



Inside today

Page 4

Is DSM-5 really 'the psychiatrist's Bible'?

Page 9

Linking together genetics, memory and psychiatric disorders

Page 14



Migration and psychosis: Testing the hypotheses

Page 15

Past, present and future perspectives in suicide prevention

Page 18

Keeping the social elements of mental health in mind

Page 20

Stemming the regression in geriatric psychiatry



Page 26

Reconnecting mind and body

Welcome to the 22nd European Congress of Psychiatry in Munich!

It is a great pleasure to welcome you, on behalf of the European Psychiatric Association (EPA), to the annual European Congress of Psychiatry, a major meeting of International Psychiatrists dedicated to promoting European Psychiatry and to improving mental health in Europe.

Celebrating its 31st anniversary this year, the EPA recognises the importance of strong historical links to European Psychiatry and to Munich, with its proud tradition of Psychiatry, making it an excellent choice for the 2014 Congress.

In Munich, the capital of Bavaria, it is hard not to come across fascinating stories, people and places. One local historic character that faced challenges throughout his life was King Ludwig Otto Friedrich Wilhelm II, one of the most legendary figures in Bavarian and German history and who built many of the wonderful castles in this region such as Neuschwanstein and Linderhof.

Much mystery surrounds the former Bavarian Regent's life and death even to this day, and he is known by many nicknames, including the Swan King

and the Dream King. The Presidential Speech during the Opening Ceremony discussed King Ludwig and the challenges Psychiatrists face in developing a patient-doctor relationship.

You will enjoy an exciting scientific programme that covers the most important aspects of diagnosis and treatment in Psychiatry and examines the latest achievements in the field. It is a great honour to welcome Professor J John Mann, Professor Andreas Papasotiropoulos and Professor Mario Maj to present the Plenary Lectures at EPA 2014, along with many other excellent colleagues.

Through a variety of sessions, the EPA brings you to the cutting edge of research and practice within psychiatry, with "Pro and Con" debates, State of the Art lectures, EPA Academia Educational courses and a dedicated



European Early Career Psychiatrists Programme. The EPA is committed to helping psychiatrists network, share research and clinical expertise and to learn from colleagues across Europe and beyond. The EPA strives to allow these valuable connections to continue and flourish.

We hope that you enjoy a productive and enriching Congress, and look forward to welcoming you to Vienna in 2015!

Danuta Wasserman

- EPA President
- Professor of Psychiatry and Suicidology, Karolinska Institute (KI)
- Head and Founder of the National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) at KI, Stockholm, Sweden
- Director for the WHO Collaborating Centre for Prevention of Mental Ill-Health and Suicide

ALCOHOL-DEPENDENCE – FROM DISEASE TO TREATMENT

Satellite Symposium

Monday 3rd March, 2014

18:45–20:15

Room 14A

Programme

- Welcome and introduction
Chair: Jonathan Chick, UK
- Alcohol dependence and psychiatric comorbidities
Henri-Jean Aubin, France
- Clinical relevance of alcohol reduction
Jonathan Chick, UK
- Integration of psychosocial support and pharmacotherapy
William D. Dundon, USA



EPA Opening Ceremony

EPA 2014's Opening Ceremony gave delegates a very warm welcome on Saturday evening, with President Danuta Wasserman (Karolinska Institute, Stockholm, Sweden) commencing the proceedings by introducing a musical performance of Dvořák's Dumky trio (Op. 90) performed by psychiatrists Anna-Maria Leimkühler, Cornelius Schule, and David Rehm (Psychiatric Clinic of the Ludwig-Maximilians University, Munich, Germany) – a piece befitting for Munich as Bavaria's capital and one of the leading European cities in both classical music and psychiatry.

Defining the EPA's mission and future goals, Professor Wasserman said: "We need to be creative; to build a future on new ideas, to have the scientific knowledge and the clinical knowledge. We need to involve all people that are working in the organisation, and we need also to be open to different psychiatric traditions. Personally, I think it is important to not be one-sided or single-minded; we need to be very aware of inclusion of all traditions, but also of gender, age, geography and local traditions.

Local Organising Committee Chair Peter Falkai (Psychiatric Clinic of the Ludwig-Maximilians University, Munich, Germany) followed with his welcome speech, in which he described the evolving emphases in psychiatric research and practice over past decades, putting the EPA's current and future goals into focus. "Hans-Jür-

EPA 2014 looks to a future of new ideas



EPA CONGRESS NEWS

Publishing and Production

MediFore Limited

EPA President

Danuta Wasserman

Local Organising Committee Chair

Peter Falkai

Editor-in-Chief

Rysia Burmicz

Editors

Pete Stevenson, Alastair McQueen

Design

Peter Williams

Industry Liaison Manager

Cheryl Cagiola

Head Office

19 Jasper Road

London SE19 1ST, UK

Telephone: +44 (0) 20 8761 2790

editor@medifore.co.uk

www.medifore.co.uk

Copyright © 2014: European Psychiatric Association.

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, transmitted in any form or by any other means, electronic, mechanical, photocopying, recording or otherwise without prior permission in writing of the EPA. The content of *EPA Congress News* does not necessarily reflect the opinion of the EPA Board or Committees.

gen Möller, who was Chair between 1994 and 2012, followed the fields established [before him], but put special emphasis on genetics and brain imaging. It is important to stress that he had an important focus on clinical research, especially innovative metabolological and psychometric aspects.

"The question is: what do we need today? Is

it something special? I don't think so. I think we continue along these lines. The patient is in the centre, and we try to genotype, phenotype and actually characterise the patient in order to be able – on the basis of understanding the pathophysiology – to go into personalised therapy and the longitudinal course."

Giving a flavour of the ways that these goals



David Rehm, Anna-Maria Leimkühler and Cornelius Schule (Psychiatric Clinic of the Ludwig-Maximilians University Munich, Germany)

EPA Opening Ceremony

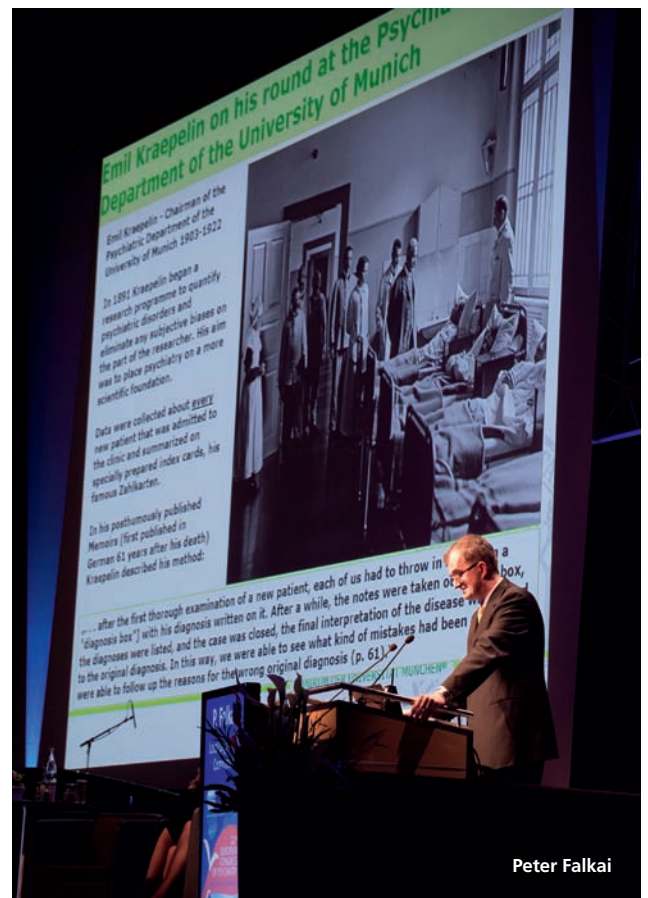
are being achieved at the Psychiatric Clinic of the Ludwig-Maximilians University, Professor Falkai said: "One is the development of biomarkers. The question is are we able, based on imaging, to predict who has a high, low or intermediate risk of actually developing psychosis. The second focus is that we would like to improve medication. We can't replace it – I don't think we could find something completely new, but we could add things we will be better in. We are currently focussing on so-called risk genes for psychosis, and based on that we tried to disentangle the pathways underlying these risk genes, and then we repurpose drugs, screen for new drugs and do clinical studies."

Professor Wasserman then drew lessons from the biography of King Ludwig II of Bavaria, who struggled with mental illness and whose ultimate death, officially ruled as suicide, is something of a historical enigma. "It can be hard, even today, for a family to admit that a loved one died by suicide, and blame from others is still not unusual," Professor Wasserman said. "Today, approximately 10% out of 193 countries which are members of the UN

are still treating suicide as a crime. It is 2014.

"Carrying consciously or unconsciously the historical burden of the stigma around suicide and mental disorders influences the very complex patient-psychiatrist relationship... Psychiatry is an art, and being a psychiatrist is a balance between advanced medical knowledge with the weight of emotion, empathy, experience and self-knowledge. The knowledge of counter-transference aspects – our emotions and behaviours towards our patients – is in most European countries today a part of the regular residents' training, which is of course an enormous progress. Today I touched upon our personal-professional dilemma of not being too far or too close to our patients and to be aware of our emotions and behaviours towards them, both conscious and unconscious."

Concluding the ceremony, Professor Wasserman urged a continuing engagement with the networking opportunities at the EPA congress, in evolving psychiatry self-knowledge, and with achieving research and clinical practise goals.



Peter Falkai



DSM, ICD, RdoC, and psychiatry's shifting seas

The recent publication of the DSM-5 has been preceded and followed by recurring media statements that the DSM is 'the bible of psychiatry'; that psychiatric diagnoses are invalid because they are not based on biological tests; and that the Research Domain Criteria (RDoC) project is going to transform psychiatric diagnosis. Mario Maj (University of Naples SUN, Naples, Italy), who will present his plenary session on the topic tomorrow, outlined his thoughts in an interview with *EPA Congress News*.

Is the DSM 'the bible of psychiatry'?

That the DSM is the main reference for psychiatrists in their diagnostic practice worldwide is certainly not correct. A survey carried out recently by the World Psychiatric Association and the World Health Organization in random representative samples of members of national psychiatric associations of 44 countries (including 21 European countries) found that in only 8 of those countries the DSM-IV was the main reference for clinicians in diagnostic practice, and that in 12 of the 21 European countries the DSM-IV was used by less than 10% of psychiatrists.

The main reason for this, which emerged from the survey, is that psychiatrists prefer flexible diagnostic guidance allowing for cultural variation and clinical judgement, rather than strict diagnostic criteria. It has been repeatedly documented that the spontaneous clinical process does not involve checking in an individual patient whether each of a series of symptoms is present or not, but whether the characteristics of the patient match one of the templates of mental disorders that the clinician has built up in his or her mind.

Furthermore, several cut-offs and time frames provided by the DSM do not have a solid empirical basis, and operational criteria generate a high proportion of subthreshold and 'not otherwise specified' cases, contribute to create an artificial comorbidity and tend to oversimplify

psychopathology.

Is it true that psychiatric diagnoses are invalid because they are not based on biological tests?

Psychiatry is certainly not unique in the field of medicine in making diagnoses which are not based on biological tests. Migraine and multiple sclerosis are widely quoted examples of physical conditions whose diagnosis remains a clinical one, and hundreds of other diagnoses in medicine have been made correctly for centuries on a clinical basis before laboratory tests became available. It has even been pointed out that for some physical conditions the indiscriminate use of laboratory tests has reduced rather than increased the reliability of diagnosis.

Furthermore, it is important to underline that most laboratory tests in medicine are probabilistic, not pathognomonic, markers of disease. Their results have always to be

hypertension and diabetes) to become the subject of controversy as to the appropriate threshold for the diagnosis. In fact, whether blood pressure or glycemic levels are normal or pathological depends on the clinical outcomes they predict, and the relevant evidence may under some circumstances (e.g., during pregnancy for glycemia) be unclear or controversial.

The crucial element, therefore, is not whether the threshold for the diagnosis is based on a biological test or a set of clinical variables, but whether the threshold has a sufficient predictive validity. So, the unavailability of biological tests should not discourage us from actively searching for a validation of our diagnostic thresholds based on their clinical utility.

What is the RDoC project, and is it true that it is going to transform psychiatric diagnosis?

The RDoC project aims to generate a diagnostic system based upon neuroscience and behavioral science rather than descriptive phenomenology. In order to pursue this objective, five functional domains have been identified on the basis of a consensus among experts, each consisting of behavioural dimensions that have been at least preliminarily related to specific brain circuits.

The promise and the limitations of this project have been discussed in the Forum of the February issue of *World Psychiatry*.¹ The project endorses the old assumption that all mental disorders are brain diseases, and can therefore be described in terms of abnormalities of brain circuits. However, it has been repeatedly pointed out that damage to the neural substrate may not be necessary for failure of psychological function. Furthermore, a variety of higher-order processes may intervene between the level of neurobiological vulnerability and that of psychopathological manifestations, so that a bottom-up reductionistic approach becomes insufficient.

