Syllabus and Proceedings

AMERICAN PSYCHIATRIC ASSOCIATION
ANNUAL MEETING

Prevention Through **Partnerships**

Advances in Medicine

Saturday, May 20, 2017

Medical Mysteries and Practical Med Psych Updates: Is It "Medical," "Psychiatric" or a Little of Both...?
Chair: Robert McCarron, D.O.
Presenters: Pritham Raj, M.D., Jeremy DeMartini, Glen Xiong, M.D., Matthew Reed, M.D.

EDUCATIONAL OBJECTIVE:
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 Medical Mysteries 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. A focus will be placed on covering general medical topics that are particularly important to the practice of psychiatry.

Pain Medicine and Psychiatry
Presenter: David J. Copenhaver, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Describe the biopsychosocial model and the relationship to pain; 2) Describe the effect of pain on mood; 3) Describe the effect of mood on pain and pain tolerance; 4) Describe novel therapies that address pain and mood; and 5) Compare rational polypharmacy to other treatment methods.

SUMMARY:
In the report "Relieving Pain in America," published in June of 2011, the Institute of Medicine provided shocking insight into pain care in the United States. The Institute of Medicine report described eye-opening statistics stating over 100 million Americans suffer from chronic pain, with a cost of $635 billion each year in medical treatment and lost productivity. Further, as the public health crisis of prescription drug abuse continues to grip the nation, the need to understand the biology of pain and the risks and benefits of various pain treatments becomes critical. Despite these alarming concerns, few resources have been dedicated to study pain. Pain is the least studied phenomenon at the National Institutes of Health (NIH), yet the most common reason patients proceed to the emergency room seeking care. Moreover, many studies have documented substantial deficits regarding pain education in many pre-licensure curricula in various health fields. Essential to the assessment of chronic pain is a detailed working knowledge of the biopsychosocial model and the influence of mood on pain and vice versa. The following dynamic discussion will allow for a brief but important review of how pain figures into the model and the critical relationship between mood and pain. Next, we will address novel therapies that address both mood and pain and dive into the complex phenomenon of how we physically respond and experience pain. Finally, we will review the most salient points regarding rational polypharmacy and specific treatment strategies that may prove useful for patients suffering from chronic pain.

Top 10 Medical Stories 2016: A Practical and Comprehensive Review of What We Need to Know
Chair: Monique Yohanan, M.D.

EDUCATIONAL OBJECTIVE:
1) Review the key medical literature from 2016 with a special focus on stories that are newsworthy and likely to impact clinical practice; 2) Provide an appraisal of the quality of the evidence supporting literature selected for inclusion; and 3) Emphasize disease and lifestyle factors that are associated with an increase in cardiovascular risk.

SUMMARY:
The medical treatment of people with psychiatric conditions is essential to optimal care. Disparities in morbidity and mortality for psychiatric patients are often related to medical diseases, in particular, cardiovascular disease. Cardiovascular diseases and cardiovascular risk factors including diabetes, hypertension and hyperlipidemia are common in

people with psychiatric diagnoses. In addition, behavioral health factors, such as sedentary lifestyle, impact psychiatric patients in a disparate fashion. This session presents the top 10 medical stories of 2016. Selected articles represent topics that are both newsworthy and likely to impact clinical practice. Each publication selected will include an overview of the quality of the evidence.

Monday, May 22, 2017

Using Technology to Help Your Practice: A Practical Overview
Chair: John Luo, M.D.

EDUCATIONAL OBJECTIVE:
1) Incorporate appropriate security measures with smartphones and computers to maintain confidentiality of health information; 2) Recognize security risks of phishing attacks and avoid malware; 3) Appropriately utilize social media for marketing and outreach to patients; 4) Assess their online e-reputation and implement strategies to improve reputation; and 5) Assess smartphone applications for use with patients.

SUMMARY:
Technology use today touches almost every aspect of the psychiatric practice, including documentation, billing and communication. There are a great number of Internet-based applications, including electronic medical records, social media, search engines, and health information resources, that hold both great potential good as well as harm with regard to patient care. Smartphones and tablets as well access this wealth of information, and their "apps" show great promise to change the delivery of health care. This session will cover issues of security, privacy, connectivity, and innovation in technology use in psychiatric practice.

Advances in Psychiatry

Saturday, May 20, 2017

Advances in Long-Term Psychodynamic Psychotherapy
Chair: Glen O. Gabbard, M.D.
Presenters: Eve Caligor, M.D., Robert Michels, John Gunderson, M.D., Mardi Horowitz, M.D.

EDUCATIONAL OBJECTIVE:
1) Illustrate how to use psychodynamic psychotherapy in PTSD patients; 2) Treat narcissistic personality disorder with dynamic therapy; 3) Learn about therapeutic processes in managing BPD patients; 4) Understand when transference work in indicated in dynamic psychotherapy; and 5) Identify and treat resistance in psychodynamic psychotherapy.

SUMMARY:
This session will provide an overview of long-term psychodynamic psychotherapy in present-day practice. Dr. Robert Michels will elaborate on the concept of resistance and how it can be successfully and usefully incorporated into the therapy setting. Dr. Mardi Horowitz will discuss PTSD and its treatment. He will cover the current controversies about the role of exposure in the treatment and describe his research on using psychodynamic therapy as an alternative to exposure treatment. Dr. Eve Caligor will illustrate a transference-focused psychodynamic therapy for narcissistic personality disorder. Dr. John Gunderson will show how to apply good psychiatric management to BPD and present the data suggesting that it is just as effective as other empirically validated therapies for BPD. In so doing, he will also provide an overview of what psychodynamic therapeutic processes comprise good psychiatric management. Finally, Dr. Glen Gabbard will illustrate the role that transference work has in long-term psychodynamic psychotherapy. He will base his recommendations on the research he has been involved with in Norway and at the Menninger Clinic. In all five presentations, there will be an emphasis on how research informs the psychotherapist's interventions. Theory and practical clinical strategies will be discussed in terms of how one applies to the other. The continued role of long-term psychodynamic psychotherapy will be emphasized. To make this case, there will be numerous references to the growing database of studies that lead to the conclusion that psychodynamic psychotherapy can be considered an empirically validated entity for use in depression, anxiety disorders, some personality disorders. patients who have been traumatized, and those who

come to therapy with an uncertain view of their condition and what it is they are seeking. Each presenter will provide brief case examples where the mechanism of action can be illustrated, and the decision-making regarding what intervention is most helpful will be discussed as well. A central feature of long-term psychodynamic therapy is that each individual is unique, and the therapeutic approach has to be adjusted to who the patient is and what the patient wants and needs. There will also be discussion of how one prepares the patient for long-term psychodynamic psychotherapy, both in terms of postulated mechanisms of action and what role the patient has to play in making the therapy effective. The presenters will provide ample time for discussion with the audience so questions and concerns can be considered. Each of the presenters will also have the opportunity to respond to other presenters' lectures. Dr. Glen Gabbard will chair and serve as the moderator of the entire session in addition to serving as one of the presenters.

Advances in Psychopharmacology in the Medically Ill

Chair: Stephen Ferrando, M.D.
Presenter: James Levenson

EDUCATIONAL OBJECTIVE:

1) Become familiar with specific major risks of psychotropic drugs in a variety of medical conditions and perioperatively; 2) Choose appropriate psychotropic drugs for specific medically ill patients; and 3) Identify alternative routes of administration for psychotropic drugs in patients who are NPO.

SUMMARY:

This session is devoted to advances in the use of psychiatric medications in patients with comorbid medical illness, relevant to all psychiatrists but especially those whose practices include patients in general medical settings. Key topics include guidance on dosing in patients with organ impairment, alternate routes of administration and assessing the realistic magnitude of psychotropic risks in the medically ill. We will particularly focus on practical clinical questions such as how should we prescribe patients after gastric bypass surgery? How much should we worry about SSRIs causing bleeding? Which psychiatric drugs should be stopped before elective surgery? Which psychiatric drugs cause osteoporosis? Time will be allotted to answer audience members' questions.

Sunday, May 21, 2017

The New Motivational Interviewing of 2017: Learn the Essentials, Practice Your Skills and Help Your Patients Change

Chairs: Petros Levounis, M.D., Carla Marienfeld, M.D.
Presenters: Natassia Gaznick, Bachaar Arnaout

EDUCATIONAL OBJECTIVE:

1) Describe the new terminology for the spirit and processes of motivational interviewing (MI) based on the third edition of *Motivational Interviewing*; 2) Practice the four processes of motivational interviewing in interactive small- and large-group formats; and 3) Discuss the rationale for using the new motivational interviewing approach in everyday clinical practice.

SUMMARY:

Motivational interviewing (MI), first detailed in William R. Miller's 1983 landmark paper and then in Miller and Stephen Rollnick's books (1991, 2002, 2013), has been transformational in medical care. Despite being released in 2013, the approach and spirit in the third edition of *Motivational Interviewing* has only very slowly made its way into the armamentarium of most clinical psychiatrists, even those who work hard to help patients change behaviors. Indeed, the third edition contains a more streamlined four-process approach that does not utilize even some of the most famous principles and skills from prior iterations. MI requires continual practice and skill refinement. This session will build upon known concepts in MI and update those with the latest terminology, understanding, uses, and skills in MI using a combination of didactics and interactive large- and small-group sessions. MI is of special importance because it can be viewed as the essential clinical skill for engaging patients in treatment and motivating patients to reduce substance use and to follow through with specific recommended behavioral or pharmacological treatments. It is also challenging to master. It requires restraining old tendencies such as asking lots of closed-ended questions, telling patients what

to do or confronting patients who don't follow recommendations. MI also involves learning sophisticated new skills, such as using reflections instead of closed questions; using complex reflections; and using the tactical combination of open questions, reflections and summarizations to move the patient toward change. In the third edition of *Motivational Interviewing*, the dimensions of the spirit of MI have been refined and expanded, consisting of partnership, acceptance, compassion, and evocation. In the conversation toward change, MI utilizes four processes: engaging, focusing, evoking and planning. These processes overlap and are not always sequential. Instead, they build upon each other, and there is flexibility to return to a previous process for reinforcement prior to continuing the conversation about change. Greater emphasis is needed on preventive health care and on helping patients to give up destructive substance use and to make other changes toward healthier lifestyles. We need to be more effective at motivating our patients toward healthy behavior. MI is, arguably, the essential skill for helping patients change, and it should be part of the armamentarium of every clinician. Reinforcing and updating one's knowledge and skills in MI as MI evolves to be more useful and understood is an essential part of the basic skills needed by any clinician working to help patients change their behaviors.

Monday, May 22, 2017

Update on the Management of Side Effects of Psychotropic Medications
Chairs: Joseph F. Goldberg, M.D., Andrew J. Cutler, M.D.
Presenters: Rajnish Mago, M.D., Vivien Burt, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Recognize clinical predictors of adverse drug effects and methods to assess and minimize their impact on treatment outcomes; 2) Identify pharmacogenetic predictors of adverse effects from psychotropic medications; 3) Describe strategies for managing and counteracting adverse metabolic, neurological and genitourinary adverse psychotropic drug effects; and 4) Describe methods for recognizing and managing potential teratogenic risks associated with antidepressants, mood stabilizers and antipsychotic drugs.

SUMMARY:
Psychiatrists are increasingly called upon to evaluate somatic and psychiatric symptoms and differentiate them from possible iatrogenic effects of psychotropic medications. The growing use of multidrug regimens for major psychiatric disorders makes such distinctions all the more challenging. Teasing apart side effects from primary illness symptoms is often complex and requires a facile working knowledge of diverse end-organ drug effects and pharmacokinetic interactions, recognition of subpopulations at increased risk for adverse effects, and awareness of plausible versus unlikely pharmacodynamic effects. The goals of this symposium are to outline for attendees a systematic approach for assessing and managing suspected adverse effects from psychotropic drugs. Presentations will focus on methods for anticipating and recognizing possible adverse drug effects; managing the interplay between perceived adverse effects and medication adherence; distinguishing medically serious from non-serious adverse effects; detecting clinical and pharmacogenetic risk factors that increase propensity for specific adverse effects; implementing risk-benefit analyses when deciding whether to discontinue a perceived offending agent versus treat-through side effects or utilize novel pharmacological antidotes; and methods for anticipating and managing known possible teratogenic risks of mood stabilizers, antipsychotics and antidepressants. Methods will be described for discussing side effect concerns with patients, placing them in proper context and engaging patients in a shared decision-making process about optimal treatment decisions.

Wednesday, May 24, 2017

Advances in Marijuana and Mental Health
Chair: Michael T. Compton, M.D., M.P.H.
Presenters: Abraham Nussbaum, MD, FAPA, Arthur Robin Williams, Garrett Sparks, Marc W. Manseau, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) List five characteristics of most medical marijuana

programs; 2) Describe key aspects of legislation pertaining to medical marijuana and legalization of recreational marijuana use; 3) List five adverse effects of the use of synthetic cannabinoids; 4) Describe the medical management of synthetic cannabinoid intoxication; and 5) List three psychosocial approaches to the treatment of marijuana addiction.

SUMMARY:
American society is highly ambivalent about marijuana use. Some hold that marijuana is a harmless substance that should be legalized; others believe that it may confer therapeutic benefit for patients with certain illnesses. Some view it as generally problematic with no health value, and yet others have serious concerns about the drug's potential for addiction and worsening of mental health. Despite our society's equivocal stance, many states have passed or are moving forward with legislation on medical marijuana programs, and some states have legalized marijuana outright, even though such state legislation conflicts with federal law. Media and lay interest around marijuana has grown exponentially in recent years. While the debate within society continues, controversy within the medical community persists as well. Nonetheless, accumulating evidence from psychiatry does implicate marijuana use, especially in adolescence, as a risk factor for poor educational achievement, cannabis and other substance use disorders, and schizophrenia and other psychotic disorders. This, in light of increasing marijuana use (not decreasing, as in the case of cigarette smoking and alcohol use) among middle and high school students, complicates the discourse on legalization. Evidence is mixed as to whether legalization (for either medical or recreational purposes) will increase the use of marijuana among adolescents. The relevance of this topic is further confirmed by recent trends in the use of synthetic cannabinoids, ongoing controversy over the "gateway drug" hypothesis and many recent peer-reviewed articles on the effects of marijuana on mental health. This session will provide a comprehensive and balanced overview at a time when academics are redoubling efforts to understand the biology and consequences of marijuana use and policymakers are seeking guidance on questions of legalization. Speakers will address the following areas: 1) an overview of the complex connections between marijuana and mental health and mental illnesses; 2) medical marijuana, including the scientific basis for claims about marijuana's efficacy in treating various health conditions (e.g., neuropathies, cancer pain, HIV, neurologic conditions, glaucoma), as well as clinically relevant information about indications, dosing, administration, response, side effects, drug-drug interactions, and monitoring; 3) recent, current and proposed legislation in the U.S.--at the local, state and federal levels--pertaining to medical marijuana, as well as recreational marijuana; 4) the latest treatment approaches for cannabis use disorder, including both proven and investigational pharmacological and psychosocial treatments; and 5) synthetic cannabinoids, including the biology, physiology, epidemiology and legislation pertaining to these novel substances of abuse, as well as their physical and psychiatric effects.

Advances in Research

Monday, May 22, 2017

Advances in Research and Programs Reducing Psychiatric Service Demand
Chair: Herbert Pardes, M.D.
Presenters: Renée L. Binder, M.D., Robert Freedman, Francis Lee, J. John Mann, M.D., Charles Reynolds

EDUCATIONAL OBJECTIVE:
1) Acquaint psychiatrists and other mental health professionals with serious factors that can predict a suicide attempt; 2) Inform mental health professionals of work showing that adolescents may have structural influences on their functioning that can make them particularly vulnerable to anxiety disorders; 3) Acquaint mental health professionals with examples of the expansion of health care providers treating mental health disorders with innovative uses of lay health counselors, primary care clinics, etc; 4) Inform mental health professionals about the search for genes whose early effects on the young child may represent powerful negative forces and result in psychiatric illness in later years; and 5) Elaborate roles and uses of *DSM* diagnosis in legal decision making.

SUMMARY:
As knowledge expands regarding the development and extent of psychiatric illness, diverse approaches are being developed to address the growing need, enhance our ability to develop prevention techniques and increase the number of available treatment providers. In addressing the enormous demand for mental health care, learning from developments in other fields and introducing new techniques including new provider personnel constitute important steps in facilitating the global attack on mental illness. In impoverished communities, resources are sparse. Many groups are now incorporating interventions conducted by those other than mental health professionals. Lay health counseling is a new strategy in multiple communities. There are also widespread care efforts to include primary health care practitioners. Scientists are seeing the possibility of learning lessons from related fields. Uncovering risk genes for child and adult mental illness leads to creation of possible interventions as early as the prenatal period to alleviate the effects of known risk factors for mental illness. One example to be discussed is the stunning success of maternal folic acid supplements for severe developmental abnormalities. As one extrapolates from one illness to another, scientists seek similar or parallel interventions for severe mental illness. Preventions takes many forms. The American Psychiatric Association has expressed widespread distress at excess criminalization of the mentally ill. Factors that exasperate the potential for mental illness may be related to the interaction between patients and frequently ill-advised techniques of police and the judiciary. Psychiatrists and judges are working to decrease the likelihood of this exacerbation of individuals' negative potentials, thereby reducing the number of people with psychiatric illness as well as the level of dysfunction. Prevention techniques are also being studied for adolescent psychiatric disorders. First, early intervention is generally recommended. Second, studies suggest that inborn structural factors may make adolescents more vulnerable during the adolescent phase. Recent work in suicide theory has identified predictive factors. Family history of suicide and mood disorders, as well as personal history of impulsive aggression are noteworthy in identifying people at great risk. Subclassification of mood disorders based on brain imaging and neurological indices may foster personalized treatment. Innovative techniques for reducing the frequency of mental illness are welcomed. Rehabilitation treatment is invaluable. Preventive techniques, if effective and widely used, can contribute to containment of the explosive numbers we are seeing.

Case Conferences

Saturday, May 20, 2017

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 Lu, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the *DSM-5* Outline for Cultural Formulation; 2) Apply the *DSM-5* Outline for Cultural Formulation to a clinical case; 3) Recognize the stigma of mental illness in Asian Americans; and 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 that 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 seven 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. After the film showing, Francis Lu, M.D., will present a brief overview of the *DSM-5* Outline for Cultural Formulation (revised from the one in the *DSM-IV*) and will work with the audience to apply the Outline for Cultural Formulation to the patient and the family. The Outline for Cultural Formulation consists of five sections: cultural identity, cultural concepts of distress, cultural stressors and supports, cultural features of the clinician-patient relationship, and overall assessment.

Sunday, May 21, 2017

An Eye for an I: A 35-Year-Old Woman With Fluctuating Oculomotor Deficits and Dissociative Identity Disorder
Chair: David Spiegel, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the relationship between trauma and dissociation; 2) Understand the relationship between dissociative and neurophysiological states; and 3) Learn about the role of hypnosis in identifying and controlling dissociative symptoms.

SUMMARY:
Physiological changes across identity states among individuals with dissociative identity disorder (DID) are particularly interesting symptoms because they can be objectively measured and hold promise for revealing neural mechanisms underlying dissociation. Neurological and pseudo-neurological symptoms in particular have been noted among DID patients, including variation in autonomic arousal, consistent with the comorbid PTSD present in many DID patients. In particular, differences in dominant handedness and ophthalmological changes in different dissociative states have been reported. The new dissociative subtype of PTSD in *DSM-5* has drawn more attention to the link between trauma and dissociation. The idea that dissociative phenomena might be associated with changes in the coordination of brain function is consistent with research on brain effects of the related phenomenon of hypnosis. Recent studies have demonstrated that hypnotic states are related to reduced activity in the dorsal anterior cingulate cortex, a key node in the salience network. Hypnosis is also related to increased functional connectivity between the left dorsolateral prefrontal cortex (LDLPFC) and the insula, providing a pathway for enhanced mind-body control. Greater inverse functional connectivity between the LDLPFC and the default mode network, notably the medial prefrontal cortex and the posterior cingulate cortex, during hypnosis suggests a mechanism for depersonalization and dissociation of identity. In this case conference, we report a case of marked psychophysiological differences involving visual acuity and ocular movement control among the four alternate personalities of a 35-year-old woman with dissociative identity disorder. She had been considered legally blind, but her visual acuity changed from 20/200 to 20/60 when hypnosis was used to experience a childhood identity, and her marked resting nystagmus reduced substantially. A videotape of the patient will be presented demonstrating changes in the visual symptomatology and recounting her experience of psychotherapy. To our knowledge, only one similar case has been reported in the literature to date. For our patient, differences in visual acuity, frequency of pendular nystagmus and handedness were observed both when the alternate personalities appeared spontaneously and when they were elicited under hypnosis. We then discuss trauma-focused psychotherapy involving training in self-hypnosis, which can teach patients a means of working through traumatic experiences, and accessing and controlling dissociative states and symptoms. Inducing alterations in dissociative states can be an

effective means for understanding and controlling dissociation.

Monday, May 22, 2017

In the Wake of the CDC Opioid Guidelines and the National Pain Strategy: Treating the Patient With Pain and Addiction
Chair: Will M. Aklin, Ph.D.
Presenter: Sean Mackey, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the changing landscape with the recent CDC Opioid Guidelines and the National Pain Strategy and how it impacts care of the patient with pain who is prescribed opioids; 2) Identify the unique challenges of assessing and caring for a patient with comorbid pain and substance use disorder (SUD); and 3) Integrate appropriate risk assessment and mitigation strategies for SUD in a comprehensive management approach for pain.

SUMMARY:
The Institute of Medicine report on Relieving Pain in America noted approximately 100 million adult Americans suffer from pain at an estimated annual direct and indirect expense of $600 billion. Concurrently, the U.S. has been addressing a public health epidemic of prescription drug abuse and unintentional drug overdose deaths. The recently released CDC Guideline for Prescribing Opioids for Chronic Pain includes numerous recommendations for physicians to take greater responsibility for assessing, monitoring and mitigating risks of opioid misuse and abuse when prescribing opioids and providing patients with ongoing education. The competing demands on physicians (e.g., patient outcomes, documentation, increased patient volume, patient satisfaction, fear of regulatory scrutiny, etc.) make this a daunting task. Patients with a history of substance abuse disorders (SUDs) experience trauma and acute painful medical illnesses, may have to undergo surgery, and suffer chronic pain-much like patients without SUDs. These patients require treatment for pain. Undertreatment of these patients is a particular problem in patients with opioid dependency and/or methadone maintenance. This case conference will review the strategies for management of acute and chronic pain in the addicted patient-focusing on patients with opioid addiction. We will present cases of a person with chronic pain and (time permitting) acute perioperative pain-both with coexisting SUD involving opioids. We will outline the unique challenges of assessing and treating these patients within the context of optimizing outcomes while minimizing risks. We will discuss the methods of assessing a patient's pain, use of non-opioid adjuvants for pain management, the importance of nonpharmacological pain management therapies, and appropriate monitoring and risk mitigation strategies.

Should a Patient With Nonterminal Psychiatric Illness Be Given Access to Physician Assisted Suicide? A Case Discussion
Chair: David F. Gitlin
Presenters: Mark Komrad, M.D., James Bourgeois

EDUCATIONAL OBJECTIVE:
1) Consider a case in which a patient with a psychiatric condition only requests physician-assisted suicide in a country where that option is legally available; 2) Learn the ethical arguments that support and oppose fulfilling such a patient's request; 3) Debate whether or not there is any such thing as an "untreatable" and/or "insufferable" psychiatric disorder; and 4) Discuss and debate the new APA position statement regarding administering interventions for non-terminally ill patients for the purpose of causing death and its implications for our profession in those countries where such practices are occurring.

SUMMARY:
Since 2002, Belgium, Luxembourg and the Netherlands have allowed physician-assisted suicide and active euthanasia for patients with both terminal and nonterminal conditions. They have also removed any distinction between physical and mental suffering. This made patients with psychiatric disorders only, and which are deemed "untreatable" and "insufferable," legally eligible for these interventions by their physicians. Recently, over 200 patients each year with psychiatric disorders only are being helped to suicide in those countries, often killed by their own treating psychiatrists, typically by lethal injection. Canada passed a similar law in 2016,

but excluded psychiatric patients. However, that exclusion is currently being challenged in the courts and by legal scholars. In the U.S., there are now seven states that have legalized physician-assisted suicide, but for the terminally ill only. Advocacy groups, like Final Exit, are pushing for these "rights" to be extended to those without terminal illness, including psychiatric patients. No country that has introduced assisted suicide has been able to restrict it to the terminally ill. Inclusion of the non-terminally ill and psychiatric patients is widely expected to follow the emerging laws in the U.S., under the banner of parity and similar equality-based notions. A case will be presented of a patient requesting assisted suicide who has a psychiatric disorder only. Discussants will debate the ethical appropriateness of granting that request. In doing so, considerations that arise where such practices are legal will be considered, including 1) if there are distinctions between physical and mental suffering; 2) if psychiatric disorders are ever untreatable; 3) how much limited access to mental health resources plays a role in whether or not psychiatric conditions can be treated; 4) how much countertransference and projective identification might influence assessments of hopeless untreatability and insufferability; 5) if a patient should be allowed to determine if a condition is untreatable by refusing potentially effective treatments; 6) if different standards of competency should be developed for such decisions than are currently used forensically; 7) if psychiatrists have an ethos that ethically proscribes fulfilling the suicidal wishes of their nonterminal patients, through prescriptions or injections, even if society declares this a "legal right;" and 8) how language can be used to color this debate. Reference will be made to the new APA position statement regarding psychiatrists administering euthanasia or assisted suicide of the non-terminally ill and its implications for colleagues practicing this in countries where it is now legal or eventually becomes so.

Courses

Saturday, May 20, 2017

Buprenorphine and Office-Based Treatment of Opioid Use Disorder

Directors: Petros Levounis, M.D., John A. Renner Jr., M.D.
Faculty: Andrew J. Saxon, M.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the rationale and need for medication-assisted treatment (MAT) of opioid use disorder; 2) Apply the pharmacological characteristics of opioids in clinical practice; 3) Describe buprenorphine protocols for all phases of treatment and for optimal patient/treatment matching; 4) Describe the legislative and regulatory requirements of office-based opioid pharmacotherapy; and 5) Discuss treatment issues and management of opioid use disorder in adolescents, pregnant women, and patients with acute and/or chronic pain.

SUMMARY:
This course will describe the resources needed to set up office-based treatment with buprenorphine for patients with opioid use disorder (OUD) and review 1) *DSM-5* criteria for opioid use disorder and the commonly accepted criteria for patients appropriate for office-based treatment of OUD; 2) confidentiality rules related to treatment of substance use disorders, Drug Enforcement Administration requirements for recordkeeping, and billing and common office procedures, 3) the epidemiology, symptoms and current treatment of anxiety, common depressive disorders and ADHD, as well as 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. Physicians who complete this course will be eligible to request a waiver to practice medication-assisted addiction therapy with buprenorphine for the treatment of opioid dependence.

Eating Disorders and Obesity Management for the General Psychiatrist
Directors: B. Timothy Walsh, M.D., Evelyn Attia, M.D.
Facultys: Deborah Glasofer, Ph.D., James D. Lock, M.D., Ph.D., Laurel Mayer, M.D., Janet Schebendach, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Learn how to identify and evaluate individuals with eating disorders using *DSM-5* diagnostic criteria; 2) Learn evidence-based pharmacological strategies for treating anorexia nervosa, bulimia nervosa and binge eating disorder; 3) Be introduced to tools used in evidence-based psychosocial treatments for eating disorders and obesity; 4) Learn about the psychological symptoms that commonly co-occur with obesity and the treatment adaptations that may be useful in managing psychiatric patients with obesity; and 5) Identify effective treatments for children and adolescents with eating disorders.

SUMMARY:
Eating disorders are serious psychiatric illnesses associated with high rates of morbidity and mortality. They affect more than 10 million individuals in the U.S. and account for increasing rates of disability among adolescent and young adults worldwide, according to studies of the global burden of disease. Eating disorders are frequently associated with other psychiatric symptoms and syndromes, including mood, anxiety and substance use disorders. Psychiatrists and other mental health clinicians who may not specialize in eating disorder treatments will commonly identify eating and weight problems among their patients and may not know how best to manage these features. This course serves as a clinical and research update on eating disorders and obesity for the general psychiatrist. The lectures will include an introduction to diagnosis and evaluation of eating disorders by Dr. B. Timothy Walsh, including guidance regarding the use of the Eating Disorders Assessment for *DSM-5* (EDA-5), an app-based diagnostic tool. Dr. Evelyn Attia will review evidence-based medication treatments for eating disorders. Dr. Deborah Glasofer will discuss psychological treatments for adults with eating disorders and will present clinically useful tools from manualized treatments such as cognitive behavioral therapy (CBT). Dr. James Lock will review psychosocial treatments for children and adolescents with eating disorders and discuss special issues that affect younger patients with these challenging conditions. Dr. Laurel Mayer will speak on the presentation and evaluation of obesity for the psychiatrist. Dr. Mayer will additionally discuss effective treatment strategies for obese psychiatric patients. Dr. Walsh will present a clinical research update, emphasizing new neurobiological findings in anorexia and bulimia nervosa.

Identifying and Helping Older Adults With Mild Neurocognitive Disorders
Director: James M. Ellison, M.D., M.P.H.
Facultys: Donald A. Davidoff, Ph.D., David P. Olson, M.D., Ph.D., Jennifer Gatchel, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Explain the criteria and significance of the mild neurocognitive disorder (MiND) diagnosis; 2) Discuss the functional impact and prognosis of MiND; 3) Describe the clinical assessment, including neuropsychological assessment, for MiND; 4) Learn about the growing importance of neuroimaging biomarkers in appreciating and assessing MiND; and 5) List and discuss seven evidence-based steps to support optimal cognitive aging.

SUMMARY:
How can we identify mild neurocognitive disorder (MiND) and differentiate it from normal cognitive aging and major neurocognitive disorder? How can we asses, delay and prevent MiND? This course will address these questions and more. The course was developed to help clinicians understand the significance of the *DSM-5's* newly defined syndrome, mild neurocognitive disorder. The multidisciplinary team of lecturers will address the disorder's definition; causes and natural history; assessment using clinical, neuropsychological and advanced imaging techniques; and state-of-the-art evidence-based interventions. Before current biomarker studies validated the existence of this clinical syndrome, mild cognitive symptoms were often attributed to depression or anxiety. Mood disorders can indeed be accompanied by cognitive symptoms, but the nature of the relationship between these symptom categories is multifaceted. In various individuals, the signs of depression can be a prodrome of cognitive impairment, a risk factor for cognitive decline, a manifestation of a shared underlying etiology, or a reaction to progressive functional limitation. Identifying which one or more of these paradigms is most fitting can pave the way for effective intervention. Mild age-associated

changes in cognition reflect aging of the brain, much as changes in glomerular filtration and reduced aerobic capacity can accompany aging of the kidneys and heart. The aging brain does not, as once believed, lose vast amounts of neurons over time; however, changes in synaptic structure, diminished activity of key neurotransmitters, altered integrity of white matter, and global loss of volume are typical findings in older brains. The functional manifestation of these changes is reflected in the different norms that apply to neuropsychological test performance of older subjects. The majority of older adults note mild changes in memory or other cognitive functions, and fear of memory loss is one of the most prevalent serious health concerns in this population. Fortunately, these changes are simply a minor nuisance for many. "Subjective cognitive impairment," a syndrome that has attracted the attention of researchers and clinicians, describes individuals, usually older adults, with more compromised cognitive functioning that still falls below the sensitivity of standardized screening tests. Subjective cognitive impairment is not yet a *DSM-5* diagnosis, but it is can be a precursor to mild neurocognitive disorder. Concerns about memory may lead an older adult to seek evaluation. Others may express concern about language, executive function or other cognitive areas.

Sunday, May 21, 2017

Cognitive Behavior Therapy for Severe Mental Disorders: Building Treatment Skills That Work
Director: Jesse H. Wright, M.D., Ph.D.
Facultys: Douglas Turkington, M.D., David Kingdon, M.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe key modifications of CBT for severe mental disorders; 2) Detail CBT methods for suicide risk reduction; 3) Describe CBT methods for delusions and hallucinations; and 4) Detail CBT methods for chronic and severe depression.

SUMMARY:
There is growing evidence that cognitive behavior therapy (CBT) is an effective method for treating patients with chronic and severe mental disorders such as treatment-resistant depression and schizophrenia. This course helps clinicians gain CBT skills that can be added to pharmacotherapy when medication does not give adequate relief of symptoms. Common clinical problems targeted in the course include hopelessness and suicide risk, delusions, hallucinations, and entrenched maladaptive behaviors. Course faculty, who have helped develop and test CBT methods for severe mental illness, will demonstrate key methods with role plays and videos. Participants will have the opportunity to discuss application of CBT for their own patients. Examples of skills that will be learned are developing an effective antisuicide plan, modifying delusions with CBT, teaching patients coping methods for hallucinations, engaging difficult-to-treat patients, using creative methods for behavioral activation, and enhancing treatment adherence.

Good Psychiatric Management of Borderline Personality Disorder
Director: John Gunderson, M.D.
Faculty: Brian Palmer, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
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). GPM's emphasis on psychoeducation about genetics and prognosis and its integration of medications is consistent with other good psychiatric care. It uses management strategies that are practical, flexible and commonsensical. Listening, validation, and 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.

Integrating Neuroscience Into the Clinical Practice of Psychiatry

Director: Melissa Arbuckle, M.D., Ph.D.
Facultys: David Ross, M.D., Ph.D., Michael J. Travis, M.D., Jane L. Eisen, M.D.

EDUCATIONAL OBJECTIVE:

1) Appreciate the value of incorporating a neuroscience framework into the everyday clinical practice of psychiatry; 2) Feel confident and empowered that, with or without a neuroscience background, they can integrate cutting-edge neuroscience knowledge in routine clinical settings; and 3) Access resources and examples of how they might use new and innovative methods to educate patients, relatives, residents, and medical students about clinically relevant neuroscience findings.

SUMMARY:

Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry, yet most psychiatrists have relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of access to neuroscience teaching faculty. In addition, neuroscience has generally not been taught in a way that is engaging and accessible. The focus of this course will be on strategies to incorporate a modern neuroscience perspective into clinical care and bring the bench to the bedside. Attendees will be exposed to new learning activities to further integrate neuroscience into their psychiatric practice in ways that are both accessible and engaging and which encourage lifelong learning. The course will include several workshops: 1) "Basic Neuroscience" will review the basic neuroanatomy of the brain using readily available resources that can be accessed in any clinical setting; 2) "Clinical Neuroscience Conversations" is loosely modeled on the idea of the one minute preceptor, i.e., neuroscience teaching that can be done in the moment, with minimal preparation and directly linked to a clinical case; 3) "Neuroscience in the Media," in which a recent media psychiatric neuroscience article is reviewed and structured format used to critique the media coverage of the piece, find and appraise relevant literature, and then role play how one might communicate about this; and 4) "Talking Pathways to Patients" begins by reviewing the neurobiological underpinnings of a particular psychiatric disorder; participants then role play how they might discuss these findings with a patient, with an emphasis on understanding both symptoms and potential treatment options.

Psychiatric Disorders in Pregnant and Postpartum Women: An Update

Director: Shaila Misri, M.D.
Facultys: Deirdre Ryan, M.B., Barbara Shulman, M.D., Tricia Bowering, M.D., Shari I. Lusskin, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify risk factors and be familiar with individualized treatment intervention for women with perinatal mood disorders; 2) Understand the principles of pharmacotherapy in bipolar disorders I and II in perinatal women and be familiar with teratogenicity, neonatal withdrawal and long-term effects of medication treatment; 3) Understand the effects of perinatal mood/anxiety disorders in mothers, fathers and children and learn about nonpharmacological treatment interventions; 4) Be aware of the effects of anxiety on fetus/child development and review clinical presentations and treatment options; and 5) Understand the impact of untreated maternal illness on fetus, child and family and be aware of evidence-based treatment guidelines.

SUMMARY:

This course will provide a comprehensive overview of research updates and current clinical guidelines on a variety of psychiatric disorders in pregnancy and lactation. These will include major depressive disorder; bipolar spectrum disorders; posttraumatic stress disorder; and anxiety disorders such as generalized anxiety disorders, obsessive compulsive disorders and panic disorders. In depth research

updates in perinatal psychopharmacology will be presented. Additionally, the course will focus on new knowledge with regards to psychotherapeutic interventions with cognitive behavioral and interpersonal psychotherapy. The novel approach of mindfulness-based cognitive therapy will be introduced. Effectiveness of light therapy, infant massage and alternative therapies will be discussed, and mother-baby attachment issues will be reviewed. Up-to-date information will be presented on postpartum mental illness in fathers, including their role in aiding maternal recovery from postpartum psychiatric illnesses. This interactive course encourages audience participation and discussion of complex patient scenarios or case vignettes. The course is specifically designed to update the audience on the cutting-edge knowledge in this subspecialty.

Talking With Your Patients About Marijuana: What Every Psychiatrist Should Know
Director: Henry S. Levine, M.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the CNS activity of cannabis and the physiological actions of cannabis and the cannabinoid system; 2) Discuss the medical usefulness and hazards of cannabis, particularly pertaining to psychiatric and substance abuse disorders; 3) Discuss the medicolegal climate regarding cannabis and legal restrictions on the medical use of cannabis; 4) Take a relevant history from, listen to, educate, and counsel patients who wish to use or are using cannabis for medical treatment or who are using it recreationally while in psychiatric treatment; and 5) Discuss the appropriateness of and techniques for making a cannabis use recommendation.

SUMMARY:
Marijuana, according to NIDA, is "the most commonly used illicit substance." However, according to state, not federal, laws, medical marijuana is legal in 25 states and the District of Columbia. Four states have also legalized recreational use of marijuana. As the number of states legalizing marijuana grows, more patients are turning to us, their doctors, for advice and information regarding marijuana's risks and benefits. Some patients with psychiatric illness are using marijuana recreationally as well, without knowledge of its effects. Both groups deserve education based on our scientific knowledge. However, despite research to the contrary, the U.S. government still considers marijuana a Schedule I substance "with no currently accepted medical use and a high potential for abuse." The federal stance, though recently revised, still inhibits research on the science of marijuana and has promoted an attitude toward marijuana's risks and benefits that is not scientifically based. We need to be able to counsel and educate our patients based on objective, scientific data. Too much is said with authority about medical aspects of marijuana--pro and con--that is misleading and deceptive. This course will teach the practitioner to understand the risks and benefits, restrictions, and seductions their patients face in considering cannabis use. The faculty will review the 2,500-year-long history of cannabis use in medicine and the more recent history of restrictions on research and use of cannabis in the U.S. We will discuss the cannabinoid system, CB1 and CB2 receptors, and their distribution and function, as well as endogenous cannabinoids. We will cover cannabis's routes of administration, bioavailability, distribution and elimination, and the unique actions of various cannabinoids. We will then present clinical research and its limitations on the usefulness of cannabis in psychiatric conditions--including anxiety, depression, psychosis, PTSD, and sleep--and its role in violence. We will also review clinical research on its usefulness in nonpsychiatric medicine, including its actions in patients with inflammation, pain, spasm, loss of appetite, nausea, epilepsy, and HIV. We will present data on the FDA-approved cannabinoids. The faculty will detail hazards of cannabis use, including addiction, accidents, psychosis, cognitive deficits, withdrawal, heart and lung illnesses, and other psychiatric symptoms. We will describe the legal restrictions and limitations on psychiatric practitioners who may be asked by their patients to issue a "cannabis recommendation." We will teach the practitioner to take a history relevant to the use of medical cannabis. We will discuss ways to listen to and talk with patients who are interested in using or are actively using cannabis for medical reasons or who are using cannabis recreationally

while in treatment for a psychiatric disorder. We will not address screening for or treatment of addiction.

Updates in Geriatric Psychiatry
Director: Rajesh R. Tampi, M.D., M.S.
Facultys: Shilpa Srinivasan, M.D., Aarti Gupta, M.D., Ilse Wiechers, M.D., M.H.S.

EDUCATIONAL OBJECTIVE:
1) Describe the epidemiology and neurobiology of major psychiatric disorders in late life; 2) Define the assessments for major psychiatric disorders in late life; 3) Discuss the latest treatments for major psychiatric disorders in late life; and 4) Enumerate the controversies in the management of psychiatric disorders in late life.

SUMMARY:
Psychiatric disorders are not uncommon in late life. Illnesses like dementias, behavioral and psychological symptoms of dementia, 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 fewer 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 psychiatrist, primary care clinicians, advance practice nurses, and physician associates will be expected to see many of the older adults with psychiatric illness. There are only a limited number of educational courses for clinicians 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. We have designed a comprehensive review course for clinicians who want to gain expertise in caring for older adults with psychiatric disorders. This course will be a one-stop shop for those who intend to receive the most up-to-date information on 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. The APA Annual Meeting is a perfect venue for such a review course, as it attracts a significant number of psychiatric clinicians who would benefit from such a course.

What Every Psychiatrist Needs to Know About Epilepsy
Director: Gaston Baslet, M.D.
Facultys: Tatiana Falcone, M.D., Elia Pestana-Knight, M.D., Jana Jones, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Apply knowledge about the bidirectional relationship between epilepsy and psychiatric disorders to improve interdisciplinary collaboration and treatment outcomes for patients with epilepsy; 2) Perform a comprehensive evaluation in patients with seizures and successfully navigate challenging clinical manifestations that require careful diagnostic clarification; and 3) Design a treatment plan that follows current evidence and integrates the neurobiological and psychosocial contributions that epilepsy and its treatment have in various psychiatric presentations.

SUMMARY:
Psychiatric disorders are common in patients with epilepsy, beyond what is expected with a chronic medical condition. Both neurobiological and psychosocial factors contribute to the expression of psychopathology in patients with epilepsy. Clinical and translational research demonstrate a bidirectional relationship between epilepsy and a wide range of psychiatric disorders, including depression, anxiety, attention deficit/hyperactivity disorder, autism spectrum disorder, psychosis, and suicide. Despite these robust data, the mental health needs of many epilepsy patients remain unmet and impact the quality of life of these patients and the management of their illness. This course will guide clinicians on how to evaluate the challenging differential diagnoses of epilepsy patients, such as psychiatric disorders that mimic seizures as well as behavioral and affective symptoms that represent seizure manifestations. We will discuss in detail a wide variety of psychiatric manifestations (including depression, anxiety and attention deficit/hyperactivity disorder) in the context of

epilepsy. The course will also include a review of current antiepileptic drugs and their impact on mood, behavior and cognition, as well as the impact of psychotropic medications on seizures. Evidence-based psychosocial interventions that address mood, anxiety and executive dysfunction in epilepsy will be discussed in detail. Emphasis will be placed on the need for interdisciplinary collaboration to clarify diagnosis, select appropriate therapies and optimize outcomes. Faculty will include experts in neurology, neuropsychiatry, clinical psychology, and neuropsychology who possess a wealth of clinical expertise in the evaluation and treatment of patients with epilepsy with comorbid psychiatric diagnoses. We will present illustrative cases showcasing the complexity of these clinical scenarios. Participation from the audience will be encouraged.

Monday, May 22, 2017

Acute Brain Failure: Neurobiology, Prevention and Treatment of Delirium
Director: Jose R. Maldonado, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the strengths and weaknesses of various screening and diagnostic instruments used for the detection of delirium; 2) Recognize the main risk factors for the development of delirium in the clinical setting; 3) Describe the evidence regarding the use of nonpharmacological techniques (e.g., light therapy, early mobilization) in delirium prevention and treatment; 4) Define the evidence behind the use of antipsychotic agents in the prevention and treatment of delirium; and 5) Recognize the evidence behind the use of nonconventional agents.

SUMMARY:
Delirium is a neurobehavioral syndrome caused by the transient disruption of normal neuronal activity due to disturbances of systemic physiology. It is also the most common psychiatric syndrome found in the general hospital setting, causing widespread adverse impact to medically ill patients. Studies have demonstrated that the occurrence of delirium is associated with greater morbidity, mortality, and a number of short- and long-term problems. In the short term, patients suffering from delirium are at risk of harming themselves (e.g., falls, accidental extubation) and of accidentally injuring their caregivers due to confusion, agitation and paranoia. In the long term, delirium has been associated with increased hospital-acquired complications (e.g., decubitus ulcers, aspiration pneumonia), a slower rate of physical recovery, prolonged hospital stays, and increased placement in specialized intermediate and long-term care facilities. Furthermore, delirium is associated with poor functional and cognitive recovery, an increased rate of cognitive impairment (including increasing rates of dementia), and decreased quality of life. This course will review delirium's diagnostic criteria (including new *DSM-5* criteria), subtypes, clinical presentation and characteristics, available diagnostic tools, the theories attempting to explain its pathogenesis, and the reciprocal relationship between delirium and cognitive impairment, as well as summarize behavioral and pharmacological evidence-based techniques associated with successful prevention and treatment techniques. We will also use delirium tremens (i.e., alcohol withdrawal delirium) as a way to better understand delirium's pathophysiology and discuss novel, benzodiazepine-sparing techniques in order to better control the syndrome and prevent its complications while avoiding the deliriogenic effects of benzodiazepine agents.

Dialectical Behavior Therapy for Psychiatrists: A DBT Toolkit for Treating Borderline Personality Disorder
Director: Beth Brodsky, Ph.D.
Faculty: Barbara Stanley

EDUCATIONAL OBJECTIVE:
1) Be familiar with the basic theory and interventions of dialectical behavior therapy (DBT); 2) Use the DBT psychotherapy approach to enhance empathy for and treatment engagement with BPD patients; and 3) Incorporate targeted DBT interventions and principles to manage suicidal behaviors and treatment nonadherence.

SUMMARY:
Individuals with borderline personality disorder (BPD) present treatment challenges for even the most trained and dedicated clinicians. The BPD diagnosis is one of the most stigmatized of the mental illnesses, notorious for treatment resistance,

high treatment utilization and dropout rates, recurrent suicidal and nonsuicidal self-injurious (NSSI) behaviors, and, consequently, clinician burnout. Dialectical behavior therapy (DBT) is an evidence-based psychosocial treatment with proven efficacy in decreasing suicidal and NSSI behaviors and treatment dropout in BPD, yet few practicing psychiatrists have been exposed to DBT in their training. This course will provide an overview of the DBT treatment approach and focus on teaching clinical psychiatrists and psychopharmacologists targeted DBT interventions that can enhance clinical management of the most difficult behaviors presented by these patients, such as suicidal and NSSI behaviors, ideation, and communications; frequent help-seeking; interpersonal hostility; and medication and general treatment nonadherence. These interventions include validation strategies to enhance empathy and treatment engagement; commitment strategies to establish collaboration toward reaching behavioral goals and prioritizing treatment focus on life-threatening behaviors; use of a diary card to track mood, suicidality, medication adherence, and related symptoms; behavioral analysis of suicidal and dysregulated behaviors to enhance problem solving; a protocol for effective between-session contact; and distress tolerance skills for reducing impulsivity. Participants will leave the class with a DBT toolkit to incorporate into their clinical practice.

Emergency Psychiatry: Evaluation and Treatment of the Crisis Patient

Director: Kimberly D. Nordstrom, M.D., J.D.
Facultys: Jon Berlin, M.D., Leslie Zun, M.D., Seth Powsner, M.D., Scott Zeller, M.D.

EDUCATIONAL OBJECTIVE:

1) Learn when to consult with your emergency medicine colleagues; 2) Understand why they order targeted labs rather than universal panels; 3) Learn techniques in engaging agitated patients; and 4) Understand the thought process behind finding the “right” medicine for the patient.

SUMMARY:

No matter the type of environment in which you practice psychiatry, you will experience patients who are in crisis. 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 course serves as a primer as well as an update for psychiatrists in the evaluation and management of psychiatric emergencies. The course faculty offer decades of experience in emergency psychiatry. Participants will learn about the role of medical and psychiatric evaluations and the use of risk assessment for 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). Special emphasis will be given to psychopharmacological treatments in the emergency setting. The course is divided into two parts; the first focuses on evaluation, and the second focuses on treatment. A combination of lectures and case discussion will cover fundamental and pragmatic skills to identify, assess, triage, and manage a range of clinical crises. Course faculty includes emergency psychiatrists and an emergency medicine physician to help provide various viewpoints and allow for rich discussion. The course will close with the course director leading a debate with faculty over best treatments for specific case scenarios. The intent of this exercise is to demonstrate that there is not one "right" answer and to exhibit the thought process behind treatment decisions.

Essentials of Assessing and Treating Attention-Deficit/Hyperactivity Disorder in Adults and Children

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

EDUCATIONAL OBJECTIVE:

1) Understand the current model of ADHD as

impairment of executive functions in children, teens or adults; 2) Identify the role of emotions and motivations in ADHD and how these are integrated into executive functions; 3) Adapt medication treatments for persons whose ADHD is complicated by various comorbid disorders; and 4) Tailor psychosocial and behavioral treatments for children, adolescents and adults with ADHD.

SUMMARY:
This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and who have mastered basic concepts and skills for the treatment of ADHD. It will introduce new models for understanding the involvement of emotions and motivations in ADHD and will describe how treatments need to be modified in cases where ADHD is complicated by additional psychiatric disorders. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by depression, bipolar disorder, substance use disorders, 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, e.g., family conflicts, discrimination in schools and work settings. This course will illustrate how clinicians can 1) assess persons for ADHD in ways that account for these complicating factors; 2) select appropriate medications, including combined agents, for treatment of complicated ADHD and comorbid disorders; and 3) develop treatment interventions that may effectively address ADHD with psychiatric, developmental, familial, educational, and social system implications.

Essentials of Assessing and Treating Attention-Deficit/Hyperactivity Disorder in Adults and Children—Encore
Directors: Thomas E. Brown, Ph.D., Anthony Rostain, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Understand the current model of ADHD as impairment of executive functions in children, teens or adults; 2) Identify the role of emotions and motivations in ADHD and how these are integrated into executive functions; 3) Adapt medication treatments for persons whose ADHD is complicated by various comorbid disorders; and 4) Tailor psychosocial and behavioral treatments for children, adolescents and adults with ADHD.

SUMMARY:
This advanced course is designed for clinicians who have completed basic professional education in assessment and treatment of ADHD and who have mastered basic concepts and skills for the treatment of ADHD. It will introduce new models for understanding the involvement of emotions and motivations in ADHD and will describe how treatments need to be modified in cases where ADHD is complicated by additional psychiatric disorders. Emphasis will be on treatment of adults, adolescents and children whose ADHD is complicated by depression, bipolar disorder, substance use disorders, 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, e.g., family conflicts, discrimination in schools and work settings. This course will illustrate how clinicians can 1) assess persons for ADHD in ways that account for these complicating factors; 2) select appropriate medications, including combined agents, for treatment of complicated ADHD and comorbid disorders; and 3) develop treatment interventions that may effectively address ADHD with psychiatric, developmental, familial, educational, and social system implications.

Evaluation and Treatment of Sexual Dysfunctions
Director: Waguih William IsHak, M.D.

EDUCATIONAL OBJECTIVE:
1) Acquire practical knowledge and skills in the evaluation of sexual disorders; 2) Acquire practical knowledge and skills in the treatment of sexual disorders; and 3) Learn to apply gained knowledge/skills to real examples of sexual disorders.

SUMMARY:

This course is designed to meet the needs of psychiatrists 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 nonpsychiatric 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.

Mind-Body Programs for Stress, Anxiety, Depression, PTSD, Military Trauma and Mass Disasters: Lecture and Experiential

Directors: Patricia L. Gerbarg, M.D., Richard Brown, M.D.

Facultys: Chris C. Streeter, M.D., Beth Abrams, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe how heart rate variability and sympathovagal balance contribute to overall well-being and stress resilience; 2) Apply polyvagal theory to understand how voluntarily regulated breathing practices (VRBPs) help shift the organism from states of defensive disconnection toward a state of safety and connectedness; 3) Discuss the vagal-gamma-aminobutyric acid theory of inhibition and its potential relevance to treatment of stress-, anxiety- and trauma-related disorders; 4) Experience coherent breathing for stress reduction and learn how VRBPs can be used to reduce anxiety, insomnia, depression and symptoms of PTSD; and 5) Experience open focus attentional training for stress reduction, improved attention, and relief of physical and psychological distress for clinicians and their patients.

SUMMARY:

Dr. Richard P. Brown and Dr. Patricia Gerbarg use PowerPoint slides, lecture, video clips, experiential practices, and Q&A. This repeat of last year's course is updated with new research. Breath-Body-Mind (BBM) uses simple practices, primarily voluntarily regulated breathing practices (VRBPs) with coordinated movements derived from yoga, qigong, martial arts, meditation, and modern neuroscience. Easily learned for relief of stress, anxiety, depression, PTSD, and pain, these practices can be modified for different settings: private offices, clinics, hospitals, groups, schools, military bases, and disaster sites. We present developments in understanding how VRBPs rapidly improve sympathovagal balance, emotion regulation and symptom resolution in a wide variety of disorders and patient populations. The evolving neurophysiological theory incorporates concepts of polyvagal theory (Stephen Porges); interoception; and interactions between the autonomic nervous system, GABA pathways, emotion regulatory circuits, neuroendocrine response, and social engagement networks. Polyvagal theory asserts that physiological states characterized by increased vagal influence on heart rate variability support social engagement and bonding and inhibit defensive limbic activity. A specific feature of trauma-related disorders—disconnection, disruption of bonding—will be explored. Dr. Gerbarg will briefly update research evidence that specific VRBPs, in combination with other practices, resulted in significant rapid improvements in psychological and physical symptoms in studies of GAD, veterans with PTSD, bowel disease, and survivors of mass disasters such as the 2004 Southeast Asian tsunami, 9/11 World Trade Center attacks, and war and slavery in Sudan. Dr. Chris Streeter will present phase 1 data from a mass resonance spectroscopy study of the effects of yoga and coherent breathing on mood and brain GABA levels in patients with major depressive disorder. Dr. Brown guides participants through rounds of movement with VRBPs: Coherent Breathing, 4–4–6–2, Breath Moving, "Ha," and Open Focus Meditation. The gentle movements can be done standing or sitting and are suitable for adults and children. Awareness and mindfulness of breath and changes in mental and physical states is

cultivated. Attendees enhance learning by participation in group processes. Dr. Gerbarg covers clinical issues, indications, contraindications, risks, benefits, and guidelines for augmenting psychotherapy with VRBPs. Cases illustrate pain resolution and restoration of connectedness/bonding through VRBPs that shift the individual from states of fear and immobilization to states of safety and bonding. Cases include a victim of sexual abuse, an Operation Iraqi Freedom veteran mental health specialist, a former U.S. Air Force U2 pilot, a second-generation Holocaust survivor, and a health care worker in Sudan. Resources for skill development are given. Bring a yoga mat, towel or blanket.

Motivational Interviewing as a Core Communication Style for Psychiatrists
Director: Michael A. Flaum, M.D.
Facultys: Brian Hurley, M.D., M.B.A., Carla Marienfeld, M.D., Florence Chanut, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe what is meant by "the paradoxical effect of coercion" and why it is a central tenant of motivational interviewing (MI); 2) Improve ability to formulate simple and complex reflections; 3) Demonstrate at least three techniques to elicit change talk; 4) Explain the "ask, inform, ask" model of guiding a change plan; and 5) Describe how the spirit of MI relates to the core elements of mental health recovery.

SUMMARY:
Motivational interviewing (MI) is a method and style of interpersonal communication initially developed for the treatment of substance use disorders. MI is distinguished from other counseling styles through the clinician's intentional arrangement of the conversation so that it is the patient, rather than the clinician, who voices the argument for changing problematic behaviors. This is a radical departure from traditional helping conversations. Since its introduction in the early 1980s, the utility and effectiveness of MI has been recognized and validated in a wide variety of areas both within health care and beyond, yet its utilization in psychiatry remains relatively limited and is typically reserved for patients with substance abuse problems. The potential for MI is markedly broader. We suggest the utilization of MI as a default communication style and way of interacting with patients is an ideal way to promote a "recovery-oriented" approach to mental health care. Additionally, the MI style promotes a "positive psychiatry" approach across the full spectrum of patients. In this course, the core elements of both the technique and the so-called "spirit" of MI will be introduced, discussed and demonstrated, along with the rationale behind them. The course will include experiential learning (i.e., participants will actively practice core MI skills via simulations, role plays and "real plays"). This will include practice aimed at improving reflective listening, strategies to elicit and reinforce "change talk," responding to "sustain talk," and navigating discord. We will also discuss, demonstrate, and practice exchanging information and doing initial assessments and routine follow-up visits in an MI-consistent manner. The course is designed for learners of MI at all levels, including those who have had no prior exposure to MI.

Patient-Centered and Interprofessional Approach to Managing Behavior Disturbance in Advanced Dementia
Director: Maureen C. Nash, M.D., M.S.
Facultys: Sarah Foidel, O.T.R./L., Maria L. Shindler, M.S.N.

EDUCATIONAL OBJECTIVE:
1) Differentiate between common types of dementia; 2) Describe a framework for nonpharmacological interventions; 3) Utilize an evidence-based algorithm for pharmacological interventions; 4) Access resources for detecting and treating delirium; and 5) Apply practical principles to these challenging clinical problems.

SUMMARY:
Successful treatment requires a holistic view of assessment, symptom interpretation and knowledge of the evidence base. A model of an interprofessional team assessment including psychiatry, nursing and occupational therapy will be provided in this course. This course is designed for psychiatrists, primary care providers, occupational therapists, advanced practice nurses, and others who desire to learn how to assess and manage

behavior disturbances in those with dementia. This course is designed by and for clinicians with a solid basis in the current evidence. Cases will be used throughout the course to illustrate diagnostic issues and treatment dilemmas. The course will thoroughly review assessment, pharmacological and nonpharmacological management, and quality-of-life issues. Management for both inpatient and outpatient situations will be covered, with an emphasis on the most difficult situations, typically those who are referred to emergency rooms or who are inpatients in adult or geriatric psychiatry units. The first half will be an overview of behavior disturbance and how to measure disturbance while determining the proper diagnosis. Determining the type of dementia and detecting delirium is emphasized for proper management. Next there will be discussion of interprofessional, evidence-based 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 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.

Risk Assessment for Violence
Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:
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, respectively; and 3) Indicate three factors that increase the likelihood that violent command hallucinations will be obeyed.

SUMMARY:
Mentally ill and substance-abusing clients present many risks for professionals. This course is designed to provide a practical map through the marshy minefield of uncertainty in assessing the risk for violence. The demographics of violence and the specific incidence of violence in different psychiatric diagnoses will be reviewed. Dangerousness will be discussed in persons with psychosis, mania, depression, and personality disorders. Special attention will be given to persons with paranoid delusions, erotomanic delusions, command hallucinations, homosexual panic, and the new *DSM-5* diagnosis of premenstrual dysphoric disorder. New research will be presented on the precipitating factors that cause paranoid patients to commit serious violence. Personality traits and childhood antecedents of adult violence will be covered. Instruction will be given on taking a history from potentially dangerous clients. Techniques will be demonstrated in the elucidation of violent threats and "perceived intentionality." Dr. Resnick will suggest approaches to reduce the risk of malpractice liability. A videotaped vignette will allow participants to identify risk factors and develop a violence prevention plan.

Suicidality Assessment and Documentation for Health Care Providers
Directors: David V. Sheehan, M.D., M.B.A., Jennifer Giddens

EDUCATIONAL OBJECTIVE:
1) Conduct and properly document a thorough suicidality assessment; 2) Identify the different suicidality disorder phenotypes and identify the treatment most likely to be helpful for each phenotype; and 3) Properly monitor suicidality during the course of pharmacological and other treatments for psychiatric disorders and understand the limitations of and problems associated with suicide prediction.

SUMMARY:
Suicide is the 15th leading cause of death worldwide and a leading cause of malpractice actions in psychiatry. Clinicians become alarmed when patients discuss suicidality. The product information on most psychiatric drugs advises clinicians to assess and monitor their patients for suicidality before starting and throughout the course of treatment. The expectations on how to properly conduct and document suicidality assessments increased significantly following the inclusion of boxed warnings on suicidality for most psychiatric medications, but health care providers need

guidance on how to do this in a time-efficient manner. Skillful assessment protects patients, and documentation protects the health care provider. This course operationalizes how to properly assess and document suicidality: 1) start with three screening questions for suicidality; 2) those who screen positive move on to more detailed assessment with a suicidality tracking scale; 3) if clinicians want even more detailed information on a patient's suicidality, they can use an expanded suicidality tracking scale and a suicide plan tracking scale; 4) regardless, use the structured diagnostic interview to classify a patient's suicidal symptoms into the 11 suicidality disorder phenotypes; 5) determine a course of treatment based on suicidality disorder phenotype; 6) document and summarize the findings from previous steps in the medical record for medicolegal protection; and 7) Use the suicidality tracking scales to monitor response to treatment. The faculty will involve the audience interactively at frequent intervals throughout the course through liberal use of question and answer discussions, small-group discussions, role playing, a simulation exercise, and instructional simulation games. The faculty will provide all course participants with templates and practical assessment tools that are useful in clinical practice settings.

The Clinical Assessment of Malingered Mental Illness
Director: Phillip J. Resnick, M.D.

EDUCATIONAL OBJECTIVE:
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 address 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.

Tuesday, May 23, 2017

Advanced Strategies for the Assessment and Treatment of Complex ADHD
Director: Thomas E. Brown, Ph.D.
Faculty: Anthony Rostain, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Explain the new model of ADHD as the developmental impairment of executive functions and its implications for assessment and treatment; 2) Describe strategies for treating ADHD in those with other psychiatric comorbidities; 3) Utilize research-based criteria to select, fine-tune and augment medications for the treatment of ADHD; 4) Design and monitor treatment for patients with ADHD that do not respond to first-line treatment using integrated medication and psychosocial approaches; and 5) Describe 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 the 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 the developmental impairment of executive function, highlighting research that supports this model and describing implications for assessment and treatment. 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. Augmentation strategies for treating individuals who cannot tolerate or do not respond to first-line treatment will be described. Discussion of case materials will illustrate ways in which ADHD can be complicated by psychiatric

comorbidity and by a diversity of interacting psychosocial factors.

Conversion Disorder: Update on Evaluation and Management
Director: Gaston Baslet, M.D.
Faculty: William Curt LaFrance Jr., M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Perform a clinical evaluation of patients with conversion disorder in collaboration with a neurologist and communicate the diagnosis in a way that reinforces engagement in treatment; 2) Recommend, seek advice on or execute the most appropriate treatment plan based on the current evidence from medical literature; and 3) 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 the *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 in the evaluation and treatment of these patients. We will present illustrative cases showcasing the complexity and heterogeneity of patients with conversion disorder.

ECT Practice Update for the General Psychiatrist
Director: Peter Rosenquist, M.D.
Facultys: Charles Kellner, Donald Eknoyan

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

SUMMARY:
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 this 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, ECT stimulus dosing, 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 and the status of efforts to modify the classification of ECT by the FDA. 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.

Evidence-Based Psychodynamic Therapy: A Pragmatic Clinician's Workshop
Directors: Richard F. Summers, M.D., Jacques P. Barber, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Become aware of the substantial evidence base supporting psychodynamic psychotherapy; 2) Improve treatment selection by applying a contemporary and pragmatic framework for delivering psychodynamic psychotherapy; 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 pragmatically oriented, interactive course will help clinicians provide focused and evidence-based psychodynamic therapy to a wide range of appropriate patients. By providing a clear and consistent model connected to evidence and technique, we simplify and clarify the psychodynamic approach and help clinicians feel they are providing a contemporary and state-of-the-art treatment. This lively and participatory course will include many video clips of therapy sessions, participant discussion about technique, and a group exercise on defining the core psychodynamic problem of a presented patient. The course follows the arc of therapy by discussing the central concepts of therapeutic alliance, core psychodynamic problems, psychotherapy focus, and strategies for change. Presentation of the relevant evidence is paired with the model and specific techniques to bolster the clinician's confidence in the effectiveness of the method.

Exploring Technologies in Psychiatry
Directors: John Luo, M.D., Robert Kennedy, M.D.
Facultys: Steven Chan, M.D., M.B.A., John Luo, M.D., Carlyle Chan, M.D., John Torous, M.D.

EDUCATIONAL OBJECTIVE:
1) Review the various current and emerging technologies and connections that are possible in psychiatry and medicine; 2) Evaluate emerging technologies and how they impact clinical practice today and tomorrow; and 3) Recognize the pros and cons of electronic physician-patient communication.

SUMMARY:
This is a newly revised course that addresses the important aspects of managing information and technology that has become an integral 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. Whether it is collaborating with a colleague over the Internet, using a teleconferencing system, 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.

Neuroanatomy of Emotions
Director: Ricardo M. Vela, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the functional neuroanatomical interrelationships of the hypothalamus, amygdala, septal nuclei, hippocampus, and anterior cingulate gyrus; 2) Identify major limbic fiber connectivity, trajectories and 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; and 5) Discuss the implications of neurodevelopmental abnormalities of migrating neurons in schizophrenia.

SUMMARY:
Psychiatry has been revolutionized by the development of brain imaging research, which has expanded our understanding of mental illness. This explosion of neuroscientific knowledge will continue to advance. In April 2013, President Obama called for a major initiative for advancing innovative neurotechnologies for brain research. NIMH has launched the new Research Domain Criteria (RDoC) 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 main neurocircuitry 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 using 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.

Treatment of Schizophrenia
Director: Philip Janicak, M.D.
Facultys: Rajiv Tandon, M.D., Jeffrey T. Rado, M.D., M.P.H., Stephen R. Marder, M.D.

EDUCATIONAL OBJECTIVE:
1) Appreciate the growing emphasis on early recognition and interventions to favorably alter the prognosis of high-risk individuals; 2) Describe the clinically relevant pharmacological aspects of first- and second-generation antipsychotics, as well as novel therapies; 3) Better understand the efficacy, safety and tolerability of antipsychotics when used for acute and long-term management of schizophrenia; and 4) Describe recent approaches to integrating medication strategies with psychosocial and rehabilitation programs.

SUMMARY:
The treatment of schizophrenia and related psychotic disorders is rapidly evolving, with 12 second-generation antipsychotics now available in various formulations (i.e., clozapine, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, iloperidone, paliperidone, asenapine, lurasidone, brexpiprazole, and cariprazine). 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 (e.g., recovery).

Understanding and Treating Narcissistic Personality Disorder
Director: Frank E. Yeomans, M.D.
Facultys: Otto F. Kernberg, M.D., Eve Caligor, M.D., Diana Diamond, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Recognize and appreciate the range of narcissistic pathology; 2) Understand the pathological grandiose self and its role as the psychological structure that underlies narcissistic personality disorder; 3) Understand treatment techniques that address narcissistic resistances and help engage the patient in therapy; 4) Understand treatment techniques that help patient and therapist work with the anxieties beneath the grandiose self; and 5) Work with the typical attachment styles of narcissistic patients.

SUMMARY:
Narcissistic disorders are prevalent and can be among the most difficult clinical problems to treat. Narcissistic patients tend to cling to a system of thought that interferes with establishing relations and successfully integrating into the world. Furthermore, these patients can engender powerful countertransferential feelings of being incompetent, bored, disparaged, and dismissed or, 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 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.

Focus Live! Clinical Neuropsychiatry
Moderator: Mark H. Rapaport, M.D.
Presenter: Sheldon Benjamin, M.D.

EDUCATIONAL OBJECTIVE:
1) Build awareness of the underlying mechanisms in neuropsychiatric disorders: MTBI, cognitive impairment, epileptic seizures and depression, frontotemporal dementia, and other presentations; 2) Apply increased understanding of clinical neuroscience and be better able to diagnose neuropsychiatric disorders; and 3) Self-test their knowledge of disorders in clinical neuropsychiatry, their symptoms and treatments.

SUMMARY:
General psychiatrists are increasingly expected to be able to diagnose common neuropsychiatric disorders. Residents must now achieve milestones in neuropsychiatry and neuroscience as part of general psychiatry training. In this FOCUS LIVE interactive session, multiple-choice questions are presented that are intended to review common disorders at the interface of psychiatry and neurology. These conditions often present to psychiatrists, initially or eventually, as behavioral or mood changes, cognitive impairment, or psychosis emerge. Topics to be reviewed are cognitive impairment; mild traumatic brain injury; autoimmune limbic encephalitis; biological and psychosocial underpinnings of nonepileptic seizures, comorbid seizures and depression; and behavioral variant frontotemporal dementia. Participants in the FOCUS LIVE session answer multiple-choice questions using personal computer/smartphone technology to assess their knowledge and review the evidence for challenges and treatments for disorders of clinical neuropsychiatry. Participants compare result anonymously to peers for self-assessment credit. Multiple-choice questions are presented on the screen; participants answer, and a histogram is shown on screen. The presenter delivers rationale and key points. To claim self-assessment credit, participants go online after the session. There they will be able to review the complete rationales and references for the questions and claim self-assessment credit.

Focus Live! Depression: Challenges and Treatments
Moderator: Mark H. Rapaport, M.D.
Presenter: Raymond Lam, M.D.

EDUCATIONAL OBJECTIVE:
1) Review multiple-choice questions and test their knowledge; 2) Recognize the challenges clinicians face in the treatment of major depressive disorder and the use of the evidence base supporting various treatment options; and 3) Apply an increased understanding of psychotherapy, pharmacotherapy and combination treatment options for MDD.

SUMMARY:
Depression is the leading cause of disability worldwide. Despite considerable advances in psychiatry's understanding of major depressive disorder and its treatment, only one-third of patients achieve full symptom remission with initial treatment, and most go on to experience recurrence. Current information about depression treatment is presented through multiple-choice questions addressing clinical challenges faced routinely by clinicians as they navigate the treatment course with patients who have major depressive disorder. Clinical and evidence questions regarding combining antidepressants with psychotherapy, available psychotherapies for depression, strategies to overcome treatment-resistant depression, the

current role of second-generation antipsychotics, comorbid medical illness, and clinical strategies for assessing and treating cognitive dysfunction in major depressive disorder will be discussed. Participants in the FOCUS LIVE session answer multiple-choice questions using personal computer/smartphone technology to assess their knowledge and review the evidence for challenges and treatments for major depressive disorder. Participants compare their result anonymously to peers for self-assessment credit. Multiple-choice questions are presented on the screen; participants answer, and a histogram is shown on screen. The presenter delivers rationale and key points. To claim self-assessment credit, participants go online after the session. There, they will be able to review the complete rationales and references for the questions and claim self-assessment credit.

Forums

Saturday, May 20, 2017

Doctors in White Coats: Historically Black Colleges and Universities' Contribution to Medicine
Chairs: Kimberly Gordon, M.D., Ranna Parekh, M.D., M.P.H.
Presenters: Rahn K. Bailey, M.D., William B. Lawson, M.D., Danielle Hairston, M.D., Steven Starks, M.D., Ayana Jordan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the skills fostered in HBCUs/HBMS in not only enhancing the scientific competencies of physicians but also the cultural and structural competencies of medical professionals; 2) Discuss the future role of HBMS in maintaining quality health care and teaching programs in public hospitals/facilities serving predominantly poor communities; and 3) Discuss the role of partnership between HBCUs/HBMS and predominately White research-intensive institutions in the elimination of disparities in health.

SUMMARY:
Despite advancements in diversity and health equity in pre-medical and medical school training-reputable schools such as Howard University, Meharry Medical School, Morehouse School of Medicine, and Xavier University of Louisiana-only 3.5% of physicians and fewer than two percent of professor-level faculty at U.S. medical schools are African Americans. Historically Black colleges and universities (HBCUs) and medical schools (HBMS) continue to be overlooked as a resource to address health care workforce shortages and the growing needs for a diverse health workforce, despite our commitment as a nation to health equity and eliminating health disparities. Many educators ponder how tiny Xavier University in New Orleans manages to send more African-American students to medical school than any other college in the country. Health workforce graduation rates help illuminate the roles of institutions of higher education in meeting workforce needs. HBCUs represent just three percent of the nation's population of higher education institutions, and despite relatively small endowments and low institutional resources, HBCUs have remained among the nation's top educators of Blacks who go on to earn STEM doctoral degrees; 44% of the STEM doctoral degrees are in the biological and biomedical studies, and over 70% come from Howard and Meharry. Special attention to those graduates who attend medical school is indicated. A closer look is indicated to see what these institutions' contributions are to the field of medicine, particularly subspecialties such as family medicine, obstetrics-gynecology, psychiatry, pediatrics, and internal medicine. The performance of these institutions is often measured by graduation rates, which are about 21% lower than non-HBCUs, as well as debt levels that often exceed those reported by students at predominantly White institutions. What has not been discussed in enough detail is the value these schools have in training culturally responsive and structurally competent health professionals. Minority health and public health professionals, particularly African Americans, know well the extrinsic and intrinsic value of HBCUs in building a resilient and diverse workforce. Research papers such as those created by the Equal Opportunity Project show that HBCUs have a better track record at fostering mobility than many thought. Interestingly, the upward mobility of a few minority physicians represents a significant percentage of the high-quality and diverse health professionals dedicated to maintaining the health of an increasingly diverse nation. Special attention is

needed to address many "safety-net" hospitals that have lost their ability to maintain their accreditation, leading to a reduction and/or loss of HBMS postgraduate training positions, further reducing the minority health professional pipeline and weakening the HBMS infrastructure We must recognize HBCUs as a valuable resource for educating underrepresented groups as health professionals. Increasing resources and enhancing support for building the capacity of HBCUs to produce health professionals is vital to addressing disparities and achieving health equity for our nation.

Minding the Future: What Physicians and the APA Can Do to Help Eliminate Childhood Poverty and Achieve Health Equity

Chair: Kenneth Thompson, M.D.
Presenter: Benard Dreyer, M.D.
Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the impact of poverty on the health, development and well-being of America's children; 2) Realize the various roles physicians and their associations can play in addressing childhood poverty; and 3) Appreciate the underlying humanitarian mission and power of medicine as a profession.

SUMMARY:

Nineteen percent of American children under 18 live in poverty, the largest impoverished demographic. Over 20% under age five live below the Federal Poverty Level; nearly 10% live on less than $33 per day for a family of four. While impacting overall health, childhood poverty's "toxic stress" effects are particularly psychiatric in nature—on the brain, the mind, relationships, learning, emotions, and worldview. It is associated with maturational lags in stress regulation and emotional processing. The deeper children live in poverty, the greater the gap with developmental norms. The effects on academic lags are measurable. By fourth grade, 50% of poor children have difficulty reading. Most never catch up. Poverty's effects continue into adolescence, with exaggerated response to stress, emotional dysregulation and impact on memory; high rates of high school dropout; and more high-risk behaviors. Young people experiencing poverty and its related trauma, violence and hunger have levels of anxiety seven times that of their non-impoverished peers. Poor children become poor adults, with lower academic achievement, self-esteem, productivity, and earnings and higher rates of morbidity, disability and mortality. The childhood poverty rate captures health across the life span. It is the 21st century equivalent of infant mortality, indicating the health and well-being of our society. Eliminating childhood poverty in America will markedly improve the health and well-being of the nation and reduce health inequities. It is practicing 22nd century geriatric psychiatry today. Between 1998 and 2010, the UK reduced childhood poverty by 30%, through concerted societal action involving individual interventions and major policy changes. Broad advocacy to accomplish something similar in America is underway. Physicians, psychiatrists among them, see the deleterious effects of childhood poverty every day. What the house of medicine does—or doesn't—add to this effort matters. Fortunately, the AASP Abraham Halpern Humanitarian Award winner, Benard P. Dreyer, M.D., has inspired and organized the American Academy of Pediatrics (AAP) to say and do something. In his lecture, he will explain what the AAP has done and why and will invite psychiatrists and the APA to join this imminently practical, deeply moral and essential crusade.

Schumann, Bipolar Disorder and the Creative Process

Presenter: Richard Kogan, M.D.

EDUCATIONAL OBJECTIVE:

1) Appreciate the relationship between bipolar disorder and the creative process; 2) Understand why bipolar patients are often resistant to following treatment recommendations; and 3) Recognize the vast improvement in mental health care from the 19th century to the 21st century.

SUMMARY:

Robert Schumann represents one of the best examples of the blurred boundary between creative genius and psychiatric illness. The foremost exponent of the Romantic movement in music, he ignored traditional styles and instead wrote magnificent music that was based purely on a desire

to express his inner state of mind. Psychiatrist and concert pianist Richard Kogan will trace the course of Schumann's bipolar disorder and its connection to his career as a composer. Dr. Kogan will explore how Schumann 1) composed voluminously during hypomanic periods but stopped writing completely toward the end of his life, when a severe depression culminated in a suicide attempt and eventual self-starvation in an insane asylum; 2) invented, at age 21, two imaginary companions —Florestan (passionate and assertive) and Eusebius (introspective and passive)—who episodically appear during his compositions; and 3) wrote powerful music at the urging of inner voices but was ultimately tormented by his auditory hallucinations. Dr. Kogan will perform excerpts from Schumann's music to illuminate the discussion. He will explore how extreme fluctuations in mood can be both potentially beneficial and harmful in the creative process. He will also describe the nightmarish conditions in psychiatric hospitals in 19th century Europe and contrast this with modern-day treatment practices.

Tuesday, May 23, 2017

Effective Alcohol Treatment: What Is It, Who Offers It and Where Can I Find It?
Chair: Lori Ducharme, Ph.D.
Presenter: Lori Ducharme, Ph.D.
Discussant: Robert Huebner, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Be familiar with evidence-based AUD treatment practices; 2) Understand the hallmarks of high-quality AUD treatment; and 3) Know how to search for local, effective AUD treatment providers.

SUMMARY:
It is common to encounter patients with active alcohol use disorder (AUD), but it can be surprisingly difficult to find effective treatment options to which they can be referred. In this session, NIAAA staff review the hallmarks of high-quality alcohol treatment, the variety of professional treatment services available and how to find them. They will then introduce a new tool designed to streamline this search: the NIAAA Alcohol Treatment Navigator, an online resource that will provide step-by-step guidance on how to search for professional treatment options and how to verify the quality of care provided. The Navigator is designed for use by patients and their families but can also be a valuable resource for clinicians needing to make referrals to specialty addiction treatment. The forum will include ample time for Q&A about evidence-based AUD treatment, provider credentials, professional directories and resources, and using the Navigator as part of a shared decision making approach.

Interactive Sessions

Saturday, May 20, 2017

Meet the Authors: Using Transference-Focused Psychotherapy to Meet the Challenges of Borderline Personality Disorder
Chair: Otto F. Kernberg, M.D.
Presenter: Frank E. Yeomans, M.D.

EDUCATIONAL OBJECTIVE:
1) Gain an understanding of the strategies, tactics and techniques of effective psychodynamic psychotherapy for borderline personality disorder; 2) Gain an understanding of the role of identity integration in borderline personality disorder and its resolution; and 3) Increase their understanding of how to recognize and use countertransference effectively in therapy.

SUMMARY:
The treatment of borderline patients is one of the most challenging areas in mental health. Many clinicians are pessimistic and consider stabilization of symptoms the best possible outcome. However, research data and clinical experience allow for a more optimistic outlook. We can now offer patients the chance to also achieve improvement in work/vocation and love/intimate relations. Transference-focused psychotherapy (TFP) is an evidence-based treatment for borderline and other severe personality disorders that engages the patient both on the affective level and the cognitive/reflective level. TFP combines an emphasis on structure and limit-setting with analytic exploration of the patient's psychological conflicts. TFP focuses on the activation of affects in the therapy setting combined with exploration of the

patient's perceptions associated with the affects. The therapist helps the patient tolerate and understand the experience of intense affects--and the conflicts among them--as they emerge in the therapeutic relationship. In this setting, the patient can better understand the "gut reactions" that have led to chaos in their life. Research has shown that therapy can help diminish the activation of parts of the limbic system and increase activation of the prefrontal cortex. This change at the level of brain activation is correlated with both symptom change and change in important psychological functions. This session will feature discussion with the authors on how TFP utilizes an understanding of the psychological structure of the borderline patient to effectively treat both the symptoms of the distress and disturbances in the sense of self and relations with others.

Sunday, May 21, 2017

An Update on Antidepressant Development
Presenter: Alan F. Schatzberg, M.D.

EDUCATIONAL OBJECTIVE:
1) Review current limitations in antidepressant efficacy; 2) Present data on the status of new antidepressants in development; and 3) Discuss potential use (efficacy and limitations) of ketamine in refractory depression.

SUMMARY:
Most patients who suffer from major depression eventually respond to antidepressant medication, psychotherapy or a combination of both. However, a considerable minority may not respond to typical strategies, and there is a need to develop agents with novel antidepressant mechanisms. In this session, we review the current approaches to patients with refractory depression and present data on a number of novel approaches that have been or are being studied. These new strategies have relied on alternative mechanisms of action to currently approved agents. They include ketamine and other glutamatergic agents, O-botulinum toxin A, glucocorticoid antagonists, CRH-R1 antagonists, mixed μ opioid receptor agonists/antagonists, etc. Glutamate is a key neurotransmitter that is excitatory in the central nervous system. The system consists of a number of pre- and postsynaptic receptors, as well as receptors located on glia. Of particular importance are NMDA and AMPA receptors. Ketamine is a potent NMDA antagonist, and that antagonism may result in a release of glutamate from the presynaptic neuron, which may stimulate AMPA receptors. We discuss efficacy and safety of ketamine antidepressant data on a number of glutamatergic agents under study. Of note, other NMDA antagonists such as memantine have not been found effective antidepressants in clinical trials. O-botulinum toxin is approved for a number of indications beyond cosmetics, including migraine headaches and cervical spasms. Data are presented from two smaller-scale trials that indicate that single injections of the agent can induce longer-term responses in depressive symptoms. A possible biological explanation may be that it is affecting a brain circuit via a peripheral injection of the toxin. We will also review the efforts to develop antidepressant and antipsychotic agents that work via modulation the HPA axis and mixed μ opioid agonists/antagonists. Unfortunately, several of these have failed to separate from placebo. We discuss possible reasons for these failures, including poor target validation, limited knowledge of therapeutic blood levels and resultant underdosing, protocol violations, etc. Possible methods for overcoming problems encountered in developing these new strategies will be reviewed.

***Ordinarily Well*: Perspectives on the Controversy Over Antidepressant Treatment of Depression**
Presenter: Peter D. Kramer, M.D.

EDUCATIONAL OBJECTIVE:
1) Appraise the argument that antidepressants work largely through classic placebo effects; 2) Identify strengths and shortcomings in research used to bolster claims of placebo efficacy in the treatment of depression; 3) Analyze possible confounding variables in the research that informs current popular debates about antidepressant efficacy; and 4) Consider social forces that bear on contemporary debates about pharmacological approaches in depression treatment.

SUMMARY:
In recent years, under banners like "Antidepressant

Lift Is All in Your Head," general-audience media, from *USA Today* to *60 Minutes* to the *New York Review of Books*, have promulgated the notion that psychiatry's most widely prescribed medications are little more than placebos with side effects. Once marginal, the view that antidepressants lack inherent efficacy in the treatment of depression has gained currency in the mental health professions as well, along with accompanying beliefs that the medications are limited in their clinical effectiveness and that they have at best a marginal role in the treatment of non-severe mood disorders. In *Ordinarily Well: The Case for Antidepressants*, Dr. Peter Kramer suggests that the backlash against the drugs is less science than cultural trope. In this interactive session, based on research for that book, Dr. Kramer will review the history of the antidepressant-as-placebo claim and the evidence advanced to support it. Along the way, participants will assess the strengths, limitations and current status of pharmacotherapy outcome trials and the uses of and confounding variables besetting meta-analysis, the method most often used to summarize the results of those trials. This session will consider social forces that might promote the debunking of medical model approaches to mood disorder. Throughout, the session will focus on the clinical moment. When it comes time to decide--prescribe or not--what expertise do we want physicians to bring to bear? This session constitutes an opportunity for colleagues, and practitioners especially, to examine the bases for their choices in the care of depressed patients, to share their observations about outcomes, and to reflect on what is at stake in this controversy for patients and for our profession.

The NIMH: Programs, Priorities and Plans
Chair: Joshua Gordon, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the role and mission of the National Institute of Mental Health; 2) Identify key research priorities in mental health; and 3) Discuss important issues facing psychiatric research.

SUMMARY:
The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery and cure. I arrived at the NIMH in September, 2016, and am spending my first year as director learning as much as I can from those inside and outside the NIMH who are committed to the success of this mission. In this session, I will discuss some of what I've learned so far and outline research priorities with short-, medium- and long-term timeframes. I will also touch on issues of importance to the mental health research community, including maximizing the utility of the RDoC and experimental therapeutics approaches, as well as weighing the relative contributions of consortia-driven "big science" vs. hypothesis-driven "small science." The session will be interactive so I can learn directly from APA members about their views and priorities in these areas.

Monday, May 22, 2017

Meet the Author: Boundaries and Boundary Violations
Presenter: Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the ethical standards of boundaries in psychiatric practice; 2) Identify when a boundary crossing has become a boundary violation; 3) Equip physicians with guidelines to use to prevent violating a patient's boundaries; and 4) Improve good ethical practice of working within a frame.

SUMMARY:
One of the major ethics problems encountered in psychiatric practice is a failure to maintain an ethical frame constituted by professional boundaries between patient and psychiatrist. These would include confidentiality, minimal touch, very little self-disclosure on the part of the psychiatrist, no financial exchanges other that what is appropriate for the psychiatrist's fee, abstention from sexual contact of any kind, and no meetings outside the treatment sessions. The time and place of the session and its duration are also part of the frame. Numerous case examples in which psychiatrists did not maintain the boundaries will be presented and discussed. There will be great emphasis on how to foresee vulnerability and risk based on early signs of countertransference problems in the psychiatrist.

Types of boundary violations will be illustrated along with the harm they may do to the treatment and the patient. A typology of psychiatrists who become involved with boundary violations will be discussed, including lovesickness, predatory psychopathy, masochistic surrender, and psychotic disorders. While much of the presentation and discussion will focus on egregious boundary violation, there will also be consideration of minor boundary crossings that do not cause harm to the patient. Many of these crossings, like accepting a small, inexpensive gift that the patient has made, actually facilitate the therapeutic alliance and help the patient to feel understood and supported. In addition, we will consider the thorny aspects of boundaries in cyberspace. What does one do if one is "friended" by a patient on Facebook? What does one do with a text message that comes at 11 p.m.? Does one Google a patient to see if the patient is concealing important information from the psychiatrist? Are there circumstances in psychiatric practice where Googling a patient might be quite appropriate? Are there other situations in psychiatric practice where Googling would be considered nosy and intrusive? What role does consultation play in the prevention of boundary violations? How can one appropriately enlist a consultant? What are some of the pitfalls of using consultants as a way of preventing boundary violations? A final issue to be discussed is whether or not psychiatrists who have violated boundary violations can be rehabilitated. In the absence of hard data on outcomes, we have to rely on anecdotes. How can we ensure that boundary violators will not repeat what they have done before? What is the ideal set-up for a rehabilitation program? Sexual and nonsexual violations will be discussed.

Meet the Authors: *Learning DSM-5 by Case Example*

Presenters: Michael B. First, M.D., Andrew E. Skodol, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize that *DSM-5* criteria define diagnostic prototype; 2) Understand that there is considerable heterogeneity within those prototypes; and 3) Learn that a case-based approach is an effective way to learn about prototypes and heterogeneity.

SUMMARY:

Learning DSM-5 by Case Example is designed to help readers learn about *DSM-5* diagnoses using a case-based approach. Most experienced clinicians make *DSM-5* diagnoses not by systematically applying *DSM* diagnostic criteria but instead by matching a patient's symptoms to "prototypes" of the *DSM* disorders that the clinician has internalized over the years and that are based on his or her own clinical experience seeing patients with particular diagnoses. The book contains close to 200 cases, at least one for each *DSM-5* disorder. In order to illustrate the typical diagnostic heterogeneity of *DSM* presentations, more than one case is included for almost half of the disorders, showing variations in symptoms, course and developmental issues. In this session, Drs. First and Skodol will present a selection of cases for discussion, illustrating both the use of prototypical presentations to learn *DSM* definitions, as well as cases demonstrating diagnostic heterogeneity.

Pain and Psychiatry

Chair: Nora D. Volkow, M.D.

EDUCATIONAL OBJECTIVE:

1) Better understand recent increasing trends in the misuse, abuse and potentially fatal consequences of prescription opioids; 2) Better understand the complex challenges involved in balancing the benefits of using opioids with the risk of adverse and potentially lethal consequences; and 3) Better understand strategies that will increase awareness of the growing problem.

SUMMARY:

Chronic pain is a major health problem, exacting enormous costs for medical care and decreased productivity, and is expected to increase in the coming years as the incidence of associated diseases increases in the aging U.S. population. Opioids--long recognized for their analgesic potency--are particularly beneficial for the management of severe acute pain, but their use for chronic pain is increasingly being questioned. Not only do they rapidly lead to tolerance, necessitating dose increases to sustain analgesia, but their use can result in addiction even in those suffering from pain.

Moreover, some individuals addicted to prescription opioids are transitioning to heroin, which is cheaper and easier to procure. Effective medications do exist for the treatment of opioid use disorders, but they are not being widely utilized. In recent years, the dramatic growth in the use and misuse of opioids has taken center stage in addiction science. This opioid abuse epidemic has prompted increased research efforts to prevent and treat opioid use disorders and to develop strategies to curtail the tragic fatalities associated with opioid overdoses. It has also fueled efforts to find improved treatments for pain, including safer analgesics; increase our knowledge of pain pathways and potential biomarkers for pain; identify new targets for pain control; and develop non-medication strategies for pain management. Equally critical are ongoing efforts to improve pain treatment, prevent substance use disorders and improve outcomes in addiction through education of health care providers.

Tuesday, May 23, 2017

Behavioral Health Policy Priorities in the Trump Administration: How Psychiatry Can Be an Agent for Change
Presenter: Kana Enomoto, M.A.

EDUCATIONAL OBJECTIVE:
1) Understand national policy issues confronting behavioral health in 2017; 2) Describe efforts/resources available to inform advocacy at the patient, health system and local levels; 3) Understand the role SAMHSA plays in advancing quality treatment of early psychosis; and 4) Describe future directions for policy on integrated care.

SUMMARY:
What does behavioral health care look like in the Trump administration? The change in administration signals broad changes in the nation's health care system that could reshape the behavioral health field. Ms. Enomoto will explore the changes underway and on the horizon for behavioral health. She will examine potential challenges as well as opportunities that exist for psychiatrists and health care professionals to be change agents at every level—patient; health system; and the local, community, state, and federal levels. She will highlight SAMHSA's plans for actively engaging with psychiatrists and the behavioral health workforce through its Office of the Chief Medical Officer to address some of the important issues we face nationally. Ms. Enomoto will consider a number of key issues, including 1) What are the administration's behavioral health priorities for fiscal year 2018? 2) What are some of the issues to watch on the legislative and regulatory agenda? 3) How might these priorities impact mental health and substance use disorder prevention, treatment and recovery support strategies over the next four years? 4) How have the 21st Century Cures Act and Comprehensive Addiction Recovery Act of 2016 shaped the federal response to the opioid crisis? What role can psychiatrists play in addressing the crisis as subject matter experts and advocates? 5) How is "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health" influencing American attitudes toward prevention and treatment of SUDs? How can psychiatrists use information in the report as a resource for their practice and for education and advocacy? 6) What is on the horizon for improving treatment of SMI—including prodrome and first episode, as well as those with complex or unmet treatment needs? 7) How can the Section 223 Demonstration Program for Certified Community Behavioral Health Clinics become a "game changer" in the way integrated, accessible, quality health care is provided in the community? 7) What are the challenges and opportunities in the changing landscape of prevention?

Meet the Author Discussion Groups: Psychiatric Interview of Children and Adolescents
Presenter: Claudio Cepeda, M.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the history of psychiatric interviewing of children and adolescents; 2) Discuss physical contact in children and adolescents; 3) Discuss the importance of the genogram in the diagnostic assessment; and 4) Discuss the systematic assessment of psychotic features.

SUMMARY:
The comprehensive child and psychiatric interview

has a short history-no more than four decades. Prior to 1970, a period dominated by psychoanalytic and developmental thinking, it was customary to spend most of the diagnostic effort questioning parents about the child's symptoms and developmental history. The evaluation of the child was outsourced to clinicians with less training, i.e., social workers, child therapists, and others who were giving the task of making observations on the child's play. No direct diagnostic inquiry into the child was ever made. Research in child psychiatry demanded validity and reliability in the diagnostic protocols. Descriptive diagnostic criteria as indicated in the *DSM-II* and *-III* promoted consensus along diagnostic paradigms. The advent of the Kiddi-SADS with a comprehensive diagnostic and "manualized" questioning protocol became a pioneer model of direct diagnostic questioning of the child. Joaquin Piug-Antic and others broke with traditions and began a direct inquiry of the child. What now we take for granted took many years in its making. The challenge in contemporary psychiatry is to give due justice to the diagnostic process. A comprehensive, valid and relevant interview is the most cost-effective intervention the child and adolescent psychiatrist can provide to the child and their family. The biggest obstacle to a comprehensive and effective diagnostic process is the need for expediency. By cutting corners and accelerating process, the interviewer dispenses with the exploration of a number of areas. Furthermore, if the family perceives the examiner is rushing, it will be more difficult to build a diagnostic and treatment alliance with them. Body contact with the child/adolescent patient has been established with strict rules. Physical contact during the physical examination is obligatory. Child psychiatrists gave up opportunities for valuable diagnostic and health-promoting interventions when they outsourced the PE and neurological screening. Each diagnostic interview requires the development of a family genogram (organogram) with explicit inquiry as to the presence of psychiatric disorders in the parents and parents' siblings, as well as the psychiatric history and history of suicide in the two prior generations. The inquiry into the presence of psychiatric disorders in siblings of the identified child is very relevant. The exploration of psychosis should be systematic in every child and adolescent diagnostic interview. The examiner should be ready to confront or to deal with parental defensiveness, even in highly educated parents. For the exploration of psychotic symptoms in preschoolers, the examiner should enlist the assistance of the parent(s). It is more difficult for a parent to deny the implication of the child's answers when the parent completes the inquiry.

Meet the Author: *DSM-5 Casebook and Treatment Guide for Child Mental Health*
Chair: Cathryn A. Galanter, M.D.
Presenters: John T. Walkup, Lisa Cullins, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn about evidence-based assessment in child and adolescent psychiatry; 2) Learn about evidence-based treatment in child and adolescent psychiatry; and 3) Learn about case-based teaching.

SUMMARY:
The *DSM-5 Casebook and Treatment Guide for Child Mental Health* incorporates advances from the *DSM-5* and new updates in evidence-based assessment and treatment of children's mental health. The authors and editors present 29 cases written by experts in the field to provide readers with realistic examples of the types of children and adolescents clinicians may encounter in practice; each case is accompanied by two commentaries from field-leading clinicians (including child and adolescent psychiatrists, psychologists, social workers, and nurses) who draw from the combination of evidence-based interventions, biopsychosocial approaches, a systems perspective, and commonsense thinking. In addition to providing a diagnostic formulation, the commentaries purposely address different treatment approaches-psychotherapeutic and psychopharmacological. Commentaries also address how to integrate these different approaches. Our meet the author presentation will be an opportunity for participants to meet with the co-editor and authors of the book to discuss approaching clinical cases using evidence-based assessment and treatment. We will also discuss case-based learning, including how participants can use the book and their clinical cases to learn about evidence-based assessment and treatment, as well as how educators can use cases from the *DSM-5 Casebook* or clinical experience to

make teaching exciting and engaging. Similarly, we will address the importance of balancing evidence-based assessments, such as rating scales, with rich descriptions of a patient's symptom history and context. We hope that the program and our book can serve as an invaluable tool for trainees, trainers and clinicians who work in child and adolescent psychiatry.

Rethinking "Trust" in Culture and Psychiatric Practice
Presenter: Nancy Nyquist Potter, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Gain an appreciation for different types of trust and why these differences are important; 2) Identify cultural factors that influence trust or distrust in psychiatry; 3) Understand the role that trust plays in how well we know and understand our patients; and 4) Acquire ideas about how to bridge difficult differences using tools such as hopeful trust, world traveling and giving uptake.

SUMMARY:
It is a central tenet of psychiatry that a trusting relationship plays a significant role in decreasing patients' distress and suffering. It is less well understood, though, how "good" trust contributes to knowledge and how distrust impedes it. This is an especially auspicious time to focus on these concepts because, as psychologist Tara Brach says, our nation is in a time of limbic hijack. Many peoples' fears and anger run high and, in times of social tension, the tendency to form group affiliations of in-groups and out-groups increases. Regardless of where people fall on the political spectrum, many of us feel uncertain about the future and about each other. And some people experience what philosopher Jill Stauffer calls "ethical loneliness," the isolation one feels when one has been abandoned by humanity, compounded by the experience of not being heard. Trust-an attitude that is difficult to navigate in the best of circumstances-becomes all the more important to foster, but also more challenging. A philosophical examination of trust and distrust, therefore, is useful in order to understand the grounding upon which we can listen well, such that we can understand patients even across differences and in the midst of fear. This interactive session sets out the concepts of trust, distrust and hopeful optimism at work in interpersonal relationships and explains how both patients and psychiatrists bring social backgrounds, beliefs and values to clinical work in ways that play a crucial role in understanding patients. I explain why an attitude of hopeful optimism is important and how it can be developed. Along the way, I introduce a number of helpful philosophical concepts, including "world traveling" and "the virtue of giving uptake." A case study will be presented to illustrate ideas and concepts at work.

Learning Labs

Saturday, May 20, 2017

A Leadership Boot Camp for Residents and Fellows
Chair: Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Describe attributes of an academic psychiatrist; 2) Outline the context for professional development; 3) Identify the various forms of feedback; 4) Learn common missteps in providing feedback and strategies to avoid them; and 5) Through interactive role-playing activities, learn strategies to meet the needs of colleagues, subordinates and supervisors without losing sight of personal goals.

SUMMARY:
Medical training does not always prepare us for leading teams, giving feedback, negotiating with supervisors and colleagues, networking, or many other everyday things in academic medicine. This interactive session will promote academic growth, nurture leadership skills, enhance feedback, and teach the basics of negotiation. Using role plays, small group discussion, vignettes, and other techniques for audience engagement, Dr. Roberts will demonstrate models for effective leadership while also helping attendees create a plan for their growth as leaders in academic medicine.

Collaborative Care Lab: Immersive Experience in Population Management Using a Registry for Team-Based Care
Chair: Anna Ratzliff, M.D., Ph.D.
Presenters: Ryan Kimmel, M.D., Amanda Focht, M.D.,

John Kern, M.D.

EDUCATIONAL OBJECTIVE:
1) Attain an in-depth understanding, through an intensive in-vivo "lab," of a collaborative care system and how psychiatric practice is different and fun within these new models of integration; 2) Operationalize the core elements of collaborative care, including population-focused care, evidence-based treatment, measurement-driven care, and team-based care; and 3) Critically compare the essential elements of collaborative care to local integrated care efforts through live participation in a fictional CC model.

SUMMARY:
Collaborative care (CC) is an evidence-based approach to integrating behavioral health services within primary care settings. Through over 80 randomized controlled trials, it has proven consistent efficacy in delivering the triple-aim in health care reform: cost savings, improved outcomes, and improved patient and provider satisfaction and access to care. Even with this overwhelming and compelling evidence base, CC has many barriers to implementation halting widespread dissemination aside from several large-scale programs. CC requires psychiatrists to rethink their role in treating individual patients, their relationship to others in the health care team, and the use of measurement-based patient-reported outcomes to guide care and recommendations-all skills that many are unfamiliar with. Existing courses taught by the APA rely primarily on lecture type methods to share these principles, so this interactive course allows participants to experience the radical framework shift necessary to implement a CC system. This learning lab will highlight the essential elements of CC through a time-intensive, problem-based simulation. Ten fictional cases will be presented to the participants, who will then be assigned into small teams of psychiatrist, PCP and care manager in charge of managing those 10 cases for a "month" of time-approximately 20 minutes. The teamlets will also be provided with registry data on outcomes for their team. Round 1 will consist of simple instructions for the teams to "manage" the 10 patients however they see fit. Clinical updates will follow for an additional two rounds, with subsequent updates in the registry to reflect measurement-based outcome changes over the simulated time scale of three months. During the third round, teamlets will be actively encouraged to utilize the data in the registry to organize their team-based discussion. The final 20 minutes will be spent debriefing the exercise and reviewing the essential elements of the CC model and their rationale from the perspective of this intensive simulation. Participants should bring their laptops/tablets to be able to participate in this interactive exercise more fully.

Sunday, May 21, 2017

Participant Debates: Ethical Issues in Psychiatry
Chair: Rebecca Brendel
Presenters: Charles C. Dike, M.D., M.P.H., Mark Komrad, M.D., Ariana Nesbit

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:
In this session, attendees will be placed in cohorts, each divided into two teams, and given ethical issues to analyze. Each team will shape their argument and debate their opposing cohort. Group discussion, video clips and interactive polling will facilitate dialogue and guide the debates.

Monday, May 22, 2017

A Leadership Boot Camp for Early-Career Academic Psychiatrists
Chair: Laura Roberts, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Identify the five missions of academic medicine and where one's interests, strengths and commitments fit; 2) Identify practical habits that help in preparing for academic promotion; 3)

Through interactive role-playing activities, learn strategies to meet the needs of colleagues, subordinates and supervisors without losing sight of personal goals; 4) Identify developmental challenges encountered in seeking fulfillment and balance in professional and personal lives; and 5) Consider life goals, internally directed vs. externally imposed.

SUMMARY:
Working in academic psychiatry is both creative and complex. The colleagues are extraordinary and the setting is inspiring. Nearly all early career faculty experience unsettling feelings of being overeducated but underprepared, however, for such labor-intensive everyday duties as writing letters of recommendation, participating on committees, formatting their curriculum vitae, obtaining a 360 evaluation, enduring compliance audits, and meeting quality performance metrics. Managing duties and dynamics and advocating for oneself are essential to success in an academic career. Without some know-how about such fundamentals in the culture of academic medicine, it will be difficult to turn to the bigger work of academic psychiatry: improving public health and caring for people with mental illness. This workshop is a down-to-earth discussion of strategies for success for early career psychiatrists. The workshop will focus primarily on 10 practical habits that may be adopted in preparing for academic advancement. Participants will identify their strengths and potential weaknesses and possible adaptive approaches to their areas of weakness. This workshop will involve interactive learning exercises and Q&A formats, and it will have a tone of warmth and collegiality.

Can Gut Microbes Affect Mental Illness?
Chair: Erika L. Nurmi, M.D., Ph.D.
Presenter: Emeran Mayer, M.D., Ph.D.
Discussants: James T. McCracken, M.D., Michele Pato, M.D., Chadi Calarge, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Describe the utility of psychotherapeutic and pharmacological treatment options; 4) Integrate knowledge of current psychiatry into discussions with patients; and 5) Identify barriers to care, including health service delivery issues.

SUMMARY:
Previously, we explored an interactive method of teaching and maintaining research literacy at the 2016 APA Annual Meeting. To model an approach to emerging data impacting clinical practice, we stimulated a live discussion of controversial psychiatric treatments entitled "Should I Recommend Ketamine and Marijuana for My Patients?" Data collected during the event suggest that residency education in research literacy is inadequate, with 55% of respondents (N=111) rating their training as poor or non-existent and only 17% solid or excellent. Only 25% of respondents expressed the ability to identify the limitations of most research reports and evaluate whether findings are clinically actionable, while 66% admitted relying solely on review articles, conferences and practice guidelines to keep their practice up to date (N=141). Over 80% of participants agreed that they would welcome and utilize the piloted approach as a tool for initial education and subsequent maintenance of competency in research literacy (N=84). Our current workshop will build on this prior experience. We will leverage the APA interactive Learning Lab to involve the audience in an expert-led discussion of a timely and debated topic. Clinician scientists on our panel will guide the audience in a critical evaluation of the evidence and identification of important questions and considerations informing clinical action. Both debates will focus on instances where preclinical genetic data has been rapidly translated to clinical use, largely by direct-to-consumer marketing. The first session, "Should I be using genetic testing to guide prescribing?" addresses the commercially available genotyping services that offer prescribing guidance to clinicians based on patient genetic profiles. While individualized precision medicine is an important national goal, we will evaluate whether there is sufficient data to warrant clinical implementation of testing; whether impact to outcomes is clinically meaningful; and whether the health care field is prepared to understand, explain and respond to information provided. The second session, "Can gut microbes affect mental illness?" will explore the complex interactions between the

digestive and nervous systems (the gut-brain axis) and accumulating data supporting a role for gut dysbiosis in mental illness. Our ability to profile the gut microbiome (genetic microbial signatures) has stimulated a growing appreciation of the interdependence of the microbiota and the host in neurodevelopment, inflammation, energy balance, aging, stress response, and behavior. While our understanding of the impact of gut microbes on the development and treatment of mental illness remains limited, patients commonly turn to natural diet or probiotic approaches over evidence-based treatments. We will examine whether these intriguing insights presently support clinical action.

"Cloaks and Clergies": The Case of Patient B
Chair: Lawrence McGlynn, M.D., M.S.

EDUCATIONAL OBJECTIVE:
1) Provide culturally competent care for diverse populations; 2) Integrate knowledge of current psychiatry into discussions with patients; and 3) Identify barriers to care, including health service delivery issues.

SUMMARY:
A highly interactive learning lab that will push attendees to use their medical and investigative skills to solve the complicated medical history of an anonymous patient. During this fun and engaging session, team up with fellow colleagues to solve clues, role play, brainstorm and interrogate characters from the patient's life, and put your sleuthing skills to the test in this mystery of Sherlock Holmes proportions. Each participant will work through a complex case and through the process of deduction determine the medical history of a real-life patient. You will learn and practice necessary critical thinking skills while diving deep into this gripping tale of medical mystery.

Mock Depositions: What You Need to Know *Before* Sitting in the Hot Seat
Chair: Kristen M. Lambert, J.D., M.S.W.
Presenter: Yad M. Jabbarpour, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand what a deposition is and recognize the difference between a court-ordered deposition, notice of deposition and subpoena for deposition; 2) Appreciate the importance of preparing for a deposition with counsel and the importance of having counsel with you at deposition; 3) Explore tips that may be helpful in avoiding some of the potential pitfalls that may impact the defensibility of a case; and 4) Observe mock depositions involving an unintentional patient overdose.

SUMMARY:
Approximately three percent of psychiatrists will have a lawsuit filed against them in their career. However, most will encounter a deposition either as a treating physician, as an expert, in a family law matter (divorce, custody), or on other matters. How a psychiatrist appears at a deposition can have a lasting impact throughout his/her career, far beyond the issue at hand. Specifically, how a defendant appears during questioning at a deposition can change the value of a case and can impact whether a case proceeds to trial or forces settlement. In addition, depending on the circumstances, a non-party witness can also be added as a defendant in a lawsuit when he/she was not at the outset of the case. This interactive and informative learning lab session will teach participants what to expect and how to be prepared for depositions. Attendees will learn the common tactics attorneys use during depositions and understand how to respond to different personalities. The session will focus on a case study where there is an inadvertent death as a result of an overdose of prescribed medications. Further, PDMPs will be discussed and explored. This session will provide lessons learned by watching attorneys examine a mock defendant psychiatrists, plaintiff and an expert witness. Risk management principles will be provided throughout the session, which will provide attendees with tips when they may be faced with a deposition. Attendees will have an opportunity to discuss best ways to answer questions, evaluate the depositions, discuss how the depositions may impact a case, and examine what could have been done differently.

Should I Be Using Genetic Testing to Guide Prescribing?
Chair: Erika L. Nurmi, M.D., Ph.D.
Presenter: James L. Kennedy, M.D.
Discussants: James T. McCracken, M.D., Michele

Pato, M.D., Chadi Calarge, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Describe the utility of psychotherapeutic and pharmacological treatment options; 4) Integrate knowledge of current psychiatry into discussions with patients; and 5) Identify barriers to care, including health service delivery issues.

SUMMARY:
Previously, we explored an interactive method of teaching and maintaining research literacy at the 2016 APA Annual Meeting. To model an approach to emerging data impacting clinical practice, we stimulated a live discussion of controversial psychiatric treatments entitled "Should I Recommend Ketamine and Marijuana for My Patients?" Data collected during the event suggest that residency education in research literacy is inadequate, with 55% of respondents (N=111) rating their training as poor or non-existent and only 17% solid or excellent. Only 25% of respondents expressed the ability to identify the limitations of most research reports and evaluate whether findings are clinically actionable, while 66% admitted relying solely on review articles, conferences and practice guidelines to keep their practice up to date (N=141). Over 80% of participants agreed that they would welcome and utilize the piloted approach as a tool for initial education and subsequent maintenance of competency in research literacy (N=84). Our current workshop will build on this prior experience. We will leverage the APA interactive Learning Lab to involve the audience in an expert-led discussion of a timely and debated topic. Clinician scientists on our panel will guide the audience in a critical evaluation of the evidence and identification of important questions and considerations informing clinical action. Both debates will focus on instances where preclinical genetic data has been rapidly translated to clinical use, largely by direct-to-consumer marketing. The first session, "Should I be using genetic testing to guide prescribing?" addresses the commercially available genotyping services that offer prescribing guidance to clinicians based on patient genetic profiles. While individualized precision medicine is an important national goal, we will evaluate whether there is sufficient data to warrant clinical implementation of testing; whether impact to outcomes is clinically meaningful; and whether the health care field is prepared to understand, explain and respond to information provided. The second session, "Can gut microbes affect mental illness?" will explore the complex interactions between the digestive and nervous systems (the gut-brain axis) and accumulating data supporting a role for gut dysbiosis in mental illness. Our ability to profile the gut microbiome (genetic microbial signatures) has stimulated a growing appreciation of the interdependence of the microbiota and the host in neurodevelopment, inflammation, energy balance, aging, stress response, and behavior. While our understanding of the impact of gut microbes on the development and treatment of mental illness remains limited, patients commonly turn to natural diet or probiotic approaches over evidence-based treatments. We will examine whether these intriguing insights presently support clinical action.

Tuesday, May 23, 2017

Innovation and Design Thinking in Mental Health Care
Presenter: J. Andrew Chacko, M.D., M.S.E.

EDUCATIONAL OBJECTIVE:
1) Understand what innovation and design thinking really are and what role they can play in the future of mental health care; 2) Understand some of the barriers to innovation in health care; and 3) Learn and practice some basic tools of design thinking and understand how it can greatly improve your patient engagement, transform your practice and reshape your personal life.

SUMMARY:
What is innovation? How is innovation in health care different? Why is it important for us as psychiatrists to understand? We will answer all those questions and more. The word innovation is so overused that it seems to have lost all meaning. And yet, if you are an outsider, it can feel quite daunting--something to do with technology and apps and interoperability. In this session, we will dig through all the

misconceptions to arrive at what it really means. Simply put, innovation is a novel way to solve a problem. By first looking at other industries, we can delve into why innovation is critically important for us to understand and embrace. An inability to innovate and anticipate the future led to the collapse of titans of industry like Kodak and Blockbuster, while the opposite propelled young companies like Uber and AirBNB to the front of their respective packs. Interestingly, as physicians, we may feel secure in our field. Or are we? We will look at some of the companies/technologies that are driven by personal experience or lured by a piece of the $3.1 trillion U.S. health care pie. While we sit here, hundreds of software, hardware and app developers are trying to find better solutions to delivering mental health care that is more accessible, affordable and even fun for their clients. Even many of our patients, disgruntled with the state of mental health care, are out looking for "better" answers than we are providing. We will see how fellow clinicians--NPs, psychologists, pharmacists, social workers, MFTs--have already greatly modified our roles. So how do we navigate this new world? Better still, how do we master it? This highly interactive workshop will look at the fundamental reasons why innovation is particularly difficult in the health care space and will discuss design thinking as a process for innovation. Doctoring is very much like designing, and a better understanding of design can help us as we craft treatment plans and increase patient engagement. Among clinicians, as psychiatrists, we are particularly well suited for the first and possibly most critical step in design--to truly understand the problem--and that can put us at the helm, shaping the course not only of our discipline, but of medicine in general. We will learn and practice some of the same tools to enhance creative problem solving that the leading design firms in Silicon Valley use and apply them to problems we encounter in our practice. Innovative thinking can not only reshape your practice but can transform your personal life as well. And for a select few, whom these ideas ignite, it may radically alter your career.

Treatment Lab: To Treat or Not to Treat
Chair: Philip R. Muskin, M.D., M.A.
Presenters: Roger S. McIntyre, M.D., Stephen M. Stahl, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:
Should I treat this patient or should I wait? Is use of pharmaceutical treatment worth the cost and risk of side effects to the patient? These are only two of the many questions clinicians must confront when determining the best course of action for their patients. This interactive learning lab session will explore the question of "to treat or not to treat" using case studies and debate between experts to help you determine the proper treatment options for patients where considerations of treating early psychopathology for depression or bipolar symptomatology arises. After presenting each case, session panelists will debate whether they would treat or not and debate the proper course of treatment. After each debate, the audience will choose whether to treat or not to treat using the most modern audience response technology. Then everyone will discuss the most popular treatment decision. When providers are confronted with difficult treatment choices, they often feel they are alone. This session will allow collaboration between participants in a low-risk environment so they will have a better understanding of the best available treatment options when such a decision truly must be made.

Lectures

Saturday, May 20, 2017

Personalized Medicine in Psychiatry: The New Holy Grail
Chair: Bruce J. Schwartz, M.D.
Lecturer: Charles B. Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand progress in elucidating predictors of

disease vulnerability in mood and anxiety disorders; 2) Understand progress elucidating genetic and brain imaging predictors of treatment response to antidepressants and psychotherapy in major depression; and 3) Understand the biological basis of the putative biological predictors of treatment response.

