American Psychiatric Association



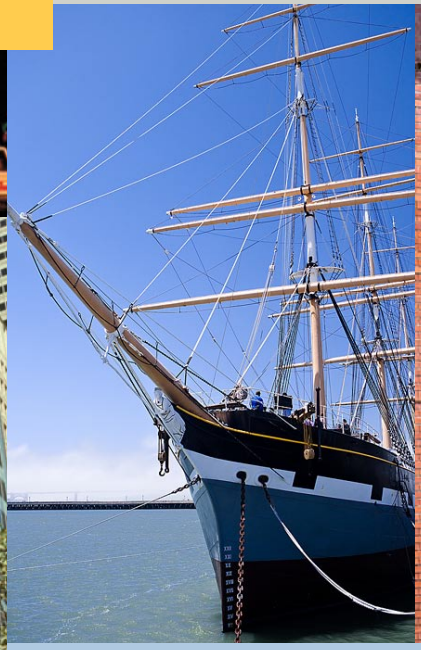
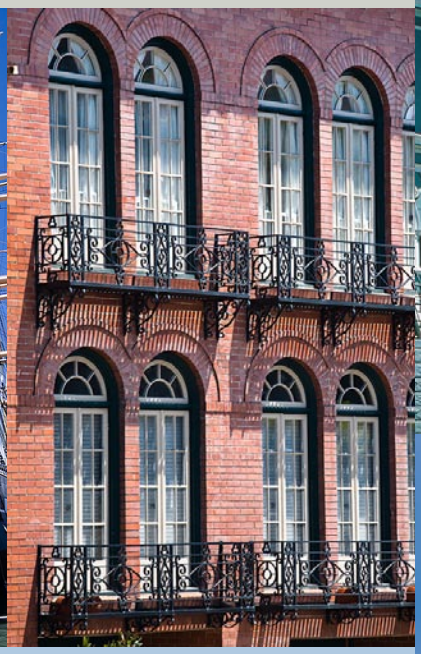
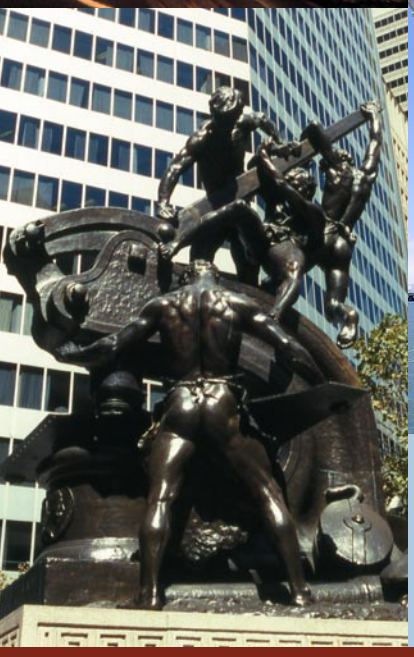

162ND ANNUAL MEETING

San Francisco

SHAPING OUR FUTURE: SCIENCE AND SERVICE

MAY 16–21, 2009




2009 SYLLABUS

SYLLABUS
AND
SCIENTIFIC PROCEEDINGS

IN SUMMARY FORM

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

San Francisco, CA
May 16-21, 2009

Published by

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May 2009

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FOREWORD

This book incorporates all abstracts of the Scientific Proceedings in Summary Form as have been published in previous years as well as information for Continuing Medical Education (CME) purposes.
Readers should note that most abstracts in this syllabus include educational objectives, a list of references, and a summary of each individual paper or session.
We wish to express our appreciation to all of the authors and other session contributors for their cooperation in preparing their materials so far in advance of the meeting. Our special thanks are also extended to Scientific Program Office staff and the APA Meetings Department.

Joespha A. Cheong, M.D., -Chairperson
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Full Texts

As an added convenience to users of this book, we have included mailing addressess of authors. **Persons desiring full texts should correspond directly with the authors.** Copies of papers are not available at the meeting.

EMBARGO: News reports or summaries of APA 2009 Annual Meeting presentations contained in these program materials may not be published or broadcast before the local time and date of presentation.

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

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OTHER FORMATS ALPHABETICALLY

American Psychiatric Association
Continuing Medical Education Requirement

APA Continuing Medical Education Requirement

By referendum in 1974, the membership of the American Psychiatric Association (APA) voted to have participation in Continuing Medical Education activities be a condition of membership. The CME requirement aims at promoting the highest quality of psychiatric care through encouraging continuing professional growth of the individual psychiatrist.

In May 1976, the Board of Trustees endorsed the following standards of participation in CME activities: All APA members in the active practice of psychiatry must participate in at least 150 hours of continuing medical education activities during a three-year reporting period, of which a minimum of 60 hours must be in category 1 CME activities. Category 1 activities are those programs sponsored by organizations accredited for CME and that meet specific standards of needs assessments, planning, professional participation and leadership, and evaluation and other activities which meet the AMA definition of category 1. The 90 hours remaining after the category 1 requirement has been met may be reported in either category 1 or category 2, which includes meetings not designated as category 1, reading, research, self-study projects, consultation, etc. APA members residing outside of the United States are required to participate in 150 hours of CME activities during the three-year reporting period, but are exempt from the categorical requirements.

Obtaining an APA Three-Year Continuing Medical Education Certificate

The APA CME certificates are issued to members upon receipt of a report of CME activities. You may report your activities to the APA in print or electronically using the official APA report form. This form may be obtained from the APA Department of Continuing Medical Education, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209, (703) 907-8661, or on the APA web site at www.psych.org.

Members may also receive the CME certificate by submitting a copy of your current Physician's Recognition Award (PRA) from the American Medical Association to the APA Department of CME at the address listed above.

Reciprocity With AMA
By completing the APA's CME membership requirement and qualifying for the APA CME certificate, members may also qualify for the standard Physician's Recognition Award (PRA) of the American Medical Association (AMA). APA provides documentation of reciprocity, which can be forwarded (with a fee) to the AMA.

The APA maintains a record of member CME compliance and reporting. However, the APA does not keep detailed or cumulative records for members; members are responsible for maintaining their own records. Members may maintain and track their CME activities on the APA web site, www.psych.org/cme, through the CME recorder.

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

PRESIDENTIAL ADDRESS

SHAPING OUR FUTURE: SCIENCE AND SERVICE

Psychiatrists, medical doctors who specialize in mental health, bring unique training and experience to the prevention, diagnosis, and treatment of mental disorders causing untold disability and pain to millions of human beings all over the world. We function in a world torn by armed conflicts and economic crises, a world in which every country is struggling to devise systems that will bring the best possible care to patients at an affordable cost. As busy as we are in our laboratories, offices, mental health centers, and hospitals, we must acquire the tools and spend the time we need to play an active role in the formation and implementation of the public policies that create the environment in which we work and our patients and their families try to achieve supportive relationships, clear thinking, and productive activity. This meeting is packed with scientific discovery and practical applications. Sessions comparing the health care systems of several countries offer us the opportunity to use the successes and avoid the failures of policy makers as we advocate for constructive change in health care delivery. We use our science---biological, psychological, and sociological---in the service of the relief of human suffering, our source of inspiration and the effort to which we have devoted our lives.

SUNDAY, MAY 17, 2009

12:30PM- 2:30PM

INDUSTRY-SUPPORTED SYMPOSIUM 01

DELIVERING OPTIMAL CARE FOR COMPLEX BIPOLAR PATIENTS: AN AUDIENCE GUIDED SYMPOSIUM

SUPPORTED BY ASTRA ZENECA

Gary Sachs, M.D., Massachusetts General Hospital, 50 Staniford Street, 5th Floor, Boston, MA 02114

EDUCATIONAL OBJECTIVES:

At the end of this symposium, attendees will be able to: 1) Describe a strategy for maximizing the use of effective treatment while minimizing the continued use of ineffective treatments; 2) Describe the role of quality measures of care for bipolar disorder in quality improvement activities; 3)Review how the payors are contributing to increasing the quality of care for patients with bipolar disorder; and 40 Discuss how a multimodal approach can be used to deliver improved quality of care for this disease.

SUMMARY:

The evidence-based guiding treatment of bipolar disorder has grown considerably over the last decade. It is now possible to develop meaningful standards of care. Even the best guidelines have limited application to guide clinicians in the management of patients in clinical practice and many bipolar patients still do not receive formal assessments or optimal therapy. The considerable resources spent in bipolar care inconsistent with guidelines and recognition that substandard care may actually increase the risk of negative outcomes, have motivated the development of national quality standards for bipolar disorder. Findings from the STEP-BD study and other real world-based treatment studies are shedding light on topics such as the impact of substance abuse and other comorbidities, the ineffectiveness of standard antidepressant therapy for bipolar depression and how structured psychosocial interventions can enhance treatment outcomes, particularly in complex cases resistant to standard therapies. Payor/claims data provide a picture of bipolar care where a substantial fraction of spending accounts for treatments not meeting standards of practice, much of it being care advised against in guidelines. Among the barriers to achieving guideline concordant care is lack of clear measures to determine if a patient is adequately responding to medication and how to adjust treatment regimens to assure that each treatment trial come to a definitive conclusion. Addressing these issues and a systematic approach to treatment can enable psychiatrists to provide better care by being familiar with the latest utilization and quality evidence used in establishing treatment guidance and applying this evidence in a systematic way to their care of patients with bipolar disorder. Ultimately, recognizing and applying indicators of high quality bipolar care s an important and relevant practice topic as it provides the basis for optimizing management of bipolar disorder.

NO 01A

WHAT DEFINES QUALITY OF CARE IN BIPOLAR DISORDER?

Richard C Hermann, M.D., 800 Washington Street, Boston, MA 02111

SUMMARY:

Research studies indicate that the quality of care for bipolar disorder varies widely nationwide – a finding the Institute of Medicine (IOM) has observed to be true throughout health care, not just for bipolar or other psychiatric disorders. In response, the IOM, professional organizations, accreditors, payors and employers have all encouraged clinicians, hospitals and health plans to undertake measurement-based QI activities. These activities are not without controversy, because they rely heavily on available quality measures: their clinical importance, the burden of data collection they impose and the fairness of comparing performance across sites. This presentation will examine different approaches to assessing quality of care for bipolar disorder, including their strengths and limitations. Outcome measurement examines how patients respond to the treatment provided. Process measures compare actual care to care recommended by practice guidelines. Guideline recommendations may be based on research evidence, clinician consensus or a combination of the two. Structure measures examine the capacity of a practice, facility or plan to delivery high quality care. Although the technology of quality measurement is at a relatively early stage of development, the stakes are rising for clinicians. Performance is increasingly becoming linked to reimbursement, subject to public disclosure, and playing a role in physician credentialing.

NO 01B

WHAT DOES THE PAYOR'S DATA ON QUALITY OF CARE TELL US?

Phyllis Greenwald, M.D., 1100 1st Ave, King of Prussia, PA 19406

SUMMARY:

Optimization of care for the bipolar disorder patient population is a common goal for both clinicians and payors. Evidence-based treatment is generally the most cost effective treatment. Payors are developing methods to measure the provision of quality, evidence-based treatment, and to differentially reimburse the providers of such treatment. While pay for performance programs consistent with evidence-based guidelines are further along in many medical specialties, such programs are just starting in the behavioral health field. An example of a project in the payor industry to improve the quality of care for patients with bipolar disorder was initiated in 2007. National data from psychiatric hospitalizations and pharmacy claims were collected for patients with discharge diagnoses of bipolar disorder (manic or mixed episode) to evaluate if they had prescriptions filled for antidepressants within 60 days of hospital discharge. While APA practice guidelines indicate that bipolar patients with manic or mixed episodes should have antidepressants weaned and discontinued, the results of this study indicate that over half of the patients had antidepressant prescriptions filled within a short time following hospitalization. Information from this initiative has provided the opportunity to follow up with antidepressant prescribers with a practice guideline reminder. Payors are in

a unique position to serve as a resource for physicians in the effort to assess and treat complex clinical conditions due to the wealth of data collected by the payors, including hospital, office, laboratory, pharmacy, diagnostic, and claims data. Additionally, payors are beginning to outreach directly to the patient population through disease management programs. In collaboration with the treating clinician, payors can help to enhance and improve the overall high quality of care for our patients.

NO 01C

HOW DO WE KNOW IF MEDICATIONS ARE WORKING?

Michael J Ostacher, M.D., 50 Staniford Street, Suite 580, Boston, MA 02114

SUMMARY:

Polypharmacy is the rule rather than the exception in the treatment of bipolar disorder, with the average patient prescribed between three and five different classes of medications at any given time. The complexity of symptoms in bipolar disorder – periods of depression, mania, hypomania, and mixed states; subsyndromal symptoms of both poles of illness; concurrent comorbid conditions such as anxiety, ADHD, and substance abuse; and the sensitivity of patients to psychosocial stress – makes it highly likely that multiple medication classes will be initiated during treatment. While the purpose for starting medications is usually clear, the reason for continuing medications is frequently less certain; this is especially the case when the goals are relapse prevention and functional improvement. For patients, the risks of continuing ineffective treatment can be great, not least from the exposure to agents that may have significant long-term health consequences without benefit, but also from the potential that medications may be counteracting each other's effects while impairing functioning and wellness. An iterative approach to medication monitoring in the context of complex symptomatology over a patient's lifespan that offers the opportunity for patients and clinicians to determine whether to continue, change, or discontinue treatments will be presented.

NO 01D

HOW DO WE CARE FOR COMPLEX BIPOLAR PATIENTS?

Gary Sachs, M.D., Massachusetts General Hospital, 50 Staniford Street, 5th Floor, Boston, MA 02114

SUMMARY:

Bipolar disorders are characterized by complexity which creates significant obstacles to clinical management. Along with permutations of depressive and manic symptoms, patients with bipolar disorder typically suffer from multiple general medical and psychiatric comorbidities which contribute additional impairment and dysfunction. Attempts to treat these conditions can be frustrated by diagnostic uncertainty, non-adherence to treatment recommendations, and confusion between symptoms of the underlying illness, effects of substance misuse, and the combined adverse effects of treatments. Furthermore, data from personality studies suggest low agreeableness and low conscientiousness are among the signature traits of bipolar disorder (BP).

REFERENCES:

1) Busch AB, Frank RG, Sachs G. Bipolar-I depression outpatient treatment quality and costs in usual care practice. Psychopharmacol Bull. 2008; 41(2):24-39

2) Busch AB, Ling D, Frank RG, Greenfield SF. Changes in the quality of care for bipolar I disorder during the 1990s. Psychiatr Serv. 2007; 58(1): 27-33

3) Miklowitz DJ, Otto MW, Frank E, et al. Intensive psychosocial intervention enhances functioning in patients with bipolar depression: results from a 9-month randomized controlled trial. Am J Psychiatry. 2007; 164(9): 1340-7.4) Sachs GS, Nierenberg AA, Calabrese JR, et al. Effectiveness of adjunctive antidepressant treatment for bipolar depression. N Engl J Med. 2007; 356(17): 1711-22.

12:30PM-2:30PM

INDUSTRY-SUPPORTED SYMPOSIUM 02

DEVELOPMENT OF NEW AGENTS FOR THE TREATMENT OF SCHIZOPHRENIA

SUPPORTED BY DAINIPPON SUMITOMO PHARMA AMERICA, INC.

Steven Potkin, M.D. Department of Psychiatry and Human Behavior, University of California, Irvine, Brain Imaging Center, 5251 California Avenue, Ste. 240, Irvine, CA 92617

EDUCATION OBJECTIVES

At the conclusion of this session, the participant should be able to : 1) Recognize unmet needs in the development of new agents for the treatment of schizophrenia; 2) Identify barriers to the rapid development and approval of new agents; 3) Discuss potential drug development targets to improve cognition in patients with schizophrenia

SUMMARY:

The field of psychiatry has made significant strides over the last 50 years in developing strategies for managing the symptoms of schizophrenia. As the goal of treatment has shifted from symptomatic reduction toward remission and recovery, a number of unmet needs have emerged. New drug treatments are a key step toward addressing these needs, and a number of agents are in various stages of testing. Drug development is a multifaceted and multistep process with many challenges along the way. Both Appropriate symptom targets and pharmacological mechanisms must be identified and characterized, and appropriate methods for studying them must be established. Drugs require testing in laboratory animals, as well as toxicology, safety and efficacy trials in humans. At each stage along the way there is the potential for the agent to be abandoned, modified or retested. Faculty in this interactive, case-based symposium will review unmet needs in the treatment of schizophrenia as well as discuss new symptom domains and mechanisms of action that are likely to be targets for emerging drug development.

NO 02A

UNMET NEEDS IN SCHIZOPHRENIA

Adrian Preda M.D. 101 The City Drive , Orange, CA 92868

Over the last 50 years, the field of psychiatry has made enormous strides in identifying effective strategies for managing the core symptoms of schizophrenia. A variety of effective pharmacotherapies exist for both acute and maintenance treatment, and a number of psychosocial strategies and programs have been developed. For instance, remission rates with current treatment are often found to approach 90% in first episode patients and 50% in more chronic populations. Yet there are significant unmet needs in this patient population, as the field shifts away from symptom control to recovery. Effective treatment of cognitive symptoms, for example, has so far remained elusive with current treatments, and the presence of these symptoms can prevent recovery. Patient medication adherence is low and continued strategies and efforts are needed in this area to maximize outcomes. Access to care continues to be a challenge for many patients with schizophrenia and a rethinking of the role of psychiatrists in the overall medical management of their patients has already occurred. This role shift is of particular importance given the long-term cardiometabolic risks associated with the use of some atypical antipsychotic medications. Clearly, challenges exist at the research, clinician, patient, and system levels. In this presentation, faculty will review the major factors undermining successful long-term outcomes for patients with schizophrenia, and will lead an interactive discussion regarding ways to measure and address them with existing as well as emerging resources.

N0 02B

DRUG DEVELOPMENT IN PSYCHIATRY: ISSUES AND TRENDS

Kenneth Kaitin, Ph.D.

SUMMARY:

Drug development efforts are proceeding at a rapid pace as scientists and industry try to address unmet needs in the treatment of schizophrenia. Getting a newly developed compound to the marketplace is a long an arduous task with many steps, challenges and pitfalls along the way. In part, the complexity of the process arises from the number of stakeholders involved in generating the compound, testing its effects in animal models, and conducting Phase I, 2, and 3 clinical trials to assess toxicity, safety, dosing, and efficacy in humans. At each juncture there is the potential for the compound to be abandoned, and even those that reach a formal application to the FDA may not receive approval. As previous attempts to address unmet needs have been unsuccessful, new laboratory models have been developed for evaluating agents, and new pharmacological targets are being identified. Physicians attempting to navigate this process to stay abreast of new developments will inevitably encounter many questions. What is the role, if any, of NIH in this process? What is the role of the pharmaceutical sponsor and what are their limitations? What does the FDA look for, and why do applications get denied? Faculty in this symposium will discuss the steps involved in getting a novel drug to the marketplace, and will use approved, non-approved and pending treatments as case studies along the way.

NO 02C

LATE STAGE AND RECENTLY APPROVED ANTIPSYCHOTIC AGENTS

Steven Potkin, M.D. Department of Psychiatry and Human Behavior, University of California, Irvine, Brain Imaging Center, 5251 California Avenue, Ste. 240, Irvine, CA 92617

SUMMARY:

In keeping with the urgent need for advances in the pharmacotherapy of schizophrenia, a number of medications are in various stages of the pipeline on their way to seeking FDA approval. Some of these agents are simply new formulations of existing medications, others have been proposed as adjunctive or combination therapies, while still others represent novel pharmacologic approaches to management. Faculty in this symposium will review agents in Phase III testing as well as those that have recently been through FDA review, with an emphasis on the way in which specific agents are expected to advance care and improve outcome. Data from clinical trials on these agents will be reviewed, and, in the case of those with novel mechanisms of action, the pharmacology of the agents will be described. Faculty will lead an interactive discussion about recently approved and emerging agents and their integration into practice. Patient cases will be used to illustrate the ways in which newly available medications may address existing treatment gaps.

NO 02D

NEW TARGETS FOR DRUG DEVELOPMENT

Philip Harvey,Ph.D. Professor of Psychiatry and Behavioral Sciences Emory University School of Medicine Woodruff Memorial Building101, Woodruff Circle, Suite 4000 Atlanta, GA 30032

SUMMARY:

The pharmacology of cognitive impairment in schizophrenia is still evolving and new drug targets are identified often. These targets include both well-known transmitter systems, such as the dopamine, glutamate, serotonin, norepinephrine, GABA, and acetylcholine, as well as nontransmitter brain processes such as white matter integrity and inflammatory processes. The success rate in transmitter based approaches has been limited to date, with clear failures recorded in most of the transmitter systems just mentioned. There are several possible reasons for these failures, including the need to continue concomitant antipsychotic medications in the patients and lack of clear guidance on doses and penetrance into the CNS. An additional substantial issue is whether medications should be developed that target positive and negative schizophrenia symptoms as well as cognitive abnormalities (i.e., Broad spectrum agents). Such agents might reduce the potential problem of interference from concurrent antipsychotic medications. While this idea appears reasonable, regulatory concerns have been expressed regarding demonstrating that the cognitive effects with such agents would be direct or due to reductions in other symptoms. We will critically evaluate the evidence that “pseudo-specificity” is an issue in cognitive enhancement trials in schizophrenia. We will also

evaluate the possibility that non-transmitter based approaches have promise, including anti-inflammatory treatments, promotion of neurogenesis, and modulation of white matter integrity. Further, we will examine previous efforts and evaluate them in terms of whether possible modification in research designs, subject populations, or dosing or delivery strategies could have a more beneficial finally. Finally, we will consider data regarding alternate outcomes targets, including direct measures of disability, have more potential to detect change than the standard cognitive tests used in previous efforts.

REFERENCES:

1.Cummings JL.Optimizing phase II of drug development for disease-modifying compounds.Alzheimers Dement. 2008 Jan;4(1 Suppl 1):S15-20.

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3. Potkin SG, et al. J Clin Psychopharmacol. 2008 Apr;28(2 Suppl 1):S4-11

4. Terry AV Jr, et al. Cognitive dysfunction in neuropsychiatric disorders: Selected serotonin receptor subtypes as therapeutic targets. Behav Brain Res. 2008 Jan 31

12:30PM - 2:30PM

INDUSTRY-SUPPORTED SYMPOSIUM 03

EFFECTIVE TREATMENT OF ALZHEIMER DISEASE – TRANSLATING GUIDELINES INTO PRACTICE: AN INTERACTIVE PANEL DISCUSSION

SUPPORTED BY FOREST LABORATORIES, INC

George Grossberg, M.D., 1221 South Grand Blvd., St. Louis, MO 63104

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1)Evaluate and contrast available pharmacologic therapies available for treating patients with Alzheimer disease (AD); 2) Appraise and contrast the published guidelines for pharmacologic management of patients with AD; 3)Have increased confidence in the pharmacologic and nonpharmacologic management of patients with AD

SUMMARY:

The purpose of this symposium is to allow the participants the opportunity to compare and contrast the variations between published guidelines for the treatment of Alzheimer Disease (AD). Recently, a committee representing the American College of Physicians and the American Academy of Physicians produced and published a set of guidelines for the pharmacologic treatment of dementia. The guidelines concluded that because evidence of effectiveness of these drugs is scant, the use of dementia drugs should not be used routinely for patients with AD. These new guidelines are at variance with those of other groups, including the American Academy of Neurology, the American Association for Geriatric Psychiatry, and the American Psychiatric Association.6 Because of these and other variations between published guidelines, there is confusion among practitioners regarding the best practices for treating patients with AD, and a need for clarification and discussion of these guidelines among the various clinical disciplines. To address these needs, a moderated discussion among participants representing primary care, psychiatry, and neurology is proposed to debate the differences in guidelines for pharmacologic therapy of patients with AD.

NO 03A

PUTTING PRACTICE RECOMMENDATIONS FOR AD PATIENTS INTO PRACTICE: CONFUSION FOR CLINICIANS

Wm Maurice Redden, M.D., 4394 West Pine Blvd Apt#106, St. Louis, MO 63108

SUMMARY:

AD is an underdiagnosed illness that profoundly alters the mental and physical state of the patient, and places an enormous burden on primary caregivers. The aims of patient care management are to delay disease progression, delay functional decline, improve quality of life, support dignity, control symptoms, and provide comfort at all stages of AD. To achieve these aims, professional organizations in different clinical specialties have proposed guidelines that, unfortunately, differ from each other. There is a need among clinicians who treat patients with AD to understand the rationale behind these disparate recommendations in order to make informed decisions and optimize patient care. For example, the AAGP recommended that the cholinesterase inhibitors should be considered as part of the care for treating the cognitive symptoms of mild to moderate AD, as long as patients do not have contraindications and they are used only after careful education of patients and their caregivers. In addition, the AAGP stated that memantine is indicated for moderate to severe AD, and its use earlier in milder dementia may be justified. They recommended that "a discussion with patients of the pros and cons of memantine is now part of the care for patients with AD with moderate to severe dementia." On the other hand, the recent ACP and AAFP guidelines state that the available clinical evidence does not support prescribing these medications for every patient. Therefore, according to these latter guidelines, the approved AD drugs should not be routinely used for patients with dementia. These conflicting recommendations make it difficult for both young and experienced practitioners to understand the best practices for AD patient management. This presentation will discuss the views of a young practitioner trying to sort through the recommendations.

NO 03B

PRACTICE RECOMMENDATIONS FROM THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

Gary W Small, M.D., UCLA Semel Insitute for Neuroscience & Human BehaviorSuite 88 201760 Westwood Plaza, Los Angeles, CA 90024

SUMMARY:

The American Association for Geriatric Psychiatry (AAGP)

has put forth a recent position statement regarding the effective, systematic care and treatment of patients with dementia resulting from Alzheimer disease (AD). The statement includes a series of therapeutic interventions (pharmacologic and nonpharmacologic) for patients with AD and their caregivers. These interventions do not produce a cure of the underlying disease and do not appear to stop its progression, but they have been found to benefit both patients and their caregivers. This 'Dementia Care,' model aims to delay disease progression functional decline, improve quality of life, support dignity, control symptoms, and provide comfort at all stages of AD, and is based on scientific evidence of beneficial outcomes, with acceptable risks. The model also targets improving the pathophysiological understanding of the biology of AD. Although limited, the existing evidence, coupled with clinical experience and common sense, is adequate to produce a minimal set of care principles. The AAGP position statement affirms the existence of a minimal set of care principles for patients with AD and their caregivers and thus considers the detection and treatment of AD to be typical care practice for physicians and other licensed clinicians. This discussion will review the AAGP position statement, the scientific evidence behind the statement, and the current challenges for the field in achieving the statement's aims.

NO 03C

MANAGEMENT OF DEMENTIA: AN EVIDENCE BASED REVIEW FROM THE AMERICAN ACADEMY OF NEUROLOGY

Martin R Farlow, M.D., 541 Clinical Drive, Indianapolis, IN 46202

SUMMARY:

The Quality Standards Subcommittee of the American Academy of Neurology Practice issued an evidence based review on the management of dementia. Their practice recommendations for the pharmacologic treatment of AD included the statement that "cholinesterase inhibitors should be considered in patients with mild to moderate AD…although studies suggest a small average degree of benefit." This recommendation was labeled as "standard," which means that it reflects a high degree of clinical certainty. For this subcommittee, standard recommendations usually require Class I evidence that directly addresses the clinical questions, or overwhelming Class II evidence when circumstances preclude randomized clinical trials. Other recommendations regarding pharmacologic treatment included vitamin E considered in an attempt to slow progression of AD; selegiline was listed as a practice option because evidence from study supported its use, but it had a less favorable risk–benefit ratio. The panel found that there was insufficient evidence to support the use of other antioxidants, anti iflammatories, or other putative disease modifying agents specifically to treat AD because of the risk of significant side effects in the absence of demonstrated benefits. It was recommended that estrogen should not be prescribed to treat AD. The evidence and support for these recommendations will be discussed, along with other important recommendations.

NO 03D

CURRENT PHARMACOLOGIC TREATMENT OF DEMENTIA: PRACTICE GUIDELINES FROM THE AMERICAN COLLEGE OF PHYSICIANS AND THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Charles A Cefalu, M.D., 1070 Old River Road, Slidell, LA 70461

SUMMARY:

The ACP and AAFP developed guideline to present the available evidence on current pharmacologic treatment of dementia. The targeted literature search included evidence related to the effectiveness of 5 U.S. Food and Drug Administration–approved pharmacologic therapies for dementia for outcomes in the domains of cognition, global function, behavior/mood, and quality of life/activities of daily living. They found that the available clinical evidence does not support prescribing these medications for every patient. Although the evidence shows statistically significant benefits of treatment with some cholinesterase inhibitors and memantine for all kinds of dementia, these benefits, on average, are not clinically significant for cognition and are modest for global assessments. Their recommendation, labeled as "weak" and supported with moderate quality evidence, is that clinicians should base the decision to initiate a trial of therapy with a cholinesterase inhibitor or memantine on an individualized assessment of the patient and the patient's family. They further stated that the approved AD drugs should not be routinely used for patients with dementia. This presentation will discuss the scientific support and rationale behind these guidelines.

REFERENCES:

1) Cummings JL. Alzheimer's disease. N Engl J Med. 2004;351:56 67.

2) Qaseem A, Snow V, Cross JT Jr, et al. Current pharmacologic treatment of dementia: a clinical practice guideline from the American College of Physicians and the American Academy of Family Physicians. Ann Intern Med. 2008;148:370 378.

3) Doody RS, Stevens JC, Beck C, et al. Practice parameter: management of dementia (an evidence based review). Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology. 2001;56:1154 1166.

4) Lyketsos CG, Colenda CC, Beck C, et al. Position statement of the American Association for Geriatric Psychiatry regarding principles of care for patients with dementia resulting from Alzheimer disease. Am J Geriatr Psychiatry. 2006;14:561 572.

7:00PM-9:00PM

INDUSTRY-SUPPORTED SYMPOSIUM 04

NEUROBIOLOGY, PREDICTION AND MANAGEMENT OF ANTIPSYCHOTIC NON-RESPONSE IN PATIENTS WITH SCHIZOPHRENIA

SUPPORTED BY LILLY USA, LLC]

Christoph U Correll , M.D., The Zucker Hillside Hospital,

Psychiatry Research75-59 263rd Street, Glen Oaks, NY 11004

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Discuss underlying neurophysiology of antipsychotic response and reasons for treatment nonresponse in patients with schizophrenia; 2) Evaluate patients for early nonresponse to treatment with atypical antipsychotics; and 3) Identify and implement evidence-based combination, switching or augmentation strategies for appropriate management of patients with schizophrenia

SUMMARY:

Functional recovery and remission are both attainable goals for many patients with schizophrenia, but measuring a patient's progress along the path to recovery can be challenging for the clinician. Improved early decision-making by a psychiatrist for an individual patient's care can potentially result in more positive patient outcomes. A crucial early step that can affect the course of long-term treatment is for the patient to respond effectively to initial antipsychotic therapy. Conventional strategies had patients on a single agent for up to six weeks prior to determining an antipsychotic's efficacy; studies have since indicated that the biggest changes in core psychotic symptoms occur during the first four weeks of therapy. Moreover, accurately measuring response to medication during the first two weeks of treatment can provide a strong indication of whether a patient's symptoms are likely to show improvement during an extended therapeutic regimen, allowing the clinician to re-evaluate therapeutic strategies earlier. This type of knowledge can allow the practicing psychiatrist to make decisions sooner about adjusting the therapeutic strategy to meet the needs of each patient. Whether to continue with monotherapy, switch to another agent, or employ combination therapy approaches, are all options that can be considered earlier in he treatment regimen, increasing the potential for improved outcomes for patients with schizophrenia. This symposium will discuss the recent studies predicting response to antipsychotics, and assess their potential impact on and implementation into psychiatric practice.

NO 04A

NEUROBIOLOGY, CORRELATES AND MEASUREMENT OF ANTIPSYCHOTIC NON-RESPONSE IN SCHIZOPHRENIA

John M Kane, M.D., 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

Schizophrenia is a heterogeneous disorder in terms of clinical presentation, treatment response, course and long-term outcome. Clinicians are faced with the necessity to make decisions on a daily basis as to the success or failure of an acute treatment trial of antipsychotic medications. At the same time most practice guidelines tend to suggest waiting four to six weeks before deciding that a therapeutic trial is ineffective. There is confusion as to what is meant by "response," whether it is initial response or ultimate response. In addition there is considerable variability in how response is defined in clinical trials. These issues take on particular importance as length of hospital stays become shorter and shorter and more and more attention is focused on the cost-effectiveness of particular treatment strategies.

NO 04B

EARLY PREDICTION OF ANTIPSYCHOTIC NON-RESPONSE IN SCHIZOPHRENIA

Stefan Leucht, M.D., Klinikum rechts der Isar, Ismaningerstrasse 22, Munich, 81675

SUMMARY:

A significant proportion of patients with schizophrenia do not respond to the first antipsychotic drug prescribed. This has been traditionally ascribed to a delay of onset of antipsychotic drug action, or clinicians starting at a lower dose of agent and gradually increasing to the therapeutic dose. Recent meta-analyses have suggested that the antipsychotic effect instead starts comparatively early. Small studies conducted prior to the development of the atypical antipsychotics suggested a correlation between early response and pronounced later response, but did not provide clinically-relevant information for psychiatrists.

NO 04C

THERAPEUTIC MANAGEMENT OF ANTIPSYCHOTIC NON-RESPONSE IN PATIENTS WITH SCHIZOPHRENIA

Christoph U Correll , M.D., The Zucker Hillside Hospital, Psychiatry Research 75-59 263rd Street, Glen Oaks, NY 11004

SUMMARY:

In order to get patients with schizophrenia effectively to their ultimate treatment goals, clinicians must make evidence-based decisions early in the management process that influence eventual outcomes. Early response to therapy is more predictive of good patient progress towards recovery, as it lowers the risk of relapse. Should a patient not respond to initial therapy, what are the options for the clinician?

REFERENCES:

1) Leucht S, Busch R, Kissling W, Kane JM.Early prediction of antipsychotic nonresponse among patients with schizophrenia J Clin Psychiatry. 2007 Mar;68(3):352 60.

2) Correll CU, Malhotra AK, Kaushik S, et al. Early prediction of antipsychotic response in schizophrenia. Am J Psychiatry. 2003;160:2063-2065.

3) Agid O, Kapur S, Arenovich T, et al. Delayed-onset hypothesis of antipsychotic action: a hypothesis tested and rejected. Arch Gen Psychiatry. 2003;60:1228-1235.

4) Kinon BJ, Chen L, Ascher-Svanum H, Stauffer VL, Kollack-Walker S, Sniadecki JL, Kane JM.Predicting response to atypical antipsychotics based on early response in the treatment of schizophrenia. Schizophr Res. 2008 Jul;102(1-3):230-40.

7:00 PM-9:00PM

INDUSTRY-SUPPORTED SYMPOSIUM 05

THE PATHOPHYSIOLOGY OF ADHD: IMPLICATIONS FOR TREATMENT

SUPPORTED BY SHIRE US, INC.

Timothy E Wilens, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Differentiate the mechanisms of action of medications used to treat ADHD; 2) Explain the roles of dopamine and norepinephrine in ADHD pathophysiology and treatment; and 3) Discuss the role of nicotinic receptor agonists as future treatments for ADHD.

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder affecting children and adolescents. It frequently persists into adulthood, causing substantial impairment in school, work, family, and social settings. Increasingly, evidence from neurobiological, neuroimaging, and neuropsychological studies, family and genetic research, and biochemical data on the mechanisms of action of ADHD medications has begun to converge. These studies are providing insight into the pathophysiology of ADHD and are clarifying the roles of neurotransmitters in ADHD and its treatment. In this symposium, these systems will be discussed in more detail, with emphasis on the catecholamines and the emerging data on nicotinic agents.

NO 05A

THE NEUROBIOLOGY OF ADHD: OVERVIEW OF THE MECHANISMS OF EFFICACIOUS AGENTS

Paul G Hammerness, M.D., 185 Alewife Brook ParkwaySuite 2000, Cambridge, MA 02138

SUMMARY:

Neurobiological studies of ADHD have implicated the dysregulation of noradrenergic and dopaminergic systems in the brain stem, striatum, cerebellum, and prefrontal cortex. The mechanisms of action of ADHD medications in these regions can give further insight into the pathophysiology of ADHD. The efficacy of stimulants in ADHD treatment, for example, appears to be related to their effects on noradrenergic and dopaminergic function. The efficacy of tricyclic antidepressants in ADHD is also thought to be based on their effects on catecholamine function, particularly the reuptake of norepinephrine. Atomoxetine also has effects on norepinephrine; it specifically inhibits presynaptic norepinephrine reuptake. Studies suggest that this inhibition may ultimately result in increases in dopamine in the prefrontal cortex, resulting in improved cognitive function. Preclinical studies of bupropion demonstrate that it affects the reuptake of dopamine and norepinephrine. The alpha agonists clonidine and guanfacine affect norepinephrine neurotransmission. The mechanisms of action of these efficacious agents implicate dopamine and norepinephrine dysfunction in ADHD and suggest future directions for clinical research.

NO 05B

ROLE OF DOPAMINE IN ADHD

Darin D Dougherty, M.D., CNY2612; 149 13th Street, Charlestown, MA 02129

SUMMARY:

Several lines of evidence suggest that abnormalities in the dopamine system play a major role in ADHD. For example, neuroimaging studies have found that several brain regions are smaller in volume in ADHD patients compared with controls. These include the caudate nucleus and the globus pallidus, which both have a high density of dopamine receptors. Genetic studies have found an association between ADHD and variants in the genes for the dopamine transporter and the dopamine receptor type 4. Knockout mice missing the gene for the dopamine transporter are exceedingly active compared to wild type mice. In addition, the therapeutic effects of methylphenidate appear to occur through its interaction with the dopamine transporter, resulting in an increase in synaptic dopamine. This presentation will summarize the converging evidence on the role of dopamine in ADHD and its implications for treatment.

NO 05C

ALPHA-2A AGONISTS STRENGTHEN PREFRONTAL CORTEX FUNCTION

Amy F Arnsten, Ph.D., Dept. NeurobiologyYale Medical School, 333 Cedar St, CT 06510,

SUMMARY:

Prefrontal cortical (PFC) circuits are disrupted in neuropsychiatric disorders such as ADHD. The PFC is key for the regulation of attention and behavior: It allows us to inhibit distracting stimuli, sustain and shift attention, and to suppress inappropriate impulses. The PFC performs these high order functions through networks of interconnected neurons, which are very sensitive to their chemical environment.. Moderate levels of the catecholamines dopamine (DA) and norepinephrine (NE) are essential to PFC function, but either too little or too much of these substances greatly impairs prefrontal function. The beneficial effects of DA arise from appropriate levels of D1 and D4 receptor stimulation, while NE has beneficial effects through stimulation of postsynaptic alpha2A adrenergic receptors on PFC neurons. Alpha-2A receptors are localized on dendritic spines near network inputs. Stimulation of these receptors—e.g. with guanfacine—strengthens network inputs and enhances PFC regulation of behavior and attention. Conversely, blockade of alpha-2 receptors in the PFC in monkeys impairs working memory, induces hyperactivity and weakens impulse control, similar to patients with ADHD. Genetic weakening of the synthetic enzyme for NE—i.e. alterations in dopamine beta hydroxylase—similarly leads to weakened PFC function in humans. Research in animals indicates that treatments for ADHD (methylphenidate, atomoxetine, guanfacine) indirectly or directly enhance alpha-2A receptor stimulation in PFC, thus strengthening PFC regulation of attention and behavior. Thus, a logical story is

emerging regarding the etiology of ADHD and its treatment.

NO 05C

NICOTINIC RECEPTORS AND AGONISTS IN ADHD

Timothy E Wilens, M.D., 55 Fruit Street, YAW 6A, Boston, MA 02114

SUMMARY:

Pharmacologic stimulation of the cholinergic system results in improvements in cognitive processes. Nicotine and other agonists of the nicotinic acetylcholine receptors (nAChRs) have been shown in animal studies to improve performance in learning, spatial and working memory, processing speed and ability, inhibition, selective accuracy, detection, and overall attention. In humans, activation of the nAChRs has been shown to improve temporal memory, attention, cognitive vigilance, and executive function. The neuronal nAChRs are located in the amygdala, frontal cortex, midbrain dopamine nuclei, and the dorsolateral thalamus, consistent with their role in cognitive processes. The receptors are ligand-gated ion channels composed of 5 subunits which create a cation channel through the membrane. Twelve subunits have been identified which can combine in vitro in different permutations to form 5-subunit receptors with distinct electrophysiological and pharmacologic properties. The in vivo forms of the receptors have not been completely elucidated, but the most common high-affinity nicotine binding sites in the brain are nAChRs known as a4ß2*. This receptor, and to a lesser extent the a7 nAChR, appear to play a significant role in cognition. Nicotinic acetylcholine receptor agonists are being developed as possible treatments for ADHD. In this presentation, evidence for the role of the cholinergic system in ADHD and the utility of nAChR agonists in ADHD treatment will be reviewed.

REFERENCES:

1) Wilens TE: Mechanism of action of agents used in attention-deficit/hyperactivity disorder.J Clin Psychiatry 2006;67 Suppl 8:32-8

2) Arnsten AF, Scahill L, Findling RL: alpha 2-Adrenergic receptor agonists for the treatment ofattention-deficit/hyperactivity disorder: emerging concepts from new data. J Child Adolesc Psychopharmacol 2007 Aug;17(4):393-406

3) Spencer TJ, Biederman J, Madras BK, Dougherty DD, Bonab AA, Livni E, MeltzerPC, Martin J, Rauch S, Fischman AJ: Further evidence of dopamine transporter dysregulation in ADHD: a controlled PET imaging study using altropane. Biol Psychiatry 2007 Nov 1;62(9):1059-1061

4) Wilens TE, Decker MW: Neuronal nicotinic receptor agonists for the treatment of attention-deficit/hyperactivity disorder: focus on cognition. Biochem Pharmacol 2007 Oct 15;74(8):1212-1223

7:00PM-9:00PM

INDUSTRY SUPPORTED SYMPOSIUM 06

AUGMENTATION STRATEGIES FOR MAJOR DEPRESSIVE DISORDER: THE EVIDENCE FOR EFFECTIVE CLINICAL DECISION MAKING IN IMPROVING PATIENT CARE

SUPPORTED BY BRISTOL MYERS SQUIBB

Madhukar H Trivedi, M.D., 5323 Harry Hines Boulevard, Dallas, TX 75390

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1)Discuss and interpret the clinical implications of factors underlying inadequate response to antidepressant therapy in patients with MDD2) Compare and contrast the rationale for using different second line strategies in patients who do not respond adequately to antidepressants; and 3) Evaluate the clinical trial evidence for the use of atypical antipsychotics in the management of MDD

SUMMARY:

Major depressive disorder (MDD) affects about 15 million adults in the US, and ranks consistently as the leading cause of disability worldwide. Around two thirds of patients treated with approved first line antidepressant therapies for major depressive disorder do not respond or partially respond yet do not achieve remission. Recent studies into clinical features that may predict treatment resistance, such as pharmacogenetic factors, have suggested the psychiatrist may be able to provide more focused care for patients by identifying treatment options earlier that are more likely to be efficacious.The use of second line or adjunctive strategies, including non pharmacologic therapy, or switching, combination or augmentation approaches with pharmacologic agents, for patients with partial response to antidepressant therapy also provides an effective clinical tool to promote patient outcomes in MDD. Augmentation therapy typically refers to the addition of a non antidepressant compound to an antidepressant regimen. Studies have investigated the use of a number of agents with differing mechanisms of action for this purpose, including stimulants and mood stabilizers. Recent larger scale clinical trial evidence has also supported the effective and safe use of selected atypical antipsychotics as augmentation agents in treatment resistant major depression.This symposium will provide a review of inadequate response to antidepressant therapy in MDD, factors that may predict treatment resistance, and present an evidence based approach for the management of MDD, using different second line strategies to overcome treatment resistance to first line options.

NO 06A

ATYPICAL ANTIPSYCHOTICS AS AUGMENTATION AGENTS FOR MAJOR DEPRESSIVE DISORDER: EFFICACY AND TOLERABILITY.

George I Papakostas, M.D., Massachusetts General Hospital, Harvard Medical School, 15 Parkman Street, WACC#812, Boston,

MA 02114

SUMMARY:

Despite the progressive increase in the number of pharmacologic agents with potential antidepressant activity, many patients suffering from major depressive disorder continue to be symptomatic. For example, in the first level of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, only about 30% of patients had achieved a remission of their depressive episode following up to 12 weeks of therapy with the selective serotonin reuptake inhibitor citalopram. Clearly, there is an urgent need to develop safer, better tolerated, and more effective treatments for MDD. The use of the atypical antipsychotic agents as adjunctive treatment for treatment resistant major depressive disorder (TRD) represents one such effort towards novel pharmacotherapy development. Atypical antipsychotic agents have been hypothesized to be beneficial in mood disorders, including TRD as a result of their complex monoaminergic mechanisms of action. After an initial series of positive case reports, series, and small clinical trials, subsequent larger scale projects had yielded conflicting results. However, more recently, larger scale clinical trials have supported the effectiveness of at least some of these medications. This session will summarize the existing data regarding the effectiveness of these medications in the treatment of TRD, including both biochemical rationale and clinical data. Data focusing on the relative safety and tolerability of these agents will also be reviewed, followed by an outline of potential future directions for research in this area.

NO 06B

INADEQUATE TREATMENT RESPONSE IN MAJOR DEPRESSIVE DISORDER: PREDICTORS AND STRATEGIES FOR SELECTING NEXT STEP TREATMENTS

Roy H Perlis, M.D., 15 Parkman Street, WACC 812, Boston, MA 02114

SUMMARY:

A majority of individuals treated for major depressive disorder (MDD) do not reach remission with the initial antidepressant treatment, and studies such as the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) suggest that a subset will not recover despite multiple treatment trials. If these individuals could be identified early in their course, it might be possible to select more intensive or comprehensive treatments to improve their outcomes. This presentation will review the clinical features which have been associated with treatment resistance in MDD, including recent findings from STAR*D. It will also examine the results of studies suggesting that genetic variation may implicate specific genes for SSRI response or treatment resistance. A major focus will be how such results can be translated into clinical practice – that is, when and how is genetic testing useful for guiding treatment.

NO 6C

EFFECTIVE MANAGEMENT OF TREATMENT RESISTANT DEPRESSION: EVIDENCE BASED APPROACHES BEYOND FIRST LINE ANTIDEPRESSANT MONOTHERAPY

Madhukar H Trivedi, M.D., 5323 Harry Hines Boulevard, Dallas, TX 75390

SUMMARY:

Antidepressants such as SSRIs and SNRIs are typically used as approved first line treatment options for major depressive disorder, but despite their use, 30% to 46% of patients do not respond or do not have an adequate response (partial responders) to initial therapy and only 25% to 35% experience full symptom remission. The treating clinician should be prepared to utilize diverse multi step treatment strategies, with both pharmacologic and nonpharmacologic interventions, and employ agents with a variety of mechanisms of action to effectively get individual patients to remission. Switching between medications when patients are only partially responding to therapy yet not experiencing adverse events can carry some risk, and potentially remove the therapeutic benefit of the first agent. Combination therapy approaches allow retention of the first line agent's therapeutic benefit, and permit interventions of different types to be added appropriately and evaluated for their response. This presentation will compare for the audience the advantages and disadvantages of different strategies for the management of MDD in patients who have an inadequate response to first line therapy, with an emphasis on factors that may affect the clinician's use of any strategy for individual patients.

REFERENCES:

1) Perlis RH.Pharmacogenetic studies of antidepressant response: how far from the clinic? Psychiatr Clin North Am. 2007 Mar;30(1):125 38.

2) Trivedi MH, Hollander E, Nutt D, Blier P.Clinical evidence and potential neurobiological underpinnings of unresolved symptoms of depression.J Clin Psychiatry. 2008 Feb;69(2):246 58.

3) Warden D, Rush AJ, Trivedi MH, Fava M, Wisniewski SR.The STAR*D Project results: a comprehensive review of findings. Curr Psychiatry Rep. 2007 Dec;9(6):449 59.

4) Shelton RC, Papakostas GI.Augmentation of antidepressants with atypical antipsychotics for treatment resistant major depressive disorder.Acta Psychiatr Scand. 2008 Apr;117(4):253 9.

MONDAY, MAY 18, 2009

7:00AM- 9:00AM

INDUSTRY-SUPPORTED SYMPOSIUM 07

AUGMENTATION STRATEGIES FOR MAJOR DEPRESSIVE DISORDER: THE EVIDENCE FOR EFFECTIVE CLINICAL DECISION-MAKING IN IMPROVING PATIENT CARE

SUPPORTED BY ASTRA ZENECA

Madhukar H Trivedi, M.D., 5323 Harry Hines Boulevard, Dallas,

TX 75390

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss and interpret the clinical implications of factors underlying inadequate response to antidepressant therapy in patients with MDD; 2) Compare and contrast the rationale for using different second-line strategies in patients who do not respond adequately to antidepressants; and 3)Evaluate the clinical trial evidence for the use of atypical antipsychotics in the management of MDD

SUMMARY:

Major depressive disorder (MDD) affects about 15 million adults in the US, and ranks consistently as the leading cause of disability worldwide. Around two-thirds of patients treated with approved first-line antidepressant therapies for major depressive disorder do not respond or partially respond yet do not achieve remission. Recent studies into clinical features that may predict treatment resistance, such as pharmacogenetic factors, have suggested the psychiatrist may be able to provide more focused care for patients by identifying treatment options earlier that are more likely to be efficacious.The use of second-line or adjunctive strategies, including non-pharmacologic therapy, or switching, combination or augmentation approaches with pharmacologic agents, for patients with partial response to antidepressant therapy also provides an effective clinical tool to promote patient outcomes in MDD. Augmentation therapy typically refers to the addition of a non-antidepressant compound to an antidepressant regimen. Studies have investigated the use of a number of agents with differing mechanisms of action for this purpose, including stimulants and mood stabilizers. Recent larger-scale clinical trial evidence has also supported the effective and safe use of selected atypical antipsychotics as augmentation agents in treatment-resistant major depression.This symposium will provide a review of inadequate response to antidepressant therapy in MDD, factors that may predict treatment resistance, and present an evidence-based approach for the management of MDD, using different second-line strategies to overcome treatment resistance to first-line options.

NO 07A

ATYPICAL ANTIPSYCHOTICS AS AUGMENTATION AGENTS FOR MAJOR DEPRESSIVE DISORDER: EFFICACY AND TOLERABILITY.

George I Papakostas, M.D., Massachusetts General Hospital, Harvard Medical School, 15 Parkman Street, WACC#812, Boston, MA 02114

SUMMARY:

Despite the progressive increase in the number of pharmacologic agents with potential antidepressant activity, many patients suffering from major depressive disorder continue to be symptomatic. For example, in the first level of the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study, only about 30% of patients had achieved a remission of their depressive episode following up to 12 weeks of therapy with the selective serotonin reuptake inhibitor citalopram. Clearly, there is an urgent need to develop safer, better tolerated, and more effective treatments for MDD. The use of the atypical antipsychotic agents as adjunctive treatment for treatment-resistant major depressive disorder (TRD) represents one such effort towards novel pharmacotherapy development. Atypical antipsychotic agents have been hypothesized to be beneficial in mood disorders, including TRD as a result of their complex monoaminergic mechanisms of action. After an initial series of positive case reports, series, and small clinical trials, subsequent larger scale projects had yielded conflicting results. However, more recently, larger scale clinical trials have supported the effectiveness of at least some of these medications. This session will summarize the existing data regarding the effectiveness of these medications in the treatment of TRD, including both biochemical rationale and clinical data. Data focusing on the relative safety and tolerability of these agents will also be reviewed, followed by an outline of potential future directions for research in this area.

NO 07B

INADEQUATE TREATMENT RESPONSE IN MAJOR DEPRESSIVE DISORDER: PREDICTORS AND STRATEGIES FOR SELECTING NEXT-STEP TREATMENTS

Roy H Perlis, M.D., 15 Parkman Street, WACC 812, Boston, MA 02114

SUMMARY:

A majority of individuals treated for major depressive disorder (MDD) do not reach remission with the initial antidepressant treatment, and studies such as the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) suggest that a subset will not recover despite multiple treatment trials. If these individuals could be identified early in their course, it might be possible to select more intensive or comprehensive treatments to improve their outcomes. This presentation will review the clinical features which have been associated with treatment resistance in MDD, including recent findings from STAR*D. It will also examine the results of studies suggesting that genetic variation may implicate specific genes for SSRI response or treatment resistance. A major focus will be how such results can be translated into clinical practice – that is, when and how is genetic testing useful for guiding treatment.

NO 07C

EFFECTIVE MANAGEMENT OF TREATMENT-RESISTANT DEPRESSION: EVIDENCE-BASED APPROACHES BEYOND FIRST-LINE ANTIDEPRESSANT MONOTHERAPY

Madhukar H Trivedi, M.D., 5323 Harry Hines Boulevard, Dallas, TX 75390

SUMMARY:

Antidepressants such as SSRIs and SNRIs are typically used as approved first-line treatment options for major depressive disorder, but despite their use, 30% to 46% of patients do not respond or do not have an adequate response (partial responders) to initial therapy and only 25% to 35% experience full symptom

remission. The treating clinician should be prepared to utilize diverse multi-step treatment strategies, with both pharmacologic and nonpharmacologic interventions, and employ agents with a variety of mechanisms of action to effectively get individual patients to remission. Switching between medications when patients are only partially responding to therapy yet not experiencing adverse events can carry some risk, and potentially remove the therapeutic benefit of the first agent. Combination therapy approaches allow retention of the first-line agent's therapeutic benefit, and permit interventions of different types to be added appropriately and evaluated for their response. This presentation will compare for the audience the advantages and disadvantages of different strategies for the management of MDD in patients who have an inadequate response to first-line therapy, with an emphasis on factors that may affect the clinician's use of any strategy for individual patients.

REFERENCES:

1)Perlis RH.Pharmacogenetic studies of antidepressant response: how far from the clinic?Psychiatr Clin North Am. 2007 Mar;30(1):125-38.

2) Trivedi MH, Hollander E, Nutt D, Blier P.Clinical evidence and potential neurobiological underpinnings of unresolved symptoms of depression.J Clin Psychiatry. 2008 Feb;69(2):246-58.

3) Warden D, Rush AJ, Trivedi MH, Fava M, Wisniewski SR.The STAR*D Project results: a comprehensive review of findings. Curr Psychiatry Rep. 2007 Dec;9(6):449-59.

4) Shelton RC, Papakostas GI.Augmentation of antidepressants with atypical antipsychotics for treatment-resistant major depressive disorder.Acta Psychiatr Scand. 2008 Apr;117(4):253-9.

7:00AM-9:00AM

INDUSTRY-SUPPORTED SYMPOSIUM 08

ADHD FAQS: PRACTICAL ANSWERS FOR THE OFFICE-BASED PRACTITIONER

SUPPORTED BY SHIRE US, INC

Gabriel Kaplan, M.D., Hoboken University Medical Center, 535 Morris Avenue., Springfield, NJ 07081

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to enumerate adult ADHD criteria, and understand the cardiovascular risks of stimulants, the process of ADHD/bipolar differential diagnosis, and the outcome findings of ADHD/SUD comorbidity.

SUMMARY:

Advances in the understanding, destigmatization, and pharmacology of Attention Spectrum Disorders have led to an increase in the number of patients seeking medical care. For instance, the number of prescriptions for adults is now growing at a much faster rate than that of the traditional younger population. As a result of the mainstreaming of ADHD treatment, more and more community office based clinicians are commonly confronted with day to day, real life clinical questions, such as: Is there cause for concern regarding the cardiovascular effects of stimulants? How does one approach the "Bipolar versus AHDH" differential diagnosis issue? What are the main diagnostic issues in adult ADHD? What is the impact of comorbid substance use on the management of ADHD? This symposium will provide practical answers to these frequently asked questions.

NO 08A

HOW DO I IDENTIFY AND TREAT ADULT AHDH?

Gabriel Kaplan, M.D., Hoboken University Medical Center, 535 Morris Avenue., Springfield, NJ 07081

SUMMARY:

Attention Deficit Hyperactivity Disorder (ADHD) causes significant disruption to a wide range of functions in adults such as work, interpersonal relationships, and driving. Furthermore, hyperactive boys with conduct problems are at increased risk for adult criminality. A recent study showed that the prevalence of adult ADHD is 4.4% but that only 10.9% of the study sample had received treatment in the previous 12 months. Thus, considerable barriers appear to exist to the identification and treatment of a very common and highly impairing adult psychiatric illness. An informal internet survey reveled that only 8% of responders felt comfortable making a diagnosis of ADHD in adults. There is some controversy regarding diagnostic criteria. For instance, DSM IV may be too restrictive for adults because of its requirement to document impairment before age 7. Once the diagnosis is made, renewed concerns regarding stimulants' cardiovascular effects and abuse potential have called for more comprehensive risk/benefit assessments. This presentation will summarize adult ADHD symptomatology, available accepted diagnostic processes, and current treatment options with the goal of increasing the office based clinician's comfort with identifying and treating the condition.

NO 08B

CARDIOVASCULAR EFFECTS OF STIMULANTS--IS THERE CAUSE FOR CONCERN?

Donald E. Greydanus, MD (Professor, Pediatrics & Human Development, Michigan State University 1000 Oakland Drive, Kalamazoo, MI 49008-1284, Gabriel Kaplan MD

SUMMARY:

On February 9, 2006, the Drug Safety and Risk Management Advisory Committee of the FDA voted to place a black box warning regarding cardiovascular risks of stimulant medications for ADHD management. On April 22, 2008 the American Heart Association issued guidelines advising that patients taking stimulant medications should have an EKG screening before receiving a prescription for anti-ADHD medications. This session will consider current recommendations by various groups regarding a potential link between cardiovascular risks and stimulants in children, adolescents, and adults with ADHD who are placed on stimulant medication. What type of cardiovascular screening should be done? Should an EKG be performed on all patients before staring anti-ADHD medications? Should patients with heart disease be placed on these medications? Key points

in cardiovascular examination will be considered and guidelines provided for clinicians in this regard.

NO 08C

HOW DO I APPROACH THE BIPOLAR VS. ADHD ISSUE

Jeffrey H. Newcorn, M.D., Mount Sinai School of Medicine, Dept of Psychiatry, Box 1230, One Gustave L. Levy Place, New York, NY 10029

SUMMARY:

Attention Deficit Hyperactivity Disorder (ADHD) and Bipolar are frequently occurring (especially ADHD) and highly impairing conditions, and children and adolescents frequently present for evaluation with complaints of either or both disorders. Differential diagnosis can be challenging, due to the frequent co-occurrence and overlap of symptoms. Some reports suggest that as many as 15% of youth with ADHD have BPD; others state that the condition is relatively rare. Children and adolescents with ADHD + BPD are among the most challenging to diagnose and treat. Major unresolved issues are: 1) when is it possible to treat ADHD symptoms in youth with BPD; 2) which of the medication(s) for ADHD (i.e., stimulants; atomoxetine; other non-stimulants) is (are) least likely to aggravate mania; 3) when to use anti-psychotic and/ or mood stabilizing agents in children and adolescents; and 4) which one(s) to use once this decision has been made. This presentation will review current approaches to differential diagnosis, and discuss different approaches to treatment - with special focus on distinguishing the two conditions and providing treatment to the child with comorbidity. Key questions are how to prioritize treatments, and how and when to use combination treatments.

NO 08D

HOW DO I MANAGE THE ADHD/SUD COMORBIDITY?

Iliyan Ivanov, M.D., Assistant Professor, Mount Sinai School of Medicine, Dept of Psychiatry, One Gustave L. Levy Place, New York, NY 10029,

SUMMARY:

Childhood disruptive behavior disorders such as Attention Deficit/Hyperactivity Disorder (ADHD) and Conduct Disorder (CD) have been associated with elevated risk for the development of early-in-life Substance Abuse Disorders (SAD). Moreover, conduct problems in adolescence are also highly comorbid with addiction disorders. The symptom overlap between comorbid disruptive behavior disorders and substance abuse presents a particular challenge to clinicians, treating adolescents with these conditions. As some evidence suggest, therapeutic response to well validated biological treatments (e.g. stimulants) may differ between individuals with ADHD alone and ADHD+comorbid CD/SAD. Moreover, stimulant medications, which are approved as first line treatments for ADHD, also exhibit a considerable potential for abuse, misuse and diversion. Therefore, stimulants' abuse potential presents additional challenges to the treating psychiatrists in respect to proper monitoring of stimulant treatment and identifying early signs of potential abuse. In result, alternative strategies have been developed for the treatment of adolescents with ADHD/SAD comorbidity. This presentation will review the prevalence of adolescent ADHD/SAD comorbidity, the relationship between stimulant treatment and adolescent substance abuse and evidence supported treatment options that psychiatrist may consider for the management of these co-occurring disorders.

REFERENCES:

1) Biederman J, Spencer TJ, Wilens TE, Prince JB, Faraone SV. Treatment of ADHD with stimulant medications: response to Nissen perspective in the New England Journal of Medicine. J Am Acad Child Adolesc Psychiatry. 2006 Oct;45(10):1147-50

2) Mannuzza S, Klein RG, Truong NL, Moulton JL 3rd, Roizen ER, Howell KH, Castellanos FX. Age of methylphenidate treatment initiation in children with ADHD and later substance abuse: prospective follow-up into adulthood. Am J Psychiatry. 2008 May;165(5):604-9

3) Galanter CA, Leibenluft E. Frontiers between attention deficit hyperactivity disorder and bipolar disorder. Child Adolesc Psychiatr Clin N Am. 2008 Apr;17(2):325-46, viii-ix

4) Cumyn L, Kolar D, Keller A, Hechtman L. Current issues and trends in the diagnosis and treatment of adults with ADHD. Expert Rev Neurother. 2007 Oct;7(10):1375-90.

7:00PM- 9:00PM

INDUSTRY-SUPPORTED SYMPOSIUM 09

ANXIOUS DEPRESSION: DIAGNOSTIC AND TREATMENT ISSUES

SUPPORTED BY TAKEDA PHARMACEUTICALS

Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Differentiate anxious depression from major depression and appreciate the neurobiological and phenomenological differences between these subtypes; 2)Diagnose anxious depression in routine clinical practice; and 3)Develop treatment plans for patients with anxious depression that recognize the importance of psychotherapy in treatment and the typically less robust response to pharmacotherapy.

SUMMARY:

Anxious depression is a common subtype of depression in clinical practice. It is typically defined as an episode of major depressive disorder with either high levels of co-occurring anxiety symptoms or co-morbid anxiety disorder. In addition to this clinical phenomenology, recent investigations have unveiled significant associations between this subtype and specific genetic polymorphisms and/or specific patterns of brain circuitry activation. As a result of the STAR-D trial, we now know much more about the clinical course and treatment issues associated with this common subtype of mood disorder. From a therapeutic perspective, these patients generally have poorer outcomes than patients presenting with an episode of

major depression of comparable severity that is not accompanied by prominent anxiety symptoms. On average, monotherapy with antidepressants is relatively less efficacious in patients with anxious depression compared to those with uncomplicated major depression, and patients with anxious depression tend to report more side effects and to drop out from treatment more easily. For these reasons, various augmentation strategies are commonly employed in the management of these patients, despite the fact that empirical evidence for the efficacy and/or safety of some of these strategies is very limited. In light of these issues, the role of psychotherapy in the treatment of patients with anxious depression is especially important. Several forms of psychotherapy appear to be particularly helpful for patients with anxious depression, although more studies are clearly needed.This discussion of the most up-to-date information on the diagnosis and treatment of anxious depression will assist the clinician in managing this difficult-to-treat group of patients and suggest to clinical researchers those questions that most urgently require study.

NO 09A

HOW DO WE DEFINE ANXIOUS DEPRESSION?

John Zajecka, M.D., 1700 W. Van Buren 5th Floor, Chicago, IL 60612

SUMMARY:

There is a rapidly evolving paradigm shift in the diagnosis and management of mood disorders in order to achieve the expected rates of remission and recovery. Among the revisions that may have the greatest impact on long-term outcome, is the recognition and acceptance that concurrent depression and anxiety is highly prevalent and may require a refined approach to diagnosis, differential diagnosis, and assessing outcome in a depressed population.

NO 09B

NEUROBIOLOGY OF ANXIOUS DEPRESSION

Audrey R. Tyrka, M.D., 345 Blackstone Boulevard, Providence, RI 02906

SUMMARY:

Anxious depression, defined as major depressive episodes with prominent or comorbid anxiety, is an important clinical entity. Depressive and anxiety disorders frequently co-occur, and evidence from behavioral genetics studies indicates that anxiety and depression may represent manifestations of a unified disorder. Recent work suggests that depressive and anxiety disorders may have common neurobiological origins. Stress and trauma, as well as temperamental sensitivity to stress, precede the development of depressive and anxiety disorders. Several genes that regulate monoamine pathways or activity of the hypothalamic-pituitary-adrenal (HPA) axis have been associated with both major depression and some anxiety disorders. Recently, a number of studies have also identified genes that interact with environmental stress to produce risk for major depression and for anxiety-related traits. Neuroimaging and neuroendocrine studies further reveal abnormalities of neural and hormonal function in association with depression and anxiety, and with anxious depression specifically. This presentation will discuss these emerging findings in genetics, neuroimaging, and neuroendocrinology as they relate to the pathophysiology of this important clinical condition.

NO 09C

PHARMACOTHERAPEUTIC STRATEGIES IN THE TREATMENT OF ANXIOUS DEPRESSION

Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114

SUMMARY:

The presence of anxious depression has typically been associated with poorer treatment outcome compared to non-anxious depression. In fact, in most but not all studies, individuals with anxious depression were also found to be less likely to respond to antidepressant treatment than those without anxious depression, regardless of the type of antidepressant used. In addition, no significant differences in efficacy have typically been shown among antidepressants of the same or different class, with the exception of a pooled analysis showing significantly higher rates of remission with a serotonin norepinephrine reuptake inhibitor compared to a selective serotonin reuptake inhibitor. The association between anxious depression and poorer response to antidepressant treatment may account for the results of a recent study showing that the concomitant use of anxiolytics/hypnotics was a significant predictor of treatment resistance in older adults with depression. This presentation will review the various therapeutic strategies that clinicians use in the treatment of anxious depression, including monotherapy with antidepressants and augmentation and combination therapies. In particular, polypharmacy is used quite commonly to treat anxious depression. Although many of these treatments have not yet been approved for anxious depression, augmenting agents such as benzodiazepines, non-benzodiazepine hypnotics, anticonvulsants, atypical antipsychotics, and buspirone are common pharmacological options. This presentation will review the empirical evidence in support of these therapeutic interventions in anxious depression and will discuss their limitations.

NO 09D

PSYCHOTHERAPEUTIC APPROACHES TO ANXIOUS DEPRESSION

Amy Farabaugh, Ph.D., 50 staniford, Boston, MA 02114

SUMMARY:

Anxious depression, a subtype of depression, appears to be quite prevalent, is often challenging to treat, and likely represents a complex interplay of biological and psychosocial factors. The relationship between depression and anxiety is not well understood and there has been limited attention to the optimal use of psychosocial interventions, such as cognitive behavior therapy (CBT) for anxious depression. Although psychopharmacological treatments for anxious depression are effective, there are often high rates of non-remission and of subsequent relapse and recurrence. Premature discontinuation of medication by patients with anxious depression is also a

common clinical challenge. Moreover, antidepressants do not provide an individual with strategies and skills for coping with associated functional impairment. Quality of life impairments, such as underachievement, occupational and economic status issues, and relationship difficulties, appear to require skills training over and above medication management. Psychosocial interventions potentially offer the advantage of providing specific skill sets to individuals to help them address both anxiety and depressive symptoms, ideally increasing the likelihood that they will respond/remit with antidepressant treatment and decreasing their chances of relapse.

REFERENCES:

1) Farabaugh A, Fava M, Mischoulon D, Sklarsky K, Petersen T, Alpert J. Relationships between major depressive disorders and comorbid anxiety and personality disorders. Compr Psychiatry. 2005;46:266-71.

2) Ninan PT, Rush AJ, Crits-Christoph P, Kornstein SG, Manber R, Thase ME, et al. Symptomatic and syndromal anxiety in chronic forms of major depression: effect of nefazodone, cognitive behavioral analysis system of psychotherapy, and their combination. J Clin Psychiatry. 2002;63:434-41.

3) Perlis RH, Moorjani P, Fagerness J, Purcell S, Trivedi MH, Fava M, Rush AJ, Smoller JW. Pharmacogenetic analysis of genes implicated in rodent models of antidepressant response: association of TREK1 and treatment resistance in the STAR(*)D Study. Neuropsychopharmacology. 2008 Feb 20. {Epub ahead of print}.

4) Fava M, Rush AJ, Alpert JE, Balasubramani GK, Wisniewski SR, Carmin CN, Biggs MM, Zisook S, Leuchter A, Howland R, Warden D, Trivedi MH. Difference in treatment outcome in outpatients with anxious versus nonanxious depression: a STAR*D report. Am J Psychiatry. 2008;165:342-51.

TUESDAY, MAY 19, 2009

7:00AM-9:00AM

INDUSTRY SUPPORTED SYMPOSIUM 10

BIPOLAR DISORDER THROUGHOUT THE LIFE CYCLE: TREATMENTS AND TREATMENT EXPERIENCE

SUPPORTED BY PFIZER INC.

Joseph Calabrese, M.D. ,University Hospital of Cleveland, Department of Psychiatry,11100 Euclid Ave. Cleveland, OH 44106

EDUCATIONAL OBJECTIVES:

After this session, learners will be able to: Compare the risk of continuation or discontinuation of treatment among pregnant women with bipolar disorder; Review the clinically useful treatment guidelines that can be used in the care of children and adolescents with bipolar disorder; Discuss treatment and treatment experience of geriatric patients receiving medication for bipolar disorder; Describe the metabolic side effects of traditional mood stabilizers and novel psychotropic agents.

SUMMARY:

Bipolar disorder is a highly recurrent illness that requires mood stabilization both from below baseline as well as above baseline, but evidence suggests that the depressed phase predominates the symptomatic lives of most patients. The management of bipolar disorder poses a wide range of challenges in pregnant women, children, adults, and geriatric patients.Pregnancy and breastfeeding constitute special challenges in the treatment of bipolar disorder due to the teratogenicity of mood stabilizers and the antipsychotics. Risk to the fetus must be weighed against the risk inherent in manic and depressive episodes during pregnancy. In contrast to adults, children and adolescents more often present manic or mixed, not depressed. There are efficacy and safety issues unique to treatment for this patient population. In elderly bipolar disorder patients, however, there is limited age-specific evidence that can contribute to rational treatment approaches. Illness severity, high mortality, vulnerability to side effects, and relapse recurrence are other important issues for this age group. In addition, side effects such as weight gain, metabolic problems including Type 2 diabetes mellitus, changes in lipid levels, and transaminase elevation pose a challenge not only in adults but among children and adolescents. The symposium will meet the need of clinical psychiatrists in elucidating the treatment options in all categories of patients ranging from children, adults, geriatric patients and women during pregnancy. Bipolar disorders are lifelong disorders which typically result in lifelong disability. Optimal treatment for the broad spectrum of patients and alleviation of side effects can have a major impact on disease management and long-term outcomes.

NO 10A

UNDERSTANDING THE CHALLENGES OF REPRODUCTIVE MENTAL HEALTH: PREGNANCY AND LACTATION

Adele Viguera M.D., M.P.H. ,9500 Euclid Avenue, Desk P57. Cleveland, OH 44195

SUMMARY:

Substantial gaps remain in our knowledge of the course, risk factors, and treatment effects among women with bipolar disorder during pregnancy. Some studies suggest that pregnancy may be protective against risk of recurrence. More recent reports quantify risk of recurrence associated with mood-stabilizer discontinuation during pregnancy, noting that continuation treatment is associated with a two-fold reduction in risk of depression. Recent treatment guidelines for the management of bipolar disorder have noted that no specific controlled treatment trials in pregnancy have been conducted, but that treatment appeared to be of value in pregnancy and was associated with variable teratogenicity. Postpartum, the mother with bipolar disorder experiences a markedly increased risk of depression. Most mood stabilizers and atypical antipsychotics are found in low levels in the nursing infant and do not appear to have an adverse effect on the well-being of the child. However, investigators caution that breastfeeding while receiving mood stabilizers is only appropriate for a highly selected group. The safety of treatment for bipolar disorder during pregnancy and lactation can be improved with close clinical monitoring, pre-pregnancy treatment planning, and careful consideration of the risks and benefits associated with pursuing or deferring treatment.

NO 10B

TREATMENTS AND TREATMENT EXPERIENCE: FROM ADULT TO LATE LIFE

Martha Sajatovic M.D., University Hospitals Case Medical Center, 11100 Euclid Avenue, Cleveland, Ohio 44106

SUMMARY:

Until relatively recently, research on treatments for older adults with bipolar disorder has received little attention, despite the complexity of needs for this particularly vulnerable population. Lithium, anticonvulsant compounds, and atypical antipsychotic medications are effective and widely utilized pharmacologic treatments in mixed age populations with bipolar disorder. However, data specific to geriatric bipolar populations are quite limited. Older adults are especially vulnerable to adverse drug effects as a result of their multiple chronic diseases, use of multiple concomitant medications, and the pharmacokinetic and pharmacodynamic changes that accompany aging. Tolerability concerns with foundational treatments for geriatric patients with bipolar differ from younger populations, and drug titration and targeted maximum doses are likely to require modification. Secondary analyses from mixed-age population databases have suggested a beneficial role in older adults for lithium, lamotrigine, quetiapine, and olanzapine. Preliminary data are encouraging for the atypical antipsychotic aripiprazole. However, larger and controlled trials are needed to validate the findings from smaller sample analyses. Subjective experience with medication treatments may affect illness outcomes among populations with bipolar disorder. Studies that focus on the personal experience of the individual, such as qualitative analyses, may expand our understanding of perceived treatment effects, concerns and hopes/expectations for medication treatment among populations with bipolar illness. While individuals with bipolar disorder appreciate the mood-stabilizing effects of medications, concerns regarding long-term adverse effects and discrepancy between actual effects of medications and hoped for outcomes can be substantial. Subjective experience with medications should be explored in order to optimize treatment collaboration and outcomes.

NO 10C

MANAGEMENT OF METABOLIC SYNDROME ACROSS THE LIFE CYCLE IN BIPOLAR DISORDER

David Kemp, M.D.

Bipolar disorder and cardiometabolic illnesses share biological underpinnings of early developmental origin. Metabolic adaptations to adverse intrauterine environments may increase the risk of developing insulin resistance and cardiovascular disease in adulthood. Poor metabolic health among patients with bipolar disorder is reflected by an increase in deaths from natural causes, including a life expectancy that is more than 20 years shorter compared with the general population. The relationship between mood disorders and metabolic dysregulation appears bidirectional, as negative health behaviors linked to depression result in metabolic abnormalities, while metabolic syndrome and Type 2 diabetes independently increase the risk of developing depressive symptoms. Accumulating evidence substantiates the contribution of mood stabilizing medications to the elevated rates of obesity, metabolic syndrome, and dyslipidemia observed in bipolar disorder. Despite its pragmatic importance, monitoring of metabolic abnormalities remains inadequate, and clinicians may underestimate the risk associated with psychotropic medication during maintenance phase treatment. Atypical antipsychotics also present unique challenges when used across the life cycle, including in utero adverse effects on infant birth weight and greater propensity for weight gain when used in children and adolescents. This presentation will review the epidemiology, overlapping pathophysiology, and treatment of cardiometabolic risk across the life cycle of patients with bipolar disorders.

REFERENCES:

1) Ketter TA, Calabrese JR: Stabilization of mood from below versus above baseline in bipolar disorder: A new nomenclature. J Clin Psychiatry. 2002 Feb;63(2):146-151.

2) ACOG Practice Bulletin No. 87 November 2007: Use of psychiatric medications during pregnancy and lactation. Obstet Gynecol. 2007;110:1179–1198.

3) Kowatch RA, Fristad M, Birmaher B, Wagner KD, Findling RL, Hellander M; Child Psychiatric Workgroup on Bipolar Disorder. Treatment guidelines for children and adolescents with bipolar disorder. J Am Acad Child Adolesc Psychiatry. 2005 Mar;44(3):213-235.

4) Young RC. Evidence-based pharmacological treatment of geriatric bipolar disorder. Psychiatr Clin North Am. 2005;28(4):837-69.

7:00PM- 9:00PM

INDUSTRY-SUPPORTED SYMPOSIUM 11

NOVEL APPROACHES TO ASSESSING AND TREATING DEPRESSION IN THE MEDICALLY ILL

SUPPORTED BY LILLY USA LLC

Bradley N. Gaynes, M.D., CB # 7160, School of Medicine, Chapel Hill, NC 27599-7160

EDUCATIONAL OBJECTIVES:

Identify evidence-based strategies for diagnosing depression in medically-ill populations, Recognize the emerging evidence supporting the role of cytokines and the inflammatory response in the development of depressive illness,and Distinguish clinical trial evidence (both pharmacologic and non-pharmacologic) that best manages depression in the medically-ill population, including those patients who are defined as treatment resistant

SUMMARY:

Half of patients with major depressive disorder (MDD) have a coexisting medical illness. Comorbidities are a red flag for worse clinical outcomes, including a slower response to treatment, greater chance of treatment resistance, and higher risk of relapse following successful treatment. Recent research has improved our understanding of how best to diagnose and manage depressed, medically-ill patients. A key first step is the successful identification of depressive illness in the medically-ill patient. Dr. Simon will review evidence-based strategies to identify MDD and monitor treatment response in this challenging population with a

focus on particularly relevant medical illnesses such as diabetes. Emerging evidence supports the role of cytokines and the inflammatory response in the development of depressive illness. Dr Trinh will review the results of these and other pathophysiologic mechanisms to provide an up-to-date understanding of the biologic underpinnings of the MDD/medical illness comorbidity. Consideration of risk factors for worse outcomes can guide MDD treatment in the medically ill. Dr Gaynes will review available clinical trial evidence and address how best to manage depression in this population, including considerations of both newer pharmacotherapies and non-pharmacologic treatments. Finally, given the greater risk of a failure to remit in this group, strategies to address treatment resistant depression (TRD) are crucial. Dr Fava will review recommendations to address patients with TRD, including recommendations from STAR*D and the use of newer pharamacotherapies.

NO 11A

ASSESSING MOOD AND SOMATIC SYMPTOMS IN THE MEDICALLY-ILL, DEPRESSED PATIENT

Simon Gregory, M.D., 1730 Minor Ave, Seattle, WA 96101

SUMMARY:

Prevalence of depressive illness is significantly elevated in people with chronic medical conditions and is associated with numerous adverse effects including poorer medical prognosis, more severe pain and somatic symptoms, increased disability, and increased mortality. Several misconceptions have hampered recognition and effective treatment, namely that depression is an inevitable consequence of chronic illness; depressive symptoms in medical patients often reflect medical "mimics" of depression; standard depression diagnostic criteria or symptom measures are not valid or accurate in people with chronic medical illness; and disability and functional impairment are determined by severity of medical illness rather than by depression. These misconceptions often reflect traditional prejudices regarding psychiatric illness, and they are not supported by empirical evidence. Misdiagnosis of medical illness such as depression is much less common than the converse. Even in patients with serious chronic medical conditions, physical symptoms attributed to medical illness are often more closely tied to depression. Standard diagnostic criteria and measures for depression appear just as valid in medically-ill patients as in the general adult population. Somatic symptoms that are typically considered indicators of depression (i.e., fatigue, changes in weight or appetite, or psychomotor changes) should not be discounted in people with chronic medical illness. Improvement in depression leads to corresponding improvements in disability and daily functioning, even when medical illness does not improve. Data from several large observational studies of depression in chronic medical illness will be reviewed to evaluate this evidence.

NO 11B

PATHOPHYSIOLOGY OF SOMATIC SYMPTOMS AND MEDICAL ILLNESS IN MAJOR DEPRESSIVE DISORDER

Janet M Witte, M.D., 7 Whitman Street, Somerville, MA 02144

SUMMARY:

Emerging evidence supports the role of cytokines and the inflammatory response in the development of major depressive disorder (MDD). Not only does the brain contain immune cells, these cells can respond to inflammatory stimuli by producing proinflammatory cytokines. In addition, both neuronal and nonneuronal brain cells express receptors for these mediators. Studies in animals have demonstrated that acute activation of proinflammatory cytokine signaling in the brain is associated with withdrawal from their physical and social environment, including decreased motor activity, social withdrawal, reduced food and water intake, increased slow-wave sleep, and altered cognition—deficits similar to depressive symptoms. In humans, major depressive disorders develop in roughly one-third of patients treated by recombinant human cytokines IL-2 and interferon alfa; MDDs are more prevalent in patients afflicted with conditions leading to chronic inflammation (cardiovascular diseases, type 2 diabetes, and rheumatoid arthritis) than in the general population. Although depression is a known risk factor for mortality in cardiovascular disease, prior explanations stressed the impact of depressive symptoms on adherence to treatment. A growing understanding of the role of inflammation has major implications for the treatment of major depression: biomarkers of inflammation may become intermediate measures of response to treatment of depression, and drugs targeting inflammatory mediators may open the way to new pathways to treat depressive symptoms. This presentation will review the pathophysiologic mechanisms to provide an up-to-date understanding of the biologic underpinnings of the MDD/medical illness comorbidity.

NO 11C

AN EVIDENCE-BASED GUIDE FOR TREATING DEPRESSION IN THE MEDICALLY ILL

Bradley N. Gaynes, M.D., CB # 7160, School of Medicine, Chapel Hill, NC 27599-7160

SUMMARY:

Depressed patients with comorbid medical disorders have increased morbidity and greater functional impairment, and, additionally, medical comorbidities are a risk factor for treatment resistance in major depressive disorder (MDD). When treating MDD, knowledge of comorbidities may be used to guide initial treatment decisions. Dr Gaynes will first review the current evidence regarding the impact of specific medical illnesses including cardiac disease, stroke, HIV/AIDS, and diabetes on depression outcome with attention to associated changes in efficacy. A growing body of data has begun to address whether medical comorbidities may inform the selection of the intervention for treatment of depression. Accordingly, Dr Gaynes will review the evidence for both pharmacologic and nonpharmacologic treatments in this at-risk population with consideration to the role of medical and psychiatric collaborative care. His discussion will involve available evidence that directly compares the effectiveness of specific treatments. Dr Gaynes will conclude by reviewing available evidence addressing the role of newer treatments, both pharmacologic and non-pharmacologic, for patients with MDD and comorbid medical disease.

NO 11D

MANAGEMENT OF TREATMENT-RESISTANT PATIENTS WITH SOMATIC SYMPTOMS AND MEDICAL ILLNESS

Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114

SUMMARY:

Treatment resistance in depression is quite common in "real world" clinical practice and tends to be associated with a greater degree of medical comorbidity, as suggested by findings from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. In addition, a pilot study from our group on the prevalence of somatic symptoms in patients with treatment-resistant depression (TRD) showed that 95% of patients with TRD reported at least 1 somatic symptom. The pilot study also found that high levels of somatic symptoms found during the screening visit predicted poorer response to treatment with the tricyclic antidepressant nortriptyline. These studies, therefore, suggest the need to use perhaps even more aggressive treatment strategies in the presence of treatment resistance associated with medical comorbidities and/or somatic symptoms. On the other hand, it is unclear what should be the appropriate next-step treatment approach for these patients. Many clinicians favor treatments that match side effects with symptom profiles, but the empirical evidence in support of this approach is lacking. This presentation will review the pertinent studies in the literature and will discuss their clinical implications.

REFERENCES:

1) Ludman EJ, Katon W, Russo J, et al. Depression and diabetes symptom burden. Gen Hosp Psychiatry. 2004;26(6):430-436.

2) Simon GE, Von Korff M, Lin E. Clinical and functional outcomes of depression treatment in patients with and without chronic medical illness. Psychol Med. 2005;35(2):271-279.

3) Thase ME et al. Am J Psychiatry. 2007;164:739

4) Rush AJ et al. N Engl J Med. 2006;354:1231; Trivedi MH et al. N Engl J Med. 2006;354:1243

MONDAY, MAY 18, 2009

11:00AM-12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 01 FORENSIC PSYCHIATRY

No.1
DIFFERENCES BETWEEN MEN AND WOMEN FOUND NOT GUILTY BY REASON OF INSANITY FOR HOMICIDE OFFENSES AT NAPA STATE HOSPITAL

Jessica Ferranti, M.D., 2230 Stockton Blvd., Sacramento, CA 95817
Mohamed A. Al-Zahrani, Ph.D., Mahmoud Rashad, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe three differences identified in female homicide offenders compared to male homicide offenders; 2) Describe three differences in the criminal characteristics identified in female homicide offenders compared to male homicide offenders; and 3) What is the McNaughten test for insanity?

SUMMARY:

This study examines the differences between men and women found not guilty by reason of insanity for homicide offenses. Until very recently, there has been very little information regarding female criminality in general and even less regarding women who commit murder. Female homicide offenders who have been found Not Guilty by Reason of Insanity comprise a very small population and as a result, there is very little research on this subgroup. Few studies have provided an exhaustive comparison of male and female insanity acquittees. Specifically, this study will include all women found Not Guilty by Reason of Insanity who were hospitalized at Napa State Hospital in California at any time between January 1991 thru August of 2005 (n= 45). A random sample of 45 men committed during that same time period for the same offenses was selected for comparison purposes to examine differences between genders. Areas of interest are psychosocial and crime characteristic variables including: age, gender, ethnicity, education level, marital status, Axis I and II diagnoses, psychiatric symptoms, history of violence, substance use, abuse history and criminal history. There is a body of literature regarding psychosocial characteristics of women homicide offenders but few studies that investigate crime characteristics such as the relationship of the perpetrator to the victim, method, and type of weapon used to commit the crime. We are currently undergoing extensive evaluation of the Napa State Hospital database as well as a careful review of medical records for collection of additional data. Results are pending analysis. Unlike many other studies that focus on insanity acquittees in general, this study is unique in its focus exclusively on homicide offenders found not guilty by reason of insanity with a larger sample size than in previous studies and will provide more detail about criminal characteristic variables.

REFERENCES:

1) Brownstein, H., Spunt, B., Crimmins, S., Goldstein, P., & Langley, S (1994). Changing patterns of lethal violence by women: A research note. Women & Criminal Justice, 5 99-118.
2) Putkonen, H., Komulainen, E., Virkkunen, M., Eronen, M., Lonnqvist (2003). Risk of repeat offending among violent female offenders with psychotic and personality disorders. Am J Psychiatry, 160, 947-951.

No. 2
HOMICIDE DURING THE FIRST EPISODE OF PSYCHOTIC ILLNESS

Olav Nielssen, M.B.B.S, 299 Forbes St, Darlinghurst, 2010 Australia, Large, M.M., BSc, M.B.B.S., FRANZCP

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that the risk of homicide and other serious violence is greatest during the first episode of psychotic illness, prior to initial treatment.

SUMMARY:

It has previously been believed that homicide is associated with chronic mental illness and that homicides by those with schizophrenia occur at a rate of about one per 3000 patients per annum. We present data from a study of homicides during psychotic illness in NSW, Australia, which shows that more than half of the homicides were committed in the first episode, before initial treatment. We show similar findings in studies performed in other countries. We also present the results of a study comparing the proportion of homicides during the first episode of illness and the duration of untreated psychosis (DUP), which shows that the proportion of homicides by first episode patients is higher in countries with longer DUP.

REFERENCES:

1) Nielssen OB, Westmore BD, Large MM, Hayes RA. Homicide during psychotic illness in New South Wales between 1993 and 2002. Medical Journal of Australia 2007; 186:301-304

2) Large M, Nielssen O. The relationship between the duration of untreated psychosis and homicide in the first episode of psychosis. Social Psychiatry and Psychiatric Epidemiology 2008; 43 (1):37-42

No. 3
CHARACTERISTICS OF MENTALLY ILL OFFENDERS FROM 100 PSYCHIATRIC COURT REPORTS

Yasser Elsayed, M.D., M.S., Institute of Psychiatry , Faculty of medicine, Ain Shams UniversityAbbasia, Cairo, Egypt, CAIRO, AIN, Barbara E. McDermott, Ph.D., Cameron Quanbeck, M.D., Andreea Seritan, M.D., Charles Scott, M.D. SHAMS UNIVERSITY Egypt

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to :1) Recognize the importance and the main priniciples of psychiatric court report; 2) Identify the demographic and clinical characteristics of mentally ill offenders; and 3) Know the main obstcales facing psychitrists during assessment of criminal responsibility of offenders.

SUMMARY:

There is an increasing probability that the psychiatrist will, willingly or not, come into contact with mentally ill offenders in the course of practice. Hypothesis and Aim of the work: The growth of economy of the Arab Gulf Countries at the last decades was associated with growth of all systems needed to support this econ-

omy including mental health and Justice systems. So, what about the process of legal accountability in this region? The aims of this work were to investigate the rates of different mental disorders in 100 court report and to know the characteristics of mentally ill offenders and a lot of other study questions were also addressed. Subjects and Methods: All cases referred from different departments of the legal system to the forensic committee for assessment of criminal responsibility during 13 month duration were included. A specially designed form was done for data collection and included demographic charcateristics, clinical variables and details of the crimes and investigations. Results: Men constitute 93% of cases. Offenders who were younger than 40 years were 73%. Schizophrenic cases were 13%, substance related cases constitute 56% and amphetamine alone were 21% of cases, 8% were bipolar manic, 4% were major depressive disorders, 10% were antisocial personality disorder, 51% of cases were classified as having low education. Unemployment was found in 34% of cases. The final decision of the forensic committee was full responsibility in 46% of cases and partial responsibility in 11% of cases and 33% were irresponsible. 58% of cases had a contact with psychiatric health care prior to the offence and in 9% of cases contact was in the previous 12 weeks. History of similar offence was found in 32% of cases. 14% of offences were murder, 8% were sexual crimes, and 31% were violence and Simple crimes. Discussion and Conclusion: the ability of the legal system to detect cases was good as only 10% were free from mental illness. The ability of the health care system to predict crimes and offences was weak as 58% of cases had previous contact with health care system before the crime. Substance abuse especailly amphetamine played an important role. More research is needed to further our understanding of the association between mental disorders and antisocial behavior.

REFERENCES:

1) Freeman, R. J. and Roesch, R. : Mental disorder and the criminal justice system: a review. International Journal of Law and Psychiatry 12:105-115, 1989.

2) Sirotich Frank: Correlates of Crime and Violence among Persons with Mental Disorder: An Evidence-Based Review . Brief Treatment and Crisis Intervention 2008 8(2):171-194.

SCIENTIFIC AND CLINICAL REPORT SESSION 02- MEASUREMENT OF PERSONALITY DISORDER SEVERITY

No. 4
THE SEVERITY INDICES OF PERSONALITY PROBLEMS (SIPP-118) AS A CLINICAL INSTRUMENT

Dineke Feenstra, M.A., P.O. Box 7, Halsteren, 4660 AA Netherlands
Roel Verheul, Ph.D., Espen Arnevik, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the Severity Indices of Personality Problems (SIPP) as a promising new self-report questionnaire for the measurement of (mal)adaptive personality functioning in daily clinical practice. Following from the presentation of several diagnostic case studies, the participant learns that the SIPP can be a useful assessment tool in the assessment procedure of personality pathology.

SUMMARY:

Objective: The Severity Indices of Personality Problems (SIPP-118) is a new self-report questionnaire focusing on the core components of (mal)adaptive personality functioning. The SIPP consists of 16 facets (subscales), which are clustered into 5 higher order domains: self-control, identity integration, relational capacities, social concordance and responsibility. These five domains represent core components of (mal)adaptive personality functioning. The SIPP was developed and tested in clinical and non-clinical adult and adolescent populations. This presentation focuses on the diagnostic qualities of the SIPP among patients samples.

Method: The diagnostic value of the SIPP will be illustrated with different case studies among adults and adolescent patients who were assessed during the intake procedure of a treatment centre offering psychotherapy for personality disorders. We will show, with axis I and axis II case studies, how the SIPP can be useful as an assessment tool, as well as how the SIPP can give useful information in a treatment selection procedure.

Results: Combined with (semi-)structured interviews that provide information about axis-I or axis-II diagnoses (e.g. SCID I and/or SCID II) and general personality questionnaires (e.g. NEO-PI-R), the SIPP provides additional information not only about level of maladaptive personality functioning, but also about on which personality domains more adaptive levels of functioning (i.e. indicators of personal strengths) are still present.

Conclusions: The SIPP is a promising dimensional assessment tool for both adults and adolescents with personality pathology. The possibility to SIPP domain-scores on a continuum of maladaptive-adaptive functioning illustrate the potential of the SIPP as a useful instrument in treatment selection procedures.

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No. 5
SEVERITY INDICES OF PERSONALITY PROBLEMS (SIPP-118) IN ADOLESCENTS: FACTOR STRUCTURE AND VALIDITY

Joost Hutsebaut, Ph.D., De Beeklaan 2, Halsteren, 4661 EP Netherlands, Dineke Feenstra, M.A

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to know that the SIPP-118 is a useful dimensional outcome instrument to measure the core components of (mal)adaptive personality functioning in adolescents.

SUMMARY:

Objectives: The Severity Indices of Personality Problems (SIPP-118) is a self-report questionnaire focusing on the core components of (mal)adaptive personality functioning. The SIPP was developed and tested in an adult population. Among adult patients, the 16 facets of the SIPP fit well into 5 higher order domains: self-control, identity integration, relational capacities, social concordance and responsibility. The aim of this presentation is to show psychometric results of the SIPP in different samples of adolescents.

Method: The five-factor model of the SIPP was tested through Confirmatory Factor Analysis in a clinical (n=284) and non-clinical (n=406) sample of adolescents. Validity was tested by comparing SIPP-scores in both samples and between personality disordered and non-personality disordered adolescents (tested by SCID-II). We also correlated the SIPP with other instruments measuring personality pathology (DAPP-BQ and DEQ-A).

Results: The factor structure could be replicated in the adolescent sample, although a structure with four factors would better fit our data. The SIPP appears to have good validity: more pathological SIPP-scores were found in the clinical sample and more specifically in the sample of personality disordered adolescents. SIPP-scores correlated as expected with related questionnaires. Discussion: The SIPP is promising as a questionnaire for the measurement of (mal)adaptive personality functioning in adolescents. It is however not yet clear whether the current five-factor structure also provides the best fit for adolescents. Therefore, further research comparing different models is needed.

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No. 6

THE SEVERITY INDICICES OF PERSONALITY PROBLEMS - A NEW DIMENSIONAL QUESTIONNAIRE FOR MEASURING (MAL) ADAPTIVE PERSONALITY FUNCTIONING

Helene Andrea, Ph.D. De Beeklaan 2, Halsteren, 4708 EX Netherlands, Helene Andrea, Ph.D., Joost Hutsebaut, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to identify the SIPP as a promising new self-report questionnaire for the measurement of (mal)adaptive personality functioning. The participant should in particular be able to recognize the discriminant and convergent validity of the SIPP in comparison to well-established instruments, together with the a good sensitivity to change.

SUMMARY:

Objective: Instruments for the measurement of the severity of personality pathology are scarce. Furthermore, clinicians and researchers are still in need of valid instruments for the measurement of structural changes in personality functioning as a result of psychotherapeutic interventions.

This presentation reports the validity and sensitivity to change of a new dimensional self-report questionnaire developed to measure core components of (mal)adaptive personality functioning, the Severity Indices for Personality Problems (SIPP), encompassing five higher-order domains (self-control, identity integration, relational capacities, social concordance and responsibility). The SIPP has already been translated in six languages.

Method: The SIPP was administered to adult patients with personality disorders (PDs) from the Netherlands and Norway (total n>2000), and to individuals from the Dutch general population (n=478).

Measures for symptomatic distress and/or personality functioning were also available in the form of scores on the SCL (Symptom Checklist), DAPP (Dimensional Assessment for Personality Pathology), NEO-PI-R (NEO Personality Inventory-Revised), or CIP (Circumplex of Interpersonal Problems), depending on the study sample. Among n=800 Dutch PD patients, a shortened form of the SIPP was administered before, during and after psychotherapeutic treatment.

Results: SIPP-scores were associated with, but also partly independent from symptomatic distress measures. Discriminant validity was also found with respect to other personality functioning measures. Longitudinal analyses showed that PD patients were less likely to report maladaptive personality functioning during and after psychotherapeutic treatment, and this change was only moderately associated with symptomatic improvement.

Conclusions: The SIPP provides a set of five valid dimensional indices of core components of (mal)adaptive personality functioning, with a focus on changeable (mal)adaptive capacities.

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1) Verheul R, Andrea H, Berghout CC, Dolan C, Busschbach JJV, Kroft PJA van der, Bateman AW, Fonagy P: Severity Indices of Personality Problems (SIPP-118): development, factor structure, reliability, and validity. Psychol Assess 2008; 20: 23-34.

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SCIENTIFIC AND CLINICAL REPORT SESSION 03 GENETIC, NEUROIMAGING, AND NEUROPSYCHOLOGICAL STUDIES IN SCHIZOPHRENIA

No. 7

DOES ABERRANT STIMULUS SALIENCE LEAD TO PSYCHOSIS IN SCHIZOPHRENIA?: A 20-YEAR LONGITUDINAL STUDY

Martin Harrow, Ph.D., 1601 West Taylor Street, M/C 912, Chicago, IL 60612, Thomas H. Jobe, M.D., Linda S. Grossman, Ph.D., Cherise Rosen, Ph.D., Robert Faull, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will have knowledge of new data bearing on recent theories of stimulus

"salience" in schizophrenia. This theory posits that the basis of psychosis in schizophrenia is a dysregulated hyperdopaminergic state leading patients to assign aberrant "salience" or importance to environmental events and internal representations. They also will know newer views on how antipsychotic medications permit the resolution of psychotic symptoms.

SUMMARY:

Objective: A prominent theory by S. Kapur proposes that psychosis results from a dopamine-mediated state of aberrant salience. Kapur notes that a central role of dopamine is to mediate the "salience" of environmental events and internal representations. This theory of aberrant stimulus salience involves a deregulated dopamine system that fires and releases dopamine independent of cue and context. The current longitudinal, 20-year, research assessed this theory by studying the link in schizophrenia between aberrant stimulus salience and prolonged periods of psychosis.

Method: We assessed 96 patients (including 51 schizophrenia patients) from the Chicago Followup Study at index hospitalization and then followed them up 6 times over the next 20 years. We employed standardized research instruments to assess aberrant stimulus salience, positive and negative symptoms, psychosocial functioning, rehospitalization, global outcome, recovery, and medication treatment at each of the 6 follwoups.

Results: 1) Aberrant stimulus salience is not unique to patients with schizophrenia, nor is it unique to psychotic patients. 2) However, the data indicate a strong link between aberrant stimulus salience and psychosis. Schizophrenia patients with aberrant stimulus salience had more frequently recurring psychosis over a 20 year period ($p<.01$). 3) Schizophrenia patients vary in their vulnerability to aberrant stimulus salience.

4) Other types of psychotic patients (e.g., psychotic bipolar patients) also show a significant relationship between aberrant stimulus salience and frequent psychosis ($p<.05$).

Conclusions: The current longitudinal data support major aspects of theories about dopamine-mediated states of aberrant stimulus salience as one prominent factor involved in psychosis. However, our data indicate that other factors (e.g., trait anxiety, premorbid developmental achievements, prognostic factors) also contribute to vulnerability to psychosis in schizophrenia.

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No. 8

ASSOCIATION OF G-1438A POLYMORPHISM OF 5HT2A RECEPTOR WITH SCHIZOPHRENIA IN THREE ETHNIC GROUPS IN MALAYSIA

Zahurin Mohamed, B.S.C., Ph.D., Dept of Pharmacology, Faculty of Medicine, University of Malaya, Kuala Lumpur, 60000 Malaysia Vijaya Lechimi Raj, M.Sc., Shamsul Bin Mohd Zain, B.Sc., Tiong Chea Ping, M.B.B.S., Nor Zuraida Zainal, M.Psy.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to appreciate the role of single nucleotide polymorphisms of serotonin 2A receptors in the aetiology of schizophrenia and the implications of ethnicity on genetic presentation of schizophrenia.

SUMMARY:

Schizophrenia is the fourth leading cause of disability in the world. The 5HT2A receptor gene has been shown to contribute to the pathogenesis of schizophrenia. Research has shown that there are many single nucleotide polymorphisms (SNPs) in the 5HT2A receptor. The G-1438A polymorphism of the 5HT2A receptor lies just upstream of the promoter region and may affect expression of the gene by altering promoter function. Identification of genes involved in schizophrenia will give a better understanding of the condition and has the potential to improve therapeutic outcomes in schizophrenia patients. Patients who fulfilled DSM-IV criteria were recruited from the University Malaya Medical Centre Psychiatric Clinic. A total of 224 patients (63 Malays, 99 Chinese and 62 Indians) and 285 controls (115 Malays, 95 Chinese and 75 Indians) were recruited. Blood samples were taken for DNA extraction. Genotyping was done by Polymerase Chain Reaction-Restriction Fragment Length Polymorphism assay. Chi-square test was used for statistical analysis. The results of the study showed that allelic frequencies were significantly ($p<0.001$) different between controls and patients. The A allele had 2.083 times (95% CI: 1.480 to 2.931) higher risk for schizophrenia. The allelic frequencies between Indian controls and patients were similar whereas for the Malays and Chinese, there was a significant difference ($p=0.001$). The genotype frequencies (GG, GA and AA) between controls and patients were significantly ($p<0.001$) different prior to stratification of the ethnic groups. When the GG and AA genotypes were compared, the odds ratio indicated that AA had 3.716 (95% CI: 1.665 to 8.289) times higher risk for schizophrenia. The genotype frequencies between ethnic groups showed a significant difference ($p<0.05$) between controls and patients for Malays and Chinese but not for the Indians. This indicate that this gene did not have an association with schizophrenia among the Indian population but may play a role in Malays and Chinese. In conclusion, there is an association between the G-1438A polymorphism of the 5HT2A receptor and the occurrence of schizophrenia .

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1) Herken H, Erdal ME, Esgi K, Virit O, Aynacioglu AS: The Relationship Between the Response to Risperidone Treatment and 5-HT2A Receptor Gene (T102C and 1438G/A) Polymorphism in Schizophrenia . Bull Clin Psychopharmacol 2003; 13:131-66.

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No. 9

MEG ANALYSIS OF EARLY PROCESSING OF FACIAL EXPRESSIONS IN SCHIZOPHRENIA AND CONTROLS

Stephen Lewis, M.D., 5015 Royene Ave. NE, Albuquerque, NM 87110 Billy J. Jimenez, BA, Garrett W. Hosack, Mitchell R. Tyler, B.S.,

Minxiong Huang, Ph.D, Jose M. Canive, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Identify key components of the system that recognizes facial expressions of emotion; 2) Describe the early divergence in processing patterns between subjects with schizophrenia and a control subjects; and 3) Discuss how the results of this study compare with results that might be predicted by current models of visual recognition of facial expressions.

SUMMARY:

People diagnosed with schizophrenia have been shown to have deficits in social cognition, and these deficits are related to impairments in social function and quality of life. Although a broad range of hypotheses have been generated about the origins of these deficits, the mechanisms of social perception in both the general population and in schizophrenia remain speculative. We report new findings of divergence between control and schizophrenia populations in early stages of visual processing of facial expressions of emotion.

We studied the early (<200ms) processing of facial expressions of emotion in the ventral temporal lobe with magneto-encephalography (MEG). Subjects were presented facial and control stimuli, including photographs of faces with both neutral expressions and unambiguous expressions of basic emotions, with instruction to attend to a distracting stimulus. We found responses consistent with the established finding that processing of stimuli with facial expressions is lateralized in the control population, with significantly greater activation of the right fusiform gyrus (FFG) than the left FFG cortex. In contrast, the subjects with schizophrenia had no significant lateralization of this process. Further, we were able to localize anatomically distinct patterns of cortical activation in the FF G for different emotions, and these patterns varied between the two populations. This is to our knowledge a unique finding.

Support for our results in the current literature is reviewed, and the significance of these findings for the understanding of social perception in the general population and in schizophrenia is discussed. This discussion includes difficulties reconciling these and other recent findings with existing models of the visual processing of facial expressions.

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1) Lopez-Ibor JJ, Lopez-Ibor MI, Mendez MA, Moron, MD, Ortiz-Teran L, Fernandez A, Diaz-Marsa M, Ortiz T: The perception of emotion-free faces in schizophrenia: a magneto-encephalography study. Schizophr Res 2008; 98:278-286

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SCIENTIFIC AND CLINICAL REPORT SESSION 04

ADJUNCTIVE TREATMENT AND COMORBIDITY IN SCHIZOPHRENIA

No. 10

EFFECTS OF ADJUNCTIVE TREATMENT WITH ARMODAFINIL IN SCHIZOPHRENIA

*Ashwin A. Patkar, M.D., 2218 Elder Street, Suite 127, Durham, NC 27705, John M. Kane, M.D., Richard S.E. Keefe, Ph.D., James M. Youakim, M.D., Jane Tiller, F.R.C.Psych., Ronghua Yang, Ph.D., Deepak C. D'Souza, M.D.***EDUCATIONAL OBJECTIVES:**

At the conclusion of this session, the participant should be able to evaluate and discuss the tolerability of adjunctive armodafinil 200 mg/d and its potentially clinically relevant effects on the negative symptoms of schizophrenia and its effects on positive symptoms and cognition.

SUMMARY:

Objectives: Armodafinil, the R-enantiomer of modafinil, has been shown to improve wakefulness, memory, and attention in patients with excessive sleepiness associated with obstructive sleep apnea, shift work disorder, and narcolepsy. This 4-week, double-blind, placebo-controlled, proof-of-concept study evaluated tolerability and efficacy of adjunctive armodafinil therapy to olanzapine, oral risperidone or paliperidone in 60 adults with schizophrenia.

Methods: Dosing began at 50 mg/d (armodafinil or placebo) and was titrated by 50 mg on days 2, 4, and 6 to armodafinil 50 mg/d (n=15), 100 mg/d (n=15) or 200 mg/d (n=15) or placebo (n=15).The primary outcome measure was the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS) Consensus Cognitive Battery and a secondary outcome measure was the Positive and Negative Syndrome Scale (PANSS). Tolerability was assessed.

Results: No apparent improvement in cognitive deficits was seen with armodafinil (50 mg effect size -.04; 95% CI: -.81, .73; 100 mg .09; -.68, .86; 200 mg .15; -.66, .95) compared with placebo on the MATRICS composite score. Compared to the placebo group, the armodafinil 200 mg/d group showed greater reductions in the PANSS negative symptom scale score (1.69; .78, 2.60) and the PANSS total score (.73; -.08, 1.54). There were no significant differences on the PANSS positive symptom scale score. One patient in the placebo group had a serious adverse event of worsening psychosis. Armodafinil was generally well tolerated. The most common adverse events (armodafinil vs placebo, n) were diarrhea (5 vs 1) and headache (4 vs 1).

Conclusion: As an adjunctive treatment, armodafinil 200 mg/d may improve the negative symptoms of schizophrenia without worsening positive symptoms over 4 weeks. There was no clear benefit on cognition. Additional appropriately powered, double blind, placebo-controlled study are required to confirm these findings.

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No. 11

PREVALENCE OF ALCOHOL USE DISORDERS IN SCHIZOPHRENIA: A SYSTEMATIC REVIEW AND

META-ANALYSIS

Jouko Miettunen, Ph.D., Department of Psychiatry, University of Oulu, P.O.Box 5000, FIN-90014 Oulu, Finland, Oulu, 90014 Finland, Johanna Löhönen, M.A., Hannu Koponen, M.D., Ph.D., Matti Isohanni, M.D., Ph.D., Johanna Koskinen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to realize prevalence and clinical importance of alcohol use disorders in schizophrenia patients.

SUMMARY:

Objective: Alcohol use disorders (AUDs) represent significant comorbidity in schizophrenia. Previous reviews have reported a wide range (12-55%) of dual diagnosis prevalence: however, there is no agreement on overall prevalence. Our aim is to present recent studies of AUD, estimate overall prevalence, and study characteristics affecting the prevalence of AUD.

Method: We conducted a search using three electronic literature databases and a manual search on articles published in 1996-2007. Metaregression was used to study how prevalence is affected by different study characteristics.

Results: Altogether 58 studies met our criteria. The median of current AUD prevalence was 10.1% (IQR=4.6-24.5, 19 studies) and median of lifetime AUD prevalence 22.2% (IQR= 12.1-32.0, 45 studies). In studies using DSM-III-R the median prevalence was higher than in studies using DSM-IV, ICD-9 or ICD-10 (32.3/18.1/10.3/5.9%).

Conclusions: Our systematic literature search found a wide range of prevalence estimates of AUD in schizophrenia patients. Approximately every fifth schizophrenia patient had AUD diagnosis. When contrasted to studies published between 1990-95 our results show a descending trend in AUD prevalence: however, AUDs are still common in schizophrenia patients. The decrease may be explained by changes in diagnostic systems, although it is also possible that other addictive substances, such as cannabis, have replaced alcohol in some countries. Other sample characteristics did not affect to the prevalence estimates.

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2) Dixon L. Dual diagnosis of substance abuse in schzophrenia: prevalence and impact on outcomes. Schizophr Res 1999; 35(Suppl):93-100.

No. 12

ZOLPIDEM IN TREATMENT-RESISTANT CATATONIA: CASE REPORTS AND LITERATURE REVIEW

Cristinel Coconcea, M.D., 185 Pilgrim Road, Boston, MA 02215

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize catatonic states and special needs of patients experiencing catatonia; 2) Understand the current physiopathological hypothesis of catatonia; and 3) Consider using an evidence-based algorithm for the diagnosis and mangement of catatonia

SUMMARY:

Background: According to recent statistics, 5–9% of all psychiatric inpatients show some catatonic symptoms. Of these, 25–50% are associated with mood disorders, 10–15% are associated with schizophrenia, and the remainder are associated with other mental disorders. Recent developments in the treatment of catatonia are raising the GABAa vs GABAb hypothesis of catatonia.

Methods: This paper describes 7 cases of benzodiazepine-resistant catatonia responding to treatment with zolpidem and critically reviews the current literature on the treatment of catatonia, proposing an algorithm for the diagnosis and treatment of this condition.

Results: All 7 patients in this report are showing similar catatonic symptoms, lack of response (or partial response) to other treatments, and same patterns of response to zolpidem, including an initial zolpidem challenge test.

From the review of the literature on catatonia, there is growing evidence suggesting the role of GABAa agonists in the treatment of catatonia, as well as for the possible pro-catatonic effect of the GABAb agonists, with important potential clinical applications in the treatment of this severe condition.

Conclusions: Zolpidem, a GABAa specific agonist appears to be a new and safe therapeutic approach for catatonia, potentially useful in benzodiazepine-resistant patients. More research will be needed in order to replicate and further understand the mechanism and sites of its activity. Various agents described in the literature as useful for the management of catatonia are critically reviewed in terms of mechanism of activity and strength of evidence, and an evidence-based algorithmic approach to the diagnosis and treatment of catatonia is proposed.

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SCIENTIFIC AND CLINICAL REPORT SESSION 05- PSYCHOPHARMACOLOGY: PSYCHOSTIMULANTS; AND ANTIDEPRESSANT SIDE EFFECTS

No. 13

LINKING ATTENTION-DEFICIT/HYPERACTIVITY DISORDER RATINGS AND CLINICAL GLOBAL IMPRESSIONS SCORES IN STUDIES OF LISDEXAMFETAMINE DIMESYLATE IN ADHD

Richard Weisler, M.D., Campus Box 7160, Chapel Hill, NC 27599-7160, Lenard A. Adler, M.D., Stephen V. Faraone, Ph.D., Bryan Dirks, M.D., Mohamed Hamdani, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the clinical meaning of total and change scores on the Attention-Deficit/Hyperactivity Disorder Rating Scale Version IV (ADHD-RS-IV) in relation to severity and improvement on the Clinical Global Impressions (CGI) scales from 2 similarly designed studies of lisdexamfetamine dimesylate (LDX) in adults and children with ADHD.

SUMMARY:

Objective: To provide additional understanding of the clinical significance of Attention Deficit/Hyperactivity Disorder Rating Scale IV (ADHD-RS) total and change scores in relation to Clinical Global Impressions-Severity or Improvement (CGI-S/I) categories.Methods: Equipercentile linking technique identified scores on the ADHD-RS and CGI, that have the same percentile rank, in 2 similarly designed, randomized, double-blind, placebo-controlled trials of lisdexamfetamine dimesylate (LDX) in children and adults with ADHD. The methodology can link or equate treatment effects in one scale to effects in another scale that is easier to interpret clinically. A potential limitation to interpreting the link analysis was the use of the same rater for both the ADHD-RS and CGI. Results: 405 adults and 270 children were included in this analysis. LS mean ADHD-RS change scores ranged from -8.2 to -18.6 for adults and -6.2 to -26.7 for children. Moderately, markedly, severely, and extremely ill adults had mean (SD) baseline ADHD-RS-IV scores of 36.2 (4.86), 42.2 (6.15), 45.4 (5.09), and 53.0, respectively. In children, those moderately, markedly, severely, and extremely ill had scores of 38.8 (6.20), 45.5 (5.87), 48.2 (4.05) and 50.5 (4.04), respectively. At endpoint, 309 of 405 adults and 206 of 270 children were very much, much, or minimally improved. Very much, much, and minimally improved adults had mean (SD) change from baseline ADHD-RS-IV scores of -30.4 (7.82), -20.5 (7.27), and -11.3 (5.95), respectively. Children who were very much, much, and minimally improved had mean (SD) change scores of -33.2 (9.42), -25.7 (7.27), and -9.8 (6.56), respectively.Conclusions: These results facilitate clinical interpretation of the positive changes on the ADHD-RS scale in 2 clinical trials of LDX. In addition, severity of illness can be established with total ADHD-RS score. The findings were consistent between the 2 populations.Supported by funding from Shire Development Inc

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No. 14

ANTIDEPRESSANT-INDUCED EXCESSIVE SWEATING (ADIES): MEASUREMENT AND TREATMENT

Rajnish Mago, M.D., 833 S Chestnut St East, Suite 210 E, Philadelphia, PA 19107, Barry W. Rovner, M.D., Constantine Daskalakis, Sc.D., Michael E. Thase, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of antidepressant-induced excessive sweating; 2) Describe the clinical features of antidepressant-induced excessive sweating and the disability associated with it; 3) Recognize the potential role of terazosin in the treatment of this side effect; and 4) Recognize the value of objective measurement of excessive sweating and the challenges associated with such measurement

SUMMARY:

BackgroundAntidepressant-induced excessive sweating (ADIES) occurs in 5-14% patients on antidepressants, usually persists, and causes distress and functional impairment. This is the first clinical trial for any treatment for it.

MethodsSixteen patients with moderate or greater ADIES and on stable doses of antidepressants were enrolled. Two weeks of baseline ratings preceded 6 weeks of open-label terazosin (an unselective alpha-1 blocker) 1 to 6 mg/day. Also, we developed and pilot tested a novel Ambulatory Measurement of Excessive Sweating (AMES) device.

Results Median terazosin dose was 3 mg (range 1-6 mg). Clinical Global Impression – Severity (CGI-S) statistically significantly ($p < .001$) decreased from a median of 5 (marked) at Baseline (range 4-6) to 2 (borderline) at the last visit (range 1-4). At the last visit, median Clincal Global Impression (CGI-I) score was 2 ("much improved") and all 16 patients were Responders (CGI-I of 1 or 2). At the last visit, CGI-S was 1 (none) for 4 patients, 2 (borderline) and 3 (mild) for 5 each, and 4 (moderate) for 1 patient.

Based on daily self-ratings, daytime sweating severity ($p=.023$) and duration ($p=.007$), and nighttime sweating severity ($p=.003$) were statistically significantly reduced. Adverse effects occurring in more than 1 patient were dizziness (n=5) and dry mouth (n=2). No significant changes in pulse, blood pressure, orthostatic change in blood pressure, and ECG's were found.

AMES recorded skin conductance/ temperature, and ambient temperature/ humidity once a minute. Sweating severity/duration were measured and it captured both sweating episodes noted by subjects in daily diaries and additional episodes. Patients who used the AMES device rated it "Very helpful."

Conclusions

Terazosin may be very effective and relatively well-tolerated for this important but neglected side effect, and the device may be a valuable adjunct to assessment.

Supported in part by a NARSAD Young Investigator Award 2006 to Dr. Mago

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No. 15

ARMODAFINIL ONCE DAILY SUSTAINS WAKEFULNESS THROUGHOUT THE DAY IN PATIENTS WITH EXCESSIVE SLEEPINESS ASSOCIATED WITH NARCOLEPSY

Thomas Roth, Ph.D., One Ford Place, Detroit, MI 48202, John R. Harsh, Ph.D., Russell Rosenberg, Ph.D., Ronghua Yang, Ph.D., Gregory A. Rippon, M.D., M.S., James K. Walsh, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the efficacy and safety of armodafinil once daily for

improving and sustaining wakefulness in patients who experience excessive sleepiness associated with narcolepsy.

SUMMARY:

Objectives: Armodafinil, the R-enantiomer of modafinil, is a long-acting, non-amphetamine wakefulness-promoting agent effective for the treatment of excessive sleepiness (ES) associated with obstructive sleep apnea, shift work disorder, and narcolepsy. The racemate, modafinil, often requires split or higher doses to maintain wakefulness throughout the day and into the early evening. A post hoc analysis of a 12-week, randomized, double-blind study was performed to assess the effectiveness of once-daily armodafinil in sustaining wakefulness in patients with excessive sleepiness associated with narcolepsy.

Methods: Adults patients were randomized to receive armodafinil 150 mg (n=65) or 250 mg (n=67) or placebo (n=64) once daily (before 8 am, or at 7 am on visit days). Mean sleep latency (MSL) was assessed through the 20-min Maintenance of Wakefulness Test, performed every 2 h beginning at 0900 for a total of 6 tests.

Results: The MSL of patients was significantly improved by 2.8 min in the armodafinil 150 mg group, 3.5 min in the armodafinil 250 mg group and 3.2 min in the combined armodafinil groups relative to the change from baseline in placebo at the final visit ($P<0.02$ for all). Over the last four tests (1-7 pm), MSL was significantly improved by 2.9, 3.4, and 3.2 min in the armodafinil 150-mg, 250-mg, and combined groups, respectively, relative to placebo ($P<0.03$ for all). Armodafinil was generally well tolerated.

Conclusion: Armodafinil once daily was effective in improving wakefulness throughout the day and into the early evening in patients with ES associated with narcolepsy.

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1) Schwartz JRL, Feldman NT, Bogan RK, Nelson MT, Hughes RJ. Dosing regimen effects of modafinil for improving daytime wakefulness in patients with narcolepsy. Clin Neuropharmacol 2003;26:252-257.

2) Harsh JR, Hayduk R, Rosenberg R, Wesnes KA, Walsh JK, Arora S, Niebler GE, Roth T. The efficacy and safety of armodafinil as treatment for adults with excessive sleepiness associated with narcolepsy. Curr Med Res Opin 2006;22:761-774.

SCIENTIFIC AND CLINICAL REPORT SESSION 06-BIPOLAR DISORDER

No. 16
WHO RECEIVES GUIDELINE-BASED PHARMACOTHERAPY FOR BIPOLAR DEPRESSION?

Megan Ehret, Pharm.D., 200 Retreat Ave, Hartford, CT 06106, John W. Goethe, M.D., Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVES:

The participant will be able to discuss the demographic and clinical features associated with receiving guideline-based pharmacotherapy for bipolar depression.

SUMMARY:

Objective: To identify demographic and clinical features associated with receiving guideline-based pharmacotherapy for bipolar depression.Methods: Demographic and treatment data were recorded in consecutively admitted inpatients age 18-59 with a clinical diagnosis of bipolar I disorder, depressed (1/05-12/07,n=281). Pharmacotherapy was blindly rated as consistent or not with published guidelines. Associations were identified with stepwise logistic regressions.

Results: 232 patients (82.6%) received a mood stabilizer, most commonly divalproex (32.7%), lithium (28.1%), or lamotrigine (20.6%). 204(72.6%) received an atypical antipsychotic, most commonly quetiapine (34.9%). 56 patients did not receive an antidepressant. 33 patients were discharged on an atypical antipsychotic without a mood stabilizer. Only18 patients were discharged on monotherapy. Atypical antipsychotics were more likely to be prescribed to blacks (87.9%) versus whites (68.9%), Latinos (82.1%), or other races (71.4%)(OR=3.1) and to patients with psychotic features (88.4% vs. 65.6%, OR=4.0). Women were less likely to be prescribed a mood stabilizer (77.7% vs. 91.2%, OR=0.3) and were more likely to receive an atypical antipsychotic in the absence of a mood stabilizer (OR=3.6). Patients with psychotic features (29.1% vs. 12.3%, OR=3.5) or borderline personality disorder (35.9% vs. 12.0%, OR=4.5) were more likely to receive >4 psychotropic medications; Blacks were the least likely to be prescribed >4 psychotropic medications (3.0% versus whites 19.4%, Latinos 14.3%). Readmission within six months (27% of patients) was more likely in those on a benzodiazepine (OR=2.5) and those with psychotic features (OR=1.8)

Conclusions: Consistent with previous reports, many in the sample did not receive guideline-based treatment and those at increased risk were women and patients with psychotic features or borderline personality. Use of non-standard regimens did not increase the readmission rate, however.

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1) Lim PZ, Tunis SL, Edell WS, Jensik SE, Tohen M. Medication prescribing patterns for patients with bipolar I disorder in hospital settings: adherence to published practice guidelines. Bipolar Disorders 2001;3:165-173.

2) Thase ME. Bipolar Depression: Issues in diagnosis and treatment. Harv Rev Psychiatry 2005;13:257-71.

No. 17
PSYCHIATRIC ADMISSIONS AND HOSPITALIZATION COSTS IN BIPOLAR DISORDER IN SWEDEN

Anne Tiainen, M.P.H., R.N., Långholmsgatan 30, Stockholm, 117 33 Sweden, Ösby U, MD., Backlund L, MD., Edman G, Ph.D., Adler M, MD., Hällgren J, BSc., Sennfält M, Ph.D., van Baardewijk M, Ph.D., Sparen P,Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the increased risk of readmissions for patients with bipolar disorder and realize the costs link to patients with unfavorable outcome.

SUMMARY:

Background: Hospital admission for patients with bipolar disorder is generally required in acute manic episodes, which are difficult to treat in an outpatient setting. Analyzing patterns of hospital admission rates is important in order to estimate treated prevalence and outcome in both the acute and remitting phases

of the disease.

Specific purpose: To analyze trends in hospital admissions for bipolar disorder and also for the bipolar subdiagnoses in Sweden from 1997 to 2005, to calculate readmission rates during five years follow-up and to estimate the economic impact of hospitalizations.

Methodology: The study is based on the Swedish Patient registry. Bipolar disorder was determined according to the International Classification of Diseases; (ICD 10; F30,-F31) and was subdivided into manic depressive, mixed and unspecified/other episodes. First admissions and readmissions were calculated for each year and for patients in five years follow-up. Fixed hospitalization costs were calculated for each year. The diagnoses are clinical, and based on hospital admissions. Thus, our results do not generalize to bipolar patients treated only as outpatients.

Results: The number of bipolar admissions was relatively stable during 1997 to 2005. Around half had a manic and another quarter a depressive subdiagnosis. The hospitalization costs were stable around 56 M € per year. Of all patients with their first inpatient diagnosis in 2000, the average readmission rate during five years follow-up was 1.2. Of those patients, 15% had 66% of the readmissions.

Finding: Patients who have 66% of readmissions suggesting that these patients should be specifically targeted with the aim of improved understanding of the reasons for frequent relapses.

Summary: The study characterizes the cost driver that represents the largest portion of bipolar hospitalization costs and it is important to understand for payers and policy makers.

REFERENCES:

1) Blader JC, Carlson GA: Increased rates of bipolar disorder diagnoses among U.S. child, adolescent, and adult inpatients, 1996-2004. Biological psychiatry 2007;62:107-114.
2) Kleinman L, Lowin A, Flood E, Gandhi G, Edgell E, Revicki D. Costs of bipolar disorder. Pharmacoeconomics 2003; 21:601-622.

No. 18

SYMPTOMS AND TREATMENT OF BIPOLAR DISORDER IN SWEDEN

Mats Adler, M.D., Karolinska Universty Hospital Huddinge, Stockholm, SE-14186 Sweden, Gunnar Edman, Ph.D., Marc van Baardewijk, Ph.D., Karin Sennfält, Urban Ösby, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to assess better prognosis, treatment and symtom profiles in a cohort of bipolar partients.

SUMMARY:

Two hundred and thirty bipolar patients were recruited from a specialized psychiatric outpatient department for patients with affective disorders in Sweden. Diagnoses, medication and symptoms were recorded. Patients were followed for 12 months and hospitalisations during that time were recorded. Symptom profiles were correlated to medication and the initial ratings ability to predict hospitalisation within a year was investigated. More than half of the patients (60 %) rated themselves as normothymic at the index visit, while a quarter of the patients (23 %) rated high on both depression and mania, 13 % high in depression only, and 4 % high in mania only. High manic scores were found to predict relapse leading to rehospitalization within a year. Lithium was by far most frequent treatment drug, prescribed to more than three out of four patients. Other mood stabilizers were prescribed to more than a third of the patients, while antipsychotics were prescribed to less than a third of the patients. Only 4 % of the patients were drug-free. Just less than half the patients (45 %) were treated with monotherapy (lithium, a mood-stabilizer, an antidepressant or an antipsychotic drug). Half the patients (52 %) were treated with more than one drug. A quarter had lithium in combination with another mood stabilizer, also a quarter had a combination therapy including an antipsychotic, and 17 % had a combination therapy including an antidepressant. The only significant differences in drug treatment, related to symptom assessment, were that patients low in depression were more frequently treated with lithium (84 % vs. 64 %) and less often treated with an antidepressant (14 % vs. 32 %). The symptom scale used in the study showed good internal consistency using conventional test theory methods, while an Item Response Theory based analysis showed opportunities for improvement of assessment techniques.

REFERENCES:

1) Judd LL, Schettler PJ, Akiskal HS, Maser J, Coryell W, Solomon D, et al. Long-term symptomatic status of bipolar I vs. bipolar II disorders. Int J Neuropsychopharmacol. 2003 Jun;6(2):127-37.
2) Perlis RH, Ostacher MJ, Patel JK, Marangell LB, Zhang H, Wisniewski SR, et al. Predictors of recurrence in bipolar disorder: primary outcomes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). Am J Psychiatry. 2006 Feb;163(2):217-24.

SCIENTIFIC AND CLINICAL REPORT SESSION 07- THE BROAD REACH OF PSYCHIATRY: STUDYING HISTORY, PEACEKEEPING & THE ROLE OF SPIRITUALITY IN SCHIZOPHRENIA

No. 19

THE MODERN HISTORY OF AMERICAN PSYCHIATRY: UNINTENDED CONSEQUENCES

Milton Kramer, M.D., 1110 N Lake Shore Dr.23S, Chicgo, IL 60611

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to to have an understanding of the possibility that a well intentioned event may have unfortunate consequences and be alerted to consider the possible negative consequences of either individual or profession wide changes

SUMMARY:

The history of psychiatry as a series of important events is of interest in its own right. However, attention to the consequences of such events is of even greater interest as it invites us to scrutinize our activities for what unintended consequences may result from our choices and behaviors. Examples will be offered from the modern history of American psychiatry in which unfortunate unintended consequences resulted from well intentioned actions such as the closure of State Hospitals resulting in patients ending up in nursing homes, jails and on the street. The result of the focus on medication treatment which has lead to the neglect

of the patient as person and involving large sums of money has lead to significant conflicts of interest that question the validity of research findings and led to the questionable involvement of psychiatrists in research patient recruitment is another example. These serious ethical issues are the result of decisions made in regard to medication development, approval and marketing. The consequences of using employer based health insurance has led to blocking the development of a single payor and impeded the development of universal health care. Many other examples exist and the current suggestion that neurology and psychiatry be combined into a neuroscience specialty needs to be examined with a view particularly to negative unintended consequences

In any historical review, recognition that what is presented is the author's view and open to question, revision or rejection

REFERENCES:

1) Sabshin M. Changing American Psychiatry: A Personal Perspective. Washington,DC: American Psychiatric Publishing Inc.,2008
2) Shorter e. A History of Psychiatry. New York: Free Press, 1997

No. 20

IS PEACEKEEPING PEACEFUL? A SYSTEMATIC REVIEW

Jitender Sareen, M.D., PZ-430 771 Bannatyne Ave, Winnipeg, R3E 3N4, Murray B. Stein, M.D., FRCPC, M.P.H,. Siri Thoresen, Ph.D., Mark Zamorski, M.D., M.H.S.A., Shay-Lee Belik, M.Sc., Gordon J.G. Asmundson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the common sequalae of being deployed to a peacekeeping mission.

SUMMARY:

Background. Numerous countries have sent troops on countless United Nations peacekeeping missions. Over the last 20 years, there has been concern about the dangerousness of peacekeeping missions for soldiers. Peacekeeping missions also have different dimensions of stress on soldiers compared to combat missions. The objective of the present paper was to systematically evaluate the literature on the association between deployment to a peacekeeping mission and distress and suicide.

Methods. Peer-reviewed publications were found through searches with keywords in Medline, PsychInfo and contacting authors in the field. Studies were included in the review if the study specifically involved soldiers deployed to a peacekeeping mission.

Results. Studies included in the review had soldiers from numerous countries and included peacekeeping missions with varying levels of conflict. The results of the review revealed three broad categories of studies on peacekeeping: 1) cross-sectional studies on distress and mental disorders, 2) prospective studies on distress and 3) studies focused on suicide. Many (but not all) studies reported higher levels of post-deployment mental disorders, distress and suicide. Correlates of distress and mental disorders included level of exposure to traumatic events during deployment, number of deployments, pre-deployment personality traits/disorder and post-deployment stressors. The prevalence of posttraumatic stress disorder among peacekeepers ranged between 5% and 12%, and was associated with poor health and increased rates of medical service utilization.

Conclusions. Although the majority of peacekeepers do not suffer from mental health problems, a substantial proportion develops mental health problems (especially posttraumatic stress disorder). Further study of risk factors for mental illness and empirical interventions that prevent mental illness are required in this population.

REFERENCES:

1) Thoresen S, Mehlum L, Moller B: Suicide in peacekeepers: A cohort study of mortality from suicide in 22,275 Norwegian veterans from international peacekeeping operations. Soc Psychiatry Psychiatr Epidemiol 2003; 38:605-610.
2) Sareen J, Cox BJ, Afifi TO, Stein MB, Belik SL, Meadows G, Asmundson GJG: Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care: Findings from a large representative sample of military personnel. Arch Gen Psychiatry 2007; 64:843-852.

No. 21

SPIRITUAL AND RELIGIOUS COPING IN SCHIZOPHRENIA: CLINICAL IMPLICATIONS

Philippe Huguelet, M.D., Consultation Eaux-Vives, Rue du 31-Décembre 36, Geneva, 1207 Switzerland, Sylvia Mohr, Ph.D., Laurence Borras, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have acquired a greater knowledge about the role of spiritual/religious coping among patients suffering from schizophrenia, as well as the role it may have as an explanatory model of their condition. They should also learn about the sort of issues that may arise whilst performing a spiritual assessment, and how to intervene accordingly

SUMMARY:

Objective: In a quantitative and qualitative research, we studied the role of religion/spirituality as a coping mechanism among 236 patients with psychotic disorders in Geneva (Switzerland) and in Québec (Canada). Religion was used as a positive way of coping in 79% of subjects and as a negative way of coping in 16% of patients. Also, more than half of the patients had representations of their illness and treatment (i.e. explanatory models) directly influenced by their religious convictions, positively in 31% (test sent by God to put them on the right path, a gift from God or of God's plan) and negatively in 26% (punishment of God, the devil, or possession). Thus it appears that religion can 1) help patients, in the sense of coping and recovery, and 2) influence their adhesion to treatment. But how can we integrate these important issues in our care?

Method:

We will present results from the study of a new sample of 80 psychotic outpatients randomized into two groups, one of those undergoing a spiritual assessment (SA) with their own psychiatrist. The group with SA was examined with respect to 1) accep-

tance of the spiritual assessment, 2) spiritual experiences/ practices/beliefs, and 3) what arises in terms of a) potential problems and b) specific interventions. The 3 month outcome of this group was compared to the control group with regard to patients' compliance and satisfaction with care.

Results: Qualitative analysis shows that all patients accepted well the SA. Areas of potential intervention were 1) illness representation (i.e. to build a bridge between patients' representation and medical considerations), 2) social skills (e.g. making contacts with religious community), 3) work on identity (religion/ spirituality is often a key component of identity, which can be severely damaged because of psychosis), 4) spiritual struggle (which may be embedded into delusion with religious content), 5) liaison (e.g. addressing to chaplain or clergy) and 6) relational aspects (e.g. psychotherapeutical work on the investment on God as a paternal figure). Preliminary quantitative analyses after 3 months' outcome showed that patients' satisfaction with care was significantly better in the SA group.

Conclusion: It appears that SA is likely to bring about important clinical issues in patients with chronic schizophrenia.

REFERENCES:

1) Mohr S, Brandt PY, Gillieron C, Borras L, Huguelet P: Toward an integration of religiousness and spirituality into the psychosocial dimension of schizophrenia. Am J Psychiatry 2006;163:1952-1959

2) Borras L, Mohr S, Brandt PY, Gilliéron C, Eytan A, Huguelet P. Religious beliefs in schizophrenia: their relevance for adherence to treatment. Schizophr Bulletin 2007; 33:1238-1246

SCIENTIFIC AND CLINICAL REPORT SESSION 08- STUDIES IN PSYCHOTHERAPY

No. 22

FOLLOW-UP PSYCHOTHERAPY OUTCOME OF PATIENTS WITH DEPENDENT, AVOIDANT AND OBSESSIVE-COMPULSIVE PERSONALITY DISORDERS - A META-ANALYTIC REVIEW

Witold Simon, M.D., Ph.D., Brigham Young University 284 Taylor Building P.O. Box 28626, Provo, UT 84602-8626

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the complexity of symptomatology of Cluster C individuals, as well as recognize the treatments effectively tailored for those clients.

SUMMARY:

Assessing how many patients maintain their gains after the end of the therapy has been an interest for psychotherapy outcome researchers. The current study examines evidence related to the maintenance of treatment gains in individuals diagnosed with Cluster C personality disorders. Fifteen studies, published between 1982-2006, met criteria for inclusion. The effect size standardized mean difference statistic was used. Improvement occurred most of the time between pretreatment and posttreatment. However, social skills training often produced effect sizes that were larger for posttreatment-follow-up. Study indicates that cognitive-behavioral and psychodynamic approaches and social skills training may be beneficial for Cluster C patients. Ambiguity remains whether DPD, AVPD or OCPD patients benefit more from the therapy.

REFERENCES:

1) Lambert MJ, Ogles BM. The efficacy and effectiveness of psychotherapy. In: Lambert MJ, editor. Bergin & Garfield's Handbook of psychotherapy and behavior change, 5th edition. New York, John Wiley & Sons; 2004, pp. 139-193.

2) Roth A, Fonagy P. What works for whom? A critical review of psychotherapy research. New York, The Guilford Press, 2005.

No. 23

THE EFFECTIVENESS OF EVIDENCE-BASED TREATMENTS FOR MAJOR DEPRESSIVE DISORDER IN A ROUTINE CLINICAL SETTING; RESULTS FROM AN OBSERVATIONAL STUDY

Frenk Peeters, M.D., Ph.D., PO Box 5800, Maastricht, 6202 AZ Netherlands, Marcus Huibers, Ph.D., Jeffrey Roelofs, Ph.D, Jim van Os, M.D., Ph.D., A. Arntz, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize difficulties pertaining to generalizing results from clinical trials to routine clinical settings in the treatment of major depressive disorder (MDD). Furthermore, the participant will understand the effectiveness and its predictors of evidence-based treatments for MDD in an outpatient setting.

SUMMARY:

The efficacy of some acute-phase treatments for major depressive disorder (MDD) is well established in randomized controlled trials (RCT's). However, for over a decade concerns have been expressed about the utility of generalizing the results of RCT's to daily clinical practice. A major doubt among many scientists and clinicians is if depressed patients respond to and remit equally well in evidence-based treatments outside the realm of a highly controlled study.

The present naturalistic study was designed to examine the effectiveness of pharmacotherapy (PHT), IPT, and CBT (either alone or in combination with PHT) in the treatment of MDD in a community mental health center in the city of Maastricht, The Netherlands. After a diagnostic work-up, consisting of an open interview and the SCID-I, patients (n=189) were informed about treatment options in the mood disorders program. Typically as in a naturalistic treatment setting, choice of treatment was made in agreement by patient and therapist but predominantly patient-preference guided. The clinical course during treatment was assessed at 8, 16, and 26 weeks. In comparison, the effectiveness of these evidence-based treatments appeared to be equal and overall approached the effect-sizes reported in RCT's. In this presentation, we will (1) present these clinical outcomes in this naturalistic study, and (2) address possible predictors of outcome in the various treatments.Implementation of evidence-based treatments for MDD to routine daily practice is possible and seems, given it's good effectiveness, well justified.

REFERENCES:

1) Hollon SD, Jarrett RB, Nierenberg AA, Thase ME, Trivedi M, Rush AJ: Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? J Clin Psychiatry 2005; 66(4):455-68

2) March JS, Silva SG, Compton S, Shapiro M, Califf R, Krishnan R: The case for practical clinical trials in psychiatry. Am J Psychiatry 2005; 162(5):836-46

NO. 24

THE EFFECTIVENESS OF A GROUP-ORIENTED INPATIENT CBT PROGRAM

Katherine Lynch, Ph.D., Weill Cornell Medical College,21 Bloomingdale Road,, White Plains, NY 10605, Courtney Berry, M.A., Lorri Ovryn, M.S., Nickeisha Henry, Psy.M., Andrea Weiner, M.A., and Sarah Chung, M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the challenges associated with the development and assessment of a comprehensive cognitive behavioral inpatient program; Understand the benefits of a structured group-oriented CBT program; 2) Appreciate how use of structured CBT programming can foster patient engagement, encouraging their active role in treatment; and 3) Realize the contributions of scientific inquiry in informing and evaluating clinical programming

SUMMARY:

In recent years, inpatient treatment has been faced with many challenges, including briefer admissions and increased fiscal limitations that have significantly impacted service delivery. An ongoing struggle for inpatient units remains how to maximize treatment for a heterogeneous inpatient population with the minimal resources available. This study aimed to evaluate the effectiveness of a comprehensive group-oriented CBT program as implemented in a clinical setting, The Women's Unit of New York Presbyterian Hospital. In addition, the study sought to identify patient characteristics that predict engagement in and response to treatment. Finally, this study evaluated patient functioning at both one and three months post-treatment, assessing any longer term gains.

Participants were female inpatients ages 18 to 65 struggling with a variety of mental health problems. They completed a battery of self-report assessments and a brief measure of cognitive functioning at admission and discharge from the unit. Participants also completed weekly reassessments of overall functioning and a one and three month follow-up assessment post-discharge. T-tests indicated significant improvement in functioning from admission to discharge on a variety of outcome measures. No specific patient characteristics were found to consistently significantly predict response to treatment; however, partial correlations indicated that participation in the group therapy program was correlated with improvement in functioning. Analyses also revealed significant differences in group participation among diagnostic groups. The implications of these findings and the adaptability of a group-oriented CBT program to diverse inpatient units will be discussed. Finally, there will be a discussion of the limitations and future directions for research and programming.

REFERENCES:

1) Durrant, C., Clarke, I., Tolland, A., & Wilson, H.: Designing a CBT Service for an Acute Inpatient Setting: A Pilot Evaluation Study. Clinical Psychology and Psychotherapy, 2007, 14:117-125.

2) Wright, J.H., Thase, M.E., Beck, A.T., & Ludgate, J.W. (eds.): Cognitive Therapy with Inpatients: Developing a Cognitive Milieu. New York, Guilford Press, 1993.

TUESDAY, MAY 19, 2009, 11:00AM-12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 09-CHILD AND ADOLESCENT PSYCHIATRY

No. 25

MEDICATION TRENDS IN NEW-ONSET PEDIATRIC BIPOLAR DISORDER AMONG MEDICAID-INSURED YOUTH

Aloysius Ibe, B.S., M.S., 1700 E. Cold Spring Lane, Baltimore, MD 21251, D.J. Safer, M.D., L. Magder, Ph.D., Y. Bronner, Sc.D., S. Valluri, M.S., M.P.H., J.M. Zito, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the patterns of psychotropic drug utilization in Medicaid-insured youth with a diagnosis of pediatric bipolar disorder (PBD); and 2) Characterize trends across the decade (1997-2006) in terms of the frequency of the leading psychiatric diagnoses preceding and comorbid with PBD.

SUMMARY:

Introduction: Recent studies have shown a 40-fold increase in outpatient youth diagnosed with bipolar disorder over a 10 year period (Moreno et al., 2007). The same study showed that youth are more likely than adults to receive a comorbid diagnosis such as attention-deficit hyperactivity disorder (ADHD). An inpatient study showed a 3-fold increase in the primary discharge diagnosis of PBD in youth over a 9 year period (Blader & Carlson, 2007). Methods: The data source was reimbursement claims from a mid-Atlantic state Medicaid program for the years 1997, 2001, and 2006. The dataset comprised youth aged 2 to 19 years on January 1st of the study years, and enrolled in the Medicaid program for 270 days of continuous eligibility (180 days pre- and 90 days post-bipolar diagnosis).. Psychotropic medications were assessed according to the following American Hospital Formulary Service modified drug classes: stimulants, antipsychotics, antidepressants, anticonvulsant-mood stabilizers, and lithium. The category 'any psychotropic' also included alpha-agonists, and anxiolytics/hypnotics. Psychotropic medication use was assessed in the 90-day period before and after the PBD diagnosis. Results: In 2006 compared to 1997, after adjusting for age group, gender, race/ethnicity and eligibility category, there was a 4.4-fold (CI 2.9-6.6) increase in stimulant use (31.4% vs 13.3%), and a 3.6-fold (CI 2.6-4.9) increase in antipsychotic use (51.3% vs 33%) among those with recent PBD diagnosis. Within 2006, pre-post findings showed little difference in psychotropic medication use for stimulants, lithium, and antidepressants, and a significant increase in antipsychotics (39.7% vs 51.3%, $p<0.0001$). Conclusion: The substantial increase in PBD across the decade corresponded with increased antipsychotic and continuing stimulant use post-PBD compared to pre-PBD.

REFERENCES:

1) Blader, J. C. & Carlson, G. A. (2007). Increased rates of bipolar diagnosis among U.S. child, adolescent and adult inpatients, 1996-2004. Biological Psychiatry, 62, 107-114.

2) Moreno, C. M., Laje, G. G. M., Blanco, C. M. P., Jiang, H. P., Schmidt, A. B. C., & Olfson, M. M. M. (2007). National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. Arch Gen Psychiatry, 64, 1032-1039.

No. 26

PHYSICAL ACTIVITY AND FITNESS IN ADOLES-

CENTS AT RISK FOR PSYCHOSIS

Jenni Koivukangas, B.Med Sairaalanrinne 4A8, OULU, 90220 Finland, Koivukangas J, B.Med., Tammelin T, Ph.D., Kaakinen M, MSc., Mäki P, M.D. Moilanen I, Taanila A, Veijola J, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should understand that subjects at risk for developing serious psychiatric illness may have life-style including low level of physical activity. This causes low cardiorespiratory fitness and maybe risk for developing various somatic symptoms and illnesses in the long run. One should pay attention to physical activity in clinical work with psychiatric patients.

SUMMARY:

Background: Low physical activity relates to development of cardiovascular and metabolic illnesses. Subjects having psychotic disorder have been found to have elevated risk for these somatic diseases. Evidence regarding physical activity among subjects at risk for psychosis is practically non-existing. We had an opportunity to study physical activity and physical fitness in subjects at risk for psychosis in a relatively large birth cohort sample.

Methods: The Northern Finland 1986 Birth Cohort is an unselected general population based birth cohort including 9,432 children born alive in the two Northernmost provinces in Finland. At the age of 15/16 years they participated in clinical examination including a questionnaire including items about physical activity. Participants had also an opportunity to participate in a cycle ergometry test measuring maximal oxygen consumption. The Finnish Hospital Discharge Register was used to find out psychoses in parents during 1972-2000 and psychoses in subjects during 2002-2005. The familial risk for psychosis was found out of altogether 7,020 participants in 122 subjects. 33 subjects developed psychosis during the follow-up time of 2002-2005.

Results: Subjects who developed psychoses after the field at age of 15/16 were physically more inactive (adjusted OR 3.2; (95% CI 1.5-6.9) and had low maximal oxygen consumption (adjusted OR4.2; 1.4-12.5). Subjects who had more than 6 prodromal symptoms of psychosis were less active than those who had only few symptoms or no symptoms Familial risk for psychosis did not associate with physical activity in the offspring.

Conclusions: Subjects who developed later psychotic illness reported relatively low level of physical activity and also their cardiorespiratory fitness was low. Low level of physical activity may not be a consequence of the psychotic illness itself, but may reflect general life-style of subjects at risk for psychotic illness.

REFERENCES:

1) Roick C, Fritz-Wieacker A, Matschinger H, Heider D, Schindler J, Riedel-Heller S, Angermeyer MC: Health habits of patients with schizophrenia. Soc Psychiatr Epidemiol 2007; 42:268-276

2) Tammelin T, Ekelund U, Remes J, Näyhä S: Physical activity and sedentary behaviors among Finnish youth. Med Sci Sports Exerc 2007; 39:1067-1074

No. 27

METABOLIC SYMPTOMS IN ADOLESCENT PSYCHIATRIC INPATIENTS

Michael Stevens, Ph.D., 200 Retreat Avenue, Hartford, CT 06106, John W. Goethe, M.D., Danielle E. Francois, B.A., Bonnie L. Szarek, R.N., Deborah Piez, M.S., L.P.C.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants will be able to identify clinical characteristics predictive of metabolic syndrome symptoms in adolescent psychiatric inpatients.

SUMMARY:

Objective: To determine the prevalence of metabolic syndrome (MetS) symptoms in psychiatric inpatients age 12-17 and the associated clinical and demographic features.

Methods: The sample included all adolescents admitted 1/2005-9/2007 (n=698). Binary logistic regression was used to examine associations between the 5 ATP-III criteria for MetS and the demographic, diagnostic, and treatment variables for the sample.