The second point is a pragmatic



Mario Maj

one. In order to usefully replace current symptom-based diagnostic categories, the proposed new set of behavioural and biological measures will need to have a test-retest reliability and a sensitivity-specificity in predicting outcomes at least equal to current symptom-based measures, and to be applicable and cost-effective in a reasonable range of clinical settings; something clearly not attainable in the foreseeable future.

The RDoC project is more likely to produce neurobiological measures which help in subtyping current diagnostic entities, in order to improve prediction of outcome and treatment response, rather than in replacing those entities.

Nevertheless, developing cross-walks between the RDoC and the DSM/ICD approaches, in a climate of reciprocal respect, is an endeavour that can only enrich psychiatry and related disciplines. On the clinical side, this may involve the search for experiential, as opposed to behavioural, intermediate phenotypes; the refinement of currently identified dimensions of some disorders; a more precise definition of broader dimensional groupings or spectra (such as internalizing/externalizing disorders), and a greater emphasis on the longitudinal component in the assessment of psychopathology, including the identification of definite stages when possible.

Professor Maj presents 'DSM-5, ICD-11, RDoC and the future of diagnosis in psychiatric practice' tomorrow at 11:45 in Room 14B.

Reference

1. Cuthbert BN. The RDoC framework: facilitating transition from ICD/DSM to dimensional approaches that integrate neuroscience and psychopathology.

"Developing cross-walks between the RDoC and the DSM/ICD approaches, in a climate of reciprocal respect, is an endeavour that can only enrich psychiatry and related disciplines."

Mario Maj (University of Naples SUN, Naples, Italy)

interpreted on the basis of clinical judgement. A paper recently published in *JAMA Internal Medicine* actually reported that, in medicine, the patient's history typically accounts for 75% or more of the diagnostic decision when evaluating common symptoms, while physical examination accounts for 10-15% and diagnostic tests generally for less than 10%.

Moreover, the availability of biological tests has not prevented some physical conditions which – like most mental disorders – lie on a continuum with normality (such as

Which comes first: Psychiatric assessment or psychotherapy?



Sunday morning featured two eminent speakers locked in debate over a question that has dogged the field of psychiatry and psychotherapy for years: should patients undergo a psychiatric assessment before psychotherapy?

Speaking in favour of the notion was Patrice Boyer (Paris Diderot University, Paris, France), while Franz Caspar (University of Bern, Switzerland), argued against it.

Patrice Boyer

"My position is very clear," Professor Boyer told *EPA Congress News*. "As psychiatrists we are physicians, we are MDs, and the main role for a physician when practicing medicine is to identify symptoms, to do a diagnosis, and to propose the right treatment."

For Professor Boyer, psychiatric assessment is a mandatory part of this process. In his talk, he detailed the three core elements of his reasoning.

The first is to establish any underlying medical conditions, as he explained: "Many psychiatric disorders are clearly linked to a medical condition, or to the effects of medication, or a substance of abuse. But to carry out such a diagnosis is not

in the competencies, both from a practical and a legal perspective, of psychologists, nurses, social workers or therapists."

"For this reason it's almost a legal matter," he added, noting that this does not exclude psychotherapy following assessment.

He continued: "The second reason is the fact that there are a substantial number of psychiatric disorders which are not good indications for psychotherapy. If we are not capable of identifying which conditions are not good indications, we could mislead the patient to use a less therapeutic strategy, which could be time consuming – and very costly."

Elaborating on his point, Professor Boyer noted how certain conditions, such as paranoid persecutory disorders, or psychotic OCD, are poorly suited to psychotherapy. "You can have an idea of those only if you conduct a proper psychiatric examination and a full psychiatric assessment with diagnostic interviews and sometimes rating scales to know the level of severity and the subtype of the disorder," he explained.

"As psychiatrists we are physicians, we are MDs, and the main role for a physician when practicing medicine is to identify symptoms, to do a diagnosis and to propose the right treatment."

Patrice Boyer (Paris Diderot University, Paris, France)

The third reason to conduct a psychiatric assessment, said Professor Boyer, is that even among the conditions which are listed as potential indications for psychotherapy, there are subtle differential diagnoses to be made at a psychiatric level to ensure that the proper therapeutic method is chosen.

"For example, depression some-

times has some subtle dementia features, and differential diagnosis between dementia and depression can be very difficult. Of course the psychotherapeutic methods are not at all the same [for managing these indications]," Professor Boyer explained.

"The first rule of a physician is to do the diagnosis to be able to have a clear prognosis, and then to treat," he concluded. "You could say in real life it is not necessary to do this, that the patient is feeling better and believing in their therapy, but you can never know what will happen. Just as in physical medicine, if you have not conducted the proper examination, you could be surprised by the evolution of the patient."

Franz Caspar

Professor Caspar began his presentation during the session by referring to literature evidence that points towards the importance of a psychiatric assessment that incorporates patient history, their mental status and a physical examination. "One can't agree more that these should definitely be important parts of the assessment," he said.

"I would also say that diagnosis is by far not sufficient, and there is importance of 'non-diagnostic' aspects; for example, interpersonal assessment."

Looking to the patient history component of assessment, Professor Caspar noted that it is not only the history of objective facts that need to be listed, but also an exploration of the 'significant other history' using CBASP (cognitive behavioural analysis system of psychotherapy), which has value in assessing the impact that people close and important to the patient have had.

"I think the question cannot be whether a psychiatric assessment in this sense is necessary before starting therapy – I would not take a position against that," said Professor Caspar. "I think we should be focussed on the question of who should do this assessment."



For the physical examination aspect at least, Professor Caspar went on to say that it was "obvious" that this should be performed by a medical doctor. However, for the rest of the criteria, he said that he was not so sure if the appropriate medical training is needed.

Taking a step back, Professor Caspar commented first on the validity of patient statements – a crucial factor in assessment. In a typical case, a psychiatrist would read reports of past treatments that the patient has had, listen to their own personal account, and then gauge credibility.

"The situation is a bit more complicated because of course the patient also has a picture of the psychiatrist in mind; he knows at the end that the psychiatrist will write a report which will or won't allow them to go into treatment," said Professor Caspar.

He then moved on to focus on the current realities in care, first referring to examples from his own training, whereby emergency room psychiatric assessment facilities were largely comprised of psychologists, nurses and social workers, rather than psychiatrists. "The doctor was only on call, and there only if needed," he said.

He added: "It was obviously

Continued on page 6

Which comes first: Psychiatric assessment or psychotherapy?

Continued from page 5

possible for them to [efficiently] perform this first assessment in triage, without the presence of medical doctors."

Looking to the current practice in Germany, Professor Caspar explained that patients are able to go directly to a psychological therapist which is then paid for by insurance, although a medical doctor must be involved to confirm the absence of somatic causes. In neighbouring Switzerland, psychologists are able to treat first, and then recommend further medical examination if deemed necessary. "I do not necessarily think a doctor is needed, except in the physical examination," said Professor Caspar. "Non-medics and psychologists seem to rightly request medical examinations when needed."

Speaking of the current realities in the provision of mental health-care, Professor Caspar explained that much of the assessment leading (or not) to psychotherapy is done by general practitioners (GPs), which brings its own share of problems. For example, he spoke of an approximate 50% rate of correct diagnosis of clinically-relevant depression. "We need to improve the possibility to diagnose," said Professor Caspar. "It is not easy to recognise some of the symptoms, and GPs are often not conscious that somatic disorders may be the basis for psychosocial problems."

He continued, saying that part of the current reality is also the fact that medical training is expensive, and psychiatry is a relatively unattractive path for young physicians. In addition, migration of qualified psychiatrists from poorer countries to richer countries affects both the balance of expertise, and as well as opening up language and cultural problems where patient and doctor are less likely to have a strong relationship. These factors – especially within the economic climate of today – mean that the training of psychologists can be a very attractive option, with lower costs.

Offering his conclusions, Professor Caspar said: "I think psychiatric assessment, with an emphasis on

the 'assessment' part, is absolutely needed... but is it necessarily defined as something done by a physician? I'm not sure."

"Medical assessment of possible somatic causes is recommendable, although not obviously needed in all cases. I would still prefer it, just to be on the safe side. There are many arguments (costs of training,

availability of a sufficient number of professionals with medical training and language or cultural fit) to include non-medical assessors. The question of course is, do psychological psychotherapists really want this? For the patients, yes."

He added that he was still unsure as to whether or not we should invest in forensic expertise to

examine whether people truly had, for example, an inability to work, as this may have implications for validity. In his final remarks, Professor Caspar emphasised that if physical assessment has been carried out by a doctor, in his opinion there is no reason why non-medical professionals cannot make decisions about patient care and treatment.



The poster features a background image of a European city with a prominent church tower and mountains in the distance. Overlaid on this is a large red rectangle containing white and blue text. At the top is the EPA logo (a globe with 'EPA' text) and the full name 'EUROPEAN PSYCHIATRIC ASSOCIATION'. Below this, the title 'EPA MEMBERSHIP' is written in large blue letters, followed by 'Join EPA for only €100 annual fee' in smaller blue text. A paragraph in white text invites individuals to join by completing an application form on the website www.europsy.net/join-us. The poster then lists 'THE ADVANTAGES OF EPA MEMBERSHIP:' in blue, followed by five categories: LEARN (Keep informed about the latest scientific research and treatments), NETWORK (Integrate the network of European practitioners and researchers in Psychiatry), CONTRIBUTE (Get involved in the association and take an active part in the development of psychiatry in Europe), ADVANCE (Accelerate your career and professional development), and INFLUENCE (Have a voice and a role in shaping the future of the profession). Below these is a section titled 'MEMBER BENEFITS:' in blue, followed by a bulleted list of 10 benefits. At the bottom, the website www.europsy.net is repeated in white text.

EPA
EUROPEAN PSYCHIATRIC ASSOCIATION

EPA MEMBERSHIP

Join EPA for only €100 annual fee

To become an individual member of EPA, you are invited to complete an application form on the EPA website: www.europsy.net/join-us.

THE ADVANTAGES OF EPA MEMBERSHIP:

LEARN
Keep informed about the latest scientific research and treatments

NETWORK
Integrate the network of European practitioners and researchers in Psychiatry

CONTRIBUTE
Get involved in the association and take an active part in the development of psychiatry in Europe

ADVANCE
Accelerate your career and professional development

INFLUENCE
Have a voice and a role in shaping the future of the profession

MEMBER BENEFITS:

- An electronic subscription to European Psychiatry journal
- Discounted registration fees for the annual European Congress of Psychiatry
- Preferential prices for EPA Academia Educational Courses
- An invitation to EPA General Assembly and right to vote (depending on membership category)
- Access to the EPA Extranet and member directory
- An invitation to join 19 scientific Sections
- Visibility on European Psychiatric Network
- Personal copies of EPA Minds and Minds Online newsletters
- Annual Member's Round Table dinner

Find out more at: www.europsy.net

Is there a future for social psychiatry in Europe? Room 5 Monday 3 March 17:00-18:30

'All psychiatry is social'



Dinesh Bhugra

Our brains are affected by factors such as upbringing, lifestyle and socio-economic environment, thus it is important to recognise that psychiatry has an core social component, delegates will here this evening in a symposium tasked with exploring the future of social psychiatry in Europe.

"Our brains are affected by the way we are brought up," Dinesh Bhugra (Institute of Psychiatry, King's College London, UK) told *EPA Congress News*. "That determines the way we think, the way we identify stress, the way we express distress and the way we deal with it.

"Increasingly there is evidence that, for example, attachment patterns in childhood – i.e. how we attach ourselves to significant figures as children – affects the brain structure and the plasticity of the brain, and how neurocircuits are formed."

He added: "Certain somatic conditions run in families, so that cannot be entirely social – there has to be a genetic component – but we

also know that children who have a conduct disorder in childhood are six times more likely to develop personalities disorders when they grow up.

"There is considerable evidence to say that is what happens. I think

"The poorer you are, the more likely you are to have a poor diet, smoke, have a lack of fitness and so forth. It is a range of factors which come together."

Dinesh Bhugra (Institute of Psychiatry, King's College London, UK)

it would be useful to bear in mind as the child is growing up, and as they are trying to explore their inner and external world, that is where prevention comes in. We know that children who are bullied are more likely to bully themselves. So somehow we need to break that cycle."

As psychiatry deals with not only the brain but also the abstract concept of 'the mind', Professor Bhugra emphasised that it is important to

be open to an array of social and economic factors that may not have been previously considered. "We know social inequalities make a lot of difference in the prevalence of psychiatric disorders," he continued, adding that studies have now shown increased risks of mental disorders in the less affluent outskirts of certain major cities.

"The poorer you are, the more likely you are to have a poor diet, smoke,

"The poorer you are, the more likely you are to have a poor diet, smoke, have a lack of fitness and so forth. It is a range of factors which come together."

Dinesh Bhugra (Institute of Psychiatry, King's College London, UK)

have a lack of fitness and so forth. It is a range of factors which come together."

Crucially, he stressed that there is a tension within psychiatry to separate discussion of biological and social factors, when these factors actually have a direct relation that should be realised. He said: "The whole point is that social factors affect biology. The diet we have, the child development and the way children are brought up affect the way we think, the way we see the world, the way we see ourselves and the way we cope. Social factors by themselves do not cause the problems, there has to be a degree of vulnerability. What I'm arguing is that there is a mixture of the two. It is not either/or."

