



EPA CONGRESS NEWS

The official daily newsletter of the 21st European Congress of Psychiatry

Sunday 7 April 2013 Day 1

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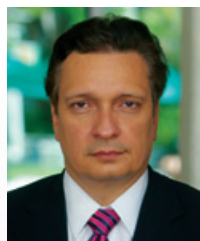
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Welcome, colleagues

It is with great pleasure that I welcome you to the 21st European Congress of Psychiatry in Nice.

This year marks the 30th anniversary of the European Psychiatric Association, thus it offers a natural opportunity to both reflect on the past three decades of psychiatry and also look to the future of where we would like our journey to take us in the next 30 years. In tribute, this year's programme features special presentations, Round Tables, networking events and discussions that will set the tone as we usher in the next era of European psychiatry.

We are already off to a fantastic start, having welcomed 33 European National Psychiatric Associations (NPAs) with more than 77,000 members to the EPA in the last year. These collaborations will serve to enhance our knowledge and understanding of different traditions, cultures and viewpoints across Europe, thus fostering reciprocal exchange of ideas and approaches that will boost the advancement of patient care in these economically challenging times.

We welcome these new associations alongside the fruitful and dynamic relationships of our long-established collaborators, the World Health Organization (WHO), European Union (EU), European Union of Medical Specialists (UEMS), European Federation of Asso-

ciations of Families of People with Mental Illness (EUFAMI), European College of Neuropsychopharmacology (ECNP), World Psychiatric Association (WPA), European Brain Council (EBC), European Federation of Psychiatric Trainees (EFPT) and the European Conference on Schizophrenia Research (ECSR).

As we look to the future, it is apparent that we need to place more focus on consciously improving the health of psychiatric professionals, encouraging ourselves and all those in the field to invest more effort in improving our working conditions as well as individually taking care of our own health, both mental and somatic. The latter by increasing awareness about the role of diet, exercise and sleep. And the congress will be no exception – as well as offering healthy Mediterranean cuisine throughout, we will be hosting organised walks between hotels and the Acropolis, as well as asking plenary lecture attendees to join us in a pre-lecture warm-up with the help of our very own congress exercise guru.

By strengthening our well being and health, we will be better prepared to serve our patients and by giving good examples, our patients will profit in the treatment process.

As always, the cutting-edge scientific programme returns with a rich



Danuta Wasserman

array of core symposia, plenary lectures, state of the art lectures, pro and con debates, early career sessions, posters and sponsored sessions that offer a comprehensive and enlightening view of the very latest insights in psychiatry and its associated fields.

I hope that you have an enlightening and enjoyable congress, and I look forward to seeing you again in Munich, Germany, 2014.

Danuta Wasserman

EPA President

*Head of the National Prevention of Suicide and Mental Ill-health (NASP) at Karolinska Institute, Stockholm, Sweden
Director for the WHO Collaborating Centre for Prevention of Mental Ill-Health and Suicide*

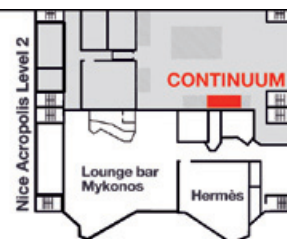


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continuum
evolution in ADHD

Pharmacological treatment of ADHD Athéna Sunday 10:00-11:30

Taking a step back in ADHD

The debate over the increasing prescription of ADHD medication sets the stage for a discussion of the questions that genetic studies can answer in the disorder. During his presentation today on the promises of genetics, Gil Zalsman (Sackler School of Medicine, Tel Aviv, Israel) will take delegates through the nature versus nurture debate in ADHD, emphasising the importance of continuing collaborative efforts to understand the disorder better.

Every fifth adolescent in high school in the US takes Ritalin, according to recent data from the Centre for Disease Control (CDC) in the US.¹ "ADHD is considered as an epidemic in Europe and the US," said Professor Zalsman. "There is a big debate about it: is it really a disease? Is it actually part of culture? In this culture, everybody has a cellphone and everything is so quick. Maybe we are creating this disorder. Some other people say that it is nothing but a neurological disorder. The main assumption is that we simply come to a diagnosis more often. The debate in the US is that there is over-diagnosis. The criteria are too wide, and actually the whole story of the epidemic of ADHD is a matter of diagnosis and awareness. The same is true for PDD [pervasive development disorder] and autism in the US and

Europe. We see a very large increase in the numbers, almost ten-fold, during a decade in autism spectrum diagnosis, and this led the DSM-V to change the diagnosis."

Professor Zalsman will demonstrate that ADHD is at least partially genetic, with evidence from twin and adoption studies, as well as genomics. He said: "The prevalence in identical twins is two to three times more than in non-identical twins, which means that if you share the same DNA, the odds of having ADHD if your brother has it is sometimes around 50 percent. Adoption studies show the same: there is a major genetic contribution to ADHD."

The high heritability of ADHD has prompted genetic studies, looking at either candidate gene regions or scanning the genome as a whole. While contradictory findings are a frustration for the scientific community, they may belie the complexity of the multiple genetic and environmental factors that make up an individual's ADHD symptom profile. "Often studies found a few candidate genes, but none of them can be said to be the gene for ADHD," said Professor Zalsman. "It seems that some findings are not replicable. In some cases, the findings are true in boys and not in girls. Some findings are negative, while others are positive on the same gene. The current state is that we actually have no gene in our hand, and it seems that in many other disorders in psychiatry – and especially in child psychiatry – that the genetics of the disorder is multifactorial. There is more than one gene and there is more than one factor. So it is actually an interaction between few key genes and the environment together."

When prescribing for ADHD in the young, the normal distribution of developmental rates that children display must be taken into account, said Professor Zalsman, adding that attention span may take longer to develop in some children than others. "A child that was born a few hours ago has no attention span and we expect him to do so."

"A normal baby has very high distractibility, and this is important for its development. Every noise, every new sight that comes in front of him, he will follow. When you are six years old, we expect you to have about 13

minutes of attention span. Yes, some kids are way behind, but it doesn't mean that they have a disorder. Some kids are shorter than others, some kids have less motor skills, some kids have an attention span of 15 minutes, not 13. Some people in my profession think that since it is only developmental, if you wait long enough this kid will catch up; so actually it is unfair to Ritalin to everyone who is a little behind in the

same way that we don't give growth hormone to every kid that is a little bit short in the first few years of school!"

While this may be the case, Professor Zalsman was also careful to stress that some individuals will never attain normal adult measures of attention span. In adulthood, and even in childhood and adolescence, the problems of ADHD do not end when the school bell rings. "We see today about seven to 10 percent of adults

with ADHD. Most of the problems of these kids are much bigger than school. They are impulsive, they have behavioural problems, they are not attentive, and they are impulsive often within their peer group so they are not popular. They have a lot of problems with their parents, because they behave badly. So they have low self esteem, and very high rates of depression and other comorbidities. One of the studies we have done has shown that the rate of suicidality is higher, the suicidal ideation and attempts are higher. So actually, these kids are vulnerable in many things, and their functioning in school is only part of the problem."

The complexity of multiple genetic and environmental factors, together with the theory of over-diagnosis, presents a significant challenge for research. Moreover, genome-wide studies require thousands of subjects to attain the statistical power that is necessary for a hypothesis-free study of such a vast array of data. "The only way really to do it is to have consortia and collaboration," said Professor Zalsman.

"The EPA, and especially the Child Psychiatry section that I am chairing at the EPA, is trying to promote collaboration between people. This is what EPA is about. We have to join hands and do it together. If I have 200 kids and someone in Holland has another 200 kids, and someone in

Continued on page 18

EPA CONGRESS NEWS

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State of the Art lecture: Early detection and treatment of depression Apollon Sunday 15:45-16:30

A wake-up call for clinical psychiatry

The sophistication of clinical diagnoses that psychiatrists make in their practice far outstrips that of the assessment methods used in psychiatric research, Giovanni Fava (University of Bologna, Italy) will communicate in a State of the Art lecture today that examines the early detection and treatment of depression.

In an interview with *EPA Congress News*, he spoke about reviving the status of clinical judgement as a scientific way of formulating clinical decisions. By discussing the current clinical issues surrounding major depressive disorder in his lecture, Professor Fava will uncover some of the possibilities for improving clinical research, diagnosis, acute treatment and long-term management in this and other disorders.

Early intervention can be achieved by the observation of prodromal symptoms, but these symptoms may be most helpful in recognising the onset of relapse in individuals, simply because of their high inter-individual variability and lack of diagnostic specificity. "Yes, there is a prodromal phase of depression, but it is not specific," said Professor Fava. "In other words, the symptoms that may occur vary among patients and they may take place in depression, panic, social phobia, and other disorders."

Introduced some 20 years ago, Fava and Kellner's staging theory¹ is now a familiar face on the psychiatric scene, comprising the prodromal phase, acute manifestations, residual phase, and chronic phase (in attenuated or persistent form). While the prodromal phase cannot be confirmed until the emergence of an acute phase, if this occurs at all, it is nevertheless useful in the longer term.