Results: 36.1% of the sample were positive for one or more of the MetS criteria, which is comparable to, but slightly higher than estimates (32.4%) from the National Health and Nutrition Examination Survey epidemiological study of same-aged adolescents. 34.1% of the psychiatric sample had triglycerides >= 110 mg/dL, 25.3% had waist circumference in the 90th percentile or higher, 17.5% had decreased HDL cholesterol, 3.4% had FBS >= 110 mg/dL, and 0.6% had a diagnosis of hypertension. Binary logistic regression identified 3 variables associated with having >=1 MetS criteria: female (OR=1.43), treatment with atypical antipsychotics (OR=2.23), and receiving more than 2 psychotropics (OR=1.43). Binary logistic regression using the subsample for which all MetS measurements were available found 3 additional associated variables: older (16-17) age (OR=2.01) and treatment with aripiprazole (OR=2.19) or lithium (OR=6.63). The HDL criterion was associated with older (16-17)age (OR=2.76) and treatment with aripiprazole (OR=2.20); increased waist circumference was associated with being Latino (OR=1.58) and treatment with lithium (OR=2.76).

Conclusions: These findings suggest that more than a third of adolescent inpatients meet at least one of the criteria for MetS and that females, Latinos, and those exposed to certain psychotropics are at relatively greater risk. These data may have implications for the cardiovascular health of psychiatrically ill adolescents.

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1) Saland JM: Update on the metabolic syndrome in children. Curr Opin Pediatr 2008; 19: 183-191

2) Fraguas D, Merchan-Naranjo J, Laita P, Parellada M, Moreno D, Ruiz-Sancho A, Cifuentes A, Giraldez M, Arango C: Metabolic and hormonal side effects in children and adolescents treated with second-generation antipsychotics. Journal of Clinical Psychiatry 2008; 69: 1166-1175

SCIENTIFIC AND CLINICAL REPORT SESSION 10-CROSS-CULTURAL PSYCHIATRY

No. 28

GENES, MEMES, MIGRATION, AND MENTAL ILLNESS

Hoyle Leigh, M.D., Department of Psychiatry, Univ. of California, San Francisco-Fresno, 155 N. Fresno St.,, Fresno, CA 93701

EDUCATIONAL OBJECTIVES:

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

to recognize the interaction among genes, memes, culture, stress and mental illness, especially in immigrant populations and devise the means of harmonizing the conflicting memes and attenuating pathogenic memes.

SUMMARY:

Purpose: To illustrate the gene-meme-stress interaction in mental illness using migration as a model.Background: Mental illness can be conceptualized as the result of an interaction between genes and memes in the course of development. Memes are bits of information that form the basis of culture. Memes are replicators, like virus, and infect the brain. Memes are introduced into the brain early in life in the form of culture, and they take up residence in the brain, often unconsciously. Development is an interaction among the genes, resident memes, and incoming memes that results in a symphony of genes being turned on and off and of memes replicating or becoming dormant. In this process, certain memes emerge as a coherent and conscious selfplex. Mental illness may arise when there is a disruption in the equilibrium between dominant memes and incoming new memes that result in a stress reaction. Migration is an example of stressful situation when the individual is exposed to a new meme pool. Method: An examination of literature reveals that the incidence of mental illness is high among migrants. This is particularly true of involuntary migrants such as refugees. Results: The symptomatology and presentation of mental illness in migrants reflect those of their culture of origin, indicating the resurgence of pathogenic memes that were introduced early in life and have been dormant. In involuntary migration, there may be a frank conflict between existing dominant selfplex and the incoming new memes. The resulting stress may create conditions for the replication of dormant pathogenic memes and mental illness. Some of the protective factors include the presence of subculture, i.e. meme pool of the original culture, family support, and good preparation for the migration. Conclusion: Mental illness prevalent among migrants can be conceptualized as the result of the stress caused by conflicts between memes introduced early in life and the massive infusion of new memes in the new meme pool in genetically vulnerable individuals. Treatment may be geared toward the introduction of new memes that may integrate the conflicting memes and attenuate the pathogenic memes.

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2) Aunger, R., Darwinizing Culture: The Status of Memetics as a Science. 2000, New York: Oxford University Press

No. 29

ONE-YEAR FOLLOW-UP STUDY OF THE CULTURALLY SENSITIVE COLLABORATIVE TREATMENT (CSCT) FOR CHINESE AMERICANS WITH DEPRESSION

Adrienne van Nieuwenhuizen, B.A., 50 Staniford Street, Boston, MA 02114, Sue Chen, B.A.; Pauline Tan, M.S.; Wan-Chen Weng, B.A., M.A.; Pei-Han Cheng, M.S.; Maurizio Fava, M.D.; Albert Yeung, M.D., Sc.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the effectiveness of using culturally sensitive collaborative treatment for identifying, engaging, and treating depressed Chinese immigrants in primary care settings.

SUMMARY:

This study investigated long-term (12 month) effect of culturally sensitive treatment for depression in Chinese Americans.

The Culturally Sensitive Collaborative Treatment (CSCT) screens primary care patients for depression at a Chinese American clinic, educates and treats them via a bicultural/bilingual psychiatrist. In CSCT, depressive level (Hamilton Rating Scale for Depression, HAM-D) was evaluated at baseline and 6 months (end of treatment) and illness beliefs (Explanatory Model of Interview Catalogue, EMIC) at baseline. This study investigated depressive level and illness beliefs one year post-CSCT. HAM-D scores were compared among baseline, 6 month and follow-up using t-tests. Illness beliefs at baseline and follow-up were compared by chi-square tests with $p<0.05$ considered significant.

45 patients were recruited. HAM-D scores at 6 months and follow-up were significantly lower than baseline. HAM-D scores at 6 month and at follow-up were not significantly different. Comparison of distribution of illness beliefs between baseline and follow-up revealed that in all 5 categories (chief complaint, name of illness, stigma, perceived cause, and most important help sought), there is a significant difference. Reported chief complaints shifted from only psychological/emotional or somatic symptoms to mixed mood-somatic-social. Unfamiliarity of depression dropped coupled with an increase of reported depression and increase in denial of depression. Stigma dropped significantly. Major perceived cause remained psychological stress with a decrease in unknown. Most important help sought changed from primary care to either mental health care or lay help.

Thus, this follow-up study demonstrates that CSCT is effective in treating depressive patients both short-term and long-term. CSCT has also demonstrated the ability to educate patients in recognizing a spectrum of symptoms as depression and may be a solution for reducing undertreatment of depression in ethnic minority immigrants.

REFERENCES:

1) Yeung AS, Kung WW, Chung H, Rubenstein G, Roffi P, Mischoulon D, Fava M: Integrating psychiatry and primary care improves treatment acceptability among Asian Americans. General Hospital Psychiatry 2004; 26: 256-260.
2) Yeung AS, Yu SC, Fung F, Vorono S, Fava M: Recognizing and Engaging Depressed Chinese Americans in Treatment in a Primary Care Setting. Int J Geriat Psych 2006; 21(9): 819-23.

No. 30

PREVALENCE OF CHILDHOOD TRAUMA IN PSYCHIATRIC AND PRIMARY CARE CLINICS IN CITIES ALONG THE U.S.-MEXICO BORDER

Alejandra Postlethwaite, M.D., 2209 John Jay Ave, Calexico, CA 92231, Andres Felipe Sciolla, M.D., Miguel Angel Fraga-Vallejo, M.D., M.Sc, Lisandro Maya-Ramos, B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Identify the prevalence of childhood trauma (CT) between Mexican adults who seek care in primary care and psychiatric

clinics along the U.S. Mexican border; 2)Recognize if different types of parental bonding correlate with CT; 3)Better understand how the relationship between immigration status, acculturation, familial and environmental risk factors affect CT outcomes; and 4)Better understand reactions to disclosure of CT.

SUMMARY:

Data show that length of stay in the U.S. and acculturation predict worse overall health among Latino immigrants. Childhood trauma (CT) has not been studied among Mexicans, although this possibly worsens the effects of immigration on health outcomes.

Objectives: The aim of this study is to determine the prevalence of CT among patients in primary care (PCC) and mental health (MHC) clinics in border cities in Mexico and the U.S; to document the characteristics of parental bonding (PB) and the reactions of caregivers to the disclosure of maltreatment; and to study the relationship between immigration and acculturation and the prevalence of CT and PB.

Methods: We recruited 523 adult participants from PCC and MHC between U.S. and Mexican sites. Participants filled out self report questionnaires, which included the Childhood Trauma Questionnaire (CTQ), the brief Short Acculturation Scale for Hispanics, the Parental Bonding Instrument (PBI) accompanied by five questions regarding disclosure of trauma, and demographic data.

Results: Multiple regression analysis involving 11 predictor variables (sex, nation, clinic type, age, income, education, PBI: father and mother PBI care and protect subscales (SC) and acculturation) were performed for each of the five CTQ SC and for the abuse and neglect composite CTQ scales. Significant predictors for abuse were family income, father and mother PBI care SC and a quadratic effect of acculturation. Significant predictors for neglect were education and the father, mother PBI care SC. Sex was a significant predictor for the sexual abuse SC. Education was a strong predictor for the neglect scales. Income was a significant predictor for the abuse SC but not for the neglect SC. Acculturation was a significant predictor when treated as a quadratic predictor for the abuse SC only.

Conclusion: Preliminary results emphasize the need to develop trauma-competent MH services in both countries aimed at treating CT victims and their families.

REFERENCES:

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2) Katerndahl DA, Burge SK, Kellogg ND, Parra JM. Differences in childhood sexual abuse experience between adult Hispanic and Anglo women in a primary care setting. J Child Sex Abus. 2005; 14(2):85-95

TUESDAY, MAY 19, 2009, 11:00AM-12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 11-DIAGNOSTIC ISSUES

No. 31

HETEROGENEITY OF THE JEALOUSY PHENOMENON IN THE GENERAL POPULATION: AN ITALIAN STUDY

Donatella Marazziti, M.D., Dipartimento di psichiatria, Neurobiologia, Farmacologia e Biotecnologie, Univerrsity of Pisa, Pisa, 56100 Italy, Giorgio Consoli, M.D., Mario Catena Dell'Osso, Ph.D., Alfredo Sbrana, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to to distinguish between four possible sub-types of normal jealousy (depressive, anxious, obsessive and paranoid) using a new questionnaire ("Questionario della gelosia, QUEGE").

SUMMARY:

Jealousy is an emotion ranging from normality to severe psychopathological domains. In the present study, we explored, among a cohort of 500 healthy university students, the possibility to distinguish between four sub-types of "normal" jealousy (depressive, anxious, obsessive and paranoid) by means of a new questionnaire ("Questionario della gelosia, QUEGE"). QUEGE is a self-report instrument comprising 30 items which explore the presence, frequency and duration of feelings and behaviours related to jealousy, set up in order to investigate 4 hypothetical psychopathological profiles: depressive, paranoid, obsessive and anxious. The factor analysis identified 5 rather than 4 clear-cut factors: self-esteem, paranoia, interpersonal sensitivity, fear of being abandoned, obsession. Women showed statistically significant lower levels of self-esteem and higher levels of obsession than men. The younger age (<25 years) was associated with lower self-esteem and higher levels of paranoia and obsession, while being single was associated with lower self-esteem and higher levels of obsession. The present study provides evidence of the reliability and validity of the QUEGE instrument, which would seem to identify the presence in the general population of five psychopathological dimensions within the jealousy phenomenon.

REFERENCES:

1) Mullen, P. E., Martin, J. (1994). Jealousy: A community study. British Journal of Psychiatry, 164, 35-43.

2) Marazziti, D., Di Nasso, E., Masala, I., Baroni, S., Abelli, M., Mengali, F., Mungai, F., Rucci, P., & Cassano, G.B. (2003). Normal and obsessional jealousy: A study of a population of young adults. European Psychiatry, 18, 106-11.

No. 32

OLFACTORY REFERENCE SYNDROME (ORS): A SYSTEMATIC REVIEW OF THE WORLD LITERATURE

Millia Begum, M.B.B.S, M.Eng., Flat 2/1, 36 Dudley drive, Glasgow, G12 9SA Scotland, P.J.McKenna, M.A., M.B., Ch.B., MRCPsych

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the phenomenology of ORS; 2) have a knowledge of its pathogenesis; 3) provide care and treatment to these patients based on our research evidence; and 4) learn the problems of current classification of ORS based on the above understanding.

SUMMARY:

Objective: Olfactory reference syndrome is characterized by a fixed belief that one is emanating body odor despite evidence to the contrary (1). It has been classified as delusional disorder-so-

matic subtype *(DSM-IV*) or persistent delusional disorder (ICD-10). Over the century, various modalities of treatment have been utilized on a 'trial and error' basis. To our knowledge, there is no randomized controlled trial of treatment in ORS.Here the authors sought to resolve discrepant findings concerning its phenomenology and treatment outcome by conducting a systematic review of the evidence.

Method: A comprehensive literature search was conducted for case reports and case series describing the condition. Studies that met the inclusion criteria were examined in order to: A. Clarify the phenomenology of ORS; B. Study its precipitating factors; and C. determine treatment outcomes.

We also sought to examine the comparative effectiveness of antipsychotic drugs, antidepressants and psychotherapy.

Results: From over a hundred articles, 80 case reports met criteria for inclusion for our review. In over half of these cases, symptom onset appears to be in their adolescence. A precipitating event has been recorded in about 50% of these cases. The symptom profile of ORS appears to be that of an overvalued idea in contrast to other concepts (2).

The evidence from the world literature suggests the response to antidepressants and to a lesser extent psychotherapy appears to be much better than antipsychotic drugs.

Conclusions: Our findings suggest that ORS has been misclassified as a delusional disorder. The phenomenology and treatment outcomes appear to be similar to an anxiety disorder. Antidepressant and psychotherapy appear to have a better success rate. Revising the nosology of ORS is important, as morbidity of ORS is very high in this condition.

REFERENCES:

1) Pryse-Phillips W: An olfactory reference syndrome. Acta Psychiatr Scand 1971; 47:484–509.
2) PJ McKenna : Disorders with overvalued ideas. The British Journal of Psychiatry 145: 579-585 (1984)

No. 33

DIMENSIONALITY AND ETIOLOGY IN PSYCHIATRIC RESEARCH

Stephen Shanfield, M.D., 122 Chester St. #2, San Antonio, TX 78209

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the complexities of dimensional issues as they relate to the etiology of psychiatric disturbance along with their implications for causality research.

SUMMARY:

Objectives This paper explores dimensions of psychiatric behavior as they apply to causality research. Method: The author draws from the research and clinical literature.

Results The current diagnostic categories were developed in the early drug trial era out of concern for the need for reliability in research. Their origins along with the building blocks, symptoms, are largely 19th century constructs and drawn from a non empiric base. The term dimension has different names with a similar meaning, components, factors, facets, elements, supra or subunits, all associated with categories.

Recent attention has focused on the validity of the categories along with their dimensions in the course of planning for the *DSM-V.* The lack of biomarkers for any category appears to be an element driving the discourse. The categories have unselected and unmeasured elements not in the definition of the disorder. There are hidden assumptions and submerged statements that lead to errors in inference about etiology. Cooccurrence is common and a particular problem in unselected samples. Also, the major disorders have components that overlap with other disorders. Moreover, specific disorders have multiple and unmeasured components. In a study of severe depression, anxiety and hostility as well as depression are embedded in the disorder, each having a different biological substrate. Clinicians recognize this and commonly use medications for dimensions that cross diagnostic lines. The symptoms themselves have embedded confounds. For instance, hallucinations often accompany delusions and vice versa. Hallucinations commonly occur with many of the senses.

The dimension of executive dysfunction, signifying problems with frontal lobe function, has been implicated in psychiatric impairment. On another level, there is a gradient of psychopathology between normal and psychiatrically disturbed.

Conclusions

Likely what we define as disorders are various combinations of dimensions with differing biological elements that cut across the current categories. A return to the study of smaller units of psychopathology is merited. However, there must be agreement among research communities that dimensional research is of value. This will require considerable change as the categories are at the center of the grand narratives of the field.

REFERENCES:

1) Helzer JE, Kraemer, HC, Krueger RF. Wittchen, HU: Dimensional Approaches in Diagnostic Classification: Refining the Research Agenda for DSM-V. Washington DC: American Psychiatric Publishing, Inc, 2008.
2) Katz MM: Clinical Trials of Antidepressants: Time to Shift to a New Model. Journal of Clinical Psychopharmacology 28:468-470 2008

SCIENTIFIC AND CLINICAL REPORT SESSION 12

METABOLISM, METABOLIC SYNDROME AND CARDIOVASCULAR DISEASE IN SCHIZOPHRENIA

No. 34

SCHIZOPHRENIA-SPECTRUM DISORDERS WERE ASSOCIATED WITH CARDIOVASCULAR DISEASE SYMPTOMS, INDEPENDENT OF KNOWN RISK FACTORS FOR SYMPTOMS

Stephen Woolley, D.Sc., M.P.H., 200 Retreat Avenue, Hartford, CT 06106, John W. Goethe, M.D., Lisa Fredman, Ph.D., Alisa Lincoln, Ph.D., Timothy Heeren, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the possible effects of schizophrenia-spectrum disorders (SSDs) and symptoms on the longitudinal development of symptoms of cardiovascular disease (CVD), independent of any effect of atypical antipsychotic effect; 2) The range of possible effects of life style factors on CVD symptom development; and 3) The effects SSDs on CVD symptom development independent

of life style factor effects.

SUMMARY:

Objective: Given the extensive evidence that atypical antipsychotics, smoking, poor diet, and low physical activity are risk factors for cardiovascular disease symptoms (CVDs), we assessed the risk of CVDs associated with schizophrenia-spectrum disorders (SSDs), independent of these factors.

Methods: A community sample from the Epidemiologic Catchment Area study (1980-85), aged 40-64 years, without any of 7 CVD symptoms (e.g., chest pain, heart palpitations) at baseline, was followed for 1 year. Associations between 18 symptoms (e.g., individuals believing someone was watching, spying or following them) or 3 SSDs and the incidence of CVD symptoms were examined. Logistic regression analyses controlled for demographics and psychiatric conditions including substance abuse. In addition, sensitivity analyses adjusted for the possible effects of smoking, diet, and physical activity on the SSDs–CVD symptoms association.

Results: SSDs were associated with a 4-fold significant increase in the odds of developing >1 CVD symptoms (adjusted odds ratio[OR]=4.41) and 3- to 4-fold increases in the odds of individual CVD symptoms, including more than a 50% increase in the odds of developing chest pain. These results remained after controlling statistically for psychiatric conditions and substance abuse, and sensitivity analyses showed these associations were robust after accounting for the possible effects of lifestyle factors. Individual SSD symptoms were associated with increased odds of CVD symptoms (ORs ranged 1.6 – 2.8). Depressive disorders, substance abuse, and especially having anxiety spells/attacks were associated with increased risk (1.3 to 2.6-fold) of >1 symptoms.

Conclusions: This study provides evidence that SSDs are associated with elevated risk of CVD symptoms, independent of the effects of atypical antipsychotics, smoking, diet, and physical activity level.

REFERENCES:

1) De Hert M, Schreursa V, Sweersa K, Van Eycka D, Hanssensb L, Šinkoc S, Wampersa M, Scheend A, Peuskensa J, van Winkel R: Typical and atypical antipsychotics differentially affect long-term incidence rates of the metabolic syndrome in first-episode patients with schizophrenia: A retrospective chart review. Schizophr Res 2008;101:295-303

2) Kelly C, McCreadie RG: Smoking habits, current symptoms, and premorbid characteristics of schizophrenic patients in Nithsdale, Scotland. Am J Psychiatry 1999;156:1751-1757.

No. 35

RAPID METABOLISM OF PSYCHOPHARMACOLOGICAL DRUGS AND AKATHISIA: A TWO WAY KNOCK-OUT PUNCH TO THERAPY IN PSYCHOTIC COURT-ORDER DETENTION PATIENTS

Carel de Blécourt, M.D., Ph.D., Kienvenneweg 18, Rekken, 7157 CC Netherlands

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be (1) convinced of the necessity to monitor plasma levels of antipsychotics in Court-Order detention patients and (2) estimate the value of therapeutic drug monitoring for the doctor-patient relationship.

SUMMARY:

Aim: Investigate whether prescribed antipsychotics have yielded effective plasma levels.

Method: In three groups of ten inpatiens (Pompe Foundation for Forensic Psychiatry, 2007) and in one group of ten inpatients (Forensic Psychiatric Center Oldenkotte, 2008) plasma level monitoring was done after informed consent in patients who were using antipsychotic medication in average or high dose. Some were on oral medication, taken under control, others used depot preparations. Co-prescribed drugs were judged for possible pharmacogenetic drug-drug interactions. To exclude a possible role of ultrarapid metabolism, pharmacogenetic investigation was carried out in addition in the patients of the last group of ten patients.

Results: In ten out of 30 and in three out of ten patients, respectively, so in one third, plasma levels were subliminal or relatively low. No duplication of the gene for CYP2D6 was found.

Discussion: Based on the pharmacogenetic outcome the hypothesis of ultrarapid metabolism had to be rejected. One might assume, however, that the intensity of metabolism of the CYP2D6 in this special subgroup of patients was at the fast side of the Gaussian distribution. After scrutinizing the data it occurred that a high percentage of these patients suffered from severe side effects, especially from akathisia, indicative for hypersensitivity for this side effect at even subliminal plasmalevels. Both limitations might have led to a selection bias. Probably, when these patients were advised, at the time prior to the offence, to increase the dose of the antipsychotic, they rejected this proposal out of fear of side effects. By adjustment of the dose and after treatment of the akathisia in the present patients, therapeutic effect could be improved.

Conclusion: Special attention should be given from the point of view of prevention in General Mental Hospitals to identify these special subgroup of patients in advance. Plasma level monitoring favors the doctor-patient relationship.

REFERENCES:

1) Touw DJ, Neef C, Thomson AH, Vinks AA.Cost-effectiveness of therapeutic drug monitoring: A systematic review. Ther Drug Monit. 2005;27:10-17.

2) Perlis RH, Ganz DA, Avorn J, Schneeweiss S, Glynn RJ, et al. Pharmacogenetic testing in the clinical management of schizophrenia: A decision-analytic model. J Clin Psychopharmacol. 2005;25:427-434.

No. 36

OATMEAL VERSUS DONUTS: TREATING METABOLIC SYNDROME/OBESITY USING CBT/DBT IN AN INNER CITY SPMI POPULATION

Joanne Caring, M.D., Joanne Caring, MD, Unit Chief, C.S.S. Program, Metropolitan Hospital Center, 1901 First Avenue, New York, NY 10029

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify some effective methods to foster weight loss and exercise in this population.

SUMMARY:

Objective: The problems of obesity, metabolic syndrome, and diabetes in the Latino and African-American S.P.M.I. population are well known, complex, and difficult to treat. The team implemented a comprehensive protocol to improve body mass inde anincrease exercise in this population.

Methods: We initiated a Quality Improvement Study in 2005 in compliance with the N.Y.C. Department of Health and Mental Hygiene's mandate for ongoing quality assurance. This is a report on data at 36 months in a Quality Improvement Study in an inner city S.P.M.I. Continuing Day Treatment Program. All clients with a B.M.I. >30 were included in the Quality Improvement Study. In Phase I there were 33 clients and in Phase II there were 31 clients. We developed a comprehensive prospective program to promote healthy eating habits, weight loss, and increased exercise. Our interventions were based on and informed by C.B.T., D.B.T., and adherence techniques.

Results: In Phase I (months 1-21) 67 % (n=22) of clients lost weight. In Phase II (months 21-36) 55% (n=17) of clients lost weight. Due to the natural client turnover during the 36 months of the study, Phase 1 and 2 each encompassed somewhat different individual clients. For the clients who participated from 2005 to 2008 (n=24), 46% (n=11) of clients lost weight and 79% (n=19) lost weight, maintained weight, or gained 6 pounds or less. There was a five-fold increase in exercise session participation.

Conclusion: Treating obesity and increasing exercise are well documented global public health issues. Few effective protocols exist for treating obesity in the S.P.M.I. population. That these clients lost weight indicates that effective interventions can produce results even in this population. These interventions may help decrease the risk and incidence of diabetes and cardiovascular disease in the S.P.M.I. population.

REFERENCES:

1) : Beck J: Cognitive Therapy; Basics and Beyond. New York, The Guilford Press, 1995

2) : Meichenbaum D, Turk DC: Facilitating Treatment Adherence – A Practitioner's Guidebook. New York, Plenum Press, 1987

SCIENTIFIC AND CLINICAL REPORT SESSION 13 DIAGNOSTIC ISSUES IN THE SCHIZOPHRENIA SPECTRUM

NO. 37
IS SCHIZOAFFECTIVE DISORDER A DISTINCT CLINICAL ENTITY?

John Goethe, M.D., 200 Retreat Avenue,Hartford, CT 06106, Hartford, CT 06106, Bonnie L. Szarek, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the demographic and clinical features that distinguish schizoaffective disorder from bipolar disorder and schizophrenia.

SUMMARY:

Objectives: To identify variables uniquely associated with a clinical diagnosis of schizoaffective disorder (SA) vs a diagnosis of schizophrenia (SZ) or bipolar (BP).

Methods: All patients admitted 1/01 to 12/07 with a clinical diagnosis of SA, SZ, or BP (n=5102) were compared on demographic and clinical variables. (Metabolic Syndrome (MetS) measures were collected in only the last three of these years (n=2669).) Data analyses included logistic regressions.

Results: Compared to BP patients the SA group was more likely to be age = 40 (OR=1.27) and black (OR=1.78) but less likely to be female (OR=0.67). Compared to SZ, however, SA was less likely to be = 40 (OR=0.82) and black (OR=0.61) but more likely to be female (OR=3.06). SA had greater risk than BP for an LOS > 13 days (the top quartile for the sample as a whole) (OR=1.33) but less risk than SZ (OR=0.76). Atypical antipsychotic use was much more common in SA vs BP (OR=4.47) or SZ (OR=1.34). A diagnosis of substance abuse was less likely in SA vs BP (OR=0.64) but more likely vs SZ (OR=1.61). Similarly, personality disorders were less likely in SA vs BP (OR=0.74) but more likely vs SZ (OR=3.08). MetS was more common in SA (36.5%) compared to SZ (25.0%) or BP (23.7%) ($p<.001$, OR=1.75); of the individual MetS criteria only the blood pressure (OR=1.30) and waist circumference (OR=1.84) measures were significantly more common in SA. Among SA patients MetS prevalence was significantly greater in females than males (40.9% vs 31.4%, $p<.037$), but prevalence did not vary by gender in SZ or BP.

Conclusions: Comparisons of these three diagnostic groups revealed statistically significant differences in the distributions of demographic (age, gender, race) and clinical (LOS, co-diagnoses, MetS) variables. SA patients had the highest risk only on metabolic measures; on all other distinguishing variables their risks were at intermediate points between those for SZ and BP.

REFERENCES:

1) Peralta V, Cuesta MJ. Exploring the borders of the schizoaffective spectrum: a categorical and dimensional approach. J Affect Disord 2008; 108:71-86

2) van Winkel R, van Os J, Celic I, Van Eyck D, Wampers M, Scheen A, Peuskens J, De Hert M. Psychiatric diagnosis as an independent risk factor for metabolic disturbances: results from a comprehensive, naturalistic screening program. J Clin Psychiatry 2008; 69:1319-1327

No. 38
DIAGNOSTIC STABILITY IN PATIENTS WITH SCHIZOAFFECTIVE DISORDER COMPARED TO SCHIZOPHRENIA AND BIPOLAR DISORDER

Bonnie Szarek, R.N., Institute of Living 200 Retreat Avenue Hartford, CT 06106, John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) describe the patterns of change in diagnosis in schizoaffective disorder, vs schizophrenia and bipolar; and (2) discuss the clinical and demographic features associated with a change in diagnosis.

SUMMARY:

Objective: To identify variables associated with a change in diagnosis in patients with a clinical diagnosis of schizoaffective (SA) vs bipolar disorder (BP) or schizophrenia (SZ).

Methods: The investigators compared demographic and treatment variables in consecutive inpatients who had a discharge diagnosis of SA, BP or SZ and at least one subsequent hospital-

ization during the study period (1/2000-12/2007, n=2504). Associations with a change in diagnosis were identified with stepwise logistic regressions.

Results: Patients with a diagnosis of SA at any hospitalization were least likely to have this diagnosis for all admissions (30.6% vs 37.0% for BP and 46.9% for SZ). It was rare for patients to be given a diagnosis of BP at one admission and SZ at another (0.6%), but about 10% of patients received diagnoses of SA and SZ and another 10% diagnoses of SA and BP. A change to/from a diagnosis other than SA, SZ or BP was most common among patients who, at some time, were BP (37.0% vs 22.5% in SA and 16.3% in SZ). Within the SA group those with no change in diagnosis were more likely to be age = 40 (OR=1.24) and less likely to have a substance abuse co-diagnosis (OR=0.73). There was a similar pattern in the SZ group (OR=1.71 for age = 40, OR=0.61 for substance abuse), and patients consistently diagnosed as BP were also less likely to have substance abuse (OR=0.84). For BP, however, age was not relevant, and race was less likely to be Latino (OR=0.37) or black (OR=0.37). A co-diagnosis of personality disorder decreased the odds of a change in diagnosis in SZ (OR=0.76) but had no effect in SA or BP patients.

Conclusions: As expected, patients whose diagnosis at any hospitalization was SA were more likely to have a change in diagnosis. However, a change in diagnosis was very common (>50%) in all three diagnostic groups, and the variables associated with diagnostic instability differed by diagnosis.

REFERENCES:

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2) Chen YR, Swann AC, Burt DB. Stability of diagnosis in schizophrenia. Am J Psychiatry 1996; 153:682-686

No. 39

DEPRESSION AND ITS TREATMENT IN PATIENTS PRESENTING WITH LATE-ONSET DELUSIONAL DISORDER (LODD)

Rebecca Anglin, M.D., 301 James South, F416, Hamilton, ON, L8P 3B6 Canada, Patricia I. Rosebush,M.Sc.N, M.D., Michael M. Mazurek, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize that (1)the majority of patients presenting with LODD are also depressed. (2)Depression in patients with LODD resolves with treatment of the psychosis and does not require anti-depressant medication.

SUMMARY:

Background: Mood symtpoms can be prominent in the majority of patients diagnosed with LODD. Whether these symtpoms resolve with treatment of the psychosis, or whether they require antidepressant medication remains controversial. This issue is particularly relevant in older patients, who are very susceptible to medication side effects and toxicity when exposed to multiple medications. Method: We prospectively studied patients age 45 and older who presented psychiatrically for the first time and who met *DSM-IV* TR diagnostic criteria for delusional disorder.Those with dementia were excluded.Assessments were comleted at presentation, at 72 hours and biweekly thereafter, until discharge, using the HAM-D, HAM-A, BPRS, GAF,YMRS, PANSS, CGI and EPS rating scales, by a research nurse blind to diagnosis or medications. All patients were treated with low-dose antipsychotic agents at the discretion of the treating physician.

Results:Ninety-three patients (56 female, 37 male) with an average age of 66.2 (range 45-90)were assessed. Mean BPRS (SD) at presentation was 48(9). Fifty-six (60%) met criteria for major depression with HAM-D scores >17. Seventeen of the 56 patients(30%) had active suicidal ideation or had made a suicide attempt. Depression resolved completely, with HAM-D scores <7, in 46/56 patients (82%) within one week of antipsychotic treatment alone.

Conclusions:(1)The prevalence of depression in patients presenting with LODD is high.(2) Depression in these patients responds robustly to treatment with anti-psychotic agents alone.

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SCIENTIFIC AND CLINICAL REPORT SESSION 14 PSYCHIATRIC ISSUES RELATED TO PREGNANCY AND BREAST FEEDING

NO. 40

POSTPARTUM DEPRESSION AND BREAST FEEDING IN AN URBAN POPULATION WOMEN IN MALAYSIA

Nor Zainal, M.B.B.S, M.Psy., Pantai Valley, Kuala Lumpur, 50603 Malaysia, Anandjit Singh, M.B.B.S., Jesjeet S Gill, M.Psy., Rosie Jowan, M.Med.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize that exclusive breast feeding plays an important protective role against the development of postpartum depression; 2) Understand the implication on mother's mood if mixing both bottle and breast feeding; and 3) Realize that knowledge and evidence of this can be utilized in programs that promote the benefits of breast feeding.

SUMMARY:

Objectives: To determine the incidence of postpartum depression and its relationship with breast feeding in mothers during their postpartum period. Methods: This was a cross sectional study done within 6 months in a medical centre, Kuala Lumpur on all postpartum mothers who fulfilled the inclusion and exclusion criteria of the study population. All socio-demographic data including the mothers' pregnancy and clinical histories were obtained. The breast feeding status was obtained whether they were exclusive/non-exclusive or not breast feeding. MINI International Neuropsychiatric Interview questionnaire was used to diagnose Major Depressive Episode–postpartum. Results: A total number of 411 mothers participated. 48% of the mothers practiced exclusive breast feeding, 40% were mixed feeding and 12%

were not breast feeding. The incidence of postpartum depression was 6.8%. Univariate analysis showed mothers who delivered via caesarian section, not working, low social support, family history of depression and with previous history of depressive illness were significantly associated with postpartum depressive episode. The non-exclusive breast feeding (mixed and not breast feeding) and not breast feeding mothers were significantly associated with postpartum depression as compared to the exclusive breast feeding mothers (OR=28.9, 95%CI 3.8-200 and OR=43.5, 95%CI 5.6-333.3 respectively). Multivariate regression analysis showed only breast feeding status and previous history of depression were found significantly associated with postpartum depression. Conclusion: Exclusive breast feeding was significantly a protective factor against postpartum depression. In view of that, policy makers in Malaysia should consider laws that help promote mothers to continue exclusively breast feed their infants such as extending the mandatory maternity leave, legislation to ensure setting up of breast feeding corners and child care centers at workplace, allow optional non-paid leave or even allowing them to work from home.

REFERENCES:

1) Eberhard-Gran M, Eskild A, Opjordsmoen S: Depression in postpartum and non-postpartum women: prevalence and risk factors. Acta Psychiatr Scand 2002; 106:426-433
2) Mezzacappa ES, Katkin ES: Breast-feeding is associated with reductions in perceived stress and negative mood in mothers. Health Psychol 2002; 21:187-193

NO. 41

PSYCHOTIC DENIAL OF PREGNANCY: ETHICAL AND LEGAL CONSIDERATIONS FOR TREATING PHYSICIANS

Melissa Nau, M.D., 401 Parnassus Ave, San Francisco, CA 94143, H. Eric Bender, M.D., Judith Street, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the ethical and legal considerations when working with pregnant psychotic women; 2) Understanding of relevant legal precedent as well as information about how to better assess and treat patients who refuse prenatal care.

SUMMARY:

This paper begins with a presentation of a clinical case at a California public hospital in which a homeless schizophrenic woman presented at 35-weeks pregnant. She was psychotic and in full denial of her pregnancy; the patient was subsequently held against her will in the hospital on the basis of grave disability until the delivery of her fetus. As the treatment team confronted decisions regarding optimal management of the patient's health and the health of her fetus, numerous ethical and legal considerations arose. What is the legal precedent for such a case? How invasive can and should doctors be to provide care for the fetus? The authors seek to explore the relevant legal precedent for treatment of pregnant women who are incompetent to make medical decisions. This is done through examination of civil and criminal precedent involving both competent and incompetent pregnant women. At the conclusion of the article, the authors propose a framework by which to approach this very challenging question.

REFERENCES:

1) McCullough, Laurence B., PhD, Coverdale, John H., FRANZCP, and Chervenak, Frank A, MD: Ethical challenges of decision making with pregnant patients who have schizophrenia. Am J Obstet Gynecol 2002; 187:696-702.
2) Pregnant Women and the Fourteenth Amendment: A Feminist Examination of the trend to eliminate women's rights during pregnancy. 26 Law & Ineq. 171

No. 42

POSTTRAUMATIC GROWTH AND QUALITY OF LIFE IN BREAST CANCER PATIENTS

Derya Iren Akbiyik , M.D., Ph.D., Bulbulderesi Cad. 50/5, Ankara, 06660 Turkey, Haldun Soygur, M.D., Ph.D., Merve Yuksel, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to know that cancer diagnosis as an ongoing source of stress can have an strengthening effect on patients and cause a psychological growth which has a relationship between quality of life.

SUMMARY:

Objective: The aim of the study is to evaluate the posttraumatic growth in breast cancer patients and search the correlates with quality of life and sociodemographic data.

Method: Breast cancer patients who had admitted to radiotherapy services of the Ankara Oncology Research and Training Hospital were given a posttraumatic growth scale and a quality of life scale (EORTC)along with the sociodemographic data forms. The terminal patients were excluded if they were unable to answer the forms themselves.

Results and conclusion: There was a meaningful positive relation between posttraumatic growth and QoL. The younger age and educational levels had some impact on this relationship.

REFERENCES:

1) Sharon Manne, Jamie Ostroff, Gary Winkel, Lori Goldstein, Kevin Fox, Generosa Grana. Posttraumatic Growth After Breast Cancer: Patient, Partner, and Couple Perspectives. Psychosomatic Medicine 66:442-454 (2004).
2) Bellizzi KM, Blank TO. Predicting posttraumatic growth in breast cancer survivors.Health Psychol. 2006 Jan;25(1):47-56.

SCIENTIFIC AND CLINICAL REPORT SESSION 15

EXPLORING SUCIDALITY: ASSESSMENT AND THE IMPACT OF SPIRITUALITY AND ECONOMIC CONDITIONS

No. 43

MEETING THE CHALLENGE OF RISK ASSESSMENT: TOWARDS A NEW SCALE OF SUICIDE ASSESSMENT: THE SCALE FOR IMPACT OF SUICIDALITY - MANAGEMENT AND ASSESSMENT

Amresh K. Shrivastava, M.D., D.P.M., 467, Sunset Drive, Regional Mental Health care, St.Thomas, Ontario, N5H 3V9 Canada, Charles Nelson, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To explore Concept of risk; 2) To understand advances and limitations of prevailing Concept; 3) Understand risk assessment, & its significance in Clinical Practice; aand 4) Explore

newer ways of Coping with Challenges of Risk Assessment & Discuss about a new scale, SIS-MAP (The Scale for Impact of Suicidality - Management, Assessment and Planning of Care

SUMMARY:

Risk assessment is an important clinical responsibility, which can be 'life-saving' in nature. Literature on risk factors has become voluminous; however a traditional risk assessment does not take into account the most relevant factors. This likely reflects the prevailing conceptualization of risk, which has not been fully and completely tied to clinical outcomes. Psychopathology is currently understood in biopsychosocial terms. A more progressive conceptualization of risk should consider the interplay of both risk and protective factors. The present work proposes a model of risk depending upon 'trait' risk and 'state' risk factors. The joint impact of such a risk is evaluated against protective factors. Further it conceptualizes that risk consists of several domains and each of these domains contribute to causation of suicidal ideation. These domains include consideration of biological, psychological, social-environmental, spiritual & protective domains. The present study examined the utilization of a new structured clinical interview called the Scale for Impact of Suicidality Management, Assessment and Planning of Care (SIS-MAP). SIS-MAP ratings were evaluated against a group of incoming psychiatric patients over a 6-month period. Participants consisted of adult male and female patients at RMHC, St. Thomas, Canada between February and August 2008. Preliminary analysis supported that the SIS-MAP is a valid and reliable tool to determine the level of psychiatric care needed for adults with suicidal ideation. Clinical cut-off scores were established from the observed mean differences in the patients' total scores and level of care needed. A canonical discriminant function analysis was conducted in order to evaluate whether SIS-MAP total scores were predictive of admission. The analysis resulted in a total 74.0% of original grouped cases were correctly classified (Wilks Lambda = .749, $p<0.001$). The specificity of the scale (correctly identifying individuals who did not require admission) was 78.1% while the sensitivity of the scale (correctly identifying individuals who required admission) was 66.7%. The false positive rate was 33.3% while 21.9% of cases resulted in a false negative. The measure also demonstrated moderate-high inter-rater reliability (between 0.70 and 0.81 ($X= .76$), $N=20$, $p<.001$).

REFERENCES:

1) Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A.L., & McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. Suicide and Life-Threatening Behavior, 37, 353-365.

2) Sanchez, H.G. (2001). Risk factor model for suicide assessment and intervention. Professional Psychology, Research and Practice, 32, 351-358.

No. 44

ECONOMIC FACTORS AND SUICIDE RATES - ASSOCIATIONS OVER TIME IN FOUR COUNTRIES

Alfonso Ceccherini-Nelli, M.D., Old Bisley Road, Frimley, RG4 7BA United Kingdom, Stefan Priebe, Dr.Med.Habil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognise the heterogeneity of methods may explain much of the inconsistencies of findings on economic factors and suicides in the literature; 2) there is a strong association between economic factors and suicide rates, with unemployment having the largest impact on suicide rates; and 3) in the evaluation of suicide prevention strategies, unemployment rates should be considered as a potentially confounding factor.

SUMMARY:

Context: Suicides account for more than 30,000 deaths per year in the United States alone. Suicide rates change over time, and the factors influencing them remain poorly understood. Economic factors, in particular unemployment, have been suggested as a major influence. Yet, the evidence for this has been inconsistent, which may be partly explained by shortcomings of the statistical methods used.

Objective: To establish the associations over time between major economic factors and suicide rates in the United States and Europe.

Design: Time series analytical techniques (unit root and cointegration tests) were applied to test the associations over time between economic factors, i.e. unemployment, real gross domestic product per capita and the consumer price index, and suicide rates in the United States, United Kingdom, France and Italy. Traditional correlation analyses were used when appropriate.

Setting, participants and main outcome measure: Death rates by suicide intentional harm as collected by national agencies in the United States (1900-1997), United Kingdom (1901-2006), France (1970-2004) and Italy (1970-2001).

Results: Cointegration and correlation tests showed a long run association between economic factors and suicide rates. Increase of unemployment consistently predicted an increase of suicide rates, and vice versa, over long historical periods and in different nations. Real gross domestic product per capita and the consumer price index were also linked with suicide rates, but this was not consistently so and the direction of the association varied.

Conclusions: Unemployment is a major factor influencing suicide rates over long periods of time and in different national contexts. It needs to be considered as a confounding factor in evaluations of suicide prevention strategies.

REFERENCES:

1) Durkheim E (1897) On Suicide (Penguin Classics) Richard Sennett (Introduction), Robin Buss (Translator) London 2006

2) Blakely T.A., S C D Collings, and J Atkinson Unemployment and suicide. Evidence for a causal association? Journal of Epidemiology and Community Health 2003;57:594-600

No. 45

RELIGION, SPIRITUALITY AND SUICIDE IN A LARGE COMMUNITY SAMPLE

Daniel Rasic, B.S., M.D., 1573 Vernon St, Halifax, B3H 3M8 Canada, Shay-Lee Belik, B.Sc., Brenda Elias, Ph.D., Laurence Y. Katz, M.D., Murray Enns, M.D., Jitender Sareen, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session the participatn should be able to: 1) Understand the associations between religion, spirituality and suicidal ideation and attempts in both the general population

and in those with mental disorders; and 2) Recognize how social supports relate to this relationship.

SUMMARY:

Background: Studies show that religion and spirituality are associated with decreased rates of mental illness. Some studies show decreased rates of suicide in religious populations, but the association between religion, spirituality and suicidal behaviors in people with mental illness are understudied. Few studies have examined the influence of social supports in these relationships.

Methods: Data were drawn from the Canadian Community Health Survey 1.2. Logistic regression was used to examine the relationship between spiritual values and religious worship attendance with 12-month suicidal ideation and attempts. Regressions were adjusted fro sociodemographic factors and social supports. Interaction variables were then tested to to examine possible effect modification by presence of a mental disorder.

Results: Identifying oneself as spiritual was associated with decreased odds of suicide attempt (adjusted odds ratio-1 [AOR-1]=0.65, CI: 0.44-0.96) but was not significant after adjusting for social supports. Religious attendance was associated with decreased odds of suicidal ideation (AOR-1=0.64, 95% CI:0.53-0.77) but not after adjusting for social supports. Religious attendance was associated with decreased odds of suicide attempt and remained significant after adjusting for social supports (AOR-2=0.38, 95% CI: 0.17- 0.89). No significant interaction effects were observed between any of the tested mental disorders and religion, spirituality and suicidal behavior.

Limitations: This was a cross-sectional survey and causality of relationships cannot be inferred.

Conclusions: Results suggest that religious attendance is associated with decreased suicide attempts in the general population and in those with a mental illness independent of the effects of social supports.

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2) Colucci, E., Martin, G., 2008. Religion and Spirituality along the suicidal path. Suicide and Life Threat. Behav. 38, 229-244.

SCIENTIFIC AND CLINICAL REPORT SESSION 16- PANIC & ANXIETY DISORDER

No. 46

FREQUENCY AND CLINICAL CORRELATES OF ADULT SEPARATION ANXIETY DISORDER IN 508 OUTPATIENTS WITH MOOD AND ANXIETY DISORDERS

Stefano Pini, M.D., via Roma 67, Pisa, 56100 Italy, Marianna Abelli, M.D., Alessandra Cardini, Ph.D., Lisa Lari, Ph.D., Camilla Gesi, M.D., Matteo Muti, M.D., Simona Calugi, Ph.D., Giovanni .B. Cassano, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose adult separation anxiety disorder in clinical settings and recognize its impact on individual's level of functioning

SUMMARY:

Objectives: To evaluate frequency and clinical correlates of adult separation anxiety disorder (ASAD) in a large cohort of patients with mood and anxiety disorders.

Method: Overall, 508 outpatients with anxiety and mood disorders were assessed for principal diagnosis and comorbidity by the SCID-I. Separation anxiety into adulthood or childhood was evaluated by the Structured Clinical Interview for Separation Anxiety Symptoms (SCI-SAS), the Separation Anxiety Symptoms Inventory (SASI) and the Adult Separation Anxiety Checklist (ASA-CL). Other scales were also used for psychopathology. Level of functional impairment in three inter-related domains, work/school, social and family life was assessed by the Sheehan Disability Scale (SDS).

Results: Of the total cohort of 508 patients with mood and anxiety disorders, 105 (20.7%) were assessed as having ASAD without a history of childhood separation anxiety; 110 (21.7%) had ASAD with a history of childhood separation anxiety and 43 (8.5%) reported a history of separation anxiety disorder during childhood only. Analysis of mean age-of-onset of separation anxiety shows that the majority of the respondents classified as ASAD without a history of childhood separation anxiety cases began in early 20s. Patients with ASAD had higher rates of anxiety comorbidity and a greater number of affective episodes than those without ASAD. Multivariate analysis of covariance showed that ASAD was associated with severe role impairment in work and social relationships after controlling for potential confounding effect of anxiety comorbidity.

Conclusions: Adult separation anxiety disorder is likely to be much more common in adults than previously recognized. The disorder has been found to have a substantial impact on level of functioning after controlling for mood and anxiety comorbidity. Research is needed to better understand the relationships of ASAD with other co-occurring affective disorders.

REFERENCES:

1) Shear K, Jin R, Ruscio AM, Walters EE, Kessler RC. Prevalence and correlates of estimated DSM-IV child and adult separation anxiety disorder in the National Comorbidity Survey Replication. Am J Psychiatry 2006;163: 1074-1083

2) Pini S, Abelli M, Mauri M, Muti M, Iazzetta P, Banti S, Cassano GB. Clinical correlates and significance of separation anxiety in patients with bipolar disorder. Bipolar Disord 2005;7: 370-376

No. 47

LONG-TERM TREATMENT OF PANIC DISORDER WITH CLONAZEPAM OR PAROXETINE: A RANDOMIZED NATURALISTIC OPEN STUDY

Antonio Nardi, M.D., Ph.D., Laboratory of Panic & RespirationFederal University of Rio de JaneiroR Visconde de Piraja 407/702Rio de Janeiro RJ22410-003Brazil, Rio de Janeiro, 22410003 Brazil, Antonio E. Nardi, M.D., Alexandre M. Valença, M.D., Rafael. C. Freire, M.D., Roman Amrein, M.D., Fabiana L. Lopes, M.D., Isabella Nascimento, M.D., Valfrido L de-Melo-Neto, M.D., Anna L. King, Psy.D., Gastão L. Soares-Filho, M.D., Aline Sardinha, Psy.D., Michelle N. Levitan, Psy.D., Rafael T. da Costa, Psy.D., Marco A. Mezzasalma, M.D. Ana C. de Cerqueira, M.D., Marcio Versiani, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Analyze the similarities and differences of a long term treatment with clonazepam monotherapy, or paroxetine monotherapy or their combination in panic disorder patients; 2) Recognize the dose, main side effects, and response profile of each drug and their combination. and 3) Observe that the features of long term treatment with these drugs in panic disorder.

SUMMARY:

Objective: to describe with prospective methodology the therapeutic response to clonazepam or paroxetine in an open naturalistic 3-year treatment of panic disorder (PD). Methods: A total of 120 PD outpatients (DSM-IV) were openly treated with clonazepam or paroxetine for 8 weeks. Those who responded entered a 3-year follow-up. Demographic and clinical features were compared in the two groups. The principal instruments used to evaluate response were the Clinical Global Impression, the number of panic attacks and the Hamilton Scale for Anxiety (HAMA). Results: Efficacy was evaluated by Intent to treat, last value carried forward. The HAMA did not differ between the groups at baseline and during the treatment. In the acute treatment phase (8 weeks) and at the end of the long-term follow-up both groups had a significant and similar response - 86.8% of the clonazepam group and 73.0% of the paroxetine group had a complete remission of panic attacks. The mean dose for clonazepam was 1.9 ± 0.2 mg/day and for paroxetine 33.8 ± 9.8 mg/day. There was no difference in the scale scores, and the reduction in panic attacks from baseline to end-point did not differ between the groups. The most common adverse events during treatment were tremor/shaking, nausea/vomiting, sexual dysfunction and appetite/weight change in the paroxetine group and drowsiness, sexual dysfunction and memory/concentration complains in the clonazepam group. Conclusion: PD patients using clonazepam or paroxetine had an equivalent response during acute and long term treatment. The response of clonazepam, of paroxetine, and their combination were clearly maintained during the long term follow-up. The patients using clonazepam had significantly less side effects than the paroxetine group.

Acknowledgements: Brazilian Council for scientific and technological development (CNPq). Grant: 554411/2005-9

REFERENCES:

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2) Pollack MH, Simon NM, Worthington JJ, Doyle AL, Peters P, Toshkov F, Otto MW: Combined paroxetine and clonazepam treatment strategies compared to paroxetine monotherapy for panic disorder. J Psychopharmacol 2003; 17:276-282.

No. 48

EFFECTIVENESS OF A MINDFULNESS-BASED COGNITIVE THERAPY PROGRAM AS AN ADJUNCT TO PHARMACOTHERAPY IN PATIENTS WITH PANIC DISORDER

Borah Kim, M.D., 351 Yatap-dong, Bundang-gu, Seongnam, 463-712 Korea, Sang-Hyuk Lee, M.D., Ph.D., Yoon Shik Shin, M.D., Shin Young Suh, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to reconize that Mindfulness-based cognitive therapy could be effective at relieving anxiety sensitivity and panic symptoms in patients with panic disorder

SUMMARY:

Background: Mindfulness-based cognitive therapy (MBCT) has been widely used to treat patients with depressive disorder to prevent relapse.

Objective: The aim of this study was to investigate the acceptability and effectiveness of MBCT in patients with panic disorder who had current panic and residual symptoms.

Methods: Twenty-four patients with anxiety disorder(PD=19 at baseline) were assigned to either MBCT for a period of 8 weeks. The Anxiety sensitivity index (ASI-R), Albany Panic and Phobia Questionnaire (APPQ), Panic Disorder Severity Scale (PDSS), and Hamilton Anxiety Rating Scale (HAM-A) were used to measure at baseline, and after the programs had been running for 8 weeks.

Results: The MBCT group demonstrated significantly improvement in subjective and objective rating scale according to all anxiety and panic (ASI-R, p=0.00; APPQ p=0.00; HAM-A, p=0.00; PDSS, p=0.00) scores. Agoraphobia, socialphobia, interoceptive subscales of APPQ also showed significantly improvement in the MBCT group. And also anxiety reaction, cardiovascular, respiratory, cognitive subscale of ASI-R showed significantly improvement in the MBCT group.

Conclusions: MBCT may be effective at relieving anxiety sensitivity and panic symptoms in patients with panic disorder. However, well-designed, randomized controlled trials are needed.

REFERENCES:

1) Williams JM, Alatiq Y, Crane C, Barnhofer T et al. Mindfulness-based Cognitive Therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning. J Affect Disord. 2007;107:275-279.
2) Segal ZV, Williams JMG, Teasdale JD: Mindfulness-based cognitive therapy for depression : a new approach to preventing relapse. New York, Guilford Press, 2002.

WEDNESDAY, MAY 20, 2009, 11:00AM-12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION17
BORDERLINE PERSONALITY DISORDER

No. 49

PARENTAL VIEWPOINTS OF TRAJECTORIES TO BORDERLINE PERSONALITY DISORDER

Marianne Goodman, M.D., James J Peters VA Medical Center 130 West Kingsbridge Road, Bronx, NY 10468, Uday Patil, M.A., Joesph Triebwasser, M.D., Elizabeth Diamond, MA, Atara Hiller, B.A., Perry Hoffman, Ph.D., Harold Koenigsberg, M.D., Larry Siever, M.D., Antonia New, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list features from infancy, childhood and adolescence that may contribute to the development of borderline personality disorder.

SUMMARY:

Background: In efforts to identify precursors and describe trajectories for the development of borderline personality disorder (BPD), we sought to solicit viewpoints from parents with children diagnosed with BPD.

Methods: We developed a survey containing approximately 100 questions for parents to complete on their BPD offspring and unaffected siblings. The questions cover aspects of the child's life from pregnancy through young adulthood, family history, treatment history, and respondent demographics. A link to the survey was located on the website of the National Education Alliance for Borderline Personality Disorder (NEA-BPD), an organization offering support and services to families of BPD patients. BPD offspring are identified by meeting diagnostic criteria embedded within the survey and having been given a diagnosis of BPD by a professional at some point in their life.

Results: We report on 234 female offspring meeting strict criteria for BPD and 87 unaffected siblings. Parents of daughters with BPD describe the presence of affective symptomatology starting in infancy, including significant differences from non-BPD probands in moodiness, and trend level differences in sensitivity, and self-soothing difficulties during the first year of life. These affective symptoms persist after infancy, and couple with interpersonal difficulties that manifest themselves in toddlerhood and elementary school. By adolescence, difficulties with impulsivity, aggression, acting out, and self-destructive behaviors dominate the profile.

Conclusions: These data suggest that BPD prodromal features can be identified as early as infancy. BPD may be viewed as a tempermental disturbance in affect coupled with adolescent impulsivity.

REFERENCES:

1) Crick, N. R., Murray-Close, D., & Woods, K. (2005). Borderline personality features in childhood: a short-term longitudinal study. Dev Psychopathol, 17(4), 1051-1070.
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No. 50

LIFETIME PATTERNS OF PSYCHOTHERAPY AND MEDICATION UTILIZATION IN FEMALES WITH BORDERLINE PERSONALITY DISORDER- RESULTS OF AN ON-LINE PARENTAL SURVEY

Marianne Goodman, M.D., James J Peters VA Medical Center 130 West Kingsbridge Road, Bronx, NY 10468, Lauren Steffel, B.A., Uday Patil, M.A., Joseph Triebwasser, M.D., Elizabeth Diamond, M.A., Atara Hiller, B.A., Perry Hoffman, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the extensive lifetime use of mental health treatment resources in some patients with borderline personality disorder and the factors that predict greater use.

SUMMARY:

Background: Borderline Personality Disorder (BPD) has been associated with an extensive use of mental heath resources (Bender et al, 2006), however life-time patterns of treatment usage and overall costs for BPD is relatively unstudied.

Methods: We developed an on-line survey containing approximately 100 questions for parents to complete about their BPD offspring, covering clinical variables including life-time treatment history and cost. BPD offspring are identified by meeting diagnostic criteria embedded within the survey and having been given a diagnosis of BPD by a professional at some point in their life.

Results: We report on 427 female offspring meeting our criteria for BPD and a smaller sub-set of survey respondents completing detailed questions about specific treatments (n=176).

Initial evaluation: Behavior (58%) and anger issues (46%) were the most highly endorsed reasons for initial evaluation. MDD was the most common diagnosis and only 16% received a diagnosis of BPD on first presentation. Initial treatment recommendations included medication (60%) and therapy (64%).

Lifetime treatment: Respondents endorsed extensive lifetime treatment including: medication use (91%), psychological treatment (90%) and at least one psychiatric hospitalization (85%). Life-time antidepressant use totaled 82% while antianxeity and antipsychotic agents had 55% and 49% prescribing rates respectively. Individual therapies were pervasive with probands receiving cognitive behavior therapy (39%), dialectical behavior therapy (26%) and psychoanalysis (29%).

Overall cost: Survey respondents endorsed mean insurance expenses of $ 87,305 with a standard deviation of $273,574. The out-of-pocket expenses mean value was $ 48,028 with a standard deviation of $168,115.

Conclusions- BPD can be associated with extensive use of psychotherapy and psychotropic medication resources including large out of pocket expenses. Clinical predictors of higher treatment use and expense will be discussed.

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1) Bender DS, Skodol AE, Pagano ME, Dyck IR, Grilo CM, Shea MT, Sanislow CA, Zanarini MC, Yen S, McGlashan TH, Gunderson JG.Prospective assessment of treatment use by patients with personality disorders.Psychiatr Serv. 2006 Feb;57(2):254-7.
2) Zanarini MC, Frankenburg FR, Hennen J, Silk KR.Mental health service utilization by borderline personality disorder patients and Axis II comparison subjects followed prospectively for 6 years.J Clin Psychiatry. 2004 Jan;65(1):28-36.

No. 51

IS BORDERLINE PERSONALITY DISORDER UNDER DIAGNOSED?

David Meyerson, B.A., 2230 N. Orchard Street, Chicago, IL 60614, Joseph Triebwasser, M.D., Vincent Passarelli, Psy.D., Shauna Weinstein, B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Identify the reasons for underdiagnosis of borderline personality disorder (BPD) and the implications underdiagnosis and/or misdiagnosis can have on treatment; 2) Recognize some of the key differences between BPD and other illnesses that are often confused with BPD.

SUMMARY:

Borderline personality disorder is a chronic, debilitating condition that is estimated to be present in 0.5-5.9% of the general population. However, the complexity of the disorder, the long-standing stigma associated with it, and the overlapping symptomatologies with other disorders, may result in its underdiagnosis. Objective: We hypothesize that (1) BPD is underdiagnosed, (2) BPD patients tend to be misdiagnosed with other disorders from which they in fact do not suffer, and (3) the underdiagnosis and/or misdiagnosis of BPD has implications for treatment. Method: Doctoral-level clinical researchers assigned diagnoses to study participants using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Structured Interview for DSM-IV Personality Disorders (SIDP-IV). Participants diagnosed with BPD were interviewed about their psychiatric diagnostic and treatment histories. Results: 74% of our BPD sample had never been diagnosed with BPD before study entry, despite an average of 10.44 years since their first psychiatric encounters. Even among our BPD participants with histories of suicidality and/or parasuicidality, 68% had never been diagnosed with BPD before study entry. 34% of our BPD sample had been diagnosed with at least one other psychiatric disorder that they in fact did not have. Lifetime misdiagnosis with a "false-positive" axis I disorder was significantly correlated with a higher number of lifetime psychotropic medication prescriptions. This correlation was especially strong when the false-positive axis I diagnosis was bipolar disorder. Conclusions: All three hypotheses were supported. Careful consideration must be given to the accurate diagnosis of BPD, as misdiagnosis may lead to increased prescription of psychotropic medications that likely do not effectively treat BPD. Further research into the differences between BPD and other illnesses may help to attenuate the problem of underdiagnosis and misdiagnosis in this population.

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2) Koenigsberg HW, Harvey PD, Mitropoulou V, Schmeidler J, New AS, Goodman M, Silverman JM, Serby M, Schopick F, & Siever LJ: Characterizing affective instability in borderline personality disorder. Am J Psychiatry 2002; 159:784-788.

SCIENTIFIC AND CLINICAL REPORT SESSION 18

ALGORITHMS AND OTHER MODELS IN THE TREATMENT OF DEPRESSION

No. 52
USING THE CHRONIC CARE MODEL TO IMPROVE DEPRESSION CARE ON COLLEGE CAMPUSES

Henry Chung, M.D., 726 Broadway, Suite 474, New York, NY 10003, Michael Klein, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Reinforce the need for evidence-based depression identification and treatment; 2) Define change concepts (systems changes) used to enhance depression care on college campuses; 3) Discuss results of recently completed regional College Breakthrough Series-Depression collaborative and relevance for quality improvement and suicide prevention; and 4) Compare implementation strategies among participating CBS-D sites.

SUMMARY:

Objective: The College Breakthrough Series – Depression (CBS-D) was a regional healthcare QI initiative intended to enhance the routine clinical care/management of college students with depression, promote early identification of depressed at-risk students, and enhance suicide prevention activities.

Methods: Using the IHI Breakthrough Series (BTS) Chronic Care Model, eight participating university health centers worked together over 12 months to achieve seven quality goals for evidence-based depression identification and treatment. Well established principles of systematic coordinated care for managing depression and methods of overcoming barriers to change were taught over three formal learning sessions and regular email and phone contact in between sessions. Principles of coordinated care implemented included routine depression screening, integration with primary care, care management, and systematic patient outcomes tracking.

Results: Predetermined process and treatment quality goals were articulated prior to student enrollment. Over 71,000 college students were screened for depression. 801 students with depression were followed for treatment; 36% were minority students. Two-thirds of process measures and all three treatment goals were met. 93% received evidence-based treatment within 4 weeks of the initial diagnosis; 49% of depressed students in treatment showed an improvement within 8 weeks; 45% had a partial remission within 12 weeks; 52% reported functional improvement within 12 weeks.

Conclusions: The IHI BTS approach offers a promising approach to increasing access to quality depression care for college students. CBS-D data on depression screening rates and detection of clinically depressed students in medical settings suggests that earlier intervention, and coordinated transition into treatment and systematized efforts aimed at treatment retention improve treatment outcomes.

Funding: Aetna Foundation, New York Community Trust

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2) Chung H, Klein M: Improving Identification and Treatment of Depression in College Health. Student Health Spectrum, June 2007; 8-13.

No. 53
CBASP AND BRIEF SUPPORTIVE PSYCHOTHERAPY FOR AUGMENTATION OF ANTIDEPRESSANT NONRESPONSE IN CHRONIC DEPRESSION

James Kocsis, M.D. 1300 York Ave, New York, NY 10065, Alan J. Gelenberg, M.D., Barbara Rothbaum, Ph.D., Daniel N. Klein, Ph.D., Madhukar H. Trivedi, M.D., Rachel Manber, Ph.D., Martin B. Keller, M.D., Andrew C. Leon, Ph.D., Steven Wisniewski, Ph.D., Bruce A

Arnow, Ph.D., John C. Markowitz, M.D., Michael E. Thase M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the rationale for the REVAMP (Research Evaluating the Value Of Augmenting Medication with Psychotherapy) Study and be familiar with the evidence regarding the use of medication and psychotherapy as treatments for chronic depression in the short term.

SUMMARY:

Prior studies have found that only a minority of patients with chronic depression attained full remission with antidepressant medications alone. We therefore proposed and conducted a study of adjunctive psychotherapy in patients with less than complete response to an initial medication trial titled: CBASP Augmentation for Treatment of Chronic Depression AKA - REVAMP (Research Evaluating the Value of Augmenting Medication with Psychotherapy).

DESIGN: This NIMH sponsored trial compared 12 weeks of: 1) continued pharmacotherapy and adjunctive treatment with the Cognitive Behavioral Analysis System of Psychotherapy (CBASP), 2) continued pharmacotherapy and adjunctive treatment with Supportive Psychotherapy (SP) and 3) continued pharmacotherapy alone (MEDS). Chronically depressed patients with a current major depression (DSM-IV) received pharmacotherapy for a 12-week period (phase 1) based on prior history of antidepressant response. Those not achieving remission were randomized to receive the next-step pharmacotherapy options per algorithm with or without adjunctive psychotherapy (phase 2).

RESULTS: 491 of 808 subjects entering phase 1 were classified as NR's or PR's and randomized in phase 2 (CBASP & MEDS=200, SP & MEDS=195 and MEDS only= 96). Mean HAMD scores dropped from 25.9 to 17.7 in the NR's and 15.2 to 9.9 in the PR's. No statistically significant differences were found among the three treatment groups in the proportions of full responders (15%), partial responders (22.5%)and nonresponders (62.5%), or the degree of changes on Hamilton Depression Scale scores during phase 2.

CONCLUSIONS: Although nearly 40% of this group of chronically depressed patients responded or remitted to this second step of treatment, we found that neither of the psychotherapies significantly improved acute phase therapy outcomes over and above that of a flexible, individualized pharmacotherapy regimen. A longitudinal assessment of potentially later-emerging benefits is ongoing.

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1) Keller MB, McCullough JP, Klein DN, Arnow B, Dunner DL, Gelenberg AJ, Markowitz J, Nemeroff CB, Russell JM, Thase ME, Trivedi M, Zajecka J. (2000). A comparison of Nefazodone, the Cognitive Behavioral Analysis System of Psychotherapy, and their combination for the treatment of chronic depression. NEJM, 342: 1462-1470.

2) Kocsis JH, Gelenberg AJ, Rothbaum B, Klein DN, Trivedi MH, Manber R, Keller MB, Howland R, Thase ME. Chronic Forms of Major Depression Are Still Undertreated in the 21st Century: Systematic Assessment of 801 Patients Presenting For Treatment. J. Affective Dis 2008;110:55-61.

No. 54

CAN CLINICIANS IMPROVE ANTIDEPRESSANT REMISSION RATES WITH BETTER TREATMENT ALGORITHMS?

Richard Metzner, M.D., 60 Cindercone Circle, Sedona, AZ 86336, Andrew P. Ho, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand strengths and limitations of research designs assessing remission rates in depressed patients receiving treatment; 2) Comprehend why certain statistical methods might or might not accurately identify predictors of remission; 3) Demonstrate familiarity with recent evidence regarding new antidepressant treatment algorithms; and 4) Treat depressed patients more effectively.

SUMMARY:

According to the STAR*D study group nearly 7 in 10 MDD patients fail to remit after first-step antidepressant treatment, with few predictors to guide second-step choices. We contrast those findings with the more positive results we obtained in a 33 month study of depressed patients treated in 80 naturalistic primary care and psychiatric settings throughout the United States. Participating clinicians volunteered to receive guidance from an online program called the TTDI, which suggested antidepressants on the basis of patient responses to a 17 item printed questionnaire. The TTDI program was accessed successfully 1,164 times. A sample of 117 patients repeated the TTDI questionnaire between 10 days and 6 months after initial evaluation. Of those 61 were first-step patients. After a mean of 5.7 weeks, they evidenced a 59% remission rate on the TTDI (convergent validity between TTDI and both HDRS and Zung SRS: $p<.01$). TTDI score improvements were also highly significant ($p< .001$; paired t tests). Despite the high remission rate achieved by weighing combinations of TTDI responses in recommending AD's, analysis of the those items using logistic regression did not demonstrate significant predictive value for any of them alone. The conclusions of this study were limited by the fact that that most of the patients were treated without follow-up TTDI testing. Nonetheless, the fact that the TTDI algorithm helped produce a 59% remission rate in a first-step sample without demonstrating predictive value for any specific item, suggests that researchers may need to find other statistical methods to evaluate predictors of antidepressant effectiveness.

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1) Rush AJ, Wisniewski SR, Warden D, Luther JF, Davis LL, Fava M, Nierenberg AA, Trivedi MH: Selecting among second-step antidepressant medication monotherapies: predictive value of clinical, demographic, or first-step treatment features. Arch Gen Psychiatry 2008; 65:870-80.

2) Andreescu C, Mulsant BH, Houck PR, Whyte EM, Mazumdar S, Dombrovski AY, Pollock BG, Reynolds CF 3rd: Empirically derived decision trees for the treatment of late-life depression. Am J Psychiatry 2008;165:790-2.

SCIENTIFIC AND CLINICAL REPORT SESSION 19- PREMORBID FACTORS AND COURSE IN SCHIZOPHRENIA

No. 55

REMISSION IN SCHIZOPHRENIA: A NATIONAL SURVEY OF CLINICAL AND PSYCHOSOCIAL ASPECTS

Yoram Barak, M.D., M.H.A., 15 KKL Street, Bat-Yam, 59100 Israel, Dov Aizenberg, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify schizophrenia patients in remission and to recognize defecits in either clinical or psychosocial remission states.

SUMMARY:

Background: clinical and psychosocial remission amongst schizophrenia patients is nowadays a defined goal of treatment. This necessitates incorporating quantifiable psychosocial variables with traditional symptomatic data as both influence remission.

Objective: to assess psychosocial remission in schizophrenia (using the PSRS) along with the quantification of symptomatic remission in a large cohort of community dwelling schizophrenia patients.

Method: psychiatrists, nurses and social workers endorsed the PSRS and the American Psychiatric Association symptomatic remission criteria (APA-SR) for schizophrenia patients they have been treating for 6 months or more. Data as to gender, age and pharmacological treatment of each patient were also collected.

Results: of 445 participants who completed the survey, 268 (60%) were psychiatrists, 161 (36%) nurses and 16 (4%) social workers. Patients mean age was 43.4 + 13.1 years; 61% were men and 39% were women. Antipsychotic treatments were as follows: Per-os (PO) 243 (55%), IM long-acting typical antipsychotics (LAT) 102 (23%) and IM long-acting risperidone (Consta) 100 (22%). Overall, 37% of patients achieved symptomatic remission and 31% achieved psychosocial remission. Rates of symptomatic remission were significantly higher in patients treated by LAT and Consta compared with PO (51% and 48% vs., 29% respectively, p=0.0003). Rates of psychosocial remission were also significantly higher in patients treated by LAT and Consta compared with PO (43%% and 41% vs., 24% respectively, p=0.003).

Conclusion: about a third of schizophrenia patients in Israel were in remission. IM long acting preparations were associated with higher remission rates. Treatment choice may thus influence rates of remission.

REFERENCES:

1) Andreasen N C, Carpenter W T, Kane J M, Lasser R A, Marder S R, Weinberger D R: Remission in schizophrenia: proposed criteria and rationale for consensus. Am J Psychiatr 2005; 162: 441–449.

2) van Os J, Drukker M, à Campo J, Meijer J, Bak M, Delespaul P: Validation of Remission Criteria for Schizophrenia. Am J Psychiatry 2006; 163: 2000-2002.

No. 56

SCHIZOPHRENIA IN THE OFFSPRING OF ANTENATALLY DEPRESSED MOTHERS IN THE NORTHERN FINLAND 1966 BIRTH COHORT – A GENE X ENVIRONMENT INTERACTION

Pirjo H. Maki, M.D., Ph.D., P O Box 5000, Peltolantie 5, Oulu, 90014 Finland, Tiina Riekki, B.Med., Jouko Miettunen, Ph.D., Matti Isohanni, M.D., Peter B. Jones, M.D., Juha Veijola, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand that antenatal depression is common. However, it may not increase the risk for schizophrenia in the offspring without Familial Risk for psychosis. Instead, in the offspring with both familial risk and maternal depressed mood, the risk for schizophrenia tends to increase. Maternal antenatal depression may act as an additive factor for subjects vulnerable for schizophrenia.

SUMMARY:

Objective: Schizophrenia is considered to be a neurodevelopmental disorder arising as a result of interactions between genetic vulnerability and environmental risk factors. We studied the association between mothers' antenatal depressed mood and schizophrenia in their adult offspring with special consideration to familial risk for psychosis.

Methods: In the Northern Finland 1966 Birth Cohort mothers of 12,058 children were asked at mid-gestation at the antenatal clinic if they felt depressed. This general population birth cohort of the children was followed up for over 30 years, being record-linked with the Finnish Hospital Discharge Register (FHDR) for detecting psychosis in the subjects. The FHDR was also used for identifying psychosis in the parents. Familial Risk for psychosis was considered as a genetic risk factor and mothers' depression as an environmental risk factor.

Results: Of the mothers, 13.9% had depressed mood during pregnancy. Offspring with Familial Risk of psychosis and depressed mother had the highest cumulative incidence of schizophrenia, 7.4% (OR 10.3; 4.6-23.0 adjusted for sex and obstetric complications). Of the offspring with only psychotic parent without antenatal depression, 2.3% got schizophrenia (OR 2.6; 1.2-5.4). In the offspring without Familial Risk of psychosis and with maternal depression the risk of developing schizophrenia was not elevated (OR 1.0; 0.6-1.9).

Conclusion: Mothers' depressed mood during pregnancy per se is unlikely to increase the risk for schizophrenia in the offspring, but may effect in subjects at risk for psychosis. This finding is an example of a gene x environment interaction in the development of schizophrenia. Maternal antenatal depression may act as an additive factor for subjects vulnerable for schizophrenia.

Acknowledgements: This work was supported by grants from the Signe and Ane Gyllenberg Foundation and the Academy of Finland.

REFERENCES:

1) Caspi A, Moffitt TE, Cannon M, et al.: Moderation of the effect of adolescent-onset cannabis use on adult psychosis by a functional polymorphism in the catechol-O-methyltransferase gene: longitudinal evidence of a gene X environment interaction. Biol Psychiatry 2005; 57:1117-27

2) Mäki P, Veijola J, Rantakallio P, et al.: Schizophrenia in the offspring of antenatally depressed mothers – a 31 year follow-up of the Northern Finland 1966 Birth Cohort. Schizophr Res 2004; 66:79-81

No. 57

CHILD AND ADOLESCENCE SYMPTOMS PREDICTING PSYCHOSIS

Juha M. Veijola, M.D., P O Box 5000, Peltolantie 5, Oulu, 90014 Finland, Jouko Miettunen, Ph.D., Marika Kaakinen, M.Sc., Irma Moilanen, M.D., Anja Taanila, Ph.D., Pirjo Mäki, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand not to draw any predicting statements from child's symptoms. Frank psychosis may be predicted only in adolescence and maybe not from childhood symptoms.

SUMMARY:

Objective: Various symptoms and behaviour problems during childhood and adolescence have been reported to precede later psychotic episode. We had a possibility to study in a prospective setting which kinds of symptoms predict first episode psychosis.

Method: Members (N= 9,215) of the Northern Finland 1986 Birth Cohort, an unselected general population cohort, were examined at ages of 7-8 and 15-16 years. The 7-8 –year field study included Rutter B2 questionnaire for teachers and the 15-16 –year field study included a 21-item PROD-screen questionnaire screening prodromal symptoms of psychosis. The Finnish Hospital Discharge Register was used to find out new cases of hospital treated mental disorders. The follow-up of psychotic and non-psychotic disorders was from 1998 to 2005 for Rutter B2 scale analysis and from 2002 to 2005 for PROD-screen analysis.

Results: There were 37 new cases of psychosis (0.45%) during 1998-2005. Rutter B2 antisocial and neurotic symptoms in 7-8 year-olds did not associate statistically significantly with later psychosis.

Of the subjects 17 (0.3%) were treated due to first episode psychosis during 2002-2005 and 95 (1.5%) due to non-psychotic disorder. Those who developed psychosis had more positive, negative and general symptoms in the PROD-screen questionnaire than those who developed non psychotic disorder and also those without disorder.

Conclusions: Symptoms assessed by teachers at age of 7-8 years did not predict later psychosis. This is understandable as Rutter Scale is not meant to be assessing psychotic symptoms. On the other hand psychotic-like self assessed symptoms at age 16 did predict later psychosis. This study emphasises the fact that frank psychosis may be predicted only in adolescence and maybe not from childhood symptoms.

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2) Rutter, M. (1967) A children's behaviour questionnaire for completion by teachers. Journal of Child Psychology & Psychiatry, 8, 1-18.

SCIENTIFIC AND CLINICAL REPORT SESSION 20 TRAUMA AND PTSD

No. 58

THE USS COLE BOMBING: ANALYSIS OF PREEXISTING FACTORS AS PREDICTORS FOR DEVELOPMENT OF POSTTRAUMATIC STRESS DISORDER

Keith Nasky, D.O., 620 John Paul Jones Circle, Portsmouth, VA 23708, Edward Simmer, M.D., M.P.H., Neil Hines, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be able to identify which individual characteristics have been shown to confer resilience against developing posttraumatic mental illness versus those characteristics that may portend susceptibility.

SUMMARY:

On October 12, 2000, suicide bombers aboard a small craft attacked the USS Cole (DDG-67), an event that caused an explosion killing 17 and injuring 39 members of its crew. In the aftermath of the bombing, mental health support was provided to the crew. In effort to best assess the crew's mental health needs, the Naval Medical Center Portsmouth Special Psychiatric Rapid Intervention Team (SPRINT) administered the Zung Self-Rating Depression Scale and the Impact of Event Scale–Revised (IES-R) to the sailors who had been aboard during the attack. The results revealed that higher rank, older age, and male gender were protective factors against developing symptoms of posttraumatic stress, whereas lower rank, younger age, female gender, being injured or having a friend injured or killed were associated with the development of symptoms. Other preexisting factors examined did not demonstrate any predictive value. These findings suggest that some factors bestow resilience; some confer susceptibility in general; and some particular susceptibilities are found more often in one group than others. A better understanding of these factors may lead to the development and implementation of interventions better tailored to address individual needs. Although our data chiefly corroborates previous work, several factors make this study unique. Most noteworthy, we evaluated data collected from a relatively large population of subjects who were all members of a single military unit - a ship's crew - who together experienced the same traumatic event. One of our study's strengths is its external validity towards a specific group. Our sample population, a single military unit in the aftermath of a distinct traumatic event, is representative of the subpopulation for which we hope to provide better care.

REFERENCES:

1) Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. J Consult Clin Psychol, 68(5), 748-766.

2) Schnurr, P. P., Lunney, C. A., & Sengupta, A. (2004). Risk factors for the development versus maintenance of posttraumatic stress disorder. J Trauma Stress, 17(2), 85-95.

No. 59

EMOTIONAL DISTRESS AND OTHER HEALTH-RELATED DIMENSIONS AMONG ELDERLY SURVIVORS OF THE SHOA LIVING IN THE COMMUNITY

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EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role that psychological distress has in the long-

term outcome of individuals exposed to severe trauma.

SUMMARY:

Background: In prior community studies survivors of the Holocaust scored higher on emotional distress (ED) than Europe-born Jews that were not in Nazi-occupied countries during World War II .

Objective: Are elderly survivors, who by definition have survived the hassles of a long life, equally distressed? ED was assessed among a population of elderly Shoa survivors living in the community, about 55 years after the end of WWII. ED was also examined by the severity of exposure to adverse life conditions during the war. In addition, other health-related dimensions were measured.

Methods: A national survey of 5,055 respondents, of whom 4,231 were Jewish-Israelis, was conducted among community residents aged 60 years and over. The research population included former residents of Nazi-occupied countries (N = 896). This group was compared with Europe- and America-born individuals that resided elsewhere during WWII (N = 331). All respondents were administered, among many other items, the 12-GHQ to measure ED and a questionnaire that included sociodemographic and other health-related variables. Bivariate and multivariate methods of analysis were used to compare distributions and to identify relevant factors.

Results: The group of elderly survivors was significantly more distressed than the comparison group. Individuals who had been in ghettos, hiding, or labor or extermination camps had higher mean scores than survivors who were in Nazi-occupied countries, but were spared those experiences. Multivariate analysis showed that the direct effect of the Shoa experience was no longer evident when two other Shoa-dependant variables, years of education and number of chronic health conditions, were entered into the model. Sleep disturbances were more often present in the survivors than among their counterparts, including after controlling for other variables. Social activities that contribute to well-being were more limited among survivors.

REFERENCES:

1) Levav I: Individuals under Conditions of maximum adversity: the Holocaust, in Adversity, Stress, and Psychopathology. Edited by Dohrenwend BP. New York,Oxford University Press, 1988, pp 13-33.

2) Levav I, Abramson JH: Emotional distress among concentration camp survivors. Psych Med 1984; 14:215-218.

No. 60

PSYCHOPATHOLOGY AMONG HOLOCAUST SURVIVORS SIXTY YEARS THEREAFTER

Itzhak Levav, M.D., M.S., 2 Ben Tabai Street, PO Box 1176, Jerusalem, 91910 Israel Asaf Sharon, M.A., Jenny Brodsky, M.A., Annarosa Anat Shemesh, M.P.H., Robert Kohn, M.D. M.Phil.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the long-term outcome of psychopathology among individuals exposed to severe trauma.

SUMMARY:

Objectives. While there is rich clinical literature on the psychiatric disorders of Holocaust survivors, community-based surveys have been limited to examining emotional distress. This study, based on the Israeli component of the World Mental Health Survey, reports on anxiety and mood disorders, sleep problems, emotional distress and other health conditions identified in a sample of community-based Holocaust survivors that were young during the years of World War II (N = 145), and compared with a suitable unexposed population sample (N = 143).

Methods. Respondents were selected from the National Population Register and administered the Composite International Diagnostic Interview, to diagnose psychiatric disorders; the GHQ-12, to measure emotional distress; and items exploring sleep disturbances, pain, obesity, self-report of cardiovascular problems, smoking, and use of mental health services.

Results. Survivors had higher lifetime (OR=6.77, 95% CI 1.89 – 24.20) and 12 month-prevalence rates (OR=22.50, 95% CI 2.47 – 204.82) of anxiety disorders; more current sleep disturbances (OR = 2.5, 95% CI 1.42- 4.41); and increased emotional distress scores ($t = 3.62$, $df = 279$, $p < 0.001$) than the comparison group. All those results were adjusted for confounding variables.

Conclusion. Psychopathology was still identifiable among the Holocaust survivors. Although children, adolescents or young adults at the time, the traumatic events they experienced retained visible effects 60 years after the end of World War II.

REFERENCES:

1) Eitinger L: Pathology of the concentration camp syndrome. Arch Gen Psych 1961; 5:371-379.

2) Solomon Z, Prager E: Elderly Israeli Holocaust survivors during the Persian Gulf War: a study of psychological distress.

Am J Psychiatry 1992; 12:1707-1710.

SCIENTIFIC AND CLINICAL REPORT SESSION 21- SUICIDE IN SPECIALLY DEFINED POPULATIONS

No. 61

SUICIDE AMONG FEMALE VETERANS DURING 2005: FINDINGS FROM THE NATIONAL VIOLENT DEATH REPORTING SYSTEM

Bentson McFarland, M.D., Ph.D., 3181 S.W. San Jackson Park Road, Portland, OR 97239, Mark S. Kaplan, Dr.P.H., Nathalie Huguet, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to list risk factors for suicide among female veterans, describe the numbers of female veterans in the population, and discuss strategies to assess suicide risk among female veterans.

SUMMARY:

Objective: There are over a million women veterans in the United States and veterans comprise about 1.6% of the adult female population. Women now make up substantial fractions of the armed services ranging from 6% of the Marine Corps to 19% of the Air Force. A small longitudinal study (by the present authors) based on the National Health Interview Survey linked with the National Death Index suggested that female veterans might be at elevated risk of suicide compared with other women. The objective of the present cross-sectional study was to confirm or refute the earlier findings.

Method: Data from the 2005 National Violent Death Reporting

System (NVDRS) and the Census Bureau's 2005 American Community Survey were used to compare suicides among female veterans versus non-veteran women. The NVDRS collects detailed data about all violent deaths (including suicides) based on information from death certificates, coroner or medical examiner reports, and interviews with surviving family members or friends. Analyses were stratified by age and race.

Results: In the 16 states that participated in the NVDRS during 2005 there were 57 female veteran suicides and 1,405 non-veteran female suicides. The suicide death rate among female veterans was 11.3 per hundred thousand women per year versus a suicide death rate of 5.0 per hundred thousand women per year for female non-veterans. The Mantel-Haenszel odds ratio for suicide among female veterans (versus other women) was 2.39 (with 95% confidence interval of 1.83 to 3.11). The test for heterogeneity of the odds ratio among the strata was not significant.

Conclusions: In summary, this cross-sectional study confirms earlier findings suggesting that female veterans may be at elevated risk for suicide. Clinicians are advised to assess female veteran patients of all ages and ethic groups for suicide risk.

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1) Kaplan MS, Huguet N, McFarland BH, Newsom JT. Suicide among male veterans: a prospective, population-based study. Journal of Epidemiology and Community Health 2007; 61:619-624.

2) Kaplan MS, McFarland BH, Huguet N, Newsom JT. Sooner versus later: Factors associated with temporal sequencing of suicide. Suicide & Life-Threatening Behavior, 2006; 36:377-385.

No. 62

A MULTI-SITE STUDY OF THE INCIDENCE AND NATURE OF INPATIENT SUICIDE ATTEMPTS

Virginia L. Susman, M.D., New York Presbyterian Hospital, Westchester Division, 21 Bloomingdale Road,, White Plains, NY 10605, Lisa Shea, M.D., Theodore Mucha, M.D., Joseph Gold, M.D., Robert Roca, M.D., Judi Giorgi-Cipriano, R.N., Mary Brinson, M.S., O.T., Gail Nelson, R.N., Gail Tsimprea, Ph.D., Sharon Chaput, R.N. CSHA, Barbara Charen, R.N.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify demographic, diagnostic and other clinical risk factors for suicidal behaviors among inpatients and the most likely methods and situations utilized. Participants will also understand that the identification of risk does not necessarily correlate with predictability. Participants will be able to make informed plans for staff training, for inpatient unit design and for treatment approaches for suicidal patients.

SUMMARY:

Assessing and mitigating the risk of suicide are two of the most important indications for contemporary inpatient treatment. At the same time, ever-decreasing lengths of stay, finding and allocating scarce resources to train new staff and retain experienced staff, and the rising costs for updating and upgrading the safety features of treatment environments, present great challenges to organizations committed to maintaining the highest standards for quality and safety.

Inpatient suicides are rare and are not reported or studied systematically. Suicide attempts are even less reliably and rigorously reviewed. In an effort to contribute to the understanding of the incidence and nature of serious suicide attempts, six leading psychiatric hospitals, each a member of the historic Ivy League Consortium, shared and compiled their data. To strike a balance between examining a maximum number of cases and minimizing variability in practice, the six year period 2002-2007 was studied. There were a total of 153,522 discharges. Over time and across the 6 hospitals, the average length of stay ranged from 8.3 to 20.9 days. Using a working definition for a serious suicide attempt as one in which there was the potential for lethality if the patient were not found or stopped, 142 attempts and 3 completed suicides were identified. The implications of these findings and associated data on diagnoses, demographics, methods utilized and other clinical circumstances will be presented. That there were only three completed suicides is notable as compared to other reports over recent years, and possible reasons for this decline will be discussed. Analysis of the circumstances and nature of the suicide attempts identified in this study will include recommendations for refining educational and communication practices regarding ongoing risk assessment. The need for, and relative value of environmental modifications and monitoring will also be addressed.

REFERENCES:

1) Mills, PD, DeRosier, JM, Ballot, BA, Shepherd, M, Bagian, JP Inpatient Suicide and Suicide Attempts in Veterans Affairs Hospitals. Joint Commission Journal on Quality and Patient Safety, 2008, 482-488

2) Powell, J, Geddes, J, Deeks, J, Goldacre, M, Hawton, K Suicide in psychiatric hospital inpatients. British Journal of Psychiatry. 2000, 266-272.

No. 63

ASSOCIATION BETWEEN ANTIDEPRESSANT HALF-LIFE AND THE RISK OF SUICIDAL IDEATION OR BEHAVIOR AMONG CHILDREN AND ADOLESCENTS

Eric Smith, M.D., M.P.H., 8 Hultin Circle, Holden, MA 01520

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the relationship between antidepressant halflife and the risk of suicidal ideation or behavior in the FDA meta-analysis of pediatric antidepressant trials. They should also be familiar with varying mechanisms that may explain any halflife - suicidality relationship and ways these mechanisms can begin to be tested through research.

SUMMARY:

Background: This study sought to determine from a recent meta-analysis of pediatric antidepressant trials if a general property of antidepressant medications -- the multiple-dosing medication half-life -- is associated with risks for suicidal ideation or behavior.

Methods: Relative risks for suicidal behavior (ideation, attempt, or preparation) for seven antidepressants were obtained from both the FDA's initial and published versions of their pediatric antidepressant meta-analysis. The correlation between the relative risk for suicidal behavior and antidepressant half-life was

examined using a nonparametric test, Spearman's rho.

Results: A significant correlation (? = 0.929; p=0.003) was observed for the initial analysis, as previously reported by Weiss and Gorman. The correlation was robust to a change in the suicidality ranking for the longest half-life medication, fluoxetine, that occurred when results from the Treatment of Adolescent Depression Study (TADS) were included in the published meta-analysis (? = 0.786, p=0.036).

Limitations: In addition to limitations common to meta-analyses, our analysis has additional uncertainties including the fact that adult, rather than pediatric, antidepressant half-life data were used due to an unavailability of published information. In addition, risks for suicidal ideation/behavior may vary for reasons other than half-life (e.g. study eligibility criteria, illness severity or responsiveness to treatment, diagnoses, etc.).

Conclusions: The risk of suicidal ideation or behavior in short-term antidepressant trials involving children or adolescents, as defined in the recent FDA meta-analysis, appears to be potentially at least partly associated with antidepressant half-life. Although any relationship is tentative, approaches to investigating several potential candidate mechanisms for any association are discussed.

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1) Smith EG. Association between antidepressant half-life and the risk of suicidal ideation or behavior among children and adolescents: confirmatory analysis and research implications. Accepted for publication in the Journal of Affective Disorders
2) Weiss J.J., Gorman, J.M., 2005. Antidepressant adherence and suicide risk in depressed youth. Am. J. Psychiatry 162, 1756-1757.

SCIENTIFIC AND CLINICAL REPORT SESSION 22- SUBSTANCE USE DISORDER IN PSYCHOSES AND BIPOLAR DISORDER

No. 64
CANNABIS WITHDRAWAL IN PEOPLE WITH SCHIZOPHRENIA

David Gorelick, M.D., Ph.D., NIDA IRP, Baltimore, MD 21224, Douglas L. Boggs, Pharm.D., Deanna L. Kelly, Pharm.D., Fang Liu, M.S., Jared A. Linthicum, M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) recognize the major symptoms of cannabis withdrawal; 2) understand how people with schizophrenia experience cannabis withdrawal

SUMMARY:

Objective: Cannabis use is common among people with schizophrenia and may influence clinical course and treatment response. Cannabis withdrawal may serve as a negative reinforcer for cannabis use (Copersino et al., 2006), yet very little is known about the experience of cannabis withdrawal among people with schizophrenia. This study aimed to address this gap in knowledge. Method: People in treatment for schizophrenia or schizoaffective disorder (DSM-IV criteria), > 18 years old, > 8th grade English reading level, had made > 1 "serious" (self-defined) attempt to quit cannabis use, and gave written informed consent completed a Marijuana Quit Questionnaire. Results: 54 people provided usable data, with a mean (SD) age of 40.1 (10.9) years, 66.7% male, 53.7% white, 37% African-American. 46% reported lifetime cannabis use > 1000 times. Their age at 1st cannabis use was 16.5 (6.1) years, at 1st regular use 17.2 (4.8) years, and at 1st cannabis-related problem 17.5 (4.8) years. 57.4% reported using more cannabis than at first to get the same "high" (suggestive of tolerance); 92.5% reported experiencing at least one withdrawal symptom; 55.5% experienced >4 symptoms. The commonest withdrawal symptoms were anxiety (54%), increased craving (50%), depression (48%), and boredom (46%). 10% of subjects resumed cannabis use to reduce or avoid withdrawal symptoms, suggesting that withdrawal served as a negative reinforcer for relapse. Conclusions: People with schizophrenia were more likely to experience cannabis withdrawal symptoms (92.5% vs. 42.4%) and less likely to relapse because of withdrawal (10% vs. 33%) than has been reported for people without psychiatric comorbidity. Cannabis withdrawal is a relevant focus of clinical attention for both groups.

Acknowledgment: Supported by the Intramural Research Program, NIH, National Institute on Drug Abuse and NIDA Residential Research Support Services Contract HHSN271200599091CADB.

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2) Copersino ML, Boyd SJ, Tashkin DP, Huestis MA, Heishman SJ, Dermand JC, Simmons MS, & Gorelick DA: Cannabis withdrawal among non-treatment-seeking adult cannabis users, Am J Addict 2006; 15:8-14.

No. 65
IS USE OF ILLEGAL NON-CANNABINOID SUBSTANCES ASSOCIATED WITH PSYCHOTIC SYMPTOMS?

Nina Kuzenko, M.D., PZ-412 PsycHealth Centre, 771 Bannatyne Avenue, Winnipeg, R3E 3N4 Canada, Jitender Sareen, M.D., Katja Beesdo, Ph.D., Axel Perkonigg, Ph.D., Michael Höfler, Ph.D., Roselind Lieb, Ph.D., Hans-Ulrich Wittchen, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Demonstrate an understanding of the significance of using the population attributable fraction in demonstrating association between illegal substance use and psychotic symptoms; 2) Describe the pharmacologic actions of non-cannabinoid substances; and 3) Discuss new data from an epidemiologic study showing an association between non-cannabinoid substances and psychotic symptoms.

SUMMARY:

Objective First, we examined the association between dopamine-modulating non-cannabinoid illicit substance use and psychotic symptoms. Second, we tested whether the association is unique to use of these substances or if it is mediated by other substance use.

Methods A community sample of N=2719 adolescents and young adults (14-24 years at baseline) was prospectively followed up over 10 years. The Munich Composite International

Diagnostic Interview was utilized to assess substance use and psychotic symptoms.

Lifetime presence of two or more psychotic symptoms, excluding substance-induced psychotic symptoms, was the outcome. We examined use of cocaine, amphetamines, psychedelics, and a group combining all three, where the substance was used five or more times. Multiple logistic regression analyses with adjustment for sociodemographic factors, childhood adversity, common mental disorders, and other substance use was utilized. The population attributable fraction (PAF) was calculated from weighted percentages of persons who used the given substance(s) and experienced two or more psychotic symptoms, and adjusted odds ratios.

Results Lifetime use of cocaine, amphetamine, or psychedelics, or all three substances was significantly associated with psychotic symptoms (adjusted odds ratios ranging between 1.66-2.40). Although there was an association, the proportion of psychotic symptoms attributable to use of the substances studied (PAF) was less than 10%.

Conclusion The present study adds to the growing body of literature that suggests that illicit drug use is associated with onset of psychotic symptoms. Early intervention programs targeting the reduction of illicit drug use among individuals vulnerable to psychosis should be considered.

This study was funded by the German Federal Ministry of Education and Research (BMBF) and by the Deutsche Forschungsgemeinschaft (DFG).

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2) Lieb R, Isensee B, von Sydow K, Wittchen H-U: The Early Developmental Stages of Psychopathology Study (EDSP): A Methodological Update. Eur Addict Res 2000; 6:170-182.

No. 66

COMORBID ANXIETY AND SUBSTANCE USE DISORDERS CONFOUND THE CLINICAL DIAGNOSIS OF BIPOLAR I BUT NOT II: IMPLICATION FOR MOOD STABILIZER USE

Keming Gao, M.D., Ph.D., 11400 Euclid Avenue, Suite 200, Cleveland, OH 44106, David E. Kemp, M.D., Carla Conroy, B.A., Stephen J. Ganocy, Ph.D., Joseph R. Calabrese, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the confounding effect of the co-occurrence of anxiety and substance use disorders on the clinical diagnosis of bipolar disorder and their implication for mood stabilizer use.

SUMMARY:

Objectives: Bipolar disorders are commonly misdiagnosed or undiagnosed. Anxiety (ADs) and substance use disorders (SUDs) are the two most common comorbidities in bipolar disorders. This study explored the associations between comorbid ADs or SUDs and baseline diagnostic status in patients with rapid cycling bipolar I or II (RCBDI or II) disorder and the number of previous mood stabilizer uses.

Methods: Extensive clinical interview and Mini International Neuropsychiatric Interview were used to ascertain DSM-IV diagnoses of RCBD, SUDs, and ADs. Status of diagnosis (undiagnosed, misdiagnosed, diagnosed) and history of mood stabilizer use were determined at the initial assessment. Baseline data of four similar clinical trials were used. T-test, Chi-square or Fisher's exact was applied where appropriate.

Results: Of 566 patients (RCBDI n=320, RCBDII n=246), 46% had history of ADs and 67% had a lifetime SUDs. Overall, 51% was diagnosed, 37% was misdiagnosed, and 12% was undiagnosed. Patients with BPII had significantly higher rates of misdiagnosis compared to their BPI counterparts (52% vs. 26%) regardless of the co-occurrence of ADs (50% vs. 31%) or SUDs (51% vs. 29%) with all p values of = 0.0001. However, the presence of ADs was associated with an increased rate of misdiagnosis only in RCBDI, 31% vs. 20% ($p = 0.0231$), but not in RCBDII, 50% vs. 53%. Similarly, the presence of a lifetime SUD was associated with increased rates of undiagnosis, 12% vs. 5% and misdiagnosis 28% vs. 18% in RCBDI with both p values < 0.08, again not in RCBDII. In a subgroup analysis, patients with ADs had fewer mood stabilizer uses than those without ADs, 0.85 ± 1.03 vs. 1.34 ± 1.40 ($p = 0.006$).

Conclusion: Presence of ADs and/or SUDs was associated with an increased risk of misdiagnosis in patients with RCBDI, but not in those with RCBDII. The lower number of mood stabilizer uses in patients with ADs might be the consequence of previous misdiagnosis.

REFERENCES:

1) Hirschfeld RM, Lewis L, Vornik LA: Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder. J Clin Psychiatry 2003; 64:161-174.
2) Simon NM, Otto MW, Weiss RD, Bauer MS, Miyahara S, Wisniewski SR, Thase ME, Kogan J, Frank E, Nierenberg AA, Calabrese JR, Sachs GS, Pollack MH; STEP-BD Investigators: Pharmacotherapy for bipolar disorder and comorbid conditions: baseline data from STEP-BD. J Clin Psychopharmacol 2004; 24:512-220.

SCIENTIFIC AND CLINICAL REPORT SESSION 23-EPIDEMIOLOGY

No. 67

SURVEY OF WORLD PSYCHIATRIC ASSOCIATION (WPA) MEMBER SOCIETIES ON CHILD SEXUAL ABUSE AND PHYSICIAN-PATIENT SEXUAL RELATIONS

Donna Stewart, M.D., University Professor and Chair,Women's Health ProgramUniversity Health Network. 200 Elizabeth St, EN-7-229, Toronto, M5G2C4 Canada, Erik Venos, B.Sc., Iram Ashraf, B.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: This presentation will discuss the results of a survey on Child

Sexual Abuse (CSA) and Psychiatrist-Patient Sexual Relations (PPSR) policies by the WPA member societies to inform the audience of international policies and challenges.

SUMMARY:

Objectives: The Madrid Declaration and its revisions are the WPA's standards on ethics in Psychiatry(1). This presentation will discuss the results of a survey on Child Sexual Abuse (CSA) and Psychiatrist-Patient Sexual Relations (PPSR) policies by the WPA member societies to inform the audience of international policies and challenges.

Methods: E-mail surveys on CSA and PPSR were sent to 128 WPA member society presidents in 105 countries.

Results: Responses (n = 69) represented all world regions. With regard to CSA all member countries have laws against this, but 18% of countries do not require physicians to report CSA. Only 45% of member societies felt their members were well informed on CSA, and most recommended further education. With regard to PPSR, 87% of countries or societies have laws or policies against this. Only 47% of societies felt their members were well informed about PPSR and 100% felt that further education would be helpful. Reported penalties ranged from death to no action.

Conclusion: The results of the survey demonstates a need for better advocacy, policies, sanctions and education related to CSA and PPSR in many countries and member societies around the world.

REFERENCES:

1) World Psychiatric Association. Madrid Declaration on Ethical Standards for Psychiatric Practice. WPA General Assembly; 1996; Madrid.

2) Robinson FE, Stewart, DE. CMAJ; 1996; 154: 643-649.

No. 68

PARENTAL MENTAL ILLNESS AND SUDDEN INFANT DEATH SYNDROME: THE ROLE OF MATERNAL SMOKING, OBSTETRIC RISK FACTORS AND SOCIAL ADVERSITY

Roger Webb, Ph.D., M.S.C., Room 2.311, University Place, Oxford Road, Manchester, M13 9PL United Kingdom, Susanne Wicks, B.S.C., Christina Dalman, Ph.D., Andrew R. Pickles, Ph.D., Louis Appleby, M.D., Preben B. Mortensen, Dr.Med.Sci., Kathryn M. Abel, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to know: 1) Parental psychiatric admission per se confers higher SIDS risk. Risks are especially high if both parents have such history, or the mother has an alcohol/drug disorder; 2) Relative risks linked with parental mental illness roughly doubled following the Swedish national risk reduction campaign of 1992; 3) High risk factor prevalence persists in this population, especially social adversity and prenatal maternal smok

SUMMARY:

Background & purpose: Following national risk reduction campaigns, Sudden Infant Death Syndrome (SIDS) cases have become increasingly concentrated among disadvantaged families, including those with parental mental illness. However, causal mechanisms explaining higher risk in this group are poorly understood. We aimed to estimate relative risk vs. the general population, explore potential effect modification by the 1992 Swedish risk reduction campaign, compare distributions of risk factors with and without parental mental illness, and conduct multivariate analyses.

Method: We studied all 2.5 million Swedish singleton births, 1978-2004. Psychiatric admissions from 1973, maternal prenatal smoking from 1983, and obstetric and social risk factors were obtained by linkage between national registers.

Results: Risk was higher with parental psychiatric inpatient care and particularly so if both parents were admitted (OR 6.85, CI 4.68-10.02), or if the mother was diagnosed with an alcohol/drug disorder (OR 6.54, CI 4.92-8.71). Following the national campaign, risk factor prevalence remained high in these parents and relative risks increased. Meanwhile maternal prenatal smoking rates fell overall, but to a lesser degree in families with mental illness, and maternal smoking prevalence remained high (57%) if both parents were admitted. During 1992-2004 smoking and low educational attainment jointly accounted for half of the excess SIDS risk linked with any maternal admission: crude OR 4.42 (CI, 3.15-6.20); adjusted OR 2.24 (CI, 1.55-3.22). Obstetric factors had minimal confounding effects.

Conclusions: Tailored approaches to communicating standard safety advice to this high-risk group are required. In particular mentally ill pregnant women should be strongly encouraged and supported to stop smoking. Families with two affected parents require particularly high levels of support. A better understanding is needed as to why high risk factor prevalence persists among these parents.

REFERENCES:

1) King-Hele SA, Kathryn KM, Webb RT, Mortensen PB, Appleby L, Pickles AR: Risk of sudden infant death syndrome with parental mental illness. Arch Gen Psychiatry 2007; 64: 1323-1330.

2) Howard LM, Kirkwood G, Latinovic R. Sudden infant death syndrome and maternal depression. J Clin Psychiatry 2007; 68: 1279-1283.

No. 69

SMI, SPMI, SED, FMD: WHY CAN'T WE USE ONLY ONE MENTAL HEALTH INDICATOR?

Deepak Prabhakar, M.D., M.P.H., 22200 Green Hill Road #106, Farmington Hills, MI 48335

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Identify different mental health indicators used by various federal, state and local organizations; 2) Recognize that the use of different indicators lead to difficult interpretations and the task of making valid comparisons almost impossible; 3) Recognize that the use of different indicators at various geographic levels leads to difficulty in making valid policy recommendations.

SUMMARY:

The Mental Health Parity Act represents a global change in the executive viewpoint and places equal impetus on mental health (MH) and physical health (PH) healthcare coverage. This modification lead to development of various classifications of mental illness (MI) also called MH indicators which were employed by

states to reimburse onsumers. These MH indicators differ depending on reporting agency thus creating difficult comparisons and interpretation of population-level mental health illnesses. We present data using current mental health indicators to report adult and adolescent mental health status for Dallas County, Texas. The National Institutes of Mental Health (NIMH) reports 26.2% of adult Americans suffer from a diagnosable MI while the BRFSS reports annual prevalence between 8% to 12% of Frequent Mental Distress (FMD) for Texas. Substance Abuse and Mental Health Services Administration (SAMHSA) reports 12-month Serious Mental Illness (SMI) prevalence of 6.6% and 12-month Severe & Persistent Mental Illness (SPMI) prevalence of 5.1% for Dallas County adults. Among children and adolescents, annual Serious Emotional Disturbance (SED) prevalence is 7.5% for Dallas County. NorthSTAR, a behavioral health managed care program, reports service-specific prevalence of DSM IV disorders, with Major Depression (36% to 52%) and Schizophrenia (26% to 40%) constituting the majority diagnosis among adult Dallas County clients. States usually make use of economic criteria in order to reimburse consumers diagnosed with various *DSM* diagnoses. However, *DSM* is based on self-reported symptom complex and is not designed to prioritize the needs of consumers. *DSM* does not place as much stress on the level of "functional impairment," which is an essential criterion used to define serious mental illness and other mental health indicators. There is a need for a mechanism to consistently measure mental health and functional status of individuals. SMI, SPMI, and SED utilize the *DSM IV* criterion in conjunction with the level of functional impairment. Therefore, it is vital that future data collection efforts also utilize both variable categories in order to make valid comparisons with national and state level data.

REFERENCES:

1) Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. (2005a). Health-Related Quality of Life: Annual trend data (Nationwide or by State, 1993-2006). Retrieved November 3, 2007 from http://apps.nccd.cdc.gov/HRQOL/

2) Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2006b). National Survey on Drug Use and Health, 2002. (2006). Retrieved October 30, 2007 from http://www.oas.samhsa.gov/2k2State/html/appA.htm#taba.20

SCIENTIFIC AND CLINICAL REPORT SESSION 24 METABOLIC EFFECTS OF PSYCHOTROPIC MEDICATION

No. 70
DO CARDIOVASCULAR RISK FACTORS IMPEDE ANTIDEPRESSANT TREATMENT RESPONSE?

Dale D'Mello, M.D., Department of Psychiatry, Michigan State University, St Lawrence/Sparrow Hospital, 1210 W Saginaw Lansing, MI 48915, Lansing, MI 48917, Alric Hawkins, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) appreciate the high prevalence of cardiovascular risk factors such as obesity, smoking, hypertension dyslipidemia and diabetes in patients hospitalized with depression; and 2) understand how concurrent cardiovascular risk factors may impede antidepressant response.

SUMMARY:

Patients with depression carry a disproportionate burden of cardiovascular risk factors such as cigarette smoking, obesity, dyslipidemia, diabetes, and hypertension. The impact of these risk factors on treatment outcome has not been satisfactorily elucidated. Objective: The purpose of the present study was to examine the impact of cardiovascular risk factors on depression treatment outcome. Methods: Patients who were hospitalized with depression on the adult psychiatry unit of a general hospital in mid-Michigan during calendar years 2006, 2007 and 2008 completed a brief cardiovascular risk questionnaire. The cohort of patients who received electroconvulsive therapy (ECT) following failure to respond to drug treatment was compared to those who responded to antidepressant medications. Results: The 187 patients who participated in the study included 119 women and 68 men, who ranged in age from 18 to 75 years. Forty-three (23%) of the 187 patients failed to respond to antidepressants and subsequently received electroconvulsive therapy (ECT). Those who received ECT had a disproportionately high prevalence of cardiovascular risk factors. The relative risk of hypertension in drug non-responders was 1.6, diabetes mellitus 2.4, dyslipidemia 1.8, obesity 1.6. The presence of cardiovascular risk factors was associated with a later onset of depression. The age of onset of depression was 36 (SD=13) years in patients with diabetes, compared to 30 (SD=12) years in non-diabetic individuals ($F=5.5$, $df=1$, $p<0.05$). It was 34 (SD=14) years in patients with dyslipidemia, compared to 29 (SD=12) years in others ($F=4.85$, $df=1$, $p<0.05$). The age of onset was 33 (SD=13) years in hypertensive individuals compared to 29 (SD=12) years in normotensive patients ($F=4.66$, $df=1$, $p<0.05$). Conclusions: The presence of cardiovascular risk factors in patients hospitalized for depression was associated with a later onset of depressive illness and with non-response to antidepressant medications.

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1) Iosifescu DV, Clementi-Craven N, Fraguas R, Papakostas PI, Petersen T, Alpert JE, Nierenberg AA, Fava M: Cardiovascular Risk Factors May Moderate Pharmacological Treatment Effects in Major Depressive Disorder. Psychosomatic Medicine 2005;67:703–706.

2) Simon GE, Ludman EJ, Linde JA, Operskalski BH, Ichikawa L, Rohde P, Finch EA, Jeffery RW: Association between Obesity and Depression in Middle-aged Women. General Hospital Psychiatry 2008;30:32–39.

No. 71
DEPRESSIVE SYMPTOMS AND RISK FOR 10-YEAR CARDIOVASCULAR MORBIDITY AND MORTALITY

Hannu Koponen, M.D., Ph.D., Department of Psychiatry, Kuopio University Hospital and Kuopio University, P.O.Box 1777, Kuopio, FIN-70211 Finland, Mauno Vanhala, Esko Kumpusalo, Sirkka Keinänen-Kiukaanniemi, Jari Jokelainen, M.Sc.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the association and mechanisms between depression and increased CVD morbidity and mortality.

SUMMARY:

Objective: Depression is associated with increased mortality. As less is known how much depression increases the cardiovascular disease (CVD) risk we evaluated the l0-year CVD mortality and

morbidity risk associated with depressive symptoms and metabolic syndrome.

Method: The study was conducted in Pieksämäki area, South-Savo, Finland, where all inhabitants born in the years 1942, 1947, 1952, 1957 and 1962 (N=1294) were invited for a comprehensive health check-up during 1998. The prevalence of depressive symptoms was measured with Beck Depression Inventory with cut-off score of 10 points, and the SCORE and Framingham risk indices were calculated in this middle-aged population-based sample. The modified National Cholesterol Education Program – Adult Treatment Panel III -criteria for MetS were also employed.

Results: The overall risks were 1.7 (S.D. 2.5; SCORE) and 4.2 (S.D. 4.4; Framingham). 15.9 % (N=144) and 27.0 % (N=209) of all cases shoved a high/very high risk according to SCORE (> 3 %) and Framingham (>10 %) function. Depressive symptoms were associated with increased CVD mortality risk in males: SCORE OR 2.7; 95%CI 1.4-5.4 and Framingham function OR 2.4 (95%CI 1.3-4.6). In females, the OR for Framingham was 1.3 (95%CI 0.7-2.5). Framingham function > 20 % was present in 3.9 % (N=36; OR for males 2.8 95%CI 1.2-6.7 and females OR 5.0 95%CI 0.3-81.9).

Conclusions: In our sample, depressive symptoms in males were associated with increased 10-year CVD event risk.

REFERENCES:

1) Koponen H, Jokelainen J, Keinänen-Kiukaanniemi S, Kumpusalo E, Vanhala M: Metabolic syndrome predisposes to depression. A population-based 7-year follow-up study. J Clin Psychiatry 2008;69:178-182.
2) Dimsdale JE: Psychological stress and cardiovascular disease. Journal of the American College of Cardiology 2008; 51: 1237-1246.

No. 72

WEIGHT GAIN, INCREASES IN CHOLESTEROL, TRIGLYCERIDE, AND GLUCOSE LEVELS IN SCHIZOPHENIC PATIENTS TREATED WITH CLOZAPINE, OLANZAPINE AND HALOPERIDOL

Menahem Krakowski, M.D., Ph.D., Nathan Kline Institute for Psychiatric Research140 Old Orangeburg Road, Orangeburg, NY 10962, Pal Czobor, Ph.D., Les Citrome, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand better the metabolic side effects associated with atypical antipsychotic agents; and 2) Identify the effect of ethnicity on these metabolic side effects.

SUMMARY:

OBJECTIVE: Clozapine and olanzapine have been associated with weight gain and with cholesterol, triglycerides, and glucose changes. The goal of this study was to assess the effects of clozapine and olanzapine and that of haloperidol on these metabolic parameters in aggressive patients with schizophrenia.

METHOD: 110 inpatients with schizophrenia or schizoaffective disorder with a history of physical assaults were included in a randomized double-blind 12-week study. Planned assessments included fasting glucose, cholesterol and triglycerides which were collected at baseline and at the end of the study. Ninety-three patients provided blood samples at baseline and at least at one point after random assignment to clozapine (N=34), olanzapine (N=31) or haloperidol (N=28), during the treatment trial.

RESULTS: There were significant differences among the three medication groups in weight gain (ANCOVA; F=8.37, df=2, 93, p<.001); patients on clozapine and on olanzapine gained significantly more weight than patients on haloperidol. There were significant differences among the groups in cholesterol (ANCOVA; F=4.32, df=2, 92, p=.02), triglyceride (ANCOVA; F=4.84, df=2, 90, p=.01), and glucose (ANCOVA; F=4.74, df=2, 87, p=.01) levels. Pairwise comparisons between the groups indicated a significantly greater increase in these blood levels in the clozapine group as compared to the haloperidol group, but no significant differences between the olanzapine and haloperidol groups. An effect of ethnicity was observed, as African-American patients, in this sample, were more likely to develop metabolic abnormalities on clozapine than on olanzapine.

CONCLUSIONS: In this prospective randomized trial of aggressive schizophrenic patients, clozapine and olanzapine, but not haloperidol, were associated with weight gain. Clozapine was associated with increases in both lipids and glucose. This effect was most prominent in the African American patients.

REFERENCES:

1) Stroup TS et al. Effectiveness of olanzapine, quietapine, risperidone, and ziprasidone in patients with schizophrenia following discontinuation of a previous atypical antipsychotic. Am J Psychiatry 2006; 163:611-22.
2) Lamberti JS, Costea GO, Olson D, Crilly JF, Maharaj K, Tu X, Groman A, Dietz MB, Bushey MP, Olivares T, Wiener K: Diabetes mellitus among outpatients receiving clozapine: prevalence and clinical-demographic correlates. J Clin Psychiatry 2005; 66:900–906.

THURSDAY, MAY 21, 2009, 11:00AM-12:30PM

SCIENTIFIC AND CLINICAL REPORT SESSION 25- THE SETTINGS OF PSYCHIATRY: FROM TELEPSYCHIATRY TO THE EMERGENCY ROOM

No. 73

TELEPSYCHIATRY – NEW APPROACH IN TREATMENT OF CROSS-CULTURAL POPULATION: PATIENT ACCEPTABILITY STUDY

Davor Mucic, M.D., Havneholmen 82, 5th, Copenhagen V, 1561 Denmark

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to use presented results in order to treat ethnic minorities via their own mother tongue rather than via interpreters by using telepsychiatry.

SUMMARY:

INTRODUCTION Asylum seekers, refugees and migrants are without doubt underserved on their respective mother tongue wherever hosted. National and International telepsychiatry service was established between Denmark and Sweden in order to increase access to cross-cultural expertise. Patient acceptability study was conducted to assess the patients' attitudes toward the quality, advantages and disadvantages of telepsychiatry service.

METHODS

Over a period January 2005-December 2007, 61 patients were treated via telepsychiatry by clinicians that speak patients` respective mother tongues. Video-conferencing equipment connected the Little Prince Psychiatric Centre in Copenhagen with two hospitals, one asylum seekers' centre and one social institution in Denmark. These stations were also connected to the Swedish department of the Centre. Number of languages spoken was 8 while the number of nationalities treated was 9. No interpreter assistance has been used.

After the end of the telepsychiatry contact all patients were asked to complete a satisfaction questionnaire.

RESULTS:Patients reported a high level of acceptance and satisfaction with telepsychiatry. They expressed a wish to use telepsychiatry via their mother tongue, rather than interpreter-assisted mental health care in the future.

DISCUSSION: The restricted physical contact and non-verbal communication of telepsychiatry was compensated by the fact that the doctor and patient spoke the same language and had similar cultural and/or national references. Danish telepsychiatry project was one of the first to serve such specific patient populations [1]. Furthermore, it was the first international telepsychiatry collaboration established in Europe [2]. The results of the survey may contribute to further development of, primarily, European Telepsychiatry Network. However, this model may be used in order to conduct a larger international telepsychiatry service capable to provide mental health care toward diversity of patient populations underserved on their mother tongue worldwide.

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1) Mucic D : "Telepsychiatry Pilot Project in Denmark", 2007, World Cultural Psychiatry Research Review 2007, 2:3-9. http://www.wcprr.org/pdf/JAN07/2007.01.0309.pdf
2) Mucic D : "International Telepsychiatry, patient acceptability study". J Telemed Telecare 2008; 14:241-243.

No. 74

VIDEOCONFERENCING FOR DELIVERING GROUP INTERVENTION TO REDUCE PTSD AND DEPRESSION IN WOMEN LIVING IN RURAL COMMUNITIES

Cheryl Koopman, Ph.D., 401 Quarry Road, Room 2327, Palo Alto, CA 94305-5718, Kate Collie, Ph.D., Mary Anne Kreshka, M.A., Susan Ferrier, B.S.N., Rebecca Parsons, L.C.S.W., Kathy Graddy, B.A., Speranza Avram, Patty Mannell, Xin-Hua Chen, B.A., James Perkins, Dr.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify at least three advantages of using videoconferencing to deliver group interventions to reduce PTSD and depression in medically ill populations living in rural communities.

SUMMARY:

Objective: Medically ill populations living in rural areas are likely to exhaust their usual sources of psychosocial support while experiencing PTSD and depression, but are unlikely to have local access to professionally-led group interventions. The purpose of this research is to evaluate the use of video-conferencing to deliver group intervention to reduce PTSD and depression among a medically ill population in rural communities.

Method: Twenty-seven women who were on average 60.7 years of age (SD=9.2) who lived in the Intermountain Region of northeastern California participated in 8-session group intervention based on supportive-expressive group psychotherapy and led by an oncology social worker. While participating at their local clinics, in real time women interacted with a group therapist and other women located in other, distant clinics. Using a split-screen, the women in each site saw the women in all the other sites as well as the group therapist. Women completed measures pre- and post-intervention, including the Center for Epidemiologic Studies Depression Scale and the Posttraumatic Stress Checklist.

Results: Women reported high levels of satisfaction and ease in adapting to the use of this technology. Older as well as younger women were comfortable using videoconferencing and said the groups were valuable because they promoted information sharing and emotional bonds with other women with breast cancer. They emphasized the importance of a professional facilitator and identified advantages of using videoconferencing for support groups. Pretest and posttest comparisons showed significant decreases in depression and posttraumatic stress disorder symptoms.

Conclusions: The findings of this study provide support for the use of videoconferencing to deliver group intervention to reduce PTSD and depression symptoms in this medically ill population living in rural communities.

Funding: This study was funded by the California Breast Cancer Research Program.

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1) Monnier J, Knapp RG, Frueh BC. Recent advances in telepsychiatry: An updated review. Psychiatr Serv 2003; 54:1604-1609.
2) O'Reilly R, Bishop J, Maddox K, Hutchinson L, Fisman M, Takhar J. Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial. Psychiatr Serv 2007; 58:836-843.

No. 75

GENDER DIFFERENCE OF FREQUENT VISITORS IN THE PSYCHIATRIC EMERGENCY ROOM

Chieh-Hsin Lin, M.D., 130, Kai-Suan 2nd Rd.; Ling-Ya District; Kaohsiung 802, Taiwan, Kaohsiung, 886 Taiwan, Ching-Hua Lin, M.D., Chao-Wen Hsu, M.D., Cheng-Chung Chen, M.D., Frank Huang-Chih Chou, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to learn that frequent visitors in the psychiatric emergency room are a unique group, and gender difference considerations should be included in the intervention for these patients.

SUMMARY:

Objective:The purpose of this study was to examine the demographic and clinical characteristics of female and male frequent visitors in the psychiatric emergency room, and to identify risk factors for these patients.

Methods:Data were collected over four years for patients who visited psychiatric emergency room. Frequent visitors were defined as patients who visited psychiatric emergency room greater than 8 times during the four-year study period. Univariate analy-

sis of variance and logistic regression models were used to determine group differences.

Results:Independent risk factors for frequent visitors were previous psychiatric emergency visit and hospitalization history, having insight and thought form problems, without suicidality, substance-related problems and appearance and behavior problems, greater number of previous ER visit, younger age at onset and longer years of education. Female and male frequent visitors were different in many demographic and clinical characteristics. Predictors were also different in female and male frequent visitors.

Conclusions:Female and male frequent visitors had different demographic and clinical characteristics; also predictors of the two groups were significantly different. Frequent visitors in the psychiatric emergency room are a unique group, and gender difference considerations should be included in the intervention for these patients.

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1) Arfken CL, Zeman LL, Yeager L, White A, Mischel E, Amirsadri A. Case-control study of frequent visitors to an urban psychiatric emergency service. Psychiatr Serv. 2004 Mar;55(3):295-301.
2) Sullivan PF, Bulik CM, Forman SD, et al. Characteristics of repeat users of a psychiatric emergency service. Hosp Community Psychiatry. 1993 Apr;44(4):376-80.

SCIENTIFIC AND CLINICAL REPORT SESSION 26-ANTIPSYCHOTIC MEDICATION IN SCHIZOPHRENIA

No. 76
LONG-TERM TREATMENT WITH ASENAPINE VERSUS OLANZAPINE IN SUBJECTS WITH PREDOMINANT, PERSISTENT NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

Nina Schooler, 350 Community Drive, Manhasset, NY 11030, Pilar Cazorla, Alex Kouassi, Wil den Hollander, Phillip Phiri, Larry Alphs, John Panagides, Armin Szegedi, Robert W. Buchanan

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the criteria used to identify research participants with predominant, persistent negative symptoms of schizophrenia; 2) Discuss the long-term effects of asenapine on predominant, persistent negative symptoms of schizophrenia in comparison with the effects of olanzapine; 3) Describe the long-term adverse effect profile of asenapine compared with that of olanzapine in this subject population.

SUMMARY:

Introduction: The efficacy, safety, and tolerability of asenapine vs olanzapine were assessed in a previously presented double-blind 26-week core study in subjects with predominant, persistent negative symptoms of schizophrenia. We now report on a double-blind 26-week extension of that study.

Methods: Subjects in the core study had schizophrenia with stable, predominant, persistent negative symptoms (baseline PANSS negative symptom Marder factor score >/=20, with score >/=4 on at least 3 of the 7 Marder factor items). Subjects were randomized to asenapine 5 to 10 mg BID or olanzapine 5 to 20 mg QD for 26 weeks and were maintained on the same regimen for the 26-week extension. The primary endpoint was change with asenapine vs olanzapine in NSA-16 total score from core study baseline. Efficacy was analyzed using a mixed model for repeated measures.

Results: Of 481 subjects randomized in the core study, 349 completed 6 months of treatment; 306 entered the extension study, and 266 completed 1 year of treatment. LS mean ± SE changes in NSA-16 total score were –16.9±0.98 (from 61.7±0.85 at baseline) for asenapine vs –15.4±0.85 (from 60.4±0.74) for olanzapine (P=0.2344). Little change was seen in positive or depressive symptoms, suggesting that the improvement in negative symptoms was a primary treatment effect. Changes in the Quality of Life Scale score, a secondary endpoint, were 18.7±1.64 (from 45.1±1.63 at baseline) for asenapine vs 16.4±1.4 (from 47.7±1.42) for olanzapine (P=0.2838). For asenapine vs olanzapine, respectively, the incidence of treatment-emergent AEs was 85.1% vs 74.4%; treatment-related AEs, 56.0% vs 58.1%; EPS reported as an AE, 9.7% vs 4.1%; and LS mean weight change from baseline, –1.4 kg vs 4.0 kg (P<0.0001).

Conclusion: Asenapine was comparable to olanzapine in subjects with predominant persistent negative symptoms of schizophrenia over 1 year of treatment. Asenapine was well tolerated, with an advantage in weight change vs olanzapine.

REFERENCES:

1)Potkin SG, Cohen M, Panagides J: Efficacy and tolerability of asenapine in acute schizophrenia: a placebo- and risperidone-controlled trial. J Clin Psychiatry 2007 68:1492-1500
2)Lindenmayer JP, Khan A, Iskander A, Abad MT, Parker BJ: A randomized controlled trial of olanzapine versus haloperidol in the treatment of primary negative symptoms and neurocognitive deficits in schizophrenia. Clin Psychiatry 2007 68:368-379

No. 77
FACTORS ASSOCIATED WITH THE USE OF ATYPICAL ANTIPSYCHOTICS AMONG THE SCHIZOPHRENIC POPULATION: GENERATIONAL AND DISEASE SEVERITY EFFECTS

Bernard Astruc, M.D., Pépinière Paris Santé Cochin, 29 rue du Fg Saint-Jacques, Paris, 75014 France, Frederic Rouillon, M.D., Ph.D., Helene Verdoux, M.D., Ph.D., Guillaume Vaiva, M.D., Ph.D., Florence Thibaut, M.D., Ph.D., Frederic Limosin, M.D., Ph.D., Beatrice Beaufils, Daniel Geoffroy, M.D., Veronique Adnet-Markovitch, M.D., Raluca Rosetti, M.D., Bruno Falissard, M.D., Ph.D., Jacques Benichou, M.D., Ph.D., Michel Rossignol, M.D., FRCP(C), M.Sc., Fanny Depont, Ph.D., Lucien Abenhaim, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to recognize the demographic, clinical and time-related factors associated with the use of atypical antipsychotic in the treatment of schizophrenia in naturalistic conditions.

SUMMARY:

Background: Second generation, 'atypical' antipsychotics (AA), are now widely prescribed in schizophrenia.

Objectives: To describe the characteristics associated with the

patterns of use of AA in a schizophrenic population, including health- and time-related related factors.

Methods: 1675 schizophrenic patients were recruited in 175 public and private hospitals. The inclusion criteria were schizophrenia (DSM-IV), age 15 – 65, ambulatory or hospitalized for less than 3 months. Multivariate logistic regression and splines on the prescription of antipsychotics were controlled for age, gender, education and a series of health status-related variables (BPRS, CGI, GAF, past suicide attempts, hospitalization status, co-morbidities, others). Results are presented as adjusted odds ratios (aORs) with their 95% confidence intervals [in brackets]

Results: Significant adjusted odds ratios for AA use were observed for age (1.6 [1.3-1.9]), high school education (1.7 [1.2-2.0]) and absence of legal guardianship (1.6 [1.3 -2.0]). The prevalence ratio in atypical vs. typical antipsychotic utilization decreased steadily from 15-24 years-old to 55-64 years-old to be ca. 5 times less in older than in younger age groups; adjusted splines confirmed this tendency. Detailed results of subgroup analysis per duration of disease and composite severity index will be presented at the conference.

Conclusions: Schizophrenic patient using atypical antipsychotics were younger, more educated and more independent than non AA users. Whether this is due to selective prescribing, to a "generational cohort effect' or to the effect of the drugs will be discussed.

This study received an unrestricted financial support from Janssen-Cilag France.

REFERENCES:

1) Verdoux H, Bégaud B: Pharmaco-epidemiology: what do (and don't) we know about utilization and impact of psychotropic medications in real-life conditions? Br J Psychiatry 2004; 185:93-4
2) Ashcroft DM, Frischer M, Lockett J, Chapman SR: Variations in prescribing atypical antipsychotic drugs in primary care: cross-sectional study. Pharmacoepidemiol Drug Saf 2002; 11(4):285-9.

No. 78

ETHNIC DIFFERENCES IN LENGTH OF STAY AND CHOICE OF ANTIPSYCHOTIC MEDICATION AMONG IN-PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

Karen Bullock, Ph.D., M.S.W., 200 Retreat Avenue, Hartford, CT 06106, Bonnie L. Szarek, R.N., John W. Goethe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe demographic and treatment factors associated with length of stay for Black vs White vs Latino in-patients with schizophrenia

SUMMARY:

Objective: To identify racial differences in length of stay (LOS), and the association of demographic and treatment factors

Methods: A retrospective analysis of discharge data for Black, White and Latino inpatient adults (4/1/04-3/31/06) with schizophrenia (n=741). Race was the primary predictor variable. Independent variables included demographics and treatment with typical vs. atypical antipsychotics. Associations with LOS were estimated using ANCOVA and correlations.

Results

The sample was 31.3% Black, 46.6% White and 22.1% Latino, 73.3% male and mean age of 41.5+2.1 years (16 to 85 years). LOS for Whites (16.3+ 14.4days) was significantly > than Blacks (14.0+ 18.8 days) and Latinos (10.3+ 7.5 days). The differences in LOS across racial groups were statistically significant for Blacks vs. Whites (x2=17.3, df=1, p<.001). There were also significant differences in antipsychotic use; Blacks were more likely to be treated with typical antipsychotics vs. Whites (48.7% vs. 32.2%, p<.001) or Latinos (31.1%, p<.001) but, these differences did not explain the variation in LOS. Neither age no gender was significantly associated with LOS.

Conclusion

The data suggest that LOS varies by race and that the differences remain after adjusting for demographic and treatment variables. Further studies are needed to explore additional factors that may account for racial differences in the treatment of schizophrenia.

REFERENCES:

1) Kreyenbuhl J, Zito JM, Buchanan, RW, Soeken KL, Lehman AF: Racial disparity in the pharmacological management of schizophrenia. Schizophrenia Bulletin 2003 29:183-193.
2) Sajatovic M, Donenwirth K, Sultana D, et.al.: Admissions length of stay and medication use among women in an acute care state psychiatric facility. Psychiatric Serv 2000 51:1278-81.

SCIENTIFIC AND CLINICAL REPORT SESSION 27- GAMBLING, ADDICTIONS AND COMPULSIONS

No. 79

PATHOLOGICAL GAMBLING: AN UPDATE ON NEUROPATHOPHYSIOLOGY AND PHARMACOTHERAPY

Pinhas Dannon, M.D., Rehovot Community Mental Health & Rehabilitation Clinic, Rehovot, 76449 Israel, Katherine Lowengrub, M.D., Yael Dembinsky, M.D., Moshe Kotler, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the major neuropathophysiological hypotheses of pathological gambling and possible treatment strategies.

SUMMARY:

Neurobiological research has shown the potential involvement of the serotonergic, noradrenergic, dopaminergic and opioid dysfunction in the pathophysiology of pathological gambling (PG). In this paper, we present a review the current theories of neuropathology of PG with particular attention to the role of the neural circuitry underlying motivation, reward, decision-making, and impulsivity. This paper also presents a literature review of current pharmacologic treatment strategies for PG and discusses the role of non-pharmacologic interventions. Finally, a hypothetical model of clinical subtypes in PG is presented. This model attempts to integrate current knowledge in the field of PG regarding neuropathology, psychiatric comorbidity, family history, genetics, course of illness, gender, and response to pharmacologic

treatment. We conclude with the recommendation that the possibility of subtypes may provide a method for matching pathological gamblers with specific pharmacotherapies.

REFERENCES:
1) Kertzman S, Lowengrub K, Aizer A, Nahum ZB, Kotler M, Dannon PN. Stroop performance in pathological gamblers. Psychiatry Res 2006;142(1):1-10
2) Kim SW, Grant JE, Adson DE, Shin YC. Double-blind naltrexone and placebo comparison study in the treatment of pathological gambling. Biol Psychiatry 2001;49(11):914-21

No. 80

PSYCHIATRIC, BEHAVIORAL, AND ATTITUDINAL CORRELATES OF AVOIDANT AND OBSESSIVE-COMPULSIVE PERSONALITY PATHOLOGY IN PATIENTS WITH BINGE EATING DISORDER

Daniel Becker, M.D., Mills-Peninsula Medical Center, 1501 Trousdale Dr., Burlingame, CA 94010, Marney A. White, Ph.D., Robin M. Masheb, Ph.D., Carlos M. Grilo, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the correlates of avoidant and obsessive-compulsive personality pathology—with respect to psychiatric comorbidity, eating behaviors, and eating attitudes—among patients with binge eating disorder.

SUMMARY:

Objective: This study examined the correlates of avoidant and obsessive-compulsive personality disorder (PD) pathology—with respect to psychiatric comorbidity, eating disorder pathology, and associated psychological factors—in patients with binge eating disorder (BED). Method: Subjects were a consecutive series of 347 treatment-seeking patients who met DSM-IV research criteria for BED. All were reliably assessed with semistructured interviews to evaluate DSM-IV axis I psychiatric disorders, axis II PDs, and the behavioral and attitudinal features of eating disorder psychopathology. Results: Fifty-two (15%) subjects had avoidant PD features, 40 (12%) subjects had obsessive-compulsive PD features, 27 (8%) subjects had features of both avoidant and obsessive-compulsive PDs, and 228 (66%) subjects had features of neither PD. The groups did not differ in age, gender, ethnicity, education, or body mass index. The groups did, however, differ significantly in the total number of comorbid psychiatric diagnoses, the frequency of depressive and anxiety disorders specifically, and in measures of eating disorder psychopathology and psychological functioning. The avoidant and the obsessive-compulsive PD groups had significantly more psychiatric comorbidity than the group without these PD features, but less than the combined PD group. The avoidant and the combined PD groups had the greatest severity of eating disorder pathology. All three PD pathology groups had significantly greater negative affect than the non-PD group, while self-esteem was lowest for the avoidant and combined PD groups. Conclusions: Avoidant and obsessive-compulsive PDs are common in patients with BED. The presence of these forms of PD pathology—separately and in combination—is associated with clinically meaningful diagnostic, behavioral, and attitudinal characteristics. These findings suggest approaches to sub-grouping BED patients, based on PD characteristics, and may also have implications for treatment.

REFERENCES:
1) Bruce KR, Steiger H, Koerner NM, Israel M, Young SN: Bulimia nervosa with co-morbid avoidant personality disorder: behavioural characteristics and serotonergic function. Psychol Med 2004; 34:113-124
2) Grilo CM, White MA, Masheb RM: DSM-IV psychiatric disorder co-morbidity and its correlates in binge eating disorder. Int J Eat Disord, in press

No. 81

PROBLEM VIDEO GAME USE: ASSESSMENT AND ASSOCIATION WITH DIMENSIONS OF PSYCHOPATHOLOGY

Vladan Starcevic, M.D., Ph.D., Nepean Hospital; Dept of Psychological Medicine; PO Box 63, Penrith NSW, 2751 Australia, Guy Porter, B.A, M.B.B.S., David Berle, B.A., M.Psychol, Pauline Fenech, B.Psych.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: (1) learn how people with problem video game use can be identified; (2) appreciate connections between problem video game use and certain aspects of psychopathology; and (3) better understand issues in the debate of whether problem video game is to be conceptualized as mental disorder.

SUMMARY:

Objective: There have been controversies regarding the recognition of problem (excessive) video game use and its relationship with psychopathology. The aim of this study was to shed more light on these issues.

Method: We conducted an international, anonymous online survey, which consisted of the Symptom Checklist 90 (SCL-90), a measure of overall distress and psychopathology, and Video Game Use Questionnaire (VGUQ). In addition to collecting various information, the main purpose of the VGUQ was to identify problem video game users by means of the provisional criteria. These criteria reflect the crucial features of problem video game use – loss of control over playing video games and specific, multiple adverse consequences – and were developed on the basis of the concept of behavioral addiction and the relatively specific aspects of problem video game use.

Results: A total of 1945 survey participants completed all questions. Respondents identified as problem video game users (n=156, 8%) differed significantly from others on variables that provided independent, preliminary validation of our provisional criteria for problem video game use. They played longer than planned and with greater frequency, and more often played even though they did not want to and despite knowing that they should not do it. Problem video game users scored significantly higher on the global symptom severity of SCL-90 and on all dimensions of psychopathology. Their scores were especially high on obsessive-compulsive tendencies, interpersonal sensitivity, depression, and paranoid ideation.

Conclusions:

People with problem video game use can be reliably identified by means of a questionnaire and on the basis of our provisional criteria. These criteria require further validation. Problem video game use is strongly associated with various aspects of psycho-

pathology in causally complex relationships. This has important implications for the conceptualization and management of problem video game use.

REFERENCES:

1) Block JJ: Issues for DSM-V: Internet addiction. Am J Psychiatry 2008; 165:306-307.
2) Shapira NA, Lessig MC, Goldsmith TD, Szabo ST, Lazoritz M, Gold MS, Stein DJ: Problematic Internet use: proposed classification and diagnostic criteria. Depress Anxiety 2003; 17:207-216.

SYMPOSIA

MONDAY, MAY 18
2:00PM-5:00PM

SYMPOSIUM 1

SPOTTING THE WOLF IN SHEEP'S CLOTHING: CLINICAL CHALLENGES IDENTIFYING AND TREATING UNPRESENTED CO-MORBIDITY

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Estimate the prevalence of substance use disorders among individuals with concurrent psychiatric disorders; 2) Identify at least two screening instruments for SUDs: discuss the strengths and limitations of each; 3) Articulate at least two challenges of screening for SUD among the severely mentally ill and 4) Outline treatment options for pharmacotherapy for at least two psychiatric diagnoses that concurrently use illicit drugs.

NO 01A

THE PREVALENCE OF SUBSTANCE USE DISORDERS AMONG PSYCHIATRIC POPULATIONS

Carlos Blanco-Jerez, M.D., 1051 Riverside Drive, Unit 69, New York, NY 10032

SUMMARY:

Over the last thirty years, a number of studies using a variety of methodologies have consistently shown that substance abusers have high rates of psychiatric comorbidity. It is now widely accepted that, despite questions about the independence of many psychiatric disorders from the substance use disorders, rates of psychiatric disorders are high even after several weeks of abstinence. Presence of psychiatric comorbidity is associated with a more chronic and severe spectrum of substance abuse. and worse prognosis. In addition, they are more likely to engage in behaviors that may increase the risk for transmission of HIV and other infectious diseases.

A number of studies by several groups have also shown that treatment of the comorbidity can improve the prognosis of individuals with substance abuse, yet this comorbidity goes frequently untreated. National data indicate that only 8 percent of individuals with substance abuse and co-occurring disorders receive treatment for both disorders and is not predicted by demographic and clinical variables, or by level of physical or psychosocial functioning. These data suggest that the problem of undertreatment is not limited to a few specific groups of the population but rather, there are factors that prevent the majority of individuals with co-occurring disorders from obtaining the care they need.

The current presentation will review the comorbidity between substance use disorders and other psychiatric disorders in the general population using data from several recent national epidemiological surveys (e.g., National Epidemiologic Survey on Alcohol and Related Conditions, National Comorbidity Survey Replication), as well as in selected clinical settings. Novel statistical methods (e.g., PG-estimator) will be used to assess the comparability of findings in clinical and epidemiological samples and the implications for clinicians, researchers and policy-makers.

NO 01B

SCREENING FOR SUBSTANCE USE DISORDER AMONG INDIVIDUALS WITH SEVERE MENTAL ILLNESS

Stanley D. Rosenberg, Ph.D., 1 Medical Center Drive, Lebanon, NH 03756

SUMMARY:

Substance use disorder in persons with severe mental illness is associated with a variety of adverse consequences, including medication non-compliance, symptom exacerbation, rehospitalizations, increased risk for HIV and hepatitis C infection, and increased risk for violent behavior. Despite the clinical relevance of substance abuse in clients with severe mental illness, and the high rates of substance abuse in this population, estimated rates of detection for substance abuse in psychiatric settings are quite low.

While there is broad agreement on the value of screening for substance abuse in psychiatric service settings, a number of barriers to detection have been cited, including the difficulties of conducting interviews for alcohol and drug use with acutely ill psychiatric patients; schizophrenic clients' tendency to underestimate the adverse effects of substance abuse, and patients' proneness to nondisclosure.

Moreover, standard screens developed for more general populations (e.g., the MAST), have shown poor sensitivity/specificity with psychiatric patients. Laboratory tests, such as blood, urine, or saliva drug screens also may have poor sensitivity because of rapid extinction of substances and thresholds for detection.

To overcome these barriers to detection, brief, easy to administer screening instruments should be employed that exhibit high sensitivity, specificity, positive predictive value, negative predictive value and overall classification accuracy in people with severe mental illness. Accurate screening can lead to more thorough assessment, and more appropriate triage to needed care (e.g., integrated mental health and substance abuse treatment; infectious disease testing and referral). Appropriate substance abuse screens have been developed but require broader validation and periodic updating as preferred drugs of abuse evolve over time.

NO 01C

MOTIVATIONAL INTERVIEWING FOR SUBSTANCE ABUSE AMONG ADOLESCENTS WITH PSYCHIATRIC COMORBIDITY

Richard A Brown, Ph.D., 345 Blackstone Blvd. Providence, RI 02906

SUMMARY:

Adolescents with substance use disorders (SUDs) frequently

suffer from concomitant psychiatric disorders. Unfortunately, substance use problems among adolescents presenting for psychiatric treatment are often not adequately assessed or addressed despite the deleterious consequences of this comorbid psychopathology. Brief interventions represent flexible and potentially effective approaches toward addressing substance use problems in adolescent psychiatric settings. This presentation will discuss the rationale and the utility of brief interventions for reducing substance use among adolescents with SUD in these settings. In addition, a discussion will follow on why Motivational Interviewing (MI), in particular, may be well-suited for use with adolescents. An example of how an MI intervention is currently being applied, in the context of a NIDA-funded, randomized clinical trial, with substance abusing adolescents hospitalized in an inpatient psychiatric treatment facility will be provided. Lastly, discussion will focus on the various challenges associated with delivering the brief MI intervention to a high-risk population of substance abusing youth in an inpatient setting.

NO 01D

DIAGNOSIS CHALLENGES FOR CO-OCCURRING ADHD AND SUBSTANCE USE DISORDERS

Frances Levin, M.D., 1051 Riverside Drive, New York, NY10032

SUMMARY:

Attention-deficit/hyperactivity disorder (ADHD) is an impairing condition that occurs in a 3-5% of the adult population. ADHD is overrepresented in substance-abusing populations seeking treatment, with rates ranging from 15-24%. There are numerous issues that complicate diagnosing ADHD in adults and additional factors that impede making a valid and reliable diagnosis in substance-abusing populations. These issues may lead to both under-and over-diagnosis of ADHD. While screening instruments and computer testing may have some clinical utility, they cannot be used without a careful psychiatric assessment to determine if an individual has ADHD. Strategies of how to best carry out a comprehensive assessment for ADHD in substance abusers will be presented. Further, the validity and clinical utility of certain diagnostic categories, such as ADHD.NOS (not otherwise specified) will be discussed. The importance of accurate diagnosis cannot be overstated since it may impact on how to proceed with treatment, both for the substance use disorder and the concurrent psychiatric comorbidity/comorbidities.

NO 01E

THE TREATMENT OF CO-OCCURRING MOOD AND ANXIETY DISORDERS IN ADDICTIONS

Kathleen Brady, M.D., 171 Ashley Avenue, Charleston, SC 29425

SUMMARY:

Mood and anxiety disorders are common in individuals with substance use disorders. However, accurate diagnosis can be difficult because of the symptom overlap between acute intoxication and withdrawal rom substances of abuse and mood/anxiety symptoms. In this presentation, diagnostic difficulties and strategies to approach the diagnosis of mood and anxiety disorders in individuals with addictions will be reviewed. Investigations of pharmacotherapeutic strategies for the treatment of mood and anxiety disorders in individuals with substance use disorders will be reviewed. Several promising studies exploring agents used to decrease alcohol consumption in alcohol-dependent individuals with mood and anxiety disorders will also be explored. Finally, recent studies exploring psychotherapeutic approaches to the treatment of co-occurring mood and anxiety disorders in individuals with addictions will be discussed.

REFERENCES:

1) Compton WM, Conway KP, Stinson FS, Grant BF: Changes in the prevalence of major depression and comorbid substance use disorders in the United States between 1991-1992 and 2001-2002. Am J Psychiatry. 2006; 163(12):2141-7; Conway KP, Compton W, Stinson FS, Grant BF: Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry. 2006; 67(2):247-57.

2) Rosenberg SD, Drake RE, Wolford GL, Mueser KT, Oxman TE, Vidaver RM, Carrieri KL, and Luckoor R: The Dartmouth Assessment of Lifestyle Instrument (DALI): A Substance Use Disorder Screen for People with Severe Mental Illness, American Journal of Psychiatry. 1998; 155(2):232-238, .

3) Levin FR: Diagnosing attention-deficit/hyperactivity disorder in patients with substance use disorders. J Clin Psychiatry. 2007; 68 Suppl 11:9-14; Faraone SV, Biederman J, Spencer T, Mick E, Murray K, Petty C, et al. Diagnosing adult attention deficit hyperactivity disorder: are late onset and subthreshold diagnoses valid? Am J Psychiatry, 2006; 163:1720-1729.

4) Brady KT, Verduin ML, Tolliver BK. Treatment of patients comorbid for addiction and other psychiatric disorders. Curr Psychiatry Rep. 2007; 9(5):374-80.

SYMPOSIUM 2
ADJUSTMENT DISORDERS: PROBLEMS IN CONCEPTUALISATION, CONUNDRUMS IN CLASSIFICATION

EDUCATIONAL OBJECTIVES:

At the end of this presentation the participants will be: 1) Aware that adjustment disorders are common in a variety of clinical and cultural settings; 2) That there is considerable diagnostic overlap with other disorders since they are are poorly conceptualised; 3) that new subtypes are worthy of inclusion in future classifications; and 4) That dimensional as distinct from categorical approaches to classification should be considered.

NO 02A

RECENT ADVANCES IN THE STUDY OF ADJUSTMENT

DISORDERS

Andreas Maercker, M.D., Binzmühlestr. 14/17, Zurich 8044 Switzerland

SUMMARY:

Introduction: This overview presents conceptual developments in distinguishing adjustment disorders (AJD) from normal distress. Our own research on AJD has focused on the validation of a new model of adjustment disorder which proposes AJD to be a particular form of stress response spectrum disorder (together with PTSD and Acute Stress Disorder; Horowitz, 2000). AJD is characterized by intrusions, avoidance of reminders and failure to adapt.

Methods: The first study investigated 160 patients with an AIC defibrillator (Maercker et al. 2007). In a second study we examined whether AJD is distinct from PTSD, complicated grief, major depressive disorder and subsyndromal depression. A representative sample of 712 elderly from the urban area of Zurich, was assessed by standardized interviews or questionnaires. The third study used WHO multisite data of refugees to explore AJD index events and prevalences. 3048 people from four different refugee settings in Ethiopia, Algeria, Gaza, and Cambodia were assessed. Index events for AJD were defined as non-directly life threatening events (e.g., loss of property, forced separation from family) in distinction to *DSM*-defined traumatic events (e.g., direct life threats or witnessing).

Results: The new AJD criteria proved to be a successful psychometric standard for diagnostic application. In study one, 17% of the sample were diagnosed with AJD. The most common subtype was AJD with mixed emotional features. In study two, AJD index events (e.g., family conflicts, financial problems) were indicated by 52%, with a 2.3% current prevalence of AJD. Co-morbidity rate for AJD and other *DSM-IV* disorders was 46%, and 38% between that of AJD and subsyndromal disorders. In the third study on refugees the majority of the subjects had experienced one or more AJD-related life event (81-100%). The revalence of AJD ranged from 6% in Ethiopia to 40% in Algeria. The highest co-morbidity rates were between AJD and PTSD, followed by anxiety disorders.