He continued: "I think the major message is that we need to look at the whole patient. They have to be at the heart of everything we do. That includes what a patient's understanding is of what is going on. The difference between disease and illness is also part of the social science argument. Doctors are trained to deal with disease, and when disease has social dimensions it becomes an illness. Patients are more interested in illness: they want to get better, but because they want to go back to their jobs, make money and look after their families etc."

Regarding how can we ensure a better understanding of the influence of social factors on disorders of the brain, Professor Bhugra cautioned that it will be a complex journey, especially given that natural social differences in different regions or countries need to be factored in. That being said, he suggested a broader strategy

would be to try and be more mindful of the social aspects important to both the cause and effect of individual illnesses, to arm ourselves more effectively in distilling the social impact on psychiatry.

Professor Bhugra will present his view that 'All psychiatry

is social' during the session 'Is there a future for social psychiatry in Europe?', held this evening at 17:00 – 18:30 in Room 5.

Psychiatry's Eternal Summer

A special session dedicated to the challenges and opportunities that face trainee psychiatrists in the transition towards specialist psychiatry will take place today at the EPA Congress, as part of the European Early Career Psychiatry (EECP) programme. Presentations will be made on the choices and dilemmas people face in their personal and professional life, the nature of the rapid changes in the field of psychiatry, with perspectives from the length and breadth of Europe.

In an interview with *EPA Congress News*, Professor Danuta Wasserman, EPA President, spoke about the three areas of life that she will be considering: time management of both work and family; failure and choices; and appreciation of all phases of life. She begins her talk with a video excerpt from last year's Opening Ceremony, which she edited especially from a performance called "YOU", which reflects upon these important 'life projects'.¹

The first part of the film features Sir David Attenborough, along with his wife and mother, on the theme of parenthood and the work-family balance. Professor Wasserman said: "The dilemma of how we divide time between two large life projects – work and family – is not new. The balance of a successful career and a healthy, functioning family life is a very real situation for all of us and we manage it in different ways. Prioritisation of one life project can result in negligence of another.

"The second project and perhaps the most thought-provoking is that of



Danuta Wasserman speaking at the 2013 EPA Congress

failure," Professor Wasserman continued, posing the question: "Can failure be a success? Or is a failure always a failure? How does one cope with the negative connotations of failing? To fail is to not realise what is

In the final part of the film, Professor Wasserman examines the nature of our life experiences as we move through the 'seasons' of our lives. While emphasising that this cycle of change must be embraced, she said:

"Can failure be a success? Or is a failure always a failure? How does one cope with the negative connotations of failing? To fail is to not realise what is important, to not prioritise."

Danuta Wasserman (EPA president)

important, to not prioritise. We need to realise that life is made up of many 'unimportant' daily details. These are actually what are important in life."

"The great existentialist philosopher Albert Camus made the point bluntly: 'In the depth of winter, I finally learned that within me there lay an invincible summer.'"

From a broader perspective, the context in which psychiatrists operate is changing at a similarly rapid pace, with implications for research, education and clinical practice in mental health, and this topic will be discussed by Andrea Fiorillo (University of Naples SUN, Naples, Italy) to conclude the EECP presentations. The new agenda for the EECP that Dr Fiorillo will speak on includes topics such as rediscovering psychopathology, improving the efficacy of available psychiatric treatments, promoting psychiatry as medical

discipline, and delivering effective mental health care in new and modern settings, such as the school, workplace, etc. Also being discussed are the evolving

needs of today's patients' clinical and social needs, together with the promotion of psychiatry's public image, the involvement of psychiatrists in scientific societies and the recruitment of young doctors into the field of psychiatry.²

Professor Wasserman will present 'How to choose priorities in one's life' in this session dedicated to early career psychiatrists. The session, taking place in Room 11 at 15:00-16:30, is concluded by the presentation 'Opportunities for early career psychiatrists,' given by Andrea Fiorillo.

References

1. <http://www.europsy.net/congresses/previous-congresses/epa-2013-nice-presidential-video-film-and-lecture-life-as-a-project/>
2. A. Fiorillo et al. Opportunities for early career psychiatrists (abstract). 22nd European Congress of Psychiatry, 2014 March 1-4. International Congress Centre Munich, Germany.

Genetics of Human Memory: From Gene Hunting to Drug Discovery Room 14B Monday 3 March 11:45-12:30

Linking genetics, memory and psychiatric disorders

The knowledge and therapeutic applications associated with the genetic study of human memory will take centre stage today in a plenary lecture journeying through the recent findings and powerful future potentials of gene hunting and drug discovery for memory dysregulation and psychiatric disorders.

The lecture will be given by Andreas Papassotiropoulos (Transfaculty Research Platform, Molecular Neuroscience, Basel, Switzerland), who spoke to *EPA Congress News* to outline the main messages he hopes to communicate. "One of the core issues in psychiatry in general – and this is something indisputable – is that we are in a crisis with regards to pharmacological treatment of psychiatric disorders," he said. "The medications we have right now have more or less the same concepts – and in principle they are mostly the same drugs – as they were in the 1970s. There are only very few developments, mostly with regards to safety, but not really with regards to the efficacy of medication."

Professor Papassotiropoulos went on to stress that this comes alongside the fact that several pharmaceutical companies have now minimised their effort in psychopharmacology and drug discovery. Although the reasons behind this are manifold, a few main arguments could be put forward, as Professor Papassotiropoulos described: "First, we are still relying on animal models for developing drugs, which in some aspects of psychiatry might be highly problematic... and many of these are simply wrong."

He added: "We cannot have a reliance on animal models for human-specific diseases, because psychiatric diseases are human-specific. The second problem is in psychiatry itself, and psychiatric diagnosis. The psychiatric diagnosis



"We cannot have a reliance on animal models for human-specific diseases, because psychiatric diseases are human-specific."

Andreas Papassotiropoulos (Transfaculty Research Platform, Molecular Neuroscience, Basel, Switzerland)

we use right now uses very heterogeneous concepts of diagnosis. For example, depression is a huge group of diseases, and as long as we treat psychiatric diagnosis as concepts... based only on phenomenology, we run into severe problems. So it's time to use the human model for human-specific

better understand disorders. "The perfect example for this is memory, and this is why I will be talking about the genetics of memory," he said.

Professor Papassotiropoulos outlined three facets of memory that need to be considered. The first, episodic or declarative memory, relates to tasks such as remembering purchases made at the supermarket the day before. Secondly there is emotional memory, which – as the name suggests – is the propensity for a person to preferentially recall emotional information from their lives rather than so-called 'non-emotional' memories. Lastly, working memory is harnessed to remember temporary events such as phone numbers.

"These three aspects of memory: working, episodic and emotional, are very physiological," said Professor Papassotiropoulos. "And these complicated aspects are dysregulated in many psychiatric diseases. For example, working memory is dysregulated in schizophrenia and in depression. Episodic memory is dysregulated in Alzheimer's disease. Emotional memory is dysregulated in anxiety disorders and also in post-traumatic stress disorder."

"And here we are talking about a continuum, for example of working memory capacity in humans, and some of us are very good, some of us are bad, some of us are in the middle. This can be tolerated up to a certain extent. When the deficit becomes too large then it leads to the development of psychiatric disease, for example schizophrenia."

These dysregulatory aspects of memory have led Professor Papassotiropoulos and colleagues to study the deconstruction of psychiatric diseases into measurable, cognitive categories which can be quantified in healthy individuals. "Not in diseased subjects, because what you measure in diseased subjects is already distorted. It is already difficult to nail it down in terms of biology," he said.

By recruiting large populations of healthy individuals and quantifying the spectrum of variability of cognitive performance within them, they hope to identify certain genetic

disease. This is one of my core messages."

With this in mind, the question arises of how to develop these human models? For Professor Papassotiropoulos, one important direction is the use of genetics. When taking into account that most disorders are not binary in nature, such that people are not simply 'depressed' or 'not depressed' but may exist within a dimensional continuum, Professor Papassotiropoulos suggested that genetics would help investigate the dysregulation of normal emotional and cognitive functions in order to

Continued on page 10

Linking genetics, memory and psychiatric disorders

Continued from page 9

factors which, in turn, can point to molecules that could be targeted to combat psychiatric disease.

"Of course, some of the paths we have identified are related to molecules which are very difficult to target, so they are not what we call 'well-druggable'," said Professor Papassotiropoulos. "Some of these molecules are related to really very basic functions of cells, not only of neurons but of the entire body, which makes pharmacological manipulation of these molecules very different, because it will come with certain systemic side effects."

Thus far, several well-druggable molecular pathways related to the three memory categories have been identified, and Professor Papassotiropoulos will focus on two in particular during his plenary lecture. The first, known as the neuroactive ligand-receptor interaction pathway, contains a number of druggable molecules, including the histamine H1 receptor. This particu-

lar receptor is related to adverse memory capacity, i.e. the tendency of a person to recall traumatic or more negative episodes in life, thus has implications in disorders such as post-traumatic stress disorder,

"Genetics with complex traits can lead to the identification of druggable pathways, and to the application of drugs."

Andreas Papassotiropoulos (Transfaculty Research Platform, Molecular Neuroscience, Basel, Switzerland)

for example. "Therefore it would be very nice if one could develop a drug which suppressed, specifically, adverse memory, but not memory in general of course – you don't want to compromise memory capacity," said Professor Papassotiropoulos.

He continued: "So we thought, there are a lot of drugs out there that are anti-histaminic drugs taken

for allergies; perhaps these drugs, if we make a clinical trial, could perhaps suppress emotional memory capacity, specifically as predicted by the genetic trial."

To that end, testing with the classical first-generation anti-histamine drug diphenhydramine in healthy subjects was shown to indeed have a suppressive effect on adverse memory. "This was a very important finding for us because it was the first proof of concept study ever done that showed that yes, genetics with complex traits can lead to the identification of druggable pathways, and to the application of drugs," said Professor Papassotiropoulos.

The second drug-gable pathway that will be discussed during the plenary lecture pertains to working memory – an important piece of the schizophrenia puzzle. Specifically, Professor Papassotiropoulos will outline a recently-published large study incorporating both healthy individuals ($n=2,824$; young and old), and thousands of schizophrenia sufferers ($n=32,143$).¹ "There we identified a pathway which we called voltage-gated cation channel path-

ways, and this pathway is involved in the process of working memory, both in health and in disease", said Professor Papassotiropoulos. "Most importantly we identified a subset of this pathway, which is associated specifically with brain activation in two highly-relevant regions of the brain for working memory."

He continued: "This pathway helps us identify, according to their genetic background, people who, let's say, have a dysregulated working memory due to this pathway. So we can sub-characterise and sub-type our individuals according to their genetic background. The other nice thing is that the voltage-gated cation channel pathway, as the name suggests, contains ion channels. In the brain, ion channels are perfectly druggable, and there are a lot of drugs – for example anti-epileptic drugs – that work against ion channels. Even some drugs against bipolar disease are ion channel modulators and so forth. So now we have a whole catalogue of candidates for ion channels we can target specifically and use for drug discovery."

References

1. A Heck et al. Converging Genetic and Functional Brain Imaging Evidence Links Neuronal Excitability to Working Memory, Psychiatric Disease, and Brain Activity. *Neuron* (13 February 2014; In press)



Delegates at 2013's opening ceremony

An Experiential Approach to Psychosis Room 14C Tuesday 4 March 10:00 – 11:30

Are hallucinations *really* hallucinations?

The concept of hallucinations, particularly within the framework of schizophrenia, needs fundamental revision to ensure they are not misdiagnosed, delegates will hear tomorrow morning at the congress.

Presenter Michael Musalek (Anton Proksch Institute, Vienna, Austria) will be arguing that the diagnosis of hallucinations is often misguided, with scrutiny of the symptoms reported by patients suggesting that many fall outside of hallucinatory classification.

Hallucinations themselves are commonly defined as the presentation of sensory perceptions despite a lack of adequate stimulus, and they fall broadly into categories that include auditory, visual, tactile, coenesthetic, gustatory or olfactory hallucinations. Professor Musalek will note that of these, auditory hallucinations are of the utmost diagnostic importance as they play a major role in schizophrenia diagnostics. "If you look accurately at the phenomenology of hallucinations, or what patients report, it becomes quite clear that it is a really a rather inhomogeneous group that we are dealing with," he told *EPA Congress News*.

"There are some people who really hear the voices, others hear inner voices, and others hear the voices from outside. Some of the voices can be defined as female or male, but in other cases they cannot define that. But if you really hear

voices, you always can distinguish between male and female voices. So this means that it is really an inhomogeneous group."

As such, study of patient reports points towards a multitude of cases where there is little evidence of 'real' hallucinations – i.e. there is no sensory perception disorder at play, rather other psychopathological phenomena. "It is not very

clearly defined what is really meant by this term 'hallucinations'," said Professor Musalek. "The problem is that there is not much influence of psychopathological knowledge in the diagnostic criteria. There are more groups working on that now, but we know much more about the basic phenomena."