"The important thing is that symptoms are very variable, but for the same patient, relapses tend to take place with the same symptoms," said Professor Fava. "How can this be used for addressing residual symptoms, the symptoms which persist after you have been treated and after the most important symptoms get better? For instance, you may feel well in your mood, but you may still have problems sleeping. I will describe an approach that is making use of this way of categorising symptoms that is longitudinal, and not cross-sectional, as is the DSM."

He went on to question the refinement of the classification systems, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD), in their present state, saying that precise treatment guidelines cannot be defined from them.



Giovanni Fava

"They are too broad," he said. "They can consist of different things that need to be addressed. This will really be one of the crucial issues of my talk: a single intervention is unlikely to solve the clinical problem. Whether pharmacotherapy or

tion, and emphasised the importance of both 'self-therapy' and psychotherapy as tools for changing patterns of behaviour and improving self-awareness. Hence, he proposed a sequential treatment strategy that observes the principles of staging. This approach entails the use of antidepressant drugs during the acute phase, and the use of psychotherapeutic strategies during the residual phase while drugs are tapered and discontinued. While this method relies on the impetus of the patient as well as the availability of psychotherapy, Professor Fava noted the considerable advantages of reduced relapse rates and the discontinuation of medication.

In his latest look at the use of extended clinical measurements that form the basis of clinical judgement, in relation to the standard diagnostic criteria, Professor Fava identified several innovative strategies that he hopes will go on to provide the foundation for a more detailed, thorough approach to evidence-based study. Clinimetrics, repeated patient assessment, staging of both symptoms and other factors (such as treatment resistance), and macroanalysis are some of the most prominent potential strategies that will be presented in his State of the Art lecture.³

The methods of clinical judgement, embracing this complexity, should be reflected in clinical research as it is in clinical practice. Evidence-based medicine, randomised controlled trials and meta-analyses can neglect the clinical histories of patients, whose previous treatments and chronicity can influence the effectiveness of treatment.⁴ "There should be a much more

refined assessment," said Fava. "The treatment protocol should derive from this assessment. I will attack evidence-based medicine as being non-scientific. Evidence-based medicine is based on the average patient; I never see the average patient. I would love to see them! I get all of the most complicated, atypical, strange cases as time goes by."

"The important thing is that symptoms are very variable, but for the same patient, relapses tend to take place with the same symptoms. How can this be used for addressing residual symptoms, the symptoms which persist after you have been treated and after the most important symptoms get better?"

Giovanni Fava (Bologna, Italy)

Professor Fava will deliver his State of the Art lecture on the early detection and treatment of depression, and the role of clinical judgement, at 15:45 this afternoon in room Apollon.

References

1. Fava & Kellner. Staging: a neglected dimension in psychiatric classification. *Acta Psychiatr Scand*. 1993;87(4):225-30.
2. Fava GA et al. Cognitive behavioral treatment of residual symptoms in primary major depressive disorder. *Am J Psychiatry*. 1994;151(9):1295-9.
3. Fava GA. Clinical judgment in psychiatry. *Requiem or reveille?* *Nord J Psychiatry*. 2013;67:1-10.
4. Tomba E. Nowhere Patients. *Psychother Psychosom*. 2012;81:69-72.

psychotherapy, we are dealing with complex issues that need sequential, different approaches, the consideration of various components of the depressive disorder."

The lingering spectre of residual symptoms is unlikely to vanish by pharmacological treatment, as evidenced by the 1994 study carried out by Fava et al.² Professor Fava described examples of the compound problems that can arise from the extended use of antidepressant medica-

State of the art lecture: Improving Schizophrenia Outcome Apollon Sunday 15:00-15:45

Better ‘functioning in real-life’ for people with schizophrenia

This afternoon plays host to a state of the art lecture that will explore how we can improve the outcome of schizophrenia patients when returning to the community, with emphasis placed on improving function in everyday life, and not just the lessening of symptoms.

“Several changes have occurred in the past decade with relationship to the conceptual frame of schizophrenia outcome,” Silvana Galderisi (University of Naples SUN, Italy) told *EPA Congress News*. “In the past we have had very diffuse ideas that schizophrenia was a progressive illness with a poor outcome. And this dates back to authors such as Bénédict Morel or Emil Kraepelin who considered the disorder as very chronic and deteriorating with a poor prognosis.

“A change in this perspective took place and some researchers as well as clinicians started to endorse a more optimistic view of the outcomes of schizophrenia to the point that they felt unsatisfied of a concept of outcome limited to the improvement of symptoms of the illness, and wanted to have a much more ambitious goal: having patients living a satisfactory life in the community.”

Critically, it was observed that while patients were returned to community life with fewer symptoms, the limitations in ‘functioning’ still had a significant impact on their quality of life. This concern led researchers and clinicians alike to develop different perspectives on what would be a proper and appropriate outcome for a patient.

However, as Professor Galderisi noted, to this day there is still great discussion as to how ‘functional’ status in the community can be ascertained, not least because measuring the symptoms has been hitherto defined by clinicians and

researchers through many decades of research. As such, functioning in the real-life is a concept that is hard to trace. “I will briefly touch upon different definitions of ‘functioning’ in real life, and will then move to the discussion relevant to what do we know at this point, what do we need to know and to address in order to improve outcome,” she said.

Indeed, improvement of functioning in the real-life depends on several variables, some of them relevant to the illness, some to personal resources, some others to the context in which the person lives. To improve functional outcome, we need to address as many variables as possible. For example, looking at illness related variables (e.g. symptoms and cognitive impairment), while positive symptoms are effectively treated, there are few

“Some researchers as well as clinicians started to endorse a more optimistic view of the outcomes of schizophrenia... and wanted to have a much more ambitious goal: having patients living a satisfactory life in the community.”

Silvana Galderisi (University of Naples SUN, Italy)

available treatments for negative symptoms, especially those defined as persistent, and for cognitive impairment.

“Therefore, I will focus the attention on the new treatments for negative symptoms and cognitive impairment,” said Professor Gal-



Silvana Galderisi

derisi. “At least what is considered today state of the art in these concepts and also the possibilities to find new treatments of these aspects that so far have not been really treated successfully.”

She continued: “Then we have to consider variables relevant to the person’s resources. In fact, people may have the same symptoms and the same type of cognitive impairments but they may be very different as far as some of their individual resources are concerned. And here I am talking of course of people’s coping strategies, people’s recovery styles, people’s resilience – which need to be regarded as important resources in the treatment

process. Among personal resources, an important variable to consider is physical health – known to have an impact on patient outcome.”

Professor Galderisi will also briefly address the importance of context-related variables. She said: “I will mention the possibility that

families’ social-economic status, the dimension of the social network of persons and the stigma associated to the illness in different contexts can also influence the possibility for people with schizophrenia to lead a fulfilling life.”

Briefly touching on this aspect, Professor Galderisi referred to recent studies of her own which compared schizophrenic patient outcomes in the communities of several northern and southern European locations: “We found out to our surprise that patients living in Naples [south Europe] were actually more frequently employed, even though they lived in a context where having a job was more difficult than in the other sites,” she explained. “And so we concluded in this paper that probably in the south of Europe there is a lower tendency to stigmatise mental illness and to exclude affected people from social life and from working opportunities.”

Professor Galderisi will discuss current views of schizophrenia outcome, the main variables influencing it, and the unmet needs and future perspectives in management of schizophrenia in her state of the art lecture ‘Improving Schizophrenia Outcome’, held today at 15:00-15:45 in Room Apollon.

European Mental Health Care in the Time of Economic Crisis Galliéni 5 Monday 15:00-16:30

Putting psychiatry and the patient first

The cultures that make up the European community can lend each other useful insight into approaches towards mental health care amid turbulent economic times, delegates will hear on Monday in a special session that will put the spotlight on patients' and doctors' rights, stigmatisms and the various implications that a struggling economy brings.

Speaking to *EPA Congress News* ahead of his talk about the importance of upholding the needs of the patient as a matter of human right, António Pacheco Palha (Hospital San Joao, University of Porto, Portugal) shared his opinions on the role of the psychiatrist within the spectrum of treatment during this critical period.

Professor Palha began by describing his perspective on the role of the psychiatrist in current mental health reform, namely in Portugal, highlighting that practice does not always follow policy. "Psychiatrists are, many times, an aside," he said. "There are different technicians on the ground – social workers, rehabilitative workers, from the community and from the municipality. And sometimes there are local and national councils of forty people created to address issues in mental health, but they come to nothing.

"I am living here [in Portugal] and I see a lot of discrepancies. Now with the crisis and the new management in health systems we ask: what is the best time to attend to the patient? Five minutes, fifteen minutes, thirty minutes? How many



António Pacheco Palha

days he can spend as an inpatient? Seven days? Fifteen days? How can we save money? There are now new problems like this that derive from the crisis. Yet the patient has rights to dignity and the best care. Meeting the needs of the client is a human rights question."