SUMMARY:
Personalized or precision medicine is generally conceptualized as having two principal components. The first is identification of individuals who are at risk for one or another disorder. An example would be the use of BRCA1 and BRCA2 mutations, which have been associated with a marked increase in the risk for breast and ovarian cancers. The second is to identify, in individual patients, their optimal treatment. This approach has been very successful in oncology and infectious disease. Personalized medicine in psychiatry is in its infancy. This lecture will summarize progress made in both principal components of personalized medicine with a focus on mood and anxiety disorders. Clearly, success will require a significantly better understanding of the pathophysiology of these disorders. Defining biologically distinct endophenotypes of, for example, major depression or posttraumatic stress disorder (PTSD) will accelerate major advances in the field. In terms of disease vulnerability, considerable progress has been made in identifying genetic polymorphisms that interact with environmental factors such as child abuse and neglect to regulate vulnerability to depression and PTSD. These studies have become the prototype gene-environment interaction models for diathesis to major psychiatric disorders. In addition, these studies have clearly demonstrated the importance of epigenetic mechanisms in disease vulnerability. As important, however, is the second major focus of personalized medicine, namely the matching of the most effective and safe treatment to an individual patient. Simply stated, for example in major depression, how does a psychiatrist know whether a patient should receive any one of the many effective evidence-based treatments? More specifically, should the patient receive a selective serotonin reuptake inhibitor (SSRI), serotonin/norepinephrine reuptake inhibitor (SNRI), mirtazapine, tricyclic antidepressant (which one?), monoamine oxidase inhibitor (MAOI), cognitive behavior therapy (CBT), repetitive transcranial magnetic stimulation (rTMS), or electroconvulsive therapy (ECT)? If the patient does not respond to one of these monotherapies, what then? Antipsychotic drug augmentation? Combination pharmacotherapy and psychotherapy? Two antidepressants? The possibilities are endless, but the longer the patient remains ill, the higher the rate of suicide, drug and alcohol abuse, and worsening of comorbid medical disorders. This lecture will highlight our current knowledge of prediction of antidepressant response with a focus on both genomics and functional brain imaging. The current results are promising and presage a time when such techniques will be immensely useful to the practitioner.

The Dark Side of Compulsive Alcohol and Drug Seeking: The Neurobiology of Negative Emotional States
Lecturer: George Koob, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe three conceptual stages of addiction and the significance of negative reinforcement as a driving force (the “dark side”) in two of the three stages; 2) Identify circuits in the brain’s stress system that demonstrate plasticity in response to excessive drug intake and support the negative emotional states that drive the dark side of addiction; and 3) Describe how neuroplastic changes in the medial prefrontal cortex facilitate the progression of addiction.

SUMMARY:
Addiction to alcohol and drugs has been conceptualized to involve three stages: the binge/intoxication stage, the withdrawal/negative affect stage and the preoccupation-anticipation ("craving") stage. The construct of negative reinforcement, defined here as drug-taking that alleviates a negative emotional state created by drug abstinence, is particularly relevant as a driving force in both the withdrawal/ negative affect and preoccupation-anticipation stages in alcohol addiction. The negative emotional state that drives such negative reinforcement is hypothesized to derive from dysregulation of key neurochemical circuits that form the brain stress systems within the

extended amygdala. Specific neuroplasticity in these circuits includes the extrahypothalamic corticotropin-releasing factor (CRF) stress systems and the dynorphin-Κ opioid aversive systems the in the extended amygdala. Excessive drug taking is also accompanied by deficits in executive function produced by neurocircuitry dysfunction in the medial prefrontal cortex that may facilitate the transition to compulsive-like response and relapse. Thus, compelling evidence exists to argue that plasticity in the brain stress systems, a heretofore largely neglected component of addiction, is triggered by acute excessive drug intake, is sensitized during the development of compulsive drug taking with repeated withdrawal, persists into protracted abstinence, and contributes to the development and persistence of addiction. The neuroplasticity of the brain stress systems in drug addiction not only provides understanding of the neurobiology of negative reinforcement mechanisms in all forms of addiction, but also provides key insights into how the brain processes negative emotions relevant to all of psychopathology.

Too Much of a Good Thing: How Historic Survival Traits Are Now Killing Us
Chair: Steve H. Koh, M.D., M.P.H.
Lecturer: Lee Goldman, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the different eras of public health challenges faced by humans since our first appearance about 200,000 years ago; 2) Understand how key genetic survival traits that protected our ancestors for more than 7,000generations are now the leading causes of human disability and death; and 3) Understand potential solutions to this new conundrum.

SUMMARY:
Based on evidence from isolated human societies "discovered" in the past century, approximate life expectancy at birth was probably about 33 years for Paleolithic hunter-gatherers. Remarkably, about 200,000 years and about 7,000 generations later, church records show that pre-industrial European life expectancy was still 33 years in 1800. Leading causes of death continued to be infectious diseases, as well as starvation, dehydration, murder, and injuries. Life expectancy began to increase with the advent of the industrial era and reached 65 years by 1950. However, the benefits of higher standards of living were partially offset by pollution, especially of air and water, as well as man-made hazards such as cigarette smoking, motor vehicle accidents, and alcohol and drug abuse. In the third era of leisure and plenty since about 1950, U.S. life expectancy has increased from 65 years to about 80 years, but we now face epidemic obesity, diabetes, hypertension, anxiety/depression/suicide, and ischemic cardiovascular disease. These modern public health challenges are, paradoxically, directly linked to the same genetic traits that evolved over the pre-industrial millennia to help our ancestors avoid starvation, dehydration, murder, and bleeding to death, especially after childbirth. Now, each of these previously protective genetic traits is "too good"-it causes more deaths than the challenges for which it evolved. For example, twice as many Americans now die from suicide as from murder, even for firearm-related deaths. Our now mismatched ancestral genes will undergo spontaneous mutations, but even mutations that could be beneficial for the modern leisure era will not spread if their benefit is not realized until later in life, after successful procreation. And even if there were some selection pressures in their favor, substantial genetic change would take at least tens of generations to spread widely. As a result, we must look at other ways to address the modern challenges of this genetic mismatch. Individual behavior change is always a worthy goal but is difficult to achieve, as evidenced by rising worldwide obesity rates. Legislation and regulation have been helpful in reducing manmade hazards such as pollution, smoking and motor vehicle accidents, but less so for other health challenges. Medical advances probably account for 85-90% of the increase in life expectancy since 1950 and can increasingly be used to block the effects of the genes that cause modern disease. The proof of principle for this last approach, often called precision medicine, is exemplified by a series of genes that markedly increase cholesterol levels but that are no longer necessary, as evidenced by the lack of adverse health effects when one or even both copies are deactivated. Our future health will be critically dependent on how we use a variety of approaches

to address this mismatch between our Paleolithic survival genes and our modern leisure lifestyle.

Sunday, May 21, 2017

Alcohol, Stress and Glucocorticoid Effects on Relapse and Brain Recovery: Implications for Biomarker and Treatment Development
Lecturer: Rajita Sinha, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Identify stress and alcohol effects on the autonomic and hypothalamic-pituitary-adrenal (HPA) axis that stimulate the glucocorticoid response; 2) Understand the effects of stress and binge-heavy alcohol use on brain circuits involved in adaptive and resilient coping; 3) Identify brain regions related to high alcohol craving and motivation and alcohol relapse risk; and 4) Describe therapeutic compounds and behavioral approaches that decrease alcohol-related hyperarousal and craving with the potential to decrease alcohol relapse risk.

SUMMARY:
Background: Growing evidence indicates that alcohol use disorders (AUDs) are associated with multilevel peripheral and brain adaptations in stress and homeostatic pathways that significantly impact cognitive, affective, alcohol craving, and reward processes. However, how chronic alcohol abuse changes these pathways, and whether biomarkers can be developed to identify those most at risk for relapse at treatment entry to evaluate treatment efficacy and brain recovery from alcoholism, has not been well studied until recently. **Methods:** Data from several multimodal neuroimaging and human laboratory experiments combined with prospective clinical outcomes and recovery approaches will be presented. Participants include healthy social drinkers, binge and heavy social drinking individuals, and inpatient and outpatient treatment-engaged individuals with AUDs at varying points of abstinence and recovery who participated in separate laboratory, neuroimaging and clinical outcome studies. Multimodal neuroimaging using structural and functional magnetic resonance imaging (MRI and fMRI) assessing structural gray matter volume and functional neural responses to stress, alcohol cues and neutral relaxing stimuli and laboratory experiments assessing autonomic and hypothalamic-pituitary-adrenal (HPA) axis basal states and responses to alcohol motivation, stress, drug/alcohol cue, and neutral states were conducted in both patients and control social drinking volunteers. Prospective treatment and recovery data in the AUD patients in conjunction with neural and neuroendocrine biomarkers of relapse and recovery over a 90-day treatment and recovery period will be presented. **Results:** Findings will focus on dysfunctional hyperactive basal and neutral-relaxed state autonomic and HPA axis measures (heart rate, cortisol, cortisol/ACTH ratio), higher brain-derived neurotrophic factor (BDNF), lower medial frontal brain volume and hyperactive neutral state ventromedial prefrontal cortex (VmPFC), and ventral striatum and blunted VmPFC response to stress and drug/alcohol cue, with each predicting greater risk of future relapse and poor recovery outcomes. Using receiver operating characteristics (ROC), sensitivity and specificity of neural and neuroendocrine recovery prediction accuracy will be presented. Pharmacological and behavioral treatments that change specific target biomarkers will be shown to illustrate an experimental medicine approach in AUD treatment. **Conclusion:** Findings presented will illustrate neural and neuroendocrine measures that may be further developed as optimal biomarkers of relapse risk, and implications for the development of novel therapeutics using personalized medicine approaches in the treatment of alcohol use disorders will be discussed. This research was supported by R01-AA013892; R01-AA020504; UL1-DE019586, and PL1-DA24859.

Bipolar Disorder: The Heartland of Hispanic Psychiatry
Chair: Mauricio Tohen, M.D.
Lecturer: Eduard Vieta, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Summarize the contribution of Hispanic psychiatry to bipolar disorder; 2) Educate others on hot topics around the management of bipolar disorder; and 3) Acknowledge receipt of the Simon Bolivar Award.

SUMMARY:
Hispanic psychiatry combines the tradition of Spanish-speaking countries with the strong influence

of North American approaches. Spanish is spoken by over 500 million people, and language is a key element in the practice of psychiatry and mental health research. Hispanic psychiatry has traditionally addressed many of the mental health issues that emerge in their local countries, but if any condition has attracted the interest of the psychiatrists working in Spanish-speaking countries, that is bipolar disorder. This condition may be particularly attractive to psychiatrists in general because it encompasses a strong neurobiological background with rich psychopathological features and dynamics. People living with bipolar disorder often have intense and unique lives, and their mental health status can range from absolute normality to delusional states, with great room for improvement if adequately treated. Hispanic psychiatry, including individuals and teams working in countries in which Spanish is the official language or one of the main ones, has outstandingly contributed to the progress of knowledge in that particular field, and Hispanic psychiatry also has leadership positions in the International Society of Bipolar Disorders. For these reasons, bipolar disorder is likely the heartland of Hispanic psychiatry.

Depression and Comorbid Medical Illness: A Major Cause of Morbidity and Mortality
Chair: Bruce J. Schwartz, M.D.
Lecturer: Dwight L. Evans, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the prevalence of depression in comorbid medical illness; 2) Discuss the depression-related mechanisms that may be involved in the morbidity and mortality of comorbid medical illness; and 3) Assess the efficacy of antidepressant treatment in comorbid medical illness.

SUMMARY:
Depression is a risk factor for morbidity and mortality in a wide range of human diseases. The medical burden of depression is increasing, and the World Health Organization ranks depression as the leading cause of disability in middle-and high-income countries, projecting that by the year 2030, depression will be the leading cause of disability worldwide. The mood and cognitive changes of depression are the tip of an iceberg of a syndrome that affects most of the body though endocrine, immune and autonomic nervous systems changes. Patients with illnesses as varied as cardiovascular disease, diabetes, cancer, and HIV/AIDS face a higher risk of functional impairment and possibly accelerated disease progression if they have a comorbid mood disorder. A considerable body of evidence suggests that depression is associated with immune suppression and immune activation. Depression-associated cellular immune suppression may be a mechanism whereby depression may have an adverse effect on immune-based diseases such as cancer and HIV/AIDS. Depression-associated immune activation may be a mechanism whereby depression may have an adverse effect on diseases such as cardiovascular disease and diabetes. Antidepressant treatments have generally been effective in the treatment of the symptoms of depression in the medically ill, but larger-scale studies have yet to determine if the treatment of depression in the medically ill might improve overall medical outcomes, prevent disease progression and improve survival.

Good News for Patients Who Attempt Suicide (and Their Psychiatrists)!
Chair: Linda L. M. Worley, M.D.
Lecturer: Konrad Michel, M.D.

EDUCATIONAL OBJECTIVE:
1) Define a person-oriented approach to the suicidal patient; 2) Appraise meanings and implications of a model of suicide as goal-directed action; 3) Evaluate the evidence for effectiveness of ASSIP; 4) Name the therapy process factors involved in ASSIP; and 5) Outline the implications for general models of understanding suicidal behavior.

SUMMARY:
How can clinicians improve treatment engagement of suicidal patients? The Attempted Suicide Short Intervention Program (ASSIP), a novel brief therapy for people who have attempted suicide, in a recently published RCT with 120 patients, has been highly effective in reducing the risk of reattempts over 24 months. ASSIP consists of three individual sessions, followed by regular letters sent to patients. The treatment is aimed at establishing a strong therapeutic alliance, based on a model of

understanding suicide as an action and not as a symptom of psychiatric disorder. The implications of this model are 1) that every suicidal patient has a personal history and 2) that patients have a narrative competence to tell their "suicide story." The focus on the patient's narrative is a strong basis for a therapeutic alliance-a sine qua non for a meaningful therapeutic interaction. The therapeutic alliance is further strengthened by a video playback session in which patient and therapist together watch and comment on the video-recorded narrative interview. An interactive handout is aimed at establishing a shared model of suicidality, summarizing several concepts of suicidal behavior, including medical risk factors and insights from neurobiological research. The concept of the suicidal mode, described as an acute mental state in which a person is not in the position to act rationally, can be helpful in reducing patients' feelings of guilt and shame following self-harm. In the third session, a brief case conceptualization is formulated in a collaborative way, followed by a list of personal warning signs and safety strategies. The therapeutic relationship is continued with regular semi-standardized letters signed personally by the therapist. Dr. Michel will discuss the meaning of a person-oriented approach to the suicidal patient and the implications of a model of suicide as goal-directed action. He will describe the dual role of the therapist who should be an empathic listener but who should also assess the patient's mental state and decide on the clinical management. He will present ASSIP step by step, give an overview of the therapy process factors involved and mention problems of implementation in clinical practice. He will describe why it is important that a brief therapy has a clearly defined treatment goal, is highly structured and is easy for the patient to understand. He will discuss the evidence for the effectiveness of ASSIP and compare it with other established treatments. Finally, Dr. Michel will argue that it may be necessary to revise the models of suicidal behavior we use in clinical work as well as in public prevention campaigns.

Pediatric Psychosomatic Medicine: A Field in Development

Chair: Linda L. M. Worley, M.D.
Lecturer: Maryland Pao, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify three ways in which adult psychosomatic medicine (PM) differs from pediatric PM (PPM); 2) Identify three training pathways into PPM; and 3) Describe two current areas of research in PPM.

SUMMARY:

Pediatric psychiatry was conceived of by Drs. Leo Kanner and Adolf Meyer as child psychiatric consultation and teaching of pediatricians in a pediatric setting. As medical care and technological advances for the treatment of children progressed, new problems in coping, adjustment and adaptation occurred for those children in hospitals. Concurrently, chronic behavioral and psychiatric problems became a full-time outpatient focus of child psychiatrists. However, a group of child psychiatrists focused particularly on the interface of hospital pediatrics and child psychiatry, which led to the subspecialty formally called pediatric consultation liaison. This field has subsequently been named pediatric psychosomatic medicine after the APBN formally recognized the subspecialty psychosomatic medicine in 2003. Dr. Maryland Pao has been the director of a psychiatric consultation liaison service since 1992, first at Johns Hopkins Children's Center, then at Children's National Medical Center and most recently at the National Institutes of Health Clinical Center. In addition, she is the clinical director and deputy scientific director of the Intramural Research Program at the National Institute of Mental Health. Dr. Pao will give an overview of the progress made in pediatric psychosomatic medicine over the past few decades, including in the areas of training and current research. Dr. Pao will specifically address the history of pediatric CL, then highlight the multiple training pathways that lead to becoming a PPM clinician today. Lastly, she will present her research in developing suicide risk screening tools for different pediatric settings and in creating a developmentally appropriate advance care planning guide for adolescents and young adults with potentially life-limiting illnesses called Voicing My CHOiCESâ„¢. Many pediatric psychosomatic medicine psychiatrists work at the interface of pediatrics in primary care settings and hospitals where the management of children in the hospital has become

increasingly complex. The field will continue to grow as we continue to develop new treatments and children are living longer. We need to meet the integrated care needs of children, adolescents and young adults in primary care.

Raising the Bar for Treating Suicidal Behavior Disorder

Chair: Nancy Diazgranados, M.D.
Lecturer: Philippe Courtet, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Identify pharmacological treatment available for at-risk patients; 2) Understand suicide risk and antidepressants use; 3) Investigate pain processing in suicide to discover new treatments; 4) Follow neuroscience-based psychosocial treatments; and 5) Understand new perspectives of monitoring and intervention offered by m-health.

SUMMARY:

Despite enlargement of therapeutic alternatives, suicidal behavior (SB) incidence has not decreased in decades. Recently, the increased risk of SB during the first weeks of an antidepressant treatment has been a critical issue. This led to warnings, although untreated major depressive episode represents the main risk factor of SB. Predictors of worsening suicidal ideation and occurrence of SB during the first weeks of treatment were prospectively investigated in large depressed cohorts. Clinical predictors were related to depression (e.g., severity, duration, response) and history of SB. When instituting an SSRI, prescribing a higher dose than recommended may be harmful. Now the challenge is to also identify biological predictors (e.g., neurotrophic, glutamatergic systems, cytochromes), but suicidal patients would be less responsive to antidepressants. Patients who are most in need of efficient antidepressants do not benefit adequately from those currently available. Several controlled studies performed in at-risk patients reveal some rationale for new pharmacological strategies. This acknowledgement should influence researchers to study new biological systems (e.g., glutamatergic, opioidergic, inflammatory systems) in order to provide innovative treatments for SB. A potentially relevant method of research is to study pain processing. Clinical studies reported both physical and psychological pains are associated to all suicidal phenotypes independently of depression. Moreover, social pain opens new ways of understanding SB at different levels: role of dysfunctional social cognitions increasing sensitivity to negative social cues, role of cerebral regions involved in socialization, physical pain, and SB. A focus on pain may thus help to identify new predictors of suicidal risk and explore antisuicidal properties of targets modulating pain. The mu opioidergic system is a candidate, as animal, pharmacological and imaging studies have demonstrated it dampens physical pain and modulates social pain. Could the current public health issue of opioid drug-related death be interpreted as an additional hint of opioidergic involvement in SB? Recently, buprenorphine appeared to be a valuable option to reduce suicidal ideation (and psychological pain). Some psychotherapies have also been shown to reduce suicidal risk. Acceptance and commitment therapy may counteract cognitive and emotional processes involved in SB. Finally, the current development of e-health technologies provides opportunities to monitor suicidal risk to detect in vivo environmental risk factors and develop rapid interventions. Ecological momentary assessment already helped to identify specific stressors predicting suicidal ideation in daily life. “Antisuicidal applications” will probably soon be developed in the line of preventive recontact strategies. Restoring social connection and targeting molecular mechanisms of pain will provide an enriched arsenal to efficiently treat suicidal patients.

Suicidal Behavior: From Genes to Prevention at the National Level

Chair: Nancy Diazgranados, M.D.
Lecturer: Gil Zalsman, M.D., M.H.A.

EDUCATIONAL OBJECTIVE:

1) Understand where we stand in understanding suicidal behavior in young people; 2) Introduce the gene x environment x timing (GxExT) interaction model in depression and suicidality; 3) Demonstrate an animal model for assessing the GxExT hypothesis; 4) Share findings from a postmortem study of high school suicide victims; and 5) Share findings from a large systematic review on suicide prevention at the national level.

SUMMARY:
Suicide is the second leading cause of death in the U.S. in ages 15–34. To improve suicide prevention in youth, we need to develop new tools and approaches for detecting those at risk and better interventions to reduce risk. Prevention efforts directed at children and adolescents exposed to serious childhood adversity may reduce the risk of later mood disorders and suicidal behavior and translational imaging studies may reveal the brain circuits involved. This lecture will review exciting new models and research that offers a path forward in suicide prevention of young people. After understating the scope of the problem and the clinical risk assessment of young patients with suicidal ideation or behavior, we will show that most of young suicide victims suffered from a combination of depression and stressful life events. Evidence show that early stressful life events (SLE) predict depression and anxiety in carriers of specific polymorphisms and alter brain responses. This lecture will describe the role of genes, environment and timing of SLE in changing the brain and behavior in a vulnerable and resilient strain of rats. The effects in gray and white matter tracts implicated in the risk for depression and suicidal behavior will be demonstrated. We will review the findings from a postmortem study of high school suicide victims and suicidal behavior among soldiers in the military. Finally, we will share data published over the last decade from a large systematic review of evidence for the effectiveness of suicide prevention interventions at the national level. Some controversial video clips for suicide prevention will be shown and discussed. We will conclude with some future direction in clinical approaches and research of suicidal behavior in youth.

Suicide Risk and Prevention in Mood Disorders: Advances and Translation of Research Into Practice
Chair: Nancy Diazgranados, M.D.
Lecturer: Erkki T. Isometsä, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Know current epidemiological estimates on risk of suicide or suicide attempts among patients with mood disorders; 2) Understand the importance of illness course for suicide risk in mood disorders and know the essential clinical risk factors and indicators of risk; and 3) Know the current state of the art pertaining to biomarkers for suicide risk.

SUMMARY:
The WHO estimates about 800,000 individuals worldwide to die by suicide annually. In psychological autopsy studies, at least half of all suicides are found to have suffered from depressive or bipolar disorders preceding death. Register-based representative studies estimate lifetime suicide risk for psychiatric patients with mood disorders at four to eight percent. Recognition and treatment of suicide risk among patients with mood disorders is a central task for suicide prevention. While there is abundant literature on suicide risk factors and evaluation, there are nevertheless major difficulties in reliable estimation of suicide risk and uncertainty of best practices pertaining suicide prevention. In part difficulty in estimating suicide risk suicide is inherent to prediction of any rare events. For clinical decision-making, due to numerous putative factors influencing risk, clearer estimates for risk factor potency and predictive power are needed to judge who is at risk and when. Recent research has advanced in producing estimates for potency of risk factors. In particular, longitudinal perspective and tracking variations in clinical symptoms and states are important. Risk of suicide deaths and attempts in mood disorders cluster remarkably strongly into major depressive and mixed illness episodes, and time spent in them is a major determinant of accumulating risk. It is therefore an important task for future research on suicide risk in mood disorders to clarify the causal pathways through which the numerous risk factors exert their influence. These may involve both modifying risk when high-risk illness states are present or influencing their duration. Treatments may influence suicide risk both by reducing time ill and level of risk while ill. Direct evidence for preventive effects of pharmaco- or psychotherapies remains limited, however. Lithium is found in observational and randomized studies to reduce risk of suicide deaths and attempts. Among patients over 25 years old, antidepressants reduce intensity of suicidal ideation in RCTs. Ecological evidence from both the U.S. and Europe shows sales of antidepressants to covary with declining regional suicide rates. However, besides issues of treatment

availability, poor adherence is a central obstacle in treatment provision. Improving quality and continuity of treatment and integrating pharmacotherapies with psychosocial interventions is likely to advance suicide prevention. Research on suicide in mood disorders proceeds on multiple fronts. Improvements in methodology of brain imaging and neurocognition research yield improved understanding of brain mechanisms and abnormalities in decision-making related to suicidal behavior. Research on experience sampling (ecological momentary assessment) may open the temporal dynamics of suicidal behavior. Digital phenotyping based on patterns of use of mobile devices may provide means for future large-scale research on suicidal behavior.

Synergy: Integrating Psychiatry Into Medical Care
Chair: Linda L. M. Worley, M.D.
Lecturer: Michael Sharpe, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the dimensions of integrated care; 2) Understand the arguments for integrating psychiatry into medical care; 3) Appraise the evidence for the effectiveness of integrating psychiatry into cancer care; and 4) Appreciate and know how to address the obstacles to integrating psychiatry into medical care.

SUMMARY:
Psychiatry has existed separately from other areas of medicine for too long. Whilst there are now many policy initiatives proposing that we reintegrate psychiatry with other branches of medicine, achieving integration in practice is far from straight forward. This lecture will examine what integration means, review the arguments for a greater degree of integration of psychiatrists into medical services and describe research into the effectiveness of integrating psychiatry with specialist medical care, using clinical trials in cancer services as an example, Dr. Sharpe will then discuss the benefits and challenges of working in a more integrated way with specialist medical services, both for inpatient and for ambulatory care services, using examples from the Oxford University Hospitals. Problems to be overcome and practical solutions to these will be described. The integration of psychiatry into specialist medical care is a complex and challenging process, but it is also one that we must and can succeed in.

***The Evolution of Forensic Psychiatry*: A Tribute to Its Founders, Developers, Teachers, and Practitioners**
Chair: David Lowenthal, M.D.
Lecturer: Robert Sadoff
Presenters: Kenneth J. Weiss, M.D., J. Richard Ciccone, M.D., Octavio Choi, M.D., Ph.D., Thomas G. Gutheil, M.D.

EDUCATIONAL OBJECTIVE:
1) Develop an increased appreciation of the involvement of psychiatry and psychiatric concepts in legal matters; 2) Discover that forensic psychiatry has emerged as a mainstream subspecialty of psychiatry; 3) Be alert for scientific aspects of psychiatry that can inform legal decisions and health policy; and 4) Recognize the value of forensic psychiatric concepts in nonpsychiatric areas of medical practic.

SUMMARY:
The book *The Evolution of Forensic Psychiatry* was written to illustrate several important aspects of this growing influential subspecialty of psychiatry, not only for other nonforensic psychiatrists, but for all who work in the mental health field and associated legal arenas. Major areas of evolution include history, current developments and future directions. Clearly, the book could not have been written by one person, but required a number of leaders who initiated modern concepts, those who broadened the field by introducing specialized training and accountability in practice, and those with vision who foresee its use in future matters. I was fortunate to be invited by Dr. Jonas Rappeport to the inaugural meeting of what later became the American Academy of Psychiatry and the Law (AAPL) in 1969. From the initial eight who attended, the Academy has grown to over 2,000 members worldwide. Dr. Ken Weiss, who chairs this panel, is the recognized historian of forensic psychiatry, presenting significant aspects of the utilization of forensic psychiatry in America during the 19th and 20th centuries, referring to his predecessors, Drs. Gregory Zilboorg, Jacques Quen, Bernard Diamond, and Isaac Ray. I was also fortunate to study with two great

mentors: Prof. Samuel Polsky and Dr. Melvin Heller of the Temple University Unit in Law and Psychiatry. My greatest fortune was to become colleagues with those giants of forensic psychiatry who developed and broadened the field through specialized teaching, Board examinations, and certification through the American Psychiatric Association and the ACGME. They are the ones to be honored here for their continued work in improving the field by outstanding practice and by training the next generation of forensic psychiatrists. These include, but are not limited to, the following (in no particular order, but who did contribute chapters to this book): Kenneth Weiss, M.D., Thomas Gutheil, M.D., J. Richard Ciccone, M.D., Philip Resnick, M.D., Richard Rosner, M.D., Annie Steinberg, M.D., and Charles Scott, M.D. There are also a number of professionals from many different universities who made significant contributions to the development and evolution of forensic psychiatry who did not contribute to this book and should be recognized. In summary, the field depends on a number of highly trained professionals in many different fields linked to the law who utilize forensic psychiatric concepts regularly and also share with forensic psychiatrists concepts of their profession that influence the work that we do. It is the mutual learning and sharing that makes it so successful. Finally, the future directions are becoming important, especially the use of neuroscience in legal matters. Further discussion will clarify and limit its use. The evolution continues.

What Can the Clinician Learn From Research to Improve Suicide Prevention
Chair: Bruce J. Schwartz, M.D.
Lecturer: J. John Mann, M.D.

EDUCATIONAL OBJECTIVE:
1) Educate clinicians about new research on causes of suicide; 2) Teach an explanatory and predictive model of suicidal behavior; and 3) Describe implications for clinical care.

SUMMARY:
In the Western world, suicide is often a complication of an untreated or inadequately treated psychiatric illnesses. Only a subgroup of such patients are at heightened risk for suicide. New knowledge has emerged about decision making, mood regulation, social distortions, and learning that is relevant for the predisposition or diathesis for suicidal behavior. Four domains have been identified together with their underlying neural circuits: decision making, learning and problem solving, social distortions, and mood regulation. New knowledge has also emerged about the related specific neurotransmitter systems. This lecture will describe these four domains of the diathesis for suicidal behavior and their neural circuitry and the direct implications of this knowledge for clinical practice in terms of suicide prevention.

Monday, May 22, 2017

Culture, Ethics, Communication, and the International Medical Graduate
Lecturer: Ramaswamy Viswanathan, M.D., Sc.D.

EDUCATIONAL OBJECTIVE:
1) Appreciate that there is variation among cultures in the relative value placed on the ethical principle of beneficence when it conflicts with the principles of patient autonomy and veracity; 2) Learn how cultural differences influence clinical behavior such as communicating the news of death of a patient to the family, approach to medical decisional capacity assessment or recognizing late-life depression; and 3) Learn how clinicians can bridge the cultural divide between themselves and their patients, including differences in religious values.

SUMMARY:
A quarter of the physicians in the U.S. are international medical graduates (IMGs). Most of the IMGs in the U.S. are foreign-born and come from different cultures. Many cultures are more paternalistic than the U.S., have more submissiveness to authority and foster more indirect communication of difficult subject matter. The scale is tilted in the direction of beneficence when there is a perceived conflict between the ethical principle of beneficence and the principles of patient autonomy or veracity. In a study by lecturer Ramaswamy Viswanathan and colleagues on how physicians communicate the news of unexpected death of a patient to a family over the telephone, 88% of foreign-born physicians preferred critical notification that entailed a temporary concealment of the truth

for the perceived emotional protection of the recipient, in contrast to 67% of American-born physicians preferring to do so. In face-to-face communication in that situation, 72% of foreign-born physicians preferred a graded approach in informing about the death, in contrast to 30% of American-born physicians preferring so. The preferential focus on beneficence can be helpful in some situations, less adaptive in others. In the lecturer's experience, as IMGs acculturate into American culture, there is a gradual shift toward giving more importance to autonomy and veracity when conflicting with beneficence, a shift toward more direct communication, and more ease with these changes. The cultural, accent and idiomatic differences of IMGs, while creating awkwardness and difficulties in the beginning in some patient encounters, do bring strengths in other situations. This is especially true in dealing with multicultural patient populations. These issues are brought into sharp relief when dealing with patients who refuse lifesaving or clearly beneficial treatments. Cultural perspectives may also influence behavioral assessment. A study found that IMG psychiatrists and family physicians were less likely to diagnose and treat late-life depression than United States medical graduates. Graduate medical education programs need to pay more attention to helping IMGs acculturate. With the use of case examples, this lecture will also explore how clinicians can bridge the cultural divide between themselves and their patients, including differences in religious values. The presentation will also discuss how working with a culturally diverse faculty and staff is educational and rewarding.

Defense Health Agency and Mental Health: Family and Service Members
Chair: Steve H. Koh, M.D., M.P.H.
Lecturer: Racquel Bono

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Identify barriers to care, including health service delivery issues.

SUMMARY:
Uniformed service members often struggle with a variety of mental illnesses, but stigma and misinformation adversely impact the treatment of this population. The Defense Health Agency (DHA) assists servicemembers through administration of the TRICARE Health Plan, providing health programs to 9.4 million servicemembers, both active and veteran, and their families, among other services. In this session, Vice Admiral Raquel Bono, director of the DHA, will discuss the impact the DHA has had on mental health for servicemembers and their families.

Living Foods That Together Strengthen and Build Support for the Peripheral Nervous System, Consequently Building Health of Both the Central and Peripheral Nervous Systems
Chair: Philip R. Muskin, M.D., M.A.
Vice-Chair: Drew Ramsey, M.D.
Lecturer: David Bouley

EDUCATIONAL OBJECTIVE:
1) Describe new research findings in psychiatry and neuroscience and how they may impact practice; 2) Apply quality improvement strategies to improve clinical care; 3) Provide culturally competent care for diverse populations; 4) Describe the utility of psychotherapeutic and pharmacological treatment options; and 5) Integrate knowledge of current psychiatry into discussions with patients.

SUMMARY:
In this lecture, Chef David Bouley will discuss the effects of food on mental health and how good foods can improve health and strengthen the central and peripheral nervous systems.

Managing Up: Dynamic Following in an Organizational Setting
Chair: Wayne Creelman, M.D.
Lecturer: Barry K. Herman, M.D., M.M.M.

EDUCATIONAL OBJECTIVE:
1) Understand the concept of managing up in an organizational setting; 2) Manage up as a unique leadership skill set; 3) Comprehend the concept of

alignment of personal and organizational goals; 4) Develop effective strategies for managing up; and 5) Understand the role that executive coaching can have in managing up.

SUMMARY:
All organizations require "dynamic followers." Managing up in any organization is a unique leadership skill set that requires multiple capabilities. Soft skills are character traits and interpersonal skills that characterize how one relates to others. Often, unique strategies are essential to effective managing up. Executive coaching can lead to enhanced soft skills that can sometimes make a difference in successfully managing up. Managing up in any organization is a deliberate effort to bring understanding and cooperation to a relationship between individuals who often have very different perspectives. Alignment of personal and organizational goals is a key to effective managing up. Developing a personal action plan is a strategic approach to navigating the organizational landscape. Effectively managing conflict is critically important; failure to do so can have dire consequences. Soft skills can often be "coached," and the role of personal or executive coaching can significantly improve self-awareness. There are telltale signs of when attempts at managing up fail; one should recognize these and act accordingly. Managing up is a skill set that can be developed. Effective managing up is essential for success in any organizational setting.

Promoting Physician Competence Across the Lifespan: Targeted Lifelong Learning and Continuous Practice Assessment and Improvement
Chair: Lowell Tong, M.D.
Lecturer: Sandra Sexson, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize that self-selected general CME does not ensure maintenance of physician competence over the lifespan; 2) Discuss the importance of structured self-assessment as a part of planning for lifelong learning and maintenance of competence in practice; 3) Recognize the importance of looking at one's own practice as a part of maintaining competence in practice; and 4) Develop an individualized comprehensive approach to address lifelong learning and practice improvement.

SUMMARY:
Traditionally, physicians have relied heavily on passive types of CME offerings as their method for continually optimizing their abilities to practice evidence-based medicine. Recent studies have demonstrated that such a passive approach does not always ensure that physicians stay current in this age of exploding information advances. This lecture will address some of the findings that suggest physicians need to do more than participate in passive CME. How physicians typically choose topics for CME may not always address areas of weakness. The literature supporting the concern that physicians typically do less well on knowledge-based examinations of competence as the years pass in practice will be reviewed, along with some evidence that also suggests that those in solo practice face a greater challenge in maintaining evidence-based practice than those practicing in groups. The presentation will discuss specific methods for developing individualized plans for improving the physician knowledge base in order to facilitate adequate maintenance of competence that is an unquestioned goal for most, if not all, physicians in practice. Additionally, ways for physicians to personally examine their own practice in an organized yet not too demanding way, comparing their practice habits to those identified by specialty organizations as best practices through practice guidelines, will be identified. Evidence suggests that we as physicians do not always do what we think we are doing. Personal guided assessment of our practice habits can identify ways in which physicians can be sure that they are incorporating the best evidence into their everyday work with patients. We need to ascertain that we are doing what we think we are doing. Emphasis will be placed on incorporating specially developed practice guidelines based on up-to-date research and consensus. Finally, the presentation will point toward the goal of constant and deliberate self-assessment, strategic lifelong learning, and recurrent assessments of actual practice implementation of what is learned as a journey, not a definitive destination, one that must continue throughout the lifetimes of physicians' practice.

The Pharmacogenomics of Bipolar Disorder
Chair: James L. Kennedy, M.D.
Lecturer: John R. Kelsoe, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand pharmacogenomics and its purpose; 2) Learn to use pharmacogenomic tests in clinical practice; and 3) Better understand the genetics of lithium response.

SUMMARY:
After its onset at an average age of 19, patients with bipolar disorder frequently undergo several years of medication trials until the optimal effective medication is identified. During this period, they continue to suffer and be at risk for suicide. Usually, an effective regimen is identified, but current knowledge and practice provides little guidance to physicians in selecting medications. The overall goal of pharmacogenomics is to develop genetic tests that predict medication response and side effects in order to address this problem. Lithium is the first and remains the best overall mood stabilizer for bipolar disorder. There is also data that suggest that lithium response is heritable among families with bipolar disorder and that lithium responsive bipolar disorder, may in fact, be a distinct subform of illness with a different mechanism. Under this model, people who respond to lithium have a form of bipolar disorder in which the cellular pathways disrupted are modulated by lithium. Therefore, identifying genes and gene variants that influence lithium response may also serve to better understand the cause of bipolar disorder. Toward these goals, we have conducted the Pharmacogenomics of Bipolar Disorder Study (PGBD). The PGBD took a two-pronged approach that used induced pluripotent stem cells (iPSC) to identify genes changed by lithium and then tested variants in those genes for association to lithium response. The PGBD included 11 international clinical sites that conducted a clinical protocol in which patients with bipolar disorder type I were first stabilized on lithium monotherapy over four months, then followed for two years and monitored for relapse. 585 subjects were enrolled and analyzed along with another 115 subjects from an identical VA study for a total of approximately 700 patients. As 700 subjects was not likely to be sufficient for a genomewide association study, we developed the iPSC strategy to reduce the number of statistical tests and improve the power to detect genes. Skin biopsies were obtained from three of the best lithium responders and three of the worst lithium responders. iPSCs were established and differentiated to hippocampal interneurons. All the neurons from BD patients exhibited a three-fold higher spontaneous rate of action potentials, termed hyperexcitability, than did the controls. When cells were treated in vitro with lithium, this high firing rate returned to normal but only in the cells that came from patients who responded to lithium clinically. Recapitulating the clinical response in the culture dish was a remarkable finding that further validated hyperexcitability as a model. Genes whose expression changed are now being tested for association to lithium response. Genetic test panels derived from studies such as this must also be tested for efficacy in the clinic, and several studies indicate they are useful. So armed, psychiatry will be soon be able to practice precision medicine, tailoring treatment to the patient.

Tuesday, May 23, 2017

Antidepressant Treatment for Pregnant Women: Three Decades of Conceptual Evolution
Chair: Philip Wang, M.D., Dr.P.H.
Lecturer: Katherine L. Wisner, M.D., M.S.

EDUCATIONAL OBJECTIVE:
1) Define the categories of reproductive outcomes that have been studied for SSRI antidepressants; 2) Explain the risks of major depressive disorder during pregnancy; 3) Review the risks of SSRI medications during pregnancy; 4) Discuss the strengths and weaknesses of research strategies applied to this area of investigation; and 5) Summarize a conceptual framework for personalizing discussions of risks and benefits in the process of decision making.

SUMMARY:
Major depressive disorder (MDD), a common complication of pregnancy, is associated with physiological alterations and psychosocial sequelae that negatively impact pregnancy outcomes. It is associated with poor nutrition, obesity, smoking,

alcohol and drug use, interpersonal violence, poverty, and suicide. MDD increases the risk for preterm birth and infants small for gestational age. Postpartum depression occurs in about one in seven women and also confers risk to the developing infant by complicating the development of maternal role function, with lasting effects on children's cognitive and emotional development. With recognition of the risks of MDD during the perinatal period, SSRIs have become one of the most common classes of drugs prescribed to pregnant women. Pharmacotherapy during pregnancy is a reasonable choice when balanced against the risks of MDD. However, the interpretation of studies examining the association of SSRI use with reproductive outcomes is complicated by the fact that the mother and fetus are also affected by MDD and its psychosocial sequelae. Recent studies have illustrated the impact of confounding factors in this literature. For example, the association between antidepressant use during pregnancy and offspring cardiac defects were attenuated, and became nonsignificant, with increasing levels of adjustment for confounding factors. Exposure to SSRI is associated with a two- to three-fold increase in the rate of preterm birth, although the risk is similar to that for exposure to MDD (without SSRI) after adjustment for confounding factors. No differences in mental development related to in utero SSRI exposure have been reported; however, less favorable motor development has been observed. Poor neonatal adaptation has been reported in up to 30% of infants exposed to SSRIs during the third trimester. Investigators have reported that pregnant SSRI-treated and -untreated women have similar levels of depression. Treated women may have more severe disease (and be partially responsive) compared to untreated women. Another explanation is inadequate dosing due to the dramatic changes in pharmacokinetics, which result in progressively lower plasma SSRI concentrations and reduced efficacy. Optimization of SSRI dosing during pregnancy dictates several treatment goals: 1) the drug must be at the dose that produces the best response with tolerable side effects for the woman; 2) a continuous measure of symptoms must be repeated and adjustments made to maintain optimal antidepressant efficacy; and 3) the resolution of pregnancy at birth requires dose adjustment as the woman transitions to the breastfeeding state. Once a strategy for optimal pharmacological treatment for pregnant women is developed, studies exploring potential benefits can be undertaken to balance the extensive literature on risks. This is the goal of an ongoing NICHD-funded study, Optimizing Medication Management for Mothers With Depression, which will be described.

Can I Get There From Here? Attaining Leadership Roles While Doing What You Love
Lecturer: Maria A. Oquendo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Apply quality improvement strategies to improve clinical care; 2) Provide culturally competent care for diverse populations; 3) Describe the utility of psychotherapeutic and pharmacological treatment options; 4) Integrate knowledge of current psychiatry into discussions with patients; and 5) Identify barriers to care, including health service delivery issues.

SUMMARY:
Leadership in a medical setting involves accepting a greater level of responsibility, which can often seem overwhelming. How can new leaders adjust to the responsibilities of leadership without losing the very aspects of their careers that make the health care profession so rewarding? In this lecture, APA President Dr. Maria Oquendo will explore strategies for adjusting successfully to a leadership role within a variety of health care settings.

Childhood-Onset Schizophrenia: Update 2017
Chair: Philip Wang, M.D., Dr.P.H.
Lecturer: Judith Rapoport, M.D.

EDUCATIONAL OBJECTIVE:
1) Become familiar with the differential diagnosi of childhood-onset schizophrenia; 2) Become familiar with the nonspecific nature of genetic risk from chromosomal copy number variants (CNVs) associated with childhood-onset schizophrenia; and 3) Become familiar with the striking response to clozapine treatment for early onset patients.

SUMMARY:
Stratification by age of onset has been a useful

approach to clinical research across all of medicine. Since 1990, the NIMH Child Psychiatry Branch has been recruiting patients age 5-18 with documented onset of schizophrenia before their 13th birthday. Childhood-onset schizophrenia (COS) is a rare form of the disorder, but clinical, neuropsychological, familial, and biological measures, as well as response to treatment, indicate continuity with the more typical later-onset disorder. Evaluation included a two outpatient screening followed by inpatient observation, which included a three-week drug-free period. It became clear that COS is overdiagnosed, as only 20% of referrals met *DSM-IV* criteria for the disorder. There were two areas in which biological factors were more striking for our patients: anatomic brain MRI and genetic risk factors. During adolescence, there was a relatively low level of cortical gray matter that was more dramatic than that seen for later-onset patients during their young adult years. In addition, COS patients as a group had a greater frequency of sex chromosome and other chromosomal abnormalities, copy number variants associated with neurodevelopmental disorders, and a higher total score for common variant risk than their healthy siblings. Child psychiatrists have been understandably reluctant to use clozapine because of the greater risk for bone marrow suppression. Our double-blind comparison studies, as well as later systematic open trial and long-term follow-up, support previous studies that indicate that early onset treatment-resistant patients may be particularly responsive to clozapine.

Culturally Sensitive Collaborative Treatment for Chinese Americans in Primary Care
Chair: Francis Sanchez, M.D.
Lecturer: Albert Yeung, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the barriers for depressed Asian-American immigrants in accessing mental health treatment; 2) Know how to provide culturally sensitive treatment to depressed Asian-American immigrants; and 3) Learn the effectiveness of using culturally sensitive collaborative treatment for engaging and treating depressed Asian immigrants in primary care settings.

SUMMARY:
Depression is prevalent among Asian Americans, and many of these patients are unfamiliar with the concept of depression. Depressed Asian Americans frequently do not complain about their mood symptoms, leading to underrecognition of their illness. Recognition of depressed Asian Americans in primary care alone does not result in adequate treatment by primary care physicians. We designed and implemented a comprehensive approach: culturally sensitive collaborative treatment (CSCT) for treating depressed Asian Americans in primary care. CSCT includes systematic depression screening, actively contacting people who screen positive for depression, cultural consultation to depressed patients by a psychiatrist trained in cultural sensitivity to introduce the concept of depression, treatment of depression by primary care physicians based on established guidelines, and care management by a bilingual and bicultural care manager under the supervision of a psychiatrist. This lecture will discuss the cultural background leading to the barriers faced by Asian Americans with depression to receive psychiatric treatment. After that, the study on a telepsychiatry-based CSCT will be described, and its outcomes will be discussed.

Soul Machine: The Invention of the Modern Mind
Chair: Iqbal Ahmed, M.D.
Lecturer: George J. Makari, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn how and where the concept of the modern mind emerged; 2) Learn the scientific and political debates that surrounded this new concept of mind; and 3) Learn about how the idea of a material mind led to fundamental assumptions we hold about mental health and illness.

SUMMARY:
This lecture will review the history of the creation of the modern Western mind. From the origins of modernity, a time when a crisis in religious authority and the scientific revolution led to searching questions about the nature of human inner life, the lecture reviews the story of how a new concept-the mind-emerged as a potential solution, one that was part soul and part machine but fully neither. Writers, philosophers, doctors, and anatomists worked to construct the notion of the mind as a natural entity,

not an ethereal one. Conducted in a cauldron of political turmoil, their efforts spanned 150 years and would underwrite the birth of the mind sciences, liberal politics, secular ethics, and radical visions of the self, society, the ordering of knowledge, and the sources of unreason. This is a synthetic history of the mind, madness and the emergence of psychological man in the Western world.

Wednesday, May 24, 2017

Racism and Mental Health: Pathways, Evidence and Needed Research
Chair: Lara J. Cox, M.D.
Lecturer: David Williams, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Identify two mechanisms by which the subjective experience of racism can affect mental health; 2) Describe at least two ways in which institutional mechanisms of racism can affect mental health risks; 3) Describe psychosocial resources that can reduce or mitigate some of the negative effects of interpersonal discrimination on mental health; and 4) List at least one pathway by which interventions can reduce the level of prejudice and discrimination at the individual level and the level of societal racism.

SUMMARY:
There is a large and growing body of research on the association between racism and health, and mental health outcomes are the most frequently studied. This lecture provides an overview of current empirical findings of the multiple ways in which racism can affect mental health and discusses its implications for mental health research, policy and practice. It will discuss theory and evidence regarding the influence of institutional, interpersonal and individual racism both within and outside of the clinical context. It will also highlight areas for further investigation. Evidence regarding promising interventions to reduce racism, ameliorate its harmful health effects and promote health equity will also be discussed.

The National Neuroscience Curriculum Initiative: Planning for the Future of Psychiatry
Chair: Ronald Winchel, M.D.
Lecturer: Melissa Arbuckle, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Appreciate the value of incorporating a neuroscience framework into the clinical practice of psychiatry; 2) Identify new interactive approaches for teaching and learning neuroscience in a way that is both accessible and engaging; and 3) Access resources for educating patients, relatives, residents, and medical students about clinically relevant neuroscience findings.

SUMMARY:
Over the past two decades, advances in neuroscience have dramatically enhanced our understanding of the brain and of the neurobiological basis of psychiatric illness. While biological models of mental illness once emphasized "chemical imbalances," modern perspectives increasingly incorporate the role of genetics and epigenetics, a more nuanced understanding of neurotransmitters and corresponding second messenger systems, the importance of neuroplasticity, and the functional dynamics of neural circuits. While these theoretical advances are impressive, neuroscience has not significantly altered routine patient care, nor has it meaningfully changed the way clinicians communicate with each other or the lay public about our field. A number of factors have slowed this transition. First, many practicing psychiatrists trained in an era prior to these scientific advances and have not had ready access to this work. For those interested in learning neuroscience, the depth and complexity of the material may be intimidating if not overwhelming; traditional, lecture-based approaches to teaching may be relatively ineffective; and material may feel distant or inaccessible when presented in isolation--often devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the importance of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience is poised to assume in psychiatry, we continue to underrepresent this essential perspective in our work. The National Neuroscience Curriculum Initiative (NNCI) was developed to address this concern. The NNCI is an NIH-funded collaboration with the mission of developing and

disseminating clinical neuroscience teaching resources to practicing psychiatrists, residents and students. The guiding principles of the NNCI are to maintain an integrative, patient-centered approach; use evidence-based principles of adult learning through innovative and experiential learning exercises; and ensure that materials can be implemented by anyone, anywhere, regardless of content expertise. During this session, participants will be introduced to some of the NNCI's most successful strategies to incorporate a robust neuroscience perspective alongside our other rich traditions and to translate the latest findings from the bench to the bedside.

Master Courses

Saturday, May 20, 2017

Becoming Mindful: Integrating Mindfulness Into Your Psychiatric Practice
Director: Seema Desai, M.D.
Facultys: Petros Levounis, M.D., Kerry Wangen, M.D., Ph.D., Rebecca Hedrick, M.D., Sarah Zoogman, Ph.D., Matthew Diamond, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Identify how mindfulness can be a useful tool in psychiatric practice for the clinician and the patient and understand how to access online resources and case-based practice examples; 2) Participate in three mindfulness-based exercises: "Focus on Breath," "Mindful Communication" and "Mindfulness and Technology"; 3) Critique the science and evidence base for clinical applications of mindfulness in specific patient populations; and 4) Articulate important obstacles and contraindications to the use of mindfulness in treatment settings.

SUMMARY:
Interest in yoga, meditation and related 'mindfulness'-based practices has grown, including for use in individual therapy. This course is for the practitioner or trainee who is interested in sharpening her or his skills in mindfulness based on the clinical evidence base and best practice standards. This course will begin with an introduction to mindfulness, inviting participants to engage in a "Focus on Breath" exercise and group discussion led by an experienced faculty member. The next segment of the course will focus on mindfulness for the clinician. This session will involve a dyadic exercise in "Mindful Communication," followed by group discussion. This section will also assist participants in preparing for common barriers, hang-ups and contradictions in mindfulness techniques. The audience will then have a chance to learn about using mindfulness with patients through a guided discussion of the evidence base, seminal clinical trials and common patient-based applications of mindfulness. This section will also involve case-based study and question and answer query with audience. Finally, the audience will have an opportunity to consider "Mindfulness and Technology" during an interactive session highlighting and surveying relationship between the two and the relevance of technology in the field of mental health. The final section will also assist participants in evaluating and mastering technological tools for practicing mindfulness. Workshop faculty include researchers, practitioners and authors of publications on mindfulness who have successfully integrated mindfulness approaches into child and adolescent, consult and liaison, and general adult practices. Audience engagement through active question and answer discussion will be encouraged throughout the course, as well as participation in individual mindfulness exercises and case-based discussion, including audience cases and experiences. Through practice of mindfulness, clinicians themselves can cultivate an attitude of compassion, increase empathy for patients, improve their ability to attend to patients in sessions, and decrease burnout. Patients benefit through enhanced attention and emotion regulation and increased self-awareness, leading to improved overall functioning. Practicing mindfulness is learnable, teachable and enjoyable for the practitioner, with colleagues and for patients. The evidence to date points to real outcomes: improved clinician-patient relationships, enhanced qualities in the clinician, patient symptom reduction, and improved sense of well being and overall functioning in patients.

Sunday, May 21, 2017

Pediatric Psychopharmacology

Director: Karen Dineen Wagner, M.D., Ph.D.
Facultys: James J. McGough, M.D., Christopher McDougle, John T. Walkup

EDUCATIONAL OBJECTIVE:
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 childhood psychiatric disorders.

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 disorder. 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.

Monday, May 22, 2017

Street Drugs and Mental Disorders: Overview and Treatment of Dual Diagnosis Patients
Director: John W. Tsuang, M.D.
Facultys: Timothy Fong, M.D., Larissa Mooney, Reef Karim D.O., M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the issues related 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 Epidemiologic Catchment Area (ECA), fifty percent of general psychiatric patients suffer from a substance abuse disorder. These patients, so-called dual diagnosis patients, are extremely difficult to treat and are big utilizers of public health services. This course is designed to familiarize participants with the diagnosis and state-of-the-art treatment for dual diagnosis patients. We will first review the different substances 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 model versus the abstinence model for dual diagnosis patients.

Tuesday, May 23, 2017

Essential Psychopharmacology
Director: Alan F. Schatzberg, M.D.
Faculty: Charles DeBattista, M.D., D.M.H.

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

SUMMARY:
This master course in psychopharmacology will present new material on the pharmacological treatment of major psychiatric disorders. The course

will involve presentation of data, Q&A and case discussions.

Media Workshops

Saturday, May 20, 2017

***3 1/2 Minutes, Ten Bullets*: Psychiatric Perspectives on Race-Related Shooting Deaths in America**
Chairs: Ruth Shim, M.D., Sarah Y. Vinson, M.D.
Presenters: Ernesto Gonzalez, Karinn Glover

EDUCATIONAL OBJECTIVE:
1) Examine the specific case of the shooting death of an unarmed African-American teen by viewing the documentary film *3 1/2 Minutes, Ten Bullets*; 2) Consider the various systems-level contributors to recent race-related shooting deaths in America; 3) Discuss how mental health disparities, the criminal justice system and social determinants of mental health underlie these events; 4) Evaluate the diverse perspectives of those affected by race-related shooting deaths and their various portrayals in media and society; and 5) Explore the role of the psychiatrist and other mental health professionals in addressing racism, violence and extrajudicial killings.

SUMMARY:
Recent tragic events have thrust issues of race, discrimination, policing, and violence into a national spotlight. However, psychiatrists and other mental health professionals may feel conflicted about their roles and responsibilities in addressing the aftermath of these events, as well as the role of the psychiatrist in preventing future events from occurring. Furthermore, many psychiatrists may not feel they have the expertise or knowledge necessary to discuss issues of racism, discrimination and bias. In this media workshop, the Sundance-winning documentary film *3 1/2 Minutes, Ten Bullets* will serve to introduce the topic and frame a subsequent discussion on issues of racism, discrimination, implicit bias, and violence and their impact on minority populations, particularly African-American men and boys. The subsequent discussion will help psychiatrists consider their personal role in addressing racism and violence in their communities and in the United States as a whole, as well as help guide psychiatrists to begin to address racism, discrimination and implicit bias in their own practices and communities. The perspectives of the victims, the surviving family and friends, the assailants, and the surrounding community will be discussed, and the systems-level factors, including mental health disparities, the criminal justice system and the social determinants of mental health, will be considered and explored.

***Managing the Fix*: A Film About Treating Addiction in the Age of Pills**
Chair: Helena Hansen, M.D., Ph.D.
Presenters: Marc Galanter, M.D., Joel Braslow, M.D., Ph.D., Sandra Walker, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the impact of racial disparities in access to addiction pharmaceuticals on patients; 2) Weigh the advantages and disadvantages of opioid maintenance as a harm reduction measure; and 3) Explain the ways that psychosocial interventions complement pharmaceutical treatments for addiction.

SUMMARY:
This media workshop will feature a 54-minute documentary feature, *Managing the Fix,* written and directed by addiction psychiatrist and anthropologist Helena Hansen. The film portrays the complexities of treating opioid dependency with opioid maintenance (methadone and buprenorphine) by following three opioid-dependent people through the addiction treatment system in New York City. Their stories highlight racial patterns of access to care, the impact of harm reduction, and the importance of community building and the arts in addressing histories of trauma among people in recovery. Discussants will examine the policy and practice implications of racial patterns of addiction pharmaceutical promotion and use, as well as the role of harm reduction and psychosocial interventions in addiction.

Screening and Discussion of the HBO/NIAAA Documentary Film *Risky Drinking*
Chair: George Koob, Ph.D.

EDUCATIONAL OBJECTIVE:
1) State the prevalence of “risky drinking” in the

United States; 2) Describe the drinking trajectories of the four people profiled in the HBO film *Risky Drinking* and how they may relate to patients you've seen; and 3) Identify different paths to lower risk of drinking or recovery and how they may (or may not) relate to or inform your current recommendations for patients.

SUMMARY:
Nearly 70% of American adults drink alcohol, and nearly one-third of them engage in problem drinking at some point in their lives. Produced by HBO Documentary Films and The National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health, *Risky Drinking* is a no-holds-barred look at a national epidemic through the intimate stories of four people whose drinking dramatically affects their relationships. Through immersive storytelling, expert commentary and animation, this film offers a new perspective on alcohol use as it falls along a broad spectrum of risk and includes lifesaving information about what can help people dial back or stop their drinking. The film aims to provoke a much-needed conversation about how to identify risky drinking and to suggest alternatives to a one-size-fits-all approach that prevents many people from seeking help. At the conclusion of the film, Dr. George Koob, director of the National Institute on Alcohol Abuse and Alcoholism, will lead a discussion.

Sunday, May 21, 2017

***Do the Right Thing*: A Film Viewing and Discussion**
Chair: Lloyd I. Sederer, M.D.
Presenters: Patrice K. Malone, M.D., Ph.D., Alan Stone, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn about communities and the racism they can foster; 2) Learn about racism and how police action can make things worse; and 3) Consider two approaches to combating racism.

SUMMARY:
Do the Right Thing (1989) was written, directed and produced by Spike Lee, who was nominated for an Oscar for best original screenplay. Lee also played the role of Mookie, the pizza delivery man and our observer on the scene. As the heat of summer intensifies, so does the antipathy between whites and blacks in Bedford-Stuyvesant, Brooklyn. By the evening of this one-day-long story, a confrontation erupts between Sal, the Italian-American owner of a local pizza shop, and several local black characters, one a friend of Mookie's. Violence ensues, and a black man is killed by the police, which triggers a riot. More police action, meant to dispel the mob, aggravates the situation. The film concludes with a reference to the views of violence of both Martin Luther King and Malcolm X. In addition to Mr. Lee, the cast includes Danny Aiello (nominated for best supporting actor), Ossie Davis, Ruby Dee, Bill Nunn, John Turturro, Samuel L. Jackson, and Rosie Perez. *Do The Right Thing* has been recognized as one of the most culturally significant films in this country. It is a brutal window into racism and community hatreds and the violence they can spawn.

Use of Video as a Stimulus for Trauma Narratives in Vietnam Combat Veterans With PTSD
Chairs: Rohini S. Mehta, M.D., Maria Llorente, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify at least two media modalities used in narrative medicine; 2) Recognize the value of using film in clinical practice; and 3) Anticipate possible emotional reactions to the use of video and select appropriate films accordingly.

SUMMARY:
The field of narrative medicine is a burgeoning one, and one that can be particularly useful in the care of patients with combat-related PTSD. The initial portion of this media workshop will be dedicated to reviewing the general principles of narrative medicine and the role of film to facilitate group discussion. After gaining an understanding of how media modalities can be implemented in clinical practice for therapeutic benefit, the group will watch a documentary film entitled *Escape From Fire Base Kate*. This film details the story of a young commanding officer and his troops during an intense three-day siege of a small firebase near the Vietnam-Cambodia border in 1969. The primary narrative is supplied by 12 of the U.S. soldiers who were present during the siege, and the film features actual audio recordings of radio communications that occurred

between ground and air forces. The study team developed a survey questionnaire to be given to veterans after completing the viewing of this film to objectively assess emotional response, and the results of this data are currently being analyzed and will be presented during the workshop. Attendees will also be able to complete a modified survey at the conclusion of the film. The final portion of the workshop will be dedicated to an interactive discussion between the study team and participants, gauging responses to the film and discussing possible emotional reactions that may be elicited from combat veterans. As well, a guideline for choosing appropriate media modalities will be provided to clinicians treating Vietnam combat veterans with PTSD for future implementation in clinical practice.

Monday, May 22, 2017

Spray Can Junky: Psychodynamic and Behavioral Explorations of Sensation-Seeking Through the Mind-Blowing Art of *Exit Through the Gift Shop*
Chairs: Petros Levounis, M.D., Natalie Smith, Psy.D.
Presenters: Olivia Gibson, Marcus Hughes, Asha Martin

EDUCATIONAL OBJECTIVE:
1) Discuss historical, cultural and evolutionary dimensions of thrill seeking and contrast with those of graffiti art; 2) Describe the physiological changes and psychological constructs associated with sensation-seeking behavior; and 3) Define common and rare behavioral addictions according to *DSM-5* guidelines.

SUMMARY:
Exit Through the Gift Shop is a documentary film that premiered at the Sundance Film Festival in 2010 to critical acclaim and was nominated for the Academy Award for Best Documentary Feature. Frenchman Thierry Guetta is on a quest to film the greatest street artists in the world. His clandestine adventures eventually lead him to England-based graffiti artist, Banksy. The two work together until Banksy, intrigued with the filmmaker, turns the camera around and makes Guetta the subject. As one of the film's subjects will eventually say of what follows, "It is anthropologically, sociologically a fascinating thing to observe, and maybe there is something to be learned from it." The goal of this workshop is to answer this challenge and find within the film lessons meant to improve our own psychiatric acumen and, ultimately, the lives of our patients. First and foremost, this film is about packaging and repackaging. From a psychodynamic perspective, if Guetta is merely a character and the film is a mockumentary (as many have suggested), then he is a construct himself. He is the repackaging through which the audience should come to understand the absurdity of the commercialization of street art. In psychoanalysis, a skillful therapist leads the patient to take apart an experience and reorganize it in her or his mind in order to process it fully. This film masterfully walks us through a review of metaphor, narrative and psychoanalytic constructs in the organization and reorganization of the human mind. From a historical perspective, graffiti is as old as civilization itself. Its endurance attests to a primal drive to subvert and challenge convention. Is this urge a hindrance or a benefit to human progress today? It has been proposed that sensation-seeking behavior was necessary for human evolution, in which case, is it merely outdated genetic hardwiring to be overcome or the key to our continued survival? Thierry Guetta becomes obsessed with filming street artists in part because he enjoys the danger and risk involved. He and the artists are thrill seekers, so-called "adrenaline-junkies." Psychiatrists are routinely confronted with the complexities of sensation-seeking behavior and frequently called upon to distinguish among its many healthy and unhealthy manifestations. In this workshop, we will explore sensation seeking from psychodynamic, historical, artistic, neurobiological, and physiological perspectives. In addition, we will underscore the addictive aspects of such behaviors through the lens of the relatively novel paradigm of behavioral addictions (sometimes also referred to as process addictions). Dr. Levounis, co-author of the American Psychiatric Association Publishing's 2015 book *The Behavioral Addictions*, will lead a team of medical students with diverse interests and expertise in art and psychiatry in a discussion of the film and its multiple psychiatric dimensions.

Using the *Fifty Shades of Grey* Story to Learn About Psychoanalytic Concepts and Psychosexual Growth

and Development
Chair: Lawrence K. Richards, M.D.
Presenter: Michael Blumenfield, M.D.

EDUCATIONAL OBJECTIVE:
1) Use this movie in lieu of live patients to present clinical material; 2) Illustrate psychodynamics associated with human growth and development; and 3) Discern why this story has achieved such a strong interest, especially among women.

SUMMARY:
The case histories of the primary people and closely related persons in *Fifty Shades of Grey* are as follows: Anastasia Rose Steele is a normal "girl," immature in some sectors with special skills in others. She's a normal young woman about to graduate from college with honors. She's smart, she's fairly analytical, she's intermittently clumsy, she's prettier than she sees herself, and she's a virgin. Being young, she is prone to periodic poor judgement or mishaps-this occurring when she hasn't yet learned to process all the inputs to and within her CNS. Her biological father was a veteran who died early in the marriage, and her mother is on her fourth marriage; Ana's been living with her stepfather, has his last name, and fully relates to him as her father. She plans to move to Seattle and continue living with her college "roommate," the beautiful Kate with the wealthy parents. There's this rich Seattle-area genius in the business world with the proverbial Grecian God looks named Christian; his adoptive mother is Dr. Grey, who was taken with him when she examined him in the ER after police brought in this preschool child who was found with his dead mother. He's an adult now, and sees his psychiatrist regularly. He has a younger brother expert in construction and an adoring young sister who is the enthusiastic and somewhat indulged last child-and is about Ana's age. He's the area's great catch, and he's used to females falling for him. He and Ana meet; it's Jane Austen-with sex and technology. This session will provide an opportunity to learn about psychoanalysis and the brain "software" functions referred to as psychodynamics while showing the sexual aspects of human growth and development in action. Attendees will benefit from presentations by, and the opportunity to ask questions of, members of a psychoanalytic organization co-founded by one of Dr. Richards teachers, the American Academy of Psychoanalysis and Dynamic Psychiatry, as Dr. Michael Blumenfield, L.A. movie critic and a past president of AAPDP will present. Dr. Richards points out how the "life history" of the male lead (Christian) connects with major biopsychosocial forensic evolution as "appreciation" of growth and development progressed over centuries.

Tuesday, May 23, 2017

Lessons From the Birth of the Women's Movement for Today's Women's Health and Health Equity: The Film *She's Beautiful When She's Angry*
Chairs: Francis Lu, M.D., Christina Mangurian, M.D., M.S.
Presenters: Nada L. Stotland, M.D., M.P.H., Shannon Suo, M.D., Debbie R. Carter, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify what key issues the women's movement from 1966 to 1971 fought for and against; 2) Identify how a social movement of culture change for health equity affecting social determinants of mental health evolves from individual efforts to encompass collective efforts in groups and organizations; and 3) Understand the heterogeneity of the women's movement by sexual orientation, race/ethnicity, social class, and geographic region, among other factors.

SUMMARY:
She's Beautiful When She's Angry (2014, 92 minutes) is a provocative and rousing look at the buried history of the birth of the women's liberation movement from 1966 to 1971. The film offers a unique focus on local and lesser-known activists, including the Boston authors of *Our Bodies, Ourselves*, the Chicago Women's Liberation Union and grassroots organizations across the country, using never before seen archival footage, music from the period and four artful re-enactments. The film depicts the early days of the National Organization for Women (NOW). At the same time, young women, frustrated with their second-class status in civil rights and peace groups, started a new movement called women's liberation. They proclaimed that "the personal is political" and

demanded sexual equality in every part of daily life. Featuring interviews with early feminists Kate Millett, Fran Beal, Rita Mae Brown, and many others, *She's Beautiful When She's Angry* shows women fighting back with humor and sometimes with fury—daring to be "bad." *She's Beautiful When She's Angry* reveals a wide-reaching movement with women's rock bands, poetry readings and impromptu protest actions. The film shows many aspects of the movement: poets and publishers in San Francisco (Susan Griffin and Alta); lesbian activists (Rita Mae Brown and Karla Jay) who made the slur "lavender menace" into a term of liberation; Chicago women who started a pre-Roe underground abortion service (Judith Arcana and Heather Booth); and the Boston women who wrote *Our Bodies, Ourselves*, named by *Time Magazine* as one of the most important books of the 20th century. The film shows many strands of early feminism, including the voices of women of color and struggles over issues of class and lesbian rights. Major themes appear throughout the film: the struggle for freedom and equality and a woman's right to control her own body -in terms of sexuality, health care and reproductive rights. The film also links to present-day issues, showing young women inventing their own forms of feminist action, with "slut walks" protesting rape culture in New York and Texas protests over the closing of abortion clinics. That story still resonates today for women who are facing new challenges around reproductive rights and sexual violence, as the film shows present-day activists creating their generation's own version of feminism. *She's Beautiful When She's Angry* is a film about activists made to inspire women and men to work for women's health, health equity, feminism, and human rights. The director/producer is Mary Dore, an award-winning documentary producer who brings an activist perspective to her films. She has produced dozens of television documentaries for PBS, New York Times TV, A&E, and the Discovery Channel. Her TV work has won Emmys, Cine Golden Eagles and Cable Ace Awards.

Presidential Symposia

Saturday, May 20, 2017

Conducting Clinical Trials in Geriatric Psychiatry
Chairs: Mary Sano, Ph.D., Olga Brawman Mintzer, M.D.
Presenters: Mary Sano, Ph.D., Maria I. Lapid, M.D., Joan Mackell, Olga Brawman Mintzer, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the basics of clinical trial design in geriatric psychiatry, including dementia, depression and behavioral disturbances; 2) Recognize regulatory and human subject issues in clinical trials with an emphasis on geriatric psychiatry studies; and 3) Understand the operational and financial mechanics of conducting clinical trials.

SUMMARY:
Clinical trials differ from medical care in purpose, methods and risk justification, all of which have specific challenges in geriatric psychiatry. This presidential symposium will review the features of clinical trial designs for indications in geriatric psychiatry such as dementia, depression, agitation, and other behavioral disturbances. Variables that affect the operational aspects of these studies include biological targets, diagnostic criteria, outcomes measures, study duration, and data analysis. These, as well as special considerations for elderly populations, contribute to staffing decisions and recruitment strategies. The first presentation will discuss these aspects of trials; offer strategies for finding, training and retaining the appropriate work force; and describe the importance of understanding cognitive and behavioral ratings. Strategies for successful recruitment from multiple sources of potential participants by building lasting bonds to engage aging communities will be presented. The second presentation will decipher regulatory guidelines and requirements and focus on the obligations of the principal investigator. The historical perspective will be presented, which leads to the current expectation of good clinical practice (GCP) to ensure reliable and humane approaches to research. This will include the understanding of the Code of Federal Regulations (CFR) Title 21: how to comply with GCP. Delegation of roles will be discussed. Requirements for successful site selection, regulatory record keeping, site visits, and understanding and preparing for the monitoring and auditing process will also be discussed. The third presentation will discuss the role and purpose of the institutional review board (IRB) in clinical trials and

review IRB considerations in clinical trials pertinent to geriatric, psychiatric and/or vulnerable subjects. Considerations for capacity assessment, identification of a legally authorized representative, informed consent, and protection for vulnerable subjects will be discussed. The fourth presentation will offer guidelines for determining whether a particular trial is a good fit for your practice. Evaluating the match between your practice or community and features such as entry criteria, work load, staff and space resources, and study length are critical to success. A sample of "site-interest surveys" will be presented. This presentation will also discuss the contract and budget negotiations and evaluating the financial risks and benefits of a trial. Analyzing clinical trial agreements, including indemnification, payment schedule and screen failure reimbursement, is critical to ensure a financially sound program. Topics will include determining the true cost of procedures, assessing hidden costs and savings, negotiating with sponsors and vendors, and billing oversight. The discussion will provide insight to how these principles apply to specific trials in dementia, geriatric depression, agitation, and other behavioral disturbances.

Paving the Way to Improving Global Mental Health in High- and Low-Resource Countries
Chair: Milton Wainberg, M.D.
Presenters: Gary Belkin, Annika Sweetland, Dr.P.H., M.S.W., Francine Cournos, M.D., Pamela Collins

EDUCATIONAL OBJECTIVE:
1) Have a better understanding of the global mental health treatment gap; 2) Have a better understanding of what has been done in the past to address the gap; and 3) Have a better understanding what needs to be done in the future to address the gap.

SUMMARY:
The Global Burden of Disease Study 2010 not only corroborated findings from 1990 about the significant burden of mental and substance use disorders, but it also determined that the burden of these disorders had worsened. Mental and substance use disorders are now the leading cause of years lived with disability globally. Lack of human resources, poor to no financing, weak governance, and mental illness illiteracy and stigma all contribute to the global mental health treatment gap, which in comparison to high-income countries is worse in low- and middle-income countries and in low-resource settings of high-income countries. The goal to vastly spread access to care in low-resource settings requires multiple strategies to increase resources and capacity building to implement and scale up effective interventions for the prevention and treatment of mental and substance use disorders. In spite of this well-documented global burden of mental illness, both inherent risks for and devastating impact on other comorbidities, including communicable (e.g., HIV, tuberculosis) and non-communicable diseases, efforts to address the global mental health treatment gap have been sparse in comparison to the well-funded (nonmental health) global health programs. Concerns about the low research to practice and policy yield are far worse in the mental health field, even in high-income countries. The global mental health treatment gap requires investing in implementation science with participatory approaches and practice-based production of research in low-resource settings of high-income countries, as well as in low- and middle-income countries. This symposium will discuss methods to address the global mental health research and treatment gap.

Sunday, May 21, 2017

Diversity Issues in Psychotherapy
Chair: David L. Lopez, M.D.
Presenters: Allan Tasman, M.D., Karimi G. Mailutha, M.D., M.P.H., Deborah Cabaniss, M.D., Elise W. Snyder, M.D.
Discussant: Elizabeth L. Auchincloss, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify and understand the issues that arise when sociocultural diversity (different backgrounds between psychotherapist and patient) is present; 2) Learn psychodynamic psychotherapy techniques that have improved treatment outcomes when there are sociocultural differences between psychotherapist and patient; and 3) Learn about the learning processes and self-exploration that different psychotherapy experts have been through, as they have encountered sociocultural diversity.

SUMMARY:
For decades, psychiatrists who treated patients in psychodynamic psychotherapy assumed that all patients responded to classical technique in the same manner. Only recently have psychodynamic psychiatrists realized that sociocultural diversity requires the therapist to modify how information is processed and how it is conveyed to the patient. From the first contact on the telephone to how an interpretation is delivered, diversity has taken an increasingly central role in establishing rapport and understanding the individual within his environment. The training process in psychodynamic psychotherapy includes developing a rapid, visceral ability to connect at an interpersonal emotional level. This is done through intuitively identifying speech patterns and personal styles of communication that the therapist notices from the first contact. The therapist then uses these observations to best deliver information to the patient. For example, a psychotherapist quickly learns to be very precise with an obsessive patient or to tolerate the self-importance of the narcissistic one. Only recently has the understanding of diversity been included in the repertoire of the psychodynamic psychiatrist, since the sociocultural differences will make these patterns look different depending on the patient's background. For a psychodynamic psychiatrist, the modifications to the technique to be diverse-competent will seem obvious since these increase the interpersonal connection. The intense emotional bond between patient and therapist that occurs in psychodynamic psychotherapy allows the patient to realize when his therapist is not diverse-competent. Very often, patients feel that therapists who are not diverse-competent only understand their problems partially. This can interfere with treatment, and in some instances, it will derail it to the point of failure or abandonment. Therapists who become aware of this new area of study can now identify and correct it. Being diverse-competent does not mean understanding all cultures or social environments, but rather following an ongoing process. The first step is becoming aware of one's limitations in this area and then developing openness and interest for other sociocultural backgrounds. The final step is being willing to question one's biases related to other sociocultural backgrounds and accepting them without assigning subjective labels. As simple as this may seem, in practice this is a complex task since very often some of these diverse factors are intertwined with frank pathology. Being able to distinguish between diverse non-pathological factors and diverse pathological factors is the purview of the most seasoned psychodynamic psychiatrists. This symposium provides the opportunity to update therapists in this new area of study with examples provided by seasoned therapists, as well as therapists who come from other cultures and have encountered their own challenges.

Should Unsuccessful Suicide Attempters Be Allowed to Die? Life and Death Decisions on the Consultation-Liaison Service
Chair: J. Michael Bostwick, M.D.
Presenters: J. Michael Bostwick, M.D., Lewis Cohen, Rebecca Brendel

EDUCATIONAL OBJECTIVE:
1) Learn to distinguish behaviors lumped under a general “suicidality” rubric that constitute phenomena as diverse as noncompliance and requests to discontinue life-sustaining treatment; 2) Appreciate an emerging entity in which patients with recent suicide attempts ask not to be psychiatrically “revived” but rather to be allowed to die; and 3) Consider how the American ethical and legal landscape regarding end-of-life decision making is evolving as more states endorse physician-assisted suicide.

SUMMARY:
Among the most common requests a consultation-liaison (C/L) psychiatry service receives is for assistance in assessing and managing suicidality. Some patients have voiced what appears to be suicidal ideation. Others have been admitted to a nonpsychiatric service after suicide attempts serious enough to require ongoing medical or surgical care. In the first instance, the C/L psychiatrist has to sort out the nature of the "suicidality," a term applied generically to phenomena as diverse as noncompliance, self-injurious behavior without intent to die or desire to end treatment. In the second instance, the team asks for help with a patient's disposition when post-attempt medical or

surgical care is completed. The C/L psychiatrist must have familiarity with relevant legal statutes. This symposium proposes a model aiming to distinguish, on the one hand, "suicidal" phenomena based on if the patient collaborated with family, friends or doctors in deciding to pursue acts that could hasten the end of life and, on the other, if the desire of the act called "suicidality" was intended to hasten death. The model argues that painting disparate entities with the same broad brush obscures differences among them that-once clarified-can help to guide decision making about the nature of treatment the patient requires. The symposium will then present a rarely described entity in which patients who, having made grievous attempts on their lives, in the wake of these attempts ask to be allowed to die rather than to be transferred to a psychiatric facility for further treatment. These cases challenge prevailing assumptions that suicidal behavior is always driven by depression that-once vanquished-will restore the suicidal person's desire to live. They also draw into question an implicit assumption that those with recent self-harm lack the capacity to make decisions on their own behalf about the nature of ongoing care, specifically when their wishes to end restorative care conflict with medical mandates to preserve life at almost all costs. The question of whether unsuccessful suicide attempters should be permitted to die arises against a background in which the American ethical and legal landscape is changing as more states endorse patients' rights to ask for physician-assisted suicide (PAS) to control their destinies as life nears its end. A third component of this symposium will summarize current American statutes regarding PAS, as well as ethical and legal principles that enter when recently self-destructive patients ask to be permitted to die. In sum, symposium attendees will consider a model for distinguishing various behaviors lumped under the general rubric of "suicidality," learn about an emerging entity in which patients with recent suicide attempts ask not to be psychiatrically "revived," and explore evolving ethical and legal implications.

Monday, May 22, 2017

Medicinal Cannabis
Chair: Igor Grant, M.D.
Presenters: Mohini Ranganathan, M.D., Staci Gruber, M.D., Daniele Piomelli, M.D., Ph.D., Thomas Marcotte, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the endocannabinoid basis of cannabinoid action; 2) Understand the known and likely medicinal benefits of cannabis; and 3) Explore the therapeutic potential in neuropsychiatry of cannabidiol.

SUMMARY:
Cannabis has been used as a therapeutic agent for millennia and was part of the U.S. pharmacopeia until the 20th century. Recent progress in understanding neurobiology of the endocannabinoid signaling system has provided an improved scientific basis for examining the mechanisms of therapeutic action of the cannabinoids. A number of clinical trials have provided moderate to strong evidence that cannabis may be useful in the management of neuropathic pain, spasticity of multiple sclerosis, improving weight gain with patients with cachexia, and reducing nausea and vomiting. Newer research suggests the possibility that some cannabinoids may be promising in the treatment of certain forms of epilepsy, anxiety disorders and possibly schizophrenia. The challenges for the future will be how to standardize cannabis purity and dosage and deliver it in a form that is as well controlled as other medications. Additional promising areas include the development of novel molecules that in various ways modify the functioning of the endocannabinoid system.

Neuroscience-Based Nomenclature (NbN) for Psychotropic Drugs: Progress Report and Future Plans
Chair: David J. Kupfer, M.D.
Presenters: Joseph Zohar, M.D., Michael J. Travis, M.D., Deborah Bilder, M.D., Stephen M. Stahl, M.D., Ph.D.
Discussant: Pierre Blier, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Briefly review the current problems with the existing nomenclature; 2) Introduce a new language based on pharmacology and proposed mode of action for existing and new compounds; 3) Identify avenues for dissemination and training of M.D.s and

other mental health professionals; 4) Identify systems for incorporating new compounds and new clinical targets into the NbN system; and 5) Ensure its international adoption and outline plans for revisions over the next five years.

SUMMARY:

This presidential symposium will provide a clear framework how the neuroscience-based nomenclature (NbN) can be used to improve our understanding of psychiatric drugs and how such a new language will benefit translational neuroscience and provide an asset for new treatments for brain disorders. The current lack of precision, noted by clinicians as well as patients, is slowing advances in this field. The approach taken by the NbN has several advantages, including 1) a much better connection to basic and clinical neuroscience; 2) greater precision arising from a nomenclature based on modes of action rather than the disorder or disorders for which a compound was initially approved; 3) reduced stigma associated with taking a compound that may bear the name of a disorder or symptom, such as psychosis, from which the patient does not even suffer; and 4) greater ease in educating professionals, patients and their families about psychopharmacology. Furthermore, the availability of an informational app that can be revised periodically by expert consultation can facilitate overall dissemination and rapid adoption by journal editors, reviewers and those who are contributing to the scientific literature. This update on the NbN project will describe new developments and proposed new directions. The endorsement of the five international organizations continues, and editors of 22 scientific journals are now supporting this development through editorials and commentaries. Presentations to a variety of research and clinical audiences are ongoing. Two major new major initiatives include education and training efforts for psychiatric clinicians, trainees and other mental health professionals. Second, the area of child and adolescent psychopharmacology will be pursued actively. This symposium will begin with a brief introduction to the present NbN app (Joseph Zohar) and will be followed by a presentation by Michael Travis on the implications for residency education. Deborah Bilder will then discuss the application of the NbN to the treatment of children and adolescents. Stephen Stahl will discuss the implications for the major psychiatric disorders. Finally, Pierre Blier will serve as discussant of the above presentations and talk briefly about the Canadian experience.

Tuesday, May 23, 2017

Crucial Developments in the Practice of Geriatric Psychiatry

Chairs: Daniel D. Sewell, M.D., Rajesh R. Tampi, M.D., M.S.

Presenters: Jürgen Unützer, M.D., M.P.H., David Oslin, Brent Forester

EDUCATIONAL OBJECTIVE:

1) Enumerate the evidence for integrated care models in the care of older adults with depression; 2) Highlight different integrated care models both in the private sector and the Veterans Administration health care system; 3) Review the experience of rural patients with the Pennsylvania Program of All-Inclusive Care for the Elderly (PACE); and 4) Discuss the role of a geriatric psychiatry consultation liaison service in an integrated health care system.

SUMMARY:

The population of the United States is aging. Currently, 13% of the population, or approximately 41 million individuals, is over the age of 65. This number is projected to increase to over 80 million by 2050. It is estimated that approximately 20% of these older adults also have diagnosable psychiatric illness. Available evidence indicates that over one-fifth of older adults with diagnosable psychiatric illness also have a comorbid medical illness. These individuals with comorbid medical/surgical and psychiatric disorders have higher rates of morbidity and mortality than individuals without medical/surgical comorbidities. Additionally, the cost of care for individuals with comorbidities is significantly greater than the cost of care for individuals without comorbidities. Given the available evidence, it is important for older individuals with comorbid psychiatric and medical and/or surgical illnesses to be provided appropriate follow-up care from a mental health clinician. Studies evaluating the effectiveness of integrated care models for these high-risk individuals have

shown promising results. The American Association for Geriatric Psychiatry (AAGP), a national leader in the care of older adults with psychiatric illness, is promoting the use of integrated care models for improving the care of vulnerable older adults. In this symposium, we will first review the evidence for using integrated care models in the care of older adults with depression. We will then review the integrated care models both in the private sector and the Veterans Administration health care system. Next, we will review the experience of rural patients with the Pennsylvania Program of All-Inclusive Care for the Elderly (PACE). Finally, we will discuss the role of a geriatric psychiatry consultation liaison service in an integrated health care system.

Demystifying Psychodynamic Psychotherapy
Chairs: Deborah Cabaniss, M.D., Cristina Alberini, Ph.D.
Presenters: Cristina Alberini, Ph.D., Deborah Cabaniss, M.D., Otto F. Kernberg, M.D., Barbara Milrod, Catherine E. Monk, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand basic science research that investigates psychodynamic concepts; 2) Understand clinical research that investigates psychodynamic concepts and treatment; and 3) Understand educational methods that clearly convey psychodynamic concepts and treatment to students and patients.

SUMMARY:
The problem of psychoanalysis is not the body of theory that Freud left behind, but the fact that it never became a medical science. It never tried to test its ideas. Psychodynamic psychotherapy, Freud's original "talking cure," has been used clinically for over 100 years, yet despite the fact that the clinical and theoretical insights produced by psychoanalysis and psychodynamic therapy are vast and deep, the underlying scientific bases remain largely unstudied. This gap leads to the somewhat "mystical" reputation of this mental health discipline. Today, we have the know-how, interest and motivation to renew the investigation of psychodynamic psychotherapy and to thus "demystify" it. The aim is not to prove or disprove Freud's writings, but rather to use psychoanalytic concepts and treatment as starting points for deepening the understanding of the mind, mental health diagnoses and treatments. This presidential symposium, co-chaired by Cristina Alberini, a neuroscientist and psychoanalyst, and Deborah Cabaniss, a psychodynamic psychotherapy educator and author, will consider maps for moving toward using psychodynamic concepts and treatment to further understand the mind and brain.

Improving Police Response to Persons With Mental Illness
Chair: Emily A. H. Keram, M.D.
Presenters: Debra Pinals, M.D., Tashia Hager, Liesbeth Gerritsen
Discussant: Jeffrey S. Janofsky

EDUCATIONAL OBJECTIVE:
1) Learn about local and national programs aimed at improving police response to persons with mental illness; 2) Gain practical knowledge that supports and enhances skills in developing and improving law enforcement training, consultation and operations; and 3) Gain familiarity with core police practices, including use of force decision making.

SUMMARY:
This presidential symposium, presented by the American Academy of Psychiatry and the Law, is an effort to foster APA members' interest in working at the interface of law enforcement and mental illness. The use of force by law enforcement (LE) has come under increasing public scrutiny in the wake of recent high-profile officer-involved shootings nationwide. Several of these incidents have focused attention on police contact with mentally ill subjects. Mental health clinicians bring unique expertise to law enforcement training, consultation and operational support that can improve police response to this vulnerable population. Dr. Keram and Dr. Pinals will review various models of law enforcement mental health training and response to individuals in crisis. Training materials and suggestions for developing an effective approach to teaching this unique population are reviewed, with an emphasis on the importance of trauma-informed law enforcement response. It is well recognized that histories of trauma can be associated with aggression, irritability and hypervigilance, all of which can contribute to an escalated interaction

with law enforcement. State academy-level and in-service trainings for police in several states have incorporated elements of information surrounding trauma-informed approaches to de-escalation. Dr. Pinals will review the rationale of this approach, as well as a description of some of the teaching points. The speakers will review the operational support services psychiatrists provide to law enforcement agencies. Real time consultations are provided to crisis (hostage) negotiators, SWAT and others. Post-incident consultation includes support for officers involved in traumatic incidents. Recent additions to consultation are "inoculation" training and annual check-in programs for crime scene investigators. The potential for and suggestions to avoiding dual agency conflicts are reviewed. Finally, the speakers will present an example that illustrates actual operational consultation. Portland, Oregon, is succeeding in improving LE contacts with the mentally ill. In 2012, the Portland Police Bureau and the United States Department of Justice entered a settlement agreement following several high-profile incidents, resulting in the creation of the Bureau's Behavioral Health Unit. Members of the unit will describe its four tiers of police response to the mentally ill: crisis intervention training, the Enhanced Crisis Intervention Team, the proactive Behavioral Health Response Team, and the Service Coordination Team. A role-play training exercise will be demonstrated as well. Finally, in 2016 the International Association of Chiefs of Police (IACP) convened an advisory group to update their initiative "Improving Police Response to Persons With Mental Illness." Dr. Keram, who served on the advisory group, will outline its "One Mind Campaign," an effort to advance delivery of these services nationwide.

Specifying If and When an Intense Suicidal Crisis May Occur: Proposed New Syndromes and New Directions on Acute Risk

Chair: Thomas Joiner, Ph.D.
Presenters: Jessica Ribeiro, Igor Galynker, M.D., Ph.D., Jan Fawcett, Greg Hajcak

EDUCATIONAL OBJECTIVE:

1) Describe the features of new proposed suicide-related syndromes; 2) Discuss new research directions on agitation's and insomnia's roles in suicidal behavior; and 3) Discuss new research on machine learning approaches to suicide risk.

SUMMARY:

The overall theme of this presidential symposium is to describe proposed new suicide-related syndromes, as well as new research and concepts focused on acute risk for suicidal behavior. Specifically, Dr. Joiner will propose the new syndrome of acute suicidal affective disturbance (ASAD) and discuss its reliability, validity and clinical utility, as well as consider any possible unforeseen harm the establishment of new suicide-related diagnostic entities may cause. ASAD's features include a geometric increase over hours or days in intent for death by suicide, an intractable sense of disgust with self and/or others, and overarousal (i.e., at least two of agitation, marked irritability, insomnia, and nightmares). Dr. Galynker will describe suicide crisis syndrome, a similar but not identical syndrome to ASAD, with an emphasis on a hopeless sense of entrapment. Dr. Ribeiro will discuss new developments in machine learning approaches to acute suicide risk assessment, taking prediction sensitivity and specificity to some of their highest levels to date, and Dr. Fawcett will discuss a research program on the role of agitation in suicide risk. Finally, Dr. Hajcak will discuss new electrophysiological findings involving a potential brain signature of the transition from suicidal ideation to suicidal behavior.

Teaching With Technology

Chair: Sheldon Benjamin, M.D.
Presenters: Carlyle Chan, M.D., John Luo, M.D., Art Walaszek, Michael J. Travis, M.D.

EDUCATIONAL OBJECTIVE:

1) Organize email in a fashion that promotes efficiency; 2) Learn how to create more engaging LCD slide presentations; 3) Learn about alternatives to PowerPoint that may improve engagement; 4) Improve online security with safer passwords, public Wi-Fi access and cloud backup; and 5) Utilize an easy method for creating teaching videos.

SUMMARY:

New technology will never replace good teaching, but it can make good teachers into more effective

ones. Most psychiatric educators are digital immigrants, and many feel that they don't have sufficient time to sample the apps that seem to constantly emerge. In addition, frequent news about online security breaches has made the use of Internet applications seem even more daunting. This symposium will focus on electronic resources for psychiatric educators and practitioners based on workshops that have taken place at the American Association of Directors of Psychiatry Residency Training. A mix of in-depth and brief presentations will be used to allow participants to sample as many applications as possible. Emphasis will be placed on demonstrating the basics of readily available technology while recommending techniques that will improve online security. Participants will learn from five career psychiatric educators how to 1) impose order on the chaos of their email inbox; 2) take control of their online identity while discovering information about themselves from previously unknown sites; 3) safely access public Wi-Fi nodes; 4) create secure passwords; 5) use cloud computing solutions to back up data; 6) easily create videos for use in teaching; 7) format PowerPoint slides to increase audience impact; 8) utilize Prezi as a PowerPoint alternative to structure presentations as metaphors; and 9) use Explain Everything, a whiteboard app that can be deployed to create content for flipped classrooms, live classroom use or use in patient education. Emphasis will be placed on consideration of the risks and benefits of each technology in education and on specifics of how to use each technology demonstrated. Participants having laptops or tablets with cellular Internet access may wish to bring them to the session. "How-to" handouts will be provided for download by participants.

Wednesday, May 24, 2017

Cannabis Use Disorders: Management, Emerging Issues, and Best Practices for the General Psychiatrist

Chairs: Kevin Gray, Christina Brezing
Presenters: A. Eden Evins, M.D., M.P.H., Laurence Westreich
Discussant: Frances Levin

EDUCATIONAL OBJECTIVE:

1) Diagnose and treat patients with cannabis use disorders and co-occurring psychiatric disorders, including PTSD, psychotic disorders and ADHD, based upon the latest scientific evidence; 2) Identify and manage important issues specific to adolescents with cannabis use disorder; 3) Recognize emerging issues related to cannabis in the workplace; and 4) Understand current and future applications of mobile health in the assessment and treatment of cannabis use disorders.

SUMMARY:

Cannabis is the most widely used illicit drug in the United States. Social and policy trends, as reflected in national surveys and state legislation, demonstrate increasing acceptance and use of cannabis with decreasing perception of harm, which will likely result in an increased occurrence of cannabis use disorder, making cannabis use disorder an already large and growing problem. As with other substance use disorders, cannabis use disorder commonly co-occurs with non-substance-related psychiatric disorders, putting all psychiatrists at the front lines to identify and address cannabis use and treat cannabis use disorders. The combination of a quickly growing and evolving body of evidence around cannabis use and psychiatric disorders, particularly in vulnerable populations like adolescents; no FDA-approved medication treatments; and an ever-changing legal landscape around cannabis poses challenges for clinicians across different treatment settings. This symposium will provide the latest information with regard to cannabis use disorders and co-occurring psychiatric disorders in addition to highlighting emerging issues in adolescents, applications of technology and workplace concerns regarding cannabis use. First, we will present the latest evidence with regard to the complex and bidirectional relationships between cannabis use and non-substance-related psychiatric disorders, including PTSD, psychotic disorders and ADHD, highlighting treatment considerations. Second, we will review topics specific to cannabis use and cannabis use disorders in the important subpopulation of adolescents. Then we will discuss the current environment around mobile health applications for cannabis use and future directions technology may point us in toward improving assessments and treatment of cannabis use

disorders. Finally, we will review how the changing state laws around the legalization and medicalization of cannabis are confronting employers with new and complex issues around employees' use of cannabis. The symposium will conclude with a lively discussion on the topics we covered. Ultimately, we aim to help all psychiatrists feel more comfortable diagnosing and treating patients who suffer from cannabis use disorders in addition to recognizing major issues as a result of the changing landscape with regard to laws on cannabis and fast-paced technological advances.

Current Issues in Child and Adolescent Psychiatry
Chair: Gregory K. Fritz, M.D.
Presenters: Karen Dineen Wagner, M.D., Ph.D., John T. Walkup, James J. McGough, M.D., Eraka Bath, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the unique aspects of pediatric integrated care, why it is often overlooked and a screening/early intervention/prevention model as applied in a primary care setting; 2) Describe evidence-based treatments for bipolar disorder in children and adolescents; 3) Identify the risks for commercial sexual exploitation and the commonly associated mental health problems for this population; 4) Describe one difference in both phenomenology and treatment for chronic vs. episodic irritability in youth; and 5) Identify the disorders associated with failure to launch, the ages of onset for various psychiatric disorders that impact failure to launch, and how lack of treatment for early-onset psychiatric disorders lead to accumulated disability and vulnerabilities for severe maladaptive behaviors.

SUMMARY:
This presidential symposium highlights some key updates relevant to all child and adolescent psychiatrists (CAPs). Dr. Fritz begins the symposium with a talk that provides the theoretical and empirical underpinnings of the movement toward pediatric integrated care. Many CAPs are unfamiliar with the rationale behind integrated care and uncomfortable with the significant changes in practice that are proposed. This presentation addresses those concerns. Barriers to implementing integrated care models in our current health care delivery system are addressed. Dr. Wagner then discusses the course of bipolar disorder in youth and provides an update of evidence-based treatments. Dr. Walkup describes the course of untreated anxiety as it moves into adolescence and young adulthood and describes the treatment strategies required to reduce the young person's anxiety and build needed adaptation and coping skills required for adult functioning in the context of family involvement. The underrecognition and undertreatment of anxiety disorders in childhood or early adolescence has left a large percentage of anxious older adolescents and young adults struggling with the transition to adulthood. The failure of anxious older adolescents and young adults to achieve independence is the result of untreated anxiety, cultural forces, and child rearing practices that emphasize parental overprotectiveness and accommodation of avoidance behavior. Treatment of these patients requires a multimodal approach that includes substantial family involvement. Dr. McGough then presents data from a pilot controlled study of stimulant plus SSRI for severe mood dysregulation. Chronic irritability and associated outbursts in youth are largely addressed with antipsychotic medication, but emerging work suggests that stimulants and SSRIs might provide measurable treatment benefit with less side effect risk. Results of Dr. McGough's pilot study are consistent with other reports suggesting stimulants are a first-line therapy for chronic irritability. In spite of small sample size, SSRI-therapy appears to provide added improvement in some patients. Definitive controlled trials in larger samples are necessary to establish a firm evidence base for treating severe mood dysregulation and related disorders. Dr. Bath reviews her work with sexually exploited girls, who often exhibit their traumatic experience through substance use-related behaviors, such as running away, and disruptive behaviors that increase their contact with the law. The lack of well-established intervention strategies reflects a poor understanding of the unique needs of this population and how best to deliver these services. Court settings may represent a reliable way to reach commercially sexually exploited youth (CSEY). The Succeeding Through Achievement and Resilience (STAR) Court, a specialty diversion court in Los Angeles, is a model program that provides

mental health and substance use treatment to CSEY on probation for prostitution-related charges.

From Extreme Environments to Therapeutic Landscapes: Race, Psychiatry and the Legacy of Chester Pierce
Chairs: Ezra Griffith, M.D., Helena Hansen, M.D., Ph.D.
Presenters: Maria A. Oquendo, M.D., Ph.D., Anita Everett, M.D., Saul Levin, M.D., M.P.A., David Williams, Ph.D., Carl C. Bell, M.D., Mindy Fullilove, M.D., Helena Hansen, M.D., Ph.D.
Discussant: Ezra Griffith, M.D.

EDUCATIONAL OBJECTIVE:
1) List at least three social determinants of racial inequality in mental health; 2) Explain the proposed institutional mechanisms of their action; and 3) Describe at least three actions psychiatrists can take to address institutional racism in their practices and their advocacy.

SUMMARY:
This presidential symposium will honor the late Dr. Chester Pierce, an important figure in the history of the APA who put race and racism on the official agenda of the organization over four decades ago. The symposium will bring together thought leaders in the fields of institutional racism, race as a social determinant of health and institutional mental health interventions. The discussion will begin with an overview of the way race and racism shape mental health outcomes in the contemporary U.S., including the impact of law enforcement, educational and income inequalities, housing segregation, and community mistrust on public mental health systems. Speakers will then propose a range of interventions psychiatrists can make to stem institutional racism as a determinant of their patients' mental health. The symposium will conclude with reflections on applications of Dr. Pierce's theories of extreme environments and therapeutic landscapes in contemporary psychiatric practice, research and policy advocacy, as well as their implications for the activities of the APA.

Psychiatric Services **Gold Star Paper: "Isn't It Time to Change Usual Care to Measurement-Based Care?"**
Chair: Lisa B. Dixon, M.D., M.P.H.
Presenters: John Fortney, Ph.D., Jürgen Unützer, M.D., M.P.H., Lori Raney, M.D., Mark Williams

EDUCATIONAL OBJECTIVE:
1) Discuss the empirical support for measurement-based care (MBC); 2) Provide examples of implementation of MBC and clinical impact on outcomes; and 3) Understand the policy implications of recent initiatives designed to promote adoption of MBC.

SUMMARY:
Measurement-based care (MBC) refers to the systematic administration of symptom rating scales and using the results to drive clinical decision making at the level of the individual patient. The feasibility of MBC adoption has been demonstrated in several large-scale pragmatic trials and clinical demonstration projects, but adoption in usual care has lagged. Recently, providers, advocates, policymakers, payers, and regulators have sought consensus around adoption of MBC, which raises the importance of ensuring that psychiatrists remain informed and on the leading edge of this shift in what is accepted for "usual care." As not all stakeholders agree on the value of MBC, this symposium will address the key questions and engage the audience in dialogue. The presenters in this symposium have reviewed the evidence for MBC and have extensive experience in research, policy, clinical practice, and payment models. We will present evidence to support the feasibility of adoption of MBC in primary care and mental health care settings and discuss opportunities for transforming usual care, including system transformation supports (e.g., existing integrated care training that facilitates MBC) and policy changes (e.g., ACA, MACRA) that will influence adoption. There are numerous brief structured symptom rating scales that have strong psychometric properties. Randomized controlled trials of interventions with timely feedback of patient-reported symptoms to the provider as part of medication management and psychotherapy consistently reported better outcomes when compared to usual care. Presenters will also summarize evidence for ineffective approaches, including one-time screening, assessing symptoms infrequently and providing feedback to

providers outside the context of the clinical encounter. In addition to the primary gains of measurement patient care for individual patients, aggregated patient data create additional opportunities for provider/clinic quality improvement, demonstrating value to payers, promoting population health and ultimately achieving health equity. The barriers to adopting MBC are worthy of a concerted effort to engage-its time has come.

Sticky Floor or Glass Ceiling? An Open Panel Discussion About Keeping and Advancing Women in Academic Psychiatry
Chair: Cheryl B. McCullumsmith, M.D., Ph.D.
Presenters: Anita Raj, Ph.D., Gail Erlick Robinson, M.D., Karen Cropsey, Psy.D., Robert McCullumsmith, M.D., Ph.D., Erika Saunders, M.D.
Discussant: Apoorva Mandavilli

EDUCATIONAL OBJECTIVE:
1) Understand key factors associated with lack of retention and senior parity for women in academic psychiatry; 2) Understand the impact of a lack of representation of women as speakers at national meetings; 3) Understand systematic and individual process improvements that can aid advancement of women in academic psychiatry; and 4) Share our stories and bond as women and men interested in promoting women in academic psychiatry.

SUMMARY:
Women are entering medicine and psychiatry in record numbers, now representing 50% or more of entering medical students, neuroscience graduate students and psychiatry residents. However, retention of women in academics and the representation of women as speakers at national meetings and in senior positions in academic psychiatry still lags behind. This symposium will engage the audience with our panelists to discuss several topics critical to the advancement of women in academic psychiatry, including retention of women faculty in academic settings; representation of women as speakers at national meetings; and advancement of women to senior academic positions such as chair, dean and president. Strategies that work for both individual and institutional development will be proposed. Panelists will discuss career trajectories and personal experiences, and then the symposium will be open for interactive discussion and problem solving. The symposium discussant will be Apoorva Mandavilla, an award-winning science journalist and founding editor and editor-in-chief of @Spectrum, an authoritative news source for scientists interested in autism. She has contributed to the *New York Times* and other publications on issues of gender equity in science and medicine. Panelists include Gail Robinson, M.D., professor of psychiatry and obstetrics/gynecology at the University of Toronto and the director of the Women's Mental Health Program, UHN, and president-elect of the American College of Psychiatrists; Anita Raj, Ph.D., director of UCSD's Center of Gender Equity and Health and professor in the Division of Global Public Health, Department of Medicine. Dr. Raj has published extensively on gender inequity issues from the results of the National Faculty Survey through the Association of American Medical Colleges (AAMC) Group on Women in Medicine and Science. Karen Cropsey, Psy.D., associate professor at the University of Alabama at Birmingham, author of "Why Do Faculty Leave? Reasons for Attrition of Women and Minority Faculty From a Medical School;" Erika Saunders, M.D., chair and director of the mood disorders program of the Department of Psychiatry at Penn State College of Medicine; and Cheryl McCullumsmith, M.D., Ph.D., and Robert McCullumsmith, M.D. Ph.D., associate professors at the University of Cincinnati Department of Psychiatry and Behavioral Neuroscience.

Rapid-Fire Talks

Saturday, May 20, 2017

Rapid-Fire Talks: Focus on Depressive Disorders

No. 1
Chronic Illness Self-Care Among Latinos With Depression in Program for All-Inclusive Care for the Elderly: Strategies to Improve Quality of Care
Presenter: Anne Escaron, Ph.D., M.P.H.
Co-Authors: Michael Hochman, M.D., M.P.H., Pearl Iwao, M.S.W., Maria Aranda, Ph.D., M.S.W., M.P.A., Martin Serota, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify workforce and contextual factors with the potential to improve the standard of care in one federally qualified health center; 2) Learn how this information may help health center operations plan for and support quality improvement efforts; and 3) Discuss strengths and limitations of federally qualified health center resources to improve the standard of care.

SUMMARY:
Background: The increasing prevalence of chronic illness among older adults necessitates the development and implementation of integrated medical and social community-based long-term care services. AltaMed Health Services Corporation, federally qualified health center (FQHC) and IPA in Southern California, is an optimal setting to promote chronic illness self-care with the goals of reducing disability and improving quality of life in a cost-effective manner among a low-income Latino population. The purpose of this case study is to describe promising strategies to improve quality of care for Latinos 55 and over with depression through the culturally tailored Programa Esperanza-or Project Hope-randomized controlled trial. **Methods:** The USC School of Social Work developed this behavioral activation approach for a Latino geriatric patient population, in which bachelor's-level social workers and health educators deliver individualized, bilingual problem solving therapy (PST) sessions to participants involving a series of sessions to promote self-care for a range of chronic illnesses including type II diabetes and arthritis. For the study, participants from AltaMed's Program for All-Inclusive Care for the Elderly (PACE) were screened for cognitive status and depression. Those screening positive were randomized to either the PST or usual care group. Study outcomes were tracked by interventionist self-report at the site level. The USC team generated research progress reports. **Results:** To date, 1,047 potential participants were screened, and 185 were enrolled in the program. Of those enrolled, 22 participants have received all sessions, and 53 participants are still completing sessions with interventionists. Key challenges include access to private spaces for sensitive conversations, identification of prospective study participants, maintenance of continuity between sessions, and interventionists juggling multiple competing duties in the highly regulated PACE setting. Anecdotal evidence to date suggested social work supervisors play a key role in working around internal barriers to screening, enrollment and intervention delivery. **Conclusion:** Programa Esperanza represents a novel approach for promoting self-management skills among older Latinos with comorbid depression. Participants report positive perceived benefits, though we await objective results from this randomized trial. Lessons learned from this study suggest that changing the standard of care in FQHCs must include empowering frontline staff with the resources they need to have the desired impact. For FQHCs taking on research partnerships, building on existing accurate quality and outcomes tracking systems and existing workflows are an essential component for study success.

No. 2
Scopolamine—The Other Rapid-Acting Antidepressant: Clinical and Preclinical Neurobiolgical and Behavioral Findings
Presenter: David Janowsky, M.D.

EDUCATIONAL OBJECTIVE:
1) Delineate scopolamine's anticholinergic antidepressant effects; 2) Integrate adrenergic-cholinergic balance hypothesis with scopolamine's antidepressant effects; and 3) Compare the effects of ketamine with scopolamine in depressed patients and animal models.

SUMMARY:
Background: In 1972, Janowsky et al. proposed the adrenergic-cholinergic balance hypothesis of affective disorders, suggesting that depression was a product of increased acetylcholine activity relative to noradrenergic (or dopamine) activity in the brain. Thirty-four years later, Furey et al., at the NIMH Clinical Center in Bethesda, Maryland, reported in the *Archives of General Psychiatry* that the centrally acting anticholinergic agent, intravenous scopolamine, exerted rapid antidepressant effects, findings consistent with the above adrenergic-cholinergic hypothesis. Subsequent studies by the same group at NIMH demonstrated replication of scopolamine's antidepressant effects, demonstrating efficacy in bipolar depression and in treatment-

resistant depression and suggesting increased effectiveness in women, but no independent verification or refutation has occurred subsequently by outside groups. Thus, although a decade has passed since scopolamine was first reported to be an effective antidepressant, no other follow-up clinical studies have been reported. However, a rapidly growing body of preclinical animal studies have supported the potential of scopolamine and related anticholinergic agents to be promising rapidly acting anticholinergic agents. The lack of studies attempting to replicate scopolamine's antidepressant effects contrasts with the great interest and drug industry support for the study of intravenous ketamine, its efficacy having been replicated multiple times since 2006 when it and scopolamine were reported within a few months of each other in the *Archives of General Psychiatry*. **Methods:** This talk will review the limited number of promising studies demonstrating scopolamine's antidepressant effects in humans. Covered in detail will be the rapidly growing body of recent preclinical studies suggesting that scopolamine exerts neurochemical effects on depression-relevant brain areas and on behavioral models of depression consistent with its antidepressant effects. The talk will also outline how scopolamine affects other depression-relevant neurochemicals such as serotonin and dopamine, gaba, etc., integrating other observed neurochemical changes in depression with changes in cholinergic activity. **Conclusion:** Scopolamine's antidepressant effects and rapid action are consistent with the earlier-proposed adrenergic-cholinergic hypothesis of mood disorders. There is a growing body of preclinical data supporting scopolamine's antidepressant effects. Since scopolamine appears to act rapidly, exert efficacy in nonresponsive depressed patients and be effective in bipolar depressed patients, these promising results deserve replication and scientific support.

No. 3

Metabolic Syndrome in Young Adults With and Without Depression: A Cross-Sectional Study of the Roles of Inflammation and Stress

Presenter: Stephen Woolley, D.Sc.

EDUCATIONAL OBJECTIVE:

1) Discuss the association between metabolic syndrome (MetS) risk and presence/absence of depression among young adults; 2) Understand evidence of the roles of systemic inflammation and stress (both psychological and laboratory measures) in risk of MetS in the compared study populations; and 3) Discuss the effects of additional behaviors, attitudes and biomarkers on the associations between MetS, inflammation and stress.

SUMMARY:

Background: Metabolic syndrome (MetS) is associated with increased risk of chronic diseases, and its prevalence is high among psychiatric patients. This study examined risk of MetS and five MetS criteria (MetC) associated with 1) depressed psychiatric patients (PP) versus non-patients (NP); 2) elevated C-reactive protein (CRP); 3) elevated cortisol; and 4) self-reported stress. **Methods:** Participants were nondiabetic PP and NP with no antihypertensive treatment (ages 18-25) enrolled April 2014 through July 2016. Potential MetS risk factors were assessed by interviews, physical exams and laboratory tests. Validated scales measured depression, stress, anxiety, and sleep quality; physical exams measured blood pressure, BMI and waist circumference (WC); laboratory tests measured lipids, glucose, insulin, cortisol, and CRP. Bivariate/regression analyses calculated odds ratios (OR) of MetS/MetC (α=0.05). **Results:** Compared to NP (N=106), PP (N=90) were 20% more likely male, older (x¯=21.4 vs. 20.3), twice as likely black, and one-fifth as likely Asian/Pacific Islander. Only PP had MetS (N=7), and PP also had greater odds of MetC and related conditions, for example WC (OR=7.4, p<0.001), triglycerides (TRIG) (OR=4.0, p<0.01), HDL (OR=1.9, p=0.07), glucose (OR=3.4, p=0.07), having met one, two or more MetC (ORs=5.4 and 3.2, both p<0.001), insulin resistance (IR) (OR=7.1, p=0.001), and BMI≥30 (OR=7.6, p<0.001). Among PP, the level of CRP was statistically significantly greater, as were the proportions having at least moderate stress (47.4% vs. 9.3%), at least moderate anxiety (74.4% vs. 11.1%) and poor sleep (87.8% vs. 25.0%). Across the whole sample, CRP was positively associated with MetC and related conditions, including WC, TRIG, having met one, two or more MetC, IR, and BMI≥30. However, cortisol was negatively associated with

MetS, WC, having met two or more MetC, IR, and BMI≥30. Severe self-reported stress was positively associated with MetS (p=0.02), HDL (p=0.001) and having met two or more MetC (p=0.04); severe anxiety was positively associated with TRIG (p<0.05). Associations among MetC-related factors and biomarkers differed by PP versus NP (e.g., in PP the CRP having met two or more MetC association [OR=4.5, p<0.05] differed from the NP association [OR=1.2, p=0.99]. In regression analyses controlling for demographics, stress, poor sleep, and IR, PP versus NP was associated with WC, TRIG and HDL (ORs≈3.1-34.0); in separate regression analyses, CRP was only significantly associated with WC and TRIG (ORs≈3.0-8.2) but not when IR was controlled. **Conclusion:** PP versus NP was associated with increased risk of MetS, MetC and related conditions. CRP was positively associated with PP versus NP, IR, WC, and TRIG. Cortisol was negatively associated with PP versus NP and MetC and related conditions. Self-reported stress and anxiety were positively associated with PP versus NP and some MetC. Increased odds of MetC and related conditions were also found for IR and poor sleep. Further study is needed. This study was supported by Hartford Healthcare Corporation.

Rapid-Fire Talks: Focus on Diversity and Health Equity

No. 1

The Impact of Culture on End of Life Decisions

Presenter: Mahmoud Aborabeh, M.D.
Co-Author: Saba Syed, M.D.

EDUCATIONAL OBJECTIVE:

1) Promote cultural competency among practitioners who provide care at end of life; 2) Demonstrate effective ways of addressing cultural differences and conflicts regarding end of life care goals; and 3) Highlight the importance of developing empathic understanding, rapport and trust to achieve mutually satisfying goals of care.

SUMMARY:

Cultural essentially shapes people's perspective on the meaning of illness, suffering and death. End of life decision making is challenging for most patients and their family members. It becomes particularly difficult when there are cultural factors impacting the patient's decisions. Styles of communication and expectations regarding the role of the physician, patient and family vary among different cultures. Such differences are intensified when they occur against the backdrop of experiences of societal oppression or inequalities in medical care and create conflicts regarding end of life care goals. We present a case of an Egyptian male with terminal metastatic colorectal cancer where the family did not want the patient to know the extent of his illness or prognosis. The physician's need to emphasize the patient's right to be informed about his condition and treatments was misperceived as uncaring and ignorant by the family. The patient and his family were adamant to continue receiving chemotherapy, despite the fact that the oncologist believed it was medically futile. With introduction of palliative measures and hospice care, the patient and his family perceived these measures as the hospital trying to save money by withholding treatments from them. Involvement of a psychiatry fellow from the same cultural background helped the patient and his family establish trust and better rapport with the medical providers. It facilitated clarification of the family's concerns regarding the goals of care, and it enabled medical providers developed cultural sensitivity and better understanding of the patient's and family's reactions to their discussions. Our case highlights the importance of negotiation between the cultural views of the physicians and the patients and their families in clinical encounters to reach mutually acceptable goals. Addressing and respecting cultural differences increases trust and leads to better clinical outcomes and satisfactory care for patients and their families.

No. 2

Say Hello to Bias

Presenter: Kali D. Cyrus, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Apply early American history to understanding the current context of systemic racial inequality; 2) Consider how key sociological topics such as bias, prejudice and racism influence individual thoughts and behaviors as a physician; 3) Increase awareness of how an individual’s privilege operates in the greater medical community when caring for

patients; and 4) Learn key strategies to mitigate individual biases.