He added that psy-

chopathological phenomena such as ego identity disorders, overvalued ideas, illusionary misinterpretations of real experiences, interpretations of delusional mood, delusional experiences, and/or delusional states of 'being' in the world are often misdiagnosed as hallucinations.

This is part of the problem in treating the underlying condition leading to hallucinations. Delayed or misdiagnosed treatment, that doesn't do enough to quell the hallucinatory episodes, is a dangerous situation. With this in mind, what does Professor Musalek believe can be done to revise

"It is not very clearly defined what is really meant by this term 'hallucinations'. The problem is that there is not much influence of psychopathological knowledge in the diagnostic criteria."

Michael Musalek (Anton Proksch Institute, Vienna, Austria)



our strategies for hallucinatory treatment? "I think in clinical practice we need to use multidimensional diagnostics, as we call it, where we focus on special phenomena," he said. "We then look for the pathogenesis of this phenomena, and then treat it directly. So that is what we are doing in clinical practice. But unfortunately in the diagnostic category you won't find that."

"And therefore these kinds of diagnostics are not much help for clinical practice. I am quite sure that the ICD-11 will be largely the same as the DSM-5. So I think we have missed a very good chance [for revision], and now we will have to wait for another 10, 15 or 20 years for more accurate and better-proven diagnostics."

Professor Musalek will present a phenomenological and diagnostic discussion of 'real' hallucinations during the session 'An Experiential Approach to Psychosis'; held tomorrow morning at 10:00 – 11:30 in Room 14C

Alcohol Dependence from Disease to Treatment Room 14A Monday 3 March 18:45-20:15

All or nothing – Can alcohol dependence be managed without abstinence?

A session exploring recent and emerging innovations in alcohol dependence therapy, sponsored by Lundbeck, takes place this evening at the EPA Congress. Jonathan Chick (Medical Director, Castle Craig Clinic, Scotland) will discuss the results from three trials investigating nalmefene for a reduction approach to alcohol consumption, and he described this work to *EPA Congress News* ahead of the session.

The traditional requirement for complete abstinence of most treatment services could be holding some patients back from seeking help, said Professor Chick. "A review of the literature from community follow-up studies, as well as treatment follow-up studies, does show that some people are able to manage a stable long-term reduction of consumption as well as, of course, some people managing total abstinence."

However, for those people that would prefer a reduction goal, and where the clinician agrees that the approach is compatible with good health, the success rate is not high. It is to address this therapeutic gap that Lundbeck has been evaluating a medication specifically with the indication of reduction of drinking as the goal, said Professor Chick.



Jonathan Chick

"Some people are able to manage a stable long-term reduction of consumption as well as, of course, some people managing total abstinence."

Jonathan Chick (Medical Director, Castle Craig Clinic, Scotland)

"A large proportion of people who drink to excess find difficulty in stopping their drinking at the point at which other drinkers find no difficulty," he continued.

Nalmefene, an opioid system modulator, was not trialled in patients who needed a medicated alcohol detoxification, explained Professor Chick, although many of them were very heavy drinkers with abnormal liver function. "In the

studies that Lundbeck conducted, the patient was instructed to take the medication at least one hour before they started to drink, or if they were in a situation where they might have been at risk of drinking."

To date, two six-month European multicentre studies, in addition to a one-year multicentre study, have been conducted, all placebo-controlled and randomised. Describing the key results from the trials that he will present during this evening's session, Professor Chick said:

"Nalmefene was associated with a reduction of heavy drinking days and a reduction of overall alcohol consumption compared to placebo, and a greater improvement in mental health symptoms in the quality of life questionnaire, plus a greater improvement in liver enzymes than the placebo group," he explained.

He concluded: "It is encouraging because it widens the menu that we can offer to patients with alcohol related problems. I hope that for patients who are not ready or not willing, or perhaps actually don't need to follow an abstinence treatment programme, their medical advisers will consider using an aid like this to reduce their drinking."

Professor Chick presents "Alcohol Dependence from Disease to Treatment" this evening in Room 14A at 18:45 – 20:15. This Lundbeck-supported symposium will also feature a discussion of the psychiatric comorbidities of alcohol dependence, as well as discussions of the hurdles that patients face when seeking treatment, and a proposal for the integration of psychosocial support and pharmacotherapy.



State of the Art: Ways out of Treatment Resistant Depression Room 14B Sunday 2 March 15:00-15:45

Guy Goodwin

Working through the options in treatment-resistant depression

This afternoon Guy Goodwin (University of Oxford, UK) will present the state of the art in depression management in treatment resistant patients. In an interview with *EPA Congress News*, he outlined the current options available to patients, and some thoughts on the directions in which research ought to be heading.

How would you define 'treatment resistant', especially given the possibility that some of these patients are misdiagnosed or simply haven't received the appropriate range of treatments?

Treatment resistance is not well defined. At its most basic, it is a failure to respond to a previous treatment or treatments. [Because of] the need to make this precise for clinical trials by companies seeking an indication, it has converged on failure to respond to one antidepressant retrospectively and one prospectively. However this is arbitrary and other, more complicated efforts to 'stage' treatment resistant depression have also been made. In practice, clini-

cians know when they are struggling to get a patient better.

What therapies have emerged in recent years as promising in treatment-resistant depression, and how has this been supported by continuing improvements in defining its theoretical framework?

The standard approach is now augmentation with an antipsy-

chotic like aripiprazole, olanzapine or quetiapine. I think it would be misleading to suggest that this approach was led by any kind of conceptual breakthrough. Guided serendipity remains key in our field. In a similar vein, ketamine has emerged as the first glutamatergic modulator that seems to have

antidepressant efficacy. While combining treatments is an attractive option for different classes of drugs, combining psychological treatments with drug treatment remains an underdeveloped option for research. Since we can see some of the consequences of cognitive re-training and antidepressant drug treatment in fMRI paradigms, it is disappointing that

combining drug and psychological treatments remains so pragmatic.

How do you envision the future of therapy and diagnosis in the way we deal with individuals suffering from depression?

I expect to see developments from genomics in the coming years. Some of this might be very simple: polymorphisms may affect the target receptor and hence prevent or enhance drug action. There appears to be at least one example of this kind of effect that may have reduced the apparent efficacy of reboxetine.

On the other hand, personalizing treatment, to use the current buzz word, will be much more difficult if it requires our understanding better the networks of molecules that seem to be implicated by genetic studies. Thus, there is now growing confidence that we can associate a range of genetic variation, from SNPs [single nucleotide polymorphisms] to CNVs [copy number variations], with psychiatric disorders but even the hits carrying quite high penetrance seem to occur at a range of different places in putative regulatory or signalling pathways. The single gene/single disorder association simply does not exist in psychiatry.

If I had to make a single point about the state of psychiatry, it is that as molecular science opens up our understanding, it also gets really difficult. This means that it is a disastrous time for the profession to turn away from the medical model for understanding and treating our illnesses, as has been policy in some countries (notably my own) in recent years.

"While combining treatments is an attractive option for different classes of drugs, combining psychological treatments with drug treatment remains an under developed option for research."

Guy Goodwin (Professor of Psychiatry, Medical Sciences Division, University of Oxford, UK)

Professor Goodwin will present his state of the art lecture 'Ways out of Treatment Resistant Depression' in Room 14B on Sunday 2 March at 15:00.

An interplay between psychosis and migration?

Sunday's programme featured a session dedicated to early results from EU-GEI (EU Gene-Environment Interaction),¹ a project tasked with delving deeper into episodic psychosis, and investigating the interplay between genetic and environmental factors which increase the risk of schizophrenia and other psychotic disorders.

In her presentation, Elsje van der Ven (Rivierduinen Mental Health Institute, Leiden, the Netherlands) discussed the observation that there is an increased risk of psychotic disorders seen in immigrants, deconstructing three hypotheses along the way.

"The first is selective migration, which was proposed by Ødegaard,² a Norwegian psychiatrist, in the 1930s," said Ms van der Ven. "He discovered that Norwegians who migrated to the US had a higher risk than either Norwegians that stayed at home, or the local population in the US. He thought that migration was a prodromal symptom of schizophrenia, i.e. he thought that once somebody no longer fitted in socially, then that person was more likely to migrate, and whether they migrated or not they would have developed schizophrenia anyway."

To test this first hypothesis, Ms van der Ven and colleagues harnessed data from Swedish military conscripts, who were tracked as to their migratory choices, development of psychosis, and other factors (cannabis use, for example). "We basically found that those who migrate later in life generally have a higher IQ (which is



"We are trying to blend these populations that are more exposed to certain effects into one [social defeat] hypothesis, and I believe this hypothesis presents the most viable one we can work with right now."

Elsje van der Ven (Rivierduinen Mental Health Institute, Leiden, the Netherlands)

a protective factor for a psychotic disorder), they were socially better adjusted – also a protective factor – and on the other side they were more likely to use cannabis, and more likely to be brought up in a city."

Crucially, when risk factors were balanced, and a hypothetical risk established, the data did not point towards immigrants having more risk factors for psy-

chotic disorders when compared to non-immigrants.

The second hypothesis tested was bias, i.e. the notion that many people deemed to have 'psychosis' may not at all, but rather may exhibit specific cultural traits that are alien to the new nation in which they are

residing. In brief, Ms van der Ven explained that data collected from Canadian studies did not point to any significant differences in symptom profiles between native residents and immigrants. That being said, there were recorded incidences of poverty of speech or uncooperative behaviour from certain ethnic minority groups.

"Thus with my research I want to show that I can invalidate these two hypotheses of diagnostic bias or selective migration, and I want

to – as proposed by one of my collaborators – explore the concept of social defeat," said Ms van der Ven. This third hypothesis pertains to the effect that social exclusion may have on psychosis risk, i.e. someone who is genetically vulnerable may be excluded from the 'majority', and in turn they may then develop psychosis. "One of the reasons why we think this hypothesis is most valid is that we've seen that not only ethnic minorities are at an increased risk of psychosis, but also children that experience trauma; children that are being bullied," said Ms van der Ven. "These are experiences that make you feel socially excluded."

"Urban upbringing is also a factor, as there is more competition in the city, so many feel more excluded or defeated in that sense. Children with autistic spectrum disorder also have a higher risk, so we are trying to blend these populations that are more exposed to certain effects into one hypothesis, and I believe this hypothesis presents the most viable one we can work with right now."

Although presently in its early stages, Ms van der Ven plans to publish data this summer, with a few core papers exploring comparisons between psychosis rates in immigrants and non-immigrants, and city or rural lifestyles. "I think that now we are getting into the phase where we are actually beginning to get closer and closer to what all this actually means," she said. "The increased risk we see in immigrants is just the tip of the iceberg. We don't see what is underneath."

References

1. UK Clinical Research Network. EU Gene-Environment Interaction study (Available at <http://england.ukcrn.org.uk/>)
2. Ødegaard Ø. Emigration and Insanity. Acta Psychiatr Neurol Scand Suppl. 1932; 4: 1-206.

"We still have a long way to go" in suicide prevention

The first of this year's plenary lectures took place on Sunday morning, in which J John Mann (Columbia University, New York, USA) looked back over what we have achieved in suicide prevention during the last 30 years.

In a conversation with *EPA Congress News*, Professor Mann began by suggesting that one of the main problems in measuring how far we have come in suicide prevention is that it is hard to be confident that the measurements of suicide rates are that reliable over such a long period of time. "If we look at the rates in the US, in 30 years they haven't changed that much, so that suggests that we're not doing that well," he said.

"On the other hand the factors that may increase or decrease the rates have been varying over this time. We can see that because even if you compare the rates of say 50 years ago to today, they don't seem that different. What you do see is that there was a big increase in rates for a number of years, and then there was a long decrease in rates... so something has changed. If you do sophisticated epidemiological analyses, there does seem to be some impact of anti-depressant prescription rates, so one of the things we've learnt a lot about has been the potential impact of treatment of depression on suicide risk."

Professor Mann added that, 30 years ago, the general consensus was that suicide was basically a complication of depression, thus there has been a huge change in our understanding over the last three decades at least. "We now

appreciate that suicide is a complication of other psychiatric illnesses other than just depression," he said.

In addition, the diathesis-stress model has been developed, which takes into account the inherent way in which an individual reacts to extrinsic stimuli, i.e. his or her susceptibility to certain disease types, and factors in environmental stressors that may exacerbate symptoms.¹ "This has had an impact on

all, there has been a whole series of post-mortem brain studies of suicide, which have revealed a great deal about the biology of the diathesis of suicide. An ever-increasing number of studies in suicide attempters now use cognitive neuroscience methodology to examine decision making. There has been a set of studies using brain imaging methodologies which have looked at the circuitry that



J John Mann

Mann was genetics and epigenetics, looking at how a set of genes involved in, particularly, the stress response and immune response, may be linked to the risk of suicidal behaviour. This may provide a potential causal set of mechanisms that could explain aspects seen in brain imaging, cognitive neuroscience testing and studies of regulation of mood.