The treatment of the patient must be put first, said Professor Palha, and this begins with diagnosis, which emerges from a foundation of clinical skills. He emphasised that psychiatrists, while considering social and community elements of patient care, must retain this foundation. "In the southern [European] countries in this [economic] crisis, we have a very nice composition of law and intentions, etc. In reality, everybody talks about mental health within the community of psychiatrists, but we have forgotten psychiatry. Psychiatry is a clinical speciality that deals with body and mind, and social elements. We need to pay attention to psychiatry. Psychiatrists can fulfil the

needs of the human rights of the patients.

"The first human right of the patient is to be well treated in the best setting with the best techniques, medicines and psychotherapies. We have to pay attention to all these things. When we have a lot of countries such as in Europe, regardless of political problems, the reality is that the situation is good if we have conditions for good living and good care in the community."

Professor Palha then went on to describe how important it is that psychiatrists should remain involved in cases as they progress from the acute to the chronic or remissive stages. He said: "Schizophrenia is

we have many new treatments, new techniques, and new medicines, rehabilitation is now very sophisticated and we need to keep in touch with that."

Professor Palha was instructive in formulating recommendations as part of his work on the board of the Portuguese Society of Psychiatry and Mental Health as Past President, however he was keen to emphasise that the reality on the ground can be very different. He cited few resources as a critical issue in serious conditions such as schizophrenia and obsessive-compulsive disorder. He added that policy does not always take into account practical issues of modern life (such as working families being unable to provide care for a schizophrenic relative), and that many psychiatrists are striving to take these factors into consideration.

Professor Palha concluded on a note of

problems (schizophrenia, bipolar disorders, dementia, etc.) are not exclusively problems of the brain; they are problems of the mind, which is inside the brain. So we have to come back a little bit to what we can once again call neuropsychiatry. A neuropsychiatry perspective will also take care of the social part, because the mind came from society. When I started my training in psychiatry, I was in the last part of neuropsychiatry, but now it is coming back again."

Professor Palha also added that early diagnosis and establishment of a treatment programme, together with continual evaluation during treatment, is the key to a successful rehabilitation. He said: "Even in dementia there are two sides: in the early stages of dementia, there are a lot of things that psychiatrists can do – that rehabilitation and stimulation can do. It

is not the final step of life. But early diagnosis is the base of everything. We know that if you diagnose within months of the onset, the prognosis is fantastic compared to after five years. I think we need to be much more broad-minded, not to follow the DSM religiously. And the first diagnosis very often is not definitive. The psychiatrists' rights

to have the best conditions to treat and rehabilitate their patients are one of the main supports for the fulfillment of patients' rights in these days."

"But early diagnosis is the base of everything. We know that if you diagnose within months of the onset, the prognosis is fantastic compared to after five years. I think we need to be much more broad-minded, not to follow the DSM religiously. And the first diagnosis very often is not definitive."

António Pacheco Palha (Hospital San Joao, University of Porto, Portugal)

a chronic disease, like the majority of the important diseases in medicine such as rheumatoid arthritis or diabetes. But why do they become social cases? Rheumatoid arthritis does not become a social case. [Schizophrenia patients] pass through another kind of treatment and care, but they should remain under the supervision and the care of the psychiatrist. Because

optimism, with a bugle call for neuropsychiatry as the front line of patient care that considers social influences as well as clinical symptoms in order to deal with a particular condition. "There are many papers appearing that ask: what is the future of psychiatry? And we cannot give its place to neurology. Neurology knows about brain, and we know that severe mental health

Professor Palha will give his presentation 'Patients' and doctors' rights: the dignification of the psychiatrists in these days' during the European Forum session on mental health; 15:00-16:30, Monday, room Galliéni 5.

Pharmacological treatment of ADHD Athéna Sunday 10:00-11:30

Pharmacotherapy is neither the beginning nor the end of ADHD treatment

It is now known that Attention-Deficit/Hyperactivity Disorder (ADHD) is a highly heritable lifespan disorder, but diagnosis may only arrive in adulthood, leaving sufferers with a set of complex and interrelated array of symptoms and disorders, delegates will hear this morning at the congress. Sandra Kooij (PsyQ, The Hague, the Netherlands) spoke to *EPA Congress News* about her own research in adult ADHD, explaining the way in which pharmacological treatments are being used as part of a battery of strategies that tackle pragmatic issues, such as the learning of organisational skills, and other physical and psychiatric issues such as obesity, sleep disorder, depression and anxiety.

"ADHD is a lifespan disorder that starts in early childhood and happens to continue into adulthood and into old age," said Dr Kooij. "Based on recent studies, we now know that ADHD is also prevalent in older adults, and the prevalence rate is between 3% and 5% throughout lifetime."

As with many heritable complex disorders, the genetic expression of ADHD is influenced by environmental factors. Although symptoms are similar throughout the duration of the disorder, different life stages come with different sets of individual responsibilities and expectations that give rise to changes in ADHD expression. "A child does not have to organise himself or herself as adults do," said Dr Kooij. "Adults [with ADHD] have more difficulties in planning, organising and paying attention. You don't expect children to do this all for themselves – parents and teachers play an important role. ADHD children need much more support – that is well known."

Adults with ADHD often end up relying on a spouse to organise their lives, but this can lead to unbalanced and difficult relationships.



Sandra Kooij

Dr Kooij continued: "ADHD is often accompanied by mood swings, anger outbursts, and also problems in relationships and spending too much money. These people are restless; they are famous for job-hopping and partner-hopping. They are easily bored and need new challenges, and this is all part of the syndrome. The symptoms lead to impairment in daily educational work and relationships, and it may lead to substance abuse. Alcohol and drugs may diminish the symptoms for a time, and of course this can lead to addiction and, again, financial issues.

So there is a whole cascade of problems and people trying to solve their problems in their own way that may make it even worse."

With a relatively low public profile, it is understandable that the mean age of adults referred to a clinic for ADHD is 35 years in the

"They have lived all their lives with the disorder, having problems in several different areas without knowing what was wrong or what to do about it. So when they come in, they are impaired in functioning, otherwise you would never get a diagnosis. If you have no impairment, you have no reason to make a diagnosis; this is very important."

Sandra Kooij (PsyQ, The Hague, the Netherlands)

with the disorder, having problems in several different areas without knowing what was wrong or what to do about it. So when they come in, they are impaired in functioning, otherwise you would never get a diagnosis. If you have no impairment, you have no reason to make a diagnosis; this is very important."

Diagnosis requires extensive assessment of the onset and severity of symptoms going back to childhood, which can only be done by talking to the individual patient, and if possible their spouse and family members – particularly parents. Kooij developed with colleagues the Diagnostic Interview for ADHD in adults (DIVA 2.0). Thanks to the support of European Network Adult ADHD members, it is now available for free in nine languages at www.divacenter.eu. There is also a DIVA 2.0 App for electronic scoring of the interview. "In addition, we assess all comorbidities that come with ADHD," said Kooij. "ADHD seldom comes alone; it is usually comorbid with depression, anxiety, addiction, and sleep problems. The mean number of disorders in an ADHD adult is three."

Sleep problems occur in 80 percent of patients, beginning in childhood as well as persisting chronically. Interestingly, ADHD patients are typically late-evening people – or 'night owls' – and whether someone is a night owl or an early-riser is well-known to be driven mainly by genetics, with most people falling somewhere in between these extremes. But late-evening tendencies are not very compatible with normal working hours, resulting in chronic shortening of sleep duration. "The short sleep duration has been studied extensively by internal medicine and they have shown that it is detrimental to physical health, that it is associated with obesity, diabetes, hypertension and cancer," said Dr Kooij. "Because ADHD patients find sleep difficult from childhood on,

Netherlands. Dr Kooij explained the diligence required in forming a clinical evaluation with such complex patients: "They have lived all their lives

Pharmacological treatment of ADHD Athéna Sunday 10:00-11:30

they have chronic difficulties with short sleep duration."

Dr Kooij's own studies into sleep and physical health in ADHD have thrown up some interesting potential therapies that serve to bring forward sleep onset. She noted: "We have shown that melatonin is delivered too late in ADHD patients. It is more than 1½ hours too late compared to normal controls. So one of the reasons for their sleeping late is because the hormones are not available on time. We have treated them with melatonin at night and light therapy in the morning already in order to advance sleep onset and to increase the sleep duration in order to prevent long term disadvantages in physical health."

Pharmacotherapy, the subject of Dr Kooij's presentation at the

congress, is but a single facilitating piece in a puzzle of interdependent therapeutic options. Being so complex, treatment for adult ADHD involves addressing its

"Once the medication works, they are then better able to plan and to have an overview of tasks and time. So it enables patients to learn new skills that were not easy to administer before, because attention was always wandering...so it is the first step after psycho-education in order to facilitate psychological treatment."

Sandra Kooij (PsyQ, The Hague, the Netherlands)

myriad physical and psychological offshoots and comorbidities using a combination of strategies such as psychoeducation, medication,

psychological treatment and light therapy. "Light therapy is in relation to sleep and winter depression," explained Dr Kooij.