SUMMARY:
Health care disparities arise from a complicated series of events involving individuals, systems and, at times, the environment. While disparities in care are influenced greatly by structural inequality, we must also examine the role of the provider in exacerbating the gaps in access, treatment and outcomes for minority groups. Additionally, the role of the provider presents itself as a notable topic worth addressing through medical education. For example, there is a growing body of literature examining the link between physicians' implicit biases and decision making that disadvantages marginalized populations. This talk describes how bias influences our cognition, how bias operates within our personal and professional context, and how our biases are informed by the history of discrimination within this country. In addition to discussing bias, we outline other key sociological concepts such as prejudice, racism and privilege. Using historical examples such as the Dred Scott case, we discuss how these sociological factors arise out of the context of legally enforced discrimination in the United States. We will then review the concept of privilege with concrete examples provided by Peggy McIntosh's privilege list. Finally, we will review strategies to better recognize, and hopefully reduce the impact of, bias in everyday living.

No. 3
Diversity Beyond the Numbers: Actualizing the Potential of a Truly Diverse Health Care Workforce
Presenter: Jeremy D. Kidd, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Appreciate ways in which “diversity” efforts extend beyond recruitment and hiring; 2) Conceptualize “underrepresented” as the underrepresentation of the perspectives, experiences, values, and ideas held by certain groups or individuals that do not belong to the majority; 3) Define and identify “privilege,” including ways in which it may affect workplace interactions in health care; and 4) Name at least two concrete methods for promoting the perspectives, experiences and ideas of underrepresented individuals and communities within health care institutions.

SUMMARY:
The National Academy of Medicine recognized the need for a diverse workforce in its landmark 2002 report "Unequal Treatment." This report connected workforce diversity to the goal of eliminating bias in health care delivery. Since then, numerous initiatives have targeted this goal and led to gains in the number of women and racial/ethnic minority individuals entering the health professions. Despite these efforts, there is still evidence of significant wage and promotion disparities in medicine. This presentation will explore some of the potential reasons for these persistent disparities. One useful concept in this discussion is that of "privilege." Privilege refers to the concrete (e.g., economic) as well as psychological or emotional advantages that a person or group is afforded in society due in part to their membership in a majority group. For example, Black parents often teach their children about racism and the potential for racist interactions. One privilege of being White is not having to consider racism on a daily basis. For gay and lesbian people, there is often subtle pressure to keep their sexual orientation a secret from colleagues. For heterosexual people, it is a privilege to have the dominant culture assume one's heterosexuality and to have that assumption match reality. Lack of privilege can affect self-efficacy and the degree to which perspectives expressed by those from minority groups are considered by leaders, administrators and policy makers. Having minority voices at the table is a first step. How does psychiatry as a profession ensure that those voices are taken seriously and represented at all levels? Through a Socratic questioning exercise, this presentation will help attendees identity their own privilege(s). In doing so, this will illustrate that most people have privilege (to varying degrees) that is largely unconscious and still dialectically compatible with forms of earned notoriety (e.g., being a schizophrenia expert). After illustrating this concept, we will explore concrete ways to use privilege to elevate the perspectives, viewpoints and contributions of underrepresented groups in the workplace. One such skill is amplification. Because minority perspectives may differ from the dominant

organizational culture, points raised by minority group members are more likely to be bypassed or only superficially acknowledged. Through amplification, group members with more privilege repeat the statements made by minority members while simultaneously attributing the idea to the original group member. Over time, the goal of amplification and other such interventions is to both acknowledge the presence of privilege in diverse workplaces and to intentionally challenge it in ways that incorporate minority perspectives into the dominant culture. As a result, we have the potential to work more collaboratively with our colleagues and to deliver better care to our patients.

Rapid-Fire Talks: Focus on Forensic Psychiatry—Part 1

No. 1
The eHARM: An Innovative and Ground-Breaking Fifth-Generation Structured Risk Assessment Process That Allows for Analytics in Psychiatry
Presenter: Gary Chaimowitz, M.B., Ch.B.

EDUCATIONAL OBJECTIVE:
1) Demonstrate the use of analytics in risk management psychiatry; 2) Introduce a cutting-edge structured risk management process; and 3) Improve understanding of violence risk assessment, prediction and management.

SUMMARY:
The Hamilton Anatomy of Risk Management-Forensic (Psychiatry) Version (HARM-FV) is one of four versions of the structured professional judgment tool, the HARM, specifically designed for use in the management of risk posed by adult patients in acute and chronic psychiatric settings. We began to develop these tools nearly a decade ago in order to meet a need for a practical and easily implemented set of tools and risk assessment processes. The tools have been implemented in multiple settings, and the research is promising. They have been designated best practices. The essence of the HARM-FV is that it is a team-based risk assessment structured professional judgment tool that is easily to use and implement. It is completed at the clinical interface (team meetings). It is intuitive, quick and evidence-based and brings a risk management process to general psychiatry where none existed. After a decade of use, we determined to transform the HARM-FV into an electronic analytics tool that would collect and aggregate data at the clinical interface, essentially as the clinical team conducted their regular decision making. This evolved into the Electronic Hamilton Anatomy of Risk Management (eHARM). Six months after launching our eHARM-Forensic Version, after presenting this version both nationally and internationally, and after receiving endorsement from an international medical magazine, we have received interest in and have taken the first steps to developing an eHARM-General Version. We believe that this innovation will be absolutely groundbreaking for general psychiatry and will meet a large need for such a structured, intuitive and innovative risk assessment process. The eHARM is an electronic tool that allows physicians to enter their regular risk assessment reports using drop-down menus in a self-populating form. It stores all previous reports within one file, which allows users to easily access and print past reports. The most sensational part of this tool, however, is the built-in patient- and group-level analytics. Once a clinical team has completed at least two reports for a given patient, the eHARM will automatically graph that patient's performance on specific risk factors, aggressive incidents and overall risk. In addition, a component of the eHARM, referred to as the Aggregator, will allow physicians to upload numerous patient reports and view trends in diagnoses, risk factors, program participation, medication, and more. Over a dozen analytics will be generated automatically with the click of a button; however, physicians will also have the ability to download all of the data contained in each uploaded HARM report into an SPSS file. The database derived from the eHARM can inform research, improve service planning, and measure and evaluate outcomes for risk and quality management. Ultimately, the eHARM means saving time and money and, importantly, providing the right care for the right patient at the right time in psychiatry.

No. 2
Bridging the Gap in the Health Care Chain: Relational Care in Forensic Psychiatry
Presenter: Ivo van Outheusden

Co-Author: Petra Schaftenaar, M.Sc.

EDUCATIONAL OBJECTIVE:
1) Provide insight on the problems of the health care chain from the patients' perspective; 2) Understand how relational care and special aftercare programs can contribute to risk management and reduction of recidivism; and 3) Understand what elements are important to deliver this method of treatment.

SUMMARY:
Background: Research in The Netherlands shows that recidivism among forensic patients with an involuntary hospital admission, following a short judicial measure, is high. Among the characteristics of the background of these patients are histories of discontinuity and many efforts by care institutions to build up a positive therapeutic or working alliance. With so many relatively short-term stays in a hospital, the patients' motivation to invest in yet another trusting relation drops to a minimum. One of the characteristics of the health care chain is the ongoing building up and breaking down (or stopping) of working alliances-after discharge, the relationship between patient and health care worker will end. Also, the most important forensic specialism (risk management) doesn't seem to endure when the patient has been transferred to the regular health care. In this talk, we will present the theoretical base, implications and results of a new paradigm in forensic care and discuss the meaning and impact of the health care chain from the perspective of our forensic patients. **Methods:** The (at least) one-year follow-up recidivism rates of two cohorts ("treatment as usual" (TAU), N=41 and "aftercare," N=45) are compared and analyzed. A file study (N=92) has been done in another aftercare cohort in order to describe the intervention. **Results:** Preliminary results show a longer time at risk (without recidivism) for the aftercare cohort. Also, a significant difference in change on recidivism for the TAU and aftercare cohorts was found (χ^2 (1)=6.13, p=0.01). 442 contacts were registered, mostly phone calls (63%) and visits (20%). The mode in length of stay is 0.5-1 year (35.8%); the mode of duration aftercare is 1-1.5 years (21.7%). **Conclusion:** Relational care and aftercare can contribute to the reduction of recidivism when focus is on the trusting relationship and the meaning of this relationship for the patient. These results show that a different paradigm can stop the revolving door of forensic recidivism. This research was conducted in one forensic health care institution. Multicenter research is suggested.

No. 3
Physician Limitations During Involuntary Commitment: A Filicide-Suicide Case Involving Multiple American States
Presenter: Jenilee Generalla, M.D.
Co-Author: Kathleen C. Dougherty, M.D.

EDUCATIONAL OBJECTIVE:
1) Analyze challenges during an involuntary commitment; 2) Discuss limitations when multiple states are involved; and 3) Examine how the steps to protect the victim weaken the case to extend commitment.

SUMMARY:
A 47-year-old African immigrant single mother was involuntarily committed to an acute inpatient psychiatric hospital. She was en route from her home state (HS) to her destination state (DS) with plans to commit suicide and murder of her six- and nine-year-old daughters. Multiple friends and family contacted the police of the DS, who initiated a multistate manhunt. She was located via GPS at a Pennsylvania (PA) motel and involuntarily committed for psychiatric evaluation. A mental health hearing granted the maximum 20-day commitment in order to gather collateral information, assess for risk, and develop and execute a safe discharge plan. Collateral informants, including her friends and family in her HS, were contacted, and they confirmed in detail her plans of filicide/suicide. Her brother was given physical custody of her children by child protective services (CPS), but he did not believe the accusations. The patient did provide proof of future planning and produced a plausible claim as to why she was headed toward her DS, although not all points in her claims were well supported. By the time of the next extension hearing, there was insufficient proof of imminent danger. She did not make statements of harm and did not exhibit signs of dangerous behavior. Her friends and family refused to testify for the extension hearing. Although mandated

outpatient follow-up was recommended, a court order in PA would not have been upheld in DS. Upon her discharge, DS CPS did follow up with visits upon return to her DS home. One week following her discharge, she and her children were found unconscious in their home, with plastic bags over their heads, next to nitrogen gas tanks. Although CPR was attempted, they later died in a nearby medical center. The patient denied all accusations of plans for harm throughout her admission and refused any medication or therapeutic treatments. She did not engage in dangerous behavior to elicit forced medications. By her brother taking physical custody and DS CPS agreeing to visit, the patient was taken out of her planned timeline and situation of driving alone with her children to contact with her children supervised by her brother and DS CPS. Her friends and family had reached a point that they did not feel it was necessary to testify in an extension hearing. This case, thus, illustrates some of the various limitations faced by the physician during an involuntary commitment. The balance between risk and patient privacy rights becomes difficult to manage. Additionally, when dealing with interstate issues, decisions made in one state may not be upheld or executed in another. Finally, for every step that was taken to formulate a safe discharge plan, this resulted in a weakened case for further involuntary commitment.

Rapid-Fire Talks: Focus on Neuropsychiatry

No. 1

Thalamocortical Dysrhythmia: An Outlandish Idea or Clinical Reality?

Presenter: Alfonso Ceccherini-Nelli, M.D.

EDUCATIONAL OBJECTIVE:

1) Outline the history of non-epileptic cerebral dysrhythmia as a concept; 2) Systematically review the prevalence of cerebral dysrhythmias among major psychiatric disorders; 3) Report the preliminary results of a case series study of the treatment of cerebral dysrhythmia with zopiclone and clozapine; and 4) Offer suggestions for future research based on our preliminary findings.

SUMMARY:

Background: Hill (1944) defined dysrhythmic aggressive behavior as a syndrome marked by psychopathic personality, violent behavior and a resting EEG typified by predominance of 4-6Hz rhythms, with most frequent bilateral localization in post-central regions. The pathophysiological relevance of slow thalamocortical oscillations in the theta frequency band (4-8Hz) in a wide spectrum of chronic, severe and therapy-resistant neurological or neuropsychiatric disorders was emphatically reaffirmed by Llinas et al. (1999). **Methods:** We conducted a systematic review of EEG studies to determine the prevalence of non-epileptic dysrhythmia in a wide spectrum of psychiatric disorders. We reported on a case series of 30 difficult to treat patients with various *DSM-5* diagnoses who had excessive expression of delta or theta resting EEG rhythms and/or a syndrome characterized by cognitive deficits, impulsivity and aggression. These patients were treated off-label with zopiclone and antipsychotics or zopiclone and clozapine. Whenever possible, EEGs were administered before and after the start of zopiclone. EEGs were clinically interpreted by a neurologist. **Results:** Our systematic review indicates that excess delta and theta waves in resting EEGs is observed more frequently in patients with neurodevelopmental and neurocognitive disorders than normal controls. Our case series of 30 difficult to treat patients (16 males; average age 38, range 18-64 years) with impulsive/aggressive behavior included *DSM-5* diagnoses of neurocognitive disorders (7), neurodevelopmental disorders (11), major psychoses (10), and personality disorders (2). In this case series, 14 (46%) patients had excess delta and/or theta waves in their resting EEG. For two of these patients, who had the most remarkable remission (cases 1 and 22), resting EEG completely normalized after treatment augmentation with zopiclone. However, as a result of the unusual high response rate in this case series (70%), excess delta/theta expression did not appear to predict better response to zopiclone or zopiclone and clozapine than clinical descriptive criteria (71% vs. 68%, respectively). **Conclusion:** Our preliminary findings support the existence of non-epileptic thalamocortical dysrhythmia in a large proportion of patients with severe disruptive, impulsive behavior and poor response to standard treatments. A large proportion of our case series responded to zopiclone

augmentation of standard antipsychotics or in combination with clozapine. Quantitative EEG may provide advantages over the clinical interpretation of EEG in the diagnosis of thalamocortical dysrhythmia. Further research is warranted to test these hypotheses.

No. 2

Validation of the Stanford Proxy Test for Delirium (S-PTD) in the Critical Care Setting

Presenter: Jose R. Maldonado, M.D.
Co-Authors: Renee M. Garcia, M.D., Andrea Ament, M.D., Earl Andrew B. De Guzman, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify the most significant differences between *DSM-5* and prior delirium diagnosis criteria; 2) Understand the psychometric properties of the new instrument, PTD, as a tool for the screening of delirium in medically ill individuals; and 3) Understand the benefits of using standardized tools, such as PTD, in the prompt identification of patients with delirium to allow for timely intervention and treatment.

SUMMARY:

Background: Delirium is the most prevalent psychiatric disorder found in the general medical setting. It is associated with increased morbidity and mortality, increased health care costs and a range of other negative outcomes among medically ill patients. While several validated tools are currently used to screen for delirium in the hospital setting, studies have shown that delirium is misdiagnosed or not detected in over 50% of case across various health care settings, up to 85% in the ICU. This may partly be due to the reliance of these validated tools on the patient's report of symptoms or active participation on the delirium screening tool itself. Instead, a screening tool relying on the observations of nursing staff could potentially provide a more accurate assessment of patient symptoms. **Methods:** We developed a new tool for the recognition of delirium, the Stanford Proxy Test for Delirium (S-PTD), based on combining *DSM-5* and ICD-10 criteria. The S-PTD eliminates the need for direct patient participation in the assessment; instead, nurses complete the tool at the end of their shift, thus using the full shift for patient interaction to gain the information needed to diagnose delirium. In our original pilot study, the S-PTD was blindly evaluated compared to a validated tool (i.e., CAM) and clinical assessment (i.e., *DSM-5* criteria). In the original study, a total of 227 subjects in a combined medical/surgical/neurology inpatient unit were blindly assessed. The results suggest that the PTD has a sensitivity of 79% and a specificity of 91%, and it only took the average nurse less than one minute to complete the questionnaire. **Results:** In the current study, the tool will be tested against the CAM-ICU, the ICDSC and a neuropsychiatric evaluation to determine the psychometric qualities of the S-PTD among critically ill patients, most of whom will be ventilated and under various degrees of sedation. We hypothesize that the PTD will have superior predictive value as compared to these other measures. The study was approved by Stanford's IRB committee. The study is ongoing. We expect to include 200 critically ill patients and have the data analyzed by the time of presentation. If the results of this phase of the study are as good as our previous study (presented at last year's APA Annual Meeting), we will be able to unveil not only the first delirium assessment tool based on the *DSM-5*, but the only tool that is validated among mechanically intubated and non-intubated individuals, providing seamless assessment of delirium across all clinical settings. **Conclusion:** This is the first diagnostic tool for delirium based on *DSM-5* and ICD-10 criteria. The tool is easy to use, yet comprehensive, and eliminates the problem of patients' lack of cooperation or inability to cooperate in the examination. The use of observation-based tools, such as PTD, may enhance the early recognition and diagnosis of delirium.

No. 3

Catatonia-Delirium: A Challenge in Consultation Psychiatry

Presenter: Kamalika Roy, M.D.

EDUCATIONAL OBJECTIVE:

1) Acknowledge and demonstrate clinical overlap and differences in two disorders; 2) Understand available literature as evidence of clinical overlap; 3) Understand the neurobiological mechanisms of the catatonia-delirium interface; and 4) Provide appropriate treatment in challenging cases where

the features of two disorders are complicating management.

SUMMARY:

Background: Catatonia is a complex neuropsychiatric disorder with behavioral and motor components that often overlap with a more common diagnosis of delirium. Most accept that catatonia describes motor symptoms and not a disturbed sensorium, though episodic change in sensorium is sometimes seen in catatonia. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*), delirium prohibits a formal diagnosis of catatonia due to another medical condition. **Case:** We describe three cases of overlapping symptoms of catatonia and delirium where management was challenging considering the disinhibiting effect of lorazepam used for treatment of delirium and lack of access or consent for electroconvulsive therapy (ECT), making the treatment of catatonia difficult. Two cases had electrolyte imbalance and one had urinary tract infection associated with delirium, which were treated medically, with partial improvement of behavioral symptoms of delirium. They met the screening and full criteria for catatonia on Bush Francis Rating Scale and on *DSM-5*, but a reasonable dose and duration of lorazepam worsened their mental alertness, blood pressure and disinhibition. All three cases responded well to N-methyl-D-aspartic acid (NMDA) antagonist memantine, as there was either a lack of consent or a lack of access for ECT. Antipsychotic medications and mood stabilizers were used on an as-needed basis, though sparsely in two cases, so making an inference that memantine effectively treated the catatonia would be premature. However, it certainly opened an area of discussion about the overlapping features and a possibility of two disorders coexisting. **Discussion:** Francis and Lopez-Canino systematically demonstrated the presence of catatonic symptoms in delirium patients. They proposed that catatonia might account for the motor components of hypoactive delirium. Some authors suggested that the requirement of clear consciousness for a diagnosis of catatonia in medical patients is more hypothetical than clinically useful, showing a high association between catatonia symptoms and the hypoactive or mixed type of delirium. The debate over whether catatonia and delirium exist on a spectrum has treatment implications with the potential to prolong hospitalization and increase mortality. The proposed mechanism of memantine being used in some catatonia cases is based on the theory that it blocks NMDA receptors and helps reduce the glutamate excitotoxicity, which in turn resolves the GABA hypofunction seen in catatonia. The clinical evidence of successful use of NMDA antagonists draws further attention to their potential role in treatment of the specific subgroup of catatonia that presents with delirium.

Rapid-Fire Talks: Focus on Psychopharmacology

No. 1

Antipsychotics in Special Populations: Double Down or Avoid Completely

Presenter: Adriana E. Foster, M.D.
Co-Authors: Akiva M. Daum, M.D., Daniel Castellanos, M.D., Alina Gonzalez-Mayo, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify the antipsychotics with higher abuse potential and their desired effects; 2) Create a treatment plan for patients with schizophrenia on antipsychotic combinations, including an appraisal of the risks and benefits; 3) List the principles that guide the use of antipsychotics in children and adolescents with developmental disabilities; and 4) Interpret the evidence on the use of antipsychotic medications for the treatment of aggression in traumatic brain injury.

SUMMARY:

Research to date does not support using antipsychotic medications for the treatment of alcohol, stimulant, opioid, cocaine, or tobacco use disorders in humans despite extensive studies. Antipsychotics, especially quetiapine and olanzapine have been misused for their sedating effects and reports of euphoria, though are rarely the primary drug of choice, but rather combined with other substances to help with the "comedown," such as mixtures cocaine and quetiapine or olanzapine combined with hallucinogens. Antipsychotics have been used for the treatment of psychosis induced by substances of abuse, both illicitly and through prescription. Antipsychotic combinations are prescribed in 10-30% of cases of schizophrenia

despite risks and limited efficacy. In a secondary analysis on PROACTIVE (Preventing Relapse Oral Antipsychotics Compared to Injectables-Evaluating Efficacy) study data, in which 305 patients with schizophrenia and schizoaffective disorder were followed for 30 months after randomization to long-acting injectable risperidone or oral second-generation antipsychotic, we explored the effect of switching to monotherapy on patients who entered the study on antipsychotic combinations. Patients on combinations had significantly more hospitalizations prior to study entry and relapsed earlier, and monotherapy did not influence their illness course. These results validate clinical decision making and call for additional treatment guidance for this patient group. The use of antipsychotic medications in children and adolescents with developmental disorders is common, but the evidence base is limited. Target symptoms like irritability, self-injury, violence and explosive outbursts are best addressed first with psychoeducation and therapy that addresses behavior, speech and language, and social skills and family dynamics, as well as treatment of comorbid medical problems. Antipsychotic monotherapy represents a level two intervention and must take into account the fact that children and adolescents with developmental disorders may be more sensitive to antipsychotic side effects, as illustrated in our case presentation. Traumatic brain injuries (TBI) result in motor impairments, mood symptoms, behavioral dyscontrol, psychosocial deficits, personality and cognitive changes, delirium, and aggression. Aggressive symptoms after TBI often involve prefrontal cortex or untreated mood or psychotic disorders. There are no FDA-approved drugs for the treatment of aggression in TBI, but many agents are possibly effective, including antipsychotics, antidepressants, mood stabilizers, anticonvulsants, and beta blockers. Longstanding evidence exists that first-generation antipsychotics worsen cognitive disturbances, while more recent studies show that second-generation antipsychotics may improve both aggressive behavior and cognition. Given the multiple TBI-related symptoms and diagnoses, it is essential to have an individualized pharmacological approach for every patient.

No. 2

Prescribing Second-Generation Antipsychotic Medications of Higher vs. Lower Metabolic Risk: The Role of Patient Characteristics

Presenter: Alisa B. Busch, M.D., M.S.
Co-Authors: Haiden A. Huskamp, Ph.D., Vanessa Azzone, Ph.D., Sharon-Lise T. Normand, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Identify the health conditions that constitute metabolic syndrome; 2) Understand the prevalence of routine monitoring of patients for metabolic syndrome, as recommended by the American Psychiatric Association and American Diabetes Association; and 3) Understand which patient characteristics are associated with the selection of second-generation antipsychotics in higher versus lower metabolic risk categories and the changes over time in prescribing patterns.

SUMMARY:

Background: Second-generation antipsychotics increase the risk for metabolic syndrome (typically defined as diabetes, hypertension, hypercholesterolemia, and/or obesity), placing individuals at greater risk for cardiovascular disease and early mortality. In 2008, after the 2004 American Psychiatric Association and American Diabetes Association consensus statement on second-generation antipsychotic metabolic syndrome risks, the antipsychotic market expanded to include generic versions of (mostly) higher-metabolic-risk medications and more choices of newer, more expensive agents in lower-risk categories. This study examines if patient characteristics are associated with differences in higher- versus lower-risk second-generation antipsychotic prescribing patterns among Medicare patients with psychotic disorders and whether prescribing patterns changed during this time period. **Methods:** We performed an observational study using claims data from a 20% national sample of Medicare fee-for-service beneficiaries diagnosed with a psychotic disorder (schizophrenia, bipolar-I disorder, major depression with psychotic features) who filled one or more prescriptions for a second-generation oral antipsychotic in a given study year (years 2006-2011; N=351,141 person-years). We categorized second-generation antipsychotics into two risk categories (higher vs. lower). We then fit a

multinomial probit regression model linking prescription fill of a higher- versus lower-risk antipsychotic to patient demographic and clinical characteristics and study year. **Results:** The person-year study cohort was 46.7% male, 75.1% White, 17.4% Black, and 4.3% Hispanic; 79.4% were older than 65. The odds of filling a higher-risk second-generation antipsychotic decreased from 2006 to 2011 (e.g., compared to 2006, 2007 OR=0.94 (95% CI [0.91, 0.98]) and 2011 OR=0.66 (95% CI [0.64, 0.68]). Male gender and older age were associated with increased risk of a higher-risk second-generation antipsychotic (male OR=1.65, 95% CI [1.62, 1.68]; age [relative to age 18-24] 25-34 OR=1.13, 95% CI [1.05, 1.22]; age over 65 OR=2.36, 95% CI [2.03, 2.74]). Individuals with a mental health admission or ER visit in the year (OR=1.38, 95% CI [1.36, 1.41]) were also more likely to fill a higher-risk antipsychotic. While having cardiovascular disease was associated with a small increase in odds of a higher-risk antipsychotic (OR=1.03, 95% CI [1.00, 1.05]), beneficiaries with metabolic syndrome disorders were less likely to have such a prescription (compared to no metabolic syndrome diagnoses, e.g., having one condition OR=1.06, 95% CI [1.03, 1.09] or four conditions OR=0.76, 95% CI [0.73, 0.79]). **Conclusion:** Newer second-generation antipsychotics with lower metabolic risk are increasingly being prescribed over time, despite the entry of generics that are less expensive but have higher metabolic risk. There appears to be some tailoring of prescribing based on the number of metabolic syndrome diagnoses, but not among individuals who already have cardiovascular disease. More research is needed to understand the demographic findings of higher-risk prescribing (e.g., older age and male gender).

No. 3

Psychedelics and Psychiatry: Past, Present and Future

Presenter: Fernando Espi Forcen, M.D.
Co-Author: Matthew Brown, D.O., M.B.A.

EDUCATIONAL OBJECTIVE:

1) Become familiar with historical background in psychedelic therapies; 2) Review the most recent literature on psychedelic drugs and their use in mental health; 3) Express their thoughts about the use of psychedelic drugs in clinical practice; 4) Learn about current psychedelic advocacy groups; and 5) Discuss future aspects of psychedelic treatment in psychiatry.

SUMMARY:

Psychedelic psychiatry explores the use of psychedelic drugs in therapy and mental illness. Psilocybin, ayahuasca, ibogaine, and other natural psychedelic plants have been used in different cultures for centuries for psychological and spiritual healing. After the discovery of LSD by Albert Hoffman in Switzerland, a number of studies came in the 1960s showing possible benefits from this drugs in psychotherapy, alcoholism and depression. During the last decade, a new wave of interest in psychedelic psychiatry has produced a significant number of studies suggesting several clinical applications. For instance, an article published in *JAMA Psychiatry* has shown significant decrease in anxiety in patients with cancer after psilocybin ingestion. A number of studies have shown anticraving benefits of ibogaine. A recent British article published in *Lancet Psychiatry* has shown dramatic reduction in depressive symptoms in patients with treatment-resistant depression. The neuroscience of psychedelic is still not well understood. A neuroimaging study with fMRI shows that a decrease in blood oxygen flow at the restrosplenal and parahippocampal cortex might explain ego disintegration and other psychedelic effects. Several neurotransmitters have been associated with its psychedelic effects, such as serotonin and glutamate. Over the last few years, a number of advocacy groups such as MAPS and several psychedelic meet-up groups suggest retaking psychedelic research in psychiatry. Our objective is to review past and recent literature on psychedelics, exploring the current state of the art and evidence-based research findings to this date.

Rapid-Fire Talks: Focus on Quality and Outcome Studies

No. 1

Improving Cardio-Metabolic Screening in the Adult Psychiatry Outpatient Setting: A Resident-Run Quality Improvement Project

Presenter: Raminder Pal Cheema, M.D.

Co-Authors: Sasidhar Gunturu, M.D., M.B.B.S., Wen Gu, Ph.D., Panagiota Korenis, M.D., Ketki Shah, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the prevalence and magnitude of cardiometabolic side effects of antipsychotics; 2) Understand cardiometabolic screening guidelines; and 3) Offer suggestions for future research, based on our study findings.

SUMMARY:
Background: Patients with serious and persistent mental illness (SPMI) die 25 years earlier than the general population, with cardiovascular disease being the most common cause. Forty-three percent of participants of clinical antipsychotic trials of intervention effectiveness (CATIE) had metabolic syndrome at enrollment. In NY state, a study involving 10,000 Medicaid clients with schizophrenia or depression showed 52% incidence of metabolic syndrome and 92% clients with one or more risk factors. **Methods:** Baseline data were collected for 2,826 patients receiving adult psychiatry outpatient services at Bronx Lebanon Hospital Center, by retrospective chart review. Based on the data, interventions were developed to 1) educate providers and patients and 2) update the electronic medical record to comply with cardiometabolic screening guidelines. **Results:** Out of 2,826 patients studied, 55% (N=1,563) were prescribed antipsychotic medications. Baseline prevalence of risk factors for cardiometabolic syndrome was found to include hypertension (39%), obesity (35%), smoking (34%), diabetes mellitus (25%), hyperlipidemia (25%), and cardiovascular disease (3%). Results also demonstrated low compliance to screening guidelines in the preceding six months (Lipid panel<25%, serum glucose=37%, HbA1c=20%, Weight=57%, BMI=55%, and smoking cessation treatment=11%). **Conclusion:** Our baseline data emphasize the lack of compliance to cardiometabolic screening guidelines and the magnitude of risk factors in our patient population. Our proposed interventions-including but not limited to education (providers and patients), electronic medical records documentation alerts and reminders to improve screening compliance, monitoring patients at high risk (with a plan to switch to low-risk antipsychotics), and smoking cessation intervention-will be reviewed. In addition, we will evaluate the efficacy of these interventions in the outpatient study group in comparison to baseline data.

No. 2
Associations Between LOS and Readmission: Variability by Time to Readmission and Diagnosis
Presenter: John W. Goethe, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the differences by diagnosis in the association of LOS and risk of readmission; 2) Compare and contrast the variables associated with increased versus decreased readmission; and 3) Discuss the role of time to readmission in examining the association of LOS and readmission.

SUMMARY:
Background: Length of stay (LOS) and readmission (RA), widely used metrics in health care, have been associated in psychiatric studies with cost of care and clinical outcome. However, most previous studies have investigated these associations using only a single time metric, such as RA within one month or one year after discharge from the index hospitalization. Because associations between LOS and RA at one time interval may not be found at another, the investigators assessed associations between LOS and time to RA at each of four intervals. Similarly, because these associations may vary by diagnosis they examined associations for each of four diagnoses as well as for the sample as a whole. **Methods:** The sample was inpatients ages 18-64 discharged between Q1 2010 and Q3 2015 with a *DSM-IV* clinical diagnosis of major depressive disorder (MDD, N=3915), schizophrenia (SZ, N=837), schizoaffective disorder (SA, N=1045), or bipolar disorder (BP, N=1785). Logistic regressions (assessed at a=0.05) examined associations between risk of RA (within 15, 30, 90, and 180 days) and LOS, comparing the lower quartile (four days) to both the upper (10 days) and middle two quartiles (five to nine days). **Results:** Mean LOS was 8±7.51 days in the sample as a whole but varied significantly by diagnosis. (For example, mean LOS for SZ (12.14) was significantly greater than for SA (10.94, p=0.05), BP (7.91, p=0.001) and MDD (6.96, p=0.001)). LOS of four days, compared to 10, was associated with increased risk of RA in SZ for all RA intervals (ORs=1.69-2.17)

but with decreased RA risk in MDD (OR=0.60-0.64). LOS was also associated with RA in SA, but only for the 180 day interval (OR=1.63). In BP, there were no significant associations between LOS and RA. In the regressions comparing LOS of four days to five to nine days, the results were similar in SZ (increased risk of RA for all intervals (ORs=1.74-3.79), but this association was only significant in MDD for 180 days (OR=0.82) and not significant in SA or BP within any time interval. **Conclusion:** In this study, the associations between LOS and risk of RA varied by the time interval examined; few studies have considered that variations in time-based metrics may alter the results in research about the associations between LOS and RA. The findings were strongest in SZ; LOS of four days was associated with increased RA risk for all time intervals and LOS comparisons. The findings were also strong in MDD, but only in the contrast of four- to 10-day LOS. Unexpected was that similar associations were not found in SA and SZ and that there were no significant LOS-RA associations in BP. That in SZ increased RA risk was associated with LOS of four days suggests that longer LOS provides greater stability. That in MDD, LOS of four days was associated with a 40% lower RA risk suggests that there may be a subset of MDD patients for whom very brief hospitalization is sufficient, perhaps due to lower illness severity/risk of recurrence. Further study is needed.

No. 3

Prediction Challenges of Readmission in an Inpatient Psychiatric Unit: A Resident-Run Performance Improvement Project

Presenter: Muhammad Zeshan, M.D.
Co-Authors: Raminder Pal Cheema, M.D., Amina Hanif, M.D., Katya Frischer, Wen Gu, Ph.D., Aos S. Mohammed Ameen, M.D., Maria Reynoso

EDUCATIONAL OBJECTIVE:

1) Introduce different tools to predict 30-day readmission in an inpatient psychiatric unit; 2) Compare the results of our tool (ZAC) to existing tools (LACE, READMIT); 3) Emphasize addressing the potentially avoidable high rate of early psychiatric readmissions by identifying individuals at a high risk of readmission; and 4) Offer suggestions for future research based on our study findings.

SUMMARY:

Background: Hospital 30-day readmission rates have become a growing concern in health care. According to the Center for Medicare and Medicaid Services (CMS), hospital readmissions potentially cost Medicare more than $26 billion annually, and an estimated $17 billion of that expenditure is due to readmissions that could have been avoided. The data show that one of the top five causes of readmission is mental and/or substance use disorders, which accounts for about one in every seven Medicaid readmissions. The data also reveal important concerns about the complexities driving readmission and the factors predicting readmission. While there are no definitive predictors of readmission, specific clinical factors have been identified to assess a patient's risk of readmission in medical settings. Historically, the LACE score (length of stay, acuity of admission, comorbidities, and emergency department visits in the previous six months) has been utilized as a tool to assess a patient's likelihood of readmission. Recent evidence suggests that the READMIT score (repeat admissions, emergent admissions (i.e., harm to self/others), diagnosis (psychosis, bipolar and/or personality disorder), unplanned discharge, medical comorbidity, prior service use intensity, and time in hospital) better correlates with readmission in a patient being discharged from a psychiatric hospital. To identify factors that better predict the likelihood of readmission among our own hospital's patient population we created the "ZAC score" (Zeshan, Amina, Cheema). No studies exist directly comparing the predictive value of the LACE tool to the READMIT tool. **Methods:** We compared the LACE score, READMIT score and ZAC score for 170 patients to identify which tool is a more accurate predictor of readmission. **Results:** Our data indicate that the LACE score may be no better than chance at predicting readmission, whereas the READMIT score and ZAC score have a positive correlation with the chance of readmission, with statistically significant results. Furthermore, both READMIT and ZAC scores have statistically significant results for predicting chance of 30-day readmission, but without significant difference between their predictive powers. **Conclusion:** Our quality improvement project results reflect that readmission is a

multifactorial issue and is difficult to predict based on any single specific patient variables. We aim to bring light to the need for future research to better understand how to identify patients at risk for readmissions.

Rapid-Fire Talks: Focus on Schizophrenia

No. 1

Impact of Follow-Up Care on Readmission Rates in a Population-Based Sample of Patients With Schizophrenia

Presenter: Paul Kurdyak, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Understand the role of performance measurement in mental health system performance; 2) Learn about the readmission rate for individuals with schizophrenia; and 3) Understand the impact of postdischarge physician follow-up on readmission rate for individuals with schizophrenia.

SUMMARY:

Background: About one in four inpatients with schizophrenia are readmitted within six months after discharge. We assessed the association between physician follow-up care within 30 days of discharge and readmission within the subsequent 180 days. **Methods:** Among inpatients with schizophrenia discharged between 2007 and 2012 in Ontario, Canada (N=19,132), we compared patients who had follow-up care with a primary care provider (PCP) only, psychiatrist only or both types of providers to a no follow-up referent group. The primary outcome was psychiatric readmission in the subsequent 180 days. Secondary analyses stratified the sample based on readmission risk (low, medium, high) at discharge. **Results:** About 35% of patients had no follow-up care 30 days after discharge. Patients with some type of physician follow-up had similarly lower readmission rates compared to those with no follow-up (PCP only: 22.2%, aRR=0.88, 95% confidence interval [CI] [0.81, 0.96]; psychiatrist only: 21.6%, aRR=0.84, 95% CI [0.77, 0.90]; both: 21.3%, aRR=0.82, 95% CI [0.75, 0.90]; no follow-up: 25.5%). Two-thirds of patients with schizophrenia were at high risk for readmission based on a validated measure of readmission risk. The effect of physician follow-up was significant for these high-risk patients only (PCP only: 19.9%, aRR=0.85, 95% CI [0.77, 0.94]; psychiatrist only: 28.7%, aRR=0.84, 95% CI [0.77, 0.92]; both: 16.7%, aRR=0.81, 95% CI [0.73, 0.90]; no follow-up: 34.7%). **Conclusion:** Timely physician follow-up is associated with reduced early readmissions, with the greatest reduction among patients at high risk of readmission at discharge. Since more than one-third of schizophrenia patients had no physician visit 30 days after discharge, improving physician follow-up rates may help reduce readmission rates on a population level.

No. 2

The Risk of Severe Hepatic Outcome in Schizophrenia Patients With Viral Hepatitis: A Nationwide Population-Based Cohort Study

Presenter: Chun-Hung Chang, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the prevalence and incidence of viral hepatitis, including hepatitis B virus (HBV) or hepatitis C virus (HCV) in schizophrenia patients; 2) Discuss the long-term association between severe hepatic outcome and viral hepatitis in schizophrenia patients; and 3) Discuss the risk of severe haptic outcome and the use of antipsychotics among schizophrenia patients.

SUMMARY:

Background: Schizophrenia patients with comorbid viral hepatitis, including hepatitis B virus (HBV) or hepatitis C virus (HCV), are a growing concern. However, the long-term outcome of schizophrenia patients with comorbid viral hepatitis remains unclear. **Methods:** Using a nationwide database, the Taiwan National Health Insurance Research Database, subjects who had first been diagnosed with schizophrenia between 2002 and 2013 were identified. The schizophrenia patients with viral hepatitis, including HBV or HCV, were designated as the viral hepatitis group. A 1:2 ratio was used to select age-, gender-, and index year-matched controls without viral hepatitis. Patients who had severe hepatic outcome before enrollment were excluded. The two cohorts were observed until December 31, 2013. The primary endpoint was occurrence of severe hepatic outcome, including liver failure, liver decompensation, liver transplantation, and liver cancer. **Results:** Among

16,365 newly diagnosed schizophrenia patients, we identified 614 patients with viral hepatitis and 1,228 matched patients without viral hepatitis between January 2002 and December 2013. Of the 1,842 patients, 41 (2.22%) suffered from severe hepatic outcome during a mean follow-up period of 3.71±2.49 years, including 26 (4.23%) from the viral hepatitis cohort and 15 (1.22%) from the control group. In schizophrenia patients, the Cox proportional hazards analysis showed that the risk increased with viral hepatitis by 3.576 (95% confidence interval [CI] [1.862, 6.868], p<0.001). Moreover, schizophrenia patients with HCV had higher risk than those without viral hepatitis (hazard ratio 5.072, 95% CI [1.612, 15.956], p≤0.001). Furthermore, in the viral hepatitis group, patients exposed to paliperidone treatment had reduced risk (hazard ratio 0.208, 95% CI [0.073, 0.592], p=0.089), while those exposed to chlorpromazine use had increased risk (hazard ratio 1.246, 95% CI [0.499, 3.115], p=0.616). Liver decompensation is the most common among schizophrenia patients who developed severe hepatic outcome (76.92%). **Conclusion:** Schizophrenia patients with comorbid viral hepatitis, especially HCV, have higher risk of severe hepatic outcome. Patients receiving paliperidone treatment had reduced risk although not significant. Further evaluation of hepatic function and antipsychotic use in schizophrenia patients with viral hepatitis is needed. **Keywords:** Severe Hepatic Outcome, Viral Hepatitis, Schizophrenia

Rapid-Fire Talks: Focus on Trauma- and Stressor-Related Disorders

No. 1

Coping Mechanism of Community Under War Zone in Afghanistan

Presenter: Afshan Channa, M.B.B.S.
Co-Author: Harim Mohsin

EDUCATIONAL OBJECTIVE:

1) Explore the prevalence of PTSD in war zone inhabitants; 2) Determine the coping mechanism of Afghani inhabitants in war zones; and 3) Understand the association of PTSD with coping styles and other independent variables.

SUMMARY:

Background: The mechanism to cope in a war zone in Afghanistan is uncertain, irrespective of conversation about their resources. This cross-sectional study evaluates the prevalence of PTSD in the inhabitants living in a war zone in Afghanistan and determines their coping style. **Methods:** Afghani soldiers age 12 and above visiting psychiatric services at Liaquat National Hospital, Pakistan, were recruited from October to December 2015. A Pashto-speaking data collector administered the Brief Cope Scale and PTSD checklist (PCL) to determine their coping style and PTSD, respectively. He was blinded to the clinical assessment of the psychiatrist. **Results:** Sixty-seven male patients with mean age 27.99 were recruited. 50.7% were younger than 25, 62.7% were married, 98.5% had conventional madrassa education, 70.1% were unemployed, 89.6% lived in a joint family system, and 94% had strong religious inclination. 44.8% had been personnel for 5–10 years. 73.1% had supportive family. The source of motivation was 45.1% fellow partisans, 26.5% death of loved ones, 23.5% religious beliefs, and 4.9% trauma (e.g., house invasion or witnessing violence). Ninety-seven percent had no PTSD, with a mean score of 27.25. On the contrary, 91% were diagnosed with major depressive disorder employing standard psychiatrist assessment. Conventional madrassa education against PTSD was significantly associated with p value of 0.03. Among adaptive coping styles, active coping was significantly associated against PTSD (p=0.03) and being engaged in a holy war for 5–10 years (p=0.04), emotional support through marriage (p=0.01), positive reframing with unemployment (p=0.04), acceptance with partisans who were strongly religiously inclined (p=0.005), and motivation by fellow personnel (p=0.03). Among maladaptive coping styles, self-distraction was significantly associated with PTSD (p=0.04), unemployment (p=0.04), low religious inclination (p=0.008), and trauma (p=0.01); denial was associated positively with conflictual family attitude toward holy war (p=0.01); substance use with source motivation of trauma (p=0.02); and venting with PTSD (p=0.02), unemployment (p=0.008), joint family setup (p=0.02), and source motivation of the deaths of loved ones (p=0.01). **Conclusion:** Despite

living in a war zone, only three percent of Afghani soldiers reported PTSD. Conventional madrassa education was inversely associated with PTSD. There was significant association of PTSD with active coping, self-distraction and venting coping styles. Moreover, adaptive coping style—active coping, emotional support, positive reframing, and acceptance—and maladaptive coping—self-distraction, denial, substance use, and venting—were more commonly employed. This study may be an insight into the psychological guards against development of PTSD and their strong coping mechanism.

No. 2

High-Lethality Suicide Attempt as a Precipitant of Acute Stress Disorder

Presenter: Alyson Gorun
Co-Authors: Brian Fidali, Caitlin Snow, M.D., William Apfeldorf

EDUCATIONAL OBJECTIVE:

1) Understand attempted suicide as an underrecognized risk factor for developing acute stress disorder (ASD); 2) Demonstrate how ASD following a suicide attempt (SA) can impact treatment considerations and prognosis; and 3) Consider inclusion of high-lethality suicide in screening for potentially traumatic life events.

SUMMARY:

Background: Acute stress disorder (ASD) is a known risk factor for completed suicide. However, little is known about instances in which nonfatal suicide attempts (SAs) might themselves serve as traumatic events that predispose individuals to acute stress reactions. In this talk, we present a case of a woman with an acute stress reaction following a high-lethality SA and discuss the prognostic and therapeutic implications. To our knowledge, this is the first case report to describe an SA as a traumatic event that precipitated ASD. **Case:** Mrs. D. is a 65-year-old married Caucasian woman with bipolar II disorder and no prior hospitalizations or SAs who was admitted to an inpatient psychiatric unit following a high-lethality SA. Prior to admission, Mrs. D. had been functionally incapacitated secondary to three months of severe depression, anxiety, sleep dysregulation, irritability, and impulsivity. On the day of admission, she attempted suicide by placing a space heater into her bathwater, and when that did not result in injury, she used a kitchen knife to lacerate her body, requiring medical admission. At time of transfer to an inpatient psychiatric unit, Mrs. D. exhibited depressive symptoms (HAM-D: 27/58) and marked alexithymia (TAS: 65/100), but no symptoms of mania (YMS: 3/60) or psychosis. Additionally, Mrs. D. met criteria for ASD with suicide attempt-related symptoms of intrusion, negative mood, dissociation, avoidance, and arousal. Mrs. D. received 10 ECT sessions and psychotherapy aimed at her ASD symptomatology. She was discharged 1.5 months later on venlafaxine 225mg daily and valproate 500mg daily (last level 120 µg/mL). Her HAM-D was 4/58. **Discussion:** Screening for SA as a precipitant of an acute stress response is not included in commonly used tools such as the Live Events Checklist. Identification of acute stress symptoms has important prognostic ramifications, including development of PTSD, worsening long-term prognosis and contribution to suicidality. Thus, treatment specifically for ASD symptomatology, including CBT, exposure therapy and psychoeducation, would result from appropriate screening. This case report highlights prognostic and therapeutic importance of recognizing SAs as a trauma. We believe that patients should be screened for acute stress response following high-lethality SAs in order to facilitate early intervention to reduce the patient's risk of developing PTSD and associated comorbidities.

No. 3

The Risk of Secondary Traumatic Stress: Providing Medical and Behavioral Health Care During Combat

Presenter: Elizabeth A. Penix
Co-Authors: Joshua E. Wilk, Paul Y. Kim, Amy B. Adler, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Describe the association between secondary traumatic stress and individual functioning in deployed health care personnel; 2) Discuss the risk associated with specific psychotherapy techniques in secondary traumatic stress reported by a subsample of deployed behavioral health providers; and 3) Identify protective factors that can reduce the risk of

secondary traumatic stress in a subsample of deployed behavioral health providers.

SUMMARY:
Health care personnel responsible for treating trauma patients are at risk for symptoms of secondary traumatic stress (STS). However, there are gaps in understanding STS. First, research regarding the degree to which STS is associated with lower levels of individual functioning is limited and contradictory. Second, it is unclear whether the delivery of specific psychotherapy techniques is associated with STS. Previous research addressing this topic is limited and confounded by global self-report unrelated to actual treatment delivery. Third, STS has not been examined in military health care personnel deployed to combat. These health care personnel experience threats to their own safety while managing the treatment of trauma patients as well. Thus, this study examined STS, individual functioning and the delivery of psychotherapy techniques in a sample of deployed health care personnel. A cross-sectional survey was administered to military health care personnel during a deployment to Afghanistan (N=236) in 2013. Hierarchical regression analyses examined the association between STS and both job performance and family connection, controlling for demographics. For a subgroup of 39 behavioral health providers, STS was regressed on burnout, self-care (e.g., making time for self-reflection, asking for help when needed) and delivery of different psychotherapy techniques (in-vivo exposure, narrative exposure, cognitive restructuring, and supportive psychotherapy). In all, 44% of health care personnel endorsed at least mild STS symptoms. STS was negatively associated with job performance ($p=0.002$) and family connection during deployment ($p<0.001$). In the subgroup analysis, narrative exposure ($p<0.001$) was the only psychotherapy technique associated with STS. In addition, self-care was inversely associated with STS in behavioral health providers. Thus, STS was associated with job performance, family functioning, self-care, and the provision of a specific psychotherapy technique. Together, these findings identify potential risks associated with treating traumatized patients in a deployed context. Results suggest that STS appears to take a toll on individual functioning during deployment. Further, narrative exposure may be a risk factor for the development of STS in behavioral health personnel. As exposure-based techniques are relatively common in evidence-based treatments for PTSD, the association between narrative exposure and STS is of concern. Follow-up work should use a longitudinal design to assess the long-term impact of STS and examine potential methods for protecting health care personnel from STS during a combat deployment, such as self-care.

Sunday, May 21, 2017

Rapid-Fire Talks: Focus on Addiction Psychiatry

No. 1
Synthetic Cannabinoids: An Emerging Threat to Mental Health in New York and the Rest of the United States
Presenter: Agdel J. Hernandez Colon, M.D.
Co-Authors: Iuliana Predescu, Sheikh Hoque

EDUCATIONAL OBJECTIVE:
1) Increase the understanding of the acute and chronic effects of synthetic marijuana on mental health; 2) Emphasize the need for a rapid-screening test to be available in emergency rooms in order to screen/diagnose patients presenting with acute symptoms of suspected K2 use disorders; and 3) Demonstrate knowledge about best treatment strategies for management of acute and chronic use of synthetic marijuana.

SUMMARY:
Background: Recently, there has been a noticeable significant increase in recreational use of synthetic marijuana, especially among young people and the homeless, possibly due to low price, accessibility and high potency. As per the New York Department of Health and Mental Hygiene's 2016 Advisory #20, from July 11 through July 13, 130 individuals experienced adverse events and were transported to emergency departments (EDs) after suspected ingestion of synthetic cannabinoids (SC). Nearly half (46%) of the K2-related ED visits were among residents of Brooklyn neighborhoods. SC act on the same receptors as delta-9-tetrahydrocannabinol but have five times greater affinity. Some of the acute symptoms are intense anxiety, agitation,

hallucinations, paranoia, suicidal ideation, depression, catatonia, nausea, vomiting, high blood pressure, tremor, seizures, and violent behavior, similar to those of phencyclidine (PCP) or cocaine. The chronic effects of SC are less well known; however, the patients who have used it report having cognitive impairments and prolonged psychotic symptoms. SC can be highly addictive, and physical dependence could develop in just a few weeks of regular use. Due to severe withdrawal symptoms, such as cravings, anxiety, insomnia, anorexia, nausea and vomiting, headaches, diaphoresis, and tachycardia, the rate of relapses is increased. Despite the fact that since July 2012 SC have been considered by the DEA as "necessary to avoid imminent hazard to the public safety" due to their high abuse potential and lack of medical use, there is still no lab test available in the EDs to identify SC use. Regarding management, there is insufficient literature regarding the treatment strategies for these patients. Based on clinical experience, guidelines can be established for treatment. **Objective:** The primary aim of this study is to identify the acute and chronic effects of synthetic marijuana by conducting a selective literature review. The second aim is to emphasize the need for a rapid screening test to be available in the ER setting. The third, but not the least important, aim is to suggest guidelines for the management of the patients with acute or chronic use of synthetic marijuana. **Methods:** A selective literature review will be conducted to identify the current information about the effects of synthetic marijuana and management. For the second part of the study, charts will be reviewed to identify subjects who reported using SC. For the subjects who meet the inclusion criteria, data pertaining to age, sex, race, presenting symptoms, duration of use, treatment, concomitant medication, and urine toxicology results will be collected from the charts. The study will be conducted after the IRB approval is obtained. **Results:** Data will be available once study commences, pending IRB review and approval in November 2016, and will be presented during the talk.

Rapid-Fire Talks: Focus on Child and Adolescent Psychiatry

No. 1

Autism Spectrum Disorders and Maternal Lifestyle: Let's Talk About Glucose?

Presenter: Silvia Hoirisch-Clapauch, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Review the mechanisms by which hyperglycemia may affect the developing brain; 2) Discuss the links between risk factors for autism spectrum disorder and abnormalities of carbohydrate metabolism in the mother, the embryo, the fetus, and the neonate; and 3) Provide new insights into the pathogenesis of medication-related autism spectrum disorder.

SUMMARY:

Background: Autism spectrum disorder (ASD) encompass a group of developmental disorders characterized by impaired social interaction, learning, communication, and behavior problems. Functional magnetic resonance imaging in ASD patients has consistently shown white matter disconnectivity, which has been related to abnormal neuronal migration and synaptogenesis. **Methods:** We performed a systematic review to clarify how abnormalities of carbohydrate metabolism may affect the developing brain, increasing the risk of ASD. **Results:** Intrauterine hypoglycemia may cause epigenetic changes that affect gene expression, impairing pathways involved in connectivity. It may also prevent the activation of such pathways or damage the neurons through the formation of oxygen free radicals, lactate or advanced glycation end products. Obesity, stressful life events, alcohol abuse, diabetes mellitus, and terbutaline use are among the many risk factors for intrauterine hyperglycemia that are also risk factors for ASD. Neonatal hypoglycemia, when prolonged or severe, is also a risk factor for ASD. The mechanism seems to involve energy deprivation. We have recently demonstrated that maternal lifestyle within 24 hours before delivery has a tremendous impact on neonatal glucose levels. Apparently, a high-carbohydrate diet near delivery, especially when combined with physical inactivity, would cause maternal hyperglycemia, leading to fetal and neonatal hyperinsulinemia and neonatal hypoglycemia. When these two maternal risk factors were used as screening criteria for neonatal hypoglycemia, more than 10% of the babies

identified were full-term appropriate-for-gestational-age infants born to nondiabetic, slim mothers. Since all of them had been missed by current screening strategies, we postulate that unrecognized neonatal hypoglycemia may have an important role in ASD pathogenesis. Some authors have found evidence of an increased risk for ASD following SSRI exposure during pregnancy. Valproate use, which increases the risk of ASD, reduces the signs of neonatal hypoglycemia. It remains to be determined how SSRIs affect the signs of neonatal hypoglycemia and whether mothers on SSRIs while pregnant with ASD children had an unhealthy lifestyle during pregnancy, especially near delivery. **Conclusion:** The hypothesis that unhealthy maternal lifestyle is a risk factor for ASD should be seriously considered, as lifestyle changes, namely a balanced diet and daily exercise, might have dramatic consequences on improving behavior and enhancing cognition of the offspring.

No. 2

Can Subsyndromal Manifestations of Major Depression Be Identified in Children at Risk?

Presenter: Kenny Lin, M.D.
Co-Author: Mai Uchida, M.D.

EDUCATIONAL OBJECTIVE:

1) Distinguish between pediatric major depression versus subsyndromal depression; 2) Name at least one clinical significance for identifying a child/adolescent with subsyndromal depression; 3) Define the Child Behavioral Checklist (CBCL); and 4) Articulate how the CBCL can be used to identify children of greatest risk for depression.

SUMMARY:

Background: Children of parents with major depression (MDD) are at significantly increased risk for developing major depression themselves; however, not all children at genetic risk will develop MDD. We investigated the utility of subsyndromal scores on the Child Behavior Checklist (CBCL) Anxiety/Depression scale in identifying children at the highest risk for pediatric MDD from among the pool of children of parents with MDD or bipolar disorder. **Methods:** The sample was derived from two previously conducted longitudinal case-control family studies of psychiatrically and pediatrically referred youth and their families. For this study, probands were stratified based on the presence or absence of a parental mood disorder. **Results:** Subsyndromal scores on the CBCL Anxiety/Depression scale significantly separated the children at high risk for pediatric MDD from those at low risk in a variety of functional areas, including social and academic functioning. Additionally, children at genetic risk without elevated CBCL Anxiety/Depression scale scores were largely indistinguishable from controls. Significant Outcomes: 1) We found significant dysfunction in children with subsyndromal range scores on the CBCL Anxiety/Depression scale, indicating that subsyndromal MDD in itself is morbid. 2) Children with elevated CBCL Anxiety/Depression scale scores had significantly elevated lifetime rates of psychiatric disorders compared to those without elevated scores. Children with both elevated CBCL Anxiety/Depression scale scores and a parent with a mood disorder had the highest lifetime rates of psychiatric disorders. Limitations: 1) Included in this analysis were children of parents with MDD or bipolar disorder due to limited statistical power of restricting to parental MDD. 2) Our sample is primarily Caucasian and may not generalize well to other ethnic groups. **Conclusion:** These results suggest that the CBCL Anxiety/Depression scale can help identify children at highest risk for pediatric MDD. If implemented clinically, this scale would cost-effectively screen children and identify those most in need of early intervention resources to impede the progression of depression.

No. 3

Gender-Related Childhood Adversities' Dimensions in the General Population: Does One Size Fit All?

Presenter: Bruno Mendonça Coêlho, M.D.
Co-Authors: Geilson L. Santana, Laura H. Andrade, Yuan-Pang Wang

EDUCATIONAL OBJECTIVE:

1) Understand how common early childhood adversities (ECAs) are experienced by individuals throughout their lives; 2) Learn that ECA are a multidimensional set of risk factors, and some of them are scarcely reported, although they are sensitive data; 3) Comprehend the differences in the dimensionality of ECA in men and women and

understand the correlation between their dimensions in both genders; and 4) Incorporate the lessons from this study into clinical practice in order to learn how to assess ECA and what to expect when assessing them (using the therapeutic alliance to improve such tasks).

SUMMARY:
Childhood adversities (CA) comprise a group of experiences individuals suffer through life, and they are very frequent in the general population. They are implicated in psychiatric outcomes, probably reflecting an underlying common mechanism. Nevertheless, the dimensions of CA involved in later life remain elusive. The aim of this study is to examine the clustering of CA in a representative sample of the general population and to depict their dimensionality investigating their profile by gender. Information on parent mental illness, parent substance misuse, parent criminality, family violence, physical abuse, sexual abuse, neglect, parental death, parent divorce, other parent loss, physical illness, and economic adversity were assessed in 5,037 subjects of the general population. Confirmatory factor analysis model fit indicators, in addition to exploratory analysis, determined the best number of dimensions of CA. Rasch model from item response theory models (IRT) explained the contribution of each adversity on the results. All analyses were also performed by gender. Thus, in order to cater to the whole spectrum of CA and, since some adversities are more difficult to be disclosed, they should be considered clusters of liability factors rather than a distinct group with common characteristics. CA were widespread in 53.6% of the sample; the majority presented with two or more CA. For total sample and for men, a three-factor model had the best model fit, while a two-factor model was better for women. A group of four adversities (physical abuse, neglect, parental mental disorders, and family violence) co-occur independent of the presence of other adversities in both genders and in the total sample. This seems to imply a common component of dysfunctional families and violent environments. This is an important observation since some researchers suggests that the characteristics of the childhood home environment are more important for developing psychopathology, for instance, than the presence of a specific adversity. On IRT models, women endorsed more adversities in comparison to men and to the total sample. Despite low endorsement, five CA were relevant to the sample: sexual abuse, physical illness, parental criminal behavior, parental divorce, and economic adversity. In conclusion, CA are a multidimensional group of events frequently experienced by individuals during childhood and adolescence. Since most CA are sensitive data, the individuals do not easily report some of them in face-to-face interviews. The occurrence profiles of those experiences differ in males and females and, in general, they cannot be seen as a homogeneous group.

Rapid-Fire Talks: Focus on Community Psychiatry

No. 1
Psychiatry in Rural Areas and HIV: Addressing Barriers and Optimizing Access to Care
Presenter: Karl Goodkin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Expand their knowledge and capacity to address the needs of psychiatric patients impacted and affected by HIV; 2) Understand barriers to obtaining psychiatric care in rural areas for populations with HIV; and 3) Identify how to reduce gaps in psychiatric services using telepsychiatry in rural areas for populations with HIV.

SUMMARY:
Background: Data suggest that specific factors separately account for the growth of HIV cases in rural areas. Southern states today account for an estimated 44% of people living with HIV in the U.S., despite having 37% of the overall population. Thus, we will focus on HIV infection in the rural South. We will approach this area from the perspective of two separate trajectories: HIV in rural areas and HIV in the South. A strong consideration for local, community factors will be included in all of the following areas: economic factors; educational institutions; and historic, regional and geographic challenges. Rural factors that can trigger higher rates of HIV include high poverty and incarceration rates, lack of educational opportunities, exposure to substance use and sex work, inadequate transportation systems, barriers to accessing health

care, and shortages of health professionals. **Results:** HIV diagnoses among Black men who have sex with men (MSMs) increased in the Deep South from 25.9% in 2008 to 31.4% in 2013. The Deep South had the highest death rate where HIV was the underlying cause for any region and had the highest number of individuals dying from HIV in 2008-2013 (N=21,308; 43%). Epidemiological evidence for mental health differences between urban and rural areas is variable. Some evidence exists for increased depressive disorders in rural areas that does not always persist after control for other contextual factors. However, prescribed opioid use disorder and neonatal abstinence syndrome have been less frequently investigated, yet these disorders do occur more frequently in rural areas. **Conclusion:** For persons in rural areas, always consider referral to therapies available online. Teletherapy can be provided as email therapy, online chat therapy, videoconference therapy, and computer-guided therapy. Email therapy has the advantages of being able to communicate over great distances and can be accessed at any time; it can allow time to plan the best response and projection on to the therapist. Online chat therapy has the advantages of chatting over a day or setting specific chat time appointments or allowing group chat times to be added to in-person therapy to add potential for later responses after the therapist has been seen to further interpret, process and respond. Videoconference therapy has the advantages of potential for immediate responses with the therapist being enhanced by nonverbal cues and tone of voice being available to interpret, process and respond. Computer-guided therapy uses multiple technologies and represents an intrinsically different electronic technique in which patients type words or speak into a computer microphone and receive therapeutic responses based upon a computerized program-mostly cognitive behavior therapy.

No. 2

Racial and Ethnic Disparities in Identifying and Treating Depression Among Arab, Asian, Black, Hispanic, and White Patients

Presenter: Florence Dallo, Ph.D., M.P.H.
Co-Authors: Deepak Prabhakar, M.D., M.P.H., Brian K. Ahmedani, Ph.D., M.S.W.

EDUCATIONAL OBJECTIVE:

1) Demonstrate an understanding of the proportion of Arab, Asian, Black, Hispanic, and White patients who are screened for depression; 2) Compare positive screening rates for depression among Arab, Asian, Black, Hispanic, and White patients; and 3) Identify the proportion of Arab, Asian, Black, Hispanic, and White patients who are referred for follow-up care after a positive depression screen.

SUMMARY:

Background: As the U.S. becomes more diverse, it is imperative to consider racial and ethnic differences in health outcomes to improve health care in Michigan. Racial and ethnic disparities in the prevalence and treatment of depression are pervasive and well documented. These disparities have been reported using traditional racial and ethnic categories used in the U.S. census. Though helpful, this limits interpretation of the disparity data for racial and ethnic groups that are subsumed under major racial groups. One such ethnic group is Arab Americans, who are classified as "White" Americans in health studies. While there are some preliminary data on mental health among Arab Americans, there is a paucity of research on depression among Arab Americans. Given that the Detroit Metropolitan area has a sizeable Arab-American population (approximately 500,000), it is particularly relevant and important to understand potential disparities in depression prevalence and care using local-level data to improve health care for this population in Michigan. **Objective:** The overall aim of this study is to examine depression identification and treatment approaches by comparing Arab, Asian, Black, Hispanic, and White Americans. The specific aims are to 1) investigate whether Arab Americans are screened for depression at the same rate as other racial and ethnic groups; 2) estimate the proportion of Arab Americans who screen positive for depression compared to other racial and ethnic groups; and 3) assess whether Arab-American patients receive the same types of assessment and treatment services as other racial and ethnic groups after a positive depression screen. **Hypothesis:** We hypothesize that Arab Americans will be screened, screen positive and receive follow-up care less often for depression than White patients and similarly to some minority

groups. **Methods:** This is a retrospective cohort study. The study population will include adult patients (18 and older) seen at Henry Ford Health System (HFHS) in 2014 and 2015. The database captures all diagnoses, procedures, medications, and other clinical data for HFHS patients, including the Patient Health Questionnaire 9 (PHQ-9) depression screening scores collected at primary care and behavioral health visits. The PHQ-9 is a widely used measure of depression and depression severity. The nine items directly map onto the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) criteria for major depressive disorder. Scores range from 0-27 (with 27 indicating the most severe depression), with a score of 10 or higher considered moderate depression and consistent with a *DSM* major depressive disorder diagnosis. In addition, because the database does not capture Arab-American ethnicity, we will augment the identification of Arab Americans by linking administrative data with a validated and reliable Arab surname list. **Results:** Results and analyses of the data will be presented in this talk.

Rapid-Fire Talks: Focus on Psychiatric Rehabilitation and Recovery

No. 1

Palliative Care Approaches in Psychiatry: A Possible Way of Rethinking the Care of Patients Suffering From Severe and Persistent Mental Illness?

Presenter: Manuel Trachsel, M.D., Ph.D.
Co-Authors: Martina Hodel, Scott A. Irwin, M.D., Ph.D., Nikola Biller-Andorno, Paul Hoff, Florian Riese

EDUCATIONAL OBJECTIVE:

1) Specify the crucial factors in the treatment of patients with severe and persistent mental illness; 2) Compare therapy-oriented, recovery-oriented and palliative-oriented approaches in psychiatry; and 3) Discuss the attitudes of psychiatrists toward palliative care approaches for patients suffering from severe and persistent mental illness.

SUMMARY:

Background: Palliative care aims to improve quality of life for patients suffering from a life-threatening disease. Taking as a precedent the treatment of the dying cancer patient, it has been advocated that the benefits of contemporary palliative care should also be available to patients with chronic diseases for which curative treatments are considerably less or no longer promising. The implications of the application of palliative care principles in the context of psychiatry are not much explored, and the sparse debate with regard to this subject is controversial. **Objective:** It is hypothesized that some patients with severe and persistent mental illness (SPMI) may benefit from a palliative approach. The first goal of this study was to identify how psychiatrists conceptualize SPMI and, based on what principles they specify, objectives for treatment. The second goal was to investigate the impact of chronicity, mortality and unbearable suffering on psychiatrists' attitudes to the question of whether patients with SPMI might benefit from a palliative approach. **Methods:** In a nationwide questionnaire-based study, 1,500 members of the American Psychiatric Association (APA) were randomly drawn and surveyed. The survey items asked about psychiatrists' attitudes to the treatment of patients suffering from SPMI. In addition, systematically modified clinical case vignettes were presented to determine what factors psychiatrists assume to be critical in the treatment of patients suffering from SPMI. **Results:** Preliminary findings of the survey are presented, focusing on such questions as "Can mental illness be terminal?" and "How important is a curative approach in the treatment of SPMI?". In addition, findings from participants' evaluations of the clinical cases are discussed. **Conclusion:** This talk illuminates how psychiatrists conceptualize SPMI and discusses the suitability of a palliative approach and potential benefits for this vulnerable group of patients. The findings may contribute to the discussion around remaining treatment options for patients with SPMI once traditional curative approaches are exhausted.

No. 2

Efficacy of Long-Term Residential Treatment for Serious Mental Illness

Presenter: Michael Knable, D.O.

EDUCATIONAL OBJECTIVE:

1) Understand the design of a comprehensive residential treatment program; 2) Understand efficacy of residential treatment in reducing

symptoms; and 3) Understand efficacy of residential treatment in improving employment and socialization skills.

SUMMARY:
Background: Most jurisdictions in the United States have a large unmet need for long-term care in private and public sectors for patients with serious mental illness (SMI). The availability of state hospital beds has declined dramatically in recent decades, and the number of residential beds for patients with SMI in the U.S. is substantially lower than that found in other developed countries. In this talk, we present results from the first 85 patients treated at ClearView Communities, a long-term residential treatment center in Frederick, Maryland. **Methods:** The study design was naturalistic follow-up of consecutively admitted patients to a private residential treatment center. Patients were treated with a variety of psychotherapies, supported employment and evidence-based psychopharmacology. **Results:** The mean age of the patients was 29.3; they had been ill for an average of 12.2 years and had had an average of 6.3 prior hospitalizations. The average length of stay in residential treatment was 6.6 months. Diagnoses of the treated patients were 39% schizophrenia, 51% mood disorders and 11% other disorders. There was a significant degree of comorbidity with personality disorders and substance use disorders. On average, patients experienced a 17% improvement on functional measures (Multnomah Community Ability Scale), a 25% reduction in scores related to psychosis (Brief Psychiatric Rating Scale), and a 76% reduction in scores related to depression (Montgomery-Åsberg Depression Scale). On average 38% of discharged patients were competitively employed, 16.7% were working as volunteers, and 30.7% were attending school. On average, 56.7% of discharged patients were living independently, 13.7% were living with family members, 15.7% were in other residential facilities, 2% had been readmitted, 1% was hospitalized, 2% were homeless, 3.7% had died from medical illnesses, and 3.7% had died from suicide. The hospitalization rate prior to admission was 0.84 admissions per year, and the hospitalization rate for discharged patients was 0.57 admissions per year. **Conclusion:** Although not a randomized, controlled trial, the results from this naturalistic study suggest that residential treatment improves illness and functional outcomes for patients with SMI.

No. 3
Diabetes Quality of Care and Outcomes: Comparison of Individuals With and Without Schizophrenia
Presenter: Paul Kurdyak, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the burden of diabetes among individuals with schizophrenia; 2) Learn about the quality of diabetes care among individuals with schizophrenia compared to those without; and 3) Learn about the impact of schizophrenia on diabetes-related adverse health outcomes.

SUMMARY:
Objective: Individuals with schizophrenia are more likely to develop diabetes than individuals without schizophrenia. The objective of this study was to determine the quality of diabetes care and diabetes-related health outcomes among individuals with and without schizophrenia. **Methods:** We conducted a retrospective cohort study. As of April 1, 2011, we identified all individuals with diabetes in Ontario with and without a diagnosis of schizophrenia. The main outcomes were quality of diabetes care (guideline-concordant testing for HbA1c, lipid testing and eye exams) and diabetes-related emergency department (ED) visits and hospitalizations between April 1, 2011, and March 31, 2013. We compared quality of care and diabetes outcomes among those with and without schizophrenia, adjusting for demographic, illness severity and health service utilization variables. **Results:** We identified 1,131,375 individuals with diabetes, among whom 25,628 (2.3%) had schizophrenia. Schizophrenia was associated with reduced likelihood of optimal diabetes care (all three of HbA1c, lipid testing and eye exams) (adjusted OR [AOR]=0.64, 95% CI [0.61, 0.67]) and increased likelihood of diabetes-related ED visits (AOR=1.34, 95% CI [1.28, 1.41]) and hospitalizations (AOR=1.36, 95% CI [1.28, 1.43]). **Conclusion:** Individuals with diabetes and schizophrenia have lower rates of recommended testing and higher rates of diabetes-related hospital visits than those with diabetes but without

schizophrenia. Research is needed to understand patient, provider and system factors underlying these disparities and test related interventions to close the gaps in quality of care.

Rapid-Fire Talks: Focus on Somatic Treatments

No. 1

Electroconvulsive Therapy (ECT) in Treatment-Resistant Depression (TRD): A 12-Month Cohort Study in the City of Milan, Italy

Presenter: Dario Delmonte
Co-Authors: Silvia Brioschi, Barbara Barbini

EDUCATIONAL OBJECTIVE:
1) Understand when ECT could be a useful therapy; 2) Understand the long-term outcome of ECT; and 3) Understand the main variables associated with better/worse outcome of ECT.

SUMMARY:
Background: Despite appropriate treatment, 30-40% of patients with a depressive episode don't achieve improvement. Depression is associated with high morbidity and mortality. Pharmacological treatment is the first choice; other approaches are widespread. In Milan, we treat about 20 inpatients per year with ECT for TRD (Thase and Rush criteria). Although ECT is considered one of the most effective antidepressant therapies, the maintenance strategy and relapse prevention still remain an open topic. We performed an observational study for responsiveness, tolerability and long-term outcome of ECT, analyzing main predictors. **Methods:** The sample was recruited between 2005 and 2015: 54 inpatients undergoing bitemporal ECT twice per week with MECTA spectrum device. We collected main demographic and clinical data. Hamilton Rating Scale for Depression (HAM-D) and Mini Mental State Evaluation (MMSE) were administered before and after the treatment to assess the course of illness. Follow-up evaluations were performed at the first, third, sixth, and 12th month after treatment. Clinical response was defined as 50% reduction of HAM-D score at the endpoint from baseline, remission as HAM-D score at the endpoint less than 8. T-Test, χ^2 and survival analysis were performed. **Results:** 33 (61.1%) females and 21 (38.8%) males participated in the study (mean age 59.1±11.4 years): 40(74.0%) bipolar, 14(25.9%) major depression. Mean age at onset was 40.2±13.8. Mean number of episodes was 4.6±3.5. Mean duration of current episode was 47.6±36.9 weeks. Mean HAM-D basal score was 30.6±4.9. Twenty-three patients (42.5%) had severe delusional depression, and 13 (24.1%) attempted suicide. Each patient underwent a cycle of ECT (mean N° 7.0±2.9). Pharmacological treatment was administered upon clinical need. We had a response rate of 92 and a remission rate of 44%. No patient discontinued the treatment due to side effects. During the follow-up period, we had the following relapse rates: within the first month, 5.5%; within the third, 3.7%; within the sixth, 16.6%; and within the 12th, 14.8%. At the end of the follow-up period, 32 of 54 patients (59.4%) exhibited well-being. Predictors of higher relapse rate were longer period of depression (T=3.9, p=0.00), basal MMSE score under 25 (χ^2=2.9, p=0.08), concomitant cerebrovascular abnormalities (Kaplan and Meier survival analysis, p=0.06). Predictor of lower relapse rate was remission (χ^2=2.5, p=0.1). **Conclusion:** Our Italian experience confirms that ECT is a powerful antidepressant, especially in patients with severe long-lasting depression, refractory to treatment. ECT is also a safe procedure; no adverse effects were reported in our sample. After the 12-month observation period, 60% of patients were still well, treated with pharmacotherapy. Mild cognitive impairment and/or structural abnormalities (atrophy, vasculopathy) together with a longer period of illness were the main variables associated with worse response rates and higher relapse rates. Early intervention and full acute remission are predictors of better outcome.

No. 2

Electroconvulsive Therapy in Transitional Age Youth

Presenter: Nicole M. Benson, M.D.
Co-Authors: Stephen J. Seiner, M.D., Paula Bolton, M.S., Robert C. Meisner, M.D., Casey Pierce, B.A., Garrett Fitzmaurice, Sc.D., Alisa B. Busch, M.D., M.S.

EDUCATIONAL OBJECTIVE:
1) Understand that transitional age youth constitute a unique clinical population with distinct psychiatric and neurodevelopmental characteristics; 2) Understand that when electroconvulsive therapy is used in transitional age youth, it is associated with

clinical improvement in this population; and 3) Consider the association between substance use and clinical improvement in transitional age youth who receive electroconvulsive therapy when considering such treatments.

SUMMARY:
Background: Transitional age youth (TAY) constitute a unique clinical population with distinct psychiatric and neurodevelopmental characteristics. Electroconvulsive therapy (ECT) is a highly efficacious, well-tolerated treatment for major depressive disorder (MDD) and psychosis in adults; however, little is known about the effectiveness of ECT in TAY. **Objective:** Assess whether acute phase ECT in TAY is associated with improvements in clinical outcomes and whether screening positive for a substance use disorder (SUD; alcohol or drug) is associated with differences in treatment outcomes compared to those screening negative for SUD. **Methods:** All patients age 16-25 (TAY) who received ECT at McLean Hospital between May 2011 and January 2016 and who, prior to starting ECT, completed self-reported SUD screens (AUDIT-C and a single-item drug screen) and the Behavior and Symptom Identification Scale-24 (BASIS-24) completed the BASIS-24 again after the fifth ECT treatment. For five of the BASIS-24 domains (i.e., all domains except SUD), longitudinal changes in mean BASIS-24 domain scores from baseline to the fifth ECT treatment were assessed; mean changes by SUD screening status were also examined using linear mixed models. **Results:** A total of 186 TAY met inclusion criteria for the study. Sixty-one percent screened positive for SUD; the mean age was 21.2±2.6. Among all patients, ECT was associated with significant clinical improvement (score decreases) in all five BASIS-24 domains during the acute phase treatment: depression/functioning (-0.701±0.066, p<0.001), interpersonal relationships (-0.353±0.062, p<0.001), self-harm (-0.622±0.068, p<0.001), emotional lability (-0.284±0.061, p<0.001), and psychosis (-0.124±0.042, p=0.004). Compared to TAY screening negative for SUD, TAY with co-occurring SUD had greater improvement in depression/functioning (-0.411±0.129, p.=0.002) and emotional lability (-0.314±0.121, p=0.010) domains after five ECT treatments. **Conclusion:** ECT in TAY was associated with significantly improved clinical outcomes during acute phase treatment. TAY screening positive for SUD had better acute phase ECT outcomes in self-reported depression/functioning and emotional lability than TAY screening negative for SUD. More research is needed to further clarify TAY patient characteristics that may be associated with differential ECT outcomes and to determine whether the differential improvement in depression/functioning and lability for TAY who screen positive for co-occurring SUD may be due to confounding factors such as temporary abstinence from substances during treatment.

No. 3
Subtypes of Depression Predicting a Severe Course of Illness: Insights From Data-Driven Studies
Presenter: Hanna M. van Loo, M.D.

EDUCATIONAL OBJECTIVE:
1) Obtain knowledge of characteristics of a severe subtype of depression; 2) Understand course of depression as a multifactorial phenomenon; and 3) Be acquainted with new data-driven methods to classify psychiatric disorders.

SUMMARY:
Background: Patients with major depressive disorder (MDD) differ considerably in terms of clinical presentation, course of illness and etiology, which complicates "one size fits all" solutions in research and treatment assignments. Clinical subtypes of depression have not resolved this problem, as these were shown to have limited predictive value. The goal of our study was to search for data-driven subtypes of depression as an alternative, i.e., subtypes informed by similarity patterns in data. **Methods:** We used data from 8,261 respondents with lifetime *DSM-IV* MDD in the World Mental Health Surveys to discover subtypes of depression predicting subsequent course of illness. Two data mining techniques, ensemble recursive partitioning and Lasso-generalized linear models, followed by k-means cluster analysis were used to search for subtypes based on a broad set of depressive and anxiety symptoms during the index episode, family history and lifetime comorbidity. Course of illness measures included persistence (number of years with an episode, number of years with an episode

lasting most of the year) and severity (hospitalization for MDD, disability due to MDD). The identified subtypes were validated in an independent prospective validation sample of 1,056 subjects with lifetime MDD in the National Comorbidity Survey in order to obtain accurate estimates of prediction accuracy. **Results:** We found three subtypes of depression characterized by a severe, moderate and mild course of illness, mainly differentiated by a combination of anxiety, suicidality and a young age of onset during the initial depressive episode. Addition of information on lifetime psychiatric comorbidity resulted in subtype distinctions that were more accurate in distinguishing between patients with a more and less severe course of illness; in particular, anxiety disorders were associated with a more severe course of illness. Prediction accuracy of these subtypes was promising: in the validation sample, area under the curves (AUCs) for the three-cluster classification varied between 0.63 and 0.71 for the outcomes indicating years with (chronic) episodes and 0.73 and 0.76 for outcomes indicating severity (hospitalization, suicide attempts and disability). **Conclusion:** Results suggest that clinically useful MDD subtypes can be discovered using data mining methods. Furthermore, these subtypes were multifactorial-different types of predictors (symptoms, comorbidity, family history) improved prediction accuracy. Future research is warranted to further improve prediction accuracy and test the subtype distinctions in clinical samples in order to benefit decision making in clinical practice.

Rapid-Fire Talks: Focus on Women's Health

No. 1

MAANASI—Of Sound Mind—A Program by Women for Women: Mental Health of Six Million People on a Shoe String Budget

Presenter: Geetha Jayaram, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the epidemiology of depression worldwide in low- and middle-income countries; 2) Develop culturally congruent interventions through integrated care; and 3) Assess outcomes and sustain program objectives over a decade.

SUMMARY:

One in four persons is affected by a mental disorder at some point in their lives. By 2030, depression will be a leading cause of disease burden globally. Close to a million people die of suicide each year. In low- and middle-income countries, over 75% of the mentally ill receive no care. Lack of resources and uncoordinated and inefficient systems of care are pervasive. The rates of common mental disorders among women are twice or more the rate among men. Young persons commit suicide at three times the rate in developing countries as that seen in Western countries. An aim of the WHO comprehensive mental health plan 2013-2020 is to focus on social and health care, scaling up of services, disseminating information on mental health needs, and diminishing stigma. The Maanasi program, initiated and directed by a partnership of academicians, Rotarians and other humanitarian efforts, has met the needs of six million households and 206 villages since its inception in 2002. The 26-minute video gives a detailed psychiatric presentation of cultural expressions of both common and psychotic mental disorders, their successful treatment and rehabilitation of female patients. The video depicts one transatlantic global effort at integrated mental health care in the true spirit of community psychiatry, offering a low-cost model that can be emulated in both low-income countries as well as developed nations.

No. 2

Women and PTSD: Sex-Based Differences and Military Impact

Presenter: Paulette R. T. Cazares, M.D., M.P.H.
Co-Author: Elizabeth Yoder, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the differences in prevalence of PTSD in men and women; 2) Describe sex-based differences in the etiology of PTSD; 3) Describe sex-based differences in treatment of PTSD; 4) Describe the differential impact sex-based differences have on women in the military; and 5) Describe resources available to active duty women with PTSD.

SUMMARY:

Evidence is mounting that shows sex-based

differences in the etiology, management and treatment of PTSD. In women, there is particular focus on the differences in etiology of this disorder and how that relates to treatment. Specifically, assault, including domestic violence and sexual assault, are risk factors for women. These types of trauma may be more successfully treated with specific therapies. This background is equally true for women in the military. Although the number of women is increasing across all services, active duty women also face the risk of gender isolation and exposure to combat. This talk details the general background of the sex-based differences in PTSD and how this relates to military women and military readiness. Further, it details the growing resources available to women on active duty.

No. 3

Psychiatrically Ill, Scared and Pregnant: Implications of Fear-Driven Avoidance of Psychotropics in Pregnancy

Presenter: Simriti K. Chaudhry, M.D.
Co-Author: Leah Susser, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand how fear of psychiatric medication exposure in pregnancy often leads to undertreatment of moderate or severe mental illness during pregnancy; 2) Demonstrate how fear-driven avoidance of psychotropics during pregnancy can paradoxically lead to more exposure to both untreated illness and increased medication exposure than may have otherwise been required; 3) Understand the risks and effects of maternal illness exposure on the developing fetus; and 4) Demonstrate aforementioned points using an example of a woman with OCD with illness obsessionality in pregnancy leading to undertreatment of psychiatric illness and to psychiatric hospitalization.

SUMMARY:

Background: There is a paucity of literature discussing how anxiety of medication exposure in pregnancy subsequently results in undertreatment of maternal psychiatric illness. There is little discussion of the implications of avoidance of appropriate medication management in pregnancy. Avoidance of pharmacotherapy in pregnancy can increase fetal exposure to illness and contribute to progression of illness, which may require higher medication doses and/or more medications than may have otherwise been used to treat illness in less acute stages. **Objective:** The purpose of this talk is to highlight the consequences of fear-driven avoidance of pharmacotherapy in pregnancy and demonstrate how it can result in paradoxical increased fetal exposures to both medications and maternal illness. Though medication exposure has potential risks to the fetus, in some cases, the risks of untreated severe mental illness may be greater than medication exposure. We review literature that shows exposure to maternal illness is not benign. **Methods:** We present a case report of a pregnant woman who was psychiatrically hospitalized at 26 weeks for severe OCD. Her obsessions and compulsions were related to believing that she and her daughter had various severe medical illnesses. Her OCD symptoms prevented her from being treated, both because her compulsions interfered with attendance at therapy appointments and because of her delusional level of fear of effects of medication exposure on the developing fetus. We use the case to exemplify how avoidance of pharmacotherapy in pregnancy results in additive exposures of both medications and illness to the developing child. We discuss a review of literature of the effects of untreated psychiatric illness and subtherapeutic medication exposure on child outcome. **Results:** A 33-year-old woman, 26 weeks pregnant, was psychiatrically admitted for worsening obsessions of various serious medical illnesses in both herself and her three-year-old daughter. The patient's obsessions related to medical illness also manifested with delusional concerns about the effects of medication exposure on the developing fetus. These fears resulted in the patient taking a subtherapeutic dose of sertraline (25mg) and severe worsening of her OCD, which ultimately resulted in poor self-care and psychiatric hospitalization. Her fear of medication exposure led to increased fetal exposure to maternal illness. In many cases, fear of in utero psychiatric medication exposure for severe mental illness can lead to both worsening of maternal illness and to increased medication exposure from high psychotropic doses or polypharmacy required to treat the more severe illness. **Conclusion:** Avoidance or delay in

pharmacotherapy in the pregnant, severely psychiatrically ill patient may lead to greater adverse effects on maternal and child outcomes as a result of the patient's progression to more severe illness and exposure of subsequent high medication doses and maternal distress.

Monday, May 22, 2017

Rapid-Fire Talks: Focus on Academic Psychiatry

No. 1

***Research Watch*: Development and Educational Impact of a Resident-Led Research Newsletter**

Presenter: Awais Aftab, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the development and structure of a resident-led research newsletter; 2) Appreciate the educational impact of a resident-led research newsletter; and 3) Recognize that resident-led research newsletters could be another potential tool for educators in residency training.

SUMMARY:

Background: *Research Watch* is a monthly newsletter created and managed by psychiatry residents at University Hospitals Case Medical Center/Case Western Reserve University. It aims to inform residents and faculty of notable articles published in prominent psychiatry journals. Such resident-led research digests in residency programs are uncommon, and to the best of our knowledge, the educational impact of such an initiative on resident learning has not been reported before. A dedicated team of curators, headed by a chief curator, reviews psychiatry research journals and provide concise summaries of the results and findings. This project was launched in August 2016. The curator team, under the guidance of the chief curator, selects key psychiatric journals and divides them among curators for review. A regular feature titled "Highlights" further synthesizes the key points of each reviewed article, creating a high-yield section that is quick to read. Once assembled, the newsletter is circulated via email to the residents and faculty. Of note, this research digest has been lauded as valuable by the Ohio Psychiatric Physicians Association, and all issues of the e-publication are available for viewing on their website. We wondered if this project has had an impact on the scholarly interests and productivity of our trainees. By means of a self-report resident survey, we set out to investigate this question. We hypothesized that the newsletter exerts educational impact with a dose-response relationship. **Methods:** An anonymous, voluntary paper questionnaire was distributed to all psychiatry residents at the program. The survey inquired about the degree of exposure (quantified as "exposure index") and contribution to the newsletter, and a set of questions asked residents to estimate how much of the improvement they attributed to the influence of the newsletter, rating the attribution between 0% and 100%, in the areas of interest in scholarly activities/research, knowledge of current psychiatric research and participation in scholarly activities/research. The survey also inquired if the newsletter had any impact on their clinical practice. **Results:** There was a response rate of 93%. The percentage of residents reporting perceived non-zero impact of the newsletter was 44%, 48%, 40%, and 40% in each of the following areas: interest in scholarly activities/research, knowledge of current psychiatric research, participation in scholarly activities/research, and clinical practice. The degree of exposure and contribution to the newsletter positively correlated with various areas of educational impact, consistent with hypothesized dose-response relationship. **Conclusion:** Resident-led research newsletters could be a potential tool for educators. This talk will also detail how various barriers in development were overcome and how a process for selection and review of articles was created. Furthermore, the author will discuss how this could be feasible in other residencies.

No. 2

Comfort Level and Barriers to the Appropriate Use of Clozapine for Patients With Schizophrenia Disorders Among U.S. Psychiatric Residents

Presenter: Balwinder Singh, M.D., M.S.

Co-Authors: Andrew Hughes, M.D., James L. Roerig

EDUCATIONAL OBJECTIVE:

1) Identify current clozapine prescription practices among U.S. psychiatric residents and fellows; 2) Provide insight into specific reasons for clozapine

prescription hesitancy; and 3) Identify areas for improving appropriate prescription of clozapine.

SUMMARY:
Background: Clozapine is the treatment of choice for treatment-resistant schizophrenia; however, physicians' prescribing practices reveal that only five percent of patients are being prescribed clozapine in the United States. Prior surveys of mental health providers have identified multiple causes for underutilization of clozapine, notably prescribers' limited knowledge, lack of experience and significant discomfort with clozapine's side effect profile. However, no previous survey has been conducted to assess the U.S. psychiatric residents' level of comfort in prescribing clozapine. **Objective:** The purpose of this study was to assess the comfort levels and barriers to appropriate use of clozapine by U.S. psychiatric residents and fellows. **Methods:** An online survey was sent to program directors of ACGME-affiliated psychiatry residency programs. An accompanying email requested the survey to be distributed to current residents. The survey included questions regarding demographics, clozapine prescribing practices, comfort levels with prescribing, and perceived barriers to prescribing. Two reminder emails were sent before the survey was closed. **Results:** A total of 164 residents completed the survey; 52% were female and 84% were in the age group of 25-34. Thirty-seven percent of responders were in the early part of their training (PGY-1 and -2), and 63% were PGY-3 or higher. Only one-third of respondents had a clozapine clinic in their program. Regarding indication of clozapine use, 99%, 84%, 76%, and 56% of the residents were aware of the use of clozapine for treatment-resistant schizophrenia, recurrent suicidal behavior, untreatable extrapyramidal side effects/tardive dyskinesia, and Parkinson's disease psychosis, respectively. About two-thirds of residents responded that their patients met the criteria for clozapine use, of which two-thirds had one to five patients on clozapine. For those who started clozapine treatment for their patients, the majority (82%) reported a significant improvement on clozapine. Only five percent responded that their patients stopped clozapine, and four percent had significant side effects. Only 18% of the residents felt very comfortable in initiating clozapine, and 41% felt somewhat comfortable. The two main reasons for not starting the patient on clozapine were 1) side effect profile (41%) and 2) limited experience and inadequate training in clozapine use (38%). More than four-fifths of residents (83%) responded that they would feel more comfortable in prescribing clozapine if they were trained in a clozapine clinic. **Conclusion:** Despite having many patients who qualify for clozapine treatment, 41% of residents do not feel comfortable with its prescription. Primary concerns include the side effect profile, frequent blood monitoring and a lack of experience with its use. The majority of respondents felt that they would be more comfortable prescribing clozapine if they had the opportunity to train in a clozapine clinic.

No. 3
A Simulation to Teach Integrated Care in Undergraduate Medical Education: "Getting to Know Patients' System of Care" (GPS-Care) Experience
Presenter: Zarah K. Chaudhary, M.Sc.
Co-Authors: Sanjeev Sockalingam, M.D., Maria Mylopoulos, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe a novel simulation-based integrated care educational experience in undergraduate medical education to support training in complexity and chronicity; 2) Identify areas of impactful learning pertaining to the experiences of complex patients' interaction with the system of care; and 3) Identify core concepts of integrated and collaborative care training that can foster integrated care competencies in the context of the broader undergraduate medical curriculum.

SUMMARY:
Background: Increasing patient complexity with co-occurring physical and mental health issues has led to the emergence of integrated care models of practice. Despite their prominence, limited literature exists on how to introduce integrated care training for complexity comorbidity early in undergraduate medical education (UME). What is more, no existing interprofessional collaboration training program to date has employed simulation, a potential model to support training for integrated physical and mental

health care. This study explored medical students' perceptions regarding a novel UME integrated care educational experience called the "Getting to Know Patients' System of Care" (GPS-Care). Its aim was to provide a patient perspective of care coordination and system navigation challenges using an interprofessional simulation-based experience. Specifically, GPS-Care uses a patient-centered approach to allow medical students to understand experiences of complex patients' interaction with community agencies and other health professionals as part of chronic disease management. **Methods:** The GPS-Care Experience is a simulation program where medical students role play scripted patients with comorbid physical and mental health conditions and experience patients' navigation care challenges as they undergo simulated visits with various health care professionals to address their specific health needs. Twenty first- and second-year medical students participated, and 19 completed written reflections following debrief. We conducted a qualitative thematic analysis of students' written reflections consisting of coding and interactive analysis to generate themes. **Results:** Qualitative analysis of students' written reflections generated four key areas of impactful learning: 1) understanding the perspective of the patient with co-occurring physical and mental health illnesses; 2) understanding the system of care; 3) an increased understanding of patients' integrated care needs; and 4) a desire to facilitate the holistic and integrated care of patients in order to fulfill the needs of patients with complex mental and physical illnesses. **Conclusion:** The GPS-Care Experience is a novel approach to introducing core concepts of integrated care early into preclinical training. After participating in GPS-Care, students reported a better understanding of patients' experiences with comorbid physical and mental health conditions and the related challenges with navigating the health care system. Specifically, students had increased awareness of patient values, systems of care and patient navigation issues (e.g., care fragmentation) and expressed a desire for improving integrated and holistic care in their future practice and novel approaches to achieving continuity of care. Our data demonstrate the value of adopting principal features of the GPS-Care simulation in UME to inspire students to be adaptive in their future practice in meeting complex patients' needs.

Rapid-Fire Talks: Focus on Bipolar and Related Disorders

No. 1

Panic Attacks Induced by a Computer Simulation in Patients With Panic Disorder and Agoraphobia

Presenter: Rafael C. Freire, M.D., Ph.D.
Co-Authors: Veruska Andrea-Santos, M.A., Rafael F. Garcia, Antonio E. Nardi, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the methods to provoke panic attacks in panic disorder patients; 2) Recognize the importance of exposure to computer simulations and virtual reality in the treatment of panic disorder; and 3) Acknowledge that computer simulations are useful tools in panic disorder research.

SUMMARY:
Background: There are several useful methods to induce anxiety in patients with panic disorder with agoraphobia (PDA). In a previous study, a computer simulation (CS) induced anxiety in medicated PDA patients, but few had panic attacks. Our aim was to ascertain if a CS could induce panic attacks and anxiety in PDA patients not under medication. **Methods:** Sixteen healthy controls (HC) and 16 patients who fulfilled *DSM-IV* criteria for PDA were recruited for this study. These patients were not on pharmacological treatment. The anxiety level was measured with the Subjective Units of Distress Scale (SUDS) before, during and after the exposure. The Diagnostic Symptom Questionnaire (DSQ), used to evaluate panic attack symptoms, was rated after the exposure. Panic attacks were considered present if there were four or more symptoms, according do *DSM-IV* criteria. The CS was a 3D computer animation of a short bus trip from a first-person perspective. **Results:** Anxiety levels at baseline were higher for the PDA patients, compared to HC. The exposure produced an anxiety increase in PDA patients, but anxiety levels did not increase in HC. Patients had high DSQ scores (15, SD=10) and 93.8% (N=15) of them had panic attacks, while controls had low DSQ scores (1, SD=1; $p<0.05$) and only 6.2% (N=1) had panic attacks. **Conclusion:** This study

indicated that CS exposure may induce anxiety and panic attacks in patients with PDA. CS exposure may be a useful tool in the research and treatment of PD patients.

No. 2
Treating Major Depression With Yoga: A Randomized Controlled Pilot Trial
Presenter: Sudha Prathikanti, M.D.

EDUCATIONAL OBJECTIVE:
1) Summarize overall effectiveness and limitations of conventional treatments for major depression, including existing pharmacotherapies and psychotherapies; 2) Compare the design and results of our clinical trial of yoga for major depression with previous yoga studies described in the literature; and 3) Offer suggestions for future research on yoga for depression, based on our study findings.

SUMMARY:
Background: Conventional pharmacotherapies and psychotherapies for major depression are associated with limited adherence to care and relatively low remission rates. Yoga may offer an alternative treatment option, but rigorous studies are few. **Objective:** This randomized controlled trial with blinded outcome assessors evaluated an eight-week hatha yoga intervention as mono-therapy for mild to moderate major depression. **Methods:** Investigators recruited 38 adults in San Francisco meeting criteria for major depression of mild to moderate severity, per structured psychiatric interview and scores of 14-28 on Beck Depression Inventory-II (BDI). At screening, individuals engaged in psychotherapy, antidepressant pharmacotherapy, herbal or nutraceutical mood therapies, or mind-body practices were excluded. Participants were 68% female, with mean age 43.4 years (SD=14.8, range=22-72) and mean BDI score 22.4(SD=4.5). Twenty participants were randomized to 90-minute hatha yoga practice groups twice weekly for eight weeks. Eighteen attention control participants were randomized to 90-minute yoga history education groups twice weekly for eight weeks. Certified yoga instructors delivered both interventions at a university clinic. Primary outcome was depression severity, measured by BDI scores every two weeks from baseline to eight weeks. Secondary outcomes were self-efficacy and self-esteem, measured by scores on the General Self-Efficacy Scale (GSES) and Rosenberg Self-Esteem Scale (RSES) at baseline and eight weeks. **Results:** In intent-to-treat regression analysis, yoga participants exhibited significantly greater eight-week decline in BDI scores than controls (p=0.034). In subanalyses of participants completing final eight-week measures, yoga participants were more likely to achieve remission, defined per final BDI score of 9 (p=0.018). Effect size of yoga in reducing BDI scores was large, per Cohen's d=-0.96 [95%CI, -1.81 to -0.12]. Intervention groups did not differ significantly in eight-week change scores for either the GSES or RSES. **Conclusion:** In adults with mild to moderate major depression, an eight-week hatha yoga intervention resulted in statistically and clinically significant reductions in depression severity.

Rapid-Fire Talks: Focus on Forensic Psychiatry—Part 2

No. 1
Medicolegal Considerations in Treating Patients With Severe and Enduring Anorexia Nervosa
Presenter: Patricia Westmoreland, M.D.

EDUCATIONAL OBJECTIVE:
1) Define the term severe and enduring eating disorders; 2) Appreciate difficulties in certifying patients with anorexia nervosa; 3) Understand when certification is likely to be helpful; 4) Distinguish between harm reduction, palliative care and end of life care; and 5) Appreciate circumstances in which end of life care is appropriate for patients with anorexia.

SUMMARY:
Anorexia nervosa is the psychiatric illness with the highest mortality rate. Impaired judgment and cognition (due to the effects of starvation on the brain) often result in patients refusing treatment. Treatment is effective if patients are treated early in the course of their illness and undergo full weight restoration as well as intensive therapy. Involuntary treatment can be both lifesaving and critical to recovery. Between April 2012 and March 2016, 109 patients (5.2% of patients admitted to Eating Recovery Center (ERC) in Denver) were certified.

Thirty-nine percent of these patients were transferred from ACUTE, a medical unit established to treat patients with severe medical complications resulting from their eating disorders. Thirty-one percent of certified patients successfully completed treatment. Forty-two percent of certified patients returned for a further episode of care at ERC. Twenty-four percent of certifications were terminated, as involuntary treatment was not found to be helpful. Conclusions that are supported by these data are that 1) patients with anorexia nervosa who are the most medically ill often require involuntary treatment and 2) while many patients who are certified successfully complete treatment, involuntary treatment is not helpful almost one-quarter of the time. Many of these patients for whom certification is ineffective are those who suffer from severe and enduring eating disorders (SEED). Patients with SEED often experience cyclical weight restoration and weight loss. Many of these patients question the value of serial treatments or continued care. They often consider a harm reduction model or palliative care. Patients, families and providers may also contemplate if a compassionate death would be better than an ongoing lifetime of suffering. While there are arguments for and against futility in SEED, it is critical to understand whether (or when) patients are competent to make the decision to continue active treatment or to die.

No. 2

Transforming Incompetence: A Matter of Time

Presenter: Cristina M. Secarea, M.D.
Co-Author: Philip Candilis, M.D.

EDUCATIONAL OBJECTIVE:

1) Define competence and incompetence to stand trial; 2) Describe the restoration process in state facilities; 3) Recognize factors influencing length of time to restoration; 4) Offer guidance in estimating the time needed for restoration; and 5) Identify remediable variables influencing restorability.

SUMMARY:

The forensic literature is unclear on the most consistent influences on length of time needed to restore (LOR) inpatients' competence to stand trial. Some studies find that a younger age at admission and a more severe charge are associated with an increased likelihood of restorability, while others emphasize the relationship between LOR and IQ or diagnosis. Generally speaking, intellectual developmental disorders and psychotic disorders have a strong influence, although differences in sample size and population affect the generalizability of data. The two largest restorability studies in the literature agree on some factors that positively influence adjudicative competence, like younger age, female sex and presence of mood disorder, but disagree on the influence of psychosis. Other studies do not comment on LOR, and only one study focuses on "treatment-specific variables" like medication adherence and "behavioral management problems" like seclusion and restraint. No studies appear to explore the influence of specific classes of medication or emergency episodes requiring involuntary medication. Our sample consists of 312 incompetent to stand trial (IST) inpatients at a state psychiatric facility. 78.2% were male, and 52.2% belonged to the youngest age group (18-40). The two most common diagnoses were psychotic disorders and substance use disorders. The mean length of time for competence restoration was 56.3 days. We found a significant difference ($p<0.01$) in LOR by type of charge, where IST inpatients charged with a felony had longer LOR compared to misdemeanors. With regard to diagnosis, IST individuals diagnosed with cognitive disorders and psychotic disorders trended toward longer LOR ($p=0.24$ and 0.06). IST inpatients treated with antipsychotics had the longest LOR, whereas IST inpatients with no prescribed medication had the shortest. Medication nonadherent patients restored seven days faster than the ones complaint ($p=0.11$). Unlike other competency restoration studies, we explore the effect of treatment adherence on restoration by monitoring refused doses of psychotropic medication and categorizing the refusals by medication class. By identifying specific adherence factors influencing time to competence restoration, we anticipate drawing more precise conclusions about the remediable factors influencing inpatient competence restoration.

No. 3

Competence to Stand Trial Reports Conducted by Community Psychiatrists and Psychologists: The

Good, the Bad and the Ugly
Presenter: Barbara E. McDermott, Ph.D.
Co-Authors: Chad Woofter, Sarah Homsy

EDUCATIONAL OBJECTIVE:
1) Understand the importance of conducting thorough evaluations when assessing a defendant's competence to stand trial; 2) Understand the need for conducting malingering assessments to rule out feigned mental health symptoms; and 3) Understand that distinguishing between diagnoses can impact treatment for restoration to competence.

SUMMARY:
Background: Competence for criminal adjudication is required in the U.S. for criminal defendants. In most jurisdictions, community mental health professionals perform competence evaluations for the court. The standard for trial competency is that a mental disorder or defect is present that renders the defendant unable to understand the proceedings or to assist in their defense. Although judges make the ultimate decision, court evaluators play a significant role in the process. Most studies have found evaluator and judge agreement to approximate 90% or more. Because judges typically agree with evaluators' opinions, the quality of the evaluation is critical. **Objective:** This study was designed to determine if court evaluators abide by required statutes and if a relationship exists between certain aspects of court-ordered evaluations and patient characteristics (e.g., length of stay or incidence of malingering). **Methods:** Since 2008, we have conducted admission assessments on patients committed to a state hospital as incompetent to stand trial (IST) for restoration. Areas assessed included symptoms, malingering and competence. We examined the court reports conducted by community psychiatrists and psychologists for all patients admitted as IST between August 1, 2012, and July 30, 2013. Reports were coded to capture information such as, for example, the use of structured assessments, if the evaluator formed an opinion on diagnosis, if *DSM* criteria were used, and whether or not evaluators addressed both aspects of the competence standard. **Results:** We coded 464 court reports associated with 347 patients. Findings suggest that the majority of evaluators did not formulate an opinion regarding diagnosis and that, when a diagnosis was provided, *DSM* criteria were used in less than nine percent of the reports. We found a clear relationship between diagnosis and length of stay, with patients with bipolar disorder evidencing shorter length of stays than patients with a diagnosis of schizophrenia or schizoaffective disorder. Patients diagnosed with psychotic disorder NOS evidenced a malingering rate of 35%, more than two times that of admissions in general. Those diagnosed by the evaluators with schizophrenia evidenced a malingering rate of almost 30%. Interestingly, although MDs and PhDs conducted the bulk of the evaluations, MDs and PsyDs were substantially more likely to consider if the defendant was malingering. PsyDs were much more likely to administer structured assessments of malingering. **Conclusion:** Many jurisdictions in the U.S. rely on community evaluators, with varying levels of training. Our results indicate that formulating an appropriate diagnosis is a necessary step in these evaluations and that an assessment of malingering is an important component. These results highlight the need for training community evaluators in the conduct of competence to stand trial assessments.

No. 4
Risk Factors for Violence in Schizophrenia: The Role of Psychopathy, Impulsivity, Aggressive Attitudes, and Background Historical Variables
Presenter: Menahem I. Krakowski, M.D.
Co-Author: Pal Czobor, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the role of specific personality traits and attitudes in the etiology of violence in schizophrenia and in the general population; 2) Understand how background historical risk factors contribute to personality traits and attitudes that lead to violence; and 3) Differentiate between the types of violence and risk factors in schizophrenia and in the general population.

SUMMARY:
Background: Violent behavior in schizophrenia has serious clinical and societal consequences, but is poorly understood. Psychopathy, impulsivity and aggressive attitudes are important in the etiology of this violence. Historical background variables also play a role. **Objective:** Our goal was to evaluate

these factors in violent patients with schizophrenia (VS) and three comparison groups: nonviolent patients (NV), healthy controls (HC) and nonpsychotic violent subjects (NPV). **Methods:** 142 subjects were included: 34 HCs, 35 NPVs, 34 NVs, and 39 VS's. Life History of Aggression (LHA), Psychopathy Checklist (PCL-SV), Buss-Perry Aggression Questionnaire (BPAQ), and Barratt Impulsiveness Scale (BIS-11) were administered. Both LHA and PCL-SV were based on personal records in addition to self-report. Background information was obtained. The various dimensions of each scale were investigated to obtain a detailed profile of the groups. **Results:** There were significant differences among the four groups in psychopathy (PCL-SV: $F=118.4$, $df=3,140$, $p<0.0001$), hostile/aggressive attitudes (BPAQ: $F=11.0$, $df=3,140$, $p<0.001$) and impulsivity (BIS-11: $F=8.50$, $df=3,140$, $p<0.001$). NPVs had significantly more severe impairments than the other groups, including VS's ($p<0.01$), and VS's more severe than NVs and HCs ($p<0.01$). Some specific dimensions of these scales contributed most to the group differentiation. These included the two PCL-SV dimensions, two of the four BPAQ dimensions (i.e., physical aggression [attitudes about physical aggression, e.g., "If I have to resort to violence to protect my rights, I will"] and anger) and two of the six BIS-11 dimensions (i.e., motor impulsiveness and self-control), which indicate lack of behavioral control and a tendency to act quickly without considering consequences. These specific dimensions are strongly associated with violence. Besides differences in mean values, the two violent groups differed significantly ($p<0.01$) with regard to the degree of association of PCL-SV and BPAQ with LHA. They were more strongly linked to LHA in NPVs than VS's ($r=0.70$, $N=35$, $p<0.001$ for PCL in NPV versus $r=0.44$, $N=39$, $p<0.01$ in VS; $r=0.64$, $p<0.001$ for BPAQ in NPV; and $r=0.37$, $p=0.02$ in VS). The four groups differed also on the background variables. Drug abuse/dependence and childhood/adolescence behavior problems, including truancy, school disciplinary problems, fire setting, and cruelty to animals, were more frequent in both violent groups than in nonviolent groups ($\chi^2=20.7$, $p<0.01$). **Conclusion:** Violence in schizophrenia is associated with personality, attitudinal and historical risk factors that exist in violent populations in general. A better understanding of violence in schizophrenia can be gained if nonpsychotic violent subjects are included. In these subjects, the disturbances were more severe and more tightly linked to violence.

Rapid-Fire Talks: Focus on Integrated and Collaborative Care

No. 1

Measurement-Based Care: Using Multidimensional Assessments to Drive Improvements in Outcomes in Integrated Care Settings

Presenter: Steve Daviss, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the benefits and challenges of using measurement-based care in integrated primary care settings; 2) Describe the risks and benefits of using single-dimension instruments (e.g., PHQ-9) versus multidimensional instruments for screening and assessments; 3) List at least three multidimensional assessment tools; 4) Discuss the workflow challenges of implementing mental health assessment tools in primary care settings; and 5) Explain how multidimensional assessment tools can be used for population health analytics.

SUMMARY:

The principle of measurement-based care aids primary care practitioners in the use of treatment protocols that leverage results from standardized symptom measurement scales. Most such scales measure a single dimension of symptoms (like depression) while missing important comorbid symptoms (e.g., PHQ-9 lacks bipolar or anxiety symptoms). The *DSM* Cross-Cutting Scale is one of several examples of broader, multidimensional screening and assessment tools that move the field away from diagnosis-based assessment (e.g., *DSM*) and toward symptom-based assessment (e.g., RDoC). The benefits of using tools that address a range of symptoms that commonly present in primary care settings-such as depression, bipolar disorder, PTSD, anxiety disorders, alcohol and drug use, and functional impairment-must be balanced by challenges that include workflow, data interoperability, complexity, practitioner education, care management, and access to care. Indeed, organizations that set quality standards (e.g., NCQA,

The Joint Commission, USPSTF, CMS) are increasingly recognizing the importance of broader assessments for measurement-based behavioral health. The speaker will review these issues and discuss their impacts for psychiatrists; primary care and other health care providers; and patients, payers and policy makers.

No. 2

A Cross-Sectional Prospective Comparison of Collaborative Care and Colocation Treatment for Depressed, Low-Income, Diverse Patients in Primary Care

Presenter: Michelle Blackmore, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Understand how the integrated collaborative care model (CCM) compares to the colocation model in primary care for depression in low-income, culturally diverse patients; 2) Describe the key care management elements that support CCM compared to standard colocation that can help intensify treatment; and 3) Identify potential sustainable and scalable features of colocation and CCM when integrating behavioral health into primary care.

SUMMARY:

Background: Although substantial research demonstrates the effectiveness of integrated care models, there are very few studies that compare clinical outcomes in depression for a colocation model versus a collaborative care model. As health care reform efforts support integrated model sustainability and scalability, understanding whether there are differential outcomes achieved can help practices allocate resources appropriately. An academic medical center with large ambulatory primary care practices (N=19) serving primarily Medicare and Medicaid recipients with significant racial and ethnic diversity began offering integrated care primarily through colocation (usually a licensed clinical social worker and a part time psychiatrist) in the fall of 2014. In February 2015, seven sites were chosen to begin implementation of the integrated collaborative care model (CCM) as part of a Health Care Innovations Award from the Center for Medicare and Medicaid Innovations. The CCM program aimed to improve care quality through the addition of a care manager to the behavioral health team, allowing enhanced "between-visit" care and case reviews in a multidisciplinary team, facilitated by a measurement-informed care patient registry. **Methods:** A cross-sectional natural experimental design compared depression symptom severity outcomes for patients attending Montefiore primary care sites employing colocated care (N=12) and sites utilizing CCM (N=7). Depression symptom severity was measured with the Patient Health Questionnaire 9 (PHQ-9). Patients were enrolled in the study if they scored 10 or above on the PHQ-9, indicating moderate to severe depression. Eligible patients receiving both intervention types had access to short-term psychotherapy, concrete social services and medication management. At 10 to 16 weeks (mean=12 weeks) following enrollment, patients were readministered the PHQ-9 by a trained and blinded independent assessor over the phone. **Results:** A total of 240 participants were enrolled (N=122 at colocation sites; N=118 at CCM sites). Significant within-group reductions in depressive symptoms were observed in the colocation sites (difference=2.23, $p<0.0003$) and the CCM practices (difference=5.04, $p<0.0001$). Between-group differences indicated patients in CCM sites demonstrated significantly greater reduction in depressive symptoms compared to patients at the colocation sites (difference=-2.81; $p=0.0005$). **Conclusion:** The CCM intervention appears to result in a significantly greater reduction in depressive symptoms compared to the colocation model across a range of Montefiore primary care clinics serving low income, diverse patients. Replication will be necessary in larger samples to further support these findings.

No. 3

Implementing the Chronic Care Model for Opioid and Alcohol Use Disorders in Primary Care

Presenter: Katherine E. Watkins, M.D., M.S.H.S.

EDUCATIONAL OBJECTIVE:

1) Describe how the chronic care model can be applied to the treatment of opioid and alcohol use disorders in primary care; 2) Identify implementation strategies that can be used to prepare primary care settings to deliver treatment for opioid and alcohol use disorders; and 3) Identify the resources necessary for primary care practices to implement

the chronic care model for opioid and alcohol use disorders.

SUMMARY:

Background: Effective treatments for opioid and alcohol use disorders are available, yet only a small percentage of those needing treatment receive it, leading to increased morbidity and mortality and complicating the management of other chronic illnesses. Policy makers and providers are increasingly recognizing the importance of primary care in reducing unmet need; however, few primary care settings provide treatment, and there has been little guidance on how primary care settings can integrate substance use treatment into routine care. This talk describes a collaborative planning process used by researchers and community providers at a multisite federally qualified health center to apply the chronic care model to the delivery of treatment for opioid and alcohol use disorders. The goal was to develop and implement a clinical intervention that would support the delivery of brief psychotherapy and medication-assisted treatment. The work was undertaken within the framework of the chronic care model to ensure the intervention would include the elements known to be important for chronic illness care. **Methods:** We used focus groups and interviews to solicit staff and provider input on barriers and facilitators and organized the results by how results mapped onto the model. We then identified implementation strategies for each identified implementation barrier, the intended organizational changes and the materials necessary to carry out each strategy. **Results:** The end product of the collaborative planning process was a clinical intervention: integrated collaborative care. For each aspect of the continuum of care (screening and identification; referral to behavioral health; longitudinal assessment; treatment planning; and initiation of either brief therapy, medication-assisted treatment or both) a care protocol specifies what action should be done, who is to carry it out, how it is to be accomplished, when it should occur, and the resources needed. Motivational interviewing techniques and multiple opportunities for patient engagement were incorporated into the protocols. The intervention included a new position, that of the care coordinator, whose role was to introduce patients with a positive screen to the available treatment options, assess motivation, and encourage treatment initiation and adherence. The care coordinators used a patient registry to do population-based management on all patients identified and to track outcomes for those who initiated treatment. We describe the method and outcomes of the collaborative planning process and discuss the implications of the work for the integration of substance use treatment with primary care. **Conclusion:** A collaborative planning process can be used to apply the chronic care model to the treatment of opioid and alcohol use disorders in primary care and to develop a feasible and acceptable clinical intervention.