If one looks to the public perception of suicide, it is difficult to gauge overall opinion when compared to 30 years ago, but Professor Mann suggested that while stigma seems to have improved on the whole (although this varies greatly

As an example, he spoke of a question posed to him regarding whether or not a university could be blamed for not providing free legal aid to a student who had died by suicide following prosecution for the release of confidential data. Firstly, as Professor Mann described, suggesting a link between a policy that did not provide legal aid and a 'meaningful' suicide risk was absurd. Secondly, he stressed that this kind of questioning – although only one circumstance – served as an example that understanding is still lacking as to the causes, effects and proper care pathways more important in suicide risk. "It illustrates the problem that as much as we are educating the public, and mental health care professionals, psychiatrists and others, we still have a long way to go," he said.

Another question posed to Professor Mann was whether or not antidepressants were 'overused' in the treatment of depression. "I said to this person, if we were talking about cancer, and the use of chemotherapy, would it ever cross your mind to ask if the use of chemotherapy for cancers is overused?" said Professor Mann. "Or in the treatment of hypertension to reduce the risk of kidney failure and stroke? I'm not saying it is not a legitimate question, but I just don't think people understand that it is a real illness."

He concluded: "I think there is definite room for improvement here."

References

1. J J Mann, Neurobiology of Suicidal Behaviour. *Nature Reviews – Neuroscience* 2003; 4: 819-828.

"There is the potential for combining all of this work not only to detect high-risk patients, but also to develop a toolbox of biomarkers that can look at therapeutic interventions that may reduce the risk of suicidal behaviour."

J John Mann (Columbia University, New York, USA)

trying to understand societal or social factors in terms of suicide risk," said Professor Mann. "We now realise that it is not just the environment that determines what goes on in terms of suicide risk, but the reaction of the individual to the environment which varies a lot from person to person."

With this in mind, Professor Mann suggested that this is one area where we are now armed with more appropriate understanding for psychiatric illness, stepping away from the previous suggestion that suicide is a simple recipe of psychiatric illness combined with extensive distress.

"This has been a much-neglected area, and there has been an explosion of research in different directions as a result of it," continued Professor Mann. "First of

was initially unidentified in suicide, but also in decision making – linking abnormalities in the circuitry to suicidal behaviour.

"And finally there is the potential for combining all of this work, not only to de-

"We now realise it is not just the environment that determines what goes on in terms of suicide risk, but the reaction of the individual to the environment which varies a lot from person to person."

J John Mann (Columbia University, New York, USA)

tect high-risk patients, but also to develop a toolbox of biomarkers that can look at therapeutic interventions that may reduce the risk of suicidal behaviour."

Another area of exploration highlighted by Professor

depending on the circumstances), there are several personal experiences he has been privy to that suggest there is still confusion or misinformation underpinning people's understanding in many cases.

Psychedelic-assisted psychotherapy – could psilocybin treat depression?

Psilocybin is being studied as a potential therapy for depression, with a clinical efficacy trial taking place later this year, delegates will hear during a special ECNP symposium this morning on the topic of developing fast strategies towards new pharmacological treatments in mental disorders.

The psychedelic drug has also shown promise in managing other anxiety-related disorders and could form part of an effective treatment in combination with dynamic psychotherapy, Robin Carhart-Harris (Imperial College London, UK) will reveal in his presentation 'Psychedelic-assisted Psychotherapy: The case of Psilocybin'. Because psilocybin is already known to be non-lethal in humans, research with later phase clinical trials are already feasible, Dr Carhart-Harris told *EPA Congress News* in a pre-session interview.

"One advantage of exploring the potential of drugs like psilocybin is that they've been used by humans a lot, whether that is recreationally, or historically in the 1960s when it was used for psychotherapy. So there's an advantage there in that the phase I work has already been done and the drug can be fast-tracked to phase II studies," he explained.

That psilocybin – the active element in so-called magic mushrooms – could act as an antidepressant may surprise some people, but in fact there is a long history of using this and other psychedelic agents such as LSD for treating mental disorders, said Dr Carhart-Harris.

"From a historical standpoint, psilocybin was developed in the late 1960s and arrived off the back of a lot of excitement around LSD and its application in psychotherapy for a number of different disorders – addiction (particularly alcohol dependency) mood disorders, anxiety, and depression," he said.

Although the drug showed promise early on, research was



Robin Carhart-Harris

"It has a kind of special appeal over either pharmacotherapy or just doing psychotherapy. It's trying to take advantage of both modalities."

Robin Carhart-Harris (Imperial College London, UK)

effectively halted when the drugs were made illegal in the late 1960s. "That had a big impact on the legitimate research that was going on," said Dr Carhart-Harris.

"Both practically – it was difficult to get the drugs, there was pressure from the authorities about carrying out the research – and there was stigma as well because all of the sudden the option shifted around LSD and psychedelic drugs."

However, psychedelic drugs were 're-discovered' as a potential therapy for mental disorders in the mid to late 1990s, said Dr

Carhart-Harris. Since then, to the present day there have been a small number of pilot studies which have once more shown promise.

"There are findings published in the American Journal of Psychiatry, showing that a single dose of psilocybin can be effective in patients with end-stage cancer, who are suffering anxiety about dying," said Dr Carhart-Harris. "There was a decrease in the patients anxiety scores and also depression scores. So that was a promising preliminary result."

"There have been other studies in healthy volunteers showing improvements in mood that has been lasting with a single dose of psilocybin, and our own work has looked at the acute effects of psilocybin, and also MDMA – which is kind of hybrid psychedelic – and LSD as well," he said.

"We looked at the acute effects of these drugs on the brain and found that changes with brain activity are consistent with other antidepressant medications. We have this developing picture that most of these drugs may be effective in treating certain psychiatric disorders, but also we're

learning about how they might be effective as well," he added.

Dr Carhart-Harris went on to talk about the treatment regimes he is investigating for the drug. "It is different to the classic chronic medication model that you have with classic antidepressants; it is more akin to the ketamine model which has been rolled out, when patients are given a small number of acute

"With ketamine the effect is quite short lived. Now we think one of the advantages of psilocybin and potentially LSD is that the antidepressant effect may be more sustained than ketamine."

Robin Carhart-Harris (Imperial College London, UK)

A Fast Strategy towards New Pharmacological Treatments' - is that short enough? Room 13B Monday 3 March 10:00-11:30

administrations with the drug," he explained.

"With ketamine the effect is quite short lived. Now we think one of the advantages of psilocybin and potentially LSD is that the antidepressant effect may be more sustained than ketamine."

He added: "In our own forthcoming trial in psilocybin for depression, we have two treatment sessions a week apart and

the patients first receive a low dose and then what we call an active dose, a higher dose, for the second session."

During the acute administration, patients are guided through the experience, but it is a mostly hands-off process, explained Dr Carhart-Harris. "In the lead up to that, we use relaxation techniques and guided imagery and we also have music. So we present a posi-

tive environment for the experience. We prepare the patients for what the experience might be like and how to negotiate feelings of anxiety and this kind of thing.

"Then it is relatively passive. We are always present; there is a psychotherapist there and a psychiatrist, as well as another 'guide' as they are called. But otherwise, we leave the patients to have their own experience with-

out trying to direct it too much beyond the initial guidance. There isn't any structured psychotherapy as such. It is more about the drug changing their way of thinking and us providing support around that."

The therapy falls between the paradigms of managing depression with either antidepressants or psychotherapy, said Dr Carhart-Harris. "It is a combination of both really. It has a kind of special appeal over either pharmacotherapy or just doing psychotherapy. It is trying to take advantage of both modalities," he explained. "The drugs can enhance psychotherapy, but the model is that, in depression, there is classically a negative cognitive bias in the world featuring unyielding pessimism, as the patient is self critical, sometimes aggressively so and also can't look towards the future, either at all or with any optimism," he added.

"That style of thinking becomes very entrenched, and what psychedelic drugs do (so it seems), in terms of observing the effects on cognition and how they affect the brain, is to increase the flexibility of cognition. So the mind is more supple and freed up from whatever habitual patterns it has acquired through the process of becoming depressed," he said.

Elaborating on the potential mode of action of psilocybin, he added: "It is certainly explained in a cognitive sort of way but it could also be explained in a neurobiological sort of way where we change the brain activity – some of the networks disintegrate under the drug and also the brain seems to shift states more freely as well."

Dr Carhart-Harris' study 'Giving psilocybin for the treatment of Depression' is due to start in summer this year. The team also have an LSD neuroimaging study planned to look at the acute effects of LSD on the brain, beginning in the early summer.

Dr Carhart-Harris will speak on the topic of 'Psychedelic-assisted psychotherapy: The case of Psilocybin' on Monday 3 March at 10:20 in Room 13B.



**EPA 2014
SCIENTIFIC PROGRAMME**

To access the EPA 2014
Munich mobile app:

Event URL: <https://crowd.cc/epa-2014-munich>
App download URL: <https://crowd.cc/s/1Qte>



EPA Congress App in Apple Store



.....

EPA Congress App - Google Play



.....

Information at your fingertips

**Kristian Wahlbeck**

Keeping social elements of mental health in mind

Kristian Wahlbeck (National Institute for Health and Welfare, Helsinki, Finland) will give his State of the Art lecture this afternoon on the social determinants of mental disorders. Speaking to *EPA Congress News*, he explained the value of social interventions, both on the individual and societal level, arguing that they are an overlooked resource that can be both effective and inexpensive.

"I will be covering the social origins of mental health and mental ill health," began Professor Wahlbeck. "Many of these social determinants are childhood determinants; that is how the social contact you have during childhood fosters self-esteem and psychological skills. I will also cover the social determinants in adult life, for example, the social capital, the social networks, and the social support that we have

as adults. I am also going to cover some specific issues like unemployment and the effect of unemployment on mental health."

Much work in defining the social determinants of mental health has already been done with extensive longitudinal registry studies, forming the groundwork for the implementation of well-considered and effective change. "We know what kind of public policy supports mental health for the population," said Professor Wahlbeck. "We also know, on the individual level, the risk factors – like poverty, unemployment, being a victim of violence, and so on – which put the individual at risk of mental disorders. So we do know the issues already."

Defining more closely

how exactly 'social capital' can be harnessed, and the possible obstacles that may get in the way of this, Professor Wahlbeck continued: "Social capital can be dissected into different dimensions. One is surface support (the support that

you get from people around you, your neighbours and friends and so on), and one is social trust (the feeling that you can trust in other people and in society). These are things that, both on the individual level and on the societal level, we can impact.

"One example could be Iceland. Iceland had a major economic crisis. Everybody was afraid that the numbers of suicides would increase, that there would be more and more depression and mental health problems. But actually this did not happen. What happened was that the social capital started to increase. People started to take care of each other; to support each other more than in the time of economic boom. This is partly because they had more spare time. So we did not see any increase in suicide or depression, even though they had a major economic breakdown. This shows that the social factors can actually have a major impact on the

"Peer support is a very good thing that we could foster between our patients. This is an inexpensive and very effective way of improving quality of life in people with mental health problems."

Kristian Wahlbeck (National Institute for Health and Welfare, Helsinki, Finland)

Social Determinants of Mental Disorders Room 14B Monday 3 March 15:45-16:30

prevalence of mental disorders.”

But how generalisable is this finding? There are many factors and repercussions of a financial crisis that differ from one country to the next, as do the responsive adaptations in social policy that can impact certain socioeconomic classes more than others. “One would be concerned, for example in Greece, that the financial crisis will hit very

hard the poor and lower middle class. There are already reports from Greece that there is an increase in depression and suicide.”

So how can policy and lower-level social intervention make a difference in situations such as this? “On a policy level, universal access to mental health care is extremely important,” said Professor Wahlbeck. “Poor people have more mental

health problems. In an equal society, they should have more access than rich people. On an individual level, it is important to understand that it can make a difference with social interventions; peer support is a very good thing that we could foster between our patients. This is an inexpensive and very effective way of improving quality of life in people with mental health problems. Other-

wise, it is important to see that it is not only the health interventions that matter for people, but social interventions can make a difference too. We tend to forget that, being in the medical profession.”

Professor Wahlbeck will present his State of the Art lecture, ‘Social Determinants of Mental Disorders’ today at 15:45 in Room 14B.

Deciphering the genetic architecture of schizophrenia - progress at last Room 14A Sunday 2 March 10:00 – 11:30

Schizophrenia: A family matter?

The role of genetics in schizophrenia was under the spotlight yesterday afternoon, with delegates privy to the latest understanding of risk variants and phenotypic variance in the illness.

Speaking to *EPA Congress News* ahead of the session, Hilleke Hulshoff Pol (University Medical Center Utrecht, the Netherlands) explained that, given current estimates of a 60 to 80% genetic risk for schizophrenia, it is imperative to explore these genetic factors and understand more about the impact of schizophrenia within family units.

Using MRI, Professor Hulshoff Pol has been able to identify subtle brain abnormalities in patients with schizophrenia, as well as family members deemed at higher risk. “Clearly these brain abnormalities are genetic, and cannot be attributed to effects in patients such as medication or the fact that they are ill, etc.,” said Professor Hulshoff Pol.¹

“Another issue is that the brain is plastic throughout life, so there are changes over time, even in adults, both in terms of decline – which we would expect also to increase with age – and some of the abnormalities of schizophrenia. These are progressive, and some of these effects are genetic.”^{2,3}

In other work, Professor Hulshoff Pol and co-workers have been harnessing network analysis to examine the connectivity of the brain, with an emphasis on how abnormal connectivity may have an influence on disorders such as schizophrenia.⁴

In terms of therapeutic application, Professor Hulshoff Pol stressed that it is still an issue left wanting. “It is obviously a very important question,” she said. “It is something we cannot answer definitely at this time.