"Medication for anxiety, depression and ADHD, and psychological treatment to educate and support patient and family, to facilitate the patient to learn organisational skills – they have never learned them. So once the medication works, patients are then better able to plan and to have an overview of tasks and time. So it enables them to learn new skills that were not easy to administer before, because attention was always wandering, or they were never looking when they were explained in school or at home. Speed of reading and information processing may improve with

medication. So it is the first step after psycho-education in order to facilitate psychological treatment."

Reiterating that the issues arising from ADHD can be solved by a combination of means that can be facilitated by pharmacological treatment, Dr Kooij concluded with a quick overview of the drugs that she will be discussing during her talk. "We prefer long-acting stimulants in adults because it reduces the dosing frequency, and this is important because patients are chaotic and forgetful in nature," she said. "So if you have too many doses per day they will forget it easily and the medication will not be effective. Stimulants are the first choice, but there are other proven effective medications as well, like atomoxetine and bupropion."

Dr Kooij will discuss her work in adult ADHD during this morning's session 'Pharmacological treatment of ADHD from a lifetime perspective – benefits and drawbacks', held in room Athéna at 10:00.

Shire Breakfast Symposium.

A new option in ADHD treatment.

ADHD is a diverse and multifaceted condition; different patients have different needs and different treatment goals. This symposium will introduce a new option for the treatment of ADHD. The programme will also outline the importance of accurate diagnosis, treatment and re-assessment of ADHD to minimise impact on patients' lives.

We look forward to welcoming you to what we hope will be an informative and interactive session.

Please join us

Date:
Monday, 8th April 2013

Time:
7:00AM to 8:00AM
Breakfast will be served

Meeting room:
Congress centre, Méditerranée

SPEAKERS

Dr. Michel Lecendreux – Chairman
Child Psychiatrist – Robert Debre Hospital,
Paris, France

Dr. David Coghill
Consultant Child and Adolescent Psychiatrist/Senior Lecturer,
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Dr. Kenny Handelman
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Shire

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Is mindfulness an evidence-based treatment? Apollon Sunday 10:00-11:30

Being mindful of the evidence in therapeutic approaches

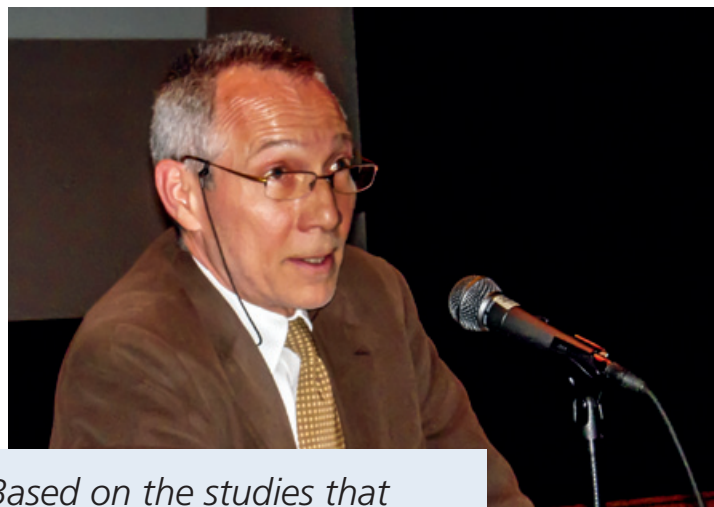
A pro/con debate that will examine whether mindfulness therapy is truly evidence-based will take place this morning, with two invited experts offering opposing viewpoints on this aspect of the promising clinical intervention strategy.

With origins in eastern meditation and traditional yoga, mindfulness can be summarised as a particular attention state which is characterised by intentional and non-judgmental observation of present moment experiences, including body sensations, feelings, thoughts, and external stimuli from the environment.¹

Encapsulating practices that include both mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT), both approaches have gathered momentum as therapeutic tools, but the question of whether their utilisation is truly evidence-based is still a bone of contention.

Speaking in support of the evidence-based nature of mindfulness during the session will be Guido Bondolfi (University of Geneva, Switzerland), who will offer a review of both MBSR and MBCT approaches and their underlying evidence. In addition, he also hopes to communicate the benefits of mindfulness directly, with the help of audience interaction. "An idea was to even try to invite people in the audience to participate to a brief mindfulness exercise in order to let them be closer to the practice – i.e. not only understanding the rationale but also experiencing it for a few minutes," he told EPA Congress News.

Moving on to discuss the studies in the field of mindfulness, Professor Bondolfi noted that during the last decade or so, there have been several well-controlled studies that have focussed on the efficacy of mindfulness in the reduction of stress, anxiety and depressive symptoms. "There have been more



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Guido Bondolfi (University of Geneva, Switzerland)

and more studies on the efficacies of these approaches, and there are many more studies intending to understand the mechanisms – with neuroimaging studies as well," he said. "So I will probably also discuss a little about the main mechanisms and also the efficacy of these mindfulness based approaches."

With the frame of the debate in mind, Professor Bondolfi pre-empted some of the criticisms that might be put forward against the evidence-based nature of mindfulness. He said: "Of course there are not so many studies comparing mindfulness approaches to effective psychological treatments like cognitive behavioural therapy [CBT] or interpersonal psychotherapy, especially in preventing depressive relapses. And what is still lacking are studies comparing these new approaches with well-studied and well-confirmed psychotherapeutic approaches."

He added: "The MBSR pro-

gramme has been proposed for many different kinds of problems – anxiety, pain, stress difficulties – and it seems to address more

general mechanisms involved in several psychological problems and is not diagnostic-specific. This might be another criticism I suppose."

Professor Bondolfi continued to note that an interesting observation surrounding mindfulness is that early on it was proposed as something "esoteric or strange" in the field of medicine or psychiatry, but more recently, because of experimental and

"In order for us to call [mindfulness] evidence-based, it's not enough that it is efficacious, it has to be efficacious and it has to work for the reasons it is supposed to work."

Joel Swendsen (Aquitaine Institute for Cognitive and Integrative Neuroscience, Bordeaux, France)

people were more reluctant about these 'strange' things, but now based on the studies that we have done, and what is published, they realise now that it is something that is evidence-based," he said.

Adding his thoughts ahead of his 'con' viewpoint in the debate, Joel Swendsen (Aquitaine Institute for Cognitive and Integrative Neuroscience, Bordeaux, France) began by saying that the enthusiasm and passionate support of mindfulness as an evidence-based treatment is a very positive step, but for him, it is critical that we take a step back and analyse the true nature of the treatment. "I want it to work; I want it to be something that really is useful, but in order for us to call it evidence-based, it's not enough that it is efficacious, it has to be efficacious and it has to work for the reasons it is supposed to work," he said.

Crucially, Dr Swendsen stressed that as we know, being in human contact with other people is something which has a range of benefits for many disorders, thus we need to identify whether it is truly the mindfulness aspect of therapy that is conveying benefit or is it other, more general (yet effective) components. "In order for us to justify the words 'evidence-based', it needs to be because there is something really specific about mindfulness," he said.

He added: "And that's where we get into trouble, because there are so many studies that show that mindfulness works, but the question is do we have the methodologies in place to show us that it works because of mindfulness? If you look at the criteria for evaluating the efficacy of psychotherapies in clinical trials, there are some criteria that are focussed on the first question of efficacy, and other methodological elements that are focussed on the question of mechanisms of change, and does it work because of the therapy itself versus other things?"

To examine this concept in more detail, Dr Swendsen gathered the 10 most highly cited clinical trials on the

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New Perspectives in Psychopathology Athéna Monday 17:00-18:30

Translating phenomenology into treatment

Phenomenology attempts to put order to the experiences reported by psychiatric patients, and thus is a useful tool to help us understand, differentiate and separate clinical data, delegates will hear on Monday during a session that examines new advances in psychopathology.

"Phenomenology was introduced in psychiatry by Karl Jaspers in the beginning of the 20th century as a method to get access to the subjective experience of patients," began Jean-Michel Azorin (Sainte-Marguerite Hospital, Marseille, France) in a conversation with *EPA Congress News*.

"But at that time it acquired a more general meaning which is to delineate and put to the fore the role played by subjectivity in the constitution of any type of experience, whether scientific or everyday life. So it helps both the patient experience and the psychiatrist experience."

Of course, the task of objectively reviewing a huge amount of subjective factors experienced by patients is a mammoth task, compounded by the fact that the patient may experience something radically different than their doctor may perceive. "This is linked to the fact that we tend to interpret the research of randomised controlled trials as directly valuable for clinical practise," said Professor Azorin.

"But this is not the case. For the individual patients, the effectiveness of treatment is highly variable depending on all those personality factors, the world in which the patient is living, the environment of the patients, and this way of putting obsessions on subjectivity is a way to deal with the scientific approach in psychiatry and the difference between the scientific model and clinical practice."

In his presentation, Professor Azorin will focus more on an introduction of phenomenol-



Jean-Michel Azorin

ogy as a method to access a patient's subjective experience; his main message being the importance of putting into evidence the role played the subjectivity in the recovery process.