Rapid-Fire Talks: Focus on Neuroscience and Genetics

No. 1

Translation of Resilience as a Measurable Clinical Entity for Prevention in Psychiatry

Presenter: Gopalkumar Rakesh, M.D.
Co-Authors: Srinath Gopinath, M.B.B.S., Kammarauche Asuzu, M.H.S.

EDUCATIONAL OBJECTIVE:

1) Explain the difference between layman use of the term “resilience” and a neurobiological explanation of the same; 2) Elucidate how clinically characterized resilience could be crucial to clinical assessment and prevention of mental illness; 3) Elucidate clinical ways of quantifying resilience and enumerate components of “resilience battery”; and 4) List possible e-health applications for assessment and quantification of resilience.

SUMMARY:

This talk will explore three studies. 1) Resilience as a neuropsychological trait shapes an individual's response to stress, and a lack of resilience may predispose individuals to mental illness. A few studies have attempted to elucidate the neurobiological basis of resilience. Translating these basic neuroscience findings of resilience into measurable objective clinical endpoints may provide a means for evaluating therapies with the potential to curtail the development of mental illness in vulnerable populations. By standardizing it to be a clinical entity, we choose to validate and quantify

techniques that help estimate resilience, helping to predict not just vulnerability but also prognosis. In populations exposed to stress, this will enable prevention of onset of psychiatric disorders before onset. Imaging, EEG, pupillometry, serum markers, and genetic markers have been linked to resilience and are possible candidates for inclusion in a resilience battery. We summarize available literature and present a unique perspective on this. We searched databases such as PubMed, Cochrane, EmBase, and PLOS to select relevant studies on the topic. 2) Most imaging studies to chart the influence of stress and assess resilience focus on the hippocampus, amygdala and the anterior cingulate cortex. Individuals with a history of maltreatment or abuse in childhood show compromise in the sizes of the hippocampal subfields. Studies provide evidence of a negative influence of childhood maltreatment on the CA1-3 subfields, dentate gyrus and subiculum of the hippocampus, with studies also demonstrating a correlation between hippocampal size and symptomatology in borderline personality disorder. White matter changes in the corpus callosum have also been linked to trauma exposure in adolescents. Structural alterations and functional activity in the medial prefrontal cortex and amygdala have also been shown to play important roles in fear learning, extinction, and development of PTSD and depression. We searched databases for all studies on the topic to summarize current literature available. 3) Scales such as the Conner Davidson Rating Scale (CD-RISC) and Adverse Childhood Events (ACE) Questionnaire, in combination with mood charting and imaging/serum biomarker information, could potentially enable us to have the ideal tool to measure resilience. Measuring these in real time using mobile applications could help in dissemination of the concept and interventions for the same. We performed a literature search on the topic using known databases such as PubMed, EmBase, PLOS, and Cochrane. **Conclusion:** We wish to postulate futuristic concepts such as "resilience reserve," "molecular resilience" and "resilience battery."

No. 2

Advances in Translational Research in Preclinical Models of Drug Addiction

Presenter: Sucharita Somkuwar, Ph.D.

Co-Authors: Christie Fowler, Ben McKenna

EDUCATIONAL OBJECTIVE:

1) Identify major neuronal pathways and brain regions implicated in drug and alcohol addiction; 2) Understand the role of specific nicotinic acetylcholine receptors in the habenulo-interpeduncular pathway in mediating nicotine reinforcement and aversion; 3) Understand how novel diffusion tensor magnetic resonance imaging models characterize microstructural tissue changes in pathologies related to addictions; 4) Understand neuroimaging correlates for oligodendroglial and cerebrovascular function in the prefrontal cortex in relation to alcohol relapse; and 5) Appreciate the value of preclinical research to advance the understanding of drug addiction.

SUMMARY:

Effective therapeutic strategies for addiction are limited, partially because the neural mechanisms underlying addiction are not well understood. Recent advances in genetics and neuroimaging have begun to provide molecular and biological leads, which through rigorous preclinical research may generate translationally relevant targets for therapeutic development and companion diagnostics. Our objective for this talk is to highlight research for several drugs of abuse-nicotine, methamphetamine and alcohol-to identify novel addiction mechanisms and thus provide a basis to reveal valuable insights into the human condition. First, novel brain circuits implicated in nicotine dependence will be discussed. Findings demonstrate that alpha-5 nicotinic acetylcholine receptor (a5nAChR) neurons in the habenulo-interpeduncular circuit and downstream pathways mediate nicotine self-administration, thus suggesting a potential mechanism for increased vulnerability to tobacco/nicotine dependence in individuals with allelic variation of the a5nAChR gene, CHRNA5. Second, we will test persistent methamphetamine (METH)-induced neurotoxicity using a novel in vivo diffusion tensor imaging (DTI) methodology that estimates and corrects for free-water diffusion in fractional anisotropy (FA). Findings reveal that methamphetamine decreases FA in the caudate, increases FA in dorsal hippocampus and entorhinal cortex, and decreases free-water diffusion

throughout the brain, thus indicating that METH triggers potentially distinct mechanisms of neural damage, such as neural inflammation, edema and gliosis, in a brain region-dependent manner. Finally, we will present a potential de novo mechanism for alcohol relapse from recent magnetic resonance imaging studies with a widely established chronic intermittent ethanol vapor (CIE) model of alcohol addiction. Specifically, temporal changes in grey matter volume, myelination and blood-brain barrier (BBB) integrity were investigated in the medial prefrontal cortex (mPFC), a brain region implicated in impaired decision making and relapse. T2 relaxation revealed that mPFC grey matter volume was persistently decreased in CIE rats through six weeks of protracted withdrawal. FA was decreased at 21 days compared to controls, suggesting dysmyelination that corroborated with previous findings of disrupted oligodendroglial homeostasis in the mPFC. Gadolinium-enhanced T1 relaxation was not altered during ethanol withdrawal, suggesting no BBB leakage was associated with the previously found molecular evidence of cerebrovascular dysfunction during alcohol withdrawal. In conclusion, evidence for novel pathways and cellular mechanisms likely mediating nicotine, methamphetamine and alcohol addiction will be discussed in this talk, and, importantly, these findings have potential to provide new avenues for addiction therapeutic strategies.

No. 3

Toward a Psychiatric Game Theory: The Mathematics of Attachment, Grief and Complicated Grief

Presenter: Lawrence Amsel, M.D., M.P.H.
Co-Author: Erica Griffith, B.Sc.

EDUCATIONAL OBJECTIVE:

1) Understand the proper use of reward learning theory and game theory in developing models of psychopathology; 2) Compare three different models of grief: the Freudian, the cognitive behavioral and the game theoretic; and 3) Discuss the use of formal modeling in directing future empirical studies of complicated grief.

SUMMARY:

Background: Our goal is to reduce the subjectivity of psychiatry by translating descriptive psychopathology into well-defined and empirically measurable concepts that also fit into mathematical models. This approach borrows from economic analysis of behaviors and computational cognitive science (CCS). We draw on the reward learning (RL) and game theory (GT) literatures that address how human agents utilize reward/fear information in the service of reaching their goals. We show that models based on RL and GT correspond nicely to empirical findings in the complicated grief lterature. In *Mourning and Melancholia*, Freud proposed that grieving involved de-cathecting, or emotionally "neutralizing," individual, discrete memories of the deceased. Contemporary psychiatry has, perhaps too quickly, abandoned these ideas. Meanwhile, evidence-based treatments of complicated grief (CG) have taken a CBT approach. **Methods:** Our first model takes an RL approach to understanding attachment formation as a process that sets up a structure of expected utilities for shared experiences. This can be described by the attachment equation. The mirror image of attachment is the normal grief reaction to loss, given by an equation that captures the difference between expected reward and actual reward (prediction error) now set up by the loss of the partner. (Equations will be presented.) This model captures elements of both Freudian and contemporary theories of grief. It sees the grieving process as looking backward and forward simultaneously. Looking forward, it serves as a series of exposure/habituation exercises that allow for a reattribution that transforms the expectations of negative utility for future experiences into more tolerable experiences. Looking back, it allows for piecewise detachment from shared memories that together constituted the relationship. In our second model, we see the individual as divided between two internal agents, again bridging Freudian and GT models. One agent, the desired future self (DFS), seeks to restructure her life by becoming an independent agent without the expectation structure of the former relationship. The other agent, the ghost (G), plays a denial position and attempts to hold on to the relationship. We show that under certain circumstances this model can lead to a classic prisoner's dilemma-like game that manifests as a behavioral trap. **Conclusion:** These

mathematical models, while quite abstract, predict the empirical phenomenology of attachment, grief and complicated grief. Psychiatry can benefit by using these concepts and their related mathematics to model psychopathology, which in this context are seen as the "failure modes" of CCS. This may also provide a conceptual bridge between the *DSM* system and the RDoc approach.

Rapid-Fire Talks: Focus on Non-Pharmacological Treatment

No. 1

Intensive Transitional Treatment Programme: Impact on Psychiatric Emergency Admissions and Length of Stay on the Inpatient Unit

Presenter: Neeraj Bajaj, M.D.
Co-Authors: Jonathan Fairbairn, M.D., Mir N. Mazhar, M.D.

EDUCATIONAL OBJECTIVE:

1) Study the Intensive Transitional Treatment Programme (ITTP) as an alternative to psychiatric admissions; 2) Review the role of transitional day hospital programs in bridging inpatient and community care; and 3) Examine the feedback of patients utilizing the psychiatric day hospital.

SUMMARY:

Background: The Intensive Transitional Treatment Programme (ITTP) is a new outpatient program at Kingston General Hospital, a tertiary academic center in Kingston, Ontario, Canada, in August 2014. ITTP offers intensive, rapid access to short-term multidisciplinary psychiatric treatment to patients presenting to the emergency department and other acute services. ITTP provides rapid access to both psychiatric and psychotherapy input for four to six weeks. This treatment model provides an alternative to inpatient psychiatric care and facilitates the transition between the inpatient and community treatment settings. **Methods:** A retrospective study of psychiatric emergency department presentations (N=8,816) and admissions to the inpatient psychiatric unit (N=1,862) at Kingston General Hospital was performed during the 12-month period before and after implementation of the ITTP. Participant satisfaction was measured using an anonymous feedback questionnaire. **Results:** Following the implementation of ITTP, a significant decrease in median psychiatric admission length of stay was observed (p=0.03). In addition, there was a significant reduction in the number of psychiatric admissions via the emergency department (N=134, p=0.01). Analysis of anonymized feedback from patients attending ITTP was very positive among participants, with all participants surveyed recommending the program to others. **Conclusion:** The ITTP model for psychiatric services can bridge the gap between deficient community psychiatric services and expensive overburdened inpatient services. ITTP can serve as an effective alternative to inpatient admission and facilitate the transition from inpatient to outpatient treatment settings. Participants viewed ITTP as a positive therapeutic intervention.

No. 2

Digi...What? An Overview of Technology Advances for Dementia Care

Presenter: Bruce D. Bassi, M.D., M.S.
Co-Authors: Uma Suryadevara, M.D., Stephen Welch, M.D.

EDUCATIONAL OBJECTIVE:

1) Name various types of technology used by patients, caretakers and providers for the purpose of dementia care; 2) Perform an assessment of a patient's needs and recommend the most appropriate technology for that individual; 3) Cite current scientific data concerning efficacy of technology for dementia care; and 4) List barriers of technological innovation and implementation for dementia care.

SUMMARY:

The concept of assistive technology is not new; at one point, a call bell might have been considered new and innovative. But assistive technology today is no longer this simple. The term assistive technology incorporates a wide range of devices, including complex home monitoring systems that could cost thousands of dollars to implement. As clinicians and as caregivers of our family members, we want to know if these devices are cost effective, easy to use and safe. Major technological advances have pollenated virtually every aspect of dementia care, with the bloom of low-cost devices, sensors

and software. There have been so many changes that people have difficulty navigating this field. For example, technological advancements have been made in diagnosing dementia (facial recognition, rating scales), gathering data (wearables, monitors), inputting data (EHRs), slowing cognitive decline (apps), improving patient safety (GPS devices, item locators), educating caregivers (websites), alleviating caregiver burnout (online support groups), and even caring for patients (social robots, telemedicine). The question on everyone's mind is "Do they work?" There are numerous studies to answer this question, but such studies are fraught with challenges. By nature of dementia's progressive course over time, patients are scattered among various stages of the illness, making generalizability of study results a big problem. Some studies make broad generalizations beyond the sample surveyed. Additionally, caregivers may potentially have negative opinions and perceptions of technological advancements, making it even more difficult to obtain participants. Not only may caregivers have negative perceptions of technology, but their perceptions may differ from the developer's. The production of a new device or software requires extensive research by the developing team to make sure they meet the needs of the user. The development team needs to consider barriers including the user's potentially poor technical knowledge or negative perception of the technology. Once the technology has been developed, there exists the challenge of marketing it, explaining why it would be helpful and then implementing that change. The impact that technology has on this field is tremendous. The number of individuals diagnosed with dementia is in the millions, and there are even more caregivers. The perception of new technology is generally positive, as it can have a substantial impact on quality of life. Although there has been no frontrunner call bell in this area because of the wide variability of needs, there will continue to be new assistive devices designed for every part of that patient's care team. The studies in this field may be difficult to interpret and generalize to a whole. In summary, the field of dementia care has a litany of new technologies with little guidance of the most effective devices on the market. We hope to provide some direction in navigating this quickly growing field.

No. 3

McLean Hospital Spirituality and Mental Health Consultation Service: A Novel Approach to Integrated Treatment

Presenter: Morgan M. Medlock, M.D., M.Div.

EDUCATIONAL OBJECTIVE:

1) Discuss the importance of patient spirituality/religion to mental health treatment; 2) Explain the rationale and impact of a spirituality and mental health consultation service implemented within a private psychiatric hospital; and 3) Apply a clinical model for implementing similar services in other institutions.

SUMMARY:

Background: A considerable body of research has shown that spirituality is functionally associated with mental health, yet this topic is rarely addressed in psychiatric practice. This is unfortunate since many patients wish to speak to their providers about spiritual life. In a recent survey of over 250 psychiatric patients at McLean Hospital, 60.5% reported affiliation with a religious group, 70.8% reported "fairly" or greater belief in God, and 58.6% reported "fairly" or greater interest in integrating spirituality into their treatment. Our study assessed the feasibility and interest in creating a spirituality and mental health consultation service that provides patients and staff with tools and knowledge for integrating spirituality into psychiatric treatment. **Methods:** McLean Hospital recently launched a Spirituality and Mental Health Program (SMHP), a hospital-wide initiative to provide clinical intervention as well as education and research on spiritual issues in mental health. The program curriculum includes individual case consultation throughout the hospital involving assessment and recommendations regarding how patient spirituality may be clinically relevant. The consultation service is available for all levels of care: inpatient, partial, residential, and outpatient. **Results:** Over the last ten months, SMHP clinicians have been referred and seen approximately 40 patients for individual case consultation. Patients have been asked to provide feedback regarding their consultation experience, and data collection is ongoing. Thus far, patients and staff have given strongly positive feedback regarding

the need and impact of this novel clinical intervention. **Conclusion:** To our knowledge, this is the first consultation service that fully integrates patient spirituality into a clinical care model (i.e., clinician-based rather than chaplaincy-based). Developing a consultation service focused on spiritual assessment and intervention is feasible, acceptable to staff and patients, and may have a significant impact on clinical outcomes.

Tuesday, May 23, 2017

Rapid-Fire Talks: Focus on Gender and Sexuality

No. 1

Transgender in College: Can Colleges Step Up to Meet Their Needs? The FSU Experience

Presenter: Ludmila De Faria, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the specific health and mental health needs of transgender college students; 2) Discuss how the use of mental health services among transgender college students can attenuate short- and long-term negative outcomes; and 3) Discuss the role of college health centers in facilitating and coordinating health and mental health service use for the transitioning student.

SUMMARY:

Although the past decade has brought increased visibility and acceptance for lesbian, gay, bisexual, transgender, and other sexual minorities, many college LGBTQ students continue to be at a disproportionate risk for harassment and violence. Colleges attempt to provide support and encourage the development of programs that provide education and advocacy, as the mental health of these students often suffer an impact. Unfortunately, college counseling centers and health services have been slow to respond, with a recent study assessing that only a small percentage explicitly offer assistance, mostly via websites mentioning individual or group counseling opportunities or offering a pamphlet with information and resources. Transgender students often battle specific issues when trying to coordinate health care and receive treatment for ongoing transitioning. These students have often relocated to a new town and are away from their usual support system, including families. They may spend significant time and resources locating nearby providers and arranging transportation. Their effort may impact their mental health and academic success. In order to assist this population and their unique needs, Florida State University developed a protocol that facilitates access to a centralized, multispecialty group to assist transgender students at any stage of their transitioning process. This talk will present the Florida State University experience and ongoing outcome and its impact on student success. Students are able to see multiple providers, including a psychiatrist, a primary care physician and an endocrinologist, all practicing in an integrated setting. In addition to that, providers have been identified in each service within the health center who are informed and comfortable treating the transgender population, including at our women's clinic. We also provide a collated and vetted list of local and regional services that may be needed, including surgery.

No. 2

Gender Nonconforming Youth and Families Outside the Guidelines: What Are Mental Health Clinicians to Do?

Presenter: Richard R. Pleak, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize guidelines for working with gender nonconforming youth; 2) Identity clinical conundrums in working with gender nonconforming youth and their families; and 3) Discuss treatment options for gender nonconforming youth.

SUMMARY:

Background: Clinicians-expert and not-are seeing increasing numbers of gender nonconforming children and adolescents and their families who are seeking gender transition in ways that are not covered or are discouraged in the existing guidelines. Such situations include age, Tanner staging, disagreements in the families, social situations, affordability, insurance denials, and psychiatric and medical illness and instability. This talk is for reflection and comments on these "outside the box" circumstances. Existing guidelines are very useful, but they have their limitations for many of our

patients. The presenter has served on committees that developed two of these guidelines (AACAP and APA). These guidelines include the Endocrine Society Guidelines, the World Professional Association Standards of Care, the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter, the American Psychiatric Association (APA) Task Force Report, and the American Psychological Association Resolution and Guidelines. **Methods:** Cases will be presented as illustrations of clinical conundrums in working with gender nonconforming youth and their families. **Conclusion:** "Outside the box" or "outside the guidelines" presentations of gender nonconforming youth and their families can be challenging for all, even for expert clinicians. There are often no single best answers for these situations. The mental health provider can be of particular help in extensively assessing the pros and cons with the family and including the team of clinicians in the decisions. Minimizing the potentially greater risks for not adhering to professional guidelines, especially with a lack of evidence for doing so, is essential, as is advocating for what is best for our patients. This often involves intensive work with families and may necessitate repeated appeals to insurance companies. Such exceptional patient care creates excellent opportunities for involvement within our professional organizations to revise and update our existing guidelines, with the detailing of exceptional circumstances that warrant clinical care outside the usual guidelines.

No. 3

Transgender Offenders: Working With Transgender Inmates Behind Bars

Presenter: Donald Lewis, D.O.

EDUCATIONAL OBJECTIVE:

1) Understand the problems facing transgender inmates in custody; 2) Understand the legal obligations concerning treatment of transgender inmates; and 3) Understand medical and mental health treatments offered transgender inmates.

SUMMARY:

Transgender inmates are difficult to treat in the community. They truly need team care from medical and mental health care providers. This is much more difficult for those who become incarcerated. Transgender offenders make up a very small percentage of the overall inmate population but can tax resources and cause much countertransference among staff. This brief talk will explain the legal problems concerning transgender inmates and detail the current changes to federal policy that allow for more medical, mental health and surgical treatment. Among the discussion points will be housing-which gender facility do the inmates belong to, the sex assigned at birth or their preferred gender facility? How much treatment is offered to the inmates? Hormone therapy? Voice training? Hair removal? Clothes/make up? Cosmetic surgery? When is sex-reassignment surgery indicated? How does that work for an incarcerated person? The Federal Bureau of Prison has changed policy over the last few years to become much more inclusive of this treatment population. They have a multidisciplinary team that reviews every transgender inmate upon initial designation to the Bureau as well as every transfer inmate. They have developed a transgender resource guide for staff as well as clinical practice guidelines for treatment. These will be discussed and explored during the session. Problems encountered will be discussed in a group setting to learn how to best treat this population while they are incarcerated.

No. 4

Beyond Cultural Competency: How to Introduce a Discussion About Health Disparities Into One's Department/Organization

Presenter: Kari M. Wolf, M.D.

EDUCATIONAL OBJECTIVE:

1) Define institutionalized racism; 2) Describe how discrimination influences health outcomes; and 3) Explore opportunities to introduce the topic of discrimination into discussion in one's home institution.

SUMMARY:

While cultural competency is taught in all medical schools and residencies, not all go beyond this teaching to address social determinants of health, inequities in health and the role race plays in determining health outcomes. Furthermore, some people are uncomfortable discussing issues of race

and acknowledging that discrimination is an important factor impacting health. However, "a substantial body of evidence highlights the relationship between race, racism and health status. Blacks are disproportionately burdened by poorer access and lower quality of care even when controlling for factors such as income, education and insurance." How, then, do we teach learners cultural competency, including discussions of discrimination? In this talk, we will discuss tactics to implement a framework for ongoing discussions of racial disparities in health. We will share the experience of one department and examine strengths and limitations of this approach. The talk will highlight ways to introduce the concept of structural factors/institutionalized racism and how they contribute to health disparities. We will also share our experience with creating an ongoing discussion across the entire department by hosting numerous grand rounds throughout the year focused on social determinants of health. We will discuss the initial resistance and how we overcame that to continue this important dialogue. Finally, participants will brainstorm how to begin a discussion on health disparities in their own institution.

Rapid-Fire Talks: Focus on Suicide and Risk Evaluation

No. 1
Family Functioning and Suicidality in Depressed Adults
Presenter: Gabor I. Keitner, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn about the role of the family in current and subsequent suicidality; 2) Recognize the importance of including the family in the assessment and treatment of depressed adults; and 3) Offer suggestions for future research based on our study findings.

SUMMARY:
Background: A number of risk factors have been identified as predictors of suicidal behavior in depressed patients, including age of onset, previous suicide attempts, family history of suicidality, and history of depression chronicity. None of these variables are amenable to clinical intervention. Suicidal behavior often occurs in the context of difficult interpersonal relationships. Problematic family functioning, for example, has been found to be associated with suicidal behavior. Little attention has been paid to such findings in spite of the fact that family and interpersonal conflicts are amenable to modification. **Methods:** This talk will review evidence, from two studies, for the association between dysfunctional family relationships and current and subsequent suicidal behavior. Study one assessed 121 depressed inpatients and their families at the time of their admission. In this study, we found that suicide-attempting depressed inpatients perceived their family's functioning to be significantly worse than did their families and worse than nonsuicidal depressed inpatients. Multiple regression analysis identified three independent variables that were associated with suicide attempts: age of depression onset ($p<0.003$), number of hospitalizations for depression ($p<0.02$) and poor family communications ($p<0.02$). These three factors accounted for 22.9% of the variance. Study two assessed 80 depressed inpatients during an acute episode and two years later (mean=27 months) to determine factors associated with current and recurrent suicidality. Perception of poor family functioning was associated with recurrent suicidality two years after the index episode. Patients who were suicidal at follow-up also reported significantly more changes in their families (moves, divorces, separations) than those who were not suicidal. **Conclusion:** Problematic family functioning was evident in depressed adults with current and subsequent suicidality, highlighting the importance of including families in the assessment and treatment of depressed patients. Studies are needed to determine if providing family interventions can modify suicidality.

No. 2
Clinical Features of Borderline Personality Disorder Patients With Versus Without a History of Suicide Attempt
Presenter: Leo Sher, M.D.

EDUCATIONAL OBJECTIVE:
1) Compare clinical characteristics of borderline personality disorder patients with or without a history of suicide attempt and healthy subjects; 2)

Determine factors that may be predictive of suicide attempts in BPD patients; and 3) Offer suggestions for improvements in clinical care of BPD patients based on our study findings.

SUMMARY:
Background: Patients with borderline personality disorder (BPD) are at high risk for suicidal behavior. However, many BPD patients do not engage in suicidal behavior. **Methods:** In this study, we compared clinical features of BPD patients with or without a history of suicide attempts and healthy volunteers. **Results:** Compared with healthy volunteers, both BPD groups had higher Affective Lability Scale (ALS), ALS-Depression-Anxiety Subscale, Barratt Impulsivity Scale (BIS), and Lifetime History of Aggression (LHA) scores and were more likely to have a history of temper tantrums. BPD suicide attempters had higher ALS, ALS-Depression-Anxiety Subscale and LHA scores and were more likely to have a history of nonsuicidal self-injury or temper tantrums compared to BPD nonattempters. Also, BPD suicide attempters were more likely to have a history of comorbid major depressive disorder and less likely to have comorbid narcissistic personality disorder (NPD) in comparison to BPD nonattempters. About 50% of study participants in each BPD group had a history of comorbid substance use disorder (SUD). **Conclusion:** Our study indicates that BPD patients with a history of suicide attempt are more aggressive, affectively dysregulated and less narcissistic than BPD suicide nonattempters.

No. 3
Guns, Mental Illness and Suicide: A Close Look
Presenter: Jose R. Maldonado, M.D.
Co-Author: Renee M. Garcia, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the relationship between mental illness and violence; 2) Understand the relationship between accessibility to firearms and suicide risk; and 3) Understand the risk factors and potential interventions for suicidal individuals.

SUMMARY:
America is not a particularly violent society, yet it has a homicide rate that is nearly seven times and a suicide rate that is 20 times higher than 22 high-income countries. One in four Americans experience a mental health problem each year, while only 30% of those with mental illness receive treatment. People living with a mental illness are victims of violence at a rate that is 11 times higher compared to the general population. Recent events related to mass shootings in the media portray those with mental illness as a menace to society. In reality, only four percent of violent crimes involve those with a serious mental illness, and only two percent of violent crimes committed by the mentally ill involve weapons. Suicide assessment and management is one of the most important and difficult tasks in psychiatry. Global suicide rates have increased 60% over the past 45 years. Suicide is the tenth leading cause of death globally. Each year, over 30,000 people have died by suicide in the U.S. (approximately 105 suicides per day) and one million worldwide (WHO). The overall suicide rate is rising so rapidly that it now outnumbers deaths from car crashes. It is estimated that there are 10-40 nonfatal suicide attempts for every completed adult suicide, about 100-200 among adolescents. Suicide rates vary based on factors such as race, ethnicity, gender, and age. Suicide is typically impulsive in nature. As such, many patients remain uncertain to the last moment, with little premeditation, and are often ambivalent about dying. No short-term risk factor(s) have been identified to determine when, or even if, a patient will attempt or complete suicide. In fact, commonly used criteria for approving hospitalization for potentially suicidal patients have not been proven predictive of future attempts. The easy access to guns in America has a disproportionate effect among the mentally ill when it comes to suicide. About 85% of attempted suicides with a gun result in fatalities, compared to only four percent of attempted suicides among all other methods (e.g., overdose, hanging, self-stabbing) resulting in fatalities. In fact, 19,392 of the 31,000 deaths from guns in the United States in 2010 were suicides, far more than the number of homicides or unintended shooting deaths. This talk will review the psychobiological factors associated with suicide; review suicide warning signs; and assist clinicians in conducting an adequate, individualized suicide assessment so that providers are able to identify, treat and manage acute, patient-specific suicide risk factors, including specific interventions.

Rapid-Fire Talks: Focus on Technology—Part 1

No. 1

Using Telepsychiatry With High-Risk Populations

Presenter: Rachel Zinns, M.D., Ed.M.
Co-Author: John Kenny

EDUCATIONAL OBJECTIVE:

1) Discuss the evidence base for using telepsychiatry to treat high-risk populations; 2) Assess telepsychiatry implementation models with respect to safety measures; and 3) Identify strategies for managing clinical risk using telepsychiatry.

SUMMARY:

Telepsychiatry has been used with increasing frequency to mitigate physician shortage and to improve access to psychiatric treatment. Indeed, the need for telepsychiatry services has been so great that clinical practice has outpaced research on the topic. Moreover, outcome studies on telepsychiatry tend to look at quality measures such as patient satisfaction, wait times and no-show rates. Few studies measure clinical outcomes, and even fewer do so in high-risk populations. Because of this, psychiatrists are often hesitant to treat psychotic or suicidal patients using telepsychiatry. The purpose of our talk is to present the audience with both evidence of the effectiveness of telepsychiatry for high-risk populations and a framework for assessing telepsychiatry implementation models with respect to safety measures. We will discuss strategies for minimizing and managing clinical risk using telepsychiatry. We will present a retrospective study in which all the patients in a state hospital-operated outpatient clinic were treated solely by telepsychiatry by one psychiatrist for a year. Compared to the previous year, when the clinic received traditional in-person treatment by several "covering" psychiatrists, psychiatric hospitalization rates decreased from 23% to 18%, and incidents of suicide and violence decreased from 12% to 5%. Furthermore, clinical outcomes from the telepsychiatry clinic were compared to outcomes from other clinics within the same state hospital system. Compared to the averages from all the clinics in the system, the patients in the telepsychiatry clinic had six percent fewer psychiatric hospitalizations, seven percent fewer psychiatric emergency room visits, eight percent fewer incidents of suicide or violence, and seven percent fewer medical/surgical hospitalizations. The study shows that telepsychiatry is not a barrier to safe and effective treatment of high-risk outpatient populations. We will also discuss several models of telepsychiatry implementation and factors within clinical practice that can mitigate safety risk. Both systems and interpersonal strategies for managing clinical risk through telepsychiatry will be presented. We will present a case of a high-risk patient safely managed in the outpatient setting using telepsychiatry.

No. 2

Telepsychiatry to Reduce Treatment Gap

Presenter: Tanjir Rashid Soron, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Share the experience of initiating a telepsychiatry service in Bangladesh; 2) Discuss the challenges and opportunities of developing a telepsychiatry service in a developing country; and 3) Understand the long-term impact of telepsychiatry and the future psychiatric service trend.

SUMMARY:

A healthy mind matters for a happy and healthy life. However, mental illness never gets adequate attention and priority from the state, society and family in developing countries like Bangladesh. This country of 160 million is loaded with at least 16% adult and 18% children patients with psychiatric disorders. Bangladesh is struggling to manage the huge burden with fewer than 200 psychiatrists and 50 certified clinical psychologists. At this moment, a psychiatrist is supposed to serve more than a million patients. Moreover, the psychiatrists are condensed in the main cities; people lack any sort of psychiatric service in rural areas. The information and telecommunication sectors have developed tremendously in recent years. Every family has mobile phone, and the Internet has covered every part of the country. A perfect setup is ready for mHealth- and eHealth-based psychiatric service here. Telepsychiatry can provide standard mental health care using the least amount of money and the available minimum manpower. People from the

most remote parts of the country will be able to communicate with psychiatrists using their cell phones. Moreover, mobile apps provide more opportunities and freedom to access health services and data gathering that can ultimately help to establish personalized mental health service. People like to share socially and culturally unacceptable or taboo thoughts more in mobile apps or over the phone than in a face-to-face interview. However, the privacy and confidentiality of patient data, obtaining informed consent, and ensuring equity of access are challenging. In 2016, Bangladesh started a nationwide telemedicine service under direct supervision of the Ministry of Health, and telepsychiatry has started its journey. However, telepsychiatry has yet to establish at a large scale. If the service can be provided by experts and scientifically, it will transform the mental health scenario. Telepsychiatry produces similar results as face-to-face interventions in most instances. The patients, family, society, and state need to consider this issue to ensure a better mental health within their budgets.

No. 3

Building Mental Health Capacity in Primary Care: An Evaluation of a Project ECHO Mental Health Pilot

Presenter: Sanjeev Sockalingam, M.D.
Co-Authors: Eva Serhal, M.B.A., Amanda Arena, Ph.D., Allison Crawford, M.D., M.A.

EDUCATIONAL OBJECTIVE:

1) Understand the unique challenges of providing mental health care in rural communities; 2) Describe the Project ECHO© model and how it is used to support primary care providers; and 3) Summarize the key findings from the ECHO Ontario Mental Health pilot program evaluation.

SUMMARY:

Background: Primary care providers (PCPs) are first-line responders for individuals experiencing mental health concerns. In rural and underserved areas, where access to specialists is limited, severe and complex mental health and addiction disorders are often managed within primary care, leaving some PCPs feeling under-resourced and isolated. Specialists at the Centre for Addiction and Mental Health (CAMH) and the University of Toronto (UofT) have adopted the Project Extension for Community Healthcare Outcomes (Project ECHO©) model to support providers in managing patients with complex mental health needs in primary care settings across Ontario. Project ECHO aims to address disparities in access to specialist care between urban centers and rural communities by building PCP capacity using a "hub" and "spoke" tele-education model. Currently, there is limited evidence to support the use of this model for mental health care. Therefore, the aim was to objectively evaluate a pilot Project ECHO mental health program, ECHO Ontario Mental Health at the Centre for Addiction and Mental Health and the University of Toronto (ECHO-ONMH). Primary outcome measures were PCP knowledge and perceived self-efficacy. Secondary objectives included participant satisfaction, engagement and sense of professional isolation. It was hypothesized that PCP knowledge and self-efficacy would improve with participation.
Methods: ECHO-ONMH was evaluated using Donald Moore's continuing education evaluation framework and corresponded to levels 1-4 (number of participants to perceived competence). Participants completed pre-post multiple-choice tests and self-efficacy scales. Weekly questionnaires assessed satisfaction with the setting and program delivery.
Results: Performance on knowledge tests and self-efficacy improved post-ECHO (knowledge change was significant, $p<0.001$; increase in self-efficacy approached significance; $p=0.053$). Attrition rate was low (7.7%); average weekly participation included 34 providers representing 26 sites. Satisfaction ratings were consistently high across all domains, with spokes reporting reduced feelings of isolation.
Conclusion: This is the first study to report objective mental health outcomes related to Project ECHO. The results indicate that high participant retention is achievable and provide evidence for increased PCP knowledge and self-efficacy in the management of mental health disorders. Although preliminary, these findings support the use of this intervention to build PCP capacity and suggest the Project ECHO model may be a vehicle to reduce urban-rural disparities in access to mental health care.

No. 4

Outcomes of an Online Computerized Cognitive

Behavioral Treatment Program for Treating Chinese Patients With Depression
Presenter: Albert Yeung, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the potential for using of online cognitive behavior therapy (CBT) for treatment of depression; 2) Understand the challenges of treating Chinese patients with depression in an outpatient setting; and 3) Learn about the design and outcomes of a pilot study using online CBT to treat Chinese patients with depression in an outpatient setting.

SUMMARY:
Background: Many Chinese people with depression avoid seeking mental health treatment, and they seek help at primary care clinics, where there are usually inadequate resources to treat mental conditions. **Objective:** This pilot study examined the feasibility, safety and effectiveness of using an online, computerized cognitive behavior therapy (CBT) for treating Chinese patients with depression. **Methods:** Seventy-five Chinese patients with depression in the outpatient clinics of a hospital were randomized into a five-week intervention. The intervention group (N=37) received the Chinese translated version of MoodGYM in addition to their usual treatment, and the control group (N=38) continued with their usual treatment. Participants completed the 20-item Center for Epidemiologic Studies Depression Scale (CES-D) before and after intervention. **Results:** The mean age of participants was 33 (SD=9.2); 77% were female. The intervention group and the control group did not differ in age, gender ratio or baseline CES-D score, but the intervention group had a small but significantly higher numbers of years of education. Seventy-eight percent (N=29) of participants in the intervention group and 84% (N=32) of patients in the control group completed the post-treatment assessments, and no serious adverse events were reported. We conducted multivariate linear regression analyses to compare the change in CES-D scores for completers after the intervention. Results indicated that while both groups significantly improved at post-test, the intervention group improved significantly more than the control group ($t(59)=2.37$, $p=0.02$). **Conclusion:** The results from this study suggest that MoodGYM is a feasible and efficacious augmentative treatment, specifically when used within an outpatient clinic population. With this small sample size, we were able to demonstrate that the addition of MoodGYM to usual care improved treatment outcomes among depressed Chinese patients in an outpatient clinic. To better serve Chinese patients, future online, computerized CBT programs need to adopt local cultural orientations and topics.

Rapid-Fire Talks: Focus on Technology—Part 2

No. 1
Using Interactive Voice Response to Enhance Collaborative Care for Low-Income, Ethnically Diverse Patients With Depression and Anxiety in Primary Care
Presenter: Michelle Blackmore, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand how the collaborative care model (CCM) links behavioral health services to primary care for low income, ethnically diverse patients; 2) Describe how innovative technology support can promote sustainability and scalability of CCM in primary care across the lifespan for a broad range of behavioral health disorders; and 3) Identify ways to adapt technology to maximize care management resources and patient follow up to improve multidisciplinary teamwork in fast-paced primary care settings.

SUMMARY:
Background: The collaborative care model (CCM) is effective in integrating behavioral health in primary care settings, and use of patient-centered technology within this model is on the rise. Such technology (e.g., interactive voice response [IVR], smartphone applications, video conferencing, and patient registries) may help ensure population health care demands are better met and resources maximized, especially in the promotion of patient self-management. At an academic medical center serving low-income, ethnically diverse populations, a CCM model was implemented in seven primary care sites. The CCM model aimed to advance multidisciplinary care teamwork and provide enhanced case supervision and "between-visit" care, facilitated by an IVR technology pilot. **Methods:** Behavioral health teams were integrated into seven

Montefiore primary care sites to work collaboratively with primary care physicians. As part of the CCM, patients were offered short-term, evidence-based treatment (e.g., psychotherapy, medication management) and enrollment in phone-based IVR, an automated call system that collects patient self-report depression and anxiety symptoms and progress in between visits using the Patient Health Questionnaire-9 (PHQ-9) and Generalized Anxiety Disorder Screener-7 (GAD-7), respectively. During the IVR calls, patients were also offered a behavioral activation tip and medication check-in question. **Results:** 322 out of 402 patients offered IVR consented to receiving the calls. Of the 202 who answered an IVR call, 49% completed a symptom scale through the automated call system. During the time IVR was employed, telephonic outreach contributed to 37% of total clinical follow ups, with 10% of data collected through IVR. Of the 77 patients who completed the end of call feedback survey, 66% and 31% said IVR was very easy to moderately easy to use, respectively. Eighty-one percent said they'd answer follow-up IVR calls. Additionally, 75 patients answered the question on whether IVR made them "feel like the team cared," with 91% responding "yes." **Conclusion:** Patients indicate a positive experience of care delivered through IVR. Utilizing IVR to support collaborative care has the potential to assist in maximizing resources and improving between-visit follow-up and treatment plan engagement. This in turn can improve scalability and sustainability of the CCM. Strategies to adapt this technology to promote patient self-management and improve clinic workflow in fast-paced primary care settings will be explored.

No. 2

Online Access to Mental Health Notes (OpenNotes): Impacts on Trust and Power in the Patient-Clinician Relationship

Presenter: Steven K. Dobscha, M.D.
Co-Authors: Lauren M. Denneson, Ph.D., Risa Cromer, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Describe challenges for mental health clinicians as they communicate with patients and write clinical notes in the context of OpenNotes; 2) Describe the effects of reading clinical notes online on patients and on the patient-clinician relationship; and 3) Consider new approaches to writing notes in practice.

SUMMARY:

Background: The national OpenNotes initiative promotes patients having direct electronic access to their medical records, including clinical progress notes. Mental health notes often contain sensitive information, and it has been suggested that OpenNotes' use in mental health care may result in unique negative consequences. Alternatively, OpenNotes may help patients feel more informed about their health and more engaged in care. OpenNotes has been available to all Veterans Health Administration (VHA) patients since 2013. In this study, we explored mental health clinician and patient perspectives and experiences related to OpenNotes and how OpenNotes is affecting the patient-clinician relationship. **Methods:** At one large VHA medical center, we conducted individual, semi-structured qualitative interviews with 28 mental health clinicians and nurses and 28 patients receiving mental health care who had used OpenNotes. Transcripts were coded and analyzed using a modified grounded theory, thematic analysis approach utilizing iterative, constant comparative techniques to code inductive and deductive themes. Two analysts coded transcripts, and all authors participated in analyzing code reports for themes. **Results:** Mental health notes often describe aspects of the therapeutic process that are not shared with patients. Clinicians expressed concern that by reading notes, patients could negatively misinterpret their notation or feel judged or stigmatized. Clinicians expressed a strong desire to protect patients from potential harm that might result from reading notes. Some clinicians felt that notes have the potential to undo the considerable work they do in session to develop the therapeutic relationship. However, clinicians also felt that their discomfort with OpenNotes helps keep them accountable, ultimately resulting in improved care and documentation. Patients reported that the therapeutic relationship is essential to mental health care and that feelings of trust in particular are critical to the therapeutic process. Reading clinical notes can either strengthen or strain trust in their

mental health clinicians; perceptions of transparency and respect conveyed in notes are central to maintaining trust. **Conclusion:** OpenNotes is substantially affecting how mental health clinicians perceive, document and provide care for patients- these impacts reflect a shifting power dynamic in the patient-clinician relationship that stems from changes in the control of information and a decreased ability of clinicians to protect patients from the negative consequences of reading notes. Clinicians and patients agree that OpenNotes has the potential to be both beneficial and harmful to the therapeutic relationship. Clinicians can help mitigate the negative impact of OpenNotes by ensuring there is consistency between what occurs during appointments and what appears in notes and by highlighting patient individuality and strengths in notes.

No. 3
Quality Assessment of Apps for Mental Health Conditions
Presenter: Michael Knable, D.O.

EDUCATIONAL OBJECTIVE:
1) Understand the factors associated with quality in smartphone apps for mental health; 2) Understand the different methods of rating apps; and 3) Understand issues that might contribute to the design of more effective mobile apps.

SUMMARY:
Background: At least 3,000 mobile apps that claim to have relevance for mental health conditions are currently on the market. Most apps are not tested in controlled trials and are not subject to scrutiny by regulatory agencies. Therefore, the International Mental Health Research Organization (IMHRO) established PsyberGuide (PG), a website designed to evaluate mental health apps and to provide unbiased information about them to consumers. In this talk, we compare the results of two different rating systems applied to apps on the PG site. **Methods:** The PG site currently lists 76 products. All of these were rated by one observer with the PG rating scale, which provides ratings for research basis, funding support, specificity of intervention, availability of consumer ratings, advisory support, and software updates. Fifty-seven of the products were rated by two independent raters using the Mobile App Rating Scale (MARS), which contains items related to engagement, functionality, aesthetics, information content, and subjective quality. Correlations between the PG and MARS scales were tested to determine the degree to which the scales measure independent or overlapping data. The inter-rater reliability of the MARS scales was also determined. **Results:** The range of scores for the PG scale was 14-86%, with a mean of 51.4%. The range of scores for overall MARS ratings was 1.63 to 4.75, with a mean of 3.61. Scores on the PG rating scale were only weakly correlated with those on the MARS scale (r=0.28). The intra-class correlation coefficient for the MARS ratings by the two raters was highly significant at 0.90. **Conclusion:** The PG rating scale, which seeks to measure the quality of information related to mobile apps, was not correlated with the MARS rating scale, which is weighted more toward user experience of apps. Therefore, the two scales provide different types of information about apps. The inter-rater reliability of the MARS scale is highly statistically significant when administered by trained raters.

Special Sessions

Saturday, May 20, 2017

Applying the Integrated Care Approach: Collaborative Care Skills for the Consulting Psychiatrist
Director: John Kern, M.D.
Faculty: Mark Duncan, M.D.

EDUCATIONAL OBJECTIVE:
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 includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model-the integrated care approach with the strongest evidence base. 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 collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at four sessions during the Annual Meeting.

Sunday, May 21, 2017

Applying the Integrated Care Approach: Collaborative Care Skills for the Consulting Psychiatrist
Director: John Kern, M.D.
Faculty: Lorin Scher, M.D.

EDUCATIONAL OBJECTIVE:
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 includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model-the integrated care approach with the strongest evidence base. 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 collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at four sessions during the Annual Meeting.

Physician Wellness and Burnout: A Town Hall Discussion With APA Leadership
Chair: Richard F. Summers, M.D.
Presenters: Anita Everett, M.D., Saul Levin, M.D., M.P.A.

EDUCATIONAL OBJECTIVE:
1) Learn about members' experiences with professional burnout, wellness and resiliency; 2) Learn about causes and predictors of professional burnout, as well as interventions to enhance wellness; and 3) Learn about potential APA efforts focused on promoting physician wellness.

SUMMARY:
Professional burnout and mental health vulnerability are significant concerns affecting physicians-in-training and practicing physicians. Professional burnout can impact physicians' health and quality of life, the quality of care they provide, and their productivity and workforce participation. There is substantial evidence of burnout and vulnerability among psychiatrists. Opportunities exist to enhance psychiatrist wellness through research, education and intervention. APA leadership wants to hear from members regarding drivers of burnout, strategies for promoting wellness and factors that contribute to professional satisfaction. Attendees will have the opportunity to express their concerns and ideas directly to APA leadership.

Monday, May 22, 2017

Applying the Integrated Care Approach: Collaborative Care Skills for the Consulting Psychiatrist
Director: Anna Ratzliff, M.D., Ph.D.
Faculty: Ramanpreet Toor, M.D.

EDUCATIONAL OBJECTIVE:
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 includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model-the integrated care approach with the strongest evidence base. 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 collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at four sessions during the Annual Meeting.

Conversations on Diversity
Chair: Ranna Parekh, M.D., M.P.H.
Presenter: Helena Hansen, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Afford APA members the opportunity to share experiences, history and perspectives about diversity in organized psychiatry; 2) Discuss how health care and patient demographics are impacted by diversity; and 3) Share ideas that will help the APA better serve its MUR constituents, patients and communities.

SUMMARY:
Conversations on Diversity and Health Equity With APA Members was created in 2015 to provide a

setting where APA members could share experiences, histories and perspectives about diversity. Additionally, the program serves to help the APA and the Division of Diversity and Health Equity (DDHE) customize goals and programming. Participant feedback is used to assist the APA/DDHE in better serving its MUR constituents, patients and families. The event is evolving as a platform for members to increase awareness and cultural competence and to facilitate their understanding of diversity as a driver of health care and institutional excellence.

Management of Cardiometabolic Risk in the Psychiatric Patient

Chairs: Jeffrey T. Rado, M.D., M.P.H., Aniyizhai Annamalai, M.D.

Presenters: Jaesu Han, M.D., Robert McCarron, D.O., John Onate, Lydia Chwastiak, M.D., M.P.H., Aaron Gluth, Lori Raney, M.D.

EDUCATIONAL OBJECTIVE:

1) Review the causes of excess mortality in the severe mental illness (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 is desired; and 5) Discuss the rationale and a proposed framework for psychiatrist management of chronic physical conditions.

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 has been 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). The APA recently (July 2015) approved a formal position statement calling on psychiatrists to embrace physical health management of chronic conditions in certain circumstances. Ensuring adequate access to training is an essential aspect of this new call to action. 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 special session provides an in-depth, clinically relevant and timely overview of all the leading cardiovascular risk factors that contribute heavily to the primary cause of death of most persons suffering with SMI and allows for the profession of psychiatry to begin to manage some of the leading determinants of mortality and morbidity in patient populations frequently encountered in psychiatric settings.

Still Shell Shocked After All These Years: Debating Military Mental Health Outcomes

Chair: Simon Wessely

EDUCATIONAL OBJECTIVE:

1) Discuss similarities and differences in military mental health between the U.S. and British Armed Forces following Iraq/Afghanistan; 2) Debate the treatment and care of soldiers by psychiatrists in the United States and the United Kingdom—to screen or not to screen, that is the question; and 3) Interpret the clinical significance of natural history, factors associated with shell shock, and improving mental

health and its public understanding in the country and internationally.

SUMMARY:
This session will discuss similarities and differences between U.S. and UK mental health outcomes in our Armed Forces following Iraq and Afghanistan, as well as include a discussion of "shell shock" in the context of current mental health treatments.

Tuesday, May 23, 2017

Applying the Integrated Care Approach: Collaborative Care Skills for the Consulting Psychiatrist
Director: Anna Ratzliff, M.D., Ph.D.
Faculty: Lori Raney, M.D.

EDUCATIONAL OBJECTIVE:
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 includes a combination of didactic presentations and interactive exercises to provide a psychiatrist with the knowledge and skills necessary to leverage their expertise in the collaborative care model-the integrated care approach with the strongest evidence base. 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 collaborative care skills. Topics include supporting accountable care, leadership essentials for the integrated care psychiatrist and an introduction to implementation strategies. Core faculty will enrich this training experience by sharing their own lessons learned from working in integrated care settings. The APA is currently a Support and Alignment Network (SAN) that was awarded $2.9 million over four years to train 3,500 psychiatrists in the clinical and leadership skills needed to support primary care practices implementing integrated behavioral health programs. The APA's SAN will train psychiatrists in the collaborative care model in collaboration with the AIMS Center at the University of Washington. This training is supported as part of that project. The same training will be offered at four sessions during the Annual Meeting.

Symposia

Saturday, May 20, 2017

Advancing Biological Markers for PTSD
Chairs: Charles R. Marmar, M.D., Marti Jett, Ph.D.
Presenters: Kerry Ressler, M.D., Ph.D., Rasha Hammamieh, Daniel Lindqvist, Rachel Yehuda, Ph.D.
Discussant: Dewleen Baker

EDUCATIONAL OBJECTIVE:
1) Obtain an increased understanding of genetic heritability and risk of PTSD following trauma exposure; 2) Understand the relevance and implications of epigenomics and gene methylation in the context of PTSD and related symptoms and comorbidities; 3) Understand the link between circulating blood cell counts, inflammation and PTSD symptomatology; 4) Understand the association between neuroendocrine molecular markers and PTSD; and 5) Understand the corticolimbic white matter abnormality related to traumatic brain injury (TBI) and the potential to implement the method in PTSD.

SUMMARY:
This symposium will present updated findings from DoD-funded case-control studies of biological markers of PTSD. Management of PTSD is complicated by the overlapping symptoms of its comorbidities, the diagnostic reliance on self-report

and a time-consuming psychological evaluation process. The purpose of this research is to facilitate an objective, unbiased method of diagnosis and advance development of treatment strategies. Study participants included male and female OEF/OIF/OND veterans (deployed to Iraq or Afghanistan after 9/11) with and without PTSD, based on the Clinician-Administered PTSD Scale for *DSM-IV*. Study procedures involved a fasting blood draw (before and after dexamethasone), structural and functional brain imagining, 24-hour urine collection, neurocognitive testing, and self-report questionnaires. This symposium will provide findings from a male veteran cohort training sample and test sample (matched by age and ethnicity), a female veteran cohort, and a validation study examining stability of markers over time, including reassessments of previously enrolled participants after one to two years as well as enrollment of new participants. Five presentations will be given regarding biomarkers and PTSD. We will first review approaches to understanding genetic architecture and mechanisms by which genetic heritability increases risk for PTSD following trauma exposure among the cohorts studied as well as an external sample, recent findings on the role of noncoding RNA in regulating protein-coding genes involved in stress regulation, and progress in genetic pathway analyses and gene x environment interactions as additional approaches to identify mechanisms of heritability for stress-related disorders. Next, we will present findings related to blood epigenomics and hypermethylated genes, investigated as to the implications for behavior, immune response, nervous system development, and relevant PTSD comorbidities such as cardiac health and diabetes. The third presentation will address increased circulating blood cell counts in combat-related PTSD and associations with inflammation symptom severity. The fourth presentation will discuss neuroendocrine and molecular marker findings in male and female veterans, demonstrating a neuroendocrine signature that is fairly reliable in discriminating groups of persons with and without PTSD. The final presentation will review an innovative imaging study conducted on the diffusion spectrum data, including 52 traumatic brain injury (TBI) cases and 26 healthy controls matched for age and ethnicity. Group differences in structural connectivity were detected among major corticolimbic white matter tracts, with potential for discriminating TBI and PTSD cases.

Can I Still Have Sex With My Spouse? Sexual Intimacy and Decision-Making Capacity in Cognitively Impaired Older Adults

Chair: Eitan Z. Kimchi, M.D.
Presenters: Daniel D. Sewell, M.D., Marilyn Price, M.D.

EDUCATIONAL OBJECTIVE:

1) Be familiar with the currently available information on how to assess if a person living with dementia has the capacity to consent to sexual intimacy; 2) Reflect upon the importance of having candid discussions with patients and families on patients' sexual preferences; 3) Understand the constructs of decision making capacity; and 4) Grasp how various decisional competencies are recognized legally.

SUMMARY:

The media recently drew attention to the unsettling trial of Henry Rayhons, a 78-year-old man in Iowa accused of having sex with his wife while she was living in a nursing home with dementia. Staff members there believed she was mentally incapable of consenting to sex. The state charged Mr. Rayhons with sexual abuse in the third-degree, a felony, for which he was eventually found not guilty. This case highlights the challenge for our society to balance individuals' rights to engage in one of life's primal pleasures and acts of self-expression with the clinical, legal and ethical obligations to protect vulnerable individuals who may be unable to consent due to cognitive impairment. A panel, comprised of two geriatric psychiatrists and a forensic psychiatrist, will summarize the currently available information and published guidelines on how to assess whether a person living with dementia has the capacity to consent to sexual intimacy. We will clarify ways that various decisional competencies are recognized legally. We will discuss how sexual intimacy fits into the current framework of competency and decision-making abilities. We will illustrate the importance of having open dialogue with patients and families on patients' sexual preferences, akin to discussions on end-of-life care.

At the end of the symposium, we will invite the audience members to share personal experiences about addressing sexual intimacy with patients and families.

Caring for Trafficked Persons: How Psychiatrists Can Utilize a Collaborative and Innovative Approach to Care for This Vulnerable Population

Chairs: Rachel Robitz, M.D., Vivian Pender, M.D.
Presenters: Jamie Gates, Eraka Bath, M.D., Tom Jones, Crystal Isle, Charisma de los Reyes, Laura McLean, Susan Munsey

EDUCATIONAL OBJECTIVE:

1) Describe potential challenges of delivering care to trafficked persons; 2) Explain how a psychiatrist can collaborate with the justice system to create a diversion court to meet the needs of trafficked youth; 3) Discuss how a psychiatrist can collaborate with the educational system to identify and treat trafficked youth; and 4) Discuss therapeutic techniques that can be used when working with trafficked persons.

SUMMARY:

Human trafficking is the second largest and fastest-growing criminal industry in the United States and is estimated to make 33.9 billion dollars worldwide. The majority of women who have been trafficked report physical and sexual violence, and rates of mental health problems are high in this population. Some trafficked populations have PTSD rates of 77% and rates of depression of 76%. Moreover, in one study of trafficked women, 41.5% of the women had attempted suicide at one time in their past. While the needs of this population are high, it can be a difficult population to both identify and serve. While 87.8% of trafficked women have seen health care providers while they were being trafficked, trafficked persons are unlikely to disclose that they are being trafficked, and health care providers have little training in how to identify trafficking survivors. Once trafficking survivors have been identified, they have complex needs spanning multiple disciplines. Moreover, there is little data on how best to meet the needs of this population. This symposium brings together individuals across disciplines to discuss ways to address human trafficking. Disciplines that will be represented include forensic child psychiatry, adult psychiatry, anthropology, child protective services, community-based organizations, and law. The symposium will also highlight the stories of both male and female survivors who currently run survivor-led organizations. Following a panel presentation by each of the disciplines, we will break into small groups to discuss innovative solutions. Groups will be divided by area of interest and will cover topics ranging from interacting with the justice system, interacting with the educational and child welfare systems, collaborating with community organizations, collaborating with survivor-run services, providing psychiatric care to this population, and doing research with this vulnerable population. By the end of the symposium, providers should begin to understand how to use multidisciplinary teams to prevent, identify and care for trafficked persons.

Co-Managed Inpatient Care: There Is More Than One Way to Skin a Cat—Case Presentation and Panel Discussion for Med-Psych Inpatient Care

Chairs: Gen Shinozaki, M.D., Philip R. Muskin, M.D., M.A.
Presenters: Ellen Coffey, Christopher Burke, Diego L. Coira, M.D., Aubrey Chan, Parashar Ramanuj
Discussant: Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVE:

1) Describe the benefit of a collaborative model where a psychiatrist is integrated in medicine service; 2) Describe the benefit of a collaborative model where a medicine hospitalist actively participates in psychiatric inpatient care; and 3) Describe the benefit of a traditional medical psychiatric unit model.

SUMMARY:

The first 120 minutes of the session will be devoted to an introduction to the wide variety of approaches for co-managed inpatient care, ranging from the onsite hospitalist/consultant model to a medical psychiatric unit. Onsite consultation models include a model from Columbia where a psychiatrist is integrated in medicine service (Muskin), and a model from Hennepin where a medicine hospitalist actively participates in psychiatric inpatient care (Coffey). A traditional medical psychiatric unit has been implemented in Iowa since the 1980s, and a brief

history and current status will be presented (Shinozaki). A similar model, recently developed in Long Island, has successfully expanded (Burke). Tips for success in the development process will be discussed. The challenges and strategies to overcome them from administrative and financial standpoints will be presented from a leadership perspective (Coira). Also, the trainee's perspective on training in such model will be reported (Chan). Finally, research from New York looking at facilitators and barriers to integrating mental health and primary care services will be discussed (Ramanuj). **Columbia:** Muskin (co-chair/discussant) will discuss a model from Columbia where a psychiatrist is integrated in medicine service. **Hennepin**: Coffey (speaker 1) will discuss a model from Hennepin where a medicine hospitalist actively participates in psychiatric inpatient care. **Iowa:** Shinozaki (chair) will discuss a traditional medical psychiatric unit that has been implemented in Iowa since the 1980s and present a brief history and current status. **Long Island:** Burke (speaker 2) will describe a program recently developed in Long Island, which has successfully expanded. Tips for success in the development process will be discussed. **Hackensack:** Coira (speaker 3) will discuss the challenges and strategies to overcome them from administrative and financial standpoints and from a leadership perspective. **Iowa Resident:** Chan (speaker 4). **Columbia:** Ramanuj (speaker 5) will describe research looking at mechanisms to integrate mental health and primary care services. The following 60 minutes will be devoted to an interactive panel session based on real-life experience from the example case presentations to make the benefit of co-managed inpatient care clear to the audience. For that goal, several intriguing cases will be presented, and each team will discuss how they approach these clinical challenges from each model's standpoint. Examples include 1) gunshot wound as suicide attempt requiring tube feeding and wound care but no recollection of what he has done due to traumatic brain injury; 2) acetaminophen overdose as suicide attempt requiring NAC IV, reporting continuous suicidal ideation; 3) suspected case of factitious disorder with recurrent and not healing wound; and 4) chronic schizophrenia with severe cellulitis requiring IV antibiotics, but refusing it.

Decriminalizing Mental Illness Using the Sequential Intercept Model: An Overview and Update on Recent Trends

Chairs: Tobias Wasser, M.D., Reena Kapoor, M.D.
Presenter: Simha Ravven
Discussant: Madelon Baranoski, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Identify the components of the Sequential Intercept Model; 2) Understand the practical application and research basis for commonly employed mental health interventions in the Sequential Intercept Model; and 3) Advocate more effectively for patients who are involved in the criminal justice system.

SUMMARY:

The overrepresentation of individuals with severe mental illness in jails and prisons is a long-recognized challenge at the intersection of the mental health and criminal justice systems. This issue is particularly prevalent for providers working in community settings, where socioeconomic factors and chronic illness further elevate patients' risk. In 2006, Munetz and Griffin described the Sequential Intercept Model, a conceptual framework for reducing this burden by identifying a series of opportunities or "intercept points" for diverting individuals with mental illness from the criminal justice system. Intercept points include the initial point of police contact (pre-booking), post-arrest initial detention and hearings, post-initial hearings (e.g., jails, courts, forensic evaluations), community reentry following a period of incarceration, and community corrections and support. Consistent with this model, many states have designed and implemented a number of diversionary interventions. Each intercept point provides an opportunity for a variety of mental health interventions, some of which have a greater evidence base to support them than others. In this symposium, we will first provide participants with an overview of the Sequential Intercept Model as originally outlined by Munetz and Griffin. Each presenter will then review a particular interception point, the types of commonly employed interventions at that point of interception and the recent evidence base supporting the programs' use. Finally, presenters will offer practical strategies to

aid community clinicians in effectively collaborating with criminal justice and forensic practitioners at each point of interception to overcome barriers and advocate for their patients.

Intimate Partner Violence and Sexual Violence Against Women: A New Competency-Based Curriculum for Psychiatrists, Residents and Medical Students

Chairs: Donna E. Stewart, Dinesh Bhugra, Ph.D.
Presenters: Marta Rondon, Louise Howard, Michelle B. Riba, M.D.
Discussant: Helen Hermann

EDUCATIONAL OBJECTIVE:

1) Understand the importance of intimate partner violence (IPV)/sexual violence (SV) in psychiatric practice; and 2) Understand how to teach psychiatrists, residents and medical students using the World Psychiatric Association curriculum on IPV/SV.

SUMMARY:

Thirty percent of psychiatric patients, especially women, have a lifetime history of intimate partner violence (IPV) or sexual violence (SV), which may be key contributors to many mental health problems, including depression; anxiety; PTSD; somatization; chronic pain; sexual, sleep and eating disorders; suicide and self-harm; substance abuse; and other risky behaviors. Needs assessments show that most psychiatrists and their trainees do not know how to ask about or respond to IPV or SV. Consequently, IPV/SV are often undisclosed and, therefore, treatment may be suboptimal. Mental health professionals need better education on identifying and addressing these topics. The World Psychiatric Association (WPA) recently listed IPV and SV as one of its priorities in its work plan. A group of international experts on this topic, including three World Health Organization and several WPA advisors, reviewed the literature and developed a competency-based curriculum on IPV/SV for trainees and practicing psychiatrists. It also suggests ways of measuring competency on these core competencies at increasing levels of complexity from medical students to residents to practicing psychiatrists. This new curriculum includes PowerPoint teaching slides, 12 case vignettes with teaching points for discussions, two video interviews, and a set of references with abstracts. The curriculum addresses definitions, epidemiology, how to ask, and evidence-based treatment of victims of both IPV and SV. The curriculum was endorsed by the WPA in 2016 and now appears at http://www.wpanet.org. Early uptake has been excellent. This symposium will feature Dr. Donna Stewart (Canada), Prof. Louise Howard (UK) and Dr. Marta Rondon (Peru), who will present the content of the curriculum on IPV and SV, followed by some written and audiovisual cases with teaching points. Prof. Dinesh Bhugra, president of the World Psychiatric Association, will open the session, Dr. Michelle Riba of the APA and the WPA will coordinate the discussion, and Prof. Helen Hermann, president-elect of the WPA, will provide closing remarks. This overview of the curriculum will assist the audience in implementing education on IPV/SV for medical students, residents and practicing psychiatrists to improve mental health clinical care.

Mentally Ill and Traumatized Populations in South Sudan: Community Outreach and Breath-Body-Mind Treatment for Impoverished States

Chairs: Patricia L. Gerbarg, M.D., Richard Brown, M.D.
Presenter: Atong Ayuel Akol, M.D.

EDUCATIONAL OBJECTIVE:

1) Discuss the challenges faced by South Sudan in providing mental health services to individuals with mental illness and traumatized survivors of war; 2) Explain fundamental neurophysiological principles that account for the effects of voluntarily regulated breathing practices on sympathovagal balance and heart rate variability; 3) Describe the use of a mind-body program to relieve stress and symptoms of trauma in South Sudan; 4) Practice coherent breathing as a component of self-care for relief of personal and work-related stress; and 5) Utilize resources provided for further learning about the use of mind-body practices in clinical populations and following mass disasters.

SUMMARY:

South Sudan exemplifies the problems faced by African nations and other countries with few resources to meet the needs of war-affected populations living under extreme stress due to

poverty, trauma, disease, and the threat of recurring violence. Since the creation of an independent South Sudan in 1956, civil wars between the north and the south have repeatedly traumatized the population, prevented development of infrastructure, and left the country with huge numbers of mentally ill people and a handful of health care professional with few resources to provide care. Since July 9, 2011, when South Sudan became an independent country, it became necessary to create models and policies to deal with health in general and mental health in particular. Dr. Atong Ayuel, director of mental health for the Ministry of Health of South Sudan and the only practicing psychiatrist in South Sudan, has been tasked by the Ministry of Health to develop a plan to address the mental health needs in her country. Dr. Ayuel will describe mental health services, needs of the mentally ill and the training of mental health professionals in a mind-body program-Breath-Body-Mind-as one of the mental health interventions for South Sudan. Dr. Richard P Brown and Dr. Patricia Gerbarg adapted a mind-body intervention, Breath-Body-Mind (BBM) for use in post-disaster areas to rapidly relieve anxiety, insomnia, posttraumatic stress disorder, and depression. Dr. Gerbarg will review the neurophysiology and evidence base supporting the safety, feasibility, and effectiveness of this program, including its use in South Sudan during the past five years where it is effective, readily accepted by the Sudanese, and becoming par for the mental health care system. Video clips show how Dr. Brown teaches BBM to psychologists, health care and relief workers, psychiatric patients, and, recently, liberated slaves, including adults and children, in South Sudan. Dr. Brown will lead symposium attendees through a set of practices that enable participants to experience the effects on their own mental and physical states. Health care professionals affected by stress can use these practices for self-care and integrate them into individual and group therapies. Large group interventions are relevant in the U.S. and other countries affected by the worldwide epidemic of stress. Resources for further learning are provided.

New Horizons in Tardive Dyskinesia Research
Chairs: Stanley N. Caroff, M.D., Cabrina Campbell, M.D.
Presenters: James L. Kennedy, M.D., Christopher F. O'Brien, M.D., Hubert H. Fernandez, M.D., Maryka Quik, Ph.D., D. James Surmeier, Ph.D.
Discussant: Jeffrey Lieberman, M.D.

EDUCATIONAL OBJECTIVE:
1) Demonstrate how to treat tardive dyskinesia within the context of managing patients with serious mental illness; 2) Understand advances in genetic susceptibility for tardive dyskinesia to eventually identify patients at risk and potential therapeutic drug targets; 3) Apply the principles underlying the use of two new vesicular monoamine transporter type 2 inhibitors in the treatment of tardive dyskinesia; and 4) Identify the neurobiological mechanisms underlying tardive dyskinesia and the development and potential use of nicotinic and muscarinic agonists in its treatment.

SUMMARY:
Tardive dyskinesia (TD) is a polymorphic, hyperkinetic, extrapyramidal movement disorder associated with prolonged use of antipsychotic and other dopamine antagonist drugs. Although often mild, primarily affecting orofacial musculature and frequently masked by ongoing antipsychotic treatment, TD is potentially irreversible and may be socially disfiguring as well as compromise eating, speaking, breathing, or ambulation. Concern over TD was a principal factor motivating past efforts to develop new antipsychotic drugs with reduced extrapyramidal liability. Although prevailing evidence suggests that the newer generation of antipsychotic drugs are indeed less likely to cause TD, at least compared with older high-potency antipsychotics, clinical familiarity with TD remains important for several reasons: older high-risk antipsychotics are still in use, there is a potential risk for TD even with newer agents in susceptible patients, antipsychotics are more widely marketed and prescribed in the population, and thousands of patients already have TD due to prior antipsychotic treatment. While multiple mechanisms have been proposed for TD, resulting in numerous trials of diverse remedies, there are no standard, approved treatments for TD. However, recent findings from animal models and rigorous controlled trials afford the opportunity to advance a broad, evidence-based algorithm for the treatment of established TD within

the context of managing patients with serious mental illness. To address this need, we begin by reviewing data on genetic susceptibilities underlying the risk of developing TD, which eventually could be used to identify both patients at risk and potential targets for future drug development. Based on the dopamine supersensitivity hypothesis, we then discuss recent evidence supporting the safety and efficacy of two new vesicular monoamine transporter type 2 inhibitors in development for the treatment of TD, which offer the possibility of improved pharmacokinetic properties and better tolerability. Finally, we will hear from two research groups conducting innovative research on cholinergic mechanisms underlying TD and the promise of developing specific nicotinic and muscarinic agonists in the treatment of TD.

Patient Suicide in Residency Training: The Ripple Effect

Chairs: Daphne C. Ferrer, M.D., Joan Anzia, M.D.
Presenters: Deepak Prabhakar, M.D., M.P.H., Andrew Booty, Alexis A. Seegan, M.D., Hohui Eileen Wang, M.D., Rachel Brooke Katz, M.D., April Seay, M.D., Julie Owen, M.D., Rachel Conrad, M.D.
Discussants: Sidney Zisook, M.D., James W. Lomax, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify feelings resident psychiatrists and supervising psychiatrists may have after a patient commits suicide; 2) Demonstrate understanding of a need for improvement in preparing residents for the likelihood of suicide in their career and in supporting residents who experience patient suicide during training; 3) Demonstrate knowledge of strategies, including video training and postvention protocols, used to prepare residents and support them after a patient commits suicide; and 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 (CDC), in 2014, suicide was ranked as the tenth leading cause of death, accounting for 42,773 deaths. Studies estimate that 20–68% of psychiatrists will lose a patient to suicide in their careers. 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 available 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. This symposium will begin with a presentation from a residency training director who will discuss the challenges in educating trainees about the impact of patient suicide and will show brief clips from a video, “Collateral Damage: The Impact of Patient Suicide on the Psychiatrist,” which 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. This will be followed by presentations from psychiatry residents from various residency programs across the United States sharing their experience of having a patient die by suicide. Small group discussions led by panelists will follow, allowing for sharing of experiences with patient suicide among audience participants. Several attending psychiatrists will then discuss the development of support systems including educational curricula and a postvention protocol for residents who experience patient suicide at their home training programs. Next, two psychiatry residency program directors will present a brief vignette with a question and answer portion on suicide-related knowledge issues along with other competencies. Lastly, we will conduct a large-group discussion of strategies for improving supports for residents The symposium will close with final comments and an open question and answer portion from the audience.

Pediatric Psychiatric Emergencies: A Discussion on Systems of Care for Psychiatric Consultation Within Several Hospital Systems

Chair: Megan Mroczkowski, M.D.
Presenters: Nicole Guanci, M.D., Argelinda Baroni,

Vera Feuer, Jeffrey Vanderploeg
Discussant: Patrick Kelly

EDUCATIONAL OBJECTIVE:
1) Understand the most common presentations and impact of pediatric psychiatric emergency visits; 2) Appreciate the extant literature on standards of care for pediatric psychiatric consultation in the emergency department; 3) Identify models of care used in four different hospital systems; and 4) Recognize suggested management and treatment guidelines for pediatric psychiatric emergencies for providers and referrers.

SUMMARY:
On average, more than 30 million children present to emergency departments (EDs) in the United States annually, of which an estimated three to four percent present with psychiatric or behavioral chief complaints. Mental health professionals, primary care professionals and schools often refer patients with suicidal ideation and aggression to the ED. In 2006, the American Academy of Pediatrics and the American College of Emergency Physicians issued a joint policy statement that children with acute mental health crises require multidisciplinary care, including the use of specialized screening tools, pediatric-trained mental health consultants, broader availability of treatment options, and communication throughout the health care system. Psychiatry consultations to evaluate patients with suicidal ideation or aggression exist within a myriad of system of care models. This symposium will highlight four such systems, present a review of the literature on standard of care for emergency child psychiatric evaluation, and then utilize two standardized cases (one aggressive child, one with suicidal behavior) to demonstrate the clinical services provided in four different systems of emergency child psychiatric care: The Bellevue Hospital children's comprehensive psychiatric emergency program (CPEP), Morgan Stanley Children's Hospital of New York-Presbyterian, Cohen's Children's Medical Center (CCMC), and The Connecticut Emergency Mobile Psychiatric Service (EMPS or Mobile Crisis). Our discussant will discuss each of the four models and comment on strengths, weaknesses, and aspects of a community or hospital system that would best fit each type of service. Additionally, the discussant will discuss the approach and resources required to optimally evaluate patients in the ED. The ultimate goal of this symposium is to provide insight into both the risk assessment and decision-making processes within the ED, along with creating a forum for discussion on optimization of pediatric emergency psychiatric care for general psychiatrists, child and adolescent psychiatrists, and other clinicians.

Physician-Assisted Death (PAD): Challenges of the Psychiatrist's Role
Chair: John Peteet, M.D.
Presenters: Rebecca Brendel, James Bourgeois, Lawrence Kaplan, Sonu Gaind, John Peteet, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the ethical issues involved in providing PAD; 2) Understand the process of developing guidelines for evaluating individuals for PAD; 3) Appreciate the challenges of assessing decisional capacity in neurocognitively impaired individuals; and 4) Recognize the potential risks of offering PAD for psychiatrically impaired individuals.

SUMMARY:
Physician-assisted death (PAD) is now legal in five U.S. states (OR, WA CA, MT, VT) and Canada. Psychiatrists called upon to help assess decisional capacity and psychiatric illness face a number of questions: What is their role in assessing vs. helping patients considering PAD to cope? What guidelines are appropriate for the institutions within which they work? What should clinicians who have ethical reservations about PAD do? Presenters in this symposium will address the psychiatrist's role from a range of perspectives: Dr. Rebecca Weintraub Brendel will begin with historical context in the U.S. through an exploration of the legal development of physician-assisted death as a platform for an ethical analysis of physician-assisted dying. Dr. James Bourgeois will discuss the issues involved in assessing decisional capacity in neurocognitive illness and in conducting psychiatric evaluations for physician-assisted dying. He will be joined by Dr. Lawrence Kaplan in describing the development and implementation of mental health evaluation guidelines for the End-of-Life Option Act (EOLOA) for the UCSF Cancer Center, including various challenges

encountered in specific oncology populations. Dr. Sonu Gaind will discuss the evolution of PAD policies in Canada and the work of the Canadian Psychiatric Association Task Force on Assisted Dying, focusing on issues relevant to mental illness, which he has chaired. Finally, Dr. John Peteet will describe euthanasia of patients with psychiatric disorders in the Netherlands from 2011 to 2014. The session will encourage discussion of these complex issues in light of the experience of the audience.

The Dilemma of Antipsychotic Drugs: When to Start and When to Stop

Chairs: Sandra Steingard, M.D., Michael A. Flaum, M.D.
Presenters: David A. Lewis, M.D., Joanna Moncrieff, M.D., Christopher Gordon, M.D.
Discussant: Lisa B. Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Understand the evidence for and implications of structural brain damage associated with exposure to antipsychotic drugs; 2) Understand the concept of a drug-centered approach to psychopharmacology and its implications; 3) Understand the impact of delaying use of antipsychotic drugs; 4) Understand the evidence suggesting the need to conduct more research on antipsychotic withdrawal; and 5) Understand a collaborative approach to working with individuals who are experiencing an early psychotic episode.

SUMMARY:

The use of antipsychotic drugs garners scrutiny on many fronts. Many people for whom they are prescribed choose not to take them or follow standard guidelines for treatment. These drugs, while helpful for many, also carry a significant side effect burden. Weight gain, increased risk of diabetes and tardive dyskinesia are among the most concerning. In recent years, evidence has emerged that challenges standard practice guidelines that recommend that these drugs are started as soon as possible after the emergence of psychotic symptoms and, in most instances, continued indefinitely. The data include basic science research suggesting these drugs may cause structural and histopathological brain changes. In the clinical realm, some evidence suggests that long-term chronic use of the drugs may be associated with worse long-term functional outcomes. This symposium will address these issues. The presenters reflect different perspectives on which data is most salient and to what extent it should influence clinical work. Questions to be addressed include 1) What is the evidence that antipsychotic drugs cause structural brain damage and to what extent should the available data influence clinical practice and be discussed with patients? 2) What are the implications of a drug-centered model of psychopharmacology? 3) When, if ever, is it appropriate to offer a drug taper, and how can this be safely achieved? 4) Is delaying the introduction of antipsychotic drugs a valid clinical approach? 5) How to we bring these complex questions into the clinical setting? David Lewis will begin by presenting his work examining structural, cellular and molecular measures in macaque monkeys exposed to antipsychotic drugs. He will offer his opinion regarding the impact this data should have on clinical work. Joanna Moncrieff will follow with a discussion of the drug-centered model for thinking about these drugs, focusing on their subjective effects. She will also present early data from a large UK-based randomized controlled trial to evaluate a gradual antipsychotic withdrawal program in people with multiple-episode schizophrenia and psychosis. Sandra Steingard will discuss her experience in using a shared decision model in discussing and implementing antipsychotic drug tapering in a group of 71 individuals who have been followed for five years. She will also address the topic of the impact of duration of untreated psychosis on long-term outcome. Chris Gordon will discuss his experience in utilizing a shared decision-making model, Collaborative Pathways, in a group of individuals who are experiencing a first episode of psychosis. Lisa Dixon will be the discussant for the symposium. Michael Flaum will serve as moderator and discussant.

Theatrical Vignettes as an Educational Tool to Improve Communication in Asian-American Families

Chairs: Rona Hu, M.D., Amy Poon, M.D.
Presenters: Megan E. Baker, M.D., Steven Sust, Paula Tran, Grace Lee, Grace Liu
Discussant: Francis Lu, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the challenges faced by Asian-American families with adolescents, including the possible impact of cultural expectations about success and mental health; 2) Understand a unique method of community outreach and education involving mental health clinicians acting in theatrical vignettes and interacting with the audience; and 3) Recognize common challenges and concrete strategies to improve communication between parents and adolescent about difficult emotional topics including dating, self-harm behaviors, school performance, and acculturation.

SUMMARY:
Palo Alto, California, is a Bay Area community with a population of 66,853 located in the northwest corner of Santa Clara County. Since 2009, the community has experienced two separate suicide clusters-defined as a group of three or more suicides in close time or geographic proximity. In a community that is demographically 64% white and 27% Asian according to the 2010 U.S. census, Asian-American male adolescents have been disproportionately represented in these suicides. Following the second suicide cluster in 2014-2015, the Stanford Center for Youth Mental Health and Well-Being conducted a set of focus groups to better understand the community's perception of current mental health needs and possible solutions. Participants included parents and adolescents of both Asian and non-Asian descent. Participants identified stigma against mental health as a significant barrier to accessing mental health services, and they voiced a need for more community education, resources and support. Adolescents discussed feeling intense pressure from schools, parents and peers to achieve personal and academic success. Asian adolescents additionally identified cultural expectations of success and cultural stigma against mental health as barriers to openly communicating with their parents and seeking help for their struggles. Among Asian participants, both parents and adolescents identified generational and cultural gaps in understanding mental health issues that affect youth. In other workshops throughout the year where Stanford faculty partnered with local schools, parents identified difficulty discussing emotional topics with their adolescents and specifically requested a more "hands-on" way of learning skills to better communicate with their adolescents. In response to this request, Rona Hu, M.D., a Stanford psychiatry faculty and Chinese American, developed several vignettes as a tool for educating parents on effective communication. The vignettes, which will be performed in this symposium, simulate difficult, real-life scenarios that parents face, with specific emphasis on challenges that may arise in Asian-American households. This interactive symposium will commence with speaker introductions and background information regarding the suicide clusters in Palo Alto. Presenters will then role-play seven vignettes while fielding questions from the audience. Each vignette depicts a different topic, including dating, school pressure and bad grades, teens feeling embarrassed by unacculturated parents, excessive video game playing, and depression and self-harm behavior. For each vignette, the actors will initially demonstrate problematic communication, and after moderation and comments from the actors-in-role, they will repeat the scenario with improved communication style. Afterward, there will be active discussion including how to apply these principals to other communities.

Top Treatment Challenges in Persons With IDD and Psychiatric and/or Behavioral Disorders
Chairs: Robert J. Pary, M.D., Janice Forster, M.D.
Presenters: Jeffrey I. Bennett, M.D., Talha Baloch, M.D., Dorcas Adaramola, M.D.

EDUCATIONAL OBJECTIVE:
1) Discuss the management of persons with IDD who have disorders of ingestion; 2) Discuss the evaluation and treatment of aggressive behavior in individuals with IDD; 3) Describe the evaluation and treatment of sleep/wake disorders in persons with IDD; 4) Discuss the management of self-injurious behavior in persons with IDD; and 5) Discuss cognitive impairment in persons with IDD.

SUMMARY:
Over 25 years ago, an APA task force on the treatment of adults with intellectual/developmental disabilities (IDD) stressed training to manage the mental health problems of community-dwelling

persons with IDD. Years later, the consensus is that the training needs have been largely unmet. This symposium addresses several challenging behaviors in persons with IDD: self-injurious behavior (SIB), physical aggression toward others, disorders of ingestion, disorders of the sleep/wake cycle, and cognitive impairment. The presentation on SIB will provide a scheme to understand the sensory, psychosocial and neurochemical context of this challenging behavior. This scheme can also serve as a basis to understand the subsequent other challenging behaviors. SIB can modulate both sensory overload and deprivation and often serves to maintain an automatic balance. Few environments tolerate SIB, and countertransference to these phenomena can perpetuate the behavior. SIB, even in the same syndrome, can have multiple etiologies. Skin picking that is automatic and mindless can respond to N-acetylcysteine, but if the picking is due to severe stress, then environmental alterations may be needed. Anxiolytic or anti-impulsive medications may help depending on the context. If pain is motivating the picking, naltrexone may help. Physical aggression by persons with IDD is a common referral issue. The presentation on aggression will review the multiple factors that may result in a person with IDD becoming aggressive. These factors can range from psychosocial stressors to psychiatric disorders to physiological changes associated with medications or medical conditions. Clarifying the pertinent etiology may warrant diagnostic studies, ongoing data collection and provisional treatment strategies until a more definitive plan is determined. Complicating the treatment plan may be consideration of available personal and financial resources. The presentation on disorders of ingestion includes eating inedible items (PICA), insertion of foreign objects into body orifices (polyembolokoilomania), excessive food intake resulting in potential for vomiting or aspiration (gorging), and regurgitation of contents of esophagus or stomach back to the mouth so as to rechew and reswallow. These conditions can lead to the necessity for emergency medical attention. The presentation on disorders of sleep/wake cycle will focus on an approach to these conditions that usually interfere with daily functioning and often cause significant distress to others in the environment. As the other presentations have emphasized, no one condition causes sleep/wake problems. The presentation will offer strategies when the initial treatment plan is unsuccessful. The presentation on cognitive impairment will discuss the differential diagnoses and management.

Understanding and Treating Personality Disorders: A Severity-Guided Psychodynamic Framework

Chair: Eve Caligor, M.D.

Presenters: John Clarkin, Richard Hersh, M.D., Frank E. Yeomans, M.D.

Discussant: John M. Oldham, M.D., M.S.

EDUCATIONAL OBJECTIVE:

1) Review new developments in the conceptualization and classification of personality disorders, focusing on severity and the distinction between symptoms and underlying personality organization; 2) Understand a contemporary psychodynamic approach to treatment of personality disorders; 3) Apply a clinically oriented approach to assessment of personality disorders that can be an integral part of the standard psychiatric evaluation; and 4) Apply basic psychodynamic interventions, employed in longer-term treatments, that have clinical utility in a variety of shorter-term and acute settings.

SUMMARY:

Recent developments in our understanding of personality disorders (PDs) have emphasized 1) the dimension of severity as a predictor of course and outcome and 2) the distinction between symptoms versus underlying personality organization, expressed in chronic self and interpersonal functioning, in tracking course and outcome. This symposium will introduce participants to a contemporary psychodynamic, object relations theory-based approach to PDs across the spectrum of severity. Presentations will provide an overview of a longer-term, specialized treatment package for personality disorders that targets pathology of self and interpersonal functioning. Presentations will cover the clinical objectives and core techniques that define this treatment approach, focusing on how techniques are modified across the spectrum of severity. Presentations focusing on specific techniques will cover systematic assessment, establishing and maintaining a treatment contract,

and managing clinicians' emotional responses to patients with personality disorders. Presenters will highlight the general clinical utility of these techniques, illustrating how they can be implemented by clinicians working with patients in shorter-term, symptom-oriented treatments and in acute treatment settings.

Sunday, May 21, 2017

Complementary and Integrative Treatments in Psychiatric Practice
Chair: Philip R. Muskin, M.D., M.A.
Presenters: Patricia L. Gerbarg, M.D., Richard Brown, M.D., Harris A. Eyre, Ph.D., M.B.B.S., Jerome Sarris, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Identify herbal treatments that can be useful in the treatment of anxiety, depression and other psychiatric disorders; 2) Integrate S-adenosylmethionine into treatment of patients with depression; 3) Discuss the evidence base and potential benefits of tai chi and qigong in treating psychiatric disorders; 4) Discuss the effects of voluntarily regulated breathing practices on sympathovagal balance, stress response and social engagement systems; and 5) Access information and tools to develop skills in the use of voluntarily regulated breathing practices as adjunctive therapies in psychiatric practice.

SUMMARY:
International experts, who contributed to *Complementary and Integrative Treatments in Psychiatric Practice* by American Psychiatric Association Publishing (2017), discuss the evidence base, treatment issues, safety, efficacy, and future directions for complementary and integrative medicine (CAIM) in psychiatric practice. Guidelines for decision making, combining CAIM approaches and integration with conventional treatments are provided. This symposium offers a sampling of treatments covered in the book, chosen by therapeutic potential, evidence base, safety, clinical experience, geographic and cultural diversity, and public interest. Phil Muskin shares his perspective on the importance of CAIM in current and future psychiatric practice. The presentation by Jerome Sarris includes some well-studied phytomedicines, including St John's wort (*Hypericum perforatum*), kava (*Piper methysticum*), roseroot (*Rhodiola rosea*), and chamomile (*Matricaria recutita*). He also covers lesser-known extracts: kanna (*Sceletium tortuosum*), galphimia (*Galphimia glauca*), and L-theanine from *Camelia sinensis*. Richard P. Brown discusses the natural antidepressant S-adenosylmethionine (SAMe), which has been shown to be as effective as prescription antidepressants without many of the more troubling side effects of pharmaceuticals. Mind-body interventions such tai-chi, qigong and yoga are becoming recognized as legitimate therapies for mental disorders and brain health. Helen Lavretsky points out that they can be safer and have larger treatment effects than many traditional pharmacotherapies. She reviews the evidence for efficacy of mind-body interventions in a broad range of neuropsychiatric disorders, potential neurobiological mechanisms and new data from recent trials of Kundalini yoga and tai chi for late life mood and cognitive disorders. Patricia Gerbarg updates neurophysiological theories and clinical studies of breathing practices in the treatment of anxiety and traumatic stress-related disorders. Drawing upon polyvagal theory, she explores the effects of mind-body treatments, particularly therapeutic breathing practices, on stress response, sympathovagal balance, trauma resolution, cognitive function, empathy, and connectedness. Dr. Brown leads participants through some of the therapeutic movement, breathing and attention focus practices he has used in treating psychiatric patients, individuals with serious medical illness, veterans, and survivors of mass disasters in the U.S., South Sudan and Berlin. Clinicians will acquire valuable insights into complementary and integrative practices for self-care, patient care, community resiliency, and disaster response.

Empowered Women Empower Women: Opportunities and Challenges for Women Psychiatrists in Academia, Leadership and Beyond
Chairs: Isabel Schuermeyer, M.D., M.S., Margo Funk, M.D., M.A.
Presenters: Kathleen Franco, Karen Jacobs, D.O.

EDUCATIONAL OBJECTIVE:
1) Identify obstacles women in psychiatry face

compared to their male colleagues and learn ways to promote equality in their workplace; 2) Recognize the impact of advocacy on their career and how to further develop this; and 3) Identify ways of managing outside pressures (such as motherhood) despite working in a high-pressured field.

SUMMARY:
Psychiatry is one of the more common specialties women choose to go into after completing medical school. Despite this, there are still many challenges unique to women in this field. Women are underrepresented in leadership positions in academic psychiatry departments. Even outside of academic departments, women are often underrepresented in leadership positions within advocacy groups and professional organizations. These trends are improving over time, but there are things that we can do to improve our degree of representation within leadership positions in our field. Psychiatrists who are also, or become, mothers are faced with balancing two positions, each of which has high demands. Long work hours, unpredictable work schedules and limited peer support at work can significantly complicate the ever-changing difficulties associated with raising children. The goal of this highly interactive symposium is to summarize the multiple challenges unique to women practicing psychiatry, as well as ways to face these challenges and further their careers. Interactive exercises will be used with participants and will address issues such as negotiating, networking strategies, setting limits, connecting with a mentor, and balancing (or juggling) demands between work and family/home. The instructors have each, in their own way, faced many of these challenges and continue to thrive at work and at home. The instructors include a medical school dean, a past president of a state chapter of the APA, a residency director, and leaders in other areas of psychiatry.

Exploring Epigenetics-Driven Multimodal Interventions: Diets, Nutraceuticals, Exercises, and Brain Games in Alzheimer Dementia
Chairs: Simon Chiu, M.D., Ph.D., Michel Woodbury-Farina, M.D.
Presenters: Mariwan Husni, M.D., Mujeeb Shad, M.B.B.S., M.Sc., John Copen, M.D., M.Sc.
Discussant: James Fleming, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the basics of epigenomics in modulating brain-behavior-cognition functions in Alzheimer's dementia (AD); 2) Evaluate evidence of customized diets (e.g., Mediterranean diet) and nutraceuticals in targeting epigenetic signaling involved in regulating Abeta amyloid, tau and inflammation; 3) Understand how epigenetics machinery interacts with genomics: single-nucleotide polymorphism (SNP) in influencing diet and drug responses in AD; 4) Understand how cross-talks of physical activity and exercises and CNS-cardiovascular systems may enhance cognition through epigenetics signaling; and 5) Identify the caveats in translating epigenomics-driven interventions to quality geriatric care.

SUMMARY:
Recently, increased attention has been drawn toward the adverse impact of disease burden of the aging population and Alzheimer's dementia (AD) on limited health care resources. In the post-genomic era, the rapidly growing field of epigenetics has enlarged our understanding of AD beyond gene mutations at selected gene loci. The epigenetics primer consists of heritable changes in gene expression and chromatin remodeling, independent of changes in the primary DNA sequences. The epigenetic components (DNA methylation, histone modifications, and non-coding RNA [ncRNA]) modulate cognition and brain-behavior functions in AD. Aging epigenomics involves genes being turned "on" and "off" via complex epigenetics machinery. The epigenetics landscape offers exciting avenues for a biomarker diagnostic toolbox to complement brain imaging and CSF analysis of beta-amyloid and tau levels. The mechanisms whereby epigenetics interacts with single-nucleotide polymorphism (SNP) variants in modulating drug responses are largely unexplored in aging and in AD. Converging evidence supports the model of epigenetic dysregulation in age-dependent cognitive impairment and AD. Bioactive nutritional factors target epigenetics signaling pathways capable of reversing or silencing abnormal gene activation and regulating neurogenesis and inflammation. We review critically the intriguing findings from translational and clinical

studies showing that phytochemicals from dietary sources and spices exert beneficial neuroprotective effects through facilitating transcriptional and translational events involved in cognitive functions. Randomized controlled trials conclude that adherence to the basic components of Mediterranean diets at the cross-roads of nutritional epigenomics and the brain-cardiovascular nexus has consistently yielded robust outcomes in reducing cardiovascular risks and slowing cognitive decline in mild cognitive impairment (MCI) and early AD. We will review the findings on the cognitive and behavioral effects of selected nutraceuticals in targeting epigenetics signatures in AD and propose that innovative epigenetics-based drug discovery platforms targeting enzymes and signal pathways regulating DNA methylation and histone acetylation and deacetylation and ncRNA can reshape future drug development in AD. We will examine the neuroinflammation theme in AD and introduce newcomers to reset the epigenomics toward neural rejuvenation mode in aging. Exercise epigenomics intersect at the cross-roads of cardio-respiratory fitness and brain health. Digitally delivered brain games represent a new mode of engaging AD patients through creative use of communication-interactive devices to maintain and improve functional outcomes of AD. Systemic issues-fiscal, regulatory and safety-of translating research findings on multimodality intervention to real world milieu will be discussed. In summary, our proposed paradigm shift toward personalized precision medicine can produce optimism waves in AD.

New Guideline Recommendations for Strengthening Psychiatric Practice

Chairs: Laura J. Fochtmann, M.D., Michael J. Vergare, M.D.

Presenters: George Keepers, Victor I. Reus, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe potential benefits of using evidence-based guidelines in clinical psychiatric practice; 2) Discuss the ways in which the amount and quality of relevant research evidence shapes the development of clinical practice guideline recommendations; and 3) List at least three APA practice guideline recommendations related to treatments for psychiatric disorders.

SUMMARY:

Practice guidelines are of increasing value to psychiatrists by synthesizing advances in research and providing consensus-based guidance when research evidence is unavailable. With the shift to quality-based payment methodologies, practice guidelines will take on even greater importance. This symposium will provide an overview of the APA's practice guidelines program and discuss new recommendations relating to the treatment of alcohol use disorders, eating disorders and schizophrenia. For each guideline, we will describe evidence that underlies key recommendations. In addition, we will discuss some of the challenges that arise in developing practice guidelines as well as approaches to implementing guideline recommendations in psychiatric settings. Use of audience response will foster exchange with attendees about the recommendations and barriers to guideline use. Attendees will be encouraged to give examples of successes and challenges of adopting practice guideline recommendations in their own practices. They will be asked to share their preferences for accessing guidelines (e.g., web, textbooks, pocket cards, phone apps) and offer suggestions for making guidelines more useful in their daily practice. Plans for future guideline topics will also be discussed.

Personality and Syndrome Disorders: It Is All in How You Look at It

Chair: James H. Reich, M.D., M.P.H.

Presenters: Michael B. First, M.D., James H. Reich, M.D., M.P.H., Harold W. Koenigsberg, M.D., M. Mercedes Perez-Rodriguez, M.D., Ph.D., Rona Hu, M.D.

Discussant: Emil Coccaro, M.D.

EDUCATIONAL OBJECTIVE:

1) Have a better understanding of several different models of personality pathology; 2) Have a better understanding of the biology of avoidant personality disorder; 3) Have a better understanding of the biology of borderline personality disorder; and 4) Have a better understanding of the relationship of psychotic disorders to personality.

SUMMARY:

The relationship of two disorders can be affected greatly by how the two disorders are defined. At this point in American psychiatry, we have several possible models. For example, we have the "big five" dimensional personality models, and we have the existing *DSM-5* model as well as an alternate *DSM-5* model. There is considerable literature on the relationship between personality and personality pathology and the syndrome disorders such as anxiety and depression. The goal of this symposium is to examine how different personality conceptualizations alter the relationship between personality pathology and syndrome disorders. The symposium will start with a presentation of where we are in terms of some current models of measuring personality pathology, including *DSM-IV*, *DSM-5* and dimensional models. In the area of personality and anxiety, we will have a presentation of comorbidity of personality in social anxiety disorder and panic disorder and how different views of personality can change the perception of the relationship between personality pathology and these disorders. This will be followed by a presentation on amygdala activation in anticipation of regulating emotions in avoidant personality disorder patients and MRI structural data on avoidant personality disorder patients. There will be an examination of how biological factors can help us define the best way to conceptualize borderline personality disorder. Finally, there will be a presentation on the relationship of personality to the psychotic disorders.

The Goldwater Rule: Pro and Con
Chair: Nassir Ghaemi, M.D., M.P.H.
Presenters: Paul S. Appelbaum, M.D., Alan Stone, M.D., Jerrold Post, Claire Pouncey, M.D., Ph.D.
Discussant: Paul Summergrad, M.D.

EDUCATIONAL OBJECTIVE:
1) Define and explain the Goldwater Rule and how it has been used over the years; 2) Analyze viewpoints in favor of and opposed to the Goldwater Rule; 3) Appraise ways in which the Goldwater Rule has been, and is, used in different public settings; and 4) Judge how the Rule may and may not be useful for the profession and for the public.

SUMMARY:
In the last 50 years, the Goldwater Rule was set up as an ethical standard for how psychiatrists should comment on public affairs. The Rule has been discussed in relation to living political figures—such as presidential candidates as in 1964 and recently—but also in relation to psychiatric evaluation of foreign leaders conducted by U.S. government agencies and psychiatric examination of historical documents related to past deceased leaders. In recent years, debate has grown as to whether the Goldwater Rule should remain unchanged or if it is too strict and should be revised. In this symposium, distinguished leaders—including former APA presidents, forensic psychiatrists, and experts in philosophy and psychohistory—will comment on both sides of this controversy.

The Role of the General Psychiatrist in the Management of Patients With Pain
Chairs: Carlos Blanco-Jerez, M.D., Ph.D., Geetha Subramaniam, M.D.
Presenters: Martin Cheatle, Alla Landa, Ph.D., Eric Collins, Jeffrey Borckardt
Discussant: Ivan D. Montoya, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Understand the role of the general psychiatrist in managing pain; 2) Be familiar with the most common pharmacological and nonpharmacological approaches to pain; and 3) Be aware of the benefits and risks of using opioids to treat pain.

SUMMARY:
This symposium will teach the general psychiatrist (i.e., the non-pain expert) how to recognize pain in their patients and help them decide when to treat and when to refer. It will also provide information on how to avoid common pitfalls in the management of pain. Pain is a highly prevalent condition, with recent estimates suggesting that chronic pain affects approximately one-third of the U.S. population and constitutes one of the most common symptoms for which patients seek medical attention. It is associated with intense personal suffering, high rates of disability, and an economic burden surpassing half a trillion dollars per year due to the cost of medical treatment and productivity losses. Concerns about undertreatment of pain have led to rapid growth in the rates of prescription opioids and

a dramatic increase in the prevalence of prescription opioid use disorders, which themselves pose risks of premature mortality. Psychiatrists often see patients with pain, yet most psychiatrists feel uncertain about their role in the treatment of pain. The role of this symposium will be to present a variety of treatments for pain, including pharmacological, nonpharmacological and multimodal approaches to pain. At the end of the symposium, the audience should feel more comfortable with the recognition and assessment of pain, as well as have a general framework to decide what and when to treat and when to refer to the pain specialist.

Transpeople in the Military: Mental Health Concerns for Active Duty and Veterans and the Impact of Being Allowed to Serve Openly
Chair: Amir Ahuja, M.D.
Presenters: Shane Ortega, Aaron Belkin, Paula Neira

EDUCATIONAL OBJECTIVE:
1) Comprehend the basic terminology and epidemiology of transgender people in our country and in the armed forces; 2) Identify the mental health disparities of transpeople as active duty servicemembers and as veterans; 3) Identify strategies to combat discrimination and prejudice in the military; 4) Understand the policy of the U.S. Government in regards to this issue and the impact it has had on transpeople; and 5) Utilize resources and strategies in the community to assist transgender servicemembers and veterans with their mental health.

SUMMARY:
To be transgender means to identify with a different gender than the one assigned at birth. Dealing with this discrepancy is very difficult for many transgender people, and both the internal stress and external stressors have resulted in a high incidence of mental health issues. One particular population within this community that deserves specific attention is transgender military servicemembers and veterans. Not much attention is paid to this segment of the community, and this is partly due to the fact that the ban on transgender people serving openly was just lifted in 2016. The stigma surrounding being transgender causes many active duty servicemembers and veterans to not get the appropriate treatment, including necessary medical procedures. This certainly includes mental health. In this symposium, we plan to tackle this issue from multiple fronts. As a psychiatrist working in one of the largest LGBT centers in the world, Dr. Amir Ahuja comes into contact with veterans regularly and sees many transpeople as patients. By sharing cases and an overview of the demographic research, he will discuss concerns and statistics regarding discrimination of transgender people in health care (even in mental health care) and the specific concerns of transgender people in the military and at the Veterans Administration. After that is Sergeant Shane Ortega, who is widely known as the first openly transgender person to serve openly in the U.S. military. He has been on over 400 combat missions in Iraq and Afghanistan and served both as a woman under the ban and as a man after the ban on transgender service was lifted. He can speak to his own struggles and those of other transgender military servicemembers and veterans. Shane even voluntarily took a psychological evaluation from the military and will discuss this as well. Next, we have Aaron Belkin, a highly accomplished activist within the LGBT center and the director of the Palm Center. Aaron will speak about the spearheading effort of the Palm Center to get the ban in the United States lifted earlier in 2016. He has decades of experience in activism and a particular interest in this issue, so he will discuss the politics of this and also the human cost of the ban. Finally, Paula Neira, who is a transgender lawyer and someone who served in the U.S. Navy for six years, including in Operation Desert Storm. She left the military in 1991, went to law school and now advocates for transgender veterans like herself. She will discuss her own struggles in terms of mental health and her advocacy in law regarding transgender military servicemembers and veterans. She will also discuss strategies to make the VA and other health facilities and practices more welcoming to transpeople and their families. Then a panel discussion will give the audience a chance to delve deeper into this topic from many angles. It should be a rewarding discussion squarely focused on mental health but put in context by experts on all sides of this issue.

Untangling Psychiatric Genetics in Clinical and Non-Clinical Settings: Ethical, Legal and Social Issues

Chairs: Maya Sabatello, Ph.D., LL.B., Paul S. Appelbaum, M.D.
Presenters: Jehannine Austin, Ph.D., Kenneth S. Kendler, M.D.
Discussant: Elyn R. Saks, J.D., LL.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Establish the landscape of psychiatric genetics: what we know, what we don't know and prospects for the future; 2) Discuss the role of genetic counselors in translating emerging molecular genetic findings into health practices and benefit for individuals with psychiatric disorders and their families; 3) Explore the possible uses of psychiatric genetics in civil courts and their implications for justice; and 4) Identify ethical, legal and social issues arising from the use of psychiatric genetics in medical and other settings.

SUMMARY:
Next-generation genomic sequencing technologies create new possibilities for understanding, predicting, preventing, diagnosing, and treating psychiatric disorders. They have facilitated the development of an increasing number of biobanks and genomic databases—including the national Precision Medicine Initiative—that collect medical, genetic and other lifestyle information from participants in the hope of advancing research on psychiatric and other medical disorders. However, as the availability of genetic information grows, the application of psychiatric genetic knowledge in clinical and non-clinical contexts, as well as the translation of science into policy and lay discussions, raises a host of ethical, legal and social issues that require consideration. These include challenges related to insufficient knowledge of psychiatric genetics among clinicians and the general public, conveying complex and uncertain—yet critically important—information to patients and their families, the possible use of such data in nonmedical contexts that may be detrimental to persons with psychiatric conditions, privacy concerns, and the impact of genetic data on persons at risk for psychiatric disorders. These concerns are heightened by the stigmatization of persons with psychiatric conditions. In this symposium, we begin by describing the landscape of psychiatric genetics, including major developments and challenges to psychiatric genetic research and to professionals' and the public's understanding of the nature of genetic risks and effects for psychiatric disorders. We will then discuss how psychiatric genetic counseling can improve care for patients and their families and identify "best practices" for genetic counseling in psychiatry. Next, we will explore the possible uses—and misuses—of psychiatric genetic evidence in civil court contexts and how such evidence may interfere with the administration of justice. Finally, we will discuss the ethical issues arising from the growing availability of psychiatric genetic data, including their impact on self-concept, family relationships and clinicians' duties to their patients. A discussant will comment on the presentations and identify questions and areas for further development.

Monday, May 22, 2017

A Novel Approach for Delirium Prevention, Prediction, Screening, and Treatment: New Medications, Machine Learning and a Newly Developed EEG Device
Chair: Gen Shinozaki, M.D.
Presenters: Kotaro Hatta, John Cromwell, Joseph J. Rasimas
Discussant: Philip R. Muskin, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Describe the benefit of ramelteon in the prevention of delirium; 2) Describe the role of machine learning in the prediction of delirium; 3) Describe how simplified EEG can detect delirium; and 4) Describe various effective pharmacotherapy treatments for delirium, depending on the situation.

SUMMARY:
Delirium Prevention Ramelteon/Suvorexant Study:
It has been generally suggested that use of a pharmacological delirium prevention protocol has not been shown to reduce the incidence of delirium. We performed two multicenter randomized placebo-controlled trials: 1) a ramelteon study and 2) a suvorexant study. Sixty-seven newly admitted 65-89 year-old patients were randomly assigned to ramelteon (8mg/d; N=33) or placebo (N=34) for seven nights. Sixty-two patients were randomly assigned to suvorexant (15mg/d; N=36) or placebo

(N=36) for three nights. The main outcome was incidence of delirium. Ramelteon was associated with lower risk of delirium (3% vs. 32%, p=0.003), with a relative risk of 0.09 (95% CI, 0.01-0.69). Similarly, we found that delirium occurred significantly less often in suvorexant patients than those taking placebo (0% vs. 17%, p=0.025). **Machine Learning Prediction:** Postsurgical complications, including delirium, are a major cause of increased lengths of stay and of hospital readmissions, which increase health care costs. Attempts to systematically and reliably identify patients at risk for such complications have largely failed in practice due to impractical methods of implementation. Computational health care makes use of automated mathematical modeling to identify at-risk patients and associate this with actionable interventions. We have employed machine learning and predictive analytics in such an approach to predict the postsurgical complication of surgical site infection using 2,211 encounters over a two-year period and developed a validated model with an AUC (c-statistic) of 0.75 and accuracy of 75%. Application of this approach to the prediction of delirium will be reported. **Bispectral EEG to Screen Delirium:** Delirium screening has largely depended on screening instruments, such as DRS or CAM, which have not been consistently implemented. Although EEG is well known to be useful to detect delirium, its use was practically limited to neurologists. Simplified EEG has been used in other specialties such as anesthesia to monitor depth of sedation and in ECT to monitor seizure. Our preliminary data from a pilot study of bispectral EEG was able to differentiate patients with and without delirium. **Delirium Treatment With Various Agents:** While delirium is a complex syndrome without clear targets for intervention, best medical practice should focus on treatment of the underlying cause. In some cases, neurophysiological impairments can be targeted directly with centrally acting antidotes like physostigmine, flumazenil, and naloxone. With proper patient selection, these agents may be employed for diagnostic and therapeutic purposes with superior efficacy in some cases of delirium. Standard antipsychotics are not only inferior or insufficient, but potentially harmful. Nonstandard medications like valproate, gabapentin, and alpha-2 adrenergic agonists may provide safe symptom management. Novel strategies will be discussed.

Accelerated Biological Aging in Serious Mental Illnesses: Are These Disorders of the Whole Body and Not of the Brain Only?

Chairs: Dilip V. Jeste, M.D., Owen Wolkowitz, M.D.
Presenters: Philip D. Harvey, Ph.D., Lisa Eyler, Ph.D.
Discussant: Henry A. Nasrallah, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the phenomenon of accelerated physical aging with increased medical comorbidity and mortality in persons with serious mental illnesses; 2) Learn the role of systemic biomarkers of aging in individuals with schizophrenia, major depression and bipolar disorder; and 3) Provide routine assessment, prevention and early interventions for aging-associated physical illnesses in people with psychiatric disorders.

SUMMARY:

Serious mental illnesses (SMI) such as schizophrenia, major depression and bipolar disorder are associated with increased prevalence of physical illnesses at a younger age and greater mortality compared to the general population. Persons with these disorders have 15- to 20-year shorter lifespans than the population without SMI. Two-thirds of the excess deaths in these individuals are from “natural causes” such as cardiac and metabolic disorders that typically occur at a much older age in the population at large. We propose a provocative hypothesis that serious mental illnesses are more than just brain diseases, as they are associated with a wide range of physical dysfunctions, comorbidity and mortality, indicating more rapid biological aging that is systemic and generalized. This conceptualization of SMI has major implications for understanding their biology and pathophysiology, as well as their treatment. The putative accelerated biological aging may be secondary to both SMI and SMI-related factors (i.e., obesity, sedentary lifestyle, unhealthy diet, higher levels of smoking, antipsychotic medications, and poor health care). Understanding mechanisms underlying biological aging, its consequences, and malleable risk and protective factors may lead to development of new preventive and therapeutic interventions for reducing the

excess medical comorbidity and mortality in SMI. As significant medical morbidity takes years to develop, effective interventions will require an ability to detect abnormalities in aging-related biomarkers early in the course of illness. Blood-based biomarkers of systemic aging include those reflecting mechanisms of inflammation, immune dysfunction, metabolic disturbances and cell toxicity. Similarly, biomarkers of brain aging include objective neurocognitive testing as well as structural and functional brain imaging. This symposium is unique in bringing together clinical researchers focusing on both systemic and brain aging in persons with SMI. The speakers are experts with multiple peer-reviewed publications and NIH grants in schizophrenia (Jeste and Harvey), major depression (Wolkowitz) and bipolar disorder (Eyler). They will review the relevant literature and present new findings from their own ongoing studies. Thus, there will be four presentations, each for 25 minutes, followed by Q&A for five minutes. Next, the discussant (Nasrallah) will tie the presentations together and provide a summary of take-home points for the audience. At the end, there will be a general discussion from the floor for 35 minutes. Thus, a total of one hour will be devoted to Q&A and comments from the audience, ensuring that this session is interactive. An important message from this symposium will be that the aim of the treatment of persons with SMI should not be restricted to reducing psychopathology only; it must include prevention and treatment of systemic physical illnesses too.

Addressing the Social Determinants of Mental Health in Urban Areas

Chairs: Stephan M. Carlson, M.D., Jose Vito, M.D.
Presenters: Hugh Cummings, M.D., Jason Hershberger, M.D.
Discussant: Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:

1) Define social determinants of mental health and explain how they lead to health inequities; 2) Describe one action they can take to increase racial equity in their community or institution; 3) Identify one intervention or policy they can advocate for as a mental health professional that will enhance safe and nurturing environments for children; 4) Discuss a possible intervention to educate urban stakeholders on how to reduce the food gap in their communities; and 5) Understand how incarceration affects the individual prisoner once released and how it impacts the families of prisoners.

SUMMARY:

The purpose of this symposium is to introduce the concept of social determinants of mental health (SDOMH) and to identify strategies at a neighborhood level that improve health outcomes in urban areas. We have understood for some time that social determinants play a fundamental role in our health, yet addressing these has not been a focus of the health care system in general nor in mental health. This symposium is timely because value-based reimbursement and increased accountability of health care systems and providers are making it necessary for clinicians to address social determinants of mental health. Dr. Carlson will introduce the symposium with a framework focused on social justice. He will then turn to his presentation on making neighborhoods “trauma informed,” using East Brooklyn as a case example. Recent research indicates that there is likely a very high percentage of East Brooklyn residents who were traumatized as children and that the consequences of that trauma on both physical and mental health can be lifelong if left untreated. This presentation will focus on the causes, consequences and solutions to civilian trauma. Dr. Cummings’ presentation will discuss how racism and discrimination impact mental health. Racial segregation in housing is an example of institutional racism that produces and perpetuates disparities such as low quality and poorly resourced schools and inadequate and unsafe housing. Dr. Cummings will discuss strategies that have been used to address institutional and community racism. Dr. Hershberger will tackle the pressing issue of mass incarceration and discuss how we can work toward ensuring healthier, safer lives for East Brooklyn’s African-American youth, who are disproportionately incarcerated. His presentation will touch on public policy, economics, social science perspectives on preventing crime, the use of diversion of offenders, and other solutions to lessen the intergenerational damage and improve the communities in East Brooklyn. Dr. Vito will focus on food insecurity,

sometimes referred to as the “health food gap." Many urban, low-income communities and communities of color do not have opportunities to buy healthy foods like fresh fruits and vegetables. This is usually due to issues of affordability, access and unhealthy food preferences. The consequences are increased diet-related diseases like obesity and diabetes. Dr. Vito will emphasize how obesity and diabetes have become epidemics in urban areas. He will note how city tax incentive programs may improve healthy food sources. He will also discuss how initiatives such as First Lady Michelle Obama’s “Let’s Move” campaign are educating elementary-age children on healthy eating and helping to narrow the food gap.

Bipolar Disorder Practice Innovation and Controversy
Chair: Mark Frye, M.D.
Presenters: Michael Gitlin, M.D., David Miklowitz, Katherine Burdick
Discussant: Robert Post

EDUCATIONAL OBJECTIVE:
1) Better understand the impact of new research on bipolar disorder; 2) Better understand the facilitation of new research into clinical practice; and 3) Better understand the impediments of new research into clinical practice.

SUMMARY:
Over the last decade, substantial neurobiological, pharmacological and psychosocial research has advanced our understanding of bipolar disorder (BP). This symposium will focus on current and controversial topics in the field, reviewing new research and its impact or impediment on successful clinical translation. First, Dr. Frye will review the potential role of biomarkers in the diagnosis and treatment of BP. Unlike other fields of medicine where diagnosis and treatment are often based on clinical examination and validated biomarkers, psychiatric diagnoses are still based on behavioral observation and symptom endorsement. This presentation will review key studies that have investigated genes and proteins associated with disease risk and treatment response. In addition to bipolar biomarker replication studies, research that distinguishes risk from unipolar depression or schizophrenia vs. healthy controls, or combine risk assessment in adolescence, are of greater potential value to clinical practice. Second, Dr. Gitlin will review the impediments to functional recovery after bipolar episodes and suggest targets for therapeutic interventions to enhance function. The two dominant factors that correlate with functional impairment in bipolar individuals are subsyndromal depression and disease-associated neurocognitive impairment. The recognition of subtle depressive states and more aggressive treatment of bipolar depression are core elements of treatment to optimize function. For cognitive impairment, modafinil armodafinil may be helpful and safe, while dopaminergic stimulants have a more complex risk/benefit ratio. Cognitive remediation should also be considered. Third, Dr. Miklowitz will review targeted psychosocial treatments that can improve outcomes for young patients with BP or high-risk conditions. Because adolescents and young adults often live with and are dependent on their parents, the patient’s family should usually be included in treatment. Family psychoeducation and skill training (as manualized in family-focused treatment and dialectical behavior therapy) are promising methods of conducting early intervention. With effective treatment and family support, young patients with BP can learn to manage their disorder and become independent and healthy adults. Finally, Dr. Burdick will review the rapidly emerging data around neurocognitive functioning in patients with BP—comparing them with other clinical samples in an effort to delineate where overlap exists and how to potentially differentiate those patients at highest risk for poor cognitive outcome. This presentation will begin to address neurodevelopmental and early life risk factors for cognitive impairment as well as the clinical and biological consequences. Clinical implications will be highlighted and described in the context of a precision medicine model with the ultimate goal of tailoring interventions such that each patient might receive the right treatment at the right time.