Conclusion: All three studies indicate the usefulness of the new concept of AJD and its use for different psychiatric contexts, i.e., epidemiology, psychosomatics, and refugee health.

NO 02B

ADJUSTMENT DISORDERS AND THE DSM-V: CONSIDERATIONS FOR DIMENSIONAL (SPECTRUM DIAGNOSES) VERSUS CATEGORIAL.

James J Strain, M.D., 1 G. L. Levy Place, New York City, NY 10029

SUMMARY:

Introduction: The Adjustment Disorders (AD) are a sub-threshold diagnosis which lie between normal behavior and major mental disorders. They have questionable reliability and validity as they have no specific symptom check list to facilitate their diagnosis. However, they permit the identification of pathology early and are a focus for important psychological work. The DSM-V has focused on "Dimensional Approaches in Diagnostic Classification" in contrast to the current categorical lexicon. This has important implications for the AD and their placement in a revised taxonomy.

Method: Using a computerized structured inventory that contained initial psychiatric consultation diagnosis for medically or surgically ill patients as well as discharge psychiatric diagnoses for 1,801 consultations it was possible to observe the stability of diagnosis: major affective disorder (MAD), AD, dementia, delirium, somatoform disorders. From 1039 consecutive consultation referrals in an international collaborative study using the same computerized structured inventory, psychiatric comorbidities with AD were observed.

Results: The following per cent of initial diagnoses were changed at discharge: MAD 23%; AD 18%, dementia 14%; delirium 8%, somatoform disorders 0%. The MAD were most often changed to AD. The AD were often changed to organic mental disorder or "no diagnosis." The most frequent comorbidities diagnosed with AD were personality disorder and organic mental disorder.

Conclusion: With the development of *DSM-V* it is considered that diagnoses such as the AD may be better classified as dimensional versus categorical. That would be in consonance with diagnoses changing over time, having various comorbidities, and a progression to more serious pathology or returning to less with a change in stressors, treatment, or alterations in a medical condition. This would also put the AD under the respective genre of disorders that is specified by their secondary description, e.g., depression, anxiety, mixed emotional features, conduct disorder etc., rather than in their own category.

NO 02C

CAN ADJUSTMENT DISORDER AND DEPRESSIVE EPISODE BE DISTINGUISHED? RESULTS FROM THE ODIN STUDY

Patricia P Casey, M.D., 63 Eccles Sreet, Dublin 7 Ireland

SUMMARY:

Introduction: No large-scale epidemiological study has included adjustment disorders (AD) for consideration yet it is considered to be a common psychiatric diagnosis.

Methods: Using a two stage screening method, those above a threshold score for possible caseness on the Beck Depression Inventory (BDI), were interviewed using SCAN to identify those with depressive episode and AD. Variables that might distinguish AD from depressive episode were examined.

Results: The prevalence of AD was extremely low with one center having no cases. Finland, the country with the highest prevalence, only achieved a frequency of 0.8 and 1% respectively for urban and rural sites. Logistic regression failed to identify any variables that independently differentiated AD from depressive episode. Findings relating to severity of symptoms using BDI were robust.

Conclusions: Reasons for the failure of even robust results, such

as BDI severity, to distinguish AD from depressive episode are considered of which problems in conceptualizing AD are the most likely. Further studies are required.

4. POSTTRAUMATIC EMBITTERMENT DISORDER

Michael Linden, M.D., Lichterfelder Allee 55, Teltow/Berlin 14513 Germany

SUMMARY:

Background: Adjustment and reactive disorders are a heterogeneous group of mental disorders. Diagnostic criteria are vague and scientific research is limited inspite of the fact that in clinical practice these disorders play a major role.

Methods: The "Posttraumatic Embitterment Disorder (PTED)" is introduced as a concept for a subgroup of adjustment disorders. In a series of empirical studies the clinical profile, diagnostic criteria and first therapeutic interventions have been developed.

Results: Core criteria of PTED are that a negative life event precipitates an emotional response of embitterment and feelings of injustice, with intrusive memories of the event. Additional symptoms are feelings of rage (91.7%), helplessness (91.7%), agitation (91.7%), anger (85.4%), down-heartedness (83.3%), loss of interest (83,3%), humiliation (81.3%), sleep disorders (97.2%), despair (72.9%), shame (64.6%), insult (46.8%), aggression (41.7%) and man others, including even thoughts of enlarged suicide. Performance in daily activities and roles is impaired. This condition last longer than 3 months and shows a tendency for chronicity. Patients often reject help and are difficult to treat.

Conclusions: About 50% of persons in the general population report about recent events that arouse feelings of embitterment. With growing intensity, this becomes a disabling condition in about 2% to 3%, similar as with anxiety. First ideas on a specific type of treatment, i.e. "wisdom therapy" are discussed.

Ref.: Linden et al: Posttrraumatic Embitterment Disorder, Hogrefe, Bern 2008

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3) Dobricki M, Maercker A, Komproe IH, de Jong JT. Adjustment disorders after severe life-events in four postconflict settings. Europ Arch Psychiat Clin Neurosc (in press).

4) Linden M, Baumann K, Rotter M, Schippan B Posttraumatic embitterment disorder in comparison to other mental disorders. Psychother Psychosom. 2008 77(1):50-6. Epub 2007 Dec 14.

SYMPOSIUM 3
DELIVERING PSYCHIATRY IN RURAL PERU: THE AYACUCHO MENTAL HEALTH PROJECT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) To be informed about the status of psychiatric illness and treatment in the rural developing world; 2) With a focus on the example of a functioning psychiatric clinic in an Andean city in Peru in which the presenters have been involved for several years; and 3) Learn about many of the issues involved in delivering psychiatric care in the developing world.

NO 03A

THE AYACUCHO MENTAL HEALTH PROJECT

James Phillips, 88 Noble Avenue, Milford, CT 06460

SUMMARY:

This presentation begins with some general information about the state of psychiatric illness and treatment in the rural developing world. The thrust of these introductory comments is that there is a high incidence of illness and virtually no treatment in the greater part of the world's population.

The presentation then moves to a description of a psychiatric clinic in an Andean city, Ayacucho, Peru, in which the presenters have been involved for several years. The clinic was started by a Filapina nun, Sister Anne Carbon, who is also a psychiatric nurse, in the autumn of 2003. Sister Anne began with local volunteer nurses and a volunteer psychiatrist from Lima. In June, 2004 two of us, working in conjunction with the Peruvian American Medical Society (PAMS), joined the clinic team. Over the course of the past five years the clinic has grown into a fully functioning outpatient psychiatric clinic. We have evaluated and treated about 2,200 patients, and more than 700 are in active treatment at this time. Service and medications are free or at nominal cost.

I will describe the operation of the clinic, including the range of programs in place, the role of the Peruvian psychiatrists who volunteer one weekend per month to do psychiatric evaluations and medication follow-ups, and the role of the American psychiatrists and psychologists, who visit the clinic twice per year for direct service and staff training, ship donated medications from the US, provide ongoing consultation and supervision via e-mail and Skype, and contribute and raise money to support clinic expenses such as nurses' salaries. This presentation will provide the symposium participants with one example of a functioning psychiatric clinic in an impoverished developing world setting.

NO 03B

CONSTRUCTING A FORMULARY FOR A PSYCHIATRIC CLINIC IN THE DEVELOPING WORLD

Mark D. Rego, M.D., 203 Broad Street, Milford, CT 06460

SUMMARY:

Building a formulary in any psychiatric institution has become a challenge. Budgetary concerns, competing evidence about medication efficacy and managed care pressures are the burdens of formulary committees. Constructing a formulary for a clinic in a developing country (usually in an impoverished area) brings fur-

ther challenges. Our experience in Ayacucho, Peru has brought with it an education in the international use and transport of psychotropic medications. These issues will be reviewed using Peru as an example but with an attempt to generalize to other parts of the world.

Some of the most difficult issues are as follows: assuming medications will not be plentiful, which ones should be chosen to optimize efficacy, safety and multiplicity of use (i.e. the same medication for different symptoms)?

How should cost drive the above considerations? Should extremely effective and perhaps extremely inexpensive drugs be used when therapeutic monitoring is required but unavailable or expensive? How should drugs be procured: individual donations from drug companies, donations from NGO's, purchased from generic manufacturers or purchased from international dispensaries? Each choice has its advantages and disadvantages. The generic company option opens the troubling theme of counterfeit medicines that is just now plaguing international medicine.

Lastly we will consider host country regulations for donations and distribution of medicines. This step, particularly going through customs can be the most difficult.

By the end of this presentation the participant will have a thorough framework that encompasses each step of the formulary building process in a remote, third world clinic.

NO 03C

PSYCHIATRIC TREATMENT IN A TRILINGUAL SETTING

Stephen J. Bittner, M.D., 111 Piedmont Road, Columbus, OH 43214

SUMMARY:

As the need for psychiatric care becomes a priority in developing countries, the issues of transcultural diagnosis and treatment may be strongly influenced by language interpretation between psychiatrist and client. The Ayacucho project represents a complex living laboratory for these issues. The patients are either bilingual, Spanish AND Quechua, or monolingual, Spanish OR Quechua. The psychiatrists are either monolingual (English or Spanish) or speak Spanish as a second language. The nurses, usually present at interviews, speak Spanish and Quechua but no English.

The presentation will review the literature on the dilemmas of doing psychiatry through interpreters, as exemplified by trilingual Ayacucho: 1) the problems of literal translation of specific words and concepts ("mood swings", "susto", "nati") as they move among Quechua, Spanish and English and are then plugged into the DSM-IV categories; 2) the problems of incomplete bilinguality as people struggle in their first language to understand and be understood in their second language (e.g.: nurses "translate" the psychiatrists' second-language Spanish into Spanish understandable by the Quechua-Spanish speaking patients, or the patients' Spanish into Spanish understandable by the psychiatrists); 3) the problems of "nuance" and "tone" and culturally influenced non-verbal communication, so crucial for all psychotherapeutic interaction, are so easy to miss in the multi-lingual/transcultural setting.

Doing psychiatric work through interpreters is challenging and takes time, patience, practice, a good working relationship with one's interpreter, and careful attention to non-verbal communication. But the Third World desperately needs mental health care, and patients are enormously appreciative.

NO 03D

THE USE OF SKYPE BY THE AYACUCHO TEAM IN FOLLOW UP SUPERVISION AND OTHER CONTACTS WITH PATIENTS AND STAFF

Galen W Stahle, M.D., 4685 Maple Hill Drive, Deephaven, MN 55331-9258

SUMMARY:

Evaluation and follow-up of psychiatric patients in areas remote from the treating psychiatrist's home base is always a problem. Individual psychiatrists have, for many years, followed patients by telephone, mail or e-mail when face-to-face meetings have been temporarily disrupted. More recently, some areas in the United States have used telepsychiatry for that purpose and, in fact, that type of service has recently received an incentive from Medicare in the form of enhanced payment for that service.

Follow-up of patients and supervision of staff and residents present problems of another magnitude when the patients are in a remote Peruvian town and the psychiatrists are scattered across the United States. To solve this problem our team has used Skype in the past for supervision of staff. We are also attempting to work out a protocol to enable us to use this technology to actually interview the patients live for the purpose of medication management after face-to-face initial interviews and/or evaluations. This presentation will briefly review the technology involved in Skype and our experience of that technology in our work with long-distance psychiatric follow-up of patients and supervision of personnel. It will also look at the limitations and problems associated with that technology. We hope this will promote better patient-doctor communication as well as improve the quality of service we are able to render in this difficult situation.

NO 03E

EVALUATION OF CHANGE IN INDICATORS OF MENTAL HEALTH IN AN ANDEAN REGION OF PERU

Luis E Bedregal, Ph.D., One Long Wharf Drive, New Haven, CT 06511

SUMMARY:

This presentation addresses the development of a database to track client demographics, psychiatric diagnoses, and service utilization in the Ayacucho clinic. In addition, the database will serve the implementation of standardized mental health and substance use instruments such as the Time Line Follow Back (TLFB), the Leeds Dependence Questionnaire (LDQ), the Brief Symptom Inventory (BSI), and the Post Traumatic Stress Disorder Checklist (PTSD-C). These instruments will assist in assessing longitudinal outcomes on mental health and substance use.

Patients are assessed with these instruments at baseline and every three months. In the presentation the database and the various research tools will be described in detail.

We expect that the database and research instruments will accomplish the following objectives: 1) generate information about characteristics of our patient population such as demographics, diagnoses, and treatment adherence; 2) assess treatment outcome on indices of psychiatric and substance abuse disorders; 3) study interactions and correlates of mental disorders, patient characteristics, and recovery; 4) provide a model for the use of a database for tracking psychiatric treatment in a developing country setting.

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1) Miller G: The unseen: Mental illness's global toll. Science 2006; 311: 458-461.

2) Patel V, Saraeno B, Kleinman A: Editorial: Beyond evidence: The moral case for international mental health. Am J Psychiatry 2006; 163: 1312-1315.

3) Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips M, Rajman A: No health without mental health. Lancet 2007; 370: 859-877.

4) Jacob KS, Sharan P, Mirza I, Garrido-Cumbera M, Seedat S, Mari JJ, Sreenivas V, Saxena S: Mental health systems in countries: Where are we now? Lancet 2007; 370: 1061-1077.

SYMPOSIUM 4
STALKING: RISK MANAGEMENT AND TREATMENT OF OFFENDERS AND VICTIMS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) understand the impact of stalking; 2) describe treatment approaches for victims and offenders; and 3) list safety measures for victims.

NO 04A

A COMPREHENSIVE APPROACH TO THE TREATMENT OF STALKING VICTIMS

Gail E Robinson, M.D., 8-231 E.N., 200 Elizabeth St, Toronto, ON M4W 3M4 Canada

SUMMARY:

Treatment of stalking victims requires a comprehensive approach including education, supportive psychotherapy and a discussion of practical measures. Education to victims about the nature of stalking, including common emotional reactions helps to validate the patient's feelings, reduce self-doubt, and mobilize her. It is important for victims to receive the message that this is not their fault. Supportive therapy will increase the woman's self-esteem by helping her to assert herself with the stalker and, if necessary, the authorities. Therapists can empower the victim to take control through (1) documentation and collecting evidence and (2) taking safety precautions.

While treating victims, therapists must be aware of many countertransference issues that may interfere with effective therapy. Therapists may over-identify with the patient's powerlessness or hesitate to take on a case out of fear of the stalker. Female therapists may protect themselves against the realization of their own vulnerability by blaming the victim. However, a female therapist may create an empathic environment in which the patient can experience, contain and tolerate her feelings of powerlessness. Countertransference reactions in a male therapist can lead to overprotectiveness, overdefensiveness, or anger that can interfere with his ability to be helpful to the patient.

NO 04B

STALKING OF HEALTHCARE PROFESSIONALS

Karen M Abrams, M.D., Department of Psychiatry University Health Network, 200 Elizabeth Street, Suite 8EN-212 Toronto, Ontario M5G Canada

SUMMARY:

Healthcare workers are especially vulnerable to being a victim of stalking, most often from stalkers who are intimacy seeking, resentful or incompetent. They regularly see lonely or mentally unstable individuals who may misconstrue sympathy and attention as romantic interest. Therapists may be vulnerable as a result of erotic transference. Stalking occurs in both outpatient and inpatient settings. The limited literature on this subject suggests that a significant number of clinicians experience some type of stalking and suffer adverse consequences yet most lack any type of training to deal with this. To assess the prevalence and consequences of stalking of physicians, the authors sent out questionnaires to over 3000 randomly chosen physicians in the Greater Toronto Area. Return rate was over 35%. Prevalence and types of stalking identified will be discussed as well as the psychological impact on the physicians harassed. Increased awareness of this phenomenon and appropriate interventions could reduce escalation of harassing behaviors. Suggestions for management of stalkers in the healthcare setting will be discussed.

NO 04C

TREATMENT OF STALKING-OFFENDERS

Werner Tschan, M.D., PO Box 52, Basel 4012 Switzerland

SUMMARY:

Mental health professionals are more and more confronted with stalking cases - the therapeutic intervention is the best possible approach for the prevention of further escalation. The intervention dilemma describes that each intervention can contribute to further escalation; an assessment, gathering collateral information and planning the intervention strategy help avoiding negative consequences.

Indirect intervention helps targeted victims to cope with the threat; whereas direct intervention are addressed towards the offender. Such intervention is best carried out under the umbrella of a legal framework. Health care service providers have to cooper-

ate with law enforcement authorities in such cases. The author discusses practical considerations in the assessment and management of stalking offenders.

NO 04D

WORKPLACE ASSESSMENT OF VIOLENCE RISK

Stephen G White, Ph.D., P.O. Box 597008-294, San Francisco, CA 94159

SUMMARY:

Dr. White will discuss how dynamic workplace threat assessment and threat management intertwine in resolving workplace violence risk scenarios. He will present the WAVR-21 (Workplace Assessment of Violence Risk), a 21-item structured professional judgment guide (SPJ), published in 2007 by him and Dr. Reid Meloy. SPJs reflect the current direction of assessment technology in using instruments specific to different violence-prone populations, and based in empirical knowledge and the state of professional practice. The WAVR-21 is designed to assess workplace targeted or intended violence, i.e., violence against specific or opportunistic targets personally known, recognized, or symbolically important to the attacker, who is motivated by a desire for justice, revenge, or notoriety for real or perceived "wrongs". Favorable inter-rater reliability statistics now exist for the WAVR-21 risk factors, and validity studies are underway. Dr. White will use a case presentation and various examples to demonstrate dynamic workplace threat management and the need for flexibility and multi-disciplinary collaboration.

NO 04E

STALKING THREAT MANAGEMENT

Jeffrey Dunn, 1149 S. Broadway, Los Angeles, CA 90015

SUMMARY:

Detective Jeff Dunn is a 21-year veteran of the Los Angeles Police Department and the officer -in-charge of the Threat Management Unit. He has an extensive background which includes burglary, child abuse, and sexual assault investigations and has investigated and/or supervised hundreds of stalking and threat related cases. He has recently been called upon to develop a training program to bring victim advocates and law enforcement together to manage and provide support in cases of domestic violence-related stalking. Det. Dunn will discuss celebrity stalking and general threat assessment and management tactics.

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1) Abrams KM, Robinson GE. Stalking Part 1: An Overview of the Problem. Can J Psychiatry
1998; 43: 473-476.
2) Abrams KM, Robinson GE. Stalking Part 2: Victims' Problems with the Legal System and Therapeutic Considerations. Can J Psychiatry 1998; 43: 477-481
3) White, S.G., & Meloy, J.R. The WAVR-21: A Structured Professional Guide for the Workplace Assessment of Violence Risk. San Diego: Specialized Training. 2007
4) Abrams K, Robinson GE. Treating Victims of Stalking. Directions in Psychiatry. 27:25-33, 2007.

SYMPOSIUM 5

UNDERSTANDING AND ADDRESSING ADOLESCENT ALCOHOL CONSUMPTION AND ALCOHOL USE DISORDERS IN THE CONTEXT OF OVERALL DEVELOPMENT

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to recognize how developmental processes influence alcohol use and alcohol use disorders in children and adolescents, as well as how development itself can be affected by the use of alcohol. Participants will understand the goals of developmentally based treatment approaches and recognize why they are likely to be more effective than approaches that do not take development into account.

NO 05A

EARLY DEVELOPMENT AND CONTINUITY OF RISK FOR EARLY DRINKING, PROBLEM DRINKING, AND ALCOHOLISM FROM EARLY CHILDHOOD TO ADULTHOOD

Robert A Zucker, Ph.D., 4250 Plymouth Road, Ann Arbor, MI 48109-2700

SUMMARY:

The period before age 10 traverses an extraordinary amount of developmental ground, encompassing the prenatal period, infancy, toddlerhood, the preschool years, and early middle childhood. A large number of relationships and social contexts are traversed, the brain is undergoing remarkable growth and change, and the fundamental self and social regulation systems have some stability by the end of the period. For about 90% of children experience with drinking has not taken place, but although drinking outcomes are still in the future, a number of precursive factors are being shaped that are predictive of later problem outcomes, including early and problem use as well as alcohol use disorder (AUD).

Concepts about alcohol as a drug and rudimentary schemas about use are being developed, as are early expectancies about what effect this beverage/drug has when consumed. Parent expectancies about children's use are also present and changing during this time. These are ALCOHOL SPECIFIC risks. There are also NONSPECIFIC RISKS--precursive factors risk-related to drinking but also to a number of other problem outcomes. Two major nonspecific risk factors for the later emergence of problem drinking are behavioral undercontrol and negative affectivity; both are very early predictors of earlier onset, faster emergence of drinking problems, and AUD in early adulthood. Other early

influences affecting risk development include marital assortment and drinking during pregnancy.

The talk reviews the substantial evidence for early identification of risk, describes the evidence for a resilient pathway even in high risk environments, and discusses issues that need to be dealt with in order to better specify the pathways into risky drinking and into prevention. The presentation concludes with a discussion of methodological and analytic challenges that research in this age range provides, and describe some of the core substantive research agenda items that still need to be addressed.

NO 05B

APPLYING A DEVELOPMENTAL FRAMEWORK TO ALCOHOL-RELATED BEHAVIORS: AGES 10 – 15.

Michael Windle, Ph.D., 1518 Clifton Road Rm. 420, Atlanta, GA 30322

SUMMARY:

The developmental interval spanning ages 10-15 is associated with a range of changes across biological (e.g., puberty) and psychological systems, as well as physical and social contexts. Significant changes in brain structure and function are evident during this age interval, with modifications in important components of the temporal, parietal, and prefrontal cortices, in addition to refinements in the synaptic connections of neurons associated with dendritic "pruning". Psychological and social changes also occur with regard to increases in psychological autonomy and personal identity, shifts toward peers as major socialization agents and reorganized parent-child relationships. Changes in physical contexts occur in transitions from elementary to middle school and from middle school to high school. During this age 10-15 interval there are not only a multitude of changes occurring, but also there may be dysynchronies in these changes that heighten adolescent vulnerabilities for alcohol use and other co-occurring problems behaviors. Alcohol use is most commonly initiated during this age interval and escalates to relatively high levels of use. For example, in 2004 the lifetime use of alcohol has been reported at 64.2% among 10th graders and over 35% reported alcohol use in the last 30-days. Critical developmental research questions exist. including how alcohol use impacts, and is impacted by, other developmental and maturational changes occurring in biological, psychological, social, and physical systems. Human and animal model studies are needed to investigate the interactions among these complex systems to obtain a better understanding of the major causes and consequences of alcohol use on adolescent processes and outcomes to guide interventions.

NO 05C

APPLYING A DEVELOPMENTAL FRAMEWORK TO ALCOHOL-RELATED BEHAVIORS FROM MIDDLE TO LATE ADOLESCENCE

Sandra A. Brown, Ph.D., 9500 Gilman Drive, MC0109, McGill Hall, Room 4137, La Jolla, CA 92093-0109

SUMMARY:

Middle to late adolescence is marked by remarkable transitions in development and includes the phase life (ages 18-20) in which alcohol dependence is most likely to first emerge. Developmental processes, including the transition to independence and self-regulation, are coupled with accelerations in risk taking, contextual changes and new roles to produce behavioral problems, including AUDs. Not only do developmental transitions lead to hazardous alcohol use, but youth with pre-existing risks (genetic or environmental) appear most vulnerable to developing alcohol problems.

Alcohol use during this phase of adolescence is notable for lower frequency but higher doses per episode than alcohol use in later adulthood. As a result, the consequences of these more hazardous patterns of alcohol use include both transient changes (e.g., injuries, depression, and anxiety) and which more protracted effects on development (e.g., moderation of neuroanatomical development, school drop-out, and early pregnancy). Specific developmental features of this age range include progression in the educational system, driver's license, romantic and sexual relationships, and employment and first independent residence. These behavioral progressions unfold in the context of ongoing biological, cognitive and social development. Each of these role additions create specific adaptational demands and appear to be impacted by alcohol use and AUDs. Gender and culturally specific trajectories add to the developmental diversity and complex array of factors with reciprocal relations with alcohol consumption.

This presentation provides a developmental framework through which the emergence of AUDs of late adolescence can be conceptualized, examples from our longitudinal studies of developmentally relevant alcohol related problems, and implications for developmentally tailored alcohol interventions.

NO 05D

DEVELOPMENTALLY INFORMED RESEARCH ON THE EFFECTIVENESS OF CLINICAL TRIALS (DIRECT) WITH ADOLESCENTS WITH ALCOHOL PROBLEMS

Eric F. Wagner, Ph.D., 11200 SW 8th Street, Miami, FL 33199

SUMMARY:

My presentation will focus on adolescent developmental issues and processes most likely to impact response to treatment for alcohol use problems. The need for research that blends developmental science and treatment outcome research is widely acknowledged, among both researchers and clinicians focusing on adolescents with alcohol use problems.. Unfortunately, scant information currently exists about developmentally informed approaches to understanding and addressing alcohol abuse (and other drug abuse) among teenagers. In the hope of moving developmentally informed research forward, my presentation will review the extant literature addressing the degree to which developmental issues and processes have been considered in adolescent alcohol treatment research. Moreover, promising concepts and methodologies from applied developmental science will be discussed, as will various developmental processes and transi-

tions that may influence on adolescent risk behavior including alcohol use. Finally, guidance based on examples from NIAAA-funded research will be offered as to how applied developmental science conceptualizations and methodologies may be successfully incorporated into randomized clinical trials, as well as clinical practice, with adolescents with alcohol use problems.

NO 05E

EVIDENCED-BASED TREATMENTS FOR ALCOHOL USE DISORDERS IN ADOLESCENTS

Deborah Deas, M.D., MUSC 67 President Street, Charleston, SC 29425

SUMMARY:

For decades, the treatment of adolescent alcohol use disorders was modeled after interventions used in adult populations without considerations of the developmental differences between the two populations. During the early 1990's, researchers and clinicians began to explore treatments developed specifically for adolescents, however many of the studies were not controlled. More recently, an increasing number of controlled treatment outcome studies that compare two or more modalities emerged to target adolescent alcohol use disorders. This presentation will review psychosocial treatments such as family-based interventions, motivational enhancement therapy (motivational interviewing), behavioral therapy, and cognitive-behavioral therapy as well as a limited number of pharmacotherapy studies for the treatment of adolescents with alcohol use disorders.

REFERENCES:

1) Underage Drinking: A Developmental Framework
Ann S. Masten, Vivian B. Faden, Robert A. Zucker, and Linda P. Spear Pediatrics 2008; 121: S235-S251.

2) Early Developmental Processes and the Continuity of Risk for Underage Drinking and Problem Drinking
Robert A. Zucker, John E. Donovan, Ann S. Masten, Margaret E. Mattson, and Howard B. Moss Pediatrics 2008; 121: S252-S272.

3) Transitions Into Underage and Problem Drinking: Developmental Processes and Mechanisms Between 10 and 15 Years of Age Michael Windle, Linda P. Spear, Andrew J. Fuligni, Adrian Angold, Jane D. Brown, Daniel Pine, Greg T. Smith, Jay Giedd, and Ronald E. Dahl
Pediatrics 2008; 121: S273-S289.

4) A Developmental Perspective on Alcohol and Youths 16 to 20 Years of Age Sandra A. Brown, Matthew McGue, Jennifer Maggs, John Schulenberg, Ralph Hingson, Scott Swartzwelder, Christopher Martin, Tammy Chung, Susan F. Tapert, Kenneth Sher, Ken C. Winters, Cherry Lowman, and Stacia Murphy Pediatrics 2008; 121: S290-S310.

SYMPOSIUM 6
IN OR OUT?: A DISCUSSION ABOUT GENDER IDENTITY DIAGNOSES AND THE *DSM*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Have a greater familiarity with the *DSM-V* revision process; 2)Understand some of the diverse viewpoints within the transgender advocacy community that surround inclusion, modification; and 3) Deletion of Gender Identity Disorder in the Diagnostic Manual.

NO 05A

THE *DSM-V* REVISION PROCESS: PRINCIPLES AND PROGRESS

William E Narrow, M.D., Suite 1825 1000 Wilson Blvd, Arlington, VA 22209

SUMMARY:

The *DSM-V* will be published in 2012, the culmination of a 13-year process of research planning, data collection and analysis, and stakeholder review. This presentation will review *DSM-V* development activities to date, along with anticipated future activities. The working definition of "mental disorder" will be reviewed and principles guiding the *DSM-V* revision process will be addressed. The *DSM-V* Task Force and Work Group structure will be presented, with some of the overarching themes that these groups will address, such as age, gender, culture, disability, and interactions with general medical conditions. Finally, gaps in knowledge as well as advances in our understanding of Gender Identity Disorder since the publication of *DSM-IV* will be summarized and placed in the context of the work of the *DSM-V* group addressing this condition.

NO 06B

BEYOND CONUNDRUM: STRATEGIES FOR DIAGNOSTIC HARM REDUCTION

Kelley Winters, Ph.D., 100 Dercum Drive #8372, Keystone, CO 80435

SUMMARY:

Since Gender Identity Disorders were first introduced in the *DSM-III* in 1980, the focus of what constitutes psychopathology in successive revisions of the *DSM* has shifted further away from distress with one's assigned or birth sex toward a greater focus on gender identity or gender expression that differ from one's birth sex. The consequences of conceptualizing gender identity as "disordered" include barriers to transition and related medical care, burdens of social stigma associated with psychiatric disorder or sexual deviance, loss of civil liberties and social legitimacy, and false positive diagnoses of individuals who meet no other definition of a mental illness.

Proposed strategies for harm reduction in the diagnostic criteria, supporting text, nosological placement and titles of gender disorders include increased emphasis on distress with physical sex characteristics or ascribed social gender role (gender dysphoria).

Individuals who meet diagnostic criteria and may benefit from treatment should be further differentiated from those who do not. Moreover, social gender nonconformity, otherwise ordinary gender expressions, the consequences of societal prejudice or intolerance, and sexual orientation should be excluded as symptomatic of mental disorder. The publication of the *DSM-V* is an opportunity for APA to affirm that, in the absence of dysphoria, gender identity and expression that vary from assigned birth sex are not, in themselves, grounds for diagnosing a mental disorder.

NO 06C

ALIGNING BODIES WITH MINDS: THE CASE FOR MEDICAL AND SURGICAL TREATMENT OF GENDER DYSPHORIA

Rebecca Allison, M.D., 10636 North 11th Street, Phoenix, AZ 85020

SUMMARY:

The scientific understanding of any medical condition evolves as new diagnostic and therapeutic advances are applied in its management. On occasion, a new treatment is introduced for a specific condition and is found to produce outcomes that are a significant improvement over previous treatment(s), even if the mechanism by which the new treatment works is not fully understood. There are many examples of this in general medical practice.

Today, both the appropriateness of diagnosis and the appropriate treatment of gender dysphoria generate controversy. However, many outcomes studies support the benefit of medical and surgical treatment to enable successful gender transition for persons whose gender identity is at variance with the gender assigned at birth. The results of the latter outcomes studies are examined and compared with the results of persons treated with behavior modification rather than with surgery and/or hormonal medications.

Given the success of medical and surgical management, the role of psychiatrists and other mental health professionals in the management of persons with gender dysphoria will have to evolve. For example, young people seeking to transition today may be highly self-educated about their medical and surgical options. They are often dismissive of being diagnosed with a mental disorder. In addition, many who have transitioned in recent years, both male to female and female to male, reject diagnostic categories that imply a sexual motivation for transition. As a practical matter, many who transition have bypassed the mental health system and long-standing requirements for "letters" of permission for surgery, traveling to countries whose surgeons do not require such letters. In addition, these individuals may feel little need for ongoing mental health services after transition.

Nevertheless, persons who transition may still be at risk and in need of treatment for stress induced psychological issues not unique to gender dysphoria; and psychiatrists and other mental health professionals do have a role to play in their care.

NO 06D

THE ROLE OF MEDICAL AND PSYCHOLOGICAL DISCOURSE IN LEGAL AND POLICY ADVOCACY FOR TRANSGENDER PERSONS IN THE U.S.

Shannon P. Minter, J.D., 870 Market Street, Ste 370, San Francisco, CA 94102

SUMMARY:

Current efforts to win basic legal and policy protections for transgender persons in the U.S. depend heavily on educating courts, legislators, and other policymakers about the medical and psychological aspects of transgender identity. In particular, in order to overcome the widespread belief that transgender persons are delusional or can be "cured" by learning to accept their birth sex, advocates have drawn upon current medical and psychological knowledge and practice to establish a number of basic propositions: (1) gender identity is a real, integral aspect of personal identity; (2) some people are born with a gender identity that differs from their natal sex; (3) efforts to change a person's core gender identity are futile and unethical; (4) transsexualism, also known as gender identity disorder, is a legitimate and serious medical condition; (5) sex-reassignment is medically necessary for many transsexual persons; (6) for the great majority of transsexual persons, sex reassignment is highly effective; (7) the goal of medical treatment is to enable a transsexual person to be comfortable with his or her gender and that specific treatments must be evaluated on an individual basis; (8) many transsexual people do not obtain genital reconstructive surgery and that such surgery is not required in order to "complete" transition; (9) being transgender does not affect a person's ability to be a good employee or parent; (10) from a medical and psychological perspective, a person who has a male gender identity should be considered male and a person who has a female gender identity should be considered female. Drawing upon their experience as legal and policy advocates for transgender persons, the authors explain how medical and psychological information has played a critical role in efforts to establish basic protections for transgender persons and why elimination of a medical diagnosis for transgender persons would be devastating to those efforts.

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SYMPOSIUM 7
RELATIONSHIP OF SUBTHRESHOLD PSYCHIATRY TO AXIS II (PERSONALITY DISORDERS)

EDUCATIONAL OBJECTIVES:

At the conclusion of the presentation, the participant should be

able to: 1) recognize the limitation of the categorical diagnosis of personality disorders in *DSM IV* and ICD 10; 2) Learn the overlap of axis I and II in personality disorders e.g. schizotypal and schizophrenia, borderline and bipolar, avoidant and social phobia etc.; 3) Recognize the disadvantages and advantages of the dimensional approach in personality disorders and 4) Diagnose personality disorders.

NO 07A

RELATIONSHIP OF SUBTHRESHOLD PSYCHIATRY TO PERSONALITY DISORDERS

Ahmed Okasha, M.D.3, Shawarby Street ,Kasr El Nil Cairo 11411 Egypt

SUMMARY:

Personality disorders were considered previously as forme fruste of the co existing diagnosis. The now clearly established fluctuation in reported levels of manifestations over time in patients with personality disorders might argue in favour of a dimensional continuum model --to some degree analogous to the exacerbation and remissions of axis I disorders-- presenting a challenge to stable and long duration as one of the *DSM-IV-TR* generic defining features for all personality disorders. Subthreshold conditions (dysthymia, generalized anxiety, cyclothymia and others) may be considered another nosologic challenge in the interface of axis I and axis II disorders. The presentation will outline the discriminatory problems between subthreshold symptoms, axis I and II (e.g. schizotypal with schizophrenia, borderline personality with bipolar II, avoidant with social phobia etc..)

Lastly the inclusion of subthreshold diagnosis with axis I, II personality disorders in a dimensional model will help clinicians to guide their practice and facilitate their conceptualization of the patients' pathology. The emergence of subthreshold psychiatry in diagnostic systems will accommodate the suggested nosology of having both categorical and dimensional approaches together .

NO 07B

PERSONALITY DISORDERS, THEIR THRESHOLDS AND PUBLIC HEALTH

Norman Sartorius, M.D.14 Chemin Colladon, Geneva 1209 Switzerland

SUMMARY:

Personality disorders are different from other disorders in the classification of mental disorders in that they have two thresholds – one to distinguish them from normality and the other to distinguish them from psychotic and other disorders. This characteristic is one among several reasons for the insistence of experts on personality disorders that a dimensional approach to the classification of personality disorders should replace the currently widely used categorical approaches.

Clarity about both of the thresholds of personality disorders - in a categorical or a dimensional system of classification - is of considerable public health importance. The definition of these two thresholds will co-determine the size of the burden that these disorders present; help in the definition of needs for mental health care; influence the treatment and the assessment of its success; and contribute to the definition of questions that need to be examined in future research. A clear definition of the thresholds of personality disorders will also facilitate their investigation in a longitudinal perspective of development over time which might produce indications about ways of dealing with risk factors and thus contribute to the prevention of the occurrence of the personality disorders.

NO 07C

SCHIZOPHRENIA /SCHIZOTAXIA: A GENETIC PREDISPOSITION OF SCHIZOPHRENIA.

Ming T Tsuang, M.D., University of California, San Diego, 9500 Gilman Drive, MC 0603, Medical Teaching Facility, Room 453 La Jolla, CA 92093

SUMMARY:

The search for vulnerability syndromes to identify risk for schizophrenia continues to grow as new technologies are developed and multidimensional conceptualizations are advanced. One such approach has been to reformulate Paul Meehl's notion of 'schizotaxia' to identify clinically meaningful symptoms in first-degree, non-psychotic biological relatives of patients with schizophrenia. Recent studies provide support for the view that cognitive deficits and negative symptoms provide a useful basis for the classification of schizotaxia, and predict function in related, independent measures. Preliminary new data will be presented from subjects assessed at the Mental Health Institute, Second Xiangya Hospital of Central South University, Changsha (Hunan, China). This study uses diagnostic, neuropsychological, clinical and physical measures of function to assess adult, non-psychotic, first-degree biological relatives of patients with schizophrenia. Schizotaxia involves the identification of: 1) neuropsychological deficits in declarative memory, sustained concentration and executive function; and/or 2) negative symptoms in these subjects. Additional measures of cognitive function are also administered, as are self-report measures of social function, and medical measures that emphasize cardiac, hepatic, lipid and glycemic control. Relatives classified as schizotaxic are compared statistically with relatives who do not meet criteria, and with healthy control subjects. We will present evidence showing that deficits in selected cognitive and clinical domains predict a wide range of additional independent cognitive and clinical deficits in a subset of non-psychotic, adult relatives of schizophrenia patients. These deficits are similar to those seen in schizophrenia, and reflect identifiable areas of vulnerability that may eventually serve as useful treatment targets.

NO 07D

ON THE SHARED DIATHESIS OF BORDERLINE PERSONALITY AND BIPOLAR

Hagop S Akiskal, M.D., VA Psychiatry Services (116-A) 3350,

La Jolla Village Drive, San Diego, CA 92161

SUMMARY:

Borderline personality, though officially classified as a Personality disorder, is a complex condition which sits uncomfortably between Axis I Affective, PTSD, Dissociative and Impulse Control, as well as other Personality, Disorders. Once thought to be a disorder on the border of schizophrenia, current data suggest greater overlap with affective dysregulation and major depression. Closer scrutiny suggests that many borderline patients often meet criteria for ultra-rapid cycling and depressive mixed states, considered typical for cyclothymic and bipolar II disorder. Family history for bipolar disorder is prevalent in the latter, an association which is deemed to be "modest" in the borderline literature. Indeed, loci on the short and long arms of chromosome 18 have been reported for cyclothymia/bipolar II, but not borderline personality; what bipolar II and borderline disorders share is the s polymorphism of the serotonin transporter. "Comorbidity" with eating, alcohol/substance use disorders and mood lability, and importantly high suicidality, are also shared characteristics. Despite the high rhetoric and drama that has characterized the borderline/bipolar II debate, a shared psychologic and biologic diathesis seems to underlie this interface. These considerations are of great theoretical, clinical and public health significance.

NO 07E

GENERALIZED ANXIETY DISORDER AND AVOIDANT PERSONALITY DISORDER

Juan J Lopez-Ibor, M.D., Director Institute of Psychiatry & Mental Health Hospital Clinico, San Carlos Complutense University of Madrid Avda, Prof. Martin Lagos, s/n 28040 Madrid 28035 Spain

SUMMARY:

Present classification systems in psychiatry rely on the clinical manifestations, mainly the symptoms, to differentiate among different disorders. They have had the great advantage of creating a common language for psychiatrists all over the World. But they have drawbacks that are increasingly recognized, leading to the interest in other methods, especially those based on the physiopathology of the different disorders.

The present systems have lead to a strict separation of so to say clinical disorders of axis I of *DSM-IV* and personality disorders of axis II. The firsts are conceived according categories while the second are considered in a dimensional fashion. Furthermore, the anxiety disorders themselves are also separated among themselves. When going from classifications based on symptoms towards other taking into account pathogenetic mechanism there is a need to find common features among different disorders. In the case of anxiety and related disorders present systems are in line with behaviour therapy perspectives while pathogenetic methods have to relay on a common feature which is morbid anxiety and in a second stage, to delve into the (secondary) mechanism which lead to the different clinical manifestations, often considered as defense mechanisms. From this perspective a personality disorder, the avoidant personality, will join clinical disorders such as generalized anxiety. This, of course, is not new. During decades the more was know about a of personality, the higher the chances of becoming an axis I disorder. Epileptic personality disorder is part of the organic personality disorders, depressive personalities are most of them considered as disthymias, and cyclothymic personality is nowadays cyclothymia. Furthermore, in ICD-10, but not in *DSM-IV,* schizotypal personality has become schizotypal disorder, among the schizophrenic and delusional disorders. Some long term studies support the unity of many of the disorders mentioned.

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SYMPOSIUM 8

EDUCATING A NEW GENERATION OF PHYSICIANS IN PSYCHIATRY: REPORTS FROM WINNERS OF APA INNOVATIVE TEACHING GRANTS

SUPPORTED BY APA CORRESPONDING COMMITTEE ON MEDICAL STUDENT EDUCATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants should be familiar with;1) innovative teaching projects in psychiatry; 2) learn techniques for engaging medical students such as providing intensive mentoring by faculty, and offering clinical opportunities in preclinical years that link psychiatry with other medical specialties; and 2) will hear how medical schools have created electives that bring students into contact with psychiatric patients in non-traditional ways that mitigate stigma

NO 08A

CHANGING PERSPECTIVES: REDUCING THE STIGMA OF MENTAL ILLNESS IN MEDICAL STUDENTS THROUGH THE LIVING MUSEUM PROJECT

Janis Cutler, M.D., 1051 Riverside Drive, #125, New York, NY

10032

SUMMARY:

Background: Stigma plays a significant role in shaping future physicians' views of individuals suffering from psychiatric disorders.1, 2 Experiences characterized by intimacy in which participants interact with relatively equal status around cooperative tasks effectively reduce stigma.3, 4 We have designed an intervention to combat stigma against mental illness among preclinical medical students: visits to a state psychiatric facility's "Living Museum," a combination art studio and display space in which all the art work has been produced by psychiatric patients. Our hypothesis is that visiting the "Living Museum" will reduce students' stigmatization of individuals suffering from severe psychiatric disorders by demonstrating their humanity, individuality, and creative potential. Specifically, we hypothesize that students who have already visited the Living Museum will have more positive attitudes towards psychiatric patients than students who have not yet had the Living Museum experience; and that students with more capacity for empathy may experience a greater impact from the visit on their attitudes.

Methodology: Half of the first year class visited the Living Museum this past spring semester and half will visit during the fall semester. Students interact with patient-artist guides who show their work and discuss their experiences creating art. Students will complete a self-assessment instrument at the beginning of the fall course. The instrument will measure capacity for empathy and attitudes towards psychiatric patients.

Results: The 2 groups of students (those who visited the Living Museum and those who did not) will be compared to determine: 1) the impact of the visit on their attitudes towards psychiatric patients; and 2) any associations between the students' empathic capacities and the impact of the visit.

NO 08B

A SCHOOL-BASED MEDICAL STUDENT CURRICULUM FOR EDUCATION IN CHILD AND ADOLESCENT PSYCHIATRY

Justine Larson, M.D., 515 Philadelphia Avenue, Takoma Park, MD 20912

SUMMARY:

At the Johns Hopkins School of Medicine, the basic science curriculum in the first year is heavily lecture-based. Students consistently indicate their desire to have more meaningful interactions with patients. In response to this interest, as well as a desire to expose medical students to child psychiatry, a program was developed in partnership with the with the Johns Hopkins Child and Adolescent School-Based Mental Health Program to pair medical student mentors with school-aged children and adolescents who are receiving mental health services.

The program is designed to offer students an in-depth educational and clinical experience in community-based child psychiatry while offering children with mental and behavioral health issues an opportunity to have one-to-one, longitudinal relationships with a young adult. Students meet weekly with their buddies over the course of ten months and have the opportunity to engage in recreational activities with the kids and to observe elements of their clinical care. The student participants meet monthly for conferences to discuss salient child psychiatry topics and write two reflection papers about their experiences. They are paired with a child psychiatry resident and faculty member and are encouraged to bring questions and concerns to their mentors.

In this presentation, we will discuss what we have learned in the program's pilot year. We will discuss the challenges encountered in implementing the program, including establishing the program within the existing structure of the medical school curriculum and negotiating competing demands on student's time. We will also present student reflections on their experience in the program and the results of our pre- and post-intervention surveys. Finally, we will discuss directions for the future and recommendations to other schools that may wish to implement similar programs.

NO 08C

TEACHING 3RD YEAR MEDICAL STUDENTS BRIEF MOTIVATIONAL INTERVIEWING SKILLS TO USE IN COUNSELING PATIENTS WITH MENTAL ILLNESS ON SMOKING CESSATION

Brenda J.B. Roman, M.D., 627 S. Edwin C. Moses Boulevard, Dayton, OH 45042

SUMMARY:

People with mental illnesses are nicotine dependent at rates that are two to three times that of the general population; however few physicians feel that they can be successful in modifying patients' behaviors. Motivational interviewing, which incorporates empathy, open-ended questions and reflective listening, has been identified as a useful tool for physicians to learn in order to improve counseling skills in health behavior change. In order to teach motivational interviewing skills for future physicians, and improve the health of the severely mentally ill by providing smoking cessation programs, this project examined whether students develop greater confidence in their ability to counsel patients regarding smoking cessation.

Questionnaires were given to the students to assess pre-clerkship knowledge of motivational interviewing principles and their confidence in the ability to counsel patients regarding behavior change. A one hour didactic module on the principles of motivational interviewing was given to all students during orientation week. Then in a two hour session, students were given the opportunity to practice motivational interviewing skills through role play. During the rotation, some students rotate with faculty who utilize motivational interviewing, and others rotate with faculty who do not, as part of their working with patients regarding smoking cessation. At the end of the rotation, students were asked to fill out the same questionnaire of knowledge regarding motivational interviewing and their confidence in counseling patients regarding behavior change. The data collected during the academic year will be presented.

NO 08D

PREVENTING AND MANAGING METABOLIC SYNDROME AMONG THE SERIOUSLY MENTALLY

ILL: TEACHING BEHAVIORAL MEDICINE TO MEDICAL STUDENTS

Jason B Rosenstock, M.D., 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:

Non-psychiatrists frequently feel unprepared to face psychiatric issues in their practices, including behavioral approaches to diet and exercise. By teaching behavioral medicine to medical students, we believe that students will be more confident about working with psychiatric patients, and perhaps more inclined to choose psychiatry.

To enhance teaching of behavioral medicine, we developed a "mini-elective" for second-year medical students that address a major health problem: metabolic syndrome among patients with serious and persistent mental illness (SPMI). Behavior change interventions in this population have been shown to help with nutrition, exercise, and diabetes prevention/management. Our mini-elective provides a series of didactic sessions about basic behavioral health principles and training in specific techniques and approaches for a psychiatrically-ill population. Six students developed teaching plans and materials used to run a series of patient groups at our SPMI clinic, as well as individual lifestyle coaching sessions; individual treatment plans were developed based on a review of metabolic risk factors. Motivational interviewing, materials, and incentives were used to help patients achieve their goals. These goals were then communicated to the psychiatrist, therapist, and primary care physician as a treatment plan created by the student and patient.

We will present outcome data in the form of pre/post questionnaires about attitudes, comfort, and knowledge, and specialty choice preferences, among mini-elective participants and controls. Patient outcomes will include specific metabolic measures.

This project provides early clinical exposure to psychiatry, connecting students to faculty mentors. It counters stigma against SPMI or obese patients, and student nihilism that behavior change is impossible. It allows students to work in a multidisciplinary team. Finally,this methodology that can easily be replicated at other schools.

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SYMPOSIUM 9
EFFECTIVE ASSESSMENT AND TREATMENT OF SEXUAL DYSFUNCTION IN ADULTS AND THE ELDERLY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1)Recognize the importance of assessing sexual functioning during treatment of mental illness; 2) Be familiar with the methods for assessing sexual function and the clinical presentation of psychotropic-induced sexual dysfunction; 3) Recognize the unique clinical aspects of sexual dysfunction in older adults; and 4) Understand the literature supporting the currently available treatment options for addressing sexual dysfunction.

NO 09A

CLINICAL PRESENTATION AND ASSESSMENT OF SEXUAL DYSFUNCTION IN PATIENTS WITH PSYCHIATRIC ILLNESS

Jeffrey D. Raynor, M.D., G.W. Bryan Psychiatric Hospital, 220 Faison Drive, Columbia, SC 29203

SUMMARY:

While sexual function is of considerable importance to patients with mental illness, it is often not assessed by psychiatrists. Sexual dysfunction is common in people with mental illness. Furthermore, comorbidities like diabetes and hypertension are unfortunately common in our patients, and they also can cause sexual dysfunction. Failing to assess sexual function before starting treatment may lead a clinician to wrongly attribute problems to medication when other factors may be to blame. Sexual functioning involves a number neurotransmitters relevant to psychopharmacology. Dopamine is linked to libido, acetylcholine to arousal, and norepinephrine and serotonin to orgasm. Medications with serotonin reuptake activity can lead to anorgasmia. Neuroleptics, particularly first generation antipsychotics, may decrease libido directly via dopamine blockade or due to hyperprolactinemia. Anticonvulsants and anxiolytics can also cause sexual dysfunction. If symptoms are not detected, adherence is adversely affected. For patients on neuroleptics, non-adherence may be inaccurately attributed to lack of insight or poor response to medications. A number of useful survey instruments have been developed to accurately measure sexual dysfunction both in research settings and clinical practice. Even without these instruments, a psychiatrist's willingness to ask questions about sexual function may yield important results. While patients may be reluctant to spontaneously volunteer concerns about sexual function, there is strong evidence to suggest they are willing to discuss this topic if directly questioned by their doctor. Thorough assessment and proactive management of sexual dysfunction can improve attitudes towards medication and increase trust between doctor and patient.

NO 09B

TREATMENT OF PSYCHOTROPIC-INDUCED SEXUAL DYSFUNCTION

Travis O. Bruce, M.D., University of South Carolina, School of Medicine, 3555 Harden Street, Ext Suite 301, Columbia, SC 29203

SUMMARY:

The treatment of sexual dysfunction in patients receiving psychotropic medication can be critical to ensuring medication compliance and to allowing the patient to maintain a good quality of life. The effects of different psychotropics can cause varying sexual dysfunctions, including decreased libido, erectile dysfunction, and delayed orgasm or anorgasmia. The literature supports a number of potential treatment options for sexual dysfunction and pharmacotherapy that depends on the type of dysfunction present. A number of options for treating psychotropic-induced sexual dysfunction have been proposed, including waiting for adaptation, lowering dosages, switching medications, "drug holidays," and pharmacological reversal. Options for pharmacological reversal include medications that target noradrenaline, serotonin,, dopamine, acetylcholine, histamine and nitric oxide systems. Knowledge of these treatment options and the literature that support them can help clinicians decide on appropriate management of psychotropic-induced sexual dysfunction.

NO 09C

SEXUAL DYSFUNCTION IN LATE-LIFE: BEYOND "VITAMIN V"

Shilpa Srinivasan, M.D., 3555 Harden Street, Ext Suite 301, Columbia, SC 29203

SUMMARY:

Demographic changes have led to a burgeoning sexually active older adult population. While previously regarded as nonexistent or even inappropriate or unsafe, the importance (and prevalence) of sexual activity in older adults is still under-addressed in clinical discussion.

Physiological sexual response declines with normal aging. Menopause-related changes include those to anatomy, sexuality, and sexual response along with decline in libido and sexual frequency. In men, testosterone reduction is associated with decline in sexual drive. Up to 30% of adult men and 50% of adult women experience at least one form of sexual dysfunction, with rates increasing in later life. The cause of sexual dysfunction in older adults is multifactorial, with medical illness, iatrogenic effects, psychiatric comorbidity and psychosocial variables playing roles. The complexity of sexual function in older adults is further increased when considering the effect of dementia. Dementia can be associated with sexually inappropriate behaviors, adding to caregiver burden and calling into question the fundamental ability to consent to sexual activity especially in long-term care facilities.

The treatment of sexual dysfunction in older adults begins with a thorough assessment, requiring open communication between the patient, their partner, and a responsive clinician. Such assessments include complete medical and psychiatric history, mental and sexual status exam, physical exam, hormone assays, and diagnostic tests. Treatments include psychoeducation, reassurance, health and lifestyle modification, psychological interventions, management of medication-related sexual side effects, and pharmacotherapy, with hormone replacement featuring prominently in female sexual dysfunction, and oral phosphodiesterase inhibitors and penile implants utilized in male sexual dysfunction.

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SYMPOSIUM 10

THE NEUROBIOLOGICAL EVIDENCE FOR TRANSGENDERISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to; 1) Learn transgenderism, Gender Identity, Gender Expression, Gender Role Behavior, Gender Dysphoria and Transsexualism; 2) Understand the Standards of Care (WPATH) for treatment; 3) The neurobiological evidence for gender differences in the human brain and genetic inheritability of Transsexualism will be presented; and 4) Current US medical practices in the Treatment of GID in children, adolescents and adults will be discussed.

NO 10A

BRAIN GENDER IDENTITY

Sidney W. Ecker, M.D., 132 Silver Tail Lane, New Hope, PA 18938

SUMMARY:

Gender Identity is that innate sense of who you are in this world with reference to your sexuality and behavior, not necessarily corresponding to your genitalia and reproductive organs. Transgenders are atypical and "think" as the opposite gender. Certain areas of the brain have been shown to be sexually dimorphic. They are different in structure and numbers of neurons in males versus females. Protein Receptors for the sex hormones in dif-

ferent areas of the brain (limbic and anterior hypothalamic) must be present in sufficient numbers to receive those powerful hormones. There are androgen receptors (AR), Estrogen Receptors (ER), and Progesterone receptors (PRs). ARs or ERs are predominant at different times in different parts of the human brain. Hormone receptor genes have been identified in humans, which are responsible for sexually dimorphic brain differentiation in the hypothalamus. The groundwork in brain gender identity is gene-directed and takes place by forming male and female hormone receptors in the brain before the gonads and hormones can influence them. Multiple genes acting in concert determine our sexual identity. The human brain continues to make neurons and synaptic neuronal connections throughout life. This contributes to Gender Role Behaviors making individuals in the continuum of gender identity. Gender behaviors must be differentiated from gender identity (Hines). Gender Identity cannot be predicted from anatomy (Reiner). Brain gender identity is determined very early in fetal development, but gender expression, expressed as behaviors requires hormonal, environmental, social and cultural interactions, which evolve with time. One cannot deny the profound effects of Testosterone, Estradiol and other steroids on genital differentiation in-utero or their effects on behavior from birth or the physical and mental cross gender changes caused by exogenous hormones, but gender identity is determined before and persists in spite of these effects.

NO 10B

TRANSSEXUALITY AS AN INTERSEX CONDITION

Milton Diamond, Ph.D., 1960 East-West Road, Honolulu, HI 96822

SUMMARY:

The *DSM* considers transsexuality a medical condition in which an individual is dysphoric due to an irrational feeling of discordance between physical appearance as a male or female and the gender felt appropriate. This talk will present evidence that the feelings can actually be appropriate because the brains of such persons have seemed to develop along the typical path of one sex while their somatic body has developed along the typical path of the other.

It is fairly well accepted that prenatal genetic and endocrine forces heavily influence sexual development. At levels significantly lower than those needed to modify the soma these prenatal influences are believed to bias behaviors via brain modifications. Since an individual is reacted to by society in accordance with his or her phenotype rather than unseen brain "type," this discordance is disturbing. Eventually the individual involved believes the solution is to modify the phenotype rather than change the brain.

3. NOVEL APPROACHES TO ENDOCRINE TREATMENT OF TRANSGENDER ADOLESCENTS AND ADULTS

Norman Spack, M.D., Endocrine Division, Children's Hospital Boston/Harvard Medical School, 300 Longwood Avenue, Boston MA 02115

SUMMARY:

Nearly all transgendered adults recall feelings of being in the wrong body early in childhood. Patient histories resonate with the common theme of dressing secretly in the clothes of the opposite gender during childhood. However, the age at which a transgendered individual fully acknowledges his or her gender identity varies from mid-childhood to middle age. Delayed acknowledgment can usually be traced to a fear of stigmatization and rejection by family, friends and employers. A small percentage of children who are emphatic and consistent in their desire to be the opposite gender (less than 20% of the above) prefer to be called by a pronoun and name consistent with their gender identity. Their friends, dress and activities correspond with that identity. Their greatest fear is puberty because of the irreversible changes that threaten how they are perceived (their "gender attribution"). During adolescence, when unwanted and permanent secondary sexual characteristics transform the patient's body into an adult form that is asynchronous with the brain, depression and anxiety are typical reactions. When menses become a monthly reminder of femaleness in a teenager with a male identity, self-abusive behavior is common. The incidence of suicide among transgendered youth is high. Who is qualified to assess a patient's condition for referral for endocrine treatment and ultimate surgery? "Standards of Care" have been created by WPATH, the Harry Benjamin International Gender Dysphoria Association, a professional society that includes mental health professionals, endocrinologists, internists and surgeons (www.wpath.org). The standards define stages of treatment, beginning with "extensive exploration of psychological, family and social issues" by a mental health professional who has abundant experience working with this population, and only then moving to physical intervention, which should take place in stages, from reversible to irreversible interventions.

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SYMPOSIUM 11
COMPREHENSIVE HIV PSYCHIATRY UPDATE

EDUCATIONAL OBJECTIVES:

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

to:1)Understand the incidence of neuropsychiatric and psychiatric illness in HIV/AIDS; 2) Understand the diagnostic and treatment approaches to psychiatric symptoms in people with HIV/AIDS; 3) Understand the pathophysiology of HIV-1-associated neurocognitive impairment and disorder; and 4) To recognize that there are drug interactions between HIV medications and psychiatric medications.

NO 11A

HIV/AIDS MEDICAL UPDATE

Paul Volberding, 4150 Clement Street, VAMC, 111 San Francisco, CA 94121

SUMMARY:

There are an increasing number of antiretroviral agents being used to treat HIV-infected patients. To successfully diagnose and treat patients with HIV/AIDS, psychiatrists need to understand the biomedical aspects of AIDS as well as patterns of HIV infection in special patient populations. Treating HIV-infected persons, however, is becoming increasingly complex. While antiretroviral regimens have fewer side effects, adherence to treatment is as crucial as ever and must be durable for many years. This session will provide the most up-to-date epidemiological information, guidelines for antiretroviral therapy, and considerations for patients with a history of drug use or mental illness. The session will include a lecture and question and answer period providing participants the opportunity to discuss individual clinical concerns.

NO 11B

NEUROPSYCHIATRIC OVERVIEW OF HIV/AIDS

Robert Daroff Jr., M.D., 4150 Clement Street, Box 116C, San Francisco, CA 94121

SUMMARY:

Since the beginning of the epidemic over 27 years ago, the role of the psychiatrist has been critical in the management of HIV/AIDS. The prevalence of HIV among people with severe mental illness is estimated to be approximately ten times that in the US general population, and even higher among people with co-morbid substance use disorders. Psychiatric conditions may reduce compliance with HIV treatments and increase the likelihood of high risk sexual and drug use behaviors. Depressive disorders are nearly twice as common in HIV positive subjects compared to matched controls and may be associated with disease progression. Psychiatrists must consider the potential direct effects of HIV on the central nervous system and on other organ systems when assessing psychiatric complaints. In addition, persons with HIV are often on multiple medications that may have psychiatric side effects or may induce complex drug-drug interactions. Approximately 12% of people with HIV have a concurrent diagnosis of drug dependence, further complicating assessment and treatment. This presentation will review (1) the epidemiology of mental health disorders in HIV; (2) the differential diagnosis and evaluation of psychiatric symptoms in the context of HIV; (3) the general psychopharmacologic and psychotherapeutic treatment approaches to mood, anxiety, and psychotic disorders in HIV; and (4) the potential role of the psychiatrist in HIV prevention and as a member of an integrated, multidisciplinary approach to HIV medical care.

NO 11C

NEUROCOGNITIVE DECLINE

Karl Goodkin, M.D., 8730 Alden Drive, Suite E-101, Los Angeles, CA, 90048

SUMMARY:

Although HIV-1-associated dementia and minor neurocognitive disorder have declined in incidence, HIV-1-associated neurocognitive impairment continues to be a frequent and clinically important focus in the combination antiretroviral therapy (CART) era. This change is consistent with neuropathological changes noted in which the encephalopathy has actually become more common, although less severe than in the pre-CART era. The clinical manifestations of the HIV-1 associated neuocognitive disorders themselves have changed, with chronic inactive and fluctuating forms of the dementia, for example, becoming more common. Long-term toxicities of the antiretrovirals themselves are now known to contribute to the etiology of these disorders. Thus, new criteria have been promulgated for HAD and MND, and asymptomatic neurocognitive impairment has been added as a condition to be diagnosed. The laboratory markers for neurocognitive disorder risk, progression, and treatment response that were useful previously for these disorders are no longer highly predictive in the CART era. Hence, these conditions remain diagnoses of exclusion. Documented, effective therapies for these treatment targets remain largely constrained to the CNS-penetrating antiretroviral regimens and the psychostimulants. The recently FDA-approved antiretroviral drugs in the classes of CCR5 antagonists and integrase inhibitors deserve study for neurocognitive disorders, along with antiretroviral adjuvant pharmacotherapies specific to the CNS.

NO 11D

PSYCHOPHARMACOLOGY

Gabrielle Marzani-Nissen, M.D., HSC Box 800623, Charlottesville, VA 22908

SUMMARY:

The current psychopharmacology for HIV/AIDS recognizes particular drug interactions between HIV medications and psychiatric drugs. Highly active antiretroviral therapy, known as HARRT, is the drug regimen which needs to be taken every day for viral suppression and control of the disease. HAART is broadly divided into three categories which follow predictable metabolic pathways in the liver known as the cytochrome p450 system. HAART can compete with psychiatric medications in the liver, block or slow down these pathway (inhibit) or increase the

activity or enhance the pathway (induce). HARRT is metabolized by the cytochrome 3A4 and the 2D6 pathways which are the same ones used by many psychiatric drugs. An overview of the clinically significant interactions will be offered. Clinicians will be introduced to medication interaction tables that are free, reliable, easy to use and readily available by the internet. Clinicians will also appreciate the potential dangers of certain medications such as trazodone due to drug-drug interactions as well as other prescribed and over the counter medications. Recreational drugs (including "club" drugs) and their interactions will be discussed as well.

Some HIV medications which are the backbone of treatment (such as efavarenz or Sustiva) can worsen symptoms for individuals with major depression or post-traumatic stress disorder. This can lead to non-adherence to the medications. Pharmacologic strategies will be discussed. Both individuals taking HAART as well as individuals with HIV who do not yet require HAART can have increased sensitivity to medications which are commonly used in psychiatry. These include lithium, valproate, antidepressants and antipsychotics. These will be discussed. Recognition of the stage of HIV/AIDS of the individual can be helpful in making medication determinations and this will be described as well.

REFERENCES:

1) Bing EG, Burnam MA, Longshore D, et al. Psychiatric disorders and drug use among human immunodeficiency virus-infected adults in the United States. Arch Gen Psychiatry. 2001; 58:721-28.

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SYMPOSIUM 12
THE OC SPECTRUM IN THE ATHLETE: PSYCHOPATHOLOGY OR COMPETITIVE EDGE?

SUPPORTED BY INTERNATIONAL SOCIETY FOR SPORT PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Diagnose OC spectrum disorders in the athlete, with an emphasis on how these symptoms can be adaptive for, or conversely, destructive to, athletic performance; 2)They will then learn to recognize the unique ways these entities can present in this patient population; and 4) will become familiar with strategies for treating the athlete with OC spectrum disorders.

NO 12A

AN INTERNATIONAL LEVEL ATHLETE'S STRUGGLE WITH OBSESSIVE COMPULSIVE DISORDER

David O Conant-Norville, M.D., 15050 SW Koll Parkway, Suite 2A, Beaverton, OR 97006

SUMMARY:

Obsessive Compulsive Disorder (OCD) is a common psychiatric disorder that afflicts persons of all ages and genders. Symptoms can severely interfere with daily functioning. When OCD occurs in competitive athletes, athletic performance often declines and the athlete suffers great emotional hardship.

This presentation is based on the real life story of a young and talented water polo player from the British national team, Lisa Gibson, and her battle to overcome OCD so that she can perform at the highest level in the sport. This shared presentation will feature Lisa Gibson describing her life and the development and effect of symptoms. David Conant-Norville M.D. will discuss the difficulties and treatment strategy as the treating psychiatrist.

Important themes to be explored and highlighted are: the unique challenges that OCD symptoms present to the elite athlete struggling to overcome the disorder while keeping it all secret for coaches and team mates; the fear of discovery and loss of control which can distract the athlete from attaining peak athletic performance and may lead to the athletes demoralization; the unique competitive mind set and training skills that the elite athlete hones and how these skills can help the athlete overcome OCD; and the psychopharmocological challenges and anti-doping issues that each psychiatrist should know when treating the elite athlete.

NO12B

ATHLETES AND SUPERSTITION

Thomas S Newmark, M.D., Department of Psychiatry, 401 Haddon Avenue, Cooper University Hospital, Camden, New Jersey 08103

SUMMARY:

Athletes routinely engage in ritualistic behavior which is often linked to superstitions. This paper will describe various superstitions that athletes engage in with particular examples. Superstitions will be defined and differentiated from OCD Disorder. The reason athletes are superstitious and the impact this will have on their performance will be discussed. An athlete will be interviewed to describe his/her superstition and their perception of how this could impact performance. The psychology of superstition will be discussed as it relates to athletes and teams.

NO 12C

THE OC SPECTRUM IN THE ATHLETE: PSYCHOPATHOLOGY OR COMPETITIVE EDGE

Saul I Marks, M.D., 4001 Leslie Street, Toronto, M2K1E1 Ontario, Canada

SUMMARY:

Obsessive Compulsive rituals are seen in almost every athlete

and in most sports. At times these rituals are seen to give the athlete a competitive edge.

The purpose of this presentation is to look at the athlete who develops full blown OCD and how this can effect their career. The objective is to see how the use of both optimum psychotropic medication, not on the prohibited substance list, in combination with cognitive behavioural therapy can be used to aid the athlete to return to their sport even at the elite international level.

A consult was done by the leading expert in OCD in Canada on a springboard and tower diver who had been on the Senior National Diving Team. Her progress in both her symptoms and medication alterations were followed as was her progress in her athletic endeavors.

Early intervention, diagnosis and proper treatment is essential for any psychiatric illness. This presentation will show how the elite athlete needs not only the same treatment as the general population, but attention to side effects of the psychotropic medications is essential if athletic performance is to be optimized.

REFERENCES:

1) Kamm, RL: Interviewing Principles for the Psychatrically Aware Sports Medicine Physician, in Clin Sports Med 24 (2005) 745-769.

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SYMPOSIUM 13 WITHDRAWN

SYMPOSIUM 14
INCREASING THE LIKELIHOOD OF ACHIEVING REMISSION IN DEPRESSION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Discuss new clinical approaches to treatment that may increase the likelihood of remission; and 2) Discuss the potential role of biomarkers in directing treatment decisions in depression.

NO 14A

MEDICATION ALGORITHMS FOR ANTIDEPRESSANT TREATMENT: LESSONS LEARNED FROM STAR*D AND OTHER PRACTICAL CLINICAL TRIALS

Madhukar H Trivedi, M.D., Exchange Park, American General Tower, 6363 Forest Park Road., Suite 13.354 Dallas, TX 75390-9119

SUMMARY:

No one antidepressant treatment is effective for everyone, despite the availability of a large number of treatment alternatives. Many patients do not experience a satisfactory clinical benefit from their initial treatment. For various reasons including inadequacy of pharmacological management, less than 30% of patients benefit sufficiently (i.e., have a remission) from a first antidepressant trial. The remaining 70% (non-remitters and non-responders to the initial treatment) must move on to the "next step" where patients receive some alternative to the initial failed trial. Many recent efforts including the Texas Medication Algorithm Project, NIMH funded STAR—D project, NIMH funded REVAMP project and other practical clinical trials all attempted to determine the most effective treatment strategies for patients who do not benefit adequately (symptom remission) from initial treatment. The treatment protocols aim to determine and to implement an adequate dose and duration of medication (or psychotherapy) at every stage following the initial failed trial. The most important clinical challenge revolves around choosing the best augmentation/combination of pharmacological and of psychotherapeutic treatments and addressing the associated symptoms of anxiety, insomnia, fatigue and other somatic symptoms. Current evidence for adjunctive treatments as well as measurement-based approaches will be discussed.

NO 14B

STRATEGIES FOR MEDICATION MANAGEMENT OF TREATMENT RESISTANCE: LESSONS FROM STAR*D

Maurizio Fava, M.D., 55 Fruit Street, Boston, MA 02114

SUMMARY:

The nationwide STAR*D study, whose goal was to assess the effectiveness of adequately delivered treatments in "real world" outpatients who have major depressive disorder (MDD), included four levels of treatment (see http://www.nimh.nih.gov/healthinformation/stard.cfm). All participants began at Level 1 and were treated with the antidepressant citalopram, a selective serotonin reuptake inhibitor (SSRI). If they did not achieve satisfactory outcomes, participants could go on to successive levels in an attempt to determine the best next steps after the first treatment did not work. What STAR*D shows is that, just as in

the treatment of other general medical conditions, even if the first-step treatment does not result in full benefit, a range of second-step treatments is available and they are effective. In addition, these results indicate that for some patients, while early benefits may occur with these treatments within the first 3 to 6 weeks, remission may not be realized until 10 to 12 weeks. During this time it seems important to adjust the dose as tolerated and to not prematurely stop treatment. The results of STAR*D also show that 50 percent of people with MDD can achieve remission within the two treatment steps using this approach. The third and fourth steps of treatment in STAR*D do not appear to be as effective as the first two-steps in terms of bringing about remission to study participants. This presentation will focus on the overall lessons learned from this large, real world study of the treatment of MDD.

NO 14C

USE OF EEG BIOMARKERS TO DIRECT SELECTION OF ANTIDEPRESSANT MEDICATION

Andrew F Leuchter, M.D., 760 Westwood Plaza, Room 37-452, Los Angeles, CA 90024

SUMMARY:

Quantitative electroencephalography (QEEG) detects the effects of medication on the brain, and in particular the effects of antidepressant medication. QEEG cordance, which involves recordings from all brain regions, detects changes that identify after one week those will respond or remit at eight weeks with a high degree of accuracy. Such "whole head" QEEG recordings are time consuming and therefore may have limited clinical utility. The BRITE-MD study (Biomarkers for Rapid Identification of Treatment Effectiveness in Major Depression) examined changes in brain electrical activity using a very limited number of electrodes from the frontal region, in order to detect similar results. In this study, the use of the Antidepressant Treatment Response Index (ATR) predicted response in patients treated with escitalopram or bupropion and appeared useful for identifying subjects who would selectively respond to one or the other of these two medications. ATR predicted response and remission with 74% accuracy, whereas clinician prediction based upon global impression of improvement was not associated with outcome. The ability to predict which patients will respond or remit, using a greatly reduced number of frontal electrodes, could make QEEG a clinically useful tool for enhancing treatment outcomes in MDD.

NO 14D

COLLABORATIVE CARE APPROACHES TO DEPRESSION

Jurgen Unutzer, M.D., Box 356560, Seattle, WA 98195

SUMMARY:

This presentation will provide an overview of collaborative, stepped care approaches to treating depression in primary care and other general medical settings.

We will review the development of evidence-based models of collaborative care for depression in which mental health professionals collaborate with primary care providers to help improve care for depression.

We will summarize the 'core components' of effective, evidence-based collaborative care programs including the principle of 'stepped care' for persistent depression, and the application of collaborative care models for depression in diverse populations and practice settings. We review evidence for the IMPACT model of depression care (www.impact-uw.org) as one example of collaborative care for depression. This program has been shown in a large randomized control trial with 1,801 adults age 60 and older who met SCID criteria for major depression and / or dysthymic disorder to double the effectiveness of usual care for depression, increasing the likelihood of a treatment response at 12 month follow-up from 19 % in usual primary care to 45 %. We will also discuss other benefits of collaborative depression care including improvements in physical pain and functioning and long-term cost savings associated with collaborative care. Finally, we will discuss findings from a systematic effort to help implement evidence-based collaborative depression care in over 150 primary care practices across the country.

NO 14E

CAN GENETIC BIOMARKERS HELP DIRECT TREATMENT FOR DEPRESSION?

Gonzalo Laje, M.D., 6001 Executive Boulevard, Room 8184, MSC 9663, Bethesda, MD 20892-9663

SUMMARY:

Many patients can expect major depressive disorder to improve with antidepressant treatment, however, only a minority experience full remission. While antidepressant treatment outcome is at present unpredictable, it may have a partial genetic basis. Genetic predictors of treatment outcome were found in 1953 patients with major depressive disorder who were treated with citalopram in the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study. A selection of 68 candidate genes was genotyped with 768 single nucleotide polymorphism markers chosen to detect common genetic variation. A significant and reproducible association between treatment outcome and a marker in the HTR2A and GRIK4 genes was found. Other markers in GRIK2, GRIK4 and GRIA3 among other genes also showed evidence of association with side-effects reported in this sample, these include treatment emergent suicidal ideation, treatment emergent insomnia and sexual dysfunction. Taken together with prior neurobiological findings, this new genetic data makes a compelling case for a key role of HTR2A and glutamate pathways in the mechanism of antidepressant action.

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4) Leuchter AF, Marangell LB, Burgoyne K, Sigl J, Jain R, Zisook S, McCracken J, Iosifescu D. Biomarkers for Rapid Identification of Treatment Effectiveness (BRITE): Testing Symptoms and Biomarkers as Predictors of Response and Remission in MDD. Poster presented at the Annual Meeting of

the American Psychiatric Association, May 2008.

SYMPOSIUM 15
THE TRANSMISSION OF BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Understand the level of BPD's familiality; its associations with other major psychiatric disorders; and 2) Its possible mechanisms of transmission via attachment, phenotypes, and endophenotypes.

NO 15A

THE AGGREGATION OF DIB-R AND *DSM-IV* BORDERLINE PERSONALITY DISORDER

Mary C Zanarini, Ed.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478

SUMMARY:

Objective: The purpose of this study was to assess the familial aggregation of borderline personality disorder (BPD). Method: The borderline psychopathology of 261 first-degree relatives of 109 female probands meeting both Revised Diagnostic Interview for Borderlines (DIB-R) and *DSM-IV* criteria for BPD was assessed using two semi-structured interviews of proven reliability. The borderline psychopathology of 243 relatives of 95 comparison female probands meeting neither criteria set for BPD was assessed in the same manner. Results: 8.8% of the first-degree relatives of borderline probands met both DIB-R and *DSM-IV* criteria for BPD vs. only 1.7% of the relatives of non-BPD probands. This difference yielded a high and statistically significant odds ratio (95% confidence interval) of 6.4 (2.0-20). The results were almost the same when only the DIB-R criteria for BPD were considered (8.8% vs. 2.1%; odds ratio: 5.0 (1.8-14)). In contrast, 11.1% of the relatives of borderline probands and 8.6% of the relatives of non-BPD probands met *DSM-IV* criteria for BPD, yielding a non-significant odds ration of 1.2 (0.64-2.4). Conclusions: The results of this study suggest that that a BPD phenotype derived from a multi-faceted diagnostic system that requires the presence of symptoms in all of the core sectors of borderline psychopathology aggregates strongly in families. They also suggest that the *DSM-IV* criteria for BPD are too broad to identify such a phenotype.

NO 15B

FAMILIAL COAGGREGATION OF BPD WITH AXIS I DISORDERS

James I Hudson, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

The degree to which borderline personality disorder (BPD) may coaggregate with axis I psychiatric disorders in families, and thus may share familial factors with these conditions, has been incompletely studied. Previous research has been inconsistent, but has suggested that BPD may coaggregate with major depressive disorder and possibly other conditions. However, previous studies have usually been limited by an assessment of a limited range of disorders, small samples, non-ideal comparison groups, and at times, information about relatives obtained from probands rather than relatives themselves and assessment of relatives that is not blinded to proband status.

We conducted a family study in which probands and their first-degree relatives were given the Revised Diagnostic Interview for Borderlines (DIB-R) and the Diagnostic Interview for DSM-IV Personality Disorders (DIPD-IV) to diagnose BPD and the Structured Diagnostic Interview for DSM-IV to diagnose axis I disorders. Three groups of probands were selected on the basis of the following lifetime diagnoses: 1) BPD; 2) no BPD; and 3) major depressive disorder. Assessments of relatives were performed blinded to proband status. Coaggregation was assessed by statistical associations derived from structural models (Epidemiology 2008;19:431-439).

In a preliminary analysis of 262 probands and 615 relatives, we found that BPD showed substantial coaggregation with bipolar I disorder and anxiety disorders, but displayed little or no coaggregation with major depressive disorder, substance use disorders, and eating disorders. Whereas these results are consistent with some studies, they are not with others, particularly with regard to major depressive disorder.

NO 15C

FAMILIAL AGGREGATION OF ATTACHMENT IN BORDERLINE PERSONALITY DISORDER

Lois W Choi-Kain, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

This presentation will report preliminary results from a study of the familial aggregation of attachment in families of individuals with borderline personality disorder (BPD). Interest in these results is found by a prior literature showing that 1) parental attachment styles strongly predict infant attachment behaviors, 2) environmental factors contribute more to variance in attachment style than genetic effects in twin studies (Brussoni et al. 2000), 3) BPD is characterized by insecure attachment particularly of the preoccupied, fearful, unresolved, and disorganized types (Levy, 2005), and 4) the preoccupied attachment style was found by this group of authors to distinguish BPD subjects from both depressed and non-borderline comparison subjects.

Using data from 484 relatives of BPD probands, and 232 non-BPD probands, familial aggregation of attachment styles was assessed by the Relationship Questionnaire. There was very little evidence of familial aggregation of the secure, fearful, and dismissing attachment style. In contrast, the preoccupied attachment style was found to have significant familial aggregation (estimated increase in score in relative for each increase of 1 unit increase in proband: 0.15 [95% confidence interval: 0.04-0.26], p = .008). These results suggest that familial factors contribute

to the preoccupied attachment style, but not to other attachments styles. Implications for future clinical and empirical efforts will be discussed.

References: Levy KN: The implications for attachment theory and research for understanding borderline personality disorder. Development and Psychopathology 2005; 17: 959-986

NO 15D

FAMILIALITY OF BPD'S COMPONENT PHENOTYPES

John G Gunderson, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

Based on factor analytic research, BPD psychopathology has repeatedly been shown to have three core components: i.e, Affective Instability, Impulsivity, and Interpersonal Instability. In the present study these components are assessed using the *DSM-IV* criteria relevant to each and by using the corresponding section scores from the DIB-R. This presentation describes results of preliminary analyses of their familiality using 261 relatives of BPD and 243 relatives of non-BPD probands.

Results indicate that DIB-R measured traits aggregate significantly in families, with Affective and Interpersonal Instability showing stronger aggregation than Impulsivity. Traits measured by *DSM-IV* criteria show non-significant levels of familiality, but confirm the relative weakness of the Impulsivity component.

The results suggests that while the Impulsivity component helps explain BPD's comorbidity with other impulse spectrum disorders, they indicate that Affective Instability; namely, chronic dysphoric states, and Interpersonal Instability; namely, hypersensitivity to rejection appear to be more specific and central to BPD psychopathology. How these results agree and differ from prior results will be discussed. More definitive future analyses will be conducted to verify these findings, to examine familiality of these phenotypes with alternative measures, and to explain their interactions.

NO 15E

AN ENDOPHENOTYPIC APPROACH TO BORDERLINE PERSONALITY DISORDER

Larry J. Siever, M.D., One Gustave Levy Place, Box 1230, New York NY 10029

SUMMARY:

Endophenotypes, that is, intermediate phenotypes or measures that may be more closely linked to underlying genotypes than the clinical diagnosis itself, may help unravel the familiality and genetics of borderline personality disorder. In a collaborative study between Mount Sinai and the University of Chicago, candidate endophenotypes were evaluated in a sample of BPD patients, patients with other non-borderline personality disorders, and healthy controls. A variety of self-report measures that reflect specific dimensions related to BPD such as impulsivity, aggression, affective instability, or interpersonal sensitivity were highly intercorrelated and distinguished BPD patients from the other personality disorder cohort and normal controls. Laboratory based measures, including the Point Subtraction Aggression Paradigm (PSAP), the Immediate Memory Test (IMT), a test for impulsivity, the blink startle reflex, a physiologic measure of affect modulation/stability were evaluated in these cohorts. These tests have been found to be heritable in identical twin studies conducted at Chicago. Specific endophenotypes were less selective for borderline personality disorder but were more closely linked to these dimensions/traits that transcended traditional diagnostic boundaries. This approach has led to the identification of serotonergic candidate genes related to the aggression and neuropeptide genes related to the interpersonal sensitivity of BPD. The potential utility for endophenotypes in familial and genetic studies of BPD will be addressed in the context of these findings.

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4) Siever LJ, Torgersen S, Gunderson JG, Livesley WJ, Kendler KS: The borderline diagnosis III: Identifying endophenotypes for genetic studies. Biol Psychiatry 51:964-968, 2002.

SYMPOSIUM 16
CONTRIBUTIONS OF NEUROSCIENCE TO MEDICATIONS DEVELOPMENT FOR ALCOHOL USE DISORDER

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) understand preclinical models with predictive validity for medications effects that modulate excessive voluntary alcohol consumption, and relapse to alcohol seeking; and 2) understand different categories of emerging treatment targets, in particular those that relate to positive versus negative reinforcement.

NO 16A

NOVEL TARGETS FROM THE DARK SIDE OF DEPENDENCE ON ALCOHOL: FOCUS ON CRF, NOREPINEPHRINE AND VASOPRESSIN

George F. Koob, Ph.D., 10550 North Torrey Pines Road, CVN7, La Jolla, CA 92037

SUMMARY:

Dysregulation of the brain emotional systems that mediate arousal and stress is a key component of the pathophysiology of alcoholism. Alcoholism is a chronically relapsing disorder characterized by a compulsion to seek and take drugs and manifestation of a negative emotional state when the drug is removed. Activation of brain stress systems is hypothesized to be a key element of the negative emotional state produced by dependence that drives drug seeking through negative reinforcement mechanisms. The role of brain arousal- stress systems, including corticotropin-releasing factor, norepinephrine, and vasopressin, will be explored in alcohol dependence, with an emphasis on the neuropharmacological actions of these neurotransmitters in extrahypothalamic systems in the extended amygdala. Compelling evidence exists to argue that the brain stress systems, a heretofore largely neglected component of dependence and addiction, play a key role in engaging the transition to dependence and maintaining dependence once initiated. A role of the brain stress systems in addiction not only provides insight into the neurobiology of the dark side of addiction but also novel targets for the treatment of alcoholism.

NO 16B

ACTIVATION OF THE NOCICEPTIN/ORPHANIN FQ SYSTEM REDUCES ALCOHOL ABUSE RELATED BEHAVIORS IN RATS WITH INNATE PREDISPOSITION TO EXCESSIVE ALCOHOL INTAKE AND ELEVATED ANXIETY.

Roberto RC Ciccocioppo, Ph.D., Via Madonna delle Carceri, Camerino, 62032

SUMMARY:

Alcoholism is an etiologically and clinically heterogeneous disorder in which compulsive alcohol seeking and use represent core symptoms. Exposure to alcohol is a necessary precondition. However, environment and heritability factors play a dramatic role in controlling individual vulnerability to developing alcohol abuse. Stress has been recognized as one of the major factors for alcohol abuse, including binge drinking and alcohol dependence. However, the interaction between environmental stress and heritable factors in the development of alcoholism is still largely unexplored. Understanding the nature of this interaction in regulating individual risk of becoming an alcohol abuser represents a major challenge in this research area and may provide invaluable help for the development of preventive strategies or pharmacotherapeutic remedies. Laboratory animal research has shown that Marchigian Sardinian (msP) rats, genetically selected for high alcohol intake, are also highly anxious and hypersensitive to stress. We used these animals to explore the correlation between innate vulnerability to anxiety, stress and alcohol abuse. In addition, this rat line was used for preclinical evaluation of new medication for alcohol dependence treatment. We found that activation of the opioid receptor-like1 (NOP) receptor by its endogenous ligand Nociceptin/orphanin FQ (N/oFQ) potently inhibits alcohol intake and relapse to alcohol seeking in msP rats. The efficacy of N/oFQ correlates with its anxiolytic and antistress action. Conversely, N/oFQ did not modify alcohol drinking in non-selected Wistar control rats. These findings suggest msP rats may represent an animal model of genetic susceptibility to alcohol abuse in which excessive drinking is linked to self-medication and tension relief mechanisms. Our studies support the results of several clinical studies showing that a large population of alcoholics have low ability to engage in stress-coping strategies and in which alcohol abuse is often a mechanism to ameliorate the negative affective state that follows exposure to anxiogenic stimuli or stress. Our finding also suggest that development of new medications using NOP agonists could be of benefit for the treatment of alcohol addiction in this patients subpopulation (Support: NIAAA AA014351)

NO 16C

N-TYPE CALCIUM CHANNEL BLOCKERS FOR ALCOHOL USE DISORDERS: FROM CELLS TO PEOPLE

Robert O. Messing, M.D., 5858 Horton Street, Suite 200, Emeryville, CA 94608

SUMMARY:

N-type calcium channels are widely distributed in the brain, including the amygdala and mesolimbic dopamine system, which regulate drug reward and self-administration. They mediate neurotransmitter release and are inhibited by several G-protein-coupled receptors. These include receptors for opioids, cannabinoids, dopamine, GABA and adenosine, all of which regulate ethanol consumption in rodents. We have previously shown that prolonged ethanol treatment increases the abundance of N-type calcium channels in mouse brain, suggesting that these channels are involved in neuroadaptive changes caused by long-term ethanol exposure. We have identified the N-type calcium channel as a therapeutic target for the treatment of alcohol use disorders through three approaches. First, we found that mice lacking N-type calcium channels drink less ethanol than their wild type littermates. Second, we showed that a novel, mixed, N- and T-type calcium channel inhibitor (NP078585, Neuromed Pharmaceuticals) reduces operant ethanol self-administration by rats and reduces the acute motor effects of ethanol in mice without having motor effects of its own. NP078585 also abolishes ethanol reward in a mouse conditioning model. Third, we have recently found that the FDA-approved anticonvulsant levetiracetam, which inhibits N-type calcium channels, reduces voluntary ethanol drinking in mice and rats. It was recently reported that in an open label study, levetiracetam (maximal dose 2000 mg/day), when administered for 10 weeks, reduced ethanol intake from 5.3 to 1.7 standard drinks per day in 20 alcohol-dependent subjects. We are currently undertaking a double-blind, cross-over study to test whether levetiracetam reduces drinking in non-dependent, heavy drinkers.

NO 16D

NEW ARRAY OF POTENTIAL TREATMENTS FOR ALCOHOL USE DISORDERS: FROM DROSOPHILA TO ELECTOPHYSIOLOGY AND MORE PREDICTIVE ANIMAL MODELS

Selena E Bartlett, Pharm.D., 5858 Horton St, Suite 200, Emeryville, CA 94608

SUMMARY:

Objective: Our primary mission is to facilitate and then translate discoveries generated from the neuroscience of addiction into treatments for alcohol use disorders (AUDs). It is clear that the treatment of AUDs is complex and different approaches will be used depending upon the age of onset of drinking, type of co-abused substance, co-morbidities such as PTSD and whether the patient is drinking or is abstinent. We have implemented a collaborative translational research model at the Gallo Center. This has lead to targets and potential lead compounds derived from candidate genes in drosophila, electrophysiological recordings in the addicted brain through to FDA approved compounds for other indications such as nicotine cessation.

Method: We perform preclinical "proof-of-concept" studies by employing both the intermittent access 20% ethanol drinking preference and operant self-administration and reinstatement paradigms. The intermittent access 20% ethanol drinking model has predictive validity and produces high ethanol consuming Long-Evans and Wistar rats.

Results: Using these models, we have shown that the partial nicotinic receptor agonist, varenicline, effectively reduced ethanol intake and operant ethanol but not sucrose self-administration and stress-induced relapse to ethanol seeking. As ~80% of human alcoholics smoke, it is imperative to consider the added effects of nicotine when trying to develop effective treatments for AUDs. In collaboration with the Heberlein lab, we show that inhibiting a novel target, the Erb-B1 receptor in rats modulates ethanol consumption and with the Bonci Lab we have shown that orexin/hypocretin receptors play an important role in modulating stress-induced relapse in rats.

Conclusions: Discoveries in the neuroscience of addiction has greatly facilitated the path to translation leading to "proof-of-concept" clinical trials and further hope for patients with alcohol use disorders.

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SYMPOSIUM 17
MONITORING EQUITY IN MENTAL HEALTH FROM A CROSS-NATIONAL PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify factors that drive inequities in mental health in lower, middle and high income countries, and 2) Understand why monitoring of mental health and illness is important to ensure quality care and accessibility of services.

NO 17A

EQUITY IN DETERMINANTS OF HEALTH AND HEALTH POLICIES INFLUENCING MENTAL HEALTH: A CROSS-NATIONAL PERSPECTIVE

Donna E Stewart, M.D., University Professor and Chair, Women's Health Program University Health Network, 200 Elizabeth St, EN-7-229 Toronto, M5G2C4 Canada

SUMMARY:

Objective: This study measures health policy indicators and reviews determinants of health indicators in a lower, middle and high income country.

Methods: This study exposed an expert panel to potential indicators which were independently ranked and consensually selected for measurement. The selected core list consisted of 17 indicators on the determinants of health and 10 health policy .

Results: The feasibility of measuring these indicators using available reports and data was assessed for all three countries and it was found 14/17 determinants of health indicators and 10/10 policy indicators were feasible. Data sources used to measure the selected core set of gender-sensitive general health indicators, included health surveys such as the Canadian Community Health Survey and National Demographic and Household Studies (Peru/Colombia), as well as mortality and hospitalization data. Analyses and data from reports were abstracted & stratified by sex, age, education, marital status, socio-economic level, and specific subgroups: immigrant status, urban/rural status and poverty level, where possible. Policy indicators were linked with indicators on determinants of mental health.

Conclusion: Knowledge of indicators on determinants of health and health policies that affect the mental health of a population will be invaluable to researchers, health professionals and policy makers and will provide stakeholders with a base to create and improve programs aimed at reducing inequities in health.

NO 17B

MONITORING EQUITY IN MENTAL HEALTH IN LOWER, MIDDLE AND HIGH INCOME COUNTRIES

Natalia Diaz-Granados, M.S.C., 200 Elizabeth Street, Room 238, Toronto OHM5 G2C4 Canada

SUMMARY:

Objective: This study set out to measure and compare 19 men-

tal health indicators in Peru, Colombia and Canada.

Methods: The indicators were selected at a meeting in Colombia by a group of key experts using a health information framework proposed by WHO. Indicators were measured using national, population-based databases and age-adjustments were performed using a WHO age distributions.

Results: Colombia and Canada's surveys had 5 indicators that were comparable with few modifications. Out of the first 9 indicators assessed (12 month prevalence of: depression, psychological distress, GAD, suicide attempts, alcohol dependence/abuse, social support, use of mental health services, psychological impairment, psychological well-being, all were feasible except for the measurement of self-esteem in Peru, Colombia and GAD in Canada. The indicators that show greatest inequities are: depression, GAD, suicide attempts, use of mental health services and alcohol dependence/abuse. Female to male ratios ranged from 1.5-2.2. Significant trends were found when the indicators were considered by age, education, marital status and income.

Conclusions: These indicators can be used to identify those patient populations most vulnerable to inequities in mental health. The results from this study will provide vital information to program planners who aim to implement, improve and monitor national mental health strategies that reduce gender inequities in different national economic conditions.

NO 17C

SOCIO-DEMOGRAPHIC FACTORS AFFECT MENTAL ILLNESS RATES DIFFERENTLY ACROSS COUNTRIES

Marta B. Rondon, M.D., Jose de la Torre Ugarte 471 (302) Miraflores, Limalima, 18

SUMMARY:

Objective: High rates of depression and anxiety across countries support the assertion that sociodemographic factors play a vital role on the prevalence of mental illness among women and men. To show the impact of social factors in a 3 country mental health indicator study.

Methods: Secondary analyses of existing, national, population-based mental health surveys from Peru, Colombia, and Canada were performed.

Results: Data shows that, in general, people with better access to social protection, higher education, employment and mental health care fare better. Women had higher rates of depression and anxiety than men in comparable circumstances. There are some exceptions that need further study: in Colombia men in the upper income quartile have more problems with anxiety compared to Colombian women, and men in Peru and Canada. In the three economically different settings, women who are separated, divorced or widowed suffer most, reflecting the burden of loneliness and social isolation, as wells as poverty. The male/female disparity is highest in this group.

Conclusions: Our results call for a stronger integration of social and biological perspectives, in the management and research agendas focusing on mental illnesses with the highest social inequities.

NO 17D

FACTORS ASSOCIATED WITH INEQUITIES IN MENTAL HEALTH CARE USE IN A DEVELOPING COUNTRY

Javier E Saavedra, M.D., Jr. Eloy Espinoza Saldaña No. 709, San Martín de Porres Lima Lima 31, Peru

SUMMARY:

Objective: To identify patterns and factors associated with the utilization of services for mental health problems in an adult population of a developing country from a gender perspective.

Methods: A population-based, 3-stage probabilistic survey sampled 2,400 residents from Lima and Callao households. Data included demographics, mental health care utilization; the Colombian Mental Health Questionnaire (modified); and the M.I.N.I (ICD-10).

Results: There were 2077 respondents. Compared to men, women reported more mental health problems in the preceding 6 months (20.8% vs. 14.0%; p=0.001) and received more health care (5.4% vs. 2.7%; p=0.007). Of those reporting no use, more women than men thought they may have needed it (66.6% vs. 44.5%; p=0.007). More women than men did not seek care due to "shame" (p=0.002), and for "fear as being seen as a mental sick person"(p=0.003). Logistic regression shows that women's use of mental health care was associated with having health insurance, reduced prejudice issues, increased family suggestion and communication, receiving medical attention for physical conditions, and past traumatic experiences. Men's use was related to increased age, having health insurance, reduced prejudice issues, family suggestion, and the presence of panic disorder.

Conclusions: Differences exist in health seeking behaviours among residents in a developing country between men and women. The results of this study suggest that a gender perspective has to be used when planning for interventions to promote opportune mental health care.

NO 17E

INCOME-RELATED INEQUITY IN MENTAL HEALTH SERVICE UTILIZATION IN COLOMBIA AND CANADA

Marie DesMeules, M.S.C., 785 Carling Avenue, Ottawa, K1A 0K9 Canada

SUMMARY:

Objective: Disparities in country development, mental health services coverage, and income level affect mental health status and service utilization. This study compares 12-month utilization of outpatient mental health services in a high-income country (Canada with national coverage for mental health services for most services) and a middle-income country (Colombia with no national coverage for mental health services) to examine income-related inequities in mental health service use.

Method: Canadian Community Health Survey and National Study of Mental Health (Colombia) data were used. Stratified age-standardized rates were compared using rate ratios.

Results: The proportion of respondents using mental health services in the prior 12-month period was significantly lower in Colombia (4.4%) than in Canada (10.3%). Women used more services than men but the inequity was greater in Canada (Female:13.5%, Male: 7.1%) than in Colombia (Female: 5.0%, Male: 3.8%). In Colombia, lowest use was found among low income men (1.1%), and this income bracket showed the highest sex disparity (Female/Male rate ratio =6.3). Highest use in Colombia was noted among high income men (7.6%) contrary to Canada in which it was noted among low income men (12.6%).

Conclusion: There is inequity in mental health service utilization by gender, income levels and country development. The disparities observed in this study partially reflect unmet need for mental health services due to cost. Alleviation of these unmet needs will require expansion and optimal allocation of services and resources.

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SYMPOSIUM 18

RECOVERY AND REHABILITATION: FROM THE PROVIDER AND PATIENT POINTS OF VIEW IN FRANCE AND THE US: VIVE LA DIFFERENCE!

FRENCH FEDERATION OF PSYCHIATRY AND THE APA

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Understand various theories and practices concerning recovery in the United States and France from the points of view of psychiatrists and patients.

NO 18A

RECOVERY FROM DISABILITY OF SERIOUS MENTAL DISORDERS: A PHASE-LINKED REHABILITATION PROCESS

Robert P Liberman, M.D., 760 Westwood Plaza, Los Angeles, CA 90095

SUMMARY:

Recovery from schizophrenia and other disabling mental disorders has now been amply demonstrated by research studies. Operational definitions of recovery have been validated and the evidence-based services required to achieve recovery have been identified. Research teams and grants with reliable measures of outcome have been required to win the appellation of "evidence-based practice". However, for those practitioners in the "clinical trenches", promoting recovery in their patients depends upon "practice-based evidence." In this presentation, case examples will be described in which practice-based evidence of progress toward recovery is illustrated through phase-linked, patient-centered services. Individualization of treatment---not feasible in research studies of recovery---is highlighted for patients proceeding through the phases of florid psychosis, stabilization, stability and recovery. For each phase of treatment, multi-modal evidence-based services are adapted for efficacy by individual attributes, needs, strengths and personally relevant goals. For optimal recovery, services must be comprehensive, coordinated, continuous, connected with phase of illness, competently delivered, collaborative and compassionate.

NO 18B

CAN WE IMPLEMENT "RECOVERY" AND REHABILITATION? : WHAT DO WE KNOW AND WHAT ARE THE IMPLICATIONS FOR SERVICES?

Marianne D Farkas, Sc.D., 940 Commonwealth Avenue, West Boston, MA 02421

SUMMARY:

Those with serious mental illnesses face many challenges but recent advances in pharmacological and rehabilitation techniques now make it possible for those with these conditions to recover and resume productive lives in the community. In the past, practice in mental health was guided by the belief that individuals with serious mental illnesses do not recover. The course of their illness was either seen pessimistically, as deteriorative or optimistically, as a maintenance course. Research over the past thirty to forty years has indicted that belief and shown that a vision of recovery can be achieved for many individuals. People with serious mental illnesses have themselves published accounts of their own recovery as well as advocated for the development of recovery promoting services. As a result, one of the most interesting and exciting developments in the field is the effort to incorporate the recognition that those with serious mental illnesses have the capability to regain the functional capacities they need to recover from the devastating effects of the illnesses and return to a productive, meaningful life. One implication of these developments in North America and other regions is that policies have been developed to make recovery the guiding vision of services. Today, particularly in the United States, the transformation of services and systems to achieve recovery outcomes has become the priority for Federal and Regional government agendas. A second implication has been that that progressive psychosocial rehabilitation practices for example, are carried out with recovery as the goal.

This presentation will provide a summary of the empirical basis for understanding recovery; identify the difference between recovery and rehabilitation and lastly, present the implications of this emerging understanding for the development of critical ingredients of recovery oriented services for individuals with serious mental illnesses.

NO 18C

AN INDIVIDUALIZED COGNITIVE REMEDIATION THERAPY FOR PATIENTS WITH SCHIZOPHRENIA :

THE RECOS PROGRAM

Pascal Vianin, Ph.D., 9 Avenue d'Echallens, Lausanne 1004, Switzerland

SUMMARY:

The "Programme de Remédiation Cognitive pour patients présentant une Schizophrénie ou un trouble associé" (RECOS – Vianin, 2007) is a program which is specifically aimed at providing individualized cognitive remediation therapy for patients with schizophrenia. Before treatment, the patients are evaluated with a large battery of cognitive tests in order to determine in which of five specific training modules – Working Memory, Visuo-Spatial Attention, Verbal Memory, Reasoning, Selective Attention - they would participate. The functional outcome of the cognitive deficits is also considered for the selection of the training modules. The patients participate in 20 sessions of training (one session per week) per module. As executive functioning has been shown to be important in predicting functional outcome, techniques of remediation are those used for dysexecutive syndrome.

Preliminary results showed a greater improvement in the modules for which training had taken place as opposed to the modules where no training had taken place. However, an improvement was observed in both types of module, indicating a learning transfer effect. Moreover, by considering results of the Wisconsin Cards Sorting Test, a superior effect size has been observed with the RECOS program than with a cognitive remediation program which does not target the deficits of each participant.

In our view, the great heterogeneity of the observed cognitive deficits in schizophrenia necessitates a detailed neuropsychological investigation as well as an individualized cognitive remediation therapy. These preliminary results need confirmation however, by using a large sample of patients.

NO 18D

FUNCTIONAL REMISSION IN SCHIZOPHRENIA: A SPECIFIC TOOL FOR EVALUATION

Pierre Michel Llorca, M.D., CMP B CHU BP 69 Clermont Ferrand 63003

SUMMARY:

Objectives: Symptomatic remission as defined by Andreasen et al (2005) is an attainable goal for schizophrenic patients. For clinicians, family and skateholders, patient level of functioning is a relevant parameter to assess, in association with symptomatic improvement.

Method: Using a Delphi method, we developed a specific tool for the evaluation of functional remission in schizophrenic patients: the EFRS (Evaluation of Functional Remission Scale). This 19 items scale evaluate 5 dimensions: Daily life, Social Activities, Social functioning, Quality of adaptation, General Health and treatment. The functioning of patient have to be evaluated during the last month.

We conducted a study to validate and define the psychometric properties of the EFRS. The study was a cross-sectional one in a sample of 531 schizophrenic patients. At the inclusion, they were in symptomatic remission using the criteria defined by Andreasen et al (2005). We use the EFRS, the Positive And Negative Symptom Scale and the Global Assessment of Functioning. We also collect the socio-demographic characteristics of the patients and treatments.

Results: The analysis was realized on 443 patients after elimination of the outliers. Using a factorial analysis, we identify 3 clinically relevant factors (social functioning, proxy functioning and treatment). A confirmatory factorial analysis confirms the three factors structure of the scale. The EFRS total score was significantly correlated with the GAF score (Pearson correlation coefficient: 0.5616, $p<0.0001$).This study confirms the psychometric properties of the EFRS, for the evaluation of functional remission in schizophrenia.

Conclusion: EFRS will be an useful tool in order to study the relationship between symptoms and functioning in schizophrenic patients. Functional remission could appear as an important outcome providing a new positive way for patients and families.

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TUESDAY, MAY 19, 2009 2:00PM- 5:00PM
SYMPOSIUM 19
SUICIDE WITHOUT A PSYCHIATRIC DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to know what groups of individuals may suicide and yet not be suffering from a psychiatric disorder and be able to differentiate them from people with psychiatric disorders.

NO 19A

HAD GARY POWERS KILLED HIMSELF

Norman B. Levy, M.D., 1919 San Ysidro Drive, Beverly Hills, CA 90210

SUMMARY:

May 1, 1960 Gary Powers, a civilian employee of the CIA piloted a plane flying over the Soviet Union taking pictures of their military installations. It was shot down, but pilot, plane and photography survived. Powers, who had a cyanide capsule supplied to him for such an occasion, chose not to take it. The U.S. initially denied that it was a spy mission, but when pilot and equipment spoke to the contrary to the embarrassment of the U.S., the Cold War worsened and, as a result, a planned meeting between Pres. Eisenhower and Premier Khrushchev was canceled. The

presenter argues that had Powers taken the cyanide, his act of suicide would not only be one done without a known psychiatric disorder, but may be viewed as an act of heroism and patriotism. Although this is an unusual case, there are others that fall into this category.

NO 19B

DIFFERENTIATING SUICIDE FROM OTHER LIFE-ENDING ACTS: A MODEL ILLUSTRATED WITH CHRONIC KIDNEY DISEASE AND DIALYSIS

John M Bostwick, 200 First Street SW, Rochester, MN 55905

SUMMARY:

Technological advances continue to yield life-prolonging treatments that complicate how death occurs. Until recently a patient's refusal to submit unquestioningly to recommended care was considered suicide, but patients now have more options. Physicians must now decide how to respond to patient requests for hastened dying. This paper proposes a four-square grid distinguishing true suicide from phenomena like treatment termination and lethal non-compliance, a situation in which the patient neither intends death nor involves others in making life-ending choices. One axis of the grid characterizes whether a patient's actions are intended to hasten death or cause death outright. The other identifies how the deceased's social and medical network are collaborating – or not – in the decision-making process. Using end-of-life decision-making in chronic kidney disease to model the potential roles of intent and collaboration in life-ending behavior, death is framed within a paradigm that reflects both end-of-life decision-making complexities and contemporary, nuanced conceptualizations of suicide and suicidal behavior. Simplistic formulations of self-induced deaths no longer apply when these deaths comprise at least four radically different scenarios according to this model, three of which would not be considered frank suicide.

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NO 19 C

OREGON'S DEATH WITH DIGNITY ACT: WHO CHOOSES PHYSICIAN-ASSISTED SUICIDE

Linda Ganzini, M.D., PO Box 1034, Portland, OR 97239

SUMMARY:

The Oregon Death with Dignity Act, which legalized physician-assisted suicide (PAS) for terminally ill patients, was enacted 10 years ago. Studies of health care professionals, patients who have made requests, and their families will be presented. Desire to control circumstances of death and maintain independence are the most important reasons for requests for PAS. Although hospice referral is the most successful intervention associated with patients changing their mind about PAS, 86% of PAS deaths are among hospice patients. Prescribing physicians and hospice professionals all ranked depression as among the least important reason for explicit requests for PAS. However, among ALS and cancer patients hopelessness predicted persistence of interest in PAS until death. In a longitudinal study of cancer patients, interest in obtaining a lethal prescription was very unstable. In a study of 56 Oregonians who had requested assisted suicide, 83% did not meet criteria for depression as determined by the Structured Dlinical Interview for DSM Diagnoses (SCID). Three patients with clinical depression did receive lethal prescriptions. Interventions that may render PAS a choice of last resort are presented.

NO 19D

DESIRE FOR DEATH IN TERMINALLY ILL CANCER AND AIDS PATIENTS: HOPELESSNESS AND LOSS OF MEANING AS CONTRIBUTING FACTORS, INDEPENDENT OF DEPRESSION

Willaim Breitbart, M.D., 641 Lexington Avenue, 7th Floor, New York, NY 10022

SUMMARY:

Initial studies examining the contributing factors leading to desire for hastened death among terminally ill cancer and ADS patients suggested a very strong role for undiagnosed and untreated depression. Rates of desire for hastened death were estimated to be from 4 to 7 times more likely amongst terminally ill cancer or AIDs patients meeting DSM criteria for Major Depressive Syndrome. More recently, with larger studies examining a broader range of potential contributing variables, the importance of such meta-diagnostic constructs as hopelessness, and loss of meaning (spiritual well-being) have been demonstrated to play an equally important, unique, and perhaps synergistic role, along with depression in leading to desire for hastened death. This paper will describe the studies demonstrating the roles of hopelessness and loss of meaning as factors contributing to desire for hastened death, independent of depression.

NO 19E

ETHICS IN SUICIDE WHICH IS NOT ASSOCIATED WITH PSYCHIATRIC ILLNESS

James J Strain, M.D., 1 G. L. Levy Place, New York, NY 10029

SUMMARY:

The Patient Self-Determination Act, which the U.S. Congress passed on November 5, 1990, gives patients the right to refuse or discontinue life-preserving medical treatment and the right to make such wishes known through an advance directive. In effect,

this bill acknowledges that some people in some circumstance consider continued living to be worse than death, and that our commitments to liberty and respect for autonomy requires us to allow others to act on their own values. In effect, it also acknowledges that choosing death is not always irrational or a mark of mental illness. This reasoning leads to the moral conclusion that we must accept decisions of competent patients to discontinue life-preserving treatments. If we also accept the view that there is no moral difference between killing and letting die, we must also accept the decision of competent patients who choose to end their lives rather than endure a chronic illness.

The Oregon Death with Dignity Act of 1996 introduces a role for doctors into otherwise personal life-ending decisions. We argue that physician involvement is justified by the duty of beneficence and also the fiduciary responsibility which entrusts the profession with distinctive knowledge, powers, and privileges to be used for the good of patients. Physicians may, therefore, have duties to 1) assess patients' decisional capacity, 2) assess the appropriateness of their decisions, and 3) support patients in implementing life-ending decisions.

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SYMPOSIUM 20
BIOLOGICAL BASIS OF SEX DIFFERENCES IN DRUG ADDICTION: TRANSLATIONAL PERSPECTIVES

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

After this symposium, participants should be able to describe from animal models research, sex differences in addiction processes and their neuroendocrine substrates. From human laboratory-based studies, describe how gender and cocaine affect brain responses to stress and drug cues, describe the impact of gonadal steroid hormones on the neural substrate of cognition and emotion in women, and sex differences in amygdala-based emotional memory processes and the role of cortisol and sex hormones.

NO 20A
SEX DIFFERENCES IN BIOLOGICAL SENSITIVITY TO THE REINFORCING EFFECTS OF DRUGS OF ABUSE IN PRECLINICAL MODELS OF ACQUISITION, ESCALATION, AND RELAPSE

Wendy J. Lynch, Ph.D., 1670 Discovery Drive, Charlottesville, VA 22901

SUMMARY:

Although women have historically had lower rates of drug abuse and dependence than men, accumulating evidence suggests that women are not less vulnerable to drug abuse than men and, with regard to certain aspects of drug abuse, may be more vulnerable than men. In this talk, I will address whether there are sex differences in several key components of drug abuse including initiation of use or acquisition of drug self-administration, the progression to addiction or compulsive and escalating patterns of drug use, relapse or reinstatement of drug seeking behavior with a specific focus on stimulant abuse. Clinical data, as well as data from studies with laboratory animals, will be discussed in order to examine the biological basis of sex differences in stimulant abuse. Clinical and preclinical data each demonstrate consistent findings between males and females during the different phases of the addiction process with females showing an equal, or even greater, biological vulnerability during acquisition and relapse and showing a more rapid course to addiction. Biological factors, including neurochemical differences and hormonal influences may contribute to sex differences in stimulant abuse. These data highlight the need to develop sex-specific prevention and treatment strategies that take into account such differences.

NO 20B
THE ROLE OF DOPAMINE IN SEX DIFFERENCES IN DRUG ABUSE

Jill B Becker, Ph.D., 205 Zina Pitcher Place, Ann Arbor, MI 48109

SUMMARY:

Sex differences are present for all of the phases of drug abuse (initiation, escalation of use, addiction, and relapse following abstinence). While there are some differences among specific classes of abused drugs, the general pattern of sex differences is the same for all drugs of abuse: females begin regularly self-administering licit and illicit drugs of abuse at lower doses than do males, drug use escalates more rapidly to addiction in females, and females are at greater risk for relapse following abstinence. These sex-specific traits are seen in both humans and non-human animals, arguing that there is a biological basis for this sex difference. In this presentation, evidence for sex-related differences in dopamine release, dopamine receptors, and basal dopamine activity will be discussed. Specifically, there are 10% more D1 dopamine receptors in the striatum of male rats than in female rats, and estradiol rapidly modlates D2 dopamine receptor binding in striatum. There are also sex differences in basal and AMPH-stimulated striatal dopamine release and estradiol enhances AMPH-stimulated dopamine release in females, but not males. Results from in vivo microdialysis in freely moving rats have found that the basal extracellular concentrations of DA are twice as high in striatum of males as in females. These sex differences reflect an underlying sexual dimorphism in dopamine function in

the striatum and nucleus accumbens that plays a role in sex differences in drug abuse.

NO 20C

GONADAL STEROID HORMONES AND NEURAL MECHANISMS OF COGNITION AND EMOTION IN WOMEN

Karen Faith Berman, M.D., 9000 Rockville Pike Bldg 10, Rm 4C101, Bethesda, MD 20892-1365

SUMMARY:

We have used PET and fMRI together with two approaches to elucidating the neurophysiological effects of gonadal steroid hormones: studying young women during 1) hormonal fluctuations over the menstrual cycle and 2) an incisive hormone manipulation protocol with 3 different hormone conditions: (i) ovarian suppression induced by the gonadotropin-releasing hormone agonist leuprolide acetate (Lupron), (ii) Lupron plus estradiol replacement, and (iii) Lupron plus progesterone (P) replacement. The former approach allows a naturalistic examination of the neural effects of estrogen (E) in the presence and absence of P. The latter approach allows the effects of E and P to be disentangled by investigating them separately and by comparing them to each other and to pharmacologically-induced temporary menopause. We have used functional neuroimaging paradigms that access neural circuitry subserving both cognition (working memory) and emotion (reward processing).

We found that during working memory, the typical prefrontal response is altered with Lupron alone and is re-established when either hormone is restored to physiological levels. We also found that fluctuations in steroid hormone levels during the menstrual cycle affect the responsiveness of reward circuitry. During the midfollicular phase, when E is largely unopposed by P, women anticipating uncertain reward activated orbitofrontal cortex and amygdala more than during the luteal phase. At the time of reward delivery, women in the follicular phase activated the midbrain and striatum more than during the luteal phase. Investigation of between-sex differences revealed that men activated ventral putamen more than women during anticipation of uncertain rewards, whereas women more strongly activated the anterior medial prefrontal cortex at the time of reward delivery. Together, these data establish a neurobiological foundation for understanding sex differences in vulnerability to drug abuse and neuropsychiatric disorders.

NO 20D

SEX DIFFERENCES IN FMRI CORRELATES OF STRESS AND DRUG CUES IN COCAINE DEPENDENCE

Marc N Potenza, M.D., 34 Part Street, Room S-104, New Haven, CT 06519

SUMMARY:

Background: Relatively little research has investigated in samples of drug dependent and control subjects differences in the neural correlates of drug- and stress-related craving states, and none have investigated for sex differences.

Objective: To use fMRI to investigate sex differences in brain activations underlying stress, craving, and relaxing states in cocaine dependent and matched control comparison subjects. Methods: 30 cocaine dependent subjects (16 female, 14 male) and 36 control subjects (18 female, 18 male) participated in an individualized script fMRI paradigm. During fMRI, subjects heard scripts of stressful, substance-related (cocaine for cocaine dependent subjects, alcohol for control subjects) or neutral-relaxing content. Four regions of interest (caudate, hippocampus, amygdala, and anterior cingulate) were selected a priori for analysis. Results: Brain imaging results yielded more robust findings than did subjective or heart rate measures. Group, condition, sex-by-condition, and group-by-sex-by-conditions effects were significant for activation of caudate, hippocampus and anterior cingulate, and sex-by-condition and group-by-sex-by-conditions effects were significant for amygdala activation. During the stress condition, cocaine dependent women as compared to non-dependent ones showed greater activation of corticolimbic circuitry, and this difference was not observed in men. During the drug condition, cocaine dependent men as compared to non-dependent ones showed greater activation of corticolimbic circuitry, and this difference was not observed in women. Conclusions: Sex differences exist in the patterns of corticolimbic activations in cocaine dependent and control comparison subjects during stress, craving and relaxing conditions. A sex-sensitive understanding of the biological relationship between stress and addiction will facilitate the development of improved prevention and treatment strategies.

NO 20E

SEX DIFFERENCES IN AMYGDALA-BASED EMOTIONAL MEMORY PROCESSES: RELEVANCE FOR ADDICTION

Larry F Cahill, Ph.D., CNLM Qureshey Lab, U.C. Irvine, CA 92697-3800

SUMMARY:

Brain mechanisms of emotional memory likely influence a wide variety of brain disorders, including addiction. Extensive research from animal and human subject studies implicate stress hormones and the amygdala as two key, interacting components of an endogenous memory modulating system for emotional events. More recent work is uncovering previously unsuspected sex differences in this modulatory mechanism. For example, recent work shows that the relationship between the stress hormone cortisol and memory in women depends on the levels of circulating sex hormones. Similarly, the amygdala shows clear sex differences not only in its relationship to emotional memory, but even during resting conditions. Given that addiction is widely viewed in large part as a disorder of memory processes, it seems certain that the rapidly unfolding story of sex influences on emotional memory must ultimately help clarify sex influences on the processes of addiction. For example, it may help provide a neurobiological explanation for previous evidence of menstrual cycle influences on craving, and on the effectiveness of treatments

(like nicotine patches) in reducing craving. Potential connections like this between the "basic science" of emotional learning and a clinical understanding of addiction, and of how addiction differs between the sexes, will be explored.

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3) Sinha R, Garcia M, Paliwal P, Kreek MJ, Rounsaville BJ: Stress-induced cocaine craving and hypothalamic-pituitary-adrenal responses are predictive of cocaine relapse outcomes. Arch Gen Psychiatry 2006; 63:324-331

4) Cahill L, Uncapher M, Kilpatrick L, Alkire MT, Turner J: Sex-related hemispheric lateralization of amygdala function in emotionally influenced memory: an FMRI investigation. Learn Mem 2004 11:261-266

SYMPOSIUM 21
CO-OCCURRING DISORDERS IN HIV POSITIVE PATIENTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how to effectively work with and treat HIV positive patients with multiple, co-occurring medical and psychiatric illnesses; 2) Review various diagnostic and treatment strategies; and 3) Describe characteristics, diagnostic approaches, and management issues prevalent in co-occurring disorders and HIV.

NO 21A
HIV AND HEPATITIS C CO-INFECTION

Elizabeth Ryan, M.D., One Gustave L. Levy Place, Box 1230, New York, NY 10029

SUMMARY:

HCV is a prevalent comorbidity in HIV that has been shown to have neuropsychiatric effects. Neurometabolic alterations suggest that a biologic process underlies the neuropsychiatric effects seen in HCV. Definable neurometabolite abnormalities (increased choline/creatine ratios and decreased N-acetylaspartate/creatine ratios) exist in a proportion of HCV and HIV-infected patients who demonstrate cognitive impairment on neuropsychological testing. We compared 28 HIV mono-infected and 28 HIV/HCV co-infected participants (who were viremic for HCV) to see if HCV viremia caused worse neuropsychiatric functioning and greater neurometabolic alterations. Both groups had CD4>200 cells/mm3 and >50% were HIV RNA undetectable. None had a history of a prior neurologic insult (i.e., CVA, TBI, seizure). There were no significant differences in neurometabolite ratios in the prefrontal dorsolateral or occipital-parietal regions. There was no significant difference in cognitive impairment between the two groups. In a sample of patients with well-controlled HIV and no other significant neurological confounds, there was a lack of a cerebral effect of HCV viremia. Previous work suggests that uncontrolled HIV may be a precursor of a direct biological effect of HCV.

NO 21B

METABOLIC DISEASE AND HIV

Marshall Forstein, M.D., 24 Olmsted Street, Jamaica Plain, MA 02130

SUMMARY:

The remarkable progress of medical science in the treatment of HIV and AIDS has been found to have a price tag attached. Physicians are encountering a litany of heretofore-unrecognized metabolic abnormalities and body-composition changes in patients receiving the antiretroviral therapy that has so greatly improved their lives. One of the most distressing observations includes visible changes in body shape and appearance as a result of lipodystrophy. HIV lipodystrophy syndrome, which includes metabolic complications and altered fat distribution, is of major importance in HIV therapy. Lipodsytrophy has significant physical and psychological effects on the individual including, but not limited to, metabolic issues, cardiovascular disease, bodily discomfort, low self esteem, depression, sexual dysfunction, social isolation, and reduced treatment adherence. During this session participants will review metabolic syndrome, discuss the impact of lipodystrophy on HIV management, diagnosis and treatment, steroid use, mental health, and quality of life.

NO 21C

PTSD AND HIV

Antoine Douaihy, M.D., 372 S. Highland Avenue, #602, Pittsburgh, PA 15206

SUMMARY:

An estimated 30%–50% of HIV patients meet the criteria for posttraumatic stress disorder (PTSD), and up to 60% of those are untreated. About two-thirds of patients reported experiencing at least one traumatic event. Those with HIV disease exhibit patterns of repeated traumatization. Routine detailed screening for trauma, PTSD, Acute Stress Disorder (ASD), and depression is important. Simply making treatment available represents a major step toward improving health outcomes. Integrated treatment is important in those with PTSD and a substance use disorder, and integrated treatment services are of value to those with HIV and PTSD or PTSD/substance use disorder. This session will review the routine detailed screening of HIV patients for PTSD, ASD, and depression and will discuss psychotherapeutic and psychopharmacologic interventions in patients with comorbid HIV and PTSD.

NO 21D

UPDATE ON SEVERE MENTAL ILLNESS AND HIV

Francine Cournos, M.D., 5355 Henry Hudson Parkway, # 9F, Bronx, NY 10471

SUMMARY:

This presentation will offer an update on HIV among people with severe mental illness, including global epidemiology and risk behavior; substance abuse and hepatitis comorbidities; approaches to primary and secondary prevention; and strategies for providing HIV-related medical care, including adherence to antiretroviral treatment.

NO 21E

SUBSTANCE USE DISORDERS AND HIV

Steven Batki, Medical Center (116P), 4150 Clement Street, San Francisco, CA 94121

SUMMARY:

Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) are critical public health problems in patients with substance use disorders (SUDs). The connection between HIV and substance use is significant because injection drug use is a major conduit for HIV transmission to heterosexual adults, women, minorities, and children. Non-injection substance use is also known to be associated with increased risk for contracting HIV. The "triple diagnosis" of HIV infection, substance use disorders and comorbid psychiatric disorders creates diagnostic problems, requires special treatment approaches, and adds to the scope of work required of treatment providers. Optimal addiction treatment for patients with HIV infection includes assessment and management of the medical problems associated with HIV. HIV infection complicates addiction treatment and conversely, substance use disorders may make the medical management of HIV more difficult. For example, the behavioral disturbances that accompany drug dependence can interfere with both engagement in and adherence to medical treatment. Substance abuse treatment is essential because it can achieve primary prevention of HIV as well as secondary and tertiary prevention. This presentation reviews the epidemiology and clinical impact of HIV infection among patients with SUDs, and also reviews the SUD assessment and treatment of HIV-infected patients, as well as models for integrating care for HIV and substance use disorders.

REFERENCES:

1) Fernandez F. Neurospychiatric Aspects of Human Immunodeficiency Virus (HIV) Infection. Curr Psychiatry Rep. 2002 Jun; 4(3): 228-31.

2) Walkup J et al. The Impact of Mental Health and Substance Abuse Factors on HIV Prevention and Treatment. J Acquir Immune Defic Syndr. 2008 Mar 1; 476 Suppl 1: S15-9.

3) Weiss JJ, Gorman JM. Psychiatric Behavioral Aspects of Comanagement of Heptitis C and HIV. Curr HIV/AIDS Rep. 2006 Nov; 3(4): 176-81.

4) Ziedonis DM et al. Improving the Care of Individuals with Schizophrenia and Substance Use Disorders: Consensus Recommendations. J Psychiatr Pract. 2005 Sept; 11(5):315-39.

SYMPOSIUM 22

STARTING OUT ON THE RIGHT FOOT: SECURING YOUR FIRST JOB AND ESTABLISHING A PSYCHIATRIC PRACTICE

Supported by APA Committee of Residents and Fellows

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand key concepts necessary for sound decision-making in securing professional employment and establishing a psychiatric practice.

SUMMARY:

REFERENCES:

1) American Psychiatric Association: Member's Corner. Practice Management for Early Career Psychiatrists: A Reference Guide. Available at http://www.psych.org/members/ecp/index.cfm (APA membership is required to access this document)

2) Fisher R, Ury W, Patton B: Getting to Yes: Negotiating Agreement Without Giving In. 2nd Edition. New York, NY, Penguin Books, 1991.

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4) Anastakis D: Negotiation skills for physicians; The American Journal of Surgery, 185(1):74-78.

SYMPOSIUM 23

SOCIAL STRESS INCREASES VULNERABILITY TO DRUG ABUSE AND DISEASE

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize how drug abuse, neuropsychiatric disturbances, and HIV/AIDS are closely linked and all are exacerbated by stres, and that vulnerability to drug use and disease, although highly individualized, may be predicted based on an individual's responses to physiologically important stress.

NO 23A

ADVERSE EFFECTS OF STRESS ON DRUG ADDICTION

Julie Blendy, Ph.D., 125 South 31st Street, Philadelphia, PA 19104

SUMMARY:

Sustained exposure to stress can lead to a number of neuropsy-

chiatric disorders, chief among them drug addiction. Addiction is a chronic brain disease in which individuals cannot control their need for drugs, despite negative health and social consequences. Although many factors can contribute to initial and continued drug use, exposure to either psychological or physiological stress at any point in the addiction cycle seems to worsen this disease, augmenting all drug-seeking behaviors, including initial drug taking, drug craving, and relapse. There are common effects of stress and drugs of abuse throughout the addiction cycle. Both animal and human studies have shown that stress enhances rewarding aspects of drugs of abuse, helps maintain chronic drug use and often is a causative factor underlying the relapse to drug taking behaviors. Stress and drugs of abuse also act similarly to affect the neurochemistry, electrophysiology, and morphology of neurons involved in drug reward pathways. Furthermore, stress and drugs of abuse produce similar molecular changes in the brain. It is clear that brains of addicted individuals are altered and respond differently to stress than non-addicted individuals. Understanding the integration of stress and addiction circuitry, as well as the molecular and cellular changes common to both following exposure to stress or drugs of abuse may facilitate the discovery of novel therapies for treating the stress-related aspects of this disorder . Such medications are likely to be an important contributing factor to a long-lasting recovery from drug addiction.

NO 23B

SOCIAL STRESS AND VULNERABILITY TO SUBSTANCE ABUSE: GENES, ENVIRONMENT AND NEURAL CORRELATES

Huda Akil, Ph.D., 205 Zina Pitcher, Ann Arbor, MI 48109

SUMMARY:

In humans, it is clear that there are multiple paths to substance abuse, including personality variables, environmental triggers and availability of drug. Few animal models have systematically explored the underlying biology of this initial vulnerability to seek drugs. We have created two genetically distinct lines of rats that show dramatic differences in their propensity to self-administer drugs of use. We have shown that these selectively bred lines exemplify many characteristics of externalizing versus internalizing disorders. Relative to the "Internalizing Disorders Rat" or IDR, the Externalizing Disorders Rat or EDR shows greater novelty seeking and risk taking behavior, less spontaneous anxiety and depression-like behavior, greater aggression, greater impulsivity and greater contextual associations (Sign tracking). Importantly, EDRs learn rapidly to take cocaine and other drugs of abuse. By contrast IDRs, while not prone to substance abuse, become much more prone to drug seeking following repeated social defeat. The increase in drug seeking in the IDRs is not immediate but takes 1-2 weeks to peak , suggesting that neural remodeling induced by stress is necessary to increase their substance abuse liability. Thus, the genetics of these animals define two paths to substance abuse— one based on risk-taking and the other on response to social stress.

These trait differences and the differential reactivity to drugs and social stress embodied in these Bred Animals are accompanied by dramatic differences in neural brain circuits. We will focus in particular on those differences associated with growth factors and with hippocampal neurogenesis which suggest a key role of the hippocampus in mediating a) the IDR vs. EDR differences in reactivity to the environment and b) the differences in reactivity to social stress that lead to drug abuse.

NO 23C

INTERACTIONS OF SOCIAL STRESSORS AND ENRICHMENT WITH SOCIAL RANK ON DOPAMINE D2 RECEPTORS AND THE REINFORCING STRENGTH OF COCAINE IN MONKEYS

Michael A Nader, Ph.D., 546 NRC, Medical Center Boulevard, Winston-Salem, NC 27157-1083

SUMMARY:

These studies utilize a homologous animal model of human drug addiction involving socially housed male cynomolgus monkeys. Early studies reported differences in brain dopamine D2 receptor availability as measured by positron emission tomography and differential sensitivity to the reinforcing effects of cocaine depending on the monkey's position in the social hierarchy (i.e., dominant vs. subordinate). We hypothesized that these effects were due to chronic stress in the subordinate monkeys and chronic environmental enrichment associated with being dominant. Following years of cocaine self-administration, the differences in D2 receptor availability between dominant and subordinate monkeys dissipated. However, the differences re-emerged during abstinence, suggesting that social variables were still impacting D2 receptor function. We have since examined several acute and chronic stressors and enrichers in order to determine their effects on D2 receptor availability and cocaine self-administration. Social reorganization (e.g., putting four dominant or four subordinate monkeys in the same social group) did not significantly affect either dependent variable. In contrast, being an intruder into a cage of unfamiliar monkeys produced large effects on cocaine self-administration that were dependent on the social rank of the intruder. Environmental enrichment, consisting of three days in an enlarged living space decreased the reinforcing strength of cocaine irrespective of social rank. Current studies are examining the effects of drugs that can increase D2 receptor availability on cocaine self-administration with and without concurrent environmental enrichment. Our goal is to determine if a combination of environmental changes and pharmacotherapy administration can robustly decrease cocaine self-administration in socially housed monkeys. Supported by R37 DA10584-13.

NO 23D

SOCIAL STRESS AND SIMIAN IMMUNODEFICIENCY VIRUS DISEASE: BEHAVIORAL AND PHYSIOLOGICAL MECHANISMS THAT AFFECT

DISEASE PROGRESSION *J*

John P. Capitanio, Ph.D., One Shields Avenue, Davis, CA 95616

SUMMARY:

Since early in the AIDS epidemic, stress has been considered a co-factor that might explain some of the considerable variation seen in rates of disease progression. We have developed an animal model to explore the role of social stress in disease, by making use of the simian immunodeficiency virus (SIV)/rhesus macaque model of AIDS. In our model, social stress is associated with shorter survival, but individual-level characteristics such as personality and serotonin transporter genotype can mitigate somewhat the physiological consequences of stress through their influence on behavioral coping. We have also demonstrated that, in lymph nodes, SIV replicates preferentially in the vicinity of sympathetic nerve fibers, which release norepinephrine locally in response to sympathetic nervous system activation. Importantly, social stress increases sympathetic innervation of lymph nodes, and functionally this increased density is associated with downregulation of gene expression for the anti-viral Type I interferons. These data will be described, and implications will be discussed for how drugs of abuse, particularly sympathomimetics, may contribute to accelerated immunodeficiency virus disease progression.

REFERENCES:

1) Cleck JN, Blendy JA: Making a bad thing worse: adverse effects of stress on drug addiction. J Clin Invest 2008; 118:454-461

2) Davis BA, Clinton SM, Akil H, Becker JB: The effects of novelty-seeking phenotypes and sex differences on acquisition of cocaine self-administration in selectively bred High-Responder and Low-Responder rats. Pharmacol Biochem Behav 2008; 90:331-118

3) Nader MA, Czoty PW: PET imaging of dopamine D2 receptors in monkey models of cocaine abuse: genetic predisposition versus environmental modulation. Am J Psychiatry 2005; 162:1473-1482.

4) Sloan EK, Capitanio JP, Tarara RP, Mendoza SP, Mason WA, Cole SW: Social stress enhances sympathetic innervation of primate lymph nodes: mechanisms and implications for viral pathogenesis. J Neurosci 2007; 27:8857-8865

SYMPOSIUM 24
WHAT'S NEW IN PHARMACOTHERAPY FOR ALCOHOL DEPENDENCE?

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) treat individuals with alcohol problems with medications that have been approved by the FDA for alcoholism; 2) identify new generation of medications that have promise in treating alcoholism; 3) demonstrate various molecular targets that influence alcohol seeking and drinking behavior; 4) determine how polymorphism of various genes can influence treatment outcome with various medications; and 5) understand the different aspects.

NO 24A

NEUROKININ 1 RECEPTOR (NK1R) ANTAGONISM: A NOVEL ANTI-STRESS MECHANISM FOR THE TREATMENT OF ALCOHOLISM

David T. George, 10 Center Drive, Bethesda, MD 20892

SUMMARY:

Stress and alcohol cues are major categories of triggers for cravings and relapse in alcoholism. Basic research has demonstrated a major role for a pathological activation of brain stress system in driving relapse and excessive voluntary drinking. Treatments that can block stress pathways therefore hold considerable promise for facilitating recovery in alcoholism. Work from several laboratories including ours has previously identified the CRH1 receptor as a candidate target in this category. Challenges in the areas of chemistry and toxicology have, however, so far prevented CRH1R antagonists from reaching human studies in which they could be evaluated for beneficial effects in alcoholism. Recently, we identified a previously unrecognized system which appears to be critically involved in stress and craving responses, the neurokinin 1 receptor (NK1R) for substance P (SP). In a translational effort, we first demonstrated that mice with a deletion of the NK1R gene have markedly low alcohol preference and consumption. We then went on to show that an oral, brain penetrant NK1R antagonist blocks spontaneous cravings for alcohol, and markedly improves global well-being in recently detoxified alcoholics. We further evaluated NK1R antagonism in a paradigm designed to mimic a real-life situation at high risk for relapse, in which patients are first subjected to a social stress, and then exposed to their favorite alcoholic beverage. The intense cravings induced by this procedure were markedly attenuated by the treatment. Finally, using fMRI, we showed that the exaggerated brain responses to stressful / aversive stimuli typically found in alcoholics are normalized by NK1R antagonism. Conversely, brain responses to positive emotional stimuli, typically attenuated or absent in alcoholics, were restored by the treatment. These findings represent the identification of a novel system involved in mediation of alcohol cravings in response to relapse triggering stimuli, and offer the first demonstration that an anti-stress mechanism might be beneficial in the treatment of alcoholism. Because safe and well tolerated NK1R antagonists have been developed for other indications, our recent alcohol data have rapidly enabled the initiation of full scale clinical trials for this indication.

NO 24B

HUMAN LABORATORY AND CLINICAL TRIAL EVIDENCE FOR GABAPENTIN TREATMENT OF ALCOHOL DEPENDENCE

Barbara J Mason, Ph.D., 10550 North Torrey Pines Road, TPC-

5, La Jolla, CA 92037

SUMMARY:

ABSTRACT

Protracted abstinence in alcohol dependence involves a state of heightened vulnerability to relapse, prolonged activation of brain stress arousal systems, and heightened responsivity to internal cues, e.g. negative affect, and external cues, e.g. alcohol. We tested gabapentin in a human laboratory model of such risk factors and randomized controlled and validated findings in a lab trial (RCT).

METHODS Lab Study: 33 cue reactive, non treatment-seeking paid volunteers with alcohol dependence were randomly assigned to one week of double-blind gabapentin 1200 mg/d or matched placebo. Subjects' subjective and physiological responsivity to pairs of affective (negative, neutral, positive) and beverage (alcohol, water) cues were then measured. Pre and post treatment measures of mood and sleep were also obtained.

RCT: 75 treatment-seeking outpatients with alcohol dependence were randomly assigned to 12 weeks of double-blind treatment with 0, 900 or 1800 mg/d of gabapentin and weekly, individual manualized counseling.

RESULTS Lab Study: Subjects were 33 alcoholics (21% female, mean age of 39.7 years). Gabapentin was found to reduce the effect of alcohol beverage exposure (relative to water) on ratings of craving and subjective arousal for affect-inducing image exposures, relative to neutral images, and to significantly improve sleep quality relative to placebo.

RCT: Subjects were 75 alcoholics (15% female, mean age of 43.9 years). Gabapentin significantly reduced the number of drinks per drinking day and improved sleep quality and mood relative to placebo.

CONCLUSIONS A laboratory assessment found gabapentin suppressed craving to alcohol cues and arousal to affective cues and improved subjective sleep quality. Results were validated in a RCT that found gabepentin significantly reduced drinking, and improved in sleep and mood relative to placebo.

NO 24C

UPDATE ON NEW CLINICAL TRIALS FOR ALCOHOL DEPENDENCE: OPIATE, DOPAMINE AND GABA/ GLUTAMATE ACTING MEDICATIONS.

Raymond F. Anton, M.D., 67 President Street, MSC 861, Charleston, SC 29425

SUMMARY:

The few FDA approved drugs for the treatment of alcohol dependence are not universally effective nor do they have large effect sizes over placebo. Therefore newer medications, and combinations of medications, are being investigated. Addiction neuroscience has pointed to the crucial roles of the opiate, dopamine, and GABA/Glutamate systems in alcohol reinforcement, and in both alcohol cue and alcohol withdrawal based craving and relapse. Our group has recently completed trials 1) with the dopamine acting medication aripiprazole, 2) with a combination of the GABA acting drug IV flumazenil with the orally active GABA/Glutamate stabilizer gabapentin and 3) with a combination of the opiate receptor antagonists naltrexone and gabapentin. The main results of these trials will be presented and discussed. Where appropriate, subpopulations of alcoholic patients who might respond to these medications will be mentioned. Potentially limiting side effects will be reviewed along with dosage considerations.

NO 24D

AN ANALYSIS OF TWO PROMISING MEDICATIONS, TOPIRAMATE AND ONDANSETRON, FOR TREATING ALCOHOL DEPENDENCE: RESULTS FROM RECENT LARGE-SCALE CLINICAL TRIALS

Bankole A. Johnson, M.D., Ph.D., D.Sc., P.O. Box 800623, Charlottesville, VA 22908-0623

SUMMARY:

Hypothetically, topiramate can improve drinking outcomes of alcohol-dependent individuals by reducing alcohol-induced reward via facilitation of central GABAergic function and inhibition of glutaminergic pathways in the corticomesolimbic system. In separate single-site and multi-site double-blind randomized controlled trials, we sought to determine whether topiramate is more efficacious than placebo as a treatment for alcohol dependence. In the single-site 12-week trial, 75 of 150 alcohol-dependent men and women received topiramate (escalating dose of 25–300 mg/day) and 75 received placebo as an adjunct to weekly brief behavioral compliance enhancement treatment (BBCET). The multi-site 14-week trial comprised 371 alcohol-dependent men and women at 17 U.S. sites who received up to 300 mg/day of topiramate (n=183) or placebo (n=188) with weekly BBCET. The data to be presented, which provide the combined outcomes from the trials using both existing and new analytical plans and multiple endpoints, shall demonstrate that topiramate (up to 300 mg/day) is more efficacious than placebo as a treatment for alcohol dependence. Furthermore, ondansetron, a serotonin-3 receptor antagonist, should, hypothetically, reduce the severity of drinking among alcohol-dependent individuals who are carriers or homozygotes for the long form of the serotonin transporter gene more than among their homozygotic counterparts with the short allele. Mechanistically, this proposed effect is due to enhanced blockade of up regulated post-synaptic serotonin receptors. Here, the results of the first prospective randomized placebo-controlled pharmacogenetic trial in the alcoholism field (N=320) that has examined this hypothesis empirically shall be unveiled.

NO 24E

PHARMACOGENETICS AND ALCOHOL DEPENDENCE

Henry R. Kranzler, M.A., 263 Farmington Avenue, Farmington, CT 06030-2103

SUMMARY:

Pharmacogenetics, which examines genetic moderators of the response to drugs, has shown promise as a strategy by which to personalize treatment for a variety of disorders. Although it is best developed in relation to cancer treatments, recent efforts have shown potential applications of this approach to psychiatric disorders, including major depressive disorder and alcohol dependence. The approach that has been employed most effectively to identify candidate genes for study in alcohol dependence begins with the identification of a medication with a known action at specified receptors, following which the genes encoding the receptor protein(s) are evaluated as moderators of treatment response. This has potential utility to identify pharmacogenetic moderators of both therapeutic and adverse effects. The gene that has been most widely studied in alcohol dependence for its potential moderator effects is OPRM1, encoding the mu-opioid receptor. This receptor has a high affinity for naltrexone, a medication approved to treat alcohol dependence. An Asn40Asp polymorphism in OPRM1 has effects on receptor expression and/or binding, though the findings are inconsistent. The polymorphism has also been shown to interact with naltrexone treatment in alcohol-dependent subjects, with some studies showing the minor (Asp40) allele to be associated with beneficial effects of naltrexone, though other studies have failed to show such an association. This presentation will review the conflicting literature on the moderating role of the Asn40Asp polymorphism in the efficacy of naltrexone in the treatment of alcohol dependence, highlighting the potential basis for the inconsistent findings. Data will also be presented on a polymorphism in GRIK1, which encodes the GluR5 kainate receptor, which binds topiramate, another medication with demonstrated efficacy in the treatment of alcohol dependence. Data on the interactive effects of this polymorphism on the effects of topiramate in clinical trials of alcohol dependence and of nicotine dependence will also be presented.

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2) Arias AJ, Armeli S, Gelernter J, Covault J, Kallio A, Karhuvaara S, Koivisto T, Makela R, Kranzler HR: Effects of opioid receptor gene variation on targeted nalmefene treatment in heavy drinkers. ACER 2008; 32:1159-1166.

3) Anton FR, Kranzler H, Breder C, Marcus RN, Carson WH, Han J: A randomized, multicenter, double-blind, placebo-controlled study of the efficacy and safety of aripiprazole for the treatment of alcohol dependence. J Clin Psycholpharmacol 2008; 28:5-12.

4) Roache JD, Wang Y, Ait-Daoud N, Johnson BA: Prediction of serotonergic treatment effiacy using age of onset and type A/B typologies of alcoholism. ACER 2008: 32:1-11.

SYMPOSIUM 25

AUTISM IN ADULTS TOWARDS A BETTER CLINICAL APPROACH THROUGH UNDERSTANDING: RECENT INSIGHTS FROM RESEARCH

EDUCATIONAL OBJECTIVES:

By the end of this session the participants will be able to: 1) Be up-dated on the current research on Autism Spectrum Disorders in Adults; 2) They will have insight in the issues of comorbidity, the social perception and information processing, the underlying neuropsychological deficits; 3)They will have become aware of the impact that a child with an ASD diagnosis may have on a family and the likelihood of one of the parents being affected; and 4) The presenters will gap the bridge between science and clinical reality.

NO 25A

NEURODEVELOPMENTAL CORRELATES OF SOCIAL IMPAIRMENT IN AUTISM: FROM INFANCY TO ADULTHOOD

Ami Klin, Ph.D., 230 South Frontage Road, New Haven, CT 06520-7900

SUMMARY:

Autism is a neurodevelopmental disorder disrupting basic mechanisms of social engagement. This presentation will provide an overview of studies of visual scanning patterns to naturalistic social situations involving individuals with autism from infancy to adulthood. These studies illustrate a programmatic effort at the Laboratory of Social Neuroscience at the Yale Child Study Center Autism Program to develop new methods to quantify core disabilities in autism. Its goal is to map the ontogeny of social engagement in human development and to create methods for the identification of vulnerabilities for autism in the first year of life.

NO 25B

DIFFUSION TENSOR IMAGING IN AUTISM AND ASPERGER SYNDROME: EVIDENCE FOR IMPAIRMENT OF LONG RANGE WHITE MATTER INTEGRITY

Wouter Groen, M.D., Reinierpostlaan 10, Nijmegen 6500, HB Netherlands

SUMMARY:

Introduction Recent studies have reported abnormal functional connectivity patterns in autism. This has led to the hypothesis that impaired integration of neural information and long distance disconnection underlies autism. However, little is known about the structural integrity of the white matter tracts that convey neural information.

Methods Diffusion tensor imaging was performed on 60 12-18-year old participants with high functioning autism, Asperger Syndrome and typically developing children matched for age, IQ, handedness, head circumference, and gender. Scans included the cerebrum and cerebellum and fractional anisotropy and mean diffusivity measures were analyzed in a voxel based morphology manner.

Results Participants with autism had lower fractional anisotropy in long distance white matter tracts including inferior and superior fronto-occipitial fasciculus and the inferior and superior longitudinal fasciculus bilaterally as well as the cerebello-pontine tract bilaterally. Fractional anisotropy in Asperger Syndrome was intermediate between that of participants with autism and controls, but group differences between participants with Asperger syndrome and the other groups were non-significant.

Conclusion The findings suggest that there is a generalized reduction of structural integrity of long distance white matter tracts in autism that connect the frontal cortex to other systems. This may contribute to impaired integration of information and the clinical manifestations in autism.

NO 25C

NEUROCOGNITIVE CORRELATES OF SUBSTANCE USE DISORDER IN ADULTS WITH AUTISM SPECTRUM DISORDER OR ADHD

Bram B. Sizoo, M.D., Nico Bolkesteinlaan, 1 Deventer, 7416 SB Netherlands

SUMMARY:

Patients with an Autism Spectrum disorder (ASD) or an Attention-Deficit/Hyperactivity Disorder (ADHD) experience significant problems in social functioning, especially with comorbid Substance Use Disorder (SUD). Earlier research indicates that SUD, ADHD, and ASD, each present with cognitive impairments to a different degree, where studies with ASD and ADHD patients have largely been constricted to children. However, the effect of comorbidity on cognitive skills in adults with SUD has not yet been reported. This study addresses the neurocognitive correlates in adult patients with ASD or ADHD in relation to current, former, or no history of SUD (SUD+, SUD^, and SUD-).

Method: In this cross-sectional study 90 consecutively diagnosed adults with ASD (n= 60) or ADHD (n=30) underwent neuropsychological tests to determine measures of attention, flexibility, planning, inhibition, and verbal as well as non-verbal intelligence.

Results: The ASD/SUD- and the ADHD/SUD- subgroups did not perform significantly different on the intelligence subtests of the WAIS III. However, in the ASD group, but not in the ADHD group, intelligence was negatively correlated with the degree of SUD. On the sustained attention task ASD/SUD- did not differ significantly from ADHD/SUD-. Yet in the ASD group, but not in the ADHD group, reaction times were significantly higher in the SUD^ and SUD+ subgroups compared to the SUD- subgroup.

Conclusion: Bearing in mind the constraints of cross sectional research, and the relatively small numbers, neurocognitive performance in adults with ADHD seems to be relatively unaffected by comorbid SUD, in contrast to adults with ASD. Surprisingly, in the SUD- subgroups there was no significant difference in the neurocognitive performance on our test battery between ASD and ADHD patients.

NO 25D

COMORBIDITY IN ADULTS WITH ASD EVIDENCE FROM DATA FROM CROSS SECTIONAL AND PROSPECTIVE CASE CONTROLLED COHORT SAMPLES

Patricia J van Wijngaarden-Cremers, M.D., PO Box 110, Zwolle, 8000 AC Netherlands

SUMMARY:

Comorbidity in individuals with ASD is more rule than exception (Martin et al.1999) yet little is known on comorbidity in adults with ASD. Mouridsen et al. (2008) found high prevalences of psychosis in adults that had been diagnosed with ASD in childhood. Ketelaars et al. (2008) reported affective comorbidity in a small sample of individuals diagnosed with ASD in adulthood. Recently (2006) we reported a remarkable comorbidity with addiction in adults with ASD.

This presentation sums the findings of comorbidity in three controlled samples of individuals (adding up to more than 200 cases) with ASD first diagnosed in adulthood assessed in a unit for developmental problems in adults and the addiction department, as compared to case controls attending a general psychiatric outpatient unit.

