working partnership between two different agencies, sharing medical records, blending organizational cultures, engaging patients in care and building a shared treatment plan.

The Connecticut Mental Health Center Wellness Center (CMHC-WC) is a primary care clinic co-located within a mental health center and funded by the PBHCI of SAMHSA.

In this workshop, we will describe the program characteristics, population served, challenges in implementation and practical solutions developed to overcome systemic barriers. We will present data on both process and outcome measures at two years of implementation. The presenters at the workshop are the key personnel involved in building this program at the mental health center. The clinical liaison with the primary care clinic, the medical director, chief operating officer and the chief executive officer will each present the challenges and innovative solutions developed at the different organizational levels of the integrated program. Members of the audience will be encouraged to share their own experiences in building an integrated program allowing for exchange of innovative ideas implemented at different agencies.

FREQUENT USERS OF THE EMERGENCY DEPARTMENT FOR MENTAL HEALTH AND ADDICTIONS: A CANADIAN PERSPECTIVE ON A COMPLEX ISSUE

Chair: Brian Furlong, M.D.

Speakers: Gloria Kovach, R.N., Brian Furlong, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Demonstrate an understanding of underlying factors contributing to mental health and addiction individuals becoming frequent users of the ED; 2) Recognize strategies to intervene with frequent users of ED that might influence patterns of use; and 3) Identify the learnings from focusing on the Top 40 mental health and addiction users of the ED.

SUMMARY:

As Canadian treatment for mental health and addictions shifts increasingly from hospitals to community services there is a small population of frequent users of the Emergency Department (ED) who consume substantial financial resources in the system however receive fragmented and inadequate care. In the summer of 2013, we examined our top 40 users of the ED within the Wellington Waterloo Local Health Integration Network, Ontario, Canada, then developed and implemented a strategy for mobilizing access to community resources and services for this specific group. In this

presentation we will examine the bridges and barriers to care for this difficult population together with a review of the impact on ED visits both during and post-project.

There is a common misconception that the mental health and addiction users are abusing the ED however our analysis reveals a complex set of factors which contribute to ongoing ED use. Surprising for us were the large percentage of frequent users already connected to but not accessing community supports. The clinical implications of our findings will be discussed.

COGNITIVE REMEDIATION TO PROMOTE RECOVERY: INNOVATIVE MODELS FROM CANADA, FRANCE, AND THE NEW YORK STATE OFFICE OF MENTAL HEALTH

Chair: Matthew D. Erlich, M.D.

Speakers: Christopher Bowie, Ph.D., Isabelle Amado, M.D., Ph.D., Matthew D. Erlich, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Learn how Cognitive Remediation (CR) programs are effective rehabilitative treatments for people with serious mental illness; 2) Understand strategies for implementation and dissemination of CR across multiple settings; 3) Learn how to personalize a CR program to align with consumer recovery goals, enhanced rehabilitation services, and individualized treatment objectives for everyday life; and 4) Identify approaches to best address administrative and financial challenges intrinsic to implementing CR in a public sector setting.

SUMMARY:

Consumers with serious and persistent mental illness have cognitive deficits that make it difficult to manage every day, yet essential, tasks of independent living. Even at first episode, cognitive deficits are the major reason for failure to return to work and school. Cognitive Remediation (CR) is a recovery-oriented, evidence-based, neuroplasticity-based training intervention that targets cognition in order to enhance functional outcomes and recovery. CR is state-of-the-art, 'in demand', and works best when aligned with recovery goals and integrated into rehabilitation programs. Public sector systems are increasingly interested in offering formalized

interventions to remedy the cognitive deficits associated with mental health disorders.

Successful implementation of CR is a function of the interplay among three critical components: (1) Understanding CR as an innovative and effective tool to enhance recovery and improve cognition among people with serious mental illness (SMI); (2) knowing the context and the quality of the environment where CR is implemented; and (3) recognizing the resources available within the system where CR will be programmed to best address the type of facilitation needed to support implementation and maintenance of the comprehensive components of CR. In this Workshop, these three components will each be addressed; moreover, the building of CR programs will be compared across two large systems, namely the New York State Office of Mental Health (NYS OMH) and the French National Health Agency.

In 2013, New York State OMH initiated a multi-site CR initiative to integrate CR in eight outpatient clinics across the state to enhance its recovery-oriented programs for SMI consumers, and to align CR with other innovative psycho treatments. In France, the need to reduce long term hospitalization and to organize health system resources prompted a 2010 CR development initiative to enhance personalized recovery across the lifespan and address local disparities in behavioral health programs. These recent initiatives provide an opportunity to discuss the three components addressed above. Namely, perception of evidence of CR as an effective tool for recovery; fiscal and system obstacles to the successful delivery of CR; resources that facilitate staff training in CR, consumer enrollment and integration with the overall recovery plan to improve outcomes. Presenters will summarize their recommendations as how to best collaborate among CR stakeholders and disseminate CR among large public service delivery systems with limited and heterogeneous resources. Presentations will set the stage for more detailed discussion of approaches of how to implement CR and increase the evidence-base for CR training programs in large public mental health systems.