Clinical Outcomes in Borderline Personality Disorder: The Good, the Bad and the Unfortunate
Chair: Marianne Goodman, M.D.
Presenters: Stephanie Stepp, Ph.D., Mary C. Zanarini, Ed.D., Shirley Yen, Paul Soloff

Discussant: John Gunderson, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the newest information on clinical outcomes for borderline personality disorder to help with discussions about prognosis and outcome; 2) Recognize modifiable risk factors that impact clinical outcomes in borderline personality disorder; and 3) Identify ways to clinically support and effectively limit more negative outcomes of patients with borderline personality disorder.

SUMMARY:
Borderline personality disorder (BPD) is a challenging disorder affecting about one to two percent of the general population, with suicide rates almost 50 times higher than in the general population. A full appreciation of the outcomes in BPD is difficult given the heterogeneous nature of the disorder and limited data to date, including retrospective follow-up studies, prospective longitudinal studies and treatment outcome studies. While these sources of data have provided the field with a fundamental yet basic understanding, new data are providing clues regarding the trajectories to diverse outcomes. This symposium will present novel findings and perspectives on clinical outcomes across diverse BPD patient groups. The panel of speakers represents many of the top clinicians and researchers in borderline personality disorder nationally. The aim is to educate attendees on cutting-edge information and recent findings to better inform clinical decision making and identify factors that can potentially impact prognosis. Dr. Marianne Goodman will begin the symposium with a historical overview of longitudinal outcomes from retrospective follow-up and prospective longitudinal studies in BPD to provide context for the symposium presentations. Dr. Stephanie Stepp will next present new longitudinal data on both positive and negative outcomes of female adolescents with BPD from the Pittsburgh Girl's Study. Next, Dr. Mary Zanarini, using data from the McLean longitudinal study, will describe the cumulative rates of "excellent recovery" reported by borderline patients and axis II comparison subjects, as well as the best predictors of "excellent recovery" among those with BPD. These predictors are predominately factors related to childhood and adult competence as well as more adaptive temperamental traits. The remainder of the symposium will focus on data regarding negative outcomes of suicide. Dr. Shirley Yen will examine prospective predictors, including time-varying predictors of suicidal behavior in a sample of individuals with borderline personality disorder from the Collaborative Longitudinal Study of Personality Disorders. Dr. Paul Soloff will discuss the relationship of suicide attempts, BPD diagnosis, clinical outcome, and modifiable risk factors using data from eight- and ten-year follow-ups. His findings suggest that attempt behavior and poor psychosocial outcomes are statistically independent, suggesting that one does not increase risk for the other. Moreover, clinical predictors of suicidal behavior and poor psychosocial outcomes overlap and include negative affectivity and impulsive aggression, which are potentially modifiable risk factors. The symposium will finish with integrative remarks from Dr. John Gunderson, who will synthesize the content in terms of clinical relevance, lessons learned and recommendations for future research directions.

Contemporary Practical Challenges in the Management of Borderline Personality Disorder
Chair: Victor Hong, M.D.
Presenters: Brian Palmer, M.D., M.P.H., John Gunderson, M.D., Heather Schultz, M.D., M.P.H.
Discussant: Richard Hersh, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand how to appropriately assess and manage psychosis in borderline personality disorder; 2) Recognize how to avoid polypharmacy in borderline personality disorder; 3) Apply good psychiatric management (GPM) principles to inpatient care of borderline personality disorder; and 4) Understand the Acute Suicidal Crisis Care Pathway—a redesigning of inpatient care to optimize treatment of borderline personality disorder.

SUMMARY:
Recent developments in the care of borderline personality disorder (BPD) have led to optimism regarding the possibility of managing these patients with a less-stigmatized, more-informed, evidence-based approach. This symposium will tackle several common challenges regarding BPD, including the

presence of psychosis in BPD, the pitfalls of managing BPD in the inpatient setting and the issue of polypharmacy in BPD. The presentation of psychotic symptoms in BPD patients is common, distressing to patients and a challenge to treat. The issues of comorbidities and misdiagnosis in BPD patients further complicate matters, and the frequent dissociation that BPD patients experience can be confused with psychosis. Furthermore, BPD patients with an unstable identity and rejection sensitivity may present in a bizarre, disorganized or agitated manner when under stress. There are pitfalls in managing psychotic symptoms in BPD patients, but there are also trends and clues to help the clinician navigate through diagnostic and treatment challenges. Dr. Schultz will discuss reasonable versus less desirable treatment options and diagnostic approaches. Though BPD patients represent 15 to 20% of admissions to inpatient psychiatric hospitals, their treatment in these settings is often not helpful. Dr. Gunderson will describe four major and recurrent problems in inpatient psychiatric management (failure to diagnose, reflexive addition or increase in doses of medications, failure to address situational stressors, and reluctance to involve families). Using the principles of good psychiatric management (GPM), he will identify practical ways in which these problems can be corrected. The Acute Suicidal Crisis Care Pathway at the Mayo Clinic is an inpatient care redesign, geared toward effectively addressing the challenges of inpatient care of BPD patients. Dr. Palmer will demonstrate that by implementing this pathway of inpatient care, to which nearly all BPD inpatients are assigned, goals of care have grown more focused, and interventions to address these goals have been systematized. Cost effectiveness data show an associated reduction in cost per case. Polypharmacy in the treatment of BPD is common and carries with it a high risk-benefit ratio. No medications have been found to be significantly or consistently effective, and emphasis on pharmacological management of BPD without concomitant psychosocial treatments is a setup for failure. Dr. Hong will review the limited evidence for pharmacological treatments for BPD patients, discuss why polypharmacy is so common and examine techniques for avoiding polypharmacy.

Cultural Aspects of Intimate Partner Violence
Chair: Gail Erlick Robinson, M.D.
Presenters: Rahn K. Bailey, M.D., Mary Hasbah Roessel, M.D., Ludmila DeFaria, Kimberly Yang, Stephan M. Carlson, M.D.
Discussant: Francis Lu, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn about the rates of IPV in various ethnic populations in North America; 2) Understand the barriers in various cultural groups to obtaining help or adhering to treatment; and 3) Learn how to improve health care and outcomes for IPV survivors in these populations.

SUMMARY:
Intimate partner violence (IPV) occurs globally, and yet different cultural views and traditions as well as socioenvironmental issues may affect how it presents and is treated. Dr. Bailey will show how black women are disproportionately impacted by fatal IPV. Compared to a black male, a black female is far more likely to be killed by her spouse, an intimate acquaintance or a family member than by a stranger. Eleven times as many black females were murdered by a male they knew than were killed by male strangers in single victim/single offender incidents in 2013. Dr. Roessel notes the rate of violence committed against American Indians, Alaska Natives and First Nations Women is the highest rate of violence compared to any other group. Indigenous women are more likely to experience interracial violence than intraracial violence. IPV against Indigenous women shows legal disparities due to tribes not having criminal jurisdiction over the non-indigenous perpetrators. Indigenous women are significantly less able to access services. Many indigenous women do not seek therapy due to barriers such as stigma, culturally insensitive therapy programs, limited resources, and trust issues interfering with adherence to therapy. Dr. DeFaria shows that data available for IPV in the Latino population may be inaccurate due to under-representation in research studies. Racial bias and a lack of understanding of within-group variations based on country of origin, ethnic ancestry, immigration history, demographic background, and diverse sociocultural characteristics has hindered the

development and planning of effective social policies targeting Latino populations. Dr. Yang reports that understanding the role of culture as it pertains to Asian and Asian-American IPV has also proved to be significantly challenging, in large part due to tremendous intraethnic diversity. Well-meaning clinicians can be misguided by using antiquated and ethnocentric theories based on Western norms, which cause them to quickly lose credibility with Asian patients. IPV is not just a heterosexual problem. Dr. Carlson points out that, nationally, the rates of IPV among lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals are similar to or greater than rates for heterosexuals. LGBTQ persons have unique barriers to seeking assistance that lead IPV survivors to be more reluctant to seek help, impacting the effectiveness of psychiatric programs and support services. Psychiatrists need evidence-based training in LGBTQ health and IPV in order to provide culturally competent, quality, patient-centered care that is nonjudgmental, does not assume all patients are heterosexual and incorporates inclusive language. All the speakers will offer ideas on providing culturally competent care to these diverse groups. Dr. Lu will discuss the importance of understanding cultural diversity.

Development of Collaboration Between Psychiatry and Other Medical Specialties in the Pacific Rim
Chairs: Tsuyoshi Akiyama, M.D., Ph.D., Anita Everett, M.D.
Presenters: Kym Jenkins, Boung Chul Lee, Yu Hai Eric Chen, San Yuan Huang, Anita Everett, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn the importance of collaboration with other specialties of medicine; 2) Learn the importance of accurate diagnosis and appropriate care for physical illnesses of psychiatric patients; 3) Learn the importance of consultation on psychiatric symptoms of patients in treatment with other specialties; 4) Learn the importance of issues involved in providing treatment for serious physical illness of patients with severe mental illness; and 5) Learn the importance to learn from each other's experience in the Pacific Rim region.

SUMMARY:

Collaboration with other specialties of medicine includes a few significant issues. First, diagnosis and care for physical illness is often inappropriate, which may contribute to short life expectancy for psychiatric patients. With regard to the care of chronic physical conditions, a recent Cochrane review revealed that evidence is insufficient to show whether diabetes self-management interventions for people with severe mental illness are effective. Also, it could not be concluded if dietary advice can have a similar benefit in people with serious mental illness as the general population. Misdiagnosing a medical illness as psychiatric can lead to increased morbidity and mortality in emergency departments. Many issues need to be overcome to improve care for chronic physical illness in psychiatric patients. Second, consultation on psychiatric symptoms of patients in treatment with other specialties is becoming more important. To cite a few examples, pregnancy and the postpartum period represent times of increased vulnerability for women with bipolar disorder, yet this condition remains underdiagnosed and undertreated. A review has highlighted the lack of research concerning collaborative models of care that facilitate rehabilitation from a traumatic injury. A review reported evidence that some consultation-liaison psychiatry services are cost-effective when involved early and referrers follow certain recommendations. Thus, in consultation-liaison psychiatry, there is a need to develop a collaborative care model or early intervention system. Third, when patients with severe mental illness develop serious physical illness, such as end-stage heart failure or cancer, and need invasive treatment, psychiatrists should collaborate with physicians of other specialties to assess the decision making and management adherence capacities to avoid adverse events. A detailed biopsychosocial formulation is recommended to identify a myriad of medical, psychiatric, social, and ethical challenges of patients who receive ventricular assist devices. To ensure that patients with severe mental illness receive effective treatment for cancer, inequalities in care need to be addressed by all health care professionals involved. Established guidelines do not exist in this area, and there is an urgent need to develop one. Psychiatrists should share their expertise with physicians and staff of other specialties in a collaborative care model. If

psychiatrists can attain this goal, this will be the best way to heighten the value of psychiatric service to the whole of medicine and to reduce stigma among the staff of other specialties. Psychiatric patients will benefit from the result. This symposium will include reports from the United States, Japan, Australia/New Zealand, Korea, Hong Kong, and Taiwan.

How Does Cognitive Aging Affect Clinical Competence of Physicians?
Chair: James M. Ellison, M.D., M.P.H.
Presenters: Anothai Soonsawat, M.D., Iqbal Ahmed, M.D., Marcia Lammando, R.N., M.H.S.A.

EDUCATIONAL OBJECTIVE:
1) List three characteristics of normal cognitive aging and three characteristics of pathological cognitive aging that distinguish it from normal cognitive aging; 2) Describe two effects of cognitive decline on physician performance; 3) Describe several different approaches to evaluating a physician whose cognitive fitness for clinical duties has been questioned; and 4) Discuss the ethical and legal implications of cognitive evaluation of aging physicians and possible responses to this issue.

SUMMARY:
In the U.S. alone, more than 120,000 practicing physicians are 65 or older. Older physicians sustain professional activity into their later years for various reasons, including dedication and fulfillment as well as financial pressures and constrained retirement plans. Concern regarding public safety related to age-associated cognitive impairment in physicians has led several other countries to enact mandatory physician retirement laws or age-based mandatory performance evaluations. No requirement for such programs has been enacted in the U.S., but many institutions have considered or adopted age-based assessment programs. Comprehensive assessment of physicians whose performance has occasioned concern is available from several programs in the U.S. These programs recognize normative effects of cognitive aging, distinguish performance-neutral cognitive changes from those that interfere with performance, and offer rehabilitative programs or other career planning options as appropriate to the findings of an individualized assessment. Whether physicians are referred to assessment for cause or asked to comply with age-based testing, a variety of ethical and legal concerns are invoked. This symposium will examine the features of normative and pathological cognitive aging, the effects of cognitive changes on performance, several approaches to age-based or cause-based assessment, and a variety of associated ethical/legal questions.

Islamophobia: Social, Religious and Clinical Perspectives
Chairs: Roomana Sheikh, M.D., Tahir Maqsood, M.D.
Presenters: Aida Spahic Mihajlovic, M.D., M.S., John Peteet, M.D., Shridhar Sharma, M.D., D.P.M., H. Steven Moffic, M.D., Farha Abbasi
Discussant: Driss Moussaoui, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the impact of Islamophobia on people of the Muslim faith in the U.S; 2) Comprehend the negative influence on physicians and health care workers in their capacity to deliver care; and 3) Learn how other religious faiths (Christianity, Islam, Hinduism, Judaism) view Islamophobia.

SUMMARY:
Even though less than two percent of all terrorist attacks over the past five years have been committed by Muslims, a widespread discriminatory ideology developed that sees no difference between Muslim and terrorist. You'll see proposals to ban Muslims, including those escaping violence and political unrest. Many Muslims in America have encountered widespread prejudice from Islamophobes in both its subtle and overt forms, resulting in subtle and overt forms of Islamophobic microaggressions. Eighty-two percent of Muslim Americans feel extremely unsafe after 9/11, contributing to the PTSD. Muslims who are wrongly associated with terrorism by Islamophobes attempt to dissociate themselves from aspects of their religion to "fit in" developed forms of identity and self disorders. Repetitive harassment is the biggest factor contributing to long-term mental health issues in Muslim populations. Clinicians are often unaware of the prejudice and stress Muslim patients face in their everyday lives. Clinicians may unknowingly promote Western ideals while rejecting Muslim customs that our society inherently views as deviant.

Part of the solution is for Muslim Americans to educate others on the issues that are unique to the Muslim community. Ten percent of our nation's international medical graduates (IMGs) hail from predominantly Muslim countries. Three percent of American physicians identify themselves as Muslim. Our Muslim colleagues are integral to our shared goal of safeguarding and improving the health of all our citizens. They are our colleagues, our teachers, our students, and caregivers to many of our neediest citizens. A study conducted at the University of Chicago finds that Muslim Americans encounter a less than inclusive and welcoming work environment during their careers and feel greater scrutiny at work compared to their peers. Nearly one in four said workplace religious discrimination had taken place sometimes or more often during their career. Many Muslim-American physicians believe they have been passed over for career advancement due to their religion. Islamophobia will be explored from Christian, Jewish, Hindu, Islamic historical, theological, cultural, and psychological dimensions of the problem as it arises within these religious traditions. Given the historical and current conflicts between those of the Islamic faith and those of other faiths, one would assume there is some natural and expectable fear of each other. There is a need to spread the correct version of religion and disseminate positive religious values characterized by moderation or tolerance, mercy that preaches acceptance of other religions.

Lithium: Key Issues for Practice
Chairs: Dana Wang, M.D., David N. Osser, M.D.
Presenters: Othman Mohammad, M.D., Leonardo Tondo, M.D., Christoforos Iraklis Giakoumatos, M.D.
Discussant: Nassir Ghaemi, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Know the latest evidences regarding the benefits of using lithium and the risks of side effects; 2) Understand strategies for minimizing lithium's long-term renal damage; 3) Understand the risks and benefits of using lithium in the pediatric population; and 4) Manage minor and major side effects of lithium such as hair loss, rashes, weight gain, and gastrointestinal complaints.

SUMMARY:

Lithium continues to be highly recommended in international guidelines for the pharmacotherapy of bipolar disorder, but worldwide usage by clinicians seems less frequent than expected. This may be due to a lack of appreciation of the strength of the evidence base favoring lithium use, but also, studies show high discontinuation rates in patients started on lithium, and clinical experience may be similar, leading to a reluctance to initiate prescriptions. The side effect burden of lithium is considerable, and clinicians may not be up to date on reasonable strategies for managing the side effects. In this symposium, we will review the advantages and disadvantages of lithium as a treatment in bipolar disorder, and discuss the major side effects and how they can be optimally managed. The program starts with a discussion of the antisuicide effect of lithium, a property that is not shared by other mood stabilizing medications as best we can tell. Lithium can also have this benefit in nonbipolar populations and even in patients whose mood symptoms do not improve from lithium. Another relatively unique advantage of lithium is its neuroprotective effects. Recent evidence of lithium's ability to counteract the cortical gray matter shrinkage associated with the bipolar condition, and a protective effect on the development of other dementing conditions, will be reviewed. Since the neuroprotective property of lithium seems most relevant when utilized early in the course of the disorder, the next speaker will review the evidence relevant to prescribing lithium in children and adolescents. The program then moves on to side effect management issues. The next speaker will focus on lithium's effect on the kidney. The latest data on the risk of chronic kidney disease and end-stage renal impairment with lithium will be presented, and the steps that can be taken by clinicians that might decrease this risk will be summarized and evaluated. The last speaker will talk about lithium side effects (other than renal) that are barriers to patient adherence, ranging from relatively minor but unpleasant ones like hair loss or tremor to more seriously health-threatening problems like weight gain. Strategies for addressing these side effects based on the best evidence will be discussed, and ideas for how to persuade patients to accept the burdens of lithium and not give up on it prematurely will be offered. The session concludes with a discussion of the symposium's presentations

by a senior expert in the treatment of bipolar disorder, who will put the data into perspective. Each presentation will be 25 minutes followed by 5 minutes of audience questioning, and there will be at least 15 minutes at the end for further questions to the panel of speakers.

Positivity in Psychiatric Treatment and Training: Learning From Clinical Cases

Chairs: Richard F. Summers, M.D., Dilip V. Jeste, M.D.
Presenters: David Rettew, M.D., Behdad Bozorgnia, Helen Lavretsky, M.D., Daniel D. Sewell, M.D.
Discussant: Richard F. Summers, M.D.

EDUCATIONAL OBJECTIVE:

1) Apply positive psychiatry principles in formulating a patient; 2) Use positive interventions in clinical care; and 3) Appreciate the synergistic interweaving of positive interventions and traditional psychiatric interventions.

SUMMARY:

Positive psychiatry, a recently defined field focusing on resilience, social engagement, positive emotion, wisdom, and character strengths, grew out of positive psychology, which focuses primarily on wellness and enhancing life satisfaction primarily in nonclinical settings. Positivity is more than an attitude, as there is a substantial empirical base for positive interventions. The questions for psychiatrists are How do I incorporate positivity in my clinical work? How can I use positive approaches in an efficient, practical way? What are the clinical dilemmas involved in applying these techniques with my patients? This symposium responds to those questions through the presentation of five cases of psychiatric care, including children, adults and older adults, by experienced practitioners who use positive psychiatry approaches in their clinical work. There will be a breakout discussion mid-way through the panel for audience members to actively participate in treatment planning for one of the cases presented. Positive interventions have been shown to enhance life satisfaction and resilience, improve health and health behaviors, and address some psychiatric symptoms. While the traditional psychiatric approach has focused on the amelioration of symptoms and syndromes, positive psychiatry complements these interventions with attempts to build strengths, resilience, buffering, and health. The cases will illustrate these interventions and their potential while also exploring some of the problems and dilemmas. For example, how can a clinician help a patient understand and work with negative thoughts and feelings while emphasizing positive experiences without a loss of empathy? There will be plenty of audience interaction, with questions and comments from the audience after each case. We will break up into small groups to discuss one of the cases after the presentation of the background information. Each group will be asked to formulate the patient from both a traditional psychiatric perspective and a positive perspective, then share the "clinical pearls" they have gleaned from that discussion. The panel will address the needs of clinicians who are hearing about positive psychiatry for the first time, as well as those who are already incorporating these ideas in their practices.

Reclaiming Mental Illnesses as Biopsychosocial Disorders

Chairs: Cabrina Campbell, M.D., Stanley N. Caroff, M.D.
Presenters: Benard Dreyer, M.D., Ruth Shim, M.D., Emily Merz, Ph.D., Joan L. Luby, M.D., Cabrina Campbell, M.D.
Discussant: Maria A. Oquendo, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Describe the evidence for socioeconomic determinants and correlates of mental illness among children and adults; 2) Understand the impact of poverty and health care disparities on the immense public health crisis in mental health as well as medical care; 3) Understand the professional obligation of psychiatrists to advocate for socioeconomic interventions and reform at both the individual and societal levels to promote prevention of mental illness; 4) Discuss the evidence on changes in brain structure and functional connectivity that mediate the link between childhood poverty and deficits in cognitive achievement and mental health; and 5) Apply evidence of socioeconomic risk factors apart from drug treatment in assessing risk and implementing interventions for metabolic syndrome among patients with serious mental illness.

SUMMARY:
Advances in neuroscience offer great promise for elucidating the biological basis of abnormal behavior, but clinical studies focused exclusively on intrinsic mechanisms may provide an incomplete picture of the science underlying mental illness. Overreliance on primary brain mechanisms alone may actually undermine development of a comprehensive and unifying theory of brain and behavior that applies to effective prevention and treatment of mental illness. External real-world material or situational factors have profound effects on human behavior, cognition and emotions, either by direct actions on the developing or adult brain or secondarily by psychological reactions to illness or environmental stress. For example, one of the most consistent findings in psychiatric epidemiology is the association between low socioeconomic status and mental illness. Even though poverty remains pervasive in the United States and is strongly predictive of increased risk of mental illness and trauma, substance abuse, violence, suicide, and incarceration, the impact of socioeconomic factors on brain function, behavior and treatment outcomes in clinical investigations has been neglected and poorly controlled. Apart from hindering precise diagnosis, treatment and recovery in clinical practice, the neglect of environmental factors also confounds neuroscience research itself by diluting patient samples with heterogeneous, non-genetic or reactive disorders and by leading to unrealistic expectations that targeted biological treatments alone ought to improve overall recovery and social functioning. Better understanding of the pivotal role and mechanisms of socioeconomic factors contributing to mental illness could also better reveal and inform opportunities for primary prevention efforts through population- and community-based public health initiatives. To allow for discussion of a collaborative advocacy campaign and new policy initiatives in partnership with other specialists, to prevent mental illness by addressing socioeconomic inequalities, we will begin with a presentation from the president of the American Academy of Pediatrics, who will describe strategic policy objectives and efforts underway to improve child health by reducing family and childhood poverty. Next, we will provide an overview of the substantial historical and contemporary evidence base of socioeconomic determinants of mental health. Then, to provide specific examples of innovative studies that attempt to integrate socioeconomic and biological variables, two research groups will present novel, cutting-edge findings demonstrating specific plasticity-based changes in brain structure and functional connectivity in children that may provide a bridging mechanism by which poverty influences subsequent defects in cognition and mental health. Finally, we will present results of an analysis of socioeconomic risk factors in the development of metabolic syndrome among veterans with serious mental illness.

Special Topics in Women's Mental Health: Beyond the Perinatal Period
Chair: Elizabeth Fitelson, M.D.
Presenters: Samantha Meltzer-Brody, Lauren Osborne, M.D., Margaret Altemus, M.D., Mayumi Okuda, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn to appropriately diagnose and treat premenstrual dysphoric disorder (PMDD); 2) Understand etiologic factors contributing to depression during perimenopause and treatment approaches including psychosocial interventions, medications and the risks and benefits of hormone therapy; 3) Recognize risk factors for intimate partner violence (IPV) and apply strategies to engage with patients across cultures on this topic; and 4) Understand the influence of hormones and immune system influence on the HPA axis and risk for psychiatric illness at times of hormonal transition in women.

SUMMARY:
For decades, much of the research in psychiatric disorders and their treatments excluded women. More recently we have learned important insights about both the biological and psychosocial determinants of mental health in women across the reproductive life cycle. This symposium covers important topics in women's mental health, from premenstrual dysphoria and perimenopause to the effects of domestic violence to hormonal and immune impact on mood in women. **Hormones and Mood:** Major depressive disorder is twice as

common in women as compared to men during the reproductive years, and it is possible that fluctuations in ovarian hormones may account for some of this disparity. This presentation focuses on understanding the neuroendocrine mechanisms of the hormone-mood connection in women, with particular implications for novel treatments at times of hormonal change such as the postpartum period. **The Immune System, Mood and Anxiety in Women:** Recent research indicates that immune system dysregulation may play a role in the heightened risk for serious psychiatric symptoms in the perinatal period, with strong evidence for an immune contribution to postpartum psychosis and a contribution to mood and anxiety symptoms. This presentation provides an overview of the psychoneuroimmunological mechanisms of affective symptoms at times of reproductive hormone transition, with emphasis on risk factors and novel treatment targets. **Premenstrual Dysphoric Disorder (PMDD):** Despite its recent inclusion as a depressive disorder in the *DSM-5*, premenstrual dysphoric disorder (PMDD) remains poorly recognized and understood by many clinicians. This presentation will focus on the presentation of PMDD across cultures, as well as diagnosis and treatment options, with a focus on recent research on treatment approaches. **Intimate Partner Violence and Mental Health in Women:** Intimate partner violence (IPV) exemplifies a public health problem.

Treating Co-Occurring Posttraumatic Stress Disorder and Alcohol Use Disorder
Chair: Murray Raskind, M.D.
Presenters: Charles R. Marmar, M.D., Jennifer Mitchell, Ph.D., Julianne C. Flanagan, Ph.D., Tracy Simpson, Ph.D.
Discussant: Magali Haas, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe the range of different biological markers for posttraumatic stress disorder (PTSD) and dual diagnosis with alcohol use disorder (AUD); 2) State the effects of intranasal oxytocin in individuals with AUD and PTSD; 3) Describe the study outcomes for a cognitive behavior therapy for substance use relapse prevention that integrated imaginal and in vivo exposure; and 4) Summarize the results of a systematic review of behavioral randomized clinical trials for individuals with co-occurring AUD and PTSD.

SUMMARY:
Treating co-occurring posttraumatic stress disorder (PTSD) and alcohol use disorder (AUD) presents many clinical challenges. Dr. Charles Marmar will discuss biological markers for PTSD and dual diagnosis with AUD. He will present findings from the Cohen Veterans Study, which includes 870 male and female veterans, deployed and non-deployed, with and without PTSD, depression and traumatic brain injury. Procedures include a fasting blood draw, structural and functional brain imaging, neurocognitive testing, self-report questionnaires and TMS-guided EEG. Findings reflect genetic and epigenomic architecture; metabolic and metabolomic factors; and neuroimaging, neuroendocrine and molecular markers, focused on mechanisms relevant to distinguishing PTSD with and without alcohol abuse. Dr. Jennifer Mitchell will discuss the effects of intranasal oxytocin in individuals with AUD and PTSD. Intranasal oxytocin in non-treatment-seeking AUD subjects with and without comorbid PTSD significantly improved recognition of easy items on a social perception task and reduced approach bias to appetitive cues. Decreases in alcohol approach bias were significantly correlated with an externalized locus of control and a more present-focused future orientation. Oxytocin-induced changes in alcohol craving were significantly correlated with attachment anxiety. Dr. Sudie Back will discuss an evidence-based, integrated psychosocial treatment: “Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure” (COPE)—a 12-session cognitive behavior therapy that integrates prolonged exposure, including both imaginal and in vivo exposure, with relapse prevention for substance use. Historically, the sequential model of treatment has been used with patients presenting with both PTSD and substance use disorders (SUD). However, outcomes of this treatment approach are suboptimal. This presentation will review the COPE therapy components and session content, as well as data from studies of COPE conducted in the United States, Australia and Sweden. Dr. Tracy Simpson will provide an overview of a systematic review of behavioral randomized clinical trials for individuals

with co-occurring alcohol/drug problems and PTSD. Most of the studies found that participants in both the target and comparison conditions improved significantly over time on SUD and PTSD outcomes, and no study found significant between-group differences on both SUD and PTSD outcomes favoring the target treatment. Despite greater treatment dropout, there was greater improvement on some PTSD outcomes for exposure-based interventions than the comparison conditions. Other behavioral interventions did not generally show an advantage over comparably robust comparators. Dr. Magali Haas will serve as discussant for this session.

Treating Survivors of Intimate Partner Violence (IPV): Lessons Learned From an Integrated Model of Services That Can Inform Best Practices
Chair: Mayumi Okuda, M.D.
Presenters: Elizabeth Fitelson, M.D., Rosa Regincos, L.C.S.W., Obianuju "Uju" Obi Berry, M.D., M.P.H., Margarita Guzman, J.D., M.B., Sylvia Vella, Jacquelyn Campbell

EDUCATIONAL OBJECTIVE:
1) Describe the effects of intimate partner violence (IPV) on mental health and the rationale for trauma-informed services for this population; 2) Identify best practices for treating IPV survivors, including clinical, legal and training recommendations; 3) Summarize practical strategies that can improve the quality of care of IPV survivors; and 4) Discuss the benefits of trauma-informed services and multispecialty collaboration to effectively treat IPV survivors.

SUMMARY:
Intimate partner violence (IPV) is a major public health problem that results in a wide range of short- and long-term adverse mental health consequences. In the general population, approximately 20% of individuals that experience IPV within a year develop a new psychiatric disorder. IPV survivors, compared to those free of IPV, are four times more likely to attempt suicide at some time in their lives. In selected samples such as domestic violence shelters, the prevalence of PTSD and MDD has been reported to be as high as 84% and 61%, respectively. IPV survivors often feel misunderstood, unsupported and even blamed when they interact with the mental health care system. Such negative experiences can perpetuate a damaging cycle of revictimization and mistrust. Providing trauma-informed care can positively impact the engagement of IPV survivors in treatment. In this symposium, we draw from our experiences working in a multidisciplinary integrated model of services to illustrate best practices for treating IPV survivors. The symposium will describe clinical, legal and training issues that need to be considered when working with IPV survivors. These practices encompass recommendations from experts in the fields of advocacy, social work, nursing, psychology, and psychiatry who have experience working with IPV survivors in a wide range of settings. The presentation will also include a description of instruments to assess for safety, risk of being revictimized and killed by an intimate partner, and assessment of short- and long-term neurological sequelae of IPV. At the conclusion of the symposium, the participant will be able to summarize practical strategies that can improve the quality of the care that they provide to survivors of IPV and other non-combat trauma survivors.

Using Mobile Phone- and Web-Based Technology to Enhance Treatment and Support Recovery
Chair: Anita Bechtholt, Ph.D.
Presenters: Kathleen M. Carroll, Ph.D., David H. Gustafson, Ph.D., Marsha E. Bates, Ph.D., Kathy Jung, Ph.D.
Discussant: Frederick Muench, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe evidence-based mobile technologies available for alcohol use disorder; 2) Understand the utility of a wearable discreet alcohol biosensor; and 3) Recognize the promises and pitfalls of digital technology and its application to alcohol treatment.

SUMMARY:
Technology offers the potential to scale up and scale out treatment for alcohol use disorder. This symposium will focus on evidence-based mobile and web approaches. Dr. Kathleen Carroll will discuss a computerized cognitive behavior therapy (CBT4CBT) for alcohol and drug use disorders. She will highlight how empirically supported, web-based therapies such as CBT4CBT enhance dissemination of effective

therapies and how basic science can strengthen web-based therapies. Dr. David Gustafson will discuss improving retention in treatment with a mobile phone-based support system. The presentation will describe studies conducted with patients leaving residential treatment and intensive outpatient programs. Both studies provided an evidence-based smartphone system (ACHESS) to people with substance use disorders. Results from both studies suggest that ACHESS and the smartphone had a substantial impact on retention. Dr. Gustafson will also demonstrate ACHESS and discuss a third study (conducted outside the addiction field) that examines the relative contribution of the phone and ACHESS. Dr. Marsha Bates will discuss using mobile phone technology to deliver a biobehavioral intervention for relapse prevention. Despite the conscious goal to remain abstinent, persons with alcohol use disorders often find that negative emotions and environmental cues seem to automatically "trigger" drinking. Her group is conducting a randomized clinical trial that uses mobile phone technology as an adjunct to treatment in women with young children. They provide an iPhone app that helps to regulate automatic-visceral reactivity to triggers of use by regulating bidirectional communication between the heart and brain. A key feature of the targeted mechanism, the baroreflex loop, is that it can be consciously manipulated using a behavioral technique called resonance breathing, which can be paced by the app in the moment and outside of the treatment context as triggers are encountered in daily life. They are examining how and for whom the baroreflex mechanism enhances behavioral control. Dr. Kathy Jung will discuss the benefits and challenges of a wearable alcohol biosensor. Self-report of alcohol consumption is notoriously unreliable, and current methods of measuring alcohol intake provide only snapshots in time that can be inconvenient. For individuals dealing with alcoholism, an objective real-time measure of alcohol consumption would valuable to treatment providers and individuals. Also, since alcohol can be a complicating factor in the treatment of many heath conditions, a way to collect accurate and timely measurements of alcohol intake could provide far-reaching health benefits. NIAAA's efforts to seek the development of an unobtrusive and discreet wearable device that can accurately and objectively measure alcohol intake will be discussed. Dr. Frederick Muench will lead a discussion focusing on the promises and pitfalls of digital technology and its application to alcohol treatment.

When a Resident Dies: Responding and Communicating About Physician Suicide

Chairs: Laurel Mayer, M.D., Melissa Arbuckle, M.D., Ph.D., Matthew L. Goldman, M.D., M.S.
Presenters: Michael F. Myers, M.D., Christine Moutier, M.D.
Discussant: Carol A. Bernstein, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the challenges of medical training/residency and the real risks of burnout, depression and suicide; 2) Disseminate the guidelines related to internal and external communications following a medical trainee's death by suicide; 3) Appreciate the multiple reactions to physician suicide and the care required to develop an appropriate response; and 4) Identify opportunities to enhance the medical student/resident voice and resources to enhance trainee wellness.

SUMMARY:

Increasing attention is being directed to the stresses and challenges to the mental health of physician trainees (i.e., residents and medical students), with a particular focus on physician suicide. It has been repeatedly demonstrated that medical students and residents experience burnout and depression at rates higher than the general population and that psychological distress increases during training. Burnout and depression independently carry increased risk for suicide. Approximately 400 physicians (inclusive of trainees) die each year by suicide. Each death reverberates through families, friends, colleagues, and the larger community. It is important, therefore, to be sensitive to these groups when responding to these events. We will begin this symposium with a brief review of the current literature on physician trainee mental health. We will then hear personal reflections from a resident who experienced the loss of a colleague early during internship and the successes and challenges he faced in trying to channel his need to "do something."

Distinct from the professional environment, the deceased was also someone's son or daughter, and we will discuss the personal impact of suicide on the family. We will then discuss the very real phenomenon of suicide contagion and present communication (both within and external to the institution) and media guidelines to minimize sensationalizing or glorifying suicide and to promote responsible reporting of such events. We will hear of the professional medical training community's responses, including at the national (ACMGE) level, to promote health and resilience among physician trainees. We will close with three case presentations, each designed to stimulate lively and thoughtful discussions focusing on the development of wellness initiatives and the ways psychiatry can be at the forefront of these opportunities.

Tuesday, May 23, 2017

A Regional Suicide Prevention Systems Approach in Noord Brabant: The Dutch Experience
Chair: Ariette Van Reekum, M.D.
Presenters: Christina Van der Feltz-Cornelis, Sjakko De Jong, Roelof Kleppe
Discussant: Kenneth Thompson, M.D.

EDUCATIONAL OBJECTIVE:
1) Discern what can be considered a preventable suicide; 2) Discern the main components of a suicide prevention systems approach; 3) Describe the four principles for suicide prevention; 4) Understand the role of a decision aid for nonmental health care providers to enhance their role in assessing suicide risk; and 5) Describe how mental and nonmental health care partners collaborate in a chain of care.

SUMMARY:
In the Netherlands, suicide rates used to be among the lowest in Europe. Since the economic recession started in 2007, suicide rates have risen approximately 30% to 1,835 suicides in 2014. This is a sharp incline despite the availability of a multidisciplinary guideline for the diagnosis and treatment of suicidal behavior since 2012. The fact that in the last two years the province of Noord-Brabant ranked second in the national rating (with 293 suicides in 2014), with the city of Tilburg ranking second with 37 suicides in 2014 (a rise of 23% compared to 2013) and the city of Breda ranking second in 2015, urgently calls for a regional suicide prevention effort in Noord-Brabant. Approximately 60% of completed suicides in Noord-Brabant are committed by persons in need of mental health care who do not receive such care, whereas 80-90% of completed suicides occur in the context of mental disorders and in moments of transition of care into a specialty mental health institution after earlier suicide attempt(s). This is due to the lack of 1) monitoring possibilities of persons at risk so far, 2) close collaboration and follow-up by health care professionals, and 3) swift entrance into specialist care for suicidal ideation. For this reason, a regional suicide prevention systems approach was started in 2016 with funding of the Netherlands Organization for Health Research and Development. This project follows the example of regional prevention studies of preventable deaths in trauma-related mortality in the U.S. In the same vein, completed suicides are considered mostly preventable deaths. A regional chain of care networks of specialty mental health institutions, general hospital and primary care emergency rooms, and public health services in Noord-Brabant has been set up with the aim to diminish preventable deaths by suicide in Noord-Brabant. This system approach focuses on 1) installing a monitoring system with decision aid to support health care professionals in reporting, assessing and monitoring patients at risk for suicide (i.e., after a suicide attempt); 2) providing swift access to persons at risk for suicide in specialist crisis teams of the specialist mental health service; 3) positioning psychiatric nurse care managers in those teams to collaborate with psychiatrists in assessment, case management and treatment of the persons at risk according to the collaborative care model; and 4) providing telephone monitoring by these nurses to the patient for a year to enhance adherence to treatment and prevent dropout. This way, the aim is to attain an actual drop, with 20% of completed suicides in Noord-Brabant after implementation of this intervention. In this symposium, several aspects of the system approach will be discussed with the audience.

Building Human Capacity for Mental Health in Low- and Middle-Income Countries
Chair: Samuel Okpaku, M.D., Ph.D.

Presenters: Robert Kohn, Janice Cooper, Samuel Okpaku, M.D., Ph.D., David Ndetei, Sergio Villaseñor-Bayardo, Milton Wainberg, M.D., Geetha Jayaram, M.D.
Discussant: Mary Kay Smith, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the treatment gap due to mental disorders worldwide and the extent of the burden of mental illness; 2) Appreciate the barriers and challenges to reducing the treatment gap due to mental disorders; and 3) Appreciate the efforts being made by some low- and middle-income countries to reduce the treatment gap in their countries.

SUMMARY:
Low- and middle-income countries account for about 80% of the world's population. The corresponding burden of disease attributable to mental disorders, neurological disorders and substance abuse in these nations is about 11%. The treatment gap (i.e., the proportion of those who need treatment to those who actually receive treatment) is about 76-80% in low- and middle-income countries, compared with 35-50% in high-income countries. Researchers have identified barriers and challenges to reducing these treatment gaps. These include, but are not limited to, the failure of advocacy to raise the profile of mental services, competition for limited resources, non-strategic human resource planning, and unavailability of psychotropic medications. The WHO has emphasized that the greatest asset for reducing the treatment gap is the availability of human resources. Some low-income countries have only one or no psychiatrists for the total population. Examples include South Sudan and Chad. Some countries have been successful in task shifting and task sharing. A variety of models to train community nurses, lay persons and traditional healers to enhance human resources in the hope of reducing the treatment gap have been successful. This symposium will highlight some models in Liberia, Sierra Leone, Kenya, India, Mexico, and Mozambique that have aimed to reduce treatment gaps in these countries.

Clinical Evidence for Alterations in CRF-Containing Circuits in Mood and Anxiety Disorders
Chair: Charles B. Nemeroff, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the role of CRF systems in the pathophysiology of mood and anxiety disorders; 2) Understand the effect of child abuse and neglect on CRF circuits; and 3) Understand the data derived from studies of CRF receptor antagonists in mood and anxiety disorders.

SUMMARY:
There is evidence from a multitude of studies that corticotropin-releasing factor (CRF) circuits are hyperactive in a substantial subgroup of patients with major depression. Thus, elevations in cerebrospinal fluid (CSF) concentrations of CRF have been reported in multiple studies of drug-free depressed patients. A variety of neuroendocrine studies using a myriad of approaches, including the CRF stimulation test, the dexamethasone/CRF test, provocative stress tests, and suppression tests, all have, taken together, provided evidence for CRF hypersecretion in depression. Postmortem studies of depressed patients and suicide victims have revealed increases in CRF mRNA expression and CRF concentrations in limbic, cortical, and hypothalamic brain regions. In addition to the aforementioned findings is a body of evidence that early life stress in the form of childhood maltreatment is associated with long-lived increases in the activity of CRF-containing neural circuits. Moreover, polymorphisms of the CRF- R1 receptor regulate the vulnerability for depression and suicide in patients with a history of child abuse and neglect. Taken together with preclinical data, these findings have formed the rationale for studies of CRF-R1 antagonists as novel antidepressant agents. The discrepancy between these findings and the lack of efficacy of these agents in clinical trials will be discussed.

Defining Neurobiological Correlates of Risk and Resilience to Mood and Psychotic Disorders
Chairs: Sophia Frangou, M.D., Ph.D., Mary L. Phillips, M.D.
Presenter: Philip Mitchell

EDUCATIONAL OBJECTIVE:
1) Understand the challenges in defining “at-risk” populations; 2) Describe neurobiological changes (e.g., brain imaging phenotypes) associated with

vulnerability to mood and psychotic disorders; 3) Describe neurobiological changes (e.g., brain imaging phenotypes) that mitigate the risk of conversion to overt disease; and 4) Reflect on ways this information can be incorporated into strategies for prevention and early intervention.

SUMMARY:
This symposium is affiliated with the Royal College of Psychiatrists, UK. It focuses on changes in the spatial and temporal characteristics of brain networks and their association with disease expression, risk, and resilience to mood and psychotic disorders. The symposium begins with a lecture by Dr. Tony David (King's College London, UK), who will present data from the Avon longitudinal study of parents and children (ALSPAC), a large English birth cohort. Dr. David will show that changes in white and grey matter, connectivity, and functional activation are associated with psychotic experiences in the general population and will discuss the predictive value of these findings for syndromal conversion to psychotic disorders. Dr. Mary Phillips (University of Pennsylvania) will present data on neural circuitry markers that can be tracked longitudinally in youth with bipolar spectrum disorders and will demonstrate their relevance to disease expression in young adults. Dr. Phillip Mitchell (University of New South Wales) will present data on functional and structural connectivity in patients with bipolar disorder (BD), individuals with familial risk to BD and healthy volunteers. His data show that risk and disease expression for BD are associated with functional and structural dysconnectivity of brain networks involved in emotional processing, particularly those centered within the inferior frontal gyrus and insula. Dr. Frangou (Icahn School of Medicine at Mount Sinai) will focus on neural network adaptations that appear to have a protective role. Specifically, her data show that although siblings of patients with BD have several dysconnectivity features, those showing hyperconnectivity within the visual ventral network during the viewing of affective stimuli and increased default mode network integration are likely to remain symptom- and disorder-free.

Developing a Ketamine Infusion Therapy Service for Patients With Treatment-Resistant Depression: Lessons Learned From the Mayo Clinic
Chairs: William V. Bobo, M.D., M.P.H., Simon Kung, M.D.
Presenters: Jennifer Vande Voort, Kathryn Schak
Discussant: Mark Frye, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the key findings from the most important studies of the effectiveness and safety of low-dose ketamine for the acute management of treatment-resistant unipolar or bipolar major depression; 2) Define the principal short- and long-term safety and tolerability concerns regarding the use of low-dose ketamine for the management of treatment-resistant unipolar or bipolar major depression; and 3) Understand the methods applied at Mayo Clinic and clinical programming steps that have been undertaken in order to develop a ketamine infusion therapy service.

SUMMARY:
One-third of depressed patients do not achieve an adequate clinical response to available treatment and are considered to have treatment-resistant depression (TRD). As such, there is an urgent need for more rapidly effective pharmacotherapies for major depressive disorder and bipolar disorder (BP) that responds poorly to conventional treatments. Multiple controlled trials have now demonstrated a rapid, nonsustained antidepressive response to a single intravenous infusion and, more recently, to repeated short-term infusions of ketamine in patients with TRD. The therapeutic potential of ketamine has stimulated considerable excitement among clinicians, patients, advocacy groups, and industry and has led to the increasing use of ketamine as an off-label substitute for ECT and other antidepressive treatments. The early adoption of intravenous, intranasal and other forms of ketamine into routine clinical practice has included the use of repeated long-term ketamine administration for TRD. A thorough review of the available evidence of clinical effectiveness and safety is timely given the increasing use of ketamine in routine practice, with an eye toward important unanswered questions about ketamine effectiveness and safety for longer-term use. This symposium consists of four lectures conducted by clinicians who are familiar with the use of intravenous ketamine in acute settings at a major

academic medical center. The first lecture will review in detail the results of randomized trials of intravenous or intranasal ketamine for treatment-resistant unipolar and bipolar major depression, highlighting methodological limitations of the most important studies and limitations of study findings for long-term ketamine administration. The second lecture will review acute and potential long-term safety concerns with the use of intravenous ketamine. That discussion will be anchored by a case report of an adult patient who deteriorated clinically after receiving poorly monitored ketamine therapy for depression over the long term. The third lecture will describe in detail the clinical processes that have been adopted at our medical center for the use of ketamine for patients with TRD. That discussion will reference lessons learned from two clinical trials of ketamine for TRD that were conducted at our site and will include procedures for patient selection and for the administration and monitoring of ketamine infusions. The fourth and final lecture will present an approach to translating ketamine research protocols to real-world care for patients with TRD, with specific discussion devoted to business modeling and clinical program development. A discussion of additional clinical issues and a question and answer period for audience members will follow.

Developing a National Mental Health Registry
Chairs: Philip Wang, M.D., Dr.P.H., Saul Levin, M.D., M.P.A.
Presenters: Grayson Norquist, Philip Wang, M.D., Dr.P.H., Diana E. Clarke, Ph.D., M.Sc., Debra Gibson, M.Sc.
Discussant: Anita Everett, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the importance of the APA National Mental Health Registry; 2) Understand the importance of the inclusion of the clinician and patient portals/dashboards as part of the APA registry; 3) Understand the key features and functionalities of the clinician and patient portals/dashboards; and 4) Understand how the clinician and patient portals can inform improvements in clinical care.

SUMMARY:
With recent changes to health care delivery, the opportunity to use patient registries to improve quality of care and patient outcomes has never been greater. Registries seek to achieve several important goals, including supporting quality reporting by physicians and other health care providers, improving the quality of care for patients, and helping provide research data needed to develop new quality measures, as well as to improve diagnostics and therapeutics. For psychiatrists specifically, a patient registry represents a simplified solution for meeting quality reporting standards while avoiding payment penalties for failure to report on use of quality measures. It also will facilitate psychiatrists meeting maintenance of certification (MOC) part IV reporting requirements. Given these benefits and the need to adapt to the rapidly shifting landscape of care delivery into one based on quality reporting, the American Psychiatric Association seeks to develop a national mental health registry that will meet Centers for Medicare and Medicaid Services (CMS) Qualified Clinical Data Registry (QCDR) certification. The registry will aid participating psychiatrists and, potentially, other behavioral health providers in meeting quality reporting requirements. The APA registry seeks to learn from and improve upon earlier registries developed by other medical specialties by incorporating clinician and patient portals/dashboards. These portals will be interoperable and allow for the electronic (e) assignment of patient-reported outcome measures (PROMs) such as the *DSM-5* Review of Mental Systems, PHQ-9, AUDIT-C, neurocognitive battery, and WHO-DAS 2.0 by the psychiatrist or his/her authorized administrative staff; the e-completion of the PROMs by the patient; and the use of the e-scored and e-transmitted results by the psychiatrist in his/her clinical evaluation of the patient. The inclusion of these portals and the PROMs is a basic but necessary step toward engaging patients in their evaluation and care. Additionally, these PROMs can aid the psychiatrist in meeting quality reporting requirements and avoiding payment penalties by augmenting data derived from the psychiatrist's electronic medical records (EMR). This symposium will cover the development of the APA registry, show how it plans to improve upon earlier registries developed by other specialties, discuss its security features, explain its benefits to psychiatrists and

their patients, demonstrate its features and functionalities, and discuss how it can inform improvements in clinical care. By the end of the symposium, attendees will be able to understand the benefits of the APA registry and determine if they would like to participate in this important initiative.

Improving Mental Health: Four Secrets in Plain Sight

Chairs: Lloyd I. Sederer, M.D., John M. Oldham, M.D., M.S.

Presenters: Lisa B. Dixon, M.D., M.P.H., Jeffrey Lieberman, M.D., Patricia L. Gerbarg, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify four "secrets" hiding in plain sight that can improve mental health; 2) Know what actions can be taken to improve mental health and patient care; and 3) Illustrate the "secrets" with science, clinical examples, history, and stories.

SUMMARY:

The symposium will focus on four foundational truths of mental health and its care, all hiding in plain sight, which Dr. Lloyd Sederer calls "secrets." They all are eminently actionable. They are 1) *Behavior serves a purpose*. The search for meaning and the identification and communication value of a behavior are too often overlooked aspects of mental health care and a lost opportunity with and for patients and their families. 2) *The power of attachment*. The force of attachment as a human need and drive must be harnessed if we are to change painful and problem behaviors. Relationships are the royal road to remedying human suffering—both individual and collective. 3) *As a rule, less is more*. Mental health treatments, both medical and psychosocial, have often been aggressive, from high doses of drugs to intensive sessions and psychic confrontation in individual and group psychotherapy. Unfortunately, these high-risk efforts infrequently provide help and often have unwanted and problematic effects. *Primum non nocere*—first, do no harm—is the first law of medicine. 4) *Chronic stress is the enemy*. From adverse childhood experiences to posttraumatic stress, chronic stress can be an underlying factor in the development of many mental (and physical) disorders. However, chronic stress can be understood and contained, thereby reducing its damage. Dr. Sederer will discuss these four secrets using material gleaned from history, research, film, and literature. Dr. John Oldham will discuss the first secret, Dr. Lisa Dixon the second, Dr. Jeffrey Lieberman the third, and Dr. Patricia Gerbarg the fourth. Audience comments and discussion will then follow.

Moving Beyond Colorblindness: Clinical Encounters Painted by the Sociocultural Contexts of Racial and Ethnic Minorities Reduce Disparities of Care

Chair: Pamela C. Montano Arteaga, M.D.

Presenters: Crystal Pinto, Jonathan Metzl, M.D., Ph.D., Andres F. Sciolla, M.D., Leila Vaezazizi, Pamela C. Montano Arteaga, M.D., Margarita Alegria, Ph.D.

Discussant: Roberto Lewis-Fernandez, M.D.

EDUCATIONAL OBJECTIVE:

1) Examine the complexities and intersections of multiple statuses/identities (e.g., socioeconomic status, cultural background and immigrant status) and how these may impact mental health; 2) Appreciate the impact of perceived discrimination and the trauma of immigration on the psychological well-being of minority populations; 3) Reason through the rationale for adopting a trauma-informed approach to avoid misdiagnosis and iatrogenesis in the diagnosis and clinical management of psychotic syndromes in ethnic minority individuals from disadvantaged backgrounds; 4) Describe differences of treatment for a specific diagnosis based on race/ethnicity as well as the implication of race/ethnicity as a risk factor for off-label and higher-risk treatment choices; and 5) Appreciate how tools that explore the sociocultural context of patients in addition to the symptom diagnostic approach can help to improve outcomes in diverse populations.

SUMMARY:

Sociocultural variations in perceptions of mental distress and help seeking behaviors are important health care issues. Different methods have been described in the literature since the field of cultural psychiatry began. However, disparities still exist in both the access to and quality of mental health care for racial and ethnic minority groups in the United States. It has been reported that racial and ethnic

minorities have less access to mental health services than Whites, are less likely to receive needed care, are more likely to terminate treatment prematurely, and in many places, are more likely to receive poor-quality care when treated. Some of the possible explanations for these disparities include a lack of understanding of cultural diversity, racism and racial stereotyping, a lack of knowledge and inclusiveness, ethnocentrism, not taking into account the preferences of minority patients, and the misassumption that evidence-based interventions are readily available for diverse populations. Discrimination based on observable characteristics such as race, ethnicity and gender have been recognized as a social determinant of health that affects the coping responses of the affected individuals and can place them at a higher risk for psychiatric disorders and physical issues. Additionally, minority individuals may experience symptoms that are undiagnosed, underdiagnosed or overdiagnosed for cultural, linguistic and historical reasons. Using a universal approach without fully taking into account the systematic differences in symptoms expression rooted on the individuals' sociocultural context could create iatrogenic practices in psychiatry. There is a need for greater understanding and awareness of the psychological distress linked to existing social concerns and personal issues, as well as for ongoing education on cultural competency tools to help close the gap. This symposium will include findings regarding racial and ethnic disparities in the diagnosis of schizophrenia, research challenges within Latino populations causing significant variability in the reported rates of mood and psychotic disorders, data on misdiagnosis among immigrants in the United States and internationally, evaluation of somatic symptoms as a common expression for depression and PTSD in Latino populations, and ethnic differences in stimulant and antipsychotic prescribing among children. Concepts of perceived discrimination, ethnic density, trauma of immigration, and illustrative cases will be discussed and formulated using elements of the cultural formulation interview and trauma-informed care tailored for disadvantaged minorities. The results of a clinical intervention implemented in a community clinic that integrated discussed elements in the symposium would be shared with the participants and opened for discussion with emphasis on increasing awareness of the importance of moving from colorblindness to reduce mental health care disparities.

Muslims, Mental Health and Life After 9/11
Chair: Balkozar Adam, M.D.
Presenters: Farha Abbasi, Laine Young-Walker
Discussant: Arshad Husain

EDUCATIONAL OBJECTIVE:
1) Identify key characteristics of Muslim-American patients and address the potential impact of religion, culture and immigration status on their mental health; 2) Understand the increased stresses, challenges and trauma experienced by Muslim-American patients and their families in the post-9/11 climate; 3) Identify the need for establishing the cultural context of mental health illnesses and how cultural characteristic will affect patients' presentation and response to treatment; 4) Apply principles from the APA's Assessment of Cultural Factors and AACAP's Practice Parameters for Cultural Competence in the evaluation and treatment of Muslim-American patients; and 5) Demonstrate a working understanding of the *DSM-5* Cultural Formulation Outline and Cultural Formulation Interview.

SUMMARY:
Muslim Americans are currently facing unparalleled distress, which is leading some of them to question the very core of their identity and feel like strangers in the country they call home. Between the derisive political climate and increasing discrimination, Muslim Americans are experiencing trauma and depression at an alarming rate. Mental health professionals are at a crossroads in deciding their commitment level to providing culturally sensitive care to their patients. The release of the *DSM-5* in 2013 marked a milestone with the introduction of the Cultural Formulation Interview and the refinement of the Cultural Formulation Outline. Still, not all clinicians have embraced these evidence-based tools. Therefore, it is imperative to increase awareness of the need to understand the cultural context of mental health symptoms and their role in assessment, treatment and clinical management. In order to provide the best care for our Muslim-

American patients, clinicians must consider culture, race, ethnicity, language, religion, customs, gender, sexual orientation, and immigration status. The goal is to go beyond stereotypes promoted in the media and genuinely understand the needs of the patient. Issues discussed in this symposium will include the impact of Islamophobia after 9/11, acculturation, stigma, and the importance of incorporating cultural strengths in treatment. Muslim Americans are a heterogeneous, historically marginalized population who trace their roots to more than 50 countries and exhibit a wide range of needs and experiences. Some are recent immigrants who struggle with post-migration stress and acculturation, while others battle to balance their traditions at home with mainstream culture at work and school. The hope is to establish a bicultural identity that allows them to feel safe and well adjusted. The stress of prejudice and discrimination in wake of national and international terrorist attacks have exacerbated many Muslim Americans' feelings of fear, anger and grief. African-American Muslims sometimes struggle with double stigma of being African-American Muslims and mentally ill, as well as having double minority status. The presenters will also address the barriers faced by recent immigrants and refugees, including those from Syria. Some immigrant patients are also fearful of speaking about the trauma they have experienced because they worry that revealing mistreatment may jeopardize the safety of family members who remain overseas. This topic is particularly important because research shows that the Muslim population in America and abroad continues to grow rapidly. Throughout the presentations, the speakers will emphasize why now is the time to understand the cultural needs of Muslim-American patients and how those needs translate into better care of patients and their families. The participants will walk away with the tools to address those needs and an understanding of how to use them.

Optimizing Treatment of Depression: The VAST-D Study

Chairs: Sidney Zisook, M.D., Somaia Mohamed, Ph.D.
Presenters: Peijun Chen, Michael E. Thase, M.D., Sanjai Rao
Discussant: A. John Rush, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the effectiveness of three commonly used switching and augmenting "next-step" strategies for depressed patients with suboptimal outcomes to an initial treatment; 2) Discuss the relationship between depression treatment outcomes and early life adversity, complicated grief, psychiatric and general medical comorbidities, and depressive features; 3) Evaluate the role of quality of life, costs, function, and positive health in selecting each of the three "next-step" treatments included in the study; and 4) Identify relative safety concerns of the three treatment approaches with respect to serious adverse events, suicide risk factors, sleep, sexual function, extrapyramidal symptoms, and metabolic parameters.

SUMMARY:

The VA Augmentation and Switching Treatments for Improving Depression Outcomes (VAST-D) study was a 35-site Veterans Affairs (VA) cooperative study (VA CSP#576) designed to determine the relative effectiveness, safety and tolerability of three commonly used "next-step" approaches for patients with major depressive disorder (MDD) who previously failed to achieve an optimal outcome after at least one well-delivered trial with their clinician's choice of antidepressant(s). Participants were randomized to receive one of three commonly used "next-step" treatments: switching to bupropion-SR (SWI-BUP), combining the index antidepressant with bupropion-SR (COM-BUP) or augmenting the index antidepressant with aripiprazole (AUG-ARI). Participants were 1,522 veterans, aged 18 or older, who remained at least moderately depressed after meeting or exceeding minimal standards for dose and duration of treatment for a nonpsychotic MDD. These veterans had been severely depressed for many years, often on and off and often persistently; often were unmarried and unemployed; had considerable anxiety, substance use, PTSD, mixed or hypomanic symptoms, and general health issues; often were untreated or undertreated for years; had histories of considerable childhood adversity; had experienced losses of loved ones that may have related to their depressions' onset or persistence; had had several previous medication trials; had current suicidal thoughts and often had made one or more attempts

at taking their own lives; were impaired in multiple domains of their lives; and had extremely negative images of their self-worth. We will begin by describing the overall design of the study and features of the participants, followed by a discussion of overall results in terms of symptoms: remission, response and relapse. Next, we will present data relevant to other important outcomes: quality of life, cost, function, and positive health. Following this, we will describe effects on the outcome of specific life events (early childhood adversity, loss and grief), comorbidity (PTSD, substance use, general medical health) and features of the depressive episode (severity, chronicity, anxious and mixed features). Finally, we will describe key safety issues with each treatment: suicide risk factors, sleep, sexual function, extrapyramidal symptoms, and metabolic parameters. At the end of the symposium, participants will be better armed to make informed choices regarding "next-step" interventions for patients with major depression.

Outpatient Commitment: A Tour of the Practices Across States

Chair: Dinah Miller, M.D.
Presenters: Ryan C. Bell, M.D., J.D., Kimberly W. Butler, L.C.S.W., M.S., Adam Nelson, M.D., Erin Klekot, M.D., Mustafa Mufti, M.D.
Discussant: Marvin S. Swartz, M.D.

EDUCATIONAL OBJECTIVE:

1) Articulate how outpatient commitment standards and practices differ in four states: New York, Ohio, Delaware, and California; 2) Understand that there may be civil rights violations involved in mandating psychiatric care; 3) Gain insight into the limitations of our knowledge about how well mandating care prevents violence or betters society; and 4) Gain knowledge into what services and practices may help individuals benefit from involuntary outpatient treatment.

SUMMARY:

Outpatient civil commitment is a controversial practice in which patients are court-ordered to treatment. It has been supported by groups such as the Treatment Advocacy Center and NAMI in a stance of “treatment before tragedy” as a way to prevent patients with a history of noncompliance with psychiatric care from decompensating, and Representative Timothy Murphy has touted it as a way to prevent another Newtown massacre. Outpatient commitment came to America’s attention when it was instituted in New York following the death of a young woman when a psychotic man pushed her onto the subway tracks, killing her. Kendra’s Law was well funded and has been studied by researchers at Duke University, including Marvin Swartz, M.D., who will serve as the discussant following the panel presentation. We will hear reports from four states: Ryan Bell, M.D., J.D., and Kim Butler, L.C.S.W., M.S., will talk about assisted outpatient treatment (Kendra’s Law) in Monroe County, New York; Adam Nelson, M.D., will discuss Laura’s Law in California; Erin Klekot, M.D., will discuss her personal experiences working with patients on OutPatient Commitment (OPC) in Ohio; and Mustafa Mufti, M.D., will talk about his experiences treating patients in Delaware and give a historical perspective on the problems his state has had regarding involuntary treatment. Marvin Swartz will add his perspective as a researcher who has studied outpatient commitment in New York and North Carolina for the past two decades. There will be time for audience input and questions. The panelists will specifically address the criteria for outpatient commitment in their states; what extra funding and resources are allocated to patients on civil court orders; what happens when a patient violates the court order, either by not coming to an appointment or by refusing parts of the treatment; how the patients feel about their involuntary care, whether they seeing positive or negative outcomes; if outpatient commitments are changing the rates of homelessness, incarceration, violence, or need for rehospitalization in their state; and if they feel it has a role in preventing mass murders, as the popular media has implied.

Primary Care Psychiatry: Global Perspectives

Chair: Eliot Sorel, M.D.
Presenters: Dinesh Bhugra, Ph.D., Helen Herrman, M.D., M.B., Anita Everett, M.D., Solomon Rataemane, Michelle B. Riba, M.D., Jennifer Severe

EDUCATIONAL OBJECTIVE:

1) Understand the challenges and opportunities of primary care and psychiatry

collaboration/integration in diverse global contexts; 2) Identify several concrete examples of primary care psychiatry's benefits for individuals' and populations' health; 3) Appreciate international opportunities and American challenges for training and education in primary care psychiatry; 4) Demonstrate an appreciation of the medical paradigm shift toward integrated systems of care and its potential catalytic role for primary care psychiatry; and 5) Understand how translating scientific evidence assists the development of responsive/effective health policies affecting primary care psychiatry.

SUMMARY:
Primary care psychiatry is rapidly emerging in the 21st century as a paradigm shift in professional practice catalyzed by multiple factors. Among them are the abundant epidemiological and economic evidence of the global burden of diseases; the global burden of disability of non-communicable diseases (NCDs), inclusive of mental disorders; the high prevalence of NCDs' comorbidities; and treatment outcomes research indicating the benefits of collaborative and integrated care in responding to the NCDs' burden of disease and of disability. NCDs such as cardiovascular disorders, diabetes, depression, and cancer account for more than 30% of the global burden of diseases and more than 40% of the global burden of disability. Recent research indicates also that mental disorders, alone, in Organization for Economic Cooperation and Development (OECD) countries have a major negative impact on the countries' economies, with an impact factor equivalent to four percent of the countries' gross domestic products (GDPs). These rapidly emerging sets of epidemiological, clinical, economic evidence stimulate innovative responses posed by the burden of diseases and of disability posed by non-communicable diseases and their comorbidities. In this symposium, we will address challenges, opportunities and choices the psychiatric profession has in the face of this evidence. We address the choices to enhance primary care and psychiatric collaboration and integration with primary care and defining the emerging model primary care psychiatry. We also address what may be the potential consequences for our patients and the profession if not doing so. We then proceed with identifying the evolving field of primary care psychiatry in diverse cultural challenges and the complexities of resources availability. We then continue with illustrating the field of primary care psychiatry in diverse cultural contexts with their specific challenges, complexities and resources availability. This is followed by describing an evolution from primary care physician to mental health trainee, trainer and care integrator; how best to respond to training and education in primary care psychiatry in the United States and internationally; and how to translate primary care psychiatry evidence into national and global health policy.

Smoking and Alcohol Use Disorder: Recent Research and Treatment Considerations
Chair: Anne M. Joseph, M.D., M.P.H.
Presenters: Christopher W. Kahler, Ph.D., Damaris J. Rohsenow, Ph.D., Lisa M. Fucito, Ph.D., Ned L. Cooney, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe a range of current behavioral, pharmacological and integrated approaches to treating co-occurring tobacco and substance use disorders; 2) Understand research findings and issues related to choosing concurrent vs. sequential interventions for tobacco and substance use disorders; and 3) Identify treatment process variables and risk factors related to both alcohol and tobacco use relapse and outcome.

SUMMARY:
The treatment of co-occurring tobacco and substance use disorders is clinically complex, and many questions remain. The focus of this symposium, chaired by Dr. Anne Joseph, is on recent research on behavioral and pharmacological approaches—used concurrently or sequentially—to address both disorders. Dr. Joseph will give the first presentation, entitled "Treatments for Persons With Co-Occurring Alcohol and Tobacco Use Disorders." This presentation will cover an earlier study suggesting that there is no benefit from treating smoking and alcohol use problems concurrently and a current trial in homeless patients testing the effects of different intensities of concurrent smoking and alcohol treatment. Dr. Chris Kahler will give the next presentation, entitled "Addressing Heavy

Drinking in Smokers Seeking Smoking Cessation Treatment." Results from a recently completed randomized clinical trial testing the efficacy of naltrexone vs. placebo in heavy-drinking smokers seeking smoking cessation treatment, including smokers with an active alcohol use disorder, will be presented. Efforts underway to adapt a publicly available smoking cessation website to address heavy drinking will also be discussed. Following Dr. Kahler, Dr. Rohsenow will give a talk entitled "Strong Treatment Combinations Are Especially Important for Smokers With Alcohol Dependence: Evidence From Four Controlled Clinical Trials." Smokers with current alcohol use disorders (AUD) were enrolled in four clinical trials testing several combinations of behavioral interventions (e.g., motivational interviewing (MI) and brief advice (BA), contingency vouchers (CV), and two pharmacotherapies. The strongest pharmacotherapy needs to be added to BA or MI for smokers with AUD, and ways to increase adherence are needed. Next, Dr. Lisa Fucito will present a paper entitled "Pharmacological and Behavioral Intervention Strategies for Heavy-Drinking Smokers." Her talk will cover simple, easy to assess clinical decision-making tools for alcohol and tobacco use and integrated interventions. Results suggest that an integrated behavioral intervention combined with varenicline may yield better outcomes for both behaviors than a behavioral focus on tobacco or alcohol alone. The final presentation, "Process and Outcome Studies of Concurrent Alcohol and Tobacco Treatment," will be delivered by Dr. Ned Cooney. His presentation will synthesize studies on improving the efficacy of smoking cessation treatment delivered concurrently with alcohol treatment. Process data collected using Ecological Momentary Assessment methodology is examined to determine changes in alcohol relapse risk factors during smoking treatment and changes immediately prior to smoking relapse after concurrent alcohol and tobacco treatment. These studies provide support for specific behavioral and pharmacological smoking interventions delivered concurrent with alcohol treatment that are associated with greater smoking abstinence.

Social Trauma: Novel Approaches to Treatment
Chairs: Sheila Judge, M.D., James Griffith, M.D.
Presenters: SuZan J. Song, M.D., Ph.D., M.P.H., Veronica Slootsky, M.D., Maria M. Bodic, M.D., Aida Spahic Mihajlovic, M.D., M.S.
Discussant: Driss Moussaoui, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize the critical role of culturally-informed diagnostic interviewing in overcoming barriers to treatment access and community outreach initiatives; 2) Learn how to incorporate the family at the center of mental health interventions for survivors of severe trauma and how to assess and evaluate family culture, stigma and conflict; 3) Understand the nature of traumatic stress in human rights abuse, the cultural and ethnic elements of testimonial therapy, and this treatment's particular effectiveness in stigmatized groups; 4) Enumerate several specific ways in which the psychiatrist can treat a person targeted by group hatred to reestablish personal identity, a sense of worthiness, and active agency; and 5) Understand the interplay of self-esteem, art and culture in reversing social isolation and reestablishing community life for refugees to the U.S. who survived war and persecution.

SUMMARY:
Social trauma can occur from a single catastrophic event or from ongoing stressful, even horrific conditions and is experienced by a defined group of any size. Social trauma is both an individual and group experience; it undermines feelings of safety and relatedness, thus altering connection to community. This AASP-WASP symposium will focus on the latest innovative strategies in addressing social trauma-unique, creative and effective interventions in the healing of trauma. Our presenters have traveled across the globe, aiding people assailed by persecution and prejudice, war and political strife, rape and torture-and then brought that expertise to treatment centers here in the United States. We are a nation peopled by waves of immigration, with unbearable homeland conditions and/or the hope of opportunity serving as its constant impetus. People often reach American shores having been deprived of their stores of resilience along the journey, with incipient or active psychiatric conditions. But effective healing exists. Testimonial therapy represents a time-limited yet successful treatment that involves culturally-specific

healing elements in each uniquely designed delivery ceremony during which the retelling and reframing of the trauma story serve to decrease negative associations. It also addresses stigma by allowing the survivor of abuse and violence to have his or her story read aloud within a supportive community. The result often leads to the building of internal cohesion as traumatized memory heals, enabling a legal tool for advocacy and asylum. Addressing the breakdown in cultural and community support, one presentation will focus on the Re:New project that therapeutically supports and empowers artisans to heal using their skills to remind and refocus ethnic pride. The isolation driven by trauma and fear affects the family in deep ways, resulting in further stigma and conflict. In this symposium, participants will learn how to assess the family culture of those traumatized and apply interventions that activate resilient factors, and ways to resolve intrafamilial conflict and stigma will also be demonstrated. Ethnic neighborhoods, representing generations of immigration, present a special treatment challenge, for without incorporating an understanding of aspects of poverty, acculturation stress and the unique aspects of the relevant subculture, diagnosis and treatment options are incomplete and unsuccessful. Each individual processes traumatic experience uniquely, and sometimes devastating symptoms such as hallucinations result. In computer-based AVATAR therapy, the interpersonal, albeit hostile, relationship between the person and the voice they hear is translated into imaging-enabling the therapist to interact as part of this unique healing triad. Cases with AV material will show key components where social trauma played a role. During the discussion period, there will be ample time for audience questions and interaction with the panel.

The Impact of Sexual Trauma on Health and Functionality in the Military Setting

Chair: Michael Bowen

Presenters: Michael Bowen, Stephanie Gaines, Cynthia LeardMann, Paulette R. T. Cazares, M.D., M.P.H.

Discussant: Paulette R. T. Cazares, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Identify the impact of sexual assault on health and functionality; 2) Recognize the issue of secondary victimization in sexual trauma; and 3) Provide insight into patterns in sexual perpetration.

SUMMARY:

This symposium will discuss various aspects of sexual assault in military populations with specific focus on five studies completed recently or currently in progress. Results of the completed studies demonstrate significant impact of sexual assault on the health of servicemembers as well as the military mission. One study showed that, among men in the military, sexual harassment and sexual assault are significantly and negatively associated with health and functionality in ways that extend to post-military life. Another study demonstrated that sexual trauma represents a potential threat to military operational readiness and draws attention to the importance of prevention strategies and services to reduce the burden of sexual trauma on military victims. A third study looks at women with PTSD and compares those deemed disabled from PTSD to those who return to duty, finding sexual assault the main contributor to military disability among these active duty servicewomen. A current study in progress is looking at secondary victimization of sexual assault victims in the military environment. Early results from this study indicate that perception of satisfaction from interactions with legal, medical, mental health, SARC, and chain of command. Another study currently in progress is a qualitative case series of 10 servicemembers convicted of sexual assault to identify patterns, insights and opportunities for further research into MST perpetration toward a goal of improving prevention. Each of these individual studies will be presented during the symposium with the overall discussion revolving around the impact of sexual assault on health, mental health and occupational demands in the military.

The Unwanted Immigrant: Mental Health and Social Responsibility

Chair: Eugenio M. Rothe, M.D.

Presenters: Andres J. Pumariega, M.D., Aida Spahic-Mihajlovic, M.D., Jacob Sperber, M.D., Ateaya Lima, M.D.

Discussant: Pedro Ruiz, M.D.

EDUCATIONAL OBJECTIVE:
1) Become knowledgeable about the historical context of U.S. immigration, how asylum is based in part on mental health factors; 2) Learn a list at least five essential social services denied to undocumented immigrants; 3) Name and briefly describe a special federal program that gives undocumented immigrants the opportunity to legalize their status; 4) Learn about the common misconceptions vs. the empirically based data about criminality among the immigrant population in the U.S; and 5) Learn about the psychological risk factors of the refugee experience and evidence-based treatment for this population.

SUMMARY:
The debate on immigration has escalated in recent years to the point of its being central in the 2016 U.S. presidential election. At the same time, this debate (and its definition of who is an undesirable immigrant) has been a continual and shifting one since the mid to late 1800s, when immigration began from Southern European nations different from the origins of the U.S.'s earliest settlers. At the same time, there has been a corollary in U.S. immigration policy where humanitarian refugees from war-torn nations or those in political conflict with the U.S. were allowed special entry, in recent years ranging from Cuban and Vietnamese refugees to Syrian refugees today. Humanitarian refuge in the U.S., or asylum, is currently based on the concept of "credible fear," which is has some clinical basis given its psychological underpinnings. In addition, the recent discourse of immigrant criminality has been critical in attempting to construct social boundaries, yet researchers studying the relationship between immigration and crime frequently note the discrepancy between actual rates and public perceptions of criminal behavior by immigrants. A growing body of literature shows that immigrants are less likely to engage in crime than U.S.-born citizens and that areas with growing immigrant populations have seen decreases in crime rates, yet despite evidence to the contrary, public opinion surveys suggest that a large number of Americans believe that continued immigration will lead to higher levels of crime. This is particularly true when surveys emphasize the illegal status of immigrants. Research findings about immigrants since the beginning of the 20th century reveal that foreign-born individuals are more commonly incarcerated due to menial crimes and that the justificatory narratives for breaking the law involve financial necessity, family needs and the claim that this behavior "does not harm others." Yet those immigrants who arrive in the U.S. with preexisting PTSD and traumas related to violence, oppression, wars, and civil unrest in their countries of origin, especially if these occur at a young age, may account for more adverse mental health outcomes, such as depression, substance abuse disorders and criminality. Poverty and marginalization in the receiving country further increase these odds. In addition, immigrants face stressors unique to the experience of migration that may exacerbate or cause mental health problems, but rates of access to care are far below those of the general population, leaving immigrants at risk of untreated mental health conditions. This symposium will highlight the ethical dilemmas and social responsibilities faced by psychiatrists when treating immigrants and refugees marginalized in the U.S. due to social disadvantage or illegal migratory status and will discuss the appropriate psychiatric treatment interventions to help these populations.

With What Tools? Dismantling Institutional Discrimination in Mental Health
Chairs: Samra Sahlu, M.D., Helena Hansen, M.D., Ph.D.
Presenters: Ruth Shim, M.D., Ernest Drucker, Ph.D., Tatiana Falcone, M.D., Carissa Caban-Aleman, M.D., Peter Bearman, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand concepts of institutional discrimination and social determinants of mental health; 2) Identify possible examples of legal and institutional discrimination in mental health; and 3) Appreciate current interventions and potential future courses of action aimed at improving outcomes for patients facing intersectional institutional discrimination.

SUMMARY:
While concepts of institutional discrimination and stigma in mental health are far from novel, insufficient attention has been given to evidence-

based institutional interventions, particularly among patients of multiple minority status. An institutional/structural analysis can be applied to critically review social determinants of mental health and systemic interventions. This symposium will begin with a review of institutional determinants of inequalities in mental health outcomes and treatment by race, ethnicity and migration status, with a special focus on mass incarceration and immigration law. The symposium will examine the criminalization of mental illness among ethnic/racial minorities and the intersectional effects of other markers of minority positions, such immigration/refugee status. It will feature studies of the impact of Drug War policies and other racialized institutional legacies on African-American and Latino mental health in the U.S. and the impact of U.S. immigration law on diagnosis and treatment of autism and other severe psychiatric conditions among undocumented migrants. The symposium will then introduce the conceptual framework of structural competency, which calls upon psychiatry trainees and practitioners to enact institutional interventions that address social determinants of mental health. Cultural humility and its use in approaches to community collaboration will also be discussed. The session will end with a review of effective institutional interventions to improve minority mental health and the role of psychiatrists in their implementation.

Wednesday, May 24, 2017

Alcohol Use and Older Adults
Chair: András Orosz, Ph.D.
Presenters: Sara Jo Nixon, Ph.D., Kira S. Birditt, Ph.D., David Oslin, Alison A. Moore, M.D., M.P.H.
Discussant: Frederic C. Blow, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Describe the differences in how alcohol affects older vs. younger adults engaged in a driving simulation task; 2) State a newly identified relationship between drinking patterns and the quality of marriages; 3) Summarize both the concerns and the potential benefits of using pharmacotherapy for alcohol use disorders in older adults; and 4) Identify four interactions related to aging and the combined use of alcohol and medications that pose risk to older adults.

SUMMARY:
This symposium will focus on a growing area of alcohol research—the effects of alcohol and aging. Dr. Sara Jo Nixon will present data comparing alcohol's acute effects across age. Older and younger non-problem drinkers are compared on behavioral and neurophysiological outcomes obtained during a driving simulation task. With no differences in placebo response or in alcohol pharmacokinetics, the groups demonstrated divergent, nonlinear effects in response to active alcohol administration. Older adults given alcohol allocated greater inhibitory processing, reduced behavioral flexibility and an inability to suppress attention to irrelevant stimuli. Dr. Kira Birditt will report on drinking in the context of marriage among middle-aged and older couples and implications for marital quality and health using data from The Health and Retirement Study and the Social Relations and Health Study. Her results show that couples tend to be concordant in their drinking status and that married people often report drinking together. Drinking concordance and drinking together is associated with higher quality marriages; drinking discordance is associated with increased blood pressure, whereas drinking together is associated with better psychological well-being. These findings indicate that it is important to consider the social context when examining drinking and its implications for marriage and health. Dr. David Oslin will discuss the use of pharmacotherapy to treat late-life addiction. Although pharmacotherapy is an evidence-based treatment option for alcohol use disorders, there is limited research on the efficacy for older adults. Concerns about using pharmacotherapy in older adults include the potential for increased rates of side effects, decreased efficacy and increased potential for interactions with other medications. Despite concerns, retrospective data suggest that age is a positive predictor of treatment response with naltrexone. Other trials demonstrate tolerance and acceptance. He will review data from selected randomized clinical trials on the acceptance, tolerability and outcomes for older adults with an alcohol use disorder, with the goal of reviewing concerns about each medication used to treat

alcohol use disorders, including topirimate. Dr. Alison A. Moore will discuss the risks of combined alcohol/medication use in older adults. It has been estimated that more than 40% of older adults who drink alcohol take medications that may interact negatively with alcohol. There are four main types of interactions that may cause adverse events: those due to 1) age-related changes in the absorption, distribution and metabolism of alcohol and medications; 2) disulfiram-like reactions observed with some medications; 3) exacerbation of therapeutic effects and adverse effects of medications when combined with alcohol; and 4) alcohol's interference with the effectiveness of some medications. Dr. Frederic Blow will serve as the discussant.

Extracts of the Medicinal Plant *Withania Somnifera* and Psychiatry: A Promising Adjuvant Treatment in Serious Mental Illness?

Chairs: Jessica M. Gannon, M.D., Roy Chengappa, M.D.

Discussant: Abhishek Rai, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize extracts of *Withania somnifera*, also called ashwagandha, as a traditional treatment in Ayurvedic medicine; 2) Identify the potential utility of ashwagandha in treatment of bipolar disorder; 3) Discuss the hypothesis that ashwagandha would have a place in treating some symptoms of schizophrenia; and 4) Appreciate the challenges and rewards of clinical research in ashwagandha as a "new," yet traditional, avenue of psychiatric treatment.

SUMMARY:

Extracts of *Withania somnifera* (WSE), or ashwagandha, have long been a mainstay treatment in Ayurvedic medicine in India. Sometimes called Indian ginseng, this herb has been used in the treatment of a wide variety of ailments; furthermore, it is considered by Ayurvedic practitioners to be a powerful "Rasayana," an adoptogen that helps protect the body from stress, including mental stress and related anxiety. In more recent years, WSE has also been proposed as a potential procognitive agent and has gained some traction as a potential treatment in serious mental illness. With the rise of government support in India for Ayurveda and other traditional medical practices, combined with growing interest in medicinal, herbal botanical products in North America, Europe, Australia, and New Zealand, researchers have been evaluating WSE for psychiatric use, both through bench research and in clinical trials. Several important bioactive constituents (withanolides, withaferin A, indosides, etc.) have been identified in WSE that support its use as an adaptogen and cognitive enhancer, demonstrating brain antioxidant, neuroprotective and memory-enhancing activity. In a rat model of stress, WSE attenuated damage to hippocampal neurons in the CA2 and CA3 region by 80%. A mouse study with a WSE derivative reversed memory deficits and induced regeneration of dendritic spines and neuronal axons. In other stress models, rodents pretreated with WSE showed significant diminution in hypercortisolemia and other indices of stress. Several randomized clinical controlled trials have demonstrated effectiveness of Ashwagandha, when compared to placebo, in the reduction of anxiety and stress among healthy subjects, as well as among those meeting criteria for anxiety disorders. We will describe the findings of these trials, and their clinical implications, in some detail. Next, we will present findings from our own research group and others, which support ashwagandha's use in serious mental illness. First, we will review the use of ashwagandha in bipolar disorder, chiefly as a procognitive adjuvant to mood-stabilizing regimens. Next, we will share previously unpublished research in the use of ashwagandha for the treatment of positive and negative symptoms in schizophrenia, as well as for the improvement of stress in this patient group. Finally, we will discuss some of the challenges and rewards of research in traditional medicines, with an emphasis on how this can ultimately inform clinical practice in a world in which patients are increasingly interested in "natural" treatments.

Global Issues in Mental Health: Primary Care and School Mental Health, Ethics and Culture, and Migrant and Refugee Mental Health

Chairs: Vincenzo Di Nicola, M.D., Ph.D., Fernando Lolas, M.D.

Presenters: Fernando Lolas, M.D., Nakita G. Natala, M.D., Aleema Sabur Zakers, M.D., M.P.H., Gabriel

Ivbijaro, M.D., Vincenzo Di Nicola, M.D., Ph.D., David Ndetei, Victoria Mutiso, Ph.D.
Discussant: Eliot Sorel, M.D.

EDUCATIONAL OBJECTIVE:
1) Appreciate global initiatives in primary mental health to deal with health disparities, complexity and comorbidity; 2) Understand the ethical dimensions of cultural competence, ethical sustainability and culture-fair guidelines in global mental health; 3) Evaluate a pilot study for implementing child mental health care in different school settings in Kenya; 4) Identify the global mental health needs of migrants and refugees in the light of changing definitions of borders and belonging; and 5) Acknowledge and accommodate the perspectives of psychiatrists-in-training in global mental health theory and practice.

SUMMARY:
After the information revolution produced a global village, the economic revolution with its global flows of goods and services, finances, and people produces globalization of life. While research on social determinants of health means mental health must be understood globally, we talk about mental health in local and static terms, confining mental health to the margins. Health problems are seen as entities rather than processes, solutions aimed at individuals instead of communities, and we overvalue biological explanations and undervalue family, social and cultural contexts for mental and relational problems. As the WHO/World Bank conference declared, "it's time to move mental health from the margins to the mainstream of the global development agenda." **Realizing the Vision for GMH Through Primary Care Transformation:** Global initiatives on mental health outcomes aim to improve on current projections for global mortality and burden of disease by 2030. People with severe mental disorder die 10–20 years earlier. Primary care transformation can narrow the science-to-service gap in GMH. Primary care data is reviewed. GMH policies are part of care in their own right rather than tools to implement care. **The Ethics of Cultural Sensitivity and GMH:** Global violence, mass migration and climate change make reflection on GMH imperative, yet ethics is local, determined by culture and custom. Developing cultural sensitivity is a challenge. "Ethical sustainability" of policies demands strong forms of social empathy and pragmatic approaches. This offers fresh insights on the global dimension of health, a hermeneutical understanding of culture, and an emphasis on new social and intellectual practices. This new conception of health permits a coherent formulation of "culture-fair" GMH. **Experiences of School Mental Health in Rural and Urban Settings in Kenya:** A pilot study to develop school mental health in rural, urban and peri-urban settings in Kenya demonstrates that it is possible to engage key stakeholders, above all the children themselves. The study concluded that life skills training is a viable intervention that can be implemented in Kenyan schools with minimal extra resources and is therefore sustainable. **Borders and Belonging: Global Migrants and Mental Health:** With over one billion global migrants, the 21st century has begun as the century of the migrant. Contentions over borders demand that our way of thinking about and dealing with migrants and borders be revised. This has implications for anthropology and geography, politics and philosophy, and not least for medicine and psychiatry. Psychiatry must redefine how we deal with migrants and refugees, their displacements and potential traumas, and their place in the world. Implications for the theory and practice of psychiatry, for global mental health, and for policy and service planning, as well as for therapeutics, are outlined. This symposium will conclude with the perspective of APA international fellows.

Integrated Care: Guide to Effective Implementation
Chair: Lori Raney, M.D.
Presenters: John Kern, M.D., Gina Lasky, Ron Manderscheid, Clare Scott
Discussant: Jürgen Unützer, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Describe the core principals of the collaborative care model of integrated care and the application to key tasks of effectiveness; 2) Discuss ways the psychiatric consultant can be most effective in collaborative care settings; 3) Explain the best practice approach to building and sustaining effective teams; 4) Understand policy barriers and solutions in integrating care; and 5) List current and emerging payment strategies to fund integrated care.

SUMMARY:
The logic and benefits of bringing behavioral health and somatic medicine together in an integrated care structure is being accepted by medical practices and introduced into specialty behavioral health centers throughout the nation. However, the actual implementation of this concept is complex and can be overwhelming. The good news is that there is an emerging framework of core principles of effective integrated care, implementation research and practice-based experience to serve as a guide. This information is useful in both traditional integration of behavioral health into general medical settings (often primary care) or integrating general medical care into a specialty mental health or substance use treatment setting. Integrated care is a nonspecific term that refers to a variety of approaches to provide physical and behavioral health care (including mental health and substance abuse) simultaneously, regardless of the location of practice. It assumes there is a care team practicing in a systematic way to provide an array of mental health, substance use or physical health services in a typically nontraditional location to provide whole person care for a given population. The collaborative care model (CoCM) is a specific type of integrated care with an extensive evidence base developed over the past two decades. With over 80 positive randomized controlled trials across numerous physical locations, diagnoses, ethnic groups, and payer populations, it is the only model of integrated care that has demonstrated and consistent outcomes. It is therefore prudent to use this rich reservoir of data and mine it not only for its well-demonstrated effectiveness, but also for a set of fundamental unifying principles, implementation processes and key features of team interactions that contributed to this success. It is the only model of integrated care that has this distinction and is the reason much of the work on effective implementation is grounded in research accumulated from trials of the CoCM.

Is Depression Ever "End-Stage?" If So, What Are the Implications?
Chair: Barbara R. Sommer, M.D.
Presenters: Alan F. Schatzberg, M.D., Laura Dunn, M.D., Hugh Brent Solvason, Meera Balasubramaniam, M.D., M.P.H.
Discussant: Paul S. Appelbaum, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the difference between treatment-resistant depression (TRD) and "end-stage" depression; 2) Learn the newest pharmacological and neuromodulatory treatments for TRD; and 3) Appreciate the issue of autonomy in patients with poor-prognosis depression.

SUMMARY:
Of patients suffering from major depression, only 70-80% experience remission, with the rest having either only a partial or no treatment response, resulting in severe emotional distress and hopelessness. Older patients in particular may experience a decline in physical health, food consumption and ambulation. Frail older patients may be at risk for falls and, after staying in bed for protracted periods, may run the risk of deep vein thrombosis. Complicating this picture is the risk of delirium when older patients are given multiple medications. After a patient has undergone several courses of oral medications and ECT without therapeutic effect, we propose that such malnourished, frail, older, depressed individuals may be seen as suffering from the psychiatric equivalent of an end-stage medical illness. The question then arises as to whether or not such severely disabled patients have the capacity to terminate care, knowing that the outcome will hasten death. While there is literature on the termination of care in patients with medical illness and concomitant depression, there is little that discusses this question as it pertains to depression as the primary illness. First, we will discuss a case that highlights this issue, defining treatment resistance, and we will review possible criteria to determine if a patient has "end-stage" depression. We will discuss the newest pharmacological and neuromodulatory approaches for refractory depression, followed by discussing the pros and cons of continuing to treat a nonsuicidal competent patient wishing to terminate active intervention with ever more invasive modalities.

Neuromaturational Consequences and Predictors of Heavy Drinking: Findings From the Consortium on Alcohol and Neurodevelopment in Adolescence

(NCANDA)

Chair: Sandra Brown, Ph.D.
Presenters: Susan Tapert, Ph.D., Adolf Pfefferbaum, M.D., Fiona Baker, Ph.D., Kate Nooner, Ph.D., Duncan Clark, M.D., Ph.D., Eva Müller-Oehring, Ph.D.
Discussant: Raquel Gur, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the impact of heavy drinking during adolescence on the processes of age- and sex-related changes in brain structure and function; 2) Understand the relationships between problematic alcohol use in adolescence and childhood trauma, executive function deficits, and other adverse childhood experiences; and 3) Be aware of the potential for NCANDA's broad array of findings from neuroimaging, cognitive testing, and behavioral and clinical assessments to guide the development or refinement of adolescent drug and alcohol interventions, treatment and policy.

SUMMARY:

Alcohol is the most commonly used recreational drug by teens and young adults (i.e., ages 12-25). Of particular concern is the high prevalence of binge drinking (consuming four, five or more drinks per occasion) and "extreme" binge episodes (10+ or 15+ drinks per occasion), which pose an elevated risk of alcohol-related harm. In 2012, the NIH-funded National Consortium on Alcohol and Neurodevelopment in Adolescence (NCANDA) was initiated to investigate adolescent brain and behavior development with a particular emphasis on the effects of drinking alcohol during this critical period of brain maturation. Investigators use an accelerated longitudinal design to characterize neuromaturational trajectories in a high-risk enhanced community sample of 831 subjects (aged 12-21 at baseline). A comprehensive research battery that includes multimodal neuroimaging, cognitive testing, behavioral interview, sleep EEG, and biospecimen collection is administered up to 10 times per subject. Ecological momentary assessment data is collected more frequently. Examination of alcohol consequences is focused on the structural and functional maturation of brain areas that actively develop during adolescence, are involved in psychological regulation, respond to rewards, and appear vulnerable to neurotoxic effects of alcohol. NCANDA investigators are also working to identify preexisting psychobiological vulnerabilities that may put an adolescent or young adult at elevated risk for an alcohol use disorder and characterize brain recovery in heavy adolescent/young adult drinkers over four weeks of monitored abstinence. This symposium will focus on initial findings from several domains. We will provide an overview of the consortium's research goals and the progress made thus far and outline the innovative aspects of NCANDA's research design and protocol that ensure uniquely precise, valuable longitudinal data. Age- and sex-related changes found in brain structure, function and sleep physiology, and the impact of heavy drinking on these processes, will be described. We will also present data characterizing complex relationships between executive dysfunction, childhood trauma and other adverse childhood experiences, brain maturation, and problematic alcohol use. Finally, we will discuss how NCANDA's findings on the deleterious effects of alcohol on adolescent development can help to guide and inform adolescent alcohol and drug preventive interventions, treatment practices, and alcohol regulatory policies.

Positive Psychiatry at the Community Level: Age-Friendly Communities

Chairs: Keri-Leigh Cassidy, M.D., Dilip V. Jeste, M.D.
Presenters: Kathleen Buckwalter, Sejal Patel, John Feather
Discussant: Amresh Shrivastava, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the principles of positive psychiatry in clinical practice; 2) Promote healthy aging at the community level in their own setting; and 3) Facilitate intergenerational activities in their communities.

SUMMARY:

The number of Americans over age 65 will increase from 49 million today to 70 million by 2030. This rapid aging of the population will overwhelm the already stressed national infrastructure for mental and physical health care. Consequently, there is expected to be a progressive shift in delivery of interventions from individual level to community-based approaches. This symposium will highlight the

critical role of psychiatry in this increasingly important area of public health. Positive psychiatry is a relatively new concept that focuses on well-being, prevention, resilience, healthy aging, social engagement, and stress management. As the primary site of health care will move from hospital and clinic to home and community, the principles of positive psychiatry will need to be employed at the community level. In recent years, several initiatives have been proposed to promote healthy lifestyles and enable older adults to age in place. A prominent one is the World Health Organization's global age-friendly communities (AFCs) network, which includes hundreds of communities worldwide. An AFC is a place where older adults are actively involved, valued and supported with infrastructure and services to effectively accommodate their needs. Specific criteria include affordable housing, safe outdoor spaces and built environments conducive to active living, convenient transportation options, opportunities for older adults' social participation and leadership, and accessible mental and physical health care services. Active, culture-based approaches, supported and developed by local communities and including an intergenerational component, are important. Cognitive behavioral tools should be used to support health behavior change on a public health scale. The proposed symposium, featuring speakers from diverse but related areas of expertise, will explore several novel applications of the principles of positive psychiatry at the community level. The presenters will share their ongoing efforts to develop AFCs in different regions, including San Diego, California (Jeste). Nova Scotia, Canada (Cassidy); Johnson County, Iowa (Buckwalter); and Washington, DC (Patel). The development, activities, accomplishments and challenges of these communities will be discussed (Feather). Future planning, evaluation, sustainability, and cost effectiveness will also be described, along with opportunities for psychiatrists and other mental health advocates to take leadership roles in this arena that will be an integral part of the future health care system. There will be five presentations, each for 20 minutes, followed by Q&A for five minutes. Next, the discussant (Shrivistava) will seek to tie the presentations together and provide a summary of take-home points for the audience. At the end, there will be a general discussion from the floor for 35 minutes. Thus, a total of one hour will be devoted to Q&A and comments from the audience, ensuring that this session is interactive.

Religion and Spirituality in Vulnerable Child and Adolescent Psychiatric Populations
Chair: Mary Lynn Dell, M.D., D.Min.
Presenters: Michael Haymer, William Holmes, Lisa Fortuna
Discussant: Margaret Stuber

EDUCATIONAL OBJECTIVE:
1) Understand the importance of religion/spirituality in the lives of autistic and other developmentally disabled individuals and families; 2) Understand religious/spiritual issues faced by sexual and gender minority youth, their families and faith communities; 3) Understand the importance of religion/spirituality among youth in foster care and implications for assessment and treatment planning; and 4) Understand the importance of religion/spirituality in minority immigrant children, especially as they deal with trauma and distress.

SUMMARY:
This symposium addresses religious/spiritual (R/S) aspects of youth and families deemed to be "vulnerable," including those who are autistic, from a sexual minority, in foster care, or an immigrant to the U.S. Many faith communities now include autism and others with developmental disabilities in their work. The inherent interpersonal, social and cognitive deficits in autism challenge understandings of abstract religious thought and traditions. These are often addressed with many of the same techniques used in public school resource rooms and in behavioral programming. Congregations have focused on making the physical place and meeting space safe and obstacle free for the disabled and often shorten and simplify rituals and worship services as adaptations to impulsivity and short attention spans. Religious communities also serve as resources for caregivers, including spiritual, financial, transportation, food, shelter, respite care, or other needs. Psychiatrists can recognize R/S needs when expressed by their autistic patients and assist faith communities serving those with autism. R/S is important to sexual and gender minority (SGM) youth and their caregivers/families. Tension may

arise between R/S beliefs and sexual/gender identities among youth and/or their caregivers. Research about the intersection of R/S with sexual orientation and gender identity concerns will be reviewed. Special attention will be directed toward clinical implications derived from the literature, as well as recent public health efforts to address health disparities among SGM youth in non-affirming faith communities. Current controversies, such as the use of conversion therapy, will be discussed in regard to clinical implications, legislative activity and efforts to ban such practices within the medical community. Issues related to R/S are important to foster youth, providing a framework for daily life as well as helping youth cope with issues particular to their world, including abuse and abandonment by authority figures who should have cared for them—all leading to difficulties trusting adults. These troubled relationships can be mirrored in the spiritual lives of these abused youth. The importance of R/S in diagnosis and ongoing treatment may not be recognized or emphasized by providers who treat this population. R/S is important to immigrant children and adolescents. Studies of Latino immigrant youth, PTSD and pastoral care will be discussed. The blending of hope and resilience that both practical theology and appropriate mental health care can contribute will be emphasized, as well as how R/S may be experienced by children in the face of adversity and in a sociocultural context. Closing discussion will emphasize common elements of R/S helpful in the assessment and treatment planning of these and other populations of vulnerable youth, their families and systems of care.

Targeting the HPA Axis and Novel Strategies to Treat Psychiatric Disorders

Chairs: Gustavo E. Tafet, M.D., Ph.D., Charles B. Nemeroff, M.D., Ph.D.

Presenters: Alan F. Schatzberg, M.D., Rachel Yehuda, Ph.D., Barbara J. Mason, Ph.D., Gustavo E. Tafet, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Identify potential ways to approach the regulation of the HPA axis, from basic research to the clinical practice; 2) Appreciate potential benefits of developing new strategies aimed at restoring the HPA axis; 3) Understand the challenges faced by the interactions between neurobiological and psychosocial factors in the treatment and prevention of mental disorders; 4) Understand the rationale for glucocorticoid-based treatments in PTSD, depression and alcoholism; and 5) Describe the results of recent studies of glucocorticoid-based treatments with PTSD.

SUMMARY:

Stress plays a critical role in the origin and development of an array of cognitive, affective and behavioral disorders, including depression and different anxiety disorders. It has been shown that both the sustained and persistent impact of environmental stressors, as observed during chronic stress, and the long-lasting effects of stressful experiences during childhood may lead to persistent hyperactivity of the hypothalamic-pituitary-adrenal (HPA) axis, which in turn may be translated into increased concentrations of CRF and cortisol, increased reactivity of the amygdala, decreased activity of the hippocampus, and decreased serotonergic neurotransmission, which together result in increased vulnerability to stress. Novel strategies aimed at controlling and further restoring the normal functioning of the HPA axis may contribute to the development of more effective treatments and preventive strategies in the interface between stress and different psychiatric disorders. Charles Nemeroff will review the studies to date on CRH-R1 antagonists in depression, PTSD and alcoholism. Alan Schatzberg will review the Phase III trials on the glucocorticoid receptor antagonist mifepristone in psychotic depression, emphasizing the role of attaining a specific blood level in clinical and biological responses. Rachel Yehuda presents on a study of hydrocortisone versus placebo augmentation of exposure therapy, as well as a recent multicenter trial of mifepristone in PTSD. Barbara Mason presents data from rodent studies indicating mifepristone blocks acquisition of alcohol imbibing behavior and reduces alcohol consumption in heavy alcohol users. Last, Gustavo Tafet will present data on the relationships between the HPA axis and serotonergic systems. Clinical implications of these studies will be emphasized.

The Battle Over Involuntary Psychiatric Care

Chair: Dinah Miller, M.D.

Presenters: Roger Peele, M.D., Paul S. Appelbaum, M.D., Elyn R. Saks, J.D., LL.D., Ph.D., Al Galves, Ph.D.
Discussant: Annette Hanson

EDUCATIONAL OBJECTIVE:
1) Articulate three different perspectives on the practice of involuntary psychiatric treatment; 2) Understand the APA's position on involuntary treatment; 3) Gain insight into why antipsychiatry groups oppose the use of involuntary treatments; 4) Hear from a civil rights attorney and learn about her own negative experiences as an involuntary patient; and 5) Learn that it is difficult to predict whether involuntary care will be perceived by the patient as helpful or traumatizing.

SUMMARY:
The practice of involuntary psychiatric treatment is sometimes viewed as essential in situations where individuals have severe psychiatric symptoms, are impaired in their ability to care for themselves and may represent a danger to themselves or others. The practice, however, is not without controversy, and the topic gets very heated and emotional, with the battlefield so charged and so loud that it becomes difficult for advocates to credit any perspective other than their own. In this symposium, we will bring together people with a spectrum of beliefs about whether and how involuntary (or forced) treatment should be used, or not. Roger Peele, M.D., will discuss the position that it is inhumane to leave people with severe disorders untreated and will talk about treatment as a way of preventing bad outcomes. Paul Appelbaum, M.D., will talk about the APA's stance on involuntary hospitalization and treatment, including the standard that should be applied to determine when involuntary treatment is needed and the APA's more recent support of legislation promoting outpatient commitment. Elyn Saks, J.D., will discuss her own experiences as an involuntary patient, including being subject to seclusion and restraint, and her work as a mental health law professor to promote the civil rights of people with psychiatric disorders. Al Galves, Ph.D., will represent MindFreedom International (MFI) and their opposition to involuntary care. MFI is a group that traditionally demonstrates outside the APA's Annual Meeting, and this will be an opportunity for APA attendees to hear that group's perspective and concerns. Please note this will not be a debate, but a respectful presentation of conflicting opinions. There will be time for audience input and questions.

The Role of Culture in Mental Health and Mental Illness: An International Perspective
Chairs: Bernardo Ng, M.D., Rama Rao Gogineni, M.D.
Presenters: Pedro Ruiz, M.D., Vincenzo Di Nicola, M.D., Ph.D., Suni Jani, Jennifer Severe, Atong Ayuel Akol, M.D.
Discussant: Michelle B. Riba, M.D.

EDUCATIONAL OBJECTIVE:
1) Appreciate culture as a key element in mental illness and mental health from an international perspective; 2) Understand the impact of culture in the delivery of mental health services; and 3) Include cultural factors in the appropriate treatment of patients and their families.

SUMMARY:
A key aspect in the appropriate delivery of care is the role that culture plays in symptom manifestation, management and successful adherence to treatment. It is imperative that clinicians identify cultural vulnerabilities, including linguistic barriers, poverty, folk beliefs, discrimination, family and community support, migratory status, combat exposure, and racism. It is imperative as well that clinicians identify cultural factors that protect against disease and favor resilience, health and growth—and how culture can be reshaped to address societal changes and prevent illness. This symposium presents an international perspective on how to identify and utilize cultural factors that prevent mental illness and favor mental health. With over one billion migrants, the 21st century has started as the century of the migrant. In a world with territorial wars, our way of dealing with migrants and borders must be revised. As such, psychiatry must redefine how we deal with migrants and refugees, their displacements, and potential traumas. Implications for the theory and practice of psychiatry, global mental health, policy, service planning, and therapy will be outlined. Despite the near universality of human trafficking, victims may manifest varied symptoms based on their cultural context, personalities, existing resources, immigration status, family connections, severity of

substance use, and associated legal issues. The clinician evaluating a human trafficking survivor requires cultural sensitivity to this traumatic experience. Industrialization and globalization have contributed to major shake-ups in traditional Indian culture, to include nuclearization of families and changes in gender roles, child rearing and work habits. Social systems with new inter-/intra-family relational paradigms are shaping a new Indian self, preparing for a world with new mental health needs. The devastating earthquake in Haiti made us aware of the mental health needs in the non-Hispanic Caribbean. Culture as an integral factor in the development of a conceptual framework of mental health and mental illness will be presented along with highlights from the WHO-AIMS report. In the midst of civil unrest, the department of mental health has worked on developing programs with community participation, respecting local cultural traditions (i.e., magical rituals and sacrifices) and introducing a scientific approach with pharmacological interventions in South Sudan. The symposium will close underscoring how academic centers must conduct research including culture as one of the essential factors in the understanding of health care utilization, integration of psychiatry and primary care, quality of care, acculturation, reinsertion to society of refuges and victims of human trafficking, resilience, and religion.

The Role of Psychiatrists in Palliative Care
Chairs: Jon Levenson, M.D., Maria Llorente, M.D.
Presenters: David Buxton, Jon Levenson, M.D., Maureen C. Nash, M.D., M.S., Colleen O'Rourke, M.D.
Discussant: Scott A. Irwin, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the history of palliative care in the medical system; 2) Understand how to do a psychiatric palliative consultation; 3) Teach physicians how to communicate more effectively; 4) Understand how to manage a patient with terminal dementia; and 5) Understand how to provide palliative care to patients with mental illness.

SUMMARY:
American hospitals are filling with seriously ill and frail adults. By 2030, the number of people in the United States over the age of 85 is expected to double to 8.5 million. This large population has led to the formation of the medical specialty palliative care. Palliative care is focused on providing physical, emotional and spiritual relief from the symptoms and stress of a serious illness. The goal of treatment is to improve quality of life for patients and their families. Palliative care is provided by a team of specialists including palliative care physicians, nurse practitioners, chaplains, and social workers who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and any stage in a serious illness and can be provided along with curative treatment. Palliative care targets specific symptoms to improve patients' quality of life. These symptoms can include acute pain, dyspnea, nausea, constipation, fatigue, and anorexia. Through a one-year fellowship, providers learn treatment modalities to ease this suffering. Psychiatrists are increasingly being asked to participate in the care of medically ill patients with far advanced disease states, including patients who are actively dying. Psychiatric symptoms often complicate the care of critically ill patients, both directly in the manifestation of acute symptoms and indirectly in the psychosocial and spiritual sequelae suffered by many patients with chronic and severe mental illness. Patients with terminal dementia and their families can also benefit from a multidisciplinary palliative approach. This symposium will present an overview of the field of palliative medicine. One presentation will focus on the specific clinical skill set psychiatrists need to comprehensively evaluate and manage patients at the end of life. Management topics will include targeted pharmacotherapy to address acute neuropsychiatric disturbances, as well as discussion of evolving types of psychotherapeutic support. We will also discuss how the psychiatric consultation can help the interdisciplinary team identify the capacity of the patient to make decisions, help restructure the definition of family when seeking proxy decision makers for incapacitated patients previously estranged by mental illness, and help patients' families understand and accept their role in using substituted judgment for patients who cannot direct their own care. Management of the demented patient will be presented along with various case vignettes. The development and evaluation of a communication skills training program that teaches

providers in the oncology setting how to communicate with patients and families about the transition to palliative care and discussing end-of-life goals of care will be also be presented.

Update on Psychiatric Care in Bariatric Surgery: What Every Psychiatrist Needs to Know
Chairs: Sanjeev Sockalingam, M.D., Raed Hawa, M.D.
Presenters: Weronika Micula-Gondek, Alexis Fertig, Wynne Lundblad, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the role that psychiatrists have in pre- and post-bariatric surgery care; 2) Identify new tools and evidence for assessing and supporting bariatric surgery patients through this weight loss intervention; 3) Apply pharmacology protocols and brief psychological interventions that improve psychiatric care after bariatric surgery; and 4) Describe an integrated care approach to managing psychiatric comorbidity and complications related to bariatric surgery.

SUMMARY:
The World Health Organization (WHO) has reported that we are in the grip of a global obesity epidemic. Bariatric surgery is recognized as an effective and durable treatment for severe obesity, and the number of surgeries in North America have increased over the last decade. However, there is emerging literature identifying the high rates of psychiatric comorbidity in this population and a myriad of mental health complications following bariatric surgery that require the involvement of psychiatrists who are skilled at identifying and managing psychosocial issues before and after bariatric surgery. Several postoperative psychiatric complications warrant attention, including psychopharmacological modifications, substance use disorders, eating psychopathology, and identification of self-harm and suicide risk. These psychosocial concerns underscore the complexity of bariatric surgery aftercare and highlight the need for psychiatric assessment and support for patients before and after bariatric surgery. As a result, the presenters of this symposium developed the recently approved APA Resource Document on Bariatric Surgery and Psychiatric Care in response to this growing need for psychiatric support for this patient population (release date: January 2017). This symposium is aimed at improving psychiatrists' awareness and confidence in managing common psychiatric issues related to bariatric surgery. Dr. Micula-Gondek will provide an overview of the evidence base and discuss approaches to assessing psychiatric readiness for bariatric surgery, including the use of evidence-based assessment tools. Dr. Fertig will present on data related to the postoperative course of psychiatric illness, including preexisting and de novo eating disorders and *DSM-5* eating disorders as they relate to bariatric patients. Dr. Hawa will summarize data on psychopharmacological issues related to bariatric surgery, specifically psychotropic medication malabsorption, medication complications and psychotropic protocols. He will also summarize postoperative risks related to body image disturbance and suicide and self-harm risks after bariatric surgery. Dr. Sockalingam will discuss the relationship between substance use disorders before and after bariatric surgery, including risk factors and early interventions to mitigate these risks. Dr. Lundblad will present the evidence for an integrated care approach to psychiatric care in patients undergoing bariatric surgery and describe an ideal integrated care model for improving psychiatric and obesity outcomes. Dr. Sockalingam will conclude the symposium with a summary of the recommendations from the APA Resource Document and the evidence for psychosocial treatments in this patient population. Psychosocial screening tools, best practice psychiatric protocols and discussion of practical office-based psychosocial interventions for bariatric surgery-related psychiatric care will be integrated throughout the symposium.

What Is Pain to the Brain?
Chairs: Steven Grant, Ph.D., Wilson M. Compton, M.D.
Presenters: Apkar Apkarian, Ph.D., Emeran Mayer, M.D., Ph.D., Jon-Kar Zubieta, M.D., Ph.D., Amanda E. Guyer, Ph.D., Richard D. Lane, M.D., Ph.D.
Discussant: David Thomas, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the similarities and differences in brain processes involved in a wide variety of pain conditions, including social and emotional distress;

2) Understand how the variety brain transmitter and receptor systems modulate pain and contribute to placebo responses; and 3) Understand adaptations in the brain associated with the development of chronic pain and preexisting brain conditions that predict risk for transition to chronic pain.

SUMMARY:
This symposium addresses advances in brain processing of different types of pain, including visceral pain and social distress, brain mechanisms of pain regulation exemplified by placebo responses, brain changes that accompany the transition from acute to chronic pain, the relation of pain to emotion and mood disorders, and how the inability to express distressing emotional states such as pain can impact clinical care. Dr. Jon Kar Zubieta will present results showing the involvement of endogenous opioid, endocannabinoid and dopamine systems in the regulation of pain. He will emphasize how these neurochemical systems contribute to placebo effects not only with respect to pain but also in mood disorders, both of which exhibit high levels of placebo responses in clinical trials and are modulated by the presence of common genetic variation. Dr. Vania Apkarian will address how dynamic interactions between nociceptive input and brain circuits commonly associated with motivation and addiction give rise to the chronic pain states. Results from a longitudinal study illustrate how brain imaging can parse brain properties that induce risk (predisposition), their interaction with injury (transition) and the resulting new brain state (maintenance) across clinical chronic pain populations. Dr. Emeran Mayer will describe interactions of the brain, autonomic nervous systems and the gastro-intestinal system that contribute to the emergence of emotional distress from visceral pain. The use of a big data approach that employs machine learning to develop brain signatures of visceral pain syndromes will be described using data from the Pain and Interoception Imaging Network, which he established as a repository for pain-related brain imaging data. Dr. Amada Guyer will focus on brain response to peer rejection and exclusion in adolescence, a period marked by heightened sensitivity to peer experiences. In adolescents, social evaluation and social exclusion tasks were found to engage a network of brain regions typically seen with physical pain. Negative peer experiences were found contribute to the relationship between childhood depression and anterior cingulate responses in adolescence to "conflicting" social outcomes (e.g., learning one is liked by a disliked peer or facing rejection from a liked peer). Finally, Dr, Richard Lane will address how implicit emotions contribute to pain amplification and suffering. A multisite clinical trial in patients with fibromyalgia found greater pain reduction with "emotional awareness and expression therapy" compared to cognitive behavior therapy. Epidemiologic studies show that early life adversity not only increases the risk for chronic widespread pain in adulthood, but also impairs awareness and self-regulation of emotional states. These finding stress the importance of understanding how the neural basis of unconscious emotion and the clinical condition of "affective agnosia" interact with nociceptive mechanisms.

Workshops

Saturday, May 20, 2017

A Culture of Safety in Psychiatric Practice and Training: What It Is, Why It Is Important and How to Create It
Chairs: Richard Holbert, M.D., Geetha Jayaram, M.D. Presenters: Jacqueline A. Hobbs, M.D., Ph.D., Regina Bussing, M.D., Herbert Ward, M.D., Jennifer Davis, D.O., Yarelis Guzman-Quinones, M.D.

EDUCATIONAL OBJECTIVE:
1) Define a culture of safety within psychiatric practice and training; 2) Discuss the six critical events the APA has identified as the most common areas in which errors occur in psychiatry; 3) Review the importance and benefits of creating a culture of safety in psychiatric practice and training; and 4) Explain common dimensions across safety culture tools, including leadership and management, group relationships, communication, and quality of work environment.

SUMMARY:
Prior to accepting our medical diplomas, we recite “First, do no harm.” A medical error can be defined

as something the health care team did or did not do that led to harm for the patient. Medical errors cost the U.S. approximately $20 billion annually. It is estimated that 10% of all deaths are caused by medical errors, accounting for over 250,000 deaths yearly, making it the third-leading cause of death in the U.S. With the accumulating data, in 1999, the Institute of Medicine published "To Err is Human," which defined the problem and proffered strategies for improving safety in health care. A culture of safety was defined by JCAHO as an integrated pattern of individual and organizational behavior and its underlying philosophy that continuously seeks to minimize hazards and patient harm that may result from the processes of care. We will further define a culture of safety in psychiatric practice and training while describing communication skills, incident reporting mechanisms, policies and procedures, safety training, high reliability, and analysis under a just culture. The APA Committee on Patient Safety has identified six areas most commonly associated with errors in psychiatry. The six areas are suicide, medication errors, aggression, falls, elopement, and medical comorbidities. Additionally, we will discuss the potential psychological consequences of receiving mental health care, looking at the effects of being on locked units, confiscating banned items and use of security devices. We will examine each of these areas, describing where our health care system fails, and offer solutions to decrease errors for these events. Research has shown that creating a culture of safety decreases medical errors and enhances health care staff morale and performance. We will review leadership and management behaviors that produce a culture of safety. We will spend time discussing communication skills, including team safety huddles that lead to improved patient care. An emphasis on incident reporting and just culture analysis will be made, demonstrating how it improves the quality of care and, ultimately, physician satisfaction. We will examine workforce and working conditions that can lead to mistakes and give potential solutions. The workshop leaders have significant leadership experience in creating a culture of safety in both inpatient and outpatient practice and with resident education on this topic. Multidisciplinary safety coach training in psychiatry will be described. Patient case examples will be provided to allow for small-group discussions and active participation. These examples will be used to get the participants to discuss their own real-life cases. The goal is for participants to understand the importance of creating a culture of safety to enhance patient care and to have an open forum for discussion. Successful implementation strategies to affect change in culture will be provided and discussed.