“Most studies have been conducted in patients with schizophrenia, or high-risk siblings that are passed the age they



“The brain is plastic throughout life, so there are changes over time, even in adults, both in terms of decline – which we would expect also to increase with age – and some of the abnormalities of schizophrenia. These are progressive, and some of these effects are genetic.”

Hilleke Hulshoff Pol (University Medical Center Utrecht, the Netherlands)

would develop it. The actual network studies in schizophrenia family members are still in the very early stages, but that is definitely something we are heading for.”

The burning question is if the risk of developing schizophrenia can be determined in children and adolescents, and ultimately better managed or prevented altogether. Professor Hulshoff Pol cautioned that, at the present time, studies are simply too small to lead to firm conclusions. “I think future studies, especially in large cohorts of children and adolescents, would allow us to do this,” she said.

“These studies would have to be longitudinal, following children over time so that we can pick up on the signals very early on. Obviously this would warrant new kinds of treatment to either decrease the chance of transition towards psychosis, or prevent it in the future.”

With this in mind, Professor Hulshoff Pol is currently overseeing studies incorporating twins (adolescents and adults) that will further explore the genetics of normal development and schizophrenia, particularly with respect to the observation that there is vastly-increased chance that the twin of a schizophrenia sufferer will also develop the disorder, when compared to the general public risk. “We’re currently setting up an enormous study to follow-up many, many more children,” said Professor Hulshoff Pol in closing.

References

1. Hulshoff Pol HE et al. Overlapping and Segregating Structural Brain Abnormalities in Twins with Schizophrenia or Bipolar Disorder. *Arch Gen Psychiatry*. 2012;69(4):349-59.
2. Brans RG et al. Heritability of changes in brain volume over time in twin pairs discordant for schizophrenia. *Arch Gen Psychiatry*. 2008;65(11):1259-68.
3. Moran ME, Hulshoff Pol HE, Gogtay N. A family affair: brain abnormalities in siblings of patients with schizophrenia. *Brain*. 2013;136(Pt 11):3215-26.
4. van den Heuvel MP et al. Abnormal Rich Club Organization and Functional Brain Dynamics in Schizophrenia. *JAMA Psychiatry*. 2013;70(8):783-792.

Stemming a regression in geriatric psychiatry

As we enter an era that will see an unprecedented percentage of people over 60 within the population, there is an increasingly pressing need to establish proper and effective psychiatric care for the older generation, delegates will hear tomorrow morning at the EPA Congress.

Discussing the history, challenges and future necessities in the psychiatric care of older patients will be Carlos Augusto de Mendonça Lima (Centre de Psychiatrie et de Psychothérapie Les Toises, Lausanne, Switzerland), who spoke to *EPA Congress News* to first offer a look back at the beginnings of geriatric psychiatry. "It was born in the UK in the 1950s, involving professionals who contributed to organise the care of older persons separately from adult psychiatric care," he said.

At its core, this geriatric psychiatry initiative hoped to improve age-specific concerns that were not catered for in typical adult centres. "For example, depression and anxiety in older people

may have the same criteria as for adults, but the consequences for the quality of life and the expression of symptoms are a little bit different, requiring different approaches for treatment and care," said Professor de Mendonça Lima. "Also we have specific diseases

associated with age, such as dementia, which also requires a lot of energy from professionals."

Unfortunately, while filled with potential, Professor de Mendonça Lima stressed that geriatric care is failing to reach its goals; looking to the last decade specifi-

cally, he added that, while dementia has received a lot of focus, it has been at the expense of many other disorders, and there is a palpable regression in general psychiatric care in the elderly. "We are going back to before the 50s, where we put older people and

adults in the same facility. That is not progress at all," said Professor de Mendonça Lima.

But what are the reasons for this? "We know that authorities invest much more in adults because they can then maybe start to work again, and contribute to



Comorbidities in Geriatric Psychiatry: an EPA - WFMH joint symposium Room 14B Tuesday 4 March 10:00 – 11:30

society, while older people cannot do that," said Professor de Mendonça Lima. However, he added that this financial reasoning is misguided, as proper intervention and care of elderly psychiatric problems can in fact save money in the long run: "The number of disorders and the accumulation of deficiencies and handicaps in old age can be quite huge."

Professor de Mendonça Lima will explore the financial implications of

this, alongside other aspects, in more detail during his talk. Regardless of the financial burden, he underlined that there is a fundamental ethical issue in providing better patient-specific care in the elderly generation. He added that one only has to look at epidemiological aspects such as suicide rates to see that the elderly generation are in need of much more focussed attention: "Peo-

"We are going back to before the 50s, where we put older people and adults in the same facility. That is not progress at all."

Carlos Augusto de Mendonça Lima (Centre de Psychiatrie et de Psychothérapie Les Toises, Lausanne, Switzerland)

ple in old age have the highest associated suicide rate in the population, with people over 65-years-old making up more than 50% of all suicides. This is another public health

problem."

Looking to the future, Professor de Mendonça Lima outlined the importance of resisting changes that will affect geriatric psychiatric care, partly by joining

together with psychiatric professionals to make concerns clear. "If the trend [is going] to be to create an ageless service, experts all around the world will denounce this," he said in closing.

Professor de Mendonça Lima will explore the public health issues of geriatric psychiatry during the joint EPA and WFMH (World Federation for Mental Health) session 'Comorbidities in Geriatric Psychiatry', held tomorrow morning at 10:00–11:30.

Is ADHD overdiagnosed & overtreated with stimulants in Europe? Room 14B Tuesday 4 March 08:00-09:30

Expert opinions in the ADHD debate

Controversy and public debate over the diagnosis and medical treatment of ADHD continues within professional and public spheres. Engaging in this debate at EPA tomorrow, with the hope of reaching some common ground, are Beate Herpertz-Dahlmann (RWTH Aachen University, Aachen, Germany) and Philip Asherson (King's College London, UK). *EPA Congress News* spoke to Professor Herpertz-Dahlmann ahead of the session about her point of view.

Could you begin by explaining your view on medication?

I am actually not against medication in children with ADHD. I think there are several severe cases who really need medication, who otherwise would not succeed in school or everyday life. However, what raises my concern is that the numbers of patients that have been diagnosed with ADHD, and even more those who get medication, have increased in a rather alarming way. To my opinion, there is really no explanation for why so many more children should have ADHD than, for example, ten years ago. Today, mild and medium cases of ADHD get medication, when I think society should have other means to integrate these children. Prevalence is about 1.5% in the ICD-10, and 5-6% in the DSM-IV. But even if you stay within the DSM, then we have a rise from DSM-III of 3.9% to DSM-IV with 6.3%.

Methylphenidate has indeed been shown to be effective in targeting brain areas such as the inferior frontal cortex and the insula. What would you propose to distinguish between

those individuals that really benefit from the use of this medication and those who could undergo therapy by other means?

It is not only the work of Katia Rubia that has demonstrated this, but also the work of Jay Giedd that has shown a growing of the brain under methylphenidate, and these are very interesting results. I think the criterion is the severity. If I have a child that is intelligent enough, who has severe problems with attention, who therefore has extreme problems at school, I would give this child methylphenidate if the attention disorder is severe enough. However, what we did in my clinic is look at the school and the IQ of children. We found a lot of children with rather low IQ who were attending more demanding schools. What I see is that some parents want to improve the academic career of that child by giving neuro-enhancement, and I

"We only look at medication, but we don't look at the other things we can do for these children."

Beate Herpertz-Dahlmann (RWTH Aachen University, Aachen, Germany)

don't think this is a good way.

In Germany (and I think this is a problem in other countries) the school day is so long that children have to go to school from 8am to 4pm. For a child with even a mild form of ADHD, this is very difficult to handle. That is where I think we should find other solutions than just giving medication, to help these children to achieve at



Beate Herpertz-Dahlmann

school: either by changing to a school that is not as difficult; or by changing the school day with longer recreational phases, giving some children the opportunity to go to school for one year longer than the rest. We only look at medication, but we don't look at the other things we can do for these children.

Beate Herpertz-Dahlmann and Philip Asherson will debate 'Is ADHD overdiagnosed & overtreated with stimulants in Europe?' tomorrow at 8:00 in Room 14B.

Steering mental health in Europe with EPA guidance

Projects and action plans tasked with providing European-wide guidance for a better future in psychiatry were laid bare yesterday evening, with invited experts sharing overviews of a number of different initiatives.

Of these, the EPA guidance initiative has been set up to plug the gap between the need for treatment and its provision. In particular, it hopes to combat poor quality, scarce and inefficient healthcare resources, improving the quality of European mental health care via the dissemination of evidence, and sharing experience and lessons between countries.

As detailed in the World Health Organisation's European Mental Health Action Plan (2013-2020), several key aspects will be focussed upon: first, the notion that everyone should be enabled to reach the highest possible level of mental wellbeing; second, all people with mental health problems have the right to be autonomous, with opportunities to take and share responsibility of decisions affecting their lives, mental health and wellbeing; third, trust needs to be established to ensure all activities and interventions are safe and effective.

Harnessing the collaborative power brought by the extensive number of national psychiatric associations that have now joined the EPA, the EPA guidance council is able to exchange expertise, goals and challenges in regular meetings. "These are supranational in the way that they try to take care of what is evidence-based knowledge in Europe, and try to break that down as to whether they can use that in their countries, and whether they can adapt to the guidelines that are going to be published," EPA Guidance Committee Chair Wolfgang Gaebel (Heinrich-Heine University Düsseldorf, Germany) told *EPA Congress News*.

For clinical topics that have little



Wolfgang Gaebel

or no practical guidance established, the EPA guidance project will utilise a rigorous, systematic approach towards retrieving evidence from different countries, leading to the establishment of new international guidelines wherever possible.

"We have a number of meetings with the other national psychiatric associations during this year's congress. I am presenting during a number of other EPA committee meetings, and we will discuss many priority topics to be picked up in the next series of guidance documents."

Wolfgang Gaebel (Department of Psychiatry and Psychotherapy, Heinrich-Heine University Düsseldorf, Germany)

This development, both at national and regional level, goes alongside a push towards more wholly-European perspectives on guidance in mental health care.

The first set of EPA guidance papers emerged in 2012,¹ covering aspects such as the use of antidepressants in unipolar depression,

suicide treatment and prevention, conflicts of interest and mental health promotion and prevention in general. Of particular note was the exploration of specialist provision of mental health and social care provision integrated across organisational boundaries. It was found that there was a discrepancy between available research on mental health services and the large diversity of existing mental health services in Europe. Furthermore, the diversity of existing mental health structures and processes was shown to impede comparisons between countries, with different trends in mental health service development between countries.

Looking to more recent months, several topics have been highlighted by the guidance committee for exploration: "One topic which has come up is the economic crisis and its effect on the future of psychiatry and mental illness," said Professor Gaebel.

He added: "We have a number of meetings with the other national psychiatric associations during this year's congress. I am presenting during a number of other EPA committee meetings, and we will discuss many priority topics to be picked up in the next series of guid-

ance documents."

The second set of guidance papers have been published earlier this year in a special edition of *European Psychiatry*,² covering aspects such as tobacco dependence in mental health, how to build trust in mental health services, post-graduate training guidance, and mental health care of migrants.

Of these papers, the build-up of trust in mental healthcare was highlighted as a priority issue. To facilitate this, the committee identified a range of influencing variables, including the public image of mental health, stigma, service safety, continued contact between patient and psychiatrist, and patient satisfaction (an umbrella term which also incorporates aspects such as a patient's perception of a psychiatrist's professionalism, honesty, flexibility, empathy and skill).

While there are several non-modifiable factors (age, culture, ethnicity for example), factors such as knowledge, professional training and stigma reduction are but some of the complex multi-dimensional factors that can be influenced effectively.

Looking to the future of European psychiatry, Professor Gaebel outlined several challenges that must be faced. These included the optimisation of mental health care in European countries; specialty training; support for young psychiatrists to ensure a future workforce can meet need; the development of integrated, multi-disciplinary care models; and the advancement and implementation of EPA guidance recommendations themselves.

Offering his conclusions as to the importance of the EPA guidance initiative, Professor Gaebel reiterated the pressing need to improve mental health care services and utilisation in Europe, as well as harmonising and optimising the quality of care, with emphasis on building trust. As a representative pillar of European psychiatry, the EPA guidance papers are a promising and powerful tool to provide detailed, evidence-based information on a supranational level.

References

1. W Gaebel and HJ Möller, *Eur Psychiatry* 2012;27:65-67
2. *European Psychiatry*. 2014; 29(2): 65-116

4TH EPA ACADEMIA SUMMER SCHOOL



Comorbidity between mental & physical disorders

29 May - 1 June 2014 Strasbourg, France

ACADEMIA FOR EXCELLENCE IN EUROPEAN PSYCHIATRY



European Psychiatric Association - www.europsy.net



#EPASummerSchool

Building the evidence for cognitive remediation

Sunday morning hosted a workshop that explored neurocognitive and social cognition training, specifically focussing on the evidence for generalisation and impact on functional outcome.