RISK MANAGEMENT: OVERCOMING BARRIERS TO IMPLEMENTATION IN TELEPSYCHIATRY

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

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand professional, boundary and safety and security considerations as well as general standard of care issues when using telepsychiatry; 2) Recognize ethical, policy, risk management and legal considerations when using telepsychiatry with patients; and 3) Explore risk management and liability exposures when using telepsychiatry with patients and identify risk mitigation strategies.

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 underserved and rural areas. As 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. There are additional risk management considerations when using telepsychiatry which differ from when the patient is physically in the psychiatrist's 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 legal and risk management updates, 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.

ADVANCES IN PHYSICIAN HEALTH: DATA FROM THE PHYSICIAN HEALTH PROGRAMS

Chairs: Philip J. Candilis, M.D., Luis T. Sanchez, M.D.

Speakers: Doris C. Gundersen, M.D., Charles P. Samenow, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify common vulnerabilities among physicians in current medical practice; 2) Recognize available evidence-based resources for addressing challenges to physician health; and 3) Describe specific methods that PHPs use to collaborate with academic institutions to provide outreach, education, and prevention in physician health.

SUMMARY:

Recent developments in physician health underscore the importance of vigilance and support for physicians facing increasing stressors in the workplace. Increased demands on physician time, complexities of electronic records and billing, and oversight that intrudes on physician autonomy all contribute to increasing burn-out and emotional exhaustion. Standards that seek to address disruptive behavior and improve patient safety similarly increase scrutiny on a workforce diminished by retirements and a dwindling pipeline of psychiatric graduates.

State Physician Health Programs (PHPs) are at the forefront of initiatives that assess and support physician health, monitor behavior, and divert physicians from disciplinary action. Studies now show effectiveness of PHP interventions in supporting return to practice and improving malpractice risk. Educational and support group efforts are common among the states, and are supported by a growing literature on their effectiveness.

This workshop presents current data from three PHPs heavily involved in the study of physician health: Colorado, Massachusetts, and Washington DC, and encourages a discussion of themes raised by their work. Colorado's PHP director and President of the Federation of State Physician Health Programs (FSPHP), Doris Gundersen, MD, will present data on the influence of PHP intervention on subsequent malpractice claims. Philip Candilis, MD, former MA Assessment Director, will present data on the effectiveness of a support group specifically tailored for physicians involved with PHPs, and Charles Samenow, MD, of the Washington DC PHP, will follow with a description of prevention and education efforts designed to address vulnerability and resilience early in physicians' careers. Luis Sanchez, MD, former President of the FSPHP and Director Emeritus of the MA PHP will lead the subsequent discussion.

WHAT EVERY PSYCHIATRIST SHOULD KNOW ABOUT EPILEPSY

Chairs: Rochelle Caplan, M.D., Fernando Espi Forcen, M.D.

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

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) At the end of the workshop participants will be able to identify the more frequent comorbidities that patients with epilepsy have and their treatment; 2) Participants will learn all the new advances in antiepileptic medications and their potential psychiatric side effects; and 3) Participants will be able to understand key issues on diagnosing and treating psychiatric comorbidities in patients with epilepsy .

SUMMARY:

Despite continued progress in the treatment of epilepsy, the psychosocial outcome in adults is reported as poor, even in patients who reach seizure-freedom. Rates of psychopathology range from 30-50% in these patients. Translational research on the neurobiology of epilepsy demonstrate the biological underpinnings of the two-way relationship between psychiatric disorders and epilepsy.

Despite these clinical and basic science findings, the mental health of these patients are for the most part unmet. Even when these patients report psychiatric symptoms to their provider, there is a long period of time before they get care. The double stigma of epilepsy and a mental health disorder sometimes negatively impact access to care in epilepsy patients. This workshop will summarize the biopsychosocial issues relevant for general psychiatrist caring for patients with epilepsy. Dr. Jones will discuss how to diagnose and treat anxiety disorders, one of the most frequent comorbidities in children with epilepsy with prevalence ranging from 5%-49% compared to the general population.. Dr. Falcone will describe the relationship between depression and epilepsy across the ages from the neurobiological and psychosocial perspectives including the role of different seizure types. She will present evidence for the poor quality of life scale in these patients even when seizures are under control and their two to four times

increased mortality rates compared to the general population; and reported suicide rate of 12% and lifetime prevalence of suicide attempts as high as 20.8%. Dr. Pestana-Knight will provide an update on antiepileptic medications and their psychiatric side effects, and discuss evidence for the positive effect of psychiatric and psychological treatment in epilepsy patients. Dr. Baslet will describe one of the most frequent consults in the epilepsy service, psychogenic non-epileptic seizures (PNES). PNES is the most common condition mistaken for epilepsy. It may also occur in patients with an established diagnosis of epilepsy. A collaborative approach between mental health professionals and neurologists is essential for an adequate diagnosis and treatment. Dr. Caplan will open up the discussion after each presentation to focus on the concerns and difficulties psychiatrists have diagnosing and treating the psychiatric comorbidities of epilepsy including PNES.

POSTTRAUMATIC STRESS DISORDER TREATMENT IN THE MILITARY: THE IMPACT OF THE IOM REPORT

Chair: Christopher H. Warner, M.D.