He expanded on this concept: "For example, in a randomised controlled clinical trial, the placebo effect is usually considered as radically different from what is called the verum ef-

fect, linked to an intervention whether pharmacological or psychotherapeutic. But if you look at the curves of response (by time) of placebo and verum, they have quite a similar shape. So one idea is to say that in fact intervention only increases the placebo response. And usually you say a placebo is something subjective, and dismiss this as objective, according to a scientific point of view."

With this in mind, Professor Azorin commented that it could be that the intervention

does not act directly on suppressing mechanical symptoms, but instead sets into motion the subjective referential process, i.e. intervention, whether pharmacological or psychotherapeutic, helps the subject to engage the recovery process.

"Recovery is what people with mental illnesses do, whereas treatment is what doctors do to facilitate recovery," added Professor Azorin. "But the effect of treatment is only an indirect effect, but an effect which suppresses the symptoms of illness."

Referring to an example, Professor Azorin commented on the interpretation of preventive action that lithium provides for bipolar and unipolar manic depression. Specifically, he stressed that while the biochemical changes caused by lithium occur very early, the true action of lithium occurs weeks or even months after.

"The idea is that the biochemical changes are responsible for behavioural changes, but these behavioural changes make sense only on the basis of the premorbid personality of these patients," he said. "So that is also related to this kind of difference between treatment and self referential recovery processes."

He added: "But phenomenological perspective interprets the effectiveness – the true effect – of treatment practises to the consequences of the biochemical changes and also behaviour changes on the active way of life of patients and the kind of reactions to the environment. So it is a complex interplay of factors, which is different way of seeing the problem as a purely mechanistic or objective action of the treatment on an independent subject."

Professor Azorin underlined that these concepts pave the way for a critique of current pharmacotherapy practices, as well as the unique source of "evidence" on which guidelines and recommendations are based.

Professor Azorin will discuss phenomenology and how to translate it to treatment during the session 'New Perspectives in Psychopathology'; 17:00-18:30, Monday in room Athéna.

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Jean-Michel Azorin (Sainte-Marguerite Hospital, Marseille, France)

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subject of mindfulness and evaluated each one according to established 10-point scales. "The results were very disappointing," he said. "Mindfulness may work, but we are on very shaky ground saying that it works for the reasons we hope it does. So my position is we can't yet say 'OK, we have this wonderful evidence-based treatment'."

"We can't yet claim that, and

we have some big problems too – big differences between studies in terms of what are the actual techniques that they are calling mindfulness, and big difference between studies as to whether they are using manualised treatments, whether they're using evaluations of treatment fidelity etc."

Offering a summary of his viewpoint, Dr Swendsen underlined that mindfulness in general is still

a very useful tool. It is something that can help people, and in most cases is rightfully indicated, thus it should have a place in therapeutic management. "I'm not at all saying that mindfulness therapy is not efficacious and should not be used," he said.

"I hope it is efficacious and can be used...my point is just how are we going to use the words 'evidence-based'. We have to be

very clear about that."

Professor Bondolfi and Dr Swendsen will delve into more detail on these concepts during the debate 'Is mindfulness an evidence-based treatment?' at 10:00-11:30 today in Room Apollon.

Reference

- 1) J Piet and E Hougaard. The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clinical Psychology Review* (2011); 31: 1032–1040

EPA guidance papers Thallie Sunday 17:00-18:30

Paving the way for better suicide treatment and prevention

This evening will feature a session tasked with exploring the EPA guidance papers on a number of topics, including mental health promotion and illness prevention, antidepressants for unipolar depression and conflicts of interest.

Offering an overview of the guidance paper on suicide treatment and prevention during the session will be EPA president Danuta Wasserman (Karolinska Institute, Stockholm, Sweden), who spoke to *EPA Congress News* ahead of the session to outline the important strategies that should be employed to combat the devastating suicide rates seen across the globe.

Beginning by discussing the link between suicide and underlying psychiatric disorders, Professor Wasserman noted mood disorders, schizophrenia, substance abuse and personality disorders as some of the major psychiatric categories that are associated with increased suicidal risk. Despite this observation, and the fact that most patients will have had contact with their general practitioner (GP) prior to attempting suicide, she added that it is still true most suicidal patients are inadequately treated, if at all.

To that end, Professor Wasserman emphasised that there are several characteristics in patients that should be explored to try and determine suicidal risk. These include previous suicidal behaviours (including those from within the family history), expressed intentions, underlying psychiatric and chronic somatic disorders, impulsive, narcissistic or aggressive traits and impaired coping strategies.

In addition, she added that genetic find-



Danuta Wasserman

ings could prove in the future to be beneficial diagnostic tools, but at the present time they are in need of further study.

The EPA guidance paper itself identifies a number of approaches and strategies that are important for suicidal prevention and treatment.¹ The first message pertains to treatment of the underlying psychiatric disorders, stating that, when considering current evidence, pharmacological treatment and cognitive behavioural therapy (CBT) should be encouraged,

while other psychological treatments, although promising, require further study to validate their efficacy.

Antidepressant treatment is recommended to decrease the risk for suicide amongst depressed adult patients, as long as careful monitoring is employed to oversee the dangerous period in the first 10-14 days of treatment (anxiolytics and hypnotics can also be supplemented when anxiety and insomnia are present).¹ Use of antidepressants in children and adolescents should only be under the supervision of a specialist.

Other recommendations include antipsychotic medications such as clozapine (effective in reducing suicidal behaviour in schizophrenic patients) and lithium, which has been shown to be effective in preventing both suicide and attempted suicide in patients with unipolar and bipolar depression.¹

However, Professor Wasserman stressed that the pharmacological aspects of suicide prevention are but part of the puzzle, and there are several other factors that are important in the treatment of patients. First, she said, was the

incorporation of a continuously-trained multidisciplinary team of specialists (psychologists, social workers and occupational therapists, for example), that will in turn offer a biological, psychological and social armamentarium of intervention.

"A multidisciplinary team can make a proper judgements as to family conditions, social support and the

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Danuta Wasserman (Karolinska Institute, Stockholm, Sweden)

rehabilitation possibilities after the discharge from the hospital," she said.

Indeed, education of GPs and other allied health workers by psychiatrists has been identified as an effective method for reducing suicide rates.¹ When this is implemented, depression, anxiety and general quality of patient care improves, also instilling better grounding as to the relevant legal, ethical and stigma issues.

"What is also important, and we are not so aware of, is to think about the security and safety both at home and in the hospital environment, because unfortunately we still have suicides due to negligence, with medications easily available or guns at home at a time when the patient is very depressed and suicidal," contin-

Suicide rates* in Europe, latest available data from the WHO 15 years and over.

- Very high suicide rates:
40,1 (Hungary) – 58,0 (Lithuania)
- High suicide rates:
25,0 (Moldavia) – 35,8 (Belarus)
- Average suicide rates
11,9 (The Netherlands) – 23,0 (Czech Republic)
- Low suicide rates:
3,4 (Albania) – 9,9 (Portugal)
- Data not available



* The number of suicide estimated per 100 000 inhabitants

EPA guidance papers Thallie Sunday 17:00-18:30

ued Professor Wasserman.

As such, ensuring a safe environment both in hospital and at home is imperative, as is the implementation of carefully-constructed follow-up plans, especially immediately after leaving hospital care – a critical juncture for many patients. Of course, an important factor in how successfully this is implemented will depend on the care framework in place for the patient. While EPA guidance states that the suicidal person should always be motivated to involve family in their treatment¹, Professor Wasserman noted that the long-term support that is both available and required for each specific individual will depend on a number of factors.

“It depends on diagnosis, the social network and how well the patients responds to treat-

ment,” she said. “If they respond well to treatment and have a good social network and good opportunities to go back to work, the follow-up period can be much shorter... but if we have patients who are not responding and have relapses, poor social networks and are not working – or for example psychotic patients or patients with abuse disorders – it can be even lifetime follow-up which must be adjusted to the resources of the patient and of the hospital.”

Even with all these important considerations and beneficial actions taken into account, the EPA guidance highlights that one should still be mindful that suicide cannot be always predicted, nor prevented, especially if there is poor compliance to an otherwise presumably effective treatment plan and follow-up care regime.¹

That being said, clearly there is great potential for improving suicide prevention and treatment via the continuous education of health care staff, and with critical assessment and iterative improvement of currently-employed routines and practices.

Professor Wasserman will explore suicide prevention and treatment in more detail during the session ‘EPA guidance papers’, held at 17:00-18:30 this evening in room Thallie.

References

- 1) D Wasserman et al. The European Psychiatric Association (EPA) guidance on suicide treatment and prevention. *European Psychiatry* (2012); 27: 129–141
- 2) Oxford Textbook of Suicidology and Suicide Prevention; a Global Perspective. Edited by D Wasserman and C Wasserman. OUP (2009).m

Treatment of Depression and Anxiety in Adult, Child and Adolescent Populations Apollon Sunday 17:00-18:30

CBT in children and adolescents

The treatment of depression and anxiety in different age groups will take centre stage this afternoon, with the spotlight placed a range of treatments including antidepressants and psychotherapeutics, genetics and cognitive behavioural therapy (CBT).