Speaking first during the session was Armida Mucci (University of Naples SUN, Italy) who discussed cognitive remediation and functional outcome, and whether there is any evidence of a relationship. "But first we have to define 'cognitive remediation'," she began.

To do this, Dr Mucci referred to another workshop held in Florence, Italy in 2010, the results of which were published in 2011.¹ Within that workshop, cognitive remediation therapy (CRT) was defined as a behaviour training-based intervention that aims to improve cognitive processes (attention, memory, executive function, social cognition or metacognition) with the goal of durability and generalisation.

"In the last decades... there have been many, many studies of the approach of cognitive remediation," said Dr Mucci, emphasising that these studies have been very heterogeneous, with top-down or bottom-up approaches using individualised or group therapy, and performed as either a standalone program or, alternatively, integrated with other psychosocial treatments such as social skills and training, for example.

Dr Mucci went on to describe the outcomes established from meta-analysis of many of these studies, beginning with the observation that when CRT is given in combination with other psychosocial treatments, the effect size on functional outcomes is larger. "This meta-analysis demonstrated that there is a need to develop this programme in combination with other programs," said Dr Mucci.

To that end, a CRT training programme was initiated that would test whether CRT would surpass the benefit of a rich psychosocial environment. "We have to demonstrate that it is needed," said Dr Mucci. This study was a randomized comparison of cognitive reme-



Armida Mucci

diation therapy versus functional adaptation skills training alone and in combination to improve cognition, functional competence, and real-world outcomes in a sample of 96 individuals with schizophrenia.² "The results of this study were that CRT produced a robust improvement in cognition," said Dr Mucci.

The second study Dr Mucci discussed, which she and colleagues setup,³ compared CRT with Neurocognitive Individualized Training (NIT), and Social Skills Individualized Training (SSIT) in 72 schizophrenic patients. Patients were evaluated at 6 and 12 months as to their cognitive, psychopathological and real-world functional indices.

Results showed that NIT had a positive effect on attention, verbal

memory and perseverative aspects of executive functioning, while SSIT produced worsening of specific domains of cognition including visuo-spatial memory and attention, but had no effect on various other domains.

The real-world functioning data showed that NIT offers a significant improvement of interpersonal relationships, and SSIT offers great benefit to quality of life.³ According to these data, cognitive training can be considered significantly more effective than social skills training in improving several aspects of real-world functioning, but social skills training can have a role in improving instrumental role subscale in quality of life.

Offering her conclusions, Dr Mucci said: "CRT is a promising

treatment with a potential impact on outcome. Compared to psychosocial rehabilitation, CRT has a specific effect on several cognitive domains. An integrated approach might target different areas of functional impairment, but integrations should be planned carefully to fully exploit the synergistic potential, as some of the interventions can even worsen aspects."

References

1. C Cellard et al. Cognitive Remediation Experts Workshop. Ritsner MS 9ed) Handbook of schizophrenia spectrum disorders. Springer 2011 (3)
2. CR Bowie et al. Combined cognitive remediation and functional skills training for schizophrenia: effects on cognition, functional competence, and real-world behavior. *Am J Psychiatry* 2012; 169:710-718
3. P Bucci et al. Neurocognitive individualized training versus social skills individualized training: A randomized trial in patients with schizophrenia. *Schizophr Res.* 2013 Aug 17

Microglia and immune-related proteins in schizophrenia Room 13B Monday 3 March 15:00 – 16:30

Protein studies point to personalised schizophrenia therapy

Identification of certain proteins within patients may provide significant predictive power in gauging the efficacy of antipsychotic drugs for schizophrenia, delegates will hear this afternoon at the congress.

Daniel Martins-de-Souza (Ludwig-Maximilians-University Munich, Germany) spoke to *EPA Congress News* to outline the concept of this work, and how it is hoped to benefit pharmacological treatment strategies. "The presentation I am going to give is about proteome analysis of plasma samples from schizophrenia patients," he said.

By sampling the blood plasma of schizophrenia patients about to begin a course of antipsychotic drug therapy (using shotgun proteomics, in which cutting-edge mass spectrometry techniques are employed), it is possible to identify and quantify the proteins within the sample, and generate a protein profile for each individual patient. This data, at time zero (T0), can then be used to cross reference against plasma readings later on: "There is a waiting time of six weeks before these patients see the doctor again, and when they do we collect the blood again, and this is what we call the T6 time," said Professor Martins-de-Souza.

Crucially, the six-week

testing is hoped to shed some light on what biochemical pathways the drugs modulate. "We want to understand what the biology is behind antipsychotic treatment," said Professor Martins-de-Souza.

"We have a considerable number of patients that do not respond properly to their medication. The problem we have in dealing with schizophrenia specifically is that patients have the drug for six weeks, so when that drug is not working – and needs to be changed (drug or dosage etc.) – then they will have to wait another

"We can associate certain proteins to the fact that some people are not going to respond [to antipsychotics]. The main idea would be to define some potential biomarkers that would indicate whether a patient is going to respond or not, before the treatment starts."

Daniel Martins-de-Souza (Ludwig-Maximilians-University Munich, Germany)

six weeks to see if the new drug performs better."

He continued: "Considering we collect the blood from these patients at T0 before they are treated, and at T6 when

they see the doctor again, we know which patients are the responders, and which patients are the non-responders. And then by comparing the profiled proteins at T0, if we define two groups of responders

and non-responders, the idea is that we can associate certain proteins to the fact that some people are not going to respond. The main idea would be to define some potential biomarkers that would indicate whether a patient is going to respond or not, before the treatment starts."

During his presentation, Professor Martins-de-Souza will also focus on the biology and biochemistry when a patient is given an antipsychotic. "The biomarker part (which is more applied to the clinics) is going to be done later in the future, because we need a more statistical tool that still requires a little more

developing. We are going to get as many samples as we can, but we are not there yet."

As the ultimate goal, this work may eventually lead to an established catalogue of proteins that could be used, alongside blood tests, to better classify or predict what antipsychotic treatments – if any – will warrant the best response from any given patient.

Professor Martins-de-Souza will deliver his presentation 'Proteomic studies in schizophrenia and effects of antipsychotic medication: relevance for the immune system', during the session 'The involvement of Microglia and immune-related proteins in the pathophysiology and treatment of schizophrenia', held this afternoon at 15:00–16:30 in Room S514.



Daniel Martins-de-Souza

Reconnecting Mind and Body in Contemporary Health Systems



Eliot Sorel



Juan José López-Ibor

An in-depth look at health systems' challenges, and the opportunities for enhancing their performance, takes place this morning at EPA 2014. The symposium examines health system's performance from the perspectives of Finland, Romania, Spain and the US, utilising strength, weaknesses, opportunities and threats (SWOT) as a model of analysis, comparison and recommendations. EPA Congress News spoke to Eliot Sorel (GWU School of Medicine & School of Public Health, and Founder of the Conflict Management Section, WPA, Washington, DC, USA), who will be introducing the proceedings and concluding them with his perspectives on the US healthcare system and the Affordable Care Act, and to Juan José López-Ibor (Fundación Juan J. López-Ibor, Madrid, Spain), who will be speaking on the Spanish

healthcare system.

This symposium is the second of its kind, the first Health Systems Performance Roundtable, which focussed on all continents, having taken place at the World Congress of Psychiatry in Bucharest in April

lems and solutions in healthcare systems is both a public health matter and an economic one. Non-communicable disease, of which mental disorders are part, take the lead in the global burden of disease. "Mental disorders and non-

likely have co-occurrence of depression, certainly in the vast majority of cases."

One of the most startling figures, noted Professor Sorel, is that the global burden of disability represented by mental disorders is between 30-45%. "There is no other set of conditions that comes anywhere near," he said. "The global burden of mental disorders per se is 14%; but the disability is 30-45%. So we need to think about it in several dimensions: what is the global burden of disease generally; what is specifically the global burden of mental disorders; what is the global burden related to comorbidities; and what is the global burden

"We need to think about it in several dimensions: what is the global burden of disease generally; what is specifically the global burden of mental disorders; what is the global burden related to comorbidities; and what is the global burden regarding disability?"

Eliot Sorel (GWU School of Medicine & School of Public Health, and Founder of the Conflict Management Section, WPA, Washington, DC, USA)

last year. The third is planned for this September in Madrid, where Asia-Pacific, Africa, Europe and the Americas will be tackled together.

The need to identify the prob-

lem of communicable disease do not occur in silos," said Professor Sorel. "They frequently co-occur. For instance, if you have diabetes or hypertension, or cancer or stroke, all of those very

regarding disability?"

Such a burden comes with a heavy cost, one that could be reduced with better organisation of

Continued on page 30

The latest on ICD-11

The classification of mental disorders in the ICD-11, which is now expected to be finally approved in May 2017 amid the need for additional development of some chapters other than Mental and Behavioural Disorders, and for a thorough review and testing

Table 1. Action Summary, Clinical Descriptions and Diagnostic Guidelines for ICD-11 Mental and Behavioural Disorders

Activities completed:

1. Development of linear structure and definitions for all ICD-11 Mental and Behavioural Disorders based on content provided by Working Groups
2. Development of field study version of diagnostic guidelines for key areas of Mental and Behavioural Disorders based on content provided by Working Groups
3. Formative field studies and professional surveys to inform structure of ICD-11 Mental and Behavioural Disorders
4. Development of Global Clinical Practice Network of 10,000 clinicians worldwide to participate in internet-based field testing of diagnostic guidelines
5. Internet-based field testing of proposed diagnostic guidelines for Disorders Specifically Associated with Stress in English, Japanese, and Spanish and for Feeding and Eating Disorders in English (other languages in progress)

Activities planned during 2014:

1. Complete field study versions of diagnostic guidelines for all ICD-11 Mental and Behavioural Disorders, Sleep-Wake Disorders, and Sexuality-Related Conditions and Dysfunctions
2. Complete internet-based field testing in multiple languages of diagnostic guidelines for ICD-11 Mental and Behavioural Disorders in other major disorder areas
3. Initiate of clinic-based field studies in multiple languages of diagnostic guidelines for ICD-11 Mental and Behavioural Disorders in major disorder areas
4. Complete field study of Primary Health Care version of the ICD-11 classification of Mental and Behavioural Disorders (ICD-11-PHC)
5. Initiate public review and comment process (May, 2014)
6. Initiate development of additional material for Clinical Descriptions and Diagnostic Guidelines version of ICD-11 Mental and Behavioural Disorders in major disorder areas
7. Complete assessment of feasibility and usefulness of Research Diagnostic Criteria related to ICD-11 Mental and Behavioural Disorders, and develop work plan as appropriate

Activities planned during 2015 - 2016:

1. Revise proposals for diagnostic guidelines based on results of field studies and review and comment
2. Finalize content for Clinical Descriptions and Diagnostic Guidelines
3. Finalize content for Primary Health Care version
4. Develop translations into official WHO languages
5. Work with partners to develop educational and implementation materials



Geoffrey M Reed

process, was discussed in detail in an educational symposium yesterday morning.

Geoffrey M Reed (Department of Mental Health and Substance Abuse, World Health Organization (WHO), Geneva, Switzerland), who is Senior Project Officer for the Revision of ICD-10 Mental and Behavioural Disorders in the Department of Mental Health and Substance Abuse at WHO, explained the latest in the revision process in an interview with *EPA Congress News*. "The timeline [Table 1] refers to the Clinical Descriptions and Diagnostic Guidelines for ICD-11 Mental and Behavioural Disorders, which is the version primarily intended for use by psychiatrists and other mental health professionals," he said.

Dr Reed explained why attending the EPA Congress was important for WHO. "A survey of nearly 5,000 psychiatrists that we conducted with the World Psychiatric Association worldwide indicated that the European region is the one in which the ICD-11 is most widely used in day-to-day clinical practice by psychiatrists. Approximately 80% of European survey participants regularly use a formal classification system in daily clinical practice, and the ICD is overwhelming the classification they use. European countries will be key early adopters of the new ICD-11 classification for official purposes when it is approved. So, the participation of European psychiatrists and other European health professionals in the ICD revision is of particular importance to us."

One way for European psychiatrists to participate in the development of the ICD-11 is through the Global Clinical Practice Network

(GCPN), a network of over 10,000 mental health and primary care professionals who have agreed to participate in internet-based field studies related to the ICD revision. Over a third of current GCPN members are from the European region. European psychiatrists and other mental health and primary care professionals can register to participate and get additional information at <http://www.globalclinicalpractice.net>. Registration is available in nine languages, including English, French, German, Portuguese, Russian, and Spanish, and field studies will also be conducted in multiple languages.

The development of a version for primary health care settings (ICD-11 PHC) is also under way, explained Dr Reed, with a similar timeline for development of the PHC version as for the Clinical Descriptions and Diagnostic Guidelines. WHO has also been considering the potential need for a version of the ICD-11 classification of mental and behavioural disorders for use in research. Dr Reed explained: "A work plan for a research version of ICD-11 Mental and Behavioural Disorders will be developed separately if a decision is made to proceed and once the parameters of the project are determined." One basis for the decision will be WHO's evaluation of the differences between the ICD-11 and the DSM-5, published by the American Psychiatric Association last year.