Speakers: Carl A. Castro, Ph.D., Elspeth C. Ritchie, M.D., M.P.H., Christopher Ivany, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the suspected shortfalls of DoD/VA PTSD Care and the implications that it has on servicemember/veteran behavioral health care; 2) Understand the recommendations for improvement of DoD/VA behavioral healthcare and the potential impact of those changes on future patient care; and 3) Recognize strategies for improving treatment effectiveness monitoring both at the individual level and in a large healthcare system.

SUMMARY:

Posttraumatic stress disorder (PTSD) is one of the signature injuries of the U.S. conflicts in Afghanistan and Iraq. The effects of PTSD can be life-long and pervade all aspects of a service member's or veteran's life including their mental and physical health, family and other social relationships, and employment. PTSD is often concurrent with other health problems such as traumatic brain injury, chronic pain, substance

abuse disorder, intimate partner violence, and depression. Most service members who experience combat or deploy to a war zone do not develop PTSD and are able to complete their deployments and reintegrate into military or civilian life without significant distress or alteration in functioning. But for the estimated 7-20% of OEF and OIF service members and veterans suffering from PTSD, readjustment from war-zone deployments and reintegration with their families and communities may be severely limited by chronic distress and disability in all aspects of their daily lives. In an attempt to prevent service members and new veterans from experiencing the long-term effects of trauma associated with military service, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) are working to identify and treat service members and veterans who have symptoms of PTSD with more than \$294 million spent by the organizations for PTSD care in 2012.

A 2014 report from the Institute of Medicine was critical of those efforts by the DoD and VA specifically citing that neither organization measure the effectiveness of treatment of post-traumatic stress disorder (PTSD), calling into question millions of dollars spent to improve service members' mental health. The report also found that neither agency has kept pace with the growing demand for PTSD treatment.

This presentation will review the specific findings and recommendations of the IOM team and discuss the rationale for making those conclusions. Representatives of the DoD and VA will outline the ongoing efforts to respond to the IOM criticism and experts familiar with the system and the DoD/VA PTSD research efforts will outline a way ahead.

PSYCHIATRY REVIEW WITH AXIS (PRAXIS) ASSESSMENT

Chairs: Anthony Tobia, M.D., Aditya Joshi, M.D.

Speakers: Tom E. Draschil, M.D., Nabil Siddiqi, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the utility of PRAXIS in achieving the core competency of Medical Knowledge; 2) Appreciate how PRAXIS may be utilized during clinical rotations where formal didactics are often difficult to implement; and 3) Recognize that PRAXIS is a simple and innovative way that residents can teach medical

students; 4) Recognize that PRAXIS is a novel way to provide board review to medical students during their psychiatry clerkship.

SUMMARY:

To address the ACGME Core Competency of Medical Knowledge, residents and students rotating through the Division of Psychosomatic Medicine at Rutgers Robert Wood Johnson Medical School participate in a weekly competition named Psychiatry Review with Axis (PRAXIS) Assessment to test their aptitude of psychopathology, psychosocial stressors related to mental illness (formerly Axis IV), and disability (formerly Axis V).

Depending on the total number, participating students and residents are divided into 2 or 3 teams. The team selected to "go first" is presented with a multi-axial assessment of a fictional character from film or literature. Course directors at Rutgers-RWJMS have created a database of assessments. Each assessment includes three specific psychosocial stressors on Axis IV. For example, the following multi-axial assessment depicts Pat Solatano, Jr. (Silver Linings Playbook, 2012).

Axis 1: Bipolar Affective Disorder

Axis 2: None

Axis 3: None reported

Axis 4: Living with parents; estranged from wife (restraining order); unemployed

Axis 5: Current GAF 55 (moderate symptoms and moderate difficulty in social functioning)

If the team guesses the fictional character correctly, they are awarded 5 points and given an opportunity to double their score by answering a board-review question pertaining to the Axis I (or II) diagnosis (e.g. bipolar disorder). Questions are taken from any of the review texts that are either a) required for the Psychiatry clerkship or b) recommended for the ABPN certifying exam. If the team is unable to guess the fictional character, additional Axis IV stressors are given (to further reveal the movie/novel's plot). With every additional Axis IV diagnosis given, a point is subtracted from the reward. When the reward shrinks to 3 points, the competing team(s) is able to buzz in to "steal" the turn. The game is played until a pre-determined score (usually 50 points) is reached.

While psychosocial and environmental factors are currently (DSM 5) covered through an expanded set of V codes that allow clinicians to

indicate other conditions that may be a focus of clinical attention, we've decided to preserve the multi-axial classification system as it provides for a simplified format for the game, and therefore best promotes learning of the stated objectives. Because we state specific stressors (and avoid all diagnostic codes) on Axis IV, this format doesn't adversely affect our teaching goals and objectives (however, we plan to modify PRAXIS as the implementation of the World Health Organization standards is further clarified).

PRACTICAL PRIVACY ISSUES

Chairs: Zebulon Taintor, M.D., Paul S. Appelbaum, M.D.

Speakers: Paul S. Appelbaum, M.D., Erik Vanderlip, M.D., M.P.H., Lori Simon, M.D., Steve Daviss, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) List issues related to electronic health records and HIPAA and other laws and regulations and how to cope with them; 2) Describe how to avoid computer and technology operations that increase the risk of confidential data being stolen; 3) take steps to limit risks of financial data being stolen apart from other steps to safeguard patient-specific sensitive data; and 4) describe how to use psychotherapy notes to maintain privacy.