It appears that affective comorbidity is by large most prominent in adults with ASD, followed by psychotic disorders, ADHD and impulse control disorders. Traumatization in childhood is frequently reported but not significantly more often in the ASD sample than in the general psychiatric controls.

These comorbidity findings have consequences for clinical management in future.

NO 25E

ASD IN PARENTS AND SIBLINGS OF EARLY DIAGNOSED INFANTS WITH ASD

Rutger J. Van der Gaag, M.D., Reinier Postlaan 12, Nijmegen, 6525 GC Netherlands

SUMMARY:

Autism Spectrum Disorders (ASD) are seriously impairing developmental disorders with a high persistence into adulthood. It is well established that genetic factors play an important role in the aetiology. Yet the genetic transmission is an intricate process and the interactions with the environment both pre- and postnatal are yet unclear. Along with heredity, de novo mutations are involved. Family genetic studies (Losh & Piven 2007) show that individuals within one family may be affected at very different degree both in terms of clinical presentation and intellectual level. In some individuals the clinical picture starts very early in life, in others the impairment may manifest for the first time well into adulthood. The latter may occur when the social complexity increases. It also seems to be the case in parents after one of their children has been diagnosed.

This last assumption is questioned in a sample of 238 children (mean age=29.6 months, SD=6.4) from the early detection project DIANE (Diagnosis and Intervention for Autism in the Netherlands) that runs in the Province of Gelderland since 2003. Pri-

mary health pediatricians refer infants at risk for ASD according to their clinical judgment and with a positive score on the ESAT (Early Screening of Autistic Traits Questionnaire Swinkels et al. 2005) to multidisciplinary teams for a full clinical assessment. The project identifies 1 in 1700 infants with classic autism (4/5 with concurrent learning disability) every year in a catchment area of 3 million. And provides the families with support and an early intervention program.

In this presentation the results of the psychopathology screening in the families will be presented. Showing high levels of affective (reactive) psychopathology, but also high levels (17% respectively 25%) of ASD diagnoses in siblings and in parents (mostly fathers). The latter are in 80% of the cases first diagnosed after the diagnosis of their child!

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SYMPOSIUM 26.
THE EFFECTS OF CITY LIFE ON MENTAL HEALTH AROUND THE WORLD

SUPPORTED BY ROYAL COLLEGE OF PSYCHIATRISTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1)understand that city life can be associated with improved or decreased mental health and increased rates of some conditions but decreased rates of others, and 2) should learn some of the stressors and some of the protective factors accounting for these differences and should know of some measures needed to improve mental health in cities.

NO 26A

THE IMPACT OF URBAN LIVING ON MENTAL HEALTH AND ILLNESS IN EGYPT.

Nasser N. Loza, M.D., 32 El-Marsad st, Helwan, Cairo, 11421 Egypt

SUMMARY:

Egypt is a highly populated country, with a multitude of problems linked to its overpopulation, and to large variations in the distribution of the population and the limited resources and services.

As a result, the effects of crowdedness and the huge pressures of life in some of its cities (Cairo for example approaching 16 million inhabitants) is interesting to explore.

We shall be looking at the subject from this angle, using the documents of the ministry of health of Egypt, and a recent survey of mental health in different governorates of Egypt (E. Hamdi et al, 2007)

NO 26B

MENTAL DISORDERS AND QUALITY OF LIFE IN LARGE METROPOLITAN AREAS IN MEXICO

Maria Elena Medina Mora, Psy.D., Calzada Mexico Xochimilco 101 San Lorenzo, Huipulco Tlalpan, Mexico City, 14370 Mexico

SUMMARY:

The aim of the presentation is to analyze the effects of living in one of the three largest metropolitan areas in Mexico (Mexico City, Monterrey and Guadalajara) on the risk of suffering violence, the prevalence of mental illness and mental health service utilization. The data are drawn from the National Psychiatric Epidemiology Survey (2001), a household survey comprising 2432 people aged 18 to 65. Results show that affective and anxiety disorders have a higher prevalence as compared to the national mean. Similar findings are observed for substance abuse and exposure to certain types of violence. These higher prevalence rates may be associated with factors such as lifestyles, overcrowding, marginalization, job instability, accidents, identity problems and

the weakening of social networks, among others.

NO 26C

METRO-URBAN MENTAL HEALTH IN DEVELOPING COUNTRIES: FROM ORIGINS TO OUTCOME: AN INDIAN EXPERIENCE

Amresh K. A. Shrivastava, M.D., 467, Sunset Drive, Regional Mental Health Care, St.Thomas, Ontario N5H 3V9 Canada

SUMMARY:

Practice of modern era everyday psychopharmacology requires the mastery of all aspects of clinical psychopharmacology and continuous updating of one's knowledge base. As the practice of psychopharmacology becomes more complex and the amount of information is growing exponentially, acquiring a comprehensive knowledge base is more complicated. There are not many comprehensive, yet easy to use sources of psychopharmacology education. The two traditional sources of information - journals and psychopharmacology textbooks have their strengths and weaknesses. The number of journal articles and the complexity of their interpretation is increasing. Publication bias may be difficult to untangle at times. Textbooks usually bring a huge, comprehensive volume of information that is difficult to digest, and behind a bit due to the delay in publication of books. Thus, there is a great need for a summary of information that is expert-generated, up-to-date, all inclusive, comprehensive, yet relatively easy to understand, easy to use for teaching by persons who are not experts in all aspects of the field, easy to update/revise and adapt to local needs ("portability"), using new communication technologies, and, last but not least - without bias and without influence of the pharmaceutical industry. The Model Psychopharmacology Curriculum fulfills these "criteria." The Core and Advanced parts of the curriculum cover the psychopharmacology of the major mental disorders (schizophrenia, mood disorders, anxiety disorders, eating disorders, sexual dysfunctions, sleep disorders) and some special areas, such as combining pharmacotherapy and psychotherapy, cultural aspects of psychopharmacology and others. These two parts truly represent the core knowledge for the advanced practice of psychopharmacology. This presentation demonstrates a broad scope of information, depth, usefulness and practicality of these two sections of Model Psychopharmacology Curriculum.

4. A POPULATION-BASED STUDY OF FIRST EPISODE PSYCHOSIS IN SÃO PAULO, BRAZIL

Paulo Menezes, M.D., Av. Drive, Arnaldo, 455 Sao Paulo, 01246-903 Brazil

SUMMARY:

The WHO studies on the incidence and outcome of psychoses carried out in the 1980s brought the notion that psychoses occurred in a uniform pattern in different cultures, but the prognosis was better for those living in developing countries. More recently, such concepts have been questioned, but empirical data from low and middle income countries are still scarce. We carried out a population-based study of first episode psychosis in Sao Paulo, the largest conurbation in South America, aimed at estimating the incidence of psychosis, investigating several potential risk factors and neuroimaging aspects in a case-control study, and assessing the outcome of psychosis in a large urban center of a middle income country. Overall, 200 cases and 400 controls were included. The incidence of psychosis was 15.8/100,000, lower than expected. Unfavorable socio-economic conditions and use of cannabis seem to increase the risk of psychosis. Structural brain abnormalities were similar to those described in samples from developed countries. One-year and 4-year follow-ups will allow answering whether the prognosis of psychosis in Sao Paulo is similar or better than the prognosis of psychosis in urban centers of developed countries.

NO 26D

CHINESE ELDERLY IN SINGAPORE : COMPARING THE MENTAL HEALTH OF AN URBAN AND A SUBURBAN POPULATION

Ee-Heok Ehk Kua, M.B.B.S., 56, Chwee Chian Road, 117641 Singapore

SUMMARY:

This study compares the mental health of two groups of Chinese elderly in Singapore - one group living in the city (n=612) and another in the suburb (n=303). The former were mainly immigrants and the latter were local born. The immigrants were from southern China and arrived in Singapore in the early 1950s.

The assessment questionnaire was the Geriatric Mental State Schedule constructed by the London-New York team (Copeland JR,et al.1976). Diagnostic criteria was according to the *DSM-IV*. Physical examination and laboratory tests including a brain scan (if indicated) were done.

The prevalence of dementia in the urban sample was 2.5% and the suburban sample 5.0%; the rate of depression was 5.7% in the former and 9.5% in the latter. In the assessment of 'life satisfaction', about 70% of elderly in both groups expressed 'good' or 'excellent' life satisfaction. In performance of activities of daily living (ADL), 17% of the suburban elderly had moderate or severe impairment in ADL compared with 5% in the urban group.

The differences in physical and mental health in both groups of Chinese elderly could be due to lifestyle and social support system. refernces

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NO 26E

THE PRACTICE OF MENTAL HEALTH PROMOTION IN URBAN PLANNING AND CITY ADMINISTRATION

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SUMMARY:

Besides expanding services to those who receive none, prevention of mental disorders and promotion of mental health make critical contributions to population mental health in all parts of the world, as described by WHO.

For the first time in history half of the world's population live in cities and this proportion is growing. Opinion leaders are now urging that rather than complain about migration into the cities we take advantage of the opportunities for economic and social development it represents. The world's slums are a key setting for achieving the UN Millenium Development Goals (MDGs). Urban poverty is a critical pathway to ill health and health inequities. The control of growth and environmental change, the opportunities for mobility, transport and meeting other people, the standards of housing and access to amenities and services are all relevant to defining the mental health of a city's inhabitants, as are the levels of safety and violence in the community. Better mental health of the inhabitants can also contribute to safer environmental and living conditions.

Public policies are needed to support and promote healthy, sustainable places to live, work and recreate. The activities of mental health promotion are ideally integrated in urban planning and city administration. To be most successful this is made explicit, through the administration understanding and encouraging mental health promotion. Just as the Healthy Cities Programme gives priority to health in the management of cities around the world, the aim is explicitly to integrate mental health promotion in urban public health planning, through the same public health processes. These include the development of partnerships and public participation, coordination of support and empowerment of local institutions in order to provide, for example, safe and accessible public transport systems or regulate the number and type of outlets selling alcohol and the use of alcohol in public areas.

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SYMPOSIUM 27
RECENT RESEARCH IN EATING DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Discuss the psychiatric issues associated with the traditional eating disorders including anorexia nervosa and bulimia nervosa; and 2) Also eating disturbances that are seen in obese individuals who are candidates for bariatric surgery.

NO 27A

PSYCHOPATHOLOGY AND EATING PATHOLOGY IN BARIATRIC SURGERY CANDIDATES

James E. Mitchell, M.D., NRI, 120 8TH Street S, 1375 Elm Circle NE, Fargo, ND 58107

SUMMARY:

Considerable research suggests that there are high rates of comorbid psychopathology and eating problems in bariatric surgery candidates. In particular, rates of depression have traditionally been found to be quite high. Also, there is evidence that individuals who have problems with binge eating or BED and/or night eating syndrome may have less of a response to the surgery in terms of weight loss, particularly if these problems reoccur after the operation. Data will be presented on a cohort of 200 subjects who were screened extensively prior to bariatric surgery and who were informed that the data that were obtained would not be shared with the surgical team unless there was some immediate risk. This was done because of the known fact that many patients attempt to hide comorbid psychopathological and eating disorder problems when they are seeking bariatric surgery because they are afraid they will be disqualified. The data suggests significant problems with comorbid psychopathology, particularly in the area of major depressive disorder. The most common medications these patients were taking were anti-depressant drugs.

NO 27B

DISORDERED EATING AND PSYCHIATRIC SYMPTOMS IN ADOLESCENTS PRESENTING FOR BARIATRIC SURGERY.

Michael J Devlin, M.D., New York State Psychiatric Institute--Unite 1161051 Riverside Drive, New York, NY 10032

SUMMARY:

Obesity is an increasingly prevalent condition among adolescents and has significant medical and psychological consequences. Severely obese adolescents often have suboptimal responses to traditional weight loss treatments. Bariatric surgery has become an increasingly available option for adolescents who have failed to respond to less invasive treatments. In an effort to characterize adolescents who present for bariatric surgery, track their behavioral and psychological response to surgery, and identify factors that predict response, we have systematically studied 75 adolescents who were evaluated for laparoscopic adjustable gastric band (LAGB) surgery.

Participants included 75 adolescents age 13-17 with body mass index of at least 40 kg/m2 or 35 kg/m2 with significant medical comorbidity. Participants were interviewed by a mental health professional experienced in eating disorders assessment and completed several self-report indices of psychopathology and qual-

ity of life. A total of 33 participants (44%) received at least one DSM-IV diagnosis. Current binge eating was reported by 21.3% and night eating by 10.7%. The mean Beck Depression Inventory score was 10.5, and 30% of adolescents scored at or higher than a clinical threshold score of 14. A history of significant suicidal ideation was present in 24%, with 8% reporting suicide attempts, and 16% reporting past or current self-injurious behavior. More than 60% of adolescents were receiving or had received mental health treatment (34.7% current, 26.7% past).

As a group, adolescents presenting for bariatric surgery have significant comorbid eating disorder and mental health problems that may both be affected by and affect the outcome of bariatric surgery. Longitudinal follow-up is needed to identify predictive factors and to provide a rational basis for adjunctive mental health interventions for high risk individuals.

NO 27C

RECENT MORTALITY STUDIES IN EATING DISORDERS

Scott J Crow, M.D., F282/2A West 2450 Riverside Avenue, Minneapolis, MN 55454

SUMMARY:

Eating disorders are known to be associated with mortality rates among the highest of any psychiatric disorder. Past research suggests most of this mortality occurs in individuals with anorexia nervosa, and that it is partially attributable to medical complications and partially to suicide.

New evidence suggests that the mortality risk may be more broadly spread across the eating disorders, and not confined solely to anorexia nervosa. In a recent study using more diagnostically diverse sample followed for nearly 20 years, mortality risk is as elevated in eating disorders, not otherwise specified as in anorexia nervosa. Further, it appears that suicide rates were substantially elevated in bulimia nervosa. Finally, mortality rates have now been examined among alternative diagnostic groupings developed using novel statistical techniques. The implications of the relationship between mortality rates and novel diagnostic systems will be discussed, and the impact of these findings on the development of *DSM=IV* will be examined.

NO 27D

A MODEL OF ALLOSTASIS FOR CONCEPTUALIZING EATING DISORDERS

Katherine A Halmi, M.D., 21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:

Purpose: Existing models for conceptualizing the biological basis of eating disorders are fragmented and not comprehensive. The purpose of this presentation is to apply a model of allostasis to eating disorders in order to facilitate an understanding of the biology of these disorders.

Method: The rationale was developed for applying a model of allostasis, a dysregulation of reward circuits with activation of brain and hormonal stress responses to maintain apparent stability, for eating disorders.

Results: There is evidence of altered dopamine and serotonin neurotransmitters function in both anorexia nervosa and bulimia nervosa. The functional state of these neurotransmitter systems activated to produce and maintain the allostatic adaptations may ultimately be depleted and thus is unable to keep up with the demand involved in maintaining these aberrant physiological states. Genetic factors can act as trait mechanisms in an organism to produce differential sensitivity within the brain reward and stress systems that interact with environmental factors to produce a state of allostasis when activated.

Conclusion: The allostatic state in eating disorders may be similar to that in drug addiction and involve neural circuits of the cortico-striatal-thalamic loops as well as dopamine, serotonin, opiod peptides, GABA, and glutamate.

NO 27E

ARE ANOREXIA NERVOSA AND BULIMIA NERVOSA REALLY EATING DISORDERS: NEW UNDERSTANDING OF PUZZLING SYMPTOMS

Walter H Kaye, M.D., La Jolla Village Professional Center, 8950 Villa La Jolla Drive, Suite C207, La Jolla, CA 92037

SUMMARY:

Individuals with anorexia nervosa (AN) have a relentless preoccupation with dieting, which results in severe emaciation and sometimes death. Now, brain imaging technology offers new insights into these puzzling symptoms. We used fMRI to assess the response to tastes of sucrose in recovered AN subjects (to avoid the confounding effects of malnutrition) and healthy control women (CW). Compared to CW, the recovered AN subjects had a significantly reduced signal in the insula, which is the primary taste sensory cortex, and regions that code reward and emotionality. For CW, self-ratings of pleasantness of the sugar taste were positively correlated with the insula signal response. In comparison, recovered AN failed to show relationships to pleasure, but did show relationships to measures of anxiety. Using a similar design, we found that women recovered from bulimia nervosa (BN) had increased insula response to tastes of sugar in comparison to CW. The anterior insula plays an important role in interoceptive awareness which involves monitoring the sensations that are important for the integrity of the internal body state and connecting to systems that are important for allocating attention, evaluating context and planning actions. Thus the role of the anterior insula is focused on how the value of stimuli might affect the body state as well as determining homeostatic appetitive needs when hungry or satiated. How are individuals with AN able to maintain a chronic diet and become emaciated when most people struggle to lose a few pounds? AN may be able to restrict food and become emaciated is because of a failure of the anterior insula to respond appropriately to hunger due to altered interoceptive homeostatic mechanisms, perhaps involving disturbed sensory-hedonic tone. In contrast, the findings in BN raises the provocative possibility that an exaggerated sensory-hedonic response to palatable foods may contribute to a vulnerability for overeating.

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SYMPOSIUM 28
PUBLICATION BIAS AND THE EFFECTIVENESS OF ANTIDEPRESSANT TREATMENT AND PSYCHOLOGICAL INTERVENTIONS IN DEPRESSION: SHOULD WE CARE?

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to; reflect on the influence of publication bias on the efficacy of antidepressants and psychological interventions in Major Depressive Disorder (MDD).

NO 28A

SELECTIVE PUBLICATION OF ANTIDEPRESSANT TRIALS AND ITS INFLUENCE ON APPARENT EFFICACY

Erick H Turner, M.D., 3710 SW US Veterans Hospital Rd, P3MHDC, Portland, OR 97239

SUMMARY:

Selective publication of clinical trials—and outcomes within those trials—can lead to unrealistic estimates of drug effectiveness and alter the apparent risk-benefit ratio. For decades, the US Food and Drug Administration (FDA) has maintained a semi-public clinical trials registry and results database. We obtained FDA review documents on 74 studies of 12 antidepressants involving 12,564 patients. We conducted a systematic literature search to identify matching publications and compared the published outcomes to the FDA outcomes.

The journal articles conveyed that 94% of the antidepressant trials conducted were positive, while the FDA analysis showed that only 51% were positive. Within the studies that were FDA-negative, 11 (31%) conveyed a positive outcome and 22 (61%) were not published. Meta-analyses of the FDA and journal datasets showed that selective publication increased ES by 32% overall (from .31 to .41) and, for individual drugs, from 11% to 69%.

We found that each of the 12 drugs remained superior to placebo, but each drug's advantage over placebo was less than a meta-analysis relying on published literature would indicate. We cannot determine whether the bias observed resulted from a drug companies' not submitting manuscripts, journals declining to publish, or both. One should not infer that selective reporting is necessarily limited to studies funded by industry or to studies of antidepressants. It might also involve nonpharmacologic treatments, such as CBT. These questions were outside the scope of this study, but future studies must address them so that clinicians can make fully informed and balanced treatment decisions.

NO 28B

PUBLICATION BIAS IS NOT RESTRICTED TO REPORTING OUTCOMES OF PHARMACOTHERAPY TRIALS

Willem WA Nolen, M.D., Hanzeplein 1 Groningen 9713GZ

SUMMARY:

With the availability of databases registering study protocols of pharmacotherapy trials, such as the FDA database and ClinicalTrials.gov, the extent of the effect of publication bias can now reliably be estimated. However, publication bias is not only a problem with regard to reporting the outcomes of clinical trials. All domains of scientific research suffer from the problem of publication bias: epidemiological studies, studies into the biology and pathogenesis of illnesses, etcetera.

As an example a recent study into the genetic basis of major depressive disorder (MDD) will be presented (Bosker et al, submitted). In a systematic review of all published studies comparing patients with MDD and normal controls, we identified 78 papers reporting on 57 candidate genes which were found at least once to be significantly ($p<0.05$) associated with MDD. In a recent large Dutch genome wide association study of 435,291 SNPs genotyped in 1,738 MDD cases and 1,802 controls (Sullivan et al, in press), we were able to do a replication study involving 55 of these 57 candidate genes. For only four genes we found some confirmation of their association with MDD. This disappointing finding may be explained by publication bias of positive results in the previous reports.

Reference: Sullivan et al. Genome-wide association for major depressive disorder: a possible role for the presynaptic protein piccolo. Mol Psychiatry, in press.

NO 28C

NONRESPONSE TO CBT AND ANTIDEPRESSANTS IN THE TREATMENT OF DEPRESSION IN MYOCARDIAL INFARCTION PATIENTS.

Elisabeth J Martens, M.D., Warandelaan 2, P O Box 90153, LE Tilburg 5000

SUMMARY:

Major depression is a common (20-25%) phenomenon follow-

ing myocardial infarction (MI) and associated with a 2-2.5 increased mortality risk. Several large-scale efforts have therefore been undertaken to treat post-MI depression, either by medication, psychotherapy or combinations in order to counter these effects (e.g. ENRICHD: Glassman et al, JAMA 2004; MIND-IT: Van Melle et al, Brit J Psych 2007). No effects on cardiovascular outcomes have been observed so far. Moreover, the effects of these interventions on the depression outcomes have been modest, and appatently even smaller than what is observed in the general population. Some studies have now shown that non-response to antidepressant treatment is associated with an increased risk of cardiovascular events (Carney et al, Psychosom Med 200x; de Jonge et al, Am J Psych 2007).

The following questions therefore become pertinent:

- Are guidelines for the treatment of depression are applicable to depression or is this a specific condition in need of different interventions

-Do current interventions for depression work for some symptoms only, and specifically those symptoms that may not be cardiotoxic?

-Do the interventions for depression work for subtypes of post-MI depression only, i.e. those subtypes that match depression observed in the general population?

-What other forms of interventions for depression should be considered in treating post-MI depression?

These questions will be addressed using data from MIND-MAPS (Myocardial Infarction and Depression- Mega-analysis of Prospective Studies), a large data set combining most of the recent studies conducted in this field.

NO 28D

HOW WELL DO WE TREAT MDD?

Claudi CLH Bockting, Ph.D., Grote Kruisstraat 2/, Groningen, 9712 TS

SUMMARY:

A recent study demonstrated that the effect size for antidepressant (AD) has been overestimated substantially (one third) due to selective publication (Turner et al., 2008.) The impact of publication bias in general in research will be discussed. Might the effect size of psychological interventions also be exaggerated by selective publication to this extend? Do we have effective treatment of depression at all? What is the impact of trial registration in AD and in psychological intervention trials? Finally, this presentation will focus on the way clinicians should view current guidelines and the efficacy of these treatments (De Jonge, Bockting, NEJM, 2008)?

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SYMPOSIUM 29
BORDERLINE PERSONALITY DISORDER: THE ROLE OF NEUROBIOLOGY AND GENES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the current findings on the role of neuropeptides in borderline personality disorder, in particular how neuropeptides may be related to the interpersonal disturbances experienced by individuals with borderline personality disorder. and 2) Treatment implications should also be understood.

NO 29A

OPIOID RECEPTOR AND OXYTOCIN GENOTYPES IN BPD

Larry J Siever, M.D.,1 Gustave L. Levy Place, Box 1230, New York NY 10029

SUMMARY:

Neuropeptides with activity determined by genetics and environmental stress play a role in separation distress, affiliation, and attachment behaviors, all implicated in borderline personality disorder (BPD). Opioids have been associated with self-injurious behavior, capacity to self-soothe, and separation distress, while oxytocin has been associated with interpersonal affiliation and trust. Polymorphisms for oxytocin and the opioid receptors were hypothesized to be related to the diagnosis of BPD and trait domains of BPD, with interaction of these associations with trauma history. Delta opioid receptor (OPRD1), mu-opioid receptor (OPRM1) and oxytocin SNPs were analyzed in samples from 235 BPD patients, 131 patients with other personality disorders, 155 healthy controls in relation to diagnostic group membership, specific BPD traits, and trauma history. Polymorphisms of the OPRD1 gene showed significant associations with identity disturbance and interaction with a history of trauma, while those of the OPRM1 gene showed significant associations with affective lability with an interaction with history of trauma. A polymorphism in OXT showed significant associations between allelic frequency and affective instability as well as inappropriate, intense anger. These data suggest that polymorphisms in the genotypes for oxytocin and for the opioid receptors may contribute to the affective instability, anger and associated identity and attachment disturbance in BPD and may be amplified by a history of trauma.

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NO 29B

DYSREGULATION OF ENDOGENOUS OPIOID SYSTEM FUNCTION IN BORDERLINE PERSONALITY DISORDER

Jon-Kar Zubieta, M.D., University of Michigan, MBNI, 205 Zina Pitcher Place, Ann Arbor, MI 48109-0720

SUMMARY:

The endogenous opioid system and μ-opioid receptors participate in the regulation of stress responses, with classic analgesic effects (e.g., stress-induced analgesia). Substantial evidence also points to its involvement in emotion regulation and environmental adaptation. For example, positive expectations, such as those introduced during the administration of a placebo, are associated with the activation of μ-opioid receptor mediated neurotransmission. A dysregulation of these mechanisms has been shown in patients diagnosed with Posttraumatic Stress Disorder (PTSD) and Major Depression (MDD).

In healthy controls, we explored whether variations in the baseline concentration of μ-opioid receptors in vivo, as well as the activation of this neurotransmitter system in response to a standardized stressor could be accounted for by impulsivity and emotion dysregulation traits. Receptor availability measures were obtained with PET and the selective μ-opioid receptor radiotracer [11C]carfentanil. Greater impulsiveness trait scores were associated with more pronounced stress-induced opioid system activity and baseline μ-opioid receptor availability in a sample of 44 healthy subjects. These effects were more pronounced in men than in women. In female patients diagnosed with BPD, unmedicated, (n=20) we observed significantly greater regional activation than matched controls (n=18) for this neurotransmitter system during an emotion challenge. These effects were obtained in the subgenual prefrontal cortex, adjacent cingulate gyrus, ventral pallidum and amygdala and were correlated with Barrett Impulsivity scores. These data demonstrate the involvement of the endogenous opioid system in traits relevant to impulse and emotion dysregulation, as well as in BPD, where both these traits form a prominent part of the clinical presentation.

Supported by grants R21 MH 069612, R01 DA 016423 and R01 AT 001415 to J.K.Z. and a Borderline Personality Disorder Research Foundation grant.

NO 29C

PAIN PROCESSING IN BORDERLINE PERSONALITY DISORDER: FUNCTIONAL AND GENETIC APPROACH

Martin Bohus, M.D. Grabengasse 1Heidelberg D69117 Germany

SUMMARY:

Several studies revealed attenuated pain perception in patients with Borderline Personality Disorder (BPD) and current self-injurious behaviour (SIB) (Bohus et al, 2006; Schmahl et al., 2008). Functional MRI studies indicated that affective-motivational and cognitive-evaluative components of the pain processing pathways, mainly the anterior cingulate cortex and the amygdala are altered. Recent research suggests an association between the termination of SIB, decline of psychopathology, and normalization of pain perception in borderline patients (Ludaescher et al., in press). Thus, it remains unclear, whether attenuated pain perception can be seen as an indicator for chronic severe stress, an epiphenomenon of current SIB or an endophenotype marker for BPD.

In order to study the genetic background of altered pain perception in BPD, we investigated a possible influence of a Catechol-O-methyltransferase (COMT) polymorphism (val158met), since this polymorphism is associated with pain regulation in healthy subjects. Twenty four female patients fulfilling DSM-IV criteria for BPD were included in this study. The number of val158 alleles was correlated with the fMRI BOLD response during painful thermal stimulation. The analysis of genotype effects was restricted to brain areas with activation by pain. In insula, dorsolateral prefrontal cortex and midcingulate the number of val158 alleles was positively correlated with the BOLD response.

Conclusions: The val158met polymorphism in the COMT gene contributes significantly to inter-individual differences in neural pain processing in patients with borderline personality disorder.

NO 29D

NEUROBIOLOGY OF SELF INJURY IN BORDERLINE PERSONALITY DISORDER

Barbara H. Stanley, Ph.D., NYSPI Unit 42 1051 Riverside, New York, NY 10024

SUMMARY:

Self injurious behavior, either with or without suicidal intent, is exhibited by a majority of individuals diagnosed with borderline personality disorder. While there has been considerable research on the neurobiology of suicidal behavior, few biological studies have examined suicidality in the context of borderline personality disorder. Even fewer studies have examined the neurobiological underpinnings of non suicidal self injury (NSSI). NSSI usually takes the form of superficial cutting, burning or self-hitting. Patients with BPD typically describe a characteristic pattern associated with NSSI: some form of intolerable emotional distress often in response to an interpersonal rejection or problem; an NSSI episode; and restoration of emotional equilibrium and relief from distress. This pattern is suggestive of an underlying neurobiological response that is occurring during NSSI. This presentation will present data that is supportive of the role of endogenous opioids in NSSI. In contrast to NSSI, the serotonergic dysfunction appears to be involved in suicidal behavior in BPD. Implications for different treatment approaches to NSSI and suicidal behavior will be discussed.

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SYMPOSIUM 30

CURRENT AND FUTURE OF THE EMERGENT FIELD OF THERAPEUTIC BRAINSTIMULATION AND NEUROMODULATION IN PSYCHIATRY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Gain broad knowledge of current issues related to brain-stimulation and neuromodulation; 2) Specifically, participants will learn about the new promising therapeutic tools, some not yet approved by the FDA, for the treatment of various mental illnesses including Anxiety and Mood Disorders and 3) An awareness of these tools and the new field of neuromodulation and brainstimulation in general is essential for contemporary psychiatrists.

NO 30A

NEUROSURGERY FOR OCD: FOCUS ON DEEP BRAIN STIMULATION

Benjamin D. Greenberg, M.D., 345 Blackstone Boulevard, Providence, RI 02906

SUMMARY:

Patients with intractable obsessive-compulsive disorder (OCD) can be candidates for sterotactic ablation or stimulation. Ablation has continued since the 1940s, with incremental advances. Modern psychiatric deep brain stimulation (DBS) began fifty years later, for OCD, in Leuven, Belgium. Ablation was largely developed empirically. DBS was influenced results ablation results and imaging-based pathophysiology models.

DBS has been applied longitudinally along the anterior limb of the internal capsule (ventral capsule of VC) and/or adjacent ventral striatum (VS). Targets include the capsule proper, ventral caudate, and caudal accumbens next to the capsule. Collaborative work with DBS of the VC/VS began in 1998. We found meaningful long-term symptom reductions and functional gains in over 60% of 26 patients. Outcomes improved in successive patients, a "learning curve" that appears primarily due to a refined surgical target. Collaborative studies of STN or ventral caudate stimulation for OCD are also underway. Inferior thalamic peduncle (a more caudal structure continuous with ventral capsule white matter and ventral striatal fibers of passage) DBS for OCD has also been studied. While differences in patient selection and small samples limit comparisons, promising effects have been described at multiple anatomical stimulation sites. This is similar to effects of lesion procedures targeting overlapping and converging circuitry, all of which have been reported to be of benefit for intractable OCD (or depression without OCD). The overall advantages and disadvantages of DBS relative to stereotactic ablation will emerge as data accumulate.

Translational research using anatomical, physiological, and behavioral methods holds promise for this rapidly-developing field. Despite foreseeable technical advances, psychiatric neurosurgery will continue to require interdisciplinary teams expert in and dedicated to long-term management of severely-affected patients.

NO 30B

FEASIBILITY STUDY OF AN IMPLANTABLE CORTICAL STIMULATION SYSTEM FOR PATIENTS WITH MAJOR DEPRESSIVE DISORDER

Darin D Dougherty, M.D., CNY2612, 149 13th Street, Charlestown, MA 02129

SUMMARY:

Introduction: Findings from fluorodeoxyglucose positron emission tomography (FDG-PET) and transcranial magnetic stimulation studies converge to implicate aberrant (hypometabolic) functioning within the left dorsolateral prefrontal cortex (DLPFC) in major depressive disorder (MDD). These findings prompted study of an investigational implantable cortical stimulation (CS) system targeting the left DLPFC.

Methods: After an observation phase (=8 weeks) on stable medication, a gender balanced cohort (aged 48±6 years) of 12 treatment-refractory MDD patients was implanted with an epidural CS system (Northstar Neuroscience, Seattle, WA). Patients were randomized to single blind active or sham stimulation for 8 weeks (primary endpoint), then active stimulation. Efficacy metrics used: Hamilton Depression Rating Scale (HDRS), Montgomery-Asberg Depression Rating Scale (MADRS), Global Assessment Function (GAF). FDG-PET data were also acquired prior to CS and at the primary endpoint.

Results: At baseline: mean HDRS=35.3±5.8; MADRS=32.7±4.6; GAF=42.3±5.8. At Week 8: HDRS decreased by 22% (active; n=6) vs. 3% (sham; n=5); MADRS decreased 22% (active) vs. 8% (sham); GAF increased 23% (active) vs. 12% (sham). At the present time (48-72 weeks of active stimulation) the mean improvement is 37% for HDRS, 38% for MADRS, and 56% for GAF. Three patients are currently in remission. No device-related serious adverse events were observed. PET results show that chronic CS increases metabolism at the left DLPFC target region.

Conclusion: The findings from this first study of a CS system targeting the DLPFC suggest that CS has a positive therapeutic effect in treatment resistant MDD. The present findings await replication and extension. The study is supported by Northstar Neuroscience Inc.

NO 30C

DEEP TRANSCRANIAL MAGNETIC STIMULATION: COMPARISON BETWEEN EFFECTS OF UNILATERAL AND BILATERAL PREFRONTAL CORTEX STIMULATION IN DEPRESSIVE PATIENTS

Abraham Zangen, Ph.D., The Weizmann Institute of Science Rehovot 76100

SUMMARY:

The H-Coils are a new development in transcranial magnetic stimulation (TMS), designed to stimulate deeper neuronal pathways compared to standard TMS. Following our previous study evaluating safety and cognitive effects of the H-coil in healthy volunteers, we studies the safety and antidepressant response induced by repeated, high-frequency TMS treatment using the H-coils over the prefrontal cortex (PFC) of 65 depressive patients who did not respond to previous medications. We compared the effects of three versions of the H-coil designed to stimulate deep PFC regions unilaterally or bilaterally. Antidepressant medication doses were gradually lowered and discontinued 2 weeks prior to TMS treatment initiation and patients were randomly assigned to treatment with one of three H-coil designs (H1/H1L/H2). The H1L coil induces stimulation of the left PFC, while the H2 coil induces bilateral stimulation of the PFC. The H1 coil preferentially stimulate the left PFC, but has some effect on the right PFC as well. Patients received TMS sessions at 20Hz, five days a week, for four weeks. Stimulation with the novel H-coils was well tolerated, with no major side effects or adverse physical outcomes. When using 120% of motor threshold to affect deep PFC regions, response rates (defined as > 50% reduction in HDRS scores) were 50%, 60% and 30%, for the H1, H1L and H2, respectively. On the other hand, when a more superficial stimulation was applied (using the H1L coil at 110% of motor threshold), response rate was 0%. The patients' subjective report using BDI showed a similar pattern of responses. Computerized cognitive tests (CANTAB) also indicated significant improvements induced by deep TMS over the PFC, especially when the higher intensity was used unilaterally. This study is the first evidence for the efficacy and the safety of deep TMS in depressive patients and indicates that high frequency stimulation over the left PFC is more effective then bilateral stimulation.

NO 30D

CURRENT AND FUTURE THERAPEUTIC USES OF RTMS

Mark S. George, M.D., 67 President Street, Room 502, North Charleston, SC 29425-0720

SUMMARY:

Background: Directly stimulating the outer cortex with repetitive transcranial magnetic stimulation (rTMS) as a potential therapy is perhaps the most widely used neuromodulation tool, likely because it is non-invasive, relatively inexpensive, and safe. However, in most diseases there is competing and conflicting information.

Methods: The authors will present an up-to-date critical literature review based on literature searches, and incorporating consensus statements from the WFSBP, the 3rd Gottingen TMS Conference, and a recent summary APPI book. 1

Results: There is class I evidence showing that daily prefrontal rTMS is an antidepressant, however there is a large failed European trial and continued controversy concerning effect size and subject and operator blinding. FDA has not approved this as of Aug, 8, 2008. There is also class I evidence that rTMS can control acute, chronic and post operative pain, and hallucinations in schizophrenia. Interesting studies have also been performed in negative symptom schizophrenia, migraine and tinnitus.

Conclusions: Studies to date show some efficacy of TMS, however many questions remain about its mechanisms of actions and the best ways to apply the technique to maximize efficacy. We will discuss the role of animal models and imaging in devising new treatment approaches.

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NO 30E

CURRENT AND FUTURE OF OTHER BRAINSTIMULATING TECHNIQUES

Alexander Bystritsky, M.D., 300 UCLA Medical Plaza, 2335, Los Angeles, CA 90095

SUMMARY:

Cranial Electrotherapy Stimulation (CES) is a noninvasive procedure that has been used for decades in the United States to treat anxiety, depression, and insomnia in the general population.

Recent studies found that CES significantly reduced the symptom burden of GAD, with a decrease in HARS score similar to that found in clinical psychopharmacology trials and PTSD. We will briefly review recent studies on the efficacy of CES. These preliminary studies should encourage further research to explore the use of CES in clinical settings. We also will review the results of recently conducted study on use of CES within fMRI documenting brain responses to CES.

Focused Ultrasound Pulsation (FUP) is a new technique that is recently proposed for exploration of the brain function and possible therapeutic neuromoducaltion. We will present preliminary results of the feasibility studies conducted in rabbit model using combination of FUP and fMRI. We will also discuss possible future uses of FUP for the diagnosis and treatment of brain related disorders and mental disorders. The possibility of using image guided brainstimulation techniques in psychiatry will also be discussed.

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SYMPOSIUM 31
PEDIATRIC BIPOLAR DISORDER: A CRITICAL LOOK AT AN AMERICAN PHENOMENON.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session participants will be able to; 1) understand the controversies surrounding the PBD diagnosis; 2) have a clear clinical understanding of the differential diagnosis of severe emotion dysregulation in children; 3) understand the contextual factors that have contributed to the increase in the PBD diagnosis and the associated use of medications; 4) consider the pitfalls of using adult disease models in children; and 5) be able to use the methods of bioethics to make clinical decisions in children previously diagnosed with PBD.

NO 31A

AUSTRALIAN & NEW ZEALAND CHILD & ADOLESCENT PSYCHIATRISTS' VIEWS ON BIPOLAR DISORDER PREVALENCE AND ON RATES OF PEDIATRIC BIPOLAR DISORDER IN THE USA

Peter I Parry, M.B.B.S., Marion CAMHS, PO Box 248, Oaklands Park Adelaide 5050 Australia

SUMMARY:

There has been a surge in diagnosis of paediatric bipolar disorder (PBD) in the USA over the past decade, in particular cases of pre-pubertal PBD. This has yet to be generally replicated in Australia or New Zealand.

The aim of this study was to survey the views of members of the Faculty of Child and Adolescent Psychiatry (FCAP) of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) with regards to PBD as to perceived prevalence, diagnostic practice and views as to why the diagnosis may have increased so dramatically in the USA.

A 16 question plus open comments survey was sent to the 328 members of the FCAP of the RANZCP currently based in Australia and NZ.

Results suggest the majority of respondents hold to traditional views that bipolar disorder is very rare in children and uncommon in adolescence. The survey had a 60% (n=199) response rate and most (53%) reported never having diagnosed bipolar disorder in the pre-pubertal age group and a further 29% estimated only ever seeing "1 or 2" cases. Most (83%) rated pre-pubertal cases as "very rare", "rare" or "not diagnosable". In contrast over 96% had diagnosed adolescent cases of bipolar disorder. Opinion varied as to whether PBD was over-diagnosed (24.5%), appropriately diagnosed (42%), or under-diagnosed (28%) in Australia and New Zealand, 5% were unsure. In contrast there was a consensus of views that PBD was over-diagnosed in the USA (90%), whilst less felt it appropriately diagnosed (3%), or under-diagnosed (1%) and 6% were unsure.

Taken in conjuction with results of a similar survey of German child & adolescent psychiatrists and the British National Institute for Health and Clinical Excellence (NICE) guidelines (2006) on Bipolar Disorder, such views support assertions that PBD remains a controversial diagnosis with limited penetration outside the USA.

NO 31B

CHANGING THE TREATMENT CULTURE IN A RESIDENTIAL AGENCY FOR YOUTH: BROADENING THE ROLE OF PSYCHIATRY

Edmund C Levin , M.D., 2424 Dwight Way, #2, Berkeley CA 94704

SUMMARY:

The task of psychiatrists serving youth in residential programs has largely shifted to diagnosis and prescribing medications. The author was able to define his role differently and was able to explore the consequences of emphasizing the role of trauma in determining the thinking, feeling and behavior of children who presented with extreme irritability and marked shifts in moods. Because such rageful children have increasingly been seen as biologically disordered, many have been given the diagnosis of pediatric bipolar disorder and thus are frequently admitted to residential programs on high doses of multiple medications which are drawn from several different classes of psycho-pharmaceuticals. When tapering trials of these medications were first attempted, it was quickly determined that changes in institutional culture, diagnostic understanding and treatment were needed to allow for successful reductions of medications and for effective psychodynamic therapy. The institutional culture was modified as new approaches to staff development, enhanced functioning of the treatment team, new ways of understanding patients and new treatment interventions were developed to facilitate working with children on less or no medication. Ultimately, when team consensus could be obtained, sequential tapering trials of medications were performed. Relevant literature is reviewed and clinical material is used to illustrate the process and consequences of change in the institutional treatment culture. Results: The number of children receiving medication, the amount and number of medications used, and the number of aggressive incident reports fell dramatically over a 2-year period. Manifestations of past trauma, rather than biochemical disorders, became the dominant focus of an analytically informed treatment. Conclusion: Treatments based more on psychodynamic and developmental considerations and less on an exclusive neurobiologic conceptualization can be efficacious.

NO 31C

PEDIATRIC BIPOLAR DISORDER: A DISPASSIONATE REVIEW OF THE LITERATURE

Glen R Elliott, M.D., 650 Clark Way, Palo Alto, CA 94304

SUMMARY:

Over the past 20 years, pediatric bipolar disorder has become a hotly contested topic, especially in the U.S., with published research and clinical opinion offering a potpourri of results about its prevalence, meaning, and appropriate treatment. More conservative approaches have focused on seeking to identify children who have a high likelihood of developing typical signs and symptoms of bipolar disorder as adults. Others have attempted to explore possible overlaps of bipolar disorder with high-prevalence childhood disorders, especially Attention-Deficit/Hyperactivity Disorder (ADHD). Still others have suggested that pediatric bipolar disorder may be the etiologic factor in a wide array of behavioral disturbances in children, including mood lability, impulse dyscontrol, and temperamental fragility. This presentation will review that literature, emphasizing how the different groups interested in this phenomenon have defined their terms and highlighting the relative advantages and limitations of the differing approaches to labeling children with this disorder. Where possible, the review will include published findings about treatment implications and known outcomes.

NO 31D

BIOETHICS AND PEDIATRIC BIPOLAR DISORDER

Mary G Burke, M.D., 1801 Vicente Street, San Francisco, CA 94116

SUMMARY:

"Pediatric Bipolar Disorder" (PBD) has engendered controversy since it was first described. This presentation summarizes the major ethical problems and dilemmas associated with PBD; it recommends the methods of bioethics to clarify both research and clinical questions.

Using a bioethical framework, the presentation reviews the following aspects of PBD: 1) Conflicts of interest and close ties between PBD researchers and the pharmaceutical industry. 2) The narrow focus of academic research on children with severe mood dysregulation, vs. the clinical realities of community populations. 3) Clinical problem-solving. Jonsen's clinical bioethics grid, and Murray's concept of "Mutualism" will be explained. These principles will be applied to clinically derived examples posing specific ethical dilemmas in the treatment of severely disturbed children previously diagnosed with PBD. By the end of the presentation, attendees will be able to use a bioethics framework to make decisions about the treatment of children with severe emotion dysregulation, and more critically assess research publications.

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1) Parry P, Furber G, Allison S: The paediatric bipolar hypothesis: the view from Australia and New Zealand. Child and Adolescent Mental Health 2008 [in press]

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4) Carlson G, Meyer SE: Phenomenology and diagnosis of bipolar disorder in children, adolescents, and adults: complexities and developmental issues. Dev Psychopathol 2006; 18: 939-969.

SYMPOSIUM 32
WORKING WITH LAWYERS

EDUCATIONAL OBJECTIVES:

Because of it's practical sharing of experiences along with analytic, erudite and esoteric ideas, at the conclusion of this session, the participant should have a fairly solid understanding of "the good, the bad, the ugly, the tricky, and the glorious" that can occur when Working With Lawyers.

NO 32A

VALUES OF MEDICINE AND THE LAW

Roger Peele, M.D., P O Box 1040, Rockville, MD 20849-1040

SUMMARY:

The values of the judiciary have a major impact on the values of medicine. Both the judiciary and medicine value a careful, respectful focus on the individual, but their approach to this focus clash. Whereas the judiciary assumes an inherent conflict between the parties in pursuing justice, medicine assumes no inherent conflict in pursuing health. The judiciary pursues its factual determinations formally, adversarially, and with highly rationally rules of evidence, medicine pursues its factual determinations informally, cooperatively, and empirical rules of science. The judiciary's fact determinations are made by laypersons, medicine's fact determinations are made by experts. Judicial decisions as to facts represent the endpoint, are fixed and final. Medicine's decisions as to facts are early, flexible and subject to change. Judiciary's focus in review is on process and scholastically based, medicine's focus in review is on results and empirical based. Judiciary's concern about error is expressed in the thought that better ten persons be found innocent than one person be found guilty. Medicine concern about error is expressed in the thought that better ten people be hospitalized unnecessarily than one die. The judiciary's adopted theories become permanent, medicine's adopted theories are tentative and subject to empirical tests. Judiciary has to assume a free will, to preserve a sense of culpability. Medicine has to assume deterministic models to achieve therapeutic predictability.

NO 32B

BROWNLEE VERSUS ME : A GOOD LAWYER DIRECTS THE PROCESS AND GETS A FAVORABLE SUMMARY JUDGEMENT

Lawrence K Richards, M.D., 714 S. Lynn, Champaign, IL 61820

SUMMARY:

Mr. Brownlee was claiming his constitutional rights to treatment were violated by the California Department of Corrections, and his pleadings laid claim against both psychiatrists and psychologists working for CDC. For reasons never learned, Dr. Richards was listed first amongst these, even though he was not a direct CDC employee as were the others. Therefore the case entered the legal system known as Brownlee v. Richards.

Dr. Richards' best idea as to why it occurred thus was that the prisoner-patient remembered him best of all, even though later psychiatrists with whom Mr. Brownlee had contact were "in charge" of Mr. Brownlee's care for months instead of a few weeks.

Mr. Brownlee was transferred by Dr. Richards from general population to "EOP" for further diagnosis and treatment, (Extended Outpatient status) because of suicidal ideation, and Dr. Richards never saw him again. EOP was 'run' by CDC permanent employees, and was essentially a separate cell block area of another building at this Sacramento area prison for men.

This brief presentation will describe the very thorough steps taken by the malpractice insurance company's lawyer to achieve the Summary Judgment favorable to the defendants, this psychiatrist's reactions and role during this process, and the subsequent story of the appeal by the prisoner, brief as it was.

It should be noted that the private lawyer's case presentation so impressed persons working in the Attny General of California's Office that the state's attorneys did not file a separate defense but 'rode' on the defense set up for Dr. Richards. It should also be noted that the overly aggressive approach taken by Calif's attny's toward Dr. Richards caused him to tell the private malpractice insurance company's attny that he, Dr.Richards, did not want to sign papers attaching his fate to those of CDC employees and to make it clear he did not share the private attny's enthusiasm for joining California's 'case.'

NO 32C

NEW OPPORTUNITIES FOR ATTORNEY/ PSYCHIATRIST COLLABORATIONS

Bruce J. Winick, J.D., Prof. of Law, Psychiatry, and Behavioral Science, U. of Miami, 1311 Miller Drive - Room G476, Coral Gables, FL 33146

SUMMARY:

A number of newly emerging areas for attorney/psychiatrist collaboration are emerging. This presentation examines some of these, all occurring in contexts that arise from the increasing influence of therapeutic jurisprudence (TJ) in lawyering. By stressing the antitherapeutic effects of litigation, TJ has placed new emphasis on the settlement of civil disputes, on alternative dispute resolution mechanisms, and on rehabilitative plea bargaining, community alternatives to corrections, and diversion from the criminal process. Yet, clients frequently suffer from various emotional difficulties and psychiatric syndromes that prevent effective lawyering in these contexts. For example, some clients frequently are too angry with their opponents to view settlement as a viable option. Attorneys increasingly are turning to psychiatrists and other mental health professionals for consultation concerning these issues.

Criminal defense attorneys increasingly are concerning themselves with the rehabilitation of their clients in plea bargaining, sentencing, and diversion from the criminal process. Similarly, a variety of problem-solving court models have emerged in recent years -- Drug treatment, domestic violence, and mental health courts -- in which judges play a significant role in attempting to achieve the rehabilitation of offenders. These attorneys and judges must increasingly deal with individuals suffering from a variety of emotional and psychiatric problems that interfere with effective legal counseling and the judicial facilitation of rehabilitation. These legal actors increasingly are turning to psychiatrists and other mental health professionals for consultation and collaboration.

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NO 32D

BEYOND GET THE MONEY UP FRONT

Thomas G Gutheil, M.D., 6 Wellman Street, Brookline, MA 02446

SUMMARY:

All novice experts are told: when dealing with lawyers, get the money up front; but there is more to this issue. In describing dealing with difficult attorneys, among the many points Dr. Gutheil will cover, a partial list is given here as examples of actual occurrences: a) attempts to change the contract by altering the job description midstream, b) phantom expert phenomena, (using the psychiatrist's name or credentials to intimidate the other side without actually retaining this expert) c) withholding and threatening wherein the expert potential witness is pressured to say what the attorney wants said, d) simple harassment, and e) the "last minute blues" wherein the attorney is asking for expert work in an excessively short-notice manner that interferes with or precludes effective ethical work by the psychiatrist.

Other problems discussed are a) late withdrawal when the psychiatirst has to withdraw well into a case because of unethical behavior by the attroney, and b) humor as a two edged sword.

Solutions for dealing with these problem areas will be suggested by the presenter, including specific contract language, leaving yourself an "escape clause," bringing ethics complaints

against attorneys in a responsible manner, and dealing with actual harassment itself.

A brief real-life video showing further practical illustration of the expert witness responding to problematic cross examination will enhance the attendees understanding of what it's like when Working With Lawyers.

NO 32E

WORKING WITH LAWYERS

Harold I. Eist, M.D., 10436 Snow Point Drive, Bethesda, MD20814

SUMMARY:

Describes experiences with lawyers during 8 years of litigation regarding personal committment to confidentiality, patient rights and quality care. Highlights differences in psychiatrist and lawyer thinking during descent into legal system.

Several phases are described: Attorney education,reversing "Guilty until proven innocent," psychiatrist education, dealing with shock and disillusionment, anger and rage. Personal ups and downs are described: isolation, impotence, fear, guilt and vindication. The presentation's educational efforts will include descriptions of emotional and financial costs if time allows.

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SYMPOSIUM 33
EMPIRICALLY VALIDATED AND EFFECTIVE PSYCHOTHERAPIES FOR BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate the advances that have been made in psychotherapeutic interventions for borderline personality disorder and the range of and differences between those interventions.

NO 33A

EVIDENCE-BASED VERSUS EFFECTIVENESS STUDIES: THE RANDOMIZED CONTROLLED TRIAL AND PSYCHOTHERAPY RESEARCH.

Kenneth R. Silk, M.D., 1500 East Medical Center Drive, F6234 MCHC, Ann Arbor, MI 48109-0295

SUMMARY:

The concept of "Evidence-Based" has become the new catchword in medicine as well as psychiatry. This presentation will serve as a brief introduction to this symposium on empirically validated psychotherapeutic interventions for borderline personality disorder (BPD). The gold standard in clinical trials has often been defined as a double-blind, placebo-controlled, randomized controlled study (RCT). A protocol that follows this particular methodology is difficult to implement in a study of a psychotherapeutic intervention. It is difficult to define and then apply what would be considered "placebo", in such a study. This presentation will also address the differences between "evidence-based" and "effectiveness" studies as well as the consideration of the application of the findings from such studies into clinical practice. Why do results from evidence-based studies not always translate well in terms of effectiveness to the actual, non-research clinical setting? How can we better understand that the statistical significance found in an RCT might not automatically convert into clinical significance? These issues will be touched upon in order to appreciate better the five presentations that will follow.

NO 33B

MENTALIZATION BASED TREATMENT: A DISCUSSION OF THEORY AND EVIDENCE

Anthony W. Bateman, M.R.C., St Ann's Hospital, St Ann's Road, London, N15 3TH UK

SUMMARY:

Mentalization is the process by which we implicitly and explicitly interpret the actions of ourselves and others as meaningful on the basis of intentional mental states (e.g., desires, needs, feelings, beliefs, & reasons). Considerable evidence has been accumulated to suggest that mentalizing develops in the context of early attachment relationships. Maintaining this ability is a core problem for patients with borderline personality disorder (BPD); mentalizing is lost rapidly in the context of emotional states, particularly during interpersonal interactions. Thus in contrast to treatments which consider BPD to be a disorder of affect regulation, or cognitive processes, or schematic representations, the MBT model suggests symptoms are secondary to loss of mentalizing which itself leads to the cardinal symptoms of the disorder – affect dysregulation, impulsivity, cognitive distortions, interpersonal sensitivity. Treatment needs to help patients preserve mentalizing even amidst emotional states and to do so must focus on the patients mentalizing capacities. Other psychotherapies for BPD may work by improving mentalizing capacity but mentalizing based treatment (MBT) is specifically organised and delivered to do so. It has been the subject of randomised controlled trials in the context or a partial hospital programme and as a 'pure' outpatient treatment programme delivered by generic mental health

professionals. Patients have been followed up 8 years following randomisation. Treatment gains were maintained. The intensive out-patient trial will be discussed in which MBT was compared with structured clinical management which offered the best available practice in services within the UK.

NO 33C

TRANSFERENCE-FOCUSED PSYCHOTHERAPY FOR BPD: AIMING FOR CHANGE IN PERSONALITY STRUCTURE

Frank E Yeomans, M.D., 286 Madison Avenue, Penthouse New York NY 10017

SUMMARY:

The RCT of Transference Focused Psychotherapy (TFT) included 90 patients. It compared TFP with Dialectical Behavior Therapy (DBT) and a control condition of manualized Psychodynamic Supportive Psychotherapy (PSP). TFP patients showed improvement in 10 of 12 variables; PSP, improvement in 6 and DBT, 5. TFP and DBT but not PSP resulted in decreased suicidality. Only TFP linked to significant decreases in anger, irritability, and assault. TFP patients were more likely to move from an insecure to a secure attachment with significant increases in reflective functioning. TFP, designed for patients with BPD and other serious personality disorders, is a twice weekly individual therapy based on psychodynamic concepts. It rests upon the idea that mental conflicts play a large role in specific symptom development. TFP places special emphasis on assessment and a treatment contract established with patient collaboration to anticipate likely threats to the patient's well-being and to the treatment. TFP may be combined with medication and other ancillary treatments. TFP explores the psychological structure that underlies specific symptoms of BPD by focusing on the fundamental split that divides in the patient's mind internal representations of self and others into extremes of bad and good. This split determines how the patient perceives and experiences himself and the world around him, supports the patient's chaotic and troubling way of experiencing self, others and the environment, and manifests itself in stormy interpersonal relations and impulsive self-destructive behaviors. Behaviors of BPD pathology are contained through structure and limit setting. Elements of the split psychological structure are observed and analyzed as they unfold in the transference. As the patient better appreciates his internal world, he can begin to understand anxieties that have kept things split off from one another. The goal is to integrate these "splits" into a more coherent sense of self.

NO 33D

DIALECTICAL BEHAVIOR THERAPY FOR COMPLEX, MULTI-DIAGNOSTIC PATIENTS – A REVIEW OF DBT'S EVIDENCE BASE TO DATE

Linda A Dimeff, Ph.D., 2133 Third Avenue, Suite 210, Seattle, WA 98121

SUMMARY:

Developed by Marsha M. Linehan, Ph.D., Dialectical Behavior Therapy (DBT) is an efficacious cognitive-behavioral treatment for multi-diagnostic, difficult-to-treat individuals with borderline personality disorder (BPD). Originally developed for chronically suicidal patients with BPD, it has been applied and adapted to a variety of complex and difficult-to-treat patients in diverse clinical settings. To date, nine published randomized controlled trials (RCTs) conducted across five research institutions support DBT's efficacy for a number of behavioral problems, including suicide attempts and self-injurious behaviors[1-5], substance abuse[6; 7], bulimia[8], binge eating[9], and depression in the elderly[10]. These and other studies have demonstrated the cost-effectiveness of DBT compared to treatment-as-usual (TAU) in reducing hospitalization, emergency room visits, medical severity of suicide attempts, and utilization of crisis/respite beds[11-13].

DBT is a comprehensive treatment program comprised of five essential functions: improving client motivation to change; enhancing client capabilities; generalization of new behaviors; structuring the environment; and enhancing therapist capability and motivation. Fulfillment of these functions is spread among various treatment modes, including individual therapy, group skills training, telephone consultation and therapist consultation meetings. DBT conceptualizes BPD as a pervasive disorder of the emotion regulation system that arises from a transaction between a person's biological vulnerability and an invalidating environment. DBT incorporates the principles of dialectical philosophy, Zen, and behavior therapy.

NO 33E

CBT FOR PERSONALITY DISORDERS (CBT-PD).

Kate M Davidson, Ph.D., Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G120XH UK

SUMMARY:

CBT is an effective treatment for borderline personality disorder (Davidson et al., 2006). Our research group has carried out rigorous evaluation of this therapy, going from single case design series through to a rigorously carried out randomized controlled trial of 106 patients with borderline personality disorder who self harmed. Compared to usual treatment, those who received CBT had significantly less suicidal acts over the one year of active therapy and one year follow-up, less dysfunctional beliefs about self and others and were less anxious and distressed. CBT was less expensive that usual treatment over the two years of the study. Further studies have shown that more skilled and competent therapists produce better patient-related outcomes. The five year follow up of patients treated in the randomised controlled trial will be reported.

The CBT-PD model is biopsychosocial. The therapy is delivered over one year and is structured around a formulation of the individual's dysfunctional core beliefs about self and other, learnt in childhood and adolescence and associated over-developed, now maladaptive, behavioural strategies. More adaptive behaviours and new ways of thinking about self and others are developed through the use of behavioural experiments and cognitive therapy techniques. The therapist style is collaborative. Inter-

personal change is supported by working with significant others where possible.

NO 33E

SCHEMA THERAPY FOR BORDERLINE PERSONALITY DISORDER

Jeffrey E Young, Ph.D., 130 West 42nd Street, Suite 501, New York, NY 10036

SUMMARY:

Schema Therapy (ST) is an integrative treatment, originally developed as an expansion of cognitive behavior therapy for personality disorders. ST also incorporates elements of attachment theory, emotion-focused therapies, and psychodynamic models. The efficacy of ST was demonstrated by a multi-center study in the Netherlands comparing ST with TFP (Transference-Focused Psychotherapy). Full recovery was achieved in 45% of the ST patients (compared to 24% in TFP). The dropout rate was 27% in ST (versus 50% for TFP). At one year follow-up, 70% of the patients in the ST group showed "clinically significant and relevant improvement". A much larger study is underway in the Netherlands now to replicate these findings. Thus far the data are very similar to the findings in the original study. Central to ST is the emphasis on "limited parenting", in which the therapist attempts to gratify the emotional needs that were unmet in childhood within the appropriate boundaries of a therapy relationship. ST focuses on the identification and treatment of 4 "schema modes" that are hypothesized to be central to BPD (the Punitive Parent, Detached Protector, Abandoned & Abused Child, & Angry Child modes). ST shares an emphasis on deep personality change with TFP and mentalization treatment, while incorporating the active, change-oriented stance of cognitive therapy and DBT.

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4) Linhan MM: Cognitive-Behavioral Treatment of Borderline Personality Disorder. Guilford Press, New York, 1993.

5) Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H. et al. (2006). The effectiveness of cognitive behaviour therapy for borderline personality disorder: results from the BOSCOT trial. Journal of Personality Disorders, 20, 450-465.

SYMPOSIUM 34 WITHDRAWN

SYMPOSIUM 35

PTSD AND ALCOHOL USE DISORDER WITH SPECIAL EMPHASIS ON RETURNING VETERANS

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify key treatment needs of patients with PTSD and alcohol use disorder (AUD); 2) Recognize special issues for returning veterans from Iraq and Afghanistan who have PTSD/AUD; and 3) Learn about several major treatment methods for PTSD/AUD patients, including both medications and behavioral therapy.

NO 35A

PSYCHOTHERAPY TREATMENTS FOR PTSD AND ALCOHOL USE DISORDER

Lisa M. Najavits, Ph.D., 150 S. Huntington Avenue, 116-B, Boston, MA 02130

SUMMARY:

Treatment of co-occurring PTSD and alcohol use disorder (AUD) can be challenging. This presentation will summarize psychotherapy models that have been developed for comorbid PTSD and AUD and evaluated in one or more outcome trials. Also, key challenges in the treatment of this population will be described. These include patient readiness and engagement, patient selection, therapist training, how symptom changes in one disorder can impact the other disorder, multiple comorbidities, and systems issues. Emphasis will also be placed on issues related to veterans, given their increasing number in both VA and community-based programs. Future directions for research on psychotherapy of PTSD and AUD wil be highlighted.

NO 35B

NEUROBIOLOGICAL DETERMINANTS OF THE COMORBIDITY OF PTSD AND SUBSTANCE ABUSE

Thomas R Kosten, M.D., Baylor College of Medicine, One Baylor Plaza, Houston, TX 77030

SUMMARY:

Post Traumatic Stress Disorder (PTSD) is relatively common among the casualties returning from Iraqi and Afghanistan (OIF and OEF) and is complicated by high rates of binge drinking leading to poor PTSD rehabilitation (Taft 2007). Returning veterans have been estimated to have rates of up to 25% for PTSD and 20% for severe alcohol abuse or dependence (AAD) (Hoge 2006; Seal 2007; Bray & Hourani 2007). Half of the PTSD cases have AAD, and this comorbidity is associated with more severe PTSD symptoms, higher AAD relapse, more psychosocial and medical problems, and more inpatient hospitalization (Jacobsen 2001).

The neurobiology of this comorbidity involves the locus ceruleus, amygdala, cingulate cortex, nucleus accumbens and ventral tegmental area, and the neurotransmitters noradrenalin (NA), dopamine, GABA, and opiates. We have delineated these pathways through complementary studies using functional MRI, acoustic startle, neuroendocrine assessments and pharmacological probes and treatments. For example, urinary NA levels are elevated during alcohol withdrawal and in PTSD, and NA alpha 1 blockers such as prazosin reduce PTSD symptoms, alcohol withdrawal and AAD relapse (Raskin 2008). Opioid antagonists like naltrexone, which can treat AAD, also reduce PTSD symptoms (Petrakis 2006). Furthermore, the functional mu opiate receptor polymorphism Asn40Asp (OPRM1), which increases OPRM1 receptor sensitivity three-fold, predicts increased cortisol response to opiate blockade and naltrexone efficacy in reducing alcohol relapse (Oslin 2002; Hernandez 2003; Anton 2006; Kreek 2004). Patients who have this polymorphism show large increases in cortisol and beta-endophin levels after alcohol or stress, and this polymorphism may be a risk factor for PTSD. Thus, the neurobiology and genetics of these disorders are converging as factors in their high comorbidity.

NO 35C

PHARMACOTHERAPEUTIC TREATMENT OF PTSD AND CO-OCCURRING ALCOHOL USE DISORDERS

Kathleen Brady, M.D., 171 Ashley Avenue, Charleston, SC 29425

SUMMARY:

A substantial number of individuals with post-traumatic stress disorder also have alcohol use disorders. Comorbidity has a negative impact on course of illness and treatment outcome. In spite of this fact, there has been little systematic exploration of the best approach to pharmacotherapeutic management of individuals with co-occurring PTSD and alcohol use disorders. In this presentation, recent data on the pharmacotherapy of PTSD and alcohol use disorders will be briefly reviewed. Data from a double-blind, placebo-controlled study of sertraline treatment of individuals with PTSD and alcohol dependence demonstrating the efficacy of sertraline in a subset of subjects will be presented. Another study suggesting promising findings with the use of disulfram or naltrexone in alcohol-dependent individuals with PTSD will also be presented. Finally, a promising area for future investigation will be discussed.

NO 35D

OUTCOMES FOR ALCOHOL MISUSING WOMEN WITH PTSD IN THE WOMEN AND TRAUMA MULTISITE STUDY IN NIDA'S CLINICAL TRIALS NETWORK

Denise Hien, Ph.D., North Academic Campus Room 8/213 160 Convent Avenue, New York NY 10031

SUMMARY:

Staggering rates of traumatic stress exposures among women in community substance use treatment reveal a significant need for therapeutic approaches which can be effectively utilized with this population. The Women and Trauma study of the Clinical Trials Network addresses implementing Seeking Safety (Najavits, 1998), an efficacious, integrated cognitive behavioral intervention for women with co-occurring PTSD and substance use disorders (SUD). This paper will examine outcomes for drinkers in the sample, focusing on the relationship between changes in PTSD clusters and alcohol misuse. A total of 353 women were recruited at seven outpatient CTPs across the United States. The study used a randomized, controlled, repeated measures design to assess the effectiveness of Seeking Safety (SS) plus standard substance abuse treatment in comparison to a control treatment (Women's Health Education, WHE) plus standard substance abuse treatment. Participants received an eligibility assessment and a comprehensive baseline assessment and, if eligible, were randomized into SS or WHE in rolling admission groups for 6 weeks (12 sessions) stratified by alcohol use disorders. Follow up assessments were conducted 1-week, 3-, 6-, and 12-months post treatment. Overall findings support the effectiveness of conducting group trauma treatments for women in drug treatment in the reduction of PTSD symptoms. Secondary analyses for this presentation will focus on participants who were alcohol misusing (heavy and binge drinking) and the impact of treatments upon alcohol use outcomes. The relationship between PTSD symptom cluster changes over the course of treatment and alcohol misuse will be presented. Implications will be discussed. Findings support the chronic disease model of addiction and its comorbidity with trauma, as well as more extensive treatment models for patients with PTSD and AODs.

NO 35E

IMPACT OF CHILDHOOD TRAUMA ON HYPOTHALAMIC-PITUITARY-ADRENOCORTICOL (HPA) ACTIVITY IN ALCOHOL DEPENDENT PATIENTS

Ingo Schäfer, M.D., Martini Strasse 52 Hamburg 20246 Germany

SUMMARY:

Background: Studies in both animals and humans suggest that early life stress alters HPA axis activity. On the other hand, such alterations have been related to psychopathology and course of illness in patients with substance abuse. In the present study, we examined relationships between childhood trauma and HPA axis activity in alcohol dependent patients controlling for current psychopathology and characteristics of alcohol abuse.

Methods: Thirty-eight consecutive subjects (42% female, 58% male) with a *DSM-IV* diagnosis of alcohol dependence were examined on day 1 (t1), day 14 (t2) and day 15 (t3) after their admission to a detoxification unit. Morning plasma levels of cortisol and ACTH were determined and a dexamethasone test (DST) was performed. Participants completed measures of anxiety, depression, PTSD, and craving, as well as the Childhood Trauma Questionnaire (CTQ).

Results: Sexual abuse was related to higher levels of cortisol

during acute withdrawal (r=.38, p=.03), and cortisol decreased significantly over time in the trauma group, but not in the non-trauma group. No differences between both groups were observed in the DST. Levels of ACTH were lower in traumatized patients and negatively correlated with the CTQ total score (t1: r=-.42, p<.01), emotional abuse (t1: r=-.33, p=.03; t2: r=-.32, p=.04) and emotional neglect (t1: r=-.39, p=.02; t2: r=-.51, p<.01), even after controlling for current psychopathology and characteristics of alcohol abuse.

Conclusions: Our findings are consistent with the hypothesis, that childhood trauma is related to a blunted ACTH response and increased sensitivity to acute stress in patients with alcohol dependence. They underline the necessity to include early life stress as a potentially confounding variable in studies examining HPA function in patients with substance use disorders, and the need for further research in the clinical consequences of these relationships.

REFERENCES:

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3) Hien DA, al. e. Effectiveness of behavior therapy groups for co-occurring PTSD and substance use disorders: Primary outcomes from the NIDA Clinical Trials Network "Women and Trauma" Multi-site Randomized Control Trial. Journal of Consulting and Clinical Psychology. in press.

4) Schäfer I, Najavits LM. Clinical challenges in the treatment of patients with PTSD and substance abuse. Current Opinion in Psychiatry. 2007;20:614-618.

SYMPOSIUM 36
PSYCHIATRIC PATIENTS OVERCROWDING IN EMERGENCY DEPARTMENTS: A CALL FOR ACTIONS

SUPPORTED BY APA COUNCIL ON HEALTHCARE SYSTEMS AND FINANCING

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify major issues of psychiatric patients and overcrowding in emergency departments; 2) Identify strategies at the local community level to how to address psychiatric crisis management and diversion; 3) Identify possible strategies that can be done at the state and national levels to address psychiatric overcrowding in ED's; and 4) Recognize ways they can mitigate psychiatric crisis in their clinical practice

NO 36A

OVERVIEW OF PSYCHIATRIC PATIENT OVERCROWDING IN EMERGENCY DEPARTMENTS

Scott L Zeller, M.D., 2060 Fairmont Drive, San Leandro, CA 94578

SUMMARY:

Long delays in treatment and overcrowding of acutely mentally ill patients in medical Emergency Departments has become a major concern across the United States, including recent front-page tragedies related to this dilemma. This overview will discuss the evolution of this problem, and will include new data and perspectives from emergency physicians, mental health professionals and health care leaders.

NO 36B

HEALTH CARE DELIVARY SYSTEM INFLUENCES AND IMPACTS- STRATEGIES FOR IMPROVEMENT

Joseph J Parks, M.D., 1706 East Elm Street, PO Box 687, Jefferson City, MO 65102

SUMMARY:

ER overcrowding with "psychiatric patients" is both a symptom and a cause of healthcare delivary system dysfunction. This session will examine Stategies of Healthcare Delivary System change to reduce the causes and address the impact of ER overcrowding by "psychiatric patients". Approaches considered will include policy change, funding opportunities, outpatient MH delivary structures, standards for ER capacity.

NO 36C

INNOVATIVE METHODS TO DECREASE PSYCHIATRIC PATIENT OVERCROWDING OF MEDICAL EMERGENCY DEPARTMENTS

Avrim B Fishkind, M.D., 1611 Missouri Street, Houston, TX 77006

SUMMARY:

The problem of psychiatric patient overcrowding of medical emergency departments often requires local interventions. These interventions include a growing array of interventions as part of a comprehensive program of delivering psychiatric emergency assessment and treatment. Some interventions are well tested such as the use of respite care as an alternative to hospitalization. Others, such as the use of emergency telepsychiatry, are just beginning to be implemented and researched. Finally, funding such interventions requires a strong local buy-in from city and county government. Planning to lobby local government and hospital emergency departments to be partners in solving the overcrowding problem will also be discussed.

NO 36D

BEHAVIORAL HEALTH SERVICE GAPS AND THE ROLE OF EMERGENCY DEPARTMENTS

Alan Q Radke, M.D., 444 Lafayette Road, North St. Paul, MN 55164-0979

SUMMARY:

With the closure of state hospitals a number of behavioral health service gaps have been revealed. It can be argued that these gap patients were being poorly served in the state hospitals. Unfortunately, now they are contributing to the overcrowding of emergency departments.

These gap subpopulations include:

1. Patients with severe mental illness (SMI) and substance use disorders in need of detoxification services.
2. Patients with SMI and a history of violence who have an acute exascerbation of their mental illness and are behaviorally disturbed.
3. Patients with developmental disabilities, traumatic brain injury or other cognitve disorder in need of crisis services.
4. Patients with SMI and chronic medical problems in need of long term care.
5. Patients with SMI and a history of community treatment failures just kicked out of their current residence.

Each of these subpopulations could be served in the community with the proper array of services. The lack of appropriate funding and policies have resulted in limited resources to address theirmyriad of needs. Therefore, patients with these gap conditions end up in crowded emergency rooms (ER). ER staff are not well trained to address these patients and are frustrated by the lack of community alternatives. A revolving door phenomenon occurs perpetuating the problem.

The major purpose of this presentation is to commence a conversation about these gaps and encourage creative thinking about solutions.

REFERENCES:

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4) New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

WEDNESDAY, MAY 20, 2009

2:00PM-5:00PM

SYMPOSIUM 37
DISABILITY REDUCTION AND REHABILITATION OF IRAQI AND AFGHANISTAN WAR VETERANS: THE ROLE OF CIVILIAN MENTAL HEALTH PROVIDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be: 1) More aware of the potential role of civilian mental health workers in reducing disability in veterans of Iraqi and Afghanistan wars; and 2) Informed of special sensitivities, skills, and knowledge to provide services to this subculture.

NO 37A

SUICIDE PREVENTION AMONG RETURNING SOLDIERS OF WAR

Donna H Barnes, Ph.D., 2610 Dawson Avenue, Silver Spring, MD 20902

SUMMARY:

The soldier suicide rate has set a record high for 2008. There needs to be a cultural shift in the military to bring suicide prevention and intervention to the forefront. This paper will outline the problem of suicide and how we can make a difference and decrease the alarming rate of suicides of returning soldiers. Solutions will be outlined as well as a brief overview of how to manage someone in a suicidal crisis.

NO 37B

MEETING THE NEEDS OF POST-DEPLOYMENT SOLDIERS: AN INTERAGENCY APPROACH

James K. Boehnlein, M.D., 3181 SW Sam Jackson Park Road, (UHN80T) Portland, OR 97239

SUMMARY:

Soldiers returning to Oregon from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) face numerous challenges with reintegration to post-deployment life. Difficulties include soldiers resuming their family role, returning to work or school, and planning for the future. This is particularly challenging for soldiers deployed from Oregon who are not active duty military, but rather are members of the National Guard or Reserve, who have faced repeat deployments since 2003.

To address these complex needs, in 2004 the VA Northwest Network Mental Illness Research, Education and Clinical Center (MIRECC) initiated a collaborative effort with the Portland VA Medical Center, Oregon National Guard Reintegration Team, the Department of Defense (DoD), and Oregon state agencies, and this has continued to the present time. Its purpose is to develop and conduct a series of summit meetings and educational interventions to facilitate coordination of health and mental health services, and to enhance education and employment opportunities for soldiers and their families while optimizing access to services and promoting community adjustment. Participating agencies meet on a quarterly basis and education conferences have been held for VA and community mental health and primary care pro-

viders, and soldiers and their families. These meetings address the practical needs of each group, thus facilitating more effective assessment, treatment and healthy reintegration to civilian life.

This presentation will discuss the goals and challenges of this interagency approach. In addition, outcomes will be described that have increased efficiency and decreased duplicate services. Discussions will include: lessons learned from our experiences; suggestions for including soldiers and families as active participants; optimizing collaboration among agencies; and providing effective leadership for development of community education and service interventions.

NO 37C

CIVILIAN ASSESSMENT OF VETERANS OF IRAQI AND AFGHANISTAN WARS

Samuel O Okpaku, M.D., 1233 17th Avenue, Nashville, TN 37212

SUMMARY:

It has been estimated that about 2 million soldiers have been deployed since the beginning of the above wars. Various estimates have been made as to what percentage of these may require psychiatric treatment. A variety of syndromes have been identified as resulting from exposure to combat. Against this background is the fact that the VA and DoD cannot meet all the assessment needs of impaired or potentially impaired veterans. Some responsibility will have to be placed on civilian providers. The assessment by civilian providers is a unique occasion for many veterans, and there are many challenges and opportunities provided. This paper will explore these themes.

NO 37D

PSYCHOLOGICAL EFFECTS OF PERSISTENT CONFLICT: STRATEGIES FOR MITIGATION AND COLLABORATION WITH CIVILIANS

Elspeth C Ritchie, M.D., 5109 Leesburg Pike, Skyline 6, Room 671, Falls Church VA 22041-3258

SUMMARY:

The Army is committed to ensuring all Soldiers and their Families receive the behavioral health care they need. Repeated deployments have led to increased distress and anxiety, and a higher demand for behavioral health services, and are prepared to respond to that demand. An extensive array of behavioral health services has long been available to address the strain on our Soldiers and Families who have experienced multiple deployments. These services include Combat and Operational Stress Control, routine behavioral health care, and suicide prevention. Chaplains, Military One Source, and Army Community Service also offer support. All Soldiers are screened with the Post Deployment Health Assessment (PDHA) and Post Deployment Health Re-assessment (PDHRA) upon return and three to six months after return from deployment. We have new initiatives to provide outreach, education and training, including "Battlemind", updated Combat and Operational Stress Control, and RESPECT-MIL. Nevertheless there are major challenges that will face our Soldiers, their Families and the nation. Collaboration with civilian providers will be essential.

NO 37E

TRAUMATIC BRAIN INJURY, TREATMENT AND REHABILITATION

James R Merikangas, M.D., 4938 Hampden Lane #428, Bethesda MD 20814

SUMMARY:

Traumatic brain injury has been a silent epidemic that has only recently been subject to epdemiological consideration and appreciation as a major form of disability in returning Gulf War Veterans. Three Veterans health centers have been funded by congress in California, New Jersey, and Washington, D.C. these "War Related Injury and Illness Study Centers" are referred veterans who have complicated problems or are refractory to treatment for specialist consultations on an inpatient ward. MRI, PET, EEG, Polysomnography, Autonomic testing and a variety of physical examinations and metabolic measures are combined with neuropsychological testing and psychiatric examination in order to thoroughly evaluate each patient.Results methods will be discussed.

REFERENCES:

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NO 37E

THE WAR ON TERRORISM: RETHINKING SYSTEMS AND SERVICES FOR IRAQ AND AFGHANISTAN COMBAT SOLDIERS AND THEIR FAMILIES

Ron E Armstead, L.C.S.W., 12 Homestead Street, Apt #2, Boston, MA 02121

SUMMARY:

Recent reports on VA health care satisfaction, access and disparities consistent with other national studies showing ethnic minorities disparities; in addition to recent studies documenting substantial mental distress and adjustment difficulties among returnees from Iraq and Afghanistan, as well as family members suggest that although DOD and VA have programs in place, many may in fact be increasingly seeking treatment in the community setting. Thus, community-based initiatives focusing on treatment, service delivery, family services, outreach, clinical services and cultural competence maybe much more applicable for a host of reasons. Clearly problems, needs and gaps in the existing service delivery system warrant much more research, and suggest rethinking is seriously needed!

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SYMPOSIUM 38
IN-RESIDENCY CLINICAL SKILLS ASSESSMENT: TRAINING FOR FACULTY EVALUATORS

SUPPORTED BY APA COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify the core competencies and specific skills evaluated by the Clinical Skills Assessment; 2) Gain understanding of the strengths and limitations of observed clinical skills assessments; 3) Learn the educational rationale for in-residency assessment of clinical skills; 4) Practice observing and rating interviewing skills; and 5) Perform and teach Clinical Skills Assessments in a residency program.

NO 38A

RATIONALE FOR A CHANGE IN THE LIVE-PATIENT EXAM AND PROGRAM REQUIREMENTS FOR THE IN-RESIDENCY CLINICAL SKILLS ASSESSMENT

Sandra B Sexson, M.D., 997 St. Sebastian Way, Augusta, GA 20912

SUMMARY:

Residency training in the United States has experienced a major change in focus over the past decade with the ACGME's focus on definition of and subsequently evaluation of core competencies in each speciality. In psychiatry major core competencies are defined in the resident's ability to establish a relationship with the patient, to conduct a productive interview and mental status examination and then develop an integrated comprehensive presentation of the case. While these competencies have been integral to training in psychiatry, actual assessment of these competenices, identification of residents with problems in these areas, and early intervention to assure that the competencies in these areas have been attained has not been undertaken in a standardized manner across all psychiatry residency training programs. Historically these competencies have been evaluated during one thirty minute examination as a part of the ABPN oral examinations for certification in psychiatry. Over the past decade the ABPN has been concerned that this one time brief examination does not adequately assess these competencies. Additionally, identifying deficiencies at the time of the certification exam after a trainee has completed training does not offer an opportunity for remediation of these skills. Therefore, the ABPN has decided that, beginning with the class of of graduating residents in 2010 training programs must administer clinical skills examinations during training, assessing these competencies. The requirement will be that a resident successfully complete at least three of these assessments during training as one of the credentials to sit for the board examination in psychiatry. The Psychiatry Review Committee has incorporated this requirement as well into the program requirements. This in-training assessment will provide more opportunities to demonstrate this competency in less stressful situations as well as identify need for remediation.

NO 38B

WHAT THE RESEARCH ON DIRECT OBSERVATION OF CLINICAL SKILLS TELLS US

Joan M Anzia, M.D., 1115 Forest Avenue, River Forest, IL 60305

SUMMARY:

A brief review of the history of assessment and evaluation in medical education in the United States will set the stage for this discussion of clinical skills evaluation. Assessment of knowledge from oral exams in the 1950's was followed by multiple-choice question exams in the 1960s and the development of computer testing in the 1980s. The 1990's brought advances in psychometrics and development of OSCEs. Recent drivers of change in medical education include an emphasis on "the end product" rather than process, accountability, and improving the quality of patient care.

NO 38C

CLINICAL SKILLS ASSESSMENT: COMPETENCIES, SKILLS, FORMS, AND ANCHORS POINTS

Richard F Summers, M.D., Office of Education, 3535 Market Street, 2nd Fl, Philadelphia, PA 19104

SUMMARY:

The six core competencies will be reviewed with an emphasis on how they will be manifest in the clinical interview. The possible venues for the clinical skills assessment, format of the assessment, and evaluation will also be presented. We will characterize the range of possible assessment experiences, and make preliminary recommendations about the potential assessment and educational value of these formats.

NO 38D

SETTING UP A CURRICULUM FOR FACULTY ON CLINICAL SKILLS ASSESSMENT

Karen Broquet, M.D., PO Box 19656, Springfield, IL 62794-9656

SUMMARY:

A curriculum designed to train faculty raters in the clinical skills verification examination has been developed. It addresses 5 main areas: 1) ABPN and RRC expectations for in-residency evaluation of clinical skills 2) The How and Why of Direct Clinical Observation 3) Setting the Examination Climate and Giving Feedback 4) Strategies for Conducting a Clinical Skills Verification Examination and Incorporating Clinical Skills Assessment into Daily Teaching and 5) Clinical Skills Examination Performance Parameters. We will present a very brief description of the curriculum, along with a discussion of ways it might be delivered.

REFERENCES:

1) Holmboe, ES. Direct observation by faculty. In Practical Guide to the Evaluation of Clinical Competence (ed. ES Holmboe & RE Hawkins), Mosby, 2008; pp. 119-29.

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SYMPOSIUM 39
INTEGRATING TREATMENT FOR SUBSTANCE USE AND POST-TRAUMATIC STRESS DISORDERS IN PATIENTS WITH CO-OCCURRING CONDITIONS

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this symposium, participants should have increased knowledge of: 1) Prevalence of co-occurring post-traumatic stress disorder (PTSD) and substance use disorders (SUD); 2) Psychotherapy treatment programs developed for patients with co-occurring SUD and PTSD; 3) Pharmacotherapy treatment programs for these patients; and 4) Challenges and opportunities for advancing an integrated medical care approach concurrently treating functional impairments associated with each disorder for substance use and post-traumatic stress disorders in civilian patients with co-occurring conditions.

NO 39A

TREATMENT OF CO-OCCURRING PTSD AND SUBSTANCE USE DISORDERS: EXPOSURE-BASED THERAPY AND MEDICATION MANAGEMENT

Kathleen Brady, M.D., 171 Ashley Avenue, Charleston, SC,29425

SUMMARY:

The treatment of co-occurring PTSD and substance use disorders is under-explored. In terms of psychotherapeutic approaches, there are a substantial number of studies which indicate that exposure-based therapy is efficacious in the treatment of PTSD. However, there has been hesitancy to utilize exposure-based therapy in individuals with co-occurring PTSD and substance use disorders for fear that the painful memories provoked by exposure will lead individuals to relapse. This has not been empirically tested. In this presentation, promising data from several studies exploring the use of exposure-based therapy in individuals with PTSD and a variety of substance use disorders will be presented. Data from a double-blind, placebo-controlled trial of sertraline in the treatment oc co-occurring PTSD and alcohol dependence will also be presented. Promising, future directions for the treatment of co-morbid PTSD and substance use disorders will be discussed.

NO 39B

STEPPED COLLABORATIVE CARE TARGETING PTSD AND CO-OCCURRING SUBSTANCE USE DISORDERS

Douglas F. Zatzick, M.D., 325 9th Avenue, Box 359896, Seattle, WA 98104

SUMMARY:

Background: Although PTSD and related conditions frequently occur among acutely injured trauma survivors, few real-world interventions have targeted these disorders. This presentation will discuss the development and implementation of a randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors with PTSD and co-morbid substance abuse .

Method: A population-based sample of 120 injured surgical inpatients ages 18 or older were recruited from the University of Washington's Harborview level I trauma center. Intervention patients (N=59) received a stepped collaborative care intervention that included: 1) continuous post-injury case management, 2) motivational interviewing targeting alcohol and drug use, and 3) evidence-based pharmacotherapy and/or cognitive behavioral therapy targeting PTSD. Control patients (N=61) received care as usual. PTSD was assessed with the PTSD Checklist 1, 3, 6, and 12-months post-injury and alcohol abuse/dependence was assessed with the CIDI 6 and 12-months post-injury.

Results: Random-coefficient regression analyses demonstrated that over time intervention patients were significantly less symptomatic compared to controls with regard to PTSD ($p < 0.02$) and alcohol abuse/dependence ($p < 0.05$). Intervention patients also demonstrated a non-significant reduction in injury recurrence as documented by automated trauma center health service utilization records (adjusted odds ratio = 0.43, 95% CI = 0.10, 1.96). Early mental health interventions can be feasibly and effectively delivered from trauma centers. Future investigations that refine routine acute care treatment procedures may improve the quality of mental health care for patients injured after individual and mass trauma.

REFERENCE:

1) Zatzick D, Roy-Byrne P, Russo J, et al. A randomized ef-

fectiveness trial of stepped collaborative care for acutely injured trauma survivors. Arch Gen Psychiatry. 2004;61(5):498-506.

NO 39C

SEEKING SAFETY: AN EVIDENCE-BASED MODEL FOR PTSD AND/OR SUBSTANCE ABUSE

Lisa M. Najavits, Ph.D., 150 S. Huntington Avenue, Boston, MA 02130

SUMMARY:

This presentation will provide an overview of Seeking Safety, which is an evidence-based therapy for PTSD and/or substance abuse. It is a present-focused CBT approach offering psychoeducation and coping skills to help patients attain greater safety in their lives. It was designed for flexible use: men or women; group or individual format; open or closed groups; diverse settings (e.g., outpatient, residential); all types of trauma and substances; acute and chronic conditions; and full or subthreshold disorders. There are up to 25 treatment topics, each representing a safe coping skill relevant to both PTSD and SUD, such as "Asking for Help," "Creating Meaning," "Compassion," and "Healing from Anger." Topics can be done in any order and the treatment can be done in few or many sessions as time allows. Seeking Safety strives to build hope through emphasis on ideals; it uses simple, emotionally evocative language and quotations to engage patients; attends to therapist processes; and offers concrete strategies that are believed essential for this population (e.g., case management and a clear session structure). In over 15 published studies that range from pilots through multisite trials, it has shown consistent positive outcomes on a variety of measures, superiority to treatment-as-usual, comparability to a gold standard treatment (relapse prevention), positive results in populations typically considered challenging (homeless, prisoners, adolescents, public sector clients, and veterans), and high acceptability among diverse clients and clinicians. It was designed with a public health focus in that it requires minimal to no training; can be done by any staff person treating patients in a clinical setting; and can be implemented at low cost. It is also has extensive implementation materials and has been translated into various languages. For more information, see www.seekingsafety.org.

NO 39D

INTEGRATING TREATMENT FOR SMOKING CESSATION AND PTSD

Andrew J. Saxon, M.D., VA Medical Center (S-116 ATC), 1660 S. Columbian Way, Seattle, WA 98108

SUMMARY:

Smoking is highly prevalent and refractory among people with posttraumatic stress disorder (PTSD). In a single site pilot study smokers undergoing treatment for PTSD (N=66) were randomly assigned to 1) tobacco use treatment delivered by mental health providers and integrated with psychiatric care (integrated care) versus 2) cessation treatment delivered separately from PTSD care by smoking-cessation specialists (usual standard of care). Integrated care consisted of 5 manualized individual therapy sessions based upon the U.S. Public Health Service Smoking Cessation Guidelines. Seven-day point prevalence abstinence was the primary outcome, measured at 2, 4, 6, and 9 months after random assignment Subjects assigned to integrated care were five times more likely than subjects undergoing the usual standard of care to abstain from smoking across follow-up assessment intervals (odds ratio=5.23). A multisite study with similar design (N=940) is underway using longer follow-up intervals out to 18 months to assess prolonged abstinence from smoking. Baseline data from that study will be presented which look at the relationship between nicotine dependence severity and PTSD symptom severity as well as the relationship between these variables and past history of alcohol, cocaine, or cannabis dependence.

5. PHARMACOLOGIC MANAGEMENT OF PTSD AND COMORBID ALCOHOL DEPENDENCE

Ismene L Petrakis, M.D., 950 Campbell Avenue, 116-A, West Haven, CT 06516

SUMMARY:

The co-morbidity of PTSD and alcohol dependence is associated with more psychosocial and medical problems, more frequent relapses and more serious symptoms than in patients without comorbid disorders. Data from 2 clinical trials will be presented. In the first, individuals with PTSD and alcohol dependence (n=93), who were psychiatrically stable, were randomized to naltrexone or disulfiram alone or in combination for 12 weeks. Outcomes included measures of alcohol use, psychiatric symptoms, alcohol craving and adverse events. Subjects with PTSD had better alcohol outcomes when treated with active medication (naltrexone, disulfiram or the combination) than they did on placebo. Individuals with PTSD were more likely to report some side effects when treated with the combination of medications. The results suggest disulfiram and naltrexone are effective and safe pharmacotherapeutic agents for individuals with PTSD. Data from a second recently completed clinical trial will also be presented. In this study, we compared the reuptake inhibitor (SRI), paroxetine with the noradrenergic reuptake inhibitor desipramine (DMI), in reducing alcohol consumption and attenuating the symptoms of PTSD in patients with PTSD and comorbid alcohol dependence. Further, this study examined whether augmentation with the opioid antagonist naltrexone further reduced alcohol consumption. The primary outcome measures included: alcohol consumption, symptoms of PTSD, self-report craving, and side effects. The preliminary analysis suggests that DMI is equally effective to paroxetine in reducing symptoms of PTSD but there was no advantage to augmentation with naltrexone. These results suggest that a noradrenergic re-uptake inhibitor (DMI) may be as effective as an SRI. Implications and future directions: These studies suggest that in relatively stable patients with PTSD naltrexone and disulfiram may be of clinical utility. In more acute patients, noradrenergic agents may be effective in treating both symptoms of PTSD and alcohol consumption.

NO 39E

INTEGRATED TREATMENT FOR PTSD AND SUBSTANCE USE DISORDERS IN VETERANS

Sonja V. Batten, Ph.D., 1401 Wilson Boulevard, Suite 400, Arlington, VA 22209

SUMMARY:

Significant progress has been made in the past decade to recognize the importance of concurrent treatment for PTSD and substance use disorders, rather than requiring substance abuse treatment to be successfully completed before trauma treatment can begin. However, simply providing concurrent treatment for the two conditions is not sufficient to truly effect change with this complex clinical presentation. A comprehensive, integrated treatment program that has been developed for the treatment of veterans with comorbid PTSD and substance abuse will be presented. This program is based on a conceptualization of this comorbidity that transcends DSM diagnoses, instead conceptualizing both PTSD and substance use disorders as disorders of avoidance. By treating these two problems as different manifestations of the same functional problem, a treatment program can be implemented that targets both issues in a truly integrated fashion. This integrated treatment program is based on principles of Acceptance and Commitment Therapy and focuses on mindfulness and willingness when dealing with difficult emotions, thoughts, sensations, and memories, rather than avoidance or even toleration of these experiences. The treatment program also emphasizes the identification of personal values for each participant, so that individuals can begin taking steps to live a life of meaning. This truly integrated dual diagnosis program will be described, and special considerations for the treatment approach with a veteran population will be discussed.

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1) Fu SS, McFall M, Saxon AJ, Beckham JC, Carmody TP, Baker DG, Joseph AM: Post-traumatic stress disorder and smoking: a systematic review. Nicotine Tob Res 2007; 9(11):1071-1084.

2) Hien DA, Nunes E, Levin FR, Fraser D: Posttraumatic stress disorder and short-term outcome in early methadone treatment. J Subst Abuse Treat 2000; 19(1):31–37.

3) Institute of Medicine: Treatment of Posttraumatic stress disorder: An assessment of the evidence. Washington, DC, Institute of Medicine, 2008.

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SYMPOSIUM 40
IMPULSE CONTROL DISORDERS: RECOGNITION AND CLINICAL MANAGEMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the neurobiology underlyng these disorders; 2) recognize the symptoms of these disorders and their differential diagnoses; and 3) be familiar with both psychotherapeutic and pharmacological treatment strategies for these disorders.

NO 40A

OVERVIEW OF IMPULSE CONTROL DISORDERS AND THEIR NEUROBIOLOGY

Eric Hollander, M.D., One Gustave L. Levy Place, Box 1230, New York, NY 10029

SUMMARY:

There are five current impulsive control disorders (ICD's) not elsewhere classified (pathological gambling, pyromania, trichotillomania, intermittent explosive disorder, and kleptomania), and four additional ICD's not otherwise specified (impulsive-compulsive shopping, sex, internet usage, and skin picking) have been proposed. In the research planning agenda leading to DSM-V, and in the current *DSM-V* deliberations, changes to this group of conditions are expected. The ICD grouping, with the exception of trichotillomania and skin picking, was not felt to be a good fit for the Obsessive Compulsive Spectrum Disorders subgroup of the Anxiety disorders. Some of these conditions (pathological gambling, as well as gaming, internet, sexual, shopping, and eating addictions) might be considered within the broader category of behavioral and substance addictions. These conditions may share some features with regards to phenomenology, comorbidity, family history, and putative neurobiology and brain circuitry. Intermittent explosive disorder might be more appropriately classified with the Cluster B personality disorders characterized by impulsive aggression.

Ventrostriatal (nucleus accumbens) mesolimbic dopaminergic pathways play an important role in both reward seeking behaviors and impairment in reversal learning, which characterize the behavioral and substance addictions. Ventromedial/orbitofrontal serotonergic mediated cortical pathways play an important role in the ability to inhibit such behaviors. These mesolimbic/ventrostriatal and ventromedial/orbitofrontal pathways can be delineated by pharmacological, neurocognitive, and functional imaging methods. Based on this translational approach from animals to humans, new treatments designed to selectively modulate these specific pathways can be developed for the ICD's.

NO 40B

COMPULSIVE SHOPPING DISORDER: A REVIEW ....?

Donald W. Black, M.D., Psychiatry Research MEB, Iowa City, IA 52442

SUMMARY:

Compulsive buying disorder (CBD) is characterized by excessive shopping cognitions and buying behavior that leads to distress or impairment. Found worldwide, the disorder has a lifetime prevalence of 5.8% in the US general population. Most subjects studied clinically are women (~80%), though this gender difference may be artifactual. Subjects with CBD report a preoccupation with shopping, pre-purchase tension or anxiety, and a sense of relief following the purchase. CBD is associated with

significant psychiatric comorbidity, particularly mood and anxiety disorders, substance use disorders, eating disorders, and other disorders of impulse control. The majority of persons with CBD appear to meet criteria for an Axis II disorder, although there is no special "shopping" personality. Compulsive shopping tends to run in families, and these families are filled with mood and substance use disorders. There are no standard treatments. Psychopharmacologic treatment studies are being actively pursued, and group cognitive-behavioral models are promising. Debtors Anonymous, simplicity circles, bibliotherapy, financial counseling, and marital therapy may also play a role in the management of CBD.

NO 40C

UPDATE ON THE CLINICAL FEATURES AND TREATMENT OF KLEPTOMANIA

Jon E. Grant, M.D., Department of Psychiatry, University of Minnesota 2450 Riverside Avenue, Minneapolis MN 55454

SUMMARY:

Kleptomania is a relatively common and often-disabling disorder that shares commonalities with both compulsive and impulsive disorders. This behavior often goes unrecognized in clinical practice, and even when recognized, clinicians are often unaware of treatment options. This presentation will review the clinical features of this behavior, including similarities with OCD and addictive disorders. The presentation will also emphasize recent research findings on effective pharmacologic and psychotherapeutic treatments, and will offer practical advice on how to successfully treat patients with this often difficult-to-treat disorder.

NO 40D

TRICHOTILLOMANIA AND SKIN PICKING - CLINICAL FEATURES AND TREATMENT

Samuel R. Chamberlain, M.D., Box 189, Addenbrooke's Hospital, Cambridge, CB0 0QQ, U.K.

NO 40E

ETIOLOGY, IDENTIFICATION, AND TREATMENT OF PATHOLOGICAL GAMBLING

Marc N Potenza, M.D., 34 Part Street, Room S-104, New Haven, CT 06519

SUMMARY:

Background: Pathological gambling can have tremendous individual, familial and extra-familial impact. Objective: To review a current understanding of the biological, environmental and clinical features associated with pathological gambling, describe current strategies for identifying individuals with the disorder in clinical settings, and communicate empirically validated treatment strategies for people with pathological gambling. Methods: Data from biological (e.g., neurochemical, genetic and brain imaging), clinical and epidemiological studies will be presented. Results: Imaging studies implicate specific brain regions (e.g., ventromedial prefrontal cortex) and neurochemical systems (e.g., serotonin) in the pathophysiology of pathological gambling. Behavioral (e.g., cognitive behavioral therapy) and pharmacological therapies (e.g., opioid antagonists) have demonstrated superiority to placebo in randomized clinical trials. Treatment studies of individuals with pathological gambling and co-occurring disorders are beginning to emerge. Conclusions: Significant progress has been made over the past decade in understanding the basis of pathological gambling and efficacious treatments for the disorder. Early identification of individuals with pathological gambling and effective guidance into treatment settings that employ empirically validated approaches should help improve the lives of individuals suffering from the disorder.

REFERENCES:

1) Hollander E, Stein DJ (Editors): A Clinical Manual of Impulse Control Disorders, Washington, DC: American Psychiatric Publishing, Inc. 2005

2) Grant JE, Potenza MN (Editors): Pathological Gambling: A Clinical Guide to Treatment, Washington, DC: American Psychiatric Publishing, Inc. 2004

3) Black, D.W. (1996). Compulsive buying: a review. Journal of Clinical Psychiatry, 57 Suppl 8, 50-54.

4) Chamberlain SR, Menzies L, Sahakian BJ, Fineberg NALifting the veil on trichotillomania. Am J Psychiatry 2007 Apr;164(4):568-74.

SYMPOSIUM 41
RECENT DEVELOPMENTS IN CROSS-CULTURAL, ETHNIC & ETHNOPSYCHOPHARMACOLOGICAL ASPECTS OF MOOD DISORDERS: A GLOBAL PERSPECTIVE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate that culture and ethnicity significantly influence the manifestation and response to treatment in mood disorders; 2) Understand the principles and application of ethnopsychopharmacology; 3) recognize cross-cultural issues in the psychopharmacological and psychotherapeutic treatment of mood disorders and 4) Obtain a global perspective on certain aspects of mood disorders.

NO 41A

ETHNOPSYCHOPHARMACOLOGY UPDATE

David C Henderson, M.D., Massachusetts General Hospital, 25 Staniford Street, Boston, MA 02114

SUMMARY:

Understanding basic psychopharmacology principles and the impact of race, sex, and culture on metabolism, response, adverse events, medication interactions and medication compliance. Eth-

nopsychopharmacology examines biological and non-biological differences across race, ethnicity, sex and culture and is critical for safe prescribing practices. A growing body of published evidence is documenting important inter- and intra-group differences in how patients from diverse racial and ethnic backgrounds experience health and illness, and is affected by pharmacologic treatment. Recommendations will be provided to improve compliance, reduce adverse events and medication interactions, and to improve clinical outcomes. Depression and anxiety are one of the most common medical/psychiatric disorders and occur across all populations, though symptom clusters may vary greatly. Pharmacologic interventions are critical in the treatment of depression. An expanded understanding of the interactions between psychopharmacological treatment and gender, ethnic and cultural diversity informs conceptualizations of psychopharmacological treatments of various populations. Differences in cytochrome P450 enzymes such as the 2D6, 2A6, 2C9/2C19 metabolism rates and their implications for prescribing psychotropic medications will be reviewed. This lecture will also review principles of ethnopsychopharmacology and highlight issues influenced by race, gender, and culture in the pharmacologic treatment of depressive disorders and anxiety disorders. The role of genetic screening for poor and slow metabolizers will be discussed.

NO 41B

PSYCHIATRIC MANAGEMENT OF HISPANIC PATIENTS: CROSS-CULTURAL ISSUES AND ETHNOPSYCHOPHARMACOLOGY

David Mischoulon, M.D., 50 Staniford Street, Suite 401, Boston MA 02114

SUMMARY:

Increasing numbers of psychiatrists nowadays work with Hispanic patients, either on a regular basis through their outpatient clinic, or by serving as consultants to general internists who are called upon to manage psychiatric disorders in patients seen in the primary care setting. This session will review the demographics of the Hispanic-American population; discuss the different challenges and obstacles faced by clinicians who work with Hispanics, including the language barrier, cultural and interpersonal factors, gender roles, and differing beliefs and attitudes about mental health; review difficulties in diagnosis, including the impact of culture-bound syndromes (such as “ataque de nervios”, and “susto”) on assessment; and review different approaches to treatment, including relevant principles of ethnopsychopharmacology, and the role of natural remedies and folk healing. The topics covered should allow the clinician to effectively diagnose and treat psychiatric disorders in Hispanic patients and communicate more effectively with these patients in the clinical setting.

NO 41C

CULTURALLY SENSITIVE COLLABORATIVE TREATMENT (CSCT) FOR CHINESE AMERICANS WITH DEPRESSION

Albert Yeung, M.D., Suite 401, 50 Staniford Street, Boston, MA 02114

SUMMARY:

This study investigated long-term (12 month) effect of culturally sensitive treatment for depression in Chinese Americans.

The Culturally Sensitive Collaborative Treatment (CSCT) screens primary care patients for depression at a Chinese American clinic, educates and treats them via a bicultural/bilingual psychiatrist. In CSCT, depressive level (Hamilton Rating Scale for Depression, HAM-D) was evaluated at baseline and 6 months (end of treatment) and illness beliefs (Explanatory Model of Interview Catalogue, EMIC) at baseline. This study investigated depressive level and illness beliefs one year post-CSCT. HAM-D scores were compared among baseline, 6 month and follow-up using t-tests. Illness beliefs at baseline and follow-up were compared by chi-square tests with $p<0.05$ considered significant.

45 patients were recruited. HAM-D scores at 6 months and follow-up were significantly lower than baseline. HAM-D scores at 6 month and at follow-up were not significantly different. Comparison of distribution of illness beliefs between baseline and follow-up revealed that in all 5 categories (chief complaint, name of illness, stigma, perceived cause, and most important help sought), there is a significant difference. Reported chief complaints shifted from only psychological/emotional or somatic symptoms to mixed mood-somatic-social. Unfamiliarity of depression dropped coupled with an increase of reported depression and increase in denial of depression. Stigma dropped significantly. Major perceived cause remained psychological stress with a decrease in unknown. Most important help sought changed from primary care to either mental health care or lay help.

Thus, this follow-up study demonstrates that CSCT is effective in treating depressive patients both short-term and long-term. CSCT has also demonstrated the ability to educate patients in recognizing a spectrum of symptoms as depression and may be a solution for reducing undertreatment of depression in ethnic minority immigrants.

NO 41D

MOOD DISORDERS IN THE ASIAN-INDIAN POPULATION: EFFECTS OF CULTURE, GLOBALIZATION & ETHNOPSYCHOPHARMACOLOGY

Rajesh M. Parikh, M.D., Jaslok Hospital and Rssearch Center, 15, Drive. G. Deshmukh Marg, Bombay, 400 026 India

SUMMARY:

The Asian-Indians are a diverse sub-group, with unique cultural norms, family traditions and religious belief systems, which may influence expression of depression and response to treatment. Mental illness is frequently viewed as an embarrassment or stigma and mood disorders are under-diagnosed and under-treated. Family involvement is substantial in all stages of treatment, including interactions with the treating physician and compliance with treatment. Cultural sensitivity is of paramount importance during interactions with patients and their families; this helps assess cultural influences on the illness and facilitate treatment ac-

ceptability and compliance, particularly with antidepressant medications. Herbal remedies and alternative treatments are widely used. Data on ethnopsychopharmacology, although limited, suggest differences in metabolism, dose requirements and adverse event profiles for antidepressant medications in this population. The influence of globalization and suggested modifications for managing depression in the Indian population will be discussed. Findings from cross-cultural studies comparing depression in college students in the India and the U.S. will be discussed.

NO 41E

MOOD DISORDERS IN WOMEN: THE INTERACTION OF CULTURE & BIOPSYCHOSOCIAL FACTORS

Shamsah B. Sonawalla, M.D., Jaslok Hospital & Research Center, 15 DR. G. Deshmukh Marg, Bombay, 400 008 India

SUMMARY:

Hormonal changes associated with a woman's reproductive cycle combined with cultural & biopsychosocial factors increase vulnerability to mood disorders e.g. the premenstrual phase, the postpartum and the perimenopausal period. Up to 80% women experience premenstrual symptoms to some extent. The menstrual phase is viewed differently in different cultures, and the experience of premenstrual symptoms is also affected by culture, in addition to biological and psychological factors. Up to 15% of women experience postpartum depression, a potentially serious condition. Researchers have found a relationship between postpartum depression and factors such as a cultural preference for a male child, lack of social organization of postpartum events and a lack of social recognition of the role transition for the new mother. Menopause is a normal transition in a woman's life; however, every woman's experience with menopause is unique and is influenced by several factors, including culture. Up to 80% of women in western societies suffer from physical and psychological difficulties at menopause. Interestingly, women in some non-western cultures appear to be significantly less affected by menopausal ills, e.g., Rajput women in India, who report minimal or no 'symptoms' of menopause. Studies suggest that women experience greater levels of stress, depression and anxiety when seeking treatment for infertility, which is traditionally viewed as a woman's problem, even if a male factor is responsible for the couple's infertility. Findings from a study on couples undergoing in-vitro fertilization in an assisted reproductive clinic in India will be discussed. The importance of understanding the cultural context and a holistic approach in treating women with mood disorders will be discussed.

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2) Women's Health and Psychiatry Pearson K, Sonawalla SB, Rosenbaum JF, eds. Lippincott, Williams & Wilkins. Philadelphia, 2002

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SYMPOSIUM 42
CHOOSING THE RIGHT TREATMENT FOR SUBSTANCE ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the pro's and con's of various medications as well as behavioral interventions for the various abused substances discussed.

NO42A

CHOOSING THE RIGHT TREATMENT FOR COCAINE DEPENDENCE

Adam Bisaga, M.D., Columbia University/NYSPI, 1051 Riverside Drive, New York, NY 10032

SUMMARY:

Cocaine abuse and dependence remain severe health problems, with treatment difficult, and no commonly accepted pharmacotherapies. A combination of pharmacological, possibly more than one medication, as well as behavioral interventions will likely be required for patients to achieve and maintain abstinence. Several pharmocotherapeutic strategies have been explored or are currently under study. Antidepressants, with desipramine most studied, have yielded inconsistent results. Trials of medications that decrease dopaminergic effects of cocaine, such as neuroleptics have not been successful. However, medications that enhance dopaminergic tone and have stimulant properties such as disulfiram, d-amphetamine, modafinil and levodopa are promising as abstinence-inducing treatments. Medications that indirectly block effects of cocaine by enhancing GABA-ergic neurotransmission such as topiramate, tiagabine, and baclofen appear to have potential as abstinence-maintenance treatments. Strategies to prevent cocaine from entering the brain are also being developed and initial results with a "cocaine vaccine" are promising. A new approach in cocaine treatment trials involves using medications in combination with a specific form of behavioral therapy. For example, addition of dopamine enhancers have increased efficacy of contingency management treatment. Although no single treatment is currently suggested, several treatment combination approaches will be discussed.

NO 42B

CHOOSING TREATMENT FOR CANNABIS DEPENDENCE

Frances R. Levin, M.D., 1051 Riverside Drive, New York City,

NY 07666

SUMMARY:

Cannabis is the most commonly used illicit drug in the United States. Compared to the early 1990's, use did not change in the early 2000's. However, the rates of abuse and dependence have increased, particularly among minority populations. A great deal of work has been completed concerning the basic mechanisms of actions, pharmacology, and neurophysiologic of cannabis. Until recently, it was not commonly recognized that heavy chronic cannabis use leads to a characteristic withdrawal syndrome upon discontinuation of use. Further, withdrawal symptoms may hinder a patient's ability to reduce or cease his/her use. Although there have been several large clinical trials suggesting that various psychotherapeutic treatment approaches may have clinical utility, no one type of psychotherapy has been found to be superior (Nordstrom and Levin, 2007). In addition, there has been a limited number of controlled laboratory and treatment trials that have assessed the efficacy of pharmacologic interventions. At present, agonist and antagonist therapies have shown promise but much more research is needed to help guide clinical practice.

NO 42C

INTEGRATING PSYCHOSOCIAL INTERVENTIONS WITH MEDICATIONS IN THE TREATMENT OF SUBSTANCE DEPENDENCE

Edward V. Nunes, M.D., 1051 Riverside Drive, Unit 51, New York, NY 10032

SUMMARY:

Psychosocial treatment is the cornerstone of treatment for addictions, either alone or in combination with medications. Several types of psychotherapeutic interventions have been developed and studied, including cognitive behavioral skill-building approaches (e.g., relapse prevention, community reinforcement approach, contingency management, motivational enhancement therapy, and 12-Step facilitation). Such interventions have served as means of achieving abstinence, encouraging lifestyle change, and promoting compliance with medications. Despite encouraging findings in treatment outcome research, many challenges remain. Behavioral interventions are not always successful in securing long-term abstinence and commitment to change. Transferring and integrating such treatment models from research to community treatment settings remains a complex task. An overview of these models will be provided, as well as their known efficacy in working with different substances. Obstacles encountered in the delivery of these approaches, the clinical implication of integrating such models, and the efforts to date to generalize research findings to community settings will be addressed.

NO 42D

PAIN AND ADDICTION: IMPLICATIONS OF SUBSTANCE USE DISORDERS FOR OPIOID THERAPY

Maria Sullivan, M.D., 1051 Riverside Drive, Unit 51,New York, NY 10032

SUMMARY:

In the general U.S. population, 50 million people report significant current chronic pain (Rudin 2001). And among primary care patients with chronic lower back pain, lifetime and current prevalence of substance use disorders are 54% and 23% respectively (Brown et al. 1996). Diversion represents a considerable public health risk. The treatment of chronic pain in substance abusers poses a significant clinical challenge. As a set of universal precautions, care providers should obtain informed consent, carry out careful baseline and repeated pain assessments, evaluate psychological and substance use issues, and reach a clear treatment agreement. It is important to distinguish clinically between different causes of opioid misuse in pain treatment (Savage et al. 2008). Stratifying patients into risk categories for addiction liability will make it easier for a clinician to determine individualized treatment strategies, including a specialty care setting when warranted, medication choice and supply, and increased monitoring with frequent visits and toxicology screens. By reviewing the various factors that contribute to the pain experience and assessing for the presence of aberrant behaviors surrounding medication use, chronic pain in substance users may be managed safely, and the risk of opioid misuse can be significantly reduced.

NO 42E

CHOOSING THE RIGHT TREATMENT FOR OPIOID DEPENDENCE

Herbert D. Kleber, M.D., 1051 Riverside Drive, Unit 66, New York, NY 10032

SUMMARY:

Withdrawal from short-acting opioids in an office-based setting is best done using the partial opioid buprenorphine with clonidine supplementation as needed. Inpatient detoxification can be similarly done or using the full agonist methadone instead. Maintenance can be either with methadone or buprenorphine. Each has pro's and con's which will be reviewed. For those not wanting agonist maintenance, the narcotic antagonist, naltrexone, can be used for blockade either in the oral form or off label the 1-month depot injection. Opioid addicts usually poorly accept naltrexone but in selected populations may be the treatment of choice. The good news in treating opioid dependence is that we have a variety of effective pharmacologic choices.

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3) American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Substance Use Disorders. 2nd Edition. H.D. Kleber, Chair, Am J Psychiatry, pp 75-84, April 2007 (supp).

4) Nordstrom, B.R., Levin, F.R.: Treatment of Cannabis Use

Disorders: A review of the Literature. Am J Addictions, 16:331-342, 2007.

SYMPOSIUM 43

SUICIDE AND AGGRESSION: A PRACTICAL TOOLKIT FROM RISK ASSESSMENT TO JOINT COMMISSION TO THE PATIENT

SUPPORTED BY APA COMMITTEE ON PATIENT SAFETY

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Discuss suicide and aggression risk assessment and risk reduction strategies with primary focus on inpatient services; 2) Clinical focus is on suicide and aggression risk assessment and risk reduction, treatment and relapse prevention, guided by the evidence-base and best practices; and 3) Failure Mode and Effect Analysis (FMEA) and other approaches will be reviewed.

NO 43A

FROM RULES TO PROTOCOLS: SUICIDE RISK ASSESSMENT IN EVERYDAY PRACTICE

Geetha Jayaram, M.D., Meyer 4-101, Johns Hopkins Hospital, Baltimore, MD 21287

SUMMARY:

From 2004-2005 the Joint Commission saw a 40% increase in sentinel events involving suicide in health care facilities, with most occurring in behavioral health and acute care hospitals.

Given risk factor data, it would make sense that statistical models employing risk factors could be used to predict suicide probability. Thus far these models have been unsuccessful in accurately using risk factors to predict which patients will commit suicide. Given the low base rates of suicide in the population, using statistical models to accurately predict suicide has been impossible, regardless of the complexity of the model.

It appears clear that, although certain factors are useful to define high-risk populations, they are not always relevant or predictive in personal assessments.

In general however, one can assess risk and protective factors for each patient, assess the environment in which the evaluation takes place, and assign a congruent level of observation to protect the patient. Suicidal patients may change in their behaviour and will need to be reassessed at each shift. Handoffs must be done with care, and in person. Care must be exercised at transitions, and changes in the level of care.

Dr. Jayaram will review a successful model of inpatient care in preventing suicide, using an algorithm to guide the clinician in patient assessment.

Refs:Textbook of Suicide assessment and Management. Robert I.Simon, M.D., and Robert E.Hales, M.D.,M.B.A. American Psychiatric Publishing. Washington DC.2006.

Oquendo MA, Currier D, Mann JJ. Prospective studies of suicidal behavior in major depressive and bipolar disorders: What is the evidence for predictive risk factors? Acta Psychiatr Scan 2006; 114: 151-158.

NO 43B

PRACTICAL APPROACHES TO VIOLENCE RISK ASSESSMENT

Marvin S. Swartz, M.D., Box 3173, Durham, NC 27710

SUMMARY:

There has been a steady proliferation of clinical and actuarial violence risk prediction instruments, but little evidence that busy clinicians employ these tools in everyday practice. Often the information needed for these assessments is not readily available or requires lengthy additional data collection. In public sector settings with diminishing clinical resources and highly prevalent violence risk, the lack of routine use is a particular dilemma. While their routine use is of obvious benefit from a legal risk management perspective, they also have the potential to improve clarity in staff communications about violence risk and improve clinical management. As a result there is a gap between the promise and availability of these tools and their deployment in real world practice settings. This presentation will briefly review the most promising violence risk assessment tools, barriers to their wide-spread adoption and suggest strategies for dissemination and implementation across practice settings.

NO 43C

SAFE-T SUICIDE ASSESSMENT FIVE-STEP EVALUATION AND TRIAGE

Jefferson B Prince, M.D., 55 Fruit Street, Child Psychiatry, Yawkey Building 6900, Boston, MA 02114

SUMMARY:

The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) pocket card provides protocols for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, developing treatment plans and interventions responsive to the risk level of patients. The pocket card includes triage and documentation guidelines for clinicians. Douglas Jacobs, MD originally conceived the model of the SAFE-T pocket card and it was developed through collaboration between Screening for Mental Health, Inc. (SMH) and the Suicide Prevention Resource Center (SPRC). The protocols and guidelines featured on the card were developed based upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors.

NO 43D

SUICIDE RISK MANAGEMENT: RESEARCH AND PRACTICE IN AN INPATIENT DEPARTMENT OF SUICIDE PREVENTION PSYCHIATRIC UNIVERSITY CLINIC SALZBURG – AUSTRIA

Reinhold Fartacek, M.D., Ignaz Harrerstrasse 79 Salzburg, A-5020, Austria

SUMMARY:

Despite a wealth of research, the management of suicide risk remains a challenge. We demonstrate our approach at the Department of Suicide Prevention in Salzburg. The assessment of suicide related risk factors with psychometrically established tools is necessary for risk estimations, but cannot eliminate the often substantial uncertainty. Therefore, besides assessment instruments, we try to counter this uncertainty by considering subjective perspectives of patients, relatives, nurses, psychotherapists, and doctors. This can only be realized within an good therapeutic alliance. Frequent contacts with the patient and regular staff meetings are necessary for a thorough risk assessment, but also for deciding how much risk should be taken, and if this risk is also bearable for patients and staff members in question.

Even when the suicide risk has found to be acute, it remains controversial if hospitalization is beneficial, especially for "chronically" suicidal patients. The debate about the efficacy of hospitalization is not new, however, there is a clear lack of empirical research. One reason for this may be that randomized controlled trials are nearly impossible to realize. To investigate which suicidal patients profit from hospital treatment, we are currently designing a study with a new methodological approach. In addition to pre- and post-measures of suicide related risk factors, we use a nonlinear dynamics approach, i.e., analyzing time series with the "Synergetic Navigation System". This allows us to measure clinically relevant characteristics of the treatment process, for example critical instability of the patient ("system") or coherency of important treatment variables. First results will be presented.

Our model of suicide management includes established assessment procedures and acknowledging the underlying uncertainty about risk assessment and efficacy of inpatient treatment, and we try to gain lacking empirical knowledge with a synergetic approach.

NO 43E

THE JOINT COMMISSION'S VIEW OF THE RESPONSE AND PREVENTION OF SUICIDE AND AGGRESSION

Robert Wise, 1 Renassance Boulevard, Oakbrok Terrace, IL 60181

SUMMARY:

The Joint Commission, through its accreditation requirements, expects an organization to actively reduce the incidence and impact of episodes of suicide and aggression. Multiple Joint Commission requirements speak to this important area of quality and safety of clinical care. These include National Patient Safety Goals and a number of standards related to sentinel events and the preventions of these events through retrospective and prospective activities. This presentation will focus on these requirements and how they can be used to improve the quality and safety of care by improving processes that can reduce and possibly eliminate these events in a healthcare setting.

REFERENCES:

1) Simon RI, Tardiff K, Textbook of Violence Assessment and Management, Washington, DC, American Psychiatric Publishing, 2008

2) Simon RI, Hales RE, Textbook of Suicide Assessment and Management, Washington, DC, American Psychiatric Publishing, 2006

3) Clinical Correlates of Inpatient Suicide, Busch KA, Fawcett J, Jacobs DG Journal of Clinical Psychiatry. 2003;64(1):14-19

4) Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, American Psychiatric Association, 4-5, November 2003

SYMPOSIUM 44

THE ROLE OF FORENSIC PSYCHIATRY IN EVALUATING PROBLEMATIC INTERNET BEHAVIORS-UNTANGLING WEBS OF DECEIT FROM MURDER TO MALPRACTICE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Assess individuals for a potential Internet addiction; 2) Organize a risk assessment of an individual referred for possession of child pornography; 3) Evaluate perpetrators and victims of online bullying; 4) Create an action plan to diminish cyberstalking behaviors; and 5) Evaluate a malpractice claim regarding Internet psychiatric treatment.

NO 44A

FORENSIC ASPECTS OF "INTERNET ADDICTION

Michael Harlow, M.D., 40 Park City Court, #5307, Sacramento, CA 95831

SUMMARY:

Michael Harlow, JD, MD will review the development of the Internet and the pervasiveness of the Internet throughout the world. He will also discuss the concept of "Internet Addiction," categories of Internet addictive behaviors, proposed definitions for this novel "diagnosis," assessment scales for problematic Internet use, and the attempted legal use of "Internet Addiction" as an exculpatory psychiatric diagnosis in criminal trials and in civil litigation. key issues related to cyberstalking to include statutes addressing electronic harassment, methods of cyberstalking, stalker subtypes, important components of the forensic psychiatric assessment, and recommended interventions to address cyberstalking behavior. Charles Scott, MD will discuss emerging trends regarding the provision of mental health care over the Internet. Psychiatric standards of care related to providers who perform Internet assessments and treatment will be highlighted.

NO 44B

PSYCHIATRIC EVALUATIONS OF DEFENDANTS CHARGED WITH INTERNET PORNOGRAPHY

POSSESSION

Humberto D Temporini, M.D., 2230 Stockton Boulevard, 2nd floor, Sacramento, CA 95817

SUMMARY:
Humberto Temporini, MD will review legal issues related to possession of Internet child pornography. Dr. Temporini will discuss the relationship of Pedophilia to the collection of child pornography, the risk assessment of offenders charged with child pornography possession, and the communication of the psychiatric evaluation findings.

NO 44C

THE INTERNET AND CHILD AND ADOLESCENT VICTIMIZATION

Jennifer A. Chaffin, M.D., 2230 Stockton Boulevard, 2nd Floor, Sacramento, CA 95817

SUMMARY:
Jennifer Chaffin, MD will review criminal and civil liability issues related to child and adolescent victimization from Internet harassment and bullying. In addition, Dr. Chaffin will provide information on common websites and communication tools utilized by youth who access the Internet. Dr. Chaffin will discuss important areas to review in the psychiatric evaluations of both juvenile perpetrators and victims of Internet harassment.

NO 44D

THE INTERNET AND CYBERSTALKING

Soroush Mohandessi, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817

SUMMARY:
Soroush Mohandessi, MD will discuss key issues related to cyberstalking to include statutes addressing electronic harassment, methods of cyberstalking, stalker subtypes, important components of the forensic psychiatric assessment, and recommended interventions to address cyberstalking behavior.

NO 44E

MENTAL HEALTH TREATMENT VIA THE INTERNET

Charles Scott , M.D., Chief, Division of Psychiatry and Law, University of California, Davis Medical Center, 2230 Stockton Blvd, 2nd Floor, Sacramento, CA 95817

SUMMARY:
Charles Scott, MD will discuss emerging trends regarding the provision of mental health care over the Internet. In particular, Dr. Scott will review the emerging psychotherapy known as "E-therapy" and advantages and disadvantages Internet psychotherapy. Potential liability issues regarding Internet treatment will be noted to include lack of adequate informed consent, limits of confidentiality, patient abandonment, and legal duties to warn and/or protect third parties. Psychiatric standards of care related to providers who perform Internet assessments and treatment will also be highlighted.

REFERENCES:

1) Deirmenjian JM: Stalking in cyberspace. J Am Acad Psychiatry Law 1999; 27:407-413
2) Mitchell KJ, Finkelhor D, Wolak J: Youth Internet users at risk for the most serious online sexual solicitations. Am J Prev Med 2007; 32:532-537
3) Ng BD, Wiemer-Hastings P: Addiction to the Internet and online gaming. CyberPsychology & Behavior 2005; 8:110-118
4) Williams KR, Guerra NG: Prevalence and predictors of Internet bullying: J Adolesc Health 2007; 41:S14-21

SYMPOSIUM 45
DROP SCHIZOPHRENIA INTERNATIONAL PERSPECTIVES

SUPPORTED BY WORLD PSYCHIATRIC ASSOCIATION'S SECTION ON REHABILITATION AND WORLD ASSOCIATION'S SECTION FOR PSYCHOSOCIAL REHABILITATION

EDUCATIONAL OBJECTIVES:
At the conclusion of this session, the participant should be able to describe the term "schizophrenia" despite the validating International Pilot Sytudy of Schizophrenia and follow-up studies, is viewed as so stigmatizing, inexact, and confusing in different countries that its use has been dropped in Japan and may be elsewhere.

NO 45A

SHOULD WE ABANDON THE TERM SCHIZOPHRENIA AFTER ALL THESE YEARS?

John A Talbott, M.D., 701 West Pratt Street, Room 322, Baltimore, MD 21201

SUMMARY:
While Emile Kraeplin described the disease, it was Eugen Bleuler who coined the term. For almost a hundred years we have used the term despite the fact that laypersons and the press constantly trivialize and misuse it, patients/consumers/victims/ etc insist it is stigmatizing and scientific leaders are sure it is not one but a cluster of disorders. With the process of DSM-V now taking shape, the usefulness of what some called a "label" in the 1960's has resurfaced. This introduction to the debate will review the history of the illness and the name, some reflections on differences in diagnosis between the US and Europe and set the stage for a discussion of the pros and cons of changing the name.

NO 45B

BEYOND THE TERM SCHIZOPHRENIA

Afzal Javed, M.B.B.S., The Medical Centre, Manor Court Avenue, Nuneaton, CV11 5HX U.K.

SUMMARY:

Schizophrenia is one of the most disabling condition of all mental disorders. Due to its chronic and progressing course, schizophrenia assumes an important place in the practice of mental health across all cultures. The use of term "schizophrenia" has however generated a lot of controversies. The professionals views vary and reservations by the patients and their families to use this term have complicated this issue to a large extent.

This paper describes the results of a survey of five groups of psychiatrists (British, Indian, Pakistani and Sri Lankan Psychiatrists working in UK and Psychiatrists working in Pakistan) about their attitude to this term and their practice about telling their patients regarding details of this illness. The results showed that concepts of psychiatrists vary considerably in this regards. Different factors affected their communication like negative outcome of this illness, danger of stigmatisation and non clarity of the term. The paper argues about implications of this issue with some possible future directions in this area.

NO 45C

JAPAN: EXPERIENCE SINCE SCHIZOPHRENIA WAS RENAMED IN 2002

Naotaka Shinfuku, M.D., Sawara-ku, Nishijin,6 Chome 2-92, Fukuoka, 814-8511 Japan

SUMMARY:

In 2002 the Japanese Society of Psychiatry and Neurology changed the name of schizophrenia ("Seishin Bunretsu Byo", literally translated as "mind-split disease") to "Togo Shitcho Sho" ("integration disorder"). The change had been requested by family groups for years, primarily to reduce stigma., which was particularly strong and very negative for the term. Advances in research and new treatment techniques were important in reaching for a different point of view. The Kraeplinian view was replaced by a "vulnerability-stress" model. Japanese treatment guidelines reflecting the new term and new treatments were adopted in 2004. This paper will discuss a) experiences to date with modifications of the model, b) stigma, c) relationships with patients, their families, and family groups, d) the number of psychiatric hospital beds, e) length of stay, f) opinions of psychiatrists and other mental health professionals about the model and communicating with patients, g) educational materials developed by psychiatrists, family associations, and mental health groups, h) ramifications for the legal system and forensic psychiatry, I) any remaining use of the diagnosis "mind-split disease", j) issues of subtypes and different clinical courses, k) research directions, l) other diagnoses of potential concern to patients and their families, and m) whether the Japanese experience might be useful to any other country or culture.

NO 45 D

WESTERN PACIFIC PERSPECTIVES ON SCHIZOPHRENIA

Luis Faustino Ignacio, M.D., PO Box 1312, Chesapeake, VA 23327-1312

SUMMARY:

The author has served frequently as Mental Health Advisor to the Western Pacific Region of the World Health Organization. The fifty-one countries in the region range from China to Palau. and include Japan. The Japanese experience with renaming what was called schizophrenia and British appeals ("dopamine dysregulation disorder") have been closely observed. Stigma and long hospital stays are problems in some countries, such as Korea, and there have been local appeals from families and patients to make a change similar to what was done in Japan. Australian and New Zealand provide strong influences for adopting a dynamic model of psychiatry with treatment in the community involving families and patients as partners. As diagnosis and treatment move closer to the onset of illness, with research on at-risk populations, the term "first break psychosis" has come into use. It is appealing in that the name itself suggests working to prevent a second break. This paper will present a country-by-country review of the twenty most populous countries in the region, especially the status of anti-stigma campaigns and system changes in relation to schizophrenia. There will be a particular focus on changing attitudes in the Philippines, where family, religion and United States influences are strong.

NO 45E

DO WE RE NAME SCHIZOPHRENIA ?

Russell D'Souza, M.D., Northern Hospital, 185 Coopers Street, Epping, Melbourne VA 3073 Australia

SUMMARY:

The current system of psychiatric diagnosis cannot describe definitive disease entities because of our inability to demonstrate "natural" boundaries between disorders. But clinicians have long been aware that diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organising and explaining the complexity of clinical experience in order to derive inferences about outcome and to guide decisions about treatment.

The validity of Schizophrenia as a diagnostic entity has been challenged, and it will be challenged until the cause of the disorder and its precise pathophysiology are known.

A new name for schizophrenia, reflecting a biopsychosocial conceptualization, may have utility in educating patients and the public. If readily translatable, it would be of great value in transcultural psychiatry. It may be clinically beneficial to psychoeducation in evidence-based treatment modalities such as medication management, multifamily group psycho-education and cognitive therapy. By emphasizing the neuropsychiatric basis of this 'highly treatable brain disorder' through its labeling, stigma

may ultimately also be reduced.

Revisions of *DSM* and ICD are forthcoming. Should the old categories of psychotic disorder, in particular the construct of schizophrenia, be retained or is a new system of representation of psychosis in order? It is argued that both scientific and societal developments point to a system of classification combining categorical and dimensional representations of psychosis in *DSM* and ICD.

This presentation will consider these issues and the reports of the Japanese experience of changing the name of schizophrenia it can be argued that a new way of representing this disorder might be beneficial in reducing the stigma of schizophrenia, help seeking and increase case finding that might impact on better outcomes for patients with schizophrenia, achieved from new evidenced based treatments.

NO 45F

SUBTYPES, ELECTROPHYSIOLOGICAL DATA POINT TO SEVERAL DIFFERENT DISEASES

Zebulon Taintor, M.D., 19 East 93rd Street, New York, NY 10128

SUMMARY:

Although Bleuler wrote of the "schizophrenias"and clinical subtypes are recognized in diagnostic manuals, research findings tend to be reported as being about "schizophrenia". Subtypes no longer present as they once did, and have been found to have little treatment or prognostic relevance. Neuroimaging techniques that have been brought to bear on schizophrenia include computerized axial tomography (CAT), magnetic (formerly nuclear) resonance imaging (MRI) and the motion pictures thereof that show activation in response to stimuli (functional magnetic resonance imaging (fMRI), positron emission tomography (PET) and single positron emission computerized tomography (SPECT), and a variety of new techniques, such as diffusion tensor imaging (DTI). As electroencepholgraph (EEG) machines have switched from analog to digital outputs, quantitative (QEEG) statistical manipulations and comparisons with data banks have yielded diagnostic probability statements, factors and dimensions EEG recordings can be sent anywhere electronically. One new project will make analytic software available via the Internet.

Among the issues arising from these techniques is what is normal? Abnormal? Schizophrenia? Are there subtypes of schizophrenia? Should we bother with subtypes of phenomenological diagnoses or proceed to a new diagnostic system based on what seems to be happening in the brain? Outcome studies related to electrophysiological variables have been reported. Effective treatments have been designed based on functional magnetic resonance findings, most notably in dyslexia. Can we hope that new definitions of psychiatric illnesses will result in reducing stigma? How can the developing world take advantage of the new science?

REFERENCES:

1) Hopper K, Harrison G, Janca A, Sartorius N: Recovery From Schizphrenia: AN International Perspective. New York, Oxford, 2007.

2) Fenton WS, NcGlashan T: Natural history of schizophrenia subtypes. I Longitudinal study of paranoid, hebephrenic, and undifferentiated schizophrenia. Archives of General Psychiatry 48(11): 969-77, 1991.

3) Galderisi S, Bucco P, Mucci A, et al: "Simple schizophrenia": a controlled MRI and clinical/neuropsychological study. Psychiatry Research 91(3): 175-184, 1999.

4) First, MB, Pincus HA, Levine JB, et al. Clinical utility as a criterion for revising psychiatric diagnosis. American Journal of Psychiatry, 161(6): 946 - 954, 2004

SYMPOSIUM 46
LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH: FAMILY APPROACHES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Better understand the role of families on the mental health of teens and young adults that identify as lesbian, gay, bisexual or transgender, as well children with gender expression varying from the norm; 2) Research findings and clinical material will provide participants both theoretical underpinnings; 3) Practical ideas to identify cases; 4) Recognize the individual and family dynamics and deliver more effective interventions.

NO 46A

PSYCHOPATHOLOGY AND GENDER VARIANCE IN A CLINICAL SAMPLE OF CHILDREN

Edgardo J Menvielle, M.D., 111 Michigan Avenue, NW, Washington, DC 2001

SUMMARY:

Objectives: This presentation describes the parents of gender variant youth who solicited assistance from a program that provides psychoeducation and peer support and compares the children of these parents to children referred to other gender clinics on the child's degree of gender nonconformity and level of psychopathology, as well as parental attitudes towards gender nonconformity. The relationships among these variables were also tested. Background: GID in children and adolescents and its long term implications are variable and poorly understood. Before the physical and psychological changes of puberty, the long term outcome of childhood gender variance is not clinically ascertainable. Various clinical centers, leaders in the treatment of GID, advocate different treatment approaches (e.g. traditional normalization versus approaches to support stigmatized identity). Some of these centers have reported high levels of psychopathology in the children, but none has so far looked at the relationship between reported psychopathology, degree of gender nonconformity and parental attitudes. Methods: All 43 parents representing 31 children, 23/8 male/female and ranging in age from 4 to 17.5 years, were screened for childhood GID. In addition to a semi-structured interview parents completed several standardized questionnaires. Results: Based on CBCL ratings the study children appear to have the same degree of gender vari-

ance as other centers. While the youth were not rated any less extreme in their gender variance, the parents rated their overall behavior as less pathological on the CBCL. Neither the parents' ratings of gender variance nor the parents' degree of tolerance of gender variance significantly predicted CBCL pathology ratings. Conclusions: Children's Program appears to attract children who are no less gender variant than other centers. The youth in this study were rated as showing less pathological tendencies as compared to reports from other centers. These results suggest that the psychoeducational and peer support model may lessen manifestations of pathology in the child. Given the small scale of the study and some potential confounders, this interpretation should be cautiously applied.

NO 46B

GENDER MADE, GENDER NURTURED, GENDER BENT: THE CHILD SHAPES THE PARENT AS THE PARENT SHAPES THE CHILD IN FAMILIES WITH A GENDER VARIANT CHILD

Diane Ehrensaft, Ph.D., 445 Bellevue Avenue, Suite 302, Oakland, CA 94610

SUMMARY:

Calling on clinical case material including consultations with parents and in-depth psychotherapy with children who go against the grain of culturally prescribed gender norms, this paper will investigate the interpersonal and intrapsychic experiences for family members when a child presents as gender fluid, gender exploratory, transgender, or protogay. The main premise of the presentation is that gender variant children present themselves to their parents rather than being made by them, and that children will shape the parents as well as parents influencing the children. An in-depth study of a single family will be presented along with clinical vignettes or evaluations from other families in the author's clinical practice and reported clinical accounts from other gender specialists. The socialization tasks of the parents will be outlined, along with an analysis of their psychological conflicts as they balance meeting their child's developmental needs against 1) preparing the children for a larger familial and cultural setting that may not welcome them and 2) metabolizing their own internal feelings about their child's gender variance. The parents' tasks will then be matched with the developmental tasks for the child who is growing against the cultural gender grain, and a link will be made between the experience of the parents in inegotiating their conflicts and the outcomes for the children as they sort out their own experience of their non-confroming gender dentity or expression. The main conclusion offered is that, to promote health, it is the parent's role to facilitate the unfolding of a child's authentic gender or sexual expression and identity, with evidence that to do otherwise by trying to adjust or undo a child's expressed gender or sexual self is to put the child at risk for psychological distress and psychiatric disorder.

NO 46C

THREE INTEGRATED FAMILY INTERVENTIONS FOR CHILDREN WITH GENDER-VARIANT BEHAVIORS: FACE-TO-FACE GROUPS, ONLINE DISCUSSIONS AND MULTI-FAMILY GATHERINGS

Catherine L. Tuerk, M.A., 2605 Northanpton Street, NW, Washintgon, DC 200015

SUMMARY:

Traditional approaches to gender variance and Gender Identity Disorder in children have focused on the individual and have largely neglected the family. In this type of approach the child is seen as deviant from normal gender roles and is coaxed to engage in gender conventional behaviors. Our intervention model takes a different stance. First, it conceptualizes variations in gender expression and sexual orientation not as problematic in themselves, but as generating rejection in others due to social convention and prejudice. Second, it privileges the family as the main site of intervention and conceptualizes the problem as relational, that is the parent child relation and the relation between the family, the family social system, and the larger society. Third, it seeks to improve these relationships through creating a support community. My presentation focuses on our Gender and Sexuality Advocacy and Education Program at Children's National Medical Center in Washington, DC. The program, which began in 1998, has a parent support group and a simultaneous social group for children with gender-variant behaviors. In addition to these services, an on-line parent group allows parents to interact and exchange support on an ongoing basis. Currently this group has more than 200 families enrolled. Through the groups, parents share their anxieties, dilemmas and wisdom, as well as resources and strategies for helping their children navigate a world which stigmatizes them. For the past two summers, families have come from all over the country to participate in a weekend family gathering: "Camp I Am". The weekend is organized and run with significant input from the families. The experience has shown to be very powerful for the children because most of them have never met, let alone spent an entire weekend with, peers with similar characteristics and interests. As in other areas of medicine, psychiatry and public health, the support group model, whether face-to-face or online, empowers parents and provides them with knowledge and coping strategies. Our program has integrated various interventions (live group, online group, multi-family gathering) to create a large support community, serve the largest possible number of families and thus maximize the reach and impact of the program.

NO46D

RAISING THE GENDER-VARIANT BOY: A PARENT'S PERSPECTIVE

Sarah Hoffman

SUMMARY:

Reflecting both personal experience and interviews with a wide range of parents, this presentation will explore how parents who accept their son's gender variance navigate a social context that is largely intolerant of femininity in males. It will discuss basic parenting challenges such as finding support, working with medical professionals, and managing family expectations. It will address how parents make gender identity and sexuality understandable

to small children, and how they choose gendered pronouns. It will also examine how parents tackle the social challenges of safety in public, school bullying, and working with schools and other organizations.Sarah Hoffman is the parent of a seven-year-old gender-variant boy and the author of magazine and radio pieces about gender variance.

REFERENCES:

1) Ehrensaft, D: Raising girlyboys: a parent's perspective. Studies in Gender and Sexuality, 2007, 8(3):269- 302

2) Hill D, Menvielle, E: "You Have to Give Them a Place Where They Feel Protected and Safe and Loved": The Views of Parents Who Have Gender Variant Children and Adolescents" accepted for the special double issue, Millennial Teens: International Perspectives on LGBT Youth, in press

3) Ryan C, Huebner D, Diaz RM, Sanchez J: Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay and bisexual young adults. Pediatrics, in press

4) Zucker, KJ & Bradley, SJ: Gender Identity Disorder and psychosexual problems in children and adolescents. New York, NY: Guildford Press, 2004.

SYMPOSIUM 47

PERSONALITY DISORDERS IN THE UNITED STATES: RELATIONSHIP TO EARLY EXPERIENCES, OCCURRENCE AND COURSE OF AXIS I DISORDERS

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Describe the NESARC study of psychiatric and substance use disorders in the U.S. general population; 2) Identify the relationship between childhood maltreatment and personality disorders; and 3) Describe the role of *DSM-IV* personality disorders in the incidence, persistence and recurrence of Axis I disorders including major depression, panic, generalized anxiety and phobic disorders, and alcohol and drug dependence.

NO 47A

RELATIONSHIP OF PERSONALITY DISORDERS TO COURSE OF MOOD AND ANXIETY DISORDERS IN A NATIONAL SAMPLE

Andrew E. Skodol, M.D., 6340 N. Campbell Avenue, Suite 130, Tucson, AZ 85718

SUMMARY:

The purpose of this presentation is to examine the impact of personality disorders (PDs) on the course of mood and anxiety disorders in a large representative sample of 34,653 respondents from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). Associations of *DSM-IV* PDs diagnosed at either of two waves of the NESARC were determined for new onsets (incidence) and persistence or recurrence of major depressive disorder, generalized anxiety disorder, panic disorder, social phobia, and specific phobia over 3 years of prospective follow-up. Significant odds ratios (ORs), controlled for sex, race/ethnicity, age, education, urbanicity, and geographic region, were found for schizotypal, borderline, and narcissistic PDs and incidence of major depressive disorder and for paranoid, schizotypal, borderline, narcissistic, and obsessive-compulsive PDs and incidence of anxiety disorders. For persistence or recurrence over the 3-year follow-up, significant ORs with identical controls were found for borderline PD only and major depressive disorder and for borderline and dependent PDs and panic disorder. Most personality disorders, with the exception of antisocial and schizoid PDs, were significantly associated with persistence or recurrence of generalized anxiety disorder and social and specific phobias. These results support the need for a thorough assessment of personality psychopathology in patients with mood and anxiety disorders to discern elevated risks of new episodes and indicators of poorer prognoses. The broad impact of PDs on the course of different types of mood and anxiety disorders has relevance also for the proposed grouping of disorders into diagnostic spectra in DSM-V. Finally, the impact of PDs on risk and outcome of Axis I disorders has significance for the development of treatments that address chronic problems in psychological and adaptive functioning in order to achieve optimal treatment outcomes.

NO 47B

PERSONALITY DISORDERS: THEIR IMPACT ON THE COURSE OF ALCOHOL AND DRUG DEPENDENCE IN THE U.S. GENERAL POPULATION

Deborah S. Hasin, Ph.D., 1051 Riverside Drive, Box 123, New York NY 10032

SUMMARY:

The purpose of this presentation is to examine the impact of personality disorders (PDs) on the course of alcohol and drug dependence over 3 years of prospective follow-up in the NESARC sample. Specifically, relationships were determined between *DSM-IV* PDs and incidence (new cases between Waves 1 and 2), relapse (recurrence at Wave 2 among those with >1 year of remission at Wave 1) and persistence (full criteria met at Waves 1 and 2) of alcohol and drug dependence. Weighted analyses controlled for sex, race/ethnicity, age, education, urban/rural area, and geographic region. Schizotypal, borderline, and narcissistic PDs predicted incidence of alcohol and drug dependence, while paranoid and histrionic PDs predicted only incidence of alcohol dependence and antisocial, avoidant and dependent PDs predicted only incidence of drug dependence. Baseline, schizotypal, borderline, and narcissistic PDs predicted relapse of alcohol dependence at Wave 2, while antisocial, schizoid and borderline PDs predicted relapse of drug dependence. Persistence of both alcohol and drug dependence was predicted by paranoid, histrionic and narcissistic PDs, while borderline and schizotypal PDs predicted persistence of alcohol dependence and avoidant and dependent PDs predicted persistence of drug dependence. These results suggest that a much broader range of personality psychopathology

is involved with the onset and course of substance dependence than has been previously considered. The impact of diverse PDs on the course of alcohol and drug dependence has relevance for proposed groupings of disorders into diagnostic spectra in *DSM-V*. Finally, the impact of PDs on the course of alcohol and drug dependence has significance for patient assessment, and for the development of treatments that address chronic, potentially overlooked problems in psychological and adaptive functioning that interfere with achieving sustained remission from alcohol and drug dependence.

NO 47C

CHILDHOOD ABUSE AND NEGLECT ASSOCIATED WITH PERSONALITY DISORDERS

Jeffrey Johnson, Ph.D., Box 60, NYSPI, 1051 Riverside Drive, New York, NY 10032

SUMMARY:

A large literature has addressed childhood maltreatment and borderline or antisocial personality disorders, but much less is known about the differential risk that childhood maltreatment poses for the development of other *DSM-IV* personality disorders. Further, such research was never conducted in a nationally representative sample of the U.S. population, and many questions remained unanswered about the associations of specific types of childhood abuse or neglect with specific personality disorders. Therefore, NESARC data were used to investigate the relationship between all10 *DSM-IV* personality disorders and childhood maltreatment in the form of sexual, physical, and emotional abuse; and physical and emotional neglect, assessed with the Childhood Trauma Questionnaire. The effect of each type of maltreatment on each personality disorder was represented by odds ratios (OR) adjusted for age, sex, education, race/ethnicity, urbanicity, region, and the other types of maltreatment. Sexual abuse was significantly associated with all 10 personality disorders (OR=1.56-3.47), as was emotional abuse (OR=1.74-2.69) and emotional neglect (OR=1.22-2.02). Except for avoidant and dependent disorders, physical abuse was associated with all personality disorders (OR=1.60-2.78), and except for dependent and histrionic disorders, physical neglect was associated with all personality disorders (OR=1.54-2.00). While the strength of the associations varied, the findings support the inference that different types of retrospectively reported childhood maltreatment are associated with a broad range of personality disorders rather than one or two particular disorders or disorders from one particular cluster. The findings underscore the importance of taking a broad range of personality disorders into account in examining the adult effects of childhood maltreatment, and suggest that the effects extend far beyond clinical populations.

NO 47D

EMPIRICALLY-DERIVED MENTAL DISORDER SPECTRUMS AND CASE CONCEPTUALIZATION: THE ROLE OF PERSONALITY IN LINKING AXES I AND II

Robert Krueger, Ph.D., Washington University, St. Louis MO 55455

SUMMARY:

Extensive comorbidity among *DSM*-defined mental disorders suggests that these disorders are not entirely separate categories of psychopathology in nature. Rather, it may be more accurate to conceptualize specific mental disorders as distinguishable manifestations of broader and integrative spectrums of psychopathological variation. A now extensive literature on mood, anxiety, substance use, and antisocial behavior disorders shows that these disorders organize empirically into two broad spectrums: internalizing disorders (disorders of emotion dysregulation, encompassing currently-defined mood and anxiety disorders) and externalizing disorders (disorders of impulse dysregulation, encompassing currently-defined substance use and antisocial behavior disorders). This presentation will review the evidence for this spectrum conceptualization and discuss the clinical utility of this model of psychopathology, with a focus on the role of personality dynamics as the core feature of specific psychopathology spectrums (e.g., disinhibitory personality as the psychological core of the externalizing spectrum). Particular attention will be paid to current efforts to elaborate the model by integrating additional forms of psychopathology. For example, this spectrum model implies coherent psychological links between *DSM* Axis I (clinical) and Axis II (personality) disorders because core personality dynamics confer risk for both Axis I and II syndromes. The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) provides the first comprehensive population-based database for extending the model to encompass all *DSM* Axis II disorders, and new data from this survey will be presented.