Focussing on CBT in children and adolescents during the session will be Krister Fjermestad (Haukeland University Hospital, Bergen, Norway) who spoke to *EPA Congress News* to frame the context of his talk, first stressing the main question to be addressed: whether the evidence base for anxiety treatment in children is similar in clinical trials versus university trials. “The main message is yes, they are comparable, but that there are some factors,” he said, adding that trials conducted in ordinary clinics have on some occasions exhibited poorer results than university-based trials.

One explanation that could account for this discrepancy in outcome is the presence of more comorbidities: “In the trials where you do find poor effects, it seems very often to boil down to comorbidity and change in problem area,” said Dr Fjermestad.

During his presentation, Dr Fjermestad will present one year follow-up data from the ATACA trial (Assessment



Krister Fjermestad

and Treatment-Anxiety in Children and Adults), a 182-patient study

which has compared group cognitive behavioural therapy (CBT) to individual CBT for different anxiety disorders in a cohort of 8-15 year olds. “The results from that trial is somewhat poorer than a lot of the other regular clinical trials that have been conducted,” he said.

“So I’m going to point as some of the reasons why that might be the case. What I’m going to focus on is whether a

manualised treatment for anxiety disorders is specific enough, or if you need to distinguish between different anxiety disorders. And the reason I’m going to point that out is it looks like we have a much better effect for generalised anxiety disorder compared to social phobia. So I am going to raise questions as to whether you can use manual-based anxiety treatment or do you need to be more specific.”

Dr Fjermestad will also focus on some of the treatment process variables that might play a part in the poorer outcomes observed, including treatment credibility, treatment motivation and therapeutic alliance. “It looks like therapeutic alliance may play a part in the effect; that is very much debated in the anxiety area because there are very mixed results,” he said.

Although these variables do not differ between the different institutionally-led trials, Dr Fjermestad postulated that increased comorbidities and diversities of disorders could in turn mean that keeping children “engaged” would have more importance.

‘Effectiveness of cognitive-behavioural anxiety treatments for children and adolescents’, as part of the session ‘Treatment of Depression and Anxiety in Adult, Child and Adolescent Populations. An Update’, 17:00-18:30; Sunday, Apollon.

“It looks like therapeutic alliance may play a part in the effect; that is very much debated in the anxiety area because there are very mixed results.”

Krister Fjermestad (Haukeland University Hospital, Bergen, Norway)

What changes will DSM-V and ICD-11 bring?

Use of the new Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and International Classification of Diseases (ICD-11) criteria in the diagnosis of depressive disorders will be explored this morning in a session dedicated to their latest iterations.

In an interview with *EPA Congress News* ahead of his presentation during the session, Mario Maj (University of Naples SUN, Italy) identified three major issues: the relationship between depression and 'normal' grief, the classification of 'mixed states' (including 'mixed depression'), and the approach to the continuum between depression and anxiety disorders.

Bereavement-related depression

The boundary between depression and a "normal" response to a psychosocial stressor is not always a clear one: "According to the DSM-IV, even if a sadness response appears understandable and proportionate to a major life event, the diagnosis of major depression must be made whenever the severity, duration and impairment criteria are fulfilled," said Professor Maj.

"The only exception to this principle is for bereavement," he continued. "After the loss of a loved one, even if the severity, duration and impairment criteria are fulfilled, the diagnosis of major depression should not be made, unless the symptoms persist for more than two months, or there is marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. The rationale is that a depressive syndrome is an 'expectable and culturally sanctioned response' to the death of a significant loved one, thus not representing in that case a mental disorder, according to the definition endorsed by the DSM-IV."

While it may be sanctioned within society, bereavement-related depression perhaps does not depart far enough from other forms of stressor-related depression to warrant its special status. These recent findings ought to prompt either an extension of the bereavement exclusion (to include other major losses) or the removal of the bereavement exclusion entirely from the criteria of depression.

"The idea to delete the bereavement exclusion has been immediately endorsed by the DSM-V leadership," said Professor Maj. "However, two more recent independent studies have reported that people with a baseline bereavement-related depression have a significantly lower risk for further depressive episodes during a follow-up period than people with a baseline non-bereavement-related depression. Furthermore, their risk is not different from that of people without a history of depression at baseline to develop a depressive episode during the same follow-up period. Furthermore, an intensive public debate has highlighted the consequences that the elimination of the bereavement exclusion



Mario Maj

should attenuate the divergence from ICD-11, which will exclude from the diagnosis of depressive episode, in line with ICD-10, 'normal bereavement reactions appropriate to the culture of the individual concerned'."

Mixed features in depressive and manic episodes

Recent research has documented that manic and depressive episodes often include contropolar symptoms, and that the occurrence of these symptoms has important prognostic and therapeutic implications.

"The DSM-IV characterisation of a mixed episode, requiring the co-occurrence of a full manic and a full depressive syndrome, does not account for the many cases in which only one of the two polarities of mood is present at a syndromal level," noted Professor Maj.

"Hence, the decision taken by DSM-V leaders to eliminate the diagnostic entity of mixed episode and to introduce a specifier 'with mixed features' to the diagnosis of both manic and major depressive episode, requiring the presence of at least three contropolar symptoms."

Unfortunately, the contropolar symptoms listed in the DSM-V definition of major depression with

mixed features include such classical manic symptoms as elated mood, inflated self-esteem and excessive involvement in risky activities, which are reported to be rare in mixed depression in both classical and recent literature. On the contrary, symptoms which are reported to be common in mixed depression, such as irritability, psychomotor agitation and distractibility, are not included in the list. "So, there will be a major discrepancy between the characterization of mixed depression provided in classical and recent literature and that proposed in DSM-V," continued Professor Maj.

"Furthermore, the DSM-V solution, contrary to the DSM-IV definition of mixed episode, will not account for 'unstable' mixed states (in which there is a very rapid transition from one polarity of mood to the other). In ICD-11, the diagnostic entity of mixed episode will be kept, and will be made flexible enough to encompass both stable and unstable mixed states, and both cases in which the two polarities of mood are present at a syndromal level, and those in which one of the polarities, although prominent, remains subsyndromal."

Approaching the continuum between depression and anxiety

Professor Maj explained that, although the occurrence of anxiety symptoms during a depressive episode has been found to be associated with a longer duration of that episode and a higher suicide risk, DSM-IV and ICD-10 do not allow to record these symptoms in cases of depression.

"Both the ICD-11 and DSM-V will give the clinician the opportunity to acknowledge the occurrence of sub-syndromal anxiety symptoms in a patient with a major depressive episode by using a specifier ('with prominent anxiety symptoms' in ICD-11, 'with anxious distress' in DSM-V)," said Professor Maj. "If the patient has a full anxiety disorder, that disorder will be diagnosed in addition to major depression in both systems. If the anxiety disorder

"The DSM-V will remain based on operational diagnostic criteria and will introduce some further specifiers as well as some... while the ICD-11 will remain based on prototypical descriptions of the various disorders."

Mario Maj (University of Naples SUN, Italy)

would have in several cultures, including a high rate of false positives and a trivialisation of the concept of major depression and consequently of mental disorder.

"The final decision of DSM-V leaders has been to proceed with the elimination of the bereavement exclusion, but at the same time to introduce a note within the text delineating the differences between normal grief and depression. This



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Strasbourg, Council of Europe



European Psychiatric Association - www.europsy.net



Under the auspices of the
Secretary General of the Council
of Europe, Mr Thorbjørn Jagland.



DSM-V/ICD-11: New Diagnostic Approaches Apollon Sunday 08:00-09:00

What changes will DSM-V and ICD-11 bring?

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der is syndromal and the depressive component is sub-syndromal, the ICD-11 will allow the application of a specifier 'with prominent depressive symptoms' to the relevant anxiety disorder diagnosis.

"The co-occurrence of sub-threshold anxiety and depressive symptoms will lead in ICD-11, in line with ICD-10, to a diagnosis of mixed anxiety-depressive disorder, while this category is going to appear in DSM-V among 'depressive disorders not elsewhere classified'."

Harmonising DSM and ICD

Clearly, differences persist between

elements of the DSM and ICD. But Professor Maj highlighted that the targets of the two systems are different. While the DSM-V is intended

between the several therapeutic options usually available in developed countries, the ICD-11 is intended for a broad range of professionals,

including general practitioners working in low-income countries, and aims to provide them with a system which is as simple as possible and usable in different clinical settings. "This is one of the reasons why the DSM-V will remain based on operational diagnostic criteria

and will introduce some further specifiers as well as some dimensions (in the case of depression, dimensions concerning the severity of the depressive episode, the

intensity of the anxiety component, and the risk for suicide), while the ICD-11 will remain based on prototypical descriptions of the various disorders."

"Both the ICD-11 and DSM-V will give the clinician the opportunity to acknowledge the occurrence of sub-syndromal anxiety symptoms in a patient with a major depressive episode by using a specifier."