SUMMARY:

Privacy breaches have become increasingly widespread in modern society and stem from many sources. Most of these occur outside psychiatry and general medicine, although medical record breaches and medical identity theft (involving information from both patients and physicians) have also worsened. Psychiatrists increasingly worry about being liable for breaches over which they have no control, but where data that they collected have been obtained. HIPAA, encryption, patients' requests for their records, use of cloud computing, password problems and other privacy issues complicate psychiatrists' daily practices. Psychiatrists want to know their risks of being hacked en masse for financial data by thieves, or individually by anti-psychiatry groups, patients' jilted lovers and others looking for data specific to patients for whom they may be caring. They want to know best practices to avoid losing data through negligence. As regional medical information systems are being

developed through Regional Health Information Organizations and Health Information Exchanges, there is concern that data can be tapped into any place along the line. Certain regulations, for example, the New York State requirement that all prescriptions be electronic by 2015, are not seen as protecting privacy and psychiatrists wonder whether they must risk divulging information about their patients in order to comply with regulations. Insurance companies have also been a source of breaches. The result has been a sense that somehow the issue has gotten out of our hands. The workshop will be directed towards these and other practical issues involved in protecting patient privacy and maintaining confidentiality. Each speaker will briefly focus on an area of concern (Appelbaun legal, Simon computer working, Taintor hacker methods) Attendees will be encouraged to present dilemmas they have for discussion by the panel.

EVIDENCE-BASED APPROACHES TO REFRACTORY OBSESSIVE-COMPULSIVE DISORDER

Chair: Jerry Halverson, M.D.

Speakers: Jerry Halverson, M.D., Bradley Riemann, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Recognize the definition of treatment refractory OCD; 2) Describe 2 reasons why your patients OCD may more difficult to treat and how to address; 3) Identify adjustments to the medications that may lead to optimized treatment of the OCD; and 4) Identify adjustments to therapy / ERP that may lead to optimized treatment of the OCD.

SUMMARY:

OCD is one of the most difficult to treat psychiatric disorders that clinicians face in their practices. OCD can be highly disabling and is often misunderstood in clinical practice. This presentation will be a practical and clinically based discussion of the current evidence based treatment of OCD that fails standard treatments. We will have a psychiatrist and a psychologist both very experienced in the treatment of refractory OCD. The presentation will begin with a discussion of the definition of refractory OCD, which is a topic of some controversy. Approaches to treatment adjustments for OCD

in adult populations will be discussed. Then we will discuss the evidence base behind various adjustments in standard treatments to treat refractory adult populations including psychotherapy and exposure response prevention therapy, and combined pharmacologic approaches. The symposium will conclude with a case based interactive discussion.

DEBUNKING STIGMA TOWARDS ELECTROCONVULSIVE THERAPY IN SPECIAL POPULATIONS: CHILDREN, ADOLESCENTS, AUTISTIC/DEVELOPMENTALLY DELAYED PERSONS, AND PREGNANT WOMEN

Chairs: Shanti Mitchell, M.D., William C. Wood, M.D.

Speakers: Neera Ghaziuddin, M.D., Lee E. Wachtel, M.D., Shanti Mitchell, M.D., Edward Shorter, Ph.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify current evidence based research supporting the use of ECT for patients with severe psychiatric illness in special populations; 2) Consider the risks vs. benefit of ECT in special populations through review of the potential side effects, relapse rates and safety of ECT; 3) Recognize the historical impact of stigma towards ECT in special populations within society and the medical community; and 4) Identify potential strategies and the importance of fostering unbiased views about ECT in special populations within the medical community, allied health community and mainstream society.

SUMMARY:

Although ECT has been established as an effective and safe treatment, its use within the field of psychiatry remains controversial and highly stigmatized. After the introduction of ECT for children/adolescents in the 1940's, its use was largely accepted and uncontroversial. ECT's initial acceptance has been followed by scrutiny and rejection secondary to cultural, social and ethical concerns within mainstream society as well as the medical community, despite research and clinical experience supporting its efficacy for managing patients with severe psychiatric illness. Addressing

stigma towards ECT is an important challenge because the use of ECT has evidence to support its safety and effectiveness when other treatments and interventions have failed. Furthermore, ECT in special populations is often viewed with increased scrutiny, stigma and false perceptions as compared to ECT in adults with psychiatric illness. This workshop will address current stigma towards ECT in special populations starting with a review of research findings and the evidence-base for ECT in special populations by speakers who have clinical experience with ECT with these patient groups. A historical perspective about the evolution of stigma towards ECT will be reviewed with focus on combating current negative stereotypes and misinformation about ECT in mainstream culture, as well addressing biased views within the medical and mental health communities. Safety, side effects, and relapse rates of ECT in special populations will also be addressed. The workshop will conclude with an audience discussion about the controversies that exist surrounding ECT in special populations, the role which stigma plays in distorting prospective benefits from ECT, and the particularly sensitive nature of introducing ECT as a treatment modality for patients with severe psychiatric illness in special populations.

A CHECKLIST FOR CHECKLISTS: TAKE-HOME TOOLS TO IMPROVE CARE AND REDUCE RISK IN PSYCHIATRIC PRACTICE

Chair: Jared Peck, M.D.