REFERENCES:

1) Grant BF, Goldstein RB, Chou SP, Huang B, Stinson FS, Dawson DA, Saha TD, Smith SM, Pulay AJ, Pickering RP, Ruan WJ, Compton WM: Sociodemographic and psychopathological predictors of first incidence of DSM-IV substance use, mood and anxiety disorders: results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. Molecular Psychiatry 2008; 13:1-16

2) Skodol AE, Johnson JG, Cohen P, Sneed JR, Crawford TN. Personality disorder and impaired functioning from adolescence to adulthood. Brit J Psychiatry 2007;190:415-420

3) Hasin DS, Stinson FS, Ogburn E, Grant BF. Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch Gen Psychiatry 2007; 64:830-42.

4) Krueger RF: Continuity of Axes I and II: Toward a unified model of personality, personality disorders, and clinical disorders. J Pers Dis 2005; 19: 233-261

SYMPOSIUM S48
SPIRITUALLY INTEGRATED TREATMENT

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize indications, potential benefits, boundary and

ethical challenges of integrating spiritual; and 2) Psychiatric approaches within a variety of therapeutic and faith-based contexts.

NO 48A

THERAPEUTIC USES OF A SHARED TRADITION TO ADDRESS PROBLEMATIC FAITH

Nadine J. Nyhus, M.D., 25 Hyland Road, Guelph, Ontario, N1E 1T2 Canada

SUMMARY:

People of faith are at times reluctant to see a psychiatrist who does not share their faith tradition and/or worldview. They may fear that the therapy could undermine their faith. On the other hand, a therapist may recognize ways that patients' experience of faith threatens to undermine their mental health or impede their emotional healing. While there are potential pitfalls involved in therapy between a therapist and patient who share a faith tradition, their shared faith tradition may provide the patient a safe basis from which to consider and to process faith-related obstacles to emotional healing. This presentation will explore potential ways in which patients' experience of religion -- in their families of origin, in their worshipping communities, and/or in their personal faith journeys -- can shore up denial of pain, increase resistance to processing trauma, erode a sense of self, or validate perfectionistic self-flagellation. Therapeutic use of a shared faith tradition to address these problems will be illustrated by case material drawn from dynamic and cognitive behavioural therapy in a private practice with individuals who have leadership roles in the Christian church.

NO 48B

SPIRITUALLY INTEGRATED TREATMENT

Yousef Abouallaban, M.D., Abu Dhabi, Abu Dhabi 000

SUMMARY:

Muslims' belief s are centrally important in shaping their judgments and in processing information. A clinician's use of religious texts can help them interpret the goals of therapy, understand the roots of their problems, continue with therapy and avoid confusing mental illness with a lack of faith. Koranic and prophetic texts can inspire a desire to change, to regain equilibrium or to achieve health. Such texts can also promote resilience, and positive ways of coping with psychological pain.

Muslim patients may misunderstand mental illness (as weak faith), particularly if cultural barriers to treatment are reinforced by the preaching of traditional leaders. Attempting to treat psychiatric illness in such patients without directly involving religious texts to demystify these issues can lead to early termination of treatment, or to a lack of progress.

This presentation will focus on the Muslim patient's understanding of mental illness and on how Koranic and prophetic texts can be used in therapy. Clinical examples will illustrate differences in treating Muslim patients in the US as compared with those in the Middle East.

NO 48C

MENTAL HEALTH PROMOTION IN THE AFRICAN AMERICAN FAITH COMMUNITY

Michael A. Torres, M.D., Center for the Integration of Spirituality & Mental Health, Inc. 309 N. Charles Street, Second Floor, Baltimore, MD 21201

SUMMARY:

It is well established that African Americans and other ethnic minorities are less likely than whites to seek mental health services. Several studies have indicated that African Americans often seek informal support and counseling from clergy and have high rates of religious participation. It is therefore important to include the faith community in efforts to raise awareness about mental illness, reduce stigma, and address unmet needs.

Since 2001, the Center for the Integration of Spirituality and Mental Health, Inc. has been involved in outreach efforts to African American communities of faith in the Baltimore/ Washington area. This presentation will describe a project that encourages the faith community to observe an "Annual Mental Health Promotion Service" during the weekend leading into Mental Illness Awareness Week in October. The service will include prayers, songs, and sermons that address mental illness and/or promote mental wellness. It may also include the voices of consumers, family members, advocates and providers. Lastly, it will incorporate anonymous screening of anxiety and depression. Any available data from this project at the time of the presentation will be discussed.

NO 48D

SPIRITUAL INTERVENTIONS IN THE TREATMENT OF DEPRESSION

John R. Peteet, M.D., 75 Francis Street, Boston, MA 02115

SUMMARY:

Depressed individuals often suffer existential distress in areas such as identity, hope, meaning/purpose, morality (guilt), and connection to others. Depression may also impair their ability to draw upon spiritual resources. For both theoretical and practical reasons, psychiatrists are often unsure of their role in providing spiritual care alongside psychopharmacologic and psychotherapeutic treatment. After considering the ethical and clinical issues involved in selecting among four possible therapeutic stances toward patients' spiritual concerns, this paper suggests a framework for recognizing and matching interventions with patients' spiritual needs. These needs vary with the diagnosis, which can range from melancholia to "the dark night of the soul".

REFERENCES:

1) Spiritually Oriented Psychotherapy. L. Sperry and E. P. Shafranske. Washington, D.C. , American Psychological Association 105-130.

2) Schultz-Ross, R.A., Gutheil, T.G. Difficulties integrating spirituality into psychotherapy. J Psychotherapy Practice and

Research 1997;6:130-138.
3) Koenig, H. G. (2005). Faith and Mental Health: Religious Resources for Healing. West Conshohocken, PA Templeton Foundation Press.
4) Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as frontline community mental health workers?: a review. J Pastoral Care 49(2): 129-47.

SYMPOSIUM 49
HOW TO APPROACH THE PREGNANT PATIENT FROM A MENTAL HEALTH STANDPOINT

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Diagnose major mental illness in a pregnant patient; 2) Demonstrate proficiency at searching the literature for safety data on medications and treatment options in pregnancy; 3) Recognize the importance of the informed consent process in treatment selection; and 4) Treat pregnant patients should the risks of her illness outweigh the risks of medications, and do so in an ethically and medico-legally sound way.

NO 49A

DIAGNOSIS AND PROGNOSIS OF MOOD DISORDERS DURING PREGNANCY AND THE POSTPARTUM PERIOD

Adele Viguera, M.D., 9500 Euclid Avenue, Desk P57, Cleveland, OH 44195

SUMMARY:

Substantial gaps remain in our knowledge of the course, risk factors, and treatment effects among women with perinatal mood disorders. Screening for major depression or bipolar disorder during pregnancy and the postpartum period is uncommon.

Some studies suggest that pregnancy may be protective against risk of recurrence. However, findings from several recent prospective cohort studies have demonstrated a high risk of morbidity during pregnancy for women with a history of either unipolar or bipolar disorder. In particular, the risk of recurrence was very high (around 70-85%), among women who discontinued maintenance treatments, especially abruptly, during pregnancy. However, the data from these reports suggest that treatment continuation substantially reduced the risk for a mood episode by two-fold or more. During the postpartum period, women are not only at risk for new onset affective disorders and psychosis, but also for recurrence of premorbid unipolar or bipolar disorder. The negative outcomes associated with postpartum illness for both mother and infant has been well established in numerous studies. Therefore, women who present during the antenatal and postnatal period with mood symptoms or a prior history of mood disorders deserve careful evaluation to determine whether these symptoms are (1) normative or pathologic, (2) evidence of new onset of affective disorder, or (3) an exacerbation of a previously diagnosed or undiagnosed depressive or bipolar illness. The objectives of this presentation will be to review a) the challenges in diagnosing mood disorders during pregnancy and the postpartum, b) recent findings quantifying the risk of recurrence during pregnancy among women with unipolar or bipolar disorder, and c) the prognosis for maternal and neonatal outcomes if symptoms are unrecognized and not adequately treated.

NO 49B

PREVENTION AND TREATMENT OF PSYCHIATRIC DISORDERS DURING PREGNANCY

Gail E. Robinson, M.D., Toronto General Hospital, 8-231 EN, 200 Elizabeth Street, Ontario, Toronto, M4W 3M4 Canda

SUMMARY:

Contrary to many people's expectations, pregnancy is not a protected period from a mental health perspective. Women can become depressed, anxious or psychotic during pregnancy. Postpartum is also a period of elevated risk for the development of psychiatric disorders, with women who are psychiatrically ill during pregnancy been more vulnerable to developing problems. The physician may encounter several different types of scenarios: the pregnant patient who becomes ill; a woman with a past history of psychiatric illness who wants to prevent a reoccurrence during pregnancy or postpartum; or a woman already taking psychotropic medication who wonders what to do during pregnancy. This presentation will discuss approaches to these various situations and offer guidelines re how to assess and manage the patient who is or wants to get pregnant. It will explain the use of medication during pregnancy, as well as other approaches to decrease risk of becoming ill during this period. Fortunately, most psychotropic medication appears to be safe for use during pregnancy. All medication use must be evaluated on a risk/benefit ratio, weighing not merely the risk of taking medication but also the risk to the woman and her fetus of not taking medication. A thoughtful and knowledgeable approach can eliminate or reduce the risk of psychiatric illness during pregnancy.

NO 49C

MEDICATING THE DEPRESSED PREGNANT WOMAN: RISK BENEFIT DISCUSSIONS AND THE INFORMED CONSENT PROCESS

Margaret Spinelli, M.D., 1051 Riverside Drive, Box 123, New York, NY 10032

SUMMARY:

It was once thought that women were protected from depression during pregnancy. However, rates of depression in the antenatal period are 14-20%, similar to those in the non-pregnancy state. However, the rate is higher in women with low socioeconomic status and psychosocial stressors. Antepartum depression is one of the best predictors of postpartum depression.

The depressed pregnant women often often has poor appetite, weight loss, insomnia and is less likely to attend to her prenatal

care. Pregnant depressed women are more likely to use nicotine, drugs or alcohol. Furthermore, stress and anxiety can have uncertain effects on the HPA axis, cause increased uterine artery constriction and has even been associated with stillbirth. Untreated bipolar disorder during pregnancy may precipitate a hypomanic, manic or psychotic episode which may place the mother and fetus in danger.

The treatment of the depressed pregnant woman necessitates skilled decision making by a psychiatrist with patient participation in the treatment selection and monitoring. The role of the physician is to inform the patient of the risks and benefits of treatment vs risks of her illness. This informed consent process is essential. While the decision to treat the pregnant woman with psychiatric illness may stir concerns about medico-legal consequences, failure to provide treatment may also result in negative outcome.

The purpose of this presentation is to teach the psychiatrist to guide the patient through a decision-making process toward optimal childbearing outcomes for both the mother and her newborn and to appropriately document the decision making process and treatment plan.

NO 49D

STAYING INFORMED AND AFLOAT: THE IMPORTANCE OF EVIDENCE-BASED CLINICAL PRACTICE IN THE TREATMENT OF MENTALLY ILL PATIENTS DURING AND AFTER PREGNANCY .

Elizabeth M Fitelson, M.D., 710 West 168th Street, 12th Floor, New York, NY 10032

SUMMARY:

A crucial component of providing expert clinical care to pregnant, postpartum and lactating patients is the ability to conduct comprehensive literature reviews and stay up to date with an ever expanding and changing field of medication safety data. Basic skills in performing literature searches on Medline, Embase, Reprotox and other biomedical databases are key to this process, but can be intimidating and daunting to many clinicians. However, honing these basic literature review skills and developing a systematic way to incorporate most current safety data into one's clinical practice is of the utmost importance in delivering informed, thoughtful and safe clinical care to these patients. This presentation will provide an inclusive overview of the leading medication safety databases. During this presentation, we will use a typical case presentation as an opportunity to demonstrate how a clinician might approach the medication safety literature with a specific women's mental health clinical question in mind. By making this literature review process explicit, we hope to disseminate a basic skill set to clinicians and in so doing, encourage more evidenced-based clinical practice.

REFERENCES:

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2) Einarson A, Pistelli A, DeSantis M, Malm H, Paulus WD, Panchaud A, Kennedy D, Einarson TR, Koren G: Evaluation of the risk of congenital cardiovascular defects associated with use of paroxetine during pregnancy. Am J Psychiatry 2008; 165(6):749-752.

3) Flynn HA, Blow FC, Marcus SM: Rates and predictors of depression treatment among pregnant women in hospital-affiliated obstetrics practices. General Hospital Psychiatry 2006; 28(4): 289-329.

4) Misri S, Reebye P, Kendrick K, Carter D, Ryan D, Grunau RE, Oberlander TF: Internalizing behaviors in 4-year-old children exposed in utero to psychotropic medications. Am J Psychiatry 2006; 163(6):1026-1032.

SYMPOSIUM 50
ADVANCES IN ELECTROCONVULSIVE THERAPY

SUPPORTED BY APA CORRESPONDING COMMITTEE ON ECT AND OTHER ELECTROMAGNETIC THERAPIES

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Identify key issues related to the use of ultra-brief pulse ECT; 2) Discuss issues related to the use of bitemporal, bifrontal and right unilateral electrode placement options; 3) Identify approaches for attempting to reduce neurocognitive side effects associated with ECT treatment; and 4) Discuss issues related to the use of continuation ECT and maintaining remission of depressive symptoms.

NO 50A

ULTRA-BRIEF PULSE ECT: EFFICACY AND COGNITIVE IMPACT-FINDINGS FROM THE UNITED STATES

Joan Prudic, M.D., NYSPI, 1051 Riverside Drive, Unit 126, New York, N Y10032

SUMMARY:

Purpose: Cognitive effects limit the use of electroconvulsive therapy (ECT), the most effective treatment for major depression. Manipulations of stimulus characteristics to reduce area of involved tissue and unnecessary electrical dose contributing to those adverse effects, specifically by decreasing the width of the electrical pulse and by using right unilateral electrode placement may decrease cognitive side effects, while preserving efficacy.

Methods: 90 depressed patients were randomly assigned to right unilateral ECT at 6 times seizure threshold or bilateral ECT at 2.5 times seizure threshold, using either a traditional brief pulse (1.5 milliseconds) or an ultrabrief pulse (0.3 millisecond) in a double masked trial design. Depressive symptoms and cognition were assessed before, during, and immediately after ECT. Similar assessments were also performed at 2 and 6 months . Patients who responded were monitored for a 1-year period.

Results: The final remission rate for ultrabrief bilateral ECT was 35%, compared with 73% for ultrabrief unilateral ECT, 65% for standard pulse width bilateral ECT, and 59% for standard pulse width unilateral ECT (all $P < .05$ after covariate adjustment). The

ultrabrief right unilateral group had less severe cognitive side effects than the other three groups in virtually all primary outcome measures assessed in the acute postictal period, and during and immediately after ECT. Both the ultrabrief stimulus and right unilateral electrode placement produced less short- and long-term retrograde amnesia. Patients rated their memory deficits as less severe after ultrabrief right unilateral ECT compared with each of the other three conditions ($P < .001$).

Conclusion: Ultrabrief stimulus markedly reduces adverse cognitive effects, and when coupled with markedly suprathreshold right unilateral ECT, but not bilateral ECT, also preserves efficacy.

NO 50B

ULTRA-BRIEF PULSE ECT: EFFICACY AND COGNITIVE IMPACT - FINDINGS FROM A LARGER CLINICAL SAMPLE (SYDNEY)

Colleen K. Loo, M.B.B.S., St George Hospital, Sydney, WA 2177 Australia

SUMMARY:

This study explored the use of a novel approach, right unilateral ECT with an ultra-brief pulsewidth (0.3ms) (RUL-UB), in comparison with standard right unilateral ECT, comparing efficacy and cognitive outcomes. Formal assessments of mood and neuropsychological functioning over a course of ECT were obtained in over 100 depressed inpatients who received RUL-UB ECT at 6 times seizure threshold, or standard right unilateral ECT (1.0ms pulsewidth) at 5 times seizure threshold. The two groups were equivalent on demographic and clinical characteristics at baseline. Assessments were by a psychologist using a battery of neuropsychological tests and the Montgomery-Asberg depression rating scale, prior to beginning the ECT course, after 6 treatments and at the end of the ECT course. Efficacy was maintained using the ultra-brief pulse width, with equivalent numbers of responders and remitters in both groups. However, the RUL-UB group required more ECT treatments on average than the right unilateral group, suggesting a slower speed of response. Seizure thresholds and initial treatment doses were significantly lower in the RUL-UB group. The results of the cognitive tests showed superior functioning in the RUL-UB group, particularly when patients were required to retain verbal or visual information over a period of delay.

NO 50C

COMPARING BIFRONTAL, BITEMPORAL, AND RIGHT UNILATERAL ELECTRODE PLACEMENT IN ECT: A MULTISITE STUDY FROM THE CONSORTIUM FOR RESEARCH IN ECT (CORE)

Charles Kellner, M.D., Behavioral Health Sciences Building, 183 South Orange Avenue, Floor F, Room 1557, Newark, NJ 07103 - 3620

SUMMARY:

This study was a multicenter, NIMH-funded, randomized, double blind, controlled trial carried out from 2001-2006. 230 acutely depressed patients, both bipolar and unipolar, were randomly assigned using a permuted block randomization scheme to one of three electrode placements during an acute course of ECT: bifrontal (BF) at 1.5 times seizure threshold (ST), bitemporal (BT) at 1.5 times ST, and right unilateral

(RUL) at 6 times ST. Patients were treated until they achieved pre-specified remission criteria and then were followed naturalistically for two months. A comprehensive neurocognitive battery was performed at baseline, after the fourth ECT, after the last ECT, and at 1 week and 2 months after the last ECT. We found no statistical evidence to suggest differences in efficacy between the three electrode placements. All three electrode placements resulted in both clinically and statistically significant antidepressant outcomes. Our cognitive data revealed few differences between the electrode placements on a variety of neuropsychological instruments.

NO 50D

AN UPDATE ON CONTINATION-ECT

Husain Mustafa, M.D., The University of Texas, Southwestern Medical Center at Dallas, Department of Psychiatry, 5323 Harry Hines Boulevard, DallasTX75390

SUMMARY:

ECT is effective Acute treatment for major depression, however Relapse post Acute-ECT is significant. To assess strategy for relapse prevention a multicenter, randomized, parallel design six-month, federally funded trial (CORE) was conducted.

Two hundred and one patients with SCID diagnosed unipolar depression who had remitted with a acute course of bilateral ECT were randomized to two treatment groups receiving either C-ECT (=10 treatments) or nortriptyline plus lithium for six months.

In both treatment groups, 46% remained remitted at study end; for the C-ECT group, 37% relapsed and 17% dropped out compared to 32% and 22% respectively in the C-Pharm group ($p=0.59$). Regression analyses indicated no statistically significant differences in overall survival curves and time to relapse for the groups.

In conclusions we found no statistical evidence that one treatment (continuation ECT or nortriptyline/lithium) is superior to the other.

Future studies are needed for relapse prevention post Acute phase ECT.

REFERENCES:

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Fink M,Taylor MA: Electroconvulsive therapy: evidence and challenges. JAMA 2007; 298:330-332
4) Continuation ECT versus Pharmacotherapy for Relapse Prevention in Major Depression: a multi-site study from CORE* Charles H. Kellner, MD, Rebecca G. Knapp, PhD, George Petrides*, MD, Teresa A. Rummans*, MD, Mustafa M. Husain*, MD, Keith Rasmussen*, MD, Martina Mueller, PhD, Hilary J. Bernstein, DHA, Kevin O'Connor, MD, Glenn Smith, PhD, Melanie Biggs, PhD, Samuel H. Bailine, MD, Chitra Malur, MD, Eunsil Yim, MS, Shirlene Sampson, MD, Max Fink, MD; for the CORE** group

SYMPOSIUM 51
INTEGRATED TREATMENT OF PERSONALITY DISORDER: PRINCIPLES AND TECHNIQUE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the rationale for an integrated approach to treating personality disorder; and 2) Deliver an eclectic array of treatment methods in an integrated and coordinated way.

NO 51A

PRINCIPLES FOR ORGANIZING INTEGRATED TREATMENT FOR PERSONALITY DISORDER

John Livesley, M.D., 2255 Wesbrook Mall, Vancouver, V64 1L1Canada

SUMMARY:

This presentation describes a framework for an integrated approach to the treatment of personality disorder in which interventions selected from different treatment models are delivered in a coordinated way. Integrated treatment is proposed as the optimal approach to treating personality disorder because outcome does not differ substantially across treatments. This suggests that rather than selecting among treatments, it would be more effective to combine effective components of each form of therapy. The challenge of such an eclectic approach is how to combine different treatment methods. Two strategies are proposed. First, treatment is organized around generic interventions common to all effective treatments. Interventions selected from the different forms of therapy are added to this structure as needed to tailor therapy to the problems of individual patients and match the flow of the patient's concerns and the progress being made. Second, evidence of changeability of personality pathology is used to conceptualize treatment in terms of five phases, each addressing a different domain of psychopathology. The initial phases of safety and containment are primarily concerned with crisis management. This largely involves the use of generic supportive interventions and medication to reduce symptomatic distress. As crises resolve, attention focuses of increasing control and regulation of affects and impulses. This usually requires the addition of cognitive-behavioral interventions to build emotional control and reduce self-harm. Gradually, treatment moves to the exploration and change of underlying emotional-cognitive structures. Here, cognitive methods often need to be supplemented with psychodynamic and interpersonal interventions. Finally, treatment moves to the integration and synthesis of a more adaptive sense of self – a phase that requires a wide array of methods to help the individual to construct a sense of identity.

NO 51B

TAILORING COMMON TREATMENT PRINCIPLES TO FIT INDIVIDUAL PERSONALITIES

Kenneth L. Critchfield, Ph.D., University Neuropsychiatric Institute, IRT Clinic, Suite 1648, 501 Chipeta Way, Salt Lake City, UT 84108

SUMMARY:

A recent American Psychological Association Task Force headed by Castonguay & Beutler (2006) distilled the general treatment principles common to all therapies from the empirical literature for depression, anxiety, substance use, and personality disorders (PD). Critchfield & Benjamin (2006) summarized these principles as they apply to personality disorder based on available research. Effective treatments were associated with a positive therapy relationship, transparency about treatment tasks and goals, direct focus on presenting concerns, balance of validation with motivation for change, and therapist access to peer supports. These principles are pragmatic in that they are based on evidence of "what works" rather than a speculative theory of psychopathology or putative mechanisms of change. The application of these principles to the treatment of personality disorder will be discussed. Rather than offering a fixed set of procedures, the approach encourages clinicians to apply these empirically-derived principles in whatever way seems most appropriate to treat the unique constellation of comorbid diagnoses and interpersonal challenges presented by a given patient. The approach will be illustrated with case examples treated with Interpersonal Reconstructive Therapy (IRT: Benjamin, 2003), an integrative approach guided by an underlying, attachment-based theory of psychopathology. Treatment goals are specified in terms of patterns of relating with self and others. A case formulation is used to tailor understanding of presenting problems, current circumstances, and patient reactions in light of patterns learned in key attachment relationships. Specific techniques are chosen from diverse schools based on the case formulation and phase in treatment.

NO 51C

AN INTEGRATED VIEW OF THERAPY TECHNIQUES

FOR PERSONALITY DISORDERS

John F Clarkin, Ph.D., New York Presbyterian Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:

Patients suffering from personality disorders have as central issues distorted representations of self and others, and behavioral disruptions in relationships with others. The various schools of therapy (e.g., cognitive behavioral, emotional expressive, pyschodynamic) have generated a range of therapeutic techniques to address these treatment issues. In this presentation, a method of integrating a range of techniques will be offered, using as organizing principles the nature of the patient's difficulties, the foci of change, and the course of treatment. The integration of techniques tailored to the individual patient optimizes the possibility of patient change.

NO 51D

INTEGRATED TREATMENT FOR PERSONALITY DISORDER WITH PROMINENT INHIBITED/ CONSTRICTED TRAITS

Giuseppe Giancarlo Dimaggio, M.D., Via Ravenna, 9/c, Rome, 00161, Italy

SUMMARY:

Evidence suggests that when treating personality disorder (PD) psychotherapists need to be empathetic, maintain ongoing assessment of the case being treated, and make an explicit contract with patients if they are to be effective. We operationalize a step-by-step procedure for delivering effective interventions intended to increase the patients' understanding of mental states, improving access to emotions, build adaptive constructions of the self and reduce symptoms. We illustrate this approach with discussion of PD with inhibited/constricted traits. A first range of interventions (stage-setting) draws patients' attention to inner states. When patients cannot describe feelings, therapists migth focus on the patient's bodily signals and then propose that those could be signs of affective experience, in order to create a shared emotional language. Stage-setting is successfully completed when patients have told detailed self-narratives, containing clear descriptions of patients' ideas and emotions and of the flow of relationships with significant others.

Before passing to interventions aimed at promoting change, therapists need to be aware of the quality of the therapy relationship and repair ruptures. Therapists avoid forcing patients to talk about topics patients are not willing to. Therapists search instead for areas of joint interest in which patients might accept to engage in a discourse focused on mental states.

Anyway alliance ruptures are the rule and therapists work at repairing them, i.e. self-disclosing and acknowledging own's contribution to problems.

If quality of the relationship is good and stage-setting is completed, does interventions focus on change by attempting to: promote fantasy/reality distinction; enrich the patient's personality repertoire, and encouraging attempts to exercise adaptive parts of the self; constructing alternative readings of others' minds, and recognizing that one's actions impact on others; acknowledging self-serving biases.

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4) Dimaggio G, Semerari A, Carcione A, Nicolò G, Procacci M: Psychotherapy of Personality Disorders: Metacognition, States of Mind and Interpersonal Cycles. London, Routledge, 2007

SYMPOSIUM 52
ME-TOO MEDICATIONS, REALLY

SUPPORTED BY APA COUNCIL ON GLOBAL PSYCHIATRY AND THE APA COUNCIL ON CHILDREN, ADOLESCENTS, AND THEIR

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate the relative value of therapeutic compounds with similar molecular structures.

NO 52A

BARRIERS TO INNOVATION IN PSYCHOPHARMACOLOGY OF SCHIZOPHRENIA

William T. Carpenter, M.D., PO Box 21247, Baltimore, MD 21228

SUMMARY:

Chlorpromazine initiated effective pharmacotherapy of persons with schizophrenia. For 50 years the FDA has approved drugs for schizophrenia with the same therapeutic mechanism. Second generation antipsychotic drugs provide neither a substantial advance in efficacy nor novel mechanism. No drug has documented efficacy for impaired cognition or negative symptoms.

A limitation to rational drug discovery is the lack of specific knowledge regarding the molecular pathology. This presentation will focus on two other barriers to therapeutic innovations: a] the ease of discovery and profit associated with marketing of "me-too" drugs, and b] using psychosis as a proxy for schizophrenia.

Schizophrenia is a heterogeneous clinical syndrome. Psychotic symptoms are common to all cases, but not unique to this disorder. Kraepelin considered avolition a core feature, and this is now elaborated as the negative symptom construct. Cognition

impairments are common, and recent studies have shown a robust relationship with functional outcomes. These core features have been neglected in drug discovery. However, a consensus has now developed that these two pathological domains are critical therapeutic targets. The FDA recognizes this consensus and has agreed on methods that exclude pseudo-specificity as appropriate for an indication for cognition or for negative symptom efficacy. The result is a substantial increase in novel mechanism drug discovery.

Domains of psychopathology may be used as phenotypes in developing animal models to predict a drug's effect in humans. The clinician will also give emphasis to these domains, as novel drugs for each condition become available. *DSM-V* may advance this conceptual framework if dimensions are added to diagnostic classes that represent the pathologies that require therapeutic attention.

NO 52B

DIAGNOSIS AND TREATMENT OF BIPOLAR DISORDER

Frederick Goodwin, M.D., 5712 Warwick Place, Chevy Chase, MD 20815

SUMMARY:

Dr. Goodwin addresses the most recent polemics about the diagnosis and treatment of bipolar disorder. He proposes several ways out of the current confusion.

NO 52C

PHARMACOLOGY LEADING TO THE CURRENT DEBATES ABOUT OLD AND NEW PSYCHOTROPICS

Alan F. Schatzberg, M.D., 401 Quarry Road, Stanford, CA 94305-5717

SUMMARY:

Dr. Schatzberg presents an overview of recent developments in pharmacology leading to the current debates about old and new psychotropics.

NO 52D

CONCEPT OF ME-TOO MEDICATIONS ON PUBLIC POLICIES

Roger Peele, M.D., P O Box 1040, Rockville, MD 20849-1040

SUMMARY:

The concept of "me-too" medications can have a huge impact on access to treatment. If the concept is granted, then the rationales to limit medication choice in the public and private sector is potentially enormous. Further, the me-too concept was apparently adopted by the FDA last year [2008] with the Vanda Pharmaceutical's application for approval of iloperidone as an antipsychotic. To avoid medications that could be of use to some patients not being available, it is essential that the APA work with the AMA to clarify the potential harm of this concept.

NO 52E

PHARMACOLOGIC TREATMENT OF DEPRESSION

Jan Fawcett, M.D. University of New Mexico School of Medicine Department of Psychiatrymcs, Albuquerque, NM 87131

SUMMARY:

Dr. Fawcett outlines the history of pharmacologic treatment of depression. Drugs that are used less often are still effective. Compounds that have recently come to the market are discussed.

REFERENCES:

1) Chandrani, G. and Tanzer A. Patent Play, Forbes September17, 2001

2) Adams, C.FDA Inundated Trying to Asses Drug Ad Piches. Wall Street Journal, March 14, 2002

3) Relman, A.S. and Angell, M. America's Other Drug Problem. New Republic, December 16, 2002

4) DHHS, OIG Compliance Program Guidance 23738

SYMPOSIUM 53
END OF LIFE CARE: A MULTIDISCIPLINARY CLINICAL AND RESEARCH UPDATE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the biopsychosocial components of quality end of life care.

NO 53A

PSYCHIATRY AND PALLIATIVE MEDICINE COLLABORATION AT THE END OF LIFE

Michael W. Rabow, M.D., 1701 Divisadero Street, #500, San Francisco, CA 94143-1732

SUMMARY:

For patients at the end of life, underlying mental illness my be exacerbated and new psychiatric distress may develop. Physical symptoms (including pain), emotional upset, interpersonal strain, and existential suffering all may combine to create very complex psychiatric and palliative care needs among patients facing either terminal or life-limiting chronic illness. Strategies for interdisciplinary collaboration between psychiatrists and palliative medicine experts will be discussed, including the appropriate role of each specialist in both identifying and treating mental illness. A special emphasis will be placed on efficient and logical psychopharmacologic management of conditions including depression, anxiety, and sleep disorders, as well as the symptoms of pain, fatigue, and nausea/vomiting. The quality of the evidence for the

use of psychostimulants at the end of life will be discussed.

NO 53B

ISSUES FACING CAREGIVERS AND FAMILY AT THE END OF LIFE

Dianne M. Shumay, Ph.D., 1600 Divisadero, Box 1725, San Francisco, CA 94143

SUMMARY:

Good end of life care focuses not only on the patient but also on the patient's primary social support network. This network includes spouses or partners and other close family and friends who are involved in day to day care, as well as others who by virtue of relationship or history are significant in the patient's life. While it is clear that the participation of these significant others makes an immense difference to dying patients and their medical or hospice teams, family and caregiver wellbeing is challenged by many factors during a loved one's illness. Families face uncertainty and unfamiliarity with the dying process and confusion about decision making and navigating provider systems. Financial and social changes, time demands and stress on resources all contribute to the burden. In particular, stress and exhaustion from caregiving and anticipatory grief contribute to distress and may adversely affect physical and emotional health. Further, a dysfunctional system of support can make it difficult for providers to optimize care of the patient if communication and decision making is disrupted or if patients' emotional or physical caregiving needs are not met. A number of factors appear to put families and caregivers at risk including preexisting medical, psychiatric, personality or family systems factors that may become more acute at this time. These factors may also be implicated in the variation of grief responses that can range from normal bereavement on one end of the spectrum to complicated grief and significant impairment in functioning on the other end. This presentation will review concerns facing families and caregivers at the end of life and describe resources and techniques for intervention. The presentation will focus in particular on caregivers and family members of patients dying from cancer with information that is generally applicable to other populations.

NO 53C

PSYCHOLOGICAL ADJUSTMENT TO END OF LIFE LOSSES: APPLICATION OF THE REINTEGRATION MODEL TO ADVANCED CANCER

Sara J Knight, Ph.D., SFVAMC (151R), 4150 Clement Street, San Francisco, CA 94121

SUMMARY:

For dying persons, losses of health, functional abilities, roles, and relationships occurring close to the end of life can be meaningful. For many, however, end of life losses are highly difficult and painful, even agonizing. Understanding how to intervene to alleviate the agonizing experiences is a compelling goal. In this presentation, we describe a framework, termed the reintegration model, for understanding how psychological adjustment to these losses may influence the psychological well-being in dying persons and the many decisions that dying persons make about daily life and medical care. Based on prior empirical work and theory on stress and coping and adult development, the model includes three key adjustment processes--comprehension, creative adaptation, and reintegration--that are critical to well-being close to the end of life and that influence decisions about palliative care. The presentation uses the example of advanced cancer to illustrate potential of the reintegration model to inform psychiatrists working in the palliative care setting.

NO 53D

END OF LIFE CARE IN DEMENTIA: A RESEARCH UPDATE

Laura B Dunn, M.D., 401 Parnassus Avenue, Box GPP-0984, San Francisco, CA 94143

SUMMARY:

End-stage dementia patients often face a lengthy end of life process. Psychiatrists can play an important role in helping patients and families navigate this process. In addition, as the population ages, psychiatrists are likely to encounter more patients who must cope with grieving the death of a parent or other loved one with dementia. Understanding the issues that most commonly arise at the end of life in dementia, including the often difficult decision making processes faced by families and other clinicians, will be increasingly important to the practicing psychiatrist. This presentation will therefore present an update on research on psychiatric aspects of end of life dementia care. Research on barriers to quality care in dying patients with dementia will be described. Studies focusing on surrogate-patient-clinician relationships in dementia care will also be highlighted, as these shed important information on how psychiatrists may be able to intervene to improve the communication of both patient and family needs to other clinicians as well as within health care systems. The importance of psychiatric care to the end of life in dementia is also underscored by studies on caregiver burden. An integrated model for the provision of quality psychiatric care at the end of life for dementia patients and families will be presented.

NO 53E

LEGAL AND ETHICAL ISSUES AT THE END OF LIFE IN CHRONICALLY MENTALLY ILL PATIENTS WITH HIV/AIDS

Jeanne M St. Pierre, M.D., 383 61st Street, Oakland, CA 94618

SUMMARY:

This presentation will describe ethical and legal issues that may arise in the care of chronically mentally ill patients with AIDS at the end of life. Treatment of HIV/AIDS in the chronically mentally ill presents a particular set of challenges. When those patients are also substance dependent, marginally housed and intermittently compliant with care, their cognitive status can

decline such that they are no longer able to make decisions regarding their care. In some communities, including San Francisco, these patients are often admitted involuntarily to locked psychiatric units in the context of worsening psychosis or dementia. The legal and ethical dilemmas facing the psychiatrist may include whether to petition the court for involuntary placement in a locked psychiatric facility, how to support the patient and caregivers regarding treatment with HAART, and whether to discharge to an uncontrolled setting despite the risk of continued drug use, further functional decline, and likely death. In this presentation we will review several case studies and discuss the role of the psychiatrist in interdisciplinary treatment of this very difficult patient population.

REFERENCES:

1) Knight SJ, Emanuel L. Processes of adjustment to end-of-life losses: A reintegration model. J Palliat Med. 2007;10(5):1190-1198.

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4) Sachs GA, Shega JW, Cox-Hayley D. Barriers to excellent end-of-life care for patients with dementia. J Gen Intern Med. 2004;19(10):1057-1063.

SYMPOSIUM 54

ENGAGING AND TREATING PERSONS WITH RECENT ONSET SCHIZOPHRENIA: PRACTICE-BASED EVIDENCE FROM THE CLINICAL TRENCHES

SUPPORTED BY AMERICAN ASSOCIATION OF COMMUNITY PSYCHIATRISTS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the obstacles to successful engagement and treatment of young persons with serious mental disorders; to recognize the sources and tenacity of denial of illness and refusal of treatment; to collaborate with family members in problem-solving and use of positive, motivating communication skills with their mentally ill relative;to carry out motivational interviewing with reluctant patients.

NO 54A

WORKING IN THE TRENCHES WITH 18 TO 25-YEAR-OLDS

Mark Ragins, M.D., 2025 E 7th Street, Long Beach, CA 90804

SUMMARY:

One of the model programs for California's Mental Health Services Act is the Transitional Age Youth Academy in Long Beach. I took over as the fifth psychiatrist in six years accepting the challenge of integrating psychiatric care into a chaotic, drop-in style, mentor based program that features three phases "Rolling In," "Tuning Up," and "Rocking Out."

1) Doctor – Patient relationships: Young people are attracted to food, fun, and cash, "drugs, sex, and rap", minimal rules and structure, high tolerance and acceptance, excitement, a peer subculture, and emotional connections. They are often unmotivated, irresponsible, and "inappropriate for therapy" with multiple levels of difficulties with trust. I've had to create relationships more based on being a good father or mentor than on being a good psychiatrist. I try to fit into their lives, "become their dealer," and "sneak in therapy."

2) Diagnostic challenges: I face a dizzying array of diagnostic conditions and therapeutic needs. DSM has serious limitations including a separation of childhood and adult conditions, a limited exposition of trauma induced and organic / developmental disorders, and a lack of developmental perspective. I've needed alternative models to create a collaborative understanding of what's wrong and how to work together to achieve their goals.

3) Revisiting "first break": From a person-centered point of view treatment is not triggered by symptom acuity, but by a combination of symptoms and social disability and disruption. Sometimes the social disability and disruption is not actually secondary to the illness, but may have pre-existed, predisposed, or just coexisted with and complicated the illness. A set of social "risk factors" emerges from this perspective. From a recovery point of view a "period of unengaged treatment" often featuring heavy pressure to achieve treatment compliance may be seen negatively as "breaking the patient's spirit" with long term effects.

NO 54B

ASSISTING THE TRANSITION FROM CHILD MOBILE TREATMENT TO ADULT ACT SERVICES FOR ADOLESCENTS WITH SCHIZOPHRENIA

Curtis N. Adams, Jr., M.D., 630 West Fayette Street, 4, East Baltimore, MD 21201

SUMMARY:

Adolescents who receive mobile treatment for the mental illness eventually reach the age of majority and are eligible to enter the adult mental health system. This transition can present challenges as their autonomy increases. Some are well prepared for this increase in autonomy and others are not. Transition from child mobile services to adult Assertive Community Treatment (ACT) services can go smoothly if several of the following strategies are employed: 1) anticipation of increased autonomy, 2) allowing the adolescent to make his choices after being given solid information about the risks and benefits of proposed treatment, 3) patience with lack of illness awareness if it is present, 4) respect for a decision to stop medication or change medication 5) and avoidance of methods of coercion or control. In this portion of the symposium, we will address each of these components in turn with the aim of improving this potentially perilous transition.

NO 54C

THE DANCE OF ENGAGEMENT-CONNECTING WITH YOUNG ADULTS IN THE PURSUIT OF MENTAL HEALTH

Andrew J. McLean, M.D., 2624 9th Avenue SW, Fargo, ND 58103

SUMMARY:

Southeast Human Service Center has developed recovery model programming to engage young people with significant mental illness. The program includes a team and group approach, with psychiatric and nursing care, case aide and case management, addiction services, as well as a full time resource coordinator assisting in various applications, tax help, and medical assistance (including accessing medical and dental care supports.)

Successful and non-successful approaches are highlighted in this presentation, as well as the barriers to bridging the "magic age of 18" between adolescent and adult clients and providers.

NO 54D

EARLY ASSESSMENT AND SUPPORT TEAM: A COMMUNITY-BASED CLINICAL TEAM FOCUSED ON IDENTIFYING, ENGAGING AND TREATING YOUTH WHO ARE DEVELOPING PSYCHOSIS

Robert Wolf, M.D., 2454 Abbey Lane, SE, Salem, OR 97317

SUMMARY:

The Early Assessment and Support Team (EAST) was developed in the Winter of 2001. Its mission was to reduce the biological, psychological and social consequences of schizophrenia and other related psychotic disorders. The team consists of an admi nistrative and clinical coordinator, a psychiatrist, nurse, several case managers, employment/educational specialist and occupational therapist.

Over a two year commitment clients and families receive an array of services including psychiatric assessment and pharmacological management, assertive community treatment, family therapy, and educational/employment/occupational therapy. Our outcome data indicate that 90% of our clients maintain their developmental goals (school,work) and equal numbers maintain their family relationships. In addition to working with individuals and families, we also put great effort in educating the community about early warning signs of psychosis, so as to reduce the duration of untreated psychosis.

Engaging adolescents is challenging and fraught with complications. It is a time of great change in one's physical body and social environment. Adolescence is a time of invincibility! Illness is a paradigm of adulthood, adolescents struggle with conceptualizing the illness model. Furthermore, despite the advances in defining mental illnesses as biological processes, adolescents resist the explanation that their thoughts, drives, desires, beliefs, and emotions may be off balance due to a biological process that has gone amiss. Therefore the engagement process requires careful choice of presentation and vernacular.

The relationship between a physician and an adolescent will undoubtedly be challenging. Privacy and confidentiality must be balanced with engagement, safety, and maintenance of the family relation. Nontraditional office spaces (like coffee shops), comfortable, pop-culture office ambiance, and less intimidating decorum can all be helpful in the engagement process.

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2) Drapalski AL, Milford J, Goldberg RW, Brown CH, Dixon LB: Perceived barriers to medical care and mental health care among veterans with serious mental illness. Psychiatric Services, 59:921-924, 2008

3) Deegan PE, Drake RE: Shared decision making and medication management in the recovery process. Psychiatric Services, 57:1636-1639, 2006

4) Achieving the promise: Transforming mental health care in America. Pub. No. SMA03-3832. Rockville MD, Dept of Health & Human Services. President's New Freedom Commission on Mental Health, 2003

SYMPOSIUM 55

SLEEP DISTURBANCES AND CIRCADIAN DISRUPTIONS AFFECTING, AND AFFECTED BY, ADDICTION TO DRUGS

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participan should be able to: 1) Recognize how sleep physiology is altered by abused drugs; and 2) How to identify signs and symptoms of drug-abuse-related insomnia and cognitive deficits; 3) Recognize that disruptions by cocaine in normal circadian clock function increase risk for depression and bipolar disorder, among others; 4) The reciprocal interactions between sleep and the immune system in substance dependence, and 5) Treatment issues related to sleep disturbances in cocaine and opiate dependents.

NO 55A

DIFFERENTIAL ROLES FOR INDIVIDUAL CIRCADIAN GENES IN BIPOLAR DISORDER AND DRUG ADDICTION

Colleen A. McClung, Ph.D., 5323 Harry Hines Boulevard, Dallas, TX 75390-9070

SUMMARY:

Bipolar disorder is highly associated with the abuse of illicit drugs. The use of these drugs by bipolar patients leads to increased hospitalization rates, an earlier age of onset for symptoms, increased aggression, and higher rates of suicide attempts. Therefore, it is important to determine the molecular mecha-

nisms that underlie these conditions and determine why they are so highly co-morbid. There are many indications that circadian rhythms and the genes that make up the circadian clock are centrally involved in both mood disorders and psychostimulant addiction. Individuals suffering from nearly all types of mood and substance abuse disorders have major disruptions in circadian functions, and the treatments for these disorders often involve modulation of the circadian clock. Genes that make up the clock are expressed at high levels in the mesolimbic dopaminergic reward circuit between the ventral tegmental area (VTA) and nucleus accumbens (NAc). Yet virtually nothing is known about the function of these genes in the VTA or NAc, and how they are involved in regulating mood and motivation. Two proteins that regulate circadian rhythms, CLOCK and NPAS2, are very similar in sequence and function; however, they have different patterns of expression within the VTA-NAc circuit. We have found that Clock mutant mice display an overall behavioral profile that is strikingly similar to human bipolar patients when in the manic state, including an increase in preference for cocaine. Interestingly, Npas2 knock-out mice are similar in their responses when tested in behavioral measures of mood, however, they have opposite phenotypes in measures of cocaine reward. Furthermore, these proteins have distinct functions in the NAc and the VTA in the regulation of gene expression following cocaine exposure. By determining the functions of these genes in reward-related regions, this will help us to better understand the co-morbid conditions of bipolar disorder and addiction.

NO 55B

DISORDERED SLEEP AND PROINFLAMMATORY CYTOKINES IN COCAINE DEPENDENCE: CLINICAL IMPLICATIONS

Michael R. Irwin, M.D., 300 UCLA Medical Plaza, Los Angeles, CA 90095

SUMMARY:

Sleep disturbance is a prominent complaint of cocaine dependent patients during usage, and also following withdrawal and abstinence. However, the high frequency of disordered sleep stands in sharp contrast with limited effort to fully evaluate sleep or to identify the mechanisms that account for sleep abnormalities associated with chronic cocaine abuse. Given evidence that cocaine addiction also leads to a striking increase in the risk of infectious disease, the complex cytokine network is one physiological system that is hypothesized to mediate both sleep and immune abnormalities in cocaine dependence.

Our studies have found that cocaine dependent patients evidence marked disturbances of sleep as compared to normal volunteers, with prolonged sleep latency, profound loss of delta sleep, and increase of rapid eye movement (REM) sleep. Second, sleep disturbance in cocaine dependence has consequences for the regulation of an inflammatory response, in which cocaine dependent patients show a decreased capacity of monocytes to express TNF-? and interleukin-6. Finally, pharmacologic TNF-? antagonism using etanercept produces significant decreases in the amount and percentage of REM sleep to low levels typically found in age comparable controls.

Understanding the bi-directional relationships between cytokines and sleep in cocaine dependence has provided novel and innovative information about the basic mechanisms of sleep regulation. Moreover, given that pharmacologic neutralization of TNF a activity is associated with significant reductions in REM sleep in abstinent alcohol dependent patients, these data suggest that circulating levels of TNF a may have a physiologic role in the regulation of REM sleep in humans.

This work was supported in part by DA16541 AA 13239 T32-MH18399, HL 079955, AG 026364, RR00827, and P30-AG028748

NO 55C

(±) 3,4-METHYLENELDIOXYMETHAMPHETAMINE (MDMA, ECSTASY) USE IS ASSOCIATED WITH SLEEP-DISORDERED BREATHING

Una D. McCann, M.D., 5501 Hopkins Bayview Circle, Room 5B71C, Baltimore, MD 21224

SUMMARY:

(±) 3,4-methylenedioxymethamphetamine (MDMA, "Ecstasy"), a recreational drug that is undergoing a resurgence in popularity, has the potential to damage brain serotonin (5-HT) neurons. The functional consequences of 5-HT neurotoxicity in humans are not well understood. However, 5-HT neurons are known to play a role in sleep and have been implicated in sleep apnea. To assess the possibility that MDMA users are at increased risk for sleep apnea, 71 abstinent MDMA users and 62 control subjects underwent all-night polysomnographic studies. MDMA users were found to have exposure-related alterations in sleep architecture and a significantly increased rate of sleep disordered breathing (SDB). Severity of SDB in MDMA users correlated with MDMA exposure. Sleep disturbance in MDMA users may play a role in cognitive deficits that have been reported in this population. Further, as SDB increases the risk for cardiovascular disease, stroke and metabolic syndrome, prior use of MDMA may increase the risk for developing these age-related disorders.

NO 55D

IMPACT OF SLEEP DEPRIVATION AND INSOMNIA ON THE DEVELOPMENT AND MAINTENANCE OF DRUG ADDICTION

Scott E Lukas, Ph.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

In spite of some success in treating drug abuse problems, transient insomnia and/or sleep deprivation can interfere with treatment. Not only are sleep disturbances very common among drug abusers but also they are rarely addressed treatment programs. Part of the reason for the lack of attention is that processes involved in sleep homeostasis and their relationship to the pharmacological profiles of psychoactive drugs have not been studied extensively. Multiple neurotransmitter systems appear to partici-

pate in the generation of sleep, but adenosine's role is becoming more important because the major adenosine metabolizing enzymes have diurnal rhythms. During prolonged wakefulness, extracellular adenosine may accumulate in basal forebrain and cortex and then promote the transition from wakefulness to SWS by inhibiting basal forebrain neurons at the adenosine A1 receptor. We observed that enhanced brain ATP following recovery sleep may reveal a restorative process. This response to increased metabolic demand and elevated levels of brain adenosine after sleep deprivation may restore brain ATP levels, resulting in elevated brain ATP levels. Our recent findings suggest that increased adenosine may not be selective for basal forebrain, but may be more general, in frontal and prefrontal areas. We present data from magnetic resonance spectroscopy (MRS) showing that short-term (<1 yr) methadone-maintained patients fail to recover energy phosphates, phosphocreatine and beta-nucleoside triphosphate during recovery after sleep deprivation while long-term patients (>1 year) had profiles more like controls. This altered brain chemistry profile is paralleled by a reduction in sleep efficiency. These results suggest that there are differential homeostatic disturbances for short- versus long-term methadone-maintained patients and controls. A better understanding of the underlying mechanisms of these changes in sleep and brain chemistry may help with long-term management of drug abuse.

NO 55E

OCCULT INSOMNIA AND ABSTINENCE FROM COCAINE: IMPLICATIONS FOR COGNITIVE FUNCTION AND THE CLINICAL TREATMENT OF COCAINE DEPENDENCE

Robert T Malison, M.D., Clinical Neuroscience Research Unit, 34 Park Street, New Haven, CT 06519

SUMMARY:

Although the presence of cognitive disturbances in cocaine-dependent populations is well established, only recently has objective evidence of abnormal sleep and sleep-dependent cognitive impairment been appreciated. Recent studies of vigilance and procedural learning in conjunction with objective (i.e., electrophysiological) measures of sleep have suggested the presence of an "occult insomnia" among abstinent cocaine abusers. Specifically, over a 3-week period of drug abstinence, cocaine dependent individuals manifest evidence of progressively deteriorating sleep (as reflected by decreased total and slow-wave sleep times). The functional relevance of the latter sleep impairment is evident in parallel deteriorations in cognitive tests of sleep dependent learning. Subjects are unaware of these deficits, however, insofar as subjective self-reports over this same interval suggest they experience progressive improvements in sleep quality (hence, the term "occult insomnia"). The nature of these sleep deficits and their impact on cognitive functioning suggest specific pharmacological approaches to their remediation. In fact, observations that recently identified cocaine pharmacotherapies (e.g., tiagabine, modafinil) appear to be successful in the amelioration of these sleep abnormalities and/or aspects of cognitive functioning, suggests potential relationships between brain sleep and reward systems. These findings suggest potentially innovative (e.g., "somnotropic") approaches to the treatment of cocaine dependence.

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THURSDAY, MAY 21, 2009 2:00PM-5:00PM

SYMPOSIUM 56

THE ARCHITECTURAL ESSENTIAL BUILDING BLOCKS AND DESIGN ELEMENTS TOWARD A GOOD ENOUGH MENTAL HEALTH SYSTEM: NATIONAL AND INTERNATIONAL PERSPECTIVES

SUPPORTED BY AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the crucial elements for a quality mental health system. Participants should be able to demonstrate awareness of both macro level issues, including economic and political forces, and micro level issues, including the implementation of best practices and direct care services.

NO 56A

IN THE NIRVANA MENTAL HEALTH SYSTEM WE ALL PAY THE SAME

Jeffrey Geller, M.D.,55 Lake Avenue, North Worcester, MA 01655

SUMMARY:

In the 1850's President Franklin Pierce, in vetoing a bill that would have made the federal government financially responsible for the care and treatment of insane persons in the United States,

indicated that if he were to sign this bill, the states would become " humble supplicants upon the bounty of the federal government." Ironically, he indicated the states would give up their "historic responsibilities"--those responsibilities were only a few decades old at this point!

Pierce was, unfortunately, correct. With the passage of Medicaid and Medicare, the states did just as Pierce predicted. And hence we have had a mental health system that is driven by every state's efforts to cost shift from state coffers to the federal budget.

What if, under a redesigned mental health system, the board and care costs to the state, to the feds, and to the indiviudal with a chronic mental illness were at a fixed rate for each no matter where the individual was hospitalized or housed? We would do away with any fiscal incentives to moving indidivuals with chronic mental illness to save money in state's/fed's/individual's pockets.

This presentation examines the current constraints on this proposed improvement to the U.S. (state by state) mental health system and presents information on why this change in financing care and ttreatment would be a major step towards the Nirvana Mental Health System.

NO 56B

CONSIDERING NATIONAL MENTAL HEALTHCARE REFORM: REPORT FROM THE APA TASK FORCE ON SYSTEMS OF CARE

Anita S Everett, M.D., 3563 Cattail Creek Drive, Glenwood, MD 21738

SUMMARY:

What are the essential building blocks for compossionate mental health services in contemporary United States? This is the question that was put before the members of a Special Task force that was convened by then President Elect, Dr Nada Stotland and chaired by Dr Stephen Sharfstein. Members of the task force included Dr. Howard Goldman, Dr. Ronald Burd, Dr. Amy Ursano and Dr. Anita Everett. In this presentation the report of this APA task force will be reviewed. The core of this report includes thirteen principles that psychiatrists would like to see as essential elements of an ideal mental health system. Each of these principles wil be presented. Following a review of the 13 principles, several of the principles will be discussed in detail and participation from the audience will be solicited.

NO 56C

GRADING THE STATES 2009: A REPORT TO THE NATION ON AMERICA'S HEALTHCARE SYSTEM FOR SERIOUS MENTAL ILLNESS

Laudan Y Aron, M.A., 2107 Wilson Boulevard, Ste. 300, Arlington, VA 22201-3042

SUMMARY:

This presentation will provide a brief 10-15 min overview of the methods/results of NAMI's upcoming (Feb 2009) report, Grading the States 2009: A Report to the Nation on America's Healthcare System for Serious Mental Illness. The remainder of the presentation will discuss (1) the types of data needed to best evaluate the performance of public mental health service systems, (2) how well-crafted perfomance measures can be used to build effective mental health service systems, and (3) how what we know now compares to what we need to know. Right now, we have a pretty good sense of the building blocks of an effective system-we have the list of ingredients (and even some powerful principles to guide us). What we don't have is strong research/evidence base to guide how these building blocks should fit together (the recipe or recipes to follow given the ingredient list). Understanding what we are trying to build is critical to achieving the "fundamental transformation" called for by the the New Freedom Commission: replacing an outmoded, fragmented, and largely ineffective system of mental health care with one that is evidence-based, recovery-focused, and consumer- and family-driven.

NO 56D

CANADIAN INNOVATIONS IN MENTAL HEALTH CARE: STEPS TOWARDS AN OPTIMAL SYSTEM

Jon J D Davine, M.D., 2757 King Street East, Hamilton, L8K 2G4 Canada

SUMMARY:

There are several features an "optimal" mental health system should have. One is universal access, so that the disadvantaged in our society are not excluded from access to top quality mental health care.

The Canadian medical system is a universal access health care system. It has a single payor, which is the provincial and federal government. In this talk, the Canadian system will be described.

The key parts of the system from a mental health standpoint are its universal access. Everyone has access to the same mental health care, and every individual is covered. Most outpatient and inpatient psychiatric services are covered, and need not be cleared with an insurance company. Medical decisions are made only by the psychiatrist. For the psychiatrist, billing is done through the government, and takes little time.

Another Canadian innovation is the "Shared Care" system, where psychiatrists work directly in family physicians' offices. In Ontario, there is a government funded initiative which supports this system. The psychiatrist works directly in the family physician's office, and does both direct patient care, and indirect supervision of other cases with the family doctor. This system supports the family doctor as a deliverer of mental health care, with available back up from a psychiatrist. This extends the reach of the psychiatrist to a multitude of patients while supporting the role of the family doctor as the deliverer mental health care. This is another Canadian innovation seen as optimizing mental health care's delivery. This program will be described in some detail.

It is felt that these types of systems and initiatives are the building blocks of an optimal mental health care system.

NO 56E

UNMET NEEDS AMONG SCHIZOPHRENIA PATIENTS AND THEIR FAMILY CAREGIVERS – SELECTED RESULTS FROM A EUROPEAN PERSPECTIVE

Hartman Hinterhuber, M.D., Anichstrasse 35, Innsbruck, A-6020, Austria

SUMMARY:

In many European countries, large mental hospitals were replaced by community psychiatric services and psychiatric inpatient units in general hospitals. Studies have shown that this often resulted in a better quality of life for people with mental disorders. Despite developing a variety of community services, it seems that many people with severe and chronic mental disorders do not receive appropriate care and their families experience marked burden. In order to assess if patients with schizophrenia and their families receive appropriate care, a survey was conducted in several Austrian provinces.

135 patients suffering from schizophrenia and their family caregivers were interviewed by means of the "Camberwell Assessment of Need" and the "Carers' Needs Assessment for Schizophrenia". This sample was drawn from psychiatric hospitals, day hospitals and community services in Austria.

About a quarter of patients had no sufficient information about their illness and its treatment, which might be a risk factor for low compliance. About a fifth of patients did not receive appropriate support concerning housing. 73% of the family caregivers needed professional counselling, but only 12% received this intervention sufficiently. While 28% of the relatives needed financial support, only 4% received this aptly. In a variety of other domains we found unmet needs among patients and their relatives.

For planning appropriate psychiatric services, knowledge about the patients' and caregivers' needs is essential. The present survey shows that provision of services often does not match the needs. Similar results were found in a study among dementia sufferers as well as in a European multi-centre study among severely mentally in Italy, Germany and the United Kingdom. All these results indicate that the allocation of resources was not sufficient when planning community psychiatric services in Europe.

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4) A Vision for the Mental Health System, Arlington, Virginia, American Psychiatric Association, APA Task Force for a Vision for the Mental Health System, Steven S. Sharfstein, Chair, April 3, 2003

SYMPOSIUM 57
PSYCHODYNAMIC PSYCHOTHERAPY: UPDATE ON EMPIRICAL EVIDENCE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; Identify empirically based reasons for considering the possible influences of transference discords as obstacles to optimum emotional information processing and change in psychotherapy.

NO57A

LONG TERM EFFECTS OF TRANSFERENCE INTERPRETATION IN DYNAMIC PSYCHOTHERAPY

Per Hoglend, M.D., PO Box 85, Vinderen, 0319 OSLO, Norway

SUMMARY:

Our study is called the First Experimental Study of Transference interpretation (FEST). Inclusion of patients started in 1994 and all follow-up assessments were ended by December 2005. One hundred patients received one year of weekly dynamic psychotherapy. One half was randomized to psychotherapy with transference interpretation, the other half to the same format of therapy, with the same therapists, but without transference interpretation (comparison group). A dismantling study means a study where one (important) treatment component is added to or subtracted from a treatment package. All patients were followed up over a three-year period after treatment termination. Unexpectedly, patients with more severe and chronic problems in interpersonal relationships had a positive effect of transference interpretations. This effect was sustained during the three-year follow-up period.

NO 57B

WORKING-OUT TRAUMATIC MOURNING: A CONTROLLED EVALUATION OF PSYCHODYNAMIC PSYCHOTHERAPY AMONG BORDERLINE PATIENTS IN A SUICIDAL CRISIS

Antonio Andreoli, M.D., HCUG 24, Rue Micheli-du-Crest, 1211 Genève, Switzerland

SUMMARY:

Since psychodynamic psychotherapy showed significant potential and may be relevant to improve mental health policies among borderline patients, this study aimed at investigating the comparative cost-effectiveness of well structured, time-limited psychoanalytic psychotherapy (TMFPP) in a large sample of acutely suicidal borderline subjects. 150 patients who had been referred to emergency room with IPDE borderline personality disorder were studied in a randomized controlled clinical trial. Meeting DSM IV criteria for major depression, severe suicidal ideation/self-harm and accepting to give written informed consent were additional inclusion criteria. Bipolar disorder I, psychotic symptoms, severe substance dependence and an insurance coverage outside the Geneva canton were exclusion criteria. After 3 to 5 days hospitalization in a crisis intervention unit of the general hospital,

consecutive subjects were randomized to 3-month out-patient traumatic mourning focused psychoanalytic psychotherapy (TM-FPP: an intervention focusing traumatic reaction to abandonment from a romantic partner, attachment disorder and masochistic idealization process), 3-month psychodynamic crisis intervention (PCC: Burnand et al., 2002) and to treatment as usual (an intensive out-patient program providing day treatment and DBT oriented psychotherapy). TMFPP and PCC were administered in a combination treatment format including Venlafaxine protocol. All interventions provided careful 24/24h risk management. Patients were evaluated on a battery of standardized instruments at intake, discharge from acute treatment (3-month) and 6-month follow-up. A preliminary data analysis indicated significant advantage at decreased costs for TMFPP compared to both crisis intervention and enhanced TAU. Extensive account of the final results and comment will be provided.

NO 57C

TRANSFERENCE FORMULATIONS BY CBT AND DYNAMIC THERAPISTS

Mardi J. Horowitz, M.D., 401 Parnassus, San Francisco, CA 94143-0984

SUMMARY:

A systematic format for transference description led to very similar quantatative and qualitative responses from groups of dynamically oriented therapists and self-identified cognitive-behavioral therapists. Equal reports of positive and negative transference reports emerged, and both groups found the format helpful in pattern description. Transference is found in both approaches to therapy, when one defines transference as patterned emotional discord in the patients in-therapy relationship views, and clarifications using such formats can improve the therapeutic alliance.

NO 57D

PREDICTING OUTCOME FROM RATINGS OF THERAPIST INTERVENTIONS

George Silberschatz, Ph.D., 3368 Sacramento Street, San Francisco, CA 94118-1912

SUMMARY:

Recorded therapies of 38 patients along with extensive treatment outcome and follow-up data comprise the primary data for this study. A reliable method of psychodynamic case formulation -- the plan formulation method -- was used to develop case formulations for each case. These formulations were then used to assess the quality ("plan compatibility") of therapist interventions: experienced clinical judges read the formulations and then rated therapist interventions in a sample of therapy hours using a 7-point "plan compatibility of intervention" scale. Correlations between these ratings and treatment outcome were significant. The results show that the goodness of fit (i.e., plan compatibility) between therapist interventions and the patient's needs (as assessed by the plan formulation) is an important predictor of treatment outcome. Implications of these findings for future psychotherapy research will be discussed.

NO 57E

EVALUATING EVIDENCE FOR THE EFFECTIVENESS OF PSYCHODYNAMIC PSYCHOTHERAPY THROUGH META-ANALYTIC METHODS

William K Lamb, Ph.D., 4150 Clement Street, 116F, San Francisco, CA 94121

SUMMARY:

The purpose of this meta-analysis is to evaluate the evidence for the effectiveness of psychoanalytic psychotherapy. Meta-analysis is a statistical procedure where outcome measures from a number of studies are first standardized to allow for comparability and then combined to form a generalized conclusion. Any empirical study that collected outcome data during pre-testing and post-testing on individual or group psychoanalytic outpatient treatment for children, adolescents, or adults qualified for meta-analytic review. A total of forty-three outcome studies of longer-term psychoanalytic psychotherapy completed by the year 2008 from both English and non-English language based sources were identified by computerized databases, by hand searches of the research literature, and by consulting psychoanalytic experts. A standardized mean change effect size was calculated for each study and represented the difference between the pre-test and post-test means for a single group divided by the pre-test standard deviation, which was adjusted statistically for the omission of control groups. Each standardized mean change effect size was weighted by the inverse of its sampling variance. Multiple effect sizes for dependent measures within a single study were averaged into one estimate in order to avoid the violation of statistical independence. With an overall weighted effect size of .81, the results indicate that psychoanalytic psychotherapy is effective and consistently so around the world. The patients in this meta-analysis represent a broad range of disorders that are typically seen in outpatient clinics and therefore these findings offer the possibility of generalizing to clinicians in a variety of settings.

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SYMPOSIUM 58

OPTIMIZING TREATMENT OUTCOME IN AXIS 1 DISORDERS: AUGMENTATION WITH FAMILY

INTERVENTIONS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the value of including families in the treatment of patients with a wide variety of Axis 1 Disorders in order to improve outcome.

NO 58A

FAMILY INTERVENTION TO IMPROVE EFFICACY AND EFFECTIVENESS OF MEDICATION FOR SCHIZOPHRENIA

Ira Glick, M.D., Departments of Psychiatry and Behavioral Sciences, and Psychopharmacology, Stanford University School of Medicine, 300 Pasteur Drive, Stanford, CA 94305

SUMMARY:

Objective: Although antipsychotic medication is the treatment-of-choice for acute and chronic schizophrenia, most patients achieve only a partial response. In part, this results from limitations of the medications- but more commonly, it results from lack of either compliance and/or family support.

Method: This paper reviews recent controlled literature on relevant family issues and on family intervention techniques and strategies for patients with acute and chronic schizophrenia.

Results: A recent meta-analytic review by Leucht and Hares, 2006 revealed that family psychoeducation can reduce relapse rates by 20% - especially those interventions that continued for more than 3 months: Family factors that negatively affect compliance and outcome include 1) families not seeking care for their affected member, 2) illness in association with breakdown of family support or 3) that force homelessness, 4) high stigma and 5) abandoning ill family member.

Summary: For most patients with either acute or chronic schizophrenia (and their families) effective antipsychotic medications should be combined with family psychoeducation and supportive intervention to both improve compliance and efficacy plus family coping strategies.

NO 58B

FAMILY SYSTEMIC MODELS FOR ENGAGING SUBSTANCE ABUSERS IN TREATMENT

Judith Landau, M.D., 1790 30th Street, Boulder, CO 80301

SUMMARY:

Family members living with addicted individuals comprise an overwhelming percentage of patients presenting with repetitive illnesses, psychosomatic symptoms and vague complaints. Fewer than 10% of addicted individuals enter treatment. Intervention through family and support system is highly effective for getting people into and completing treatment, and preventing relapse. A summary of systemic models of Intervention including the best practice model, Invitational Intervention: the ARISE Model will be presented. The original NIDA study of ARISE resulted in an 83% rate of engagement of resistant substance abusers in treatment. ARISE is also successful with other addictions, behavioral compulsions, and chronic physical or mental illness.

ARISE employs invitation rather than secrecy, surprise and ambush. The ARISE continuum of care ensures collaboration among family members, Interventionist and treatment providers through the treatment phase and well into recovery and relapse prevention. It is aimed at both individual and family long-term recovery and healing.

NO 58C

THE EFFECTIVENESS OF ADJUNCTIVE FAMILY THERAPY FOR PATIENTS WITH MOOD DISORDERS

Gabor I Keitner, M.D., Rhode Island Hospital/Warren Alpert Medical School of Brown University, 593 Eddy Street, Providence, RI 02903

SUMMARY:

The effectiveness of psychopharmacologic and psychotherapeutic treatments for patients with major depression and bipolar disorders is limited. A number of controlled treatment outcome studies of adjunctive family therapy to pharmacotherapy have been undertaken and reported. This presentation will review available evidence for the effectiveness of various forms of family interventions for patients with mood disorders.

Family therapy has been found to be comparable to individual therapy in improving symptoms of depression, particularly if marital distress is present. The addition of family therapy to pharmacotherapy for patients with more severe forms of depression has been found to improve depressive symptoms and to decrease suicidal ideation to a greater degree than the addition of cognitive therapy.

Family interventions for patients with bipolar disorder helps to reduce rates of relapse and rehospitalizations. Symptom reduction tends to be greater for the depressed than for the manic phase of the illness. Family interventions improve the family's knowledge about and understanding of the bipolar illness and helps in identifying and dealing with prodromal and residual symptoms.

Adjunctive family interventions for patients with mood disorders have been shown to improve symptom management, and to positively influence the course of illness.

NO 58D

ADJUNCTIVE FAMILY INTERVENTIONS IN PSYCHOSOMATIC MEDICINE

Alison M. Heru, M.D., 1400 Jackson Street, Denver, CO 80206

SUMMARY:

Purpose: Participants will learn the breadth and depth of current family research regarding family factors in medical illnesses.

Content: Family-focused interventions in psychosomatic medicine are presented. The family factors that are known risk or protective factors for outcome in many medical illnesses are presented. Family focused interventions in psychosomatic medicine

should address several goals; to help the family to cope and manage the continued stressors inherent in chronic disease management as a team rather than as individuals, enhance healthy family functioning, minimize hostility and criticism and reduce adverse effects of external stress and disease related trauma.

Effective family focused interventions include family psychoeducation improving patient outcome in cardiac disease, and family psychoeducation to reduce symptoms of post traumatic stress in family members of children with cancer. Individually tailored supportive and educational contact with families reduces family distress in palliative care.

Importance of presentation: Psychiatrists working in psychosomatic medicine should be aware of the role of family factors in the course of medical illness and be knowledgeable about effective family focused interventions.

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SYMPOSIUM 59

HEALING TRAUMATIC WOUNDS IN POST-GENOCIDE RWANDA: PSYCHIATRIC TREATMENT AIDS THE PEACE DIALOGUE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Better understand the necessity and goals of psychiatric treatment for Rwandan citizens after the genocide; 2)Learn about psychiatric treatment as a primary prevention tool to minimize the inter-generational transmission of trauma and an aid in rebuilding societal bonds; and 3) identify unique techniques needed for the peace building efforts in Rwanda post-genocide.

NO 59A

HEALING TRAUMATIC WOUNDS IN POST-GENOCIDE RWANDA: AN CULTURAL VIEW OF THE RWANDAN GENOCIDE

Kristen U. Welch, M.D., 70 E Lake Street, #1018, Chicago, IL 60601

SUMMARY:

Global health initiatives developed for post-conflict countries often neglect the primary need for psychiatric treatment in war-torn areas. Many serious psychiatric illnesses are seen in the years after genocide and early, effective treatment is critical to re-establishing communities and security across ethnic lines. Providing state-of-the-art psychiatric treatment becomes more necessary when other illnesses such as HIV coexist and have distinct neuropsychiatric features that require specialized diagnostic and therapeutic intervention.

As a consulting psychiatrist to the Marjorie Kovler Refugee Mental Health Program in Chicago, Illinois and the director of the Cultural Factors in Psychiatric Diagnoses and Treatment course for Northwestern University's psychiatric residency program, Dr. Welch will review the current literature addressing the cultural aspects of the 1994 Rwandan genocide. She will address how select other cultures have engaged in the reconstruction process after war.

NO 59B

HEALING TRAUMATIC WOUNDS IN POST-GENOCIDE RWANDA: PSYCHIATRIC DISORDERS AFTER GENOCIDE

Lisa A. Rone, M.D., 405 N. Wabash Avenue, Suite 4905, Chicago, IL 60611

SUMMARY:

Mistrust, fear and traumatic responses are widespread in Rwanda fourteen years after the genocide. In 2004, Pham and colleagues measured the rates of exposure to violent acts and the subsequent incidence of PTSD in five sectors of Rwanda. These reasearchers found a high correlation between severe traumatic exposure and PTSD symptoms. Additionally, they found a significant correlation between severe exposure to violent acts and pessimism about justice and reconciliation in Rwanda.

Dyregrov and colleaugues studied 3030 Rwandan children ages 8-19 in 2000, 90% of whom believed they would die in the genocide. 78.3% experienced a death or multiple deaths in the family as a result of the genocide. 69.8% of these children witnessed someone being killed or injured, often a family member. Psychologists, psychiatric nurses and psychiatrists in Rwanda have noted that there is a "contagion effect" with traumatic reactions, not only among survivors of the genocide.

School children born after the genocide reportedly react to a traumatic trigger. When one begins to express fearful thoughts or emotions, a whole classroom may dissociate and require medical treatment.

Dr. Rone, Clinical Assistant Professor of Psychiatry at Northwestern University's Feinberg School of Medicine will summarize the literature available regarding the incidence of psychiatric disorders in certain areas that have experienced genocide and other forms of ethnic violence. She will review how these illnesses are screened in different cultures and discuss some efforts global health initiatives have made and can make to provide psychiatric assessment and treatment after genocidal conflicts.

NO 59C

HEALING TRAUMATIC WOUNDS IN POST-GENOCIDE RWANDA: A VIEW FROM THE INSIDE

Mukamana Donatilla, M.S.N., Niboye 2 Kigali 002503234 Rwanda

SUMMARY:

For one month in April, Rwandans officially recognize the genocide by holding survivor testimonials throughout the country. Ceremonies are televised and held at the Kigali Genocide Memorial Center. Psychiatric admissions to the country's public psychiatric hospital, Ndera, increase during this time.

Mental health care providers get asked many questions by parents about what to tell their children about the genocide, how much to disclose personally about their own experiences and how much to expose the children to these annual commemorations. Parents also want to know how to provide support to their children who witnessed or were victims of genocidal violence when they, as parents, are still so traumatized themselves. The hard work of rebuilding a stable sense of community is inextricably entertwined with addressing the psychiatric needs of citizens who have such high rates of PTSD and depression.

Ms. Mukamana is a psychiatric clinical nurse specialist and the director of the Kigali Mental Health Institute. She will explore specific aspects of the Rwandan mental health providers' role in treating survivors of the genocide. Additionally, she will discuss some cultural elements that make providing psychiatric care to Rwandans more challenging.

NO 59D

HEALING TRAUMATIC WOUNDS IN POST-GENOCIDE RWANDA: THE PROCESS OF THE DIALOGUE FOR PEACE

Naasson MN Munyandamutsa, M.D., IRDP Kigali 00250 7109, Rwanda

SUMMARY:

An important debate is occurring in Rwandan society. There is recognition of the need for dialogue between perpetrators and survivors of the genocide. There is the hope that this dialogue will move the peace process further, establishing a firmer ground on which to re-build societal connections and protect against future ethnic violence. Yet, there are those who maintain the necessity of preserving one's own historically and culturally rich heritage to transmit to future generations. How this debate proceeds may contribute to how Rwandan society's reconstruction efforts proceed. Establishing a greater sense of safety, security and tolerance may impact the incidence of PTSD and depression for future generations of Rwandans.

Dr. Mundyandamutsa is the Research Coordinator and Deputy Director of the Institute of Research and Dialogue for Peace (IRDP), the Rwandan division of the international organization Interpeace. It is IRDP's goal to "offer a neutral space for debate and exchange" in communities of both survivors and perpretrators of the genocide. IRDP has adapted a methodology for reconstruction of countries that other Interpeace programs have used for post-conflict reconstruction efforts around the world.

Dr. Mundyandamutsa will discuss his role as both a psychiatrist and the director of IRDP in facilitating these dialogues and advancing the goals of recontruction in Rwanda.

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SYMPOSIUM 60

TREATMENT OF ALCOHOL AND CO-OCCURRING PSYCHIATRIC DISORDERS: WHAT DO WE KNOW AND WHERE DO WE GO FROM HERE?

SUPPORTED BY NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants should be able to: 1) Estimate the prevalence of co-occurring alcohol use disorders and common psychiatric disorders (i.e., schizophrenia, bipolar, mood, and anxiety disorders) in clinical and general population samples; 2) Recognize the specific and potentially "unique" impact different co-occurring psychiatric disorders have on treatment; 3) Identify promising treatment approaches; and 4) Specify high-priority research questions still to be addressed to better inform clinical practice.

NO 60A

TREATMENT OF SCHIZOPHRENIA AND CO-OCCURRING ALCOHOLISM

Alan I. Green, M.D., One Medical Center Drive, Lebanon, NH 03756

SUMMARY:

Alcohol use disorder (AUD) occurs commonly in patients with schizophrenia and is associated with an increase in schizophrenia morbidity. While the basis of AUD in schizophrenia is unknown, we and others have suggested that a dysfunction of brain reward circuitry underpins alcohol use in these patients, and that use of alcohol transiently ameliorates this dysregulated circuit but also worsens the course of schizophrenia. Typical antipsychotic medications appear to have a limited ability to decrease alcohol use

in these patients. However, preliminary studies suggest that the atypical antipsychotic medication clozapine does decrease their alcohol use. Emerging data on the effects of other atypical antipsychotics in patients with schizophrenia and AUD suggest that some of these agents may also decrease alcohol use in this population, but the data are most consistent for this effect of clozapine. Preliminary data also suggest that naltrexone and disulfiram may have some ability to limit alcohol use in this population as well. We have proposed that clozapine decreases alcohol use through its ability to ameliorate the brain reward circuit deficit in patients with schizophrenia, an effect related to its broad spectrum pharmacological actions, particularly on dopaminergic and noradrenergic systems. This presentation will review these data and will also describe recent animal studies aimed at further delineating the basis of the effects of clozapine in patients with schizophrenia and alcoholism.

NO 60B

TREATMENT OF ALCOHOLISM AND OTHER ADDICTIVE DISORDERS WITH CO-OCCURRING BIPOLAR DISORDER: REVIEW OF THE EVIDENCE

Ihsan M Salloum, M.D., 1120 NW 14th Street, Miami, FL 33136

SUMMARY:

Bipolar disorder with co-occurring alcohol and other drug dependence is highly prevalent and is associated with significant negative impacts on treatment adherence, treatment response, and course of illness. There still exist significant unmet treatment needs for this population. The goal of this presentation is to review the most promising tested pharmacological and psychosocial treatments for this population. In particular, the results of published, double-blind, placebo-controlled studies with anticonvulsants and atypical antipsychotics conducted in this population, will be reviewed. Furthermore, novel psychotherapeutic approaches for the treatment of bipolar disorder complicated by alcoholism and other addictions will be discussed. Implications for treatment implementation and for future research on emerging treatment strategies will also be explored.

NO 60C

PROBLEMS IN ASSESSMENT AND TREATMENT OF CO-OCCURRING DEPRESSION AND ALCOHOL DEPENDENCE

Helen M Pettinati, Ph.D.,3900 Chestnut Street, Philadelphia, PA 19104

SUMMARY:

The co-occurrence of depression and alcohol dependence is highly prevalent, and difficult to treat successfully. Studies have demonstrated problems in distinguishing depression as a comorbid illness from fluctuating depressive symptoms in alcoholics who are actively drinking. While some studies have shown that antidepressants may reduce depressive symptoms in these patients, most studies have not found antidepressant medications to be helpful for reducing excessive drinking. This presentation will review the latest epidemiological and clinical data on the prevalence of co-occurring alcohol dependence and depression, define problems in assessment of depression in these patients, and explore reasons why antidepressants have sometimes been only weakly effective. This presentation will also include results from a recently completed 14-week randomized, placebo-controlled clinical trial that compares sertraline, naltrexone, and their combination in the treatment of depressed alcoholics. Implications for the use of pharmacotherapy to treat patients with co-occurring depression and alcohol dependence will be explored.

NO 60D

CO-OCCURRING ALCOHOL USE DISORDERS AND SOCIAL ANXIETY DISORDER

Carrie L Randall, Ph.D., PO Box 250861, 67 President Street (4 North)Charleston, SC 29425

SUMMARY:

Social anxiety disorder is more than just shyness. Individuals who meet *DSM-IV* criteria for social anxiety disorder typically have an age of onset in the adolescent years, and they are at risk for the subsequent development of additional co-occurring Axis I disorders, including alcohol abuse/alcohol dependence. This presentation will review the latest epidemiological data on the prevalence of co-occurring AUD and social anxiety disorder, explore reasons why social anxiety in adolescents may uniquely increase the risk of developing an alcohol problem later in life, present data related to the impact of social anxiety on alcohol treatment, and finally will present results from a 16-week randomized, placebo-controlled clinical trial of paroxetine in the treatment of socially anxious alcoholics. Implications for prevention and treatment of alcohol dependence will be explored.

NO 60E

PTSD AND CO OCCURRING ALCOHOL USE DISORDERS

Kathleen Brady, M.D., 171 Ashley Avenue, Charleston, SC 29425

SUMMARY:

Posttraumatic stress disorder (PTSD) and alcohol use disorders (AUDs) frequently co-occur. Among individuals seeking treatment for AUDs, the majority report experiencing at least one traumatic event, and a substantial minority meet criteria for lifetime PTSD. In this presentation, results from a series of studies exploring etiologic connections and treatment of co-occurring PTSD and AUDs will be presented. Studies exploring the hypothalamic-pituitary-adrenal axis changes and neurobiologic connections between PTSD and alcohol use disorders will be reviewed. A number of psychotherapeutic approaches to the treatment of co-occurring PTSD and AUDs have been explored. Findings from these studies will be examined. Finally, promising approaches to pharmacotheraptueic treatment of co-occurring

PTSD and alcohol dependence will be explored.

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SYMPOSIUM 61

UNDER THE BELL JAR: THE LIFE, WORKS, PSYCHOPATHOLOGY AND TREATMENT OF SYLVIA PLATH

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: describe the events of Ms. Plath's formative years and understand the framework in which her work and psychopathology emerged; understand the interaction between Ms. Plath's talent, hard work, and success as a writer and grasp the interplay between her psychiatric illness, treatment, relationships and the course of her life; and reflect on considerations in treating someone who is famous.

NO 61A

SYLVIA PLATH: THE CHILDHOOD YEARS

Allison S Baker, M.D., 1051 Riverside Drive, Mailbox #97, New York, NY 10032

SUMMARY:

Specific Purpose: To describe Sylvia Plath's formative years, from childhood throughout adolescence and matriculation at college, and to highlight the events and currents that would mold and drive her adult self.

Content: The map of Ms. Plath's early childhood will be delineated, including key relationships, early childhood loss (death of her father), and geographical moves of importance (move to Wellesley, MA).

Methodology: By describing both Ms. Plath's own observations years later as well as various interpretations of her childhood by biographers, we consider the key and formative dynamics of Ms. Plath's early years in context and with an eye to their effect on Ms. Plath's future.

Results: Ms. Plath experienced several events in childhood that would affect the course of her life and work, most notably the death of her father from a preventable disease at age nine.

Importance of Proposed Presentation: Critical to understanding the works and psychopathology of Ms. Plath is the examination and discussion of her early years and influences.

Specific Findings: Ms. Plath experienced a blissful early childhood, shortened by early object loss and a move to the proper suburb of Wellesley which became the milieu in which her talent emerged. Further, by considering the details of Ms. Aurelia Schober's (Ms. Plath's mother) circumstance after the unexpected death of her husband, and new single parenthood with two young children as an Eastern European immigrant, her motivations for the academic and financial success of her children are put into context. This in turn is helpful for understanding the neurotic dynamic between Ms. Plath and her mother, as reflected in both Ms. Plath's poems and The Bell Jar.

Summary: Ms. Plath's early years provide insight into the person, work and ultimate demise of this eminent writer and foreshadow, to a great extent, her psychopathology.

NO 61B

SYLVIA PLATH: THE COLLEGE YEARS

Laura K Kent, M.D., 1051 Riverside Drive, PO Box 49, New York, NY 10032

SUMMARY:

Specific Purpose: To describe Ms. Plath's journey through college, her first psychotic depression and suicide attempt, and her subsequent triumphant return to academic life.

Content: Ms. Plath's college years were filled with very disappointing rejections as well as many honors and much success. Intermingled in what might have been a fairly normal college course was a crippling major depression, descent into psychosis and attempted suicide.

Methodology: Based on excerpts from her autobiographical novel The Bell Jar and from observations by biographers, the events of her college life, introduction to mental illness, and admission to McClean Hospital will be described.

Results: After the devastating news regarding rejection from a summer writing course and ensuing major depression, Ms. Plath recovered and returned to college. She had enormous subsequent success and deepened insight.

Importance of Proposed Presentation: The description of her college years set forth the tumultuous interplay between her severe Axis I illness and her significant writing talent.

Specific Findings: Ms. Plath survived a near-lethal suicide attempt, subsequent hospitalization and return to an extraordinary college career.

Summary: During her college years, Ms. Plath established herself as a prominent writer despite an immense and near lethal struggle with mental illness.

NO 61C

SYLVIA PLATH: THE CAMBRIDGE YEARS

Sara S Nash, M.D., 1051 Riverside Drive, New York, NY 10032

SUMMARY:

Specific Purpose: To describe the most productive years of Sylvia Plath's career both as writer, wife and mother. In addition, to highlight those seminal events in Ms. Plath's life at that time that would lead her not only to meet and marry Ted Hughes, but ultimately to descend into deep depression during which time she would take her own life.

Content: Ms. Plath completed Smith and met her husband, Ted Hughes during a Fullbright scholarship to Cambridge, England. She returned to the United States to teach at her alma mater briefly before moving to England to focus on her writing career and raising children.

Methodology: Through her poetry, biographers and journal entries we will describe the course of her life during this period.

Results: Ms. Plath, while extraordinarily productive after college both personally and in her career ultimately succumbed to an entrapping depression from which she was unable to emerge.

Importance of Proposed Presentation: These years of Ms. Plath's life highlight the intimate nature of both her talent and mental illness, highlighting how life's tumult can affect one's work and serve to destabilize someone with mental illness to the point of tragedy.

Specific Findings: Ms. Plath, while extremely talented, was unable to survive a life threatening depression.

Summary: Even in the midst of a depression that would ultimately take her life, Ms. Plath was able to produce some of her most talented and insightful work suggesting the intimate link in certain cases between artistic talent and crippling mental illness.

REFERENCES:

1) Plath, Sylvia: The Bell Jar. New York, Harper Perennial, 1996.

2) Plath, Sylvia: Ariel. New York, Harper Perennial, 2005.

3) Butscher, Edward: Sylvia Plath: Method and Madness. Tucson, AZ, Schaffner Press, 2003.

4) Britzolakis, Christina: Sylvia Plath and the Theatre of Mourning. London, Oxford University Press, 2000.

SYMPOSIUM 62
BORDERLINE PERSONALITY DISORDER IN ADOLESCENCE: WHAT DOES IT LOOK LIKE AND HOW IS IT TREATED?

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able recognize and diagnose borderline personality disorder (BPD) in adolescents and differentiate it from co-morbid Axis I disorders. Participants will become aware of the extent of suicidal behavior and mental health service utilization patterns of such individuals. Participants will learn about current clinical programs that target adolescents with BPD and current research trials investigating cognitive analytic therapy.

NO 62A

THE AXIS I COMORBIDITY OF ADOLESCENT ONSET BORDERLINE PERSONALITY DISORDER

Mary C Zanarini, Ed.D., McLean Hospital, 115 Mill Street, Belmont, MA 02478

SUMMARY:

Objective: The purpose of this study was to determine the lifetime prevalence of axis I disorders reported by adolescent inpatients diagnosed with borderline personality disorder (BPD). Method: Forty hospitalized girls and boys aged 13-17 who met both Revised Diagnostic Interview for Borderlines (DIB-R) and *DSM-IV* criteria for BPD were interviewed concerning axis I comorbidity using a semistructured interview (KID-SCID) of proven reliability. Results: 90% of these adolescents met criteria for a mood disorder (all unipolar in nature), 63% for an anxiety disorder other than PTSD, 18% for PTSD, 30% for a substance use disorder, and 25% for an eating disorder. In addition, 43% met criteria for oppositional defiant disorder, 20% for ADHD and conduct disorder, and 15% for separation anxiety disorder. Conclusions: The results of this study suggest that axis I disorders of an affective nature (mood or anxiety disorders) are more common in those with adolescent onset BPD than impulse spectrum disorders (substance use or eating disorders). They also suggest that childhood onset disorders have a strong association with early onset BPD and that PTSD has a relatively weak association with early onset BPD.

NO 62B

BORDERLINE PERSONALITY DISORDER IN SUICIDAL ADOLESCENTS

Shirley Yen, Ph.D., 700 Butler Drive, Providence, RI 02906

SUMMARY:

Studies of adolescent suicidality often do not assess for borderline personality disorder (BPD), in spite of strong evidence of an association in adult samples. In this study, Ss are recruited from an adolescent inpatient psychiatric unit, admitted on the basis of some suicidal behavior (e.g. attempt, threat, ideation, preparatory behaviors, or behaviors interpreted as an attempt). Baseline interviews include ratings of suicidal behavior for intent and lethality, Axis I disorders and functioning, BPD, and self-injurious behaviors. Assessments were conducted with both adolescent and parents, and consensus ratings based on best available data were used for data analyses. To date, baseline data is available on 69 ss. Of these, 31 (45%) met full criteria for BPD. Preliminary analyses indicates a trend; suicidal adolescents with BPD were more likely to be admitted following a suicide attempt compared to non-BPD suicidal adolescents ($X2 = 8.58$; $p = .07$). Furthermore, parents of BPD suicidal adolescents reported higher intent to die ($Z = -1.78$; $p = .02$) and more lethal attempts ($Z=-2.52$; $p = .018$). There were no differences between the groups on baseline levels of suicidal ideation. With regard to Axis I disorders, BPD ss were more likely to have comorbid PTSD ($X2 = 9.96$; $p = .002$); there were no significant differences between groups for depressive,

bipolar, other anxiety, eating, disruptive, and substance use disorders. BPD suicidal adolescents reported poorer relationship with their mothers. No other differences in functioning were found. These data indicate an association between BPD and suicidal behavior in adolescence, even when contrasted against a comparison group of other suicidal adolescents. These findings are preliminary as the study is ongoing. At the time of presentation, we will have more data, including a sufficient amount of follow-up data for analyses.

NO 62C

PATTERNS OF MENTAL HEALTH TREATMENT UTILIZATION IN ADOLESCENT BORDERLINE PERSONALITY DISORDER (BPD): DOES IT DIFFER FROM ADULT BPD?

Marianne S Goodman, M.D., James J Peters VA Medical Center, 130 West Kingsbridge Road, Bronx NY 10468

SUMMARY:

Background: Borderline Personality Disorder (BPD) is associated with high levels of mental health utilization. However treatment usage for BPD in adolescence is relatively unstudied, as is whether treatment patterns are similar to BPD diagnosed in adulthood.

Methods: We developed an on-line survey containing approximately 100 questions for parents to complete about their BPD offspring, covering clinical variables including treatment history. BPD offspring were identified by meeting diagnostic criteria embedded within the survey and having been given a diagnosis of BPD by a professional at some point in their lives.

Results: We report on 441 offspring with BPD - 235 "adolescent presenters" diagnosed with BPD during adolescence, and 206 "adult presenters" diagnosed with BPD as adults (age 19 and above).

Adolescent and adult presentations of BPD were associated with remarkably similar rates of lifetime co-morbid diagnoses of MDD, bipolar disorder and anxiety disorders, but adolescent presenters had higher lifetime rates of ADHD (36% vs. 26%, $p<.055$) and ODD (21% vs. 7%, $p<.0001$). With respect to treatment, adolescent presenters had slightly higher rates of hospitalization (87% vs. 80% for adult presenters, $p<.06$) but both groups demonstrated similarly high rates of lifetime use of therapy (89-91%) and psychotropic medication (89-92%).

In a subset of survey respondents completing detailed questioning about specific treatments (n=201), adolescent presenters, compared to adult presenters, were more likely to be treated with CBT and ADHD medications and less likely to be prescribed antidepressants or anti-anxiety agents.

Conclusions:

There is considerable overlap in the patterns of co-morbidities and treatment use between adolescent and adult presenters, suggesting they are part of the same continuum. However, one important distinction is the higher co-morbidity and treatment of ADHD in adolescents with BPD. Both groups can exhibit extensive use of mental health resources.

NO 62D

A HOSPITAL BASED ADOLESCENT DBT PROGRAM FOR ADOLESCENT GIRLS WITH BORDERLINE PERSONALITY DISORDER

Aguirre A Blaise, M.D., 115 Mill Street, Belmont ,MA 02478

SUMMARY:

Dialectical Behavior Therapy (DBT) was developed as a treatment for suicidal and self-injurious behaviors. A natural application for this psychotherapy is in the treatment of Borderline Personality. Medicine has moved to the establishment of highly specialized centers, focusing on discrete diagnoses. In psychiatry, there has been a similar move and we find dedicated diagnosis specific treatment units. This thinking applied to the establishment of a treatment center for adolescents with established or emerging BPD.

DBT was originally devised as an outpatient model for a therapy that would last 6 months to a year. A successful long-term adolescent residential DBT model has been described by Walsh (1). We have pioneered a short term (4-6 week) intensive residential DBT program, which incorporates individual and group therapy, telephone skills coaching, individual skills coaching, family psychoeducation and family skills coaching.

This presentation will detail a full description of the program since inception including the administrative demands of the program such as staff and patient selection as well as the course of a treatment, focusing on a typical clinical day and how the modes of therapy are integrated.

Whereas not all of what we have established is easily replicable in other centers, certain key aspects can be achieved at minimal relative cost to any organization. Firstly, identifying key clinical staff interested in working with BPD adolescents. Secondly, creating a team of these interested clinicians ready to work together. Thirdly intensively training the team in DBT, and establishing a mechanism for ongoing training for the team as well as for new staff hires.

References: (1) Walsh B. 2004 APA Gold Award: Using Dialectical Behavior Therapy to Help Troubled Adolescents Return Safely to Their Families and Communities. The Grove Street Adolescent Residence of The Bridge of Central Massachusetts, Inc. Psychiatr Serv 55:1168-1170, October 2004

NO62E

EARLY INTERVENTION FOR BORDERLINE PERSONALITY DISORDER IN ADOLESCENCE: A RANDOMISED CONTROLLED TRIAL

Andrew M Chanen, M.B.B.S., 35 Poplar Road, Parkville, Melbourne, 3052 Australia

SUMMARY:

Background: No accepted intervention exists for borderline personality disorder (BPD) presenting in adolescence. The Helping Young People Early (HYPE) Clinic is a specialized outpatient early intervention program for BPD in youth, operating in Mel-

bourne, Australia. Aims: To compare the effectiveness of up to 24 sessions of cognitive analytic therapy (CAT; Ryle 1997) or manualized good clinical care (GCC) in addition to the comprehensive HYPE service model of care. Method: Randomized controlled trial of CAT and GCC in 15-18 year-old outpatients with 2-9 DSM-IV BPD criteria. We hypothesized that, compared to GCC, the CAT group would show greater reductions in psychopathology and parasuicidal behavior and greater improvement in global functioning over 24 months. Results: 86 patients were randomized and 78 (CAT n=41; GCC n=37) provided follow-up data. There were no significant differences between the outcomes of the treatment groups at 24 months on the pre-chosen measures but there was some evidence that patients allocated to CAT improved more rapidly. No adverse effects were shown with either treatment. Conclusions: CAT and GCC are both effective in reducing psychopathology and parasuicidal behavior and improving global functioning in teenagers with sub-syndromal or full-syndrome BPD. Larger studies are required to determine the specific value of CAT in this population. Quasi-experimental comparison of CAT and GCC with historical 'treatment as usual' in the same outpatient service suggests that specialized early intervention for BPD is more effective than treatment as usual, with CAT being more effective than GCC.

REFERENCES:

1) Chanen, A. M., Jovev, M., McCutcheon, L. K., Jackson, H. J., & McGorry, P. D. (2008). Borderline Personality Disorder in Young People and the Prospects for Prevention and Early Intervention. Current Psychiatry Reviews, 4, 48-57.

2) Crick, N. R., Murray-Close, D., & Woods, K. (2005). Borderline personality features in childhood: a short-term longitudinal study. Dev Psychopathol, 17(4), 1051-1070.

3) Miller, A. L., Muehlenkamp, J. J., & Jacobson, C. M. (2008). Fact or fiction: Diagnosing borderline personality disorder in adolescents. Clin Psychol Rev. 2008 Jul;28(6):969-81. Epub 2008 Mar 10

4) Winograd G, Cohen P, Chen H.Adolescent borderline symptoms in the community: prognosis for functioning over 20 years.J Child Psychol Psychiatry. 2008 Jul 28. [Epub ahead of print]

SYMPOSIUM 63
DIFFERENT EXPERTS APPROACH A CASE OF BORDERLINE PERSONALITY DISORDER

SUPPORTED BY ASSOCIATION FOR RESEARCH IN PERSONALITY DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand how different experts approach the treatment of a borderline personality disorder case.

NO 63A

DEALING WITH AXIS I COMORBIDITY IN A BORDERLINE PERSONALITY DISORDER CASE

James H Reich, M.D., 2255 North Point Street, #102, San Francisco, CA 94123

SUMMARY:

When the clinician encounters a personality disorder it is rare that this is the only problem. Experience and empirical studies indicate that the presence of a personality disorder seldom occurs in isolation from an Axis I disorder. This comorbidity can affect treatment in at least three ways. One, there is reasonably good evidence that personality pathology may delay or complicate the course of treatment of an Axis I disorder. Two, an Axis I disorder can interfere with the management of dysfunctional personality symptoms. Three an Axis I disorder may artificially magnify the apparent importance of dysfunctional personality traits (State effects.) This presentation will discuss where to start (i.e., how to prioritize treatment); modifying treatment of an Axis I disorder in the presence of personality pathology for best outcome; managing maladaptive personality traits in the face of Axis I pathology: and recognizing state personality disorder. It will do so by focusing on the case presentation at hand.

NO 63B

A DIMENSIONAL/VULNERABILITY APPROACH TO BORDERLINE PERSONALITY DISORDERS (BPD)

Larry J Siever, M.D., 1 Gustave L. Levy Place, Box 1230, New York, NY 10029

SUMMARY:

Patients with severe personality disorders like borderline personality disorders (BPD) have vulnerabilities in multiple domains/dimensions of psychopathology including affect regulation, impulse control, cognitive capacity, anxiety and sensitivity to separation that in the context of attachment patterns and stressors and development influence their final presentation. Thus, a dimensional approach to an assessment of a patient like this would address these domains addressing whether shifts in perception of his bosses represented, for example, a devaluation from an idealized view or a clearly disjunctive cognitive appraisal suggesting possible dissociative mechanisms or cognitive impairment. Were his disagreements with supervisors secondary to his rigidity and his compulsive symptomatology, to anger dyscontrol, or cognitive/perceptual issues? Were high doses of SSRIs specifically prescribed and did they affect his anger and compulsive symptoms? What was his behavior in psychotherapy? How did his obsessive-compulsive symptoms interact with his borderline personality disorder? Careful attention to these questions generated by a dimensional approach in a clinical setting with adjunctive psychological and laboratory testing if indicated might help in developing a rational assessment of the causes of his difficulty and the dynamics of how they play out in his interpersonal and occupational life, suggesting a rational strategy for both pharmacotherapy and psychotherapy.

Reference: Siever LJ, Torgersen S, Gunderson JG, Livesley WJ, Kendler KS: The borderline diagnosis III: Identifying endophenotypes for genetic studies. Biol Psychiatry 51:964-968, 2002. Siever LJ, Davis KL: A psychobiologic perspective on the personality disorders. Am J Psychiatry 148:1647-1658, 1991.

NO 63C

SHORT-TERM PSYCHODYNAMIC SUPPORTIVE PSYCHOTHERAPY (SPSP) FOR THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

Simone Kool, Ph.D.,Frederik Hendrikstraat 47 Amsterdam 1052 HK, Netherlands

SUMMARY:

SPSP is a form of supportive-expressive psychotherapy. It is theoretically mainly rooted in aspects of Ego-psychology and Object-relation theory. SPSP is originally developed for the treatment of depression but could be applied to other stress-related psychiatric diseases as well. In several trials the efficacy of SPSP in depression has been demonstrated, also in case of comorbid personality pathology.

The SPSP protocol consist of 16 sessions, the first 8 sessions are weekly, the last fortnightly. The approach focusses on the affective, behavioral and cognitive aspects of relationships. This can be discussed from both an interpersonal or intrapersonal perspective. Depending on the focus of therapy and the capacities of the patient, the interventions of the therapist are primarily directed at providing adequate support (e.g, encouraging adaptive coping, reducing feelings of guilt) or enhancing insight by confrontation or clarification. Manifestations of defense mechanisms and transference are recognized and adapted if necessary to improve the therapeutic process, but they are not interpreted. In the beginning phase special attention will be given to determine the focus of therapy, to establish an optimal therapeutic relation in the context of the 'two-person psychology' view and how to prevent drop-out from therapy.

NO 63D

USING NIDOTHERAPY TO TREAT PERSONALITY DYSFUNCTION

Peter Tyrer, M.D., Department of Psychological Medicine, St. Dunstan's Road, London, W6 8RP U.K.

SUMMARY:

Sam is clearly unhappy. He has a personality diathesis mainly within the choleric group (B) and is hot-headed, impulsive and generally dissatisified. His personality diathesis makes him prone to anxiety and depressive disorders but if he was in the right environment he would probably be free of these symptoms altogether. If Sam's environmental problems were treated with nidotherapy over a period of 18 months there is the reasonable prospect of him finding a suitable niche where he would be able to settle and develop long-term stability. This would first require a full environmental analysis of his physical, social and personal needs. There is not much relevant information in the vignette but it does seem clear that Sam is not in an ideal scenario when he is working in a top-down organisation and he would probably be much better suited to a small group in employment or possibly even self-employed. He is obviously bright but cannot find the right outlet for his abilities and much better occupational guidance is needed. He also needs to develop some clear long-term goals once the environment analysis is complete; these need to be attainable, realistic and capable of incremental success. One thing stands out from his account is that he has very low self esteem; it is essential that this is addressed in the treatment programme. Medication is not likely to be an answer.

NO 63E

AN INTEGRATED PERSPECTIVE ON THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

John Livesley, M.D., 2255 Wesbrook Mall, Vancouver V64 1L1 Canada

SUMMARY:

Integrated treatment distinguishes between generic interventions common to all therapies and specific interventions drawn form different treatment models. Generic interventions form the basic structure of treatment. These emphasize the establishment of a collaborative alliance, consistency, validation, and building motivation. Specific interventions are added as needed to treat specific problems providing the alliance and motivation are adequate. This approach is very applicable to treating Sam: he has multiple problems including symptoms, dysregulation of emotions and impulses, maladaptive traits and interpersonal patterns, and self pathology that are unlikely to respond equally to a given approach. The emphasis on generic interventions that focus on the relationship and motivation is also pertinent given previous treatment failures, poor motivation, and intimacy problems. The therapist will need to pay careful attention to establishing the treatment contract, building the relationship through empathy, support, and validation, and building a commitment to change. Early in treatment, this approach would be supplemented with medication to treat Axis I disorders and emotional dysregulation. As rapport increases, cognitive-behavioral methods would be used increase self-regulation. Nevertheless, attention would continue to be paid to the alliance and success in symptom reduction would be used to improve the alliance and motivation. Subsequently, as self-regulation increases, treatment would begin to focus on underlying interpersonal problems. However, the previous treatment methods alone are unlikely to be optimal in treating these problems. Hence, psychodynamic, interpersonal, and constructionist methods would be added as needed to address the flow of Sam's problems and concerns. Eventually, treatment would begin to incorporate a focus on self and identity problems with the intent of helping Sam to construct a more adaptive sense of self.

NO 63F

TREATING THE CASE OF SAM WITH SYSTEMS TRAINING FOR EMOTIONAL PREDICTABILITY & PROBLEM SOLVING

Nancee S Blum, M.S.W., Department of Psychiatry, 1-189 MEB, Lucille A. and Roy J. Carver College of Medicine, The University of Iowa, Iowa City, IA 52242

SUMMARY:

This presentation describes the STEPPS (Systems Training for Emotional Predictability and Problem Solving) treatment program for Borderline Personality Disorder (BPD), and how it would be applied specifically to the case under discussion. In this 20-week (2 hours/week) outpatient psychoeducational, cognitive-behavioral, skills training approach, BPD is characterized as an emotional intensity disorder (EID) that clients learn to manage with specific emotion and behavioral management skills. Key professionals, friends, and family members (client's "reinforcement team") also learn to support and reinforce these skills. The STEPPS program is intended to supplement the client's current treatment regimen to allow the client to utilize a support system already in place, but also to help the client utilize that support system more effectively. The program is manual based with detailed weekly lesson plans for facilitators and materials for each lesson which are shared with the attendees. The program focuses on three major components: awareness of illness, emotion management, and behavior management skills. The STEPPS program can be effectively and economically implemented by facilitators from diverse training backgrounds and in a variety of settings. This program has been supported by RCTs in the US and The Netherlands. Data show that clients with BPD have improvement in multiple domains, including mood, negative affectivity, impulsivity, and gobal functioning.

REFERENCES:

1) Livesley WJ: Practical management of personality disorder. New York, Guilford, 2003

2) Tyrer P Sensky T, Mitchard S. Principles of nidotherapy in the treatment of persistent mental and personalty disorders. Psychother Psychosom 2003 Nov-Dec; 72(6):350-6

3) Blum N, St. John D, Pfohl B, et. al. Systems training for emotional predictability and problem solving (STEPPS) for outpatients with borderline personality disorder. Am J Psychiatry 2008 Apr; 165(4): 468-78

4) Reich J. Drug treatment of personality disorder traits. In Personality Disorders: Current research and treatment. 2005, Taylor and Francis, New York pp 127-146

SYMPOSIUM 64.
BAD VERSUS MAD THE FAILURE OF THE PENAL SYSTEM IN CALIFORNIA

Supported by APA Council on Global Psychiatry and the APA Council on Children, Adolescents, and Their Families

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to effectively participate in the debate as to whether users of drugs should be generally handled by the mental or the penal system. Evidence will be presented to demonstrate that treatment is an effective alternative to punishment.

NO 64A

THERAPEUTIC JUSTICE: FAMILY MEMBERS SPEAK OUT TO END DISCRIMINATION AGAINST INDIVIDUALS STRUGGLING TO RECOVER FROM ADDICTIVE ILLNESS

Gretchen Bergman, 2527 Doubletree Road, Spring Valley, CA 91978

SUMMARY:

In 2000 Proposition 36, which mandates treatment instead of incarceration was passed in California. This landmark legislation has saved over $1.5 billion and has sent over 36,000 individuals per year to treatment instead of incarceration. In November 2008, a new measure, Prop 5, the (Nonviolent Offender Rehabilitation Act)will be on California ballots, which will be an extensive expansion of this life-saving policy.

I served as State Chairperson for Prop 36, and co-founded A New PATH (Parents for Addiction Treatment & Healing) in 1999, a non-profit organization dedicated to reducing the stigma attached to addictive illness in order to increase access to therapeutic treatment opportunities in lieu of damaging punitive policies. My son, who is a recovering drug addict was caught up in the criminal justice system for a decade for non-violent possession and use. Our strategies for therapeutic justice include harm reduction techniques and advocacy for humane drug policy.

NO 64B

DECONSTRUCTING CO-DEPENDENCE: PARENTS NEED TO SHEPHERD THEIR LOVED ONES INTO TREATMENT SERVICES AND AWAY FROM PUNITIVE POLICIES

Caroline Stewart,1527 West Lewis Street, San Diego, CA 92103

SUMMARY:

Parents explore the intricacies of the disease of substance abuse and the effects of the disease on family members. Tough love approaches can be costly in terms of health, so strategies aimed at harm reduction are advised.

I seek to present a realistic understanding of the problem from a personal, as well as a healthcare perspective, and suggest actions to take in order to provide necessary support to loved ones with addictive illness, as they journey through the disease, treatment, relapse, and often incarceration.

Families are encouraged to create workable plans for reintegration with family members from institutions into the community and to advocate for therapeutic treatment opportunities, rehabilitation, and reunification.

NO 64C

NEW TREATMENTS AND BETTER PROGNOSIS

Claudio O Cabrejos, M.D., M.P.H., 4363 Donald Avenue, San Diego, CA 92117-3812

SUMMARY:

This presentation addresses progress made in the treatment of

addictions, showing that prosecution and long sentences for drug offenders should be increasing obsolete. The author presents a number of new findings.

NO 64D

TREAT OR SHUN

Kenneth A Khoury, M.D., 125 S Grape Street, Escondido, CA 92025

SUMMARY:

Thirty-five years of treatment evolution in the practice of an addiction psychiatrist has lead to powerful therapeutic alternatives to the dispiriting nihilistic isolation of those with addiction illness. Just as those with chronic mental illnesses are most effectively treated within the community of functional society, so also are those with destructive addictive illnesses. In both cases, we can now do far better than locking away feared problems in the failed hope of protecting society while only worsening outcomes, wasting precious resources, and missing the opportunity of consistent and appropriate interventions that heal.

NO 64E

CALIFORNIA'S NONVIOLENT OFFENDER REHABILITATION ACT: REDUCING THE ROLE OF ADDICTION AND MENTAL ILLNESS IN PRISON OVERCROWDING

Margaret Dooley-Sammuli, 3470 Wilshire Boulevard, Suite 618, Los Angeles, CA 90005

SUMMARY:

The Nonviolent Offender Rehabilitation Act (NORA), which will appear as Proposition 5 on the November 2008 state ballot, will change the way the state treats nonviolent offenders—implementing reforms repeatedly recommended by experts over several decades and finally substantially addressing the role that addiction and mental illness play in driving our incarceration and recidivism rates.

By expanding rehabilitation behind bars, providing more reentry services to nonviolent offenders on parole and expanding access to treatment-instead-of-incarceration for nonviolent low-level drug offenders, NORA would significantly reduce recidivism and support parolee reintegration into the community. NORA would also fund the creation of a system of care for young people with drug problems—where no system currently exists.

NORA is the necessary response to California's failed criminal justice and public health policies. Drug treatment in California is woefully under-funded. At the same time, the cost of California's prison system expands dramatically every year. Too few people who need treatment get it. Too many nonviolent drug offenders who need treatment go to jail or prison instead—over and over again. And the vast majority of people in the system need, but are not receiving, rehabilitation programs including drug treatment. NORA will take on the prison system, which is at 170% capacity, and reduce the state's recidivism rate, which--at 70%--is twice the national average.

NORA would reallocate funding to ensure that quality programs would be available for all nonviolent offenders in the system. According to the Legislative Analyst's Office, these changes would more than pay for themselves and would generate another $2.5 billion in net savings in reduced prison construction costs over the next few years.

REFERENCES:

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2) Hales, R.E.. Bourgois, J.A., et al. Self Assessment in Substance Abuse Treatment. APPI, 2008

3) APPI - Psychiatic Services in Jailes and Prisons, 2 Ed., 2000

4) Lamb, R. Issues in Community Treatment. APPI, 1999

SYMPOSIUM 65
PREVENTION AND TREATMENT OF MENTAL DISORDERS IN CHILDREN IN CARE

SUPPORTED BY APA COMMITTEE ON FAMILY VIOLENCE AND ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe programs designed to prevent children needing to go into care as well as those initiated to detect and treat mental disorders in children in care.

NO 65A

HELPING VIOLENCE EXPOSED CHILDREN: A CURRICULUM TO STRENGTHEN THE PARENT-CHILD RELATIONSHIP

Patricia J Van Horn, Ph.D., SFGH, Ste. 2100, 1001 Potrero Avenue, San Francisco, CA 94110

SUMMARY:

The literature tells us that in approximately 50% of homes where there is child maltreatment there is also violence between the adult partners. This paper will present that literature, and will make a case that, especially for young children, witnessing violence between parents may be more traumatic than sustaining child maltreatment. It will then describe a curriculum designed to train domestic violence advocates who work with mothers victimized by domestic violence. The curriculum explores the impact of witnessing violence on children's development, including contributing to emotional and behavioral dysregulation, and supports advocates to help mothers understand these developmental changes and to interact with their children in ways that will lead to children's recovery. The focus of the curriculum is on building advocates skills at intervening with children through the mother-child relationship and at supporting families by developing collaborative relationships with other systems that touch families' lives, including the child welfare system. The paper will also

describe the development of the curriculum and present preliminary data on its effectiveness to change practice.

NO 65B

INCREASING ACCESS TO CHILD WELFARE AND MENTAL HEALTH SYSTEMS BY REDUCING STIGMA

William Arroyo, M.D., 4034 Witzel Drive, Sherman Oaks, CA 91423

SUMMARY:

Dr. Arroyo is involved in designing and implementing a program to prevent children form ending up in foster care. Many troubled families do not know where to go for help or fear getting involved with the child welfare or mental health systems. This innovative program uses digital stories designed to reduce stigma related to getting help from child welfare and mental health systems among families with very young children. The aim is to increase early intervention and prevent later problems leading to the dissolution of the family.

NO 65C

THE EFFECTS OF ENHANCED FOSTER CARE ON THE LONG-TERM PHYSICAL AND MENTAL HEALTH OF FOSTER CARE ALUMNI

Peter Pecora, Ph.D., 1300 Dexter Avenue, North Floor 3, Seattle, WA 98109

SUMMARY:

Context: Although the child welfare system routinely places severely abused-neglected children in foster care, no controlled studies exist to determine the effectiveness of this intervention in improving the long-term health of maltreated youth.

Objective: To present results of the first quasi-experimental study to evaluate the effects of expanded foster care treatment on the mental and physical health of adult foster care alumni.

Design: A quasi-experimental design was used to compare adult outcomes of alumni of a model private foster care program and two public programs. The latter alumni were eligible but not selected for the private program because of limited openings. Propensity score weights based on intake records adjusted for pre-placement between-sample differences. Personal interviews administered 1-13 years after leaving foster care assessed the mental and physical health of alumni.

Intervention: Caseworkers in the model program had higher educations and salaries, lower caseloads, and access to a wider range of ancillary services (e.g., mental health counseling, tutoring, and summer camps) than caseworkers in the public programs. Youth in the model program were in care more than two years longer than those in the public programs.

Setting/Participants: A representative sample of 479 adult foster care alumni in care as adolescents (14-18 years of age) between 1989 and 1998 in either private (n = 111) or public (n= 368) foster care programs in Oregon or Washington. Over 80% of alumni were traced and 92.2% of those traced interviewed.

Results: Private program alumni had significantly fewer mental disorders (major depression, anxiety disorders, substance disorders), ulcers, and cardio-metabolic disorders, but more respiratory disorders, than public program alumni.

Conclusions: Public sector investment in higher quality foster care services could substantially improve the long-term mental and physical health of foster care alumni.

NO 65D

YOUTH EMPOWERMENT INTERVENTIONS AND FOSTER CARE

Sandra J Kaplan, M.D., 156 West 88th Street, Upstairs Apt, New York, NY 10024-2402

SUMMARY:

Youth empowerment has been referred to as a process which leads to an enhanced sense of self competency, community influence and skills development (Perkins and Zimmerman, 1995). This paper will present a review of research on youth empowerment interventions which have been utilized to enhance the functioning and mental health of adolescents in and young adult alumni of foster care. These interventions include mentoring, participation of youth in care and of alumni of care as members of child welfare system committees and meetings, youth participation during their court child custody proceedings and of interventions to enhance youth academic and vocational skills (Kaplan, Skolnik and Turnbull, 2008).

Utilization and evaluation of an intervention being utilized by the Casey Family Programs for youth in foster care which is based on SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress (DeRosa, Pelcovitz, Habib, Labruna, Kaplan, National Child Traumatic Stress Network, 2008) to enhance youth empowerment by enhancing coping and interpersonal skills of youth in foster care will be presented.

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SYMPOSIUM 66
REASSESSING THE ACTION OF PSYCHIATRIC

DRUGS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) appreciate different ways or models of understanding the action of psychiatric drugs; 2) to understand the evidence base for the different models; 3) to appreciate the ethical implications of different approaches to understanding psychiatric drug action; 4) to understand theories about the action of drugs used for manic depression and 4) use this discussion to inform their use of psychiatric drugs.

NO 66A

WHAT DO PSYCHIATRIC DRUGS REALLY DO? DECONSTRUCTING CONVENTIONAL VIEWS OF PSYCHIATRIC DRUG ACTION

Joanna Moncrieff, M.D., University College London, Department of Mental Health Sciences, Bloomsbury Campus, 67-73 Riding House Street, 2nd floor, Charles Bell House, London W1W 7EJ U.K.

SUMMARY:

In this presentation I will compare two different ways of viewing how psychiatric drugs work. The standard view, what I have called the "disease-centered" model, suggests that drugs work by helping to reverse an underlying biological abnormality or disease process. The alternative "drug-centered" model proposes that psychiatric drugs, like other psychoactive drugs, produce altered mental states. These states may suppress or obscure the manifestations of psychiatric conditions, which may sometimes be useful. I will then discuss what sorts of evidence might support the two models. As examples, I will summarise research on antipsychotics and antidepressants demonstrating that there is little evidence to support a disease centred view of their action. I will also examine the reasons for the emergence of the disease centred model, and look at the vested interests that helped it to become established. I will discuss the clinical implications of adopting the different models and suggest that a drug-centered model leads to a fuller understanding of the nature of psychiatric drugs, and empowers patients to take a more equal role in decisions about drug treatment. Psychiatrists need to become better informed about the psychoactive effects of psychiatric drugs in order to help their patients to use them wisely.

NO 66B

DOES ANYTHING STABILIZE MOODS?

David T Healy, M.D. Hergest Unit Cardiff University Bangor, U.K.

SUMMARY:

This paper will outline the differences between symptomatic and nosolytic treatments within the mental health field and will consider what the clinical trial evidence and outcomes of treatment data indicate as to whether mood stabilizers stabilise moods symptomatically or by virtue of a nosolytic effect. Quite different approaches to treatment are called for depending on whether the effects of these drugs are considered symptomatic or nosolytic. There are also quite different implications for drug development in the affective disorders domain. The paper leans towards categorising mood-stabilizers as non-specific or symptomatic treatments.

NO 66C

HIPPOCRATIC PSYCHOPHARMACOLOGY: A NEW APPROACH

Nassir Ghaemi, M.D., 800 Washington Street, #1007, Boston, MA 02111

SUMMARY:

The biological mechanisms of psychotropic medications are often seen as affecting symptom complexes, not diseases. Clinical research can be interpreted, however, in a different manner: Our psychotropic drugs, when truly effective, can, and must, treat disease entities, not merely symptoms. This approach to clinical medicine reflects the Hippocratic tradition, which has been lost in modern psychopharmacology. As augmented by William Osler, this tradition holds that physicians should identify and treat disease, not symptoms. The Hippocratic approach to psychopharmacology would emphasize the need to treat psychiatric diseases, where they can be identified, and to avoid or minimize medication treatment otherwise. Since many, though not all, of our psychotropics are symptomatic treatments, the clinical imperative then becomes to have a clear notion of disease, to carefully seek to identify when psychiatric disease is present and when it is not, and then to develop and use drugs for those diseases. I will offer specific examples particularly from the clinical literature on bipolar disorder and ADHD.

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3) Harris M, Chandran S, Chakraborty N, Healy D: Mood stabilisers: the archeology of the concept. Bipolar Disord. 2003; 5:446-452.

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SYMPOSIUM 67

THE SUICIDAL PATIENT WITH BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify important risk factors for suicide in patients with borderline personality disorder; 2) Recognize common clinical dilemmas when treating suicidal patients with borderline personality disorder; and 3) Learn empirically supported treatment

methods for managing suicidal ideation and behaviors in suicidal patients with borderline personality disorder.

NO 67A

RISK FACTORS FOR SUICIDAL BEHAVIOR IN BORDERLINE PERSONALITY DISORDER

Paul H Soloff, M.D., Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213

SUMMARY:

Recurrent suicidal behavior is a core characteristic of BPD, found in 70%–80% of patients, with an average of 3 or more lifetime attempts per patient. Completed suicide is reported in 3–10%. Our knowledge of risk factors for suicidal behavior in BPD is derived from retrospective studies of completers, cross-sectional studies of attempters and non-attempters, and prospective studies with long term follow-up. Retrospective studies of suicide completers rely on chart reviews and focus attention on documented social and vocational consequences of BPD. Completers are characterized by problems with school, employment, and finances, antisocial behavior and legal difficulties, interpersonal conflict and loss. Findings on co-morbid diagnoses are inconsistent. Cross-sectional studies of BPD attempters have the advantage of standardized clinical assessments. Attempters are characterized by a higher incidence of MDD, state depression, hopelessness and self-injury, fewer Reasons for Living and poor social adjustment. A childhood history of sexual abuse increases the risk of being an attempter. Negative life events often precede attempts. Risk factors vary over the course of the disorder. Younger patients have multiple attempts of low lethality, often motivated by interpersonal crises and loss, anger and impulsivity. Older patients have higher lethality attempts after years of chronic illness, isolation and failed treatment efforts. Prospective studies suggest that an acute co-morbid disorder, such as MDD, may constitute a danger in the short term, but that poor psychosocial adjustment increases long term risk, predicting suicidal behavior long after depression is addressed. In the long term, psychotherapy directed at supporting family, work and social relationships may prove the most effective treatment for suicidal behavior in BPD.

NO 67B

THE SUICIDAL BORDERLINE PATIENT: AN OBJECT RELATIONS APPROACH

John F Clarkin, Ph.D., New York Presbyterian Hospital-Cornell Medical Center, 21 Bloomingdale Road, White Plains, NY 10605

SUMMARY:

Transference-Focused Psychotherapy (TFP), a structured object relations approach to borderline patients, has been shown in several randomized controlled trials to be effective in reducing a number of symptom domains, including suicidality. In this approach to the borderline patient, a treatment contract is made at the beginning of treatment which specifies the responsibilities of both patient and therapist during the treatment. This agreement includes specific responsibilities for patient and therapist if and when suicidal behavior appears duirng the course of treatment. The contract setting, its responsibilities, and how they are carried out during the treatment will be described and applied to a clinical case.

NO 67C

STRATEGIES AND INTERVENTIONS FOR SUICIDAL INDIVIDUALS WITH BORDERLINE PERSONALITY DISORDER: DBT TECHNIQUES AND BEYOND

Barbara H. Stanley, Ph.D., NYSPI, Unit 42 , 1051 Riverside , New York, NY 10024

SUMMARY:

Individuals with Borderline Personality Disorder (BPD) are at high risk for suicide attempts and suicide, with a lifetime suicide rate of nearly 10%. They also engage in non-suicidal self-injury and have chronic suicidal ideation. Clinicians often feel frustrated or helpless when confronted with this population. Dialectical Behavior Therapy (DBT), developed for suicidal individuals with BPD, reduces suicide attempts, suicide urges and hospitalizations in trials by Linehan, our group and others. This treatment arms clinicians with strategies that can improve therapeutic work and outcome with suicidal individuals. The approach consists of balancing change interventions with validation strategies, directly targeting suicidal behavior as well as factors that contribute to suicide risk, including difficulties in regulating emotions, tolerating unpleasant affects as well as problems in the interpersonal domain. DBT relies on improving skills that reduce suicide risk, such as emotion regulation and interpersonal effectiveness. Skill enhancement and improved understanding of circumstances leading to dysregulation constitutes the primary "change" intervention. Chain analysis is another "change" intervention that helps patients identify triggers to dysregulation. Change techniques are balanced by "validation" strategies in which therapists validate patients' emotional experience on many levels using specific techniques. We have extended DBT to include safety planning, a technique in which patients develop a specific plan about what to do should they become suicidal. We have found safety planning to be a powerful intervention that can further reduce suicidal behavior in this population. Safety planning is an intervention that can be utilized in settings other than outpatient clinics, such as emergency departments. In this presentation we will illustrate both DBT interventions and safety planning strategies for addressing suicidal behavior in this high risk population.

NO 67D

DYNAMIC DECONSTRUCTIVE PSYCHOTHERAPY: A NOVEL TREATMENT FOR REDUCING SUICIDE RISK IN BORDERLINE PD

Robert J Gregory, M.D., Department of Psychiatry, SUNY Upstate Medical University, 750 East Adams Street, Syracuse, NY 13210

SUMMARY:

Dynamic deconstructive psychotherapy (DDP) was developed for treatment-resistant patients with borderline personality disorder (BPD), including those having co-occurring substance use disorders. DDP is manual-based and involves weekly individual sessions for a predetermined period of time and follows sequential stages. In a randomized controlled trial, DDP was effective in decreasing suicide-related behaviors in patients with co-occurring BPD and alcohol use disorders over 30 month follow-up. The treatment model is based on the hypothesis that borderline pathology and related behaviors reflect impairment in specific prefrontal neurocognitive functions that are responsible for adaptive processing of emotional experiences. Some of the consequences for this deficit include high levels of arousal and distress, mood lability and reactivity, and maladaptive interpersonal encounters that can enact and reinforce hopeless and suicidal states. DDP aims to remediate neurocognitive functioning by facilitating elaboration of emotion-laden narratives and integration of polarized attributions, as well as deconstructing negative enactments in the patient-therapist relationship that can heighten suicide risk.

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SYMPOSIUM 68
EMERGING CLINICAL APPLICATIONS OF GENOTYPE-GUIDED PSYCHOTROPICS FOR DEPRESSIVE DISORDERS

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) list the CYP450 gene polymorphisms relevant to antidepressant metabolism; 2) describe the combinatorial prevalence of CYP450 and serotonin transporter gene differences in depressed inpatients; 3) discuss these implications for utilization of healthcare resources; 4) recognize the viewpoints of early adopters of genotyping; and 5) understand the serotonin transporter gene and its role in antidepressant response.

NO 68A

GREATER UTILIZATION OF PSYCHIATRIC SERVICES IS ASSOCIATED WITH CYP450 DRUG METABOLISM DEFICIENCIES

Gualberto Ruano, M.D., Genomas, Inc., 67 Jefferson Street, Hartford, CT 06106

SUMMARY:

Objective: To determine whether polymorphisms in the cytochrome P450 genes CYP2C9, CYP2C19, and CYP2D6 have an impact on length of stay and re-hospitalization rates for patients treated for major depressive disorder (MDD).

Method: We recruited 150 psychiatric outpatients referred to the Institute of Living who were treated for MDD. DNA samples were taken and genotyped to detect deficient alleles in the genes CYP2C9, CYP2C19, and CYP2D6. We analyzed length of stay and prior hospitalization history to see if they correlate with the genotype. We define a "CYP score" summarizing the degree of deficiency in each gene, and a "CYP Index" summarizing the overall amount of deficiency across the three genes.

Results: For hospitalization history, we found that deficient metabolizers of CYP2D6 were more likely to have had their first treatment =3 years prior to the study index admission; 83.1% vs. 65.8% of functional CYP2D6 metabolizers (?2=5.19, df=1, p=.023). Also, compared with CYP2C19 functional metabolizers, deficient metabolizers were more likely to have had at least 1 psychiatric hospitalization within the previous year (65.2% vs. 45.6%, ?2=4.89, df=1, p=.027). For length of stay, we found that deficient CYP450 metabolizers (CYP Index < 4) had longer stays (8.3 vs. 5 days, p = 0.027), and deficient CYP2D6 metabolizers (CYP2D6 score < 1) in particular also stayed longer (7.3 vs. 5.8 days, p=0.006).

Conclusions: CYP450 individual and combinatorial genotypes have a significant effect on length of stay as well as re-hospitalization rates for psychiatric patients treated for depression. The likely cause is reduced efficacy or increased side effects of medications that are metabolized by the CYP450 enzymes, leading to longer stays and more frequent hospitalization. This suggests that testing for CYP450 genotypes can have a substantial impact on the quality of care as well as the economics of treatment for psychiatric disease.

Learning Objectives: Participants will be able to (1) list the CYP450 gene polymorphisms relevant to the metabolism of antidepressants, (2) describe the combinatorial prevalence of CYP450 drug metabolism deficiencies and (3) discuss the implications of CYP450 deficiencies for utilization of healthcare resources.

NO 68B

CYTOCHROME P-450 2D6, 2C19, AND SEROTONIN TRANSPORTER GENOTYPING FOR DEPRESSED INPATIENTS AT THE MAYO CLINIC MOOD DISORDERS UNIT

Simon Kung, M.D., Mayo Clinic Rochester, 200 First Street, Southwest Rochester, MN 55905

SUMMARY:

Objectives: (1) To determine the polymorphisms of cytochrome P-450 CYP2D6 (2D6), CYP2C19 (2C19), and serotonin transporter gene (5HTTLPR) on an inpatient mood disorders unit and

(2) to describe its clinical usefulness.

Methods: Patients hospitalized for major depressive disorder or bipolar depression in which their attending psychiatrist felt that genotyping might help with medication selection were included in this retrospective study. From June 2003 to October 2007, 628 inpatients were genotyped, resulting in 618 2D6, 591 2C19, and 284 HTTLPR genotypes. Almost all (97%) were Caucasian and 66% were female. 2D6 phenotypes were classified as poor (PM), intermediate (IM), normal (extensive, EM), and ultrarapid (UM) metabolizers; 2C19 phenotypes were classified as poor, intermediate, and extensive; 5HTTLPR phenotypes were classified as low (short/short, s/s), moderate (short/long, s/l), and high (long/long, l/l). Attending psychiatrists rotating through the unit were interviewed regarding their opinions of genotyping.

Results: For 2D6, there were 59 (10%) PM, 290 (46%) IM, 221 (36%) EM, and 48 (8%) UM. For 2C19, there were 17 (3%) PM, 137 (23%) IM, and 437 (74%) PM. For 5HTTLPR, there were 45 (16%) s/s, 144 (51%) s/l, and 94 (33%) l/l. Of 576 patients who had 2D6 and 2C19 genotyping, only 81 (14%) had normal phenotypes for both. Of 267 with 2D6, 2C19, and 5HTTLPR genotyping, only 12 (4.5%) had normal phenotypes for all three.

Conclusions: Depressed inpatients had polymorphisms in 2D6, 2C19, and 5HTTLPR which were phenotypically similar to that of the general population. However, when considering combinations of these three genes, very few patients (less than 14%) had normal phenotypes. Overall, clinicians felt that genotyping in certain patients presented useful information compared to no genotyping. Further studies on clinical usefulness are needed.

NO 68C

PHARMACOGENETIC TESTING IN PSYCHIATRY: EARLY ADOPTERS' ATTITUDES AND PRACTICES

Jinger G Hoop, M.D., Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin 8701 Watertown Plank Road, Milwaukee, WI 53226

SUMMARY:

Objective: Pharmacogenetic testing for polymorphisms affecting drug response and metabolism is clinically available, but there are few clinical and ethical standards for its use. We assessed the attitudes and practices of psychiatrists at three academic psychiatry departments where this testing is routinely available.

Methods: Physicians at three academic psychiatry departments considered to be "early adopters" of pharmacogenetic testing were invited to complete an Internet-based 67-item survey, including short-answer, yes/no, and 4-point Likert scale items regarding clinical practices and opinions about pharmacogenetic testing, including perceptions of its utility, risks and benefits, necessary safeguards.

Results: The 75 respondents had ordered pharmacogenetic testing a mean of 20.86 times in the previous 12 months. Most had ordered CYP450 genotyping and fewer had ordered serotonin transporter or receptor genotyping. While most respondents expressed optimism regarding the potential or testing, a few voiced concerns that it was being overhyped and overused. Testing was seen as useful in several clinical scenarios, and most useful in cases of treatment-resistant depression and medication intolerance. There was a lack of consensus regarding the risks of testing, including the risk of unwanted secondary information regarding disease susceptibility. Women were more likely than men to believe that testing carries certain risks and will be too expensive for most patients. Respondents endorsed the use of several safeguards for testing, including confidentiality, pre- and post-test counseling, and informed consent.

Conclusion: These views of psychiatrists at "early adopting" psychiatry departments provide useful guidance for the development of clinical and ethical guidelines and educational curricula. The finding of gender differences in the perception of the risks of testing merits further study.

NO 68D

THE SEROTONIN TRANSPORTER GENE (SLC6A4): UNDERSTANDING VARIABILITY AND ENHANCING THE CLINICAL UTILITY OF GENOTYPING

David A Mrazek, M.D., Dept. of Psychiatry and Psychology Mayo Clinic, 200 First Street SW Rochester, MN 55905

SUMMARY:

Objective: To review currently measurable genomic variability within SLC6A4 which is associated with the prediction of medication response.

Method: Pharmacogenomic analyses were conducted on 1914 subjects who participated in the Star*D study. Genotyping of the DNA collected from subjects participating in Star*D study was completed using both microassay technology and sequencing strategies. These pharmacogenomic analyses clarified both the benefits and limitations of the clinical genotyping of SLC6A4.

Results: Based on our analyses of the STAR*D data set and a major metaanalysis of the clinical implications of SLC6A4 variability, the current utilization of genotyping of the SLC6A4 gene for clinical practice will be reviewed. As with most laboratory testing, there is rarely an absolute relationship between the identification of any specific laboratory value and specific clinical decisions. The focus on this presentation will be to discuss how the utilization of probabilistic information regarding the activity level of SLC6A4 can improve decision making related to the management of antidepressant treatment.

Conclusions : SLC6A4 genotyping provides a probabilistic estimate of the likelihood of response to selective serotonin reuptake inhibitors in patients of European origin.

Learning Objectives Participants will be able to:

1) Discuss how three SLC6A4 variants can influence the activity of the SLC6A4 gene; 2) Apply the results of SLC6A4 testing to appropriate patients; 3) Understand current research strategies which are designed to further improve the ability of clinicians to predict antidepressant response.

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cytochrome P450 2D6 in different populations: a cross-sectional study. Ann Pharmacother 2007; 41:408-413.
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SYMPOSIUM 69
COMBATING STIGMA OF BORDERLINE PERSONALITY DISORDER

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate knowledge of the prevalence and deleterious effects of the stigmatization of people with borderline personality disorders and effective ways at combating this prejudice.

NO 69A

THE CONSEQUENCES OF STIGMA FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDERS

George Vaillant, 1249 Boylston Street, 3rd Floor, Boston, MA 02215

SUMMARY:

Many Axis II and Cluster B patients make their doctors very angry. If they are medical patients, they are very often labeled "hypochondriacs." If their doctors are psychiatrists and these anger-eliciting patients are males they are called "sociopaths" and if they are women they are called "borderline." Because of the physician's (often unconscious) anger, these diagnoses are offered not as dispassionate scientific labels but as a pejorative epithet for which the best lay translation would be "jerk." In order to remove or at least "undo" the stigma associated with the label "borderline" it is important for physicians to pull their counter transference towards Axis II patients into conscious awareness. The paper will elaborate on a variety of techniques to achieve this goal. 1. Doctors must appreciate that management of their counter-transference is their responsibility not the patients' and that medicating or punishing the patient is likely to be ineffective. 2. Behavior that annoys doctors most often reflects the coping strategies of Axis II patients: projection, schizoid fantasy, passive aggression, acting out and hypochondriasis. 3. Behavior that annoys us requires limits. 4. Behavior that annoys us requires empathy for that a careful early history is needed. Hypochondriasis (help-rejecting complaining) often leads such "fat chart patients to lack empathic social histories of trauma. 5. Taking genuine pleasure in a patient's attempts to try out new, more adaptive behaviors is very rewarding for patient and clinician alike. 6. Recognizing unidentified sedative or alcohol abuse or mental retardation often leads to alter diagnsis and a more creative therapeutic response. 7. Finally, remember, on therapist's "borderline" is another therapist's spouse. the diagnosis is often in the eyes of the beholder. Once psychiatrists have their own counter-transference under control, they can begin to mitigate stigma in the public arena.

NO 69B

MEDICAL CARE FOR BORDERLINE PERSONALITY DISORDER IN GERMANY - A EUROPEAN PERSPECTIVE

Martin Bohus, M.D., Grabengasse, 1 Heidelberg, D69117 Germany

SUMMARY:

It can be assumed that lifetime prevalence for borderline personality disorder (BPD) in Europe is akin to the USA. However, the medical care system in general is different, and the psychiatric care system particularly. This should have impacts on both, treatment and the long term course of BPD: Taking Germany as an example: On the one hand, condensed day clinic and inpatient programs up to three months, as well as outpatient psychotherapy up to 200 hours are covered by the insurance companies in general. On the other hand, psychotherapists, who provide therapy for BPD patients for which evidence of effectiveness has been reported, are sparse. As a result, the specialized inpatient programs show long waiting lists, and patients are treated far away from their psychosocial environment. Utilization of the treatment effects into daily practice remains a challenge. So far so good, the other sides of the coin however are motivational problems to exciting the psychiatric care system. A strong tendency for transition into chronicity, repetitive participation in treatment programs and endless psychotherapy are the consequences. Implementing an adequate psychiatric care structure means to balance sufficient care with strong incentives for exciting the system. The presentation will give an overview of the current medical care system for BPD and provides a view to the planned developments.

NO 69C

PSYCHOEDUCATION FOR PATIENTS WITH BORDERLINE PERSONALITY DISORDER AND THEIR FAMILIES

Joel Paris, M.D., Institute of Community and Family Psychiatry, 4333 Cote Ste-Catherine Road, Montreal H3T 1E4 Canada

SUMMARY:

Learning objective: to review research on psychoeducation in BPD and to examine its clinical application. Objective: To examine the role of psychoeducation for patients with borderline personality disorder (BPD) and for their families. Method: A systematic review of empirical literature. Results: The literature supports the importance of psychoeducation for psychiatric patients and their families, but only a few empirical studies have examined its role in BPD. It has been shown that psychoeducational methods help prepare BPD patients for treatment, add effective-

ness to standard management regimes, and provide support for families. Explaining what BPD is and how one treats it can be a challenge--particularly when patients have received other diagnoses in the past. But doing so provides patients and families with hope, particularly given recent data showing that this disorder has a relatively good prognosis and that it responds to a variety of psychotherapeutic methods. Conclusions: Psychoeducation helps prepare patients with BPD for treatment, adds to management, and supports families.

NO 69D

FAMILY AND CONSUMER ADVOCACY TO CONGRESS: FROM STIGMA TO STABILITY FOR BORDERLINE PERSONALITY DISORDER

James O. Payne, J.D., 6608 Quinten Street, Falls Church, VA 22043

SUMMARY:

In 2008 the U.S. House of Representatives voted 414-0 to adopt a Resolution supporting the month of May as Borderline Personality Disorder Awareness Month. Family and consumer advocacy led to the Resolution "as a means of educating our Nation about this disorder, the needs of those suffering from it, and its consequences." H. Res. 1005.

Family and consumer advocacy is prompting growing public, professional and Congressional attention to the need for early diagnosis and effective treatment of the Nation's most prevalent serious mental illness other than major depression - Borderline Personality Disorder (BPD). In 2006, the National Alliance on Mental Illness (NAMI) voted to include BPD as one of its five mental health priority populations. That fall, NAMI convened a BPD Expert Focus Group of eleven respected mental health clinicians and researchers plus four consumers and four family members. This benchmark event inspired family and consumer advocacy that led to passage of House Resolution 1005 by the U.S. House of Representatives.

The Congressional Resolution for BPD Awareness Month recites that "official recognition of BPD is relatively new, and diagnosing it is often impeded by lack of awareness and frequent co-occurrence with other conditions, such as depression, bipolar disorder, substance abuse, anxiety, and eating disorders." BPD is "a leading cause of suicide" and carries "enormous public health costs, and [a] devastating toll ... on individuals, families, and communities." The Resolution concludes that "it is essential to increase awareness of BPD among people suffering from this disorder, their families, mental health professionals, and the general public by promoting education, research, funding, early detection, and effective treatments."

Within a month of passage of the Resolution, the National Institutes of Health published an intramural study finding a 5.9% lifetime prevalence of BPD, making it the Nation's second most prevalent serious mental illness.

The program also will highlight further family and consumer advocacy from the partnership of NAMI, the National Education Alliance on Borderline Personality Disorder (NEA-BPD) and other public and private supporters.

NO 69E

BORDERLINE PERSONALITY DISORDER RESEARCH AT NIMH

James P Breiling, D.Phil., 6001 Executive Boulevard, Bethesda, MD 20857

SUMMARY:

Recent research findings point to a transformative shift in the view of borderline personality disorder from enduring to remitting. Awareness of these research findings should bring more screening and specialty treatment and raise interest in research concerning the disorder. Important research needs and the NIMH grant mechanisms that can be used to address these needs, directly and indirectly, will be presented. Six questions in this topic will be addressed. What is the public health need for borderline personality disorder (BPD) research? What are the past and current NIMH portfolios of BPD research? What are the obstacles to a NIMH portfolio of BPD research more commensurate with the public health need? (The challenge of the Matthew Principle.) What are the prospects for future BPD research at NIMH? How might BPD Awareness of recent findings foster a growth in BPD research? What are important BPD research needs?

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SYMPOSIUM 70

GENETIC VULNERABILITIES FOR DRUG ABUSE AND CO-MORBID MENTAL HEALTH DISORDERS

SUPPORTED BY NATIONAL INSTITUTE ON DRUG ABUSE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand how genetic variation may direct neural mechanisms which, given a particular set of gene x environment interactions, can give rise to drug addiction and co-morbid psychiatric disorders;and 2) Also be able to recognize endophenotypes that are associated with an increased risk or vulnerability

for developing substance abuse disorders and related psychiatric c-morbidities.

NO 70A

SUBJECTIVE DRUG EFFECTS AS ENDOPHENOTYPES FOR VULNERABILITY

Harriet de Wit, Ph.D., 5841 S Maryland, MC3077, Chicago, IL 60637

SUMMARY:

The initial subjective, or mood-altering, effects of drugs during the early stages of drug use influence the likelihood of continued use, and serve as a valuable endophenotype for vulnerability to drug abuse. We have studied individual variations in responses to acute doses of stimulant drugs in relation to polymorphisms in the genes involved in their neurotransmitter actions in the brain. Specifically, we have studied subjective and behavioral responses to amphetamine and caffeine in relation to genotypic variations in genes involved in several neurotransmitter systems. The findings suggest that multiple genotypic variations are associated with subjective responses to drugs, including variations that result in more pronounced negative drug effects (e.g., anxiety) that may be protective, and more pronounced positive effects (e.g., euphoria) that increase risk for continued use. Taken together, these findings illustrate a valuable new tool for identifying risk factors for substance abuse. The studies also provide a valuable tool for investigating the neural systems through which drugs produce their mood-altering effects in humans.

NO 70B

THE INFLUENCE OF GENETIC VARIANCE IN THE DOPAMINE TRANSPORTER ON BRAIN AND BEHAVIORAL RESPONSES TO SMOKING CUES

Teresa Franklin, Ph.D., Treatment Research Center, 3900 Chestnut Street, Philadelphia, PA 19104

SUMMARY:

Withdrawal-induced craving (WD) and cue-induced craving motivate drug use and relapse. However, subjective craving reports are unreliable predictors of future drug use, and in neuroimaging the substrates of craving elicited by drug cue exposure, brain responses do not always correlate with reported craving. This discrepancy has long puzzled the field. As mesolimbic dopamine (DA) is critical for reward and its predictive signals we hypothesized that genetically driven variation in DA transmission may account for the apparent incongruence. The DA transporter (DAT) SLC6A3 rapidly removes DA from the synapse after its phasic release and has a polymorphism that may influence DAT expression. Carriers of a 9-repeat VNTR allele may possess fewer DATs, which may result in slow DA clearance reflecting prolongation of the 'reward message'. This may strengthen the attribution of incentive salience to drug-associated cues and may be reflected in different neural responses. Thus, we used perfusion fMRI to image smokers carrying a 9-repeat allele (9-repeats) vs 10/10-repeat homozygotes during exposure to smoking cues (SCs). 9-repeats had increased brain activity in reward-related circuitry (amygdala, orbitofrontal cortex, ventral striatum) that did not correlate with craving. Alternatively, 10/10-repeats had decreased activity in similar regions that correlated with craving ($p<0.001$, $r2 = 0.79$-0.86). We speculate that the inability to 'label' craving combined with the strong positive brain response in 9-repeats might confer an increased vulnerability to SC-provoked relapse. As both variants are represented in smokers we speculate further that 10/10-repeats are less affected by SC exposure but experience greater discomfort from WD. These findings may have clinical relevance as genotype may predict treatment response. Investigations continue to test these hypotheses. Data on other dopaminergic components will be presented as evidence suggests their involvement in SC reactivity.

NO 70C

INTERACTING EFFECTS OF COMT GENOTYPE AND NICOTINE WITHDRAWAL ON BRAIN FUNCTION AND COGNITION

Caryn Lerman, Ph.D., 3535 Market Street, Suite 411, Philadelphia, PA 19104

SUMMARY:

Research integrating genetics and neuroimaging provides an exciting opportunity to elucidate the functional mechanisms linking genetic variation to nicotine dependence. To illustrate this potential, we will present new evidence for the role of genetic variation in the Catechol-O-Methyltransferase gene (COMT val158met) in nicotine abstinence-induced cognitive deficits and brain function. The methylation enzyme, COMT, regulates dopamine levels in prefrontal cortex. The COMT gene has a G>A transition in exon 3 that results in the substitution of a methionine for valine at codon 158 (val158met). The val allele is associated with a 3 to 4-fold increase in enzyme activity and decreased prefrontal dopamine levels. The val allele has also been linked with nicotine dependence and smoking relapse. We hypothesized that increased sensitivity to the adverse cognitive effects of nicotine abstinence among smokers with val/val genotypes may contribute to their heightened risk of relapse. In this study, 33 healthy smokers were genotyped prospectively for the COMT polymorphism and performed a visual N-back working memory task during two BOLD fMRI sessions (smoking as usual vs. >14 hrs. abstinent). Significant genotype by session interactions were observed for task reaction time and BOLD signal in right dorsolateral prefrontal cortex. Nicotine abstinence effects on performance and BOLD signal were observed only among the val/val group, the subgroup of smokers shown previously to have a higher risk of smoking relapse. These data suggest novel brain-behavior mechanisms that may link genetic variation to nicotine dependence.

NO 70D

APPROACHING COMORBIDITY IN ADDICTION GENETICS

Joel Gelernter, M.D., VA CT, 950 Campbell Avenue, West Haven, CT 06516

SUMMARY:

There is a very high rate of comorbidity of common substance dependence diagnoses with each other (e.g., co-occurrence of alcohol and nicotine dependence), and with other psychiatric disorders (e.g., cocaine dependence and posttraumatic stress disorder). This comorbidity creates opportunities and difficulties for genetics research; when a genetic variant is associated with more than one disorder, as is frequently the case, it can be challenging to determine whether or which of the associations should be considered "primary." It is a further complication that, considering the high rate of comorbidity, when a disorder such as cocaine dependence occurs without any comorbidity, this is relatively unusual, and does not represent the most clinically relevant form of the disorder. Additionally, gene-environment interplay, for example in the form of the availability of a particular substance, plays a critical role. We will discuss approaches to comorbidity in addiction genetics and some relevant results and implicated biological pathways, based on genetic linkage and association analysis in a sample of >4000 subjects collected in the course of studies of cocaine, opioid, and alcohol dependence, who were assessed with the comprehensive SSADDA polydiagnostic instrument; and results that tend to point to multiple disorders sharing common etiology.