A New Model of Care: Managing Medications and Psychotherapy From Afar Using Home-Based and Clinic-Based Technology for the Delivery of PTSD Services

Chairs: Leslie Morland, Psy.D., Tonya Masino, M.D.
Presenters: Kathleen Grubbs, Kathryn Williams, Jeffrey Poizner

EDUCATIONAL OBJECTIVE:

1) Be familiar with the current research literature supporting the delivery of evidence-based therapies for PTSD via video teleconferencing technology; 2) Understand how to utilize state-of-the-art clinical video technologies to provide easily accessible, evidence-based care to patients in the comfort of their own home, including establishing rapport with patients remotely; 3) Identify which patients and situations are most appropriate for providing in-home clinical video teleconferencing care; 4) Demonstrate an ability to discuss clinical video teleconferencing with their patients; and 5) Consider the clinical, ethical and safety issues associated with providing mental health care via video teleconferencing in the home.

SUMMARY:

Despite the prevalence of mental health disorders across the U.S., the majority of individuals in need of mental health care do not access the necessary mental health services. Many barriers exist for patients seeking psychiatric services, including transportation problems, long distances to clinics, work schedules, parenting duties, lack of local specialty providers, symptoms related to anxiety, avoidance, and the stigma associated with seeking mental health care. Clinical video teleconferencing (CVT) has the potential to circumvent some of the difficulties inherent to the traditional brick and mortar model of in-person care by allowing

providers to offer flexible hours to patients, reduced transportation cost and time, and, in some cases, allow access to care in the comfort of a patient's home. These advantages could increase utilization of mental health services and improve the adherence and compliance with psychiatric care. This interactive workshop will discuss the clinical, logistical and ethical considerations when conducting psychiatric care using technology in a rural or remote clinic as well as in a patient's home. Presenters will include both psychiatry and psychology providers from the San Diego VA Telemental Health Program. This large, innovative program delivers psychiatry and psychotherapy services via CVT to veterans located throughout the Southwestern United States and allows access to care in areas where services are limited or absent or where patients are unable to access care due to transportation or geographic or physical obstacles. Presenters will draw from a breadth of clinical case examples, clinical trials underway and current research literature. Clinical considerations will include how to ensure safety, establish rapport and manage complex co-occurring disorders remotely. We will discuss how to identify patients most appropriate for telemental health (TMH) services and relative indications and contraindications for in-home CVT. Information on adapting evidence-based psychotherapy to CVT will be discussed specifically for PTSD. Logistical considerations include developing a virtual clinical space with the patient, ensuring appropriate technology is available, providing technological support and backup, and handling the remote exchange of consent, educational and therapy materials. Ethical considerations will include managing risk, licensing and complying with policies such as the Ryan Haight Act. Workshop attendees will have the opportunity to participate in small-group exercises and will be encouraged to share views on home-based psychiatric care in their practice. The workshop is for clinicians of any level who may be considering expanding their practice to include technology delivery of mental health care. Although many of the clinical examples will focus on patients with PTSD, much of the content will be generalizable to many populations and evidence-based approaches.

A Pilot Curriculum for Psychiatry Trainees and Psychiatrists on Nonpharmacological Agitation Management in Children, Adolescents and Young Adults

Chairs: Shih Yee-Marie Tan Gipson, M.D., Lauren View, M.P.H., M.S.W.
Presenters: Ronke Babalola, M.D., M.P.H., Sally Nelson, M.Ed., R.N., Chase Samsel, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe risks, triggers and profile of agitated children, adolescents and young adults; 2) Review interventions performed in the past year at a large children's hospital; 3) Identify effective nonpharmacological interventions for agitation through the analyzed data from our research; 4) Provide hands-on experience in developing a behavioral and pharmacological plan through cases; and 5) Obtain feedback from participants of the workshop as a potential model for training curriculum.

SUMMARY:
Currently, agitated and violent patients continue to be a major challenge in hospitals nationally. Both the Joint Commission for Accreditation of Hospitals and the Centers for Medicare and Medicaid Services have mandated that hospitals move toward a restraint-free environment with an increased focus on managing patients with minimal to no use of medication or physical restraints. Most importantly, agitated patients place themselves, their caregivers and hospital staff at risk for increased physical injuries and potential emotional trauma. Despite these challenges and trends, most psychiatry trainees have limited education on how to manage this population using nonpharmacological means. Boston Children's Hospital has taken an initiative in understanding agitation in patients through the development of the Behavioral Response Team (BRT), dedicated to managing acute agitation and crises of patients on the inpatient medical units and in the ambulatory clinics. With IRB approval, the BRT has also collected data on children, adolescents and young adults age 2-20 who received care at Boston Children's Hospital and who were at risk for agitation. Using the Pearson chi-square, our data from 2016 will be analyzed to explore any associations among demographic characteristics, diagnosis and outcome achieved. Through an IRB-

approved protocol, we have also surveyed 53 psychiatry trainees regarding their current education on nonpharmacological management of agitation. These data and analyses will be discussed during the workshop, along with how they can be incorporated in treating an agitated or violent patient. This workshop is designed to serve as a potential model for curriculum on nonpharmacological management of agitation for psychiatry trainees. During this workshop, participants will break into small groups to practice problem-based learning. At the end of the workshop, participants will be able to first identify risk factors and triggers for agitation, understand nonpharmacological treatments for agitation and violence, and clinical pearls in creating behavioral plans and interventions through problem-based learning in small groups.

Acceptance and Commitment Therapy for Addictions

Chair: John D. Matthews, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the acceptance and commitment therapy (ACT) approach to the treatment of addictions; 2) Cite the six ACT processes that contribute to and promote psychological flexibility; and 3) Apply the six ACT processes to achieve psychological flexibility.

SUMMARY:

For addictions treatment, acceptance and commitment therapy (ACT) addresses three important issues: 1) relapse prevention; 2) comorbidities with addictive disorders; and 3) the importance of targeting experience and values, rather than symptom reduction, as a more effective treatment strategy. With regard to the first two points, the six processes that are cultivated in order to achieve psychological flexibility included being present, acceptance, defusion from negative constructs of the thinking mind, values clarification, and commitment to value-based actions. These six processes are in the service of preventing psychological difficulties in the future that might contribute to lapses and relapses. Also, the "psychological flexibility" model of ACT is particularly suited for conditions with high rates of comorbidities. ACT is transdiagnostic, meaning it identifies common mechanisms that are responsible for a variety of psychological problems. Transdiagnostic approaches provide an alternative treatment approach to the classic medical model. A syndromal approach often leads to sequential treatment. However, clinicians applying a transdiagnostic approach attempt to identify and treat core processes that have led to a variety of symptom clusters. With this approach, several conditions considered to be defined entities become functionally unitary. ACT provides a unique treatment approach. The primary focus of CBT is on changing the content of one's thinking; however, cognitive restructuring does not consistently help in situations where there have been multiple failures due to one's addiction. According to ACT, treatment approaches that target insight, symptom reduction and challenging thoughts can contribute to increased levels of distress, leading to experiential avoidance with the use of substances. The ACT approach can potentially enrich and enhance the innovative approach that the field of addictions has already established. In CBT, cognitive restructuring is in the service of reducing symptoms and maladaptive behaviors. According to CBT, by reducing internal and external triggers, cravings and urges to use will be diminished. However, ACT stresses that internal experiences and one's history cannot be changed at will. Negative thoughts, feelings, sensations, images, and memories just show up in conscious awareness unannounced. The more one engages in trying to figure out or explain his or her distressing experiences, the more one suffers. The approach with ACT is to determine one's relationship with these internal experiences based on their functionality. In other words, how does paying attention to those negative internal experiences help with value-based living? According to ACT, the problem is the rigidity with which thoughts control behavior rather than the content of thoughts. A life worth living is determined by committing to and engaging in value-based actions.

Army Substance Use Disorder Care: Transformation and Integration With Behavioral Health Care

Chair: Charles S. Milliken, M.D.
Presenters: Millard Brown, M.D., Christopher Ivany, M.D., Jill M. Londagin

EDUCATIONAL OBJECTIVE:
1) Review the 2012 Institute of Medicine recommendations for improving DoD substance use care; 2) Describe efforts to transform Army substance use care; and 3) Promote discussion on experiences within the DoD, the VA and civilian communities on integrating substance abuse and behavioral health care.

SUMMARY:
In 2015, the secretary of the Army directed a comprehensive review of the Army's approach to substance abuse treatment. Ultimately, he directed that substance abuse treatment be shifted from the Army's Installation Management Command to Army Medicine. That shift began October 2016. In 2012, The Institute of Medicine issued a report on their comprehensive review of DoD substance abuse. The report recommended a number of potential areas of improvement for DOD substance abuse care. This workshop will review the data on DoD substance abuse considered by the Institute of Medicine and other published DoD substance abuse data. It will highlight the approach that Army Medicine and Army Behavioral Health (BH) has taken to transitioning and integrating several hundred substance abuse personnel into the Army BH service line, particularly the embedded BH clinics, to provide high-quality substance use disorder care to soldiers. The workshop format will generate dialogue from participants at various Army installations, Veteran Affairs clinics and community substance abuse programs to discuss potential best practices for integrating substance use and mental health care.

Best Practices Behind Bars: Severe Mental Illness, Gender Dysphoria, Collaborative Care, and Corrections
Chairs: Vasilis K. Pozios, M.D., Lee H. Rome, M.D., Hanna Y. Saad, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn about the unique challenges psychiatrists face in treating incarcerated persons with severe mental illnesses; 2) Appreciate the differences in implementing a collaborative care model in a correctional setting versus the community; and 3) Understand the policies guiding the treatment of gender dysphoria in prison.

SUMMARY:
Despite efforts to divert people with mental illnesses from the criminal justice system, the largest U.S. mental health facilities remain jails and prisons. According to the Department of Justice, over one million prisoners have a mental health problem, with about half having a severe mental illness (SMI). Despite a high prevalence of SMI and limited resources, correctional psychiatrists are bringing best practices behind bars and elevating care to community standards. From gender dysphoria to integrated care, correctional psychiatrists are at the forefront of developing programs, shaping policies and advocating for a vulnerable population. Vasilis K. Pozios, M.D., Lee H. Rome, M.D., and Hanna Y. Saad, M.D., will discuss their efforts to implement a collaborative care model in the Michigan Department of Corrections—the first such program of its kind—as well as navigate care for those with gender dysphoria and tailor programming for the SMI prisoners in administrative segregation.

Break on Through to the Other Side: With Telepsychiatry and Intellectual/Developmental Disability Psychiatry
Chairs: Nita Vasudev Bhatt, M.D., M.P.H., Julie P. Gentile, M.D.
Presenters: Randon Welton, M.D., Allison E. Cowan, M.D.

EDUCATIONAL OBJECTIVE:
1) Design an effective, multifaceted division of intellectual and developmental disability (ID/DD); 2) Develop systems to provide comprehensive mental health care to ID/DD populations; 3) Create engaging, interactive learning experiences in ID/DD for residents; and 4) Sustain a focus on ID/DD populations through the development of financial support and community advocacy.

SUMMARY:
Hear from some of the prime architects and clinicians of a thriving intellectual and developmental disability (ID/DD) division that is committed to fostering innovation and using technology to provide cutting-edge services to patients with ID/DD in underserved areas. Ohio's Telepsychiatry Project began in 2012 to provide

specialized services to individuals with co-occurring mental illness and intellectual disability with the most complex needs living in outlying areas that lack the infrastructure and resources to offer the highest quality care. Currently, over 800 patients with IDD from 58 counties receive mental health treatment through this statewide grant-funded project. The project fosters innovation and the use of HIPAA-protected software for the provision of the highest quality mental health care to individuals in the state with the most complex needs. The profound impact of this program led the psychiatry residency to create a specialized ID/DD track for its residents. The division's operations, funding structure, resident training curriculum, and specialty residency track will all be discussed. Here's a preview of the outcomes: For individuals engaged in the program, emergency room visits decreased 96% and hospitalizations decreased 86%. More than 90 individuals were discharged from state-operated institutions, and none were readmitted for long-term stay, saving the state $80,000/person/year. Travel costs were reduced up to 68% by not having to travel distances for specialty psychiatric care. Individuals with ID experience mental illness at rates higher than that of the general population. There is a lack of physicians with training in ID psychiatry, especially in underserved communities. This statewide grant-funded program prioritizes patients discharged from state psychiatric hospitals, developmental centers and those with multiple emergency department visits/hospitalizations due to behavior issues, mental illness and complex medical needs. The lack of appropriate care severely impacts the quality of life for patients with ID in rural areas while also inflating the cost of care due to increased staffing needs, unnecessary hospitalizations, forced institutionalization, and expenses to transport the person out of the local area for treatment. To complement the clinical projects, the residency training program has just introduced an intellectual disability specialty educational track offered during years R2 through R4. The panel will take us through the logistics of developing and funding the program, initial challenges on the road to implementation, available resources, clinical services, and training components. An interactive format and group discussion will help determine if intellectual disability psychiatry training and utilization of telepsychiatry could be effective educational and clinical tools for the provision of quality mental health care for patients with ID and the training of psychiatry residents.

Clinical Diagnosis and Management of Mild TBI: A Neurology Perspective
Chairs: Josepha A. Cheong, M.D., David FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify and understand the diagnostic criteria for mild traumatic brain injury (MTBI); 2) Understand multiple areas of impairment/symptoms brought about by MTBI; 3) Identify pharmacological interventions for treating MTBI; and 4) identify nonpharmacological interventions for treating MTBI.

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 or civilian settings. The strengths and weaknesses of the current classification system of traumatic brain injury (TBI) are reviewed with examples. A proportion of those experiencing brief loss of consciousness or alteration of consciousness (or mild TBI [MTBI]) 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 MTBI is also presented to provide better insight as to mechanisms of damage. Current therapeutic approaches, both pharmacological and nonpharmacological, are discussed. Clinical cases will be presented to engage the audience in discussion and to illustrate various points in the workshop.

Clinical Documentation With a Jury in Mind
Chair: Kristen M. Lambert, J.D., M.S.W.

EDUCATIONAL OBJECTIVE:
1) Discuss common types of claims against psychiatrists and how documentation can make or break a defense; 2) Understand common legal pitfalls in clinical documentation and how it could impact whether a patient files a lawsuit following an

adverse outcome; 3) Recognize sound documentation principles; and 4) Minimize risk by adopting best practices to avoid professional liability claims.

SUMMARY:
Malpractice suits often involve incomplete, absent or problematic documentation. This workshop will explore common types of claims against psychiatrists and how documentation can impact the defense of a case. The workshop will discuss case scenarios, types of documentation-including written and electronic-why documentation is important, and what may/may not need to be documented in the context of psychiatric treatment. This program will discuss strategies to minimize risks. This interactive session will include documentation case examples and identify areas for improvement. The attendees will be provided with the case examples and asked to spend time on mock documentation. In addition, the attendees will be provided with a difficult patient situation in which they are faced with the prospect of needing to terminate care. They will be asked to provide examples of what is important to include in a draft termination letter to the patient and will analyze and discuss. Finally, attendees will be provided with a case example of a patient who is suicidal, and they will be asked to identify important documentation principles in a suicide risk assessment.

Community Resilience and Terrorism Risk in Post-9/11 United States: What Should Psychiatrists Know and How Can They Help?
Chairs: Aliya Saeed, M.D., Ansar Haroun, M.D.
Presenters: Nzinga Harrison, M.D., Deborah T. Rana, M.D.

EDUCATIONAL OBJECTIVE:
1) Demonstrate a basic understanding of the distribution of terrorism on American soil; 2) Understand the concept of resilience, as well as the value of a resilient community in post-9/11 United States; 3) List examples of maladaptive community responses to the threat of terrorism; 4) Identify ways in which psychiatrists can help reduce the threat of violent extremism; and 5) Understand a proposed framework for psychiatric evaluation of “suspected terrorists”.

SUMMARY:
The issue of violent extremism, also known as terrorism, has become the dominant issue of our time. Especially after 9/11, and more recent after attacks in Europe, communities are on edge. However, the public perception of this issue is often shaped by an inaccurate assessment of the threat based on emotions and not necessarily actual data. While the actual number of American deaths due to acts of ideologically driven violence remain miniscule compared to more common causes like non-ideologically driven gun violence, the psychological impact of such an act on the community at large is significant. Compared to the general population, there is also a higher rate of mental illness as well as other mental health issues among individuals who have been arrested for terrorism-related charges in the United States. Since 9/11, the United States government has engaged at many levels to counter the threat of violent extremism through a variety of steps (and missteps). In 2011, the White House issued the Strategic Implementation Plan (SIP) for Empowering Local Partners to Prevent Violent Extremism in the United States as a framework for "whole-government" actions to empower communities and promote resilience. Resilience is an individual as well as systems attribute. Resilience can be defined as the capacity of a community to maintain its core purpose and integrity in the face of dramatically changed circumstances. Resilient communities are critical in the effort to counter violent extremism. The recent spate of ISIS-directed terror attacks in Europe were conducted by members of marginalized communities, highlighting the importance of resilient healthy communities as protective against recruitment. If the communities respond to such acts by drastically altering their course or by abandoning their core values, they demonstrate poor resilience. Racism, Islamophobia and xenophobia are some of the maladaptive community responses that can exacerbate the threat of terrorism. Traditionally, mental health providers have had robust roles in informing policy, identifying factors that place individuals at risk and helping modify them, besides supporting communities who have been affected by targeted violence like school shootings. During the workshop, the audience will be actively engaged to help create a framework for how

psychiatrist can best fulfill these traditional roles in the area of violent extremism.

Confidentiality: What Every Resident Needs to Know

Chair: Tobias Wasser, M.D.
Presenters: Katherine Michaelsen, M.D., Reena Kapoor, M.D.

EDUCATIONAL OBJECTIVE:

1) Demonstrate an understanding of the concepts of confidentiality, privilege and privacy; 2) Identify common exceptions to confidentiality under state and federal law; 3) Identify appropriate steps to take when receiving a subpoena; and 4) Apply understanding of these concepts to clinical encounters with patients.

SUMMARY:

The basic principle underlying confidentiality in health care settings is relatively straightforward: patients' health information should remain private. However, respecting confidentiality between psychiatrists and patients can be complicated in practice, and difficult clinical situations often arise. Breaches of confidentiality can be grounds for legal action against psychiatrists, highlighting the importance of understanding the requirements and limits of confidentiality. In this workshop, we begin with a review of several principles critical to understanding the nuances of confidentiality. Topics reviewed will include the difference between various legal terms (e.g., privilege vs. privacy vs. confidentiality), common exceptions to confidentiality under federal and state law (e.g., mandatory reporting duties), and the extent and limits of The Health Insurance Portability and Accountability Act (HIPAA). Next, participants will engage in role play exercises. They will break into small groups and consider challenging clinical case vignettes based on real-life historical legal cases. Each group will be asked to take on the role of the psychiatrist in the case and choose a course of action in response to the vignette. The small groups will then reconvene into a larger group to discuss how they responded to the cases and the rationale underlying their approach. Finally, we will review the details of the actual historical cases and the legal precedents they set. While this workshop is particularly designed with trainees and students in mind, it will also provide an excellent refresher of the topic for more senior psychiatrists.

Creating Your Voice: A Guide to Publishing in *Psychiatric Services*

Chairs: Lisa B. Dixon, M.D., M.P.H., Roberto Lewis-Fernandez, M.D., Regina Bussing, M.D.
Presenters: Gregory Simon, Sheryl Kataoka, Marcia Valenstein

EDUCATIONAL OBJECTIVE:

1) Understand the different types of *Psychiatric Services* submissions and their requirements; 2) Match different types of article ideas to the appropriate submission category; and 3) Have greater knowledge and skills in creating publishable articles.

SUMMARY:

Writing for professional journals and other outlets can increase your professional impact and reputation. Clinicians who adopt a scholarly and empirical approach and who are astute observers can publish successfully. Research articles have one set of fairly standard requirements. However, many journals, including *Psychiatric Services*, publish papers with different demands and review criteria. For example, *Psychiatric Services* also publishes columns in a wide variety of areas, from financing and policy issues to integrated care to research and services partnerships. Frontline reports showcase innovative new programs. Understanding the criteria and how to adapt and present your ideas within different formats will increase your success in publishing. In this workshop, the editor and members of the *Psychiatric Services* editorial board will present the parameters for the different types of articles published in *Psychiatric Services*. Regular articles and brief reports present the results of original research. In general, regular articles should not exceed 3,000 words, excluding abstract, references, and tables and figures. Brief reports should be a maximum 1,800 words (excluding abstract, references and table), plus no more than 15 references and one table or figure. If you do not conduct research, other types of submissions may be appropriate. Provocative commentaries of 750 words maximum are invited for “Taking Issue.”

Authors may also submit commentaries of 1,200 to 1,600 words and no more than 15 references for the "Open Forum" section. *Psychiatric Services* columns should not exceed 2,500 total words, including text, no more than 15 references, and an abstract of no more than 100 words. The workshop will review several examples of the evolution and review process of different article types. The workshop will then allow small group discussion of participants' publication ideas. The workshop will teach attendees how to determine what is the best fit for their publication idea and what steps are needed to publish successfully. Workshop attendees will have the opportunity to meet members of the *Psychiatric Services* editorial board.

Critical Issues in the Treatment of Suicidal Physicians: Lifesaving Tips for the Practicing Clinician

Chairs: Michael F. Myers, M.D., Glen O. Gabbard, M.D.

EDUCATIONAL OBJECTIVE:

1) Review essential goals in the evaluation of suicidal physicians; 2) Identify helpful strategies in the initial and ongoing treatment of suicidal physicians; and 3) Interact with each other and acquire professional confidence when treating psychiatrically ill medical colleagues.

SUMMARY:

It has long been known that treating symptomatic physicians is a complicated business; far too often, ailing doctors do not get the same standard of care that lay patients receive. When the physician is suicidal, the consequences can be dire. This workshop is an amalgam of the combined perspectives and experiences of two senior psychiatrists who have been treating physicians throughout their decades-long careers. Over 20 minutes, Dr. Myers will discuss the following issues in assessment: 1) always apply the time-honored biopsychosocial perspective when evaluating physician-patients; 2) respect the pernicious effects of stigma and how much terror and shame drive inauthentic appraisals of physicians' personal narratives; 3) interview significant others, especially family loved ones, for essential collaborative information and (in some cases) ongoing monitoring between appointments; 4) carefully assess alcohol use and other forms of substance abuse, especially self-prescribing; 5) plan treatment using both a suicide risk assessment and suicide risk formulation; 6) when using a split treatment model of care, always be in active regular communication with the therapist. Over 20 minutes, Dr. Gabbard will discuss the following principles of good care: 1) be wary of making exceptions or treating the physician differently than how you treat other patients; 2) do not readily accept denial of suicidality in the context of depression or narcissistic injury; 3) address concerns about the impact of treatment on licensure; 4) treat sleep problems aggressively; 5) establish a strong therapeutic alliance that emphasizes the real relationship more than transference; 6) differentiate between the fantasy and the act of suicide; 7) discuss the limits of treatment; 8) investigate precipitating events; 9) explore fantasies of the interpersonal impact of suicide; 10) establish level of suicide at baseline and monitor changes; 11) use consultation to help with countertransference blind spots. Attendees are encouraged to bring questions and disguised case examples from their practices for the 50-minute discussion period.

Developing the Psychiatric Workforce of the Future: A Psychiatric Fellowship Program for Psychiatric Nurse Practitioners and Physician Assistants

Chair: Rodney Villanueva, M.D.
Presenters: Kathleen Peniston, N.P., Ryan Livingston, M.D., Charlotte Gregory, P.A., Lauren Swett, N.P., Anna McKoy, P.A.

EDUCATIONAL OBJECTIVE:

1) Understand the need for and role of psychiatric nurse practitioners and physician assistants in psychiatric clinical settings; 2) Recognize the importance of postgraduate psychiatric training for nurse practitioners and physician assistants; 3) Describe the development and structure of a psychiatric fellowship program for psychiatric nurse practitioners and physician assistants; 4) Identify modalities to evaluate the fellowship program and recognize its strengths and weaknesses; and 5) Identify ways to educate psychiatrists on providing clinical training for nurse practitioners and physician assistants who are already in clinical settings.

SUMMARY:
The shortage of mental health professionals is severely affecting access to mental health care in large segments of the U.S. population. According to the 2013 Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues by the Substance Abuse and Mental Health Services Administration, 77% of U.S. counties have a significant shortage of mental health workers, and 96% of counties had undermet needs for mental health prescribers. As a result of this situation, psychiatric practices have utilized psychiatric nurse practitioners (PNPs) and physician assistants (PAs) in order to meet the needs of patients. Carolinas Healthcare System (CHS) in Charlotte, North Carolina, makes extensive use of nurse practitioners and physician assistants in all medical specialties. In 2014, CHS established its first psychiatric fellowship training program for PNPs and PAs. The fellowship is a year-long postgraduate program that provides both a comprehensive educational opportunity as well as an enriched clinical experience. During clinical rotations, the fellows function as licensed and credentialed providers under the mentorship of faculty psychiatrists. Our workshop will educate participants about the development and structure of the CHS PNP/PA psychiatric fellowship. We will provide an overview of our current curriculum, clinical rotations, and unique opportunities provided to PNPs and PAs in the Fellowship program. We will discuss the challenges of curriculum development, faculty recruitment and fellow recruitment. The workshop will discuss the impact of the fellowship on the CHS Behavioral Health Department. The workshop will also include an opportunity for participants to ask about the experience of the fellowship from the three graduates of our first class, as well as discuss ways that psychiatrists can facilitate the training of PNPs and PAs in their own practices, even without a formal fellowship program.

Education as Integration: Teaching Psychiatric Topics to Nonpsychiatric Colleagues
Chairs: Abhisek C. Khandai, M.D., M.S., Adrienne D. Taylor, M.D.
Presenters: Diana M. Robinson, M.D., Mira Zein, Cristina Montalvo, M.D., Sanjeev Sockalingam, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe how specialty-specific learning needs can contribute to delivering effective integrated care; 2) Contrast specialty-specific learning styles and opportunities for improving psychoeducation; and 3) Use a learning style-informed framework to develop and deliver mental health education interventions for consulting specialties in integrated care settings.

SUMMARY:
Increased training in integrated care, and the skills required therein, is becoming an essential element of general psychiatry residency and addresses several competencies of the new ACGME milestones, including systems-based practices. Core competencies of integrated care include effective communication with nonpsychiatrist colleagues, as well as educating colleagues on psychiatric topics. However, successful integration of care is often complicated by communication barriers between psychiatry and other specialties. Moreover, psychoeducation of nonpsychiatrist colleagues is dependent on differences in perceived needs (what colleagues think they need to know) as well as how they learn new information. This workshop focuses on how our colleagues in five specialties-internal medicine, emergency medicine, surgery, OB/GYN, and neurology-identify gaps in psychiatric care and knowledge, while taking into account their preferred learning styles and modalities to optimize the impact of targeted educational interventions. First, in a "Family Feud" format, workshop participants will examine perceived educational needs of our nonpsychiatrist colleagues, which will then be compared to self-reported specialty needs from original data to determine areas of discrepancy and opportunity. Then, after a brief literature review of preferred learning styles and modalities of these five specialties, volunteers will role play classic interactions between psychiatry and consulting specialties. Finally, participants will be randomized into five groups representing these specialties and collaboratively develop targeted educational interventions integrating both the perceived psychoeducational needs of the specialty, as well as its preferred learning style and teaching modalities.

Fuzzies, Spots and Birds: The Psychosocial and Psychodynamic Implications of Promotions, Ranks

and Positions Within the U.S. Military
Chairs: Judy Kovell, M.D., Millard Brown, M.D.
Presenters: Argelio Lopez-Roca, Rachel Sullivan, M.D.

EDUCATIONAL OBJECTIVE:
1) Gain an understanding of the expectations and responsibilities associated with various military ranks; 2) Understand the psychosocial dynamic implications behind military promotions, ranks and positions; 3) Practice identifying such issues in simulated vignettes and practice offering practical suggestions; and 4) Learn about available resources for servicemembers and clinicians that can be of help through such transitions.

SUMMARY:
What does it mean when a soldier presents without a rank on their uniform? Why is a newly minted warrant officer or chief petty officer asking for a stimulant medication? What is leading the 25-year-old newly promoted E7 or the 28-year-old E4 to your office? What are the hidden stressors of promotion to colonel or captain? Of being a squad leader, lead petty officer or commander? Promotions are a time of celebration! More money, more prestige, more respect. And since continued military service is contingent upon an "up in rank or out of the service" model, making rank should relieve stress. Then why do servicemembers frequently present to behavioral health after they change rank, position or assignment to a new job? The easy answer is that with more rank comes more stress. While true, this generally is not the whole story. The newly promoted sergeant, chief petty officer or major is often not fully aware the role his or her new rank or position is playing in their struggles. The servicemember may present with worsening mood, irritability, anxiety, and insomnia. They may blame undiagnosed ADHD, a prior combat trauma or their boss for the distress. Not looking beyond the presenting symptoms can lead to misdiagnosis and unneeded psychopharmacological interventions. However, clinicians who understand the unique military- and service-specific implications of ranks and positions will feel empowered to identify the core issue, will diagnose appropriately, can rally resources, and will be more effective in finding practical solutions to the presenting problem. Our workshop will introduce participants to the expectations and responsibilities of enlisted and officer ranks, the subtle yet common psychosocial and psychodynamic issues surrounding ranks and promotions and practical ideas on how to move servicemembers toward solutions, strength and health. We will use case vignettes to introduce participants to the more common dynamic issues associated with taking on a new rank, position or job within the military services. During our workshop, we will use small-group discussions to practice identifying and addressing above-mentioned themes. We will provide participants with reference handouts to facilitate clinical practice.

Global Mental Health and Substance Use Disorders: Relevant Today, Tomorrow and Always
Chairs: Evaristo O. Akerele, M.D., M.P.H., Magalie Hurez, M.D., M.P.H., Craig Katz, M.D.
Discussant: Dolores Malaspina, M.D., M.P.H., M.S.

EDUCATIONAL OBJECTIVE:
1) Understand global prevalence of substance use disorders and mental health; 2) Identify and manage mental health globally; 3) Manage mental health in humanitarian situations; 4) Develop a global mental health strategy; and 5) Manage mental health in disasters.

SUMMARY:
Global mental health is a significant public health issue. It is estimated that 120 million people globally suffer from depression and 24 million from schizophrenia. About one million people worldwide commit suicide every year, and approximately 20 million unsuccessfully attempt suicide. Psychoactive substance use poses a significant threat to the health, social and economic fabric of families, communities and nations. Global psychoactive substance use is estimated at two billion alcohol users, 1.3 billion smokers and 185 million drug users. Global mental health is increasingly relevant to treatment of the diverse population in the United States. A thorough understanding of the mental health issues, perspectives, stigma, identification, and treatment across the globe is essential for optimal identification, diagnosis and treatment of our patients. In this workshop, the presenters will discuss global issues in mental health and substance use disorders in a variety of situations. All presenters

have significant global mental health experience. Improved knowledge about mental health challenges and substance use disorders in countries will enhance to the quality of care provided to patients here in the United States. It is noteworthy that a significant percentage of our patients are significantly influenced by mental health perceptions and challenges that originate in other countries.

Improving Treatment Outcomes of Physicians With Mental Illness and/or Addiction: When a Physician Becomes the Patient

Chairs: Matthew Goldenberg, M.D., M.Sc., Karen Miotto, M.D., Gregory E. Skipper, M.D.
Presenter: Itai Danovitch, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:

1) Further their understanding of the critical components and considerations regarding treating a physician with a substance use disorder or mental illness; 2) Understand risk factors for and tools and preventive measures to decrease physician behavioral issues, suicide and burnout; and 3) Provide a better understanding of how physician health programs and monitoring improve remission rates and outcomes for physicians.

SUMMARY:

Physician burnout and suicide rates are at their highest levels and steadily climbing. Workload, electronic medical records, decreased time with patients, and poor work-life balance have all be proposed as possible contributors to the epidemic of physician burnout. In contrast, physicians have the same rates of mental illness (such as depression and anxiety) and substance abuse as the general population. However, the substances physicians tend to abuse are alcohol and prescription medications (versus illicit substances for the general population). With all of these factors colliding into "physician health," it is no surprise that physician well-being committees are commonly tasked with assessing a “troubled physician.” Burnout and suicide are not limited to seasoned members of the field of medicine. Medical students and residents have burnout levels as high as 50%. We are just now starting to uncover the epidemic of medical student and resident suicide rates. Physicians often rely on self-treatment to manage their medical and mental illnesses. However, there is a better way. Residential, intensive outpatient (IOP) and outpatient programs can be specially tailored to the needs of physicians and other professionals. They must often confront issues not encountered by the general public, including licensing issues, return to work issues, and requirements of medical and hospital boards. Therefore, the delivery and quality of treatment for physicians with mental illness and/or addiction is critical. Our workshop will cover the current health care environment and the epidemiological and other risk factors that physicians face. In great detail, we will cover the process of treating a physician from a multidisciplinary approach, treating the patient from all sides, including addiction medicine, addiction psychiatry, forensic/addiction psychology, nutrition, alternative treatment options like NAAM yoga, and beyond. We will discuss the various levels of care from residential/inpatient to IOP to outpatient and the considerations that go into choosing the right level of care. We will also discuss the role of state physician health programs and monitoring for physicians. We will provide an interactive experience for the audience to help them incorporate a better understanding of both physician health and a thorough diagnostic evaluation into their practice or into the medical institution. Finally, we will discuss outcomes and remission rates for physicians and rates of physicians successfully returning to the workplace.

Income Disparities by Race and Sex in Medicine: A Closer Look at the Divide Among Marginalized Populations

Chairs: Napoleon B. Higgins Jr., M.D., Ericka Goodwin, M.D.
Presenters: Maureen Sayres Van Niel, M.D., Gail Erlick Robinson, M.D., Annelle Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Identify the income disparities between male and female physicians; 2) Understand the unique issues affecting female physicians and ultra-professionals in the workplace; 3) Discuss the impact of how mentors can improve job satisfaction among female physicians; and 4) Recognize the role of how gender and race impact hiring opportunities and career development in medicine.

SUMMARY:
There are significant differences in the annual incomes of medical physicians in the United States when it comes to gender and race. Males make more than females, and white males have the highest salaries of all, even after controlling for time, payer mix and practice environment. Differences in the workplace often cause many doctors to be in jobs that they do not feel are personally satisfying and in which they are not reaching their career goals. We will discuss how marginalized physicians often lack support or information to effectively negotiate pay and other parts of the contract for their maximum benefit. So often, marginalized physicians do not know of optimum opportunities for employment and do not have access to positions due to a lack of mentors and coaches. We will discuss career levels and how current personal and financial demands direct the type of jobs that physicians take. These demands and a lack of knowing exactly what you are looking for in a job often lead to poor job satisfaction and burnout. The lack of career direction often leaves women physicians underpaid and overworked. The stresses of maintaining a home and being a caregiver to children and aging parents can make it very difficult for a professional woman, causing her to feel as if she is being pulled between being a professional and being a "mothering caretaker," while at the same time feeling as if neither role is being done well. Other stressors for African-American women physicians, such as having the lowest pay in regards to sex and gender, in turn may cause additional issues that can weigh heavily on work-life balance and personal life satisfaction. After this workshop, participants should be better informed and empowered to negotiate medical salary contracts to improve pay, job satisfaction and the achievement of career goals.

Innovation and Progress in Public Sector Psychiatry
Chair: Jeanne Steiner, D.O.
Presenters: Aniyizhai Annamalai, M.D., Tobias Wasser, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify key elements of a progressive, recovery-oriented system of care; 2) Compare new models for the integration of services, including primary and behavioral health care, the criminal justice system, and community support and inclusion; and 3) Adopt strategies to enhance education and workforce development for the public sector.

SUMMARY:
This workshop is designed for mental health practitioners, educators and administrators who are interested in the design and implementation of model programs to serve individuals with serious mental illness and substance use disorders within the public sector. The faculty will highlight key elements of progressive, recovery-oriented systems of care, including new models of community support and inclusion, and innovative initiatives to address social determinants of health, such as food insecurity and nutrition. The second area of focus will be on models of integrated services across traditional boundaries, including primary health and behavioral health care, and innovative programs for individuals involved in the mental health and criminal justice systems. The third area of focus will include initiatives to enhance training and workforce development associated with the public sector. Examples include fellowships in public psychiatry and a Connecticut-based Latino behavioral health initiative. The presenters are faculty members of the Yale Department of Psychiatry, and the workshop is sponsored by the department's Division of Public Psychiatry. The workshop will be semi-structured, with a balance of content to be presented by the faculty along with an interactive and open exchange of ideas with the participants.

Interactive Training and Dissemination of Tobacco Cessation in Psychiatry: An Rx for Change
Chair: Smita Das, M.D., Ph.D., M.P.H.
Presenters: Andrew J. Saxon, M.D., Douglas Ziedonis, Timothy Fong, M.D.

EDUCATIONAL OBJECTIVE:
1) Explain the relevance and importance of tobacco cessation treatment in psychiatric settings; 2) Review smoking and 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 pharmacological cessation aids and their use in psychiatric settings; 4) Access "Rx for Change," a FREE web based curriculum to disseminate tobacco treatment training for health care professionals, including specific training for psychiatric settings; and 5) Offer expert consultation with panel members who are on the APA Council on Addictions Tobacco Workgroup.

SUMMARY:
Smoking and smoking-related mortality/morbidity continue to disproportionately affect those with mental illness. Among individuals with mental illness, smoking prevalence is two to four 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; examples are use/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, cost, and efficacy. 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. This workshop is well received by psychiatrists at the APA and AAAP and is consistently well rated, especially for increasing skills. The APA recommends that psychiatrists assess the smoking status of all patients, including readiness to quit, level of nicotine dependence and 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, most likely to feel that there were greater priorities in care and that smoking cessation would worsen other symptoms. Only half of U.S. psychiatry residency programs provide training for treating tobacco, while 89% of program directors have interest in a model tobacco treatment training curriculum. The APA values tobacco treatment and has a tobacco workgroup in the Council on Addictions. "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 nicotine replacement, bupropion, varenicline, 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 four-hour training, when included in curricula for psychiatry residents, is associated with improvements in knowledge, attitudes, confidence, and counseling behaviors.

Medications for the Treatment of Alcohol Use Disorder in Patients With Co-Occurring Psychiatric Disorders
Chair: Steven L. Batki, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the efficacy and safety of the FDA-approved medications for the treatment of alcohol use disorders; 2) Demonstrate knowledge of the steps involved in screening for alcohol use disorders and developing a medication-assisted treatment plan; and 3) Identify the special considerations in treating alcohol use disorder patients with psychiatric comorbidities.

SUMMARY:
This workshop will cover the use of FDA-approved and other medications for patients with alcohol use disorder and co-occurring psychiatric disorders. The workshop will review the currently available medications for the treatment of alcohol use disorder, their mechanisms of action, adverse effect profiles, and guidance regarding their safe use. A review will be presented of the current evidence for the effectiveness of these medications for the treatment of alcohol use disorder in patients with each of these important categories of psychiatric disorders: major depressive disorder, schizophrenia, bipolar disorder, PTSD and other anxiety disorders, and insomnia disorders. Emphasis will be placed on the rationale for selecting a first-line medication for alcohol use disorder in each of these co-occurring psychiatric disorders, based on the evidence of their effectiveness in patients with the specific co-occurring psychiatric disorders, their adverse effect profiles, potential for interaction with other

psychiatric medications, and adherence issues. In addition to factors specific to each medication, patient-related variables such as goals regarding alcohol use (for example abstinence or use reduction) will also be discussed.

Mental Health and Public Health Approaches in Community-Level Strategies to Countering Violent Extremism

Chair: Stevan M. Weine, M.D.
Presenters: Jalon Arthur, Stevan M. Weine, M.D., Miriam Brown, David Eisenman

EDUCATIONAL OBJECTIVE:

1) Understand current approaches to addressing violent extremism and their dependence on law enforcement; 2) Demonstrate what is presently known about the contribution that mental health and psychosocial problems make to the risk for violent extremism; 3) Be familiar with relevant conceptual models in health (e.g., public health, health care, mental/behavioral health) and discuss their applicability to countering ideologically motivated violence and radicalization; and 4) Understand cross-sector and interdisciplinary emerging and novel policy and practice frameworks and issues in countering ideologically motivated violence.

SUMMARY:

How to best address violent extremism in the United States of America is a top national security concern. Violent extremism refers to "advocating, engaging in, preparing, or otherwise supporting ideologically motivated or justified violence to further social, economic or political objectives." In the U.S., violent extremist attacks have come from the far right as well as from Islamic extremists and the far left. The rise and expanding reach of ISIS, punctuated by recent attacks in Orlando, FL; San Bernardino, CA; Paris; and Brussels, have caused concerns about violent extremism to arise in many U.S. communities. Countering violent extremism (CVE) has emerged as a key supplement to law enforcement-driven approaches to violent extremism, which investigate, arrest and prosecute. CVE refers to the "use of non-coercive means to dissuade individuals or groups from mobilizing toward violence and to mitigate recruitment, support, facilitation, or engagement in ideologically motivated terrorism by non-state actors in furtherance of political objectives." In the U.S. and other countries, there is a recent call for second-wave CVE-focused activities to be more targeted in the areas of prevention and intervention. Primary prevention activities are directed at a community-level so as to diminish exposure to risk factors and increase protective factors with respect to violent extremism. Intervention activities are directed at individuals who have already adopted extremist ideologies that condone violence or are in contact with violent extremists but who are not engaged in planning or carrying out acts of violence. These intervention activities correspond with secondary and tertiary prevention. Nowadays, new community initiatives being developed to address violent extremism are calling for including mental health services and leadership. The purpose of this workshop is to help mental health professionals understand and be equipped to consider participating in these emerging community-based violence reduction programs as practitioners, program leaders or evaluators. This workshop addresses 1) the contribution that mental health and psychosocial problems make to the risk for some persons becoming involved in violent extremism; 2) the rationale for integrating mental health strategies in dealing with the issue of violent extremism at a community level; 3) a services model for community-based violence reduction programs; and 4) ethical considerations. This presentation describes in detail our experiences building programs in several localities. We will share what we are learning about how mental health can become part of addressing targeted violence, including violent extremism. We will invite audience members to share their experiences and perspectives regarding the potential roles of mental health professionals in community-based programs.

Mental Health Impact on Immigrants and Refugees

Chair: Mackenzie Varkula, D.O.
Presenters: Carlos E. Molina, M.D., Ambreen K. Ghori, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize the need for psychiatric care in the immigrant and refugee population; 2) Critique

current policies and available resources for immigrants and refugees; 3) Discuss the need for policies and guidance for physicians to better address refugees' physical and mental needs after resettlement; and 4) Evaluate how geographic and cultural relocation impacts mental health.

SUMMARY:
Immigration has been described to be a risk factor for the development of mental health issues. These include depression, anxiety, posttraumatic stress disorder, and substance use disorder. Studies have shown that immigrants with depression are more reluctant to seek medical care. The U.S. has always welcomed immigrants, and more recently, with the apogee of the refugee crisis, knowledge is needed to facilitate consistent and evidence-based care for immigrants and refugees. There is a need to highlight the screening and treatment of the manifestations of mental health issues, to determine the challenges that families face when they migrate to the U.S., and to develop specific tools to care for them. We have completed a systematic review relating to individuals who immigrated to the U.S. In the first part of this workshop, we educate the participants on the findings of our review, allowing all present to understand how the process of immigration and acculturation might affect one's mental health. In the second part, we plan to breakout into three groups, each led by one of the workshop leaders. We plan to divide based on interest in immigrants from each of the following general areas: Europe/Middle East, Asia and Latin/South America. This small group time will be dedicated to discussing individual cases brought by participants. We plan to encourage discussion on successes/failures in treatment, as well as how available resources were identified and used. During the third part, we will regroup and compare/contrast similarities among the group discussions. We will provide and review available assessment tools pertinent to our population of interest. We will also organize recommendations for formulation of guidelines and parameters to share professionally and with advocacy groups. Risk factors for development of mental illness significant to immigrants and refugees are often related to cultural and language-related discrimination. Discrimination, then, is associated with not only depression, but also alcohol and drug abuse. Resilience is often found with strong family ties—common in immigrant families. Connecting immigrants to those with similar cultural background facilitates further integration in a community and bodes well for adjustment. Participants will complete the workshop with an overall understanding and specific tools with which they are better prepared to care for their patients who have immigrated. It is important to determine the challenges that individuals face when they immigrate to the U.S. Trauma that a refugee might experience throughout the process of immigration and resettlement can leave them with impairments that may be complex. Astute professionals, therefore, must use adequate tools to screen for mental health problems in this group. We will educate workshop participants such that they feel confident treating those who are particularly vulnerable to the negative aspects of immigration.

Mobile Mental Health Meets Clinical Psychiatry: New Tools for New Models of Care
Chair: John Torous, M.D.
Presenters: Colin Depp, Steven Chan, M.D., M.B.A., John Luo, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify at least three areas where smartphone applications and wearable sensors can support the delivery of mental health care and psychiatric services; 2) Understand patient sentiment and interest in using smartphone applications and wearable sensors to monitor their own mental health; 3) Understand the difference between passive and active data and identify how smartphones and sensors can collect data on self-reported symptoms, behaviors and physiological measurements; 4) Recognize the potential of new research models using smartphones and wearable sensors and how such can inform clinical practice and patient care today; and 5) Understand how to evaluate the role of mobile mental health technology in community clinical practice through accurately identifying the barriers, risks and benefits to patients.

SUMMARY:
As interest in digital technologies like smartphones

and sensors for psychiatric care continues to expand, it is important that psychiatrists remain educated and informed about the potential and pitfalls of these new technologies. In this workshop, we will cover four core areas of direct interest to those providing psychiatric services: patient engagement/adherence, new clinical data streams, clinical experience using smartphones, and picking the right smartphone apps. Of note, each talk will include a hands-on tech demo that can be run from the audience's own smartphone and accessed with the Internet. The audience will thus be able to interact with each presentation.

Neuromodulation Primer for Residents: An Introduction to ECT, DBS, TMS, tDCS, and MST
Chairs: Richard Holbert, M.D., Khurshid Khurshid, M.D.
Presenters: Robert Averbuch, Kathleen Burns, M.D., Sheldon Brown, M.D.

EDUCATIONAL OBJECTIVE:
1) Self-evaluate individual progress on ACGME milestones relevant to neuromodulation therapies; 2) Discuss the different types of electroconvulsive therapy (ECT) as well as the risks, benefits and dose parameters; 3) Identify indications for deep brain stimulation (DBS) in mental illness and the role of the psychiatrist; and 4) Review the literature on transcranial magnetic stimulation (TMS), transcranial direct current stimulation (tDCS) and magnetic seizure therapy (MST).

SUMMARY:
As more research becomes available, nonpharmacological, device-mediated interventions for treatment-resistant psychiatric illnesses are becoming increasingly common. Residents need to have an understanding of brain stimulation treatment alternatives, as they will likely have patients who would benefit from these treatments or may be the ones conducting them. In addition, residents must demonstrate ACGME milestones related to electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS) and other emerging neuromodulation therapies prior to graduation. ECT has been available in the U.S. since the 1940s and is the gold standard for treatment-resistant depression. We will review the media examples of ECT, as these, unfortunately, guide patients' decision making, including more recent positive examples (*Homeland*). We will review subtypes of ECT, indications, risks, dose parameters and efficacy for each. Deep brain stimulation (DBS) has been used in movement disorders, in particular Parkinson's disease, for many years, but has only recently made its way into psychiatric disorders. It has received the most attention in depression and OCD. We will cover how an OCD patient is chosen for DBS, what expertise the treatment team should have, the basics of stereotaxic surgery, how to program the stimulator for optimal benefit, and what a typical course of treatment would include. The anatomy and specifics of programming of the most common target for DBS in OCD will be covered. We will discuss side effects, data on efficacy and safety. Additionally, the ethical considerations of brain surgery on psychiatric patients will be presented to foster discussion on this issue. TMS induces electrical stimulation through a coil producing small alternating currents to the superficial layers of the cortex. It is used for treatment-resistant depression, and research is ongoing for uses in other psychiatric conditions such as bipolar disorder, substance use disorders and autism. Transcranial direct current stimulation (tDCS) is a noninvasive neuromodulatory technique that utilizes low-intensity direct current. Magnetic seizure therapy (MST) involves using high-frequency TMS to induce a seizure more focally with the purpose of decreasing the cognitive effects of ECT. We will review current research, indications and side effects of these procedures. We will illustrate the procedures using videos as well. The workshop leaders have significant experience in the use of neuromodulation therapies both clinically and in research protocols, as well as educating residents. Participants will assess their progression on neuromodulation-related milestones before and after the session. Patient case examples will be presented to the attendees to allow for small-group discussions and active participation. An open forum will occur to ask questions.

No Poster, No Publication, No Problem: A Step-by-Step Guide to Get You Started in the Scholarly Activity Process!
Chairs: Rashi Aggarwal, M.D., Nicole Guanci, M.D.

Presenters: Cristina Montalvo, M.D., Robert Rymowicz

EDUCATIONAL OBJECTIVE:
1) Identify barriers to productivity in the scholarly activity process; 2) Provide concrete steps toward choosing a topic for an abstract; and 3) Provide guidelines for undertaking a literature search and steps for writing.

SUMMARY:
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, the ACGME does not delineate specific requirements regarding what type of scholarly work residents should accomplish. 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 one study, only 30% of residents had national presentations, with 54% having no publications. Further, many psychiatric training programs lack faculty members 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; our residents have consistently presented a high number of poster abstracts at national meetings for the past five years. 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 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 to be more prepared to tackle their first poster or 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.

Perinatal and Postpartum Patient Safety: From Preconception Planning to Psychopharmacology to Maternal-Infant Attachment
Chair: Yad M. Jabbarpour, M.D.
Presenters: Yad M. Jabbarpour, M.D., Christina L. Wichman, D.O., Rebecca Bottom, Mary C. Kimmel, M.D., Maria Jose Lisotto, M.D.

EDUCATIONAL OBJECTIVE:
1) Gain competency in safety challenges associated with the perinatal and postpartum patient; 2) Recognize risks and benefits associated with psychopharmacology during the perinatal and postpartum period; 3) Understand safety issues associated with the postpartum period toward the goal of supporting maternal-infant attachment; 4) Identify the ethical principles and challenges associated with the perinatal and postpartum periods; and 5) Appreciate the importance of integration and collaboration of care to maximize treatment and safety during the perinatal and postpartum periods.

SUMMARY:
The perinatal and postpartum periods can be high risk for women with a history of psychiatric illness. Risks may range from the effect of pregnancy on the emotional well-being of the woman to high-risk safety issues including relapse, suicide, violence, and infanticide. From preconception to pregnancy to the

postpartum period, challenges can occur for psychiatrists and the women they serve. Relapse risk has to be balanced by perceived risk and benefit of continued psychopharmacological treatments, with an understanding of the evidence base associated with psychosocial treatments. Relapse rates for persons with psychiatric illness can be high. For persons with bipolar disorder, such rates have been shown to be as high as nearly 70%. Ethical principles can help guide decision making, balancing autonomy, beneficence and nonmaleficence as well as justice. Shared decision making and informed consent require being informed with the available evidence base, weighing the risk and benefits of treatment, alternatives to treatment and no treatment. Preconception planning can help navigate this process, allowing for an awareness of the risk of relapse with no or poor treatment, as well as, for example, the risk of birth defects with valproic acid, carbamazepine, lithium, and other mood stabilizers for persons with bipolar disorder. Decision making can be difficult, given that no psychotropic drug has been formally approved by the Food and Drug Administration (FDA) for use during pregnancy. Therefore, risks of teratogenicity, neonatal toxicity and long-term effects must be weighed in preconception planning, pregnancy and the postpartum period, including for breastfeeding. Integrated care and relapse prevention can be instrumental in supporting success and preventing high-risk safety events. Assessment, management and treatment of the high-risk situations during pregnancy and the postpartum period can be challenging. Safety issues can include suicide risk and violence risk, as well as risk to the pregnancy and infant. Real-world challenges can occur for clinicians, for which there is little in the literature, including management of restraint during pregnancy on inpatient units for violent and/or self-destructive, suicidal patients—especially during the third trimester. Potential strategies to mitigate risk will be reviewed to prevent restraint, as well as strategies to monitor and prevent risk if restraint is required for immediate safety. Navigation into the postpartum period can also be challenging from a treatment and safety perspective. Integrated and collaborative systems of care can support the mother and the new infant with focus especially to maternal-infant attachment to help prevent high-risk safety issues and, most importantly, to promote the development of the newborn, as well as the mother in her new role, while supporting prevention of relapse and treatment options for the woman.

Preschool Psychiatric Assessment in a Clinical Setting

Chair: Joyce Harrison, M.D.
Presenters: Pravesh Sharma, M.D., Anupriya Razdan, M.B.B.S., Nadia Zaim, M.D.

EDUCATIONAL OBJECTIVE:

1) Utilize AACAP practice parameters when performing a mental status exam (MSE) on an infant or a toddler; 2) Effectively use toys while assessing infants and toddlers; and 3) Understand the significance of infant/toddler MSE, utilizing tools learned from objectives 1 and 2 while assessing an infant/toddler.

SUMMARY:

evidence shows that the rates of the common psychiatric disorders in preschoolers are similar to those seen in later childhood. Early childhood is a critical time for prevention, early diagnosis and intervention to promote healthy development. Standardized structured interviews and assessment tools exist, but a lack of training and resources, as well as time constraints in an office setting, prevent many practitioners from feeling competent in their ability to assess very young children. Psychotropic medications are being prescribed for very young children at an exponentially increasing rate for unclear indications and presumably without age-appropriate mental health evaluations. A likely contributor to this trend is the lack of mental health clinicians with expertise in the assessment and treatment of young children. An informal survey conducted by the Infant and Preschool Committee of the AACAP revealed a wide range and inconsistency in curricula for training residents in very young child assessment. There is a clear shortage of child psychiatrists in general and an even greater shortage of child psychiatrists who are comfortable assessing and treating children under five years old. The presenters will help the participants develop a practical plan for the assessment of children in their clinics or early childhood settings. Participants will learn to use practical tools like the Infant and

Toddler Mental Status Exam (MSE) suggested by the AACAP Practice Parameters for the Assessment of Infants and Toddlers. Participants will have the opportunity to role play by using simple toys in assessment. The first portion of the workshop will include an overview of the social, emotional and developmental functioning of a young child, presented as a multimedia lecture. It will include visual aids and videos of young children at different developmental stages. The second part of the workshop focuses on teaching practitioners to implement the AACAP practice parameters Infant and Toddler MSE. The exam will be modeled by the presenters, and then toys and role playing will be used to encourage audience participation. This portion of the workshop will include video and interactive discussion, in addition to the role playing. Lively and energetic discussion and Q&A will follow. The presenters and participants will develop a practical plan for the assessment of children in their private practices, clinics or early childhood settings. Using tools like the AACAP practice parameters Infant and Toddler MSE, it is possible to evaluate very young children in private practices, clinics and community settings.

Put Your Oxygen Mask on First—Trying to Save Babies at the Expense of Mothers: A Perinatal Psychiatrist's Perspective

Chair: Lisette Rodriguez-Cabezas, M.D.
Presenters: Dana Mahmoud, Crystal Clark, Kara Driscoll, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify current best practices for the treatment of peripartum psychiatric emergencies such as agitation and psychosis, with consideration of both the mother's and baby's health; 2) Provide a risk/benefit assessment of how to utilize psychotropic medications in pregnant and breastfeeding woman who requires acute treatment; and 3) Understand the epidemiology related to suicidal ideation, self-harm and suicidal behavior around pregnancy and the postpartum period.

SUMMARY:

There is a dearth of published data on peripartum psychiatric emergencies and, therefore, many clinicians are at a loss for how to handle these patients when they come into the office or the emergency room. This population is especially tricky, as there are two patients to take care of—the mother and her child. Therefore, it is important to take into account the risks and benefits of all treatments to both. This workshop will provide attendees with practical guidance on treatment strategies for peripartum psychiatric emergencies such as agitation and psychosis based on a review of published literature. Attendees will also be informed of current data on the epidemiology of suicidality in the perinatal psychiatric population, along with differential diagnoses for postpartum psychosis. This workshop will shed light on overlooked disorders that, in severe cases, may also present as emergencies. Disorders that are commonly overlooked or misunderstood in this population include peripartum OCD, peripartum PTSD, and nausea and vomiting of pregnancy (NVP). These disorders are often seen as outpatient complaints but can result in loss of custody, hospitalization, elective termination, and other poor outcomes. Potential cultural considerations to recognize when acutely treating the perinatal patient will also be considered. After a presentation on all of the aforementioned topics, attendees will be split into groups and will be given a case example. Each group will then discuss and collaboratively develop a treatment plan for their specific case. One representative from each group will be asked to share this with the audience, and feedback will be provided by our panel of experts.

Soup to Nuts: Developing a Comprehensive Program to Address Well-Being and Mental Health During Residency

Chairs: David M. Roane, M.D., Jonathan Ripp, M.D.
Presenters: I. Michael Leitman, Marla Shu

EDUCATIONAL OBJECTIVE:

1) Appreciate the significance of depression and burnout during residency; 2) Show awareness of the range of approaches that training programs can use to enhance resident well-being and mental health; and 3) Identify one well-being initiative that can be implemented at their institution or affiliate.

SUMMARY:

Numerous studies have demonstrated high rates of depression among residents, with a significant increase in mood disorders corresponding with the start of training. Burnout also occurs with great frequency in house staff. The consequences of these untoward effects of residency can include unprofessional conduct and suboptimal patient care. At the extreme, residents may become at risk for suicidal behavior. The American College of Graduate Medical Education has begun to emphasize the importance of these concerns. Increasingly, teaching hospitals and individual residency programs are expected to address these problems and consider the well-being of their house staff. This workshop will consider the range of approaches to improving the lives of trainees. We will discuss how specific well-being initiatives, including mindfulness training, facilitated discussion, and other efforts to encourage self-reflection, may make a difference. Such approaches will be briefly demonstrated during this workshop. Additionally, participants will be actively engaged to discuss the desirability and feasibility of mandating wellness programs, as well as strategies to enlist institutional support (including budgetary resources). We will also focus on the need to identify individuals who require mental health treatment. We will have a conversation about the obstacles to treatment. Participants will be briefly surveyed about the prevalence of attitudes, among physicians, that would encourage or discourage treatment acceptance. The impact of stigma on health professionals will be highlighted. Ways to improve access to treatment such as protected time for self-care and the provision of affordable mental health resources will be covered. The moderators, who will include physician educators, a graduate medical education administrator and a resident, will prompt attendees to consider the following questions: 1) What is the best way to promote resident buy-in for well-being initiatives? 2) Can such efforts actually improve outcomes (e.g., reduce burnout or enhance professionalism)? 3) Are teaching programs in a position to identify at-risk residents and offer services in ways that can impact mental health outcomes, including suicide? and 4) Can well-being efforts be effective without addressing stressful aspects of the teaching hospital work environment? Finally, the panel will report on the formation of work groups at a large health care system designed to address various aspects of this problem in order to find comprehensive solutions that can improve each residency and support every resident.

Starting Your TMS Private Practice: What We Wish We Would Have Known!

Chairs: Kevin M. Kinback, M.D., Mahmoud S. Okasha, M.D.

Presenters: Richard A. Bermudes, M.D., Linda Carpenter, M.D., Scott West

EDUCATIONAL OBJECTIVE:

1) Understand typical reimbursement and insurance policies and how to do TMS treatment planning; 2) Recognize the staffing needs for setting up a TMS practice, with discussion of standards of care and various business models; 3) Compare the four currently available FDA-cleared TMS therapy systems; 4) Understand the training and continuing education necessary to begin practice as a TMS provider; and 5) Learn now to integrate TMS therapy into a general psychiatric practice.

SUMMARY:

Transcranial magnetic stimulation (TMS) is one of the newest and fastest-growing treatment modalities in psychiatry, with four different devices now FDA cleared for use in major depression, yet few psychiatrists have been trained in or have had direct clinical experience with this treatment. This workshop will provide a fundamental understanding of using TMS technology in clinical practice. The workshop will use an interactive format to assist the psychiatrist in analyzing the reimbursement and insurance requirements and treatment planning. Presenters will address how TMS is billed and reimbursed. We will discuss the staffing needs and standards of works, including the physics and mechanism of action of the treatment. In addition, we will review the four magnet systems that are currently FDA cleared and compare and contrast the properties of each device. We will describe the patient experience, as well as where TMS fits in the treatment algorithm based on the data from current literature and real world application. Psychiatrist training, which is recommended to develop a skill set as a TMS provider, will be outlined and reviewed. Finally, key points will be presented regarding how TMS therapy can be integrated into a new or existing

psychiatric practice. At the conclusion of the session, practitioners will have gained insight into various factors that should be considered, from reimbursement to training to implementation, and will be able to use this knowledge to set up their own TMS practices.

Talking About Our Own Mental Health and Mental Illness: Pros and Cons of Self-Disclosure
Chair: Robert S. Marin, M.D.
Presenters: H. Steven Moffic, M.D., Michael F. Myers, M.D.

EDUCATIONAL OBJECTIVE:
1) Present personal narratives that illustrate psychiatrists' experience of mental illness and mental suffering and their experience using self-disclosure to enhance their professional activities; 2) Describe ways in which self-disclosure entails risks and benefits in psychiatrists' work as clinicians, team members, educators, and leaders; 3) Describe the role of self-disclosure and other self-care strategies in preventing burnout and enhancing career satisfaction; and 4) Illustrate administrative steps to increase psychiatrists' willingness to seek psychiatric care for themselves.

SUMMARY:
This workshop will explore the challenges, risks and benefits of psychiatrists disclosing their own experiences with mental illness and emotional suffering. All attendees are welcome; since all behavioral health providers are affected directly and indirectly by the systemic meanings of mental illness, the workshop is intended for conference attendees who do not have mental illness, not just those who do. Psychiatrists are susceptible to the same forms of mental suffering as their patients. The stigma of mental illness and the personal meanings of emotional suffering present psychiatrists with the same challenges, risks and distress as their patients. It is ironic in this recovery-oriented era that psychiatrists' reluctance to self-disclose may reinforces stigma and deprive others of the benefits of self-disclosure. The workshop presentations will include brief descriptions of two presenters' personal journeys, which include their experiences with recognized mental disorders and subclinical conditions. The personal narratives will include comments on the potential impact of self-disclosure on psychiatrists' work as clinicians, educators and system leaders. We will also address the challenges and benefits of integrating clinical and administrative measures that increase the willingness of psychiatrists to seek psychiatric care for themselves. The workshop will provide extensive opportunity for questions and discussion.

Teaching Compassion Through Self-Compassion
Chairs: Robert Barris, M.D., Nyapati R. Rao, M.D.
Presenters: Ateaya Lima, M.D., Babar Saggu

EDUCATIONAL OBJECTIVE:
1) Demonstrate and practice various experiential approaches for teaching mindfulness in residency and medical student didactics; 2) Review current literature related to teaching mindfulness in various settings; and 3) Present an overview of the personal experiences and practices of the authors in integrating mindfulness strategies within diverse practice settings.

SUMMARY:
There has been an exponential growth of literature showing mindfulness to be an effective treatment in several disorders. Beyond treatment strategies, mindfulness has a rich history in improving general well-being and self-care. Training in psychiatry and its practice, caring for the chronically ill, and working to relieve their suffering means exposure to traumatic narratives and emotive content, within the context of a relational experience that stands out in the practice and training of psychiatry. Although there are several didactic or conceptual approaches to addressing themes such as empathy or compassion, it remains to be established just how far these approaches penetrate or resonate with students and residents. In contrast, an alternate approach is one that can be regarded as non-conceptual knowing and that employs the implicit and experiential rather than mere explicit modalities. Beyond lectures or formal teachings, it is the implicit approach that has the capacity to more deeply impact, penetrate and cultivate personal transformation as health care providers. In this workshop, we will discuss and demonstrate non-conceptual and experiential methods of teaching mindfulness through modalities such as eating

meditation, walking meditation, meta practice, storytelling, and tonglen. We will include embodied mindfulness practices such as yoga and tai chi. The workshop draws on personal narratives of residents and in-vivo mindfulness exercises, bridging the work of seasoned mentors with the experience of residents during training. The mindfulness strategies demonstrated in this workshop can be integrated in an experiential format in various settings and across disciplines, in didactics for residents and medical students, in psychotherapy training and supervision, in continued support at the workplace for self-care, and in reflection for better teamwork and patient care. It is this training approach that is considered to be the most potent way to guard against professional burnout, which research has shown to begin very early in medical training.

Teaching the Concepts of Diagnostic Reasoning and Cognitive Bias to Residents and Students
Chairs: Adam L. Hunzeker, M.D., Rohul Amin, M.D.
Presenters: Allison Webb, M.D., John Magera, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe and define illness scripts and problem representations; 2) Summarize the advantages and disadvantages of heuristics in clinical reasoning; 3) Recognize at least three types of cognitive biases from provided clinical vignette cases; 4) Demonstrate two types of cognitive strategies to reduce cognitive biases in provided clinical vignette cases using the cognitive de-biasing strategies card; and 5) Using provided deliverables and lesson content, implement the workshop in their didactics over a single session at their institution.

SUMMARY:
The practice of psychiatry is fraught with diagnostic ambiguity. There is a limited understanding of how the brain functions. The pathophysiological underpinnings of the diseases we treat are still being studied. Psychiatrists cannot rely on the technological advancements in imaging and laboratory testing that have benefited our fellow physicians in other specialties. It can be a daunting task to diagnostically approach a complex psychiatric patient. Incorrect diagnosis and treatment can be costly and dangerous. It is vital, as a psychiatrist, to develop and constantly assess our diagnostic approach. This continuous improvement of practice must be instilled early in training and reinforced throughout a career to limit potential sources of diagnostic error. Thought errors and bias are common in the diagnostic process. Mistakes in the diagnosis and treatment of complicated patients is inevitable. The standard is to constantly analyze our diagnostic acumen and hone our clinical approach. It is necessary for a practitioner of medicine to focus inward and analyze how we deploy cognitive strategies, utilize heuristics, and mitigate cognitive bias and think about when it is appropriate to use fast versus slow thinking. Data have shown that, through education, diagnostic reasoning skills can be improved. This workshop will help teachers become familiar with various cognitive strategy theories and learn to mitigate personal contributions of diagnostic error. Through mastery and implementation of these topics, teachers can more aptly educate their students on these topics. There is a paucity of information on this topic within the psychiatric education field. Most of the literature on this topic is contributed from internal medicine and emergency medicine. This topic is arguably more important in psychiatry given the dearth of diagnostic tools available to practitioners. Many curricula compete for the limited time available to residents and program directors. This is why we designed this introductory workshop to be delivered over a single session. The presentation is geared toward laying a foundation of knowledge and skills that lifelong learners can build on. This workshop combines the important discussions of how psychiatrists make diagnostic decisions, potential pitfalls and sources of diagnostic error. It further builds on the topics and proffers a potential rubric for efficiently introducing these topics to residents, given that residency programs are filled to capacity with educational requirements.

Telepsychiatry to Address Our Workforce Shortage: Applications, Training and Physician Perspective
Chair: Shabana Khan, M.D.
Presenters: Jack Cahalane, Ph.D., M.P.H., Kate Dempsey, Manish Sapra, M.D.

EDUCATIONAL OBJECTIVE:
1) Gain an understanding of the physicians' perspectives and experiences with telepsychiatry; 2)

Identify the various applications of telepsychiatry; and 3) Recognize the importance of medical student and resident exposure to and training in telepsychiatry.

SUMMARY:
There is a nationwide shortage of psychiatrists, particularly for subspecialties including child and adolescent and geriatric psychiatry. This shortage is most pronounced in rural and underserved areas. Telepsychiatry is an innovative approach to extend our reach and fill the gaps in care. Studies demonstrate that telepsychiatry is comparable to in-person care across a range of psychiatric diagnoses, improves access to timely care and specialists, reduces travel time and cost, and receives consistently high patient satisfaction scores. Telemedicine will likely become a routine clinical practice in the future; however, most medical students are not regularly exposed to the use of this modality in their training. The Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center (UPMC) telepsychiatry program uses live interactive videoconferencing to provide psychiatric services to a wide range of settings. This includes community mental health centers in underserved areas across the state; inpatient psychiatric facilities in rural areas; psychiatric consultation-liaison services from the main campus to network hospitals; telepsychiatry services to a kidney transplant program at a network hospital; geriatric services to a teleconsultation center located two hours away; and, more recently, a pilot program to provide direct in-home psychiatric care. Furthermore, the WPIC telepsychiatry program encourages and provides opportunities for training, supervision, education and scholarly activities to residents and students. In this workshop, we will discuss the psychiatrist's experience in providing telepsychiatry services. For example, in a satisfaction survey of 12 WPIC telepsychiatrists who provide services to community mental health centers in rural areas of Pennsylvania, 92% "agreed" or "strongly agreed" that they were able to provide good patient care using this modality, 66% agreed that the doctor-patient relationship is comparable to face-to-face visits, and 67% rated their satisfaction as "very good" or "excellent." We also anticipate presenting survey data from medical students, who observed and participated in a telepsychiatry clinic at our academic medical center, to assess their experience with the use of this modality. We will propose the development of a telemedicine curriculum for medical schools in collaboration with other specialties of telemedicine. We will conclude our workshop with a live interactive demonstration of the use of videoconferencing technology, connecting in real time with a psychiatry resident to get trainee input on their experience with telepsychiatry.

The Case for Interdisciplinary and Intergenerational Team Science in Psychiatry
Chairs: Sophie Feller, M.D., Kenneth Wells, M.D., M.P.H.
Presenters: Bowen Chung, M.D., M.S.H.S., Enrico Castillo, M.D., Jessica Kaltman, M.D., Richard Van Horn, M.Div., Loretta Jones, Th.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Engage in a group exercise to highlight the basis of team science; 2) Explore applications of team science using examples from speakers' experiences; 3) Discuss the benefits and potential challenges of team science in psychiatry and the necessity of community partners; 4) Discuss practical strategies for implementing team science and how to translate team science into clinically relevant practice in psychiatry; and 5) Explore participant experiences with team science in psychiatry.

SUMMARY:
There is a growing body of literature about the science of team science (SciTS)—that is, the study of the practice of team science—which points to the strengths of team-based approaches to science in many contexts. It is the promise of interdisciplinary team science that has compelled scientists to advocate for supporting young scholars in the pursuit of team science. A study looking at 21 million scientific papers that were published around the world since 1945 showed the increasing influence of team-based scientific research as opposed to single scientists, and this shift is ubiquitous across scientific fields. This shift from the solo researcher to a team-based approach has had the concurrent effect of expanding the scope of research from siloed fields of study into interdisciplinary and transdisciplinary efforts, also obliterating geographic boundaries to

collaboration. The potential of team science lies in the prospect that teams can combine the best features of individual disciplines—discipline-specific knowledge, theory and methods—to create innovative approaches to science. This workshop builds on an approach to team science that features clinicians in applied science, representing diverse fields, as well as community and other stakeholder co-participants. The workshop will review the approach to team science that was followed in the Community Partners in Care project, a team science-based, community-partnered, participatory comparative effectiveness trial. The trial featured a comparison of a community coalition versus technical assistance model to implement evidence-based, collaborative care for depression in under-resourced communities of color. The project won the 2014 Team Science Award of the Association of Clinical and Translational Science (ACTS) and Campus-Community Partnerships for Health Annual Award (2015), with over 100 academic and community members receiving the award. Senior researchers and community partners from this team then mentored a group of 11 fellows, residents and postdoctoral medical students to collaborate in a team science approach to using literature reviews and stakeholder interviews to develop a public health model to address emotional well-being. The workshop will review strategies from the senior team and trainees as well as mentorship strategies in team science. This will help to inform programs about approaches to cultivate team science in mature teams, among developing trainees and across the "generational" span in psychiatric research. Participants will be invited to share stories of their team science experiences and to participate in interactive exercises that stimulate thought about and clarify priorities for team science. All speakers are members of the team science group Community Translational Science Team (CTST).

The Steve Fund: Focusing on the Mental Health and Emotional Well-Being of College Students of Color
Chair: Annelle Primm, M.D., M.P.H.
Presenters: Steve H. Koh, M.D., M.P.H., Yasmin Owusu, M.D., Ludmila De Faria, M.D., Debbie R. Carter, M.D., Mary Hasbah Roessel, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify levels of stress and examples of racial bias and negative stereotyping experienced by college students of color, including students of color who are lesbian, gay, bisexual, or transgender; 2) Specify effective approaches to psychiatric care of college students of color; and 3) List at least three recommendations from the Steve Fund report on effective programs and services to support mental health college students of color.

SUMMARY:
This workshop will feature the work of the Steve Fund and will describe the disparities in levels of stress among college students of color, the mental health consequences of their exposure to racial bias and negative stereotypes, psychiatric care of racially and ethnically diverse students, and recommendations for services and programs to support their mental health and well-being. Since its founding in 2014, the Steve Fund, one of the nation's leading organizations addressing the mental health needs of students of color, has worked extensively across multiple platforms and led myriad partnerships to improve and enhance the mental health and emotional wellness of young people of color during their college years and early adulthood. The Fund has partnered with the Jed Foundation to conduct a survey to assess the level of stress of college students, which found that, compared to white students, students of color have higher levels of stress, are more likely to feel overwhelmed and more frequently feel that they are less emotionally prepared for college. The workshop will describe the initiatives the Steve Fund has undertaken to generate and disseminate knowledge; support scholarship; and establish programs, partnerships and technology innovations to promote the emotional well-being and academic success of students from racially and ethnically diverse backgrounds. In addition, this workshop will present the challenges facing students of color, from the perspectives of psychiatrist panelists. These clinicians who treat college students of African, American Indian, Asian, and Latino descent, including those who are lesbian, gay, bisexual, and transgender, will discuss what their experiences have been in serving students in a racially charged, homophobic and transphobic societal environment. They will also discuss what approaches they find

most successful in providing psychiatric care to young people who are members of these demographic groups. A set of recommendations will be discussed, which seek to optimize the emotional well-being of college students of color with diverse identities. The recommendations are derived from a survey of successful programs around the country organized by the Steve Fund and the Jed Foundation in cooperation with McLean Hospital's college student program.

Your Write to Health: How and Why to Integrate Journaling Into the Psychotherapeutic Process
Chair: Martha Peaslee Levine, M.D.

EDUCATIONAL OBJECTIVE:
1) Develop writing prompts to use in individual, family and group therapy; 2) Identify ways writing can be used for self-discovery, for themselves and their clients; 3) Experience how writing can help with healing past traumas; and 4) Define aspects of healthy journaling.

SUMMARY:
This workshop will provide a framework to understand the power of writing, which has clear emotional and physical benefits. Experiential exercises and case examples will be used to explore the potential uses of journaling within therapy. Guidelines will be provided so that participants can design their own writing exercises based on their client population and treatment needs. Research will be presented that documents the value of journaling. Writing can aid individuals as they work through traumatic experiences and can allow for the translation of emotional experiences into language. This allows our clients to understand and assimilate past experiences into a more complete and healthier view of themselves. Many of our clients often have limited opportunities or willingness to use their voices. They express their insecurities, frustrations and pain through unhealthy activities, such as disordered eating, substance abuse and self-harm. Many times, clients have swallowed their voices for so long that they are no longer in touch with their authentic selves. Writing can deepen a connection with the genuine self. Targeted writing in individual, family and group sessions can empower our clients and help them use their voices instead of their symptoms. Journaling can help our clients integrate their true stories into their lives. Journaling can also help therapists and psychiatrists connect with their own stories, which can affect their therapeutic interventions. This workshop can help you and your clients discover their "write to health."

Sunday, May 21, 2017

A Multidisciplinary Approach to Mental Health in the San Diego Jails: A Focus on Solitary Confinement
Chairs: Aaron Meyer, M.D., Nicolas Badre, M.D.
Presenters: Peter Fischetti, Steven Maraia

EDUCATIONAL OBJECTIVE:
1) Explain the variables affecting patients' quality of life within the county jail system; 2) Discuss the importance of a multidisciplinary approach in improving mental health care in jails; and 3) Understand the difficulties in releasing people from administrative segregation.

SUMMARY:
In the last two years, the San Diego Jail has faced an uphill challenge; a growing number of patients with severe mental illness were deteriorating while incarcerated. While awaiting more long-term policy changes, a group of concerned parties began meeting regularly to address this ongoing issue. Led by the jail's lead therapist, representatives from administration, nursing, therapy, frontline sworn, classification, and psychiatry started meeting weekly to discuss patients who posed behavioral challenges and were at risk for grave disability. By leaving the medical model and incorporating input from multiple parties within the jail system, this group began to address mental illness with holistic lenses. The introduction of the multidisciplinary group (MDG) allowed several positive changes, including changes in disciplinary measures, diminution in use of seclusion, housing, and welfare checks. Through a series of discussions with sworn and classification staff members, an entire floor transitioned to psychiatric housing where inmates with severe mental illness are closely monitored. On this floor, deputies are trained and incentivized for their work with the severely mentally ill. As a result, in less than 12 months, the number of grossly psychotic patients

decreased from 45 to 10. Additionally, the number of gravely disabled awaiting admission to the psychiatric stabilization unit decreased from 15 to zero. The number of people with severe mental illness in administrative segregation has decreased from 36 to 18 in a five-month period. However, the MDG continues to develop future goals, including the implementation of systems that will identify patients with severe mental illness in administrative segregation and prevent their placement in such housing. This workshop will review these challenges, as well as proposed methods in accomplishing improvements. The target audience for this presentation includes all staff and administrators who work in correctional facilities with mentally ill offenders. Presentation objectives include developing a better understanding of the different variables affecting the incarcerated severely mentally ill and ways to improve their quality of life.

Accelerated Resolution Therapy: An Effective, Brief Therapy for PTSD and Other Conditions
Chairs: Wendi Waits, M.D., Megan Marumoto, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe how accelerated resolution therapy (ART) differs from and is similar to traditional evidence-based therapies for PTSD; 2) Appreciate the strengths and limitations of research published to date on ART; 3) Explain the ways in which bench research may explain the clinical outcomes seen with ART patients; and 4) Gain first-hand experience rescripting distressing events.

SUMMARY:
Founded by Laney Rosenzweig in 2008, accelerated resolution therapy (ART) is an eye movement therapy administered in a structured protocol format to help patients achieve rapid resolution of distressing symptoms, especially those related to trauma. Despite being a relatively new addition to the therapist's toolkit of trauma treatments, ART contains all of the psychotherapy elements carrying an A-level recommendation in the 2010 VA-DoD Clinical Practice Guidelines for PTSD, including (visual) narration, exposure, stress inoculation, cognitive restructuring, and psychoeducation. Published clinical evidence on ART suggests that most patients experience clinically significant improvement after just one session and can typically achieve remission of posttraumatic stress disorder (PTSD) in five or fewer sessions. In the largest study published to date, 65% of subjects with PTSD achieved a clinically significant response in an average of 3.6 ART sessions, compared to 13% in controls. The study had a 94% completion rate. ART bears some similarities to other trauma therapies, such as eye movement desensitization disorder (EMDR) and prolonged exposure (PE), but it is more directive and easier to administer. The overall objective in an ART session is for the patient to rescript a traumatic memory through the use of eye movements, making their images as positive as possible so they are no longer distressed when recalling them. The ART protocol also helps patients break up their traumatic scenes into manageable chunks, processing out physical sensations as they arise. After the patient is sufficiently desensitized to their scene, they are instructed to rescript it however they like while performing eye movements. Rescripting of the scene shortly after desensitization appears to be critical to ART's sustained effect and is supported by bench research. Verbal or written narration is not required, giving ART a unique advantage in treating patients who can't or don't feel comfortable sharing the details of their trauma. ART empowers the patient with creating their own rescripted scenes and solutions to their problems. The therapist serves as a facilitator to the creative process, often finding the sessions extremely rewarding and even fun. This workshop will orient audience members to ART, review published and ongoing ART research, review the basic science research supporting ART's effectiveness, and examine some clinical cases. Additionally, the presenters will share some practice management tips and lessons learned based on their experience implementing ART at a large community-based hospital and in private practice.

Boot Camp for Burnout: Strategies to Promote Resilience and Wellness for Psychiatrists
Chair: Silvia W. Olarte, M.D.
Presenters: Christina Tara Khan, M.D., Ph.D., Eva Szigethy, M.D., Ph.D., Maryam S. Hamidi, Ph.D., M.Sc.
Discussant: Silvia W. Olarte, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the concept of burnout; 2) Compare the burnout experience in medical students, residents and physicians in practice; 3) Provide a comprehensive description of the clinical picture of burnout; 4) Understand the role of nutrition and wellness in everyday life and its effect on burnout; and 5) Demonstrate specific techniques that are effective in the treatment of burnout.

SUMMARY:
Burnout is a syndrome characterized by depersonalization, emotional exhaustion and a sense of low personal accomplishment that leads to decreased effectiveness at work. This phenomenon has been increasingly recognized among medical students, residents and physicians-in-practice and has been shown to negatively impact career satisfaction and patient outcomes and has more recently been linked to physician suicides. Medical students are at risk for burnout during their medical education. Burnout may influence specialty choice and impact the affected individual's perception of work-life balance. Up to 76% of residents have been shown to meet criteria for burnout and those respondents believe they provided suboptimal patient care. Physician burnout experts at the AMA and the Mayo Clinic conducted a survey of 6,880 physicians to "evaluate the prevalence of burnout and physicians' satisfaction with work-life balance compared to the general U.S. population relative to 2011 and 2014." According to the study, which was recently published in *Mayo Clinic Proceedings*, at the time of that study, approximately 45% of U.S. physicians met criteria for burnout. When a follow-up survey was conducted in 2014, 54.4% of physicians reported at least one sign of burnout. Physicians also reported lower rates of satisfaction with work-life balance in 2014 compared to a similar sample of physicians in 2011. All physicians in the study were assessed using questions on the Maslach Burnout Inventory. Increased stress and burnout also lead to health consequences, including chronic headaches, hypertension, depression, and anxiety. The data regarding the negative impact of burnout are alarming and sound a clear bell for the need for effective interventions to promote resilience and wellness among physicians and physicians-in-training. The goals of this workshop are to address burnout among physicians, with special focus among psychiatrists at different levels of training, and discuss and demonstrate methods to reduce burnout and promote resilience and wellness. This workshop will cover various stress reduction strategies and programs, including a virtual self-help program, mindfulness meditation, nutritional interventions, and cognitive-behavioral techniques.

Buprenorphine Update and Evolving Standards of Care
Chair: John A. Renner Jr., M.D.
Presenters: Andrew J. Saxon, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe treatment protocols used by psychiatrists around the country who are treating opioid use disorder with buprenorphine; 2) Discuss cutting-edge research related to the use of buprenorphine for treating opioid use disorder; and 3) Describe appropriate patient selection for the newly approved buprenorphine implants for treating opioid use disorder.

SUMMARY:
This workshop is intended for psychiatrists who have a waiver to treat opioid use disorder in an office-based setting. It will augment waiver training through case presentations and discussion of treatment challenges with expert faculty. Topics addressed will include patient engagement and monitoring, minimizing diversion, and management of acute and chronic pain. Participants will also be encouraged to share their experiences with reimbursement policies that impede appropriate treatment.

Children of Psychiatrists: 20th Anniversary
Chairs: Leah Dickstein, M.D., Michelle B. Riba, M.D.
Presenters: Anna K. Costakis, M.D., Becca Munro, Dayna Menninger, Pooja Lakshmin, M.D., Christina Demopulos

EDUCATIONAL OBJECTIVE:
1) Hear from children of psychiatrists regarding their experiences growing up in a household where at least one parent or guardian was a psychiatrist; 2) Know the challenges of parenting from other

member psychiatrists; 3) Share ways to improve our abilities to parent as psychiatrists; and 4) Problem solve with the audience regarding some of the challenges and opportunities of having a parent as a psychiatrist.

SUMMARY:
Michelle Riba, M.D., invited me, Leah Dickstein, M.D., in 1997 to join her in co-creating and co-chairing a workshop for the 1998 APA Annual Meeting in Toronto, Canada. Our concerns then, and still now, were based on what makes a good parent, how parents know when they have erred or succeeded, and what could be learned from presenters of all ages, i.e., from six-year-olds to 50+-year-olds. Over the past two decades, we have learned so much from all presenters, as well as attendees from all over the world, who eagerly join in the discussions after each presentation. Our children, across these years and through their years of education and work, have, at times, felt burdened by their parents' jobs, both at home where they answered the telephone with a voice requesting to speak to their psychiatrist-parent(s), as well as during all their school and work years when colleagues learned of their parent(s)' careers and asked for help, often 24/7. We wanted to be the best parents we could be, despite the stigma we have carried throughout our careers and still do, yet each year, the audience is so involved with similar questions, experiences and, sometimes, very creative ways to interact with their children and feel good about their parental roles and accomplishments that the standing-room-only assigned rooms, despite having tripled in size, draw more attendees and gratitude for what they have learned.

Connecting With Patients in the Life Space: A Pragmatic Approach to Web and Mobile Applications in Clinical Practice and Research
Chair: Brian Grady, M.D.
Presenters: Julie Kinn, Naomi Wilson, Kelly Blasko

EDUCATIONAL OBJECTIVE:
1) Understand and appraise web and mobile analytics as relevant to clinical practice; 2) Incorporate at least one mobile application into clinical practice: bring your own device (BYOD) or watch the demonstration; and 3) Describe and understand how to utilize the National Center for Telehealth and Technology (T2) Research Module Study Enrollment Generator, a free research tool.

SUMMARY:
The life space is that time patients spend outside the brick and mortar clinic. Digital health technology allows patients the option of continuing their psychiatric education, assessment or treatment in the life space. This workshop addresses three important aspects of connected health engagement: web and mobile analytics, mobile app practical application, and leveraging a mobile app research tool. Websites, mobile applications and social media all have the potential for collecting aggregated usage metrics. The types of analytics collected include number of visits, durations of usage, bounce rates, referrals, likes, and more. This presentation will provide you with a better understanding of the types of analytics that can be collected and potential ways they can be used to evaluate psychological health technology applications. Several real-life examples will be used to demonstrate the usefulness and limitations of these metrics. The workshop includes a hands-on exercise and demonstration of connected health technology for clinical practice using the participant's personal device. Participants will learn and practice the steps to evaluate health technology applications, explain the applications to patients and collaborate with patients to determine the best ways to use connected health technology to supplement traditional care. The presenters will discuss safety and ethical concerns, along with practical tips for successful implementation. Prior to attending, participants should download the free T2 Mood Tracker mobile application from their mobile app store to their smartphone or tablet. The National Center for Telehealth and Technology (T2) Study Enrollment Generator (T2SEG) provides data analytics for the Breathe2Relax, Virtual Hope Box and T2 Mood Tracker mobile apps. These mobile apps, as well as the T2SEG, are made available at no cost to mHealth researchers. The T2SEG gives researchers a tool to be able to collect usage information and compliance rates, as well as quantitative data that may allow them to determine if usage relates to a user's health outcomes.

Culture Is Psychiatry: Challenges and Opportunities in Teaching About Sociocultural Issues in Residency Training

Chairs: Justin Chen, M.D., M.P.H., Ranna Parekh, M.D., M.P.H.

Presenters: Nhi-Ha Trinh, Priya Sehgal, Josepha-Pearl Immanuel

EDUCATIONAL OBJECTIVE:

1) Recognize the challenges and opportunities of teaching trainees about sociocultural issues in psychiatry; 2) Understand the limitations of medical training's traditional emphasis on "cultural competence" and gain familiarity with the related but distinct concepts of cultural respect and humility; 3) Learn about the development and implementation of sociocultural psychiatry curricula at two different adult psychiatry residency training programs; and 4) Gain hands-on experience in small-group breakout sessions with sociocultural psychiatry teaching topics tailored for psychiatric educators.

SUMMARY:

The 19th-century physician Rudolph Virchow famously stated that "Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution." Perhaps in no other field of medicine is this statement more apt than psychiatry, which at its core seeks to understand and treat variations in the most fundamentally human of attributes—thoughts, feelings and behaviors. Because of this central mission, psychiatry is necessarily embedded within, and informed by, a wide array of larger intersecting systems including culture, race, gender, history, politics, spirituality, etc. Psychiatric clinicians must recognize the impact exerted by these sociocultural constructs on patients' experience and interpretation of symptoms, those same symptoms' diagnosis by medical professionals, and the ways in which patients interact with the psychiatric service system. However, teaching these concepts to trainees can be a tremendous challenge. The sociocultural systems listed above are vast, and beyond the scope of most day-to-day clinical practices. Many psychiatrists find themselves constrained by financial pressures to ever-briefer "med checks" with an ever-narrower focus on biological explanations of and solutions to patients' distress. Additionally, psychiatric educators themselves may not be familiar with sociocultural concepts in psychiatry, since historically these issues have not been emphasized or systematically taught in most psychiatric training programs. Nonetheless, if one of the goals of medicine is to "point out social problems and to attempt their theoretical solution," then psychiatrists, and in particular psychiatric educators, have a duty to acquaint themselves with the core concepts of sociocultural psychiatry and pass them along to the next generation of clinicians. This workshop tackles these subjects head on in a manner informed by theory but grounded in actual experience and practice. In this session, psychiatric educators from two different adult psychiatry residency training programs in the Boston area will present their experiences teaching sociocultural concepts to trainees. They will describe how culture can be presented as a multidimensional construct that daily informs patients' and providers' experience of both symptoms and treatment. Additionally, they will describe how the field of psychiatry itself represents its own culture, with attendant biases and blind spots. Finally, they will discuss how they have chosen to teach about the concepts of privilege, intersectionality and racial/ethnic mental health disparities. Participants will be invited to gain hands-on experience with these topics in small groups and will gain ideas for implementation within their own institutions.

Depression and Suicide in Medical Students and Resident Physicians

Chair: Priti Ojha, M.D.

Presenters: Rebecca Romero, Alana Iglewicz, M.D., Natassia Gaznick

EDUCATIONAL OBJECTIVE:

1) Review rates of depression and suicide in medical professionals; 2) Explore contributing factors to trainee mental health; 3) Demonstrate different strategies to prevent the development of depression in trainees; and 4) Practice responding to a trainee/peer with depression or suicidal ideation.

SUMMARY:
Physicians and physician trainees are at elevated risk for depression and suicide. Approximately 400 physicians complete suicide each year, though this estimate is likely an underrepresentation due to underreporting. During residency training, intern year has been shown to come with a marked increase in depressive symptoms. Similarly, 15–30% of medical students who were psychologically healthy at time of matriculation develop depression and suicidal ideation, a much higher rate compared to peers in nonmedical professions. Multiple factors contribute to higher rates of affective disorders in this highly motivated population. Peer and faculty support, process groups and curricular changes provide opportunities for feasible interventions to decrease rates of major depression and suicide among physician trainees. In this workshop, we will discuss strategies that have been implemented in the University of California, San Diego (UCSD) psychiatry residency training program to address burnout, depression and suicide, including the efforts of the Resident Wellness Committee and the Suicide and Adverse Event Committee. We will review a recent suicide in the medical school community and the steps that were taken to process it with other students, residents and faculty who were affected. We will share a model in which senior psychiatry residents lead process groups for residents of other disciplines. We will end by role playing a scenario in which participants practice responding to a trainee/peer who discloses experiencing symptoms of depression and suicidal ideation.

Empowering Trainees and Guiding Careers: Mentors and Sponsors in Clinical and Organized Psychiatry

Chairs: John O. Gaston, M.D., Nzinga Harrison, M.D. Presenters: Kevin M. Simon, M.D., Glenda L. Wrenn, M.D., Courtney L. McMickens, M.D., M.P.H., Nicolas E. Barcelo, M.D.

EDUCATIONAL OBJECTIVE:
1) Emphasize the value of career guidance from senior colleagues for the success of residents and fellows in clinical and organized psychiatry; 2) Identify opportunities and challenges in building relationships across level of training from both the senior and trainee perspective; 3) Discuss examples of highly effective career guidance for residents/fellows both by individuals and across training programs; 4) Highlight successful guidance of trainees from backgrounds underrepresented in medicine; and 5) Describe a framework for optimized career guidance during residency and fellowship.

SUMMARY:
Career guidance is essential to the success of all psychiatric residents/fellows (trainees). In contrast to research-focused trainees, who routinely acquire mentorship in the context of their academic work, trainees focused in clinical and organized psychiatry are less likely to understand the potential importance of these relationships in their professional development. They are therefore less likely to have transformative professional relationships with their senior colleagues. In many cases, however, opportunities for professional growth and career advancement depend on the invaluable contribution of role modeling and exposure that seniors can provide. From the perspective of senior colleagues, clinical and administrative duties often impede serving in an advisory role. Additionally, outside the structure of an organized lab setting, many seniors struggle to find the suitable context and opportunity to develop relationships with trainees. Given these barriers, and in the setting of clinical and organized psychiatry, supervisors may feel overwhelmed by lack of clarity regarding the appropriate benchmarks by which to evaluate the “success” of their supervisory role. With these considerations in mind, it is helpful to distinguish the unique and equally important roles of mentors and sponsors. In this interactive workshop, we will present and discuss (in small groups) strategies to foster effective programing geared toward career development for trainees. We will address the perspectives, challenges, and potential contribution of both the trainee and the senior. We will bring a special focus to work with trainees from backgrounds underrepresented in medicine (URM) and discuss how seniors and trainees can best collaborate when prior life experience is not shared. Finally, we will present a framework for optimized career guidance currently being implemented by

individual mentors and in psychiatry training programs across the United States. Participants will hear examples of successful mentorship and sponsorship in community-based settings, large university centers and organized psychiatry. These case studies will offer practical suggestions to successfully address and resolve expected challenges.

Engaging in Meaningful Quality Improvement Using Root Cause Analysis as a Novel Approach to M&M Conferences in Psychiatric Training
Chair: Tobias Wasser, M.D.
Presenters: Katherine Klingensmith, Hyun Jung Kim, Louis Trevisan, M.D., M.Ed.

EDUCATIONAL OBJECTIVE:
1) Distinguish the value of using a root cause analysis (RCA) framework over other methods for teaching mental health practitioners how to appreciate the systemic influences on adverse outcomes; 2) Identify several real-life examples of how using such a framework can improve the quality and safety of patient care; and 3) Outline ways in which implementing an RCA-based conference series can identify systemic influences on adverse outcomes or near misses and lead to improvements in patient care.

SUMMARY:
Compared to the literature from our colleagues in other medical disciplines, the literature on morbidity and mortality (M&M) conferences in psychiatry is limited. In 2009, Goldman et al. found only nine reports over the past 40 years of psychiatric M&M endeavors. Potential explanations for this dearth of M&M activities include the stigma and blaming culture sometimes associated with these forums, the relative rarity of mortality as a result of psychiatric illness, and the difficulty in clearly defining other adverse outcomes in mental health. Ideally, M&M conferences provide an opportunity for meaningful quality improvement, as they offer a chance to engage in structured peer review, careful analysis of adverse events and near misses, and education on the latest evidence-based practice. However, in practice, they often fall short. To address this disparity, we initiated a new M&M conference series for our institution's associated VA hospital to create a safe, interdisciplinary forum for the structured discussion of unfavorable outcomes and near misses utilizing root cause analysis (RCA), a systematic process for identifying the "root causes" of an adverse event. This series has focused on the need for policy revision, resource reallocation and education of staff/trainees that might enhance care within the local VA system. The success of the series has led to its expansion and implementation at our institution's private psychiatric hospital and local community mental health center, as well as psychiatry training programs in Oklahoma and Arizona. In this workshop, we present the frame for our novel RCA-based conference series; outline its success to date; and discuss how similar initiatives could be implemented at other institutions in the public, private and VA settings. We will then engage the audience in an interactive workshop in which they will divide into small groups, with each group taking on the role of a health care practitioner involved in a simulated adverse outcome. The groups will utilize the RCA model using a "fishbone diagram" tool to discuss the simulated case and analyze the systemic influences leading to the adverse outcome. The small groups will then reconvene to discuss their recommendations for improving the simulated system of care and their reactions to the role play. Finally, we will offer an opportunity for participants to discuss opportunities and challenges in implementing similar initiatives at their home institutions.

Fact, Fiction or Fraud: Clinical Documentation in Electronic Health Record Systems
Chair: Seth Powsner, M.D.
Presenters: Junji Takeshita, M.D., Carlyle Chan, M.D.

EDUCATIONAL OBJECTIVE:
1) Review challenges and pitfalls when documenting clinical encounters in common electronic health record (EHR) systems; 2) Identify specific EHR constraints that participants find impede their regular work, if not already mentioned; 3) Demonstrate practical adaptations to EHR constraints; and 4) Demonstrate proper coding to bill appropriately based on a clinical encounter and its documentation.

SUMMARY:

In hospital-based practices, handwritten notes have become an anachronism. Even in private practice, federal reimbursement policies and "meaningful use" requirements have pushed the remaining clinical world toward adopting electronic health records (EHRs). This brave new world of electronic documentation is fraught with potential missteps. This workshop will address some of the promises and pitfalls of EHR. Fact: Medical records are legal documents. They also serve as vehicles for communicating to other health professionals and as a way for treating psychiatrists to review past events/decisions. We will discuss who should have access to psychiatric records. We will review in greater detail the various purposes of documentation including legal, HIPAA, and special expectations for alcohol and substance abuse populations. We will also examine the role and content of psychotherapy notes. Fiction: Not all entries in daily EHRs are useful. We will examine uses and abuses of EHRs including: copy and paste, dropdowns, scripts, intentional omissions, errors, templates, and use of speech recognition software. We will recommend tactics to avoid these traps. We will also explore ways to produce readable, understandable clinical entries. Comprehensible, not just legible, notes are possible, and it is possible to address the needs of a variety of readers, from nursing staff and covering clinicians to utilization review staff. Fraud: While fraud is rarely deliberate, it is no small task to provide proper documentation for a given level of service to ensure proper billing. Both overbilling and underbilling are genuine causes for concern in any audit. Likewise, auditors may suspect fraud, rather than just keyboard fatigue, when clinical exam findings are copied forward day after day, one progress note to the next. We will review suggestions to substantiate the various levels of service. To reinforce the concepts presented, participants will be provided with cases of simple narratives of patient encounters. Their task will be to document on paper forms formatted to simulate the fixed options of EHR documentation and coding. Then they will share and review these with the presenters and their colleagues to correct misunderstandings and improve their documentation skills. Depending on the number of participants, we may break into smaller groups.

From Fairy Tales to the Clinical Experience: Critical Exploration and Significance of Children's Literature in Both Adult and Child Psychiatry

Chair: Carl Feinstein, M.D.

Presenters: Magdalena Romanowicz, Mali Mann, Aparna Atluru, Melissa Vallas

EDUCATIONAL OBJECTIVE:

1) Recognize that children's literature is an important component of culture and the way a society constructs and reflects social attitudes, class and gender roles, and cultural differences; 2) Identify how children's books influence construction of identity and the development of a sense of self, helping children becoming autonomous and independent adults; 3) Learn how three specific picture books, using illustrations, help pre-literate children grow emotionally and develop cognitive and empathic skills through which they negotiate their own subjectivities; 4) Recognize the healing value of texts and discuss the use of bibliotherapy in clinical practice; and 5) Choose appropriate examples of popular children's books to recommend to patients and families dealing with specific mental health conflicts.

SUMMARY:

All literature is born from the human need to tell stories that allow us to understand ourselves and others. Children's stories in particular help them to develop more mature cognitive and emotional skills. With the increasingly growing enterprise of publishing for children, several new trends arose that are interesting when examined by the field of psychiatry. Books for children are written or selected by adults and therefore serve as a documentation of psychological, cultural and behavioral interaction between the two worlds. Some of the specific trends that can be found in recent literature concern consciousness, one's own cultural heritage but also cultures of other people, sexuality, gender roles, fear, loss, trauma, and violence. If mental health professionals were aware of the richness of the information that children's books can provide, they could use them as tools in the way they understand their patients and communicate better with them. Our workshop will introduce participants to different forms of children's literature by using various

examples. We will provide information on the history of children's books and their influence on psychiatric studies. We will also discuss specific examples of how particular themes in books may influence children's development and affect their ways of seeing life. Disney adaptations are a good example of how popular culture modifies old fairy tales based on changing values of the modern life. For example, Cinderella's humility and hardworking nature are overshadowed by her good looks and ability to find a prince that will marry her. Then there is also a question of how children as readers respond during the process of reading. What are the particular aspects of books that speak to them? Small children use books as their objects. Older children look for books that will help them with articulating particular challenges that they are facing in their daily lives but also give them insight into their private, internal world. Most important, children are most likely to read books that are developmentally appropriate. During our workshop, we will provide participants with excerpts and pictures from various books that we will attempt to interpret. We will provide examples on how books may be used in therapy with patients. We will invite the participants to talk about their own books that either inspired them as children or that they have been using in their practice. The speakers in this workshop will include two child psychiatrists who provide services in major academic centers, one child psychiatrist who has recently published a children's book and works in a community mental health clinic, one psychoanalyst who has her private practice, and a child psychiatrist in training.

Helping Patients Who Drink Too Much: Using the NIAAA's Clinician's Guide
Chair: Richard Saitz, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the use of the clinician's guide and the specific relationship between alcohol consumption and the risk of alcohol-related problems; 2) Gain increased knowledge about research supporting screening, brief intervention and treatment of alcohol-related problems; and 3) Initiate a conversation about drinking in the context of their routine psychiatric practice.

SUMMARY:
The purpose of this workshop is to examine a number of clinical questions relevant to the integration of screening and brief intervention (SBI) for alcohol use disorders in the context of mental health services. There are many reasons to integrate alcohol SBI in mental health settings. First, mental health problems and alcohol problems frequently co-occur. For example, patients with any mood disorder are 2.6 times more likely to have an alcohol use disorder. Second, relatively few patients who are at-risk drinkers or meet criteria for an alcohol use disorder seek treatment in specialty settings. Most of these patients, however, do seek care on a regular basis from a mental health care provider. Third, mental health professionals are uniquely positioned to initiate the oftentimes difficult conversation about drinking behavior with their patients. Psychiatrists, psychologists and social workers bring a strong therapeutic skill set to interactions with patients, and they understand that psychiatric phenomena play a big role in the treatment of the full range of alcohol problems. Thus, willingness to adopt SBI—often low in traditional medical settings—is likely to be high among mental health professionals. Finally, there is evidence from clinical trials that full-scale, combined alcohol/mental health interventions can lead to improvements in both conditions. Whether this is the case for SBI remains to be seen, as the evidence for the efficacy of SBI targeting both mental health and substance use are less convincing. Given the relevance of SBI and mental health care, this workshop will focus on a well-known and respected tool for screening for alcohol problems developed by the National Institute on Alcohol Abuse and Alcoholism/National Institutes of Health: "Helping Patients Who Drink Too Much: A Clinician's Guide." This workshop will teach mental health professionals about this research-based alcohol screening and brief intervention tool and discuss 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.

Identifying Youth at Risk for Alcohol-Related Problems: A Clinical Tool
Chair: Sharon Levy, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Understand the typical drinking patterns among youth; 2) Understand how to use the guide and, in particular, how to screen for alcohol use, assess risk and provide brief intervention; and 3) Gain knowledge of a number of frequently asked questions about adolescent alcohol abuse.

SUMMARY:
This workshop will introduce the empirically derived "NIAAA Alcohol Screening and Brief Intervention for Youth—A Practitioner's Guide." The presentation will address the use of the guide, including the initial two-question screen, risk assessment based on well-defined criteria, advising youth at lower risk, providing brief intervention for those at higher risk, and follow-up support. Typical drinking patterns among youth will also be discussed in the context of adolescent neurodevelopment.

Implicit Racial Bias Training: A Prescription for Physicians
Chairs: Nzinga Harrison, M.D., Tiffany Cooke, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Describe the neurobiology, psychology and sociology of implicit racial bias; 2) Understand the history of racial bias in health care; 3) Describe the effects of implicit racial bias on patient care; 4) Identify our own implicit racial bias; and 5) Learn practical strategies to address implicit racial bias in health care.

SUMMARY:
Accusations of racial bias have been at the forefront of the recent public outcry over police killings of unarmed black men. With each subsequent death, the awareness of the fact that unarmed black men are killed at more than seven times the rate of other racial groups is heightened. While it may be true that overt racism is at play in some of the tragedies that have unfolded over the last two years, what is more likely happening is the behavioral manifestation of unconscious racial bias. Police officers are more likely to unconsciously perceive young black men in particular, and black people in general regardless of socioeconomic class or gender, as criminals and, as a result, are more likely to treat them as such. That unconscious bias leads to racial profiling and disparate policing. Evidence has shown that implicit racial bias training can undermine discriminatory policing behavior. The purpose of this workshop is not to focus on police, however, but rather to focus on physicians in general and psychiatrists specifically. Purely for neurophysiological reasons, it is impossible to be human and not have implicit bias. Because of American history, media images and culture, it is impossible for individuals born and raised in America to not have implicit racial bias. Because of the history of racial bias in medicine and its effect on medical training in this country, it is impossible not to have unconscious racial bias that has the ability to manifest as disparate care and poor outcomes for the patients we treat. This workshop will be interactive and include didactic presentation, audience response and a call to action, followed by Q&A/discussion. The call to action will be for participants to identify their own implicit racial biases and to identify how they can support the use of implicit bias training in their professional lives to mitigate poor health outcomes for the patients they treat. Content will focus on defining implicit racial bias from both neurophysiological and psychological perspectives, a discussion of the history of racial bias in health care, an opportunity for audience members to identify their own racial bias and consider how it has affected their practice of medicine, presentation of data regarding implicit bias training and its use in medicine, and introduction of practical strategies for physicians to support the acknowledgement and addressing of implicit racial bias in their work settings.

Integrated Medical Psychiatric Units Are Cost-Effective, Reduce Stigma, and Increase Patient and Staff Satisfaction
Chair: Diego L. Coira, M.D.
Presenters: Margaret Grady, R.N., M.S.N., A.P.N., Magdalena Spariosu

EDUCATIONAL OBJECTIVE:
1) Understand the financial impact of integrated

medical/psychiatric units; 2) Understand how integrated medical/psychiatric units help reduce the stigma of mental illness; 3) Understand how integrated medical/psychiatric units provide an excellent venue to train the next generation of health care providers; 4) Understand the importance of treating the whole person; and 5) Understand how to develop an integrated inpatient medical/psychiatric unit in their institutions.

SUMMARY:
Patients with comorbid medical-psychiatric illness could be difficult to treat. They usually receive fragmented, sequential care, increasing the cost of health care and putting the patient at risk of complications related to their care. These patients are typically admitted to a medical unit and, after stabilization, transferred to a psychiatric unit. This results in higher cost, more complications and decreased satisfaction with care. Providers are often frustrated, and there is disagreement over what team the patient "belongs" to. Medical units cannot handle agitated, psychotic patients, and psychiatric units are not equipped to treat patients who require central lines, intravenous fluids, naso-gastric tubes, etc. In this workshop, we present our 12-year experience in developing an integrated inpatient medical/psychiatric unit. We will present how we dealt with barriers like hospital administration, physicians, nurses, patients, and families. Aspects of administration, finances, admission and discharge criteria, clinical protocols, collaboration, and teaching students and residents will be covered. Findings including financial impact, clinical outcomes, staff and patient satisfaction, and case examples will be presented. We will also cover staff competencies and the teaching structure of the unit.

Keeping Your Cool Under Cross Examination
Chairs: Stephen G. Noffsinger, M.D., James L. Knoll IV, M.D.
Presenters: Jennifer Piel, M.D., Esq., Adrienne M. Saxton, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand commonly encountered clinical and forensic practice situations that may lead to deposition or trial cross examination; 2) Learn how attorneys think about and prepare for the cross examination of psychiatrists; 3) Understand ten common cross examination techniques commonly used by attorneys and how to successfully counter them; 4) Learn how to write forensic reports that minimize the potential for damaging cross examination; and 5) Understand the legal theory that underlies cross examination of the psychiatric witness.

SUMMARY:
Clinical and forensic psychiatrists are faced with cross examination during discovery depositions, hearings and at trial. Typically, clinical psychiatrists can expect to testify several times annually on issues such as civil commitment, involuntary treatment and guardianship, while the forensic psychiatrist will testify on a regular basis as an expert witness on many diverse criminal and civil issues being litigated. The cross examining attorney's goal is to undermine the psychiatrist's opinion by challenging the psychiatrist's qualifications, methodology, reasoning, and objectivity. Attorneys are usually highly skilled cross examiners, given that attorneys receive trial advocacy instruction in law school, conduct cross examination on a regular basis and understand the conceptual basis of cross examination. In contrast, clinical and forensic psychiatrists are subject to cross examination only on occasion and do not receive formal training to learn how to deal with cross examination. The novice (and sometimes even the seasoned) expert witness often unwittingly falls victim to cross examination techniques, only to find their opinions distorted or discredited altogether. This workshop will illustrate 1) how attorneys think about and prepare for cross-examination; 2) the rules of evidence that govern cross-examination; 3) specific cross-examination techniques utilized by attorneys, including the wedge, trap, pan for gold, stretch-out, minimization, collateral cross examination, back-down, channeling, shading, dilemma, fake, and undermining; 4) expert techniques to anticipate and counter cross examination efforts; and 5) several examples of effective cross examination techniques. Methods of instruction will include 1) didactic lecture; 2) vignette presentation and discussion, with video of cross examination examples; 3) audience and panel discussion; and 4) role playing involving common cross examination scenarios.

Leadership to Facilitate Continuous Performance Improvement

Chairs: Harsh Trivedi, M.D., Sunil D. Khushalani, M.D.
Presenters: Robert Roca, M.D., M.P.H., Antonio DePaolo, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Describe the importance of continuous performance improvement in achieving better health care outcomes; 2) Learn about the connection between leadership, an organizational culture and continuous performance improvement capability; 3) Enumerate at least three attributes of effective leadership that can facilitate continuous performance improvement; and 4) Identify at least two barriers that impede or slow down the development of continuous performance improvement capabilities.

SUMMARY:

To achieve the optimum outcomes expected of health care organizations today, outcomes such as "the triple aim," which involves improving the patient experience of care, improving the health of populations and lower per capita cost, or "high reliability," organizations must operate at a much higher level of performance. Performance improvement capability is a therefore a vital skill for any organization to possess. Better quality, higher safety, flawless and smooth delivery, cost reductions, employee engagement, and value enhancement are not outcomes that can be dictated by leadership or an external agency alone. They require a highly coordinated and collaborative effort between the workers and leaders of an organization. How this skill set and mindset get infused into a system and how much of it takes hold (thereby allowing a transformation to occur) depends on the values, focus, goals, support, and, above all, the culture of an organization. Culture is ultimately the net result of the principles and actions that leaders live and govern by. Transforming a workforce that demonstrates a skill set and a mindset of "continuous performance improvement" requires a certain kind of leadership, a kind of leadership that does not believe in "command and control" but believes in "unlocking" the non-utilized and potential talent of the entire workforce. It requires leaders to be respectful, disciplined curious, continuously learning, and supporting and coaching the workforce. It requires a daily management infrastructure, an understanding of systems and variation, and knowledge of how to manage change. Just as in cognitive behavior therapy, leaders guide by asking Socratic questions, thereby allowing the workforce to gradually learn to think and manage processes by themselves rather than depending on leaders to solve problems for them. It requires a management style that facilitates the development of an engaged problem-solving workforce. In this workshop, we describe principles and actions that leaders at various levels of an organization can take to create such a culture, and we will share examples of effective leadership from a large mental health care system.

Learning How to Guide Patients Through the Grief Process

Chair: Sidney Zisook, M.D.
Presenters: Katherine Shear, M.D., Merry Noel Miller, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify myths associated with grief in our culture; 2) Analyze ways to differentiate normal grief from major depression; 3) Explain the implications of the *DSM-5* changes regarding bereavement; 4) Explain how to recognize "complicated grief"; and 5) Describe an evidence-based treatment for complicated grief.

SUMMARY:

Grief is an experience that is both universal and unique to each person and each loss. We all have losses if we live long enough. Although our society does not necessarily equip us to deal with loss, most people find a way to restore a sense of meaning and purpose in life and to see possibilities for joy and satisfaction. Bereavement typically triggers acute grief and is also a major life stressor. As such, it can trigger any of a range of mental disorders, including depression. Because grief and depression share some common symptoms, some physicians are unclear about whether and how to identify a grieving patient as having major depression. Recent changes in the *DSM-5* enable physicians to diagnose both grief and depression. Bereaved individuals may

also seek help navigating grief. Most bereaved persons will adapt to loss on their own without much need for assistance, whereas others may go on to develop major depression, and some may experience protracted acute grief. This workshop will discuss current concepts in grief and will include a discussion of bereavement-related depression as well as a targeted treatment for complicated grief designed to resolve complications and help patients adapt to loss.

Managing Nonhematological Clozapine-Related Adverse Effects
Chair: Jonathan M. Meyer, M.D.
Presenters: Jennifer O'Day, George Proctor

EDUCATIONAL OBJECTIVE:
1) Understand that treatable issues are common reasons for clozapine discontinuation, not severe neutropenia; 2) Understand the evidence-based recommendations for management of sialorrhea, constipation, orthostasis, tachycardia, metabolic effects, sedation, and seizure risk; and 3) Understand the evidence-based approaches to fever and when to appropriately consider workup for myocarditis.