Speaker: Lesley Wiesenfeld, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To develop self-assessment skills in identifying opportunities for quality and safety improvement; 2) To selectively apply quality and safety improvement interventions in psychiatric practice; and 3) To improve risk-management approaches to common areas of exposure in psychiatric practice.

SUMMARY:

Given the evolution of medical practice and training in roles beyond the medical expert over the past several decades, many physicians have not had the opportunity to learn and apply manager skills to their practice in a systematic

way. Furthermore, the quality improvement literature clearly notes that most clinicians do not routinely self-assess performance or apply quality and safety principles to their work. As leaders in quality improvement curricula, we note that faculty/staff psychiatrists routinely request professional development support in the area of quality improvement science.

Whether in solo-practice or team-based care, developing a reflective psychiatric practice that includes regular attention to opportunities for quality and safety improvement can help ensure high quality care and efficiency while also ensuring good risk management. Patient complexity, health-care system expectations, and the pace of dissemination of practice-informing knowledge all contribute to challenges and opportunities in the delivery of optimally safe and quality-maximized care.

Led by Quality Improvement-trained psychiatrists and medical educators, this workshop will offer an interactive, practical, case-based approach to meeting key objectives that target improving the quality of psychiatric care provided to individual patients while also enhancing overall practice-management, risk-reduction and efficiency. An introductory self-assessment exercise/tool will be provided to help psychiatric colleagues quickly identify areas for focused attention and learning in the area of quality and safety knowledge. An overview of quality and safety improvement techniques such as lean principles, checklist-application, process-mapping and rapid cycle improvement will be shared. Applicability to key psychiatric practice challenges such as risk assessment, collaboration with primary care providers, and managing medical and psychiatric complexity will be highlighted. Participants will have the opportunity to get feedback on determining which QI tools will be maximally helpful in improving identified individual patient and practice-oriented safety and risk problems. Samples of modifiable/flexible practice tools will also be provided for participant use post-workshop.

FOOD ADDICTION AND THE METABOLIC SYNDROME: FROM INSULIN RESISTANCE TO NEUROCOGNITIVE DECLINE AND BEYOND

Chairs: Aikaterini Fineti, M.D., Gerardo Gonzalez, M.D.

Speakers: Aikaterini Fineti, M.D., Srikanth Challagundla, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) To familiarize the audience with the diagnosis and treatment approaches of metabolic syndrome and its relation to a controversial addictive behavior such as food addiction; 2) To identify three consequences of the metabolic syndrome on cognition and mental well-being; and 3) To discuss assessment and treatment strategies of the metabolic syndrome and its relation to obesity, overeating behaviors, binge eating, and food addiction.

SUMMARY:

The inability to suppress a behavior, despite the negative consequences is the hallmark of addiction. Binge eating disorder is now a formal psychiatric diagnosis with distinct diagnostic criteria in dsm-5, whereas there is a school of thought that argues that obesity may actually be a manifestation of the addiction to food. Whether obese people are addicted to food or not continues to be a topic of research and broad discussion. As the "addiction to food" theory offers an explanation to obesity and the associated metabolic syndrome, several questions arise, from "who should treat the food addicted patient?" to more complex ones like "how should we treat the patient who suffers from schizophrenia, or any other mental illness, takes atypical antipsychotics, and is also addicted to food?". Regardless of whether overeating is an addiction or not, it is now shown that overeating and obesity increase patients' risk for cardiovascular disease, stroke and cancer. Life expectancy in the generations to come is expected to drop due to the obesity pandemic we are now facing. Aside from all that, it is becoming evident that obesity, through insulin resistance and hyperinsulinemia, promotes neurodegenerative changes and neurocognitive dysfunction during a prolonged preclinical phase characterized by gradual cognitive deterioration. In this workshop we will be attempting an approach to obesity pandemic, the metabolic syndrome that it is accompanied by and the cognitive and mental health consequences of them both.

DYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINES: 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) Utilize principles of an Alliance Based Intervention for Suicide as part of psychodynamic therapy of self-destructive borderline patients; 2) Understand the symptom of suicide in borderline patients as an event with interpersonal meaning and as an aspect of negative transference; and 3) Understand common factors in treating self-destructive borderline patients derived from study of 6 behavioral and dynamic psychotherapies.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practical clinical guidance is available to help clinicians establish a viable therapeutic relationship with these patients. This workshop includes review of 9 practical principles helpful in establishing and maintaining a therapeutic alliance in the psychodynamic psychotherapy of self-destructive borderline patients. The approach is organized around engaging the patient's negative transference as an element of suicidal and self-destructive behavior. The principles are: (1) differentiate therapy from consultation, (2) differentiate lethal from non-lethal self-destructive behavior, (3) include the patient's responsibility to stay alive as part of the therapeutic alliance, (4) contain and metabolize the countertransference, (5) engage affect, (6) non-punitively interpret the patient's aggression in considering ending the therapy through suicide, (7) hold the patient responsible for preservation of the therapy, (8) search for the perceived injury from the therapist that may have precipitated the self-destructive behavior, and (9) provide an opportunity for repair. These principles are compared to a set of common factors derived from review of 6 evidence-based therapies for suicidal borderline patients. After the presentation the remaining time will be used for an interactive discussion of case

material. Although the workshop organizer will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

CLINICAL OUTCOMES IN ARMY BEHAVIORAL HEALTH CARE USING THE BEHAVIORAL HEALTH DATA PORTAL

Chair: Millard Brown, M.D.