NO 70E

GENETICS OF ALCOHOLISM AND RELATED ENDOPHENOTYPES

Howard J Edenberg, Ph.D., 635 Barnhill Drive, MS 4063, Indianapolis, IN 46202

SUMMARY:

Alcoholism is a complex genetic disease with both genetic and environmental factors contributing to vulnerability. Abuse and dependence on other drugs, and mental health disorders, frequently co-occur in alcoholics. The Collaborative Study on the Genetics of Alcoholism (COGA) is carrying out a comprehensive family-based study of alcoholism, including a prospective study of adolescents and young adults, to elucidate factors that contribute to this disease. Extensive subject interviews and electrophysiological measures are collected. Electroencephalographic (EEG) differences were mapped to a region on chromosome 4. We demonstrated that alcohol dependence and the EEG phenotype were both associated with variations in the GABRA2 gene. The association between alcoholism and GABRA2 has been widely replicated. In further analyses of this gene, we demonstrated that the association is primarily among individuals who are more severely affected by alcoholism and are also dependent on other illicit drugs. The same variation in GABRA2 is associated with symptoms of conduct disorder in young people. Variations in the kappa opioid system, in both the gene that encodes the ligand prodynorphin and the gene that encodes the kappa receptor, are associated with alcoholism. Functional studies have revealed that a variation in the kappa receptor gene affects how much the gene is expressed, which explains at least part of this association. Pharmacogenomic variations in genes that encode the alcohol dehydrogenases responsible for metabolizing alcohol are associated with alcoholism, another set of findings that have been replicated. These studies identify specific genes in which variations affect alcoholism, demonstrate effects on endophenotypes including EEG and on other psychiatric conditions, and are beginning to reveal molecular pathways through which the variations act.

COGA is supported by NIH Grant U10AA008401 from the NIAAA and NIDA.

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SYMPOSIUM 71
THE COLLABORATIVE LONGITUDINAL PERSONALITY DISORDERS STUDY: IMPLICATIONS FOR *DSM-V*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: Recognize how key results from a major longitudinal study of the course of personality traits and disorders will influence the deliberations of the *DSM-V* Task Force and its Personality and Personality Disorders Work Group.

NO 71A

ASSOCIATIONS OF PERSONALITY DISORDERS AND AXIS I DISORDERS OVER TIME: IMPLICATIONS FOR SPECTRUM MODELS

Tracie Shea, Ph.D., 700 Butler Drive, Providence RI 02906

SUMMARY:

Background: The extensive overlap among Personality Disorders (PDs) and Axis I disorders challenges the validity of current diagnostic distinctions. A key question is how best to conceptualize these associations—as distinct disorders that interact in clinically significant ways, or as reflections of shared dimensions (spectrum model). The prospective longitudinal design of the CLPS provides the opportunity to examine whether course changes in specific PDs and Axis I disorders are correlated, suggestive of shared dimensions and consistent with a spectrum mod-

el. Method: Following baseline diagnoses using semi-structured interviews, follow-up assessments were conducted at 6 and 12 months, then yearly. Longitudinal data includes monthly ratings of individual criteria for Schizotypal (STPD), Borderline (BPD), Avoidant (AVPD), and Obsessive-Compulsive (OCPD) PDs, and weekly diagnostic status ratings of Axis I Disorders. Results: Earlier findings from two years of follow-up showed improvement in STPD and OCPD to be largely independent of Axis I disorders. BPD had bi-directional associations with major depressive disorder (MDD), and AVPD had bi-directional associations with social phobia and obsessive-compulsive disorder. Preliminary findings in relation to relapse have been largely nonsignificant. This presentation will extend the examination of course associations up to 10 years, and consider implications for spectrum models.

NO 71B

TRAITS AND SYMPTOMATIC BEHAVIORS: A HYBRID MODEL OF PERSONALITY DISORDERS

Thomas H McGlashan, M.D., 301 Cedar Street, New Haven, CT 06519

SUMMARY:

Background: Personality Disorders (PDs) appear to be made up of stable trait-like features and evanescent symptomatic behaviors. The model can help explain the high categorical remission rates in naturalistic studies of PDs including the Collaborative Longitudinal Personality Study (CLPS).

Method: Using a longitudinal follow-along study of a large sample of PD-diagnosed patients (Schizotypal, Borderline, Avoidant, and Obsessive-Compulsive), we examined the course and stability of their criteria over several years. Here we report the relative stability (persistence, remission, and relapse) of the individual criteria sampled for all disorders at 2 and 6 years.

Results: Trait-like criteria remain stable while symptomatic behaviors do not. Diagnostic remission, therefore, is not always associated with functional

improvement. Collectively, these findings suggest a hybrid model of PDs: stable personality traits that are pathologically skewed, eg, affective dysregulation in BPD and shyness in AVPD, and dysfunctional behaviors that reflect pathologic traits, eg, self-cutting to modulate affect or avoiding social situations because of shyness. This hybrid model, separately grouping *DSM-IV* criteria that are longitudinally stable and those criteria that fluctuate at 2 and 6 year follow up will be presented.

Conclusions: Traits are more enduring, perhaps more proximal to genetics. Symptomatic behaviors are more intermittently expressed and likely to be linked to situational stress. They are more variable signals of the consequences of enduring warped traits, but they have high signal value for diagnosis.

NO 71C

COMPARATIVE VALIDITY OF DIAGNOSTIC MODELS FOR PERSONALITY DISORDERS

Leslie C Morey, Ph.D., MS 4235, College Station, TX 77843

SUMMARY:

The categorical classification system for personality disorder has been frequently criticized, and several dimensional models have been proposed to replace it. To examine the relative contributions of alternative models, it is important to examine antecedent, concurrent, and predictive markers of construct validity to clarify strengths and weaknesses of alternative approaches in these different domains. In the CLPS sample, three models of personality disorders were examined for validity in these domains: the Five Factor Model (FFM), the SNAP model, and the *DSM-IV-TR*. Across as series of studies, all models show substantial validity across a variety of marker variables over time. Dimensional models (including dimensionalized *DSM*) consistently outperform the conventional categorical diagnosis in predicting external variables. Contrary to some predictions, moving to greater level of specificity in trait dimensional models that focus upon lower order traits tend to fail to improve upon the validity of higher-order factors upon cross-validation. Data demonstrated the importance of both stable trait and dynamic psychopathological influences in predicting external criteria over time, with the FFM tapping the former and the *DSM-IV-TR* primarily addressing the latter influences. In general, our study results support a dimensional nosology of personality disorders that assesses both stable traits and dynamic processes.

NO 71D

IMPACT OF PERSONALITY PSYCHOPATHOLOGY ON COURSE AND OUTCOME OF AXIS I DISORDERS

Andrew E Skodol, M.D., 6340 N. Campbell Avenue, Suite 130, Tucson, AZ 85718

SUMMARY:

Among the key challenges facing the *DSM-V* Personality and Personality Disorders Work Group is to determine the clinical importance (e.g., in risk, treatment, or prognosis) of assessing personality or personality disorders (PDs) in other diagnostic domains, such as mood, anxiety, substance use, or eating disorders. The issue has relevance for deciding whether there is value in retaining a separate Axis II for the assessment of personality disorders and traits. The purpose of this presentation is to review data from the CLPS on the effects of PDs on course and functional outcomes of Axis I disorders over up to 10 years of prospective follow-up of 733 patients. Thus far, PDs in general have been shown to prolong symptomatic and functional recovery and, especially for borderline personality disorder (BPD), to increase rates of relapse and new onsets of major depressive disorder. Avoidant personality disorder (AVPD) slowed recovery from social phobia and schizotypal personality disorder (STPD) slowed recovery from generalized anxiety disorder (GAD). Obsessive-compulsive PD was associated with increased likelihood of GAD relapse after remission, STPD with social phobia relapse, and BPD with obsessive-compulsive disorder (OCD) relapse. BPD has also been shown to convey 2 to 3 times the risk of new onsets of both alcohol and drug use disorders compared to other PDs. The natural course of eating disorders, in contrast, was not affected by the presence or severity of PD psychopathology. In addition to PDs, pathological personality traits, such as negative

affectivity and impulsivity, have independent effects on negative outcomes including suicidal behaviors. Taken together, these results suggest that co-occurring personality psychopathology exerts strong negative prognostic effects on course and outcome for many patients with Axis I disorders. Any revisions of DSM-V should facilitate recognition of pathological personality in order to improve patient care.

NO 71E

PERSPECTIVES ON BPD: LESSONS LEARNED FROM CLPS

John G Gunderson, M.D., 115 Mill Street, Belmont, MA 02478

SUMMARY:

CLPS findings have confirmed BPD's syndromal integrity and its composition by three components: affective, interpersonal and behavioral. CLPS also found that BPD has a much better prognosis than expected, that short term interventions can be helpful, and that while mood disorders are not particularly significant mediators of course, interpersonal stressors are. Implications for diagnosis include dropping the current polythetic system. Implications for treatment and overall awareness of BPD are also discussed.

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SYMPOSIUM 72

MATTERS OF THE HEART: DEPRESSION AND CARDIOVASCULAR DISEASE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the psychological and physiological factors linking depression and cardiovascular disease; and 2) Their' important role in diagnosis, prevention and treatment, and in liaison with cardiologists and primary care physicians.

NO 72A

AUTONOMIC IMBALANCE, DEPRESSION AND CAD:FACING OUR SCOTOMA

Lawson R Wulsin, M.D., 231 Albert Sabin Way, ML 0559, Cincinnati, OH 45267

SUMMARY:

Problem: Severe mental illness accounts for about 25 years of potential life lost, almost twice the effect of cardiovascular disease. In the well-studied area of depression and coronary artery disease, the leading biological possibilities for linking mechanisms related to mortality include 1) reduced heart rate variability, 2) increased platelet aggregation, 3) altered hypothalamic-pituitary-adrenal axis activity, and 4) increased vascular inflammation. Psychiatric clinicians and researchers generally overlook the role of the autonomic nervous system in health and illness.

Proposal: The concept of autonomic imbalance (excessive sympathetic activity and reduced parasympathetic activity) provides a framework for synthesizing the multiple mechanisms that link depression to cardiac morbidity and mortality. The literature on the role of reduced vagal tone in the major risk factors for coronary artery disease shows how persistent autonomic imbalance promotes the development of coronary disease. And the evidence for autonomic imbalance in major depression points to the importance of learning to measure autonomic imbalance in the context of depression and other severe mental illnesses. Resting heart rate, heart rate recovery after a challenge, heart rate variability, and baroreflex sensitivity are the best measures of autonomic balance.

Conclusion: Because autonomic imbalance can be treated by a variety of approaches, it deserves our attention as a focus of research and clinical care. Psychiatrists should consider the correction of autonomic imbalance a worthy target of treatment for depression in patients with cardiac risks.

NO 72B

THE RELATIONSHIP BETWEEN DEPRESSIVE EPISODES AND ACUTE CORONARY SYNDROME (ACS)

Alexander Glassman, M.D., 1051 Riverside Drive Unit 116, New York, NY10032-1007

SUMMARY:

The relationship between depression, heart disease, and cardiovascular mortality has long been suspected and over the last two decades extensive evidence linking these conditions has accumulated. However, the relationship is much more complex than initially expected. As other presenter's in this symposium will document, major depression long before any evidence of cardiovascular disease predicts future onset of cardiovascular disease

and cardiac death. The risk of cardiovascular death associated with depression seems to increase in patients with acute coronary syndromes (ACS). In recent years research interest as focused on the cause of that association and whether treating depression would reduce that risk. This presentation will focus on whether all depressive episodes associated with ACS carry the same risk of cardiovascular death, whether antidepressant treatment in the post ACS period is safe, and whether they alters cardiovascular risks.

A number of investigators have documented that as symptoms of depression increase in post-ACS patients, the risk of cardiovascular death increases and that increase is independent of the severity of the coronary event. We recently demonstrated that a single measure of depression obtained a few weeks after a coronary event in patients with major depression, is associated with a doubling of the risk of death over the next 7 years. It is not intuitive why a single measure should be so predictive of mortality. Also recent evidence from our own studies and that of others indicates that a patient who becomes depressed for the first time following a coronary event is at the same or perhaps greater risk of death than patients with recurrent major depression.

There is strong evidence that SSRIs are safe in post-ACS patients and there is suggestive, although not definitive, evidence that they can reduce medical risks while they are being administered, but there is no evidence that they induce sustained medical benefit. However, failure of major depression post ACS on either drug or placebo is also associated with a long-term doubling of mortality and that increased risk is independent of the effect of severity. Potential mechanisms for this depression associated increase mortality will be discussed.

REFERENCES:

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MONDAY, MAY 18
2:00PM-5:00PM

SYMPOSIUM *DSM* TRACK

DSM. EVOLUTION OF THE *DSM-V* CONCEPTUAL FRAMEWORK: DEVELOPMENT, DIMENSIONS, DISABILITY, SPECTRA AND GENDER/CULTURE

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Identify the specific cross-cutting factors within and across diagnoses that inform conceptual approaches and possible revisions for *DSM-V;* 2)Have an awareness of the literature and data supporting the need to examine these cross-cutting issues; and 3) Understand the impact of integrating these cross-cutting issues into DSM-V in terms of improved diagnosis, research, and overall classification of criteria.

1. INCORPORATING DEVELOPMENTAL VARIATIONS OF DISORDER EXPRESSION ACROSS THE LIFESPAN: THE SIGNIFICANCE OF LATER LIFE

Warachal Faison, M.D., 5900 Core Road, Suite 203, North Carlston, SC 29425

SUMMARY:

Both the clinical expression and diagnosis of mental health disorders varies across the lifespan into later life. The *DSM-V* Lifespan Developmental Issues Workgroup is confronted with how to best incorporate critical aging information that may improve the diagnostic clarity of mental health disorders in the latter half of life. This presentation will give an overview of potential areas in which *DSM-V* text can be revised including "age-related features" and "age-related manifestations" as well as "age-related subtypes" incorporated into diagnostic criteria depending on the level of evidence regarding age effects on the expression of a given disorder. For all disorders we seek to increase the content in the *DSM* text that is devoted to lifespan issues and their effect on clinical expression. We will address the following areas that are relevant to diagnostic accuracy in the older adult: 1) True age-related differences, i.e., symptoms of disorders do vary by age; 2) Reduced detection of symptoms but greater functional impact, i.e., there is a higher threshold for symptom reporting and detection but potentially a lower threshold for functional impairment for a given level of symptom severity; 3) Variation through time of onset, i.e., late-onset illnesses may have unique symptom expression; and finally 4) Subthreshold presentations, i.e., clinically significant disorders may result in impairment but be subthreshold in terms of diagnostic criteria.

2. DIAGNOSTIC PARITY: INCORPORATING GENDER ISSUES IN THE *DSM V* TEXT AND CATEGORIES

Kimberly Yonkers, M.D., 142 Temple Street Suite 301, New Haven, CT 06510

SUMMARY:

Gender differences in the rates of diagnoses, clinical expression, illness course and biology have been noted for a number of psychiatric conditions. Incorporation of gender relevant information in past iterations of the *DSM* has been variable. The plan among workers involved in *DSM V* is to actively explore possible gender effects on as many levels as possible including a review of clinical, epidemiological and biological information and a re-examination of the clinical criteria for various diagnoses. It is critical that information about possible gender differences among psychiatric conditions be included in *DSM V*. It is also important

for clinical criteria to be operationalized in a way that addresses pathology equally in men and women in spite of the possibility that differences in the rates of illness among men and women may exist. In this presentation, we will present our approach and ongoing work to exploring the role of gender in *DSM V.*

3. ONE WAY FORWARD FOR PSYCHIATRIC NOMENCLATURE: THE EXAMPLE OF THE SPECTRUM PROJECT

Ellen Frank, Ph.D., 3811 O'Hara Street, Pittsburgh, PA. 15213

SUMMARY:

Psychiatric diagnosis based on pathophysiology remains a difficult and complex enterprise. Despite three decades of research based on Robins and Guze's guidelines for validators of psychiatric diagnosis, we have yet to develop a nosology based on genetic and neural markers of disease rather than clinical observation. The future of psychiatric diagnosis is in part a product of our ability to accurately create boundaries between disorders. There is an important potential role to be played by neuroscience, imaging, and genetics in identifying larger groups or "spectra" of diagnoses. Twin and adoption studies further inform our understanding of disease risk. The experts in charge of revising DSM-V face a great challenge in developing a nosological system that is both practical and rational. Our advances in neuroscience and improved understanding of the interrelationship between genetics and environment will make increasingly important contributions to the validity and reliability of psychiatric diagnosis and classification.

4. CLINICAL SIGNIFICANCE AND DISORDER THRESHOLDS IN DSM-V: THE ROLE OF DISABILITY AND DISTRESS

William E Narrow, M.D., Suite 1825, 1000 Wilson Blvd, Arlington, VA 22209

SUMMARY:

The diagnostic criteria for many *DSM-IV* disorders combine symptoms with distress or functional impairment via the clinical significance criterion. The clinical significance criterion was intended to reduce high numbers of false positives in epidemiological estimates of disorder prevalence by setting a clinical threshold for persons meeting symptomatic criteria for a disorder. The clinical significance criterion does reduce disorder prevalence in epidemiological studies, but it is not without problems. Its circular definition and melding of symptoms with functioning and distress have conceptual and real-world implications in terms of determining need for treatment and defining homogeneous groups for research. For example, the clinical significance criterion does not adequately deal with "subthreshold" or NOS conditions with significant functional impairment but not meeting symptom criteria. It does not account for emerging evidence that symptom clusters and their functional outcomes may well have different underlying mechanisms. In contrast, the World Health Organization has separated symptom syndromes from functioning and distress, in the ICD-10 and the International Classification of Functioning, Disability, and Health (ICF), respectively. This conceptualization is also not without its drawbacks. The DSM-V revision process should address the inherent problems of the clinical significance criterion, as well as the positive and negative aspects of uncoupling symptoms from disability and distress. Disparate use of terms such as impairment, disability, and functioning contribute to confusion surrounding the assessment of functioning. Adoption of terminology that is more consistent with the ICF should be considered.

5. ENHANCING RESEARCH AND TREATMENT OF MENTAL DISORDERS WITH DIMENSIONAL CONCEPTS: A *DSM-V* AGENDA

Robert Krueger, Ph.D., Campus Box 1125, St. Louis, MO 63130-4899

SUMMARY:

The current version of the *DSM* (*DSM-IV-TR*) describes all mental disorders as polythetic-categorical concepts. Lists of symptoms are presented in the *DSM*, and diagnostic category labels are assigned to patients based on observing specific patterns of symptoms. A number of notable conceptual problems emerge when using this strictly categorical system in research and in the clinic. For example, when thorough structured diagnostic interviews are used, typical patients meet criteria for more than one specific diagnosis (a phenomenon termed "comorbidity"). In addition, groups of patients with the same putative categorical label are often heterogeneous with respect to key clinical features, such as severity and prognosis.Although categorical concepts will al ways be essential in the DSM (e.g., in providing diagnostic labels for reimbursement purposes),many of the conceptual problems of a strictly categorical diagnostic system can be overcome by enhancing the DSM with dimensional concepts. For example,dimensional specifiers within diagnostic groups help to parse heterogeneity and enhance clinical case conceptualization (e.g., recording the frequency and severity of depressive episodes to predict prognosis). In addition, dimensional-spectrum concepts help in re-conceptualizing comorbidity as the natural result of broad predisposing factors enhancing risk for diverse mental disorders (e.g., the ubiquitous role of broad dimensions of personality such as negative affect in enhancing the risk for diverse psychopathological outcomes). Specific dimensional approaches and directions currently under review for potential inclusion in DSM-V will be discussed.

REFERENCES:

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3) Narrow WE, First MB, Sirovatka PJ, Regier DA, eds. Age and Gender Considerations in Psychiatric Diagnosis: A Research Agenda for DSM-V. Arlington, VA: American Psychiatric Publishing, Inc., 2007. DSM Track

DSM TRACK

PUBLIC HEALTH ASPECTS OF DIAGNOSIS AND CLASSIFICATION OF MENTAL DISORDERS: A DSM-V RESEARCH AGENDA

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: understand the public health implications of the diagnosis of psychiatric disorders; identify problems (individual and systemic) with the current diagnostic classification system in DSM and ICD; and describe specific, potential changes to DSM-V and/or ICD-11 that may better address worldwide public health needs.

SUMMARY:

This symposium will focus on salient points raised and discussed during the meeting of public health aspects of the classification of mental disorders, organized in the framework of the APIRE project undertaken to prepare the ground for the 11th revision of the International Classification of Diseases and the 5th revision of the DSM. The conference focused on reviewing the evidence and making it available to groups that will develop proposals for the revision of the classifications. The issues addressed by these participants, who represent different mental health disciplines and countries from all over the world, will include the use of classifications in public health planning at the primary health care level and in research. They will also review issues relevant to the process of developing classification, such as the involvement of consumers of mental health care in the preparation of a new system, economic factors to be considered, and the adjustment of the classifications to the context in which they will be developed and used (e.g., application to primary care settings).

PUBLIC HEALTH ASPECTS OF MENTAL DISORDERS CLASSIFICATION: THE WHO-APIRE CONFERENCE AND FURTHER THOUGHTS

Shekhar Saxena M.D.

SUMMARY:

The simultaneous revision of the DSM and WHO's ICD presents unique opportunities for harmonization, but harmonization requires that WHO's public health mission be reflected in the revision process and resulting classification. A reliable classification that accurately identifies those in need of mental health treatment will help to address public health needs but must be usable and useful to health providers. This has led WHO to establish a multidisciplinary revision process that focuses particularly on clinical utility and cross-cultural applicability. The public health utility of diagnostic classification should be considered in relation to the epidemiology of mental disorders over the lifespan and its ability to identify individuals who can benefit from targeted mental health interventions. The revision of the ICD and DSM classifications can be informed by public health, but differences in clinical and public health goals and applications make integration challenging. The goals of the WHO-APIRE Conference on Public Health Aspects of Diagnosis and Classification of Mental Disorders were: 1) to review the available evidence on public health implications of diagnosis and classification of mental disorders; and 2) to make recommendations on how the revision of ICD and DSM can serve global public health needs. Expert work groups provided 10 background papers on aspects of public health implications of diagnosis and classification of mental disorders. Summary recommendations from previous conferences in the APIRE series were also provided for consideration of their public health implications.

ECONOMIC CONSEQUENCES OF REVISING THE DIAGNOSTIC NOMENCLATURE FOR MENTAL DISORDERS

Howard Goldman M.D.

SUMMARY:

This presentation is based on a WHO report from a Conference Expert Group on the "Economic Consequences of Revising the Diagnostic Nomenclature for Mental Disorders." One of the most important reasons that a policymaker might be interested in changes in the diagnostic nomenclature is that assigning a diagnosis is an important step in demonstrating need for a particular service or resource. Demonstrated need for services or resources is often a basis for making allocation decisions and eligibility for benefits, such as transfer payments for income loss due to work disability or housing subsidies. Diagnosis is often used in policy formulation and implementation as a proxy for need. The presentation focuses on the following series of questions: What is the relationship of diagnosis to need? Assigning a diagnosis might be a valid proxy for establishing a need for any mental health service, but is it as good a proxy for determining the need for a specific level of service, such as hospitalization? Is the presence of a mental disorder alone a sufficient condition for receipt of income supports due to work disability, for compensation for loss due to impairment, or for food subsidy? If there is a change in the diagnostic nomenclature, the answers to these questions changes. The use of diagnosis as a guide to decision-making and policy formulation and implementation is affected by change in the diagnostic nomenclature.

CAPTURING COMPLEXITY: THE CASE FOR A NEW CLASSIFICATION SYSTEM FOR MENTAL DISORDERS IN PRIMARY CARE

Linda Gask Ph.D.

SUMMARY:

The primary care setting differs considerably from specialist mental health settings. For example, problems are presented in undifferentiated forms with consequent difficulties in distinguishing between distress and disorder, and a complex relationship often develops between psychological, mental, and social problems and their temporal variations. This presentation will address these differences and suggest revisions for a new, comprehensive classification system to improve applicability to primary care. Existing psychiatric diagnostic systems, including ICD-10-PHC and DSM-IV-PC, are often difficult to apply in primary care. They do not adequately address comorbidity, the substantial prevalence of sub-threshold disorders or prob lems with cross-cultural applica-

tions. Their focus on diagnosis may be too restrictive, ignoring the need to consider severity and impairment separately. ICPC-2, a classification system created specifically for use in primary care, is advantageous in that it allows for simple linkage between reason for encounter, diagnosis, and intervention. It is both necessary and feasible to develop a classification system for mental health in primary care that can meet four basic criteria: (1) It is characterized by simplicity; (2) it addresses not only diagnosis but also severity, chronicity, and disability; (3) it provides for routine data gathering in Q1 primary care as well as for training; and (4) it enables efficient communication between primary and specialty mental health care.

WHAT ARE CONSUMERS' VIEWS ON DIAGNOSES AND CAN THEY BE INVOLVED IN THE DEVELOPMENT OF NEW DIAGNOSTIC CLASSIFICATIONS?

Diana Rose Ph.D.

SUMMARY:

There is increasing interest amongst psychiatrists in involving consumers both in policy development and research, although some remain sceptical. Until now, this has not extended to the question of diagnosis and diagnostic classification systems, and thus there is not a firm evidence base on the views of consumers in this field. This presentation will synthesize the evidence that does exist. Consumers are not a homogenous group and may experience both relief and rejection as a response to diagnosis. Responses may be affected by stigma with more severe diagnoses, especially those associated with psychosis, eliciting more stigma from society. Across the world, responses may also be affected by the organization and funding arrangements of health care systems. This presentation will also address the question of whether consumers and their organizations can influence the development of new diagnostic systems. Facilitators and barriers are common and can be both organizational and attitudinal. Consultation with the plethora of consumer organizations may be difficult, as the outcomes would be less than clear. It might be possible to convene special groups of consumers, perhaps diagnosis-specific ones, although some consumers and their organizations are opposed to such diagnoses. Nevertheless, it is important to debate with these groups, however difficult this may be for both parties. Specific proposed changes to DSM and ICD will be considered from the perspective of consumers. Finally, recommendations will be made as to how the considerations addressed in this presentation might be incorporated into the new diagnostic systems of classification.

TRANSLATING PSYCHIATRIC DIAGNOSIS AND CLASSIFICATION INTO PUBLIC HEALTH USAGE

Alberto Minoletti M.D.

SUMMARY:

Public health functions, such as health situation monitoring, epidemiological surveillance, development of policies, and strategic management of health systems, are closely related to psychiatric diagnostic systems. The adequate implementation of these public health functions in mental health requires reliable diagnostic categories that respond to specific interventions. Although ICD and DSM diagnostic systems have several constraints, they have proved that their major categories and tools for measuring prevalence are functional and useful for priority setting, identification of cost-effective interventions, and development of mental health programmes in primary health care. However, the limited utility of these categories as predictors of resource utilization led several public health researchers to investigate other clinical indicators, mainly those related to distress, functionality/disability, and risk to self or others. Considering the experience of low- and middle-income countries, a universal mental health diagnostic system, merging ICD and DSM classifications, is needed. This system should be simple, transcultural, feasible in countries with different levels of income, reliable, related to available interventions, able to minimize stigma, and free of conflicts of interest. Furthermore, to ensure that a classification system operates effectively in public health, professionals dealing with mental disorders need to learn to use the nosological concepts conscientiously. Systematic assessment procedures that employ semi-structured interviews and scales can increase reliability and validity. There is also a strong need for more research on the implications of diagnostic classification systems for the essential public health functions and the development of future psychiatric classifications.

REFERENCES:

1) Kupfer DA, First MB, Regier DA (eds): A Research Agenda for DSM-V. Washington, DC, American Psychiatric Press, 2002.

2) Rose D, Thornicroft G, Pinfold V, Kassam A. 250 labels used to stigmatise people with mental illness. BMC Health Serv Res. 2007. 28;7:97.

3) Goldman H, Glied S, Alegria M. Mental health in the mainstream of public policy: Research issues and opportunities. Am J Psychaitry. 2008. 165;9:1099-1101.

4) Saxena S, Jane-Llopis E, Hosman C. Prevention of mental and behavioural disorders: implications for policy and practice. World Psychiatry. 2006. 5;1:5-14.

SPECIAL EVENT SYMPOSIUM

PSYCHOLOGICAL EFFECTS OF THE LONG WAR: STRATEGIES FOR MITIGATION

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Know the psychological effects of war., including PTSD and mild TBI.; 2) Understand the breadth of programs to mitigate the psychological effects; and 3) Understand how civilian providers can assist.

SUMMARY:

Seven years of war and repeated deployments have led to both physical and psychological wounds. This abstract will discuss both old and new challenges, including suicide, post-traumatic Stress Disorder, traumatic brain injury, and pain management. While an array of behavioral health services has long been avail able to address the strain on our Soldiers and Families, these ser-

vices are clearly strained. These services include Combat and Operational Stress Control, routine behavioral health care, and suicide prevention. Chaplains, Military One Source, and Army Community Service also offer support. We have multiple other initiatives to provide outreach, education and training, including "Battlemind", Combat and Operational Stress Control, Operational Stress Control and Readiness (OSCAR), and RESPECT-MIL. The new Defense Center of Excellence (DCoE) establishes quality standards for: clinical care; education and training; prevention; patient, family and community outreach; and program excellence. The DCoE mission is to maximize opportunities for warriors and families to thrive through a collaborative global network promoting resilience, recovery, and reintegration for PH and TBI. There continue to be major challenges that will face our service members, their Families and the nation.

UPDATES ON THE DEFENSE CENTER OF EXCELLENCE

BG Sutton, M.D.:

SUICIDE AND PSYCHOLOGICAL ISSUES IN THE UNITED STATES ARMY

Col Ritchie, M.D.

PSYCHOLOGICAL ISSUES FOR THE UNITES STATES NAVY

CAPT Hammer, M.D.

IDENTIFYING AND IMPLEMENTING PSYCHOLOGICAL HEALTH BEST PRACTICES: THE VIEW FROM THE DEFENSE CENTERS OF EXCELLENCE

CAPT Simmer, M.D.

SUMMARY:

Ensuring that our Warriors, Veterans, and their Families receive evidence-based services is a key component quality care. This session will review current efforts underway to identify and encourage the use of psychological health best practices with the Military Services, innovative practices currently being used, as well as research efforts. The role of the Defense Centers of Excellence as DoD's "open front door" in leading this project will also be described.

REFERENCES:

1. Ritchie EC, Owens M. Military Psychiatry, Psychiatric Clinics, September, 2004.

2. Ritchie EC, Senior Editor, Combat and Operational Behavioral Health, Textbook of Military Medicine, Borden Pavilion. Textbook of Military Medicine. Washington, DC: Office of The Surgeon General, US Department of the Army and Borden Institute; in press.

3. Encyclopedia of Psychological Trauma, eds Ryes, G, Elhai JD, Ford JD, Wiley, 2008.

4.The 2006 Mental Health Advisory Team Report of Behavioral Health Down Range, Traumatology, Dec 2007.

WORKSHOPS

MONDAY, MAY 18, 2009

9:00AM-10:30AM

COMPONENT WORKSHOPS

CW01. HIGH RISK STUDENT POPULATIONS: INNOVATIVE APPROACHES TO TREATMENT AND OUTREACH

AAPL/APA'S MANFRED S. GUTTMACHER AWARD LECTURE

Chair: Jerald Kay M.D., Department of Psychiatry, Boonschoft School of Medicine Wright State University
Elizabeth Place, 628 Edwin C. Moses Blvd, Dayton, OH 45401
Presenter(s): Marta Hopkinson, M.D., Leigh Anne White, M.D., Beverly Fauman

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Identify those students at high risk for developing psychiatric disorders; 2.) Understand new treatment approaches and prevention techniques for high risk students; and 3.) Appreciate barriers to help-seeking behaviors for these populations.

SUMMARY:

College student counseling centers and mental health services report increasing numbers of highly distressed students attending college and graduate school and an increased demand for services. Several subpopulations of college students are either at higher risk for developing mental health problems, or they are less likely to seek mental health services when needed, or both. These include students with disabilities, transfer students, international students, student athletes, substance abusing students,and lesbian, gay, bisexual and transgendered students. This workshop summarizes issues confronting at risk subpopulations,reasons for help-seeking or help-avoiding, and proposes outreach strategies to encourage help-seeking behavior among these students.

REFERENCES:

1) Kadison R,Digeronimo TF: College of the oerwhelmed:the campus mental health crisis and what to do about it.San Fransisco, Jossey-Bass, 2004.
2) American College Health Association/National College Health Assessment, Summarized Mental Health Data and Trends, Spring 2000-Spring 2007.

CW02. LOST AND NOT FOUND: DEPRESSION AND SUICIDE IN ELDERLY ASIAN AMERICANS

APA COMMITTEE OF ASIAN-AMERICAN PSYCHIATRISTS

Chair: *Jacquelyn Chang M.D., 1838 El Camino Real, Suite 205, Burlingame, CA 94010*
Presenter(s): *Megan Marumoto M.D., Dan Tzuang, Iqbal Ahmed M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe cultural barriers to recognizing and treating depressed elderly Asian Americans, identify both risk factors for and protective factors against suicide in elderly Asian Americans, understand current research on depression and suicide in elderly Asian Americans, and discuss culturally appropriate treatments for depressed elderly Asian Americans including psychosocial, pharmacologic, and community interventions.

SUMMARY:

Asian Americans are a diverse and rapidly growing population encompassing 54 ethnic groups and constituting more than 4% of the US population. While often portrayed as a "model minority," Asian Americans have unique and unknown hidden problems. Depression in elderly Asian Americans is frequently unrecognized and undertreated. Asian Americans have the highest rate of completed suicide among the

ethnic minority elderly. Asian-American women over the age of 65 have the highest suicide rates of any group of elderly women. Linguistic and social isolation, acculturation stress, and intergenerational conflict can often contribute to increased rates of depression and suicide in elderly Asian Americans. American society's focus on youth and individualism conflicts with traditional Asian values.

This workshop will provide an overview of depression and suicide in elderly Asian Americans. Barriers to treatment including stigma, language, and cultural values will be discussed. Asian-American patients may manifest depression in culturally specific ways that hinder detection and diagnosis. Research on elderly Asian Americans is limited, but current research on depression and suicide in this population will be reviewed. Presenters will address both the risk factors for and the protective factors against suicide in depressed elderly Asian Americans. Treatment approaches for the general psychiatrist will be given, including culturally appropriate psychodynamic, psychosocial, and ethno-psychopharmacologic interventions. The workshop will highlight elderly community treatment programs and give clinicians specific resources available online and in print. Lastly, a case will be discussed to illustrate the complexity of cultural issues facing clinicians treating depression in elderly Asian Americans. This workshop is intended for all clinicians interested in learning more about depression and suicide, elderly, and Asian Americans.

REFERENCES:

1) Leong FTL, Leach MM, Yeh C, Chou E: Suicide among Asian Americans: What Do We Know? What Do We Need to Know? Death Studies 2007; 31:417-434.
2) American Psychiatric Association Ethnic Minority Elderly Committee. Ethnic Minority Elderly Curriculum, 2006. Ahmed I, Kramer E, editors. Retrieved September 6, 2008, from the American Psychiatric Association website: http://www.psych.org/Resources/OMNA/OMNAfiles/MinorityElderlyCurriculum.aspx.

CW03. WITHDRAWN

CW04. INTERNATIONAL DISASTERS: CHALLENGES AND OPPORTUNITIES TO CONTRIBUTE

APA COMMITTEE ON PSYCHIATRIC DIMENSIONS OF DISASTER

Chair: Shirley Liu M.D., 55 North Lake Ave., Worcester, MA 01655
Co-Chair: Patcho Santiago M.D.
Presenter(s): Artin Terhakopian M.D., Arshad Husain M.D., Joseph Napoli M.D., Robert Ursano M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe fundamental public health interventions used to manage health care needs in disasters, such as the Incident Command System (ICS) and psychological first aid; 2) Understand the various roles psychiatrists can play in addressing the mental health needs of disaster-affected populations; 3) Discuss advantages, disadvantages, and challenges of contributing to those efforts on-location at the disaster versus from abroad.

SUMMARY:

Over the last 20 years, the global community has been affected by a striking number of natural and man-made disasters, in which the need for appropriate and accessible mental health care for affected populations is well-documented. In order to provide the crucial services that address trauma and trauma-related problems after disasters, whether like Hurricane Katrina or genocide in Rwanda, it is imperative that psychiatrists better incorporate themselves into disaster response efforts. In this workshop, the fundamental framework and mechanism of the Incident Command System (ICS), utilized by authorities to address the public health needs of communities experiencing disasters, and its application of psychological first aid, will be described and explained. Thereafter, experts in the field of disaster psychiatry, who have contributed to efforts in war-torn Afghanistan and earthquake-ravaged China, will present their successes and challenges in applying these public and mental health principles by means of various formats. The opportunity for questions and discussion will be provided. The Committee of Psychiatric Dimensions of Disasters hopes that this workshop will increase psychiatrists' awareness of the valuable role they play in disaster response.

REFERENCES:

1) Hobfoll SE, Watson P, Bell CC, Bryant RA, Brymer MJ, et al.: Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. Psychiatry 2007; 70(4):283-315.
2) Ritchie EC, Watson PJ, Friedman MJ: Interventions following mass violence and disasters: strategies for mental health practice. New York, Guilford Press, 2006.

CW05. CAREER ADVANCEMENT IN ADMINISTRATIVE PSYCHIATRY FOR EARLY CAREER PSYCHIATRISTS

APA ASSEMBLY COMMITTEE OF EARLY CAREER PSYCHIATRISTS

Chair: Dimitri Markov M.D., Jefferson Sleep Disorders Center 211 S. Ninth Street, 5th Floor, Philadelphia, PA 19107
Co-Chair: Marina Goldman M.D.
Presenter(s): Shivkumar Hatti M.D., Thomas Newmark M.D., Barry Herman M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to state the basic principles of administrative psychiatry, understand the administrative skills which can help psychiatrists be more effective, and list mistakes psychiatric administrators should avoid.

SUMMARY:

Most early career psychiatrists (ECPs) encounter administrative responsibilities in their every day work. The field of psychiatry also presents numerous business and executive opportunities. Yet, like most physicians, ECPs do not have the business training or experience needed for advancement in administrative positions. Because the practice of medicine is often combined with the business of medicine, this workshop, conducted by senior administrative psychiatrists, will help ECPs learn how to better manage their current administrative duties and prioritize goals to develop their careers. The workshop will be highly interactive with emphasis on eliciting the needs of early career psychiatrists and providing guidance from senior faculty.

REFERENCES:

1) Newmark TS. Administrative Psychiatry: Reflections of a Department Chair. Psychiatric Administrator 2007; 7(2):29-31.
2) Herman BK. Managing Up: Dynamic Following in an Organizational Setting. Psychiatric Administrator 2007; 7(2): 34-38.

CW06. SHOW ME THE MONEY! SUSTAINABLE FUNDING FOR EDUCATION IN PSYCHIATRY

APA/GLAXOSMITHKLINE FELLOWS

Chair: M. Justin Coffey M.D., 4250 Plymouth Rd, Ann Arbor, MI 48109

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will: 1.) Identify potential non-pharmaceutical sources of funding to support education programs in psychiatry (knowledge); 2.) Learn and develop skills to negotiate, obtain, and sustain these non-pharmaceutical sources of funding (skills); and 3.) Broaden their perspectives on funding for educational programs in psychiatry (attitudes and perspectives).

SUMMARY:

Pharmaceutical industry sponsorship has been a nearly ubiquitous source of financial support for education in psychiatry. The climate surrounding this relationship is shifting dramatically. As a result, many well-established educational programs are now challenged to identify new sources of sponsorship and support. Practical and swift solutions are necessary for the viability of many educational programs. The skills to arrive at such solutions, however, are not typically taught in formal psychiatry education. This year's American Psychiatric Leadership (APL) Fellows' workshop offers practical information to those working to sustain educational programs in psychiatry. Potential sources of non-industry funding will be identified and characterized based on such key features as types of program typically supported, type and amount of support typically provided, the process of applying, the timeline for negotiation, and their cultural or philosophical compatibility with psychiatry. The workshop will consist of a presentation of findings, an expert panel discussion, and audience participation. Participants will leave the workshop empowered with the knowledge, skills, and attitudes essential to fund educational programs in psychiatry in innovative ways.

REFERENCES:

1) Geppert CM. Medical education and the pharmaceutical industry: a review of ethical guidelines and their implications for psychiatric training. Acad Psychiatry. 2007, Jan-Feb; 31(1):32-9.
2) Lazarus A. The role of the pharmaceutical industry in medical education in psychiatry. Acad Psychiatry. 206, Jan-Feb:30(1):45-7.

11:00AM- 12:30PM

COMPONENT WORKSHOPS

CW07. REVITALIZING SERVICE: STRATEGIC PLANNING SUCCESS WITHIN DISTRICT BRANCHES AND STATE ASSOCIATIONS

APA COUNCIL ON MEMBER AND DISTRICT BRANCH RELATIONS

Chair: Nioaka Campbell M.D., 15 Medical Park, Ste 141, Columbia, SC 29203
Presenter(s): Laura Michaels J.D., Lasa Joiner, Warene Chase-Eldridge

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Identify the needs of local organizations for restructuring and revitalization; 2.) Recognize the components of a strategic plan; 3.) Examine the strengths and weaknesses of recent strategic plans throughout various district branches/state associations; and 4.) Develop a roadmap for strategic planning initiatives within their home organization.

SUMMARY:

A strategic plan represents a roadmap for an organization. It provides direction, clarity, priorities and framework for leadership, serving as a guide for achieving goals and allocating resources to serve member interests. District Branches and State Associations often struggle to adequately identify and address the priorities of members and the medical community. Declining financial support from outside resources and decreases in new membership participation demonstrate the need for grass roots' organizational restructuring. Developing a strategic plan allows an organization to have a targeted restructuring agenda and to integrate the needs of all parties. Strategic planning involves financial forecasting, budgeting, allocation of membership manpower, re-assessment of goals and membership recruitment. Contents may include a mission statement, organizational values, a vision statement and goals or strategies specific to that group. The Colorado Psychiatric Society, Georgia Psychiatric Physicians Association, Maine Association of Psychiatric Physicians and the Massachusetts Psychiatric Society were all recipients of grant funding which allowed their district branches and associations to develop strategic plans and to restructure organizations. Sharing the successes and challenges of local chapter redevelopment will enable others to incorporate this knowledge and serve within their own communities using targeted programs. During this workshop each local association will present their process of restructuring, including the assessment of need for a strategic plan in this ever changing environment. Discussion will include how each association functioned in establishing goals and programs to ensure maximization of resources and allocation of those resources to the areas identified as most beneficial. Audience feedback and small group brainstorming will encourage individuals to plan their own strategic endeavors and revitalization efforts within their local organization.

REFERENCES:

1) Klein RH. At the core: how we steer our course. Int J Group Psychother. 2005 55(2):229-43
2) Goldberg RJ. Financial management challenges for general hospital psychiatry 2001. Gen Hosp Psychiatry. 2001 23(2):67-72

CW08. COMBAT TO COMMUNITY: NEEDS AND RESOURCES FOR POST-SEPTEMBER 11TH VETERANS AND THEIR FAMILIES

APA ALLIANCE

Chair: Kay Brada, 52 Mission Road, Eastborough, KS 67207
Presenter(s): Amy Fairweather J.D., Mai-Ling Garcia B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the Iraq/Afghanistan verteran population; to better as competencies on working in and with teams and users of services.

For Early Career Psychiatrists, the American Psychiatric Association has received funding for the Transformational Leaders in Public Psychiatry Academy. This academy will focus on helping psychiatrists deal with limited resources of public mental health system, and become change agents to

improve their environments. For medical directors in community mental health centers, The Psychiatrist Leadership Development Program is designed to promote professional knowledge skills and abilities. Specifically participants gain and knowledge and abilities in performance improvement and strategic planning as well as insight into their own personal leadership strengths and weaknesses. The PLDP involves a curriculum-based training component, coupled with ongoing performance improvement projects that the participants develop under the guidance of faculty and mentors. For Community Mental Health Centers or Organizations, the Community Psychiatric Practice Mentorship Service is a sustainable, customizable, contracted service, developed and managed by the American Association of Community Psychiatrists, that provides expert psychiatrist mentors to selected psychiatrists, especially newly recruited staff psychiatrists or medical directors, for the express purpose of providing organizational consultation. The scope of this consultation includes assessment, training, guidance, motivation, and ongoing consultation. The presentation ends with a summary of important leadership skills and how participants might further learn them and apply them to their practices.

REFERENCES:

1) Pollack DA, Minkoff K: The Medical Director's Role in Organized Care Delivery Systems, in The Textbook of Administrative Psychiatry: New Concepts for a Changing Behavioral Health System. Edited by Talbott JA, Hales RE. Washington, DC, American Psychiatric Publishing, 2001.
2) Tobin, M. Edwards. J.: Are psychiatrists equipped for management rolesin mental health services? Australian and New Zealand Journal of Psychiatry 2002; 36:4–8.

TUESDAY, MAY 19, 2009

9:00AM- 10:30AM

CW10. BIRACIAL AMERICANS: CHECK ONE BOX ONLY AND THE DEVELOPMENT OF MULTIRACIAL IDENTITY

APA COUNCIL ON MINORITY MENTAL HEALTH AND HEALTH DISPARITIES

Chair: Jacquelyn Chang M.D., 1838 El Camino Real, Suite 205, Burlingame, CA 94010
Co-Chair: Kehinde Ogundipe M.D.
Presenter(s): Brett Sevilla M.D., U. Diane Buckingham M.D., Sandra Walker M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Demonstrate an understanding of the literature on biracial and multiracial identity development; 2.) Recognize the challenges of growing up biracial or multiracial in America; and 3.) Identify therapeutic issues in treating biracial and multiracial individuals.

understand the extent of the social and psychological issues confronting young veterans and their families; and to learn about resources and referral agencies for veterans affected by the Iraq and Afghanistan wars.

SUMMARY:

This program is designed to provide community behavioral health, social workers and mental health service providers a general working knowledge of social and psychological issues that affect veterans that have served during recent conflicts in Iraq (Operation Iraqi Freedom) and Afghanistan (Operation Enduring Freedom). The content is the result of an extensive review of existing literature and interviews with Iraq and Afghanistan veterans and their families. The program will describe the current population of Iraq/Afghanistan veterans, common problems that they encounter post-combat and resources that veterans can use while transitioning to the civilian life. This guide is intended to be a primer to basic issues and resources that affect Iraq and Afghanistan veterans and their families.

REFERENCES:

1) "Differences in Health-Related Quality of Life in Rural and Urban Veterans" American Journal of Public Health, October 2004, Vol 95, No 10.
2) "Key Elements in Couples Therapy with Veterans with Combat-Related Posttraumatic Stress Disorder" Professional Psychology Research and Practice. 2005, Vol. 36.

CW09. BECOMING A PUBLIC PSYCHIATRY LEADER: MENTORING MODELS FOR EVERYONE, FROM RESIDENTS TO MEDICAL DIRECTORS.

APA COUNCIL ON SOCIAL ISSUES AND PUBLIC PSYCHIATRY

Chair: Peter Chien M.D., Department of Psychiatry (MC913) University of Illinois-Chicago 912 S. Wood St. Chicago, IL 60612,

EDUCATIONAL OBJECTIVES:

At the end of this presentation, participants should be able to elucidate skills needed for leadership in public psychiatry, address the transition from clinical service to leadership and administration, understand details of 3 current and proposed national mentoring models, take the next leadership step in their own careers, and mentor others to do the same.

SUMMARY:

Psychiatrists in today's world need leadership skills in addition to their clinical skills. This presentation will present needed general administrative and leadership skills for the public psychiatry leader and ways to teach them. During residency training, system-based competencies require the resident to understand the broad health care system as well

SUMMARY:

Biracial individuals are a growing population in the United States. In the 2000 Census, 6.8 million people (2.4% of the US population) identified as belonging to two or more races. Of these individuals, 93% are biracial and 42% are children. The recently released 2008 National Population projections estimate that by 2050, 16.2 million people will identify as being of more than one racial category. Over time, psychiatrists will have increasing contact with this group as more children are born to interracial couples and more individuals identify themselves as biracial or multiracial. This workshop will review some of the existing literature on biracial and multiracial identity development. It will cover themes in racial identity development for multiracial individuals and some of the challenges of growing up biracial or multiracial, including being asked intrusive questions and experiencing pressure to affiliate with one race over another. Multiracial identity development begins during childhood after the initial realization of one's difference from others. Individuals may struggle for acceptance of their differences before finally becoming comfortable with their multiracial identity. This workshop will examine factors that can help in the development of a strong sense of multiracial identity. Clinical issues that surface in the treatment of biracial and multiracial individuals will be discussed. Presenters will share their professional and personal reflections on biracial and multiracial issues from the perspective of a Filipino/Irish child psychiatrist, an African-American biracial child psychiatrist, and African-American adult psychiatrist with biracial children. This workshop is intended for all clinicians interested in cultural issues, child and adolescent issues, and the growing multiculturalism of America.

REFERENCES:

1) Miville ML, Constantine MG, Baysden MF, So-Lloyd G: Chameleon Changes: An Exploration of Racial Identity Themes of Multiracial People. Journal of Counseling Psychology 2005; 52(4): 507–516
2) Rockquemore KA: Beyond Black: Biracial Identity in America. Thousand Oaks, CA, Sage Publications, 2002.

CW11. RECOGNITION AND TREATMENT OF DEMENTIA IN A CHANGING AMERICA

APA COMMITTEE ON ETHNIC MINORITY ELDERLY

Chair: Maria llorente M.D., 1201 NW 16th Street #116A, MIAMI, FL 33125
Co-Chair: Khushro Unwalla M.D.
Presenter(s): Carl I. Cohen M.D., Maria llorente M.D., Deborah Dallam M.D., Irving Kuo M.D., Khushro Unwalla M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Describe the changing demographic imperative of aging and the associated prevalence of the demnting illnesses; 2.) Identify the minority groups at greatest risk for dementia; 3.) List the differential diagnosis of dementia; 4.) Recognize available pharmacologic treatments for the cognitive and behavioral symptoms in dementia; and 5.) Identify ethnobehavioral management techniques for behavioral disturbances.

SUMMARY:

Practically all psychiatrists will work with older adults at some point in their career. As the population ages, the numbers of adults with dementing illnesses is expected to grow exponentially. Recognition of dementia can be challenging, as the differential diagnosis is broad. Reversible factors, such as thyroid disease and vitamin deficiencies must be considered. Overcoming healthcare provider barriers, however, is a significant problem. Reasons for this poor recognition include lack of knowledge or skills in suspecting or identifying dementia, attribution of symptoms to other causes, lack of time, and the widely held myth, even among healthcare providers, that memory loss is a normal part of aging. One diagnosed, the management of dementia is equally challenging, and clinicians need to use both behavioral and pharmacologic techniques. The goals of treatment include: aggressively managing those conditions that increase the risk for dementia, namely hypertension, diabetes and hypercholesterolemia; improving early detection; utilizing behavioral techniques, psychoeducation and pharmacologic medications to manage behavioral disturbances; and addressing caregiver burden. This Workshop will review the epidemiology of the aging of America and the significant transformation of the racial and ethnic minority makeup of the aging US population. The differential diagnosis of dementia will be discussed, with particular attention on the differing prevalences of dementia among the major minority groups. Clinical case examples will then be provided to discuss behavioral and pharmacologic management of behavioral disturbances, including examples of the need for recognition of the influence of culture on treatment preferences.

REFERENCES:

1.) Faison WE, Mintzer JE. The growing, ethnically diverse aging population: is our field advancing with it? Am J Geriatr Psychiatry. 2005;13:541-544
2.) Chodosh J, Petitti DB, Elliott M, Hays RD, Crooks VC, et al. Physician recognition of cognitive impairment: evaluating the need for improvement. JAGS. 2004; 52(7):1051-9.

CW12. HOW GENERAL PSYCHIATRISTS CAN EFFECTIVELY SCREEN & TREAT SUBSTANCE USE DISODERS

APA CORRESPONDING COMMITTEE ON TREATMENT SERVICES FOR PATIENTS WITH ADDICTIVE DISORDERS

Chair: Varinder Rathore M.D., 845 2nd Avenue, Unit 8B, New York, NY 10017
Co-Chair: Petros Levounis M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Demonstrate proficiency with regards to the basic principles of the SBRT System for assessment, treatment and intervention;

and 2.) Provide recommendations for the implementation of SBRT addiction programs.

SUMMARY:

Substance abuse's toll on the health and productivity of the United States is more than $400 billion a year. Although this amount is staggering it does not begin to reflect the human cost which by all accounts is devastating. In short, drug-abuse is the disease of our times. The SBIRT (Screening, Brief Intervention, Referral & Treatment) initiative represents a paradigm shift in the provision of treatment for substance use and abuse. Among its main objectives is an early intervention approach, targeting new populations and a comprehensive system for assessment, intervention and treatment. In addition, SBIRT encompasses motivational enhanced therapy as an effective modality in the treatment of the addicted patient. In this workshop we will present the guiding principles of SBIRT and discuss how this methodology has been an effective collaboration involving national policy, healthcare institutions and our patients with regard to substance abuse treatment. Participants will be encouraged to provide their own opinions, share clinical experiences and help the group formulate recommendations for enhancing the SBIRT model and it's applicability to present day substance abuse treatment.

REFERENCES:

1) The American Psychiatric Publishing Textbook of Substance Abuse Treatment, 4th Edition, Marc Galanter, M.D. and Herbert D. Kleber, M.D, 2008.
2) -Motivational Interviewing, 2nd Edition. William Miller, PhD. & Stephen Rollnick, PhD, 2002.
-Sober Siblings. Patrica Olsen, Petros Levonis M.D., M.A., 2008.

CW13. OUTPATIENT FORENSIC SERVICES AND INTERVENTIONS TO IMPROVE CLINICAL OUTCOMES AND REDUCE RECIDIVISM

APA TASK FORCE ON FORENSIC OUTPATIENT SERVICES

Chair: Steven Hoge M.D., Bellevue Hospital Center,462 First AvenueRoom #19N45,, New York, NY 10016
Co-Chair: Alec Buchanan Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify clinical correlates of criminal justice involvement and to understand the programmatic innovations needed to address service barriers.

SUMMARY:

Over the last generation, mentally ill individuals have flooded our jails and prisons in disproportionate numbers. The rates of re-arrest and re-conviction are very high in the population of released mentally ill inmates. Changes in penal policy and deinstitutionalization are the underlying historical forces behind this movement. Correctional care has been lacking in many areas, but only recently has attention turned to the paucity of outpatient services and interventions available to address the needs of this population. This workshop will present Task Force findings regarding innovative programs and present recommendations regarding needed changes in legal policy, systems, training, and research.

REFERENCES:

1) Hoge SK. Providing Transition and Outpatient Services to the Mentally Ill Released from Correctional Institutions, in Greifinger R (ed), Public Health Behind Bars: From Prisons to Communities. Springer, New York, 2007.
2) Osher F, Steadman HJ, and Barr H. A best practice approach to community re-entry from jails for inmates with co-occurring disorders: the APIC model. Delmar, NY: GAINS Center.

CW14. NATIONAL SECURITY, THE HIPPOCRATIC OATH, AND THE WAR ON TERROR

APA COUNCIL ON GLOBAL PSYCHIATRY

Chair: Shirin Ali M.D., 34 Elm St., Somerville, MA 02143
Co-Chair: Karinn Glover M.D.
Presenter(s): Alan Cyr M.D., Eliot Sorel M.D., Elspeth Ritchie M.D., Jeffrey Janofsky M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the ethical and moral dilemmas for psychiatrists involved in the treatment of political prisoners, understand the arguments made supporting the involvement of psychiatrists in interrogation and coercion, address questions regarding the role of interrogation in eliciting information for national security, and describe the psychological impact of torture.

SUMMARY:

The purpose of this workshop is to have an informed discussion within the psychiatric community about the moral and ethical dilemmas that arise when mental health professionals around the world participate in the torture, interrogation, or care of political prisoners. In 2006, the APA issued a position statement that strongly discouraged psychiatrists from participating in interrogations and advising interrogators. The APA Ethical Guidelines clearly prohibit psychiatrists from participating in torture. However, though the APA Ethical Guidelines state that a physician's duty to his or her patient must be "paramount," there is still active debate about whether or not psychiatrists should be involved in the interrogations.

In this workshop, we will consider how psychiatrists balance their role in interrogation and coercion with caring and advocating for political prisoners and survivors of torture. This workshop will also highlight some of the differences in interrogation mandated by the highest authority from "bottom-up" approaches. Various panelists will argue for or against the use of mental health professionals in interrogation, coercion and torture, and draw from a variety of broad perspectives on this topic, including psychological, ethical, legal, moral, and clinical.

REFERENCES:

1) Sharfstein SS, Zonana HV, Kiley KC, Stone AA, Appelbaum PS. Psychiatric participation in interrogation of detainees: ethical considerations. Program and abstracts of the 159th Annual Meeting of the American Psychiatric Association; May 20-25, 2006; Toronto, Ontario, Canada. Presidential Symposium 4.
2) Okie S. "Glimpses of Guantanamo-Medical Ethics and the War on Terror." 2005. The New England Journal of Medicine. 353(24):2529-2534.

11:00AM- 12:30PM

CW15. CURRENT TOPICS IN FORENSIC PSYCHIATRY: UPDATE FROM THE COUNCIL ON PSYCHIATRY AND LAW AND THE COMMITTEE ON JUDICIAL ACTION

APA COUNCIL ON PSYCHIATRY AND LAW AND APA COMMITTEE ON JUDICIAL ACTION

Chair: Patricia Recupero J.D., Butler Hospital
345 Blackstone Boulevard, Providence, RI 02906
Co-Chair: Jeffrey Janofsky M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the implications of recent case law concerning competence of criminal defendants to represent themselves pro se; to identify legal and ethical implications of the "dangerous patient" exception to therapist-patient confidentiality; and to explain the role and recent developments of psychiatric advance directives.

SUMMARY:

This component workshop will present an update on the work of the APA's Council on Psychiatry and Law and the Committee on Judicial Action. Presentations will address three topics: (1) the recent Supreme Court decision in Indiana v. Edwards and the competence of criminal defendants to represent themselves pro se; (2) the "dangerous patient" exception to psychotherapist-patient confidentiality and related ethical and legal questions; and (3) psychiatric advance directives (PADs). In Indiana v. Edwards, the Supreme Court recently allowed a state to provide additional competency protections for individuals seeking to represent themselves during criminal trials. Dr. Recupero will review the facts of the case as well as the Supreme Court's decision and its implications for forensic psychiatry. Dr. Weinstock will then address the dangerous patient exception. There are differences between the federal circuits on their interpretation of a possible dangerous patient exception to psychotherapist-patient privilege mentioned in a footnote to the US Supreme Court Jaffee v Redmond decision. Those circuits finding an exception have found a confidentiality violation in a Tarasoff situation means there is no privilege at later trial, when a therapist can be used solely to convict the patient after the danger has passed. The Council position will be discussed, including the desire to avoid on the federal level following California where therapists have been used soely to get a death penalty for a patient. Related complex Tarasoff situations will be mentioned in which psychiatrists face decisions on how best to deal with dangerous patients. Finally, the workshop will inform participants about PADs. Advance directives are utilized by a small, but growing, number of psychiatric patients. Dr. Hoge will discuss the implementation of advance directives in psychiatric treatment, including legal issues and clinical problems that may arise.

REFERENCES:

1) Indiana v. Edwards, U.S. Sup. Ct. No. 07-208, 2008 U.S. LEXIS 5031 (U.S., June 19, 2008)
2) Parsio A. Note: The Psychotherapist-Patient Privilege: The Perils of Recognizing a "Dangerous Patient" Exception in Criminal Trials. 41 New Eng. L. Rev. 623, Spring 2007

CW16. INDICATIONS FOR THE USE OF COMBINED TALKING THERAPY AND PHARMACOTHERAPY AND HOW TO TEACH IN RESIDENCY (BY CORRES. COMMITTEE ON GRADUATE EDUCATION)

Chair: Sidney Weissman M.D., 625 N. Michigan Ave., Chicago, IL 60611
Presenter(s): Edward Silberman M.D., David Preven, Ryan Hall M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should know when to start a patient on talking therapy and concurrent medications, when to add medications to a talking therapy and when to add a talking therapy to a medication treatment. A participant will also learn how to develop programs to teach these abilities to residents.

SUMMARY:

In this workshop we will first discuss fact that all therapy is psychotherapy. Psychiatric treatments attempt to alter behavior or self experience by either using medications or talking to a patient. Both interventions aim to alter the psychology of the patient and hence both are actually psychotherapies. Next we will address the criteria to use to determine when to add a talking treatment to a therapy based on medication treatment.

After this we will address the criteria as to when to add amedication to a talking therapy. After these discussions we will address when a patient should be started concurrently on both treatments. We will conclude the workshop with a discussion by a psychiatrirc educator as to how to teach issues of combined therapy in a residency.

REFERENCES:

1) M. Levey IN PSYCHIATRY IN THE NEW MILLENIUM ed. Sidney Weissman, Melven Sabshin and Harold Eist"A Clinical Model for Selecting Psychotherapy and Pharmacotherapy, American Psychiatic Press, Washington Dc 1999
2) F. Busch and E. Auchincloss in PSYCHODYNAMIC CONCEPTS IN GENERAL PSYCHIATRY ed by Harvey

Schwartz with E. Bleiberg and S. Weissman "The psychology of Prescribisng and Tasking Medication, American Psychiatric press Washington D.C. 1995

CW17. MEDICAL ISSUES FOR PSYCHIATRISTS IN DISASTERS

APA COMMITTEE ON PSYCHIATRIC DIMENSIONS OF DISASTER

Chair: Mark Viron M.D., 15 Parkman St. WACC812, Boston, MA 02114
Co-Chair: Nidal Hasan M.D.
Presenter(s): Brooke Parish, Catherine May M.D., Elspeth Ritchie M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participants should be able to: 1.) Understand psychiatrists' need for awareness of medical issues in disaster settings; 2.) List the most common medical conditions that present during a disaster; 3.) Demonstrate awareness of current best medical practices in diagnosing and treating these conditions; and 4.) Understand important aspects of the integration of psychiatrists in healthcare disaster response teams.

SUMMARY:

The necessity of having accessible and timely mental health services in the acute and post-disaster recovery environment is becoming more apparent with each new tragedy faced by the global population. Fittingly, psychiatrists are now commonly found participating as integral members of healthcare disaster response teams. In this role, psychiatrists are required to interact in an efficient and effective way with colleagues from other medical specialties in order to care for patients with both medical and psychiatric co-morbidities. Psychiatrists will be asked to provide psychiatric care for those with and without medical illness and, at times, may even be needed to attend directly to the medical needs of this vulnerable population. As such, it is essential that psychiatrists are aware of the most commonly encountered medical issues in the disaster setting, such as wounds, musculoskeletal pain, cellulitis, and upper respiratory infections, and the potential masking of those medical issues by psychological problems. Moreover, a general familiarity with the diagnosis and treatment of these conditions will allow for psychiatrists to function as invaluable members of the disaster medical response team. Overall, the workshop aims to inform and to stimulate discussion among attendees about the medical needs of patients in a disaster setting, to summarize general information regarding the diagnosis and treatment of these conditions, and to explore issues surrounding the integration of psychiatrists into healthcare disaster response teams.

REFERENCES:

1) Rundell JR: Assessment and management of medical-surgical disaster casualties, in Textbook of Disaster Psychiatry. Edited by Ursano RJ, Fullerton CS, Weisaeth L, et al. London, Cambridge University Press, 2007, pp 164-189.
2) Greenberg B, Nufer K, Shah M, et al: A comparison of past and present hurricane related NM-1 DMAT deployments. Paper presented at the annual meeting of the National Association of EMS Physicians, Registry Resort, Naples, FL, 2006.

CW18. ETHICAL DILEMMAS IN PSYCHIATRIC PRACTICE

APA ETHICS COMMITTEE

Chair: Wade Myers M.D., Division of Child and Adolescent Psychiatry 12901 Bruce B Downs Blvd MDC102, Tampa, FL 33612
Presenter(s): Stephen Green M.D., Elissa Benedek M.D., Lea DeFrancisci Lis M.D., Burton V. Reifler M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize common situations which may signal rofessional risk.

SUMMARY:

Past Ethics Workshops, partly composed of structured presentations, have routinely left insufficient time to adequately address complex practice issues and dilemmas raised by audience members. Therefore, 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.

REFERENCES:

1) American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. United States of America, American Psychiatric Association, 2008
2) American Medical Association: Code of Medical Ethics of the Amrican Medical Asociation. United States of America, American Medical Association 2008.

WEDNESDAY, MAY 20, 2009

9:00AM- 10:30AM

CW19. IMMIGRANT MENTAL HEALTH: CHALLENGES AND CONSIDERATIONS

APA/SAMHSA AND APA/ASTRAZENECA MINORITY FELLOWSHIPS

Chair: Shirin Ali M.D., 34 Elm St., Somerville, MA 02143
Co-Chair: Felicia Kuo B.A.
Presenter(s): Chris Esguerra M.D., Farha Abbasi M.D., Arun Gopal, Suzan Song M.D., Batool Kazim M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify intergenerational issues/traditional family roles and be sensitive to how these factors may impact patient confidentiality and autonomy; define idioms of distress and recognize that certain cultures may present with somatic complaints to represent their psychic distress; undertand the role of interpreter services in psychiatric treatment; and appreciate this population's unique barriers to accessing mental health care

SUMMARY:

Immigrant Mental Health is a topic of increasing, and undeniable, importance. By 2042, it is predicted that the white majority (defined as the non-Hispanic, single-race white population) will become a minority group in the United States based on projections from census results and assumptions about future childbearing, mortality and migration. As psychiatrists, it is imperative that we become knowledgeable about the unique issues that immigrants face, and understand how these may impact their access to, and utilization of, mental health care.

The purpose of this workshop is to introduce some of the main issues that pertain to immigrant mental health care and invite a discussion about culturally appropriate responses to these considerations and challenges. Using case vignettes and a short video clip, we will illustrate the complex issues that immigrant populations may face while navigating through the U.S. mental health care system from their initial presentation to triage, to their follow up care. We have identified a few main barriers to accessing mental healthcare for immigrant populations. We will explore intergenerational issues and traditional gender and family roles, and how these factors may impact patient confidentiality and autonomy. We will review cultural idioms of distress, and discuss how some cultures may present with somatic complaints to represent their psychic distress. We will also discuss the role of interpreter services in psychiatric evaluation and treatment - to help translate, and serve as potential cultural mediators. We will review possible psychosocial, pharmacologic and community interventions to alleviate these obstacles.

REFERENCES:

1) Cohen A, Kleinman A, Saraceno B. World Mental Health Casebook : Social and Mental Health Programs in Low-Income Countries. Kluwer Academic/Plenum, 2002. ISBN 0306467321, 978030646735
2) Sadavoy J et al. Barriers to access to Mental Health Services for Ethnic Seniors: The Toronto Study. Canadian Journal of Psychiatry. Mar 2004, Vol 49, Issue 3, p 192-199.

CW20. NATIONAL TRENDS IN PSYCHOTHERAPY BY PSYCHIATRISTS

APA COMMITTEE ON PSYCHOTHERAPY BY PSYCHIATRISTS

Chair: Eric Plakun M.D., Austen Riggs Center, 25 Main Street,Stockbridge, MA 01262-0962

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) List changes in psychotherapy practice patterns by psychiatrists and their financial, educational and clinical causes; 2.) Recognize the importance of psychotherapy as a treatment that enhances medication adherence and is efficacious independent of medications; and 3.) List responses of psychiatry to changes in psychotherapy practice patterns by psychiatrists.

SUMMARY:

A recent study showed that psychiatrists are providing less psychotherapy as part of psychiatric practice. The study attracted considerable media attention that led to responses in the press from the APA president, president-elect and chair of the committee on psychotherapy by psychiatrists. This workshop [1] reports findings from this study, [2] explores the potential financial, clinical and educational causes of these changes, [3] summarizes evidence about the value of psychotherapy for our patients, especially when conducted by psychiatrists, and [4] describes efforts by the APA and the ACGME psychiatry residency review committee to better serve our patients and our profession by securing the place of psychotherapy as part of the core identity and skill set of psychiatrists and as a central part of residency training.

REFERENCES:

1) Mojtabai R and Olfson M. National Trends in Psychotherapy by Office-Based Psychiatrists, Archives of General Psychiatry. 2008;65(8):962-970
2) Plakun, EM. Finding Psychodynamic Psychiatry's Lost Generation, Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry. 2006; 34(1)135-150.

CW21. TRADITIONAL AND PSYCHIATRIC HEALERS IN NORTH AMERICA

APA COMMITTEE OF AMERICAN INDIAN, ALASKA NATIVE, AND NATIVE HAWAIIAN PSYCHIATRISTS

Chair: Mary Roessel M.D., 74 Double Arrow Road, Santa Fe, NM 87505

EDUCATIONAL OBJECTIVES:

At the conclusion of this session: 1.) The participant should be able to understand the diversity of the Native American World view and be introduced to principles that underlie Native American Healing; 2.) Become aware of traditional healing and its intricate relation to family and community; 3.) Know how to support and receive support from Native American Healers; and 4.) Comprehend how Native American Healing promotes mental health.

SUMMARY:

This workshop will explore Native American healing. A Navajo medicine man will present a world view that explains his healing practice. Psychiatrists familiar with Native American healing traditions will explore healing within the context of western medicine, family and community. The content will include a Native American world view of healing. The content will explore the Native American family and community involvement in healing. The presenters will offer an interactive forum to show the mutual support by psychiatrists and traditional healers in healing patients and case presentations will be used as examples of this relationship.

Understanding the Native American world view of healing is critical in the practice of culturally sensitive psychiatry.

REFERENCES:

1) Healing Ways: Navajo Health Care in the Twentieth Century, Wade Davis, New Mexico Press
2) Earth is My Mother, Sky is My Father: Space, Time, Astronomy in Navajo Sandpaintings, Trudy Griffin, University of New Mexico Press.

CW22. SCHOOL BULLYING: PSYCHIATRIC AND PHYSICAL HEALTH RISKS, AND TREATMENT INTERVENTIONS

APA CORRESPONDING COMMITTEE ON MENTAL HEALTH AND SCHOOLS

Chair: Marcia Slattery M.D., University of Wisconsin School of Medicine and Public Health, Department of Psychiatry, 6001 Research Park Boulevard, Madison, WI 53719

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Identify the psychiatric and physical health risks associated with bullying; 2.) Participate in collaborative prevention, intervention, and treatment strategies for victims and perpetrators of bullying; and 3.) Understand the need for advocacy efforts for public health policies for the prevention of bullying and related health risks.

SUMMARY:

OBJECTIVE: School bullying is ubiquitous, affecting youth of all ages and socioeconomic strata. Emerging evidence suggests that bullying is linked to serious health problems and death. Adolescents who are victims and perpetrators of bullying are significantly more likely than their peers who are not involved in bullying to suffer from a range of physical and emotional problems. They are at higher risk than their cohorts for leading proximate causes of death including accidents, suicide, and homicide. Furthermore, such youth are also at greater risk for daily smoking, alcohol abuse, carrying and using weapons, running away episodes, and an array of psychiatric illnesses including depression, anxiety, attention-deficit hyperactivity disorder, and eating disorders. This workshop will focus on the identification of serious health and related morbidities affecting bullies and victims, collaborative models of intervention, and the role of public health policy. METHODS/CONTENT**:** Workshop content will: 1) review the nature, epidemiology, and ecological aspects of school bullying, 2) discuss the morbidity and mortality associated with this form of abuse, 3) propose a community-based prevention, intervention/treatment strategy, and 4) promote the implementation of a bullying prevention public health policy. Presentations will be followed by active audience participation in discussion of cases of school bullying presented by a panel of experts. RESULTS/IMPORTANCE: This workshop will address the growing problem of school bullying, with emphasis on clinical, educational, and community collaborative approaches to prevention and intervention.

REFERENCES:

1) Srabstein J, Piazza T: Public health, safety and educational risks associated with bullying behaviors in American adolescents. Int J Adolesc Med Health 2008; 20(2):223-233.
2) Kumpulainen K: Psychiatric conditions associated with bullying. Int J Adolesc Med Health 2008; Apr-Jun: 121-132.

CW23. BREAKING THROUGH A SHATTER-PROOF GLASS CEILING: WHAT KEEPS WOMEN PSYCHIATRISTS FROM REACHING THEIR LEADERSHIP GOALS?

APA COMMITTEE ON WOMEN

Chair: Claudia Reardon M.D., 6001 Research Park Boulevard, Madison, WI 53713

Co-Chair: Stacey Burpee D.O.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Understand common factors that hinder women in their efforts to fully achieve their leadership goals within medicine; 2.) Appreciate strategies that several successful female physicians have used in their leadership pursuits; and 3.) Enhance their skills in optimizing personal leadership potential.

SUMMARY:

Women physicians are increasingly represented in medical training and are often recognized as excellent clinicians, researchers, teachers, and administrators. Nonetheless, women continue to be passed over for men for higher levels of appointment in academic medicine (Jain et al., 2004). Only 12 (9.6%) of the 125 U.S. psychiatry departments are chaired by women, and 65 (35.9%) of the 181 U.S. psychiatry residency training programs are directed by women (APA database, 2008). Explanations proposed for this phenomenon include constraints of traditional gender roles, manifestations of sexism in the medical environment, and lack of available, effective, and supportive mentors. Solutions offered have included extending tenure probationary periods, confronting instances of bias, arranging for appropriate mentors, and changes in institutional practices (including provision of on-site childcare, options for work from home, and flexible maternity leave) (Yedidia et al., 2001). This workshop, submitted by the APA Committee on Women, will focus on this important topic. A panel of successful women physicians, including Gail Robinson M.D. (co-founder of

the Women's Mental Health Program at the University of Toronto and APA Women's Caucus Representative), Carol Nadelson M.D. (first woman APA President), and Dolores Malaspina M.D., MPH (renowned schizophrenia researcher and prior chair at NYU), will lead off the presentation by discussing their leadership pursuits and challenges. This will be followed by audience discussion in which attendees will have the chance to share their experiences, barriers, and successes with each other and with the panelists, with time for brainstorming of new insights into strategies for breaking through the glass ceiling once and for all.

REFERENCES:

1) Jain S and Ballamudi B. Women in U.S. psychiatric training. Academic Psychiatry 2004; 28: 299-304.
2) Yedidia MJ and Bickel J. Why aren't there more women leaders in academic medicine? The views of clinical department chairs. Academic Medicine 2001; 76 (5): 453-465.

11:00AM- 12:30PM

CW24. PSYCHIATRIC RESIDENCY TRAINING NEEDS FOR INTERNATIONAL MEDICAL GRADUATES

APA COMMITTEE ON INTERNATIONAL MEDICAL GRADUATES

Chair: Francis Sanchez M.D., 220 Faison Drive, Columbia, SC 29203

Co-Chair: Antony Fernandez M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the important learning problems of IMG Psychiatric residents and approaches to solving the problems.

SUMMARY:

International Medical Graduates (IMG) make up 50% of the first year residents in psychiatry. Unfortunately their first time pass rates on the psychiatry specialty board exams is one-half that of American Medical Graduates (AMG). The educational experience in psychiatric training for IMGs must be examined and improved to ensure that the competence level attained by all psychiatric residents is compatible. A discussion of the suggested value of a number of changes in training will be undertaken. These possible changes include: 1. instruction being more structured with explicit feedback; 2. there being more verbal recitation of assigned reading and case reports; 3. there being written exams that will encourage organizing and understanding of various topics as well as practice in conveying ideas in a written format; 4. more individual supervision to allow a more detailed exploration of issues that may arise; 5. more demonstration of interviewing and supervised interviewing; 6. practice in working collboratively with other disciplines; 7. the introduction of psychological and social theory early in training; 8. the possibility of language training focussing on pronunciation, accent reduction, and familiarity with slang usage; 9. courses in american history and culture; 10. providing mentoring relationships; and 11. tutoring in mock boards during training.The goal of the workshop is to clarifywhat educational changes might be pursued to improve the training experience for IMG residents.

REFERENCES:

1) Rao NR, Kramer M, Saunders R, Twemlow SW, Lomax JW, Dewan MJ, Myers MF, Goldberg J, Cassimir G, Kring B, Alami O. An annotated bibliography of professional literature on international medical graduates.Acad Psychiatry. 2007 Jan-Feb;31(1):68-83.
2) Kramer M.Educational challenges of international medical graduates in psychiatric residencies.J Am Acad Psychoanal Dyn Psychiatry. 2006 Spring;34(1):163-71.

CW25. MOTIVATING THE MOTIVATORS: MOTIVATIONAL ENHANCEMENT THERAPY MADE EASY

APA CORRESPONDING COMMITTEE ON TRAINING AND EDUCATION IN ADDICTION PSYCHIATRY

Chair: Kristen Moeller,1000 Wilson Boulevard Suite 1825, Arlington, VA 22209
Co-Chair: Syed Sattar M.D.
Presenter(s): Petros Levounis M.D., Tayo Obatusin M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1.) Identify the principles of motivational interviewing; 2.) Identify the benefits of motivational interviewing; and 3.) Learn and demonstrate the technique of motivational interviewing.

SUMMARY:

Motivational interviewing (MI), an evidence-based counseling approach, has received much recognition. Because of the rising interest in MI, there is increasing demand for training in this counseling approach. Motivational interviewing is an effective technique used in addiction counseling that has been adapted for use by doctors. This brief type of MI has been shown to be more effective in moving smokers towards quitting than the giving of brief advice.7 It is a patient-centered style of interviewing that helps the patient explore ambivalence associated with his or her behavior. The tone of the motivational interview is non-judgmental, positive and empathic, with the patient doing the majority of the talking. The role of the doctor is to elicit self-motivational statements and encourage the patient to come up with his or her own solutions to overcome barriers to behavior change. The doctor avoids confrontation with the patient and if resistance is encountered, he or she rolls with it. The purpose of this workshop is to demonstrate a training process that is a brief hands-on exercise in motivational interviewing and can be used to train residents in brief hands-on didactic classes.

Method:

The format will be a didactic presentation on the theory and the evidence for MI and the need for training the psychiatry residents in MI. A group discussion will then allow participants to ask questions/discuss technique.

This will be followed by a role-play based, interactive exercise with the volunteering audience that will use the principles discussed beforehand to demonstrate MI.

Result:The participants will be able to learn the theory of MI. The participants will be able to observe MI. The participants will be able to conduct and practice MI.

SUMMARY: By attending this workshop, participants will be able to review, observe and conduct Motivational Interviewing.

REFERENCES:

1) DiClemente CC, Garay M, Gemmell L: Motivational Enhancement. In Textbook of Substance Abuse Treatment, 4th Edition, edited by Galanter M, Kleber HD, Washington, DC, American Psychiatric Publishing, 2008, pp 361-371
2) Rosenthal NR, Levounis P: Polysubstance use, abuse, and dependence. In Clinical Textbook of Addictive Disorders, 3rd Edition, edited by Frances RJ, Miller SI, Mack AH, New York, The Gilford Press, 2005, pp 245-270

CW26. THE ASSESSMENT OF VIOLENCE RISK

APA COUNCIL ON PSYCHIATRY AND LAW

Chair: Alec Buchanan Ph.D., Law and Psychiatry Division Yale University Department of Psychiatry 34 Park Street, New Haven, CT 06519
Presenter(s): Alec Buchanan Ph.D., Renee Binder M.D., Marvin S. Swartz M.D., Michael Norko M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand what is meant by "acturial" and "clinical" approaches to risk assessment and discuss the merits of each; 2) Understand the processes of risk assessment in correctional facilities and acute psychiatric settings; and 3) Identify how services can best be designed to improve this aspect of psychiatric care.

SUMMARY:

The importance of violence risk assessment to psychiatric practice is reflected in the APA's creation of a Task Force on Violence Risk. The Task Force first met in September of 2008 and will run for three years. The processes of violence risk assessment in psychiatry have been divided into actuarial and clinical. The first part of the presentation will review what is meant by each of these terms, examine the data that demonstrate the effectiveness of each approach and discuss the application of these methods to clinical practice. The second part of the presentation will review the challenges presented by violence risk assessment in two environments, acute psychiatry and in correctional settings. In acute psychiatry risk factors have been identified, including the quality of the therapeutic alliance, that are not widely quoted in discussions of long term risk. In correctional settings particular considerations, such as the difficulty of forming such an alliance and the difficulty of observing the patient in settings similar to those he will encounter outside prison, make assessment more difficult. The third part of the presentation will discuss the measures that can be put in place, including training and monitoring procedures, to make services better able to manage risk.

REFERENCES:

1) Buchanan A. Risk of violence by psychiatric patients: beyond the "actuarial versus clinical" assessment debate. Psychiatric Services 59: 184-190, 2008.
2) McNeil D, Chamberlain J, Weaver C, Hall S, Fordwood S and Binder R. Impact of Clinical training on Violence Risk Assessment. American Journal of Psychiatry 165: 195-200, 2008.

THURSDAY, MAY 21, 2009

9:00AM- 10:30AM

CW27. IDENTIFYING CHILDREN AT RISK FOR MENTAL HEALTH PROBLEMS: EXPLORING HOW RISK FACTORS WORK TOGETHER IN THE EMERGENCE OF CHILDHOOD PSYCHOPATHOLOGY

APA CORRESPONDING COMMITTEE ON INFANCY AND EARLY CHILDHOOD

Chair: William Wood M.D., 1388 Sutter Street, Suite 503, San Francisco, CA 94109
Presenter(s): Helena Kraemer Ph.D., Marilyn Essex Ph.D., Joan Luby M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe how risk factors interact to influence mental health outcomes, understand how longitudinal studies with well-measured outcomes can identify risk factors and their interactions, discuss the findings of a longitudinal study designed to show the interaction of risk factors for childhood mental health problems, and appreciate how specific findings from this study are clinically relevant in the treatment of young children.

SUMMARY:

The identification and interaction of risk factors in the emergence of mental health problems is an area of critical importance for the effective screening, diagnosis, treatment, and prevention of mental illness. However risk factor analysis has primarily used specific hypothesis testing to investigate associations between a limited scope of risk factors with a particular adverse outcome. Broader exploratory studies allow for a more generalized assessment of risk factors on specific outcomes. Though such studies are often discouraged as "fishing expeditions" or "data dredging", in fact a well-performed study can elucidate a trajectory of intersecting risks over time that takes into account multiple specific risks at specific points in time. The explanatory power of a trajectory of multiple risks can greatly exceed assessments of isolated risk factors. In this workshop, leading researchers in the design and implementation of risk analysis studies share their work on the interaction of risk factors associated with childhood psychopathology, and discuss the relevance of their

findings to clinical care and future research. Dr. Helena Chmura Kraemer (Stanford University) will describe the development of the MacArthur moderator-mediator approach to assessment of multiple risk factors and their interactions. Dr. Marilyn Essex (University of Wisconsin-Madison) will present findings from her longitudinal study of risk factors associated with symptom severity and directionality (internalizing vs. externalizing) in school-age children. Dr. Joan Luby (Washington University in St. Louis) will discuss the application of risk analysis findings to inform intervention and prevention programs that benefit young children with early-onset mental health disorders. Our goal is to foster a balanced consideration of approaches to untangling the complex interactions between multiple risk factors that contribute to mental health problems among children and ultimately across the lifespan.

REFERENCES:

1) Essex MJ, Kraemer HC, et al.: Exploring Risk Factors for the Emergence of Children's Mental Health Problems. Arch Gen Psychiatry. 63: 1246-1256, 2006.
2) Luby JL, ed: Handbook of Preschool Mental Health: Development, Disorders, and Treatment. New York: Guilford Press, 2006.

CW28. OUT AND UP IN AGE: MENTAL HEALTH IN LESBIAN, GAY, BISEXUAL AND TRANSGENDER OLDER ADULTS

APA COMMITTEE ON GAY, LESBIAN, AND BISEXUAL ISSUES

Chair: Ellen Haller M.D., 401 Parnassus Ave, San Francisco, CA 94143-0984
Presenter(s): Umee Davae D.O., Ellen Haller M.D., Philip Bialer M.D., Eric Williams M.D., Stephan Carlson M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Understand unique legal challenges faced by older LGBT adults; 2.) Speak to the impact of homophobia on the mental health of older LGBT adults; 3.) Gain awareness additional challenges experienced by LGBT adults who are members of ethnic minority groups; and 4.) Appreciate the mental health impact of being a long-term survivor of HIV/AIDS.

SUMMARY:

An estimated 2.4 million gay, lesbian or bisexual Americans over the age of 55 are currently living in the United States. The history of discrimination and anti-gay bigotry, heterosexism, homophobia, bi-phobia and transphobia, as well as the ignorance of mainstream providers surrounding LGBT elder concerns and issues creates tremendous barriers to services for this population. Many LGBT seniors feel they must stay closeted in order to feel safe when seeking health care or living in assisted living facilities. Research indicates that, compared with straight counterparts, LGBT seniors are twice as likely to be single, four and a half times more likely to have no children to call upon in time of need, and two and a half times more likely to live alone. Many LGBT elders do not have traditional families, and their primary support networks often include a circle of friends. Legal challenges include the fact that partners commonly lack the rights given to legally recognized spouses or family members in terms of visitation, decision-making and caregiving. Ethnic minority LGBT elders may face even greater challenges in terms of invisibility, lack of family support, prejudice, and discrimination. This workshop will include presentations on coming out to clinicians as an older LGBT individual, depression and suicidality in LGBT elders, unique issues of older LGBT members of minority groups, long-term survivors of HIV/AIDS, and legal challenges facing this population. Active audience discussion will be included at the end of the workshop.

REFERENCES:

1) Sperber, Jodi: As time goes by: An introduction to the needs of LGBT Elders. In The Handbook of Lesbian, Gay, Bisexual, and Transgender Public Health: A Practitioner's Guide to Service; Michael D. Shankle Haworth Press, 2006: pp 247-260
2) Barker JC, Herdt G, de Vries B, Brotman S, Ryan B, and Cormier R. The Health and Social Service Needs of Gay and Lesbian Elders and Their Families in Canada Gerontologist 2003; 43: 192-202.

CW29. PROMISE AND PERILS OF ELECTRONIC HEALTH RECORD ADOPTION IN PRIVATE PRACTICE PSYCHIATRY

APA CORRESPONDING COMMITTEE ON ELECTRONIC HEALTH RECORDS

Chair: Laura Fochtmann M.D., Department of Psychiatry and Behavioral Science Stony Brook University School of Medicine HSC-T10, Stony Brook, NY 11794-8101
Presenter(s): Suzanne Albrecht M.D., Zebulon Taintor, Edward Pontius M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Describe potential advantages of Electronic Health Records (EHRs); 2.) Describe potential pitfalls of EHRs; 3.) Describe considerations in EHR selection; 4.) Describe emerging mental health EHR standards; and 5.) Describe the current status and major initiatives of the national EHR movement.

SUMMARY:

Despite the potential benefits and increasing demand for Electronic Health Records (EHRs), physician adoption has been slow. In this workshop, presenters from the APA's Corresponding Committee on Electronic Health Records will summarize some of the national activity on Electronic Health Records, and will focus on some of the perceived benefits and potential consequences of EHRs to the practice of psychiatry. Themes such as privacy and security, considerations in software selection, electronic prescribing, and emerging software standards will be covered. After brief presentations, the session will provide an opportunity for attendees to engage in open dialog on the potential benefits

and pitfalls of EHR use.

REFERENCES:

1) DesRoches CM, Campbell EG, Rao SR, Donelan K, Ferris TG, Jha A, Kaushal R, Levy DE, Rosenbaum S, Shields AE, Blumenthal D. Electronic health records in ambulatory care--a national survey of physicians. N Engl J Med. 2008 Jul 3;359(1):50-60.
2) Lawlor T, Barrows E. Behavioral health electronic medical record. Psychiatr Clin North Am. 2008 Mar;31(1):95-103.

CW30. SCHIZOPHRENIA AND AGING: COGNITIVE, MEDICAL, SOCIAL, AND PSYCHIATRIC ISSUES

APA COMMITTEE ON ACCESS AND EFFECTIVENESS OF PSYCHIATRIC SERVICES FOR THE ELDERLY

Chair: David Casey M.D., University of Louisville Department of Psychiatry and Behavioral Sciences, 401 E. Chestnut St., Suite 610, Louisville, KY 40202
Presenter(s): Mercedes Rodriguez-Suarez M.D., Lina Shihabuddin M.D., Colleen Northcott Ph.D., Garry Vickar M.D., Chantelle Simmons M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the cogntive, psychiatric, medical issues pertintent to schizophrenia and aging. The participant will recognize effectiveness and possible toxic effects of available pharmacotherapy. Social consequences of schizophrenia will be recognized. The participant will be able to list the medical comorbidities common to schizophrenia and aging, their relationships with medications, and consequences for life span.

SUMMARY:

Older persons with schizophrenia and other serious and persistent mental illnesses have been relatively unrecognized in psychiatric research and policy. They are a group of patients burdened not only with psychiatric symptoms including postive symptoms of psychosis and negative symtoms of social disengagement, but also significant medical comorbidities. Diabetes, cardiovascular diseases, and other conditions are greatly overrepresented among these patients. Unfortunately, their psychiatric illnesses and social disadvantages combine to limit their access to medical care. Life span among these patients is significantly less than their peers for a host of reasons, some known and some not fully understood. Some researchers claim that life expectancy among elderly schizophrenics may actually actually be declining, possibly related to these comorbid medical conditions but also related to the use of psychiatric medications which alter metabolism and promote weight gain. The effects of smoking, alcohol abuse, and other substances also impact the quality and quantity of life for these patients. Many aging and elderly schizophrenics also suffer from cognitive decline, which seems in most cases to differ from other dementing disorders such as Alzheimer's disease, but which is not well characterized or understood. The social consequences of a chronic psychotic illness over a lifetime cannot be underestimated. These patients often exist on the margins of society. A subgroup of elders experience chronic, more or less schizophrenia-like psychosis for the first time in late life. Whether these patients are best understood as suffering from the same essential illness as younger schizophrenics, or a different disorder with overlapping symptomatology remains to be seen. The APA Committee on Access and Effectivenss of Treatments for the Elderly is presenting this workshop to heighten awareness of this group and promote more attention to their needs.

REFERENCES:

1) Harvey P: Schizophrenia in Late Life: Aging Effects on symptoms and Course of Illness. Washington, D.C., American Psychological Association, 2005.
2) Cohen C (ed): Schizophrenia into Later Life: Treatment, Research, and Policy. Washington, D.C., American Psychiatric Press, Inc., 2003.

CW31. SCIENCE IN THE CLINIC: DOING RESEARCH AS WE CARE FOR PATIENTS

APA LIFERS

Chair: Sheila Hafter Gray M.D., Box 40612 Palisades Station, Washington, DC 20016-0612
Presenter(s): Milton Kramer M.D., Pamela Foelsch Ph.D., Mardi Horowitz M.D., Christopher Perry M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Maintain scientific consciousness in their clinical work; and 2) Participate intelligently in large-scale clinical studies; and 3) Design and implement small-scale studies in their own practices.

SUMMARY:

As emphasis shifted from studying patients to studying fundamental brain mechanisms and the effect of single interventions – pharmacological or psychosocial – on symptoms, translational research efforts and case studies became limited both in their design and in the economic support they receive. Research approaches that aim to link efficacy to effectiveness is essential if we are to meaningfully support the core clinical enterprise. This workshop focuses on two ways ordinary clinicians may contribute to progress in our science.

Large-scale studies of actual clinical experience (e.g. Clinical Care 2000) were limited by low voluntary participation even in the few instances when support was available. How may lessons learned from past failures help us reorient ourselves to facilitate involvement of psychiatrists and their patients in clinically relevant research? Is the current mandated residency education in research methodology sufficient to achieve this aim? Clinicians are constantly mindful of outcomes, evaluating the validity of their formulations and the effect of their interventions on each patient. This attitude can support contemporary psychiatrists' researching questions the answers to which are essential for good evidence-based health care. We will delineate attitudes and practical methods that can support individual clinicians who wish

to systematize and record their observations and formulations and translate these data into cases reports, small case series, and simple outcome studies of their own clinical encounters. We will illustrate ways of integrating research goals into clinical care, designing studies, working with an IRB, etc. in a range of treatment settings. Disclaimer: The opinions or assertions contained in this presentation are the private views of Drs. Hafter, Gray and Perry and are not to be construed as official or as reflecting the views or policies of the Department of Defense or any of its affiliated institutions.

REFERENCES:

1) Stricker G, Trierweiler SJ: The Local Clinical Scientist: A Bridge Between Science and Practice. American Psychologist, 50:995-1002, 1995
2) Horowitz M: Understanding Psychotherapy Change: A Systematic Guide to Configurational Analysis. Washington DC: American Psychological Association, 2005

11:00AM- 12:30PM

CW32. SAVED BY THE INTERNET? PSYCHIATRIC ADMINISTRATION AND GENERATION X

APA COMMITTEE ON PSYCHIATRIC ADMINISTRATION AND MANAGEMENT

Chair: L. Mark Russakoff M.D., 701 North Broadway, Sleepy Hollow, NY 10591

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe some of the effects of technological advances on psychiatric administration; 2) Discuss uses of various technologies (Blackberrys, teleconferencing, electronic medical records) and their implications for administrators; Discuss the use of technology to facilitate access to care and outcomes measurement will be discussed, as well as generational issues.

SUMMARY:

There are multiple opportunities that new technologies afford to healthcare. However, there are generational differences in the receptivity of staff to technological innovations. The workshop will focus on how technology is being adopted by various programs, dealing with the implementation of the new technologies and the new opportunities that evolve from their adoption. Discussion from the audience about their situations and experiences will be encouraged.

REFERENCES:

1) Rodenshauser, P. ed: Mental Health Care Administration. Ann Arbor: Univ. of Michigan Press, 2000.
2) Reid, WH & Silver SB, Eds: Handbook of Mental Health Administration and Management. New York: Brunner-Routledge, 2003.

CW33. FORENSIC ISSUES AMONG HISPANICS

APA COMMITTEE OF HISPANIC PSYCHIATRISTS

Chair: Humberto Martinez M.D., 781 East 142 Street, Bronx, NY 10454
Co-Chair: Andres Pumariega M.D.
Presenter(s): Humberto Martinez M.D., Andres Pumariega M.D., Pamela Collins M.D., Daniel Castellanos M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize particular forensic issues affecting the Hispanic immigrant in the United States. Such as: A new defense strategy against deportation of the illegal alien who is mentally ill; the use of the culture bound syndrome as a defense in a court of law; Xenophobia as it affects the mentally ill individual and their family; and in the identification of legal and policy situations that affect the mental health of children.

SUMMARY:

This Workshop will address the issues of immigration, human rights, and mental health. First presenter will give a brief description of two NGO's work in Latin America's long-term care psychiatric facilities. In the United States, illegal aliens that suffer from a mental disability have used the evidence gathered by these NGO's as a basis for a legal defense against deportation. A consequence of deportation will be exposing the individual to persecution, thus qualifying for asylum. Second presenter will provide the basis and description of the work done on the development of the APA position statement on xenophobia, immigration and mental health. Special emphasis of the presentation will be on the Hispanic immigrant and their experience in the last decades. Third presenter will describe the clinical characteristics of ataque de nervios and discuss the implications of culturally patterned dissociative states for forensic assessment. Ataque de nervios is a cultural psychiatric syndrome prevalent among US Latinos, especially those of Caribbean origin that is characterized by paroxysms of acute loss of control. Fourth presenter will address different forensic topics as they pertain to Hispanic children. Different legal situations and public policies will be reviewed in context as to how they affect the mental health of Hispanic children.

REFERENCES:

1) A. Kanter, & Dadey, K; The Right to Asylum, for People with Disabilities. Temple Law Review Vol. 73,no 4 Winter 2000, pages 1117 – 1158.
2) Capps R, Castaneda RM, Chaudry A, Santos R: Paying the Price: The Impact of Immigration Raids on America's Children. National Council of La Raza, Washington, DC: 2007.

CW34. NEGOTIATION SKILLS FOR PSYCHIATRISTS

APA CENTRAL CALIFORNIA PSYCHIATRIC SOCIETY

Chair: Andreea Seritan M.D., 2230 Stockton Blvd., Sacramento, CA 95817

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Recognize different negotiation styles by using the Thomas-Kilmann Conflict Mode instrument; 2.) Understand his/her own strengths and weaknesses in negotiation situations; and 3.) Improve their negotiation skills by practicing a scenario.

SUMMARY:

Negotiation skills are cardinal in all career developmental stages and in both academic and non-academic settings. This workshop will focus on participants' understanding of their own negotiation styles, as well as difficulties that can arise in conflict situations. Participants will reflect on their strengths and weaknesses in a negotiation situation, as well as practice a negotiation scenario highlighting those. Participants will be able to learn better negotiation skills.

REFERENCES:

1) Sarfaty S, Kolb D, Barnett R, Szalacha L, Caswell C, Inui T, Carr P. Negotiation in academic medicine: a necessary skill. J Women Health 2007; 16:235-244.
2) Kilmann RH, Thomas KW. Developing a forced-choice measure of conflict-handling behavior: the "Mode" instrument. CPP, Inc.

ISSUE WORKSHOP

MONDAY, MAY 18, 2009

9:00AM- 10:30AM

IW01. INCREASING CULTURAL COMPETENCY TO ASSESS AND AMELIORATE DISTRESS OF DIVERSE PATIENTS: EXAMPLE FROM THE CARE OF A S. ASIAN VICTIM OF SPOUSAL ABUSE

Chair: Jacob Sperber M.D., Department of Psychiatry, Nassau University Medical Center, Box 51, 2201 Hempstead Turnpike, East Meadow, NY 11554
Co-Chair: Nyapati Rao M.D.
Presenter(s): Sadaf Ahmed M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session, participant should be able to: 1) List 4 aspects of personal culture which can alter clinical presentation of psychiatric disturbance; 2) Explain 4 common errors in psychiatric assessment caused by insufficient cultural awareness; and 3) Identify effective clinical strategies for guiding immigrant patients from traditional backgrounds in India seeking to cope with spousal abuse in the US.

SUMMARY:

As a profession US psychiatrists are a multicultural group who offer to assess and differentiate the medical, personal, and situational distress in their patients, who are an even more ethnically and culturally diverse group. What are the environmental forces which mingle with and modify the expression of emotional disturbance and personal distress, and how do they vary from one socio-cultural context to another? How can we augment our own awareness of, and skills to address, this diversity of experience of emotional disturbance and distress in patients whose acculturation and social contexts differ so greatly from each other's and our own?

The workshop will review methods used to increase cultural awareness and skills for clinical application among psychiatrists. Presenters will offer brief summaries and lead discussions about: 1) Common cultural "blind spots" which diminish the effectiveness of many practitioners; 2) Current patterns of culturally unique patient presentations, reflecting new trends in immigration 3) Leading methods of improving cultural competence among psychiatrists, and evidence of the effectiveness of those methods. 4) A detailed look at how a cross cultural case was used to increase the cultural awareness and clinical skills of one psychiatrist, and how those lessons were then used to develop training tools to highlight what was learned for instruction of others psychiatry trainees. Specifically, a psychiatry resident, of Islamic heritage, a graduate of an Indian medical school, received supervision of her (US) treatment of a Hindu woman struggling to escape an abusive marital situation which had resulted from a traditionally arranged marriage which transplanted her away from her extended family in India. In a culturally sensitive way, the therapist had to address the patient's abuse/exploitation by her spouse and in-laws in the US. The resident then distilled the experience into a

case vignette, enhanced by research and 5) Participants will view and discuss excerpts from a video of a non-Asian IMG resident interviewing standardized patient (SP) enactment of this vignette. Group supervision feedback on this training exercise will be demonstrated and discussed. Advantages of this method include multiple pathways for increasing cultural awareness, which will be discussed.

REFERENCES:

1) Lim, R, Clinical Manual of Cultural Psychiatry, American Psychiatric Pub, Inc., 2006
2) Rao, N, Psychiatric Workforce: Past Legacies, Current Dilemmas, and Future Prospects, Academic Psychiatry 27:238-240, December 2003

IW02. PRACTICAL PHARMACOTHERAPY FOR THE TREATMENT OF ALCOHOL DEPENDENCE

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Chair: Robert Swift M.D., 121 South Main Street - 4th Floor, Providence, RI 02903
Co-Chair: Allen Zweben

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Know the available pharmacotherapies available for the treatment of patients with alcohol dependence, their indications, side effects and how to choose the optimal medication; 2) Understand the benefits of combining pharmacotherapy with psychosocial support in enhancing abstinence, preventing relapse and improving treatment adherence; and 3) Enhance knowledge and skills related to combining medication and behavioral traits.

SUMMARY:

Alcohol dependence is a chronic disorder that is influenced by both biological/genetic and environmental/psychosocial factors. While treatment can be effective, the prevention of relapse to drinking remains a major challenge to patients and clinicians. Historically, psychosocial therapies have been the mainstay of treatment. Several psychosocial therapies, including Motivational Enhancement Therapy, Cognitive Behavioral Therapy, 12-step facilitation, Medication Management and others have been shown to be effective in clinical studies. Recently, pharmacological treatment has emerged as a means to augment the effects of psychosocial therapies, enhancing abstinence rates and preventing relapse. Pharmacotherapies can address the biological aspects of dependence. Current FDA-approved drug therapies for alcohol dependence include aversion therapy with disulfiram, a glutamate/GABA modulator acamprosate, and an opioid antagonist naltrexone (oral and sustained release). Other medications, such as the antiepileptic topiramate, selective serotonin reuptake inhibitors (SSRIs), atypical antipsychotic medications and the serotonin-3 receptor antagonist ondansetron are commonly used off-label.

This workshop will address this knowledge gap through an expert discussion of the practical aspects of using pharmacotherapies for the treatment of alcohol dependence, with a particular focus on combining psychosocial and pharmacological treatment. Evidence will be presented for the effectiveness of pharmacotherapies. Strategies for choosing the optimal medication for particular patients and common side effects will be discussed. Pharmacotherapies are best administered in the context of a psychosocial therapy to improve medication adherence and to address psychosocial issues that may contribute to drinking. Also, therapeutic issues (both pharmacologic and psychotherapeutic) in treating the challenging patient with alcoholism and comorbid psychiatric disorders will be addressed. This workshop will be highly interactive, with the audience encouraged to contribute clinical examples and cases for discussion.

REFERENCES:

1) Swift RM: Medications in the treatment of alcohol dependence. In Handbook of alcoholism treatment approaches: Effective alternatives, (3d ed.). Edited by R Hester and W Miller, Boston, Allyn & Bacon, 2002.
2) Carroll KM. Integrating psychotherapy and pharmacotherapy to improve drug abuse outcomes. Addictive Behaviors 22(2):233-245, 1997.

IW03. INCEST - A CULTURAL PERSPECTIVE

APA COUNCIL ON GLOBAL PSYCHIATRY AND THE APA COUNCIL ON CHILDREN, ADOLESCENTS, AND THEIR FAMILIES

Chair: Rodrigo A. Munoz M.D., 3130 Fifth Avenue, San Diego, CA 92103

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to evaluate from the cross-cultural viewpoint the profound family and community consequences of incest.

SUMMARY:

In its 400 years of existence, a historical Spanish city on the slopes of the Andes has been destroyed several times by a nearby volcano. Volcanic irruptions and earthquakes have acquired a symbolic meaning that permeates every event in the city, where an aging lady, a poetess and musician, lives in the throws of a severe depression. Many know she had an abortion as an adolescent, after being assaulted by her father, supposedly a pilar of the community.

The early tragedy and the present agony are the bases for a play that has been successfully presented in South America for many months. The author, an APA member, several actors and the producer will participate in this workshop. Negotiations are being conducted to present the play in San Francisco during the APA meeting.

REFERENCES:

1) Working With Adult Incest Survivors: The Healing

Journey—by Sam Kirschner, Ph. D., Diana Adile Kirschner, Ph. D., and Richard L. Rappaport, Ph. D.; New York City, Brunner/ Mazel Publishers, 1993,
2) Treating Adult Survivors of Childhood Sexual Abuse—by William C. Nichols, Ed. D.; Sarasota, Florida, Professional Resource Press, 1992

IW04. PLAYING IN THE BIG LEAGUE: RESIDENT LEADERSHIP IN THE APA BOARD OF TRUSTEES

Chair: Molly McVoy M.D., 11100 Euclid Ave., Cleveland, OH 44106
Co-Chair: Lauren Sitzer M.D.
Presenter(s): Amy Ursano M.D., Otis Anderson III M.D., Carolyn B. Robinowitz M.D., Pedro Ruiz M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Understand the essential role that residents play in organized medicine and psychiatry; 2.) Learn about the process of leadership development and effectiveness in an organization such as the APA board of trustees; and 3.) Acquire skills and expertise in order to play a role in the future success of the field of psychiatry.

SUMMARY:

For at least two decades, resident leaders have been part of the American Psychiatric Association (APA) Board of Trustees (BOT). This action on the part of the APA BOT has permitted psychiatry residents to have a voice on all key issues affecting the profession and field of psychiatry at large. This role on the part of the residents, although important, is not always an easy one. In order to be effective and to be heard, a period of "leadership development" must occur. This role and the opprtunity for growth is crucial for psychiatry, as residents both symbolize and are the future of the profession. This worskhop was created for residents interested in leadership and faculty interested in helping develop leaders. Through this workshop, residents will learn basics about involvement in the APA at its highest level and will gain both a resident and faculty perspective on leadership in the APA. Continuing resident involvement and leadership will be crucial for the future of psychiatry and medicine in general.

REFERENCES:

1) 1. Pololi, Linda, Knight, Sharon. Mentoring faculty in academic medicine. Journal of General Internal Medicine. Volume 20, Number 9 / September, 2005
2) 2. Wipf, J. E. Pinsky, L. E. Burke, W.Turning Interns into Senior Residents: Preparing Residents for Their Teaching and Leadership Roles. Academic Medicine. 1995, Vol 70; Number 7

IW05. RISK MANAGEMENT ISSUES IN PSYCHIATRIC PRACTICE

Chair: Martin Tracy J.D., Professional Risk Management Services Inc 1515 Wilson Blvd, #800, Arlington, VA 22209
Co-Chair: Jacqueline Melonas J.D.
Presenter(s): Harland Westgate J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) identify the major high-risk psychiatric professional liability risks that lead to malpractice lawsuits; 2) discuss at least 3 risk management strategies that can be incorporated into their practices to decrease or prevent exposures to high-risk psychiatric professional liability risks; and 3) understand that effective risk management strategies support patient safety initiatives.

SUMMARY:

Based on PRMS' more than 20 years of experience managing claims and lawsuits against psychiatrists, we are able to identify common sources of malpractice actions against psychiatrists and the outcomes of such lawsuits.

Malpractice lawsuits pose a significant problem for psychiatrists in all practice settings. From our experience, PRMS has seen a 6-8% overall risk for a psychiatrist to be involved in a claim or lawsuit. It is important for psychiatrists to understand the sources of malpractice lawsuits and the malpractice risks they face as clinicians, teachers and administrators.

Participants will review and discuss malpractice case studies with the panel of risk managers (specialists with clinical, legal, insurance and risk management experience/expertise) and will use polling devices to predict trends in psychiatric liability.

Special emphasis will be placed on what can be learned from analyzing high-risk exposure liability cases. In particular, the case studies will focus on 1) patient suicide and 2) adverse events related to prescribing psychotropic medication; two frequent sources of malpractice lawsuits against psychiatrists. Other issues that have the potential to influence malpractice risk will be illustrated in the case studies (e.g., collaborative and/or supervisory relationships with non-medical therapists, off-label use of psychotropic medication, termination of the patient-psychiatrist relationship, etc.). Additionally, the cases will illustrate how including risk management strategies and actions, such as effective communication and documentation, into a psychiatrist's practice can reduce malpractice risk as well as support patient safety and quality patient care.

The workshop will conclude with the panel providing a review of risk management strategies that have the most potential to protect against high-risk psychiatric malpractice actions and with a question and answer period with the audience.

REFERENCES:

1) David M. Studdert, Michelle M. Mello, Atul A. Gawande, Tejal K. Gandhi, Allen Kachalia, Catherine Yoon, Ann Louise Puopolo, Troyen A. Brennan.
Claims, errors, and compensation payments in medical malpractice litigation. New Eng Journal of Medicine. 2006. 354:2024-2033.
2) Jacqueline M. Melonas Preventing and Reducing Professional liability risk related to psychopharmacology. Psych Times. 2005. Vol. XXIII, Issue 14.

IW06. ETHICAL, CLINICAL AND LEGAL CHALLENGES CREATED BY INFORMATION TECHNOLOGY

Chair: Malkah Notman M.D., 54 Clark Road, Brookline, MA 02445
Co-Chair: Linda Jorgenson J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize problems posed by the internet, vulnerabilities they themselves have when using it, and means to protect practitioners and patients.

SUMMARY:

Information technologies such as the internet have created many new possibilities and patterns for information use and communication, but also for new ethical, clinical, and legal problems. The workshop will describe some of these, give case examples and illustrate these with several videaos. Areas which will be explored include: privacy of patient information, psychiatrist advertising by putting content on social networking sites, bulletin boards and discussion forums for patient recruitment,

problems of googling-for example repercussions of patient finding out personal information or legal information(eg past boundary violations) about therapist, or therapist discovering information about patients,and some of the problems of e-mailing which has led to inmcreasing intimacy between therapist and patient, or intrusive communications.

REFERENCES:

1) Gutheil,T and Brodsky,A, 2007 Preventing Boundary Violations
2) Recupero,PR (2006) Legal Concerns for psychiatrists who maintain web sites. Psychiatric Services,57,450-452

IW07. TECHNOLOGY AND PSYCHIATRY: PRACTICAL AND CLINICAL TIPS FOR USING TELEPSYCHIATRY

(FOR RESIDENTS ONLY)

Chair: Jena Worley M.D., 1356 Lusitana Street 4th floor, Honolulu, HI 96813
Co-Chair: Michael Houston M.D.
Presenter(s): Don Hilty M.D., Chad Koyanagi M.D., Peter Yellowlees M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Acquire clinically applicable technical knowledge about telepsychiatry; 2) Triage which patients are better treated using telepsychiatry, within telepsychiatry guidelines and applicable service delivery models; and 3) Be familiar with media skills to help clinicians engage patients and facilitate the therapeutic alliance.

SUMMARY:

Increasing access to psychiatric services has been a challenge in many communities and technology has helped this problem through interactive videoconferencing, also referred to as telepsychiatry. Recent research has shown that telepsychiatry can be used with similar diagnostic reliability as in-person assessments. Using telepsychiatry to treat patients has also been shown to have comparable clinical outcomes, patient adherence, and patient satisfaction compared to in-person treatment.

This workshop will provide clinicians with knowledge and skills to practice telepsychiatry and also provide a forum for advanced telepsychiatrists to share information. The aim of this workshop is to provide essential technical and clinical knowledge to clinicians, including when to use it and when not to use it, through case examples and a brief summary of guidelines for clinical care. Participants will also be taught media skills of how to look good and come across well on camera. Between and following the presentations, workshop participants will be encouraged to discuss their own experiences, opinions, and ask questions with a panel of national experts in telepsychiatry. At the conclusion of this workshop, participants will be more informed, knowledgeable, and comfortable with telepsychiatry.

REFERENCES:

1) Hilty DM, Marks SL, Urness D, Yellowlees PM, Nesbitt TS: Clinical and educational telepsychiatry applications: a review. Can J Psychiatry 2004; 49 (1): 12-23.
2) O'Reilly R, Bishop J, Maddox K, et al: Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial. Psychiatric Services 2007; 58: 836-847

IW08. MINDFUL PRACTICE: UNDERSTANDING ITS ROLE IN PSYCHIATRY AND PSYCHIATRIC TRAINING

Chair: Tana Grady-Weliky M.D., University of Rochester Medical Center Department of Psychiatry 300 Crittenden Blvd., Box PSYCH/Geri-Neuro, Rochester, NY 14642

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Identify at least two components of mindful practice and 2) List at least two educational methods for teaching psychiatric residents about mindful practice.

SUMMARY:

Mindful practice refers to our ability to be aware, in the moment, with the goal of providing better care to patients and to take better care of ourselves. Being mindful is at the core of clinical competence. With this in mind the University of Rochester School of Medicine and Dentistry developed a program designed to give medical students, residents and practicing physicians tools that will assist them in becoming more mindful during daily clinical practice. The explicit aim of the program is to help participants develop self-awareness and self-care skills so that they can be attentive and present in clinical settings.

Self-awareness is an essential element of communication, technical skill, professionalism, teamwork, and life-long learning. Because of the importance of the development of these

attributes in resident physicians, the general psychiatry residency program elected to have its residents participate in the university-wide program. Topics of the five mindful practice sessions are: Noticing and Attention; Professionalism and Informal Curriculum; Relationships/Meaningful Patient Relationships; Physician Self-Care and Burnout; and Dealing with Medical Errors. Several educational methods are used throughout the curriculum including: 1). Brief awareness exercises and reflective questions; 2)"Appreciative inquiry" interviews and 3) written narratives. Components of this workshop are: 1) Definition of mindful practice and description of the curriculum (TGW); 2)a participant's perspective on the curriculum (JR)and 3)overview of the experiential aspects of the curriculum (SM). Workshop participants will engage in a mock session and will be encouraged to share their thoughts and experience with similar curricula as well as how to best measure outcomes following resident completion of these programs.

REFERENCES:

1) Epstein, RM: Mindful Practice. JAMA. 282(9): 833-839, 1999.
2) Connelly JE: Narrative possibilities: using mindfulness in clinical practice. Perspectives in Biology and Medicine. 48(1): 84-94, 2005

IW09. NEED TO REFORMULATE 'RISK' AND ITS 'ASSESSMENT' IN CLINICAL PRACTICE

WORLD PSYCHIATRIC ASSOCIATION

Chair: Amresh K. Shrivastava M.D., 467, Sunset Drive, Regional Mental Health care, St.Thomas, Ontario, N5H 3V9 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.)To explore Concept of risk; 2.)To understand advances and limitations of prevailing Concept; 3.)Understand risk assessment, & its significance in Clinical Practice: and 4.)Explore newer ways of Coping with Challenges of Risk Assessment & Discuss about a new scale, SIS-MAP (The Scale for Impact of Suicidality - Management, Assessment and Planning of Care.

SUMMARY:

Risk assessment is an important clinical responsibility, which can be 'life-saving' in nature. Literature on risk factors has become voluminous; however a traditional risk assessment does not take into account the most relevant factors. This likely reflects the prevailing conceptualization of risk, which has not been fully and completely tied to clinical outcomes. Psychopathology is currently understood in biopsychosocial terms. It can also be understood along a life time-line of risk for self harm against the backdrop of personality and coping style as well as moderating factors. A more progressive conceptualization of risk should consider the interplay of both risk and protective factors. This may provide insight into why different individuals respond differently in similar situations. The present work proposes a model of risk depending upon 'trait' risk and 'state' risk factors. The joint impact of such a risk is evaluated against protective factors. Further it conceptualizes that risk consists of several domains and each of these domains contribute to causation of suicidal ideation. These domains are biological, psychological, social-environmental, spiritual & protective domains. To test the model and the hypothesis a detailed risk assessment scale has been designed named as SIS-MAP (The Scale for Impact of Suicidality - Management, Assessment and Planning of Care). The SIS-MAP has demonstrated inter-rater reliability between 0.70 and 0.81 (X= .76), N=20, p<. 001. The scale has also demonstrated moderately high predictability for assignment to hospitalized versus non-hospitalized groups. Fifty participants ranging in age 16 to 69 years (M= 41.4, SD = 14.0) participated, the total score on SIS –MAP significantly predicted whether individuals were admitted or not (Wilk's Lambda = 0.79, $p < 0.001$). Based on these exploratory norms, clinical cut-offs were derived to guide decision making on level of psychiatric care needed. The measure is further being developed to provide a visual map to graphically represent values of risk and protective domains.

REFERENCES:

1) Bisconer, S.W. & Gross, D.M. (2007). Assessment of suicide risk in a psychiatric hospital. Professional Psychology: Research and Practice, 38, 143-149.
2) Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A.L., & McKeon, R. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention Lifeline. Suicide and Life-Threatening Behavior, 37, 353-365.

IW10. IMAGING INSIGHT: BASIC DEFINITIONS, MEASURES, AND RELEVANCE TO PSYCHOPATHOLOGY

NATIONAL INSTITUTE ON DRUG ABUSE

Chair: Steven Grant Ph.D., 6001 Executive Blvd., Bethesda, MD 20892
Co-Chair: Rita Goldstein
Presenter(s): Anthony David M.D., Jennifer Beer Ph.D., Rita Goldstein, Nora D Volkow M.D., Richard Lane

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to the participant should be able to understand how research in cognitive neuroscience has expanded our understanding of the processes and mechanisms that contribute to insight. The participant should also be able to understand how these processes contribute to difficulties or frank lack of insight exhibited in different psychiatric conditions, and be able to consider how to address such difficulties during treatment.

SUMMARY:

This workshop will combine presentations from basic cognitive, neuropsychological and clinical investigators on the definition and measurement of insight. Lack of awareness of one's behavior and symptoms (denial) is a prominent characteristic of many other

psychiatric disorders. Although increased insight component has long been considered an important part of the therapeutic process, but the mechanisms that generate insight are not well understood. The construct of insight will be described from a multifactorial perspective (e.g., does it refer to cognitive awareness, affective concern, or theory of mind?). Newly developed behavioral and functional neuroimaging measures will be assessed as potential biomarkers of impaired insight. Three basic talks will detail ongoing cognitive and neuropsychological models that use subjective self-report and objective behavioral measures to characterize insight. One clinical talk will describe the application of this knowledge to drug addiction, a psychopathology that traditionally has been identified with "denial" while now it is increasingly recognized as a disorder of the neurobiological mechanisms underlying motivation and inhibitory control; the neurobiological evidence for an underlying impairment in insight is yet to be thoroughly summarized and investigated in this disorder. The panel will thus answer the following basic questions: What is insight? How is it defined/measured? Are there individual differences (e.g., age, sex) in insight? What is its relevance to psychopathology (especially to disorders of impulse control)? What are the underlying neurobiological substrates of impaired insight in these disorders? Taken together, this panel should indicate routes for developing functional neuroimaging assays of insight and their testing in psychiatric disorders (e.g., addiction).

REFERENCES:

1) Lane RD: Neural substrates of implicit and explicit emotional processes: a unifying framework for psychosomatic medicine. Psychosom. Med. 2008 Feb; 70:214-31.
2) Beer JS, John OP, Scabini D, Knight RT: Orbitofrontal cortex and social behavior: integrating self-monitoring and emotion-cognition interactions. J Cognitive Neuroscience 2006; 18: 871-879

IW11. IMPLEMENTING A TELEPSYCHIATRY PROGRAM IN THE KERN COUNTY MENTAL HEALTH SYSTEM IN RURAL CALIFORNIA- PART 2

Chair: Salvador del Rosario M.D., 1830 Flower Street, Bakersfield, CA 93305
Co-Chair: Tai Yoo M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the six stages of developing a telepsychiatry program: needs identification, infrastructure survey, partnership organization, structure configuration, pilot implementation, and solidification. The participant will learn about our experience in the solidification stage. We hope to stimulate dialogue with the audience to engender more ideas on how to improve delivery of mental health care to the rural population.

SUMMARY:

Objective: Kern County spans over 8,000 square miles of rural California with a population of 785,000, and 26 psychiatrists centralized in the city of Bakersfield. Insufficient public transportation with mountain and desert terrain severely limit access to care. This program was started in July, 2006 with a mission to improve mental health care for the underserved rural areas. We are now in stage of solidification of our program. Method: We conducted a MEDLINE literature search from 1965 to July, 2008. A team consisting of an administrative coordinator, a technology advisor, and a clinical champion, attended a training session at the UC Davis Telemedicine Training Center at the start. This team has since met weekly to coordinate program activity. We tracked equipment usage, purpose of use, alternative activity, time saved in traveling, patient and provider satisfaction, and any problems encountered. Results: There is a growing body of research on developing a telepsychiatry program and on the efficacy of telepsychiatry. We will share our experience thus far. Clinically, after a successful pilot clinic, we have since implemented a child and adolescent telepsychiatry clinic, and two adult telepsychiatry clinics. We are starting the use of telepsychiatry in our Resident Outpatient Clinic. Other areas of clinical use include the inpatient psychiatry ward for interdisciplinary team meetings and court hearings, and the Crisis Stabilization Unit for emergency evaluations. Educationally, we have used the equipment for grand rounds, lectures, and staff training. We have also used the equipment for administrative meetings. Overall patient and provider satisfaction has been high, although we have encountered some technical, clinical, and administrative challenges.

Conclusion: Implementing a telepsychiatry program is a formidable endeavor that should improve delivery of mental health care to rural areas, where access to qualified, clinical providers is limited.

REFERENCES:

1) Hilty DM, Marks SL, Urness D, Yellowlees PM, Nesbitt TS: Clinical and educational telepsychiatry applications: a review. Can J Psychiatry. 2004 Jan;49(1):1-3.
2) Shore JH, Manson SM: A developmental model for rural telepsychiatry. Psychiatr Serv. 2005 Aug; 56(8):976-80.

IW12. USING THE *DSM-IV-TR* CULTURAL FORMULATION FOR CULTURAL COMPETENCE SKILL BUILDING AMONG PSYCHIATRY RESIDENTS

Chair: Treniece Lewis Harris Ph.D., Macht Building, Room 330, 1493 Cambridge Street, Cambridge, MA 02139
Co-Chair: Marshall Forstein M.D.

EDUCATIONAL OBJECTIVES:

Participants will learn: 1) How to apply the *DSM-IV-TR* Outline for Cultural Formulation in cultural competence training for residents; 2) how pedagogical assumptions guide the role of faculty and trainees; 3) how to determine the training focus, content and format (e.g. discussion groups, scholarly lectures, experiential exercises) applicable to their edcuational setting; and 4) How to use process factors (e.g. group norms, formative feedback, resistance) to maximize the training experience.

SUMMARY:

This workshop will introduce a model of multicultural competence education for psychiatry residents that uses the *DSM-IV-TR* Outline for Cultural Formulation as a framework for culturally sensitive mental health practice. Furthermore, statistically significant data will be presented indicating the seminar's effectiveness in increasing participants' 1) knowledge of multicultural issues in clinical practice, 2) awareness personal cultural background and position(s) of privilege and 3) application of cultural knowledge into their clinical work. After presenting research findings examining the model, the workshop will focus on facilitating participants in preliminary planning to establish a similar training model in their own academic settings. We will review the pedagogical assumptions (role of the instructor, role of the students, content and process), structural considerations (e.g. focus of the course, course content, course format and assignments) and process (e.g. group norms, feedback, conflict and resistance, instructor's process) as they were considered in developing a multicultural competence seminar in an academic medical training setting. The seminar alternated a large group lecture format with experiential small group discussions and also served as a training vehicle for faculty so that they could gain cultural knowledge and experience in facilitating discussions of cultural values and attitude exploration. The seminar content emphasized general principles of multiculturalism and social justice including but not limited to: defining culture, oppression, privilege, cultural identity development, models of acculturation and cultural transference. In this workshop participants will learn a model of multicultural competence training, will see an example of course evaluation and it's relevance to residency training goals and moreover will be given practical suggestions on ways to maximize multicultural education for psychiatry residents.

REFERENCES:

1) Harris TL, McQuery J, Raab B, Elmore S: Multicultural psychiatric education: using the DSM-IV-TR Outline for Cultural Formulation to improve resident cultural competence. Acad Psychiatry 2008;32:306-312
2) Lu FG, Primm, A: Mental health disparities, diversity, and cultural competence in medical student education: how psychiatry can play a role. Acad Psychiatry 2006;30:9-15

IW13. DIVERSION OF PRESCRIPTION STIMULANTS

NATIONAL INSTITUTE ON DRUG ABUSE

Chair: Moira O'Brien M.P.H., 6001 Executive Boulevard, Rm. 5185, MSC 9589, Bethesda, MD 20892
Co-Chair: Wilson Compton III M.D.
Presenter(s): Sean McCabe Ph.D., Timothy Wilens M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the nature and extent of prescription stimulant diversion and the implications of findings for: 1) prescribing stimulant medications for ADHD, and 2) screening and intervention efforts to identify and reduce nonmedical use and diversion of prescription stimulants.

SUMMARY:

Nonmedical use of prescription medications, including stimulants, has emerged as an issue of major public health concern in the United States. According to the 2006 National Survey on Drug Use and Health (NSDUH), an estimated 20.1 million Americans aged 12 and older have used prescription stimulants nonmedically at least once. NSDUH reports a significant increase from 2005 to 2006 in the number of people who used prescription stimulants nonmedically for the first time within the past year suggesting an escalating problem of diversion of prescription stimulants to nonmedical use. Students may be at particular risk for nonmedical use of prescription stimulants since students prescribed stimulants may be perceived as potential sources for diversion and motivations for nonmedical use may include the expectation of enhanced academic performance. Recent research has begun documenting the sources for diverted prescription stimulants, and the context, motivation and demographic profile of those most at risk for misusing and diverting stimulants. This workshop will review the most recent research findings pertaining to diversion of prescription stimulants and examine clinical implications. Issues to be addressed include: 1) definitions and prevalence of medical use, nonmedical use and diversion of stimulant medications for ADHD; 2) diversion sources of prescription stimulants and how diversion varies by demographic and other characteristics; 3) motives for nonmedical use of stimulants; 4) routes of administration and issues around drug delivery (e.g., extended-release versus immediate release) that may influence the misuse and diversion; 5) medical misuse among prescribed stimulant users; 6) association between initiation of medical and nonmedical use and drug abuse; and, 7) clinical implications of research findings and "take home" messages for clinicians. The session will devote substantial time to discussion and the audience encouraged to comment and ask questions.

REFERENCES:

1) McCabe SE: Screening for drug abuse among medical and nonmedical users of prescription drugs in a probability sample of college students. Arch Pediatr Adolesc Med 2008; 162(3): 225-231.
2) Wilens TE, Adler LA, Adams J, Sgambati S, Rotrosen J, Sawtelle R, Utzinger L, Fusillo S: Misuse and diversion of stimulants prescribed for ADHD: a systematic review of the literature. J Am Acad Child Adolesc Psychiatry 2008; 47(1): 21-31.

11:00AM- 12:30PM

IW14. CHALLENGING STIGMAS & STEREOTYPES: INTEGRATED THERAPY FOR MULTIDIAGNOSED ADDICTION PATIENTS COMBINING INNOVATIVE WITH TRADITIONAL APPROACHES

Chair: Michael Scimeca M.D., 200 W 90th St 11-H, New York, NY 10024

EDUCATIONAL OBJECTIVES:

At conclusion participants will gain appreciation of the diverse problems of multiply diagnosed patients, learning to combine

traditional and innovative approaches to more effectively treat these difficult patients using tools like team meetings with a patient, directly observed medication administration, use of peer specialists, and a flexible/modulated stance toward recovery: thus limiting stigmas and stereotypes to work more effectively with patients through patience, humanity, and respect.

SUMMARY:

The need to reorganize treatment for addiction patients who have multiple, severe problems and diagnoses is well documented; yet, there are few sites that actually provide effective integrated care leading to successful outcomes. This interactive workshop will present the workings of an actual clinic that provides an integrative team approach. The clinic's multidisciplinary staff (peer-counselors, social workers, psychologists, nurses, and psychiatrists) work with a variety of patients either/or on opiate maintenance medication, "drug-free", receiving psychotropic medications, and with multiple medical illnesses. Most patients also have social and economic problems. Services are co-located in a common space and staff meet frequently to discuss information, impressions and appropriate targeted treatment, as well as deal openly with conflicts over treatment approaches and issues-e.g. countertransference, staff "splitting", over-identification-common in working with these challenging patients. Innovative interventions include medication monitoring techniques; medical triage, psychiatrists meeting with case managers or other team members together with the patient; peer counselors advocating for patients within the greater hospital setting as well as providing community outreach to patients in crises or lost to follow-up. The overall clinic approach is based on flexibility, tolerance and patience. Program evaluation data show 1) significant reductions in the frequency of hospitalizations and "hospital hopping"; and 2) increased length of stay in treatment over comparable programs. The workshop will engage the audience in discussing their own experiences, frustrations, successes, and plans in handling similar populations. In summary, the audience will recognize the value of integrating services across traditional boundaries of programming, professional titles, and diagnoses to provide better, more effective treatment with less frustration to care givers and patients.

REFERENCES:

1) Minkoff, K: An integrated treatment model for dual diagnosis of psychosis and addiction. Hospital and Community Psychiatry 1989; 40:1031-1036.
2) Drake, RE; Mercer-Mcfadden, C; Mueser, KT; McHugo, GJ; & Bond, GR: Review of integrated mental health and substance abuse treatment for patients with dual disorders. Schizophrenia Bulletin 1998; 26:105-118.

IW15. MAN AND NON-MAN MADE DISASTERS IN ASIA: THE ROLE OF RESILIENCE

Chair: Pedro Ruiz M.D., University of Texas Health Science Center at Houston, 1300 Moursund Street,, Houston, Texas, TX 77030
Presenter(s): Russell D'Souza M.D., Tsuyoshi Akiyama M.D., Pichet Udomratn M.D., Chiao-Chicy Chen M.D., Haroon Chaudhry M.B.B.S

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1.) Understand better the role of the Asian Culture vis-a-vis disasters; 2.) Learn about the mechanism of resilience when facing major disasters; and 3.) Be better equip to assist Asian populations during disasters episodes.

SUMMARY:

Asia is a region of the world that has been continuously exposed to natural disasters and also to man made disasters. Western countries have always been eager to assist in ameliorating the outcomes of such tragedies. Mental health professional from Western countries have always volunteer to go onsite or to offer help from their own countries. Professional Psychiatric and Mental Health Societies always offer trainers and training seminars to operate onsite. Charitable organizations certainly donate funds to ameliorate the consequences of such disasters. Governments tend to offer financial support. However, little is known as to how Asians populations perceive and respond to these disasters (Wars, Tsunamis', Typhoons, etc.). Likewise, not much is also known as to the role of the native cultures vis-à-vis these disasters. In this workshop a panel of Asian mental health professionals will present and discuss their own experiences and views on this issue. Much attention will be given to the role of "resilience" among these countries and populations. These experts from India, Japan, Thailand and Taiwan will focus on the unique cultural characteristics of the Asian Continent/Region. Hopefully, these presentations and discussion will permit Western psychiatrists to learn how to address and understand these disasters not only in Asia but in the Western hemisphere as well.

REFERENCES:

1) Lopez-Ibor JJ, Christodoulou G, Maj M, Sartorius N, Okasha A (eds.): Disasters and Mental Health. West Sussex, England, John Wiley & Sons Ltd., 2005
2) Hamburg DA: No More Killing Fields: Preventing Deadly Conflict. Oxford, England, Rowan & Littlefield Publishers, Inc., 2002.

IW16. WITHDRAWN

IW17. CAN DISCLOSURE OF A DIAGNOSIS OF BORDERLINE PERSONALITY DISORDER HELP GUIDE TREATMENT FOR CLINICIANS, PATIENTS AND FAMILIES?

Chair: Richard G. Hersh M.D., 710 West 168th treet, New York, NY 10032
Presenter(s): Perry Hoffman Ph.D., dale terilli B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Understand the potential benefits of disclosing a diagnosis of Borderline Personality Disorder to a patient when indicated; and 2) Informed about interventions for patients and families which integrate acknowledgement of and education about the

borderline diagnosis.

SUMMARY:

Borderline personality disorder (BPD) is a common psychiatric disorder with high morbidity and mortality, yet clinical experience suggests that many patients with BPD are often unaware of their diagnosis even when clinicians believe the BPD diagnosis to be reliably made. Clinicians' reluctance to disclose a BPD diagnosis may reflect broad concern about the validity of the diagnosis, worry about the stigma of the diagnosis, or fear of exacerbating clinical situations by causing increased anger or suicidality in patients. Disclosure of the BPD diagnosis may have advantages for patients, however. Advantages may include: increased patient autonomy, access to psychoeducation for patients and families, and development of more specific treatment plans including pharmacotherapy, psychotherapy and psychosocial interventions. Programs designed specifically for patients with BPD focusing on patient advocacy, family psychoeducation and barriers to employment, reflect emerging opportunities integrating awareness of the BPD diagnosis. The National Education Alliance for Borderline Personality Disorder is dedicated to increasing public awareness of BPD, providing education for patients and families, and supporting research. Their Families Connections Program offers a 12-week research-based manualized family program with a focus on education about BPD, information about pertinent research, and skills training for family members informed by DBT practices. The Connections Place offers a four-month program specifically for patients with BPD designed to address barriers to employment. The group sessions and individualized vocational planning underscore the expectation that individuals with BPD can benefit greatly from reentering the workforce. Audience members will be encouraged to discuss clinical experiences involving the disclosure of the BPD diagnosis, with particular attention to the ways withholding or sharing the BPD diagnosis can shape treatment planning.

REFERENCES:

1) Gunderson JG, Hoffman P: Understanding and Treating Borderline Personality Disorder: A Guide for Professionals and Families. Washington, D.C., American Psychiatric Publishing, 2005
2) Lequesne ER, Hersh RG: Disclosure of a diagnosis of borderline personality disorder. J Psychiatr Pract 2004;10:170-176

IW18. APPLICATION OF CULTURAL VARIABLES FOR PRACTICE OF EFFECTIVE PSYCHOTHERAPY OF INDIANS SETTLED IN USA

Chair: Nitin Gupta M.D., South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Margaret Stanhope Centre, Belvedere Road, Burton Upon Trent, DE13 0RB England
Co-Chair: Vijoy Varma M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the relevance of cultural issues in the use of psychotherapy; 2) Develop an understanding of approach to assessment for psychotherapy using these cultural issues; and 3) Be able to use the cultural issues effectively in psychotherapy for patients of Indian origin in the USA.

SUMMARY:

The conventional (western) model of psychotherapy is implicitly understood to be practiced across the world in different cultures, but has come under increasing scrutiny and criticism lately. This applies to the different types of psychotherapy, and is also due to advances in psychotherapy in non-western cultures. This ever-increasing experience in transcultural psychiatry is demanding adjustments to the definition of psychotherapy. Numerous key factors unique to traditional societies have been identified that influence the nature and course of psychotherapy e.g. close and confiding relationship between doctor and patient (Guru-Chela paradigm), more permeable ego boundaries, dependency of patient, psychological sophistication, involvement of the family etc. To be effective, psychotherapy should be consistent with the social and philosophical background and belief systems of the people.

One needs to be mindful that psychotherapies that are unique to specific societies make use of the cultural fabric of that society, with its associated beliefs and aspirations and ways of seeing the world. Industrialization and adaptation of western concepts does not necessarily translate into the 'traditional mind' becoming a 'western mind'. Cultural variables can be of importance and relevance even in situations where the therapist and patient are from different ethnic groups. People from non-western cultures (especially Indians) may not place the same degree of emphasis on talking as a form of treatment, introspection, exploration etc. but look for more directive instructions from therapists.

In fact, Indian psychotherapists suggest departures from the western model; pleading for greater flexibility, greater activity on the part of the psychotherapist, and greater use of suggestion and reassurances. It becomes important and pertinent to take into account numerous considerations and concepts that require a reassessment and management from a transcultural perspective for Indian patients.

REFERENCES:

1) Varma VK, Gupta N. Psychotherapy in a Traditional Society: Context, Concept, and Practice. Jaypee Brothers Medical Publishers, New Delhi, India, 2008.
2) Varma VK. The Indian mind and psychopathology. Integrative Psychiatry 1985; 3: 290-296.

IW19. COGNITIVE THERAPY FOR PSYCHOSIS IN PRACTICE BY PSYCHIATRISTS: BASIC TECHNIQUES

Chair: Shanaya Rathod M.D., Hampshire Partnership NHS Trust, Melbury Lodge,Winchester, SO22 5DG United Kingdom
Co-Chair: Douglas Turkington

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand which of their patients with schizophrenia may benefit from cognitive therapy; and 2) Be able to incorporate

evidence-based elements of Cognitive Therapy into their work with patients with schizophrenia

SUMMARY:

Cognitive Behaviour therapy (CBT) as an adjunctive therapy for persistent symptoms of schizophrenia is now supported by meta-analyses and twenty two published Randomised controlled trials. Unfortunately, few training schemes exist and consequently trained therapists are rarely available. Psychiatrists may need to consider if they can adapt their practice to incorporate elements of CBT successfully (Turkington & Kingdon, 2000). They can build on general psychiatric engagement, assessment and formulation skills with a particular focus on the first episode of psychosis and its antecedents. General understanding of cognitive therapy processes and ways of working can be adapted. Specific work on voices, visions, delusions, thought disorder and negative symptoms can then be incorporated within the framework of identified clinical groups in clinic, community and inpatient settings. CBT compliments medication management by assisting with understanding and improving compliance with treatment and also the delusional elaboration sometimes associated, or simply faulty assumptions about the function and purpose of medication. It is also valuable in eliciting risk issues through its ways of drawing out connections between thoughts, feelings and actions, for example, in relation to passivity or command hallucinations. The workshop will use key strategies, case examples, video-interviews and allow plenty of opportunity for discussion.

REFERENCES:

1) Kingdon, D.G., Turkington, D (2002). A Casebook Guide to Cognitive Behaviour Therapy: practice, training and implementation. Chichester: Wiley
2) Kingdon, D.G., Turkington, D (due out 2004). Treatment Manual for Cognitive Behaviour
Therapy of Schizophrenia and Psychotic Symptoms. Series Editor: J. Persons. NY: Guilford.

IW20. RESIDENT WELLNESS SURVEY RESULTS AND DISCUSSION

Chair: Paul O'Leary M.D., 1225 50th St. South, Birmingham, AL 35222
Co-Chair: Hind Benjelloun M.D.
Presenter(s): Leah Dickstein M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Discuss differences between the stressed and relaxed residents, including work-hours, coping mechanisms, and mental health; 2)Discuss what coping mechanism the residents use; and 3.Discuss the main stressors of psychiatric residents.

SUMMARY:

Background: A burned-out health care worker often provides a lower quality of patient care than does a colleague who is satisfied with his or her job, according to multiple studies of job stress and burnout. Several studies have focused on health care providers, but medical residents were rarely included. Remarkably, even with the implementation of the 80-hour workweek for residents, few have investigated if the change has decreased resident stress or improved patient care, as hoped, and still fewer studied resident well-being. Hence, little is known about how "well" psychiatric residents are, what their main stressors are, and how they cope with them. Methods: The North American Resident Wellness Survey is a pilot study to investigate how psychiatry residents handle stress, the level and cause of their stress, and what coping strategies they use to deal with stress. The online survey was distributed using American Psychiatric Association's member database. 887 residents (17% of North American psychiatry residents) responded. Results:

Seven percent of residents are either dissatisfied or very dissatisfied with their life in general, 14% are either dissatisfied or very dissatisfied with their mental health and 19% are either dissatisfied or very dissatisfied with their physical health. Sixteen percent wanted to change residency programs, and 19% wanted to change careers.

Fifty-seven percent psychiatric residents rated their life of as either very stressed or stressed, with time pressure and workload being the most frequent cause of stress. Additionally, stressed residents work longer hours and use different coping mechanisms than do less-stressed residents.

REFERENCES:

1) Woodside J, Miller M, Floyd M, McGowen R, Pfortmiller D: Observations on Burnout in Family Medicine and Psychiatry Residents. Academic Psychiatry 2008; 32:13–19
2) KEIM SM, MAYS MZ, WILLIAMS JM, SERIDO J, HARRIS RB: Measuring wellness among resident physicians. Medical Teacher, Vol. 28, No. 4, 2006, pp. 370–374

TUESDAY, MAY 19, 2009

9:00AM- 10:30AM

IW21. TIPS FOR EFFECTIVE COMMUNICATION ABOUT GENETICS AND MENTAL ILLNESS WITH PATIENTS AND THEIR FAMILIES

Chair: Jehannine Austin Ph.D., Rm A3-112, 3rd Floor, 938 W 28th Ave,, Vancouver, V5Z 4H4 Canada
Co-Chair: Holly Peay M.S.
Presenter(s): Catriona Hippman M.S.C., Christina Palmer M.S., Christine Finn M.D., Laura Hercher M.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the significance of perceptions of illness causation and risk for illness re-occurrence in other family members; 2) Use different techniques to explain the current understanding of psychiatric illness pathogenesis and familial risk in lay language; and 3) Discuss issues around environmental modifications to reduce risk for illness onset

SUMMARY:

This workshop has been designed by a group of genetic

counselors, who are all members of the Psychiatric Special Interest Group of the National Society of Genetic Counselors, together with a member of the APA who has a special interest in the issues that will be presented.

Psychiatric illnesses are complex disorders - that is, they arise as a result of the combined effects of genes and environmental influences. Patients with psychiatric illnesses and their families have been shown to be very interested in receiving information about genetics as it relates to their illness, but studies have also shown that only a small minority of this population have received this kind of information. Research has also shown that psychiatrists feel that it is their responsibility to address issues relating to genetics and psychiatric illness, but that many providers feel under-equipped with the knowledge necessary to constructively address these issues.

The aim of the workshop is to provide participants with some practical strategies and tools to help them to address issues relating to genetics that may arise when they are treating patients. Through a combination of presentations from the panelists (who all specialize in providing genetic counseling for individuals affected by psychiatric illness and their family members) and interactive group work, participants will learn how to accurately discuss a) the contributions of genes and environment to the development of psychiatric illness, and b) issues relating to risks for illness re-occurrence in family members in lay language. Participants will develop an understanding of several potential reactions that patients may have to receiving this information, and will learn to respond to concerns relating to genetics in such a way that patients feel empowered, and successful adaptation is facilitated.

REFERENCES:

1) Hoop JG, Roberts LW, Green Hammond KA, Cox NJ. Psychiatrists' attitudes, knowledge, and experience regarding genetics: a preliminary study. Genet Med. 2008 May 16. [Epub ahead of print] PMID: 18496226
2) Smoller J, Rosen Sheidley B, Tsuang MT. Psychiatric genetics: Applications in clinical practice. American Psychiatric Pub, 2008 ISBN 1585622060

IW22. CLINICAL AND FORENSIC ISSUES CONCERNING INFANTICIDE, THE MURDER OF A CHILD IN THE FIRST YEAR OF LIFE BY ITS MOTHER

Chair: Malkah Notman M.D., 54 Clark Road, Brookline, MA 02445
Co-Chair: Carl Malmquist M.D.
Presenter(s): Margaret Spinelli M.D., George Parnham J.D., Carl Malmquist M.D., Elissa Benedek M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the psychiatric and social problems leading to infanticide, the legal concerns in dealing with these cases, and the need for research.

SUMMARY:

Maternal infanticide,the murder of a child in the first year of life by its mother,is a subject both compelling and repulsive. Infanticide is often committed by mothers with postpartum psychosis. Neonaticide,infanticide in the first 24 hours of birth often occurs on young women who deny or hide their pregnancy. Arguments for dissociative psychopathy vs.sociopathy have been a source of conflict. Infanticide may also be caused by abuse, neglect,or pathological mother-infant attatchment. This workshop will focus on infanticide associated with mental illness.The killing of an innocent is a crime.It demands retribution. Yet the perpetrator may be a victim too, and that recognition makes for a more paradoxical legal response.The recent case of Texas vs. Andrea Yates demonstrates our complex reaction to such tragedy and the paucity of legal and psychiatric understanding. The scarcity of literature on childbirth-related psychiatric diagnoses and because diagnostic guidelines for postpartum disorders are limited,decisions about guilt, sentencing and potential for treatment often rest in the judicial community.This workshop aims to encourage early intentification of wopmen at risk,assist psychiatrists facing the challenges of the criminal court system, and educate the judicial system from retribution to treatment and rehabilitation. Three of the presentors are past winners of the Guttmacher award.

REFERENCES:

1) Spinalli,M. ed, 2003, Infanticide Psychosial and Legal Perspectives on Mothers who Kill, APA Press
2) Oberman,M. 2003 A Brief History of Infanticide and the Law, in Spinelli,M. Infanticide, Psychosocial and Legal Perspectives on Mothers Who Kill,pp3-18

IW23. EXTENDED TREATMENTS FOR ALCOHOL USE DISORDERS

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Chair: James McKay Ph.D., 3440 Market St., Suite 370, Philadelphia, PA 19104
Presenter(s): James McKay Ph.D., David Oslin M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe at least two behavioral approaches to extended treatment for alcohol use disorders; 2) Describe the evidence regarding extended use of medications for alcohol use disorders; 3) Describe procedures used to develop adaptive continuing care models; and 4) Describe the advantages and limitations of using the telephone to provide extended continuing care.

SUMMARY:

This workshop will present behavioral and pharmacological approaches that can be used to provide extended treatment for alcohol use disorders. One of the key concepts that will be explored is adaptive treatment. In these interventions, also referred to as treatment algorithms, patient progress is closely monitored over time. If patients do not improve, treatment is

adapted (i.e., modified) according to decision rules developed either through expert consensus or experimental procedures. The decision rules also specify when treatment intensity can be decreased, in order to reduce patient burden and promote long-term participation in continuing care.

Several extended care models will be discussed. One approach makes use of regular telephone contact to monitor progress and deliver CBT-like counseling. This intervention also contains an adaptive stepped care protocol, in which additional interventions can be provided when patients are in periods of heightened vulnerability to relapse, or have begun to drink again. Research that indicates which patients are most and least appropriate for telephone continuing care will be presented. Audio tapes of actual telephone monitoring and counseling sessions will be played, to stimulate discussions regarding this intervention.

The use of several medications, including oral and injectable naltrexone, in extended treatment models will also be discussed. Participants will learn how these medications can be incorporated into treatment delivered either in medical practices or in addictions specialty care clinics. Methods for monitoring the effectiveness of a medication and changing medications will be presented. The importance of patient preference regarding medication and behavioral interventions in extended care treatment plans will be highlighted. Problems typically encountered in delivering extended treatment for alcohol use disorders will be discussed, along with possible solutions.

REFERENCES:

1) McKay JR: Is there a case for extended interventions for alcohol and drug use disorders? Addiction 2005; 100: 1594-1610

2) Garbutt JC, Kranzler HR, O'Malley SS, Gastfriend DR, Pettinati HM, Silverman BL, Loewy JW, Ehrich EW, for the Vivitrex Study Group: Efficacy and tolerability of long-acting injectable naltrexone for alcohol dependence: A randomized controlled trial. Journal of the American Medical Association 2005; 293: 1617-1625

IW24. COGNITIVE THERAPY FOR PERSONALITY DISORDERS

Chair: Judith Beck Ph.D., Suite 700,One Belmont Avenue Bala Cynwyd,, Philadelphia, PA 19004-1610

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Conceptualize personality disorder patients according to the cognitive model; improve; 2) Use the therapeutic alliance in treatment; set goals; 3) Plan treatment for patients with characterological disturbance; 4) Enhance medication adherance and 5) Describe and implement advanced cognitive and behavioral techniques.