SUMMARY:
Clozapine is the only evidence-based treatment for the management of refractory schizophrenia, schizophrenia patients with a history of suicidality and impulsive aggression in patients with schizophrenia spectrum disorders. Despite the numerous advantages of clozapine, many patients fail to complete an adequate trial of this medication due to adverse effects. Although most clinicians focus heavily on the hematological complications of clozapine therapy, the majority of patients who discontinue for medical reasons do so for manageable conditions such as sialorrhea or constipation. Given the absence of viable antipsychotic alternatives for many of these patients, the purpose of this workshop is to cover in detail the management of treatable problems associated with clozapine. This workshop will initially cover the data on discontinuation for medication-related adverse effects in patients on clozapine, emphasizing the fact that most of these represent manageable problems. The next three sections will focus on the management of the common problems associated with clozapine, including sialorrhea, constipation, tachycardia, orthostasis, metabolic effects, sedation, seizure risk, and cardiomyopathy. There will also be an in-depth review of the management of benign fever, when to consider a workup for myocarditis, and the optimal combination of clinical features and laboratory findings that characterize myocarditis. Despite advances in the treatment of schizophrenia, there are no agents that replace clozapine's unique properties. This workshop will help psychiatrists effectively manage the adverse effects of clozapine therapy to allow patients to maximize the benefits of this medication. Moreover, the information provided here should help facilitate appropriate revisiting of prior clozapine failures by empowering attendees with information about effective strategies to present to patients who stopped clozapine.

Medical Conditions Mimicking Psychiatric Disorders vs. Psychiatric Disorders Mimicking Medicine Conditions: Diagnostic and Treatment Challenges
Chairs: Catherine Crone, M.D., Lorenzo Norris, M.D.
Presenters: Yu Dong, M.D., Ph.D., Andrew R. Alkis, M.D., Aizhan Repchak, M.D., Rushi Vyas, M.D.

EDUCATIONAL OBJECTIVE:
1) Enhance the differential diagnostic skills of the trainee or general psychiatrist through use of case material to educate them about medical conditions that may present with significant psychiatric symptomatology; 2) Enhance the differential diagnostic skills of the trainee or general psychiatrist through use of case material to educate them about psychiatric disorders that may mimic medical conditions; and 3) Sharpen the awareness of the trainee or general psychiatrist regarding the significant comorbidity between psychiatric and medical conditions.

SUMMARY:
During the course of residency training, significant efforts are made to instruct residents about the recognition and treatment of primary psychiatric disorders such as major depression, bipolar disorder, posttraumatic stress disorder, panic disorder, and schizophrenia. However, exposure to cases that initially appear to be primary psychiatric disorders but are actually due to underlying medical

conditions is often lacking, despite their common occurrence. Infections, hypoxia, electrolyte imbalances, endocrine disorders, autoimmune disorders (e.g., lupus, sarcoidosis), neurologic conditions (e.g., epilepsy, multiple sclerosis, delirium/encephalopathy), and medications are just some of the causes of patient presentations that mimic primary psychiatric disorders. Awareness of these "mimics" is needed by both trainee and practicing psychiatrists, 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 both residents and psychiatrists out in practice is the recognition and management of psychiatric disorders that mimic medical conditions. Limited exposure to psychosomatic medicine during training may result in a 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 health care dollars, as well as being sources of mounting frustration and misunderstanding for medical colleagues. Requests for psychiatric involvement are not unusual, especially when medical workups are negative yet patients persist in their requests for medical/surgical intervention. This workshop will provide attendees with an opportunity to learn more about secondary psychiatric disorders (psychiatric mimics) as well as somatoform disorders (medical mimics) in a case-based format with opportunities for questions and discussion with residents, fellows and attending physicians with experience and/or expertise in psychosomatic medicine patient populations.

Military Cultural Competence 101: What You Need to Know to Provide the Best Care

Chair: Rachel Sullivan, M.D.
Presenters: Josephine P. Horita, D.O., Rohul Amin, M.D., Eric G. Meyer, M.D., Dennis A. White, M.D.

EDUCATIONAL OBJECTIVE:

1) Know what a “day in the life” of a soldier, sailor, airman, or Marine is like; 2) Appreciate the implications military culture has on care; 3) Recognize the barriers between military patients and the health care system; and 4) Identify the resources available to improve military cultural competence.

SUMMARY:

Ten percent of the current U.S. population has served in the military, and 45 million Americans are directly related to a servicemember. At the same time, only 33% of veterans receive their care from the VA; the military medical system is decreasing through recurrent base realignment efforts, and an increasing number of deployed military members are National Guard members who return home to providers who may not know they have served in the military. Despite meeting most accepted definitions of a "culture," military culture rarely receives the same consideration that other cultures do when it comes to culturally competent health care delivery. Military members, especially sensitive to whether their military service is understood and appreciated, report difficulty trusting and participating in behavioral health care efforts. Similarly, many providers feel frustrated by the paucity of tools designed to help them understand the cultural impact the military has on their patients. This workshop will explore a "day in the life" of a soldier, sailor, airman, and Marine and the implications military culture has on care to help attendees recognize the barriers between military patients and the health care system and identify the resources available to improve military cultural competence in the care they provide.

Navigating Online Professionalism and Social Media Personas: Principles and Practical Solutions for Training and Practice

Chair: Isheeta Zalpuri, M.D.
Presenters: Mirjana Domakonda, Marika Wrzosek, M.D., Sanda DeJong, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the existing guidelines governing social media use; 2) Learn how to adapt existing guidelines to their type of clinical practice; and 3) Critically assess their social media use and recognize resulting potential breaches to professional boundaries.

SUMMARY:

The advent of mobile health technology and the

proliferation of social media present unique challenges to the field of psychiatry, especially regarding boundaries and the inevitable interaction between physicians' personal lives and professional development. Several organizations have attempted to educate residents and faculty about these important issues—the ACGME and the ABPN provide specific milestones related to professionalism and social media, numerous groups (AADPRT/AMA/FSMB) have published guidelines to address online professionalism, and AADPRT has developed a curriculum to educate psychiatry residents on the topic. Social media has introduced dilemmas in educating trainees about professional boundaries. Results from an unpublished survey presented at the annual meeting of the Association for Academic Psychiatry in September 2014 established that Program Directors and Chief Residents vary in their initial approach to suspected social media-driven professionalism and boundary violations, suggesting a lack of consensus in what constitutes an online professionalism breach and how online-stimulated potential boundary violations should be addressed within residency training. This suggests that there can often be a lack of understanding and agreement among clinicians regarding how to address these issues when they arise in day-to-day practice. Once trainees enter independent practice, they need to recognize how to navigate potential professionalism concerns arising from social media communication. This will be an interactive workshop consisting of mini lectures, a video vignette and audience participation. The workshop will commence with background information regarding current guidelines for online professionalism. Presenters developed a series of video vignettes and corresponding educational guides to provide a framework by which residents and faculty can appropriately address various online ambiguities arising within the context of psychiatric training and practice. Presenters will use one of these video vignettes to stimulate discussion about how the audience could handle a proposed breach. Presenters will engage participants in interactive experiences by use of a role play to address how participants would personally deal with a patient/colleague accusing them of an online professionalism breach. These vignettes will feature a unique topic regarding online professionalism, social media use or professionalism within the practice of psychiatry as a whole, followed by a proposed solution to the dilemma. The discussion will enhance participants' comfort level with the use of social media and arm them with tools to successfully navigate the social media and e-professionalism frontier.

Rational Use of Psychotropic Medications in Patients With Sleep Disorders

Chairs: Bhanu Prakash Kolla, M.D., J. Michael Bostwick, M.D.

Presenters: Meghna Mansukhani, Subhajit Chakravorty

EDUCATIONAL OBJECTIVE:

1) Recognize the significant overlap between sleep disorders and psychiatric conditions; 2) Emphasize the impact of psychotropic medications on common sleep disorders; 3) Enhance prescribing practices by choosing psychotropic medications that can help alleviate sleep disorders; and 4) Avoid psychotropics that might exacerbate sleep problems.

SUMMARY:

Intrinsic sleep disorders (such as sleep apnea syndromes, insomnia and restless legs syndrome) are frequently comorbid with psychiatric disorders. Sleep disorders can adversely impact a patient's affect, cognition and day-to-day functioning, thus compounding their psychiatric difficulties and worsening quality of life. In addition, various medications used to treat psychiatric disorders can influence symptoms and severity of sleep disorders. In this workshop, we will introduce participants to common sleep disorders and examine their overlap with psychiatric illnesses. We will discuss the impact of psychotropic medications, both direct and indirect, on these sleep disorders. We will use case examples to illustrate the influence of psychotropic medications on sleep problems and demonstrate pharmacological dilemmas clinicians face while treating patients with comorbid psychiatric illnesses and sleep disorders. We will present current best evidence detailing the influence of psychotropic medications on sleep disorders, with a view to developing rational prescribing guidelines in these patient populations. We will use interactive learning methods to illustrate appropriate clinical decision

making and engage participants in generating treatment algorithms based on case examples.

Refugee Psychiatry: Practical Tools for Building Resilience of Displaced Persons and Refugee Communities to Migration-Related Stressors
Chairs: James Griffith, M.D., Dyani A. Loo, M.D.
Presenters: Amitha Prasad, SuZan J. Song, M.D., Ph.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Distinguish between migrants, immigrants, refugees, torture-survivors, and political asylees as having differing needs for mental health services and psychiatric care; 2) Discuss how daily life stressors and loss of familiar identities are both major sources of migration-related stress; 3) Articulate a systematic process of needs assessment for mental health services and psychiatric care of individual refugees and refugee communities; 4) Demonstrate resilience-building interventions that can help refugees cope with migration-related stress symptoms as individuals; and 5) Demonstrate resilience-building interventions that can help a refugee community to cope with migration-related stressors as a community.

SUMMARY:
Currently, 65.3 million persons worldwide have been displaced from their home countries by armed conflict, political oppression, starvation, or other catastrophes. Since 1975, three million refugees have arrived in the U.S., 40% of whom have been children. Greater awareness is needed about different categories of displaced persons, including migrants, immigrants, refugees, torture-survivors, and political asylees, who have differing needs for mental health services and psychiatric care. In the past, psychiatric care for refugees has focused primarily upon treatment of posttraumatic stress disorder (PTSD) and depression as psychiatric illnesses precipitated by the traumatic events that prompted flight from home countries. However, recent research has indicated a greater need for addressing migration-related traumas and post-migration daily life stressors that maintain symptomatic PTSD and depression. The latter contribute to persistent grief, family discord, ambiguous losses of loved ones, and feelings of helplessness that impede refugees from living healthy and productive lives. This research has prioritized the need for individual and community resilience-building interventions that address migration and post-migration stressors. During this workshop, we will 1) distinguish among different subgroups affected by displacement; 2) outline a systematic process of needs assessment for refugee mental health services and psychiatric care; 3) review current literature on best practices for addressing migration-related traumas and daily life stressors; and 4) demonstrate resilience-building strategies for refugees as individuals and as refugee communities.

SOLVD-TEEN and SOLVD-PARENTS: Can an App Help Teens and Their Parents With Depression?
Chair: Nidal Moukaddam, M.D., Ph.D.
Presenters: Asim Shah, Sophia Banu, M.D., Anh L. Truong, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the role technology can play in the treatment of depression in adolescents; 2) Identify the role technology can play in the treatment of depression in adolescents' parents; and 3) Discuss the equivalence between information collected via app versus that collected via clinical assessments.

SUMMARY:
The SOLVD (Smartphone and Online Live Assessment of Depression) study has already proven that, in adults with depression, information collected via a custom-designed smartphone app is equivalent to standardized questionnaires in the psychiatric outpatient setting. In this workshop, we will share the results of our most recent study, extended to evaluate the relationship between smartphone usage and depression symptoms in the adolescent population and their (depressed) parents using two new apps: SOLVD-TEEN and SOLVD-PARENT. It has been well established that the risk of anxiety, major depressive and substance use disorders is three time as high in adolescents of depressed parents compared to adolescents of parents who are not depressed. However, little research has evaluated how treatment of adolescent depression may influence parental depression. And while 20% of all adolescents will experience a depressive episode by

age 18, resulting in increased risk of adverse psychosocial outcomes (i.e., educational underachievement, unemployment, early parenthood, increased risk of later major depression, and substance abuse), they have low rates of seeking care or completing referrals for psychotherapy. Barriers to seeking treatment may include stigma, limited transportation, fear of speaking to providers, and cost. However, Pew Research Center has reported that 73% of teens have access to and use smartphones on a daily basis. While there has been some literature evaluating the efficacy of smartphone applications for the screening and treatment of depression in the adult population, there are currently no studies that evaluate the use of smartphone applications in the monitoring and treatment of depression in the adolescent population. Participants in this workshop will learn about the relation of smartphone-collected data and depression symptoms monitored using the Children's Depression Rating Scale (CDRS), the Patient Health Questionnaire (PHQ-9) and the Hamilton Anxiety Questionnaire (HAM-A). Parents with depressed teenagers who also have depression have benefited from adolescent treatment, and these results will be presented as well. The comorbidity of posttraumatic stress disorder and the role of regular versus intensive outpatient care in those results will be highlighted. Finally, the workshop will discuss the challenges of designing apps with clinical usefulness in mental health, and specifically for adolescents, based on our team's interdisciplinary mental health and engineering collaboration.

Tele-Mentoring for Building Mental Health Capacity in Rural Primary Care: The ECHO Model

Chairs: Allison Crawford, M.D., M.A., Sanjeev Sockalingam, M.D.
Presenters: Lisa Lefebvre, Eva Serhal, M.B.A., Amanda Arena, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Understand the Project ECHO model and the gaps in health care delivery it proposes to solve; 2) Outline the considerations required when developing and implementing a Project ECHO program; 3) Demonstrate the possibilities for technology to increase engagement and capacity in mental health education and reduce professional isolation; and 4) Describe existing evidence to support the Project ECHO model and future areas of evaluation that need to be addressed.

SUMMARY:

A high proportion of mental health and addictions are managed in primary care. However, primary care providers (PCP) have limited access to psychiatric support. Although the emergence of collaborative care has provided one answer to this growing need, there remain further challenges to building mental health capacity in primary care, particularly in remote and underserviced areas. Project Extension for Community Healthcare Outcomes (Project ECHO©) is a "hub" and "spoke" tele-mentoring model that uses a virtual community of practice to leverage scarce health care resources in rural communities; PCPs connect with a specialist team and providers practicing in similar settings to discuss complex real-world patients, share knowledge and learn best practices in the management of complex chronic illness. The Project ECHO model has been adopted globally for the treatment of various conditions, including hepatitis C, HIV and diabetes; however, its use in mental health and addictions has been limited. In 2015, the Centre for Addiction and Mental Health (CAMH) and the University of Toronto (UofT) launched the first Canadian Project ECHO focused on mental health care: ECHO Ontario Mental Health. In this workshop, we will describe the Project ECHO model and how it can be used to build specialized mental health capacity in PCPs. We will include practical approaches to implementation, curriculum development, evaluation, and the integration of technology. We will also present results from our recent literature review on Project ECHO and the outcomes of our evaluation. Dr. Lefebvre will provide an introduction to ECHO's core concepts and methodology, including the results from our recent review of international literature on outcomes related to ECHO. Ms. Eva Serhal will outline an implementation science framework developed by our team that has since been adopted by other ECHO projects. Dr. Crawford will present our methods and findings related to the development of a 32-week curriculum, using David Kern's approach. Ms. Amanda Arena will present our multilevel approach to evaluation, employing Donald

Moore's framework, along with our findings related to improved knowledge and self-efficacy. Dr. Sockalingam will describe our use of case-based pedagogical methods, including our findings on how this approach helps participants manage mental health care of increasing complexity. He will describe our application of adaptive expertise learning theory to explain these findings. In her wrap-up and summary, Dr. Crawford will discuss the future of Project ECHO and its use as a systems-based knowledge translation vehicle, along with future research priorities for the use of ECHO to improve capacity in mental health care. At the conclusion of the workshop, participants will be given a toolkit with resources on the ECHO model, implementation considerations and evaluation framework that can be used to support expansion of ECHO in their local setting.

The New Face of Diversity Education: Yale's Social Justice and Mental Health Equity Residency Curriculum

Chairs: Kali D. Cyrus, M.D., M.P.H., Robert M. Rohrbaugh, M.D.
Presenters: Ayana Jordan, M.D., Ph.D., Chyrell Bellamy, Ph.D., M.S.W., Melissa Cranford, M.D.

EDUCATIONAL OBJECTIVE:

1) Compare pedagogical approaches to diversity education in medical education; 2) Identify key steps that have shaped the evolution of the Yale department of psychiatry's cultural competence education; 3) Discuss the current efforts and alignment with the mission of social justice and value for mental health equity; 4) Identify specific resources used to meet the objectives of the social justice and mental health equity curriculum; and 5) Outline lessons learned from implementation of the curriculum and future directions.

SUMMARY:

The ACGME outlines basic standards for diversity education; however, the pedagogical strategy and amount of resources dedicated to the topic vary by institution. While the standards outlined by the ACGME provide latitude to design curriculum suited to the institution, what may result is a neglect of key topics that enforce the existence of a hidden or even silent curriculum. Understanding topics such as racism, inequity and the structures that uphold inequality are paramount for training psychiatrists. This is especially true as the nation becomes more diversified, and the sociopolitical climate surrounding the acceptance of this diversification intensifies. Our workshop will describe the development of the Yale department of psychiatry's multifaceted approach to educating residents, which is rooted in a mission of social justice and equity in access to, treatment of and outcomes of mental health. We will take the audience on a tour of our curriculum through each year of the residency, including our approach to four programs: Cultural Psychiatry, Exploring Bias, Structural Competency, and the BioPsychoSocial course. The "Cultural Psychiatry" curriculum uses residents as teachers to instruct residents on disparities in mental health, including the factors influencing disparities such as microaggressions, bias and privilege and also trains them to use cultural formulation in the psychiatric interview. "Exploring Bias" covers key topics in sociology and public health, such as social determinants of health and bias/racism/privilege and utilizes group activities to highlight the diversity in resident group affiliations. We will then describe the "Structural Competency" curriculum, which creatively helps residents understand the challenges faced by populations in the five surrounding neighborhoods of New Haven. Using individuals from the community with mental illness, substance use histories and incarceration histories as co-facilitators, residents learn how to use community resources and neighborhood dynamics in devising holistic treatment plans. Next, we will describe the "BioPsychoSocial" course, which provides a foundation for assessing patients, formulating key dynamics in the patient's presentation and designing an appropriate treatment plan. Finally, we will discuss challenges encountered during the implementation of our curriculum and future directions.

The Pharmacological Management of Persistent Violence in Psychiatric Inpatients

Chair: Katherine Warburton, D.O.
Presenters: Laura Dardashti, Michael Cummings, Jonathan M. Meyer, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the clinical value of categorizing aggression into psychotic, impulsive and predatory subtypes and how this can inform clinical decision making; 2) Understand the neurobiological basis for impulsive aggression; 3) Utilize the evidence-based data from studies of psychotic and impulsive aggression to treat patients with schizophrenia spectrum disorders, traumatic brain injury and dementia; and 4) Understand the limitations of certain medications, including the absence of efficacy data for antipsychotic use in TBI patients, and the mortality risk for antipsychotics in dementia patients.

SUMMARY:
While the presentation of aggression in unmedicated or inadequately treated psychiatric patients is often dramatic and associated with agitation, these patients often respond robustly in the short term to standard psychopharmacological interventions. The more vexing clinical issue is the management of persistent aggression toward others encountered in psychiatric inpatient and forensic settings. While the diagnostic mix weighs heavily toward schizophrenia spectrum diagnoses, intellectual disability and cognitive disorders, clinicians must accurately classify the nature of aggressive events before embarking on any pharmacological course of action. Such categorization is critical to the determination of appropriate management strategies, which are necessarily based on the interplay between underlying psychiatric diagnosis and the nature of the violent episodes. The purpose of this workshop is to provide a rational therapeutic approach to the problem of persistent aggression and violence seen in long-term psychiatric inpatient settings and to educate psychiatrists on how the categorization of violent acts informs medication strategies within the most common diagnostic groups: schizophrenia spectrum disorders, traumatic brain injury (TBI) and dementia. Self-injurious behavior and other aggressive acts toward self, as well as the acute management of agitation in minimally treated patients, are not covered here to focus attention on the more intractably aggressive patient. This workshop will initially focus on studies that led to the development of a model that characterizes aggressive episodes into one of three primary forms: psychotic, impulsive or predatory/planned/instrumental. For nonacute inpatients with schizophrenia spectrum disorders, TBI and dementia, impulsive violence is the most common form of aggression, and this workshop will provide an overview of the neurobiology of impulsive violence. The workshop will then provide data and case examples from the California Department of State Hospitals, the world's largest forensic inpatient system (6,500 beds), to illustrate how one can use the psychiatric diagnosis to pursue evidence-based pharmacological approaches for psychotically motivated and impulsive aggression while discussing how instrumental violence mandates forensic/behavioral strategies. At the conclusion of this workshop, attendees should be able to accurately categorize the types of persistent aggression seen in their patients and implement the evidence-based pharmacological approaches to managing psychotic and impulsive violence. Attendees will also gain knowledge of the limitations of certain medications, including the absence of efficacy data for antipsychotic use in TBI patients and the mortality risk for antipsychotics in dementia patients.

The Role of Child and Adolescent Psychiatrists in Collaborative Care Settings: A New Frontier
Chairs: Megan E. Baker, M.D., Gabrielle L. Shapiro, M.D.
Presenters: Lorena E. Reyna, M.D., Christina Tara Khan, M.D., Ph.D., Tiffany Ho, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe evidence-based models of collaborative care in pediatric settings; 2) Understand a variety of roles that child and adolescent psychiatrists have throughout their careers in developing children's mental health services at the interface with primary care; 3) Identify steps and challenges in moving from a colocated mental health model to an integrated care model at a federally qualified community health center; and 4) Name common challenges involved in implementing a collaborative care mental health program and identify ways to overcome these barriers.

SUMMARY:
Despite the increasing involvement of child and adolescent psychiatrists in community-based

collaborative care settings, there are few opportunities for them to exchange information, share lessons learned, discuss their roles in interfacing with primary care, and problem solve barriers addressed in everyday practice. This workshop provides that opportunity. With a focus on pediatrics and child and adolescent psychiatry, this workshop will review evidence-based integrated care models, share presenters' experiences working in collaborative care as clinicians at various stages in their careers and encourage audience participation in sharing their own experiences and challenges. The presentation will start with a review of the literature on collaborative care, with an emphasis on evidence-based models of integrated care in pediatric settings, provided by Dr. Lorena Reyna. Dr. Megan Baker will discuss experiences doing clinical rotations as a child psychiatry fellow working with a behavioral health team at a community health center. She will discuss the learning opportunities and challenges of working as a trainee providing clinical care in an evolving integrated care service. Dr. Christina Khan will offer the perspective of an early career CAP working on integrating behavioral health care within a federally qualified community health center. The presentation will outline the steps being taken to integrate behavioral health into the pediatric setting and discuss the process of cultural and institutional shift. She will identify strengths and challenges, including practical considerations, collaboration with pediatric and allied mental health providers, and roles of the child and adolescent psychiatrist. Dr. Gabrielle Shapiro will describe the startup work involved in creating an integrated mental health program in a primary care clinic in Spanish Harlem. Her presentation will address the challenges of transforming the "siloed" mentalities and practices in the clinic into a mindset conducive to collaborative care. Dr. Shapiro will provide an update on what the model looks like as a functioning entity 18 months later and discuss future goals and directions. Dr. Tiffany Ho, medical director of behavioral health services of Santa Clara Valley Health and Hospital System, will provide an overview of current progress in developing integrated behavioral health in the county's network of adult and family and children primary care behavioral health clinics. She will also review the core components of integrated behavioral health implementation, including the use of universal behavioral health screening and integrated team meetings and warm hand offs. The final 35 minutes of the workshop will be used for audience questions, contribution of their personal experiences working in similar settings and reflections on the material being presented.

The Ultimate Balancing Act: Medicine, Marriage, Motherhood, and Me

Chairs: Almari Ginory, D.O., Sarah M. Fayad, M.D.
Presenters: Kimberly Gordon, M.D., Jacqueline A. Hobbs, M.D., Ph.D., Misty Richards, M.D., M.S.

EDUCATIONAL OBJECTIVE:

1) Learn about expectations women psychiatrists have for their careers, roles and life transitions and the challenges they experience developing a work-life balance; 2) Provide guidance on how other physicians have navigated this delicate balancing of roles; 3) Provide pearls and pitfalls in balancing the multiple roles that women in medicine have; 4) Discuss the barriers to career satisfaction in psychiatry among women and underrepresented minorities in their career development; and 5) Develop techniques that facilitate stress reduction and time management to prevent burnout and work-life conflict for women physicians.

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 and 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 choice can significantly affect one of their other roles in life and lead to disequilibrium. 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. Younger generations of physicians, including women, are seeking greater work-life balance and have a unique perspective on their careers and personal lives. With the new landscape of accountable care organizations

and growing demands of mental health care delivery, women psychiatrists are invested in maintaining the profession and require support to accomplish their career goals without compromise to their personal ambitions and family obligations. 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 who 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 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 of this balancing act with a variety of women and provide an open forum for discussion of the aforementioned issues. Each of the following will provide a personal glimpse at their daily balancing act: an early career, married, African-American/minority psychiatrist coping with fertility issues and the care of parents with end-of-life issues; an early career, married psychiatrist with a spouse and two children who changed jobs based on family demands while dealing with cancer; an early career, married, Hispanic, LGBT psychiatrist with two children; a seasoned psychiatrist and program director with a child, an older stepchild in medicine and live-in in-laws; and a child and adolescent psychiatry fellow who had a child while they and their spouse were in training.

To Treat or Not to Treat: Is That the Question? the Evaluation and Treatment of Mood Disorders in Case Examples of Pregnant Women

Chairs: Kara Driscoll, M.D., Lisette Rodriguez-Cabezas, M.D.

Presenters: Crystal Clark, Dana Mahmoud

EDUCATIONAL OBJECTIVE:

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 their childbearing years. In spite of this, identification of mood disturbance is often delayed and undertreated 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 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, 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 process. 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.

Undoing Stigma Through Entertainment: Lessons From Psychiatrists Interfacing With Pop Media

Chairs: Praveen R. Kambam, M.D., Vasilis K. Pozios, M.D.

Presenter: Holly Peek, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Appreciate the role of entertainment media in potentially perpetuating and reinforcing stigma and social prejudice against individuals with mental illnesses; 2) Appreciate the potential underutilized opportunity entertainment media represents to reverse such stigma and social prejudice; and 3) Recognize limitations to existing antistigma efforts and provide potential routes to further advance mental health advocacy.

SUMMARY:
Mental health stigma kills by discouraging people from seeking help because of fear and shame. Although mental health awareness has improved, stigma persists. How do we end it? The misrepresentation of mental illnesses in mass media is, arguably, the largest contributor to mental health stigma because media shapes culture and, in turn, our perceptions of people living with mental illnesses. Can we responsibly entertain audiences acculturated to inaccurate and stigmatizing mental health depictions? How have other historically under-/misrepresented groups fared in fighting negative stereotypes through media? Does mental health stigma present different challenges that require unique solutions? Forensic psychiatrists and cofounders of the mental health and media consulting group Broadcast Thought, Praveen R. Kambam, M.D., and Vasilis K. Pozios, M.D., will present their strategy to end stigma by shifting the paradigm of mental health media representation. Drs. Kambam and Pozios will discuss how best to effect change in the entertainment industry through the active engagement of content creators, demonstrating that entertainment and advocacy need not be mutually exclusive. Holly Peek, M.D., M.P.H., will share her experiences as a medical journalist on radio, social media and print publications. Dr. Peek will discuss pitfalls and challenges in delivering accurate mental health information, as well as recommended strategies to combat stigma. By understanding the principles of storytelling, mental health advocates can more effectively consult writers and producers and even create mental health-themed content themselves. Conversely, consultants can help the entertainment industry learn from the moving life stories of those in recovery while mindfully managing brands and avoiding embarrassing public relations missteps. Innovative and responsible mental health media representations can move depictions of mental illness beyond existing tropes into new and compelling directions, changing audience perceptions in the process.

Update From the Council on Psychiatry and Law
Chair: Steven K. Hoge, M.D., M.B.A.
Presenters: Robert L. Trestman, M.D., Ph.D., Carl Erik Fisher, M.D., Stuart Anfang, M.D., Patricia Recupero, Debra Pinals, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the different kinds of policy documents produced by the APA (e.g., position statements and resource documents) and understand the procedures for their review and approval; 2) Understand the issues related to new legislation regarding physician-assisted suicide; 3) Understand the role of physician health programs and medical boards in identifying impaired physicians; 4) Understand the need for psychiatrists to provide services in jails and prisons; and 5) Understand the issues related to the conduct of research on involuntary patients.

SUMMARY:
This workshop will provide participants 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 an update on recent and ongoing issues the Council is addressing. This workshop will provide participants 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. Anfang will discuss ongoing work on an APA resource document regarding physician-assisted suicide legislation. Dr. Recupero will discuss the role of medical boards and physician health programs in the identification and management of impaired physicians. Dr. Trestman will discuss a resource document regarding the need for psychiatrists to provide treatment in jails and prisons. Dr. Fisher will discuss the development of a resource document on the conduct of research involving involuntary

psychiatric inpatients. In each area, the Council will elicit feedback from members regarding important policy issues. These topic areas may be changed if more important issues arise prior to the Annual Meeting.

Updates on Advocacy in the Era of a Trump Administration

Chair: Debra Pinals, M.D.
Presenters: Ariel Gonzalez, Esq., Patrick S. Runnels, M.D., Debra Koss, M.D., Mary C. Vance, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe current topics undertaken through the Council on Advocacy and Government Relations; 2) Delineate approaches to educating members about advocacy and legislative matters; and 3) Discuss priorities for the APA to take toward advocacy and government relations.

SUMMARY:

With the changing Administration, please come and learn about APA advocacy priorities and strategy in 2017 and beyond. Topics will include APA federal legislative priorities, how to work proactively on the Hill and in the executive branch to protect mental health services, and how the Council on Advocacy and Government Relations is developing member-based products to help you become a more effective advocate.

Utilizing Assertive Community Treatment (ACT) to Prevent Inefficient Use of Psychiatric Resources on Patients With Chronic Mental Illness

Chairs: Benjamin Ehrenreich, M.D., Ann Hackman, M.D.
Presenters: Albert Nguyen, Bhinna Pearl Park, M.D., Brian Benjamin

EDUCATIONAL OBJECTIVE:

1) Define assertive community treatment (ACT); 2) Identify which patients would benefit from ACT; 3) Describe challenges developing effective aftercare plans for highly recidivistic patients; and 4) Discuss strategies to engage patients from the emergency and inpatient settings.

SUMMARY:

As psychiatric trainees, we regularly encounter patients with high recidivism rates due to psychiatric decompensation despite frequent emergency room visits and multiple annual inpatient admissions. In 1974, an article was published detailing a program in Madison, Wisconsin, that aimed to treat patients in the community that would normally be treated in a psychiatric inpatient setting. Not only did this program find positive clinical improvements in hospitalizations, psychiatric symptoms, employment, relationships, and life satisfaction, but the cost-benefit analysis also found a reduction in overall cost. The tenets of this program serve as the foundation to what is now referred to as assertive community treatment (ACT). Some of the ACT principles include a patient-centered approach, multidisciplinary team, family involvement, vocational support, and mobile treatment. Despite the availability of a clinically and financially superior alternative to inpatient psychiatric admissions for a subset of patients, psychiatric trainees are still frequently asked to provide an aftercare plan for highly recidivistic patients whose needs are not adequately met by traditional services and who would benefit from ACT services. Although there are several ACT fidelity scales, there has been little focus on appropriately identifying individuals who will benefit from ACT's intensive, recovery-oriented outreach service, and virtually no attention has been given to ways in which referral sources might facilitate engagement between patients and an ACT team. Our workshop provides a trainee's perspective on the challenges of developing an aftercare plan for these patients and identifying individuals who may most appropriately be served in an ACT setting, Further, we will explore ways in which inpatient and emergency providers can facilitate the engagement of these individuals with ACT services, including making use of ACT on-call service, patient and family involvement, and staff education. Using the University of Maryland Medical Center, which serves an underserved urban population, as our model, we will provide cost estimates for a variety of psychiatric resources to provide insight into the disease burden of chronic mental illness. Ultimately, we hope to outline a compelling argument for the implementation of ACT as well as a thoughtful discussion across disciplines on the challenges and strategies for doing so.

What's New in Neuropsychiatry? A Primer for General Psychiatrists

Chairs: Vivek Datta, M.D., M.P.H., Sheldon Benjamin, M.D.

Presenters: Vivek Datta, M.D., M.P.H., Tom Pollak, Sepideh Bajestan, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Know when to suspect an autoimmune cause of a psychiatric presentation; 2) Become familiar with the literature on the prevalence of antineuronal antibodies in psychiatric disorders; 3) Know the manifestations of the C9orf72 hexanucleotide repeat expansion and its relevance to psychiatry; 4) Understand the behavioral variant frontotemporal dementia phenocopy syndrome and its psychiatric determinants; and 5) Discuss some of the psychotherapeutic treatments for functional neurological symptoms (conversion disorder).

SUMMARY:

In recent years, there has been an explosion of research in the field of neuropsychiatry. The promulgation of clinical neuroscience milestones for general psychiatrists has further underscored the importance of familiarity with neurological and psychiatric comorbidities, neurodiagnostic methods, and neuroscience findings relevant to psychiatric symptoms. The discovery that N-methyl-D-aspartate receptor (NMDA-R) antibody-associated encephalitis may present with psychosis and other psychiatric symptoms has led to renewed interest in the possible autoimmune etiology of a range of psychiatric disorders, with exciting prospects for the use of immunological therapies in psychiatry. It is now incumbent on the psychiatrist to be able to recognize when a psychiatric presentation may be due to an autoimmune disease. Furthermore, the discovery of the C9orf72 hexanucleotide repeat expansion has revolutionized our understanding of frontotemporal dementia. This gene has been associated with psychosis and mania that may precede the onset of dementia by many years. Conversely, some patients who present with atypical symptoms of behavioral variant frontotemporal dementia do not have degenerative disease, but a "phenocopy syndrome" that may be related to a range of psychopathology, including autistic spectrum disorders, cluster C personality traits, anxiety disorders, psychotic disorders, and bipolar disorders. Functional neurological symptoms (conversion disorder) often present a challenge for clinicians, falling as they do between the conventional boundaries of neurology and psychiatry. In recent years, there has been renewed interest in understanding the related neurocircuits and developing evidence-based treatments for conversion disorder, including cognitive behavior therapy and psychodynamic approaches. In this workshop, these important developments in neuropsychiatry, in addition to effective strategies in presenting the diagnosis of conversion disorder to patients, will be discussed as they pertain to the busy general psychiatrist. Participants are encouraged to share their own cases and solicit advice from the panel on the management of atypical psychiatric presentations.

When Love Hurts: Intimidation and Intimacy in Intimate Partner Violence

Chair: Shawna Newman, M.D.

Presenters: Nadya Friedman, M.D., Mayumi Okuda, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the characteristics, prevalence and frequency of individual forms of intimate partner violence (IPV) as well as IPV-related impact; 2) Demonstrate the impact of IPV on the physical and mental health of its victims as well as its perpetrators; 3) Describe psychological and psychoanalytic implications for victims of intimate partner violence; and 4) Describe studies examining the neurobiology of abuse and current research on the association between IPV and new onset of psychiatric disorders.

SUMMARY:

Intimate partner violence (IPV) is alarmingly prevalent and remains a serious public health problem affecting millions of Americans. For individuals who experience IPV, the impact is a major contributor to depression, anxiety, substance use, and other forms of mental illness. Remarkably, psychiatry is largely absent from research on and interventions for IPV. This workshop will focus on increasing knowledge and a better understanding of

IPV and its presence and prevalence in our society. This will include information regarding assessment of IPV, including screening, goals for prevention and available treatments that address IPV. Furthermore, the workshop will demonstrate a psychoanalytic conceptualization of the relationships between victim and abuser, as well as discuss the different areas of research on partner abuse. Our workshop will describe animal models of attachment as well as studies that can help us understand the neurobiology of attachment to an abusive partner. The presentation will also present data from a large nationally representative study in the United States and large cohort of individuals in the UK, both highlighting the association of IPV and the new onset of psychiatric disorders ranging from mood, anxiety, substance abuse, and psychotic spectrum disorders. Finally, the presentation will provide a platform for discussion of future directions of IPV research.

Women at War: Experiences of Female Psychiatrists in Combat

Chairs: Elspeth C. Ritchie, M.D., M.P.H., Connie Barko, M.D.
Presenter: Vanessa Green, D.O.

EDUCATIONAL OBJECTIVE:

1) Know reproductive and gynecological challenges for women deployed to war; 2) Understand mental health issues of female servicemembers; and 3) Hear personal stories of female military psychiatrists.

SUMMARY:

For women, 9/11 ushered in an increasing role in the U.S. military. Technically, only recently have women officially been allowed into combat occupations. However, it is now widely accepted that women have been in combat since long before 9/11. The combat exclusion rule was recently repealed, theoretically allowing women in all combat occupations if they can meet physical fitness standards. Military women also make up a high proportion of medical personnel, who see the consequences of the casualties of war. These include not just wounded soldiers and Marines, but enemy combatants and local casualties of bomb blasts and shootings. This workshop will 1) highlight the medical challenges for women in military service and on deployment, with a focus on reproductive and gynecological systems; 2) focus on mental health issues for military women; and 3) translate issues into actionable information for clinicians. Female military psychiatrists are intimately familiar with all these issues, both as servicemembers and as clinicians treating other servicemembers. They will also share their personal experiences. The textbook *Women at War* by Col. (ret) Elspeth Cameron Ritchie and Col. Anne Naclerio was published by Oxford University Press in June 2015. This workshop highlights important themes from that volume.

Monday, May 22, 2017

A Cognitive Behavioral Approach to Weight Loss and Maintenance

Chair: Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Teach dieters specific “pre-dieting” cognitive and behavioral skills; 2) Keep long-term motivation high; 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. 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 term, they generally revert 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 their clients 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 a lifetime.

A Training Course Curriculum for Psychiatrists: High-Value Care

Chairs: Ali Asghar-Ali, M.D., David A. Stern, M.D.
Presenters: Melissa Arbuckle, M.D., Ph.D., Andres Barkil-Oteo, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:

1) Describe the role of a physician as a resource manager; 2) Distinguish between the most common alternative payment methods; 3) Name the ACGME subcompetencies related to resource management; and 4) Have tools to teach other psychiatrists the essentials of resource management.

SUMMARY:

The Affordable Care Act, industry and the government are moving to address the reality that health care organizations need to provide high-value care. For the most part, however, physicians have not been a major player in driving these changes. This is not to say physicians do not play a significant role in health care costs. In fact, physician decisions (e.g., which tests, procedures or medications to order) are a main driver of spending. Moreover, recent research suggests that a portion of this spending is on treatments or tests that are wasteful (i.e., not in line with professional organization recommendations or not shown to improve outcomes over a lower-cost alternative). With this information, "value-based payment" programs are being proposed or implemented as an alternative to traditional "volume-based payment" reimbursement models. Examples of the alternative payment models include accountable care organizations (ACOs), patient-centered medical homes and bundled payment models. These changes in payment models underscore the role of the physician as a resource manager and will undoubtedly create "top-down" changes in psychiatrists' clinical practice. The ACGME milestone initiative includes "resource manager" as a competency for residents. However, what is missing is a "bottom-up" approach to teach and engage practicing psychiatrists about the importance of value-based care as a part of excellent patient care. Traditionally, psychiatry residents have received limited education on resource management. Few models exist for teaching residents how to integrate cost considerations into patient care. During this workshop, we will provide an approach to teaching resource management and high-value care that can be applied to medical students, resident physicians and practicing psychiatrists alike. We will review the increasing role of the physician as a "resource manager." This will be followed by the presentation of a resource management course that addresses how to balance the costs and the value (or clinical benefit) of various treatment decisions. The resource management curriculum has been successfully implemented at three different academic institutions, where it is taught during two interactive classroom sessions involving a variety of small- and large-group activities. Participants in the workshop will receive training materials to use at their facility, along with pre- and post-tests to assess their learners' knowledge. Finally, the workshop will introduce "next steps" in expanding our understanding of value in the practice of psychiatry.

Adding a Leaf to the Dinner Table: Making the Case for Family Therapy and Assessment in Training Programs

Chairs: Sarah A. Nguyen, M.D., Francis Lu, M.D.
Presenters: Sarah A. Nguyen, M.D., Madeleine S. Abrams, L.C.S.W., Daniel Patterson, Alison M. Heru, M.D., Esther Rollhaus

EDUCATIONAL OBJECTIVE:

1) Understand the importance of family assessment and therapy in residency programs to meet ACGME standards involving sociocultural issues and family violence, among others; 2) Describe an example of a comprehensive couples and family assessment and therapy training curriculum; 3) Understand, through case vignettes, the impact of family training on residents and fellows dealing with underserved populations in diverse, multicultural settings; 4) Discuss challenges of integrating family assessment and work with individuals, families and larger systems into residency programs and how to address these issues; and 5) Understand that reluctance to

include partners or families in training and treatment may be linked to personal family experiences and consider ways to overcome the therapist's resistance.

SUMMARY:
While the ACGME standards for general psychiatry residency programs do not explicitly acknowledge family assessment and therapy as a requirement, this workshop will demonstrate the importance of these skills to fulfill requirements concerning "sociocultural issues associated with etiology and treatment," "recognizing and responding appropriately to family violence," and knowledge of "family factors that significantly influence physical and psychological development throughout the life cycle," among others. Currently, there are only eight residency programs nationwide recognized as providing in-depth training in family assessment and therapy, defined by scheduled supervision as well as a dedicated curriculum that includes courses, seminars and electives. As psychiatry moves toward an integrative model, a more extensive understanding of family networks, dynamics and skills can guide more effective and comprehensive treatment from an individual, family and medical approach. Understanding individuals as part of a larger family and community system (hospital, clinic, residency training), as well as a system of learning, will help navigate various systems of care (i.e., health care, mental health, agencies, and legal system). In this workshop, case vignettes spanning residency and fellowship will be presented to demonstrate how continued and comprehensive family assessment and therapy training can provide a more in-depth understanding of the trainee's own family, cultural and social context and continue to influence treatment approach in any setting (inpatient, emergency room, outpatient, and consultation-liaison psychiatry). Since the populations with whom the trainees interact are culturally and socioeconomically diverse as well as largely underserved, the vignettes will address the additional challenges to providing good care. In parallel, the residents and fellows come from diverse backgrounds and life experiences as well. Thus, we will illustrate how family assessment and therapy training plays an integral role in understanding how to navigate these complexities on a personal, family and systemic level. Finally, the workshop will highlight challenges to integrating family assessment and therapy into the residency and fellowship curricula. We want to consider why marginalization and negative attitudes occur and illustrate the benefits of including skills and knowledge of families into training in psychiatry, since family assessment and interventions are underutilized and given limited importance in psychiatric training. In conclusion, ideas on how to integrate family assessment and therapy into routine patient care and training will be presented to support a more comprehensive and multimodal treatment paradigm that incorporates both family and systems perspectives.

Boundary Violations in Correctional Settings
Chairs: Ryan C. W. Hall, M.D., Susan Hatters Friedman, M.D.
Presenters: Ryan Wagoner, M.D., Renee Sorrentino, M.D., Abhishek Jain, M.D., Brian Cooke

EDUCATIONAL OBJECTIVE:
1) Identify situations in which boundary violations occur in correctional situations; 2) Compare and contrast traditional boundary violations in psychiatry with types of violations that occur in corrections; and 3) Understand how boundary violation prevention techniques in psychiatric training and practice can be applied to correctional situations.

SUMMARY:
As can be seen from the news headlines "Four Female Prison Guards Impregnated by Same Inmate," "Prison Tailor Used Food to Help Killers Escape" and "Expert: Escaped California Inmates Must Have Had Inside Help" and the fictional accounts in *The Shawshank Redemption*, boundary violations can occur in many settings and relationships outside the classic therapy setting. This workshop will review classic concepts found in therapeutic relationships of transference and countertransference and how psychiatry and psychology have traditionally encouraged practitioners to avoid boundary crossings. Seminal work on the dynamics for guard-inmate relationships such as the 1970s Stanford Prison Experiment, 1960's Milgram experiment on obedience to authority figures and other works will be discussed to provide context for the spectrum of correctional

staff/inmate interactions. The effects of gender will be reviewed (e.g., variables found in male or female correction facilities such as length of sentences, staffing, same-sex versus opposite-sex guard-inmate interactions). In cases where boundary violations occur, we will look at the different types of relationships correction employees and inmates can have (e.g., consensual, forced and manipulative). We will discuss vulnerabilities that can lead to boundary violations as well as look at the consequences of such relationships such as contraband, loss of position and creating an unsafe environment for inmates, guards and other correctional employees (e.g., correctional health personal). For the workshop portion of the session, hypothetical cases will be presented for the audience to debate and discuss. At the conclusion of the workshop, participants will have a better understanding of the dynamics found in correctional settings and how techniques from standard mental health training can be applied to this unique set of circumstances and population.

Bullying and Harassment in the 21st Century: Prevalence, Screening and Psychiatric Consequences of Cyberbullying and Online Harassment

Chairs: Almari Ginory, D.O., Christopher F. Ong, M.D.
Presenters: Krista Pinard, M.D., Yuliet Sanchez-Rivero, M.D., Laura Ginory, M.D.

EDUCATIONAL OBJECTIVE:

1) Examine the various subtypes of online harassment; 2) Review current knowledge regarding the prevalence of various subtypes of online harassment; 3) Discuss methods for screening and preventing online harassment; 4) Examine the relationship between cyberbullying and specific psychiatric disorders; and 5) Provide real-world examples of online harassment as they pertain to providers and patients.

SUMMARY:

The transition to adolescence brings on a whole new set of life challenges and experiences, arguably the most important of which is the increased emphasis on dating and relationships. While this concept is not new, the ever-growing ease of access to the Internet via ubiquitous devices such as mobile phones and tablets is definitely new. With up to 98% of young adults using cell phones in 2013 alone, it begs the question as to how the Internet has changed the way teenagers make the transition into that specific stage in life where dating and relationships become a higher priority. The purpose of this workshop is to review the fundamentals of cyberbullying regarding various types and their prevalence. We will then discuss the results of recent large-scale studies that have provided greater insight into the specific risks of developing various psychiatric disorders due to ongoing cyberbullying and online harassment. The continuing development of screening strategies for clinical use will be discussed in addition to recent, high-profile examples of online harassment. The goal will be to have an open forum where attendees can ask questions and discuss issues/concerns and to provide residents with guidelines for their practice and training.

CBT for Suicide Risk

Chair: Donna M. Sudak, M.D.
Presenters: Jesse H. Wright, M.D., Ph.D., Judith S. Beck, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Assess and modify hopelessness and suicidal thinking with CBT principles; 2) Describe research that supports CBT for reducing suicide risk; and 3) Implement antisuicide plans with at-risk patients.

SUMMARY:

Suicide is the tenth leading cause of death in the United States (2014). Cognitive behavior therapy (CBT) approaches to the suicidal patient have been proven to reduce rates of future attempts. Active and collaborative work to reduce hopelessness and specific antisuicide plans are important features of this approach to patients. This workshop will briefly review research on CBT for treating suicidal patients. Then the central features of CBT methods for suicide risk will be demonstrated. Role-play demonstrations will illustrate key points. Particular attention will be paid to the collaborative development of an antisuicide plan in a depressed patient.

Challenges in Cognitive Behavior Therapy: Overcoming Barriers to Effective Treatment

Chairs: Jesse H. Wright, M.D., Ph.D., Judith S. Beck,

Ph.D.
Presenters: Donna M. Sudak, M.D., David Casey, M.D.

EDUCATIONAL OBJECTIVE:
1) Detail key strategies for overcoming common challenges to effective implementation of cognitive behavior therapy (CBT); 2) Describe common problems in implementation of successful cognitive behavior therapy; and 3) Develop CBT formulations to address barriers to effective treatment.

SUMMARY:
Experienced cognitive behavior therapists who are authors of widely used writings and videos on 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 workshop will be on modifications of CBT for patients who have chronic cognitive and behavioral patterns that may impede the progress of treatment. 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. Specific challenges that will be addressed include 1) tailoring CBT for treatment-resistant depression; 2) working with core beliefs that can undermine therapy; 3) helping patients who are stuck in maladaptive behavioral patterns; and 4) adapting treatment for elderly persons. Workshop leaders will respond to participants' requests for guidance on working with difficult-to-treat patients. The primary educational methods used will be brief explanations of methods for overcoming challenging treatment issues, role play demonstrations of these methods and discussion with participants.

Consequences of Breaching the Standard of Care: From Lawsuits to License Action
Chairs: Adrienne M. Saxton, M.D., Dorthea Juul, Ph.D.
Presenters: Larry R. Faulkner, M.D., Stephen G. Noffsinger, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize that the potential consequences of negligent psychiatric care extend beyond lawsuits, e.g., disciplinary action by state medical boards including restriction or loss of medical license; 2) Review the concept of "standard of care" and recent trends in psychiatric malpractice lawsuits; 3) Understand the basics of psychiatric malpractice lawsuits, including the four elements of negligence, timeline of malpractice action and common pitfalls; 4) Learn about the various routes in which psychiatrists can be disciplined, different types of actions by state medical boards and trends related to psychiatrists in trouble; and 5) Practice identifying dereliction of duty, causation and potential grounds for license action in various clinical scenarios.

SUMMARY:
When the thought of negligent care comes up, the first worry that often comes to mind for a physician is "Lawsuit!" Although malpractice claims can be stressful and scary, the good news is that psychiatrists have a relatively low risk of lawsuits compared to other specialties. Nonetheless, 2.6% of psychiatrists face a lawsuit annually. Having a basic understanding of malpractice can help psychiatrists provide better, more comprehensive care to patients and can help to ease anxiety when a lawsuit is raised. Interestingly, although psychiatrists have a fairly low risk of malpractice lawsuits, studies have shown that psychiatrists tend to have higher rates of disciplinary action by state medical boards compared to other specialties. Although disciplinary action may not be the first thing that comes to mind when one thinks of breaching the standard of care, it does happen to mofe than 4,000 physicians per year. While a lawsuit would generally be paid by malpractice insurance and the psychiatrist would continue practicing, the consequences of disciplinary action can be very severe, including loss of medical license. Participants in this workshop will learn about different potential consequences of breaching the standard of care. We will have an interactive discussion about the concept of "standard of care" and review the nuts and bolts of psychiatric malpractice cases. We will discuss clinical cases and ask for audience input on the question: "Was it malpractice?" We will then turn our attention to the less frequently discussed topic of disciplinary action against psychiatrists by state medical boards. This workshop will provide an overview of the different

types of disciplinary processes, with a focus on disciplinary action by state medical boards. National trends related to disciplinary action against psychiatrists, including recent data collected by the American Board of Psychiatry and Neurology, will be presented. Participants will review cases in which varying levels of disciplinary action took place against the psychiatrist and be asked for their ideas about what the outcome was. We will end the workshop with suggestions on ways to avoid bad outcomes, including malpractice claims and disciplinary action.

Cross-Professional Training to Address the Mental Health Gap

Chairs: Lawrence Malak, M.D., Jessica Thackaberry, M.D.

Presenters: Steve H. Koh, M.D., M.P.H., Alexandra Sietsma, N.P.

EDUCATIONAL OBJECTIVE:

1) Understand the physician shortage and need for increased access to mental health care; 2) Understand the importance of cross-professional training to increase access to mental health care; 3) Understand how to implement training of primary care providers and residents; and 4) Understand the role of nurse practitioners in providing psychiatric care.

SUMMARY:

The need for psychiatric care and mental health providers continues to grow, while access to care remains limited in many communities across the country. Some studies and reports demonstrate a need for as many as 45,000 additional psychiatrists to satisfy the demands of our patients. This is an overwhelming need for our patients and our systems of care. Couple that with residency slots remaining stagnant over the last decade and our field having 50% of providers over age 55, clearly psychiatrists alone will not meet this daunting need. This demand for more providers to treat patients with unmet mental health needs creates a unique opportunity to cross-train other multidisciplinary providers in both primary care settings and psychiatric training sites and clinical practice. This workshop will examine the need for increased access to psychiatric care and mental health providers and look at efforts to help meet those needs through cross-professional training. We will review programs at UC San Diego to cross-train students and residents from various backgrounds: psychiatric nurse practitioner students in a psychiatric resident training clinic, family medicine residents based in an FQHC in Chula Vista, and family medicine nurse practitioner providers and students based in an integrated primary care setting. The formation of these joint training programs and the unique challenges and opportunities that come with cross-training providers with various backgrounds is examined and discussed with the panel of presenters and audience members.

Decrypting the CPT Codes: An Interactive Case-Based Workshop to Demystify Coding and Documentation for Psychiatrists

Chair: Gregory Harris, M.D., M.P.H.

Presenters: Jeremy Musher, M.D., Sarah Parsons, D.O., Junji Takeshita, M.D., Patrick Ying, Ronald Burd, M.D.

EDUCATIONAL OBJECTIVE:

1) Learn about changes to CPT coding and documentation requirements; 2) Become familiar with the CPT coding and valuation process (i.e., CPT and RUC) and the impact on reimbursement; and 3) Get feedback from CPT coding experts on specific coding questions.

SUMMARY:

Psychiatrists providing direct patient care are facing increasing pressure from public and private payers to code and document their services appropriately. Adjusting to the 2013 changes in CPT coding for psychiatrists, which allow for greater flexibility in documenting evaluation and management services along with psychotherapy, continues to be a struggle for clinicians and third-party payers alike. Drawn from actual inquiries from the APA Practice Management Helpline, interactions with CMS and other regulatory bodies, and experiences with third-party audits, case scenarios will be presented that will highlight the most common problems encountered by clinicians, the latest trends and controversies with third-party payers, and changes and updates from CMS, including the new collaborative care codes. In addition to reviewing basic principles of coding for evaluation and

management, some examples of the topics to be covered are proper documentation of psychotherapy, telephone and telemedicine encounters, and questions of medical necessity with regard to frequency of E/M visits. Following each case, questions will be posed to participants, and attendees will be able to assess their own knowledge of CPT coding and guide the level of discussion of the cases. Finally, at least a third of the workshop will be dedicated to participants presenting their own cases and questions to the panel of coding experts.

Disaster Psychiatry: Current Needs in Managing Climate Change

Chair: Joshua Morganstein, M.D.
Presenters: Robin Cooper, M.D., Lise Van Susteren, M.D., James C. West Jr., M.D.

EDUCATIONAL OBJECTIVE:

1) Discuss the range of adverse psychological and behavioral reactions to natural disasters, which are increasing in frequency and severity as a direct result of climate change; 2) Review the type and frequency of climate-related natural disasters and their impacts on health within participants' regions through the use of interactive online resources; 3) Describe populations most vulnerable to adverse mental health effects of climate change and review methods of enhancing individual's and community's resilience through facilitated small-group activities; and 4) Understand responses, barriers to adaptive behavioral change and communication challenges regarding the threat of climate change through participant role play.

SUMMARY:

Climate change is recognized as one of the top threats to global health in the 21st century. The social and mental health consequences of climate-related disaster events are well documented, ranging from minimal stress and distress symptoms to clinical disorder, including depression, anxiety, posttraumatic stress, and suicidal thoughts. High-risk coping behavior, such as alcohol use, has been associated with climate-related weather events. Intimate partner violence may increase as well, with women being particularly affected. In addition, population displacement and migrations, breakdown of community infrastructure, food scarcity, loss of employment, and diminished social support have serious consequences for mental health. During the workshop, the psychological and behavioral effects of climate-related weather events will be reviewed, and participants will use their mobile devices to access online resources and learn about climate change health impacts in their region. The threat of climate change can also be a significant psychological and emotional stressor. Individuals and communities are affected both by direct experience of local events attributed to climate change and by exposure to information regarding climate change and its effects. Communication and media messages about climate change can affect perceptions of physical and societal risks and projected consequences. The perception of risk regarding climate change, belief in the ability to effect change and the etiology attributed to extreme weather events are important factors impacting decisions people make regarding climate change behaviors. A panel discussion will review communication challenges in addressing climate change. Various populations are particularly vulnerable to the mental health effects of climate change and warrant special consideration. Among those at increased risk are women, children, elderly, mobility-impaired persons, and first responders and relief workers. Those from lower socioeconomic status, including many minority populations as well as migrants, refugees and the homeless, are also disproportionately impacted by climate change as a result of disparities in infrastructure, health resources, and social and economic mobility. Preexisting mental illness increases vulnerability to adverse events, as does the use of psychotropic medication. Severe weather events can damage community support systems and the infrastructure that patients rely upon, leaving those most vulnerable even more isolated and alone, further diminishing their ability to cope. Enhanced community resilience can reduce adverse mental health effects of climate change. Using contemporary media content and panel discussion, attendees will participate in facilitated, interactive application of strategies in building community resilience.

Everyday Security and Privacy Practices for Psychiatrists

Chair: John Luo, M.D.
Presenters: John Torous, M.D., Steven Chan, M.D., M.B.A.

EDUCATIONAL OBJECTIVE:
1) Recognize threats to computer security such as phishing attempts, ransomware and malware; 2) Recognize potential security risks with the use of unencrypted email, cloud services and search engines; 3) Control information access by disabling alternate boot by CD/DVD or USB and using strong passwords; 4) Incorporate information security with whole disk and individual file encryption; and 5) Utilize secure communications with encrypted email and secure messaging.

SUMMARY:
Practicing medicine today has become easier as well as more complicated with various computer technologies. Electronic medical records, email communication and electronic billing facilitate communication and data transmission, yet they also require the practitioner to have appropriate security measures in place to meet HIPAA requirements. Smartphones and tablets enable the practitioner to work at multiple sites and access medical information or communicate to patients from almost anywhere, yet many of these tools, such as a text messaging, are fraught with risk when used out of the box. Large health care systems and group practices have teams of security analysts and information security officers to address these security risks with policies as well as hardware and software solutions. However, small groups and individual practitioners often can't afford to spend a third of their annual income on a security team. While hiring a security consultant may certainly be money well spent, these experts often recommend costly solutions that, while robust, may certainly invoke more anxiety and uncertainty as small-group and individual practices try to decide what to do. The goal of this workshop is to provide education for practitioners on how to recognize the types of many security risks such as ransomware, phishing and viruses, as well as education on basic tools such as antivirus, firewalls and encryption needed to protect their computer systems. In addition, attendees will learn how to prevent bypass of their computer operating system, which is a common way for thieves to gain access to private information on the hard drive. Protecting privacy for the practitioner and the patient will be reviewed, with education on use of encrypted email and secure text messaging from smartphones and tablets.

From Flakka to Fentanyl: What's Hot and What's Not and Why
Chairs: Akiva M. Daum, M.D., Daniel Castellanos, M.D.
Presenters: Sherry Nykiel, M.D., SueAnn Kim, Donna Papsun

EDUCATIONAL OBJECTIVE:
1) List the risks associated with the unique presentations of individuals intoxicated with novel psychoactive substances; 2) Describe, with examples, the challenges to developing confirmatory tests to identify novel psychoactive substances; 3) Provide examples of interventions that have been implemented to control the outbreaks of novel psychoactive substances; and 4) Create a plan for decreasing the harm associated with novel psychoactive substances.

SUMMARY:
Novel psychoactive substances have been entering mainstream drug use at increasing rates over the past five years. While there is clearly a peak and trough to the popularity of some of these substances, efforts to successfully eradicate these often dangerous compounds from the market remains a challenge. Identifying the exact compounds in these novel psychoactive substances presents with its own challenges given the often unknown compounds and frequent fluctuations in chemical structure and popularity. Some substances have been successfully decreased, such as the recent alpha-Pyrrolidinopentiophenone (Flakka) outbreak in South Florida, while some have persisted despite the clear dangers, such as the counterfeit fentanyl and its analogs. Still a third group exists that initially shows a peak, with a subsequent decrease and then plateau in usage, as has occurred with synthetic cannabinoids. The patterns of why some drugs stay "in fashion" while others fall by the wayside is unclear. Governmental actions; law enforcement; word of mouth about risks associated with use, including overdose; or availability may all play a role

in extinguishing an epidemic. If providers were aware of "what works" to quickly eradicate an emerging epidemic, then appropriate measures could be taken to decrease the morbidity and mortality associated with these novel psychoactive substances. Our workshop will discuss common presentations of intoxicated individuals, tests that may confirm substances or their metabolites, risks associated with novel psychoactive substances, and a proposed intervention model to extinguish a novel psychoactive drug epidemic. Presenters will share cases illustrating the user's perspective. Participants will be asked to give input about their experiences and share any patterns they have noticed in an effort to establish collaborations for further research into this high-risk clinical topic.

Gender Reassignment for Forensic Inpatients
Chair: Kayla Fisher, M.D., J.D.
Presenters: Stephen G. Noffsinger, M.D., Lama Bazzi, M.D., Jonathan Barker, Robert DeRuyter

EDUCATIONAL OBJECTIVE:
1) Review clinical criteria for gender dysphoria; 2) Review a history of treatments for gender dysphoria; 3) Examine the interplay between clinical, legal and forensic factors associated with gender reassignment surgery in forensic inpatients; and 4) Examine recent case law on gender reassignment surgery in forensic settings.

SUMMARY:
Over the years, awareness of gender dysphoria (previously known as gender identity disorder) has increased, and available treatments have broadened. Gender reassignment surgery is more commonly sought by patients as treatment for their gender dysphoria. Increasingly, courts have found that the eighth amendment provided inmates with the right to gender reassignment surgery for severe gender dysphoria. Clinicians have increasingly examined the question of when gender reassignment surgery should be available in the chronic forensic psychiatric population. This workshop will utilize didactics, panel discussion and audience response to examine the complexities associated with providing gender reassignment surgery to our chronic forensic psychiatric patients. Participants will utilize information from recent case law, applicable statutes, clinical information, and forensic considerations.

Geriatric Life Transitions: New Challenges for Older Adults
Chair: Nisha Mehta-Naik, M.D.
Presenters: Caitlin Snow, M.D., Katherine Shear, M.D., Robert Abrams, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the impact of geriatric life transitions on the mental health of older adults; 2) Recognize the economic challenges faced by older adults as they manage significant life transitions, namely retirement and bereavement; 3) Identify variations in the course of bereavement, as well as future directions in research and clinical work regarding grief in the geriatric population; and 4) Demonstrate understanding and engage in a dialogue regarding common clinical challenges and effective clinical approaches when working with older adults during life transitions.

SUMMARY:
The geriatric population faces unique life transitions, each accompanied by wide-ranging biopsychosocial consequences. Certain life transitions—such as bereavement and retirement—can result in significant shifts in an individual's financial status, social support structure, and physical and mental health. Each older adult may cope with life transitions differently, and in some cases, such life events can result in positive changes in an individual's life. However, such transitions are often fundamental stressors, which can potentially result in worsened mood and anxiety symptoms. In the setting of an aging American population, with increased average life expectancies, it will become progressively more important for psychiatrists to understand the complexities of these life transitions. In this workshop, we will explore common challenges faced by psychiatrists in the evaluation and management of older adults during life transitions. We will review the economic burden and economic challenges associated with geriatric life transitions. We will also discuss the course of grief and bereavement in the geriatric population, as well as management of complicated grief. Furthermore, we will discuss current challenges and clinical tools

in working with patients through the retirement process. During the workshop, we hope to foster a conversation about working with patients during such life transitions.

Improving Physician Assessments: When a Physician Becomes Your Patient
Chairs: Matthew Goldenberg, M.D., M.Sc., Karen Miotto, M.D., Gregory E. Skipper, M.D.
Presenter: Garth Terry

EDUCATIONAL OBJECTIVE:
1) Understand the critical components and considerations when evaluating a physician with a substance use disorder and/or mental illness; 2) Better understand the epidemiology and risk factors for physician burnout and suicide; and 3) Highlight the process of a thorough fitness-for-duty evaluation and how advanced age evaluations are being utilized or not across the U.S.

SUMMARY:
Physician burnout and suicide rates are at their highest levels and steadily climbing. Workload, electronic medical records, decreased time with patients, and poor work-life balance have all been proposed as possible contributors to the epidemic of physician burnout. In contrast, physicians have the same rates of mental illness (such as depression and anxiety) and substance abuse as the general population. However, the substances physicians tend to abuse are alcohol and prescription medications (versus illicit substances for the general population). With all of these factors colliding into "physician health," it is no surprise that physician well-being committees are commonly tasked with assessing a "troubled physician." Burnout and suicide are not limited to seasoned members of the field of medicine. Medical students and residents have burnout levels as high as 50%. We are just now starting to uncover the epidemic of medical student and resident suicide rates. An intensive diagnostic evaluation of a physician is a repetitively new concept. Prior to the 1990s, physicians were confronted and, in many cases, forced into treatment. Currently, the practice is to encourage a physician suspected of having a substance abuse, mental health or behavioral problem into a minimum 72-hour diagnostic evaluation to uncover whether or not they need treatment. Physicians face similar barriers to treatment as the general population, such as shame. However, they also face barriers such as fear of losing their careers, losing medical malpractice coverage, losing credentialing/hospital privileges, and more if they are diagnosed with mental illness or substance abuse. Therefore, the delivery and quality of a diagnostic evaluation for a physician are critical. Our workshop will cover the current health care environment and the epidemiological and other risk factors that physicians face. We will discuss the process of intervention and what to do when a colleague, staff member or resident/medical student is suspected of being impaired. Finally, we will cover in great detail the process of evaluating a physician from a multidisciplinary approach, evaluating the patient from all sides, including evaluation from addiction medicine, addiction psychiatry, forensic/addiction psychology, and beyond. We will provide an interactive experience for the audience to help them incorporate a better understanding of both physician health and a thorough diagnostic evaluation into their practice or into the medical institution.

Integrating Telepsychiatry
Chair: Jay Shore, M.D., M.P.H.
Presenters: Peter Yellowlees, M.D., Lori Raney, M.D., Meera Narasimhan, M.D., Kathleen Myers, Jeffrey I. Bennett, M.D., Donald M. Hilty, Steven Chan, M.D., M.B.A., Daniel J. Balog, M.D., Robert Caudill, M.D., Edward Kaftarian

EDUCATIONAL OBJECTIVE:
1) Understand successful models of telepsychiatry, including the settings and populations in which they can be applied; 2) Comprehend challenges to adapting telepsychiatry into various health care environments and solutions and best methods of successful integration of telepsychiatry into psychiatric practice; 3) Understand how to select an appropriate model of telepsychiatric care and develop an integration plan to match the telepsychiatry model into a specific practice setting; 4) Understand core issues and challenges for the successful integration of telepsychiatry into psychiatric practices and health care organizations; and 5) Comprehend how national standards and

guidelines for telepsychiatry, clinical workflows, e-treatment team coordination, and APPS can be best adopted for the creation of telepsychiatry services.

SUMMARY:
Telepsychiatry, in the form of live interactive videoconferencing, has reached maturity as a field and is being adapted in a wide variety of health care settings. It is demonstrating its ability to increase access to care as well as shift models of health care delivery. There are now many demonstrated successful models of providing telepsychiatric care. Identifying the most appropriate model of telepsychiatry for subsequent adoption into a health care setting and practice is critical for building scalable and sustainable services. Successful integration of telepsychiatry into an individual psychiatric practice or health care organization requires careful planning, development and implementation. There are a core set of issues and challenges around clinical standards, workflow and education that need to be addressed for successful integration to occur. This workshop brings together two panels of national experts in the field to share, discuss and demonstrate their experiences with telepsychiatry. The first panel will focus on models of telepsychiatry, to include 1) store and forward asynchronous telepsychiatry; 2) telepsychiatry in integrated care settings, including “telehubs;” 3) emergency room telepsychiatry services; 4) telepsychiatric enhancement of care coordination; 5) telepsychiatry services focused on children and families; and 6) telepsychiatry in hospital systems. The presentations will review the strengths, successes, challenges, and barriers of adapting each model. The second panel will focus on the core set of issues around clinical standards, workflow and education, to include 1) national standards and guidelines for telepsychiatry; 2) clinical workflows for telepsychiatry and care coordination specific to telepsychiatry; 3) prescribing controlled substances in telepsychiatry; 4) the integration of APPS into the practice telepsychiatry; and 5) core competency needed in telepsychiatry. A lively interactive panel discussion will engage the audience in contrasting and comparing the different models. Panelist will proffer recommendations for selecting appropriate models of telepsychiatry for specific health care settings and populations. The panels will also discuss challenges and barriers to adaptation and integration in each of these areas and proffer lessons learned from the field for the audience.

Intimacy After Injury: Combat Trauma and Sexual Health
Chair: Elspeth C. Ritchie, M.D., M.P.H.
Presenters: Christopher Nelson, M.D., Rachel Sullivan, M.D., Rita R. Rein, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn how to take a sexual health history; 2) Know which medications, including SSRIs, stimulants and narcotics, cause sexual side effects; 3) Understand the rational use of phosphodiesterase inhibitors; and 4) Know the impact of decreased fertility on young servicemembers.

SUMMARY:
Combat trauma affects sexual health and intimacy in many ways. 2.7 million U.S. servicemembers have served in the wars since 9/11. The IED, or improvised explosive device, is the signature weapon of the war, targeting often the lower extremities and genitalia. Many physical war wounds directly involve sexual functioning, including extremity amputations and genito-urinary injuries. Pain and the consequent use of narcotics adds to the physical challenges of obtaining and giving sexual pleasure. In addition, facial disfigurement or burns may significantly impact self-esteem. PTSD and TBI are often called the "invisible wounds of war." Not only do these injuries clearly affect intimate relationships, their treatment involves medications that often have sexual side effects. SSRIs are notorious in the regard. Many medications used for pain and traumatic brain injury also impact sexual functioning. The majority of wounded warriors are male, but injuries happen in female servicemembers as well. Sexual assault causes severe harm to intimate relationships as well. The purpose of this workshop is to encourage medical personnel to 1) discuss sexual health with their patients; 2) understand the sexual side effects from SSRIs, narcotics and other medications; 3) learn how to evaluate and treat erectile dysfunction; and 4) understand how to mitigate the effects of physical injury, pain and disability on sexual functioning.

Is It Helicopter Parenting? Collaborating With

Parents in College Mental Health According to the Law, Best Practices and a Personal Story
Chair: Marcia Morris, M.D.
Presenters: Amy Poon, M.D., Ludmila De Faria, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the increasing levels of depression, self-harm and other serious mental health issues on college campuses, warranting a reexamination of how and when to involve parents in mental health treatment; 2) Identify laws that may limit parent involvement, creating ethical dilemmas for psychiatrists when working with seriously ill students; 3) Describe the benefits of parent collaboration in college mental health treatment based on the literature and on clinical examples; and 4) Implement effective means to interact with students and parents to promote collaboration when dealing with serious mental health issues.

SUMMARY:
The debate in the media about parental involvement in millennials' lives can get heated, with disparaging references to "helicopter parents" who swoop in at a moment's notice to solve the problems of their young adult children. This debate does not take into account the importance of parent involvement in certain situations, as when a college student faces a serious mental health issue or crisis. The issue of when and how to involve parents has become more prominent for those of us who work in the college mental health field, as we are encountering a growing number of students with more serious psychiatric problems including anxiety, depression, eating disorders, and self-harm, as well as an increase in psychiatric hospitalizations. Parents are often unaware their children are struggling, and psychiatrists and other college personnel are limited in their ability to contact parents due to FERPA and HIPAA laws, except in certain circumstances. These limits to parent interaction can put these emerging adults at risk for worsening psychiatric problems and greater harm. This talk outlines the laws around parent involvement and offers approaches psychiatrists can take to increase parent collaboration in treatment based on evidence-based literature. Clinical examples of successful collaboration will be provided, and a psychiatrist will share her personal story of the challenges to collaboration when it came to her own child. This workshop will allow mental health professionals who work with emerging adults to describe their own experiences of collaborating with parents and to define situations in which parental involvement is appropriate. It will encourage participants to reexamine their own policies and practices around parental involvement in the care of college students and consider establishing guidelines in their treatment settings. All three speakers for this talk are psychiatrists working in university mental health clinics.

It Takes a Village: Meeting the Challenge of Severe Hoarding in Older Adults
Chair: David M. Roane, M.D.
Presenters: Jackson Sherratt, Erik Bengtsen, M.D., Alyssa Landers

EDUCATIONAL OBJECTIVE:
1) Accurately evaluate hoarding symptoms in older adults; 2) Implement cognitive-behavioral techniques as a treatment for hoarding; 3) Work collaboratively with social services in addressing hoarding problems of community seniors; and 4) Appreciate the importance of advocating for struggling seniors in the community.

SUMMARY:
Hoarding is a significant problem both for the patient and the larger community. With the *DSM-5*, hoarding disorder is now an independent diagnosis. Although this syndrome typically begins by early adulthood, severity increases with age. As older adults who hoard begin to confront the medical, cognitive and social challenges of late life, the condition of their living environment may deteriorate. Mental health providers and social service agencies are often asked to manage the situation. This workshop will focus on treatment methods and community resources that can help these vulnerable seniors, who are often socially isolated, to remain safely in their homes. Workshop participants will learn how to use objective rating scales to assess patients' living conditions and the contributors to hoarding, including excessive accumulation, difficulty with discarding and lack of awareness. We will go step by step through a short-term cognitive-behavioral treatment model,

detailing with clinical examples how to conceptualize cases, address motivation and implement therapeutic methods. We will demonstrate particular techniques through the use of role play. Exposure strategies that address acquiring and discarding challenges will be showcased. The valuable role of home visits, and clinician apprehension about these visits, will be covered. In isolation, psychotherapy for hoarding with elderly patients is a limited intervention. Thus, the workshop will highlight the importance of identifying and pairing with community-based organizations that are familiar with the circumstances of hoarding seniors. These partners can provide concrete support to seniors while addressing issues of immediate safety that interfere with therapy progress. Community workers interact intensively with their hoarding clients and can strongly reinforce the aims of therapy (e.g., assist a struggling senior with homework completion). Dividing the roles of the therapist and the community agency can be challenging, and guidelines to work in an integrated fashion will be discussed. Workshop panelists will include a cognitive therapy psychologist supervisor, a community social worker, and a geriatric psychiatrist. Data on the effectiveness of a short-term comprehensive intervention with older adults will be presented. Finally, we will illustrate an approach to hoarding that builds networks between providers and includes other stakeholders, including governmental agencies, to better coordinate services for this at-risk population. Participants will be encouraged to consider ways that geriatric providers can advocate for a more successful and humane community response to seniors who hoard.

Key Characteristics, Predictors and Behaviors Associated With Short-Term and Persistent Prescription Opioid Use: A Three-Year Study
Chair: Shareh O. Ghani, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify and analyze clinical characteristics associated with any opioid use; 2) Understand the predictive models used to identify those at risk for persistent opioid use; and 3) Understand longitudinal patterns of prescription filling in members at risk for persistent opioid use.

SUMMARY:
Methods: Medical and Pharmacy Commercial Health Plan data for 2.5 million individuals aged 20-64 was analyzed for those with at least one opioid prescription. Members were stratified into four cohorts based on the number of opioid prescriptions and morphine equivalent dose (MED) during a 90-day period and followed over a three-year period for refill behavior. Persistent opioid use was defined as individuals having more than one fill over the three-year period. Cohorts were mutually exclusive with members who had continuous enrollment for three years. A logistic regression model was developed for each of the four risk cohorts to examine association between persistent opioid use, diagnoses and member characteristics. **Results:** Compared to non-opioid users, opioid users at risk for persistent opioid use had these key characteristics: certain diagnoses more likely to be in the higher-risk strata: spondylosis and other back problems (odds ratio [OR]=5.3; p<0.001), substance-related and addictive disorders (OR=4.6; p<0.001); sleep-wake disorders (OR=2.2; p<0.001), depressive disorders (OR=1.7; p<0.001), headaches (OR=2.1; p<0.001), and anxiety disorders (OR=1.5; p<0.001). Members with the following medical/behavioral services utilizations were more likely to be at higher risk for opioid use: substance abuse treatment (OR=4.5; p<0.001), ER utilization (OR=3.2; p<0.001), anesthesia procedures (OR=4.2; p<0.001), mental health utilization (OR=2.3; p<0.001), and surgical procedures (OR=2.0; p<0.001). A significant majority (80%) of members who received an initial prescription for an opioid did not get a refill. Fourteen percent of members who had two prescriptions of an opioid and a stable MED had an increase in the number of prescriptions and dosage; 12% stayed the same, while almost 74% reduced their opioid use. Over half (56%) of those with two or more prescriptions and a high MED (over 120mg) stayed at that level of utilization, indicating that this was where there was the most persistent opioid use. A longitudinal look at those who became and stayed nonusers for at least six months showed that 48% of them relapsed and became opioid users again. **Conclusion:** Through the use of comprehensive claims data, it is feasible to identify predictors that could assist in identifying individuals at increased risk for persistent opioid use.

Studying prescription fill behaviors and the persistence of prescription opioid users helps identify individuals at high risk for persistent use and may provide a better understanding of how to target interventions for inappropriate opioid use. The key finding that 48% relapse and become users indicates that programs that address opioid use need to focus on long-term support to ensure that individuals do not become dependent again. What this data do not show is the "invisible users." Literature suggests that a high percentage of those in different levels of use, misuse and risk of accidental overdose don't have these medications.

Motivational Interviewing in Current Clinical Practice: Catching Opportunities to Promote Recovery and Positive Psychiatry
Chair: Michael A. Flaum, M.D.
Presenters: Brian Hurley, M.D., M.B.A., Carla Marienfeld, M.D., Florence Chanut, M.D.

EDUCATIONAL OBJECTIVE:
1) Review core aspects of motivational interviewing (MI); 2) Describe the overlap between the core components of the spirit of motivational interviewing and those of mental health recovery; 3) Describe the difference between "positive psychiatry" and a "disease-oriented" model of psychiatry; 4) Participate in supervised real-world clinical scenarios involving the use of MI in medication adherence with specific patient populations in conjunction with other psychotherapeutic approaches; and 5) Practice various activities for teaching MI skills to their colleagues and staff for use in routine clinical practice.

SUMMARY:
This workshop will discuss the status of motivational interviewing (MI) in current psychiatric practice. We will suggest that MI remains markedly underutilized in all aspects of psychiatry relative to its uptake in many other fields and to its potential. Dr. Flaum will begin by providing an overview, context and goals for the workshop. He will then briefly describe the fundamental differences between an MI approach and other clinical styles of communication and the rationale for these differences. He will introduce the idea of how the application of the spirit and technique of MI can be a potential vehicle for a "recovery-oriented" psychiatric practice. Dr. Hurley will then expand on the basics of MI, both in terms of spirit and technique, and talk about its underuse, even in the area of addiction psychiatry, where it would be expected to be fundamental. Dr Chanut will discuss the use of MI in diverse psychiatric patient populations and settings and its potential for promoting a "positive psychiatry" approach. Dr. Marienfeld will then lead small- and large-group discussions on how to incorporate MI into various real-world clinical scenarios during routine medication management and psychotherapy appointments, and she will also lead the group in practicing "MI activities" to train colleagues and staff in various MI skills.

National Acupuncture Detoxification Association Protocol: Integrative Treatments for *DSM-5* Behavioral Health and Substance Use Disorders
Chairs: Kenneth Carter, M.D., M.P.H., Michelle Olshan-Perlmutter, F.N.P.
Presenter: Jon Marx, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Identify neuroanatomical and neurobiological underpinnings of auricular acupuncture; 2) Examine evidence-based research for efficacy of auricular acupuncture in inpatient and outpatient psychiatric settings, the military/VA, and settings of trauma and disaster; and 3) Demonstrate the NADA protocol (auricular/bead applications) for willing workshop attendees to experience the safety, ease and simplicity of the NADA protocol.

SUMMARY:
National Acupuncture Detoxification Association (NADA) acupuncture is a simple, standardized, five-point auricular needling/acupressure bead placement protocol that originated as a community response to yet another opiate epidemic in the 1970s. NADA acupuncture is increasingly recognized as a universally useful intervention in the treatment of substance use disorders specifically and more generally in behavioral health. It was recognized by SAMHSA/CSAT 2006 treatment improvement protocol (TIP) #45 as a best practice recommendation in treatment of substance use disorders. NADA protocol is further validated by the

bureau of justice assistance, U.S. Department of Justice, in their 2013 publication summarizing recent research findings on the effectiveness of acupuncture as an adjunct to substance abuse treatment. There is additional evidence for the efficacy in behavioral health more broadly, including depression, anxiety, posttraumatic stress, and pain. Research has shown that patients are likely to see improvements in engagement and retention; decrease in drug cravings, pain, anxiety, and depression; and an improved quality of life. Pharmaceuticals and psychotherapy have been the standard treatment for behavioral health diagnoses but have yielded only partial effectiveness in patients achieving sustained recovery. The NADA protocol offers an adjunctive therapy to improve patient outcomes. One of the main benefits reported by patients, providers and programs utilizing NADA is the sense of stillness, centering and well-being. The induction of this attitude is seen as contributing to improved clinical outcomes, including engagement and retention. The attitude of stillness is also suggestive of a pathway to mitigating impulsivity. Impulsivity is associated with substance use disorders and other *DSM-5* diagnoses. Impulsivity has characteristics that are manifested clinically in behaviors such as disinhibition, poor self-control, lack of deliberation, thrill seeking, and risk taking. This workshop will introduce attendees to the NADA protocol by allowing participants to experience the benefits first hand. Evidence-based research will be reviewed as to the impact this protocol can have on improving substance use disorder outcomes, depression, anxiety, quality of life, and posttraumatic stress disorder. The ease, benefits and obstacles involved in incorporating NADA treatment into hospital and community-based practices will be discussed.

Opportunities for Psychiatrists in Global Health Engagement: Lessons Learned
Chairs: Eric G. Meyer, M.D., Geoffrey Oravec, Kenneth E. Richter Jr., D.O.

EDUCATIONAL OBJECTIVE:
1) Describe two to three cultural considerations prior to engaging in providing mental health education to other countries; 2) Recognize methods to improve communication between presenters and the host nation; and 3) Defend activities outside the classroom as critical to accomplishing the mission.

SUMMARY:
The Defense Institute Medical Operations (DIMO) has sent military psychiatrists and psychologists to 89 foreign countries to provide training to local military members on disaster psychiatry. Host nations request these presentations, and the U.S. is quick to respond. These presentations cover everything from surveillance to embedding mental health providers, conceptualization of PTSD and suicide, treatment of PTSD, and methods for working with command. These missions have been widely successful, with countries requesting return visits. A critical component of these missions is to develop an understanding of the host nation. This understanding needs to include the host nation's military missions, the types and numbers of providers, the prevalence of different disorders, the available resources, available treatments, language, and cultural frameworks, along with an appreciation for their conceptualization of the U.S. military. Logistical considerations must also be accounted for—ensuring that all of the required supplies are brought to provide the intended educational experience. These experiences have demonstrated several best practices: 1) starting with a semi-structured session where local providers can explain their capabilities, struggles and needs; 2) taking time outside of the classroom to meet with local leaders and participants to increase informal communication; 3) weaving redundancy into presentations to ensure comprehension; and 4) recognizing the need to scale down presentations in case there is a language barrier while also being able to add information on the fly if time permits. The presenters will relay their experiences in psychiatric global health engagement to include best practices, lessons learned and opportunities for further outreach.

Patient-Targeted Googling: Oh! What a Tangled Web We Weave, When First We Practice to Deceive
Chair: Liliya Gershengoren, M.D., M.P.H.
Presenters: Glen O. Gabbard, M.D., Paul S. Appelbaum, M.D., Robert J. Boland, M.D., John Luo, M.D.

EDUCATIONAL OBJECTIVE:
1) Define patient-targeted googling as it applies to clinical practice; 2) Review common clinical scenarios resulting in patient-targeted googling; 3) Understand ethical and legal implications of engaging in patient-targeted googling; and 4) Develop a curriculum for psychiatric trainees that explores the nuances of patient-targeted googling.

SUMMARY:
Social media has transformed interpersonal relationships, challenging our notion of medical professionalism in the digital age. Patient-targeted googling is an example of an emerging phenomenon where physicians use Internet resources, such as Google, to gather patient information. Reasons for obtaining patient information on the Internet may be varied, ranging from necessity for collateral information to further patient care or desire to satisfy one's own curiosity. The clinical setting, whether inpatient or outpatient, can also impact the practice of obtaining Internet-based patient information. Patient-targeted googling may threaten the very nature of the nuanced relationship between a psychiatrist and their patients. While implications of patient-targeted googling on the therapeutic relationship are significant, it is also essential to consider how psychiatric trainees are taught to obtain and utilize this information. Our workshop will address the impact of patient-targeted googling on medical professionalism through consideration of boundary violations, ethical implications and opportunity for development of a curriculum for psychiatric trainees. Participants will be provided with a variety of clinical scenarios exploring aforementioned areas of consideration. We will then offer an interactive portion of the workshop highlighting information that is accessible on the Internet about a selected volunteer from the audience.

Pilots, Aircrew and Mental Health: Making the Approach
Chairs: Philip M. Yam, M.D., Rita R. Rein, M.D.
Presenters: Jed P. Mangal, M.D., Madeline B. Teisberg, D.O., M.S., Nicholas A. Tamoria, Melanie E. Roberson, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify and define the procedures, policies and intricacies within aviation psychiatry as related the military and civilian sectors; 2) Understand and explore the opportunities and potential challenges that arise when approaching aviation communities regarding behavioral health; and 3) Demonstrate effective interview skills and rapport-building techniques that lead to best outcomes when evaluating and treating pilots, aircrew and other flight operators.

SUMMARY:
The world was shocked when 150 lives were lost by the intentional crashing of Germanwings Flight 9525 on March 24, 2015. While families and friends mourned, others sought answers and explored what more could have been done to prevent this disaster. Perplexing discussions arose about pilots' mental health and well-being, physicians' ethical duties to warn, and global policies regarding aviation safety. The case highlighted the need for further research and training in aviation topics for mental health providers. Aviation psychiatry is full of complexities, from the unique personalities of the members themselves (pilots, aircrew, air traffic controllers, etc.) to the high-stress environment of flying and need for public safety. Aviators experience the tasking demands of irregular work shifts, body-physiological demands, isolation, and the life-and-death responsibility of carrying passengers or conducting military combat operations. Despite the important role health care providers have, there remains a shortage of behavioral health professionals with the embedded knowledge, training and experience to most effectively engage this complex community. In this interactive workshop, participants will learn who the aviators are and what challenges they face. Through the use of small groups, participants will review case histories of pilots and aircrew who have sought help or were referred for behavioral health evaluation. Multiple-choice questions and attendee participation will be utilized to spark conversation, exchange of ideas and improvements in clinical practice.

Psychiatry in the Courts: The APA Confronts Legal Issues of Concern to the Field
Chair: Marvin S. Swartz, M.D.

Presenters: Paul S. Appelbaum, M.D., Howard Zonana, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the process and criteria by which the APA decides to become involved as a friend of the court in major cases; 2) Discuss the issues involved in application of the death penalty in cases involving intellectual disability; 3) Recognize the ongoing legal challenges related to the right to refuse medication; and 4) Appreciate the issues involved in expanding the *Tarasoff*-type duties of mental health professionals.

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 the APA's role in these cases. Three cases will be summarized, and the issues they raise will be addressed: 1) Rosen v. Regents of UCLA involves the assault of a student by a fellow student with mental illness and the claim that the university counseling service had an obligation to warn or protect the assaulted student, despite the lack of evidence that the victim was an identifiable target. Rosen raises the question if the current statutory-based *Tarasoff*-type duties may be expanded; 2) Allmond v. DHMH, a Maryland State case defending the appropriateness of involuntary medication over the objection of a patient found incompetent to stand trial for murder in Maryland. This case raises questions of whether or not involuntary administration of medications is legally permitted under such circumstances; 3) Moore v. Texas, a Texas case challenging Texas' imposition of the death penalty on a person with intellectual disability. 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.

Psychiatry's Value in Value-Based Care: NYS DSRIP as Case Example

Chairs: Sabina Lim, M.D., M.P.H., Sharat P. Iyer, M.D., M.S.
Presenters: Brian Wong, M.D., Edwidge Thomas, D.N.P.

EDUCATIONAL OBJECTIVE:
1) Understand core principles of population health/value-based care; 2) Understand and identify key behavioral health quality and performance metrics in population health/value-based care; 3) Understand one approach toward health care system redesign, with prominent emphasis on managing behavioral health conditions; and 4) Identify potential leadership roles and value of psychiatrists and behavioral health clinicians in value-based care.

SUMMARY:
Population health management, accountable care organizations and value-based payments are hot topics in health care, with physician practices, hospitals, communities, and states scrambling to redesign services and/or introduce new programs/interventions to succeed in this new health care environment. The value of addressing mental health and substance use disorder conditions has been identified as a critical component of success in this new era of value-based care. This emphasis is found in everything from the integration of primary care and behavioral health services to care coordination/management programs targeting individuals with behavioral health conditions. This exciting new focus presents a world of opportunity for the field of psychiatry, but 1) how do we design meaningful and effective models that actually result in improved outcomes for people with mental illness and/or substance use disorders; 2) how do we define the value of and reward behavioral health services that improve care and reduce health care costs; and 3) how do we avoid having "behavioral health" become lumped into a catchall bucket of care coordination interventions, wellness management, and management of all social determinants of health? We will describe as a case example our experience with the New York State Delivery System Reform Incentive Program (DSRIP), New York State's federal waiver program to fundamentally redesign the NYS health care system, which has a major emphasis on behavioral health. The Mount Sinai

Performing Provider System (MSPPS) is one of the largest networks in DSRIP, with over 200 partners. We will provide an overview of the DSRIP initiative and its behavioral health-related projects, our strategic approach to building a network and engaging multiple provider types to standardize practices and interventions, and performance in preliminary utilization and quality metrics. We will discuss both the challenges and opportunities in order to concretely define and measure the value of behavioral health services, as well as how we can effectively emphasize the role and expertise of psychiatry and psychiatrists as leaders in value-based care.

Race-Based and Religion-Based Bullying: Impact of Race and Religion on Bullying in School-Aged American Youth

Chairs: Nzinga Harrison, M.D., Aliya Saeed, M.D.
Presenter: Leesha Ellis-Cox, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

1) Review current data about youth bullying in America; 2) Analyze the role of societal context in bullying of youth of racial and religious minority groups; 3) Describe issues and context related to race-based bullying among American youth; 4) Describe issues and context related to religion-based bullying among American youth; and 5) Explore strategies for identifying and minimizing race-based and religion-based bullying.

SUMMARY:

Bullying consists of unwanted, aggressive behaviors, including actions such as making threats, spreading rumors, and physical or verbal attacks, as well as purposeful acts to exclude the victims from groups. The 2015 Youth Risk Behavior Surveillance System reveals that 22% of children grades 9–12 experience bullying. Race is the third most commonly cited reason for cause of bullying, and 55% of Muslim youth have reported being bullied. There are differences in outcomes among youth of different subgroups, e.g., Black and Hispanic youth who are bullied are more likely to suffer academically than their white peers. Widespread use of the Internet, including social media, has been led to cyberbullying. Additionally, an overtly racist and xenophobic discourse in the mainstream media and on the Internet has anecdotally been linked to incidents of hate across the country, including in youth populations. Bullying of school age children and adolescents is associated with many negative outcomes, including impacts on academic performance, mental health, substance use, and social functioning. In the context of social constructs, which can place youth in underrepresented minorities groups at a disadvantage, the negative consequences of bullying may be magnified for these youth. The purpose of this workshop is to explore the societal context and intrinsic characteristics of bullying as applicable to racial and religious minority youth. The workshop is interactive and will include a didactic portion, case presentations, discussion, and Q&A. Content will focus on the prevalence of bullying in Black, Latino and Muslim youth, as well as specific strategies psychiatrists can employ to advocate for their patients and help identify and eliminate these types of bullying in their communities.

Refugee Mental Health: Resident Experiences in San Diego County

Chair: Maryam Soltani, M.D., Ph.D.
Presenters: Haoyu Lee, Safi Ahmed, Steve H. Koh, M.D., M.P.H., Lawrence Malak, M.D.

EDUCATIONAL OBJECTIVE:

1) Define the difference between immigrants, refugees, asylum seekers, and torture victims as patients; 2) Understand the scope of the refugee crisis in the world, United States, California, and San Diego; 3) Understand the mental health needs of refugees; 4) Describe the unique experiences of advanced resident physicians working with the refugee population; and 5) Provide the current training model and future direction of refugee mental health care with resident physicians.

SUMMARY:

The ever-growing number of refugees and asylum seekers worldwide, torn from their homeland, displaced to a foreign land, often not speaking the language and expected to assimilate into a culture vastly different from their own, who have escaped their home country to end the abuse now find themselves facing a new problem: chronic mental illness. These issues need to be brought to light and

addressed. According to the UNHCR, in 2015, an estimated 65.3 million people worldwide have been displaced from their homes. Of this group, approximately 21.3 million are refugees, and over half of the refugees are under the age of 18. Furthermore, each day, an estimated 34,000 people are displaced from their country of origin. Refugees are considered people who flee from their home country to a different country in order to escape conflict or persecution, and the term includes asylum seekers, those forced to leave their home country in an effort to avoid persecution often because of political and/or religious beliefs. These persons, in addition to suffering from physical injury, are also at high risk for chronic mental health disorders including, but not limited to, posttraumatic stress disorder (PTSD) as well as depressive, anxiety and somatization disorders. Experiencing and/or witnessing trauma is a risk factor for mental health problems. Within that, being unprepared for trauma and refugee status has been shown to be associated with even worse mental health outcomes. Refugees who have had severe exposure to violence have higher rates of trauma-related disorders, which include PTSD, chronic pain and somatic syndromes. Our workshop, through the collaboration of several speakers, will provide information on the differences between immigrants, refugees, asylum seekers, and victims of torture and help participants understand the scope of the problem within the United States, California and San Diego. We will discuss the mental health problems observed in this population and how to address them. We will use two programs initiated in San Diego County-Survivors of Torture International (SOTI) and Union of Pan Asian Communities (UPAC)-to illustrate the aforementioned point. Attendees will hear from resident physicians who will describe their unique experiences working with this population. We plan to provide a training model and future directions for refugee mental health care in the context of advanced resident physician education.

Special Populations on Inpatient Psychiatry Units: Pregnant Patients, VIP Patients and "Palliative" Psychiatric Cases

Chairs: Julie B. Penzner, M.D., Benjamin Brody, M.D.
Presenter: Michael Walton, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize the complicating social factors of working with pregnant patients, VIPs and "palliative" patients; 2) Understand the common reactions or countertransferences that special patient populations may evoke in the inpatient psychiatrist; and 3) Appreciate that addressing special patient characteristics apart from diagnosis at the outset of treatment will improve and streamline inpatient care.

SUMMARY:

Inpatient psychiatrists need to be familiar with not only major forms of mental illness but also unique personal characteristics that may complicate inpatient treatment. In this workshop, we focus on special populations that commonly cause anxiety in the treating physician: pregnant patients, VIPs and "palliative" cases, or patients who have an extensive history of poor treatment response. Perinatal mental illness is a common complication of pregnancy. Women with serious forms of mental illness may overestimate risks of teratogenicity associated with psychotropic medications, leading to abrupt medication discontinuation and high risk of relapse. Caring for these women requires the psychiatrist to be familiar with pregnancy safety data for major psychotropic medications, to collaborate with an obstetrical team for prenatal care, and to conduct an expanded safety assessment addressing the patient's ability to care for herself and her baby in the late stages of pregnancy and the postpartum period. Severe or treatment-refractory forms of psychosis may require protracted admission until the onset of labor to ensure a safe delivery. VIP patients have long been recognized as presenting special challenges for inpatient psychiatrists. Celebrity or notoriety; access to enormous wealth or social connections; unreasonable expectations; and demands from family members, anxious administrators and the patients themselves can create a vortex of distractions that impede the primary job of addressing acute psychopathology. A frequent pitfall is the demand for special privileges or deviation from typical safety protocols. Is the goal of caring for the VIP to provide the same care as everyone else? Or to treat them as a special needs group that requires a form of cultural sensitivity? Patients with an extensive history of poor treatment

response can evoke a sense of helplessness, pessimism or dread in the treating psychiatrist. These patients may have limited identity apart from the sick role; spend little of their time outside of institutional settings; and have frayed or absent psychological, social and family resources after years of illness. Comprehensively addressing their problems in an acute care model is unrealistic, and the focus of care must shift. Lessons from the recovery movement are helpful but may be insufficient. An alternative may be to borrow from the palliative care model, focusing on the patient's comfort, setting realistic goals and eliminating unnecessary discomforts. Shifting the goals of care in "palliative" inpatient cases can ease the burden of illness in the patient and also reduce caregiver fatigue. Mastering the demands of these special populations will help inpatient psychiatrists, ultimately, to work in all special circumstances and improve their satisfaction with their work. We offer case examples, literature review and interactive discussion about the complexities of inpatient care in special populations.

The Meeting of Two Personalities: Managing Countertransference From a CBT and Psychodynamic Perspective

Chair: Diana Kljenak, M.D.
Presenters: Adrienne Tan, Diana Kljenak, M.D., Kenneth P. Fung, M.D.

EDUCATIONAL OBJECTIVE:

1) Examine concepts of transference and countertransference from psychodynamic and CBT perspectives; 2) Compare and contrast CBT and psychodynamic approaches to transference and countertransference; and 3) Reflect on and practice using different approaches in managing countertransference in their own practice.

SUMMARY:

The establishment and maintenance of professional therapeutic relationships is a core component of psychiatric practice. This is highlighted in psychotherapies, given the importance of therapeutic alliance in psychotherapy outcome. Therapeutic alliance involves the mutual influence between patient and physician. Psychiatrists may possess particular expertise in the recognition and management of the personal responses elicited in interactions with patients—that is, countertransference. Both psychodynamic psychotherapy, from which the original concept of countertransference is derived, and cognitive behavior therapy (CBT) are evidence-based therapies used to effectively treat a number of mental health disorders. Traditionally, CBT has been thought of as a treatment modality that is technique-based and not as concerned with the therapeutic relationship as other forms of psychotherapy. Psychodynamic psychotherapy has been defined and distinguished from other therapeutic approaches by its emphasis on therapeutic relationship and working with transference and countertransference. However, it has been argued that countertransference has become a construct that transcends practitioners' theoretical orientation. In this workshop, the concepts of transference and countertransference will be examined from both psychodynamic and CBT perspectives. Case examples will be used to compare and contrast psychodynamic and CBT formulation and techniques to recognize and manage countertransference. Participants will be able to reflect on and practice these techniques in pairs/small groups.

The Role of Education on Cross-Cultural Psychiatry

Chairs: Swati Divakarla, M.D., Rama Rao Gogineni, M.D.
Presenters: Andres J. Pumariega, M.D., Pedro Ruiz, M.D., Ranna Parekh, M.D., M.P.H., Bishoy Kolta, M.D.

EDUCATIONAL OBJECTIVE:

1) Learn about cultural sensitivity to become culturally competent in providing cross-cultural interventions; 2) Enhance their knowledge about the role of culture on mental health and mental illness; 3) Participate in a discussion with speakers about residents' needs in training on cross-cultural psychiatry; 4) Enhance their knowledge on changing demographics in the U.S., the shortage of workforce diversity, its effect on cross-cultural psychiatry, and advocacy regarding the need for cultural competency; and 5) Learn ways of enhancing cultural sensitivity among trainees, among both U.S. and international medical graduates.

SUMMARY:
In the past decade, notions of "cultural competence" and "cultural sensitivity" have gained rapid ascendance within American medical education. The 1999 Surgeon General's report presented compelling evidence that racial and ethnic minorities collectively experience a disproportionately high disability burden from unmet mental health needs. Ethnic minority groups are expected to grow as a proportion of the total U.S. population. Therefore, the future mental health of America as a whole will be enhanced substantially by improving the health of racial and ethnic minorities. It is necessary to expand and improve programs to deliver culturally, linguistically and geographically accessible mental health services. Practicing trainees and psychiatrists should learn about the neurochemical and biologic differences between cultures resulting in well-established differences in metabolism and response to medication. Willen, Bullon and Good emphasized that residents' learning of culture should include clinical presentation of distress among different ethnocultural groups. In addition, they should address language, immigration stress, attitudes and beliefs about the people of the other cultures, prejudice, discrimination, and institutional racism, as these factors have influenced the mechanisms of psychopathology, ethics, help-seeking behaviors, acceptability of treatment, and understanding of the social and cultural determinants of their health and disparities. There is also a high number of international medical graduate (IMG) trainees facing high levels of acculturative stress as they cope and adapt to the educational and clinical demands during their psychiatric training. Appropriate role models, extended periods of orientation, and several weeks of intense supervision and guidance are effective interventions in helping them acknowledge the impact of residents' own cultural or ethnic identity on their attitudes and behavior as clinicians. These interventions can be incorporated and specialized for various points in their training. A failure to attain cultural competence during psychiatric residency can result in a limited understanding of personal cultural biases, misdiagnoses and ineffective treatment of people of diverse cultural backgrounds. This workshop, composed of senior faculty who have published and taught cultural psychiatry and a panel of multicultural/ethnic trainees from various programs, will explore these relevant issues from an experiential, didactic perspective. Where shortages of accessible services are evident, both mainstream and bilingual-bicultural providers and administrators must learn to create culturally appropriate and evidence-based systems of care. With a rapidly changing demographic in the U.S. and a shortage of workforce diversity, it is imperative to advocate for the need of formal education in cultural competence and culturally sensitive practice.

Thinking Globally, Working Locally: Establishing and Maintaining Global Mental Health Training Programs in Low-Resource Countries
Chairs: Nakita G. Natala, M.D., Danielle LaRocco, M.D.
Presenters: Carol A. Bernstein, M.D., Gordon Donnir, Sammy Ohene

EDUCATIONAL OBJECTIVE:
1) Recognize and discuss some of the ethical, educational and cultural challenges involved in the development of global mental health training programs; 2) Articulate the bidirectional opportunities afforded by global mental health programs; 3) Share experiences about creating and sustaining international partnerships; and 4) Generate potential solutions to barriers in the development of successful global mental health programs.

SUMMARY:
With increasing globalization, there has been a growing interest in global mental health training among psychiatry residency programs in North America. International experiences in residency can be invaluable to both trainees and host countries. Trainees gain cultural competence, work with underserved populations, build working partnerships across diverse institutions, and, most importantly, help bring attention to global mental health disparities. For host countries, global mental health training programs can provide support for local initiatives, enhance workforce sustainability and expand existing knowledge. The burden of mental illness is well established in the developing world. As of 2014, 60 countries had fewer than one psychiatrist per population of 100,000, and in the

same year, Ghana had sixteen psychiatrists for a population of 26 million. This workshop will explore how two residencies partnered with two medical schools in Ghana to create global mental health programs. Trainees and faculty from both U.S. and Ghanaian institutions will describe ethical and cultural considerations, logistical constraints and curricular challenges. We will discuss ways to enhance psychiatric education to promote interest in psychiatric careers among medical students in an environment where there is pervasive stigma about mental illness. Audience members will be invited to share their own experiences as well as participate in small-group analysis of several vignettes illustrating the types of dilemmas inherent in these cross-cultural collaborations.

Transgender and Gender Expansive Health: Marginalization, HIV Prevention/Treatment and Sexual Health

Chairs: Yavar Moghimi, M.D., Lawrence McGlynn, M.D., M.S.

Presenters: Kenneth Ashley, M.D., Ricardo Lozano

EDUCATIONAL OBJECTIVE:

1) Present results from the 2015 U.S. Trans Survey; 2) Present results from National Transgender Discrimination Survey and relationship to HIV risk; 3) Demonstrate how to discuss sexual health with transgender clients; and 4) Discuss transgender issues.

SUMMARY:

Recent news in the media, from the rise of pop culture stars like Caitlyn Jenner and Laverne Cox to the policy issues around transgender bathroom access laws, have put a spotlight on transgender people, yet with all the attention, there remains misinformation around the health issues that transgender people face in the United States. Transgender people are one of the most marginalized populations in society. These disparities are no more apparent than in health and mental health care. Forty-one percent of transgender people report attempted suicide, compared to 1.6% of the general population. Nineteen percent report being refused medical care due to their transgender status. The HIV statistics for transgender people are even more disheartening, as transgender people face a high risk of infection. Many transgender people experience problems with finding culturally competent health care providers. This workshop will explore the unique health care challenges transgender people face. Through this workshop, attendees will develop a better understanding of the unique needs of this population and enhance their cultural competency skills in serving transgender patients. **Part 1: Defining the Transgender Community:** This portion of the workshop will start with the presentation of three case studies, each describing a transgender individual who is struggling with comorbid mental illness and HIV. Working in groups, audience members will identify various areas on the spectrum where transgender people may fall and identify the range of transgender patients' health concerns. This activity will be followed by an interview with a transgender patient, who will share her story, background and journey of self-identification as a transgender woman. **Part 2: Stigma, Discrimination and Patient Interactions:** This portion will begin with an anonymous poll (no judgement) assessing attendee attitudes regarding work with transgender patients. Audience members will then submit questions and concerns about working with transgender patients' mental and sexual health issues. Faculty and the patient participant will then discuss stigma and barriers to care within the context of audience-submitted data, as well as highlight strategies to improving patient interactions. The transgender patient will describe previous interactions that they have had with health care providers and the difficulties they face. **Part 3: Demonstrating Appropriate Discussions Regarding Sexual Health With Transgender Patients:** This portion will begin with a role play wherein workshop participants will break into small groups. Scenarios will be given and participants will be asked to take on different roles (patient or care provider). Additionally, faculty will model an idealized visit with the transgender patient, and participants can ask questions.

What's Palliative Care Got to Do With It?

Chair: Teresa A. Rummans, M.D.

Presenters: Maria I. Lapid, M.D., Laura Dunn, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the principals and key aspects of palliative care; 2) Identify clinical situations in which palliative care is appropriate; 3) Address ethical dilemmas facing those approaching the end of life; and 4) Identify other ways of handling pain in addition to opioids.

SUMMARY:

Increasingly, psychiatric patients are dealing with both chronic psychiatric and medical problems. Psychiatrists need to be well-versed in issues facing adult patients with serious and life-limiting illnesses. Palliative care—which is associated with enhanced quality of life and reduced symptom burden at the end of life—is underutilized, in part due to lack of awareness on the part of providers regarding the principles, practices and potential benefits of palliative care. This workshop will provide an overview of palliative care principles and practices most relevant to psychiatry. Maria Lapid, M.D., will define palliative care, describe philosophies underlying palliative care, and review core evaluation and management strategies for highly prevalent symptoms. Dr. Lapid will also discuss unique contributions of palliative care in the context of caring for patients with psychiatric symptoms and syndromes. She will also identify strategies for identifying how and when to make referrals for palliative care consultation and how to work collaboratively with palliative care providers. Laura Dunn, M.D., will define spiritual care, highlight the importance of identifying and addressing spiritual needs in adults with serious or life-limiting illnesses, and describe the Spiritual Assessment and Intervention Model (Spiritual AIM), which can help guide professionals caring for those with psychiatric and medical problems. Case examples of the use of Spiritual AIM with palliative care patients will be presented. Teresa Rummans, M.D., will discuss pain management in adults with chronic pain, especially at the end of life. She will focus on how the principles and practices of palliative care can improve pain control, and she will provide a model for weighing the risks and benefits of opioid use depending on the patient's goals and clinical circumstances, as well as explore other non-opioid interventions to improve patients' quality of life.

Working With Patients Seeking Short-Term Disability Benefits From Work: Collaborating With Employers and Understanding Therapeutic Variables

Chair: Paul Pendler, Psy.D.
Presenter: R. Scott Benson, M.D.

EDUCATIONAL OBJECTIVE:

1) Increase skills in documenting clinical impressions from a "traditional" psychiatric assessment with more focused aspects necessary for a disability request from work; 2) Better understand the interplay of psychiatric assessment with work impairment assessment; 3) Learn the ways to distinguish psychosocial issues from mental health conditions and how to discuss these distinctions with patients; 4) Develop greater capacity to operationalize concepts such as "workplace stress" in order to both assess one's capacity to function and also how to provide accurate impairment presentation info for disability; and 5) Enhance their abilities to articulate to patients, employer and, when needed, disability carrier in order to facilitate a clinically appropriate return to work and how to assist in this transition process.

SUMMARY:

Depression, according to Kessler and colleagues (1999) is "associated with a higher rate of short-term work disability than virtually any other chronic condition." A recent 2015 examination of psychiatric disability found that anxiety arousal, avoidance behavior and depressive mood were all associated with long-term work disability and absenteeism. Given this trend, psychiatrists will continue to be regularly confronted with the delicate balance of providing an accurate diagnostic assessment in reviewing symptoms but also expanding their clinical repertoire to address work functioning and impairments. This exposure begins even during residency, and yet other than traditional forensic assessment training, there are few guidelines to assist psychiatrists with gaining clinical competency about when time off work is medically indicated. The notion of "workplace stress" and overall job strain has become a topic of increasing attention in the literature, with a focus on appreciating the interplay between workplace stress and perceived employee control over the workplace demands. Stressful conditions perceived in the workplace then become

part of a transactional model that addresses individual resources coupled with workplace conditions. How this type of assessment can augment the traditional psychiatric assessment and treatment will be examined. Working with the American Psychiatric Association Foundation, Partnership for Workplace Mental Health, a checklist tool continues to be developed to assist psychiatrists when having to communicate their assessment to employers and disability insurance carriers. Using clinical scenarios, we will describe how these tools can be used to augment and, in some cases, replace the variety of forms required by various agencies when certifying the need to take time off work due to a psychiatric condition. As part of this development, time will be taken to solicit feedback from attendees about the most critical elements to describe when addressing work impairments. From an employer perspective, assessing the need to take time off work requires an appreciation that emphasizes Warren's (2013) thinking concerning psychosocial issues and Gold's (2013) view of "work capacity" (balance between work supply and work demand) to better assist the clinician in working with their patients.

Tuesday, May 23, 2017

A Hippocratic Oath for Global Mental Health
Chair: Allen Dyer, M.D.
Presenters: Catherine May, Fatima Noorani, Philip Candilis, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize the Hippocratic origins of contemporary professional ethics; 2) Appreciate the difference between rule-based ethics and principle-based ethics; and 3) Imagine an "oath" for humanitarian workers and the place of altruism in the healing traditions.

SUMMARY:
The Oath of Hippocrates, written over 2,400 years ago, articulates several ethical principles that remain relevant even today. Beneficence, nonmaleficence, respect for autonomy, justice, confidentiality, respect for life, and professional boundaries are all identified in the ancient oath. The modern understanding of professions defined by their ethical commitments can trace their origins to the second paragraph of the Oath. While many sections of the original oath may seem anachronistic, appreciation of the underlying principles offers guidance for contemporary concerns. This session describes an exercise conducted at a workshop, "Building Resilience in Humanitarian Workers," in Athens, Greece, in June 2016, sponsored by the U.S. Embassy and the Greek NGO Metadrasi. Humanitarian workers dealing with the refugee crisis were taught skills in psychological first aid, mindfulness meditation, hope modules, and self-care. They were asked to identify guiding principles for a Hippocratic Oath for Humanitarian Workers.

A Resident's Guide to Borderline Personality Disorder: From the Experts (Part I of II)
Chair: Brian Palmer, M.D., M.P.H.
Presenters: John Gunderson, M.D., Marianne Goodman, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Diagnose borderline personality disorder (BPD) and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacological approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Assess suicide risk and determine appropriate level of care.

SUMMARY:
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 skills 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 suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization, with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacological treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. 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.

A Resident's Guide to Borderline Personality Disorder: From the Experts (Part II of II)
Chairs: Brian Palmer, M.D., M.P.H., Marianne Goodman, M.D.
Presenters: John Gunderson, M.D., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Diagnose borderline personality disorder (BPD) and understand its relationship to other disorders; 2) Structure an effective psychotherapy for BPD; 3) Thoughtfully choose psychopharmacological approaches that fit within a formulation of a patient's problems; 4) Effectively integrate family work into a treatment plan; and 5) Assess suicide risk and determine appropriate level of care.

SUMMARY:
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 skills 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 suicide assessment and interventions. An overview of neurobiology is included. Specifically, participants will review the diagnosis of BPD and its relationship with other disorders in order to build a basis for case formulation. Following this, the workshop examines core features of effective psychotherapy as well as aspects of treatments likely to make patients worse. Based on these principles, the workshop then examines suicide risk assessment and hospitalization, with an emphasis on practical approaches for patients in the emergency setting. Strategies and common pitfalls in psychopharmacological treatment for BPD are examined, with case material from both experts and participants. Finally, principles of family involvement are presented, including data supporting the idea that families can and should learn effective ways of decreasing reactivity and increasing effective validation. 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.

Adolescent Brain Cognitive Development Project: Window Into Youth Development
Chair: Terry Jernigan, Ph.D.
Presenters: Susan Tapert, Ph.D., Anders Dale, Ph.D, Sandra Brown, Ph.D.

EDUCATIONAL OBJECTIVE:
1) State the broad goals of the landmark Adolescent Brain Cognitive Development (ABCD) study; 2) Describe the potential utility of the findings from the

ABCD study; and 3) Describe the specific methodologies to be used in the ABCD study.

SUMMARY:

The Adolescent Brain Cognitive Development (ABCD) study is a landmark longitudinal study of brain development and child health supported by the NIH to increase our understanding of how diverse experiences during adolescence interact with changing biology to influence brain, cognitive and social/emotional development. This study combines developmental psychology, neuroimaging, cognitive neuroscience, genetics, mental health, and epidemiology with advanced techniques in bioassays, bioinformatics and mobile assessment to follow 11,500 9–10-year-olds recruited at 19 sites. We will present the goals of the study, assessments and technologies used to address these goals, and sampling methodology designed to recruit subjects with multiple dimensions of diversity. Findings from ABCD are expected to increase the ability to distinguish environmental, sociocultural and genetic factors relevant to substance use and brain development and to inform prevention, treatment and public health strategies.