Speaker: Millard Brown, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Understand how the Behavioral Health Data Portal (BHDP) is a key component in building a behavioral health system of care and a feedback-based learning organization; 2) Improve knowledge of the advantages and challenges involved in using clinical outcome metrics within behavioral health care delivery; and 3) Learn what clinical factors are associated with improved outcomes, need for increased level of care services and those who are refractory to care.

SUMMARY:

Over the past four years, the Army Behavioral Health (BH) system has been transformed into a Behavioral Health Service Line following an operating company model for standardization of care across over fifty clinics and hospitals. Part of this transformation has been the implementation of the Behavioral Health Data Portal (BHDP), a web-application that supports patient-self reports of intake assessment questions and follow-up clinical outcome measures along with real-time viewing of data by providers for support of clinical decision making. BHDP is now used in over 80% of all individual BH encounters in Army clinics. Data from over 650,000 sessions have been collected as of August 2014 and over 45,000 new sessions are collected every month. The Navy and Air Force are starting to implement BHDP as President Obama has now mandated its use across the Department of Defense. We will present findings from this data set on the initial illness burden and clinical outcomes of Soldiers receiving clinical care in the Army BH system, to include outcomes related to depression, PTSD, anxiety disorders and suicidality.

EXPERTS BY EXPERIENCE: EXPLORING EFFECTIVE METHODS FOR INVOLVING CLIENTS AND FAMILIES AS TEACHERS IN PSYCHIATRIC EDUCATION

Chairs: Sacha Agrawal, M.D., M.Sc., David Wiljer, Ph.D.

Speakers: Ivan Silver, M.D., M.Ed., Sean A. Kidd, Ph.D., Carmen E. Wiebe, M.D., Thomas E. Ungar, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) identify a range of complexities associated with involving clients and families as teachers; 2) describe a range of models and competencies for involving clients and families as teachers; and 3) use the principles of community-based research to inform the ways in which client and family involvement in education can be evaluated.

SUMMARY:

Including clients and families with lived experience of mental health and addiction issues as teachers can enrich the educational experience and positively impact the knowledge, skills and attitudes of learners in psychiatry. However, putting service users in the role of teacher also raises complex issues, from practical considerations such as how best to select, train and support service-user teachers, to ethical tensions such as how best to collaborate with service-user teachers in a way that truly empowers them (Ikko, 2003; Livingston & Cooper, 2004). This workshop will explore the theory, practice and evidence-base for effectively involving clients and families as teachers in psychiatric education. We will outline the extant literature and describe and seek input on several approaches currently in use and planned at the Centre for Addiction and Mental Health (Toronto, Canada). Examples include involving former inpatient clients as teachers to advance the recovery-orientation of inpatient unit staff; involving clients as teachers to plan and deliver curricula to continuing and postgraduate education audiences; and pairing psychiatry residents with clients as advisors. A simulation involving a service-user teacher will serve to illustrate the potential for this pedagogical model. Opportunities and strategies for evaluation will also be presented.

UPDATE ON SOMATIC SYMPTOM DISORDERS

Chairs: Daniel Williams, M.D., David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Update understanding of the DSM-5 criteria for differential diagnosis of somatic symptom disorders; 2) Update understanding of current psychological and neurobiological conceptualizations of the pathophysiological development of somatic symptom disorders; and 3) Enhance the practitioner's repertoire of the range of treatment options that can be integrated for the optimal individualized treatment of this diverse group of patients.

SUMMARY:

The workshop updates current clinical perspectives on the differential diagnosis & treatment of somatic symptom disorders (SSD's), as reformulated in DSM-5.

Somatization will be defined and the evolution of its conceptual formulation in the history of medicine and psychiatry briefly reviewed. Contemporary formulations will include the psychodynamic, learning theory, behavior analysis, neurophysiological predisposition, autoimmune sensitization, and combinations of these. Epidemiological studies, with their public health implications will be noted. Developmental considerations and the need for early intervention will be discussed.

Changes in definitions of subtypes of somatic subtypes of the SSD's between DSM-IV and DSM-5 will be reviewed, together with the rationale and clinical implications of these changes.

The importance of the tone of the referral process from primary care physician (PCP) to the consulting psychiatrist as well as helping the patient to understand and explore the role of stress and trauma in generating somatic misperceptions and malfunctions will be noted. The contributory roles of anxiety, depression, alexithymia & dissociation will be noted, as well as the routes of engaging the patient supportively in appreciating their relevance. The need for the psychiatrist to maintain the engagement of the PCP to avoid the patient feeling abandoned as well as to avoid overlooking undiagnosed physical illness will be addressed.

Psychiatric assessment of a patient referred for assessment of SSD: We advocate avoiding a rush to etiological diagnosis. Priority consideration after establishing a therapeutic rapport is elicitation of a thorough narrative history, including medical, personal, and family components. Consider potential predisposing, precipitating and perpetuating factors contributing to the presumptive SSD. It is crucial to obtain relevant medical records, insofar as the patient's rendition may be incomplete. Engaging the PCP in the supportive communication of the diagnosis is usually a prerequisite to the patient's acceptance of a treatment plan.