SUMMARY:

Cognitive therapy, a time-limited, structured, problem-solving oriented psychotherapy, has been shown in over 400 trials to be effective in treating Axis I disorders. In the past 15 years, cognitive therapy methods have been developed for Axis II disorders and research has verified the utility of this treatment approach. Cognitive therapy for personality disorders requires substantial variation from Axis I treatment. A far greater emphasis is placed on developing and maintaining a therapeutic alliance, modifying dysfunctional beleifs and behavioral strategies, and restructuring the meaning of developmental events.

In this workshop, a variety of case examples of patients with personality disorders will illustrate the principles of cognitive therapy, conceptualization of individual patients, developing the therapeutic relationship, planning treatment, and medication adherance. Roleplays will provide clinicians with demonstrations of how cognitive and behavioral techniques are employed. Questions and clinical material from participants will be encouraged throughout and a final segment will instruct interested participants in the steps they can take to learn more about this empirically validated approach for a difficult patient population.

REFERENCES:

1) Beck, J.S. (2005) Cognitive therapy for challenging problems: What to do when the basics don't work. New York: Guilford Publications, Inc.

2) Beck, A., Freeman, A., Davis, D., A., Pretzer, J., Fleming, B., Ottaviani, R., Beck, J.S., Simon, K., Padesky, C., Meyer, J., & Trexler, L. & Associates. (2004). Cognitive therapy of personality disorders, 2nd ed. New York: Guilford Press.

IW25. THE IMPACT OF MEDITATION AS A NON-PHARMACOLOGICAL INTERVENTION FOR VETERANS WITH MENTAL HEALTH DISORDERS

Chair: Julie Malphurs Ph.D., 1201 NW 16th Street (116A), Miami, FL 33125
Co-Chair: Daniella David M.D.
Presenter(s): Daniella David M.D., Julie Malphurs Ph.D., Molly Birkholm M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Examine the use of meditation at the Miami VA Healthcare System as a non-pharmacological therapy for persons with mental health disorders; 2) Discuss the potential role of non-pharmacological interventions as adjunctive therapies for persons with mental health disorders, specifically depression and PTSD;and 3) Participate in a meditation session led by a trained professional.

SUMMARY:

The prevalence of Mental Health disorders among veterans has been reported in recent studies to be as high as 26%, although barriers to care, including stigma, may result in the underestimation of the prevalence of mental health problems in this population. Using meditation as a clinical treatment offers veterans with conditions like depression and PTSD an alternative to standard forms of treatment (i.e. medication; group/individual therapy) that may be enhanced with the tools learned through meditation. Programs using forms of meditation as non-pharmacological interventions have been demonstrated

to be effective in reducing hypertension, improving diabetes, and improving outcomes in persons with traumatic brain injury (TBI). Meditation has also been shown to improve mental health symptoms including anxiety, panic, substance abuse, and stress.

The program that will be described involves veterans at the Miami VA Healthcare System from the outpatient mental health clinics who have PTSD and/or depression. The research is currently funded by a grant from the Center of Excellence in Psychological Health and TBI (Dept. of Defense). Experiences of participants in the program will be presented as well as preliminary data from the ongoing research study.

The session will introduce participants to meditation as a low-cost, non-invasive, non-pharmacological treatment as well as potential barriers to implementation of meditation as a clinical therapy. Attendees of the session will be given the opportunity to participate in a meditation session similar to those offered in the clinical and research programs described.

The introduction of meditation as a potential efficacious treatment for mental health conditions challenges existing paradigms of symptom management. One challenge that will be discussed in the session is how to educate providers about what meditation is, and how it will complement current treatment and management strategies for mental health conditions.

REFERENCES:

1) Brown RP, Gerbarg PL. Sudarshan Kriya Yogic breathing in the treatment of stress, anxiety and depression: clinical applications and guidelines. Journal of Alternative and Complementary Medicine 2005; 11:711-717.
2) Hoge CW, Auchterlonie JL, Milliken CS. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. JAMA 2006; 295:1023-32.

IW26. ASSESSMENT OF CAPACITY: DEVELOPMENTS, DOCUMENTATION & DEFENDABILITY

Chair: Michael Wise M.B.B.S, Wiser MInds Ltd, 14 Devonshire PLace, London, W1g 6HX United Kingdom
Co-Chair: Julian Beezhold M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session , the participant will be able to 1) Recognise the principles of capacity and informed consent, and their differences; 2) Recognize different resources used in the assessment of capacity; and 3) Learn new ideas for recording the information in more defendable formats.

SUMMARY:

Aim: The aim of the workshop is to help participants improve their ability to assess capacity and be aware of relevant tools for aiding decisions regarding capacity and consent. Participants will become familiar with a range of ideas on capacity relevant to different jurisdictions, as well as how legislative changes have impacted on practice.

Audience: The workshop is aimed at psychiatrists of all levels. Research has shown that there is room for improving the knowledge of the principles of capacity at all levels of experience from trainee to board registered practitioner.

Method: Teaching will be a mix of interactive exercises, demonstrations, presentation, videotaped material, and discussions. Initially participants will view a clinical dilemma and discuss whether capacity is present. A presentation will then inform participants of legal principles. A second dilemma will allow participants to determine their understanding of the principles. The second case will be used to demonstrate an algorithm, which has been used in multiple jurisdictions for the assessment of capacity. A third dilemma will illustrate the boundaries of tools and involve a group decision. Prior versions of this workshop have improved assessment accuracy from 40% to 80%.

Objectives: To be aware of the issues involved in assessing capacity, including relevant legal tests. To improve the assessment skills of participants. To learn about resources for assessing capacity and consent.

REFERENCES:

1) Owen GS, Richardson G, David AS, Szmukler G, Hayward P, Hotopf M. Mental Capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study BMJ 2008;337:a448. (30 June.)
2) Informed Consent: Information or Knowledge? Medicine & Law. 22(4): 743-50, 2003

IW27. LESSONS LEARNED ABOUT RESILIENCE AND RECOVERY FOLLOWING DISASTERS

Chair: Howard Osofsky M.D., 1542 Tulane Avenue, New Orleans, LA 70112
Presenter(s): Zack Rosenburg, Joy Osofsky Ph.D., Jose Calderon-Abbo M.D., Brymer Melissa Ph.D., Alicia Lieberman Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify factors contributing to mental health symptoms in children and adults after disaster; 2) Recognize factors leading to secondary traumatic stress and possible interventions following disaster; 3) Identify ways to support recovery and resilience following disasters, and 4) Understand the importance of psychological first aid.

SUMMARY:

Hurricane Katrina resulted in much devastation throughout the Gulf South. Recovery, especially in Metropolitan New Orleans, has been irregular and slow. New Orleans has recently been listed as having the most blighted property of any city in the United States. While mental health symptoms remain elevated, participants will share unique efforts to develop strength-based interventions leading to resilience and supporting recovery. After Howard Osofsky, M.D., Ph.D reviews the current status of recovery and resilience following Hurricane Katrina, Zack Rosenburg, J.D. will discuss the St. Bernard Project showing how rebuilding homes is crucial for rebuilding lives. It is important that rebuilding involve mental health interventions to support recovery for returning families as they deal with the memories

of loss and destruction in their neighborhoods. Joy Osofsky, Ph.D. will present data on mental health reactions of children and adolescence in the three years post-Katrina and positive results of leadership programs for students promoting resilience and recovery. While overall mental health symptoms have decreased, children continue to be impacted by subsequent trauma which contributes to severity of symptoms. Jose Calderon-Abbo, M.D. will discuss secondary traumatic stress impacting clinicians delivering health care and non-traditional evidence- based interventions to support recovery and the implementation of mind-body interventions to help both clinicians and returning adults. Melissa Brymer, Ph.D., Psy.D. will discuss Psychological First Aid and innovative cognitive behavioral strategies to support recovery and resilience. Alicia Lieberman, Ph.D. will discuss the presentations and also share helpful modification of Child Parent Psychotherapy to intervene with young children. Many of the lessons learned can be adapted for use in response and recovery following future disasters.

REFERENCES:

1) Osofsky, J.D., Osofsky, H.J., Harris, W. Katrina's Children: Social Policy Considerations for Children in Disasters. Social Policy Reports, 2007. http//www.srcd.org/spr.html
2) Calderon-Abbo, J., Kronenberg, M., Many, M., Osofsky, H.J. Fostering Healthcare Providers' Posttraumatic Growth in Disaster Areas: Proposed Additional Core Competencies in Trauma-Impact Management. Am J Med Sc 2008; 336:208-214.

IW28. WHEN PSYCHIATRY RESIDENTS TREAT MEDICAL STUDENTS: SOME CHALLENGES

Chair: Michael Myers M.D., 450 Clarkson Avenue, Brooklyn, NY 11203

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Appreciate some of the conflicts and symptoms that medical students bring to treatment; 2) Expect transference and countertransference dynamics related to identification, especially overidentification; and 3)Understand what can be learned when psychiatric residents gain early experience in treating their future colleagues

SUMMARY:

Medical student distress is a much studied entity in the professional literature of academic medicine and it is well known that many students seek professional help at some point in their training. What is less well known is how many are treated by psychiatric residents as part of their training in ambulatory psychiatry. In this workshop, the training director and the faculty person who established the program will discuss their experience in overseeing this facet of psychiatry training for PGY-III and PGY-IV residents at their institution. This will include a brief overview of the more common issues and illnesses which trouble medical students. Two residents will describe their experience of being the primary therapists to medical students who became their patients. Themes include: appreciating and respecting therapist-patient confidentiality; addressing practical matters related to stigma; accepting the anxiety of being a trainee treating another trainee where the amount of professional expertise and confidence may be small; working with transference and countertransference dynamics that are common to this dyad (intellectualization, denial, competition, intimidation, identification, collusion and gender alignment and clashing); acquiring cultural competence when the resident is an international medical graduate and the medical student is not; addressing conflict-of-interest situations when one is expected on clinical service to teach (and evaluate) a medical student who is one's patient; and accessing and obtaining state-of-the-art supervision of one's treatment, including how one's supervisor influences both the resident-therapist and the medical student-patient. One third of the workshop's time will be dedicated to and preserved for audience interaction.

REFERENCES:

1) Dyrbye LN, Thomas MR, Shanafelt TD. Medical student distress: causes, consequences and proposed solutions. Mayo Clinic Proc. 2005;80(12):1613-1622
2) Myers MF. Physician impairment: is it relevant to academic psychiatry? Acad Psychiatry 2008;32:39-43

IW29. BOOTCAMP FOR BURNOUT

ASSOCIATION OF WOMEN PSYCHIATRISTS

Chair: Tana Grady-Weliky M.D., University of Rochester Medical Center Department of Psychiatry, 300 Crittenden Blvd., Box PSYCH/Geri-Neuro, Rochester, NY 14642

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1)List components of burnout; 2)Differentiate between burnout and depression; and 3)Identify at least two strategies for preventing burnout and stress management

SUMMARY:

Burnout is a syndrome characterized by depersonalization, emotional exhaustion, and a sense of low personal accomplishment that leads to decreased effectiveness at work. Burnout is typically found in individuals employed in the "helping professions," i.e. areas in which time is spent devoting time to others. It was originally described by Maslach and colleagues and is commonly assessed with the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), a 22-item self-rated instrument. High emotional exhaustion and depersonalization scores along with low personal accomplishment scores fulfills the criteria for burnout. Burnout has been increasingly recognized among physicians. Recent studies have shown rates of burnout among physicians in practice ranging from 25-60% (Shanafelt, 2003) with 37-47% of academic faculty, and 55-67% of private practice physicians meeting established criteria for burnout. There has been limited research with regard to burnout among resident physicians. An institutional study of residents from a variety of medical specialties found that 50% of responding residents met criteria for burnout.(Martini et al.) Of the few studies of burnout in residents, only one has evaluated the rate or consequences of burnout among psychiatric residents. This workshop will review the components of burnout in physicians, in general, and

in women physicians of color, in particular. Stress management and prevention, including an experiential component, will also be included. Workshop participants will be encouraged to actively engage in discussion and experiential components of workshop.

REFERENCES:

1) Kumar S, Hatcher S, Huggard P: Burnout in psychiatrists: an etiological model. International Journal of Psychiatry in Medicine. 35(4): 405-416, 2005.
2) Fothergill A, Edwards D, Burnard P. Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. International Journal of Social Psychiatry. 50(1): 54-65, 2004.

IW30. LESSONS FROM THE POST-RESIDENCY ROAD: FOUR CAREER JOURNEYS SINCE RESIDENCY GRADUATION IN 2004, WITH INSIGHTS FROM OUR TRAINING DIRECTOR

Chair: William Wood M.D., 1388 Sutter Street, Suite 503, San Francisco, CA 94109
Co-Chair: Kathy Sanders M.D.
Presenter(s): Richard Falzone M.D., Dost Ongur M.D., Marketa Wills M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the most typical job types available to recent residency graduates, identify the most important factors to success in various career paths (academic, private practice, public sector, industry/management), discuss the fundamentals of effective career planning to maximize professional and personal success, and appreciate the potential to structure one's career activities according to personal values and priorities.

SUMMARY:

The transition from residency to post-residency employment is a process that requires planning, patience, and perseverance. Yet there are also elements of serendipity and curve balls that may be impossible to anticipate. In this workshop, four residency classmates who graduated together in June 2004 will share practical insights into preparing for life as an Early Career Psychiatrist (ECP). Each of these former co-residents has pursued career choices that reflect his or her unique way of blending psychiatry training with personalized professional interests. The presenters will outline general principals and specific suggestions that can be helpful to residents and ECPs exploring post-residency opportunities. Dr. Richard Falzone is a child/adolescent psychiatrist who will discuss the ins-and-outs of building a private practice. Dr. Dost Ongur (clinical director of the Schizophrenia and Bipolar Disorder Program at McLean Hospital) will review the practicalities of developing an academic research career. Dr. Marketa Wills (management consultant at McKinsey & Company) will talk about her experiences obtaining an M.B.A. at Wharton and entering the world of business management. Dr. Bill Wood (clinical research fellow at UC San Francisco and public sector psychiatrist) will share strategies for balancing hybrid interests that weave academic-based clinical research, public sector clinical care, and a small private practice. Finally, Dr. Kathy Sanders will give her insights on the transition to post-residency employment from her perspective as Training Director at the MGH/McLean Residency Training program. The workshop will conclude with a general audience discussion. Our goal is to foster a balanced consideration of how Members-in-Training and ECPs can strive to define and build the careers that they want, with specific consideration for the process of self-evaluation in defining goals, identifying/pursuing opportunities, and negotiating job offers.

REFERENCES:

1) American Psychiatric Association: Practice Management for Early Career Psychiatrists: A Reverence Guide. Washington, DC, American Psychiatric Association Office of Healthcare Systems and Financing, 2003/2006.
2) Roberts LW, Hilty DM, eds.: Handbook of Career Development in Academic Psychiatry and Behavioral Sciences. Washington, DC, American Psychiatric Press, Inc., 2006.

IW31. ASSESSMENT AND TREATMENT OF SLEEP DISORDERS IN ALCOHOL-DEPENDENT PATIENTS WITH ADHD AND OTHER CO-OCCURRING DISORDERS

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Chair: Kirk Brower M.D., 4250 Plymouth Road, Ann Arbor, MI 48109-2700
Co-Chair: Iyad Alkhouri M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to diagnose sleep disorders and treat insomnia in patients with alcohol dependence and co-occurring disorders.

SUMMARY:

Insomnia is common, persistent, and associated with relapse in alcohol-dependent patients. Insomnia in this population often has multiple etiologies, including co-occurring psychiatric disorders, which require assessment to guide optimal treatment. The timing and types of treatment for insomnia are important for both patients and clinicians, and evidence is accumulating to address these issues. Benzodiazepine receptor agonists, which are sometimes indicated and used safely in non-addicted patients, are frequently avoided by addiction psychiatrists because of their abuse potential. Recently published controlled trials of trazodone, gabapentin, and cognitive-behavioral therapy to treat insomnia in recently abstinent alcoholics will be reviewed. An extension of these findings to adolescents, other drug-dependent patients, as well as those with co-occurring attention deficit hyperactivity disorder, is less well-studied. Nevertheless, clinicians are commonly confronted with such patients, and they will likely benefit from a systematic approach. After two introductory lectures, participants are encouraged to discuss cases of interest to them.

REFERENCES:

1) Arnedt JT, Conroy DA, Brower KJ: Treatment options for sleep disturbances during alcohol recovery. J Addict Dis 2007; 26:41-54.
2) Friedmann PD, Rose JS, Swift R, Stout RL, Millman RP, Stein MD. Trazodone for sleep disturbance after alcohol detoxification: a double-blind, placebo-controlled trial. Alcohol Clin Exp Res 2008.

IW32. DOING IT RIGHT THE FIRST TIME: RECOGNIZING, MAINTAINING, AND SUPPORTING WORKPLACE FUNCTION

APA CORRESPONDING COMMITTEE ON PSYCHIATRY IN THE WORKPLACE

Chair: Andrea Stolar M.D., 2801 Gessner, Houston, TX 77080
Presenter(s): Marilyn Price M.D., Marie-Claude Rigaud M.D., Marcia Scott M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the importance of assessing function, tailoring treatment to symptoms; 2) Understand the value of rating scales to measure response to treatment, and 3) Understand the importance of work in health maintenance and recovery.

SUMMARY:

It is now well established that psychiatric illness results in significant loss to patients and employers due to lost productive days, absenteeism and presenteeism. There is more than money at stake. In sensitive professions such as medicine, moderate symptoms of illness may result in potentially dangerous impairment, and in other contexts, taking disability leave inappropriately may lead to a career dead-end. Translating symptoms into function, monitoring for signs of impairment, knowing when and how to support medical leave, and managing the documentation and privacy issues in communicating with employers and insurers is something not often addressed in residency training, yet is an important component of psychiatric practice. Addressing workplace issues begins with the patient assessment. Obtaining an occupational history, similar to the inquiry into educational and relationship history, provides a framework to understand our patients and how they view the world and interact with others. And in the ongoing treatment of patients, symptoms predicting risk of relapse can be identified when psychiatrists ask about work performance and stress. Assisting with adaptation to illness and recognizing the therapeutic risks and benefits of supporting work withdrawal are other components of treatment.

This interactive workshop will overview the clinical role in psychiatric disability using a case-based approach. Case examples will range from a high achieving professional whose prodromal symptoms in the context of his work, place him and others at risk, to the long out of work executive who faces significant barriers to career reentry.

REFERENCES:

1) Mischoulon D: An approach to the patient seeking psychiatric disability benefits. Acad Psych 1999;23:128-136
2) Dewa C, Lin E, Kooehoorn M, Goldner E: Association of chronic work stress, psychiatric disorders, and chronic physical conditions with disability among workers. Psych Serv 2007;58:652-658

11:00AM- 12:30PM

IW33. THE USE OF RESEARCH MEASURES IN CLINICAL PRACTICE

Chair: Joan Busner Ph.D., 575 E. Swedesford Rd, Suite 101, Wayne, PA 19087

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to administer and integrate common research tools into his or her own clinical work.

SUMMARY:

Objective: The objective of this workshop is to help psychiatric clinicians appreciate the potential utility of well-established research instruments in their own clinical practices. Research instruments are often daunting to clinicians and many clinicians have not had the opportunity to learn how the measures can enhance their ability to establish diagnoses, measure symptom severity, and measure response to treatment. Method. The workshop will provide interactive, practical, hands-on training in the use of research instruments as tools for assisting in forming accurate diagnoses, rating illness severity, and measuring intervention outcomes. Instruments have been selected for their direct applicability to the clinical setting. The workshop will focus on diagnoses the practitioner typically encounters such as Adult ADHD and Major Depressive Disorder, and will include structured diagnostic interviews, self-report measures, and brief clinician completed measures. Participants will receive copywritten measures organized by diagnosis and will view and score videotapes of actual patient interviews. Participants will have the opportunity to receive feedback and instruction, and role-play scale administration with expert feedback provided. Results. At the end of the workshop, participants will be able to administer and integrate common research tools into their own clinical work. Conclusions. The workshop will facilitate the integration of common research tools into clinical practice.

REFERENCES:

1) Conners CK,Erhardt D, Sparrow MA. Conners' Adult ADHD Rating Scales (CAARS). New York: Multihealth Systems, Inc., 1999.
2) Sheehan DV, Lecrubier Y, Sheehan KH, Amorim P, Janavs J, Weiller E, Hergueta T, Baker R, Dunbar GC. The Mini-International Neuropsychiatric Interview (M.I.N.I.): the development and validation of a structured psychiatric interview for DSM-IV and ICD-10. J Clin Psychiatry. 1998; 59 Suppl 20: 22-33.

IW34. FFT-HPI AND FIT: TWO DIFFERENT APPROACHES TO FAMILY-INVOLVED TREATMENT FOR BIPOLAR DISORDER

Chair: Igor Galynker M.D., Beth Israel Medical Center, 9th Floor 313 E 17th Street, New York, NY 10003
Presenter(s): Allison Lee M.D., Nisha VerHalen M.A., Lisa Cohen Ph.D., Annie Steele B.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be: Familiar with two models of treatment developed for families of patients with bipolar disorder - caregiver health promotion therapy (Family-Focused Therapy-Health Promoting Intervention - FFT-HPI), and Family-Inclusive Treatment (FIT) - as well as the different components and strengths of each approach.

SUMMARY:

Bipolar Disorder is a chronic mental illness that affects at least 4.4% of the U.S. population (Merikangas et al, 2007) and 1-3.7% worldwide (Kidd, 2004). Untreated, it can cause suffering and impairment in social and work functioning for both bipolar sufferers and their family members. There is persuasive evidence that: (1) making willing families an integral part of treatment improves outcome (Miklowitz et al., 2003; Renaires et al., 2004); and (2) family characteristics influence treatment outcome (Perlick, 2001). Yet, as compared to treatment protocols for chronic illnesses like diabetes, family members are seldom included in the treatment process for bipolar disorder for reasons such as: tradition, stigma and medical-legal concerns. To address this gap, an intensive Family Focused Treatment (FFT) was developed by Miklowitz et al. in 2003, and other approaches have followed. In this workshop, we will be discussing two of these approaches. Family Focused Therapy-Health Promoting Intervention (FFT-HPI - Perlick, 2004), which is based on FFT, is a 12-session cognitive-behavioral intervention helping caregivers improve their health through cognitive reframing, relaxation exercises and exposure therapy. Because lower caregiver burden is associated with improved patient outcomes (Perlick et al., 2001), FFT-HPI is additionally expected to benefit patients. Family-Inclusive Treatment (FIT - Galynker et al., 2008) is an open-ended treatment modality for patients and caregivers offering continued supportive therapy for patients and open communication with family regarding medications and symptoms. FIT is designed to be easily accessible for front-line providers in community settings. This workshop will present these approaches to family-involved treatment, discuss on-the-ground successes and pitfalls of implementation and share evidence of outcome. Essential vs. discretionary ingredients of successful family-involved treatments will be discussed.

REFERENCES:

1) Perlick DA, Rosenheck RA, Rounsaville B, Gonzalez J, Patel J, Miklowitz DJ: Health promotion among family caregivers of patients diagnosed with bipolar disorder: Development of a CBT-based intervention. Presented at the 38th annual Association for Advancement of Behavioral Therapy meeting, November 2004, New Orleans, LA.

2) Galynker I, Tross S, Kraljic H, Fama T, Lee A: Family-Inclusive Treatment (FIT) For bipolar disorder: Has the time arrived for a "Family Psychiatrist?" Presented at the the 161st annual meeting of the American Psychiatric Association, May 2008, Washington, DC.

IW35. OUTPATIENT MASTECTOMIES: OVERVIEW OF PSYCHOSOCIAL ISSUES

Chair: Zach Morairty M.D., 1500 E. Medical Center Drive, Ann Arbor, MI 48109-0295
Co-Chair: Michelle Riba M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the general psychosocial issues involved in outpatient mastectomy; 2) Review the practical aspects of identifying and addressing psychosocial issues for patients receiving this procedure: and 3) Develop interest in generating the necessary prospective studies to improve upon the current practices.

SUMMARY:

The recent trend to transition mastectomy procedures from the inpatient to the outpatient setting has implications on a patient's and family's psychosocial functioning. A review of the literature notes little evidence-based research regarding the outpatient procedure. This workshop will examine the current understanding of the psychosocial issues involved in outpatient mastectomies through a review of the literature. This review highlights a brief historical perspective of management of psychosocial issues of mastectomies done on the inpatient setting, the rationale (efficacy/safety/financial) for transition to the ambulatory setting, with a primary focus on current psychosocial issues, evidence-based interventions, and outcomes of outpatient mastectomies. Clinical examples will be provided and major psychosocial issues involved with breast cancer and mastectomy will be reviewed.

METHODOLOGY: A review of CINAHL, MEDLINE, and PsycINFO with key words "outpatient" AND "mastectomy" AND "psychosocial" was performed. Two additional searches were conducted to expand the literature to compile adequate data: (1) "outpatient" AND "mastectomy";(2) "psychosocial" AND "mastectomy."

CONTENT: An overview of psychosocial issues in breast cancer literature will be presented with specific attention to the pre-operative periods and post-operative recovery phase as it relates to patients' and their families' psychosocial functioning.

IMPORTANCE: The increased frequency in transitioning mastectomies from an inpatient to an ambulatory surgery setting is inevitable given financial and morbidity/mortality data. It is unclear how this will affect women and their families and how clinicians should emphasize resources in a multidisciplinary approach to understanding, evaluating, and treating the psychosocial issues involved. Prospective multi-center studies to measure outcomes of satisfaction, psychiatric events and health outcomes should be undertaken to address this issue.

REFERENCES:

1) Parker PA, Youssef A, Walker S, Basen-Engquist K, Cohen L, Gritz ER, Wei QX, Robb GL: Short-Term and Long-Term Psychosocial Adjustment and Quality of Life in Women Undergoing Different Surgical Procedures for Breast Cancer. Ann of Surg Oncol. 2007; 14(11): 3078-3089
2) Margolese RG, Lasry JC: Ambulatory surgery for breast cancer patients. Ann Surg Oncol. 2000 Apr;7(3):181-7

IW36. EVALUATION AND MANAGEMENT OF PATIENTS WITH EXCESSIVE DAYTIME SLEEPINESS IN PSYCHIATRIC PRACTICE.

Chair: Dimitri Markov M.D., Jefferson Sleep Disorders Center 211 S. Ninth Street, 5th Floor, Philadelphia, PA 19107
Presenter(s): Christine Marchionni M.D., Dimitri Markov M.D., Karl Doghramji M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) List primary sleep disorders associated with excessive daytime sleepiness, understand the pathophysiology of narcolepsy, and 2) Understand how hypersomnias are diagnosed and treated.

SUMMARY:

In recent years, there has been a great expansion of knowledge about sleep disorders. This knowledge, however, has not been fully implemented into clinical practice. Many psychiatrists can recognize common sleep disorders. However, more needs to be done to educate psychiatrists about diagnosing and treating sleep disorders that are associated with excessive daytime sleepiness. By addressing excessive daytime sleepiness of patients, psychiatrist can improve the physical and psychological health and quality of life of their patients.

Faculty will offer a practical framework to approach patients with excessive daytime sleepiness. We will discuss pathophysiology, clinical features, and management of primary sleep disorders associated with excessive daytime sleepiness. This highly interactive workshop will offer a practical framework to approach sleepy patients.

REFERENCES:

1) Guilleminault C, Fromherz S: Narcolepsy: diagnosis and management, in Principles and Practice of Sleep Medicine. 4th ed. Edited by Kryger MH, Roth T, Dement WC. Philadelphia, PA, Elsevier Saunders, 2005, pp 780-790.
2) Bassetti CL, Pelayo R, Guilleminault C: Idiopathic Hypersomnia, in Principles and Practice of Sleep Medicine. 4th ed. Edited by Kryger MH, Roth T, Dement WC. Philadelphia, PA, Elsevier Saunders, 2005, pp 791-801.

IW37. THE PORTRAYAL OF PSYCHIATRY IN RECENT AMERICAN FILM

Chair: Steven Pflanz M.D., 6244 Split Creek Lane, Alexandria, VA 22312

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) understand the impact of the portrayal of psychiatry in film on the public perception of psychopathology and the profession of psychiatry; and 2) Analyze critically films containing psychiatric content

SUMMARY:

The American film industry has long had a fascination with psychiatry. The history of film is replete with vivid images of psychiatrists and their patients. Perhaps unlike any other force in America, major motion pictures have the power to enduringly influence the public perception of mental illness, its treatments and the profession of psychiatry. In particular, the far-reaching appeal of films with success at the box office gives them a unique opportunity to shape the attitudes of everyday Americans. In order to understand the forces shaping the public perception of our profession, it is necessary to examine the images of mental illness and the mentally ill in commercially successful films. In this workshop, the audience will discuss the portrayal of psychiatry in contemporary films from the past twenty years, including such films as The Prince of Tides, Good Will Hunting, As Good As It Gets, A Beautiful Mind, K-Pax, The Hours, Antwone Fisher, Analyze This, and About Schmidt. Each of these films achieved a certain degree of both critical acclaim and box office success and was seen by millions of Americans. The audience will view short film clips from each of these movies, discussing each in turn. The majority of the session will be devoted to audience discussion of how we understand contemporary film to influence the image of psychiatry in America. This workshop has been consistently popular at the APA Annual Meeting, attracting large audiences and generating lively discussion.

REFERENCES:

1) Gabbard GO, Gabbard K: Psychiatry and the Cinema, 2nd Edition. Washington, DC, American Psychiatric Press, 1999.
2) Hesley JW, Hesley JG: Rent Two Films and Let's Talk in the Morning: Using Popular Movies in Psychotherapy, 2nd Edition. New York, John Wiley & Sons, Inc., 2001.

IW38. THE CHANGING MANAGED CARE LANDSCAPE FOR BEHAVIORAL HEALTH SERVICES

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Chair: Constance Horgan Sc.D., 415 South Street, Waltham, MA 02454
Co-Chair: Mark Willenbring M.D.
Presenter(s): Constance Horgan Sc.D., Constance Weisner D.P.H., Hyong Un M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this workshop, the participant should be able to: 1) Describe from a national perspective how private health plans manage access to substance use and mental health services; 2) Understand disease management approaches to these services in various types of managed care plans; 3) Discuss the

role of primary care in service delivery and the interface with specialty services; 4) recognize the many ways that management strategies can affect service delivery

SUMMARY:

Managed care has become the predominant form of health care financing and delivery in the US. Most privately insured individuals are in managed care plans where enrollment has been shifting from more tightly managed models (e.g., HMOs) toward less managed products (e.g., PPOs). This workshop explores how substance abuse and mental health services are provided within this managed care environment and how various types of management strategies may affect access and quality of services. Three brief presentations will set the stage for a highly interactive facilitated discussion.

- Using a nationally representative survey of private health plans, the first presentation describes organizational approaches, such as contracting out to specialty vendors and techniques used to manage provider networks, and individual approaches, such as cost sharing and prior authorization requirements.
- Based on data from a large integrated managed care plan, the second presentation considers the role of primary care providers based on a disease management model, ranging from screening, intervention and referral, as well as the effectiveness of primary care management post specialty treatment.
- With information from a large national health insurer, the third presentation explores disease and case management strategies around screening and brief intervention, alcohol disease management and medically assisted treatment.

Moving from a national snapshot of how behavioral health services are provided in a managed care environment, and then honing in on a more in depth focus on approaches used under two different managed care health plan types, this workshop explores how managed care can impact how services are delivered.

REFERENCES:

1) Horgan CM, Garnick DW, Merrick EL, Hodgkin D. Changes in how health plans provide behavioral health services. J Behav Health Serv Res, forthcoming. Epub available, Sep 14, 2007. DOI 10.1007/s11414-007-9084-0.
2) Merrick EL, Horgan CM, Garnick DW, Hodgkin D, Morley M. Health plans' disease management programs extending across the medical and behavioral health spectrum? J Ambulatory Care Manage, forthcoming.

WEDNESDAY, MAY 20, 2009

9:00AM- 10:30AM

IW39. SUPERVISION IN THE PSYCHIATRIC EMERGENCY DEPARTMENT: TECHNIQUES FOR MAXIMIZING THE SUPERVISOR-TRAINEE INTERACTION

Chair: Divy Ravindranath M.D., 4250 Plymouth Road, Ann Arbor, MI 48109
Co-Chair: Erick Hung
Presenter(s): Michelle Riba M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to implement well-researched educational techniques, such as the SNAPPS model for seeking supervision and the One-Minute Preceptor format for supervision, to maximize the educational potential of the emergency department.

SUMMARY:

The emergency department provides a unique training environment for trainees of all levels. In the emergency department, a trainee can witness and manage psychopathology of various sorts. They can gain practice with making an accurate assessment in a high-pressure and fast-paced situation. Supervision is critical to fostering the growth of any trainee. However, in the environment of the emergency department, this critical task can be easily neglected, jeopardizing the development of future psychiatrists.

Medical educators have developed and tested techniques for efficiently integrating clinical care with trainee education. This workshop presents two of these models. The first model, SNAPPS, calls on the learner to actively seek knowledge from the supervisor. The six steps of the model include: (1) summarize the history and findings, (2) narrow the differential diagnosis to two or three relevant possibilities, (3) analyze the differential by comparing and contrasting the possibilities, (4) probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches, (5) plan management for the patient's psychiatric issues, and (6) select a case-related issue for self-directed learning. The second model, the One Minute Preceptor (OMP), allows the supervisor to assess the learner and provide feedback, thereby fostering growth of clinical skills. The five steps of the OMP model include: (1) get a commitment, (3) probe for supporting evidence, (3) teach general rules, (4) reinforce what was done right, and (5) correct mistakes. Additionally, the workshop will include tips on soliciting and giving feedback to learners.

Participants in this workshop, both supervisors and trainees, will learn how to apply well-researched educational techniques and maximize the educational potential of the emergency department.

REFERENCES:

1) Wolpaw TM, Wolpaw DR, Papp KK SNAPPS: a learner centered approach for outpatient education. Academ Med 2003 78:893-8.
2) Furney SL, Orsini AN, Orsetti KE, Stern DT, Gruppen LD, Irby DM Teaching the One-minute preceptor: a randomized controlled trial. J Gen Intern Med 2001 16:620-4.

IW40. PATIENT SUICIDE DURING PSYCHIATRY RESIDENCY: A WORKSHOP DISCUSSION

Chair: Christina Mangurian M.D., New York State Psychiatric Institute1051 Riverside Drive, Box 111, New York, NY 10032
Co-Chair: Andrew Booty

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, participants should be able to: 1) Identify the myriad of feelings resident psychiatrists may have after a patient suicide; 2) Recognize the common colleague and residency training program responses that are typical after a patient commits suicide; and 3) Make recommendations for their home institution to help better support residents during this difficult time.

SUMMARY:

According to the Centers for Disease Control and Prevention, almost 31,000 people committed suicide in the US in 2001. Studies estimate that anywhere from 20-68% of psychiatrists will lose a patient to suicide at some point in their career.

A significant number of residents will experience the suicide of a patient during residency training. Unfortunately, open discussions about the feelings and issues raised in response to suicide are rare in training programs and in the literature. This silence may be due to the shame, guilt, fear, confusion, sadness, and other emotions that exist in residents and their colleagues and supervisors after a patient commits suicide. It is the belief of this panel that this lack of discussion interferes with the use of positive coping strategies by residents during this incredibly difficult training experience.

The workshop will begin with the resident/fellow panelists sharing their feelings and experiences after their own patients committed suicide. Attending panelists will then reflect on their own experiences with patient suicide. The audience will then be invited to share their own experiences as residents, supervisors, and training directors. The final portion of the session will be devoted to developing helpful strategies that could be proposed to residency training programs to provide better support to residents who have a patient that commits suicide.

If accepted, this would be the 3rd year of this workshop. Given the calls and e-mails received by the workshop chairs, it has proven to be incredibly useful to those who have attended and has had an impact on several training institutions. We will be discussing these novel changes that have been made to training institutions in an effort to disseminate these ideas. Also, we have a diverse panel, including resident, fellow, and faculty representation; ethnic diversity (Caucasian, Latino, African American); gender diversity; and bicoastal representation (New York, San Francisco, and Virginia). We have chosen a diverse panel to make this sensitive workshop as accessible as possible to all audience members/participants.

In general, this workshop will be dedicated to providing a safe place for residents to share the personal experience of having a patient who commits suicide, and attempt to develop better ways to support them through this experience in the future.

REFERENCES:

1) Gitlin MJ: A psychiatrist's reaction to a patient's suicide. Am J Psychiatry 1999; 156(10):1630-1634.
2) Ruskin R, Sakinofsky I, Bagby RM, Dickens S, Sousa G: Impact of patient suicide on psychiatrists and psychiatric trainees. Acad Psychiatry 2004; 28(2):104-110

IW41. PEDIATRIC GRIEF AND BEREAVEMENT: STRATEGIES TO HELP KIDS AND PARENTS COPE.

Chair: Ruth Geller M.D., 57 E. 97th Street, Apartment #17, New York, NY 10029
Co-Chair: Eva Szigethy M.D.

Presenter(s): Olle Jane Sahler, Ruth Geller M.D., David R. DeMaso M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant will be able to: 1) Apply developmental theory to understand children's conception of death; 2) Counsel a family about the expected reaction of their child to the death of someone close to them.

3) Utilize psychotherapies to support children through grief and loss; and 4) Understand the role of remembrance in parental resiliency following the death of a child.

SUMMARY:

Child and adolescent psychiatrists both in consultation-liaison and private practice settings frequently face the challenge of assisting bereaved children and their families. While adult palliative care and psychosocial oncology programs have recently contributed an impressive array of resources for helping grieving adults, there is less data available on how to help the pediatric population with bereavement. This workshop brings together acclaimed speakers with backgrounds in child and adolescent psychiatry, psychotherapy, palliative care, behavioral and developmental pediatrics, and consultation-liaison fields to provide an overview of developmental issues important in children's understanding of death and to describe innovative and empirically supported interventions to support children, parents, and families through bereavement. To help promote healing and resiliency, this workshop will provide pragmatic suggestions for working with grieving children and for supporting parents who have lost a child.

N.B.: This submission is being proposed by a resident (Ruth Geller, M.D.) who has been awarded an APA/SHIRE Fellowship and is offered as part of her APA mentorship experience.

REFERENCES:

1) DeMaso DR, Meyer EC, Beasley PJ: What do I say to my surviving children? J Am Acad Child Adolesc Psychiatry 1997; 36:1299-1302.
2) Sahler OJZ, Levetown M, Frager G: Bereaved children, in Pediatrics. Edited by Osborn L, DeWitt T, First L, Zenel J. Philadelphia, Elsevier Press, 2004, pp 1696-1700.

IW42. PRACTICAL MODELS FOR INCORPORATING EBM INTO ACADEMIC CLINICAL PRACTICES

Chair: John Young M.D., 401 Parnassus Avenue, Box 0984-APC, San Francisco, CA 94143
Presenter(s): Monica Caselli M.D., Christopher Daley M.D., Alison May M.D., Melissa Nau M.D., Lowell Tong M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the evidence cycle; 2) Appreciate the different strategies and models employed in the psychiatry training programs in one model program, UCSF Department of Psychiatry; 3) Identify barriers and opportunties to advance EBM at participants' own training programs; and 4) Select at least one strategy for application at participants' own training programs.

SUMMARY:

Evidence Based Medicine (EBM) represents an approach to clinical decision making that integrates the best available data with clinical judgment and the patient's values and preferences. EBM skills include how to translate clinical dilemmas into answerable questions, acquire and critically appraise the best available data, and then use clinical judgment in applying the data to an individual patient. The persistent gap between best and actual practice, the ever expanding volume of data and the educational dictates of the ACGME have made EBM a set of skills that every graduating trainee must now possess. As a result, every department of psychiatry and every psychiatric training program must have a strategy for incorporating EBM into its educational and clinical practices. This workshop will describe training models developed for diverse clinical contexts (inpatient and outpatient, private and public hospitals) at UCSF through the active leadership of chief residents and engage participants in identifying possible strategies to pursue at their home institutions.

REFERENCES:

1) Cook, D., et al., 6Ts teaching tips for evidence-based practitioners. Evid Based Med, 2007. 12(4): p. 100-1.
2) Hatala, R., et al., Beyond journal clubs. Moving toward an integrated evidence-based medicine curriculum. J Gen Intern Med, 2006. 21(5): p. 538-41.

IW43. PROMOTING SCHOLARSHIP & LEADERSHIP DURING RESIDENCY TRAINING

Chair: Anu Matorin M.D., 1300 Moursund, Houston, TX 77030
Co-Chair: Sandra Sexson M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Develop an increased awareness of the unique opportunities available to psychiatric residents during training that promote academic development in the area of scholarship and leadership; and2) Provide a forum for exchange of ideas to identify and implement creative strategies that foster career growth and advancement for residents in psychiatry.

SUMMARY:

Psychiatry residency training programs have an unique and important role to play in the long term career and professional development of psychiatry residents. The set of "Core Competencies" advocated by the American Council of Graduate Medical Education (ACGME) have had a major impact on graduate psychiatry training, with an emphasis on training programs to demonstrate residents' competency in the six key areas: medical knowledge, patient care, interpersonal and communication skills, professionalism, system-based practice, and practice-based learning and improvement, within an academic environnment that promotes residents' professional development and life-long learning. Furthermore, the ACGME Residency Review Committee (RRC)that reviews a given psychiatry residency training program's accreditation is assessing programs for the quality of scholarly activities and opportunities for scholarship available to their residents as one important aspect of maintaining program accreditation. Along these same lines, the American Board of Psychiatry and Neurology, has incorporated maintenance of certification exams, with a special emphasis on life-long learning. Residency training programs, combined with national organizations such as the American Psychiatric Association, the ACGME, and others, have a responsibility to train and stimulate residents to develop skills that will promote their long term professional development and success. This presentation will focus on the role of the resident, the role of the training program, the role of national organizations, including the APA and the ACGME/RRC perspective in identifying and promoting opportunities that foster psychiatry residents' scholarly activities and academic advancement. This workshop will promote a dialogue for exchange of ideas focusing on practical and creative ideas for psychiatry residents to enhance their academic development during training, as well as career-long professional development.

REFERENCES:

1) Hales DJ: Setting a Trajectory for Career-Long Professional Development. Academic Psychiatry 2007; 31:127-128.
2) Bourgeois JA, Servis M: Clinical habits and the psychiatrist: an adult developmental model focusing on the academic psychiatrist. Academic Psychiatry 2006; 30(5):365-71.

IW44. BEYOND DOCTOR-PATIENT RELATIONSHIP IN CYBERSPACE: PITFALLS, TRANSGRESSIONS, AND GUIDELINES(WHEN THERAPISTS AND PATIENTS GOOGLE EACH OTHER)

Chair: Damir Huremovic M.D., Nassau University Medical Center, 2201 Hempstead Turnpike,, East Meadow, NY 11554
Co-Chair: Nyapati Rao M.D.
Presenter(s): Jacob Sperber M.D., Shabneet Hira-Brar M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the challenges and opportunities associated with unsolicited and random informal online interactions between therapists and patients. The participant will be able to appreciate the ethical and legal aspects of informally receiving and disclosing information through online media and will be able incorporate this knowledge into their own therapeutic work with patients.

SUMMARY:

The advent of the internet has opened the virtual sphere to the therapist-patient relationship, transforming and challenging the basic principles of therapeutic relationship – duty, consent, boundaries, or confidentiality.

Beyond the use of email and designated websites for routine

therapist-patient communication, there are casual online interactions and random virtual encounters between therapists and patients which are as yet ill-defined. Recent exponential growth of online personal presence sets the stage for abundance of such casual and unsolicited virtual encounters, blurring the boundaries of traditional therapeutic relationship.

When individuals publish blogs or participate in online forums, they leave a public, often anonymous trail that can be discovered by their friends or therapists. Such material may reveal significant patient history, but questions linger about the impact of such 'bloganamnesis'. Does patient participation in these forms of virtual narrative constitute acting out of essential information which will impede or enhance therapeutic progress of patients given to splitting?

When a therapist stumbles upon a patient's blog or recognizes a patient in an online exchange, what is the therapist to do? Must therapists refrain from 'googling' patients in order to respect boundaries, or should care be modified to combine the traditional anamnesis with online queries about patients? How to address with patients personal internet information they uncover about the therapist?

This workshop addresses dilemmas of incorporating unsolicited online informal information into the official treatment plan and therapist-patient relationship. Discussion will focus on ethical and clinical aspects of these issues, to augment the minimal current literature.

Several cases illustrating random online therapist-patient encounters and collateral online history gathering, including a case of an attempted suicide outlined in an online diary, will be presented and discussed.

REFERENCES:

1) Patricia R. Recupero Law & Psychiatry: Legal Concerns for Psychiatrists Who Maintain Web Sites Psychiatr Serv, Apr 2006; 57: 450 - 452.
2) Geoffrey Neimark, Matthew Owen Hurford, and Joseph DiGiacomo The Internet as Collateral Informant Am J Psychiatry, Oct 2006; 163: 1842.

IW45. OLDER ADULTS AND THE NEUROBIOLOGY OF SUBSTANCE ABUSE

NATIONAL INSTITUTE ON DRUG ABUSE

Chair: Timothy Condon Ph.D., 6001 Executive Blvd., Bethesda, MD 20892

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the prevalence of substance abuse among older adults, identify recent trends in psychotherapeutic prescribing practices affecting this population: 2)Understand the potential impact of substance abuse on the aging adult brain; and 3) Recognize unique considerations for diagnosis and treatment of substance abuse in this population.

SUMMARY:

Substance abuse among older adults has received little attention in the past, presumably because this population has traditionally accounted for only a small percentage of the drug abuse problem in the United States. The aging of the baby boomer generation (born 1946-1964), however, will soon swell the ranks of older adults and dramatically alter the demography of American society. Several observations suggest that this expansion will likely be accompanied by a precipitous increase in the abuse of drugs, including prescription medications and illicit substances, among older adults. While it is now evident that the brain changes continuously across life, how drugs of abuse interact with these age-related changes remains unclear. The dynamic nature of brain function, however, suggests that substance abuse during older age may have more severe consequences even at lower exposures. The proposed workshop will explore the current and projected prevalence estimates of substance abuse among older adults, the changing psychotherapeutic prescribing practices affecting this generation, the potential impact of drug abuse on the aging brain, and the unique considerations for diagnosis and treatment of substance abuse in this population.

REFERENCES:

1) Dowling, GJ, Weiss, SRB, Condon TP (2008).
Drugs of Abuse and the Aging Brain.
Neuropsychopharmacology 33: 209-218.
2) Oslin DW, Pettinati H, Volpicelli JR (2002). Alcoholism treatment adherence: older age predicts better adherence and drinking outcomes. Am J Geriatr Psychiatry 10: 740–747.

IW46. AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY UPDATE: CERTIFICATION IN PSYCHIATRY AND ITS SUBSPECIALTIES

Chair: Larry Faulkner M.D., 2150 E Lake Cook Road, #900, Buffalo Grove, IL 60089
Co-Chair: Naleen Andrade M.D.
Presenter(s): David Mrazek M.D., Victor Reus M.D., Beth Ann Brooks M.D., Barbara Schneidman M.D., Robert Guynn B.A., Kailie Shaw

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe the American Board of Psychiatry and Neurology's policies and procedures for certification in psychiatry and its subspecialties.

SUMMARY:

The purpose of this workshop is to present information on the requirements for certification by the ABPN in psychiatry and the subspecialties of addiction psychiatry, child and adolescent psychiatry, forensic psychiatry, geriatric psychiatry, and psychosomatic medicine, as well as in clinical neurophysiology, pain medicine, sleep medicine, and hospice and palliative medicine. Application procedures, including training and licensure requirements, will be outlined, and the new requirements for the assessment of clinical skills during residency training will be delineated. The schedule for phasing out the Part II (oral) examinations in general psychiatry and child and adolescent psychiatry and the proposed changes in the computerized certification examinations will be presented. The

content of the extant Part I (computer-administered multiple-choice), Part II (oral), and subspecialty examinations will be reviewed, as will examination results. A substantial amount of time will be available for the panelists to respond to queries from the audience.

REFERENCES:

1) Shore JH, Scheiber SC (eds): Certification, Recertification, and Lifetime Learning in Psychiatry. Washington, DC, American Psychiatric Press, 1994
2) Scheiber SC, Kramer TAM, Adamowski S (eds): Core Competencies for Psychiatric Practice: What Clinicians Need to Know. Washington, DC, American Psychiatric Press, 2003

IW47. THE COBBLER'S CHILDREN: DEALING WITH PSYCHIATRIC PROBLEMS IN OUR OWN FAMILIES

Chair: Julia Frank M.D., 2150 Pennsylvania Ave NW, Washington, DC 20037
Presenter(s): Mitchell Cohen M.D., Kathryn McIntyre M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Recognize the advantages and disadvantages of psychiatric training in caring for family members; and 2) Be better able to support colleagues and others dealing with serious behavioral disorders in close family members.

SUMMARY:

Psychiatrists' families are not immune to serious behavioral disorders in their own members, disorders that go beyond the purported (and unproven) personality dysfunctions of therapists' children. Mental health professionals may be quicker than others to recognize signs of disturbance, yet inhibited from intervening for fear of overdiagnosing or misapplying their training. Their awareness that family dynamics affect the course of many disorders may increase their reluctance to seek help. The disorders themselves threaten the lives and well being not only of the affected person, but of everyone else in the family. The outcome of even excellent care is never certain. Wrestling with these dilemmas can enhance empathy, insight and the capacity to modify behaviors in the service of therapeutic goals. Three psychiatrists will present their personal experience as parents of children with serious behavioral disorders.Each has struggled with the problems of acknowledgement, communication with a non psychiatrist partner, and involvement as a parent with the mental health system. Such experiences repeatedly test the ability to draw boundaries between personal and professional roles. Open discussion of the presenters' experience, with invited participation from participants, may serve to reduce the stigma and isolation that attend dealing with chronic psychiatric problems in close family members.

REFERENCES:

1) Locke, J and LaGrange, D. Help Your Teenager Beat an Eating Disorder. NY: Guilford Press,2004
2) Chessick, RD. Intensive psychotherapy for the psychiatrist's family. American Journal of Psychotherapy 1977;31:516-524.

IW48. ORAL BOARDS BOOT CAMP-2009

Chair: Elyse Weiner M.D., 113 University Place, Suite #1010, New York, NY 10003
Co-Chair: Eric Peselow M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to begin creating a personalized, comprehensive strategy for studying and passing the oral board exam in psychiatry.

SUMMARY:

Oral Boards Boot Camp is a comprehensive, interactive approach to becoming an effective oral boards candidate that has been an ongoing workshop at the APA Annual Meeting for six years. Oral Boards Boot Camp seeks to help candidates hone their interview and presentation skills through a long-term practice model that they can begin at the workshop and develop right up until the examination. The chairpersons are constantly gathering information about the oral boards and incorporating it into this in-depth approach to preparation. Information from all sources is extremely important, as many changes to the board certification process are being phased in by the ABPN. The format of the workshop consists of a didactic portion where a long-term study method is presented, highlighted with actual advice from past candidates, followed by a lively discussion with ample time for audience questions. An overview of the entire oral boards preparation process is presented, from the day a candidate passes the written section until the day of the oral exam. A detailed study timeline includes, how to practice, study aids, vignettes, interview, fielding examiners' questions, how to relate to patients and examiners, travel arrangements, boards courses, how to dress, what to bring, day of the exam, and reasons for failure. Consistent with the Oral Boards Boot Camp long-term approach, we invite even the earliest future candidates, to begin working on refining their diagnostic interview and familiarizing themselves with the requirements for passing the oral boards. We also invite ABPN diplomates to attend and share their experiences with the group, adding to our knowledge of what makes a candidate successful on the oral boards. With a head start on building an individual long-term training framework, future examinees will be on the road to decreased anxiety, increased confidence, and the ultimate goal of passing the oral boards with ease.

REFERENCES:

1) Morrison J, Munoz RA: Boarding Time: A Psychiatry Candidate's New Guide to Part II of the APBN Examination, Third Edition. Washington DC, American Psychiatric Press, 2003
2) Strahl NR: Clinical Study Guide for the Oral Boards in Psychiatry, Third Edition. Washington DC, American Psychiatric Press, 2009

IW49. HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE (PART I)

Chair: William Callahan M.D., 120 Vantis, #540, Aliso Viejo, CA 92656
Presenter(s): Martin Tracy J.D., Donna Vanderpool J.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Know the 10 key tips to avoiding lawsuits and malpractice; 2) Know the 3 most frequent reasons why psychiatrists are successfully sued; 3) Understand different types of malpractice insurance, and which one is best for you.

SUMMARY:

This is part one in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered at more than 8 annual meetings and directed by faculty who have succeeded using this information. Even if you are not in private practice this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part one we focus on risk management, avoidance of malpractice suits, ways to maximize quality, and high risk issues that you must address in your practice. Drs. Callahan and Young are joined by experts in the field Donna Vanderpool, J.D., Assistant Vice President, Risk Management, Professional Risk Management Services, and Martin Tracy, J.D., President/ CEO, Professional Risk Management Services. Other sessions cover coding for maximum billing, marketing, office location and design, streamlining your practice, and business/financial principles.

REFERENCES:

1) Molloy, Patrick, Entering the Practice of Psychiatry: A New Physician's Planning Guide. Roering and Residents, 1996.
2) Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

IW50. PSYCHIATRISTS WHO HAVE HAD A PSYCHIATRIC ILLNESS: THEIR STORIES

Chair: Michael Myers M.D., 450 Clarkson Avenue, Brooklyn, NY 11203
Co-Chair: Leah Dickstein M.D.
Presenter(s): Alphonse Osinski M.D., Francine Cournos M.D., Raymond Reyes M.D., Suzanne E. Vogel-Scibilia M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Confront stigma in the house of medicine; 2) Appreciate issues around self-disclosure; and 3.) Understand how one's illness informs clinical work

SUMMARY:

Ten years ago, the co-facilitators (both specialists in medical student and physician health) of this workshop were approached by four psychiatrists who volunteered to speak openly about being diagnosed with and treated for a psychiatric illness. We partnered with the National Alliance on Mental Illness (NAMI) and presented an issue workshop on psychiatric illness in psychiatrists. This was a watershed moment in APA history as these courageous individuals shared their personal stories with their psychiatrist colleagues. This initiative has continued with workshops on this subject given at each APA annual meeting since. Our speakers this year, some of whom have spoken before, will reflect on themes such as stigma, self-disclosure, access to care, how being a patient enhances empathy, and (where relevant) how one's career path is affected by illness. This will be an interactive session as one half the workshop time is protected and preserved for discussion with the audience.

REFERENCES:

1) Cournos F. City of One: A Memoir. New York, WW Norton & Co., 1999
2) Myers MF, Gabbard GO. The Physician As Patient: A Clinical Handbook for Mental Health Professionals. Washington, DC, American Psychiatric Publishing Inc., 2008

11:00AM- 12:30PM

IW51. THE POST 9-11 ERA: UNDERSTANDING THE CULTURAL ISSUES IN THE PSYCHIATRIC TREATMENT OF MUSLIM PATIENTS

APA ILLINOIS PSYCHIATRIC SOCIETY

Chair: Nancy Abdel-Wahab M.D., 175 East 96th St., Apartment 22G, New York, NY 10128
Co-Chair: Nafisa Ghadiali M.D.
Presenter(s): Surinder Nand M.D., Nancy Abdel-Wahab M.D.

EDUCATIONAL OBJECTIVES:

At the end of the presentation, participants should be able to understand basic tenants of the Muslim faith, recognize cultural and social issues in the treatment of Muslim patients, and learn therapy recommendations to better serve this patient population.

SUMMARY:

Though Muslims are among the earliest immigrants to this country, since 9-11, there has been a greater interest in, and recognition of, the presence of Muslims in the USA. Muslims are part of a religious and cultural tradition that stems back to the 7th century. Muslims in the USA are a diverse group consisting primarily of African-Americans as well as the descendants Asian, African and the Middle Eastern immigrants. Muslims have many faith practices and family dynamics that differ from mainstream American norms. Thus, Muslim Americans may face issues other Americans may not. The issues include facing discrimination; trying to integrate rituals such as daily prayers or fasting into day-to-day life; or dealing with stricter rules regarding socializing, dressing, dating, etc. It is important for the therapist to recognize and acknowledge these dilemmas and address them in an

appropriate manner. In this session, we will present case vignettes, identify the cultural issues, discuss their impact on the patient's illness and mention therapy recommendations. In addition, we will also discuss the transferences/counter transferences of the practitioners belonging to Muslim faith.

REFERENCES:

1) Cheryl al-Mateen and Aneeta Afzal: The Muslim Child, Adolescent and Family. Child Adolesc Psychiatric Clin N Am 2004; 13: 183-200.
2) Lorraine P. Sheridan. Islamophobia Pre and Post-September 11th: Journal of Interpersonal Violence 2006; 21:317-336.

IW52. VISUAL RECOGNITION OF CATATONIA: VIDEO TEACHING SESSION

Chair: Andrew Francis M.D., Dept Psychiatry HSC-T-10 SUNY Stony Brook, Stony Brook, NY 11794

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize common clinical signs of catatonia and be able to rate them using the Bush-Francis Catatonia Rating Scale.

SUMMARY:

Background: Catatonia is clearly under-recognized in psychiatric and probably also in medical patients. Recent systematic screening studies of psychiatric admissions find an incidence of 7% to 17%. Standardized instruments such as the Bush-Francis Catatonia Rating Scale [BFCRS] may aid recognition. Catatonia is accompanied by significant morbidity and mortality, so treatment is essential, whether by addressing underlying medical and neurological illness or by targeted treatment with lorazepam and ECT which have been useful in psychiatric and 'organic' catatonia. Well-studied standardized instruments such as the Bush-Francis Catatonia Rating Scale [BFCRS] may aid in more reliable recognition and diagnosis. This rating scale was designed for use in psychiatric patients, comprises 23 items, and can be completed within a few minutes. Method: We will review the BFCRS, using several video vignettes from medical and psychiatric patients to improve identification of common and unusual presentations of catatonia and related conditions such as neuroleptic malignant syndrome. The vignettes include common and rare features of catatonia such as echopraxia, posturing, ambitendence, perseveration, automatic obedience, etc. and will have examples of successful treatment outcomes. Conclusions: The BFCRS is a practical tool for aiding recognition and quanitification of catatonic signs.

REFERENCES:

1) Francis, A. Update on Catatonia. Psychiatric Times 23: 23-24, 2006.
2) Bush, G., Petrides, G., Dowling, F., Fink, M. and Francis, A. Catatonia: I. Rating scale and standardized examination, Acta Psychiatrica Scandinavica 93: 129-136, 1996.

IW53. WATCHING THE MOVIES, BEATING THE STIGMA'S

Chair: Rudolf Feijen M.D., Roetersstraat 210, Amsterdam, 1015 AK Netherlands
Presenter(s): Rudolf Feijen M.D., Bastiaan Oele M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize the stereotypical portraying of psychiatric patients, their relatives and mental disorders by filmmakers and 2) Discuss the consequences of stigma and discrimination with their clients as a part of a psycho-educational group program.

SUMMARY:

We present the format of a psycho-educational group program we developed to help patients and their relatives to recognize the stereotypical images they have of several psychiatric issues, including themselves. Our experience is that discussing these issues supports the participants and help them beating stigma and discrimination.

At first we present and introduction on stereotypes, the different concepts of stigma and their consequences for our patients, their mental problems and our treatments. The process of stigmatization often starts long before the outbreak of the psychiatric disorder. Stigma often is not recognized because it's internalized or denied.

After we show some filmclips of American and European depiction of psychiatry. Each clip focuses on a different kind of stigma and their consequences: (1) Internalizing stigma and self rejection, (2) Rejection by their family, (3) Rejection by society and (4) Stigmatization by psychiatrists, participants are invited to discuss their experiences with stigmatization and their efforts to beat them.

REFERENCES:

1) Fink PJ, Tasman A: Stigma and Mental Illness. Washington, DC, American Psychiatric Press, 1992.
2) Robinson DJ: Reel Psychiatry: Movie Portrayals of Psychiatric Conditions. Port Huron, Michigan, 2003

IW54. PSYCHOTHERAPY UPDATE: A REVIEW OF THE CURRENT LITERATURE FOR THE PRACTICING PSYCHIATRIST

Chair: Priyanthy Weerasekera M.D., McMaster University, St.Joseph's Hospital,301 James Street South,Fontbonne 415,, Hamilton, Ontario, L8P 3B6 Canada
Co-Chair: John Manring M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants will be empirically informed about their treatment choices when considering the evidence-based psychotherapies available to treat patients with psychiatric disorders. Participants should be familiar with the empirical literature, and be able to consider individual variables as well when considering the delivery of specific psychotherapies.

SUMMARY:

The last few decades have witnessed significant advances in psychotherapy research. This research has demonstrated that there are evidence-based psychotherapies for patients with psychiatric disorders, that the therapeutic alliance is a key variable in outcome, and that individual variables help tailor treatments to patients. Of the evidence-based therapies studied to date, cognitive-behavioural, interpersonal, psychodynamic, experiential, couple, family and group, target specific psychiatric disorders or problems that commonly accompany these conditions. Level 1 evidence (that is meta-analyses or double-blind controlled trials) exists for most of these therapies across a variety of conditions. The therapeutic alliance has also been found to predict outcome early in treatment independent of therapy type, and is related to therapist skill and attributes, and to patient variables. Individual variables such as attachment styles and personality traits have also been shown to differentially predict response to treatment, indicating that not all patients with the same disorder respond similarly to the same psychotherapy.

The purpose of this workshop is to provide a psychotherapy update for the practising psychiatrist, who is not familiar with the extensive literature in this area. By reviewing this literature the clinician will become familiar with the current indications and contraindications of the various psychotherapies for patients with psychiatric disorders. How research informs practice will also be closely examined with clinical case examples. References will be provided as well as resources to assist the clinician to keep up with this challenging and exciting area.

REFERENCES:

1) Westen D, Morrison K: A multidimensional meta-analysis of treatments for depression, panic and generalized anxiety disorder: An empirical examination of the status of empirically supported therapies. J Con Clin Psy 2001:69:875-899
2) Leichsenring F: Are psychodynamic and psychoanalytic therapies effective? Int J of Psycho 2005:86:1-26

IW55. DEVELOPING A M.H.COURT FOR DOMESTIC VIOLENCE PERPETRATORS: A NEW JUDICIAL MODEL **REQUEST WED 9AM**

Chair: Lawrence Richards M.D., 714 S. Lynn, Champaign, IL 61820
Co-Chair: Bruce Winick J.D.
Presenter(s): Janetta Cureton, Juan Oms M.D., Bruce Winick J.D., Anthony Castro Psy.D., Deborah White-Labora B.S.

EDUCATIONAL OBJECTIVES:

Following presentations in 2003 and 2006 on Mental Health Courts, this session will teach about such Courts by describing and evaluating a new court process in Miami, FL that is providing specialized services for mentally ill individuals charged with domestic violence, and by presenting preliminary data of an outcome study of cases processed by this court.

SUMMARY:

People suffering from mental illness are being referred to the nation's Domestic Violence Courts, which combine civil and criminal jurisdiction. However the typical diversion programs available, such as batterer's intervention, anger management, counseling programs for drug abuse, etc., are inadequate for those with serious mental disorders

As a result, the Miami-Dade Domestic Violence Court has developed a new approach for dealing with domestic violence offenders whose violence is a product of their mental illness. Various mental health court techniques, such as judicial interpersonal skills, motivational interviewing, and behavioral contractng are used to facilitate mentally ill domestic violence offenders' acceptance of treatment for their illness, i.e. being INMT.

Hon. Debora White-Labora pioneered this new judicial-therapeutic model, and if she is able to attend she will relate historical and forensic insights regarding the process and field questions from attendees

Two forensic psychiatry fellows at U.Miami Med.Schl.Dept. Psy.& Behav.Sciences, Drs.Cureton & Ohm, will elaborate on this new judicial/therapeutic model and follow with several case studies while commenting on surfacing clinical issues.

Bruce Winick, U. of Miami Prof. of both Law and of Psychiatry, who is co-founder of therapeutic jurisprudence and was General Counsel of the N.Y.City DMH,MR,and Alcoholism Services, will situate this model within the context of other problem-solving courts, describe usual diversion methods, and discuss how this court uses principles and approaches of therapeutic jurisprudence to reach better results.

Anthony Castro, Asst.Prof.of Clinical Psychiatry, U. Miami will report the results of a retrospective and longitudinal study of 20 cases from this court over a two year period, comparing them to a sample of non-mentally ill perpetrators processed by the court in the same period.

REFERENCES:

1) Stefan, S. & Winick, B. (2005). Symposium: Mental Health Courts. Psychology, Public Policy & Law , 11:505-632.
2) Winick, B. & Wexler D. (2003). Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts. Durham, N.C.: Carolina Academic Press.

IW56. DOCTOR, IS THAT A BABY YOU ARE CARRYING: IMPACT OF PHYSICIAN PREGNANCY ON THE THERAPEUTIC ALLIANCE

Chair: Sudeepta Varma M.D., 462 1st Avenue, Ambcare Building Module 2 E, NY, NY 10016
Co-Chair: Jamae Campbell M.D.
Presenter(s): Asha Mishra M.D., Nioaka Campbell M.D., April Morciglio M.D., Kathy Vincent M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be able to; identify issues brought about with a pregnant therapist as well as address resistance that may emerge during treatment

Clinicians will be able to use the counter-transference in a positive and therapeutic manner.

Discussants will demonstrate sensitive supervisory and

administrative skills to help pregnant trainees

Colleagues of the pregnant therapist will be able to brainstorm solutions to potential conflicts and arising

SUMMARY:

Issues of transference and counter-transference are of utmost importance regardless of the type of therapy. Certain overt characteristics such as race, age, and gender of therapist are common characteristics that may elicit strong transferential feelings. The pregnant therapist, similarly can raise a variety of rich and interesting opportunities for interpretation and treatment. On the other hand, if these issues are not appreciated or addressed during treatment can serve as a potential barrier resulting in non-adherence or even early termination of treatment. Patients may experience a range of emotions from abandonment, rage to nurturing and protective instincts. Maternal transference, infantile and sexual urges are other potential reactions.

In this workshop, we will discuss the context of pregnancy in the therapeutic dyad and examine the doctor patient relationship with regards to the pregnant therapist and patient.

We will also look at residency training and what issues may come up for the pregnant resident such as issues of vulnerability, marginalization and discrimination. We will also explore the impact that the pregnancy may have on other colleagues. Finally we will explore potential solutions to dealing with conflict that may arise as a result.

REFERENCES:

1) Nadelson, C, Notman, M., Arons, E., Feldman J. The Pregnant Therapist. Am J Psychiatry 131:1107-1111
2) 2) McWilliams, N: Psychoanalytic Diagnosis: Understanding personality structure in the clinical process. New York, Guildford Press, 1994

THURSDAY, MAY 21, 2009

9:00AM- 10:30AM

IW57. PHANTOMS OF THE MIND: THE ROLE OF NARCISSISM IN THERAPIST BOUNDARY-CROSSING

Chair: Howard Book M.D., 2900 Yonge Street, Suite 101,, Toronto, M4N 3N8 Canada
Presenter(s): Carolyn Quadrio M.D., Gary Schoener Psy.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the role of narcissism and narcissistic injury in boundary crossings and boundary violations by therapists and ways of healing the transferential relationship.

SUMMARY:

This workshop will examine the role of narcissism and narcissistic injury in boundary crossings and boundary violations by therapists. The overall focus will be on narcissistic injury and the healing of a transferential relationship. Theoretical viewpoints will including self-trauma theory (Briere), Jungian perspectives (Rutter & others), and the issue of projective identification (e.g. Twemlow & Gabbard). The interlocking dynamics of the professional and the patient will be examined. The topic will be examined through a creative power point presentation built around the play and film Phantom of the Opera in which many of these themes are played out and can be easily examined. Using this dramatic theatrical vehicle some of these topics can be examined i n a non-threatening manner. The goal of this issue workshop will be to foster a discussion of the role of narcissism and narcissistic injury in the creation of therapist blind spots which can in turn lead even experienced practitioners to lose their way and cross boundaries with patients. The main presenter has utilized this approach in Australia to foster an examination of these issues. The chair and discussant will both comment from the perspective of Canadian and American experiences in examining the causes of boundary violations by therapists.

REFERENCES:

1) Twemlow, S.W. & Gabbard, G.O. (1989). The lovesick therapist. In G.O. Gabbard (Ed.) Sexual Exploitation in Professional Relationships (pp. 71-87). Washington, DC: American Psychiatric Press.
2) Celenza, A. (2007). Sexual Boundary Violations NY, NY: Jason Aronson

IW58. ** WITHDRAWN**

IW59. RESEARCH WITH SUBJECTS WHO LACK CAPACITY TO CONSENT: SURROGATE CONSENT, ACCEPTABLE RISK, AND OTHER CLINICAL AND ETHICAL CHALLENGES.

Chair: David Strauss M.D., 1051 Riverside Drive, Unit 10, New York, NY 10032
Presenter(s): David Strauss M.D., John Oldham M.D., John Luce M.D., Paul Appelbaum M.D., Jason Karlawish M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to appreciate ethical and pragmatic challenges in research with subjects who lack consent capacity.

SUMMARY:

There is great concern within the academic community that research is over-regulated by federal oversight agencies and micromanaged by institutional review boards. However, for those subjects historically seen as requiring the most protection—individuals who lack the capacity to consent to research-- federal regulations and IRB guidance are all but silent.

The research regulations require “additional safeguards” in research with “mentally disabled persons,” but the interpretation of “mentally disabled” is left to IRBs, and the required safeguards are not defined elsewhere. Also, federal rules rely on states to define who may consent on behalf of an impaired subject. Many states’ rules are crafted for health-care decisions and leave uncertainty about when or whether they apply to research. Other states have no laws applicable to surrogate-based consent. For

many institutions and IRBs, there is no clear answer (or no answer at all) to the question of who is legally authorized to consent to research for an incapable subject.

Where does this leave the field? How well does this regulatory structure protect these most vulnerable individuals from research related harms? Is necessary research involving the most seriously ill being left undone?

In this Issue Workshop, presenters will discuss research with subjects with serious mental illness, developmental disabilities, dementia, traumatic brain injury, stroke, and in intensive care settings in relation to the following questions: 1) which populations require additional safeguards; 2) do the children's regulations provide an appropriate model for research with incapable adults; 2) what are reasonable standards for informed consent and consent capacity; 3) who may serve as a surrogate and with what constraints, and 5) what are the limits of acceptable risk in surrogate based research? The workshop will offer an interactive, pragmatic, case-based, and empirically informed discussion of these issues.

REFERENCES:

1) Luce JM. Is the concept of informed consent applicable to clinical research involving critically ill subjects? Critical Care Medicine. 2003;31:S153-S160
2) Kim SY, Karlowish JH. Ethics and politics of research involving subjects with impaired decision-making abilities. Neurology. 2003 Dec 23;61(12):1645-6.

IW60. MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART I.

Chair: Oliver Stroeh M.D., 1051 Riverside Drive, Unit 93, New York, NY 10032
Co-Chair: Shefali Srivastava M.D.
Presenter(s): Jacob Ballon M.D., Melissa Nau M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Define the chief resident role more clearly; 2.) Identify effective strategies used in other programs to deal with the common difficult issues and logistical tasks faced by chief residents; 3) Share his/her own learning experiences with other participants at the workshop;and 4) Network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

SUMMARY:

This is Part I of a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and those interested in administrative psychiatry are encouraged to attend. In a recent study, chief residents reported having satisfying, positive experiences, with 90.6% saying they would choose to perform the chief resident duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature from 1980 discussed problems inherent to the role, including poor definition of the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to facilitate discussion of chief residency issues and improve the lack of information that often accompanies this role (programs typically have only 1-2 chief residents who are doing the job for the first time). This two-part workshop will include presentations from panelists who are finishing their chief year at programs across the country (including San Francisco). Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include: (1) logistical issues (making schedules, providing coverage when residents are absent, organizing retreats, improving morale), and (2) particularly difficult resident issues (how to support a resident after patient suicide or violence, how to support a resident struggling academically). Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry. It serves as a useful resident-run adjunct to the ELP chief resident meeting and, accordingly, might best be scheduled for Tuesday, May 19, 2009.

REFERENCES:

1) Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280.
2) Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276 Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280.

IW61. MALPRACTICE DEFENSE: WINNING STRATEGIES

Chair: Abe Rychik J.D., 150 E. 77th St., New York, NY 10021
Co-Chair: Eugene Lowenkopf M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the process of a medical malpractice suit; 2) Participate more effectively within the legal system;(3) Understand the relevant legal issues and the standards in responding to accusations in a Court of Law.

SUMMARY:

In every malpractice lawsuit there are a number of critical junctures at which time the physician and the attorney can positively or negatively affect the outcome of the suit, regardless of the merits of the case. This workshop presents one case from the viewpoint of the defendant psychiatrist and the defendant's attorney, with emphasis on the decisions and actions to be taken, which in this case contributed to a verdict in favor of the defendant.

The workshop presents the general legal framework and discusses the issues that arise. It offers concrete recommendations for a successful litigation outcome.

Included in this workshop are an examination of the following issues a) What constitutes malpractice? b) Venue (State or Federal) considerations. c) Reporting requirements and

insurance policy concerns. d)Role of the insurer vis-à-vis the lawyer and the defendant. e) Pre-litigation discovery. f) The pleadings. g) The discovery process (depositions, interrogatories, fact and expert documents) h) Plaintiff and defendant strategies.i) Trial proceedings. j) Post-trial activity. k) Issues of licensure and the National Practitioner'Data bank.

In summary, this workshop will provide the audience with basic knowledge and recommendations on how to most effectively proceed in a malpractice litigation.

REFERENCES:

1) Lowenkopf, EL: Memoirs of A Malpractice Suit. Jnl of Am Acad. Psychoanalysis 1995; 23(4):731-748
2) Culley C, Spisak L: So you're being sued: Do's and don'ts for the defendant. Cleve Clin J Med. 2002; 69:752-760

IW62. SC PARTNERS IN BEHAVIORAL HEALTH EMERGENCY SERVICES: ACHIEVING TOMORROW, TODAY!

Chair: Adrienne Coopey D.O., 2414 Bull Street, Room 314, Columbia, SC 29202
Co-Chair: Brenda Ratliff M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to demonstrate an understanding of the necessary relationships formed, challenges faced and solutions developed when implementing South Carolina's statewide emergency telepsychiatry consulting project. Participants will be encouraged to reflect on the relevance of telepsychiatry in solving the crisis of the rising use of emergency services by behavioral health patients.

SUMMARY:

Hospitals in South Carolina have expressed concern regarding the limited access of expert behavioral health consultation in hospital emergency departments (ED's). In many communities, behavioral health services are available only through the local mental health center and generally only during "normal" business hours. This has resulted in patients waiting in ED's often days for evaluation. The objective of this statewide telepsychiatry project is to make psychiatric consultation available in all South Carolina emergency rooms at all times. This project is the first of its kind in magnitude and focus conducted in the United States.

A total of 65 hospital ED's were offered the opportunity to participate in the project. The project began with collaboration and partnering across agencies within South Carolina to ensure cooperation and sustainability. Multiple hurdles were crossed in implementing the idea including but not limited to statewide hospital credentialing, preparing psychiatrists to treat a variety of patients within the new medium of telemedicine, addressing fears, cultural nuances and the needs of hospitals, communities, physicians, and patients, as well as privacy and state policy issues. During the initial start-up of the project these hurdles were successfully navigated using experiences of the past and our continuing collaboration with interested parties.

Outcomes measures were created using a variety of sources including surveys and databases. The State of South Carolina and the South Carolina Department of Mental Health have comprehensive databases from which much of our information is retrieved. Types of outcomes included are patient, physician, and staff satisfaction, comparison of behavioral health patient waiting days, hospital costs, number of psychiatric hospital admissions, and types of patients served. It is important that we share this information and experience so that others can begin similar projects building on our lessons learned.

REFERENCES:

1) Sorvaniemi M, Ojanen E, Santamäki O: Telepsychiatry in emergency consultations: a follow-up study of sixty patients. Telemed J E Health 2005; Aug;11(4):439-41.
2) Shore JH, Hilty DM, Yellowlees P: Emergency management guidelines for telepsychiatry. Gen Hosp Psychiatry 2007; May-Jun;29(3):199-206.

IW63. HOW TO LAUNCH A SUCCESSFUL PRIVATE PRACTICE (PART II)

Chair: William Callahan M.D., 120 Vantis, #540, Aliso Viejo, CA 92656

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Understand the use of codes for insurance to accurately reflect your work with patients; 2) Understand documentation requirements consistent with the codes you use; 3) Know where to go to get updated information on coding throughout your career.

SUMMARY:

This is part two in a three-part comprehensive course that provides you all the information you need to launch a successful private practice. It is composed of two workshops and one symposium all on one day. Offered at more than 8 annual meetings and directed by faculty who have succeeded using this information. Even if you are not in private practice this course will offer lots of useful information that will assist you in launching your career. Our material is constantly updated with up-to-the-minute solutions from our faculty with thriving practices.

In part two we focus on the complexities of using the insurance industry's procedure codes to accurately reflect your work with patients. Even if you intend to have a fee-for-service cash-based practice many patients will require "superbills" for insurance so they can get reimbursed. There are documentation requirements for each code, and not understanding them and following them can leave you prosecuted for fraud. Drs. Callahan and Young are joined by the two nationally recognized experts on coding who work with APA and AMA to make these codes and guidelines work. Chester Schmidt, M.D. and Tracy Gordy, M.D. will present and answer questions.

REFERENCES:

1) Practice Management for Early Career Psychiatrists, APA Office of Healthcare Systems and Financing, 1998.

2) Logsdon, L: Establishing A Psychiatric Private Practice, Washington, D.C. American Psychiatric Press, Inc., 1985.

IW64. MAINSTREAMING RESEARCH TRAINING INTO AN ADULT RESIDENCY PROGRAM

Chair: Stephen M. Goldfinger M.D., Professor and Chair Dept. of Psychiatry and Behavioral Sciences SUNY Downstate Medical Center Box 1203 450 Clarkson Ave., Brooklyn, NY 11203
Co-Chair: Nina Schooler Ph.D.
Presenter(s): Stephen M. Goldfinger M.D., Ellen Berkowitz M.D., Nina Schooler Ph.D., Sukriti Mittal M.B.B.S

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize shortcomings in our exposure of residents to research, assess their own program resources, and develop a curriculum and process for integrating research into their training programs

SUMMARY:

Although the Psychiatry Residency Review Committee calls on us to develop competencies in a variety of clinical and practice areas, training in research is not a focus of attention. This, despite the fact that the Institute of Medicine has warned that " ... the number of psychiatrist-researchers does not appear to be keeping pace with the unparalleled needs that currently exist in clinical brain and behavioral medicine". Certainly, not every resident will enter a career in research. Yet, in today's climate of evidence-based care and scientific advances in diagnosis and treatment, it is essential that every trainee be familiar with basic research methodology…and, who knows… maybe some of them WILL decide that a research career is for them!

At the State University of New York, Downstate Medical Center, the research endeavors and residency training were largely separate entities. Over the past several years, we have included a required rotation in research as part of our general residency training, in addition to providing formal didactics in research methodology, the use of rating scales, and basic statistics. Over the past few years, our residents have published dozens of papers and book chapters, and have presented posters and papers at dozens of psychiatric meetings nationally and internationally.

In this interactive workshop, faculty and our Chief Resident for Research and Academics will briefly describe our 'local' issues, and then open the workshop for discussions of how our model can be adapted to other programs' needs, specific structures and unique needs. This will NOT be a 'show and tell", but rather, we hope that our faculty, including internationally recognized researcher Nina Schooler, PhD, a trainee, a department chair and an Associate Training Director will serve as resources for a highly interactive and productive WORKshop!

REFERENCES:

1) Gilbert,AR, Tew,JD,Reynolds CF et al., A Developmental Model for Enhancing Research Training During Psychiatry Residency Acad Psychiatry 30:55-62, February 2006
2) Institute of Medicine: Research Training in Psychiatry Residency: Strategies for Reform. Washington, DC, National Academic Press, 2003

IW65. PSYCHIATRY IN THE AMERICAS: UPDATE FROM THE WORLD PSYCHIATRIC ASSOCIATION

Chair: Michelle Riba M.D., 4250 Plymouth Road, Room 1533 Rachel Upjohn Building, Ann Arbor, MI 48109-5769
Presenter(s): na na, Edgard Belfort M.D., Enrique Camarena M.D., Rodolfo Fahrer M.D., Alfredo Ortiz Fragola M.D., Roger Montenegro , Francisco Schnaas M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to examine various cross-cultural clinical factors in caring for patients in the Americas; review several of the clinical projects being undertaken by psychiatry colleagues in the Americas; have knowledge of opportunities for psychiatric collaborations between the Americas, and with WPA-APA.

SUMMARY:

Within the World Psychiatric Association, there have been increased linkages between member countries in the Americas. This workshop will highlight psychiatric updates on topics in the Americas related to a clinically relevant topics such as: work force; primary care psychiatry; adolescent psychiatry; role of WPA member societies in the Americas; and diagnostic issues as they relate to culture and ethnicity. Panel members will each highlight an important clinical topic in their WPA zone. This presentation will allow for audience participation and discussion between WPA and APA members.

REFERENCES:

1) Remschmidt H, Belfer M: Mental Health care for children and adolescents worldwide: a review. World Psychiatry 4:3, October 2005, 147-153
2) Mezzich JE: Institutional consolidation and global impact: towards a psychiatry for the person. World Psychiatry 5:2, June 2006, 65-66

IW66. RESPONDING TO THE IMPACT OF SUICIDE ON CLINICIANS

Chair: Eric Plakun M.D., Austen Riggs Center, 25 Main Street,, Stockbridge, MA 01262-0962

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to [1] enumerate clinician responses to patient suicide and [2] list practical recommendations for responding to patient suicide from the personal, collegial, clinical, educational, administrative and medico-legal perspectives.

SUMMARY:

It has been said that there are two kinds of psychiatrists--those who have had a patient commit suicide and those who will. Mental health clinicians often have less contact with death than clinicians from other environments. Nevertheless, each death by suicide of a psychiatric patient may have a more profound effect

on psychiatric personnel than other deaths do on non-psychiatric colleagues because of powerful emotional responses to the act of suicide, and the empathic attunement and emotional availability that is part of mental health clinical work. This workshop offers results from a study revealing 8 thematic clinician responses to suicide: Initial shock; grief and sadness; changed relationships with colleagues; dissociation; grandiosity, shame and humiliation; crises of faith in treatment; fear of litigation, and an effect on work with other patients. Recommendations derived from this and other studies are offered to guide individually impacted clinicians, colleagues, trainees, training directors and administrators in responding to patient suicide in a way that anticipates and avoids professional isolation and disillusionment, maximizes learning, addresses the needs of bereaved family, and may reduce the risk of litigation. The workshop will include ample time for interactive discussion with participants about their own experiences with patient suicide.

REFERENCES:

1) Plakun, EM, Tillman, JT. Responding to the impact of suicide on clinicians. Directions In Psychiatry, 2005; 25:301-309
2) Tillman, JG. When a patient commits suicide: An empirical study of psychoanalytic clinicians. International Journal of Psychoanalysis, 2006; 87:159-177

IW67. COGNITIVE AND BEHAVIORAL TECHNIQUES TO IMPROVE BRIEF PHARMACOTHERAPY SESSIONS

Chair: Donna Sudak M.D., c/o Friends Hospital, P.O. Box 45358, Philadelphia, PA 19124
Presenter(s): Donna Sudak M.D., Jesse Wright M.D., Judith Beck Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Use key techniques for depressed patients; 2) Use key techniques for patients with anxiety; 3) Use key techniques to promote medication adherence

SUMMARY:

Cognitive behavioral therapy has been demonstrated to be effective, both with and without medication, for a wide range of psychiatric disorders. Although many practitioners do not have the time or expertise to conduct CBT sessions, they nevertheless can learn key techniques to use when doing medication consults, to help reduce depressive and anxiety symptoms, enhance medication adherence, and improve outcomes. This workshop will focus on demonstrating the use of activity scheduling, responding to distressing cognitions, and other "high yield" interventions that can be implemented in briefer sessions. Participants will see role-play and videotape demonstrations of the intervention and learn the rationale for each strategy. We anticipate considerable discussion about the practical application of these techniques in clinical practice. The audience will receive information about other resources available to learn about this approach to patients.

REFERENCES:

1) Literature References #1 Beck, J.S. (2001). A cognitive therapy approach to medication compliance. In Annual Review of Psychiatry. Washington, D.C.: American Psychiatric Press
2) Literature References #2 Wright, J.H. (2003). Integrating cognitive therapy and pharmacotherapy. In Leahy, R. (Ed.) New advances in cognitive therapy. New York: Guilford.

IW68. HELPING PATIENTS WHO DRINK TOO MUCH: USING THE NIAAA CLINICIAN'S GUIDE

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Chair: Mark Willenbring M.D., 5635 Fishers Lane, Rm. 2047, Bethesda, MD 20892
Co-Chair: Robert Huebner Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the maximum drinking limits; 2) Know how to screen patients for heavy drinking ; 3) Know the criteria for alcohol use disorders; 4) Know how to conduct a brief intervention for at-risk drinking; and 5) Know the medications available for treating alcohol dependence

SUMMARY:

The purpose of this half-day Workshop is to teach participants to use the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Helping Patients Who Drink Too Much: A Clinician's Guide. Aimed at both primary care and mental health clinicians, the Guide provides a streamlined, research-based approach to identifying and managing the care of heavy drinkers and patients with alcohol use disorders. In early 2007, NIAAA published an updated Guide that includes a user-friendly, brief program of behavioral support for patients taking medications; a new patient handout called "Strategies for Cutting Down;" and mention of a new online resource devoted to the Guide and related professional support materials, including downloadable forms, publications, and training resources (www.niaaa.nih.gov/guide). NIAAA has fulfilled requests for many thousands of copies to individual practitioners as well as treatment centers, health maintenance organizations, state and community health programs, medical societies, and schools of medicine, nursing, and social work. Future plans encouraging the use of this valuable tool by psychologists will also be discussed.

REFERENCES:

1) National Institute on Alcohol Abuse and Alcoholism's (NIAAA) Helping Patients Who Drink Too Much: A Clinician's Guide

11:00AM- 12:30PM

IW69. MAKING THE MOST OF YOUR CHIEF YEAR: CHIEF RESIDENTS' FORUM, PART II.

Chair: Oliver Stroeh M.D., 1051 Riverside Drive, Unit 93, New York, NY 10032
Co-Chair: Shefali Srivastava M.D.
Presenter(s): Jacob Ballon M.D., Melissa Nau M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Define the chief resident role more clearly; 2) Identify strategies for maximizing administrative and professional growth, and for handling the dual role of resident and administrator; 3) Share his/her own learning experiences with other participants at the workshop; and 4) Network with chief residents from other programs, who can potentially provide ongoing support and consultation in the upcoming year.

SUMMARY:

This is Part II of a two-part workshop for incoming chief residents. Outgoing and former chief residents, residency directors, and those interested in administrative psychiatry are encouraged to attend. In a recent study, chief residents reported having satisfying, positive experiences, with 90.6% saying they would choose to perform the chief resident duties again. However, they also reported that they were less likely to have a clear statement of their responsibilities. Prior literature from 1980 discussed problems inherent to the role, including poor definition of the role, lack of training for the job, divided loyalties, and unrealistic expectations. The purpose of this workshop is to facilitate discussion of chief residency issues and improve the lack of information that often accompanies this role (programs typically have only 1-2 chief residents who are doing the job for the first time). This two-part workshop will include presentations from panelists who are finishing their chief year at programs across the country (including San Francisco). Since chief residents often face similar tasks, there will also be small group time to exchange ideas and strategies with chief residents and administrators from other programs. Issues to be addressed include: (1) logistical issues (making schedules, providing coverage when residents are absent, organizing retreats, improving morale), and (2) particularly difficult resident issues (how to support a resident after patient suicide or violence, how to support a resident struggling academically). Since 88.7% of chief residents in a recent study said that their chief experience has inspired them to seek future leadership opportunities, this workshop provides administrative training and networking for future potential leaders in psychiatry. It serves as a useful resident-run adjunct to the ELP chief resident meeting and, accordingly, might best be scheduled for Tuesday, May 19, 2009.

REFERENCES:

1) Ivany CG, Hurt PH: Enhancing the effectiveness of the psychiatric chief resident. Academic Psychiatry 2007; 31:277-280.
2) Warner CH et al: Current perspectives on chief residents in psychiatry. Academic Psychiatry 2007; 31: 270-276 Sherman RW: The psychiatric chief resident. Journal of Medical Education 1972; 47: 277-280.

IW70. THE NEW PUBLIC PSYCHIATRY: CREATING A FUTURE GENERATION OF PUBLIC PSYCHIATRISTS

Chair: Eugene Lee M.D., 198 E 121st St, 5th floor, New York, NY 10035
Co-Chair: Jules Ranz M.D.
Presenter(s): Aleksandar Micevski, Andrew Kirsch M.D., Matthew Levy M.D., Anthony Carino M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participand should be able to: 1) Describe the core elements of the Columbia University Public Psychiatry Fellowship program; 2) Identify clinical techniques, management skills and evaluation strategies of public psychiatry, in contrast to traditional approaches; 3) Demonstrate an understanding of techniques and specialized services for socially disadvantaged persons living with severe and persistent mental illnesses; 4) Apply an evidence-based clinical approach to working in public psychiatry

SUMMARY:

There is a large and growing demand for training in and provision of comprehensive, evidence-based, public psychiatric services as demonstrated by the recent increase in new public psychiatry fellowship training programs. This training is especially important since early- and mid-career psychiatrists have been demonstrated to be working more hours in organizational settings than in private practice. There has also been a recent need for recovery-oriented services, which have been identified as important component of psychiatric training. We will present a public psychiatry fellowship program, which serves as a model to help meet these critical demands.

This presentation will describe the core elements of the Columbia University Public Psychiatry Fellowship program, and it will foster discussion in how to apply a public psychiatry approach to serving persons living with severe and persistent mental illnesses. Current fellows from the program will present clinical vignettes from their training experiences in order to engage the audience in active participation. These vignettes will help presenters to explain how the core elements of the Columbia University Public Psychiatry Fellowship have informed their strategies for working in nontraditional settings, as well as nontraditional projects in traditional settings. Small-group interactions, large-group discussions, brief didactic presentations, and contrasting case formulations will be utilized to illustrate the important principles of this public psychiatry approach.

In this workshop, Columbia University Public Psychiatry Fellows will express their views on how their fellowship program implements the principles of rehabilitation and recovery-oriented services to provide innovative approaches in caring for persons living with severe and persistent mental illnesses.

REFERENCES:

1) Ranz J, Deakins S, LeMelle S, Rosenheck S, Kellermann S: Public-Academic Partnerships: Core Elements of a Public Psychiatry Fellowship. Psychiatr Serv, Jul 2008; 59: 718-720
2) Ranz J, Vergare M, Wilk J, Ackerman S, Lippincott R, Menninger W, Sharfstein S, Sullivan A: The Tipping Point From

Private Practice to Publicly Funded Settings for Early- and Mid-Career Psychiatrists. Psychiatr Serv, Nov 2006; 57:1640-1643

IW71. CROSS-CULTURAL COMPARISONS OF SYSTEM APPROACHES TO PSYCHIATRIC REHABILITATION: EXPERIENCES FROM CHINA AND SAN FRANCISCO

Chair: Yifang Qian M.D., 887 Potrero Ave., San Francisco, CA 94110
Presenter(s): Yingqiang Xiang M.D., Ziqing Zhu Ph.D., Robert Cabaj M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) demonstrate understanding of key cross-cultural issues in psychiatric rehabilitation, exemplified by the approaches used by the mental health systems in China and US; 2) identify the major similarities and differences between the respective mental health systems; and 3) discuss how such knowledge may affect their own practice and inspire ideas for changes in systems they work in.

SUMMARY:

Cultural and ethnic factors have been long known to influence the way people seek psychiatric care and to shape the delivery systems for psychiatric care. Cross-cultural comparisons of the different approaches China and the US are taking to address psychiatric rehabilitation illustrate these points. In the spring of 2008, a small delegate of psychiatrists from San Francisco visited Beijing and helped co-present The First Sino-US Summit on Mental Health Administration. The delegates described the approaches of the delivery of high quality psychiatric care through the public health system and alliances with academia. Tours of local facilities were included. A delegation of Chinese psychiatrists is also to visit San Francisco to discuss similar topics and tour facilities in 2009.

This current workshop will present the discussions from both sets of delegates that focus the understanding of the rehabilitation model from a cultural perspective and the application of that model to care systems that reflect the cultural expectations of that system. A major difference is the perspective on the individual verses society as a whole. In the US, especially in California, the care system emphasizes client rights, protection of confidentiality and customized client care. This may not focus on the good of society as a whole to the extent that the Chinese system does, as it emphasizes the concept of "harmonious society." Differences between the mufti-cultural and variety of families and homeless mix of San Francisco and that of China with its extensive but culturally more homogeneous population will also be discussed. The San Francisco system has embraced the rehabilitation model and expanded it to include integrated care for substance abuse and mental health problems in a single system and to apply the Recovery/Wellness model to the care approach. The Chinese presenters will discuss the actual models of care used and the plans for changes that are expected in the next few years.

REFERENCES:

1) Corrigan PW, Mueser KT, Bond GR, Drake RE, and Solomon P: Principles and Practice of Psychiatric Rehabilitation: An Empirical Approach; New York, Guilford, 2007
2) Weng YZ, Xiang YQ, Liberman RP: Psychiatric rehabilitation in a Chinese psychiatric hospital. Psychiatr Serv. 2005, 56(4):401-3

IW72. SHOULD HIV TESTING BE ROUTINE FOR PSYCHIATRIC PATIENTS IN INPATIENT AND OUTPATIENT SETTINGS?

Chair: Robert Daroff M.D., 4150 Clement St Box 116C, San Francisco, CA 94121
Presenter(s): Marshall Forstein M.D., Peter Jensen M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to : 1) To understand the scope of the HIV epidemic among the chronically mentally ill.; 2) To understand the rationale and impediments to broader HIV testing in psychiatric settings; and 3) To understand the merits and risks of the revised Centers for Disease Control guidelines for testing in medical settings.

SUMMARY:

Are psychiatrists doing enough to curb the spread of the HIV epidemic? The prevalence of HIV among people with severe mental illness is estimated at approximately 7%, over ten times that in the US general population. Among dually diagnosed patients, HIV infection is estimated to be 33% among injectors, 15% among non-injectors, and 11% among alcohol users. Prevention efforts, such as frank discussions about safer sexual practices and HIV testing, are infrequently a routine part of psychiatric care. In 2006, the Centers for Disease Control (CDC) introduced revised guidelines recommending HIV testing in health care settings for all persons ages 13-64, regardless of perceived risk factors. The principal rationale for the revised guidelines is that nearly half of HIV positive individuals present for HIV testing late in the course of infection, at which point treatments are less effective. There is also evidence that knowledge of one's serostatus can be a powerful vehicle to reducing high risk behaviors. Further, the CDC recommends an "opt-out" model in which patients are told that testing will take place unless they decline. Should psychiatric settings be complying with the CDC guidelines? Although it has been over two years since the guidelines were introduced, testing practices in many settings have been slow to change. Panelists in this workshop will present their experiences with testing and prevention interventions at their hospitals and clinics in San Francisco and Boston. The panelists will also (1) present the rationale for a more active role for psychiatrists in HIV prevention; (2) present background on the history of HIV testing, the types of tests available, and their accuracy; (3) present the medical data supporting earlier and broader HIV testing; and (4) present the merits and risks of adopting the CDC guidelines for testing. Ample opportunity will be provided for group discussion.

REFERENCES:

1) Centers for Disease Control and Prevention. Revised

recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006; 55 (No. RR 14);1-17.
2) Burke R, Sepkowitz K, Bernstein K, et al. Why don't physicians test for HIV? A review of the US literature. AIDS 2007, 21:1617-1624

IW73. PSYCHIATRY TRAINING FOR PRIMARY CARE PHYSICIANS, AN ONGOING CHALLENGE

Chair: Hoyle Leigh M.D., Department of Psychiatry, Univ. of California, San Francisco-Fresno, 155 N. Fresno St.,, Fresno, CA 93701
Presenter(s): Hoyle Leigh M.D., Don Lipsitt M.D., Seth Powsner M.D., Jon Streltzer M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize the specific needs of primary care physicians for psychiatric training in diagnosis, evaluation, and treatment, and formulate the means and venues of providing such training.

SUMMARY:

This workshop will explore, with active audience participation, the role of the consultation-liaison psychiatrist in the education of the primary care physician, as a continuation of the successful workshops on this topic. The moderator of this workshop (HL) will briefly discuss issues concerning psychiatric diagnosis and concepts in teaching primary care physicians based on a survey of directors of training of primary care residencies. Dr. Lipsitt will discuss the perceived needs, barriers and practice of primary care physicians in caring for patients who might be diagnosed with hypochondriasis or somatization disorder. Dr. Powsner will discuss and demonstrate innovative teaching techniques in the emergency room setting for the teaching of psychiatry in a multimedia presentation. Dr. Streltzer will present his experiences and ideas in teaching primary care physicians about chronic pain. Presentations will be limited to 60 minutes with 30 minutes for discussion with the audience. The discussion is expected to stimulate consultation-liaison psychiatrists and psychiatric educators to develop a set of minimal competencies for primary care physicians and to generate ideas that will lead to the development of more effective and efficient curricular models.

REFERENCES:

1) Leigh H, Stewart D, Mallios R: Mental health and psychiatry training in primary care residency programs. Part I. Who teaches, where, when and how satisfied? Gen Hosp Psychiatry 2006; 28(3):189-94
2) Leigh H, Stewart D, Mallios R: Mental health and psychiatry training in primary care residency programs. Part II. What skills and diagnoses are taught, how adequate, and what affects training directors' satisfaction? Gen Hosp Psychiatry 2006; 28(3):195-204

IW74. TEEN RISK-TAKING: TRANSLATING NEUROSCIENCE INTO REAL LIFE CHOICES

Chair: Rebecca Hommer M.D., 230 South Frontage Road, New Haven, CT 06520
Co-Chair: William Wood M.D.
Presenter(s): James Bjork Ph.D., Lynn Ponton

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Demonstrate a general understanding of the neural processes underlying decision-making and risk-taking behaviors and how emotional experiences influence these processes; 2) Understand the relationship between adolescent brain development and risk-taking behaviors; and 3) recognize the importance of risk-taking for adolescent development and encourage appropriate risk-taking behaviors in teens.

SUMMARY:

Adolescence is a period of enhanced exploratory and experimental behavior. This pattern of risk-taking and reward-seeking reflects normal neurodevelopmental processes, but marks adolescence as a time of heightened vulnerability to behaviorally driven morbidity and mortality. Differential sensitivity to reward, diminished fear of negative outcomes, increased susceptibility to the sway of strong emotions, and immature capacities for self-regulation and consequence appraisal may lead teenagers to make unwise or dangerous decisions. Altered or impaired decision-making processes may in turn contribute to rising rates of substance abuse among adolescents as well as the emergence of other psychopathology. Clinicians, families, and teens themselves face many challenges in navigating adolescence, caught between competing desires to encourage growth and independence yet minimize the chance of harm.

This workshop will bridge complementary perspectives on teen risk-taking behaviors, drawing from the fields of neuroscience and clinical psychiatry. Dr. Hommer will place adolescent risk-taking in an evolutionary context and describe the ways in which normal maturational processes may predispose the adolescent brain to risk. Dr. Bjork will provide an overview of the brain regions involved in risk assessment and reward-seeking behaviors, with a focus on adolescence. Dr. Ponton will draw on her clinical experiences treating teens to discuss the positive and negative aspects of adolescent risk-taking. She will address ways in which psychiatrists can foster appropriate risk-taking behaviors in adolescent patients and explain the benefits of such behaviors to teens and their families. The workshop will conclude with an interactive discussion session moderated by Dr. Wood. Providing a unique opportunity for neuroscientists and clinicians to discuss adolescent decision-making and risk-taking, this workshop aims to inform both future research efforts and practical patient care.

REFERENCES:

1) Ponton LE: The Romance of Risk: Why Teenagers Do the Things They Do. New York, NY, Basic Books, 1997.
2) Bjork JM, Smith AR, Danube CL, Hommer DW. Developmental differences in posterior mesofrontal cortex recruitment by risky rewards. J Neurosci 2007; 27(18):4839-4849.

IW75. MAKING YOUR PRESENTATION MORE

INTERACTIVE: THE BETTER WAY!

Chair: Jon Davine M.D., 2757 King Street East,, Hamilton, L8K 2G4 Canada

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Understand the superiority of interactive group teaching versus traditional didactic models in changing physician behaviour; 2) Use and participate in different group activities that enhance interactive group teaching; 3) Maximize the use of commercial film clips and audiovisual patient encounters to enhance group teaching.

SUMMARY:

Educational literature has shown that traditional didactic presentations usually are not effective in ultimately changing physician performance. Conversely, interactive learning techniques, particularly in smaller group settings, have been shown to be much more effective. In this workshop, we review the literature behind these conclusions. We discuss factors that can enhance interactive learning techniques, including room arrangements, proper needs assessment, and methods to facilitate interactive discussion. The workshop will then have an interactive component, which involves participants in different group activities, such as "Buzz Groups", "Think-Pair-Share", and "Stand Up and Be Counted", which enhance small group interaction.

The use of commerical film to enhance educational presentations has been coined "cinemeducation". We discuss techniques to help use film as a teaching tool, and then have an experiential component which will involve the direct viewing and discussion of a film clip to demonstrate principles of using films as a teaching tool.

Audiovisual tapes of patient encounters have been used as interactive teaching tools. In this workshop, we will discuss the literature describing how to maximize the use of audiovisual patient encounters as a teaching tool. We will then have another experiential component which will involve direct viewing of an audiovisual tape encounter of a patient where the group will directly participate in an interactive session using the audiovisual tape as a teaching tool. It is hoped that through experiential learning, participants will incorporate interactive techniques in their future presentations.

REFERENCES:

1) Jacques D: ABC of Learning and Teaching in Medicine: teaching small groups. BMJ vol. 328: 492-495, 2003.
2) Davis D, Thomson-O'Brien M, et al: Impact of Formal Continuing Medical Education: Do conference workshops, rounds, and other traditional continuing education activities change physician behaviour or health care outcomes? JAMA vol 282, no. 9: 867-874, 1999.

IW76. PSYCHODYNAMIC THERAPY WITH SELF-DESTRUCTIVE BORDERLINES

Chair: Eric Plakun M.D., Austen Riggs Center, 25 Main Street,, Stockbridge, MA 01262-0962
Co-Chair: Edward Shapiro M.A.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the convergence of approaches to treating self-destructive patients from DBT and psychodynamic perspectives, enumerate principles in the psychodynamic therapy of self-destructive borderline patients; 2) Implement newly acquired skills in establishing and maintaining a therapeutic alliance with such patients; and 3) Be familiar with the countertransference problems inherent in work with these patients.

SUMMARY:

Psychotherapy with self-destructive borderline patients is recognized as a formidable clinical challenge. Although much has been written about metapsychological issues in psychodynamic psychotherapy, relatively little practical clinical guidance is available to help clinicians establish a viable therapeutic alliance with these patients. This workshop includes review of 8 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) differentiation of lethal from non-lethal self-destructive behavior; (2) inclusion of lethal self-destructive behavior in the initial therapeutic contract; (3) metabolism of the countertransference; (4) engagement of affect; (5) non-punitive interpretation of the patient's aggression; (6) assignment of responsibility for the preservation of the treatment to the patient; (7) a search for the perceived injury from the therapist that may have precipitated the self-destructive behavior; and (8) provision of an opportunity for reparation. These principles are compared to Linehan's DBT and Kernberg's Transference Focused Psychotherapy (TFP). DBT and TFP arrive at a similar clinical approach to work with suicidal patients despite markedly different theoretical starting points. After the presentation, the remaining time will be used for an interactive discussion of case material. Although the workshop organizers will offer cases to initiate discussion, workshop participants will be encouraged to offer case examples from their own practices. The result should be a highly interactive opportunity to discuss this challenging and important clinical problem.

REFERENCES:

1) Plakun EM: Principles in the Psychotherapy of Self-Destructive Borderline Patients. Journal of Psychotherapy Practice and Research 1994; 3:138-148
2) Plakun EM: Making the Alliance and Taking the Transference in Work with Suicidal Borderline Patients, Journal of Psychotherapy Practice and Research 2001; 10: 269-276

IW77. CHILDREN OF PSYCHIATRISTS

Chair: Michelle Riba M.D., 4250 Plymouth Road, Room 1533 Rachel Upjohn Building, Ann Arbor, MI 48109-5769
Co-Chair: Leah Dickstein M.D.
Presenter(s): Eve Stotland Esq., Naomi Stotland, Susan Fauman, Heather Speller

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to recognize and understand how as psychiatrist-parents, their children think and feel about their psychiatrist-parents.

SUMMARY:

This annual workshop, which enables children of psychiatrists to share personal anecdotes with the audience of psychiatrist-parents and parents-to-be, has been offered to standing room audiences annually. While stigma toward psychiatry in general has diminished, psychiatrists, because of training and professional work, in addition to their professional life, bear emotional fears and concerns of how they will and do function as parents.

The four presenters will speak for 15 minutes each about their personal experiences and also offer advice to attendees. There will be a brief introduction by Dr. Dickstein to set the tone for the audience, and she and Dr. Riba will lead the 20-minute panel discussion, following the individual presentations.

REFERENCES:

1) Dickstein, LJ: an interview with Stella Chess, M.D., in Women Physicians in Leadership Roles, edited by Leah J. Dickstein, M.D. and Carol C. Nadelson, M.D., American Psychiatric Press, Inc., pp. 149-158
2) Mueller-Kueppers, Manfred: The Child Psychiatrist as Father, The Father as Child Psychiatrist (German), Praxis der KInderpsychologie und Kinderpsychiatrie, Vol. 34j(8), Nov. – Dec., 1985, pp. 309-315

IW78. THE PHYSICIAN AS PATIENT: AN INTERACTIVE WORKSHOP

Chair: Michael Myers M.D., 450 Clarkson Avenue, Brooklyn, NY 11203
Co-Chair: Glen Gabbard M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: Appreciate the range of problems that physicians bring to psychiatrists and know how to assess and treat them.

SUMMARY:

Both of the presenters have been assessing and treating physicians and their loved ones for more than 30 years. Each will give a 15 minute overview of the following key areas: the psychology of physicians that informs and is informed by the culture of medicine; special issues for minority and international medical graduate physicians; key points in the conventional and the independent evaluation of physicians; diagnostic and treatment issues (chemical and non-chemical psychiatric illness, medical illness, personality disorders, disruptive physicians and boundary violations); psychotherapies (psychodynamic psychotherapy, cognitive therapy and relapse prevention, couples' therapy); and the treatment of the suicidal physician, including reaching out to family and medical colleagues when doctors kill themselves. Attendees are encouraged to come with disguised clinical vignettes from their practices for the one hour discussion period.

REFERENCES:

1) Myers MF, Gabbard GO. The Physician As Patient: A Clinical Handbook for Mental Health Professionals. Washington, DC. American Psychiatric Publishing, Inc. 2008
2) Gabbard GO, Martinez M. Professional boundary violations by physicians. J of Medical Licensure and Discipline. 91:10-15, 2005

IW79. WITHDRAWN.

IW80. TRAINING FOR ALL PSYCHIATRIC RESIDENTS IN DOING AND EVALUATING RESEARCH AND SCHOLARLY ACTIVITY

Chair: Milton Kramer M.D., 1110 N Lake Shore Dr.23S, Chicgo, IL 60611
Presenter(s): David Bienenfeld M.D., Mantosh Dewan M.D., Milton Kramer M.D., Michele Pato M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to asess the problems in teaching research and scholarly activity to all residents and have several approaches available to teach residents to do or evaluate scholarly work and research undertakings.

SUMMARY:

The goal is admirable that all psychiatric residents become knowledgeable nabout research and scholarly work. and develop critical skills to evaluate the literature. Programs with resources to teach such skills have faculty who are unable to take the time to teach in these areas. Programs without such resources have additional issues with the lack of teachers and more clinically oriented residents who need to be motivated in these areas. We will review the efforts in three programs which have used different approaches: working up and publishing a case report [Dewan], doing retrospective chart reviews and p[oster presentations at national meetings [Kramer] and teaching faculty supervisors of residents how to teach residents to do research and scholarly activity. Specific techniques and approaches focused on completion "payoffs" are essential motivators for success. The value of these attempts to teach scholarship and research remains to be demonstrated

REFERENCES:

1) Pato MT, Pato CN. Teaching research basics toall sidents: Ten years of experience. Acad Psychiat 2001,25:77-81
2) Pincus HA. Research and clinical training in psychiatry. Psychiatr Q 1991,62:P121-133

WORKSHOPS

MONDAY, MAY 18, 2009

9:00AM-12:30PM

MEDIA WORKSHOPS

MW1. READY? OK! A FILM ABOUT CHILDHOOD GENDER VARIANCE

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

Chair: *Richard Pleak M.D., Long Island Jewish Medical Center, Zucker Hillside Hospital, ACP, Glen Oaks, NY 11004*
Co-Chair: *Sarah Herbert, M.D.*

Presenter(s): *Edgardo Menvielle, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identity issues that gender-variant children face in their families and schools, and how these issues and be affirmatively addressed.

SUMMARY:

Children with gender variance face unique issues growing up, within their families and in schools. Ready? OK! is a wonderfully delightful film that illustrates these issues and how they are confronted by a 10 year-old with an amazingly positive attitude and skills. The film portrays how a stressed out single mom must juggle work, her directionless and recently returned twin brother, and especially her precocious and gender-variant ten-year-old son, whose obsession with dresses, dolls, and cheerleading is leading to problems at his Catholic school. As a harried single mother in Normal Heights, USA, Andrea is having a tough time of it. Although her son Joshua is a smart, happy and enthusiastic ten-year-old, she worries that he's on the wrong track. With each summons to the Mother Superior's office at Joshua's private school, Andrea searches for answers to a nagging problem: How can she convince him that aspiring to be on the cheerleading squad, relishing the art of the French braid and calling Maria von Trapp his most influential role model is just not what little boys do? When you wish for a son on the wrestling team, how do you deal with one who loves fashion, dolls and pyramid formations? In this quirky and touching take on the modern family, one woman must strip away all her illusions to seek a kind of peace with herself and her son. Some hard advice from her gay next-door neighbor Charlie helps Andrea turn her focus in the right direction: inward. Embracing Joshua's individuality rather than fearing it might be the only answer, but can she do it? With comically truthful performances and a healthy dash of wacky farce, Ready? OK! explores a family on the verge of either destruction or elevation.

The discussion will be led by child & adolescent psychiatrists who are experts in working with gender-variant children and their families.

REFERENCES:

1) Pleak RR: Ethical issues in the treatment of gender atypical children and adolescents, in Sissies and Tomboys: Gender Nonconformity & Homosexual Childhood. Edited by Rottnek M. New York, New York University Press, 1999, pp. 34-51.
2) Menvielle E, Tuerk C: A support group for parents of gender non-conforming boys. J Amer Acad Child Adol Psychiatry, 2002; 41(8):1010-1013.

MW2. SILVER SPURS - SEVERE AND CHRONIC MENTAL ILLNESS, AND LIFE IN A RESIDENTIAL CARE FACILITY.

Chair: *Steven Harvey M.D., 3009 North Ballas Rd, St. Louis, MO 63131*
Co-Chair: Doug Whyte B.S.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have a greater familiarity with the everyday life and struggles of those with chronic mental illness living in a residential care facility.

SUMMARY:

Tens of thousands of our patients reside in residential care facilties designed to care for those with severe and chronic psychiatric illness. With strained budgets and other obstacles, these facilities try to help meet the day to day needs of our clients. Silver Spurs is an excellent and engaging documentary film about just one of these facilities. By following some of the patients through their day, the film reveals their struggles with vivid clarity.

This workshop endeavors to be educational, thought-provoking, and entertaining.

REFERENCES:

1) Insel TR: Assessing the Economic Costs of Serious Mental Illness. Am J Psychiatry 165:6, June 2008 663-665
2) Fleishman M: The problem: How many patients Live in residential care facilities? Psychiatric Services 55:6 p620-622

TUESDAY, MAY 19, 2009

9:00 AM - 12:30PM

MW3. THE JOY LUCK CLUB: UNIVERSAL STORIES ABOUT MOTHERS AND DAUGHTERS FROM CHINA

Chair: *Francis Lu M.D., Department of Psychiatry, 7M8, San Francisco General Hospital, 1001 Potrero Ave., San Francsico, CA 94110*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be

able to: 1) Identify different levels of acculturation and cultural identity among Chinese-Americans; 2) Understand mother-daughter dynamics across three generations.

SUMMARY:

The Joy Luck club is a 1993 film directed by Wayne Wang from a screenplay based on the 1989 novel by Amy Tan. It depicts three generations of mothers and daughters from four different families stretching back from pre-World War II China to 1980s San Francisco. With warmth and compassion, the film shows women's struggles against patriarchal society both in China and in the United States. Whereas in China, arranged marriages, husband infidelity, and polygamy were the norms, in the United States, more subtle forms of male domination are seen. Most moving is the reconciliation of the more traditionally acculturated mothers and their more assimilated daughters through transcendent dialogues of the mother-daughter pair. The resilient strength of the grandmothers emerge through the mother's stories yet to be reborn in the daughters who grew up in the United States. While the stories are particular to China, they resonate as universal stories of mothers, daughters and families in transistion through time and migration.

REFERENCES:

1) Chin JL: Relationships Among Asian American Women. Washington, D.C.: American Psychological Association Press, 2000.
2) Lim RL (ed.) Clinical Manual of Cultural Psychiatry. Washington, D.C.: American Psychiatric Press, Inc., 2006.

MW4. PROVOKED: COMBATING DOMESTIC VIOLENCE

INDO-AMERICAN PSYCHIATRIC ASSOCIATION

Chair: *Vishal Madaan M.D., 3528, Dodge St, Omaha, NE 68131*
Co-Chair: *Surinder Nand M.D.*
Presenter(s): , *Sarah Khan*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the culturally sensitive issue of domestic violence among immigrant south-east Asian women and 2) Recognize the prevalence of domestic violence and its psychological manifestations in this minority group, the predicaments faced by them, and challenges faced by the society in curbing this menace.

SUMMARY:

Workshop is based on the movie 'Provoked,' a soul-stirring and sensitive portrayal of domestic violence among immigrant south-east Asian women. The movie is based on the biography, Circle of Light and inspired by the true story of a Punjabi woman, who emigrated from India to the United Kingdom after marriage and was repeatedly abused by her husband. The movie traces the anguish and agony of the battered protagonist and explores the psychological trauma that she undergoes, before being provoked into a drastic, 'liberating,' and yet contentious action. Not only does the film highlight the plight of abused immigrant women, Provoked also raises questions regarding the legitimacy of the woman's response from societal viewpoint. It also identifies the dilemma that non-profit support organizations face when identifying the protagonist as a victim versus a perpetrator of violence. Following the movie, Dr. Madaan will review the literature regarding the problem of domestic violence among south-east Asian immigrant population and discuss cultural factors that may contribute to and perpetuate abuse in Asian immigrant homes. Ms. Khan will discuss the issues and challenges faced by her non-profit organization in providing support to these abused women. Dr. Nand will critique and explain the psychological issues dealt with in the film from a psychiatrist's viewpoint and also moderate the discussion. Discussion will also incorporate how immigrant south-Asian women may be particularly prone to flawed solutions to battering for many reasons, including cultural ideals that exert tremendous pressure to accept less than ideal solutions. The workshop will provide for a lively, interactive discussion and audience participation while raising this pervasive, yet often overlooked problem among southeast Asians residing in the US.

REFERENCES:

1) Goel R. Sita's Trousseau: Restorative Justice, Domestic Violence, and South Asian Culture. Violence Against Women 2005; 11: 639-665.
2) Midlarsky E, Venkataramani-Kothari A, Plante M. Domestic Violence in the Chinese and South Asian Immigrant Communities. Ann NY Acad Sci 2006; 1087: 279–300.

WEDNESDAY, MAY 20, 2009

9:00 AM - 12:30PM

MW5. THE BRIDGE(A DOCUMENTARY FILM ABOUT SUICIDE FROM THE GOLDEN GATE BRIDGE;DISCUSSION WITH THE FILM'S DIRECTOR AND A BRIDGE JUMP SURVIVOR)

APA NORTHERN CALIFORNIA PSYCHIATRIC SOCIETY

Chair: *Mel Blaustein M.D., Psychiatric Foundation of Northern California 251 Post Street, Ste 312, San Francisco, CA 94108*
Co-Chair: *Raymond Zablotny, M.D.*
Presenter(s): *, Kevin Hines*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) understand the nature of suicide and especially bridge suicide; 2) understand the impact of suicide on the survivors in the community; and 3) appreciate the need to reduce access to lethal sites.

SUMMARY:

People have jumped to their deaths from the Golden GateBridge since it was built in 1937. Suicides continue at a rate of about 24 per year. The eighth effort to construct a suicide barrier on the bridge in now underway. "The Bridge" is an outstanding documentary film that tells the stories of 19 individuals who jumped from the Golden Gate Bridge in 2004. A strong, controversial and poignant film, it focuses on the large number of suicides that occur each year at the Golden Gate Bridge, capturing footage of the suicides and interviewing family members. Also interviewed are people who have attempted suicide at the bridge, witnesses of the suicides and a jump survivor. The film has increased public awareness of the human stories, and the need for a suicide barrier. Following the film the audience will have the opportunity to discuss it with Eric Steel, the film's director; Kevin Hines, a jump survivor and member of the San Francisco Mental Health Board; and Raymond Zablotny, MD, a psychiatrist whose son died in a bridge jump. This film program is presented in connection with a Presidential Symposium titled "Suicide and the Golden Gate Bridge," organized by the Psychiatric Foundation of Northern California.

REFERENCES:

1) Seiden, R: Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. Suicide and Life Threatening Behavior 1978; 8(4): 203-216
2) Rosen, DH: Suicide survivors-a follow-up study of persons who survived jumping from the Golden Gate and San Francisco-Oakland Bay bridges. West J Med 122:289-294, Apr 1975.

MW6. DISFIGURED – A MOVIE ABOUT WOMEN AND WEIGHT -THE IMPACT OF APPEARANCE ON COPING WITH LIFE

Chair: *Katherine Halmi M.D., 21 Bloomingdale Road, White Plains, NY 10605*
Co-Chair: *Seymour Gers M.D.*
Presenter(s): *Glenn Gers*

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participants should be able to: 1) Distinguish between a psychiatric diagnosis of an eating disorder and someone with weight problems with no psychiatric diagnosis; 2) Develop a treatment plan for anorexia nervosa; and 3) Advise overweight and obese persons on coping strategies.

SUMMARY:

The spectrum of weight status from emaciation to obesity is associated with various emotions, coping strategies and psychiatric diagnoses. This workshop will begin with a film "disFIGURED", which poignantly brings to light the various coping strategies and emotions related to the extremes of body weight appearance. The difficulty in bringing about a change in either extreme condition is well portrayed in the film with a militant fat- acceptance group and a struggling anorexia nervosa young adult. This film provides a vibrant portrayal of women's struggles with self-esteem, control, sexuality, social pressures and comfort with one's physical self. It also provides an excellent discussion stimulus for the issues of when do these commonplace struggles become psychiatric diagnoses? Obesity is not classified as a psychiatric diagnosis. However psychiatrists and therapists may be helpful to overweight persons with the issues mentioned above or other comorbidities such as depression and anxiety. Anorexia nervosa often deteriorates rapidly into a life-threatening crisis requiring specific treatment. Early diagnosis and treatment with family therapy before age 18 is the best prevention of chronic anorexia nervosa.

REFERENCES:

1) Practice guideline for the treatment of patients with eating disorders. Am. J Psychiatry 163:7, July 2006 supplement.
2) Clinical Manual of Eating Disorders. (ed) Joel Yager and Pauline Powers. 2007, APPI press, Washington, DC.

WORKSHOPS

MONDAY, MAY 18, 2009

2:00 PM- 5:00PM

ADVANCES IN 01

ADVANCES IN NEUROPSYCHIATRY

Chair:Stuart C Yudofsky, M.D.One Baylor Plaza, MS350, Houston, TX 77030; Presenters: Robin Hurley, M.D., Paula Trzepacz, M.D., Jonathan Silver, M.D., Robert Robinson, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should have: 1) Familiarity with the most recent advances in functional brain imaging and how these are applied to understanding the brain bases of neuropsychiatric disorders; 2) How functional imaging may preclude in assessing and treating patients; and 3) Know recent scientific advances in the diagnosis and treatment of patients psychiatric symptoms and disorders associated with traumatic brain injury, stroke, and delirium.

SUMMARY:

This session will review the highlights of the recently published 5th edition of the American Psychiatric Publishing Textbook of Neuropsychiatry and Behavioral Neurosciences. To be included will be the latest basic science and research advances in key areas of neuropsychiatry to include functional brain imaging, the assessments diagnosis and treatment of emotional, behavioral, interpersonal, and social dysfunction in patients with delirium and traumatic Brain Injury of stroke. Emphasis will be placed on the translation of recent research advances into practical clinical practice.

REFERENCES:

1. Robinson RG, Jorge RE, Moser DJ, et al: Escitalopram and problem-solving therapy for prevention of poststroke depression: a randomized controlled trial. JAMA 2008; 299:2391-2400.
2. Silver JM, Koumaras B, Chen M, Mirski D, Potkin SG, Reyes P, Warden D: Harvey PD; Arciniegas D; Katz D; Gunay, I: The effects of Rivastigmine on Cognitive Function in Patients with Traumatic Brain Injury. Neurology, 2006; 12:748-255
3. Yudofsky, SC, Hales RE, eds: The American Psychiatric Publishing Textbook of Neuropsychiatry and Behavioral Neurosciences, Fifth Edition. Washington, DC: American Psychiatric Publishing, Inc., 2008.

ADVANCES IN 02

PSYCHOPHARMACOLOGY

Chair:Alan F Schatzberg, M.D. 401 Quarry Road, Stanford, CA 94305-5717; Co-Chair:Charles B Nemeroff, M.D., Ph.D.; Presenters: Terrence Ketter, M.D., William M. McDonald, M.D., Linda Carpenter, M.D., Alan I. Green, MD, Jeffrey Newport, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to provide an update on key recent advances in the treatment of bipolar disorder, major depression, schizophrenia, and pregnant women with mood disorders.

SUMMARY:

This is an update on key chapters in the Textbook of Psychopharmacology (4th Edition) and the related text, the Essentials of Clinical Psychopharmacology (2nd Edition). The symposium will address 5 major areas of pharmacologic or devise oriented therapies: bipolar disorder; atypical antipsychotics and glutamatergic agents in schizophrenia; refractory depression; brain stimulation techniques; and treatment of pregnant women. Terry Ketter will discuss the relative efficacy and side effects of treatments for bipolar disorder – mania, depression, and overall stabilization. Alan Green will present on the treatment of schizophrenia – again emphasizing efficacy vs. side effects of available antipsychotics as well as new agents under study – e.g., glutamatergic compounds. Linda Carpenter will review recent pharmacological strategies for refractory depression and William McDonald will review recent data on brain electrical stimulation devices. Last, Jeffrey Newport will present on the treatment of the pregnant mood disorder patient.

REFERENCES:

1. Schatzberg AF, Nemeroff CB (eds): Textbook of Psychopharmocology (Fourth Edition). Washington, American Psychiatric Press, 2008.
2. Schatzberg, AF, Nemeroff CB (eds): Essentials of Clinical Psychopharmacology (2nd Edition). Washington, American Psychiatric Press, 2006.
3. Ketter TA. Incorporating trial data into bipolar disorder management. J Clin Psychiatry 2008; 69(7): e21.
4. O'Reardon JP, Solvason HB, Janicak PG, Sampson S,Isenberg KE, Nahas Z, McDonald WM, Avery D, Fitzgerald PB, Loo C, Demitrack MA, George MS, SackheimHA. Efficacy and safety of transcranial magnetic stimulation in the acute treatment of major depression: a multisite randomized controlled trial. Biol Psychiatry 2007; 62(11): 1208-1216.

ADVANCES IN 03

ADVANCES IN SUBSTANCE ABUSE TREATMENT

Chair:Marc Galanter, M.D.550 First Avenue, Room NBV20N28, New York, NY 10016 Co-Chair:Herbert D Kleber, M.D., Presenters: Hugh Myrick, M.D., Laura F. McNicholas, M.D., Ph.D., Tony P. George, M.D., Marc Galanter, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to (1) evaluate and frame a treatment plan for alcohol, opioid, marijuana, and nicotine dependence; (2) apply recently developed pharmacologic approaches to substance use disorder treatment; (3) treat prescription drug abusers; and (4) optimally employ Alcoholics Anonymous in addiction treatment.

SUMMARY:

Psychiatrists are regularly confronted by a number of common substance use disorders, and should be aware that recent clinical research has greatly enhanced the options available for treatment. This session illustrates these options. The information is available in the American Psychiatric Publishing Textbook of Substance Abuse Treatment and, as a resource, the American Academy of Addiction Psychiatry. Among the most common problems confronting the clinician are the abuse of alcohol, marijuana, tobacco, and opioids. Management of abuse of each of these substances will be reviewed in light of the latest evidence-based treatments. In particular, we have a growing armamentarium of medications on which clinicians can draw, many of them introduced quite recently. These include receptor agonists and antagonists and amethystic agents, some for each of these drugs of abuse. Some are recently FDA-approved, and others are on the horizon, but show considerable promise. Additionally, consideration will be given to the problem of prescription drug abuse, one that psychiatrists are increasingly asked to address. Finally, recent findings on the psychology of AA, and how clinicians can make use of it, will be presented. Altogether, attendees will emerge better able to confront one of the principal areas of psychiatric pathology, one where practice has been broadened and improved materially in recent years.

REFERENCES:

1. Myrick HD, Wright T: Clinical management of alcohol abuse and dependence. In Textbook of Substance Abuse Treatment, edited by Galanter M, Kleber HD, Washington DC, American Psychiatric Publishing Inc., 2008, pp. 129-142
2. George TP, Weinberger AH: Nicotine and tobacco. In In Textbook of Substance Abuse Treatment, edited by Galanter M, Kleber HD, Washington DC, American Psychiatric Publishing Inc., 2008, pp. 201-213
3. Polydorou S, Kleber HD: Detoxification of opioids. In Textbook of Substance Abuse Treatment, edited by Galanter M, Kleber HD, Washington DC, American Psychiatric Publishing Inc., 2008, pp.265-287
4. Galanter M, Kleber HD (eds.) Alcoholics Anonymous and other 12-Step Programs. In Textbook of Substance Abuse Treatment, Washington DC, American Psychiatric Publishing Inc., 2008, pp.491-524
5. Compton WM, Denisco R: Prescription drug abuse. In Textbook of Substance Abuse Treatment, edited by Galanter M, Kleber HD, Washington DC, American Psychiatric Publishing Inc., 2008, pp.595-607

TUESDAY MAY 19, 2009

9:00AM-12:00PM

ADVANCES IN 04

ADVANCES IN PSYCHOSOMATIC MEDICINE

Chair:James L Levenson, M.D.Box 980268, Richmond, VA 23298-0268; Presenters: Peter A.Shapiro, M.D., Catherine Crone, M.D., James L. Levenson, M.D., Stephen J. Ferrando, M.D., and Stanley N. Caroff, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)to update the psychiatrist on psychiatric issues in cardiac diseases; 2)to update the psychiatrist on psychiatric issues in GI diseases; 3)to update the psychiatrist on legal issues affecting psychiatric care in medical settings; 4)to update the psychiatrist on psychopharmacology in the medically ill; and 5)to update the psychiatrist on severe reactions to psychopharmacologic agents.

SUMMARY:

Psychosomatic Medicinc (PM) is the newest psychiatric subspecialty approved by the American Board of Medical Specialties, devoted to the diagnosis and treatment of psychiatric conditions in complex medically ill patients. This encompasses patients with comorbid psychiatric and general medical illnesses complicating each other's management and those with psychiatric disorders that are the direct consequence of a primary medical condition or its treatment, as well as those with somatoform and fUnctional disorders; and, patients with acute psychopathology admitted to medical- surgical units, uch as after attempted suicide. While PM specialists focus on the most complcx cases, all psychiatrists take care of patients with general medical conditions receiving care from nonpsychiatric physicians. This symposium is aimed at both general psychiatrists and PM specialists.

REFERENCES:

1. Levenson, J.L. (ed), American Psychiatric Publishing Textbook of Psychosomatic Medicine, American Psychiatric Publishing, Inc., Washington, D.C., 2005.
2. Levenson, J.L. (ed), Essentials of Psychosomatic Medicine, American Psychiatric Publishing. Inc., Washington, D.C., 2007.
3. Levenson, J.L., Gitlin, D.F., Crone, C.C.: Psychosomatic Medicine. Psychiatric Clinics of North America, 30:593-863, 2007.
4. Caroff SN, Keck PE, Lazarus A, Mann SC. American Psychiatric Publishing, Inc., Washington, D.C., 2003

ADVANCES IN 05

PSYCHOTHERAPEUTIC TREATMENTS

Chair:Glen O Gabbard, M.D.6655 Travis St Suite 500, Houston, TX 77030-1316; Presenters: George Viamontes, M.D., Anthony Bateman, M.D., John Markowitz, M.D., Jesse Wright, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) conduct dynamic psychotherapy with a greater specificity of the mode of therapeutic action; 2) have a greater mastery of the most effective cognitive behavior therapy techniques; 3) become more skilled at conducting mentalization-based therapy for patients with borderline personality disorder; and 4) demonstrate knowledge about the biological mechanisms inherent in psychotherapy.

SUMMARY:

Mentalization, or better mentalizing, is the process by which we make sense of each other and ourselves, implicitly and explicitly,

in terms of subjective states and mental processes. It is a profoundly social construct in the sense that we are attentive to the mental states of those we are with, physically or psychologically. We have conceptualised borderline personality disorder (BPD) as a developmental disorder of mentalizing. In essence patients with BPD are vulnerable to loss of mentalizing when experiencing emotions within close interpersonal relationships. This vulnerability is considered in the mentalizing model of BPD to have arisen because of early attachment relationships rather than to trauma itself. Trauma is likely to be felt as part of a more general failure of consideration of the child's perspective through carer neglect, rejection, excessive control and unsupportive relationships. These can devastate the experiential world of the developing child leading to later social-cognitive functioning and behaviour coalescing in the behaviours defining BPD. There have been a number of cogent criticisms of this model - over-emphasis on attachment, lack of focus on enactment of internal object relations, and the secondary role of ggression. These will be addressed. Following a mentalizing model suggests treatment necessarily needs to focus on mentalizing. An outline of interventions promoting mentalizing will be given. But an argument will be made that in the treatment of BPD the most important issue is ensuring that interventions do not reduce mentalizing and so cause harm.

TUESDAY, MAY 19, 2009

2:00 PM- 5:00PM

ADVANCES IN 06

ESSENTIALS OF PERSONALITY DISORDERS

Chair:John M Oldham, M.D., M.S.2801 Gessner Drive, Houston, TX 77080; Co-Chair:Donna S Bender, Ph.D., Presenters: Glen O. Gabbard, M.D., Larry J. Siever, M.D, Peter Fonagy, Ph.D., Paul H. Soloff, M.D., Adrew E. Skodol, M.D., John G. Gunderson, M.D.

EDUCATIONAL OBJECTIVES:

At the completion of this session, participants will be able to demonstrate knowledge of new developments in research and treatment relating to personality disorders, with special emphasis on neurobiology, models of psychotherapy, levels of care, psychopharmacology, and new directions for *DSM-V*.

SUMMARY:

Interest in personality types has been longstanding and worldwide. Progress in our understanding of personality disorders has been a more recent phenomenon, but a rapidly accelerating one. This session, Advances in Personality Disorders, draws from The American Psychiatric Publishing Essentials of Personality Disorders to present selected, updated reviews from a much larger scope of material. We begin with a focus on models of psychotherapy and new findings relevant to the presumed mechanisms of treatment effectiveness. An in-depth review of recent neurobiological studies of patients with personality disorders will then be presented. The use of mentalization-based therapy for patients with borderline personality disorder will be reviewed, followed by a conceptual system to consider levels of care for this patient population. The latest studies on psychopharmacological interventions will then be summarized, and the final presentation will review current issues being considered in the context of the development of *DSM-V.*

REFERENCES:

1. Gabbard GO: Psychoanalysis and Psychodynamic Psychotherapy. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., in press.
2. 2.Coccaro EF, Siever LJ: Neurobiology. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., in press.
3. Soloff PH: Somatic Treatments. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., in press.
4. Skodol AE, Bender DS, Oldham JM: Future Directions: Toward DSM-V. In: Oldham JM, Skodol AE, Bender DS (eds) Essentials of Personality Disorders. Arlington, VA: American Psychiatric Publishing, Inc., in press.

ADVANCES IN 07

FORENSIC PSYCHIATRY

Chair:Robert I Simon, M.D.8008 Horse Shoe Lane, Potomac, MD 20854-3831; Co-Chair: Lisa Gold, M.D., Presenters: Robert I. Simon, M.D., Peter Ash, M.D., Jeffery Matenik, M.D., Daniel Shuman, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation the participant will be able to demonstrate knowledge of new development in forensic psychiatry, with focus on clinical-legal dilemmas, disability evaluations, school violence, correctional psychiatry and family law.

SUMMARY:

Forensic psychiatrists apply clinical and scientific expertise to legal issues in civil, criminal, correctional and legislative matters. The initial presentation will discuss the managing of clinical-legal dilemmas that supports good clinical care and avoids destructive defensive practices. The next presentation will address new disability assessment guidelines in legal and social contexts. The third presentation will highlight issues in assessing the risk of student violence in the aftermath of recent school shootings. The next presentation will cover evolving standards of care in correctional settings. The last presentation will, review the evolving law of family dissolution.

REFERENCES:

1. 0DM LII.: The Workplace jaSimon RI, Gold LII (eds.). The American Psychiatric Publishing Textbook of Forensic Psychiatry. Ar1ington VA, 2004
2. Ash P; Children and Adolescents in Simon RI, Gold LII (eds.). The American Psychiatric Publishing Textbook of Forensic Psychiatry. A.rlington, VA, 2004
3. Metzner IL, Voskin JA: Psychiatry in Correction Settings Simon RI, Gold LII (eds.). The American Psychiatric

Publishing Textbook of Forensic Psychiatry. Arlington, VA, 2004
4. Shunian DW: btroduction to the Legal System iLSimon RI, Gold LH (eds.). The American Psychiatric Publishing Textbook of Forensic Psychiatry. Arlington, VA, 2004

WEDNESDAY MAY 20, 2009

9:00AM-12:00PM

ADVANCES IN 08

HOSPITAL PSYCHIATRY

Chair:Steven S Sharfstein, M.D.6501 North Charles Street, Baltimore, MD 21204; Presenters: Ira D. Glick, M.D., Harold I. Schwartz, M.D., Patricia R. Recupero, J.D., M.D., John M. Oldham, M.D., John J. Boronow, M.D., Benjamin Liptzin, M.D., Lisa B. Dixon, M.D., M.P.H.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: define the current goals and functions of acute inpatient stays for psychiatric patients in psychiatric hospitals or units in general hospitals, with special emphasis on recent developments in subspecialized care, use of the electronic health record, financing of care, and the involvement of family members.

SUMMARY:

The purpose and function of the psychiatric hospital have changed dramatically during the 20th century from hospitals serving as the primary site of all psychiatric treatment to a more circumscribed and specialized locus of treatment within a continuum of care. Based on the recently published The Textbook of Hospital Psychiatry, the first presentation will describe the goals of an acute inpatient stay, consisting of crisis stabilization and a treatment plan that is focused on changing the trajectory of illness. The second paper will describe one subspecialty unit – the dual diagnosis (substance use/mental illness) unit – as an example of subspecialization that has taken place in the psychiatric hospital. The third presentation will focus on the electronic health record and how this technology is changing treatment and practice in the hospital. The fourth will review the financing of care today and how complex organizations such as psychiatric hospitals survive in the medical marketplace. The fifth and final presentation will describe the impact of the acute inpatient paradigm on consumers and family members.

REFERENCES:

1. Glick ID, Tandon R: "The Acute Crisis Stabilization Unit for Adults," in Textbook of Hospital Psychiatry, Steven S. Sharfstein, Faith B. Dickerson, and John M. Oldham (eds). Arlington, VA, American Psychiatric Publishing, 2008.
2. Boronow J: "Information Systems and the Electronic Medical Record," in Textbook of Hospital Psychiatry, Steven S. Sharfstein, Faith B. Dickerson, and John M. Oldham (eds). Arlington, VA, American Psychiatric Publishing, 2008.
3. Liptzin B, Summergrad P: "Financing of Care," in Textbook of Hospital Psychiatry, Steven S. Sharfstein, Faith B. Dickerson, and John M. Oldham (eds). Arlington, VA, American Psychiatric Publishing, 2008.
4. Murray-Swank A, Dixon LB, Stewart B: "Working with Families of Patients with Serious Mental Illness in the Inpatient Setting," in Textbook of Hospital Psychiatry, Steven S. Sharfstein, Faith B. Dickerson, and John M. Oldham (eds). Arlington, VA, American Psychiatric Publishing, 2008.

MONDAY MAY 18, 2009

11:00AM-12:30PM

ADVANCES IN MEDICINE 01

THE TOP 10 MEDICAL ARTICLES OF 2008: A COMPREHENSIVE AND PRACTICAL REVIEW OF WHAT WE NEED TO KNOW

Chairs:Monique Yohanan, M.D.3801 Miranda Avenue, Palo Alto, CA 94038 and Robert Boland, M.D., 345 Blackstone Blvd., Providence, RI, 02906-4800

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Recognize the publications in the Internal Medicine literature from the past year which are most likely to impact clinical practice; 2) Identify advances in Internal Medicine which have important overlap with Psychiatry, and enhance the care of patients with comorbid medical and psychiatric diagnoses; 3) Provide a critical appraisal of the evidence base and methodology of selected publications.

SUMMARY:

This session will review the most important non psychiatric medical literature published in 2008 Areas covered will include those representing important indings likely to impact clinical medical practice, with a special focus on topics common to patients with comorbid psychiatric and medical illness. Additionally, a critical appraisal of the evidence presented in these publications will be offered.

REFERENCES:

1. Straus S, I-Hong Hsu S, Ball C et al. Evidence-Based Acute Medicine. Oxford Medical Knowledge, 2002.
2. Nay R, Fetherstonhaugh D. Evidence-based practice: limitations and successful implementation. Ann N Y Acad Sci., 2007 Oct;1114:456-63.

TUESDAY MAY 19, 2009

11:00AM-12:30PM

ADVANCES IN MEDICINE 02

CURRENT ETHICAL CHALLENGES IN ASSISED REPRODUCTIVE TECHNOLOGY: A PANEL DISCUSSION

Chair: Elena Gates, M.D., UCSF Box 1688, San Francisco, CA ; Panelists: Robert Nachtigall MD, Lauri Pasch PhD and Mitchell Rosen MD

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Be familiar with the competing ethical obligations faced by providers of ART; 2) Identify the ethical contexts involved in disclosure to children conceived with donor gametes ; and 3) Describe the counseling needs of couples involved in third party parenting

SUMMARY:

New developments in and broader access to assisted reproductive technologies (ART) have resulted in a heightened public awareness of the ethical challenges faced by patients, families and fertility care providers. Fulfilling a professional obligation to support reproductive choice while also promoting the health of parents and potential offspring of ART can be challenging for providers. Particularly difficult are decisions about who is or is not an appropriate candidate for ART. Is a couple affected by a life-threatening illness, a criminal history or an unstable housing situation an appropriate candidate for ART care? In addition, a patient's intense desire for a child brings pressure to bear on her provider as he or she attempts to maximize the chance of success while minimizing harm to the woman and to her future children. If a woman intentionally seeks a twin pregnancy, should a provider accede, knowing that such a pregnancy is a risky one for both the woman and her children? Use of gamete donation raises additional challenges including the appropriate selection and compensation of donors. Should a young woman with particularly desirable traits be offered a huge sum of money for her donation of oocytes to a couple who wants to have a child? Parents who used gamete donation to build a family may choose not to disclose that fact to their children. What rights do the children then have for access to accurate information about their genetic heritage? These topics will be addressed in a lively discussion with a panel of faculty from UC San Francisco. Particular attention will be paid to issues that women or couples are likely to bring to their psychiatric providers.

REFERENCES:

1. Shehab D, Duff J, Pasch L, MacDougall K, Scheib JE, Nachtigall RD. How parents whose children have been conceived with donor gametes make their disclosure decision: contexts, influences, and couple dynamics. Fertil Steril 2008;89:179-87.
2. ESHRE Task Force on Ethics and Law 13: the welfare of the child in medically assisted reproduction. ESHRE Task Force on Ethics and Law including G. Pennings1, G. de Wert, F. Shenfield, J. Cohen, B. Tarlatzis and P. Devroey.
3. Human Reproduction Vol.22, No.10 pp. 2585–2588, 2007
4. American Society for Reproductive Medicine : Ethical Considerations of Assisted Reproductive Technologies. Ethics Committee reports and statements accessible at: http://www.asrm.org/Media/Ethics/ethicsmain.html

WEDNESDAY MAY 20,

11:00AM-12:30PM

ADVANCES IN MEDICINE 03

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

Chair:Robert M McCarron, D.O., Training Director, Asst. Clinical Professor, Dept of Internal Medicine, Department of Psychiatry University of California; Presenters: John C. Onate, M.D., Assistant Clinical Professor, Department of Psychiatry and Behavioral Sciences, Department of Internal Medicine, University of California, Davis, CA; Glen L. Xiong, M.D., Assistant Clinical Professor, Department of Psychiatry and Behavioral Sciences, Department of Internal Medicine, University of California, Davis, CA.,
James A. Bourgeois, O.D., M.D., Alan Stoudemire Professor of Psychosomatic Medicine, Department of Psychiatry & Behavioral Sciences, University of California, Davis Medical Center

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to; 1) Better understand the interplay between general medical problems and abnormal or maladaptive behavior; 2) Learn when to obtain neuroimaging studies in the context of acute or subacute behavioral disturbances; and 3) Review the management for multiple, unexplained physical complaints.

SUMMARY:

Psychiatrists often encounter clinical scenarios that may not have a clear explanation. The workshop faculty practice both internal medicine and psychiatry and will collaborate with the audience to review several case based “medical mysteries”. A relevant and concise update on several “Med Psych” topics will be discussed.

REFERENCES:

1. Bourgeois JA, Maddock RJ, Rogers L, Greco CM, Mangrulkar RS, Saint S: Neurosarcoidosis and delirium. Psychosomatics 2005; 46:148-150.James A. Bourgeois, O.D., M.D.
2. Pajouhi P, Bourgeois JA: Clozapine, fluoxetine, and benztropine-associated ileus: case report. Jefferson Journal of Psychiatry 2007; 21(1): ISSN 1935-0783; www.jdc.jefferson.edu/jeffjpsychiatry.
3. Eubanks AL, Aguirre B, Bourgeois JA: Severe acute hyperammonemia after brief exposure to valproate. Psychosomatics 2008; 49:82-83.

CASE CONFERENCE

MONDAY, MAY 18, 2009

9:00 AM-12:00PM

CASE CONFERENCES

1. PSYCHOANALYTIC CASE

Moderator: Deborah Spitz, M.D., University of Chicago Dept of Psychiatry, 5841 S Maryland Ave # MC3077 Chicago IL 60637-1447

Presenter: Melvin Lansky, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Appreciate the elements of a psychodynamic diagnostic formulation; 2) Understand the indications for and against the psychoanalytic treatment of severe personality disorders; and 3) Understand how to make use of transference and counter-transference elements in a long-term psychotherapy treatment.

SUMMARY:

This Case Conference, open to clinicians only, will address the psychotherapeutic treatment of a patient with character pathology, a treatment which begins as psychodynamic psychotherapy and moves over time into psychoanalysis. Presented by Julia Mitrevski, M.D., an advanced candidate at the San Francisco Center for Psychoanalysis, the case will be discussed by Melvin Lansky, M.D., Clinical Professor in the Department of Psychiatry at UCLA and Training Analyst and former Director of Education at the Los Angeles Psychoanalytic Society and Institute. The case presentation and interactive discussion will give participants an opportunity to observe the unfolding of a psychoanalytic case, consider the differences between psychodynamic psychotherapy and psychoanalysis proper, and understand the value of a psychoanalytic perspective in working with a patient to understand herself

REFERENCES:

1. Gabbard G, Long Term Psychodynamic Psychotherapy, a Basic Text. APPI Press, 2004.
2. Lansky M and Morrison A, eds: The Widening Scope of Shame. Analytic Press, 1997.

MONDAY, MAY 18, 2009

9:00 A.M. - 10:30 A.M.

2. A POPULATION-BASED CASE CONFERENCE ILLUSTRATING THE IMPLEMENTATION OF AN EVIDENCE-BASED, PREVENTION, INTERVENTION IN A COUNTY WITH 200,000 PEOPLE

Moderator: Carl C Bell, M.D., 8704 S. Constance, Chicago, IL 60617; Presenters: Ken Thompson, M.D. and Annelle B. Primm, M.D., M.P.H.

EDUCATIONAL OBJECTIVE:

At the end of this session, participants will be able to: 1) list the seven theoretical underpinnings of a population-based intervention; 2) list population-based strategies to implement protective interventions that prevent risk factors from being predictive of bad outcomes; and 3) list several characteristics of leadership that promote health behavior change in large populations.

SUMMARY:

Dr. Bell will depart from the typical, mundane, usual individual case conference model and introduce a new public health method of a population-based case conference illustrating the implementation of an evidence-based, prevention intervention in a county with 200,000 people. Specifically, he will describe work done in McLean County, Illinois; beginning in 2000, where the rate of removal of African-American children was 24.1/1,000 (the statewide average was 4/1,000). One of the corner stones of community psychiatry practice is consultation and education and by applying this basic principle, the rates of removal of African-American children in McLean County, Illinois decreased down to 11/1,000. A theoretically sound, evidence-based, common sense model is offered as a "directionally correct" way to ensure that at-risk populations obtain protective factors to prevent potential risk factors from generating poor health and mental health outcomes. Innovative statistical methodology will also be presented that gives some credence that the naturalistic prevention intervention that was implemented in McLean County had an impact on the rates of removal of African-American children from their families. The untoward consequences of doing such public health work will also be described. Drs. Annelle Primm and Ken Thompson will discuss the population-based case and its ramifications.