Mario Maj (University of Naples SUN, Italy)

Professor Maj will give discuss the use of DSM-V and ICD-11 classifications in mood disorders during the session 'DSM-V/ICD-11: New Diagnostic Approaches – Do they hold a Promise?', at 08:00-09:00 this morning in room Apollon.

Note: The ICD-11 chapter on mental disorders is still in preparation, and the definitions and diagnostic guidelines for depressive disorders have not yet been finalised. The text of the DSM-V has been approved by the Board of Trustees of the American Psychiatric Association (APA); it will be presented in May. As a member of the DSM-V Work Group on Mood Disorders, Professor Maj emphasised that he has been permitted to discuss only that information which has been made public through the DSM-V website and the December 1, 2012 APA press release.

ePosters @ EPA 2013

Alongside traditional poster sessions at the congress, EPA will again highlight several outstanding posters for presentation as electronic ePosters – a powerful educational tool that will allow browsing and even download (pending permission) of posters for further viewing.

There will be 14 separate ePoster sessions held throughout the congress, and within each one more than 20 of the highest scoring abstracts will be selected for special oral presentation (4-5 minutes each).

In addition, the ePosters will be available for viewing during and after the congress via a user-friendly ePoster archive that allows viewers to browse by poster sections or specific content, as well as offering the chance for them to comment on individual posters and ask questions to the authors.

For more information refer to the poster and ePoster details in the programme.

Plenary Lecture: Translating Gene and Environment Interactions Apollon Sunday 11:45-12:30

Interview: Julio Licinio

T rue to the moniker of the Age of Information, we are busy extracting information from our genes and environment that could give us clues as to how different psychiatric conditions emerge, and how to prevent and treat them more effectively. In an interview with *EPA Congress News* on the topic of his Plenary Lecture, Julio Licinio (John Curtin School of Medical Research, Australian National University, Canberra, Australia) explained how progress in the field of genetics is accelerating thanks to better study design, tools and technology.

How are genetic and environmental risk factors characterised in complex disorders, and how has our understanding of them changed?

The genetics is a very complex undertaking. What people have done is to try to parcel out what is genetic; then what cannot be attributed to genetics, people look at environmental causes. So there is research coming from both the genetic side and the environmental side.

From the genetics side, the latest trend is to analyse very large groups of patients. So far we haven't had a lot of new progress on variants, because the studies have been relatively small. But there are now some very large international collaborations with 30,000 or 40,000 patients being studied together, and the genetic signals are starting to emerge. That is one of the hottest areas now – trying to get very large cross-national samples, trying to see if you can really use the latest tools in genomics to apply to these very large samples, and then coming up with the component that can be attributed to genetics.

On the environmental side, there are two factors: one is the role of infection and inflammation in the mother just before and during pregnancy; the other factor, which is not new but has got a lot of new attention, is the impact of maltreatment and child abuse very early on, which apparently can have a very dramatic impact throughout a person's life, especially in terms of susceptibility to depression. There is a lot of relatively recent work showing that it can not only impact on mood, but also change the expression of genes that are related to depression. So we have a long term biological impact, much beyond the period of actual trauma.

You hinted at going beyond straight



genetics, looking at things like gene expression in order to identify biomarkers of specific disease traits. How far are we from the reality of understanding how these traits emerge?

We have been very far because of the technical limitations. But there has been a lot of progress, and in my estimation I would say in the next 10 to 15 years. We will have a lot of new answers that we do not have now. There has been a lot of confluence of new work that I think will make a difference in the field. I would say that there has been a lot of hype in the past. But I think that right now we have the right technology, the right tools and very large samples for

"I would say that there has been a lot of hype in the past. But I think that right now we have the right technology, the right tools and very large samples for different diseases, so that at this point we are really ready to make a major contribution – this was not the case even recently."

Julio Licinio (John Curtin School of Medical Research, Australian National University, Canberra, Australia)

different diseases, so that at this point we are really ready to make a major contribution – this was not the case even recently.

I began to work in pharmacogenomics for personalised medicine, and I got the first research grant from the National Institute of Health (NIH) in the US, which was in 1999. It was the next year that the human genome was sequenced, so there were a lot of questions then about when we are going to have personalised medicine. Everybody was talking five years, but in my head I was thinking more like 15 to 20 years. And that was 14 years ago! I think the methods are much better now, and the research is progressing really fast. There is light at the end of the tunnel.

As you note, there are two elements that can emerge from a better understanding of genetic and environmental risk: preventative interventions and the promise of more personalised medicine. Could you explain the importance that personalised medicine will have on the future of mental health?

I am very committed to this area of pharmacogenetics. In my own research, I have been looking at genetic predictors of drug response. Even with cancer, some people respond very well to chemotherapy and recover, and some people die. For many conditions, the big challenge in today's medicine is that some respond very well and others do not have a good response. In psychiatry, you need to treat people, for example, with schizophrenia or depression, for a very long time before you see a response. It is not the case that you take one dose of antidepressants and your depression goes away. So if you are taking something that is not going to work for you, it is really wasted time. It can be weeks until people come up with the right treatment. Meanwhile, there is a lot of suffering and a lot of potential for complications. The biggest challenge in psychiatry right now is for us to come up with ways to personalise treatment so that we give the right drug to the right person. I have been approaching this from the genetics perspective. Some people approach it more in terms of biomarkers. I think this is the hot frontier of the field: trying to develop tools to predict who is going to respond to what treatment.

Professor Licinio's plenary lecture on 'Translating Gene and Environment Interactions into Prevention and Treatment' will take place at 11:45 this morning in room Apollon.

Brain imaging across mental disorders: early detection and treatment Med. 5 Monday 10:00-11:30

Could imaging be the key to reduce diagnostic uncertainty in bipolar disorder?

While it is important to remember the value of clinical judgement, which takes into account emergent mental status as well as patient history, tools such as neuroimaging may be useful in confirming uncertain diagnoses and distinguishing patients by way of prognostic indicators. Ahead of her talk on diagnostic imaging in Bipolar Disorder at the congress, Sophia Frangou (Icahn School of Medicine at Mount Sinai, New York, USA) spoke with tentative optimism about what imaging has to offer the clinical community.

The challenge of diagnosis is one felt across psychiatry, because clinical assessment relies on behavioural observation and the patient's self-reporting. Professor Frangou spoke of the consequences of the subjectivity that emerges from such a qualitative approach. "The first one is that sometimes diagnoses are not reliably made," she told *EPA Congress News*. "The second one is that it fuels public scepticism as to the validity of this diagnosis."

Of course, diagnosis of bipolar disorder can be difficult, particularly when patients present with symptoms that are indistinguishable from unipolar depression. The prospect of predicting which depressed patients are likely to develop manic episodes is a seductive one. "You see the symptoms as they evolve over time, and it is very difficult to predict at the very beginning what the final clinical presentation will be," said Professor Frangou, explaining: "The tools that are being developed are really developed with a view to try and define some sort of biological, in this case, brain structural and functional parameters that can be reliably linked to particular diagnoses – in our case, bipolar disorder. This effort is beyond bipolar disorder. It involves all aspects of psychiatry. There are many different groups that are trying similar ways to confirm, validate and refine diagnosis across different fields of psychiatry."

Physiological differences may be observed between large cohorts



of patients and controls, but the 'average' patient is a very rare thing, as Professor Frangou was careful to note as she explained why she sees neuroimaging at the forefront in the race towards a tool to aid diagnosis. "You can have parameters that are abnormal in patients, and these parameters can be informative in terms of pathophysiology. But here we are looking for things that can help you do classification, which is slightly different. There are a number of variables that distinguish on average a patient from a healthy individual, but neuroimaging is perhaps our best bet at the moment to do diagnostic classification. Having said that, as the tools evolve, because they are so computationally challenging, it will be possible to test which type of information (in addition to neuroimaging) can help improve this classification effort. But the main focus really is on neuroimaging."

Diagnostic tools may also help to distinguish patients with better or worse prognoses, based on markers such as verbal intelligence and inhibitory control. But could addressing these markers lead to improvements in symptoms? "There is a degree of circularity in the thinking generally, in the sense that it is possible that these are just sim-

ply inherent dimensions that are of prognostic value but that may not be amenable to change," said Professor Frangou. "So we don't know that we can change the prognostic factors. It is similar, for example, if you have a family history of breast cancer and a particular *BRCA2* mutation: you would be at extremely high risk for breast cancer, but we can change neither your family history nor your genetic make-up. It is difficult to say at the moment that what we are identifying is necessarily a new pathway to treatment."

"What we are saying is that it is important from the beginning to identify people that do not have a particularly good prognosis to begin with, because the logical next step is to target these patients with the treatments that we have at the mo-

of inhibitory control – and we might be able to intervene then. But we are at the very beginning, identifying prognostic indicators that may or may not lead to improved diagnostic interventions. I think, generally, what one of the messages here is that although we have to be very optimistic about the future of psychiatry, we should not actually be more optimistic than our data permits," she said.