Treatment strategies to be considered include:

Psychodynamic considerations: Addressing perceived unconscious conflicts regarding anger, sexuality and dependence, among others.

Behavior modification: Restructuring environmental influences- especially re 'secondary gain' benefits of SSD symptoms.

Cognitive "behavioral therapy: Advocating conceptual reformulations, hypothesis testing, and desensitization strategies to strengthen coping capacities.

Hypnosis as a ceremonious facilitator: using dissociation as a 'restructuring' aid.

Added treatment resources to be considered:

- Physical therapy: for motor impairments.

- Psychopharmacological agents:

1. Specific [for comorbid symptoms- anxiety, depression, OCD, psychosis].

2. Non-specific: (active placebo benefits).

- Written report to PCP & patient.

- Hospitalization for intensive, multimodal treatment, if needed.

THE ULTIMATE BALANCING ACT: MEDICINE, MARRIAGE, MOTHERHOOD, AND ME

Chairs: Sarah B. Johnson, M.D., Sarah M. Fayad, M.D.

Speakers: Almari Ginory, D.O., Kathy Vincent, M.D., M.S.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Educate women physicians about roles which may conflict with each other; 2) Provide guidance on how this has been navigated by other physicians; and 3) Provide pearls and pitfalls in balancing the multiple roles that women in medicine hold .

SUMMARY:

The percentage of women entering medicine has expanded markedly in recent years with females comprising half of medical student and resident populations. These women typically have a multitude of roles: physician, spouse, mother. They must also care for themselves. Unfortunately, many of these roles conflict with the others. Yet, many strive to "have it all". Each day, these women are faced with difficult decisions in which one decision can significantly affect one of their other roles in life and lead to dysequilibrium. Learning to successfully manage the careful balance between these roles is challenging. It is seldom discussed openly and there is a lack of female mentorship to help guide the new generation of women physicians.

Many women delay marriage and having children due to the demands of medicine. This delay can be quite problematic as the years in which most women are pursuing their medical education and completing residency are the years in which most women are having children. This can lead to difficulty with conceiving or other health issues. Those that do not delay often face difficulties managing the balance of being a mother and spouse with the role of a busy, practicing psychiatrist. These role conflicts can frequently impede a woman's career success, or her home life. In addition, they often take on more home responsibilities than their spouse, which can limit their time to work toward promotion and/or tenure.

We will discuss challenges with this balancing act with a variety of women and want to provide an open forum for discussion of the aforementioned issues. A panel of women psychiatrists will share their experiences and audience participation/discussion will be utilized throughout the presentation to facilitate mentorship and teaching.

DO FIREARMS RESTRICTIONS PREVENT SUICIDE AND VIOLENCE IN PEOPLE WITH SERIOUS MENTAL ILLNESS?

Chair: Marvin Swartz, M.D.

Speakers: Jeffrey Swanson, Ph.D., Joshua M. Horwitz, J.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Discuss the evidence linking serious mental illness and violence; 2) Describe new evidence for the effectiveness of firearms restrictions in reducing risk of suicide and violent crime in persons with mental illness; 3) Assess the strength of the evidence and limitation of policies and laws to reduce gun injury and mortality in mental illness; and 4) Discuss the current policy efforts to reduce the risk of gun violence.

SUMMARY:

Recent shootings have intensified efforts to reduce gun violence by people with serious mental illness in the face of Supreme Court upholding individual rights to bear arms. Research evidence has been lacking to evaluate the public safety effects of firearms restrictions on people with serious mental illness. A recent study in Connecticut found evidence suggesting that the state's policy of reporting gun-disqualifying mental health records to the federal gun background check database significantly reduced risk of a first violent crime in a small number of people with serious mental illness, but had little impact on overall violence in the population. However, the generalizability of that study was limited by the low rate of involuntary commitment in Connecticut, the lack of a direct measure of firearms involvement in crime, and lack of any data on suicide. A new study from Florida addresses these limitations of previous research. In Florida, at least 35% of public mental health clients with serious mental illness have a gun-disqualifying history of involuntary commitment—a substantial policy exposure. For this study, a sample of over 75,000 persons with schizophrenia, bipolar disorder, or major depression was selected from state mental health services recipient records over the decade from 2003-2012. Matching administrative records from the state mental health, criminal justice, and vital records agencies were obtained to identify gun-disqualifying mental health adjudications, arrests (with all statutory arresting charges, including specific firearms violations), hospitalizations, incarcerations, and deaths (by cause of death.) Effects of gun laws will be estimated by comparing trends in firearms violence and suicide for persons disqualified vs. not disqualified from gun purchase due to mental health history, for the periods before and after the state's implementation of reporting to

the NICS. These results will be discussed in the context of federal and state-specific efforts to reduce gun violence by dangerous persons in the wake of recent shootings. Policy implications of findings will be explored.

RESIDENT WELLNESS TODAY: CURRENT CHALLENGES, PROGRAMS, AND RECOMMENDATIONS FOR TOMORROW'S TRAINEES

Chairs: Annie Trepanier, M.D., Richard Montoro, M.D.