REFERENCES:

1. Redd J, Suggs H, Gibbons R, Muhammad L, McDonald J, Bell CC. A Plan to Strengthen Systems And Reduce The Number The Number Of African-American Children In Child Welfare. Illinois Child Welfare 2005; 2 (1 & 2): 34-46. http://www.illinoischildwelfare.org/archives/spr2007/A%20Plan%20To%20Strengthen%20Systems%20And%20Reduce%20The%20Number%20Of.pdf
2. Bell CC, Bhana A, Petersen I, McKay MM, Gibbons R, Bannon W, Amatya A. Building Protective Factors to Offset Sexually Risky Behaviors Among Black South African Youth: A Randomized Control Trial, Journal of the National Medical Association, Vol. 100, No. 8: 936 - 944, 2008. http://www.nmanet.org/images/uploads/Publications/OC936.pdf
3. Proceedings from June 11 Evidence-Based Practice/Cultural Competence Meetinghttp://cehd.umn.edu/ssw/g-s/ebp/culturalcompetence/webflash/bell.html

TUESDAY, MAY 19, 2009

9:00 AM-10:30AM

3. ISSUES IN THE DIFFERENTIAL DIAGNOSIS OF

CASE CONFERENCE

MILD TBI, PCS, AND PTSD IN SERVICE MEMBERS AFTER BLAST EXPOSURE IN COMBAT.

Moderator: Marvin Oleshansky, M.D., 2418 Round Top Dr, Honolulu, HI 96822-2069; Presenter: Elizabeth L. Brent, M.D.

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to diagnose mild traumatic brain injury(TBI), understand the role of blast exposure in producing brain trauma, postconcussive symptoms (PCS), and posttraumatic stress disorders (PTSD), and gain some mastery in the differential diagnosis and treatment of blast-related mild TBI, PCS, and PTSD.

SUMMARY:

Traumatic brain injury have been called the signature injury of the wars in Iraq and Afghanistan. In addition to the high frequency of traumatic brain injuries in Service Members (SMs) surviving the polytrauma of life threatening blast exposure, a population of SMs incur a concussion or mild traumatic brain injury (mild TBI) from the blast overpressure. These closed head injuries, often without any sign of visible injury, resemble blunt force trauma of falls, motor vehicle accidents, and sports injuries in their acute and occasionally chronic clinical course. The diagnosis of mild TBI requires a brief period of loss of consciousness or alteration of consciousness and/or a history of amnesia for a time shortly before or after the inciting event. Physical, cognitive, or emotional symptoms often follow the concussion and when present for a length of time beyond one month (ICD-10) or three months (DSM-IV) comprise a Post-Concussion Syndrome (PCS). PCS in soldiers after deployment is complicated by the stress of both prior combat experience and the psychological trauma of being exposed to a potentially life threatening event that was associated with the TBI. Posttraumatic Stress Disorder (PTSD) has many symptoms that overlap with PCS. Once a diagnosis of a concussion has been established with a fair degree of certainty, efforts should be made to clarify the expectation that most mild TBIs recover spontaneously and without evident cognitive, physical, or emotional difficulties. A small percentage of SMs with a mild TBI have persistent symptoms for one to three months and less than 5 percent are thought to have symptoms at one year. Several cases illustrating the clinical challenges in the differential diagnosis of mild TBI, PCS, and PTSD will be presented.

REFERENCES:

1. Jones E, Fear N, Wessely S: Shell shock and mild traumatic brain injury: A Historical Review, Am J Psychiatry 2007; 164:1641-1645
2. Jones E, Fear N, Wessely S: Shell shock and mild traumatic brain injury: A Historical Review, Am J Psychiatry 2007; 164:1641-1645
3. Hoge CW, Terhakopian A, Castra CA, et al. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq War Veterans. Am J Psychiatry 2007;164:150-153.
4. Hoge CW, McGurk D, Thomas JL, et al. Mild traumatic brain injury in U.S. Soldiers returning from Iraq. N Engl J Med 2008;358:453-463.

DEBATES

TUESDAY MAY 19, 2009

9AM-10:30 AM

APA OUR RELATIONSHIPS TO PHARMACEUTICAL COMPANIES: THE PROS AND CONS OF REFORM

Moderator: Paul McHugh, M.D.
Pro-side: Glenn Triesman, M.D. Ph.D.
Con-side: Thomas Finucane, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this debate, attendees should be able to:1) Describe a corrupt publishing strategy designed to promote the sale of a drug; 2) Discuss why the vendors of olanzapine have sent billions of dollars to plaintiffs; 3) Provide an example of how direct-to-consumer advertising has altered the behavior of clinicians without benefiting patients; 4) Give three examples of behaviors which have been manipulated without the subjects' awareness.

SUMMARY:

Industry spends billions on researchers, clinicians, and patients. Industry influences conception, design, conduct, analysis, writing, decisions to submit, and decisions to publish research studies. Industry has explicit strategies to promote the sales of their products by influencing clinicians. Most clinicians feel they are not influenced, but most are concerned that their colleagues are influenced. Osler said, "The desire to take medicine is the main thing that distinguishes man from the animals"; direct-to-consumer advertising panders directly to that desire. If our goal is to provide the best possible care to our patients, our relationships with industry must change.

REFERENCES:

1) Biol Psychiatry. 2008 Feb 15;63(4):424-34. Epub 2007 Sep 24. Comprehensive analysis of remission (COMPARE) with venlafaxine versus SSRIs.Nemeroff CB, Entsuah R, Benattia I, Demitrack M, Sloan DM, Thase ME.
2) Results, rhetoric, and randomized trials: the case of donepezil.Gilstad JR, Finucane TE. J Am Geriatr Soc. 2008 Aug;56(8):1556-62
3) The Neurontin legacy--marketing through misinformation and manipulation. Landefeld CS, Steinman MA. N Engl J Med. 2009 Jan 8;360(2):103-6. 4 New York Review of Books

RESOLVED: PSYCHIATRY SHOULD EMBRACE MEASUREMENT-BASED CARE

Moderator: John McIntrye, M.D.
Pro-side: Madhukar Trivedi, M.D., David Katzelnick, M.D.
Con-side: Robert Michaels, M.D., Harold Eist, M.D.

SUMMARY:

Measurement-based care (MBC) includes the measurement of disease specific symptoms, side effects and adherence and is coupled with clinical decision making at critical decision points. For example, STAR-D and other large scale effectiveness studies (RESPECT-D), IMPACT, have used depression symptom scales such as QIDS-SR and PHQ-9 as measures that guide treatment. Federally funded institutions and staff model HMO's have also begun to use such measures as part of routine treatment of depression. Effectiveness studies of treatment of depression and anxiety disorders have demonstrated improved outcomes with implementation of MBC compared to treatment as usual. Wide spread use of MBC in psychiatric and primary care however has not been achieved. Barriers include concerns that MBC could decrease psychiatrist's autonomy and require additional resources that in many healthcare systems are already stretched to the braking point. There is also fear that collection of patient level outcomes could be arbitrarily used to evaluate psychiatrist's performance. In this debate two teams of experts will debate the pros and cons of embracing MBC and implementing it into routine psychiatric care.

REFERENCES

1)Trivedi MH, Rush AJ, Gaynes BN, Stewart JW, Wisniewski SR, Warden D, Ritz L, Luther JF, Stegman D, Deveaugh-Geiss J, Howland R. Maximizing the adequacy of medication treatment in controlled trials and clinical practice: STAR(*) D measurement-based care. Neuropsychopharmacology. 2007 Dec; 32(12):2479-89.
2) Phillips A. Op-ed New York Times February 26th 2006; The Mind is a Terrible Thing to Measure.

MONDAY, MAY 18, 2009,

9:00AM-10:30AM

FOCUS LIVE! 1

GERIATRIC PSYCHIATRY

Moderator: Barry D Lebowitz, Ph.D., Department of Psychiatry, University of California, San Diego 9500 Gilman Drive, La Jolla, CA 92093-0664

EDUCATIONAL OBJECTIVE:

At the conclusion of this session, the participant should be able to: 1) Understand the neurocognitive and medical comorbidity parameters of late life disorders; 2) Appreciate the signficance of late life mental disorders re all cause mortality and 3) Evaluate the significance of family and social support networks in diagnosis and treatment.

SUMMARY:

The approach to psychiatric evaluation and diagnosis in older adults requires special attention to several issues in order to provide optimal care. There are important biological, psychological, and social changes associated with either aging itself or with generational differences. This presentation will address some of the most important aspects of assessment and diagnosis that make geriatric psychiatry a unique subspecialty, including age-related variability in the clinical presentation of common psychiatric disorders, assessment and diagnosis of cognitive disorders and medical comorbidity, and common psychosocial challenges faced by older adults. Although geriatric psychiatrists are uniquely positioned to address the complexities of psychiatric illness in older adults, the fact remains that the majority of older adults who seek psychiatric care will see general adult psychiatrists without subspecialty training. However, with continued vigilance to the issues discussed, psychiatrists from a variety of training backgrounds can skillfully assess and diagnose older adults confronting psychiatric illness.

REFERENCES:

1) Charney, D.S., Reynolds, C.F., III, Lewis, L., Lebowitz, B.D., et al. Depression and Bipolar Support Alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. Archives of General Psychiatry. 60: 664-672, 2003 [PMID: 12860770]

2) Meeks, T. W., Lanouette, N., Vahia, I., Dawes, S., Jeste, D.V., Lebowitz, B. Psychiatric assessment and diagnosis in older adults: an overview. Focus: the Journal of Lifelong Learning in Psychiatry. In press.

11:00AM-12:30PM

FOCUS LIVE! 2

ANXIETY DISORDERS

Moderator: Anand Pandya, M.D., Cedars-Sinai Medical Center, 8730 Alden Drive, Los Angeles, CA 90049

EDUCATIONAL OBJECTIVE:

As a result of participation in this interactive FOCUS Live workshop, participants will: 1) Review multiple choice questions; 2) Self-assess their knowledge of the clinical management of patients and 3) Have increased understanding of approaches to PTSD and Disaster Psychiatry in order to apply this knowledge to their own practice.

SUMMARY:

In the 7 years since the 9-11 attacks and the 4 years since Hurricane Katrina, American psychiatry has developed an increased interest in the psychiatric sequellae to disasters. This has helped the field to develop greater sophistication in epidemiology and in the treatment of individuals affected by disasters. Large scale tragedies underscore the increasing role that psychiatrists play in aiding survivors, emergency workers, and broader communities to cope with disaster. The field of disaster psychiatry, itself, needs to be understood in relationship to other areas of psychiatry such as trauma psychiatry and military psychiatry. Reactions to stress occur in stages, each one characterized by a specific psychological mechanism. This multiple-choice question based presentation will provide participants with an opportunity to test their knowledge about diagnosis and treatment of PTSD and about Disaster Psychiatry.In FOCUS Live sessions, expert clinicians lead lively multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

REFERENCES:

1) Pandya A: Adult disaster psychiatry. FOCUS 2009 2-in press

2) Benedek DM, Friedman MJ, Zatzick D, Ursano RJ: GUIDELINE WATCH (JANUARY 2009): Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. American Psychiatric Association. FOCUS 2009 2- in press

2:00PM- 5:00PM

FOCUS LIVE 3

ANXIETY DISORDERS: PANIC AND SOCIAL ANXIETY

Moderator: Mark H. Rapaport, M.D. Departtment of Psychiatry, Cedars-Sinai Medical Center, Los Angeles, CA

EDUCATIONAL OBJECTIVE:

As a result of participation in this interactive FOCUS Live workshop, participants will: 1) Review multiple choice questions; 2) Self-assess their knowledge of the clinical management of patients and 3) Have increased understanding of approaches to the treatment of Panic and Social Anxiety Disorders in order to apply the knowledge to their own practice.

SUMMARY:

Anxiety disorders are among the most common mental health

problems in the United States, affecting 18% of adults in a given year and almost 30% at some point during their lifetime. They are associated with a wide range of distressing psychological and somatic symptomatology, as well as disability across broad domains of work, social and family function. There are a number of effective pharmacological and psychosocial interventions with which to treat individuals affected by social anxiety disorder and panic disorder, although there remains a significant unmet need for more effective, well-tolerated, and readily administered interventions that can move more patients from symptomatic to remitted status. In FOCUS Live! sessions, expert clinicians lead lively multiple choice question-based discussions. Participants test their knowledge with an interactive audience response system, which instantly presents the audience responses as a histogram on the screen. Questions cover existing knowledge on a clinical topic important to practicing general psychiatrists, including diagnosis, treatment, and new developments.

REFERENCES:

1) DeLong H, Pollack MH: Update on the assessment, diagnosis, and treatment of individuals with social anxiety disorder. FOCUS 2008 6:431-437

2) Stein MB, Goin MK, Pollack MH, Roy-Byrne P, Sareen J, Simon NM, Campbell-Sills L; Work Group On Panic Disorder: American Psychiatric Association Practice Guideline For The Treatment Of Patients With Panic Disorder Second Edition. American Psychiatric Associaiton. 2009. http://www.psychiatryonline.com/pracGuide/pracGuideTopic_9.aspx

MONDAY, MAY 18, 2009

12:00AM-1:30PM

DSM-V: PROGRESS IN RESEARCH AND DEVELOPMENT (*DSM* TRACK)

Chairperson: Darrel A Regier, M.D., M.P.S., 1000 Wilson Blvd, Ste 1825, Arlington, VA 22209; Presenters: David Kupfer, M.D., Norman Sartorius, M.D., Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Better understand progress being made on revisions to the *DSM-V*; 2) Identify some of the basic ways in which these potential revisions may impact public health matters; and 3) Understand how possible revisions to *DSM-V* reflect the overall conceptual framework currently in place.

SUMMARY:

The process of assessing the research and clinical issues relevant to the future classification of psychiatric diagnoses has been in motion since the start of revision process in 1999 which resulted in the publication of A Research Agenda for DSM-V in 2002. In a second phase of the revision process, the American Psychiatric Institute for Research and Education (APIRE), in partnership with the NIH and the World Health Organization, recently completed the 5-year international series of 13 diagnostic conferences with a conference on public health aspects of psychiatric diagnosis, held in Geneva, Switzerland. The co-chair of the conference, Dr. Norman Sartorius, will be leading a later symposium describing the reports that came out of that conference. This forum will briefly highlight some findings from the public health conference, including possible revision strategies to the forthcoming edition of the International Classification of Diagnoses, ICD-11. The DSM-V Task Force has been fully operational for one year, and we have both Dr. David Kupfer, Chair, and Dr. Darrel Regier, Vice-Chair, presenting reports of *DSM-V* Task Force and Work Group members' progress to date. Specifically, following this forum will be a symposium on the cross-cutting issues that underlie the conceptual changes and approaches to DSM-V, which were recently presented at the 2009 annual meeting of the American Psychopathological Association. Finally, there are 13 D*SM-V* Work Groups currently active, and we will entertain questions about their progress to date. The next iteration of *DSM* is scheduled for release in 2012.

REFERENCES:

1. Kupfer DA, First MB, Regier DA (eds): A Research Agenda for DSM-V. Washington, DC, American Psychiatric Publishing, Inc., 2002.
2. Helzer JE, Kraemer HC, Krueger RF, Wittchen HU, Sirovatka PJ, Regier DA, eds. Dimensional Approaches in Diagnostic Classification: Refining the Research Agenda for DSM-V. Washington DC: American Psychiatric Publishing, Inc.; 2008.

MONDAY, MAY 18, 2009

11:00 A.M. - 12:30 P.M.

THE RELATIONSHIP BETWEEN THE APA ANNUAL MEETING AND THE PHARMACEUTICAL INDUSTRY: HISTORICAL AND CURRENT PERSPECTIVES AND ISSUES

Chairperson: Kenneth Silk, M.D., 4250 Plymouth Road, Ann Arbor, MI 48109; Presenters: Kenneth R. Silk, M.D., Cheong Josepha, M.D., Kelli Harding, M.D., Philip Muskin, M.D., M.A., Don Hilty, M.D., James Scully, Jr. , M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants willbe able: 1) appreciate the history of the interaction of the APA and the pharmaceutical industry at its Annual Meeting; 2) Learn of the adjustments that have taken place over the years, and those upcoming, to adapt to the changing expectations of physician-pharmaceutical company interactions; 3) Understand the difference between industry supported educational events in contrast to marketing and advertising paid to the APA.

SUMMARY:

The relationship between the APA's Annual Meeting and the Pharmaceutical Industry is a complex one. A this time of increased scrutiny of the relationships between the industry and academics and physicians, in general, this symposium will attempt to provide at closer look at the multiple ways the industry and the APA interact at the Annual Meeting. The presentations will cover (1) the overall philosophy of the APA towards pharmaceutical participation at the meeting, (2) the history of that partnership or collaboration between the APA and Pharma, including education and research, (3) quality control steps by the APA attempts to separate marketing from education related to Pharma, and (4) shifts in physician--Pharma relationships for trainees, faculty and the APA. New models for future collaboration (or not) shall be put forward.

REFERENCES:

1. Swann JP: Academic Scientists and the Pharmaceutical Industry. Cooperative Research in Twentieth Century America. Baltimore: The Johns Hopkins University Press, 1998
2. Moses H III, Braunwald E, Martin JP, Their SO: Collaborating with industry - choices for the academic medical center. NEJM 2002; 347: 1371-1375.

DEVELOPING THE NEXT GENERATION OF CLINICAL/TRANSLATIONAL RESEARCHERS: INNOVATIONS IN AN ACADEMIC DEPARTMENT OF PSYCHIATRY

Chairperson: Renee L. Binder, M.D., 401 Parnassus Ave. Box 0984, San Francisco, CA 94143-0984, Presenters: Renee Binder, M.D., Daniel Mathalon, Ph.D., M.D., Kristine Yaffe, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe methods to enhance clinical and translational research in departments of psychiatry

SUMMARY:

The Director of NIH has noted that "it is more and more difficult to recruit, mentor, and retain a critical mass of clinical and translational scientists." At the UCSF Department of Psychiatry, we have developed innovations that have facilitated efforts to enhance clinical and translational research and that can serve as a model for other academic departments of psychiatry. Dr. Renée Binder, Interim Chair of Psychiatry and Associate Dean of the School of Medicine, will describe initiatives to enhance clinical translational research including the development of research collaboration groups. Dr. Daniel Mathalon, Associate Professor of Psychiatry and Co-director of the Residency Clinical Research track will describe his efforts to recruit residents into a career projectory of clinical and translational research and his innovative methods of mentoring residents. Dr. Kristine Yaffe, Professor of Psychiatry, Associate Director of the Mentor Development Program at the UCSF Clinical and Translational Science Institute (CTSI), and former Co-director of the UCSF Clinical Translational Science Training, will discuss the School of Medicine's initiatives to foster Clinical/Translational Research Pathways and the opportunities that have been developed through the CTSI mentoring program to train the next generation of mentors.

REFERENCES:

1. Zerhouni EA: "Translational & Clinical Science – Time for a New Vision" N Eng J Med 353:15 1621-1623, October 13, 2005
2. Woolf SH: "The Meaning of Translational Research and Why It Matters" JAMA 299:2 211-213, January9/16, 2008

WOMEN WITH ALCOHOL DISORDERS: RESEARCH UPDATES FOR TREATMENT INNOVATION

Chairperson: Chang Grace, M.D., 75 Francis Street, Boston, MA 02115, Presenters: Nancy Goler, M.D., Shelly F. Greenfield, M.D., MPH, Lee Ann Kaskutas, Ph.D, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to describe four, evidence-based treatment innovations for women with alcohol use disorders.

SUMMARY:

The lifetime prevalence rate for alcohol use disorders in women is 19.5%. Most are not recognized to have drinking problems, and hence are untreated. The presentations will review cutting edge research findings involving treatment for women at the individual, program, and system levels.Using drink size to talk about drinking: An innovative assessment and feedback tool for measuring alcohol consumption that uses actual drinking glasses and a computer to calculate drink sizes will be introduced.Screening and brief intervention for risk drinking women: Results from a randomized trial of screening and brief intervention for women with medical problems known to be exacerbated by alcohol will presented. Gender specific treatment for women with substance abuse: Outcomes from a trial comparing a manual-based, women-focused group therapy with a mixed gender group drug counseling suggest that a woman-focused single-gender group treatment may enhance longer-term clinical outcomes among women with substance use disorders.Linking substance use counseling with prenatal care significantly improves outcomes for moms and babies: A new standard of care is operational in nearly 40 outpatient obstetric clinics, where there is universal screening for prenatal substance use and a licensed substance abuse expert on-site for assessment and treatment. The Early Start program has resulted in improved maternal and newborn health.

REFERENCES:

1. Kaskutas LA, Kerr WC. Accuracy of photographs to capture respondent-defined drink size. Journal of Studies on Alcohol and Drugs. 2008; 69: 605-10.Goler NC, Armstrong MA, Taillac CJ, Osejo VM. Substance abuse treatment linked with prenatal visits improves perinatal outcomes: a new standard. Journal of Perinatology. 26 June 2008, doi:10.1038/jp.2008.70.
2. Greenfield SF, Trucco EM, McHugh RK, Lincoln M, Gallop RJ. The women's recovery group: a stage I trail of women-focused group therapy for substance use disorders versus mixed-gender group drug counseling. Drug and Alcohol Dependence. 2007; 90: 39-47.

TUESDAY, MAY 19, 2009

11:00AM-12:30PM

ANXIETY IN PATIENTS WITH HIV: IMPORTANCE, AND DIAGNOSTIC AND TREATMENT CHALLENGES

Chairperson: Ramaswamy Viswanathan, M.D., 450 Clarkson Avenue, Campus Box 127, Brooklyn, NY 11203-2098, Presenters: Maria Tiamson-Kassab, M.D., Aparna Dole, M.D., Philip Bialer, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Appreciate the prevalence of anxiety disorders in patients with HIV, and their adverse psychosocial and medical impact; 2) Learn what issues to consider in prescribing or not prescribing anti-anxiety and hypnotic medications that carry the risk of abuse/dependence but hold the promise of help; and 3) Appreciate the importance of interdisciplinary and psychosocial treatment approaches.

SUMMARY:

Anxiety disorders are prevalent in patients with HIV and more prevalent than in the general population. Anxiety considerably adds to the illness and stigma burden of these patients, worsens quality of life, impairs adherence to antiretroviral treatment, and

leads to substance abuse and other risky behavior. Unfortunately, anxiety disorders often go unrecognized and untreated, and their significance is under-appreciated. The increased prevalence of substance abuse in patients with HIV creates uncertainties in many clinicians' minds about the wisdom of prescribing anti-anxiety and hypnotic medications that carry the risk of abuse/dependence but hold the promise of help when other treatment alternatives are not adequate. Much research on treatment of anxiety disorders specifically excluded patients with comorbid medical illnesses such as HIV, or patients with comorbid substance abuse/dependence. Hence it is not clear what modifications need to be made in the treatment of anxiety in this patient population. This workshop will address above areas, raise challenging issues faced by front line clinicians, and discuss how best to help patients with HIV with comorbid clinical anxiety.

REFERENCES:

1. Kerrihard T, Breitbart W, Dent R, Strout D: Anxiety in patients with cancer and human immunodeficiency virus. Seminars in Clinical Neuropsychiatry 1999; 4:114-132
2. Pence BW, Miller WC, Whetten K, Eron JJ, Gaynes BN: Prevalence of DSM-IV defined mood, anxiety, and substance use disorders in an HIV clinic in the Southeastern United States. Journal of AIDS 2006; 42: 298-303

BRIDGES AND BARRIERS TO CARE: CURRENT STRATEGIES WITH UNDERSERVED POPULATIONS

Chairperson: Mark H Townsend, M.D., M.S., 3450 Chestnut StreetThird Floor, New Orleans, LA 70115, Presenters: Khushro Unwalla, M.D., Jagannathan Srinivasaraghavan, M.D., Rahn Bailey, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify distinct populations at increased risk for poor psychiatric outcome and to name at least one intervention for each.

SUMMARY:

Individuals with psychiatric conditions, who are also members of ethnic, racial, or sexual orientation minorities, have distinct barriers to effective treatment. However, new methods can better identify and treat those who are most at risk. Our workshop examines clinical approaches that reflect the diversity of the populations themselves. One such population, lesbian, gay, and bisexual youth, is at an increased risk of homelessness, which itself confers greater medical and psychiatric morbidity. Successful programs have been developed to both restore stable housing and prevent physical and psychological harm. We will also discuss the relation among spiritual, religious and cultural beliefs in ethnic minority populations. Newer methods make use of these beliefs within specific populations and are more effective in promoting adherence to psychiatric treatment. The complex relation among gender, sexual orientation and HIV transmission within the African American community will be also presented. Men who have sex with men, but identify as heterosexual, are at increased risk of acquiring and transmitting HIV, as well as of developing concurrent psychiatric conditions. Women in sexual relationships with such men are also at elevated risk. New programs have successfully increased access to health care resources by reducing the stigma associated with homosexuality. Finally, we will bring an international perspective to this topic by presenting the effect of minority status on the mental health of individuals within South Asian populations.

REFERENCES:

1. Van Leeuwen JM et al. Lesbian, gay, and bisexual homeless youth: an eight-city public health perspective. Child Welfare, 2006; 85: 151-170.
2. Mutchler MG, et al. Psychosocial correlates of Unprotected Sex without Disclosure of HIV-positivity among Men Who Have Sex with Men and Women

NEW PERSPECTIVES ON CULTURAL ISSUES IN ALCOHOL TREATMENT

Chairperson: Barbara McCrady, M.D., 607 Allison Rd, Piscataway, NJ 08854-8001

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Describe the role of the social environment in substance use disorders; and 2) Discuss the role of the family in the recognition of drinking problems, the process of change, and maintenance of change.

SUMMARY:

Dr. McCrady will discuss of the role of the social environment in alcohol and other substance use disorders (SUDs) and examine the role of the family in the recognition of drinking problems, the process of change, and maintenance of change. Research suggests that family-involved treatment enhances positive treatment outcomes for men and women with SUDs. Family involved treatment includes interventions to increase family support for behavior change, increase positive exchanges in the family, and improve communication. Most family-involved treatment has been researched using fairly lengthy treatment protocols of 12-24 treatment sessions, but recent promising research supports the efficacy of briefer protocols of 1-6 sessions. This forum will address family interventions to improve compliance with treatment and the quality of family relationships. Other issues related to families, such as helping families when the alcohol dependent patient will not seek treatment, and dealing with issues of domestic violence, may be discussed depending on audience interests.

REFERENCES:

1. McCrady, B. S., Epstein, E. E., Cook, S., Jensen, N. K., & Hildebrandt, T. (2009). A randomized trial of individual and couple behavioral alcohol treatment for women. Journal of Consulting and Clinical Psychology, 77, 243-256.
2. McCrady, B. S. (2004). To have but one true friend: Implications for practice of research on alcohol use disorders and social networks. Psychology of Addictive Behaviors, 18, 113-121.

WEDNESDAY, MAY 20, 2009

11:00AM-12:30PM

HOW TO CHOOSE A TOPIC AND SUBMIT SUCCESSFULLY TO THE APA ANNUAL MEETING: UNDERSTANDING MEMBERS' INTERESTS AND DIFFERENT FORMATS

Chairperson: Don Hilty, M.D., 2230 Stockton Boulevard, Sacramento, CA 95817

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1)how to assess if their idea is suitable and doable for the APA Annual Meeting: 2)the differences in formats of the APA Annual Meeting; and 3)how to increase the likelihood of a successful submission

SUMMARY:

Attending and presenting at national meetings is a key learning and networking experience for academic and community psychiatrists. Knowing what meetings to attend and what the program is like, is essential in having a positive experience. Likewise, when considering a submission, it is important to know what topics are of interest to attendees, what formats are used and the methods to best ensure acceptance of the submission. This forum reviews general principles of submitting a good presentation, as well as the formats that the APA uses. These formats will be reviewed, in terms of their foci, methods and expected outcomes.

REFERENCES:

1. APA Annual Meeting web site at www.psych.org

WEDNESDAY, MAY 20, 2009

12:00 NOON - 1:30 P.M.

PSYCHIATRY IN AMERICA: AN EUROPEAN PERSPECTIVE

Chairperson: Pedro Ruiz, M.D., University of Texas Health Science Center at Houston, 1300 Moursund Street, Houston, Texas, TX 77030

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Learn about the perception of American Psychiatry in Europe; 2.) Understand the major difference of our American Psychiatric profession and the European psychiatric profession; and 3.) Learn how to address the problems faced by the profession in America.

SUMMARY:

Currently, the United States has become the leader in psychiatric organization in the whole world. The American Psychiatric Association (APA) with its close to 38,000 members, and the United States with about 50,000 psychiatrists represent the largest psychiatric association worldwide and the largest group of psychiatrists in any country of the world. Despite these impressive characteristics; the United States also depict some serious psychiatric and mental health weaknesses. For instance, the role of the pharmaceutical industry in the psychiatric profession; the lack of access to care due to close to 50 million Americans without insurance coverage; the serious negative impact of the lack of parity between psychiatry and other medical/surgical specialties in the United States; and other serious flaws that exist in the field of psychiatry in the United States. Despite these strengths and weaknesses, psychiatrists from American have not reflected enough on the perspectives that American Psychiatry reflect outside of the Untied States. In this workshop, the opinion about American Psychiatry from four psychiatric European leaders will be sought and discussed. Hopefully, as a result of this workshop American psychiatrists will learn to be more humble and more reflective vis-à-vis our successes and failures of American psychiatry.

REFERENCES:

1. Menninger RW, Nemiah JC (eds.): American Psychiatry After World War II - 1944-1994. Washington, D.C., American Psychiatric Press, Inc., 2000.
2. Desjarlais R, Eisenberg L, Good B, Kleinman A: World Mental Health: Problems and Priorities in Low-Income Countries. Oxford, England, Oxford University Press, Inc., 1995.

THE MILESTONES OF RECOVERY SCALE: TRACKING RECOVERY AND GUIDING SERVICES

Chairperson: Mark Ragins, M.D., 456 Elm Avenue, Long Beach, CA 90802-2426; Presenters: Leonard Miller, Ph.D., Dave Pilon, Ph.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand a new, brief assessment and outcome tool, the Milestones of Recovery Scale (MORS) based on risk, engagement, and skills and supports, 2) Understand the rationale and validation of the MORS, 3) Understand how the MORS is used as a tool of recovery-based program and system transformation, and 4) understand how the MORS can be used to guide service delivery decisions.

SUMMARY:

The Milestones of Recovery Scale (MORS) was developed by a group of staff, administrators, and people with mental illnesses from a variety of rehabilitation / recovery based programs in California (CASRA). The MORS is a one page tool with 8 Milestones that tracks people's recovery using 3 correlates of recovery - Risk, Skills and Supports, and Engagement - from Ex-

treme Risk all the way to Late Recovery. It is a person-centered tool that incorporates the values of the recovery movement. The presenters have done several studies validating the tool including correlating it with the LOCUS. It is simple enough to be used widely. For programs and systems working on recovery based transformation it describes recovery in a concrete, easily tracked manner. It can also be used as an outcome tool and may even predict service utilization. Los Angeles County DMH has decided to rate all 50,000 of their clients regularly and is using it as a tool of their transformation and system redesign. The MORS can be used clinically within programs to: 1.) Create a picture of individual and overall program caseloads; 2.) Assist with service delivery decisions; 3.) Assist in triage and choosing services to connect people to; and 4.) Assist in promoting flow through the program to reduce caseloads.

REFERENCES:

1. Recovery from Schizophrenia: A Concept in Search of Research Liberman and Kapelowicz, Psych Serv 56 (6): 735
2. Evolution of Outcome Measures in Schizophrenia T. Burns, Brit J. of Psych Aug 1, 2007 191 (50): s1-s6

THURSDAY, MAY 21, 2009

11:00 A.M. - 12:30 P.M.

FROM THE OTHER SIDE OF THE COUCH: A PSYCHIATRISTS VIEW AS A BREAST CANCER SURVIVOR

Chairperson: Ruksana Iftekhar, M.D., 3 Cooper Plaza Suite 307, Camden, NJ 08043, Presenters: Lloyd Alcera, M.D., Elisabeth Kunkel, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to; 1) Participants will learn impact of cancer on psychosocial lives; 2) Participants will understand reactions of therapist/psychiatrist to their cancer, treatments and complications and 3) Participants will learn transference - countertransference reactions and ways of dealing in a cancer surviving psychiatrist situation

SUMMARY:

The American Cancer Society in 2004 estimated "215,990 women would have invasive breast cancer and 59,390 women would suffer in situ breast cancer. About 15 to 25 percent experience clinical depression and 23 to 44 percent manifest anxiety. They report feelings of sadness, inappropriate guilt, feelings of worthlessness, loss of interest and pleasure, difficulty concentrating, marked slowness and agitation, insomnia, fatigue, changes in appetite, intrusive thoughts of death, death wish, suicidal feelings, nervousness or jitteriness, feelings of tension, panic, being afraid to close their eyes with fear they will never wake up again. Partners, family, and friends want desperately help but feel unsure and scared themselves" (Carolyn Kaelin). Once diagnosed with Cancer, a myriad of decisions are asked to be made. Cancer patients need to decide, surgical intervention, radiation and or chemotherapy. They struggle with the idea of preserving a sense of self. They need to "move on" with their lives by learning healthy and adaptive coping skills applied to their physical, social and emotional lives. A Psychiatrist dealing with cancer needs to contain the physical, emotional, familial and social aspects of their illness during treatment. They need to make use of new ways of thinking, understanding of life, illness and death in a constructive way. They need to recognize expressed, unexpressed, conscious, unconscious reactions from their patients and address them in a therapeutically useful way. Recognition of transference - counter transference feelings and handling them appropriately will enhance treatment. Special attention should be paid to boundary crossings during the early phases of psychiatrists' cancer. Monitoring of reactions of support staff to suffering physician's patients often is necessary. The panel of presenters will make use of their personal, professional, scholarly knowledge to illustrate these foundations.

REFERENCES:

1. Kaelin,M.D.,M.P.H, Carolyn M. Living through Breast Cancer: McGraw hill. 2005
2. Galgut, Cordelia. Breast cancer: Therapist On the Other Side. The Times Online, November 10, 2007

ACCULTURATION RELATED CHALLENGES IN MENTAL HEALTH TREATMENT OF ASIAN AMERICANS

Chair: Meena Ramani, M.D.
Presenters: Tarun Bhandari, M.D., Shivani Mehata, M.D., Jovita Crasta, M.D., Noumana Hameed, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Appreciate the challenges associated with mental health treatment in Asian American Population; 2) Identify appropriate therapeutic interventions for at risk populations; and 3) Address the intergenerational discrepancies between Immigrant parents and their American raised kids.

SUMMARY:

The Asian American community is one of the fastest growing communities and the mental health issues of this population are of utmost importance. Asian Americans are often referred to as "model minority" for their strong desire for success and value for hard work. However many of them have a great deal of difficulty fitting in despite their perceived success in the community. They often experience conflict between their own culture and that of their adopted land. This has been shown to cause increased stress eventually leadingto mental illness. To make

matters worse, there is a strong cultural reluctance to seek mental health treatment especially in the first generation immigrant population. Many South Asian Immigrants are slow to assimilate since they are apprehensive about losing their own identity and original culture. There is significant stigma attached to seeking mental health treatment. Family members see themselves as primarily responsible for the individual's care and dysfunction, but frequently lack the skills, knowledge and motivations to effect help. In order to develop an effective outreach program for Asian-American population and to provide culturally competent treatment we need to adopt a holistic approach integrating Eastern and Western sensitivities. Intergenerational Discrepancy has been historically used to describe the conflict that arises due to differential acculturation between immigrant parents and their US born children. Can therapist sensitivity and competency to these issues establish authentic connections and recovery? We explore the impact of acculturation, assimilation, cultural value systems and the mechanisms of bridging this ever-widening gap. This workshop presents an in-depth discussion of the available literature, relevant case studies with effective outreach and interventions to enhance our understanding of the challenges associated with mental health treatment of Asian Americans.

REFERENCES:

1. David T. Takeuchi, Nolan Zane, Seunghye Hong, David H. Chae, Fang Gong, , Gilbert C. Gee, Emily Walton, Stanley Sue, and Margarita Alegría:Immigration-Related Factors and Mental Disorders Among Asian Americans. American Journal of Public Health 2007; 97: 84-90
2. Barry, Declan T.; Grilo, Carlos M: Cultural, self-esteem, and demographic correlates of perception of personal and group discrimination among East Asian immigrants. The Journal of nervous and mental disease 2002;190(1):32-9

NEW TOOLS AND TRENDS: SMOKING CESSATION FOR PEOPLE WITH MENTAL AND SUBSTANCE USE DISORDERS

Chair: Steve Schroeder, M.D.,

SATURDAY, MAY 16, 2009

1:00 PM- 2:30PM

LECTURE 01

SIMON BOLIVAR LECTURE IN CONJUNCTION WITH THE AMERICAN SOCIETY OF HISPANIC PSYCHIATRISTS: PREVALENCE, CORRELATES, AND RISK OF POST TRAUMATIC STRESS DISORDER: HOW LATINOS FARE COMPARED TO NON-LATINO WHITES, ASIANS, AFRICAN AMERICAN AND AFRO-CARIBBEAN

Presenter: *Margarita Alegria, Ph.D.,*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: apply findings from PTSD research about reaction to trauma associated with a person's culture to the clinical care of patients.

SUMMARY:

Context: Epidemiologic studies of posttraumatic stress disorder (PTSD) have not usually included the prevalence and predictors of PTSD for diverse ethnic and racial populations. Objective: We assessed whether PTSD varies in prevalence, criteria endorsement, and patterns of risk among a nationally representative sample of non-Latino whites, Latinos, Asians, African Americans and Afro-Caribbean. Methods: Pooled data from the Collaborative Psychiatric Epidemiological Studies (n=13, 837) is used to generate nationally-representative prevalence estimates of lifetime PTSD and to identify correlates and conditional risk for PTSD for racial-ethnic groups. Results: In multivariate analyses, we find that Asians have lower adjusted rates of lifetime PTSD and African Americans have higher adjusted rates as compared to non-Latino whites. These differences arose from distinct patterns of trauma and endorsed criteria linked to PTSD among Latinos, Asian-Americans, African Americans and Afro-Caribbean. Asians, African Americans and Afro-Caribbean have lower risk of PTSD than non-Latino whites following a standardized worst-reported event. However, African Americans higher adjusted rates appear related to greater exposure to personal trauma. For Asians, exposure to and reactions to trauma appear to be less than for non-Latino whites.Conclusions: We discuss implications for clinical care, and consider how reactions to trauma are associated with a person's culture.

SUNDAY, MAY 17, 2009

2:00 PM- 3:30PM

LECTURE 02

MANFRED S. GUTTMACHER AWARD:PSYCHOPATHIC DISORDERS WITHOUT BORDERS

Presenter: *Alan R Felthous, M.D., Henning Sass, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Understand the commonalities and differences in European and North American concepts and classifications of psychopathic disorders; 2) Understand the principal arguments for and against involuntary treatment of individuals with psychopathic disorders; and 3) Compare selected countries' differing approaches to criminal responsibility and psychopathic disorders.

SUMMARY:

Every society must contend with psychopathically disturbed individuals, even if the usual "approach" is avoidance. Not only avoidance of the psychopathic disturbances themselves, but also avoidance of or at least remarkably little regard for how such disorders are conceptualized and for how the law addresses issues that involve psychopathically disturbed individuals in other countries. Concepts of psychopathic disorders have a common heritage and yet are quite different in Europe and North America. By comparing commonalities and differences in concepts and classifications, fresh questions arise about how such disorders are to be understood and addressed. Then further comparison between European and US approaches to psychopathic disorders, in such fundamental and universal societal tasks as assignment of criminal responsibility, setting criminal sentence, allowing for mental excuses to criminal sanction, providing effective criminal rehabilitation, protecting society from harm, selecting efficacious treatments and determining for which mental disorders civil commitment is appropriate, are instructive. Without providing definitive solutions to the various and vexing problems generated by individuals with psychopathic disorders, it is hoped that by focusing international attention on this spectrum of psychopathology, more thoughtful attention will be directed to these disorders which in turn will yield more effective responses than public policies characterized predominantly by avoidance.

REFERENCES:

1. Felthous AR, Sass H (Eds.). International Handbook on Psychopathic Disorders and the Law, Chichester, UK: Wiley, 2007.
2. Kroeber, H-L, Lau S. Bad or Mad? Personality Disorders and Legal Responsibility - The German Situation. Behavioral Sciences and the Law 18(5): 679-690,2000.
3.

MONDAY, MAY 18, 2009

9:00 AM-10:30AM

LECTURE 03

SOLOMON CARTER FULLER AWARD LECTURE: PILLS TO TREAT ALCOHOLISM

Presenter: *Bankole A Johnson, M.D., Ph.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to initiate office-based treatment for alcohol-dependent individuals while they are still drinking, and understand how specific medications may be useful for those who differ genetically.

SUMMARY:

Several medications have demonstrated efficacy as pharmacotherapy for alcohol dependence, a treatable disorder. Both the oral and depot formulations of naltrexone are efficacious and are FDA approved, but they have a small therapeutic effect size. The FDA also has approved acamprosate for the treatment of alcohol-

ism based on the small therapeutic effect size found in European studies, despite the lack of efficacy found in U.S. studies. The difference in findings between the European and U.S. studies on acamprosate may be due to differing populations or subtypes of alcohol-dependent individuals, or to sampling error resulting from the small effect size. Topiramate has demonstrated promise in treating alcohol dependence. Its therapeutic effect size, based on single-site and multi-site studies, is in the medium range, and currently it appears to be the most potent medication for the treatment of alcoholism. Serotonergic medications should be administered carefully to ensure that they are provided to the subtype of alcohol-dependent individual who will benefit the most from them. Ondansetron may be beneficial for early-onset (or Type B-like) alcoholics, whereas selective serotonin reuptake inhibitors can help late-onset (or Type A-like) alcoholics. Although disulfiram is FDA approved and has been used in the treatment of alcohol-dependent individuals for more than 50 years, it must be provided under supervision to guarantee efficacy. Baclofen appears to be a promising medication for treating alcoholism, particularly among those with liver cirrhosis, but larger scale controlled studies are needed for confirmation of these early findings. Neuroscientific advances will bring about the development of even more promising medications. Pharmacogenetic approaches continue to help us understand the underpinnings of differential therapeutic responses to various medications as individualized treatment for alcohol-dependent individuals becomes the norm.

REFERENCES:

1. Johnson, B.A., Roache, J.D., Javors, M.A., DiClemente, C.C., Cloninger, C.R., Prihoda, T.J., Bordnick, P.S., Ait-Daoud, N., Hensler, J.: Ondansetron for reduction of drinking among biologically predisposed alcoholic patients: a randomized controlled trial. JAMA: The Journal of the American Medical Association 284 (8): 963-971, 2000.
2. Johnson, B.A., Rosenthal, N., Capece, J.A., Wiegand, F., Mao, L., Beyers, K., McKay, A., Ait-Daoud, N., Anton, R.F., Ciraulo, D.A., Kranzler, H.R., Mann, K., O'Malley, S.S., Swift, R.M., for the Topiramate for Alcoholism Advisory Board and the Topiramate for Alcoholism Study Group: Topiramate for treating alcohol dependence: a randomized controlled trial. JAMA: The Journal of the American Medical Association 298 (14): 1641-1651, 2007.

MONDAY, MAY 18, 2009

9:00 A.M. - 10:30 A.M.

LECTURE 04

PSYCHIATRISTS' ROLE IN PREVENTION AND INTERVENTION IN DOMESTIC VIOLENCE AMONG

Presenter: *Surinder S Nand, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Identify unique cultural issues impacting domestic abuse among the South-Asians American population; 2) Develop an understanding of how one Domestic Violence [DV] Organization in a metropolitan city is helping victims of domestic abuse from this minority group; and 3) Learn various ways that psychiatrists can prevent and intervene in domestic abuse

SUMMARY:

Domestic Violence is a pervasive problem throughout the world. It is estimated that every seven seconds a woman is abused and that one woman in four experiences domestic abuse at some stage in her life. Approximately 3-4 million women are battered every year while 8-12 million are at risk for abuse. It is estimated that 95% of abuse is perpetrated by family members. Women are abused in all races, religions, socio-economic classes and cultures. Domestic abuse is an even serious problem among minority populations with enormous effects on physical and mental health of victims as well as huge economic costs to the society. Although South Asian Americans are considered a 'Model Community' they have their share of domestic abuse. The presenter will highlight the unique socio-cultural and religious issues impacting domestic abuse in this group. She will discuss the myths about domestic abuse in this community. She will present the work of one organization called 'Apna Ghar' [Our Home] in Chicago which provides a variety of services and programs to survivors of domestic abuse. Using her involvement with this organization as an example, she will discuss how psychiatrists may get involved in prevention of domestic violence, as well as provide interventions to survivors of domestic violence.

REFERENCES:

1. Nankani S. Breaking the Silence: Domestic Violence in South Asian -American Community. Xlibris Corp, 2001
2. Gupta J, Upadhyay U.D., Gupta N -Domestic Violence in South Asian American Community -Chapter 7 in Domestic Violence in Asian American Communities : A Cultural Overview , Ed Tuyen D Nguyen, Lexington Books

MONDAY, MAY 18, 2009

9:00 A.M. - 10:30 A.M.

LECTURE 05

PSYCHIATRIC GENETICS A CURRENT PERSPECTIVE

Presenter: *Kenneth Kendler, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant will be able to: 1) Understand the four paradigms of psychiatric genetics their strengths and limitations; 2) Understand the two major ways genetic and environmental risk factors can inter-relate with each other: gene-environmental interaction and gene-environment correlation; and 3) Be familiar with new methods of molecular genetics being applied to psychiatric disorders: copy number variations (CNVs) and genome wide association studies (GWAS).

SUMMARY:

Lecture will begin with an elaboration of the four major paradigms in psychiatric genetics: simple genetic epidemiology, advanced genetic epidemiology, gene-finding methods, and molecular biology. The strengths and limitations of each of these methods will be outlined, as well as their inter-relationships. Pertinent illustrations are provided for the first three paradigms with a review of the heritability of the major psychiatric disorders

and a review of a selected set of findings from advanced genetic epidemiology including: 1) multivariate modeling that examines the role of genes in explaining the patterns of co-morbidity in psychiatric disorders; 2) adding time into genetic models to clarify the developmentally dynamic nature of gene action in psychiatric illness; 3) genotype-environment interaction and 4) genotype-environment correlation. Examples will be provided of integrated etiologic models incorporating multiple environmental risk factors into genetically informative designs. The section on gene-finding methods has a brief review of association and linkage methodologies as applied to complex traits and discuss the conceptual issue of what it means to have a "gene for" a disorder. Such phraseology, although commonly used in the professional and lay literature, is probably inappropriate for genetic influences on psychiatric illness. Review the efforts to map—using linkage analysis—susceptibility genes for schizophrenia; and follow through the story on one potential positional candidate gene, Dysbindin. Followed by questions of what the unit of replication is in these analyses, that is: the allele at a marker, that individual marker, the haplotype or the gene itself. The current status of the findings in Dysbindin will be discussed and the problems with the interpretation of the heterogeneous results. The conclusion is a review of very recent developments of the application to psychiatric disorders of studies involving copy number variation, genome wide association studies and bio-informatics.

REFERENCES:

1. K. S. Kendler. Psychiatric genetics: A methodologic critique. American Journal of Psychiatry 162 (1):3-11, 2005.
2. K. S. Kendler and Eaves L.J. Psychiatric Genetics (Review of Psychiatry), American Psychiatric Association, 2005. 256 pages.

MAY 18, 2009

9:00 A.M. - 10:30 A.M.

LECTURE 06

ETIOLOGY IN PSYCHIATRY: PHENOMES, GENOMES AND EPIGENOMES

Presenter: *James B Potash, M.D., M.P.H.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session the participant should be able to: 1) Define phenotypic subtyping strategies in mood disorders that might yield greater genetic homogeneity; 2) Name older and newer approaches to scanning the genome for susceptibility variants in psychiatric disorders; and 3) Understand the concept of the epigenome and how it might apply to psychiatry

SUMMARY:

Family, twin, and adoption studies have made it abundantly clear that genes play a major role in many psychiatric disorders. However, molecular genetics studies over 20 years have, until recently, provided less definitive insight than one would hope into disease etiology. Now, new approaches and novel, powerful technologies are combining to shed new light on ways in which genetic factors and their regulation influence psychiatric illness. In this lecture, we will focus on three aspects of this work: phenomes, genomes, and epigenomes. The phenomic approach refers to the delineation of all known clinical and biological features associated with disorders. We have used this approach in bipolar disorder to investigate whether subtypes of the illness might be more genetically homogeneous than the broader disorder. Our studies of bipolar disorder incorporating age at onset, attempted suicide, and psychotic features into linkage analyses and association analyses have provided promising candidate chromosomal regions and genes for these features or subtypes of illness. Technologically, the microarray has allowed for high density screening of the genome. Close to one million genetic variants can be studied in a single experiment in a Genome-Wide Association Study (GWAS). We have applied this approach to bipolar disorder and to major depression. The same microarray technology can be used to study chemical modifications of DNA, called epigenetic marks, across the whole genome, yielding data on the epigenome. We are studying the epigenome in the brain as compared to other tissues, across disparate brain regions, and in several psychiatric disorders. Because epigenetic marks, which regulate gene expression, can be changed by environmental factors, they may represent a point of integration between genetic vulnerability and experience.

REFERENCES:

1. Potash JB, Toolan J, Steele J, Miller EB, Pearl J, Zandi PP, Schulze TG, Kassem L, Simpson SG, Lopez V, MacKinnon DF, McMahon FJ. The bipolar disorder phenome database: a resource for genetic studies. Am J Psychiatry 2007; 164:1229-1237.
2. Ladd-Acosta C, Pevsner J, Sabunciyan S, Yolken RH, Dinkins T, Callinan PA, Fan JB, Potash JB*, and Feinberg AP. DNA methylation signatures within the human brain. Am J Hum Genet 2007;81:1304-15. *corresponding/co-senior author

11:00 AM-12:30PM

LECTURE 07

GEORGE TARJAN AWARD LECTURE: PSYCHIATRIC EDUCATION ACROSS CIVILIZATIONS: THE SEARCH FOR GURU

Presenter: *Nyapati R Rao, M.D., M.S.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To provide participants with an overview of psychosocial and communicational issues that influence psychiatric training and practice in the USA, and consequently, maximize their potential for success in American Psychiatry; 2) Recognize the cultural factors that influence international medical graduate's performance in residency trainings; and 3)Promote a better understanding of how culture influences interactions with patients/teachers/healthcare providers

SUMMARY:

International Medical Graduates (IMGs) comprise 32.4% of General Psychiatric residents, and 27.5% of members of the American Psychiatric Association. They are a heterogeneous group with different cultural, linguistic and medical educational

backgrounds. This heterogeneity creates substantial challenges for American faculties as teachers, as well as for the individual IMG residents as learners. Professional literature, such as it is, has catalogued many problems IMGs face, but has remained largely silent on explicating those problems. In this presentation, taking the case of Asian-Indian IMGs as an example, the speaker focuses on the cultural factors that influence IMGs performance in residency training. He posits that immigration induces in the resident affective, identity and cognitive disturbances –called culture shock, which may hamper his/her performance. Resolution of culture shock is a prerequisite for residents' successful training as psychiatrists and their eventual integration into the host culture. In this context, the IMG resident has two simultaneous tasks to contend with-resolution of the culture shock and adaptation to the requirements of training. Training programs may view manifestations of this struggle mainly as educational shortcomings and fail to appreciate the phase-appropriate cultural conflicts of the IMG. One such conflict is fear of failing in residency and the IMG may attempt to deal with it through a search in his/her supervisors for a Guru who is invested with considerable authority and wisdom in Hindu worldview, and who uncritically accepts his students' dependency needs and provides knowledge and guidance.

REFERENCES:

1. Neki JS: Guru-Chela Relationship: The Possibility of a Therapeutic Paradigm. Amer J. Orthopsych. 43(5):10: 755-766,1973
2. Ursano AM, Kartheiser PH, Ursano RJ: The Teaching Alliance: A Perspective on the Good Teacher and Effective Learning. Psychiatry, 70(3), 187-194,2007

MAY 18, 2009

11:00 A.M. - 12:30 P.M.

LECTURE 08

MENTAL HEALTH CARE IN THE NEW ERA OF COST CONTAINMENT

*Presenter***:** *Richard G Frank, Ph.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the drivers of mental health spending, trends in the quality of mental health care and key choices facing policy makers

SUMMARY:

For most of the past 30 years mental health spending has claimed a constant share of the nation's income (GDP). More recently mental health spending has been growing more quickly than national income. Behind these trends are rather dramatic shifts in the structure of how money is spent on mental health care. In this lecture I document the trends, identify the drivers of the trends,and assess the implications for consumers of services and providers of care. A set of brief suggestions are made for altering policies to address existing problems in mental health care delivery.

REFERENCES:

1. Frank RG and SA Glied; Better But Not Well, Baltimore: Johns Hopkins University Press
2. Frank RG, HH Goldman and TG McGuire,"Interpreting Patterns of Mental Health Cost Growth" Health Affairs (In Press)

MAY 18, 2009

11:00 A.M. - 12:30 P.M.

LECTURE 09

THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS

*Presenter***:** *Elyn Saks,*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand better what a psychotic episode is like from the inside, so to speak; 2) To understand better the kinds of intervention that may help someone with a psychosis.

SUMMARY:

Professor Saks is someone with schizophrenia who was given "very poor" and "grave" prognoses. She was expected to be unable to live independently, let alone to work. Yet that is not how her life turned out. This talk will narrate the history of Professor Saks' struggles with schizophrenia, punctuating the narrative with passages from her memoir, "The Center Cannot Hold: My Journey Through Madness." Professor Saks hopes to give her listeners a window inside the mind of someone suffering from psychosis, as well as a sense of what kinds of interventions were helpful to her. The talk will then draw some possible policy implications of her story, recognizing that Professor Saks is an "n" of only one.

REFERENCES:

1. Saks, Elyn R., The Center Cannon Hold, (2007) Published by Hyperion Books.

MAY 18, 2009

2:30 PM- 3:30PM

LECTURE 10

SUCCESSFUL AGING AND WISDOM: ARE THESE FOR REAL?

Presenter: Dilip V. Jeste, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Recognize predictors of successful aging, including those in people with mental illnesses; 2) Understand the concept of wisdom, and 3) Learn about evidence-based strategies for successful cogntive and emotional aging.

SUMMARY:

The next 25 years will witness the largest-ever increase in the numbers of elderly, and especially, those living highly functional lives. Yet, research on such "successful aging" has lagged behind

that on age-related diseases. Although it involves both mental and physical health, the critical component of successful aging requires a healthy brain and mind. This presentation will cover definition, prevalence, genetic markers, lifestyle factors, and other correlates of healthy aging as well as possible ways of enhancing the likelihood of successful aging. The Stein Institute for Research on Aging at UCSD has been conducting studies of successful aging in several thousand community-dwelling seniors ranging in age from 60 to 102. Our results suggest that a majority of the respondents feel that they are aging well, often despite physical illnesses and disability. Significant associations of successful aging include an absence of depression, high overall level of physical and cognitive activities, number of friends, resilience, and a positive attitude toward aging. On other hand, ethnicity, gender, education, income, and number of physical illnesses have no significant relationship with successful aging. I will also discuss the concept of wisdom as described from the ancient to the modern times, and review the limited empirical research in this area, including its relation to successful aging. Wisdom is a uniquely human complex trait with several subcomponents including knowledge of life, emotional regulation, insight, pro-social behavior, value relativism, and acting in the face of uncertainty. I will present a putative neurobiological model of wisdom, and suggest ways of conducting further research.

REFERENCES:

1. Montross LP, Depp C, Daly J, Reichstadt J, Golshan S, Moore D, Sitzer D, and Jeste, DV: Correlates of successful aging among community-dwelling older adults. American Journal of Geriatric Psychiatry 14:43-51, 2006
2. Meeks TW and Jeste DV: Neurobiology of wisdom?: An overview. Archives of General Psychiatry (in press, 2008).

MONDAY, MAY 18, 2009

5:30 PM- 6:30PM

LECTURE 11

WILLIAM M. MENNIGER CONVOCATION LECTURE

Presenter: Abe Verghese, M.D.

SHORT BIO:

Abraham Verghese, M.D., attended the Iowa Writers Workshop in 1990 at the University of Iowa, where he obtained a Master of Fine Arts degree. At the time he had taken a sabbatical from an active AIDS practice. His first book, My Own Country, about AIDS in rural Tennessee, was a finalist for the National Book Critics Circle Award for 1994 and was made into a movie. His second book, The Tennis Partner, was a New York Times Notable Book and a national bestseller. Dr. Verghese's riveting first novel, published by Knopf, appeared in bookstores in February 2009. Cutting for Stone – described as "intensely suspenseful, deeply moving, and unexpectedly funny – it is both an unforgettable journey into one man's astonishing life, and a story about the power, intimacy, and curious beauty in the work of healing others. An epic story of love, country and medicine, it weaves a story that is hard to put down." He has published extensively in the medical literature, and his writing has appeared in The New Yorker, Sports Illustrated, The Atlantic, Esquire, Granta, The New York Times Magazine, The Wall Street Journal, and elsewhere. Dr. Verghese is now Senior Associate Chair and Professor of the Theory and Practice of Medicine in the Department of Medicine at Stanford University. From 2002 to 2007, he was the Director of The Center for Medical Humanities & Ethics at the University of Texas Health Science Center San Antonio (UTHSCSA), where he held the Joaquin Cigarroa Jr. Chair in Medicine and was the Marvin Forland Distinguished Professor of Ethics. He has an appointment as an adjunct Professor at UTHSCSA. From 1991 to 2002, he was a professor of medicine at the Texas Tech University Health Sciences Center, El Paso where he held the Grover E. Murray Distinguished Professorship. He is board certified in internal medicine, pulmonary diseases, and infectious diseases. He serves on the Board of Directors of the American Board of Internal Medicine. He is acclaimed as a dedicated and inspiring teacher of medicine at the bedside, and a sough-after clinician and diagnostician.

TUESDAY, MAY 19, 2009

9:00 AM-10:30AM

LECTURE 12

JOHN FRYER AWARD - WITHDRAWN

TUESDAY, MAY 19, 2009

9:00 A.M. - 10:30 A.M.

LECTURE 13

LECTURE 13-MODULES OF THE MIND: DEVELOPING A POSITIVE PSYCHIATRY OF THE PERSON

Presenter: C. Robert Cloninger, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to understand the unique properties of human self-aware consciousness. The participant will see how cognitive schemas are comprised of a small number of functional components that give rise to multifaceted syndromes of mental health or illness. This provides a quickly learned approach to assessing the natural building blocks of human thought in a way that is not stigmatizing and that fosters therapeutic human relationships.

SUMMARY:

Psychiatry has long sought a way of describing and classifying mental disorders according to the natural building blocks of human thought. Success requires attention to the unique functional organization of human consciousness. Self-aware consciousness is intuitive, modular, and self-organizing. Human thought begins as a holistic set of cognitive schemas that direct our attention and organize the emotions, meanings, and values associated with our perceptions. Our initial perceptions make us vulnerable to psychopathology or allow us to adapt in ways that are healthy and satisfying. Recently I have extended my model of personality to account for the fact that human beings can change their thoughts and perceptual state of mind in self-awareness many times per

second. I discovered that the hundreds of syndromes called mental disorders in DSM emerge systematically as dysfunctions of a small set of functional modules of self-aware perception. Healthy functioning of the components of self-aware perception correspond closely to nine classical virtues: the appetitive virtues of courage, justice, and moderation, the intellectual virtues of honor, wisdom, and wonder, and the spiritual virtues of love, hope, and faith. Each of these functional forms can be expressed in several variant modes that specify the elements of mental health or illness in traditional diagnostic criteria. In this lecture I will describe how a modular model of self-aware perception provides a powerful way to measure and classify the full range of mental health and its dysfunctions. The focus on the strengths of each person reduces stigma and fosters therapeutic human relationships.

REFERENCES:

1. Cloninger CR. Feeling Good: The Science of Well-Being. Oxford University Press, 2004
2. Cloninger CR. The Science of Well-Being: An integrated approach to mental health and its disorders. World Psychiatry 2006; 5:71-76.

TUESDAY, MAY 19, 2009

9:00 A.M. - 10:30 A.M.

LECTURE 14

BORDERLINE PERSONALITY DISORDER: BIRTH PAINS OF THIS STILL-NEW DIAGNOSIS

Presenter: *John G Gunderson, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)to see how the trials and tribulations in the development of the borderline diagnosis reflects changes within and 2)to learn how early conceptions and attitudes towards borderline have unfairly stigmatized them.

SUMMARY:

This presentation will describe the development of borderline diagnosis emphasizing the significant obstacles to its acceptance (i.e. its "birth pains") and highlighting the contributions -- and the personalities -- who have helped establish its current and still fragile status within our classification system. Tracing the development of this diagnosis will be accompanied by descriptions of the associated changes within psychiatry and in my own professional growth. The ontogeny of this diagnosis begins in the era before the term was used clinically -- when "borderline" was a psychoanalytic colloquialism used for untreatable neurotics or quasi-psychotics. In the decade from 1970-1980 the borderline concept changed from a form of personality organization into a phenomenological syndrome and the boundary shifted from schizophrenia to depression. These changes came with the new problem: Akiskal's famous complaint that "borderline" was stilly only "an adjective in search of a noun". From 1980-1990 the borderline personality disorder entered *DSM*, descriptive research proliferated, and the new boundary problem became PTSD. Stilly, the diagnosis already carried such pejorative meanings (manipulative, treatment resistant) that, to many clinicians "wisdom was never calling a patient borderline". By the 1990's BPD was struggling to find a place within the biological paradigm that by then increasingly dominated psychiatry. It's lack of a specific pharmacological treatment both undermined its usage and fueled doubts about its integrity. Yet specific empirically validated psychological treatments, most notably DBT, fueled a new wave of therapeutic optimism and underlying "psychobiological dispositions" to the borderlines impulse and affect problems were identified. The current decade has been marked by unexpected discoveries of high heritability (59%) and of being "a good prognosis diagnosis". Both discoveries represent basic reversals of longstanding and deeply entrenched beliefs. Both discoveries also signaled the benefits that could derive from adequately funded research. At present, borderline personality disorder has the legitimacy of good scientific validation and the acceptance by both NAMI and NIMH. Yet psychiatry has continued to ignore or disparage this highly prevalent treatment-seeking sector of our clinical domain. Propelled by public advocacy, in 2008 the US Congress passed a resolution calling for more awareness of this extraordinarily dis

REFERENCES:

1. Gunderson JG, Links P. Borderline Personality Disorder: A Clinical Guide. Second Edition. Washington, DC. American Psychiatric Press, Inc. 2008
2. New AS, Goodman M, Triebwasser J, Siever LJ: Recent advances in the biological study of personality disorders. Psychiatr Clin N Am 2008; 31:441-461

TUESDAY, MAY 19, 2009

11:00 AM-12:30PM

LECTURE 15

KUN-PO SOO AWARD - CROSS-CULTURAL PSYCHOPHARMACOLOGY: SHAPING OUR FUTURE VIA BRIDGING SCIENCE AND SERVICE

Presenter: *Edmond H Pi, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) recognize cross-cultural factors play a role in the ethnic responses to psychotropic medications; 2) understand the roles of pharmacogenetics, pharmacokinetics, and pharmacodynamics in cross-cultural psychopharmacology; and 3) select the best psychotropic medications for patients of different ethnic and cultural backgrounds.

SUMMARY:

Over the past four decades, clinical observations and survey findings have repeatedly suggested the existence of cross-ethnic and cross-national differences in the dose requirement and side effect profiles of all major classes of psychotropic medications as well as a variety of other pharmacological agents. There are now data generated from systematic, vigorously, and scientifically designed studies of psychotropic medications probing the under-

lying mechanisms and clinical significances of pharmacokinetic and pharmacodynamic differences from a cross-cultural perspective. Ethnic differences in pharmacokinetics have further been demonstrated to be caused by genetic factors in some circumstances and environmental factors in others. As the process of "globalization", including the increasing mobility of population and migration of people to different locations/countries/continents, is swiftly moving forward, now, the societies have become much more diverse in terms of ethnicity and culture than ever before. A better understanding of cross-cultural perspective in psychopharmacology has become an essence for clinicians who treat an increasing number of psychiatric patients from different ethnic and socio-cultural backgrounds. This lecture will address the needs to shape our future in cross-cultural psychopharmacology via bridging science and service by understanding the scientific findings in the field as well as their clinical implications. These include a special focus on recent research on ethnic variations in the activity of some of the most important drug-metabolizing enzymes, genetic mutations responsible for such variations, as well as their relationship with drug responses and toxicity. This lecture will place a special emphasis on an integrative approach in which both ethnic or cultural diversity and biological diversity are taken into account and treatment is tailored to specific individual characteristics. Also, recommendations regarding how to follow the basic principles of rational psychopharmacotherapy (viz., to maximize the therapeutic effects and minimize the adverse effects) will be presented, so that physicians will be able to select the best pharmacotherapy considering target symptoms and side effects profile for psychiatric patients of different ethnic and cultural backgrounds.

REFERENCES:

1. Pi EH and Simpson GM: Cross-Cultural Psychopharmacology: A Current Clinical Perspective. Journal of Psychiatric Services, 56:31-33, 2005
2. Pi EH and Zhu WG: New Research Advances in Ethnopsychopharmacology: An Asian Perspective. Journal of International Psychiatry, 4:57-58, 2007

TUESDAY, MAY 19, 2009

11:00 A.M. - 12:30 P.M.

LECTURE 16

HOW ALCOHOLISM DEVELOPS: IDENTIFICATION OF GENETIC AND ENVIRONMENTAL INFLUENCES IN A 25 YEAR LONGITUDINAL STUDY

Presenter: Marc Schuckit, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of the session, participants will: 1) understand more about how genetic influences operate in complex psychiatric disorders; and 2) understand more regarding how models of risk for psychiatric conditions benefit by including both biological and environmental/psychological variables regarding how the disorders develop over time.

SUMMARY:

This presentation reviews recent findings from a 25-year prospective study of about 450 middle-class families, half of which have a history of alcohol dependence. The work began by identifying a 20-year old male subject who had experience with alcohol but was not alcohol dependent, and progressed by incorporating spouses and children as they entered the family. The population was evaluated approximately every five years to identify and observe over time genetically-influenced characteristics that relate to the alcoholism risk. The project has identified genes that may reflect an enhanced alcoholism risk that operates through a low level of response (or low sensitivity) to alcohol. We have also evaluated how the characteristic and associated genes relate to additional life domains such as the drinking practices of peers, a person's attitude toward drinking, ways of coping with stress, and additional characteristics in contributing to heavier drinking and alcohol problems. The emphasis of the presentation is on the most recent genetic findings regarding the low response to alcohol and observations about how this response relates to additional life elements across samples.

REFERENCES:

1. Schuckit MA: An overview of genetic influences in alcoholism. Journal of Substance Abuse Treatment 36:(1)S5-14, 2009.
2. Schuckit MA, Smith TL, Trim R, Kreikebaum S, Hinga B, Allen R: Testing the level of response to alcohol-based model of heavy drinking and alcohol problems in offspring from the San Diego Prospective Study. Journal of Studies on Alcohol and Drugs 69:571-579, 2008.

TUESDAY, MAY 19, 2009

11:00 A.M. - 12:30 P.M.

LECTURE 17

WHEN POLITICS DISTORTS SCIENCE: A PSYCHIATRIST REPORTS FROM THE TRENCHES OF THE CULTURE

Presenter: *Jack Drescher, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, participants should be familiar with both historical and contemporary examples of distorting scientific findings to achieve political goals. The participant will learn how scientific findings are used and misused in the contemporary "culture wars." Participants will learn how media routines used to report about science are exploited by political advocacy groups.

SUMMARY:

In 2007, former Surgeon General Richard Carmona testified that political pressures to distort science impeded his office's efforts to educate the public about stem cell research, sex education, emergency contraception, global climate change, prison mental health services, and secondhand smoke. In matters of public health, the influence of special interests challenging scientific findings is cause for concern. Deliberately distorting findings for personal or political reasons can serve to undermine the entire scientific enterprise. Furthermore, research created solely to support nonscientific agendas raises the question of whether science can survive in an environment of politicization at all. Yet

new scientific findings have evoked political responses throughout history. Galileo Galilei's scientific claim that the earth revolved around the sun challenged 17th century church doctrine. The 19th century findings of Charles Darwin were at the center of the 20th century's sensationalized Scopes Monkey Trials. Yet while most people of faith now accept Galileo's once-heretical findings, Darwin's theory remains a contentious issue in the contemporary social debates known as the "culture wars." This presentation provides examples of how politicized, special interest groups exploit "media routines," methods of media outlets to report stories, to distort scientific findings. Techniques include paid advertisements to create stories about science, as well as framing complex scientific issues in polarizing, black and white terms to be debated by competing advocacy groups. The goal in using the media is to influence the public's perception of scientific issues in ways that will influence the development and implementation of public policies. The presentation concludes by offering ways in which professionals can get more involved, both the local and national levels, when confronted by political efforts to misrepresent scientific findings and research.

REFERENCES:

1. Drescher, J. & Zucker, K.J., eds. (2006), Ex-Gay Research: Analyzing the Spitzer Study and Its Relation to Science, Religion, Politics, and Culture. New York: Harrington Park Press.
2. Lund, S. & Renna, C. (2003), An analysis of the media response to the Spitzer study. J. Gay & Lesbian Psychotherapy, 7(3):55-67.

TUESDAY, MAY 19, 2009

2:00 PM- 3:30PM

LECTURE 18

THE MOVEMENT FOR GLOBAL MENTAL HEALTH: WHY YOU SHOULD JOIN

Presenter: *Vikram Patel, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participants will be informed about disparities in MH treatment and a global coalition to improve clinical services for people with mental disorders worldwide.

SUMMARY:

In recent years, much has been written about the large 'treatment gap' for mental disorders. Even in countries with substantial mental health resources such as the USA, between a third and half of all persons with serious mental disorders do not receive adequate mental health care. In Africa and Asia, this proportion approaches a staggering 90% in some countries. The human rights of people with mental disorders are routinely compromised and denied. The Lancet Series on Global Mental Health, published in September 2007, sought to refocus the attention of the global health community on the treatment gap using scientific evidence to make a sound basis for advocacy. The Lancet Series called for action to scale up an evidence-based package of services for people with mental disorders combined with a commitment to protect the human rights of those affected by mental disorders. The mhGAP, the WHO's new flagship program on mental health, was launched on October 9th, 2008 in response to this call for action. MhGAP seeks to scale up evidence based packages of care for eight mental and neurological disorders. On October 10th, 2008, the Movement for Global Mental Health was launched (www.globalmentalhealth.org). The Movement for Global Mental Health aims to improve services for people with mental disorders worldwide. In so doing, two principles are fundamental: first, the action should be informed by the best available scientific evidence; and, second, it should be in accordance with principles of human rights. Drawing inspiration from the iconic Treatment Action Campaign which transformed global action for access to care for people living with HIV/AIDS, the Movement is an effort to build a grand global coalition of the diverse actors in mental health care to ensure that mental health care is made available to all those who need it. This lecture will discuss some of the critical actions that the Movement will support to it takes its place alongside those promoting HIV/AIDS treatment and maternal and child survival, and is identified as one of the great public health successes of our times.

REFERENCES:

1. Lancet Global Mental Health Group. Scaling up services for mental disorders-a call for action. Lancet 2007;370:1241-1252.
2. Patel V, Garrison P, de Jesus Mari J, Minas H, Prince M, Saxena S. The Lancet's series on global mental health: 1 year on. Lancet 2008;372(9646):1354-7.

TUESDAY, MAY 19, 2009

2:00 P.M. - 3:30 PM.

LECTURE 19

TRANSLATIONAL NEUROSCIENCE OF SCHIZOPHRENIA

Presenter: *Akira Sawa, M.D., Ph.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To provide the information of how patient tissues/cells are utilized for discovery of objective disease-associated biomarkers (diagnosis, prognosis, and treatment response) and mechanistic understanding of the disease ; 2) To provide the information of how molecular and system biology stemming from genetic susceptibility factors can contribute to mechanistic understanding of the disease and generation of genetic animal models for schizophrenia; and 3.To provide the idea of how animal studies and studies with human cells/tissues can be integrated for translational neuroscience of mental disorders.

SUMMARY:

It has been very difficult to approach schizophrenia from biology viewpoint, because of lack in molecular neuropathological clues. Recent advance in human genetics has finally provided us with some promising susceptibility genes for this disorder. Although none of them is a causal factor or a general risk factor for the disease, the genetic factors function in similar biological

contexts, e.g. disease pathways. These pathways include post-synaptic signaling associated with the NMDA-type glutamate receptor and the centrosome/microtubule cascade. Recent studies have indicated that it is very useful to build animal models by utilizing such genetic information and characterize them in the context of disease pathways. Use of patient tissues/cells may also be important to obtain disease-associated molecular clues. I will introduce our recent progress in establishing olfactory immature neurons near to the homogeneity obtained via nasal biopsy as well as induced pluripotent stem (iPS) cells from patients with schizophrenia and controls. These cells are to be used for molecular profiling studies, functional studies, especially in the context of disease-associated stress susceptibility, and drug screening. I plan to cover both animal studies based on genetic information and human cell/tissue engineering, which are indispensable and complementary elements of translational neuroscience for schizophrenia. These strategies can be applied to other mental disorders, such as mood disorders.

REFERENCES:

WEDNESDAY, MAY 20, 2009

9:00 AM-10:30AM

LECTURE 20

STARING INTO THE SUN: OVERCOMING THE TERROR OF DEATH

Presenter: Irvin Yalom, M.D.

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to 1) Recognize the role of death anxiety in psychotherapy practice; 2) Appreciate the ideas used to ameliorate death anxiety in psychotherapy and 3) Identify and make use of "awaking experiences" in therapy.

SUMMARY:

Our field focuses too much on the distant past and far too little on the future – on the inherent anxieties riveted to human existence. The terror of death plays a larger role in our inner life and our psychological problems than is generally thought. Too often psychotherapists avoid inquiry into death anxiety: either because they do not know what they can offer patients or because they have not confronted their own anxiety about death. If we come to terms with mortality in our own personal therapy and familiarize ourselves with the topic, we can offer a great deal to patients terrorized by death. Not only can we help to ameliorate anxiety but through the encounter with death we can help our patients enhance their life. As wise men have pointed out through the millennia, death confrontation can awaken us to a fuller life. Awakening experiences, if we learn to recognize them, are amply available in everyday therapy. Though ideas may help us ameliorate anxiety it is the synergy of ideas and human encounter that is our most powerful aid in therapy. I shall describe these methods and illustrate them though clinical vignettes.

REFERENCES:

1. Yalom, Irvin; Staring at the Sun: Overcoming the Terror of Death. Jossey Bass, San Francisco, 2008.
2. Yalom, Irvin; The Gift of Therapy. Harpercollins, NY

WEDNESDAY, MAY 20, 2009

11:00 AM-12:30PM

LECTURE 21

DEVELOPMENTS IN MENTAL HEALTH SERVICES IN INDIA

Presenter: *Mathew Varghese, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)Understand how a developing country deals with Mental Health services through the National Program; 2) understand the roles of the Supreme Court and the Human Rights Commission in Mental Health Care; and 3) Discuss novel service delivery programs through public-private partnership.

SUMMARY:

Mental health services in independent India were developed following the recommendations of the Bhore Committee Report in 1946. The report proposed the creation of mental health organizations at the Health Ministry, improvement of the mental hospitals of British India and establishment of new hospitals, professional training in mental health, and establishment of departments of mental health. Following on these recommendations the Indian government had initiated different programs. The All India Institute of Mental Health was started in 1954 as a training center for professionals. India was one of the first developing countries to formulate a mental health policy and the National Mental Health Program in 1982. The program aimed to integrate and deliver mental health services with general health at the primary level through the district health programs. Mental hospital beds were also steadily increased to over 25,000 in addition to beds in the general hospital departments. The government also enacted new legislations in the Mental Health Act, 1987 and the Persons with Disabilities Act, 1995. A serious problem in the delivery of services in India is the paucity of trained manpower. India has only about 3500 psychiatrists and as many psychologists, social workers and psychiatric nurses. These numbers are inadequate for a population of over one billion with the prevalence of severe mental disorders at 2% and that of common mental disorders at about 10%.Manpower has not increased over the years due to brain drain to other countries in the developed world. Thus the burden of care giving and support is borne by families in the communities. This treatment gap and the sorry state of services were highlighted by the report of the National Human Rights Commission, 1999 and the fire tragedy at Erawadi in 2001. This report and various events that followed prompted the Supreme Court of India to direct the government to augment services in 2002. Accordingly the National Program was re-strategized and the budget was increased seven fold in the last few years. Attempts have also been made to increase coverage at the district level and to train more doctors and para-professionals in shorter mental health courses. The new program also provides for public-private partnership, life skills programs for adolescents, training in counseling for school and college teachers, suicide prevention and public awareness programs. The impact of these programs in the last few years is

REFERENCES:

1. Mental Health: An Indian Perspective, 1946-2003.Eds: SP Agarwal. Director General Health Services, Ministry of Health and Family Welfare. New Delhi: Elsevier, 2004
2. Mental Health Care and Human Rights. Eds Nagaraja D and Murthy P. National Human Rights Commission, New Delhi and NIMHANS, Bangalore, 2008 (Available on line at http://nhrc.nic.in/ publications/ Mental_Health_Care_ and_Human_Rights.pdf)

WEDNESDAY, MAY 20, 2009

2:00 PM- 3:30PM

LECTURE 22

WHAT RESEARCH TELLS US ABOUT SUICIDE

Presenter: *Paula J Clayton, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) List the major psychiatric disorders associated with an outcome of suicide; 2) After the presentation, the attendee will be able to identify the acute risk factors in these illnesses that heighten the likelihood of suicide; and 3) After the presentation, the attendee will know the psychological and somatic treatments that might modify the outcome.

SUMMARY:

In the United States, as indicated from the 2005 data, suicide is the 11th leading cause of death. The overall suicide rate is 11/100,000. It is the third leading cause of death in adolescents and the fourth leading cause of death in adults from ages 25- 64. It is the second leading cause of death in college students. Still, the rate is highest in those over 85. The most important risk factor for death by suicide is having a mental disorder. Although the data from psychological autopsy studies vary by investigator, access, instrument and procedures used and country, the overwhelming majority of the more than 120 studies, regardless of the age of the deceased, indicate that about 90 % of those who kill themselves are suffering from a mental disorder. The most frequent mental disorder is major depression, followed by bipolar depression, schizophrenia, alcohol and drug abuse and other prescription medications, anorexia and Axis II disorders. Other risk factors for suicide such as specific symptoms during a depression which include anxiety, hopelessness and aggressiveness, suicide ideation and attempts, genetic factors, sociodemographic factors and environmental factors will be summarized. Finally prevention initiatives at many levels will be discussed, with reference specifically to barriers on bridges. Education for prevention will also be reviewed. The presentation will concentrate, for the most part, on an outcome of suicide in order to emphasize that the ultimate goal must be to prevent suicide. This needs to be done community by community and psychiatrists can take the lead.

REFERENCES:

1. Suicide prevention strategies: a systematic review. Mann JJ, Apter A, Bertolote J, Beautrais A, Currier D, Haas A, Hegerl U, Lonnqvist J, Malone K, Marusic A, Mehlum L, Patton G, Phillips M, Rutz W, Rihmer Z, Schmidtke A, Shaffer D, Silverman M, Takahashi Y, Varnik A, Wasserman D,
2. Yip P, Hendin H. JAMA. 2005 Oct 26;294(16):2064-74. Review.Suicide as an outcome for mental disorders. A meta-analysis. Harris EC, Barraclough B. Br J Psychiatry. 1997 Mar;170:205-28.

THURSDAY, MAY 21, 2009

11:00 AM-12:30PM

LECTURE 23

THE POWER OF PERSONALIZED LIFESTYLE CHANGES

Presenter: *Dean Ornish, M.D.*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) To understand successful strategies for motivating people to make and maintain comprehensive lifestyle changes; 2) To describe the evidence from randomized controlled trials showing that chronic diseases such as coronary heart disease and prostate cancer may be stopped or even reversed by making comprehensive lifestyle changes; and 3) To describe evidence showing that comprehensive lifestyle changes may affect gene expression.

SUMMARY:

We tend to think of advances in medicine as a new drug, laser, or surgical procedure, something high-tech and expensive. This presentation will discuss the power of comprehensive lifestyle changes, reviewing more than 30 years of research using high-tech, state-of-the-art measures to prove the power of low-tech, low-cost, and often ancient interventions. Also, the lecture will describe proven strategies for motivating people to make and maintain comprehensive lifestyle changes as well as how to personalize a way of eating and living based on an individual's needs, genes, and preferences. Finally, the presentation will describe many of the health policy implications of comprehensive lifestyle changes as both medically effective and cost effective.

REFERENCES:

1. Ornish D. The Spectrum. New York: Ballantine Books, 2008.
2. Ornish D, Magbanua MJM, Weidner G, Weinberg V, Kemp C, Green C, et al.Changes in prostate gene expression in men undergoing an intensive nutrition and lifestyle intervention. Proc Nat Acad Sci USA. 2008; 105: 8369-8374.
3. Ornish D, Lin J, Daubenmier J, Weidner G, Epel E, Kemp C, Magbanua MJM, Marlin R, Yglecias L, Carroll P, Blackburn E. Increased telomerase activity and comprehensive lifestyle changes: a pilot study. The Lancet Oncology. 2008; 9: 1048–57.

PRESIDENTIAL SYMPOSIA

MONDAY, MAY 18, 2009

2:00PM- 5:00PM

PRESIDENTIAL SYMPOSIUM 01

IS PSYCHIATRY BETTER FOR PATIENTS AND PHYSICIANS IN A REAL HEALTH CARE SYSTEM?

Chair**:** *Gisèle Apter, M.D., Ph.D., 121 bis Avenue du Général Leclerc, Bourg-La-Reine, 92340 France*

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) Present and compare information about health care systems in several other Western countries; 2)Analyze the barriers to changing health care delivery in the United States; 3) Decide what changes need to be made; and 4) Successfully advocate for improvements in our health care system.

SUMMARY:

Although we use the term 'system,' there is widespread agreement that health care in the United State, with a few exceptions, is disorganized, financially wasteful, operationally burdensome, and highly variable in quality. We spend considerably more per person on health care than any other country, but our health outcomes rank with much poorer countries. However, people cling to the familiar, and there are many other forces mitigating against change. There is a great deal of profit to be made in 'managing' health care. There are many players, often with competing interests. Governments and third party payers are reluctant to make the investments in prevention and early detection and treatment that are necessary for health improvements that may not manifest until decades later. There are financial and other disincentives to becoming a primary care physician, and we do not have enough of them. Presumably we could learn something from colleagues

who practice in countries with more organized systems, but we harbor misconceptions and prejudices about those systems of care. This symposium brings together psychiatrists from Canada, Australia, Great Britain, and France, to describe the pros and cons and day-to-day functioning of their health care systems, especially as they affect mental health care. A political science expert will discuss the barriers to, and opportunities for, improving the care and health, and the practice environment, of those of us who live and work in the United States, and tell us what we have to do to achieve those improvements.

N0 1A

THE U.S. NON-SYSTEM

Steven S Sharfstein, M.D., 6501 North Charles Street, Baltimore, MD 21204

SUMMARY:

Unique among Western countries, the United States cannot claim to have a health care "system." There are more than 1,200 private health insurance companies; a federal program that covers the elderly and disabled; and 50 different state programs that cover the poor, each with different benefits, criteria eligibility, and different rules of reimbursement. Despite this mélange of coverage, there are 47 million Americans without any health insurance during a year. Lack of coverage for psychiatric care extends to another 20 million individuals, or the coverage is so minimal that these individuals are not able to access acute psychiatric services. As a result, each state varies in its "safety net" of public mental health services for community services as well as institutional care. Emergency rooms are brimming with psychiatric patients who often remain for days waiting for a psychiatric bed in a public hospital, general hospital, or private psychiatric hospital. In some areas of the country, the bed shortage for psychiatric treatment has reached crisis proportions. There is even less access to care for children and adolescents, and early detection and treatment is non-existent. Recently-passed legislation mandating "parity" for mental health benefits in health insurance that covers mental health may bring some improvements but absent of an overhaul of the entire health system, starting with the way that care is funded, the prognosis for improvement in psychiatric treatment remains guarded.

NO 1B

NATIONAL HEALTH SERVICE IN THE UNITED KINGDOM

Dinesh Bhugra, M.B.B.S, 17 Belgrave Square, London, SW1X 8PG

SUMMARY:

National Health Service was established in the aftermath of second world war. The history of its establishment and subsequent growth with emphasis on free care at the point of delivery has raised serious questions about its success and potential failures. Until the middle of the 19th century, the state had virtually no control over the medical profession. Doctors had developed their own organisational structure which satisfied the need for self-protection. Members of the Royal College of Physicians mainly worked in the London teaching hospitals and treated those who could afford their fees. Members of the Royal College of Surgeons (who were the Company of Barbers a century before) were more experienced in the practice of medicine and treated patients both in London (in competition with the physicians) and outside. The vast majority of people were treated at the hands of members of the Society of Apothecaries, who basically prescribed medication. The state became more involved in the health of the population and regulation of the medical profession throughout the 19th and early 20th century. The 1834 Poor Law was the first acknowledgement that government had some responsibility towards the care of the population. Free services were offered by boards of guardians to those who could pass a means test. In the first half of the 20th century there were some important changes in the mode of delivery of health care and in the organisation of the medical profession . The medical profession had gained prestige and status but lacked tools; these came about with the development of microbiology, which led to the establishment of a scientific basis for medicine. National Health service as its core function has the aims of providing clinics, school services, education, and other services for the prevention and detection of disease; physi-

cal treatment (medical and surgical intervention for physical and psychological illnesses and impairment); psychological treatment for psychological disturbances and related physical symptoms and educational procedures and provision of aids to enable the physically and mentally handicapped to use their abilities as fully as possible. These functions have often varied and differently prioritised depending upon political imperatives and demands rather than needs. This presentation brings together historical data and changes in the systems in the last quarter of a century to discuss the lessons that we have learnt.

NO 1C

THE AUSTRALIAN MENTAL HEALTH SYSTEM: A COMPLEX MIX MOVING FORWARD.

Beverley Raphael, M.D., Locked Bag 1797, Penrith South Australit , 1797

SUMMARY:

The Australian Mental Health System involves both public and private sectors and is governed over-archingly by a National Mental Health Policy and strategic framework. In recent years, the collaborative approach between the National Australian Government and the State and Territories who have independent responsibilities for health and mental health in the public arena has been complemented by a whole of government approach, engaging other sectors. COAG, the Council of Australian Governments, has facilitated this national across agency initiative. Funding sources include both Commonwealth and State contributions, linkages to primary care/general practice with Australian Government funding through Medicare, and additional support provided by private sector agencies, such as Medibank Private, Australian Health Management. There are agreed priorities and performance indicators. The progressive enhancement of information systems to support reporting and evaluation contribute further. There is a strong consumer and carer movement which has a voice in all major initiatives. Legislative frameworks have moved to consistency but still sit in the local jurisdictions of State and Territory responsibility. Non-government agencies, such as the Beyondblue depression initiative, SANE and many others provide very important contributions. The greater openness with many politicians providing both personal examples and significant political support has meant that mental health is less stigmatised. A strong research agenda backs much of this work. Critical questions, however, are being systematically addressed, including impacts on the burden of disease at a population level and the individual experience of mental health care with the aims of continual improvements and a positive future trajectory.

NO 1D

THE FRENCH NATIONAL HEALTH SYSTEM : HOW MUCH CARE FOR ALL FOR HOW LONG?

Gisèle Apter, M.D., 121 bis Avenue du Général Leclerc, Bourg-La-Reine, 92340

SUMMARY:

The French National Health system was established after World War II as a structure that was to allow the public and the private sector to collaborate together to insure that the whole population had access to and obtained state-of-the-art effective health care. This meant that everyone was to participate financially to ensure security to all. Health just as care for the elderly is conidered in France a “social property” that everyone has a right to and that all should use according to their needs. The Health Branch of the National Social Security System has round-the-country agencies that pay for Public and Private Hospital bills and reimburse ambulatory care. It is a pay for care, free access to whatever hospital or physician the patient wants with nationally established rules. In this context mental health has occupied since the 1970’s a special place. Following the movement to open up mental hospitals and destigmatize mentally ill patients, population-based access to care was theoretically equally imlemented all over the country for adult psychiatric care and then a few years later for child psychiatry. Psychiatric private practice continued to function in the same way as the rest of the general health system. Both the Health system and decentralized agencies take care of prevention and early detection of mental illness. The system aims to care for everyone during the course of life whatever illness occurs. The complexity of its financial and structural organization are most often unknown to the public with the population’s expectations staying very high. Economic necessities, political attacks and health issues such as an ageing population have fragilized the system over the years. Liberty, Equality and Fraternity of health care for all seems an unattainable ideal. Does that mean we should stop trying to reach for it?

REFERENCES:

1) R. Overshott, A. Burns and D. Bhugra (2007) ‘History and structure of the National Health Service’. In Management for Psychiatrists (3rd ed), Bhugra D., Bell S. and Burns A. (eds). London: RCPsych Publications, pp 3-27.
2) Stacey M. (1988) The Sociology of Health and Healing. London: Unwin Hyman.
3) Frank RG and Glied SA: Better But Not Well: Mental Health Policy in the United States Since 1950. Baltimore, Maryland, The Johns Hopkins University Press, 2006.

PRESIDENTIAL SYMPOSIUM 02

PSYCHIATRIST RELATIONSHIP WITH INDUSTRY

Co-Chairs: Paul S Appelbaum, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit 122, New York, NY 10032, Laura W. Roberts, M.D., 8701 Watertown Plank Road, Milwaukee, WI 53226

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

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify the ethical challenges that can arise in relationships with industry, and approaches to avoiding and managing them.

SUMMARY:

Psychiatrists’ relationships with the pharmaceutical industry have come under public scrutiny because of concerns about pos-

sible negative impacts on education, research, and patient care. Supporters of such relationships point to the importance of assisting industry in producing products to improve patients' treatment (a policy encouraged by federallaw), and to the value of industry support foreducational efforts. Critics worry about the impact of industry relationships on psychiatrists' choices of treatments, and on the integrity of the research base on which the field rests. This presidential symposium will consider the ethical challenges psychiatrists face in their interactions with industry, and ways that those challenges can be avoided or managed so as to minimize their impact on psychiatrists' responsibilities to patients, trainees, and medical science. Presenters will review the empirical data on the effect of relationships with industry in medicine; the ethical principles that enter into consideration in these circumstances; and the complexities that arise when clinicians, educators, and researchers interact with the pharmaceutical industry. Integrity in psychiatry is the psychiatrist's faithfulness, both in motivation and conduct, to the ethical duties associated with his or her professional role. Trust—the foundation of the profession of medicine and the field of science—is built upon integrity. Psychiatrists,especially those who are physician-scientists, are often asked to offer their expertise to industry or participate in developing and distributing medication. This overlapping role creates potential ethical vulnerability and, at times, may represent a conflict of interest. Conflicts of interest, or the appearance of conflicts of interest, arise in situations in which professionals' responsibilities to observe, judge, and act according to the moral requirements of their role are, or will be, compromised." These may arise, for example, when clinicians receive significant monetary incentives for enrolling individual participants in protocols or when clinicians serve in roles that advance the interests of a company above the interests of a patient. Subtler conflicts of interest may exist as well, such as a clinician's desire for institutional promotion that may outweigh other ethical imperatives in the situation. Consequently, reflection on the hierarchy of ethical duties of the psychiatrist, and situations that may undermine a professional's motivations and actions, are important to the modern practice of psychiatry. Multiple safeguards exist to prevent conflicts of interest, including disclosure, oversight, role separation, educational initiatives, and financial limits. Currently, various organizations within medicine differ in their approaches and guidelines for dealing with relationships with industry. Clinicians should be aware of issues that may concern patients and are important to the preservation and enhancement of the public trust. In this session, these ethical issues, various safeguards, relevant data on overlapping roles, and potential conflicts of interest will be reviewed.

NO 2A

RELATIONSHIPS WITH INDUSTRY: WHAT THE DATA SAY

Paul S Appelbaum, M.D., New York State Psychiatric Institute 1051 Riverside Drive, Unit 122, New York, NY 10032

SUMMARY:

Physicians' relationships with the pharmaceutical and device industries have been subject to examination in a growing body of studies since the 1990s that have helped to puncture some of the myths in this area. Although many physicians claim that their relationships with pharmaceutical representatives or acceptance of small gifts have no impact on their practice, data from a number of studies indicate the contrary. Prescriptions of particular medications rise in response to visits by pharmaceutical representatives, and the distribution of gifts appears to be an effective way of increasing prescriptions as well. Explanations of the effect include the innate human tendency toward reciprocity, and the salience of small reminders in determining behavior. With regard to research funded by pharmaceutical or device companies, again investigators argue that there is no impact on their behavior. But compilations of study results demonstrate that industry-funded research is consistently more likely to generate favorable results than are independently funded studies. Here the explanation may reside less in conscious or unconscious bias by the investigator than in the study design, which may be crafted so as to obtain favorable results (e.g., by using inadequate comparators or selecting outcome measures that favor the funder's product). Relationships with industry clearly impact physician behavior and the available evidence base for clinical practice. Hence, appropriate measures to mitigate or eliminate the effect are essential to maintain the integrity of psychiatry and the rest of medicine.

NO 2B

ETHICS AND OVERLAPPING ROLES: SAFEGUARDING CONFLICTS OF INTEREST

Laura W. Roberts, M.D., 8701 Watertown Plank Road, Milwaukee, WI 53226

SUMMARY:

Integrity in psychiatry is the psychiatrist's faithfulness, both in motivation and conduct, to the ethical duties associated with his or her professional role. Trust—the foundation of the profession of medicine and the field of science—is built upon integrity. Psychiatrists, especially those who are physician-scientists, are often asked to offer their expertise to industry or participate in developing and distributing medication. This overlapping role creates potential ethical vulnerability and, at times, may represent a conflict of interest. Conflicts of interest, or the appearance of conflicts of interest, arise in situations in which professionals' "responsibilities to observe, judge, and act according to the moral requirements of their role are, or will be, compromised." These may arise, for example, when clinicians receive significant monetary incentives for enrolling individual participants in protocols or when clinicians serve in roles that advance the interests of a company above the interests of a patient. Subtler conflicts of interest may exist as well, such as a clinician's desire for institutional promotion that may outweigh other ethical imperatives in the situation. Consequently, reflection on the hierarchy of ethical duties of the psychiatrist, and situations that may undermine a professional's motivations and actions, are important to the modern practice of psychiatry. Multiple safeguards exist to prevent conflicts of interest, including disclosure, oversight, role separation, educational initiatives, and financial limits. Currently, various organizations within medicine differ in their approaches and guidelines for dealing with relationships with industry. Clinicians should be aware of issues that may concern patients and are important to the preservation and enhancement of the public trust.

In this session, these ethical issues, various safeguards, relevant data on overlapping roles, and potential conflicts of interest will be reviewed.

NO 2C

INDUSTRY AND THE INDIVIDUAL PHYSICIAN

Jonathan L Weker, M.D., P.O. Box 10, Montpelier, VT 05601

SUMMARY:

For decades, individual physicians have been the recipients of promotions from pharmaceutical entities, ranging from logo-emblazoned office supplies to meals to conference fees and travel expenses; additionally, many physicians have established remunerative ties to pharmaceutical entities as paid speakers, grant recipients and contractors. Such materially gainful interactions present a potential conflict of interest for the clinician. Research shows that while physicians generally believe that pharmaceutical largesse doesn't appreciably affect their clinical practice, patients perceive a more significant and potentially troublesome influence. Increasingly, physicians, both individually and in professional organizations, are being called upon to review and reconsider their relationships with the pharmaceutical industry. States are beginning to require that these material rewards and compensations be made public; and medical schools, hospital medical staffs and professional associations are promulgating guidelines addressing the nature and extent of physician-pharmaceutical relationships. It has been a historical given that the connection between physicians and pharmaceutical entities is necessarily a mercantile one. By and large, that premise has not been questioned. Given the value that medical practice and pharmaceutical agents both contribute to the well-being of patients, the possibility exists that clinicians, investigators and scientists in the medical profession and in the pharmaceutical industry can reconstitute a relationship between the two groups on a professional rather than mercantile foundation.

NO 2D

MEDICAL EDUCATION MEETS INDUSTRY: MOVING AHEAD

Joel Yager, M.D., 1 University of New Mexico, MSC09 5030, Albuquerque, NM 87131-0001

SUMMARY:

The complex entanglements that bind individual physicians, organized Medicine, Big Pharma, and the medical device-industrial complex generate a wide array of reactions in medical trainees. These differences spawn from varying temperaments, prior political philosophies, professional zeitgeists du jour, and peer pressures. Trainees' wide-ranging responses include moral outrage fueled by concerns for social justice, avoidant and self-protective distancing from perceived seductive industrial ploys, increased cynicism as superiors and peers develop close ties with industry, bemused and skeptical dalliances with sales reps and their sales-pitches, speakers, food, and trinkets, and semi-conflicted or un-conflicted embracing of the financial, business, and scientific opportunities afforded by industry. In this presentation we review how diverse forms of industry marketing impact trainees' perspectives and behaviors, and educational approaches designed to enable trainees to better evaluate industry-cloaked information. We conclude by offering additional suggestions to help educate increasingly self-aware consumer-practitioners. These suggestions, based on research in social psychology and behavioral economics, may assist medical students, residents, fellows and practicing clinicians to better see through and understand the assaults of "smart-marketing" and better immunize themselves against susceptibility to the subtle techniques to which they are constantly subjected so that they may make more discerning decisions regarding patient care.

NO 2E

RELATIONSHIPS WITH INDUSTRY: ACADEMIC DEPARTMENTS OF PSYCHIATRY

David A Baron, D.O., Temple/Episcopal Campus,100 E Lehigh Avenue,MAB, Suite 305, Philadelphia, PA 19125

SUMMARY:

Is there any role for the pharmaceutical industry in academic psychiatry departments? Although many view this as a contemporary hot topic, the debate goes back over half a century. Ernst Dichter, reporting to the Pharmaceutical Advertising Club of New York in 1955, asserted, "The physician expects himself to make up his own mind on the basis of objective evidence. And yet he finds himself confronted, like a housewife in a supermarket aisle, with a misery of choice which he tends generally to resolve by irrational and emotional factors". This presentation will provide a brief historical overview and offer suggestions for a role of industry in academic departments. The primary focus of the presentation will be on balancing research, education and conflict-of-interest issues. Recent APA and WPA guidelines will be highlighted.

REFERENCES:

1) Association of American Medical Colleges: Protecting Patients, Preserving Integrity, Advancing Health: Accelerating the Implementation of COI Policies in Human Subjects Research. Washington, DC, AAMC, February 2008.
2) Association of American Medical Colleges: The Scientific Basis of Influence and Reciprocity: A Symposium. Washington, DC, AAMC, June 2007.
3) Dana J, Loewenstein G: A social science perspective on gifts to physicians from industry. JAMA 2003; 290:252-255.
4) Schowalter JE: How to manage conflicts of interest with industry? Int Rev Psychiatry 2008; 20:127-133.

TUESDAY, MAY 19, 2009

2:00PM- 5:00PM

PRESIDENTIAL SYMPOSIUM 03

PSYCHIATRY AND THE CONTROL OF FERTILITY

Chair**:** *Nada L. Stotland, M.D., M.P.H., 1000 Wilson Blvd,*

Arlington, VA 22209

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to;1)Counsel patients on contraceptive and abortion techniques;2. Help patients make informed decisions about pregnancy; 3)Understand laws controlling access to contraception and abortion and 4)Involve men as patients or partners in fertility decisions

SUMMARY:

The care of children is the most demanding job in society, and often those who care for children have to earn money to support them as well. These tasks can be especially challenging for individuals coping with mental illnesses. At the same time, mental illnesses can compromise the ability to control one's fertility. When acutely ill with a mood disorder, psychotic disorder, or substance abuse disorder, our women patients can have difficulty refusing sex or using effective contraception; they are vulnerable to sexual abuse and exploitation. Patients who become pregnant in the throes of acute mental illness may feel that it is impossible and/or unwise for them to give birth to children. Therefore information and discussions about contraception, and support for women making decisions about an existing pregnancy are crucial components of good psychiatric care. This symposium will include presentations on: current contraceptive and abortion techniques; the impact of restrictive laws, policies, and attitudes; abortion in France; the literature on the psychological impact of abortion; fertility issues for male patients; and practical approaches for helping patients master fertility issues.

NO 3A

IS THERE AN ABORTION TRAUMA SYNDROME? CRITIQUING THE EVIDENCE

Nancy Adler, 3333 California St, San Francisco, CA 94143-0848

SUMMARY:

The objective of this review is to identify and illustrate methodological issues in studies used to support claims that induced abortion results in an "abortion trauma syndrome" or a psychiatric disorder. After identifying key methodological issues to consider when evaluating such research, we illustrate these issues by critically examining recent empirical studies hat are widely cited in legislative and judicial testimony in support of the existence of adverse psychiatric sequelae of induced abortion. Recent studies that have been used to assert a causal connection between abortion and subsequent mental disorders are marked by methodological problems including but not limited to: poor sample and comparison group selection; inadequate conceptualization and control of relevant variables; poor quality and lack of clinical significance of outcome measures; inappropriateness of statistical analyses; and errors of interpretation, including misattribution of causal effects. By way of contrast, we review some recent major studies that avoid these methodological errors. The most consistent predictor of mental disorder after abortion remains pre-existing disorder, which, in turn, is strongly associated with exposure to sexual abuse and intimate violence. Educating researchers, clinicians, and policy makers how to appropriately assess the methodological quality of research about abortion outcomes is crucial.

NO 3B

IS THERE AN ABORTION TRAUMA SYNDROME? CRITIQUING THE EVIDENCE

Gail E Robinson, M.D., 8-231 E.N., 200 Elizabeth St, Toronto, ON, M4W 3M4

SUMMARY:

The objective of this review is to identify and illustrate methodological issues in studies used to support claims that induced abortion results in an "abortion trauma syndrome" or a psychiatric disorder. After identifying key methodological issues to consider when evaluating such research, we illustrate these issues by critically examining recent empirical studies hat are widely cited in legislative and judicial testimony in support of the existence of adverse psychiatric sequelae of induced abortion. Recent studies that have been used to assert a causal connection between abortion and subsequent mental disorders are marked by methodological problems including but not limited to: poor sample and comparison group selection; inadequate conceptualization and control of relevant variables; poor quality and lack of clinical significance of outcome measures; inappropriateness of statistical analyses; and errors of interpretation, including misattribution of causal effects. By way of contrast, we review some recent major studies that avoid these methodological errors. The most consistent predictor of mental disorder after abortion remains pre-existing disorder, which, in turn, is strongly associated with exposure to sexual abuse and intimate violence. Educating researchers, clinicians, and policy makers how to appropriately assess the methodological quality of research about abortion outcomes is crucial.

NO 3C

ABORTION IN FRANCE : HIGH AVAILABILITY, BEST EUROPEAN FECUNDITY

Gisèle Apter, M.D., 121 bis Avenue du Général Leclerc, Bourg-La-Reine, 92340

SUMMARY:

Abortion in France was legalized in 1974 by a conservative government who had nonetheless chosen a woman as Minister of Health. It was then decided that until 12 weeks gestation , abortion was to be realized solely on the demand of the woman received alone by a physician. After 12 weeks, interruption of pregnancy necessitates a medical reason and needs to be approved by two independent physicians. The medical reasons cover a vast range, from embryo or fetal anomalies to maternal medical and mental health issues. There is no legal term limit to what is then called "therapeutic or medical" interruption of pregnancy. In 1981, government changed (French Socialist Party) and abortion became integrated in the National Health System. This meant that every public Hospital is to have facilities for reimbursed or free of charge abortion. Public Hospitals are available in all major cities and most towns of 50,000 or more population. In the early

2000's a vast debate on the date limits that should be set for non "medical abortions" finally set 14 weeks as the time of gestation for which abortion should be offered as a free choice for women. Minors are also to have free access to abortion for unwanted pregnancies. However, there still are situations where women need to go abroad for abortion (no medical reason and pregnancy discovered after 14 weeks) and theoretical equal access to all is not always totally practically true even if France is still a very organized country as far the Health system is concerned. There seems to be a national consensus in France among the population that abortion just as contraception and sexual freedom are now given and cannot be abolished. How this could be slowly gnawed at or undermined , its advantages and setbacks will be discussed.

NO 3 D

THE MARGINALITY OF THE ABORTION PROVIDER IN THE UNITED STATES

Carole E Joffe, Ph.D., 1 Shields Ave, Davis, CA 95616

SUMMARY:

This presentation will describe the marginal status of abortion provision–and abortion providers–within American jurisprudence, Congressional legislation, and mainstream medical institutions. I will start by contrasting the language used in Roe v Wade to that in the most recent Supreme Court decision, Gonzales v Carhart, in which the excessive deference to physicians in the former is replaced by expressions of contempt in the latter. I will discuss various restrictions imposed on abortion providers, particularly the notorious TRAP laws (Targeted Restrictions Against Abortion Providers), which subject these clinicians to regulations found no where else in comparable medical specialties. I will highlight the unprecedented Congressional interference in the training requirements for abortion established by the Committee on Residency Education in Ob/Gyn of the Accreditation Council of Graduate Medical Education. I will also offer data on the shortage and geographic maldistribution of abortion facilities, which have led to a severe crisis of access for many women. I will suggest that within mainstream medicine, the oots of the marginality of abortion provision are found in the pre-Roe era, and the legacy of the "back alley butcher." The second portion of my presentation will focus on the obstacles facing young physicians today who wish to provide abortion. Drawing from a book in progress, I will offer a number of examples which reveal how the stigma and shame surrounding abortion has permeated medical settings: e.g. residents fearful of "coming out" to senior physicians about their commitment to abortion; junior physicians in group practices being threatened with career ruin by anti-abortion senior partners; nurses threatening to "sabotage" a family medicine clinic about to initiate abortion care, and so on. I will conclude my remarks by mentioning some efforts now underway by the abortion rights medical community to counter this marginalization.

NO 3E

CONTRACEPTION, ABORTION AND MEN

Michael F Myers, M.D., 450 Clarkson Avenue, Brooklyn, NY 11203

SUMMARY:

The clinical study of men's feelings and attitudes about contraception and abortion has long been eclipsed by that of women, rather than existing on a parallel track. However, this is changing rapidly. With more scholarly research on the psychology of men and male reproductive physiology, this imbalance is being addressed. Given the estimate that approximately half of all pregnancies are unplanned or unwanted, and that men are key players in these conceptions, there is an urgent need for women and men to be working together with a common focus. This paper explores several themes: contemporary men's attitudes toward pregnancy and its prevention; psychological, cultural, socioeconomic and spiritual variables that influence the contraceptive decision-making of men; new advances in male contraception (especially hormonally based alternatives); attitudinal determinants in men regarding abortion decisions, including developmental notions of fatherhood; men's reactions to pregnancy termination in their partners; and future directions. By understanding how women and men use similar and different coping mechanisms s they confront contraception, unplanned pregnancy and elective abortion, we will appreciate each gender's unique appraisals, responses and choices.

REFERENCES:

1) Myers MF. The male perspective. In Stotland NL and Stewart DE, eds. Psychological Aspects of Women's
Health Care. The Interface Between Psychiatry and Obstetrics and Gynecology. Second Edition. American
Psychiatric Press Inc. Washington, DC, 2001, pp. 585-596.
2) McMahon TJ, Spector AZ. Fathering and the mental health of men. In Grant JE, Potenza MN. eds.
Textbook of Men's Mental Health. American Psychiatric Press Inc. Washington, DC, 2007, pp. 259-282.

WEDNESDAY, MAY 20, 2009

2:00PM- 5:00PM

PRESIDENTIAL SYMPOSIUM 04

WHEN THE TREATMENT FAILS THE PATIENT: PSYCHODYNAMIC CONTRIBUTIONS TO THE TREATMENT OF TREATMENT-REFRACTORY PATIENTS

American Academy of Psychoanalysis and Dynamic Psychiatry

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant willbe able to: 1) Unravel the mystery of why certain patients fail to improve; 2) Make decisions about which patients are treatable, by whom, and under what conditions; 3) Understand the meanings of medication and treatment, and communicate with patients in ways that improve adherence; 4) Use patient's early attachment experiences to improve care; 5) Help with parenting, thereby improving the overall mental health of families.

NO 4A

WHEN THE PATIENT IS A MOTHER: ADDRESSING PARENTING ISSUES IN PSYCHOTHERAPY, PROMISES AND PITFALLS JENNIFER I DOWNEY, M.D.

Jennifer I Downey, M.D.108 E 91 Street #1ANew YorkNY10128

SUMMARY:

For the woman who is a parent, feeling herself to be a "good mother" is an important aspect of self esteem. Attacks on self-esteem from events that suggest the woman is a bad mother can have severe consequences including depression and suicide.

Psychoanalytic psychology with its emphasis on the dyadic relationship between the mother and child and the use of transference in the therapy offers psychotherapists techniques to understand the dynamics of poor maternal self-esteem which may be linked at times with poor parenting performance.It has been well established that there is an intergenerational transmission of parenting behavior. Thus, when the woman's mother was neglectful or abusive, she herself is at risk of becoming a damaging parent. Reversing this pattern requires conscious effort and often clinical help.Depressed women who function well as parents when not depressed, can be benefited by conventional medication and psychotherapeutic strategies to restore them to normal mood. The focus of this presentation is the psychotherapeutic treatment of more troubled women who desire to be better mothers but are driven by only partly conscious motives to fail. Effective parenting behavior can be seen as a collection of ego functions that a woman may develop in psychotherapy when the therapist views parenting as a developmental stage of adulthood and works with the woman to increase her ability to see each child as an individual, differentiate the roles of parent and child, be able to provide appropriate affection and limit-setting for children, and build frustration tolerance. Just seeing parenting behavior as an area where ego deficits and psychiatric symptoms may be acted out gives the therapist immense therapeutic traction**.**Case vignettes will illustrate examples of intervention with mothers which enabled them to function more effectively as well as psychotherapy pitfalls which may occur when the clinician is excessively rigid or passive .

NO 4B

CHALLENGES PRESENTING IN TRANSFERENCE AND COUNTERTRANSFERENCE IN THE PSYCHOTHERAPY OF A MILITARY SERVICE MEMBER

Eugene Kim, M.D., 7012 Hawaii Kai Drive, Unit 1303, Honolulu, HI 96825

SUMMARY:

With recent explorations into the subject of treatment resistance, the literature has tended to focus on factors revolving around the patient and their illness: biological and psychological predispositions like temperament and impulsivity, and social factors such as inadequacy of basic resources that may perpetuate symptoms. This presentation will expand the focus to the role of the transference/counter-transference set in mobilizing or impeding the treatment process within the therapy. In addition to examining the resistance on the part of the patient, the presenter will discuss a case in which the resistance lay within the therapist. The presenter will share vignettes in which the therapist experienced difficulty tolerating the patient's combat trauma. This problem prevented the patient's experience from surfacing, allowing for adequate processing. Both overt and covert exhibitions of the therapist's resistance will be illustrated, identifying both supportive and exploratory psychotherapeutic techniques as potentially stimulating or inhibiting forces within the therapy. Only until these phenomena were acknowledged could interventions then be planned and implemented allowing for therapy to resume progression. Principles driving the appropriate interventions include maintenance of therapeutic neutrality and awareness of bright and blind spots. References: Goldberger, M. (1993) "Bright Spot," a Variant of "Blind Spot". Psychoanalytic Quarterly, 62:270-273. Schafer, R. (2005) Caring and Coercive Aspects of the Psychoanalytic Situation. Journal of the American Psychoanalytic Association, 53: 771-787.

NO 4C

TREATMENT RESISTANT PATIENTS IN PSYCHOTHERAPY

Michael Stone, M.D., 225 Central Park West, New York, NY 10024

SUMMARY:

Although patients with Borderline Personality Disorder [BPD] have long had the reputation of being "difficult" to treat effectively via psychotherapeutic means, they do not occupy the entire stage, nor even the center-stage, with respect to treatment-difficulty - let alone treatment resistance. Borderline patients themselves vary in their amenability to therapy – in accordance with other characteristics. In general, those with "entangled" attachment fare better than do those with "dismissive" attachment patterns, since the latter are more apt to depreciate the efforts of the therapist from the outset, and to quit treatment prematurely. Dismissive attachment is quite common amongst narcissistic patients, irrespective whether they in addition fulfill criteria for BPD. Treatment resistance is encountered often in dealing with paranoid patients because of their tendency to deceive and to form only a superficial appearance of a working alliance with the therapist. Some patients with BPD are all but untreatable, not because of narcissistic or antisocial features, but because their early lives had been marked by extreme degrees of chaos, maternal indifference and unavailability, incest, parental cruelty, and the like – with the result that they seem unable to relate to the conventional world and unable to make the kinds of personality changes that would enable them to fit in better with more stable people; they remain alienated. Treatment resistance is a more widespread issue in the forensic population, where antisocial acts and/or tendency to violence further complicate the picture. Examples from these patient populations will be given by way of illustration.

NO 4D

IMPROVING ADHERENCE TO TREATMENT – CONTRIBUTIONS OF ATTACHMENT THEORY TO OUR UNDERSTANDING OF NON COMPLIANCE

Cesar A Alfonso, M.D., 262 Central Park West # 1B, New York NY10024

SUMMARY:

This presentation will review the development and refinements of attachment theory and the recent interest in its application to the understanding of treatment adherence. Bowlby proposed that individuals internalize early life experiences with caregivers and form cognitive models that determine their view of self and others. These "internal working models" influence the kinds of interactions individuals have with others during adulthood. Refinements to Bowlby's attachment theory and development of psychometric scales to operationalize attachment theory have recently categorized secure and insecure attachment styles in clinically useful ways. Furthermore, recent research findings in populations of medically ill patients identified possible correlations between attachment styles and treatment adherence. In particular, adults with dismissing attachment style, who experienced parents as emotionally unresponsive, are known to become excessively self-reliant and resist collaborative relationships. Persons with dismissive attachment style are more often nonadherent to medical treatments, compared with others with secure or other types of insecure attachment styles. After reviewing recent research data establishing the significance of the predictive value of attachment style as it correlates with adherence, guidelines will be presented to help clinicians move patients from insecure to secure attachment styles with psychodynamic therapeutic interventions. References: Ciechanowski PS, Katon WJ, Russo JE, Walker EA. The patient-provider relationship: attachment theory and adherence to treatment in diabetes. American Journal of Psychiatry. 158(1):29-35, 2001 Jan.

NO 4E

PSYCHODYNAMIC PSYCHOPHARMACOLOGY: AN APPROACH TO PHARMACOLOGIC TREATMENT RESISTANCE

David L Mintz, M.D., 25 Main Street, Stockbridge, MA 01230

SUMMARY:

Despite recent advances in neuroscience and psychopharmacology, "treatment-resistance" remains as much of an issue as it was a generation ago. As a small but growing evidence base suggests a major role for interpersonal and meaning effects in positive pharmacologic treatment outcomes, the presenter argues that many patients are "treatment resistant" to medications because an appreciation of the patient's dynamics is not incorporated into an understanding of repeated treatment failures. In this presentation, common resistances to the effects of medications are considered, as well as ways that patients may become entrenched in treatment resistant illness from counter-therapeutic uses of medications. The presenter proposes that psychodynamic psychopharmacology advances the overall clinical effectiveness of medications with treatment resistant patients by integrating a psychodynamic appreciation of the patient with a psychopharmacologic understanding. Based on emerging evidence, a century of psychodynamic insight, and personal experience, the presenter suggests a number of technical approaches to psychodynamic psychopharmacology that may be used to address and reverse pharmacologic treatment resistance.

REFERENCES:

1) Gabbard G. Psychodynamic Psychiatry in Clinical Practice, Fourth Edition. Washington, D.C.: APA Press, 2005.
2) Jordan JV et al. Women's Growth in Connection. New York: Guilford, 1991.
3) Weiss, J. (1971) The Emergence of New Themes: a Contribution to the Psychoanalytic Theory of Therapy. International Journal of Psychoanalysis, 52:459-468.
4) Thompson D, Ciechanowski PS. Attaching a new understanding to the patient-physician relationship in family practice. Journal of the American Board of Family Practice. 16(3):219-26, 2003 May-Jun.

PRESIDENTIAL SYMPOSIUM 05

THE INVISIBLE WOUNDS OF WAR: MENTAL HEALTH NEEDS OF RETURNING MILITARY AND THEIR FAMILIES

Chair: Carolyn B. Robinowitz, M.D., 5225 Connecticut Avenue, NW, #514, Washington, DC 20015

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to Participants will gain understanding of: 1) the mental health needs of returning military and their families; 2) cutting edge treatment approaches for their care; and 3) especially PTSD and TBI ways they can contribute to alleviating the pain and suffering for these wounded warriors.

SUMMARY:

Numerous studies have documented the mental health needs of returning military — both those with physical wounds, and those without. Anxiety, depression, substance abuse, PTSD, and suicide all are taking an additional toll. Deployments, and particularly, multiple deployments have put great stress and strain not only on the military themselves, but on their families — spouses, children, and even parents. Military medicine is stretched to provide mental health care; there are insufficient mental health professionals on many military bases because of their deployment to theatre. The VA has been deluged with the need for mental health care. Families have reported difficulty in accessing the Tri-Care system and many military in the Reserve and National Guard, come from locales where mental health care to them and their families may not be easily available. Thus, there is both significant need and opportunity for psychiatrists to provide care to these veterans and their families.This symposium will address the mental health problems experienced by the military and their families, as well as provide up-to-date information on the most effective treatments particularly for PTSD and traumatic brain injury. Additionally, special issues for women military will be addressed. Family members will also describe the impact of family-oriented care and support organizations. .

NO 5A

SPECIAL NEEDS OF WOMEN AND CHILDREN

Carolyn B. Robinowitz, M.D., 5225 Connecticut Avenue, NW,

#514, Washington, DC 20015

SUMMARY:

Programs addressing needs of returning military have often been focused on men. Yet, female troops have increased in number, and they are much more likely to be in the "front lines" in Iraq where the insurgency and IED's make for constant danger. In spite of women's increased presence in the military, the military is still built on a male warriors model; women are still regarded by many as "different" and are more apt to experience harassment and intimidation as well as sexual attacks. Women are also more likely to experience violence or trauma prior to military service, putting them at risk for post traumatic stress disorder in response to traumatic experiences. Another group that can be overlooked is military offspring. Reports vary, but children of deployed military often experience stress which can influence their behavior and learning. Further, there are some families in which both parents or a single parent is deployed, forcing families to place children with grandparents or other relatives, or with neighbors. Services needed by both groups may not be readily available. The system is outstanding in its care for acute wounds, but more limited in dealing with ancillary issues. This presentation will address specific needs of women military, as well as of offspring (children) who remain behind.

NO 5B

HIDDEN WOUNDS OF WAR

Barbara Van Dahlen Romberg, Ph.D., P O Box 5918, Bethesda, MD 20824

SUMMARY:

Since the Global War on Terrorism began on September 11, 2001, over 1.8 million US troops have deployed to Iraq and Afghanistan. Well over 500,000 of these warriors have deployed more than once and many of those who serve are national guardsmen and reservists. As we might expect, many of these men and women are returning home with significant mental health difficulties. A 2008 study by the Rand Corporation found

that over 300,000 of those who have served report severe depression and/or symptoms of Post Traumatic

Stress. In addition, over 320,000 have suffered a traumatic brain injury or TBI. In response to the growing concern regarding our military's ability to meet the critical mental health needs of our returning troops, Barbara Van Dahlen Romberg, Ph.D. founded Give an Hour in 2005. Give an Hour is a national non profit

organization that is providing free mental health services to our returning troops and their families. By partnering with the major mental health associations in our country – such as the American Psychiatric Association – Give an Hour is making a significant difference to the men, women and families who serve our country.

NO 5C

TREATMENT OF POSTTRAUMATIC STRESS DISORDER (PTSD)

Robert J Ursano, M.D., Dept of PsychiatryUniformed Services University4301 Jones Bridge Rd, Bethesda, MD 20814

SUMMARY:

Nearly 1.7 million military members have been deployed to Iraq and Afghanistan in the past 5 years. War is

a life changing event – for many an important part of their life experience, for some tragic loss of life or injury and for many an experience that can impair their psychological and social function. War, a human- made disaster, can result in increased risk of PTSD, depression, substance use and concussion (TBI) as well as family conflict and the challenges of displacement and return to family and to work. National Guard and Reserve face the additional burdens of separation from their military support systems, while also facing local deployments for national emergencies. The treatment of PTSD is a core knowledge and skill for addressing the mental health needs of returning soldiers, sailors, airmen and marines. Treatment guidelines have been developed by the APA as well as VA/DoD, ISTSS and NICE. The strongest evidence supports treatment of PTSD with exposure based CBT (Prolonged Exposure Therapy) and Cognitive Processing Therapy (CPT). Strong evidence for use of SSRIs is also present, although the evidence in combat related PTSD is less well developed. Psychoeducation, case management and other supportive treatments may facilitate ongoing treatment Recent APA review of the guidelines noted the promising findings of adjunctive agents to facilitate psychotherapy and the growing literature on prazosin for combat related nightmares. Addressing depression, risk of suicide and violence are critical components of treatment planning and intervention.

NO 5D

THE ROLE OF VA AND THE DEVELOPMENT OF DOD/ STATE AND COMMUNITY PARTNERSHIPS

Harold Kudler, M.D., 605 Churchill Drive, Chapel Hill, NC 27517

SUMMARY:

Over 40% of American military veterans of Iraq and Afghanistan have already presented to VA medical facilities. Half of these are members of the Reserves or National Guard. Twelve per cent are women. More than half are age 29 or younger. Over 40% of these veterans have been at least provisionally diagnosed with

one or more mental health disorders making mental health problems the second most frequent diagnostic category among them. Less is known about the mental health problems faced by their family members. Many of these veterans reside in rural areas far from VA, state, and community mental health resources. Many also report exposure to blast injuries and other events which may result in mild to moderate traumatic brain injury. This presentation will summarize VA's unprecedented efforts to engage, assess and manage mental health problems among our nation's newest generation of veterans and will offer innovative ideas, many of which were generated by APA's Committee on Mental Healthcare for Veterans & Military Personnel & their Families, that may help guide VA/DoD/State and Community partners in their efforts to better serve our nation's veterans, their families, and their communities.

REFERENCES:

1) Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans", Rand Corporation, 2008

2) Practice Guideline: Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, American Psychiatric Association Arlington VA, November 2004
3) Romberg, BV Please Help Us Provided Needed Mental Healthcare for Returning Veteran's Medscape Today, September 21, 2007 (online).
4) Lindstrom, KE, Smith, CT et al The Mental Health of US Military Women in Combat Support Occupations. Journal of Women's Health, 2006, 15(2): 162-172

PRESIDENTIAL SYMPOSIUM 06

THE GRANDKIDS OF THE 1967 FLOWER CHILDREN" LESSONS FROM HAIGHT-ASHBURY AND FROM TREATMENT AND RECOVERY

Chair: Mark Gold, M.D., PO Box 100183, Gainesville, FL 32610

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1)compare current drug culture to the drug culture at the founding the Haight Ashbury Free Clinic in San Francisco, the epicenter of the modern drug abuse epidemic; 2) list 3 lessons from that time relevant to drug use and users today; 3) be able todefine"recovery" and review the emergence of 12 step recovery programs to their current dominant position in treatment and aftercare.

SUMMARY:

While drug use is as old as human culture, the patterns of drug use that emerged in the US during the last four decades are different from earlier drug experiences. The modern drug epidemic is characterized by the use of a wide variety of agriculturally-based and synthetic drugs used by large segments of the national population, especially youth, by highly potent routes of administration – especially smoking and IV use. In contrast earlier drug epidemics were characterized by single drugs, with less reinforcing routes of administration and often restricted to small segments of the national population. Drugs of abuse are viewed as safe until proven dangerous and medications, even new medications for cancer, viewed as dangerous until proven safe. A resurgence of drug misuse and abuse has created accidents, deaths, large numbers of binge users, chronic relapsers, and addicts seeking treatment. Academic medical centers were slow to train physicians to identify, intervene and treat or to develop viable addiction psychiatry training programs. Certainly, it appears that drugs come in and out of favor based on myths regarding safety and difficult to discern sociocultural and guerilla marketing. 2009 appears to be in many ways similar to 1969. Marijuana smoking is back and considered by many teens a harmless "herb". All of these factors are intertwined with the history, Haight Ashbury Free Clinic, Woodstock , NIDA and the story of the USA's evolving drug abuse story. One of the most important changes has occurred in the understanding of addiction neurobiology, the role of treatment and long-term recovery. Lessons learned in the 60s may be particularly relevant today as we try to prevent a new generation of drug dependence, identify and treat drug abusers early and with brief interventions, and think about the co-occurring medical and infectious diseases, neurocognitive deficits seen in "burn out" and long term abuse and dependence. What were the flower children like and what happened to them? Have we made progress and what sort of progress as part of the war on drugs? What has worked and what has not worked? Has the past taught us that drugs are dangerous or safe for children, teens, and adults? How have we benefited from decades of neurobiological and other studies? What have we learned from the success of 12 Step and other recovery programs?

NO 6A

EPIDEMIOLOGY OF DRUG USE, ABUSE, MISUSE AND DEATH FROM THE 60S TO TODAY

Bruce A Goldberger, Ph.D., 4800 S.W. 35th Drive, Gainesville, FL 32608

SUMMARY:

In the United States, the "drug experience" trend has included wide swings in the extent of drug use, abuse and misuse, both in the drugs involved and number of people affected. Starting in the mid-1960s – most dramatically during San Francisco's Summer of Love in 1967 – illegal drug use rose rapidly initially among youth, but spread to all ages and all segments of the population. Today, few people realize that the rate of illegal drug use peaked in 1978 when 25 million Americans had used an illegal drug – most commonly marijuana – within the prior 30 days. This figure fell to 14 million in 1991, after which it rose to 19 million in 2007. Because of large increases in the U.S. population over this time, the current level of illegal drug use is far lower than at the peak of the epidemic in 1978, countering the claim that the efforts to reduce illegal drug use in the country have "failed". Nevertheless, drug use, abuse and misuse is back on the rise. Marijuana and club drug use is commonplace among the youth. Furthermore, the recent resurgence of cocaine has been linked to generational forgetting or denial. Additionally, the availability of prescription drugs at home and on the streets has led to tens of thousands of poly-pharmacy deaths. It appears that the children of theSaturday Night Live generation have re-discovered mind-altering drugs.

NO 6B

LESSONS FROM FOUR DECADES OF DRUG ABUSE

Robert L DuPont, M.D., 6191 Executive Boulevard, Rockville, MD 20852

SUMMARY:

The modern drug epidemic exploded in the late 60s reaching a peak in 1978. Although today drug use is well below that level it has become endemic. While drug use has been both common and troublesome for thousands of years, today's drug scene is as new as the computer. Never before have large swaths of the global population been exposed to a broad range of dependence-producing drugs that are consumed by potent routes of administra-

tion (typically intravenous and smoked). The illegal drug supply network now sets the standard for efficient globalization.The most commonly used drugs have long histories. Although the modern drug scene has been highly visible for fourdecades for many young people drug use remains an exciting new experience because they lack the perspective of earlier experiences. Historical blindness accounts for the finding of "generational forgetting" about the common negative outcomes of drug use making generational forgetting one of the major engines of the endemic drug problem.Despite this 40 year experience, drug use remains intensely controversial and often the focus of the media

and politics. Yesterday's Flower Children have become today's parents worried about their children's drug use. Few weeks, or even days, go by without dramatic drug abuse stories. The stunning rise in the nonmedical use of prescription controlled substances, especially the opiates, in the last decade has changed the drug story in surprising ways. Who could have predicted a few years ago that the initiation of nonmedical use of opiates would exceed the initiation of marijuana use in the United States? Or that the argument that legalizing drugs would reduce harm and even reduce drug use (getting rid of the forbidden fruit incentive to use) would be mooted by the emergence of the widespread abuse of prescription drugs which seldom involve organized crime. The nonmedical use of opiates now account for more American deaths than heroin and cocaine combined. We will explore the lessons learned – and not yet learned – in these four decades including the surprising finding that a new and far higher standard is being set for outcomes of substance abuse treatment, by of all things, the care of addicted physicians now handled by state Physician Health Programs. These programs offer a useful model for all other substance abuse treatment programs which are interested in improving their generally lackluster long-term outcomes.

NO 6C

SUMMER OF LOVE: 40 YEARS LATER

David E. Smith, M.D., 876 Stanyan St, San Francisco, CA 94117

SUMMARY:

During the " Summer of Love" the Haight Ashbury Free Clinics were founded in June of 1967 to deal with the thousands of young people that flocked to the Haight Ashbury with the philosophy of drugs, sex rock and role" Better lininvng through chemistry and make love now war. The HAFC was born on the philosophy that healthcare is a right not a privilege and love needs care. In the beginning the primary focus was talking down bad LSD trips and dealing with a variety of acute medical problems including STDs. However, the drug culture soon morphed on into a heavy speed scend followed by a heroin epidemic. Smith will talk about the drug cycle of psychedelics, uppers and downers and present long-term follow up on both the young people that passed through that drug portal and have had no significant disability and compare them with the group that had major medical and psychiatric consequences.

REFERENCES:

1) DuPont RL: The Selfish Brain: Learning from Addiction. Center City, MN, Hazelden Publishing & Educational Services, 2000
2) Sturges CS. Dr. Dave: A Profile of David E. Smith, MD. Founder of the Haight Ashbury Free Clnics. Walnut Creek, CA, Devil Mountain Books, 1993
3) Gold MS, Dupont RL. Teens + Marijuana: (Still) a Dangerous Mix. Clinical Psychiatry News, p14. July 2008.
4) Dupont RL, Gold MS. Comorbidity and "self-medication". J Addict Disease 2008; 26 (S1), 13-24.

PRESIDENTIAL SYMPOSIUM 07

SUICIDE AND THE GOLDEN GATE BRIDGE

Chair: Mel Blaustein, MD, 1199 Bush Street, #600, San Francisco, CA 94109,

Co-Chair: Jerome Motto, MD, 424 Occidental Ave., San Mateo, CA 94402

EDUCATIONAL OBJECTIVES:

At the end of this symposium, the participant should be able to 1) understand the nature of suicide and especially bridge suicide; 2) explain myths and misconceptions about suicide; and 3) discuss the most effective suicide deterrents.

SUMMARY:

The Golden Gate Bridge—the most photographed man-made structure in the world—is also the number one suicide site in the world. Over 1,200 bodies have been found (not counting those washed out to sea) since the bridge was built in 1937. The toll continues at two per month. Suicide is the number 10 cause of mortality nationally but number three among young people aged 10 to 24. As psychiatrists, we know that suicides are most often impulsive acts of desperate individuals. We know that suicides are preventable. The Psychiatric Foundation of Northern California organized a Bridge Barrier Task Force in 2004 to educate the public about suicide. We addressed the question of whether bridge jumpers would go elsewhere to suicide, as well as whether suicidal individuals are exercising free will. After working cooperatively with family members of victims, mental health advocates and concerned public citizens, we persuaded the Bridge Board to conduct an engineering and environmental impact study. At the time of this symposium the Bridge Board of Directors will have made a decision about the installation of a suicide barrier on the Golden Gate Bridge. This workshop will explore public attitudes, misconceptions and myths about suicide as well as the allure and iconic mystery of the bridge. We will talk about suicide deterrents and concern with the issue of whether barriers work. The panel will include family members of bridge suicides, a jump survivor, and experts in suicide, as well as the Marin County Coroner, and the Chief Engineer of the Golden Gate Bridge.

NO 7A

A HISTORY OF GOLDEN GATE BRIDGE BARRIER CAMPAIGNS

Eve Meyer, MSW, Executive Director, San Francisco Suicide Prevention, PO BOx 191350 San Francisco, CA 94119

SUMMARY:

Eve Meyer, the executive director of SFSP for 20 years, will discuss the history of the Golden Gate Bridge suicide barrier campaigns. She will comment about the suicide prevention community's response.

NO 7B

PERSPECTIVE FROM A FAMILY MEMBER

John Brooks, 15 Claire Way, Tiburon, CA 94920

SUMMARY:

John Brooks, is a family member and bridge activist. He is also a bank media financier whose 17-year old daughter suicided from the Golden Gate Bridge in 2008. He will talk about that experience.

NO 7C

SUICIDE DETERRENTS

Ann Fleming, M.D., 1001 Potrero Ave., Ste 7M, San Francisco, CA 94110

SUMMARY:

Ann Flemming, MD is an assistant clinical professor of psychiatry at University of California San Francisco and works on the consultation liaison team at San Francisco General Hospital. She lost a physician classmate to bridge suicide in 2004. She will present an examination of suicide deterrents and focus specifically on the Golden Gate Bridge.

NO 7D

THE CORONER REPORTS ON BRIDGE SUICIDE

Ken Holmes, Marin County Coroner, 3501 Civic Center Drive, #241 San Rafael, CA 94903

SUMMARY:

Ken Holmes has been in the coroner's office since 1975. He will present demographics on bridge suicide over the years. He will also talk about the investigative process and the meetings with families after the deaths.

NO 7E

PERSPECTIVE FROM A FAMILY MEMBER

Mary Zablotny, 584 Page Street, San Francisco, CA 94117

SUMMARY:

Mary Zablotny is an artist whose 18-year old son suicided from the Golden Gate Bridge in 2005. She will reflect on that experience.

NO 7F

STORY OF A BRIDGE JUMP SURVIVOR

John Kevin Hines, 1288 – 17th Avenue, San Francisco, CA 94132

SUMMARY:

Kevin Hines, one of less than 30 Golden Gate Bridge jump survivors, will tell his unique story. Kevin has been featured on Larry King Live, Good Morning America, CNN, and publications throughout the world.

NO 7G

CONSTRUCTION OF A SUICIDE BARRIER

Denis Mulligan, Chief Engineer, Golden Gate Bridge, Highway & Transportation District, Golden Gate Bridge, Highways & Transportation District, PO Box 9000, Presidio Station

San Francisco, CA 94129-0601

SUMMARY:

Denis Mulligan has been with the GGBHTD for eight years and will discuss the engineering and architectural aspects of building a barrier on the Golden Gate Bridge. He will analyze design models and address the implementation of the newly approved net.

NO 7H

FINAL REFLECTIONS

Jerome Motto, MD, 424 Occidental Avenue, San Mateo, CA 94402

SUMMARY:

Jerome Motto, MD is a professor emeritus of psychiatry at University of California San Francisco and an internationally known suicidologist who has been involved in Golden Gate Bridge Bridge barrier campaigns since the 1970s. He will share with the audience some final thoughts about the suicide barrier.

REFERENCES:

1.Cantor, C, Hill, M. and McLachlan, E. Suicide and related behavior from river bridges: a clinical perspective. British Journal of Psychiatry (1989), 155, 829-835

2. Mann, J: Suicide prevention strategies. JAMA 2005; 294 (16): 2004-2074.

3.Reisch,T, Schuster, U, and Michaels, K. Suicide by jumping and accessibility of bridges: results from a national survey in Switzerland. Suicide and Life Threatening Behavior 37(6) December 2007; © 2007 The American Association of Suicidology.

4.Seiden, R: Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. Suicide and Life Threatening Behavior 1978; 8(4): 203-216.

PRESIDENTIAL SYMPOSIA

SMALL INTERACTIVE SESSIONS
MONDAY, MAY 18, 2009
9:00 AM-10:30AM

SMALL INTERACTIVE 01

SAFETY ISSUES IN CHILD PSYCHOPHARMACOLOGY

Presenter: Barbara J Coffey,63 Westminster Rd, Great Neck, NY 11020 1270

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to: 1) identify key concerns regarding the use of various classes of psychotropic medications in the treatment of child and adolescent patients; and 2) understand and apply the latest research findings and evidence-based guidelines in the practice of pediatric psychopharmacology.

SUMMARY:

Use of psychotropic medications, including atypical neuroleptics, stimulants, antidepressants, and anticonvulsants, in children and adolescents has risen significantly over the past decade. Many of these medications are prescribed for off label indications, and reports of adverse effects are increasing. Questions regarding safety of these treatments have emerged, including suicidality in youth treated with antidepressants, and weight gain and metabolic issues in youth on atypical neuroleptics. Safety issues in pediatric psychopharmacology will be reviewed with a focus on indications, off label uses, and adverse effects. Guidelines for a rational approach to targeted psychopharmacological treatment, including the evidence base, and beyond, will be discussed.

REFERENCES:

1. McVoy M, Findling R: Child and adolescent psychopharmacology update. Psychiatr Clin North Am. 2009 Mar;32(1):111-33.
2. Findling RL (ed.): Clinical Manual of Child and Adolescent Psychopharmacology. American Psychiatric Publising, Inc., 2008.

11:00 AM-12:30PM

SMALL INTERACTIVE 02
WITHDRAWN

TUESDAY, MAY 19, 2009
9:00 AM-10:30AM

SMALL INTERACTIVE 03-A DISCUSSION AND OPEN FORUM ABOUT DRUG INTERACTIONS

Presenter: Gary Wynn, M.D. 4215 Lorcom Lane, Arlington, VA 22207

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to identify and understand the major concepts of drug interactions as well as apply these principles to clinical practice.

SUMMARY:

This small interactive session will cover some basic principles of drug-drug interactions followed by discussion of several interesting cases that highlight these principles and illuminate the fascinating and complex aspects of drug-drug interactions. After this relatively brief introduction the floor will be open for questions and cases from the audience to allow for an interactive discussion about current clinical topics and issues surrounding drug-drug interactions. While this session will cover some basic principles of drug interactions, the discussion will primarily be for those with a minimum understanding of drug-drug interaction concepts such as enzymatic inhibition and induction.

REFERENCES:

1. Wynn GH, Oesterheld JR, Cozza KL, Armstrong SC: Clinical Manual of Drug Interaction Principles for Medical Practice. Washington, DC, American Psychiatric Publishing, Inc., 2009
2. Sandson NB: Drug-Drug Interaction Primer. Washington, DC, American Psychiatric Publishing, Inc., 2007

SMALL INTERACTIVE 04
NEUROPSYCHIATRIC ASSESSMENT FOR GENERAL PSYCHIATRISTS

Presenter: Sheldon Benjamin , M.D.55 Lake Ave N, Worcester, MA 01655 0002

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to determine the most appropriate neuropsychiatric assessment techniques for the cases discussed, and learn several axioms that demystify neuropsychiatric assessment.

SUMMARY:

Psychiatrists are frequently called upon to evaluate individuals whom they feel are atypical in some way and at higher risk of having a neurological component to their behavior. This may stem from the behavioral phenomenology; or from a history of developmental disability, learning disorder, traumatic brain injury, epilepsy, movement disorder, dementia, or other neurological disorder. Apart from referring these individuals to our neurology colleagues for consultation there are a number of diagnostic strategies that enable psychiatrists to form a hypothesis as to the etiology of a given behavior. These include the flexible application of cognitive status examination, the neurological examination, the use of neurodiagnostic assessment techniques such as neuropsychological testing, EEG, structural and functional neuroimaging, and the judicious application of laboratory testing. There is a common belief that neuropsychiatric assessment requires knowledge of long lists of arcane diagnoses. But several axioms regarding neuropsychiatric assessment can demystify the process. For developmental neurologic disorders, as in the differential diagnosis of young-adult onset psychosis, an approach us-

ing common symptoms and epidemiology can simplify the task. In other cases, recognition of common neurobehavioral patterns facilitates diagnosis.

Participants in this session are encouraged to bring neuropsychiatric problems they have encountered in clinical practice. After providing a brief introduction to a set of neuropsychiatric axioms and a differential diagnostic strategy for psychotic disorders, participants will be asked to share clinical problems from their own practice. Case discussion will focus on clinical rather than research neuropsychiatric assessment strategies, emphasizing techniques available to general psychiatrists. A neuropsychiatric approach to assessment that goes beyond DSM diagnosis can be helpful in understanding the etiology of behavioral disorders.

REFERENCES:

1. Lauterbach M, Stanislawski-Zygaj, A, Benjamin S. The Differential Diagnosis of Childhood and Young Adult Disorders that Include Psychosis, Journal of Neuropsychiatry and Clinical Neuroscience, 2008 20(4) 409-418.
2. Benjamin S. A Neuropsychiatric Approach to Aggressive Behavior, In: Ovsiew F, Neuropsychiatry for Mental Health Services, American Psychiatric Press, Inc., Washington, DC, 1999.

SMALL INTERACTIVE 05
WITHDRAWN

11:00 AM-12:30PM

SMALL INTERACTIVE 06

WHEN A PHYSICIAN IS YOUR PATIENT

Presenter: Michael F Myers, M.D.

EDUCATIONAL OBJECTIVES:

At the end of this session the participant will be able to: 1)Diagnose and treat physician-patients using a comprehensive biopsychosocial perspective; 2) Be alert to central transference and countertransference dynamics when treating physicians; and 3) Understand the myriad advocacy imperatives when physicians become our patients

SUMMARY:

This session will give attendees an opportunity to discuss the contents of the book that Dr Myers has co-authored with Dr Glen Gabbard. Possible themes and subject areas include: personality traits unique to physicians; ethnic and racial diversity in today's physicians; the 'disruptive' physician; chemical and non chemical dependence; mood and anxiety disorders; issues to note when completing independent medical evaluations of physicians; psychotherapeutic principles in treatment; approaches to relationship strain, separation and divorce; treatment basics with suicidal physicians; and outreach to family and medical colleagues when doctors die by suicide.

REFERENCES:

1. Myers MF, Gabbard GO: The Physician As Patient: A Clinical Handbook for Mental Health Professionals. American Psychiatric Publishing Inc., Washington DC, 2008
2. Center C, Davis M, Detre T et al: Confronting depression and suicide in physicians. A consensus statement. JAMA 2003;289:3161-3166

SMALL INTERACTIVE 07
APPROACH TO THE PSYCHIATRIC PATIENT

Presenter: John W Barnhill, M.D. 525 E 68th St # 181, New York, NY 10065 4870

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to:1) Evaluate a medical student patient using a biopsychosocial approach.; 2.) Assess ways in which theoretical and clinical biases might affect a psychiatric evaluation; and 3) Critique the decisions that go into creating a multi-authored text.

SUMMARY:

Approach to the Psychiatric Patient consists of over 100 short essays that comment on one of 10 clinical cases. This session will provide an opportunity to explore one of the cases in detail, both in regards to an understanding of the case as well as the behind-the-scenes decisions regarding selection of the case, the topics, and the authors. The case to be discussed consists of the outpatient evaluation of a medical student who has failed an exam. The 14 "experts on your shoulder" discuss such topics as obsessionality, narcissism, the first-generation American, complementary medicine, meditation, empathy, evidence-based psychotherapy, and the self-defeating patient. The chapter will be handed out at the session but can also be read ahead of time (email <mailto:jwb2001@med.cornell.edu>jwb2001@med.cornell.edu for a copy).

REFERENCES:

1. Barnhill JW: Approach to the Psychiatric Patient. American Psychiatric Publishing Inc., Washington DC, 2008

SMALL INTERACTIVE 08 WITHDRAWN

WEDNESDAY, MAY 20, 2009
9:00 AM-10:30AM

SMALL INTERACTIVE 09

CLINICAL MANUAL FOR THE DX & TRTMT OF PSYCHOTIC DEPRESSION - (THE DIAGNOSIS AND TREATMENT OF PSYCHOTIC (DELUSIONAL) DEPRESSION)

Presenter: Anthony J Rothschild, M.D. University of Massachusetts Medical School,Department of Psychiatry, 361 Plantation Street, Worcester, MA 01605

EDUCATIONAL OBJECTIVES:

At the conclusion of this presentation, the participant should be able to: 1) Accurately diagnose and assess patients with psy-

chotic depression.; 2) Identify the difficult differential diagnoses between psychotic depression and other psychiatric disorders; and 3) Treat patients with psychotic depression with medications, electroconvulsive therapy and adjunctive psychotherapy.

SUMMARY:

This small interactive session will focus on the diagnosis and treatment of psychotic depression, a serious illness during which a person suffers from the dangerous combination of depressed mood and psychosis, with the psychosis commonly manifesting itself as nihilistic, bad things are about to happen, type delusions. The session will be led by Dr. Anthony Rothschild, Professor of Psychiatry at the University of Massachusetts Medical School, who has devoted his career to the study of psychotic depression and has received NIMH-funding to study the treatment of this disorder. Dr. Rothschild is the author of the recently published book entitled Clinical Manual for the Diagnosis and Treatment of Psychotic Depression (American Psychiatric Publishing , Inc., 2009).

Examples of psychotic depression are unfortunately seen in every part of the world: the mother who inexplicably kills her children before killing herself or the retired, mild-mannered college professor who sets himself and his home on fire; these are all real-life examples of psychotic depression – a serious, life-threatening illness. Although psychotic depression is treatable and people can make a full recovery, unfortunately, as will be discussed in this interactive session, the diagnosis is frequently missed, leading to the prescription of ineffective treatments, and unfortunate outcomes.

REFERENCES:

1. Rothschild AJ: Clinical Manual for Diagnosis and Treatment of Psychotic Depression. American Psychiatric Publishing, Inc., Washington, DC, 2009.
2. Rothschild AJ, Winer J, Fratoni S, Gabriele M, Kasapinovic S, McShea M, Flint A, Meyers B, Mulsant B, Study of the Pharmacotherapy of Psychotic Depression (STOP-PD). Missed Diagnosis of Psychotic Depression at 4 Academic Medical Centers. 2008; J Clin Psychiatry, 69: 1293-1296.

11:00 AM-12:30PM

SMALL INTERACTIVE 10
WITHDRAWN

SMALL INTERACTIVE 11
WITHDRAWN

9:00 AM-10:30AM

SMALL INTERACTIVE 12

ANTIPSYCHOTIC POLYPHARMACY - AN EVIDENCE BASED PERSPECTIVE

Presenter: Donald C Goff, M.D., 25 Staniford Street, 2nd Fl., Boston, MA 02114

EDUCATIONAL OBJECTIVES:

At the conclusion of this session, the participant should be able to discuss the clinical evidence for and against the use of polypharmacy in schizophrenia.

SUMMARY:

Antipsychotic polypharmacy has been reported at rates as high as 30% of patients with schizophrenia, despite the absence of consistent evidence to support this approach. Two rationales have been proposed to explain this practice. The first is the use of polypharmacy to reduce side effects, either by achieving therapeutic levels of D2 occupancy by combining lower doses of two drugs with dissimilar side effect profiles or by suppressing side effects with a second drug, such as the addition of aripiprazole to reduce hyperprolactinemia. The second rationale is to improve efficacy in refractory patients. Two placebo-controlled trials have reported benefit with addition of risperidone to clozapine, possibly reflecting an increase by risperidone of D2 antagonism, although several other controlled trials have been negative. The relative evidence for each approach will be reviewed.

REFERENCES:

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