Professor Frangou concluded by talking more generally about the perceived complexity of mental illness, and the misconceptions regarding their aetiology. She stressed that, actually, studies have uncovered rather a great deal of aetiological findings, and that these can help us to quantify risk, which can then be modified therapeutically. She added: "One of the things that I think is important for clinicians as well as the public is to understand mental illness a little bit as they understand having a heart attack."

"So there are many different factors that increase your risk, and at any given time we will not know all of the factors that will increase the risk of one specific individual. The personalised prediction is the difficult one. But in principle, we know quite a lot about causes of heart attack and stroke, and also about causes of mental illness. It is a game of probabilities. It is not like an infectious disorder, where you have one bug, one illness, with a one-to-one causative relationship. I think the important shift in our understanding is that we are talking about risk rather than causality, as we do for anything in complex disorders in modern medicine."

"There is a degree of understanding that there will not be one thing that we will find that will make anything clear for any individual patient for 100 percent of the time – this is an impossibility. Very much like predicting who will have stroke, you put in your risk factors, you can say who is high or low risk, and that gives people some idea as to how they can modify that risk."

"We are at the very beginning, identifying prognostic indicators that may or may not lead to improved diagnostic interventions...Although we have to be very optimistic about the future of psychiatry, we should not actually be more optimistic than our data permits."

Sophia Frangou
(Icahn School of Medicine at Mount Sinai, New York, USA)

'Brain Imaging across Mental Disorders: Early Detection and Treatment'; 10:00-11:30, Monday, Room Med. 5.

European Mental Health Care in the Time of Economic Crisis Galliéni 5 Monday 15:00-16:30

Economic crisis is no Greek tragedy

Greece was perhaps the first and hardest hit by the economic crisis in Europe, but there are positive lessons there and elsewhere showing that solidarity, and adequate mental health and welfare provisions are all important ingredients in keeping the population resilient. George Christodoulou (Athens University, Greece), who will be presenting on the psychological and psychopathological consequences of economic disaster on Monday afternoon, spoke to *EPA Congress News* to give a comprehensive impression of the situation in Greece and to talk about the role of the family in providing support in tough times.

Tackling an issue that will be addressed in the upcoming DSM-V and ICD-11 classifications, Professor Christodoulou began with his views on the nature of depression as distinct from a sadness that is justified within a social context. "Very often in discussing the consequences of the economic crisis internationally, the newspapers talk about a depressive society, a depressive nation, and things like that," he said. "In my opinion this is not clinical depression, but it is understandable sadness which is justified by the situation of curtailing funds, of difficulties that each family has in surviving, and so on. This sadness can be protective, because it leads to a reorganisation of priorities – it is not psychopathological."

Unemployment is generally associated with suicide, but this association has not been seen within Greece according to both Greek and European statistics, although perhaps it will emerge in the coming year. Professor Christodoulou continued: "There has been an increase in suicidality – the intention for suicide. Some telephone services have shown that there is suicidal intention, but this is not reflected in the actual rate of suicide."

Homicide is another key effect of economic downturn, with some research suggesting unemployment as a causative factor. Professor Christodoulou noted that although the rate of homicide has indeed increased in Greece, it was accompanied by a reduction in the number of drunk drivers and the overall consumption of alcohol. He went on to highlight the association between alcoholism and homicide in northern European countries, which led the World Health Organisation (WHO) to recommend a reduction in the consumption of alcohol. "But this cannot be generalised to the whole of Europe, because in other countries, like Greece, we have seen the opposite: a reduction in alcohol consumption," he said.

Austerity measures might involve the cutting of state benefits and services, but a reduction in funding of mental health services could end up



George Christodoulou

costing more in the long term, according to Professor Christodoulou. "A paradoxical finding, in all cases internationally, is that those who are at greater risk are offered less protection," he said. "Mental patients can't protest with great efficiency and effectiveness like other social groups are protesting. For example, if you have people working in the traffic services, when they strike, they paralyse the city. Therefore they blackmail the government to provide greater assistance to them. If mental patients protest, nobody will care about it. What is going to happen to the economy of the country if mental patients protest? Nothing. So they are powerless."

"There is evidence to show that providing funding for prevention in the mental health area, and for the treatment of mental patients, is cost effective. It may need some money in the first stages, but then in the longer term it is cost effective, because you will have to spend much more money to treat these patients if you don't apply preventative psychiatry measures. So this is a language that finance ministers and people dealing with economics understand. So I think we psychiatrists and people who are involved in mental health visibility should point this out: that it is cost-effective to deal with mental health therapeutically, and especially preventatively."

Returning to the topic of unemployment, Professor Christodoulou suggested that Greece, bucking the European trend in terms of its suicide rate, could provide an indication as to the social principles that are protective in times of crisis. "The reason that in Greece the effects of unemployment are not so clear cut is associated

with the function of the family," he said. "It is very important that the family network is working. I attribute the fact that we haven't seen any direct association of unemployment with suicide to the support of the family. This can be primarily moral support, but also financial support to some extent. Of course this has negative side effects, because younger people are not in a position to work independently and cut the links with the family, which may be negative after a certain age. You can't depend on your parents for all your life! This speaks against independence, but on the other hand it has great positive aspects, and one of them is this one – the links of the people are very strong. So this is very good for the resilience of the population. In our situation, disasters, no matter whether they are human-made, physical disasters, or economic disasters, the two key words are resilience and solidarity. In the case of Greece, I think we have seen this solidarity functioning well."

Greek family structure reflects cultural idiosyncrasies, but the way in which economic policies respond to financial crisis can also impact on mental health. "There are some protective factors against suicide, and one of them is welfare provision. It has been shown in Scandinavia, in Finland and in Sweden, that when you have this protective factor of welfare provision, suicide does not occur despite the fact that the country is in a crisis. Also, reduction in state welfare spending in the States were accompanied by increased suicide rates, which is an indication to the same direction. In Greece, suicide rates are inversely associated with the number of primary healthcare services, and mental health service providers, and also with the number of mental health infrastructures. So the more we invest in mental health services, the less you are likely to have suicide."

Concluding with some recommendations, Professor Christodoulou advocated active labour market programmes like those of the Scandinavian region, as well as opting for reduced working hours rather than redundancy. "Since unemployment is associated with suicide, it is preferable to have lower salaries rather than dismiss somebody from work. Dismissing somebody from work, in addition to the economic destruction, also includes humiliation (which comes out of losing one's job) and the deterioration in everyday habits. So if you support the lesser of two evils, perhaps this would be productive in some way."

'The economic disaster in Europe: psychological and psychopathological consequences', as part of the European Forum session on mental health; 15:00-16:30, Monday, room Galliéni 5.

Pharmacological treatment of ADHD Athéna Sunday 10:00-11:30

Taking a step back in ADHD

Continued from page 2

Germany has 300 kids, if we join hands we have a meaningful result. If each of us publish alone, these statements are worth nothing because the power is too low. Association studies with 200 kids is not enough."

Genome-wide association studies are a critical element in identifying new genes that aren't related to any pre-existing hypothesis, noted Professor Zalsman, but such analysis isn't without its problems. He said: "They don't come with a candidate gene: we are 'fishing', and many things can pop out. The new problem with these genome-wide association studies are in multiple testing. You are testing 100,000 SNPs [single

nucleotide polymorphisms] in the DNA, in a couple of hundred kids. You have multiple testing, and only by chance will you find some very significant finding – you need to correct for this, which is not so easy and simple.

"It is a challenge. Twin studies found that heritability is between 50 to 88 percent, which is very high when you compare in to other

[disorders], not only in psychiatry but even in medicine. The main candidate genes are in the dopamine system (because Ritalin works in the dopamine system, so that is why we are looking

"In Israel, if you go into a pharmacy with a prescription for Ritalin from me, they will not give it to you because by law in Israel you can get Ritalin after 18 only if you started it as a child, because they try to avoid people using it as a drug. But many people are diagnosed at age 30! So even the government and the Ministry of Health are not aware."

Gil Zalsman (Sackler School of Medicine, Tel Aviv, Israel)

there) such as the DRD4, DRD2, MAO-A, the serotonin transporter, and DAT-1."

With emphasis on collaboration and raising awareness on both the public and the policy level, Professor Zalsman concluded with a roadmap for future research: "This is the story in genetics: you need collaboration. First of all, we need to know more about adult ADHD. We have a study on

ADHD above the age of 65; this is the only paper in the literature. Collaborators and researchers in Europe should concentrate on studying more and knowing more about adult ADHD.

"The second thing is awareness. People do believe that at age 18 when you finish high school, you finish ADHD, which is totally not true.

People with ADHD are divorced more, have more substance abuse, have more car accidents, so it's very important that people are aware that they might need treatment. In Israel, for example, if you go into a pharmacy with a prescription for Ritalin from me, they will not give it to you because by law in Israel you can get Ritalin after 18 only if you started it as a child, because they try to avoid people using it as a drug. But many people are diagnosed at age 30! So even the government and the Ministry of Health are not aware."

'Pharmacological treatment of ADHD from a lifetime perspective - benefits and drawbacks'; 10:00-11:30, Sunday, Athéna

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