Are You a Sitting Duck Online? What You Can (and Can't or Shouldn't) Do About—and Avoid in the First Place—Negative Reviews by Patients

Chair: Robert Hsiung, M.D.
Presenters: Paul S. Appelbaum, M.D., Dinah Miller, M.D.

EDUCATIONAL OBJECTIVE:

1) List three websites at which a patient can post a review of a psychiatrist; 2) Give three examples of ethical ways in which a psychiatrist may be able to improve patient satisfaction; and 3) Give one example of a response to a negative review that is likely to be constructive and one example of one that is not likely to be.

SUMMARY:

Online reviews by your patients may affect the vitality of your practice. Rating sites enable your prospective patients to take into account the opinions of your current (and past) patients. Are you prepared for a negative review? Do you feel anxious? Have you already received a negative review? Do you feel angry? A negative review may be a symptom of trouble in the doctor-patient relationship. By attending to the therapeutic alliance, you may be able to avoid negative reviews. Once posted, negative reviews may be responded to in ethical (and other) ways. We visit representative rating sites and hear how one psychiatrist responded to a negative review. We review research on online physician ratings. One psychiatrist said she discovered from online reviews what patients thought made a good doctor, what they deemed essential to care and what got them really riled. Their tales made for refreshing reading, a sea of patients' voices telling her how it really was. Medical training rarely afforded such an opportunity. A family physician said he engaged more with his patients since reading criticisms online that he spent too much time jotting notes in his tablet computer. Fifty-nine percent of respondents in a study reported physician rating sites to be "somewhat important" or "very important" when choosing a physician, although they were endorsed less frequently than word of mouth from family and friends. Five percent reported they or their family themselves ever gave ratings or comments on websites about physicians. In a study of one rating site, the number of physicians with five or more ratings rose rapidly from less than one percent in 2005 to 12.50% (14,003/112,024) in 2010. Although some physicians are concerned that online ratings will become a channel for disgruntled patients to vent their complaints, that study suggested that that was not the most common reason patients used that site. That study found statistically significant correlations between the value of ratings and physician experience, board certification, education, and malpractice claims, suggesting a positive correlation between online ratings and physician quality. However, the magnitude was small. A study comparing online and offline ratings of the same primary care physicians found that physicians who were rated lower offline were less likely to be rated online, online and offline ratings were positively correlated, and online ratings were exaggerated at the upper end. In small groups, participants learn experientially about being attuned to signs of trouble in the doctor-patient relationship. We discuss the ethics of patient satisfaction. What may psychiatrists do—and what ought they not do—to

improve patient satisfaction? We conclude with speculation about future directions and discussion.

Can Technology Help With Access and Improve Outcomes? The Scarborough Hospital Experience as an E-Therapy Hub Offering iCBT and iMindfulness
Chair: David Gratzer, M.D.
Presenters: Faiza Khalid-Khan, M.S.W., R.S.W., Shawnna Balasingham, M.S.W., R.S.W., Janany Jayanthikumar, M.S.W., R.S.W., Nadia Yuen, M.S.W., R.S.W.

EDUCATIONAL OBJECTIVE:
1) Better understand and appreciate the literature supporting e-therapies; 2) Better understand and appreciate the benefits and problems of trying to incorporate e-therapies into an adult outpatient program; and 3) Better understand and appreciate the future direction of e-therapies.

SUMMARY:
Evidence-based psychotherapies have the potential to transform the care of those with mental health problems. CBT rivals the effectiveness of medications for those with mild to moderate depression (and there is evidence of a synergistic effect between medications and CBT); mindfulness has been shown to help cancer patients cope with stress and anxiety. Yet few patients have access to these evidence-based psychotherapies in either public or private health care systems. A recent *Canadian Journal of Psychiatry* paper found that just 12% of patients with depression received CBT. The Scarborough Hospital's adult outpatient program serves Toronto's diverse east end. Recent changes have emphasized evidence-based psychotherapies, yet we face problems all mental health outpatient programs do: missed appointments and significant dropout rates, to name a couple. To enhance service, we offer a range of virtual therapy solutions—an e-therapy hub. We highlight three initiatives: 1) iCBT for mood and anxiety: While well supported in the literature, traditional CBT is impractical for some—because of physical issues (pain) or personal obligations (academic, occupational or family). A growing literature supports Internet-delivered CBT (iCBT), particularly therapist-guided iCBT. Since 2014, partnering with Queen's University, we offer iCBT—a first-of-its-kind Canadian hospital outpatient program. 2) iMindful for cancer: Cancer is strongly linked with distress and depression, yet many patients have challenges accessing psychotherapy (e.g., because of ongoing cancer treatment). We have introduced a stepped-care model built on mindfulness interventions: many patients thus have access to mindfulness apps and MP3-delievered lectures; the more impaired are offered iMindful, where this evidence-based therapy is offered through the Internet on patients' terms and schedule. 3) Psychoeducation for insomnia and psychosis: Psychoeducation can be helpful for patients and families. Poor sleep, for example, is a common symptom for physical/psychiatric disorders; sleep hygiene (with CBT-insomnia techniques) is effective. Family members of patients with psychosis benefit from psychoeducation. While we offer traditional psychoeducation groups, we also offer modules online, for convenience—available to patients and their families. For all three initiatives, we will offer data on early results, as well as clinical cases. Our workshop will include a psychiatrist and two e-therapists, as well as the administrator overseeing the project.

Challenges in Patients With Substance Use Disorders in the Oncology Setting
Chair: Maria L. Tiamson-Kassab, M.D.
Presenters: Jeremy Hirst, M.D., Carla Marienfeld, M.D.

EDUCATIONAL OBJECTIVE:
1) Explore cases of patients with substance use disorders and the impact this psychiatric comorbidity has on their cancer- and palliative-directed treatments; 2) Understand the clinical and ethical dilemmas raised by these patients; 3) Describe trends in substance use in the oncology patient population; and 4) Review screening, assessment and management of substance use disorders in the oncology and cancer pain setting.

SUMMARY:
Treating oncology patients who have a substance use disorder is quite challenging. In the past, it has often been said that problems with substance abuse are not commonly encountered in the oncology setting, yet clinical experience and increasing literature suggests that the extent of alcohol abuse,

illicit substance use and prescription misuse has increased despite few epidemiological studies conducted in this population. There is also increasing research evidence about the causal role of alcohol in cancer in seven sites. With increasing cancer survival, cancer pain management is becoming more like non-cancer pain management. Opioid misuse and substance abuse are growing problems among cancer patients. This workshop, led by a clinically active psychosomatic medicine specialist, a palliative care psychiatrist and an addiction psychiatrist, will address the problems of alcohol and opioid use disorders in the cancer population. We will show the importance of considering a complete, illness-informed, differential diagnosis when assessing substance use disorders in patients with cancer. This will include the exploration of pseudo-addiction and pharmacogenetic variability related to prescribed opioids for pain that can lead patients to behave in ways that resemble those with substance use disorders. We will also offer discussion and engagement with the audience around the impact substance use disorders have on engaging in cancer-directed and palliative therapies, successful life closure, and the use of harm-reduction techniques in cases where abstinence is not an appropriate goal. Cases will be presented, including the use of patient video interviews, and audience participation will be solicited to discuss how to manage these challenging patients successfully. An addiction psychiatrist will discuss the management of substance use disorders in the oncology setting.

Clinical Dilemmas in the Treatment of Narcissistic Personality Disorder

Chairs: Holly Crisp-Han, M.D., Glen O. Gabbard, M.D.
Presenter: Holly Crisp-Han, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize the importance of understanding transference, countertransference and resistance in the treatment of narcissistic personality disorder; 2) Understand the interplay of shame, envy and self-esteem vulnerability, along with grandiosity, entitlement and contempt, in treatments of narcissistic patients; 3) Develop tools to improve the clinician's ability to address problems that arise in the treatment of narcissistic personality disorder; and 4) Learn to engage patients with narcissistic problems and better address when rage and anger become issues in their treatment.

SUMMARY:

In the current culture, narcissism has too often become a facile term used as a label or insult that can be applied to a public figure, colleague or family member without consideration for the real challenges of dealing with narcissistic problems. As psychiatrists treating patients with narcissistic personality disorder or narcissistic traits, we must recognize the challenges these patients bring while also maintaining our stance as clinicians. In this workshop, we will emphasize that narcissistic problems occur on a spectrum and that the treatment approach must be tailored to the individual person who comes for help. Empathy, confrontation, support and interpretation all have their place, just as both transferential and nontransferential interventions are useful. The workshop will focus on the psychotherapeutic setting as well as other clinical situations such as medication visits and inpatient treatment. Regardless of setting, clinicians must deal with countertransference feelings that can be complicated, including irritation, anger, boredom, and contempt, while also managing to feel empathy toward these patients who can sometimes be difficult to engage. The treater may feel a lack of reciprocity and mutuality that invites disengagement and a sense of loneliness in the treatment for both patient and clinician. Much as these patients experience in their lives outside of treatment, in the work with the clinician, the patient may express an expectation of special treatment or entitlement. He or she may also behave in a manner that is condescending to the treater and controlling of the treatment. We will discuss the necessary balance between praise and confrontation, as well as grandiosity versus vulnerability. We will discuss how the treater can encourage the patient to mentalize and imagine how he or she comes across to the clinician and to others in his or her life. We will consider issues of resistance to treatment, such as when the patient has little motivation for change or is in treatment at the request of a spouse, family member or employer. Often, patients do not really see the problems that others see. Indeed, they are often more likely to expect that others should

conform to their distorted vision of reality. We will address narcissistic rage, as well as strategies for navigating and responding to inevitable ruptures in the treatment and disappointments in the patient's life. Feelings of envy, shame, disappointment, and anger must be considered in the treatment relationship. The workshop will include a didactic portion, presenters engaging in a discussion with the audience, and video clips and role plays that will reflect the themes we are highlighting.

Designer Drugs Update 2016: It Used to Be Bath Salts and Plant Food, Now It Is Krokodil and Flakka
Chair: Roger Duda, M.D.
Presenters: Erika Zavyalov, D.O., Caroline C. Clark, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the most popular legal highs and designer drugs currently being abused and understand the different effects users experience from various substances; 2) Describe the recommended treatments in the care of designer drug user overdose; 3) Discuss approaches to educate patients on the dangers of designer drugs and legal highs; and 4) Understand where patients source designer drugs and the pipelines bringing designer drugs to patients.

SUMMARY:
As the desire for legal highs continues, our patients are experimenting with "designer drugs" and research chemicals. Patients are experimenting with all types of designer drugs from substance with benign names like bath salts and plant food to horrifying, and enticing, names like zombie, flakka and krokodil. Clinicians need to become familiar with the symptoms and effects of designer drugs, as well as the emergency treatment of patients who have used designer drugs. Without understanding that these chemicals are ingested by our patients, a clinician could very well overlook a designer drug toxidrome because the urine drug test was negative from the lab. This workshop will educate clinicians on designer drugs. We will discuss how and where patients purchase the substances. We will discuss the physical and psychological effects of designer drugs as well as suggest methods of managing the designer drug toxidrome. Additionally, during the workshop, we will educate participants on some of the "underground" resources and websites where users document their designer drug experiences. Additionally, we will discuss some of the newest designer drugs that have been scheduled by the DEA. A brief discussion on why the designer drug trade is so profitable will also occur. We will discuss how one team of marketers were able to make over $18 million over five years. The process of how the chemicals were researched and produced, how the drug was manufactured and distributed, and the difficulty law enforcement officials had on stopping the operation will also be discussed.

Dynamic Therapy With Self-Destructive Borderlines Patients: An Alliance-Based Intervention for Suicide
Chair: Eric M. Plakun, M.D.
Presenter: Samar Habl, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn to utilize principles of an alliance-based intervention for suicide as part of psychodynamic therapy for 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 by an expert consensus panel study of behavioral and dynamic psychotherapies.

SUMMARY:
Psychotherapy with suicidal and self-destructive borderline patients is recognized as a formidable clinical challenge. Several manualized behavioral and psychodynamic therapies have been found efficacious in treatment, but few clinicians achieve mastery of even one of the manualized therapies. This workshop includes review of nine 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 noted to be congruent with six common factors developed by an expert consensus panel review of behavioral and psychodynamic treatment approaches to suicidal patients with borderline personality disorder. 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 will be a highly interactive opportunity to discuss this challenging and important clinical problem.

Enhancing Wellness: Simple Steps for Big Changes?
Chairs: Nicole Guanci, M.D., Rashi Aggarwal, M.D.
Presenters: Saba Afzal, M.D., Petros Levounis, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the increasing concern for burnout among clinicians; 2) Identify the signs and risks for burnout; 3) Understand the suggested approaches in the literature to address burnout through wellness initiatives; and 4) Practice simple skills to boost wellness during the workshop and beyond.

SUMMARY:
Burnout in medical professionals is a concept gaining increasing national attention. Burnout, which encompasses emotional exhaustion, depersonalization and a low sense of personal accomplishment, has both upstream and downstream effects, impacting clinicians, patients and, ultimately, the entire medical system. Burnout is associated with a lack of job satisfaction, poorer patient care, substance use, and mental health issues, including depression, anxiety and even suicide. However, despite increased awareness of the problem, there is a paucity of evidence in the literature to address it. In addition, the adoption of measures preventing burnout in training programs and medical institutions has yet to occur on a global level. Attention to wellness in health care providers has been proposed to decrease the risk of developing burnout and its consequences. Suggested strategies include mindfulness, positive psychology and self-care skills. This workshop will provide updates on the relevance of addressing burnout and educate participants regarding identifying the risks and signs of burnout in clinicians. We will present the latest literature covering simple proposed methods to address burnout and teach these interventions in a hands-on manner to participants. Our goal is for participants to practice strategies to increase well-being during our workshop and extrapolate these skills for use in their own lives, programs and institutions.

Ethical Dilemmas in Psychiatric Practice
Chairs: Ezra Griffith, M.D., Carol A. Bernstein, M.D.
Presenters: Marvin Firestone, Mark Komrad, M.D., Charles C. Dike, M.D., M.P.H., Stephen C. Scheiber, Beth Ann Brooks, Richard Martinez

EDUCATIONAL OBJECTIVE:
1) Recognize ethical dilemmas and common situations that may signal professional risk; 2) Understand available resources; 3) Identify boundary issues and conflicts of interest; and 4) Identify practical resolutions to ethical dilemmas.

SUMMARY:
This workshop will be entirely devoted to the APA Ethics Committee members taking questions from the audience on ethical dilemmas they have encountered, participated in or read about. Audience participation and interaction will be encouraged, and ensuing discussions will be mutually driven by audience members and Ethics Committee members. All questions related to ethics in psychiatric practice will be welcomed. Possible topics might include boundary issues, conflicts of interest, confidentiality, child and adolescent issues, multiple roles (dual agency), gifts, emergency situations, trainee issues, impaired colleagues, and forensic matters.

"For the Right Reasons": Toxic Masculinity on Reality TV and Its Application to Clinical Practice
Chair: Meera Menon, M.D.

Presenters: Nimisha Thuluvath, M.B., B.A.O., B.Ch., Allison E. Cowan, M.D., Brandon Withers

EDUCATIONAL OBJECTIVE:
1) Discuss the meaning of, history of and literature on hegemonic masculinity; 2) Evaluate, utilizing visual media, ways in which negative stereotypes of masculinity are magnified in reality dating television shows and how this affects the formation of relationships; 3) Identify patterns of toxic masculinity in clinical practice (psychotherapy clinics, the military, the prison system, and college counseling centers); and 4) Describe, in small-group discussion, how the promotion of negative aspects of masculinity, while serving a purpose, can also be maladaptive.

SUMMARY:
"I'm here for the right reasons" is a common mantra among contestants in *The Bachelor* reality television franchise. Although it is commonly repeated in a contestant's search for a loving partner, use of this phrase seems questionable, as patterns of strength and dominance are adopted by various contestants in order to "win." Researcher R.W. Connell brought the term hegemonic masculinity into the forefront in 1987. Hegemonic masculinity, also known as toxic masculinity, is the stereotypical assumption that in order to be a man, one must exhibit strength and dominance. In many settings within the United States, masculinity is demonstrated by competition, devaluation of feminine attributes in men, inability to express weakness, and the expression of emotion as anger. In this workshop, we will utilize visual media to learn about these concepts as exemplified in *The Bachelor*. In their free time, male contestants are universally praised for lifting weights and ridiculed for "displaying sensitivity" by forming friendships or pursuing artistic endeavors. Through episode production and editing, anger is rewarded and expression of sadness is devalued. Abusive contestants are given more airtime and invited to participate in spinoff shows. Men who cry are teased. Despite all contestants insisting they are present for the "right reasons" (i.e., finding a loving partner), there is competition to spend additional time with the female contestants and to win the show, without much discussion about relationship compatibility. Relationships formed by the series frequently break up, with one party citing abuse or both parties citing incompatibility. While these features of hegemonic masculinity are ubiquitous within this television series, they also occur in areas of clinical practice. We will use breakout groups and discussion to examine clinical cases in the following settings: military, prison, psychotherapy, and university. We will evaluate the reasons hegemonic masculinity arises in these settings and how it can be maladaptive. For example, such expectations can prevent men in these settings from seeking treatment. When they do seek treatment, it is not uncommon to request female providers due to the assumption that women are more caring and avoidance of expressing vulnerability in front of another male.

Frontiers in Payment Reform: The Implications of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Other Alternative Payment Models
Chairs: Pilar Abascal, M.D., Harsh Trivedi, M.D.
Presenters: Mary Anne Badaracco, M.D., Laurence H. Miller, M.D., Lori Raney, M.D., Bruce J. Schwartz, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the implications of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for their practices and organizations; 2) Understand how diverse mental health care organizations around the country are currently using alternative payment models; and 3) Discuss new frontiers in the use of alternative payment models.

SUMMARY:
In recent years, there has been a movement away from traditional fee-for-service models and toward payment models that explicitly attempt to reward quality or value. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) accelerated this movement by instituting mandatory payment reform in Medicare starting as soon as 2019. The payment reforms in MACRA will be reviewed and explained. The most common alternative payment models (APMs) outlined in the legislation will be summarized. Audience members will be encouraged to ask questions about the legislation and will gain an understanding of how MACRA will affect their

practices or organizations. Leaders in payment reform will then describe their experiences implementing these APMs in diverse health systems across the United States. They will take questions from the audience in order to demystify how these APMs can be implemented and encourage audience members to consider exploring the use of APMs in their own organizations or practices. Current opportunities for the implementation of payment reform will be discussed, and new frontiers in payment reform will be explored.

Gay Psychiatrists and the United States Military
Chairs: Elspeth C. Ritchie, M.D., M.P.H., Joseph Wise, M.D., Bob Batterson, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the evolution of laws governing being gay in the U.S. military; 2) Get a personal perspective from gay psychiatrists who have served in the military; and 3) Learn clinical techniques for working with gay servicemembers and veterans.

SUMMARY:
Gay servicemembers have long been an important part of our nation's military. They were closeted for many years, subject to harassment, bullying and involuntary separation. Prior to 1993, when "Don't Ask Don't Tell" was implemented, they could be involuntarily separated simply for being homosexual. After the "Don't Ask Don't Tell" policy was implemented, life was supposed to get better, but in many cases, it did not. In recent years, gays have been officially accepted in the military, with the allowance of same-sex marriages and partner benefits provided. However, considerable stigma remains. This workshop features the personal stories of gay military psychiatrists and clinicians who have worked with gay servicemembers and veterans. The United States of America has been at war since September 11, 2001, first in Afghanistan, then Iraq and now still Afghanistan. Approximately 2.7 million servicemembers have been deployed to the theater of war. This prolonged war, the longest in our country's history, has brought to the forefront the mental health consequences of combat and warfare. Alongside the other troops, gay military mental health workers-psychiatrists, psychologists, social workers, occupational therapists, and others-worked throughout the theaters of war. These include, of course, Iraq and Afghanistan. Recent efforts include West Africa and the Ebola virus. Mental health clinicians have been treating servicemembers for the psychological consequences associated with their experiences in battle, including killing enemy combatants, seeing wounded and killed civilian casualties, losing their friends in combat, and potentially dealing with their own physical injuries from being shot or blown up. Compounding the battlefield stressors have been homefront issues. Unlike earlier wars, most soldiers are married and have children. With a world that is globally connected through the Internet and cell phones, the news of problems back home is not shielded from the soldier on the front lines. Common problems include spouses wanting a divorce, children struggling in school, financial difficulties, and parents with health problems. For gay members, the stresses are different. They may pretend they are in heterosexual relationships or worry about being outed. The focus here will be on the personal stories of gay uniformed providers who have served throughout the last thirty years. The audience should consist of military, VA and civilian providers who are interested in these personal experiences of gay servicemembers. It will highlight lessons learned and survival strategies for gay mental health providers not only deploying in support of U.S. military operations, but to any austere and dangerous environment for a prolonged period of time.

Getting to Zero New HIV Infections: The Role of Mental Health Providers
Chair: Marshall Forstein, M.D.
Presenters: Kenneth Ashley, M.D., Daena L. Petersen, M.D.

EDUCATIONAL OBJECTIVE:
1) Define pre-exposure prophylaxis (PrEP) and the antiretroviral treatments (ARTs) 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 men who have sex with men (MSMs). 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 multidrug treatment for HIV that has increased health and longevity among people living with HIV 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 U.S. and in Africa, antiretroviral medication has been shown in MSMs and heterosexual women to effectively block HIV infection if taken daily—pre-exposure prophylaxis (PrEP). Studies show significant effectiveness for preventing HIV with good adherence to PrEP. Given the enormous impact of HIV on at-risk populations, both the CDC and the World Health Organization recommend PrEP for individuals at "high risk" for HIV who are serologically tested to be HIV negative. These population-based recommendations do not adequately assess the impact of PrEP on individuals with regard 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 people with HIV to those without HIV infection. Concerns have been voiced about spending resources on PrEP rather than on treatment for people with HIV and AIDS, especially in resource-poor nations. This workshop will provide a few brief presentations on the science of PrEP; the translation of the research into clinical practice; the psychotherapeutic, social policy 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 concerns must be considered when applying research findings to a specific clinical situation? 3) How will the use of PrEP affect decision making and risk taking among MSMs and women? 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 individuals at high risk for HIV? and 6) What possible countertransference issues might arise?

Healthy Eating Becomes Unhealthy: Emergence of Orthorexia Nervosa
Chair: Steven Crawford, M.D.
Presenters: Rebecca Sokal, Yon Park, Michael Cannon

EDUCATIONAL OBJECTIVE:
1) Define orthorexia nervosa and describe symptoms and proposed diagnostic criteria; 2) Provide a case study of a patient with symptoms of orthorexia nervosa; 3) Recognize the overlap of symptoms of orthorexia nervosa with OCD, somatic symptom disorder and psychotic spectrum disorders; 4) Discuss whether orthorexia nervosa is a distinct diagnostic entity warranting its own *DSM* diagnosis or if it is related to other eating disorders like anorexia nervosa or ARFID; and 5) Review treatment approaches and discuss further areas of research needed to better understand this condition.

SUMMARY:
Almost daily, we are faced with updates on the latest food diet, warnings about certain foods and products, and an ever-changing set of guidelines on how to live a healthier life. In this complicated cultural environment, many individuals find it difficult not to worry about their eating habits. In 1997, the term "orthorexia nervosa" was introduced in the literature, identifying a possible new disorder on the eating disorder spectrum. Patients with this proposed disorder have an unremitting obsession with proper nutrition and excessive concern about the quality and content of food products distinct from the core symptoms of the *DSM-5*-defined eating disorders anorexia nervosa or ARFID. This

fixation on food quality is prompted by an intense desire to maximize one's own physical health, leading people to develop extremely restrictive diets due to rigid avoidance of "unhealthy" foods and ritualized patterns of eating. This dietary extremism can lead to serious medical complications similar to those seen in anorexia nervosa. Patients also spend an undue amount of time reading about and engaging in food preparation, leading to social isolation and poor quality of life. While not recognized as a diagnosis in the *DSM-5*, orthorexia has been described in the literature in numerous case reports and reviews as early as 1997. In this workshop, we will define orthorexia nervosa, discuss a proposed set of diagnostic criteria and review treatment strategies. Using a specific case of a patient, we will discuss some of the challenges in diagnosis and management given the overlap of symptoms with other eating disorders, obsessive-compulsive disorder, somatic symptom disorder, and psychotic spectrum disorders. Ultimately, we hope to shed some light on orthorexia nervosa as a possible distinct diagnostic entity, describe some unique management strategies and discuss the need for further research to better understand this condition.

How to Develop a New Cultural Formulation Supplementary Module for the *DSM-5*: Military Culture Leads the Way

Chairs: Michael Hann, M.D., M.B.A., M.S., Eric G. Meyer, M.D.

Presenters: Roberto Lewis-Fernandez, M.D., Francis Lu, M.D., Ravi DeSilva, M.D., M.A., Charles C. Engel, M.D., M.P.H., William Brim, Psy.D.

EDUCATIONAL OBJECTIVE:

1) Promote the use of the *DSM-5* Cultural Formulation Interview (CFI) and the supplementary modules for cultural assessment in clinical psychiatry; 2) Explain the process for developing a new CFI supplementary module; and 3) Utilize the newly developed military CFI supplementary module when working with active, reserve and veteran military personnel and their families as patients.

SUMMARY:

The treatment of mental illness and preservation of mental health has become an international and cross-cultural practice in today's globalized society. The phenomenology of mental illness, therapeutic alliance between physician and patient, and benefits of treatment are profoundly affected by various cultural aspects. Recognizing that new approaches are necessary to treat an increasingly diverse population and that cultural considerations apply to all patients, the *DSM-5* introduced the Cultural Formulation Interview (CFI). The CFI is a set of 16 questions designed to integrate culture into mental health assessment and treatment in order to optimize patient outcomes. It also operates from the viewpoint that culture is multidimensional, individualized and applicable to any clinical encounter, regardless of the demographic characteristics of the patient or the clinical setting. In addition to the core CFI, several supplementary modules for specific cultures and groups were created. Now that the *DSM-5* is in wide publication, it has been unclear how new supplementary modules might be developed for additional clinically important cultures. This workshop will explore one example of how to develop new CFI supplementary modules using a real-world example: the military. The military was chosen out of need to improve the culturally appropriate care being provided to military and veteran patients and their families, along with the diverse and highly prescribed nature of military culture that is often misunderstood by civilian populations. The steps for supplementary module development will be discussed, to include 1) literature review; 2) justification for the module and the content of specific domains and questions; 3) multi-axial content development—"vertical" axis of domains and questions and "horizontal" axis of target population; 4) obtaining pilot data; and 5) rigorous process for content development and consideration of feedback. Psychiatric leaders involved in the creation of the CFI in the *DSM-5* will discuss the process by which a working group of experts in military culture developed a proposed military culture CFI supplementary module. The process by which this module was developed will be presented in a step-by-step didactic presentation to serve as a case study for CFI supplementary module development. Presenters will also discuss the use of the military culture CFI module in various clinical settings. Dr. Roberto Lewis-Fernandez, the lead author of the original core CFI and supplementary

modules, and other cultural psychiatry experts, including psychiatrists with expertise in military culture, will lead the discussion. Workshop attendees will then participate in facilitated small-group discussions to discuss supplementary module development and promote the incorporation of the CFI into regular clinical practice by psychiatrists at any level of training or specialization. This will be followed by live feedback from peers and experts.

How to Refer to Transcranial Magnetic Stimulation (TMS) Therapy: What to Expect and How to Do It for the General Psychiatrist

Chairs: Richard A. Bermudes, M.D., Michelle Cochran, M.D.

Presenters: Ramotse Saunders, M.D., Suzanne Kerns, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize when to refer patients for TMS therapy and identify which patients are more likely to respond; 2) Learn co-management strategies and therapeutic techniques to use with patients while they are receiving TMS therapy; 3) Learn how to monitor patients and provide aftercare for patients who have received TMS therapy; 4) Describe how to provide education about this treatment to your patients; and 5) Understand what to expect from the TMS specialty clinic or provider in your community.

SUMMARY:

Transcranial magnetic stimulation (TMS) was cleared by the FDA in 2008 for adult patients with depression who have not benefitted from prior antidepressant medication. There are a number of reasons why the general psychiatrist should be knowledgeable about TMS. There has been growth in the number of TMS specialty practices internationally and in the United States. TMS is increasingly utilized as a therapeutic tool in a number of neuropsychiatric conditions (e.g., bipolar disorder, adolescent depression, PTSD). Furthermore, a significant proportion of patients with major depression treated with antidepressants do not fully respond. In a recent meta-analysis reviewing TMS therapy for major depression, the authors concluded that for patients with major depression who have not responded to two or more antidepressants, TMS is a reasonable treatment approach. Major private and public insurance plans now have coverage policies for TMS therapy, covering an estimated 300 million individuals. Thus, the general psychiatrist will have more patients who have clinical indications and access to this treatment modality. In this workshop, participants will learn how to select patients for TMS therapy, co-manage patients, provide aftercare for patients once they have completed TMS treatment, and understand what to expect from the TMS specialty clinic in their community. The workshop will use short didactic presentations and an interactive format to assist the psychiatrist in analyzing the research supporting the use of TMS for psychiatric conditions. Information will be presented from clinical research studies and expert TMS providers so that participants understand which patients will benefit from TMS therapy and how best to educate them. Case examples will highlight therapeutic techniques to employ while patients are receiving TMS therapy. Participants will receive guidance on combining pharmacotherapy with TMS and how best to monitor patients receiving TMS with validated measurements and assessments. Workshop attendees will learn when to re-refer patients for treatment and how best to care for patients after they have completed TMS therapy. At the conclusion of the session, practitioners will have gained an insight into the application of TMS and how it fits into the general psychiatrist's practice. Attendees will be confident in when to refer patients, how to educate their patients in what to expect, how to identify a TMS specialist in their community, and how to use this knowledge to address questions on TMS from their patients.

Implementing Quality Improvement Initiatives in Pediatric Delirium

Chair: Ravinderpal Singh, M.D.

Presenters: Alexis Aplasca, M.D., Jean Teasley, M.D.

EDUCATIONAL OBJECTIVE:

1) Name the *DSM-5* classification, prevalence, contributing etiology, and negative outcomes for pediatric delirium; 2) Understand the developmental factors in the clinical presentation of pediatric delirium using validated screening tools; and 3) Expand management approach to pediatric delirium

and implement quality improvement initiatives within a health care system.

SUMMARY:
Compared to the adult population, pediatric delirium in the critical care setting and medical wards remains grossly unrecognized. Delirium in children is associated with increased morbidity and mortality, poor overall functioning, cognitive decline with poor school performance, increased medical costs, and increased length of stay. A recent study conducted in the pediatric ICU setting found a delirium prevalence rate of 47% as determined by their reference standard (child psychiatrist using *DSM* criterion). The prevalence was 35% in patients two to five years old and 56% in patients under two. Clinicians face many challenges, particularly the uncertainty of clinical significance given the developmental variability of clinical presentation depending on age. With a scarcity of child psychiatrists, the burden often lies on the primary medical teams to manage delirious patients. Many providers lack awareness, training and tools to diagnose and treat appropriately. Further, there are diverse subtypes of delirium, the most common, hypoactive type (60%), which can be hard to assess and screen. As a result, you have a decreased overall diagnosis of delirium, which can lead to poor patient outcomes and complicate overall treatment and management. Until recently, advancements of research have been lagging. There have been an increasing number of publications, validated screening tools and the creation of a delirium working group within AACAP. This workshop will provide participants with *DSM-5* classification, prevalence, contributing etiology, developmental factors associated with the clinical presentation of pediatric delirium using validated screening tools, and adverse outcomes. Further, the session will expand the management approach to pediatric delirium and discuss implementing quality improvement initiatives within a health care system. Dr. Ravinderpal Singh, M.D., is a systems-focused child and adolescent psychiatrist interested in developing interdisciplinary approaches to addressing child psychiatric needs in health care systems. Dr. Alexis Aplasca, M.D., is triple boarded and trained in pediatrics, psychiatry and child psychiatry and focused on the integration of mental health into various pediatric specialties. Dr. Jean Teasley, M.D., is a child neurologist trained in pediatric pain and palliative care, committed to improving the quality of life of pediatric patients with complex medical disorders through systems-based approaches in medical education.

Informed About Informed Consent: Toward a Model Graduate Medical Curriculum
Chair: Dominic Sisti, Ph.D.
Presenters: Anthony Rostain, M.D., M.A., Rocksheng Zhong, M.D., M.H.S., John Northrop, M.D., Ph.D.

EDUCATIONAL OBJECTIVE:
1) Understand the ethical and legal frameworks of informed consent, decision making capacity and shared decision making; 2) Reason through clinical scenarios that involve questions about a patient's valid informed consent or decision making capacity; and 3) Develop awareness of strategies for teaching trainees in psychiatry and other medical disciplines about informed consent and decision making capacity.

SUMMARY:
Informed consent is a foundational concept in modern medicine comprised of three elements: disclosure of information, decision making capacity and voluntariness. Despite physicians' ethical and legal obligations to obtain informed consent, no standard curriculum exists to teach residents relevant knowledge and assessment skills. This workshop will present an interdisciplinary approach to designing an evidence-based model graduate medical curriculum to address this gap. Focus groups conducted with residents and faculty in several departments at the Hospital of the University of Pennsylvania showed that additional training using representative cases around decisional capacity, medical-legal considerations and ethics are desired. Educational modules targeting these issues are now being piloted and tested in the Department of Obstetrics and Gynecology. The panelists will review the ethical and legal concepts underpinning consent and capacity, introduce common clinical scenarios in which these issues arise, and discuss the findings and outcomes of the model curriculum.

Innovations in Inpatient Psychiatric Care
Chair: Brian Palmer, M.D., M.P.H.

Presenters: Joseph Stoklosa, Kathryn Schak, John M. Oldham, M.D., M.S., Adrienne Gerken

EDUCATIONAL OBJECTIVE:
1) Describe principles of systems engineering and adult education helpful in implementing inpatient care pathways; 2) Identify when, how and for whom longer-term inpatient care may be highly effective; and 3) Effectively integrate principles of dialogic practice into inpatient care for patients with bipolar disorder and schizophrenia.

SUMMARY:
Inpatient psychiatric care is the most expensive and intensive level of care, and studies of treatment effectiveness and innovation are surprisingly limited. This workshop will be a highly interactive discussion using cutting-edge treatment changes at three top psychiatric hospitals as a springboard for analysis. First, we will review a hospital-wide inpatient redesign at Mayo Clinic, implementing five primary pathways of care: acute suicide crisis, treatment-resistant depression, mania, psychosis, and general. All groups, provider roles, order sets, and outcome assessments were redesigned to support pathway implementation, with a large emphasis on embedding evidence-based educational groups on each unit, complete with the production of 20 new videos and group educator guides to enhance teaching effectiveness and increase content fidelity. In addition to a reduction in cost per case, increases in staff satisfaction and quality measures will be reviewed, and implementation challenges and opportunities will be shared, focusing on expansion of the project into the Mayo Health System hospitals. Second, we will review innovative care at Menninger Clinic. Contrary to general clinical wisdom, inpatient treatment for more than a few days may be beneficial to some patients with disabling borderline personality disorder and comorbid complexity. Data will be presented from the Menninger Clinic (average length of stay=45 days) using well-established assessment measures, demonstrating dramatic improvement from admission to discharge. Follow-up data will also be presented for a subgroup of patients for up to a year after discharge. Finally, the workshop will address recovery-oriented, person-centered care on the inpatient bipolar and psychotic disorders unit at McLean Hospital. Inspired by Open Dialogue and dialogic practice, this patient-centered communication project reflects an innovative approach to treatment relationships. The project has shown that an inpatient psychiatric unit can implement collaboratively developed, patient-centered cultural changes through brief training sessions without additional cost and without adding time to existing workflows. The changes in the structure of rounds, which were acceptable to staff and patients, may improve perceived quality of care and create a more collaborative system of care.

Inpatient Suicide: Prevention and Response
Chair: Juliet A. Glover, M.D.
Presenters: Frank Clark, M.D., Rachel Houchins, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the epidemiology of suicide in inpatient settings; 2) Describe patient and environmental risk factors for inpatient suicide; 3) Discuss prevention strategies; 4) Explain measures to implement in the aftermath of an inpatient suicide; and 5) Describe ways to maintain physician wellness when faced with adverse outcomes.

SUMMARY:
Suicide is often considered the worst psychiatric outcome. Psychiatrists are trained in the assessment of suicidal patients, stratification of risk and safe disposition of patients to the least restrictive treatment setting. However, the hospital is often viewed as a “safe place” where patients can receive treatment and close monitoring. Though rare, the risk of suicide in the inpatient setting remains. The Centers for Disease Control and Prevention estimates an overall suicide rate of 16.9 per 100,000 for U.S. individuals age 18–64 in the year 2014. It is estimated that five to six percent of these occur in hospitals, with 75% occurring on psychiatric units. In February of 2016, the Joint Commission issued an alert notifying hospitals of the increasing incidence of suicide occurring in health care settings. The commission received nearly 1,100 reports of inpatient suicides from 2010–2014. The impact of these statistics is further amplified when considering the impact that a single inpatient suicide can have on a psychiatrist, the treatment team and the hospital system. These statistics and the devastating

nature of inpatient suicide highlight the importance of awareness and education of health care practitioners on suicide prevention, even in health care settings. This workshop will utilize a case-based approach to foster discussion on inpatient suicide prevention and response. Environmental risk factors as well as suicide warning signs will be reviewed. Completed suicide in the health care setting can be unnerving to the entire treatment team, but preparedness can help ease this anxiety. This workshop will provide practical steps to implement after a completed inpatient suicide, including contacting of appropriate law enforcement, notification of next of kin, patient interventions, environmental changes, and staff interventions. The potential impact of inpatient suicide on psychiatrists will be discussed, including ways to build resilience and maintain wellness.

Inside College Mental Health Programs: Interviews From the APA Studio

Chairs: Nancy Downs, M.D., Daniel Kirsch, M.D.
Presenters: Vivien Chan, M.D., Sidney Zisook, M.D.

EDUCATIONAL OBJECTIVE:

1) Describe the college mental health psychiatrist's role within academic medical centers; 2) Identify common administrative challenges for college mental health psychiatrists; 3) Identify common clinical challenges for college mental health psychiatrists; 4) Recognize how college mental health psychiatry satisfies academic departments' missions of service, research/scholarly activity, and training and education; and 5) Review successful strategies to manage transitions when providing clinical care to transitional age youth (TAY) within the structure of the academic calendar.

SUMMARY:

Young people transitioning to adulthood are a unique population with specific health and mental health indicators, needs and vulnerabilities. More than half of our nation's young people enter college, but those suffering from mental illness struggle to get the necessary care to remain enrolled. In 2015, nearly 21 million students were enrolled in U.S. colleges and universities. Early identification and treatment of mental illness in precollege youth allow students with mental health needs to matriculate to undergraduate and graduate schools and continue care in these environments. The college setting provides unique opportunities for interventions in transitional age youth (TAY) that affect the life course and impact of mental illness. Therefore, academic medical centers can and need to participate in the development of novel, evidence-based college mental health programs (CMHPs) that improve the academic success and quality of life for their students. Historically, psychiatrists have had more ancillary roles on campus, but this is changing. CMHPs developed and led by psychiatrists are now more feasible and growing in number. This workshop will employ an interactive panel discussion designed to encourage audience participation. The three panelists have forged CMHPs within academic medical centers utilizing three distinct models, which stem from their core interests in the treatment of TAY populations. The moderator is a senior residency training director with expertise in the mental health treatment of medical students and suicide prevention. First, utilizing an interview format, panelists will describe the basic landscape of mental health care within higher education and how to work collaboratively with college campus communities to provide quality psychiatric services and treatment. Next, we will discuss the multiple benefits that CMHPs provide for academic medical centers. These positive multipliers include opportunities for research, training and education in TAY populations, and service to the university. We will emphasize both challenges and opportunities inherent to CMHPs, how to manage multiple alliances, and ultimately how to create a rewarding psychiatric career in college mental health.

Interviewing the Non-Disclosing Patient: A Clinical Exercise for Psychiatric Residents

Chair: Alexander C. L. Lerman, M.D.
Presenters: Jeffrey Gruhler, Sahil Munjal, M.D., Jasra Ali Bhat, Anupama Sundar, M.D. M.P.H, Mohammad Tavakkoli, M.D.

EDUCATIONAL OBJECTIVE:

1) Recognize nondisclosure (ND) in its many and sometimes subtle presentations; 2) Identify patient ND as a ubiquitous aspect of the psychiatric evaluation, which often signals the presence of important information; 3) Recognize the capacity of

patient ND to induce effects such as anxiety, boredom and therapeutic hopelessness in the evaluating psychiatrist; 4) Respond to patient ND by placing this behavior in the context of the patient's underlying psychopathology and his/her effort to cope with those problems; and 5) Use multiple strategies in the clinical interview through which ND behavior can be engaged and incorporated into a deepening therapeutic alliance.

SUMMARY:
The validity of all psychiatric assessment rests on the willingness and capacity of a patient to provide a complete history and the psychiatrist's capacity to help them do this. Some patients provide distorted and incomplete information at critical points during an initial assessment. Some patients do so knowingly; many more do so in response to the underlying psychopathology that brought them to treatment in the first place. A skilled interviewer is often more interested in the factors that precipitate distortion and nondisclosure and by engaging these is able to elicit a deeper understanding of the patient and an improved therapeutic alliance. This workshop will present the results of a training exercise in which psychiatry residents were assigned to elicit a history from a simulated patient (SP) who had been instructed to give information that was vague, distorted or in some instances grossly false until appropriately confronted or engaged by the resident. One patient, following a near-lethal overdose in the setting of an acute life crisis, is now attempting to deny and minimize her distress. A second patient was actively psychotic, paranoid and suffering from severe somatized pain. A third patient presented with malingered auditory hallucinations but in fact suffers from chronic developmental trauma and an underlying major depressive process. Generally speaking, the trainees were able to correctly establish the underlying features of the case but tended to be less successful in understanding why a patient was less than fully candid and using such an understanding to deepen the interview process. Such difficulties frequently led to erroneous or incomplete clinical formulations, as when a resident correctly deduced that a patient was lying in order to gain admission to the hospital, but failed to inquire further and establish the patient's underlying depression, history of transient psychosis and suicide attempt. During both the training exercise and daily clinical practice, many residents describe feeling frustrated or bored by patients, failing to appreciate that this emotional experience is often a reflection of lack of trust, disengagement and restricted disclosure on the patient's part. In follow-up study of tapes of the simulated patient interviews, we have attempted to develop the capacity of our psychiatrists-in-training to view nondisclosure and distorted disclosure by patients as a critical window into a patient's state of mind and, in many instances, the patient's underlying psychopathology. During our workshop, we will present video clips of specific interactional patterns to illustrate specific challenges, e.g., engaging a paranoid patient, a patient overwhelmed by distress and shame, and a patient unable to articulate or conceptualize his underlying distress and trauma. Audience members will be encouraged to share their own vignettes in a general discussion of advanced interviewing technique.

It's Not "Just" Prozac: The Importance of Teaching the Psychodynamics of Psychopharmacology
Chairs: Elena Ortiz-Portillo, M.D., Bruce Gainsley, M.D.
Presenters: Michelle Meshman, M.D., Alessia Tognolini, M.D., Amy Woods, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand the role of psychodynamics underlying psychopharmacological treatment and their importance in supervision and training; 2) Provide trainees with tools to describe the psychodynamics that may explain treatment resistance and compliance issues in pharmacotherapy; 3) Demonstrate the ability to integrate a psychodynamic perspective in the initial evaluation of a new patient; and 4) Develop techniques to improve collaborative work with other providers.

SUMMARY:
Over the last three decades, the field of psychiatry has made remarkable advancements toward the biological understanding and treatment of psychiatric illness. Many psychiatry residency programs have centered their training on teaching residents about neurobiology and

psychopharmacology, leaving less time to educating future psychiatrists about the principles and techniques of psychotherapy, particularly psychodynamic principles. However, the psychological and psychosocial aspects of mental illness not only remain essential for diagnostic accuracy but are crucial in order to obtain positive treatment outcomes. Overreliance on the pure biological aspects of psychiatric illnesses for their treatment would lead to an impoverishment in our field and will deprive residents of very important tools, as well as a humanistic focus on meaning and relationship factors. Over the course of the workshop, we will review the rationales that make this topic relevant, including evaluating treatment resistance, physician burnout and improvement of collaborative work. The most important psychodynamic concepts (i.e., transference, countertransference, enactment, therapeutic frame, and boundaries) will be examined from the specific angle of their role and application in psychopharmacological treatment. Other topics that will be discussed include placebo, nocebo and compliance. A special emphasis will be given to the initial evaluation visit and its function in the case formulation and the expectations for the therapeutic process. The role of the psychiatrist in different models of collaborative work will be explored as well as the complex dynamics that may derive from treatment with different providers. The workshop is targeted to psychiatrists involved in training and supervision, residents, medical students, and any psychiatrist or clinician with an interest in psychodynamics and their application to clinical practice.

Ketamine for Treatment-Resistant Chronic Pain and Depression

Chairs: Waguih William IsHak, M.D., Jonathan Dang, M.D.

Presenter: Brigitte Vanle, Ph.D.

EDUCATIONAL OBJECTIVE:

1) Acquire knowledge about the current management of treatment-resistant chronic pain and depression; 2) Establish the mechanism of action for ketamine in treating chronic pain and depression; and 3) Acquire knowledge and skills about how to use ketamine for treatment-resistant chronic pain and depression and the associated challenges.

SUMMARY:

Ketamine is best known as an illicit, psychedelic club drug. Often referred to as "special K" by the media, it was synthesized in 1962 and was approved in 1970 as an anesthetic for human use. During the Vietnam War, it was used as an anesthetic to relieve pain in wounded soldiers. Since 2006, the treatment of pain and depression has been based on a trial of opioids and antidepressants as drugs of first choice. The effectiveness of the treatment is limited, with just 30-40% of patients showing adequate pain relief and remission of depressive symptoms-suggesting that a single treatment of ketamine may be useful for addressing pain and depression. Ketamine has been used in subanesthetic doses as a treatment for chronic pain and, more recently, for treatment of depression. Studies have shown that it can reverse, within 45 minutes to hours, the kind of severe, suicidal depression that traditional antidepressants can't treat or would take months to accomplish. Ketamine utility for pain and depression will be discussed during this workshop. Interestingly, ketamine's effects on depression lasted at least five days, far outlasting its concentration in blood or tissue. An understanding of ketamine's mechanism of action, which could lead to improved treatment, has been widely sought. In a recent study in *Nature* (May 2016), researchers provide evidence to indicate that it is not ketamine itself, but one of its metabolites, that is responsible for the drug's antidepressant effects. The drawback of ketamine is that its effects are short-lived and its relief is temporary. Clinical trials at the National Institute of Mental Health (NIMH) have found that relapse usually occurs about a week after a single infusion. To be used as an effective antidepressant, it would need to be administered by IV regularly. The guidelines, which follow the protocol used in the NIMH, call for six IV drips over a two-week period. The dosage is very low-about a tenth of the amount used in anesthesia. To be most effective for pain management, current data suggest prolonged infusion (4-14 days) for analgesics effects up to three months. Ketamine infusion is a popular therapy because it has a rapid onset, but the drug has hallucinogenic side effects, and the current IV route

of administration is impractical for outpatient treatment of pain and depression. There is a great need for alternative and practical methods of ketamine administration. Because previous studies have focused primarily on treating either pain or depression, our workshop will introduce participants to a novel treatment for comorbid pain and depression. We will also provide information regarding ketamine utility and mechanism of action.

Malingering Assessments 101: A Psychiatrist's Guide to Objective Malingering Tests
Chair: Charles Scott, M.D.
Presenters: Brian Holoyda, M.D., M.P.H., Azalia Martinez, M.D., Anthony Gale, M.D., Chong Yang, D.O., Charles Scott, M.D.

EDUCATIONAL OBJECTIVE:
1) Define basic strategies for the detection of malingering; 2) Describe the utility of objective assessments of malingering in clinical psychiatric practice; and 3) Teach psychiatrists how to administer and score brief, objective assessments for malingering.

SUMMARY:
Malingering is a common problem in clinical psychiatric practice. An estimated 13% of patients in a metropolitan emergency department setting were suspected of malingering. In forensic contexts, the prevalence rates are even higher, with an estimated 16% of forensic patients, 21% of defendants undergoing evaluation of criminal responsibility and half of individuals evaluated for personal injury claims determined to be malingering. The ability to evaluate malingering clinically is limited, so it is critical that psychiatrists know how to assess for malingering using objective assessments. In this workshop, psychiatrists will learn about basic strategies for detecting feigned psychiatric symptoms. We will teach psychiatrists how to administer and score some of the most commonly utilized objective assessments of malingering, including the Miller Forensic Assessment of Symptoms Test (M-FAST), the Test of Memory Malingering (TOMM), the b-test, the coin-in-the-hand test, and the Rey 1 and 2 tests. We will review user qualification and ethical issues related to the administration of these tests. In addition, attendees will learn how to document the results of objective testing for clinical and/or forensic contexts.

Malingering of Combat-Related PTSD: Implications for Military and VA Disability Systems
Chair: David E. Johnson, M.D.
Presenters: Erika Zavyalov, D.O., Vanessa Green, D.O., Philip Candilis, M.D., Rebecca Smullen

EDUCATIONAL OBJECTIVE:
1) Describe how the military and veteran disability systems compensate for combat-related PTSD; 2) Discuss techniques for detecting malingering in patients presenting with PTSD-like symptoms; 3) Discuss the somewhat controversial role of forensic psychiatry in addressing the issue of malingering in this patient population; and 4) Outline the ethics and unforeseen consequences of paying veterans disability money for lifelong chronic PTSD.

SUMMARY:
Media reports detail endless backlogs in military and VA systems for processing veteran disability claims. While many who seek PTSD services from the VA describe their symptoms exactly as they experience them, there is a subset of those who exaggerate or feign symptoms. This workshop addresses how the military and VA disability systems address, or do not address, malingering of combat-related PTSD. Clinicians struggle to discern who is accurately representing their symptoms versus those who are malingering for secondary gain. Embellishment of symptoms represents partial malingering but is not easily measured for disability purposes. Some authors allege that the disability system behooves veterans to continue to create or embellish PTSD symptoms to reap the full benefits and that they have no incentive to report positive treatment outcomes. Standardized forensic assessment instruments may help detect malingering, but their use is often discouraged or minimized. The use of collateral information to verify the occurrence of combat trauma is possibly the most effective tool for detecting malingering but is rarely performed. Reimbursing veterans with lifelong disability payments may present ethical dilemmas, such as encouraging embracement of the sick role, nonresponse to treatment and degrees of malingering. This workshop will describe the

military-VA integrated disability process, techniques for detecting malingering, and whether the disability system is helping or harming this population in the long run. Cases of actual malingering will be presented.

Managing Opiate Users Admitted to the General Hospital: Safely Avoiding Discharge Against Medical Advice

Chairs: Kenneth M. Certa, M.D., Kathleen C. Dougherty, M.D.
Presenters: Gregory Giuliano, D.O., Daniel Helman, M.D., Anthony Thomas, M.D.

EDUCATIONAL OBJECTIVE:

1) Identify risk factors for against medical advice (AMA) discharge by opioid-addicted patients admitted to general hospitals; 2) Describe different legal considerations for declining to allow AMA discharge; 3) List opioid replacement/detox/maintenance strategies that may be used in general hospital settings; and 4) Review risk management considerations for opioid-addicted patients in the general hospital.

SUMMARY:

Patients with opioid addiction frequently require hospitalization for medical complications of the addiction, as well as general human afflictions. There is no general agreement on how to manage opioid withdrawal, as well as pain control, in a general hospital setting for this population. Frequently, patients sign out against medical advice, with sometimes catastrophic results. Attitudinal issues about the degree to which opioids should be used in this setting, as well as scientific disagreements about which opioids to use, create anxiety about proper management. Developing algorithms that practitioners can buy into and reference can enhance patient experience and minimize unnecessary premature discharges. We have been working on a protocol for management of opioid-addicted individuals admitted to our general hospital. We will present the conflicting considerations we have struggled with, including misunderstanding of federal and state regulations concerning the use of opioids for detox and maintenance in settings other than licensed detox units. There have been multiple stakeholders who have tried to influence the process, with many different agendas. The use of ketamine, patient-controlled analgesia, standing and as-needed opioids, methadone, buprenorphine, and naltrexone (oral and injection), as well as clonidine and benzodiazepines, have all had their advocates. There have been varying degrees of willingness to medicate to a degree to make the patient comfortable, and arguments on how to assess comfort. Whether or not avoiding an against medical advice (AMA) discharge is a laudable goal has also been questioned. We plan to present our approach to management of difficult patients (primarily heroin users admitted for endocarditis, osteomyelitis or serious cellulitis). We will present cases for discussion in a small-group format with subsequent whole-group sharing. The case presentations will be in stages, with decision points requiring selection of approach and then what happened. We will present our successes as well as our failures and why we consider them as such. How risk management can or should play a role in the process will be reviewed.

Medical Cannabis: What Psychiatrists Should Know

Chair: David A. Gorelick, M.D., Ph.D.
Presenters: Kevin P. Hill, M.D., M.H.S., John Halpern

EDUCATIONAL OBJECTIVE:

1) Understand the differences between federal law and the various state laws governing medical cannabis; 2) Be familiar with the clinical indications for medical cannabis and the levels of scientific evidence supporting them; 3) Recognize the different clinical effects associated with various cannabis routes of administration and THC and cannabidiol concentrations; 4) Identify potential patients for whom medical cannabis might be indicated or contraindicated; and 5) Be familiar with potential public health consequences of medical cannabis use.

SUMMARY:

Use of cannabis for medicinal purposes (medical cannabis) has a centuries-long history in the U.S. and throughout the world but has been illegal in the U.S. at the federal level since 1937. Cannabis and all cannabinoids are classified in Schedule I of the Controlled Substances Act (CSA), meaning that they are considered to have a “high potential for abuse,”

"no currently accepted medical use in treatment," and "a lack of accepted safety for use" (21 U.S. Code § 812). In contrast, state-level interest in medical cannabis has been growing over the past two decades. As of September, 2016, 25 states and the District of Columbia have medical cannabis programs that are legal under state law. Another 11 states have programs allowing use of cannabidiol (or "low-THC" cannabis) to treat seizures. However, most U.S. physicians, including psychiatrists, receive little or no training about medical cannabis. Thus, they have inadequate knowledge and expertise to respond appropriately to patients who are interested in medical cannabis, to recommend it to patients who might benefit or to discourage its use by patients for whom it would not be therapeutic. This workshop fills this knowledge gap through interactive presentations by three nationally known experts. Each presentation will serve as a focus for discussion among presenters and attendees, culminating in a discussion of presented case vignettes and then general discussion. The workshop will describe the difference between "prescribing" a medication under federal law vs. "recommending" or "authorizing" medical cannabis under state law, the major medical and psychiatric conditions for which medical cannabis can be recommended (most commonly pain, cancer, multiple sclerosis or muscle spasm, seizures, nausea and vomiting, HIV/AIDS, glaucoma, posttraumatic stress disorder, and agitation associated with Alzheimer's disease), the current scientific evidence supporting those indications, major side effects associated with medical cannabis (e.g., dizziness, dry mouth, fatigue, drowsiness, euphoria, disorientation, confusion, loss of balance, motor incoordination, hallucinations), and potential public health consequences (e.g., increased motor vehicle accidents, diversion and increased misuse of cannabis, decreased use of opiate analgesics). We will also review the practical clinical pharmacology of medical cannabis, including the advantages and disadvantages of various routes of administration (smoked, inhalation of vapor, oral), cannabis strains with varying concentrations of THC, cannabidiol (CBD), THC:CBD ratios, and various doses. Workshop attendees will then apply this information to discussion of several case vignettes of patients interested in taking medical cannabis.

Mindful Movements of Qigong and Tai Chi to Increase Well-Being and Reduce Compassion Fatigue

Chairs: Colleen Loehr, M.D., Albert Yeung, M.D.
Presenters: Patricia L. Gerbarg, M.D., Richard Brown, M.D.

EDUCATIONAL OBJECTIVE:

1) Practice mindful movements of qigong and tai chi to increase well-being and reduce compassion fatigue; 2) Engage in a simple breathing practice to strengthen the parasympathetic nervous system; 3) Understand relevant research studies and clinical applications for qigong, tai chi and breathing practices; and 4) Directly experience the benefits of engaging in mindful qigong, tai chi and breathing practices.

SUMMARY:

Qigong and tai chi are ancient healing arts from China that promote physical and mental well-being. In this workshop, participants will engage in qigong and tai chi exercises to directly experience a surprising sense of refreshment and calm. Neurophysiological mechanisms of action and clinical studies of qigong, tai chi and breathing practices will be reviewed, including autonomic balance, emotion regulation, social engagement, polyvagal theory, and vagal-GABA theory. The use of specific breath practices in psychotherapy and for mass disaster relief will be discussed. Participants will experience a therapeutic integration of gentle but powerful qigong movement and breath techniques with coherent breathing and open focus meditation. These sequences have been used to relieve stress, anxiety and trauma in a wide range of patients, caregivers, active duty military, veterans, and survivors of mass disasters. Profound renewal is available through the practice of these simple, time-tested exercises. Both the didactic and experiential portions of this workshop will demonstrate that qigong and tai chi are effective tools for increasing well-being and reducing compassion fatigue.

Modern Use of Plasma Antipsychotic Levels

Chair: Jonathan M. Meyer, M.D.
Presenters: Jennifer O'Day, Eric Schwartz

EDUCATIONAL OBJECTIVE:
1) Understand the limitations of cross-sectional plasma antipsychotic data to guide treatment decisions; 2) Understand the relationship between D2 occupancy antipsychotic plasma levels; and 3) Understand how to combine information from antipsychotic plasma levels with the clinical picture to determine an appropriate course of action.

SUMMARY:
The technology to measure plasma antipsychotic levels has been available for 40 years, and commercial laboratories have assays for nearly every antipsychotic. Despite their widespread availability, many clinicians have been led to believe that routine use of plasma antipsychotic levels is of limited clinical value. The principal reasons for not using plasma antipsychotic levels include the vaguely defined upper limits for response and the fact that correlation between levels and response in cross-sectional studies are not robust in the manner seen with lithium and tricyclic antidepressants. Despite these misgivings, clozapine is often viewed as the exception to this rule. The purpose of this workshop is to show psychiatrists that the utility of tracking plasma levels during clozapine therapy illustrates important points that can be applied to many antipsychotics: 1) most antipsychotics have convincing data for a minimum response threshold; 2) plasma antipsychotic levels are critical to separating treatment failure for kinetic reasons or adherence reasons from failure due to inadequate pharmacodynamic response; 3) plasma antipsychotic levels can be used to help monitor oral medication adherence. Using data from clinical studies and case examples, this workshop will help psychiatrists understand how plasma antipsychotic levels relate to dopamine D2 receptor occupancy and clinical outcomes, as well as how variations in drug metabolism and medication adherence limit the use of dosing in many clinical situations. Basic information culled from 30 years of experimental data will be presented in this workshop to illustrate how knowledge of the correlation between oral dosages and plasma antipsychotic levels can be used to track adherence, and how plasma antipsychotic levels can be used to determine a course of action in non-responders. In addition to discussing the basic principles for effective use of plasma antipsychotic levels, sections will focus on those agents commonly used, including haloperidol, fluphenazine, risperidone and 9-OH risperidone, olanzapine, and clozapine. The timing of plasma levels for oral and depot medications will also be reviewed. At the conclusion of this workshop, clinicians should have gained significant knowledge about how monitoring antipsychotic plasma levels can assist with routine clinical decision making for many patients, not just those on clozapine.

Narcissism in the American Psyche: Theoretical, Longitudinal and Clinical Perspectives
Chair: Ravi Chandra, M.D.
Presenters: Glen O. Gabbard, M.D., Jean Twenge

EDUCATIONAL OBJECTIVE:
1) Understand and describe cross-generational data on narcissistic traits and civic engagement and intimate relationship trends; 2) Understand social media's positive and negative influences on personality; and 3) Understand clinical implications of these trends and influences.

SUMMARY:
American culture is fundamentally different now than it was 50 years ago, potentially creating generational differences in personality traits, attitudes and behaviors. Much of this change can be understood as a cultural shift toward individualism, a system that places more emphasis on the self and less on others. A series of studies have explored generational differences relevant to individualism in five large, nationally representative surveys of adolescents and adults conducted since the 1960s and 1970s (N=11 million). This research design can separate the effect of age from that of generation or time period, identifying trends due to cultural change. Studies based on these datasets find that Americans are now more extraverted, narcissistic and confident and less connected to others through both personal contact and civic engagement. With its emphasis on attention seeking and electronic communication, social media may have hastened these trends in recent years. The implications for society and individual mental health of an increase in narcissistic traits and change in quality of relationships are profound and far reaching. Understanding this research can help clinicians

understand the challenges their patients face and guide them toward appropriate remedies.

Probability, Impulsivity, Sensation, and Distortion: The Many Faces of Gambling Disorder From Studying Animals to Treating Humans
Chairs: Mayumi Okuda, M.D., Petros Levounis, M.D.
Presenters: Katherine Nautiyal, Ph.D., Frank Grazioli, L.M.S.W., Jakob Linnet

EDUCATIONAL OBJECTIVE:
1) Describe findings in human studies that illustrate different gambling disorder phenotypes; 2) Describe findings from animal models that provide insights into the pathophysiology of gambling disorders and make parallels to human phenotypes; 3) Recognize challenges in treatment of special populations with gambling disorders, including those with comorbid psychiatric and neurological disorders; 4) Illustrate how different available treatments for gambling disorders can be tailored to specific patient populations based on their phenotypes; and 5) Discuss future directions for research using phenotype-based approaches that may aid in bridging the translational gap between basic science and clinical research.

SUMMARY:
Gambling disorder is now widely recognized as an important public health problem associated with substantial personal and social costs, poor physical health, and elevated suicide rates. Furthermore, gambling disorder presents high rates of psychiatric comorbidity. Among individuals with a diagnosis of gambling disorder, 50% have also had a mood disorder, 41% an anxiety disorder and 61% a personality disorder in their lifetime. In terms of substance use disorders, 73% of individuals with gambling disorder have an alcohol use disorder, 38% a drug use disorder and 60% a diagnosis of tobacco use disorder in their lifetime. Several studies have proposed different gambling disorder subgroups based on patterns of psychiatric comorbidity and clustering of psychosocial risk factors and biological vulnerabilities that ultimately result in impaired control over gambling behavior. Neuropsychological studies of individuals with gambling disorder have shown high impulsivity levels, deficits in decision making, increased sensation seeking, and cognitive distortions. This workshop first introduces the conceptualization of a phenotype-based approach that hopes to bridge the translational gap between research and clinical practice. We first describe these phenotypes based on findings from key human studies in the field of gambling disorder. The workshop then illustrates the use of animal models that have been critical for a better understanding of the pathophysiology of gambling disorder. This segment of the workshop describes the development of rodent models of gambling, which include assessments of impulsivity, decision making and novelty seeking. In particular, the effects of alterations in serotonin and dopamine signaling on gambling phenotypes will be discussed at the cellular and neural circuit levels. Participants are introduced to different case studies that illustrate the current treatments for gambling disorder, their mechanism of action and how they target these core phenotypes. The cases also illustrate the advantages of a multimodal approach to treatment. This section highlights the importance of ongoing collaboration between therapists and neurobiologists to tailor treatments specific to patients' characteristics. Application to special populations, including those with comorbid psychiatric and neurologic disorders, are discussed. Finally, this workshop provides a platform for discussion of future direction for research in human, animal and treatment studies.

Responding to the Impact of Suicide on Clinicians
Chair: Eric M. Plakun, M.D.
Presenter: Jane G. Tillman, Ph.D.

EDUCATIONAL OBJECTIVE:
1) Enumerate clinician responses to patient suicide; 2) Implement practical steps for responding to patient suicide from the personal, collegial, clinical, educational, administrative, and medicolegal perspectives; 3) Design a curriculum to educate and support trainees around their unique vulnerabilities to the experience of patient suicide; and 4) List recommendations for responding to the family of a patient who commits suicide.

SUMMARY:
It has been said that there are two kinds of psychiatrists—those who have had a patient commit suicide and those who will. Mental health clinicians

often have less direct experience with patient death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect on psychiatric personnel than other deaths do on nonpsychiatric physicians because of powerful emotional responses to the act of suicide and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop surveys the literature on the impact of patient suicide on clinicians, while also offering results from an empirical study carried out by one of the presenters demonstrating eight experiences frequently shared by clinicians who have a patient commit suicide: 1) initial shock; 2) grief and sadness; 3) changed relationships with colleagues; 4) experiences of dissociation from the event; 5) grandiosity, shame and humiliation; 6) crises of faith in treatment; 7) fear of litigation; and 8) an effect on work with other patients. Recommendations derived from this and other studies are offered to help guide individually affected clinicians and their colleagues, as well as trainees, supervisors, training directors, and administrators, in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop includes ample time for interactive but anonymous discussion with participants about their own experiences with patient suicide—a feature of this workshop that has been valued by participants in the past.

Sleep Disorders Primer for Residents: An Introduction to Evaluation and Management of Common Sleep Disorders

Chairs: Khurshid Khurshid, M.D., Richard Holbert, M.D.

Presenters: Gary Reisfield, Yarelis Soto, M.D.

EDUCATIONAL OBJECTIVE:

1) Screen patients for comorbid sleep disorders; 2) Discuss the different types of sleep disorders as well as management options; 3) Identify symptom overlap between sleep disorders and specific psychiatric disorders; and 4) Describe treatment options for sleep disorders in patients with certain psychiatric disorders.

SUMMARY:

Sleep disorders are common and pose a significant clinical and public health problem. There is considerable overlap between sleep disorders and psychiatric disorders. Identification and treatment of sleep disorders may lead to considerable improvement in comorbid psychiatric symptoms. In this workshop, we will characterize the sleep disorders as defined in the *DSM-5* and specify the correlation between sleep disorders, sleep symptoms and psychiatric disorders, with focus on depressive disorders, bipolar and related disorders, schizophrenia spectrum disorders, and PTSD. Sleep is an important biological function and need. Sleep disorders are commonly underdiagnosed and undertreated. There is overlap between symptoms of sleep apnea and depression. Treatment of sleep apnea may lead to improvement in depressive symptoms. There is also overlap between insomnia and depression. Insomnia may be a symptom of depression, its harbinger or a symptom of unresolved depression. Management of comorbid sleep disorders is therefore important in overall management of a patient. Sleep disruptions are also common in the bipolar disorders. Patients with sleep bipolar disorder show abnormalities in circadian rhythm and have increased sleep disruptions. Patients with schizophrenia often complain of insomnia, and polysomnography in patients with schizophrenia shows an increased likelihood of increased sleep latency, decreased REM latency, decreased slow wave sleep, and decreased total sleep time. Sleep disturbances in PTSD are quite common and consist of such symptoms as insomnia, nightmares and periodic leg movement. We will review the sleep disturbances in these disorders, describe the effect sleep symptoms have on these disorders and proffer treatment options. The workshop leaders have experience in treating sleep disorders and comorbid psychiatric disorders. They have published their work in this area. Participants will assess their progression on sleep disorder-related milestones before and after the session. Patient case examples will be presented to the attendees to allow for small-group discussions and active participation. These examples and videos will be used to foster discussion and application to real patients. The goal will be to provide residents with

knowledge of sleep disorders while having an open forum for discussion and questions.

"Take Me to Your Leader": Core Competencies in Leadership, Interpersonal Dynamics and Management

Chairs: Michael Hann, M.D., M.B.A., M.S., Amanda P. Harris, M.D.
Presenters: Jeremy D. Kidd, M.D., M.P.H., Steve H. Koh, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:
1) Name the key aspects of a coaching or mentoring relationship; 2) Describe how to set mutual goals with a mentor/mentee; 3) Define emotional intelligence; and 4) Understand how emotional intelligence can be applied to group dynamics.

SUMMARY:
Whether in the hospital or the board room, a nuanced mastery of interpersonal dynamics is critical to leadership. An emotionally intelligent leader is able to identify and harness each team-member's strengths and communication style, applying them collaboratively in the workplace to improve workflow and accomplish shared goals. Higher emotional intelligence has been positively correlated with better social relationships in adults and children, better academic achievement, better social relations during work performance and in negotiations, and better psychological well-being. These traits obviously add significant value to any organization. Among all other specialties, psychiatrists are ideally positioned to serve as the experts in emotional intelligence and group dynamics within the greater house of medicine. Expertise in emotional intelligence and group dynamics is intrinsically different from more traditional "book knowledge" taught in the first two years of medical school. While the fundamentals of these concepts can be taught in didactics, expertise in these areas necessitates tutelage and practice. In other words, mentorship is required. Mentorship, both an art and a science, is necessary to attract and retain great people, communicate a leader's personal investment in the progression of their team members, and galvanize a team's effectiveness. The mentor-mentee relationship takes on many forms and when done effectively yields a significant return on investment for the time dedicated. The goals of this workshop will be to discuss current research on emotional intelligence and group dynamics, particularly as they can be applied to a successful mentor-mentee relationship and in managing group dynamic within a medical team. Various models for emotional intelligence will be defined in addition to an overview of interpersonal dynamics and organizational psychology. Subject matter experts will discuss these concepts as well as strategies for implementation into regular clinical practice. We have invited Dr. Steve Koh from UC San Diego and other experts from the UC San Diego Rady School of Management to participate in the discussion. The workshop will be organized into two modules, and each module will consist of a high-yield didactic presentation followed by interactive small-group learning activities. This will be followed by live feedback from peers and experts, as well as a final "debrief" in which attendees are able to discuss lessons learned with the expert panel. Finally, attendees will be given a summary handout of high-yield "pearls" collected from subject matter experts.

Talking With Patients About Genetic Testing and Psychiatric Disorders: A Genetic Counseling Workshop

Chair: Jehannine Austin, Ph.D.
Presenters: Christina Palmer, Carmela Thompson, Jane Peredo

EDUCATIONAL OBJECTIVE:
1) Understand some of the practical and psychosocial issues that can emerge in the context of genetic testing for psychiatric disorders; 2) Know how to explain the etiology of mental illness in a manner suitable for patients/family members and how to integrate genetic testing results into this explanation; and 3) Understand and know how to address some of the psychosocial issues associated with genetic counselling for mental illness and with receiving genetic testing results.

SUMMARY:
Clinicians across all disciplines—including psychiatry—are increasingly feeling pressure to incorporate genetics into their clinical practice. For example, psychiatrists can find themselves confronted with their patients' questions about

whether genetic testing is an option that might provide useful answers for them. However, research continues to show that many psychiatrists lack confidence in their abilities to integrate genetics into their patient care. Genetic counseling (which involves helping patients to "understand and adapt to the medical, psychological and familial implications of genetic contributions to disease") is a field at the forefront of the integration of genetics into clinical practice across a wide variety of medical specialties, within which psychiatric genetic counseling is currently emerging as a specialist discipline. Under naturalistic study conditions, psychiatric genetic counseling has been associated with significant increases in empowerment and self-efficacy among patients. In this highly interactive workshop, genetic counselors will facilitate small groups of attendees as they work through a "problem-based learning case" about psychiatric genetic counseling that was developed specifically for psychiatrists, in which a patient presents with genetic test results and asks their clinician about the meaning and significance of their results. Through this work, attendees will gain confidence in their abilities to successfully navigate the challenges associated with discussing genetic testing with patients in the clinical setting.

Taming the Tempest: Addressing Difficult Affect in Psychotherapy With CBT/ACT
Chair: Kenneth P. Fung, M.D.
Presenters: Diana Kljenak, M.D., Ari Zaretsky

EDUCATIONAL OBJECTIVE:
1) Identify challenging affect that arises during therapy and formulate an understanding of this from a CBT or ACT perspective; 2) Develop an approach toward working with difficult affect using CBT and ACT techniques; and 3) Discuss cultural considerations that may inform the use of therapeutic techniques to address difficult affect.

SUMMARY:
In the course of psychotherapy, challenging affect, ranging from attraction to anger to hate to hopelessness, may arise in the therapist, the patient or both. The emergence of such intense affect may catch even a seasoned therapist off guard and disrupt the therapeutic process, leading to an impasse. Successful negotiation of these heated moments, on the other hand, may potentially lead to a strengthened therapeutic alliance and therapeutic progress. In this workshop, we will focus on these emotionally charged moments from a cognitive behavior therapy (CBT) and an acceptance and commitment therapy (ACT) perspective. CBT and ACT are both evidence-based therapies for a variety of clinical conditions. Further, their techniques may be usefully employed in an integrated way by therapists of other modalities. This workshop will promote interest, knowledge and skills in the application of both therapies in challenging clinical situations. With CBT, decentering and other core CBT skills can be harnessed to effectively manage difficult exchanges, potentially illuminating underlying core schemas that drive problematic patterns of behaviors. Alternatively, ACT metaphors and interventions, including mindfulness techniques, may be helpful for grounding and defusion in these situations, leading to increased psychological flexibility. Participants in this workshop will be engaged in role plays and interactive exercises to explore and practice the use of CBT and ACT techniques to manage intense affect. Finally, a culturally competent approach will be integrated in the workshop to facilitate the examination of cultural and other psychosocial issues that may inadvertently complicate these clinical challenges and dynamics.

TeleMentalHealth Model of Care in Psychiatric Training and Care Delivery
Chairs: Beverly Chang, M.D., Michael H. Langley-DeGroot, M.D., Benjamin Carron, M.D.

EDUCATIONAL OBJECTIVE:
1) Demonstrate knowledge of the background current state of telepsychiatry; 2) Understand telepsychiatry implications for collaboration across disciplines, as well as collaboration across training sites; 3) Understand how telepsychiatry has been incorporated into the University of California, San Diego, and other training program curricula; and 4) Understand the "store and forward" model of telepsychiatry delivery with a particular emphasis on its advantages for geriatric mental health.

SUMMARY:

Telemedicine is an increasingly important tool in health care, leading to increased access to care, improved health outcomes and an overall cost reduction in health care delivery. Telemedicine has proven beneficial in a variety of health care specialties and has been studied in various institutions, including the Veteran Administration, the Department of Defense, correctional facilities, academic settings, and retail clinics. From a recent U.S. Department of Health and Human Services report to congress, it is estimated that 61% of health care institutions use some form of telehealth, and between 40–50% of hospitals in the U.S. currently employ some form of telehealth. Telemedicine makes use of four methods of care delivery, including live video (synchronous), store-and-forward (asynchronous), remote patient monitoring, and mobile health. Telepsychiatry specifically is a rapidly growing subspecialty due to an expanding population and a shortage of mental health providers. The U.S. Agency for Health and Research Quality has suggested that telemedicine holds distinct promise for behavioral health. Currently, 59 million Americans reside in health professional shortage areas, and another two million elderly persons are essentially homebound. The University of California, San Diego (UCSD), has a vision for providing easy-to-use solutions for clinicians and patients to connect at any time and any place. UCSD will aim to utilize one platform available on all electronic devices and have an integrated EMR connecting all resources to provide sustainable clinical services enhancing the ability to collaborate. Telepsychiatry was the first telemedicine service to be addressed at UCSD and is currently the largest telemedicine specialty, including clinic-to-clinic, clinic-to-home, crisis house, and ER assessments. Currently, we are hoping to expand to include geriatric telepsychiatry as well as partner with all University of California campuses to provide top-quality specialty care. In this clinical service line increase and expansion, it is important to incorporate telepsychiatry exposure to psychiatry residents. The workshop will show how psychiatric residents at UCSD will be engaged in this service delivery model.

The Best of Both Worlds: Treating Insomnia From Psychiatric and Psychological Perspectives

Chair: Ketan Deoras, M.D.
Presenter: Michelle Drerup

EDUCATIONAL OBJECTIVE:
1) Review different classes of agents used to address insomnia, including those used off label and those that are FDA indicated; 2) Differentiate among sedative hypnotics in terms of their usefulness in specific situations; 3) Identify and utilize components of cognitive behavior therapy for insomnia (CBT-I); and 4) Provide a framework for integrating medication management and CBT-I into the care of the patient with chronic insomnia.

SUMMARY:
Insomnia is both a debilitating consequence of several psychiatric conditions, as well as an independent contributor to them. Aside from the economic cost, its pervasiveness contributes to an overall lower quality of life and impaired functioning. The National Institutes of Health (NIH) State of the Science Conference in 2005 recommended two types of treatments for chronic insomnia: benzodiazepine receptor agonists (BzRAs) and cognitive behavior therapy for insomnia (CBT-I). However, the world of psychiatry frequently does not employ these modalities to their full potential. Although medications are frequently utilized by psychiatrists to treat insomnia, many practitioners tend to be familiar with and veer toward antidepressants with sedative hypnotic properties, rather than BzRAs more specifically indicated for insomnia. In addition, psychiatrists often remain unaware of the central tenets of CBT-I or how to integrate them into the care of patients with chronic insomnia. In this workshop, a sleep psychiatrist and sleep psychologist from the Cleveland Clinic sleep disorders center will incorporate principles of a chronic insomnia “care path” developed by the presenters for hospital-wide use throughout the Cleveland Clinic. The speakers will review sedative hypnotics, including their relative risks, benefits and indications; summarize psychological and behavioral treatment options for insomnia with a focus on CBT-I; and demonstrate how the psychiatric and psychological modalities can be used synergistically. Through a combination of didactics, case presentation and audience response, this will be an interactive workshop to encourage lively and

informative discussion of psychiatric and psychological approaches to treating chronic insomnia.

The End of Life Option Act: Perspectives and the Role of Psychiatrists
Chairs: Maria L. Tiamson-Kassab, M.D., Kristin Beizai, M.D.
Presenters: Vanessa L. Lauzon, M.D., Alan Hsu, M.D., Jeremy Hirst, M.D.

EDUCATIONAL OBJECTIVE:
1) Learn the history of the physician aid in dying laws across the country and the California End of Life Option Act in particular; 2) Recognize the differences and challenges at the intersection of state law and a federal facility, as well as the implementation at an academic center; 3) Understand the role of psychiatrists in physician aid in dying laws and the role of palliative care to prevent and relieve suffering at the end of life; 4) Teach and practice identifying untreated depression and pain at the end of life; and 5) Learn about the personal experience of applying the End of Life Option Act.

SUMMARY:
In 2016, with the implementation of the California End of Life Option Act, California became the fifth state in the nation to allow physicians to prescribe terminally ill patients medication to end their lives. The history of this movement dates back to 1997, when Oregon implemented the Death With Dignity Act, which the U.S. Supreme Court ruled in favor of upholding in 2006. Our workshop will provide a historical overview of the process and usage in the states where physician aid in dying laws have been implemented, an overview of the implementation in California, with a focus on some of the challenges. These include identifying and treating total pain and depression at the end of life, ethical issues and some of the differences in how state laws are implemented in academic medical centers versus federal hospitals. In the second half of the workshop, we will discuss case vignettes with a focus on identifying untreated depression and total pain at the end of life and engaging the audience in practicing communication skills regarding end of life.

The Opioid Epidemic: Taking on the Challenge—Addressing Stigma, Myths and Preference
Chair: Shareh O. Ghani, M.D.

EDUCATIONAL OBJECTIVE:
1) Understand practical application of the medication-assisted treatment (MAT) approach for opioid use disorders; 2) Identify case finding techniques and technological solutions in promoting MAT at a payer level; 3) Understand the barriers and challenges in the successful utilization of MAT: delivery systems, networks and payments array; and 4) Discuss the payer challenges with administering the benefits and completing parity determinations.

SUMMARY:
Objective: Medication-assisted treatment (MAT) program promotion aims to increase the utilization of MAT medications for opioid and alcohol use disorders in conjunction with psychosocial interventions while decreasing redundant health care utilization of higher levels of care through the use of evidence-based MAT medications and care coordination activities to support them. This MAT solution takes a disease management approach to alcohol and opioid use disorders. **Methods:** MAT utilization is promoted through a needs assessment that is administered when a member is admitted for treatment to an inpatient, residential treatment, intensive outpatient, or partial hospital setting and has a primary or secondary opioid and/or alcohol use disorder diagnosis. As a key component of this needs-based approach, we use analytics and algorithms to asses and stratify members into the type of case management support they need and track them into the clinically appropriate ambulatory settings. Program components include 1) surveillance and detection of members admitting to higher levels of care; 2) MAT promotion through electronic decision support tools; 3) stratification and referral; 4) care coordination activities and linkage to disease management-extending care into the community; 5) quality monitoring and outcomes reporting; 6) network sufficiency for MAT providers, including OBOT; and 7) trainings for internal staff, provider network, members, and other stakeholders. **Results:** Since the inception of the MAT program in October 2015, we have seen the following results within the members going through the MAT promotion program. More members are being

offered MAT, and there is an increasing trend in individuals discharging on MAT medications into ambulatory care. In addition, we are expecting to see a decrease in hospitalizations and fewer emergency room visits. We are also seeing a decrease in relapse rates for opioid and alcohol use disorders. We identified various types of stigma-patient stigma, community stigma and health care provider stigma-associated with the use of MAT. Other barriers included financial barriers associated with high co-pays and challenges with health plan benefits. **Conclusion:** We endorse MAT as an effective treatment option. We are committed to ensuring its widespread use in the appropriate populations. Our health plan's medication-assisted treatment solution takes a disease management approach for patients with alcohol and opioid use disorders through early intervention in the treatment process. Our organization works closely with both providers and patients to educate and inform about the clinical benefits of medication-assisted treatment. This enables us to extend effective care into the community at all levels. Providers make the difference in treatment expansion for better health outcomes. We understand the importance of a stronger and well-informed network of providers offering MAT.

The United Nations, the APA's NGO Status and Current International Crises: What Can APA Members Do?

Chairs: Aleema Sabur Zakers, M.D., M.P.H., Vivian Pender, M.D.

Presenters: Dyani A. Loo, M.D., Jennifer Severe, Rachel Robitz, M.D.

EDUCATIONAL OBJECTIVE:

1) Understand the structure of the UN and how the APA functions at the UN through the NGO committee on mental health; 2) Discuss the current international refugee crisis, torture and human trafficking and what impact they have on mental health; 3) Understand how the UN is addressing current international crises affecting mental health; and 4) Learn what you can do to make a difference related to the current international crisis.

SUMMARY:

During this workshop, we will provide an overview of the collaboration between the United Nations and the APA as it works as an individual NGO as well as through the NGO committee on mental health. We will discuss elements of the international refugee crises, present cases, discuss mental health needs, inform participants of how the United Nations is addressing these issues, and identify available resources and what you can do to help as a practitioner. The ubiquitous influence of violence can take many forms and has created over 50 million refugees, which has devastated communities and cultures through displacement. The United Nations and its stakeholders play a unique role in attaining consensus for systematic interventions, creating international and clinical recommendation to address violence and its pervasive psychosocial consequences. The United States has become home to four times as many refugees from the middle east over the past eight years, making it more likely to encounter them in your practice. As practitioners, it is important for us to recognize the effect of such traumatization on the mental wellness of our patients. Participants will have opportunities to discuss best practices, community resources and their experiences. A 30-minute Q&A session will center around how participants can best use their efforts to assist the APA in utilizing the NGO on mental health at the UN and identify areas and activities for future collaboration. This presentation is in partnership with the World Psychiatric Association.

The Use of Medication-Assisted Treatment and Behavioral Strategies to Treat Adolescents With Substance Use Disorders

Chairs: Hector Colon-Rivera, M.D., Elie Aoun, M.D.

Presenters: Patrice K. Malone, M.D., Ph.D., Lauren Teverbaugh

EDUCATIONAL OBJECTIVE:

1) Understand the risk factors that predispose adolescents and young adults to substance use disorders and the protective factors that lead to resilience; 2) Learn and practice skills necessary to conduct a primary inquiry about substance use disorder and recognize substance abuse and addiction in adolescent patients; and 3) Understand types of adolescent substance use disorder

interventions, including recovery protective services and medication-assisted treatment.

SUMMARY:
The transition from childhood to adolescence and subsequently adulthood represents two unique developmental periods with significant changes in social networks and interactions. Increasing attention has been given to the possible disruptions and expected changes of cognitive and psychosocial transitions during these periods. Adolescence and early adulthood are the peak times for initiation of substance use disorders (SUD), particularly tobacco, marijuana, prescription drugs, and alcohol. Studies report substance use among teens has increased as a direct correlate to exposure to media with suggestive cues surrounding illicit drugs. The health care provider's capacity to respond appropriately to substance use disorders in adolescents is limited at best. Adolescents are particularly vulnerable to the high risk for serious complications of illicit SUD, which include overdose, death, suicide, HIV, and hepatitis C. Both medication-assisted treatment and evidence-based SUD counseling are available but underused in this vulnerable population. In addition, access to developmentally appropriate treatment strategies is restricted for adolescents and young adults, making effective treatment out of reach for this group. This workshop will discuss the prevention, screening, evaluation, and referral to treatment of adolescents with or at risk for substance use disorders. Presenters will discuss the latest evidence-based data on the use of medication-assisted treatment and other therapies for the treatment of SUD for opioids, alcohol, tobacco, and stimulants. In addition, the workshop will address the emergent issues around the use of e-cigarettes among adolescents.

Top 10 Geriatric Psychiatry Issues for the General Psychiatrist: An Update
Chairs: Josepha A. Cheong, M.D., Iqbal Ahmed, M.D.
Presenter: Shilpa Srinivasan, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the key issues in the geriatric patient presenting in a general clinical setting; 2) Initiate appropriate treatment and management of cognitive disorders; 3) Diagnose and manage alcohol use disorders in the geriatric adult; 4) Manage insomnia; and 5) Address ethical and legal issues in the care of the geriatric patient.

SUMMARY:
With the ever-increasing population of adults over the age of 65, the population of elderly patients in a general psychiatry practice is growing exponentially as well. 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 rapidly increasing 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 workshop 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 interactive session will use pertinent clinical cases to stimulate the active participation of the learners.

Toward Beneficence: Ethical Controversies and Evolving Views on the Involuntary Treatment of Substance Use Disorders
Chair: Edmund Grant Howe III, M.D.
Presenters: James C. West Jr., M.D., Gary Wynn, M.D., Suzanne Yang, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe available legal mechanisms for the involuntary treatment of substance use disorders; 2) Understand primary clinical assumptions that underlie the use of involuntary treatment for patients with substance use disorders; 3) Identify effective strategies for engaging patients in an involuntary treatment setting; and 4) Examine the core ethical pros and cons behind different choices that psychiatrists encounter when making involuntary treatment decisions for patients with substance use disorders.

SUMMARY:
Patients with substance use disorders (SUDs) often

lack awareness that treatment may be necessary and beneficial to them. Although mandated treatment in the criminal justice system is a well-established practice, civil commitment for SUDs is less consistently applied in clinical settings. In this workshop, the legal mechanisms available in different jurisdictions for involuntary treatment of SUDs will be summarized as a starting point. A majority of states have a civil commitment statute that allows for involuntary treatment of patients with SUDs, but these statutes are not always in the mental health code, and some are infrequently used. Then, using clinical vignettes to represent challenging scenarios in an interactive discussion, presenters and attendees will examine optimal approaches, analyzed with regard to the neurobiological basis and social determinants of SUDs. Treatment decisions in jurisdictions where legal mechanisms do not allow for involuntary commitment for SUDs will then be examined, and ethical considerations in all the above contexts finally raised. Whereas SUDs have been viewed in the past as distinct from mental disorders and thus sometimes addressed in separate statutes, an evolving understanding of SUDs as brain disorders suggests that this difference may be and perhaps should be diminished in the future. Patients with SUDs often must undergo repeated treatment interventions prior to attaining insight and motivation to modify behavior. Clinicians thus face difficult ethical decisions, balancing the individual's liberty interest with beneficence and societal objectives and requirements. Patient autonomy should, for example, be strongly valued, but the effects of substance abuse may limit patient awareness of impairment, and this in turn may result in behavior that threatens public safety. Therefore, even where involuntary treatment for SUDs is legally permitted, implementing it may be ethically and clinically complex. The principal issue that the presenters will raise for discussion with attendees will be how best to engage patients to achieve long-term success, with a focus on effective strategies for establishing a therapeutic alliance in the setting of involuntary treatment. Participants will discuss successful approaches they have used to help these challenging patients, providing one another with skills for working with this population. The workshop will conclude with a discussion of how psychiatrists can contribute to societal views on problems that are implicit in the medical model of intervention. SUDs have been viewed as a moral problem, but evolving disease concepts have increasingly brought these disorders into the realm of medical science. Clinicians' primary responsibility is to the therapeutic aims for the patient. The medical rather than moral perspective offers psychiatrists the opportunity, if not the responsibility, to delineate the roles of both this profession and society in also pursuing societal objectives.

Writing a Scholarly Article

Chairs: Rachel Brooke Katz, M.D., Oliver Mathew Glass, M.D.

EDUCATIONAL OBJECTIVE:

1) Learn about opportunities available to medical students, residents and fellows to first-author, edit and review academic manuscripts early in their careers; 2) Determine which article type would be most conducive to exploring a chosen topic of interest; 3) Optimize the chances that an author's manuscript gets printed in the *Residents' Journal*; 4) Meet other young psychiatrists and collaborate with trainees in all stages of training; and 5) Identify a path toward a leadership role and/or publication in the *Residents' Journal*.

SUMMARY:

The American Journal of Psychiatry-Residents' Journal is a promising vehicle for trainees to first-author, edit and review manuscripts early in their careers. Academic writing is a challenging and fulfilling form of expression that improves with practice. Publishing in peer-reviewed journals opens opportunities to psychiatrists as they begin establishing their careers; however, most residents finish their training without a peer-reviewed publication. The reasons for this are manifold. We suspect that they include a sense that with all the demands of residency training, writing and publishing an article can seem daunting. Furthermore, once an article is written, many trainees struggle to get their work published. This discrepancy between career desire and perceived opportunity might underlie some of the physician burnout that has become epidemic in modern medical cultures. The *Residents' Journal* hopes to

bridge the gap between aspiration and opportunity by providing psychiatrists at all stages of training with a channel for self-expression. This workshop is designed to acquaint medical students, residents and fellows with the *Residents' Journal*, such that they emerge confident that they can author a manuscript in the coming academic year. Trainees will become familiar with common errors encountered during the editing process, which may preclude or delay publication. By the end of the workshop, participants will be able to identify and avoid these setbacks. They will understand the many possibilities that the *Residents' Journal* affords for leadership and ongoing collaboration. We hope that our participants will be able to describe the mission of the journal and be able to share criteria for involvement with their colleagues and peers. Psychiatrists in all stages of training will engage with one another to help identify ways for trainees to participate in the writing, editing and peer review of the *Residents' Journal*. Pioneers in academic publishing will lead short exercises that help participants develop questions that will become building blocks for publishable manuscripts. The workshop will impart valuable skills and connections that will be useful to trainees as they start to build their careers within psychiatry.

You Be the Neurologist: Making Sense of TBI Through Case Discussions
Chairs: Josepha A. Cheong, M.D., David FitzGerald, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify and discuss the definitions of severity for traumatic brain injury (TBI) (mild, moderate and severe); 2) Understand the typical symptoms of TBI; and 3) Identify the additional diagnostic tests or consultations to facilitate the diagnosis of TBI.

SUMMARY:
Mild traumatic brain injury (MTBI) is defined clinically. This clinical definition has an expected set of symptoms and an expected time course of recovery from these symptoms. The clinical definition will be presented and discussed in this workshop. However, not all patients presenting with a diagnosis of MTBI have mild TBI. Some patients may have moderate to severe TBI, based on imaging. Some patients may have additional diagnoses, which confuse the workup 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 workshop will proceed based on the interaction and responses of the audience to the various clinical cases presented. When specific symptoms or diagnostic issues are brought up (dependent on the various cases), a brief didactic portion will be presented to provide a more detailed examination of the topic or specific point of discussion.

Wednesday, May 24, 2017

Behavioral Addictions and Their Treatments Today
Chairs: John Douglas, M.D., M.B.A., Brian Hurley, M.D., M.B.A.
Presenter: Timothy Fong, M.D.

EDUCATIONAL OBJECTIVE:
1) Identify the diagnostic criteria of gambling use disorder and how these criteria are adapted in research studies of other potentially addictive behaviors; 2) Understand the main elements of the reward pathway and its stimulation; 3) Recognize similarities in the psychology and neuroscience of gambling and other behaviors such as eating junk food, excessive shopping, viewing pornography, extreme sexual practices, and playing video games; and 4) Understand the treatments of gambling use disorder and other potential behavioral addictions.

SUMMARY:
Several behaviors, including gambling, eating, sex, shopping, and playing video games, activate the neural reward pathway implicated in substance addiction. Disordered gambling is currently the only behavioral addiction included in the *DSM-5* as a substance-related disorder, largely due to a paucity of research validating the diagnostic criteria for other disordered behaviors. Additionally, there is evidence that subtypes of disordered eating, such as binge eating disorder and bulimia, activate the neural reward pathway. Some experts speculate that the shared neural reward pathway mechanism

between behavioral addictions and substance use disorders implies a common etiology, while others hold that the constellation of symptoms and impairments in functioning associated with disordered compulsive behaviors are secondary to other disorders and don't justify a distinct diagnostic category. Nonetheless, the addictive potential of behaviors such as eating, sex, shopping, and playing video games can result in loss of control with adverse personal consequences. These consequences include unemployment, failed relationships, criminal behavior, and even death. Treatment for behavioral addictions is varied and typically includes 12-step self-help groups, cognitive behavior therapy, motivational interviewing, and family therapy. These treatments can be delivered in a variety of settings, including intensive outpatient, partial hospital, and residential programs. There are no FDA-approved pharmacotherapies for disordered gambling or other behavioral addictions, but evidence of efficacy for some medications exists in select clinical trials. Additionally, some patients are able to spontaneously recover from disordered behaviors. In this workshop, we will provide an overview of gambling use disorder and its treatment. We will then lead the audience in a facilitated discussion comparing and contrasting the psychology and neuroscience of gambling and other behaviors such as eating junk food, excessive shopping, viewing pornography, extreme sexual practices, and playing video games. Finally, case examples of these behaviors will be provided, and the audience will participate in an interactive discussion of their management.

Buying Compliance: Our Best Bet for Better Antipsychotic Adherence or a Deal With the Devil?
Chair: Edmund Grant Howe III, M.D.
Presenters: Kyle J. Gray, M.D., M.A., Gary Wynn, M.D., Eric G. Meyer, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the available evidence that paying patients to take antipsychotics improves adherence rates; 2) Understand possible economic implications of direct financial incentives for medication adherence; 3) Recognize how paying patients to take their medications may affect their present and long-term outcomes; 4) Contrast the ethics of the practice of using financial incentives to improve adherence rates with other incentive practices already used in the United States; and 5) Appreciate arguments for and against the practice of paying patients to adhere to maintenance antipsychotic therapy becoming an accepted practice in the United States.

SUMMARY:
Medication nonadherence is a major problem in treating psychotic disorders. Many strategies have been used in an attempt to address this multifactorial problem, but one controversial strategy practiced in Europe for many years now continues to gather evidence of its efficacy: paying patients to take their antipsychotics. This workshop will review the existent literature demonstrating the effectiveness of this approach in improving adherence rates and will explore both the ethical and economic implications of this practice as we consider its adoption in the United States. The next speaker will examine the economic viability of this practice. We will forecast a cost-benefit analysis based on current data such as disease prevalence and reduced hospitalization rates. With a better understanding of its more practical feasibility, the workshop will turn its attention to the profound ethical questions this practice raises. While this practice raises numerous ethical considerations, we will focus primarily on issues of paternalism versus respect for autonomy, inherent coercion when obtaining informed consent and justice. We will compare the use of direct financial incentives for antipsychotic adherence with other financial incentive practices already used in health care in the United States. Examples include treatment adherence-linked representative payee programs and subsidized housing programs, as well as contingency-based smoking cessation and other substance use disorder programs. We will also consider how research ethics, which has long debated the merits of paying subjects for their participation in medical research, can inform us regarding this controversial clinical practice. Finally, we will discuss how incentive-based strategies fit with other strategies to improve treatment adherence, such as motivational interviewing. Participants will break into groups to discuss example cases where there is a problem of treatment adherence. Groups will present back to

the audience their thoughts as to the best strategies to improve treatment adherence in these cases. We will close with some final thoughts and recommendations based on the breakout group discussion.

Creativity in Medicine: An Experiential Workshop
Chair: Vineeth John, M.D., M.B.A.
Presenters: Marsal Sanches, M.D., Ph.D., Antolin Trinidad, Stanley Lyndon

EDUCATIONAL OBJECTIVE:
1) Construct a working definition of creativity; 2) Describe the recent developments in the field of neuroscience pertaining to creativity; 3) Critically examine our best creative moments in the light of circumstances that made them happen; 4) Understand the various individual and institutional impediments to leading a creative life as a psychiatrist; and 5) Apply current knowledge about creativity to enhance our individual and institutional creative potential.

SUMMARY:
Despite significant breakthroughs pertaining to the neuroscience of insight, creativity is often an ignored theme in academic medicine. Currently, only a handful of medical schools in the country offer courses on creativity and innovation, and even those courses are designed exclusively for medical students. Moreover, the business style of management in medicine, fraught with multiple regulatory systems, may actually be stifling creativity. An opportunity therefore exists to enhance the quality of teaching efforts and clinical care through formal training in creative practices and fostering a culture supportive of creativity. Once considered the product of genius or divine inspiration, creativity-the ability to spot problems and devise smart solutions-is now recognized as a prized and teachable skill. Critical/analytic thinking has long been regarded as the essential skill for success, but it's not enough to ensure success in the professional world. Creativity moves beyond mere synthesis and evaluation of data and clinical information and is indeed the missing "higher-order skill." While traditional academic expertise still matters in clinical medicine, it becomes increasingly important to develop "process skills" and strategies to reframe challenges and extrapolate and transform information. Possession of such "creative" skills is bound to positively impact clinical care, enhance one's teaching repertoire and lead to research breakthroughs. This workshop examines our current understanding of innovation and creativity, especially the fascinating research paradigms examining insight (the "aha" moment), default mode network and top-down control. The workshop will create a viable space for the participants to reflect on some of the most creative moments of their lives, so as to seek out the common variables responsible for those breakthroughs. We will achieve this using audience participation sessions in small-group format interspersed throughout the presentation. We also plan to discuss the CREATES model of creativity (Connect, Reason, Envision, Absorb, Transform, Evaluate, Stream), which provides an overarching paradigm for the creative process. In addition, we will be introducing a case study detailing the discovery of *Helicobacter pylori* by two relatively unknown Australian physicians, Drs. Robin Warren and Barry Marshall, so as to highlight the various individual and institutional factors that promote creative breakthroughs. Finally, a tool kit for enhancing creativity will be provided to help the participants develop a creative mindset while at work as well as at home.

Liberating Structures: Learn to Improve Organizational Success by Enhancing the Effectiveness of Your Leadership Team and Avoid Death
Chairs: Kari M. Wolf, M.D., Jane Ripperger-Suhler, M.D., M.A.

EDUCATIONAL OBJECTIVE:
1) Define liberating structures; 2) Use three different liberating structures to learn about liberating structures; 3) Brainstorm areas within their organization where Liberating structures would enhance collaboration; and 4) Design a liberating structure exercise than can be applied at one’s home institution.

SUMMARY:
Medicine is becoming increasingly complex. To be successful in this rapidly evolving landscape, organizations need to learn new ways to generate

ideas and solve problems. There is increasing recognition that diversity of ideas leads to better strategy and outcomes. But how does one overcome the hierarchy that exists within any organization to empower everyone on the team to share their ideas? Liberating structures offer a framework to unleash the power of every member of the team. Liberating structures constitute “processes or rules that can be put in place to encourage people to be free, creative, and get results rather than find themselves oppressed, constrained, confined, or powerless.” This workshop will provide an overview of what Liberating structures aim to accomplish. We will review the benefits that have been realized in other industries and brainstorm how those learnings can be applied to health care. Participants will have the opportunity to practice two different liberating structures and be provided with information on where to learn about dozens of other liberating structures. Using several different liberating structures to teach the workshop, participants will both learn about this leadership tool while simultaneously practice using this skill. According to the liberating structures website, "Liberating Structures are easy-to-learn microstructures that enhance relational coordination and trust. They quickly foster lively participation in groups of any size, making it possible to truly include and unleash everyone. Liberating Structures are a disruptive innovation that can replace more controlling or constraining approaches.” They afford a specific structure that can be applied to a variety of topics in both large and small settings. The presenters have participated in liberating structures with an audience of eight as well as an audience of several hundred. After participating in a liberating structure exercise only once, the presenters were able to use liberating structures to present at other national meetings and within their home department. This tool can also be applied to didactic sessions with residents, medical students and other learners. This skill-building workshop will equip participants to immediately return home to apply this new tool in their home institutions.

Making a Parody of Parity? An Update on the Battle for Equitable Mental Health Care Coverage

Chairs: Daniel Knoepflmacher, M.D., Eric M. Plakun, M.D., Susan Lazar, M.D., Meiram Bendat, J.D., Ph.D.

EDUCATIONAL OBJECTIVE:

1) Describe the current state of parity implementation and legal efforts to enforce parity laws; 2) Understand how insurance companies define the concept of “medical necessity” to privilege short-term cost savings over clinically effective treatment standards; 3) Understand the often-ignored research base supporting psychotherapy; 4) Develop utilization review standards that are ethical and consistent with parity laws when functioning as a utilization management psychiatrist; and 5) Conduct more effective insurance utilization reviews by using parity laws and knowing associated ethical issues.

SUMMARY:

Since the passage of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, nationwide efforts to guarantee (and circumvent) equitable insurance coverage for mental health care have persisted in earnest. This workshop will examine how insurance companies have failed to meet parity standards by continuing to deny coverage for widely accepted, evidence-based psychiatric treatments. We will highlight issues related to “medical necessity,” specifically how this term has been used by insurers to favor short-term cost savings over “clinical effectiveness.” Members of the panel will highlight how insurers systematically neglect crucial psychiatric interventions, including standard psychotherapy modalities and long-term residential treatment. One panelist will present a summary of published research highlighting the cost-effectiveness of psychodynamic treatments, a modality for which insurers routinely deny sufficient coverage. Another panelist will explore the ethics of psychiatrists engaging in utilization reviews based on managed care criteria that deviate from generally accepted standards and/or the federal parity law. Additionally, we will update the audience about multiple, ongoing class action suits aimed at enforcing parity through court rulings. Our workshop is designed to integrate audience participation by providing a forum for personal experiences of insurance-related challenges. We hope to promote spirited debate and to foster a concerted effort by members of the APA toward creating parity in mental health care.

Molecular Imaging to Improve Management of Patients With Suspected Dementia
Chair: Jacob Dubroff, M.D., Ph.D.
Presenters: John Seibyl, M.D., Monica K. Crane, M.D.

EDUCATIONAL OBJECTIVE:
1) Describe the utility of recently available PET tracers in the clinic; 2) Discuss the appropriate role of beta-amyloid detection using imaging or CSF biomarkers for revised diagnostic and nosological criteria for Alzheimer's dementia; 3) Identify the PET imaging tracers for brain beta-amyloid deposition, tau deposition, brain metabolism, and dopamine transport; 4) Explain clinical and pathological characteristics of Alzheimer's disease; and 5) Identify inclusion and exclusion criteria for the Imaging Dementia—Evidence for Amyloid Scanning (IDEAS) study.

SUMMARY:
Age is the best-known risk factor for Alzheimer's disease (AD), the most common cause of dementia, with more than 90% of AD cases occurring in persons aged 60 or over. Memory problems are typically one of the first warning signs of cognitive decline, and mild cognitive impairment is a potential precursor to AD. In response to the rising number of AD patients and other cognitive impairment occurrences, and after analyzing the results of a survey from 21 states on the incidence of reporting cognitive impairment, the Alzheimer's Association and the Centers for Disease Control and Prevention jointly published, in 2012, The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013–2018. The overall consensus indicates that regardless of the specific actions taken, state and local health agencies should recognize that cognitive health is a critical part of public health and should be included in public health programs and policies. When diagnosed early and accurately, opportunities exist to help patients and caregivers better manage symptoms and anticipate needs. A team approach in health care decision making offers the best chance in achieving this goal. It is well known that AD and other dementias cause changes in the brain long before the first symptoms appear, so early diagnosis and accurate progression management is crucial. Since 2012, the FDA has approved three PET tracers (F-18 Flutemetamol, F-18 Florbetaben and F-18 Florbetapir) to image adults being evaluated for AD and other causes of cognitive decline. Despite this approval, CMS's ruling that more evidence was needed to conclude that PET amyloid imaging is reasonable and necessary prompted a unified effort by SNMMI, the Alzheimer's Association, ACR, and WMIS to create an evidence development study protocol. This study, Imaging Dementia—Evidence for Amyloid Scanning (IDEAS), went into effect during the second half of 2015 and is actively recruiting patients nationwide at approved centers. The study requires both the referring physician and imaging radiologist to meet certain levels of experience in their specialty, amyloid images to achieve specific elements of quality and reproducibility, and imaging interpretation and reporting to be accurate and complete to obtain the necessary evidence needed for eventual approval by CMS. Other imaging tracers are now available to determine the presence of tau brain binding. In addition, with the future ability to use brain imaging in treatment decisions as well as diagnostic decisions, there will be additional issues to consider in the use of imaging biomarkers.

New Drug and Alcohol Testing Technologies: New Devices, EtG, EtS, PEth, Nail Testing, and More
Chairs: Gregory E. Skipper, M.D., Matthew Goldenberg, M.D., M.Sc.

EDUCATIONAL OBJECTIVE:
1) Describe how a photo digital breathalyzer can be used to monitor alcohol use; 2) List three new markers for monitoring alcohol use and how they can be used; 3) Explain considerations in deciding which matrix (blood, urine, hair, nails, etc.) to use for testing; 4) Understand the most common drug testing conundrums and how they are resolved; and 5) Describe the most common methods of cheating on drug testing and how to confront the patient.

SUMMARY:
Drug testing is important for diagnosis, treatment, monitoring, and advocacy of patients with and without substance use disorders. New technologies (e.g., new analytes, matrices and devices) have emerged over the past few years. General psychiatrists play an important role in managing

patients with primary substance use disorders and co-occurring disorders, so it is important that they be up to date regarding drug and alcohol testing. Monitoring for alcohol use has seen the greatest advances with the emergence of ethyl glucuronide (EtG), ethyl sulfate (EtS) and phosphatidylethanol (PEth) as new analytes for detection of abstinence and relapse. These new analytes are seeing widely increased use, and the matrix in which they can be detected (blood, urine, hair, and nails) is important to understand for proper interpretation. Monitoring for alcohol use is important in custody cases, with individuals who should not use alcohol because of medications and/or other psychiatric disorders, and in following patients with substance use disorders. New devices, transcutaneous monitors and mobile photo digital breathalyzers are being approved by the FDA and are being used to monitor for alcohol use. It is therefore important for psychiatrists to understand the particulars regarding how these devices are used and their benefits and limitations. In addition to describing these new analytes and devices, drug testing in general will be reviewed, with emphasis on frequently encountered complexities and conundrums (e.g., false positive results and dilute samples) and how they are resolved. The issue of patients cheating on drug tests will be reviewed.

Research Literacy in Psychiatry: How to Critically Appraise the Scientific Literature
Chair: Diana E. Clarke, Ph.D., M.Sc.
Presenters: Diana E. Clarke, Ph.D., M.Sc., Farifteh F. Duffy, Ph.D., Debra Gibson, M.Sc.

EDUCATIONAL OBJECTIVE:
1) Understand the basic study designs, concepts and statistics used in psychiatric research; 2) Identify why it is important to the individual psychiatrist to be able to understand scientific literature and interpret study concepts, design and statistics; 3) Discuss and critically appraise the scientific literature; and 4) Identify gaps in literature in a practical sense to have greater access to evidence-based care and informed clinical decisions.

SUMMARY:
The overall goal of the research literacy in psychiatry workshop is to help participants understand what it means to critically appraise the scientific literature. Throughout the session, participants will be introduced to the basic concepts, study designs and statistics in psychiatric research that will enable them to read and understand the scientific literature and appreciate the importance of being able to critically appraise the literature. Time will be allotted for participants to read a scientific article for discussion. The session will utilize a "journal club"-style interactive format in which methodological and statistical issues will be introduced and discussed on a section-by-section basis as they pertain to the scientific article. After the introduction of methodological and statistical issues related to each section, participants will be given two to three minutes to read that respective section of the article. Participants then will discuss the article, view it with a critical eye, and analyze and apply concepts learned. In summary, participants will learn how to appraise the scientific literature in a critical, thorough and systematic manner. Not only will this workshop help attendees stay abreast of changes in the field and identify gaps in the literature, in a practical sense, it will enable greater access to evidence-based care and inform clinical decisions.

The Role of Psychiatrists in Integrating Substance Use Disorder Treatment Into General Medical Settings
Chairs: Brian Hurley, M.D., M.B.A., Carla Marienfeld, M.D.
Presenter: Anton Bland, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize the substance use disorder treatment gap and describe the importance of delivering substance use disorder treatment in general medical settings; 2) Compare and contrast the four core components of integrated substance use disorder treatment delivered in general medical settings; 3) Discuss the role of psychiatrists in collaborative care, focused on substance use disorder treatment in general medical settings; 4) Develop a strategy to deliver pharmacological, psychosocial, integration/coordination, and educational/outreach services for substance use disorder treatment in general medical settings; and 5) Apply evidence-based implementation science practices to the

practice of psychiatry in integrated general medical settings.

SUMMARY:
General medical settings are opportune for the identification and initiation of substance use disorder (SUD) treatment. There is strong evidence for delivering primary care-based screening, brief interventions and referrals to higher levels of SUD care; providing integrated psychiatric, SUD and general medical treatment; and additional evidence that SUD pharmacotherapies and outpatient psychotherapies can be feasibly delivered in a variety of general medical settings. Collaborative care models have been long demonstrated to improve depression treatment outcomes in primary care, and there is emerging evidence that these models have applicability to opioid and alcohol use disorders. Population-based chronic disease management is characterized by longitudinal care delivery, integrated and coordinated primary and specialty care, explicitly supported and seamless transitions between care intensities and settings, evidence-based care plans, and the availability of subspecialty expert care. The implementation of an integrated system of care may overcome the barriers to the effective application of chronic disease management. The existing health care system has significant fragmentation, overall access problems and specific inaccessibility to highly effective SUD treatments. Building an integrated system of care within existing health care enterprises requires addressing these factors. Within this context, psychiatrists often encounter both barriers and facilitators associated with delivering SUD treatments in general medical settings, particularly for patients with SUDs co-occurring with other psychiatric conditions. This workshop will briefly review the evidence of collaborative care and other integrated care models for psychiatrists in the general medical setting-based treatment of SUDs. The panelists will review the real-world barriers and facilitators to the identification of SUDs and initiation of addiction treatment in these settings. The majority of the session will engage workshop participants in a facilitated discussion, where participants will be asked to reflect upon their institutional climates and identify key opportunities for collaborative care in their institutional settings. Participants will be split into small groups where they will be asked to develop and discuss a personal strategy for enriching their own institutional practices and promote the integration of addiction treatment into primary care. The session will conclude with a large-group reflection on the knowledge learned, skills acquired and inventory of attitudes.

When Do I Need to Obtain an EKG? The Practical What, When and Why of EKGs in Psychiatric Practice
Chairs: Rohul Amin, M.D., Adam L. Hunzeker, M.D., Jed P. Mangal, M.D.
Presenter: Aniceto Navarro, M.D.

EDUCATIONAL OBJECTIVE:
1) Recognize cardiotoxic effects of psychotropics in clinical psychiatric practice; 2) List drug- and patient-specific characteristics placing psychiatric patients at risk for sudden cardiac death; 3) Using the provided pocket algorithm card, identify triggers for obtaining EKG in psychiatric practice based on available evidence and clinical guidelines; and 4) Using the provided pocket algorithm card, demonstrate comfort with basic EKG interpretation skills, including manual QTc measurements in small groups using clinical vignettes.

SUMMARY:
The clinical utility of electrocardiogram (EKG) in medicine can be of great value to the patient and the health care delivery system. In psychiatric practice, several classes of pharmacotherapeutic interventions have an effect on the cardiac conduction system, and some drugs even carry black box warnings by the Food and Drug Administration (FDA). EKG is a cost-effective tool in the diagnostic evaluation of many clinical scenarios such as syncope or acute chest pain, for example. However, the value of EKG diminishes when obtained in healthy patients, and the interpretation of such studies is fraught with pitfalls. As such, the use of EKG in psychiatric practice requires skillful and purposeful selection. Obtaining EKGs for a psychiatrist almost always requires consultation with an outside provider, creating time and financial burdens for patients. Therefore, obtaining EKGs in all psychiatric patients would be impractical and

possibly harmful due to issues related to cost, time burden on the patient and the psychiatrist, and false positives. Psychiatric residency training and real-world practice do not sufficiently train psychiatrists in the knowledge or skills needed to navigate clinical decision trees that are required to make effective use of EKGs as a tool in their psychiatric practice. While the skill of a psychiatrist to interpret EKGs diminishes over time, they still have to know and understand the timing and settings for obtaining consultation for an EKG. In this workshop, we hope to enhance the knowledge and skills of a psychiatrist in understanding triggers and decision points regarding appropriate electrocardiographic evaluation in their psychiatric practice. These skills are important for optimal patient care and the fundamentals can be delivered to practitioners in a nominal amount of time. Our team has created an easy-to-follow pocket card that includes a decision tree algorithm for appropriate EKG evaluation, basic interpretation of EKGs, advance interrogation of QT/QTc intervals, and recommended alternative drugs for those with high risk for psychotropic-associated cardiotoxicities.