Speakers: Annie Trepanier, M.D., Leon Tourian Jr., M.D., M.R.C., Richard Montoro, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the potential met and unmet basic health needs of residents and the potential pathological presentations of struggling residents. To do so we will review data from two province-wide surveys that have obtained information; 2) Gain an understanding on the different personal and environmental factors contributing to residents developing either a well-balanced health versus an unbalanced life-style and health; 3) Share our regional and provincial experiences in implementing wellness-oriented activities for residents; and 4) Achieve an understanding of the Faculty's role in providing a secure environment and advocating for the residents general health and wellbeing.

SUMMARY:

It is increasingly said that health is not simply the absence of disease, but the presence of wellness. Self-care and healthy life habits have become a familiar refrain in our conversations with patients. A balanced diet, regular exercise and adequate sleep will help counter almost any health adversity. Physicians are notorious for being poor patients, but there is increasing evidence that our self-care and healthy life habits are poor as well, particularly in residency. Data from our own recent survey of Quebec's residents revealed that only 15.8% of Quebec's residents find time to exercise more than three times per week and 19.1% of residents sleep between four to six hours per night(1). Mental health in residency is even more taboo, but data is emerging that the unique environmental stresses that residency training poses, combined with the common personality

traits of physicians "excessive doubt, perfectionism and an exaggerated sense of responsibility" combine into the perfect storm of psychological distress. True to the physician as a poor patient stereotype, a 2003 article showed that only 2% of Canadian physicians who were identified as depressed actually sought medical attention (2). Organizational and individual responses to physician distress in the learning environment need to promote resiliency and shared responsibility. Addressing the wellness needs of residents implies addressing the wellness needs of all members of the health care team. Advocacy for healthy life-habits, early recognition of signs of distress and the shift of mentality towards positive psychology constitute potential solutions to not only treat residents in need but to also prevent adverse mental health events.

This workshop will explore the issues of self-care and wellness in today's resident. We will discuss the results of the first resident wellness survey in Quebec organized by the Federation of Medical Residents of Quebec. It includes data regarding the health habits of residents from all four medical faculties in the province of Quebec. We will also present the preliminary results of a province-wide survey on mental health and substance use amongst Quebec's residents. Efforts to introduce personal wellness and resiliency into the medical learning environment will be reviewed. The multi-pronged approaches of both faculty and resident driven activities provided in Quebec's four medical schools will be discussed (resident wellness day, cross-cultural discussions, sport). Our in-vivo experiences will help foster debate as to the future face of physician wellness.

1. Tourian, L. (2013, December 3rd). Findings of the first FMRQ resident wellness survey : Do we have a balanced and healthy lifestyle. The Bulletin : issue on Prejudice, Taboos, Stigmatization, 44-47.

2. Canadian Medical Association. Guide to physician health and well being: facts, advice and resources for Canadian doctors. Ottawa, ON: Canadian Medical Association, 2003.

CAN EARLY CAREER PSYCHIATRISTS PROVIDE PSYCHOTHERAPY IN TODAY'S HEALTH CARE ENVIRONMENT?

Chair: Norman A. Clemens, M.D.

*Speakers: Aileen Kim, M.D., Eric Plakun, M.D.,
Andrea Bandfield, M.D.*

EDUCATIONAL OBJECTIVE:

At the conclusion of the session, the participant should be able to: 1) Identify the obstacles to the provision of psychotherapy by early career psychiatrists; 2) Implement techniques to maximize the opportunity to offer psychotherapy in a biopsychosocial context in the increasing range of practice settings that are developing; 3) Balance their personal financial situation with the satisfaction of working in an environment where they can treat patients using all the skills of a well-trained and fully-developed psychiatrist; and 4) Consider the implications of the kind of patient care they provide for long-term career satisfaction. .

SUMMARY:

The practice of psychotherapy by psychiatrists is dwindling, although psychotherapy is increasingly being recognized as an evidence-based and essential component of effective, biopsychosocial psychiatric care. Early career psychiatrists are especially at risk for being disincentivized to incorporate psychotherapy into the many forms of psychiatric service they provide. This imperils their chances of becoming mature psychotherapists who can adapt their skills to the needs of a spectrum of patients, and to consult with, guide, and supervise other professionals as they become leaders. On emerging from residency training (in which psychotherapy experience in any method is generally limited) young psychiatrists usually have significant debt burdens, growing families, and the need for secure employment with benefits. Private practice seems daunting. Organized practice settings tend to direct them into doing evaluations and medication management, while psychotherapy is relegated to non-medical professionals. Even in independent office practice they encounter the difficult choice between accepting insurance with generally limited reimbursement and intrusive management of longer-term therapy -- or declining third-part payment with attendant difficulty in finding patients who can pay out of pocket. The Affordable Care Act and parity between psychiatric and other medical services, along with new forms of practice such as Accountable Care Organizations and Integrated Care with general medical practitioners offer new challenges and opportunities.

This workshop, co-sponsored by the American College of Psychoanalysts, presents evidence for this view of the situation and its consequences. Two early career psychiatrists who have included psychoanalytic supervision in their development of psychotherapy skills describe the way they have coped with the practice environment to continue that development. There will be time for extensive discussion. Hopefully this will encourage young psychiatrists to pursue proficiency in the evidence-based psychotherapeutic method of their choice, whether psychodynamic or cognitive-behavioral. How to adapt to the changing health care environment will be explored.