Asked how the ICD and DSM fitting in with the Research Domain Criteria (RDoC) initiative of the US National Institute of Mental Health (NIMH), Dr Reed responded: "It is clearly relevant to any research classification of mental dis-

Continued on page 28

Classification of mental disorders in ICD-11 Room 14C Sunday 2 March 08:00-09:30

The latest on ICD-11

Continued from page 27

orders that the world's largest funder of mental health research has decided to move away from a model based on diagnostic categories and has committed itself to a program of research based on RDoC that incorporates genetics, imaging, cognitive science, and other levels of information eventually intended to lay the foundation for a new classification system." WHO has had preliminary discussions with NIMH about the possibility of integrating perspectives based on RDoC with public health perspectives and priorities in order to develop a diagnostic manual for research, Dr Reed explained.

As a further concrete step in this exploration, WHO convened a meeting last month in Madrid, Spain entitled 'Future Directions in Research Diagnostic Criteria in Mental and

Behavioural Disorders', which brought together key members of NIMH's RDoC Work Group, top European researchers, the European Commission, and WHO to examine the rationale, near-term prospects, and long-term potential of NIMH's RDoC approach in the context of priorities for European mental health research recently articulated by the European Commission Project 'A Roadmap for Mental Health Research in Europe'. "The meeting was productive and very helpful in identifying those priority areas where there is a good fit with RDoC and those that require other perspectives and frameworks for advancing population health priorities," said Dr Reed.

The meeting also provided consultation to WHO regarding the potential usefulness of producing a research diagnostic manual keyed to ICD-11 and the type of guidance that would best assist global researchers to define samples and consider research populations in relation to specific research questions. "The discussion suggested that there is a need for a standard diagnostic resource that more effectively links NIMH's RDoC constructs with psychopathologi-

cal processes that underlie clinical phenomena, and that a deep understanding of these processes is a major strength of European researchers. "This suggests the possibility of a research classification that would be a much different resource from the Clinical Descriptions and Diagnostic Guidelines for clinicians, but would still provide a linkage to the ICD-11 framework" Dr Reed said.

Further discussions involving the NIMH, the European Commission and WHO's Advisory Group will determine the possibility and importance of taking this work forward. Dr Reed's view on the advantage of the ICD-11 over the DSM-5 as a framework for such an effort was that the DSM has historically attempted to be "all things to all people" by providing single classification for all purposes (e.g., clinical use, research, epidemiology, health statistics). "WHO has always conceptualised a research version as a separate project," he continued. "So there is no prohibition against its looking quite different from the clinical version, though it will be important to have explicit algorithms that facilitate crosswalks."

Modulation of brain activity in patients with psychiatric disorders Room 5 Sunday 2 March 15:00-16:30

Both functional magnetic resonance imaging-based neural feedback (fMRI-NF) and electroconvulsive therapy (ECT) have shown great potential as therapeutic tools in depression, delegates heard yesterday afternoon in a session dedicated to the clinical and therapeutic implications of brain activity modulation.

David Linden (Cardiff University and Cardiff and Vale University Health Board, Cardiff, Wales), presented data from his 2012 feasibility study of neurofeedback in overcoming negative cognitive schema in depression.¹ "In physiological terms, we are hoping that promoting activity and perhaps plasticity in these emotional regulation networks will have positive effects," he explained. "Psychologically, we hope to enhance a psychological mood regulation technique with direct feedback."

During fMRI-NF training, participants receive feedback on their brain activity in real time and are instructed to change this activation, by, for example, engaging in specific mental imagery, explained

Seeing is believing ECT and fMRI-NF in depression therapy



"In a way, it is personalised medicine."

David Linden (Cardiff University and Cardiff and Vale University Health Board, Cardiff, Wales)

David Linden

cues in the patient and train them," he said. "We started with the functionally activated areas based on a localiser procedure,

and then trained patients to enhance their activation to see whether that would help them overcome their anhedonia. If the imagery and memory of positive scenes and events from their past

was enhanced by the brain self-regulation protocol, that would give lasting effects on mood and clinical symptoms."

Professor Linden's group are now two-thirds of the way through a larger investigator-blinded randomised controlled trial with a recruitment target of 40 patients. "It is – as far as you can be with these types of complex interventions – very strict and rigorous in its design. In about a year's time when it is completed we can give more information about the efficacy aspect."

Professor Linden concluded with some thoughts on fMRI-NF's clinical potential. "If it were to be shown to be effective, it could be offered as a first instance, in the same way that in mild to moderate depression you might consider whether to start on antidepressants right away or to start a psychological intervention first of all," he said.

Professor Linden discussed 'Regulation of emotion networks in depression' on Sunday 2 March in Room 5.

References

1. Linden DEJ et al. Real-Time Self-Regulation of Emotion Networks in Patients with Depression. PLoS One. 2012;7(6):e38115. doi: 10.1371/journal.pone.0038115. Epub 2012 Jun 4.

Modulation of brain activity in patients with psychiatric disorders Room 5 Sunday 2 March 15:00 – 16:35

Brain changes under ECT in treatment-resistant depression

The effects of electroconvulsive therapy (ECT) on both brain activity and connectivity will be described in today's afternoon symposium dedicated to the modulation of brain activity in patients with psychiatric disorders. Oliver Pogarell (University of Munich, Germany) will present data from his pilot study comparing resting state EEG in depressed patient before and after ECT. He and colleague Daniel Keeser (University of Munich, Germany) spoke to *EPA Congress News* in advance of the session to describe their findings.

All of the patients included in the trial were treatment resistant, suffering from severe depression, Professor Pogarell explained: "The patients received EEG before ECT was started, and afterwards. We wanted to know whether there are any changes in general brain electric activity; but also, in a more sophisticated analyses of EEG, the connectivity between certain brain regions such as the frontal-temporal brain regions."

20 patients with severe depression underwent right unilateral ECT. Dr Keeser described the results: "All the patients we have looked at improved



Oliver Pogarell

"We wanted to know whether there are any changes in general brain electric activity; but also...the connectivity between certain brain regions such as the frontal-temporal brain regions."

Oliver Pogarell (University of Munich, Germany)

and connectivity, EEG is a superior imaging modality relative to fMRI in capturing the dynamic changes that occur within the millisecond range. Dr Keeser added that the team are already working on a project combining EEG and fMRI data. "One of the problems of EEG is the lack of good spatial resolution, so in the future we want to combine EEG and fMRI in patients before and under ECT."

Dr Keeser concluded: "While we know that ECT works in patients with depression, at the moment we do not really know how it works. With our study we tried to focus a little bit more on the connectivity between certain brain regions and to go into the neurocircuits in order to further our knowledge in this area."

clinically," he said. Looking at the data, the team found that delta and theta power in frontal sensor EEG electrodes significantly increased. Conversely, EEG connectivity in both sensor and source space significantly decreased. sLORETA analysis revealed sources of current density increases in the inferior frontal, superior frontal,

insular, and temporal cortices. Conducting statistical non-parametric mapping also revealed significant increases in delta activity in the middle frontal gyrus, the inferior frontal gyrus, the insular cortex and superior temporal gyrus.

Professor Pogarell then explained that, when investigating the temporal dimension of brain activity



Daniel Keeser

Reconnecting Mind and Body in Contemporary Health Systems

Continued from page 26

care. Professor Sorel continued: "I was privileged to be invited to be an expert advisor to the Organisation for Economic Cooperation and Development [OECD] in Paris. The OECD, for the first time in their history, focussed on mental disorders. In my wildest dreams as a young student of medicine I would never have thought that the OECD would have an interest in mental disorders."

This econocentric turn, explained Professor López-Ibor, is being felt in Spain as it is around the whole of Europe, and not least because of the global financial crisis. "The issue that we have here in Spain, which is also happening in other countries, is that we cannot afford what we have. Our healthcare system in Spain follows very much the model of the National Health Service (NHS) in the UK, although things are changing. I think the NHS in the UK is a very good example of how you should organise the care of patients in general. It seems to work better than other places, which does not

mean that it is perfect."

Spain comprises 17 autonomous regions, said Professor López-Ibor, each with its own healthcare system, and the mental health priorities change from one to the other. "The panorama is so different from one place to the other," he said. "With the changes in America right now, with Obamacare, this is a hot issue in healthcare. The thing is not to forget about the care of people with mental disorders, which very often happens when you make plans for a new healthcare system."

The sorts of implementations that are hoped to increase the efficiency of Spain's NHS include management models taken from the private sector, yet the threat of change has been met with resistance from some in the Spanish population. Professor López-Ibor said: "The moment of change is very complicated. Our worry is that in this moment of change, where there is shortage of money, psychiatric care will suffer more than others. That is why we organised the

whole project. There is a need for change, but how the change needs to be done is not easy, because you need a lot of consensus. Many people in this country are proud of their health service. The feeling is that we have a system which belongs to every citizen. This is a psychological issue involving the fear that cuts will come and that number of employees will be reduced, or that hours will increase, or that there will be more control."

While economics must be considered, the fundamental attitudes and values of healthcare professionals can vastly improve quality of care, as Professor López-Ibor has demonstrated over the last few years of his public clinical responsibilities. "I tried very hard to implement managerial techniques for the care of patients. I was Director of the Institute for Psychiatry and Mental Health of the Complutense University. I had 250 people working at this institute; you have to open the doors 24 hours a day, all days of the year, treating patients,

so it is a really difficult job to run.

"We have to administer what we have and what we have is not only economic resources, but it is also values and knowledge. You have to administer these to the benefit of every single patient that comes to your unit. This management is not economic management, it is the management of values, knowledge and human resources. My experience has been very positive. We were very transparent, which is important in psychiatry, because people tend to say, 'we never know what you do with your patients, you are very strange people, we don't understand what you do, you have length of stays longer than anyone else...' All of these problems you can solve if you have a good managerial approach to your activities."

Professors Sorel and López-Ibor will be speaking during the session 'Health Systems' Performance: Euro-Atlantic Perspectives', taking place today between 08:00 and 09:30 in Room 21A.

MediFore
are the proud publishers of

EPA CONGRESS NEWS

MediFore is a full-service medical communications and publishing company, working closely with local and international medical societies and associations, and industry, to develop conference publications, including newsletters and newspapers, as well as reports and medical summaries, medical writing and scientific publications



MediFore

enquiries@medifore.co.uk +44 (0) 20 8761 2790

EPA Congress Committees

EXECUTIVE COMMITTEE

Danuta Wasserman *Sweden* *President*
Patrice Boyer *France* *Past President*
Wolfgang Gaebel *Germany* *President Elect*
Julian Beezhold *UK* *Secretary General*
Philip Gorwood *France* *Treasurer*

EPA OFFICE BEARERS

Danuta Wasserman *Sweden* *President*
Patrice Boyer *France* *Past President*
Wolfgang Gaebel *Germany* *President Elect*
Julian Beezhold *UK* *Secretary General*
Philip Gorwood *France* *Treasurer*
Michael Musalek *Austria* *Secretary for Sections*
Cécile Hanon *France* *Secretary for Education*

LOCAL ORGANISING COMMITTEE

Peter Falkai *Munich* *Chair*
Hans-Jürgen Möller *Munich* *Honorary Chair*
Margot Albus *Haar bei München*
Daniela Eser *Munich*
Hans Förstl *Munich*
Alkomiet Hasan *Munich*
Florian Holsboer *Munich*
Nikolaos Koutsouleris *Munich*
Gerd Laux *Wasserburg am Inn*
Eva Meisenzahl *Munich*
Norbert Müller *Munich*
Frank Padberg *Munich*
Oliver Pogarell *Munich*
Moritz Rossner *Göttingen*
Max Schmauss *Augsburg*
Andrea Schmitt *Munich*
Thomas Schulze *Göttingen*
Florian Seemüller *Munich*

SCIENTIFIC PROGRAMME COMMITTEE

Danuta Wasserman *Sweden* *Chair*
Peter Falkai *Germany* *2014 LOC Chair*
Hans-Jürgen Möller *Germany* *2014 Honorary LOC Chair*
Patrice Boyer *France*
Sophia Frangou *USA*
Silvana Galderisi *Italy*
Philip Gorwood *France*
Cyril Höschl *Czech Republic*
Michael Musalek *Austria*
Anita Riecher *Switzerland*

ADVISORY SCIENTIFIC PROGRAMME COMMITTEE (ASPC) – MUNICH 2014

Sue Bailey *UK*

Dinesh Bhugra *UK*
István Bitter *Hungary*
Mary Cannon *Ireland*
George Christodoulou *Greece*
Doina Cozman *Romania*
Katharina Domschke *Germany*
Andrea Fiorillo *Italy*
Iris Graef-Calliess *Germany*
Siegfried Kasper *Austria*
Marianne Kastrup *Denmark*
Valery Krasnov *Russia*
Marion Leboyer *France*
Nils Lindefors *Sweden*
Mario Maj *Italy*
Merete Nordentoft *Denmark*
Janusz Rybakowski *Poland*
Pilar Saiz *Spain*
Marco Sarchiapone *Italy*
Henning Sass *Germany*
Christina van der Feltz Cornelis *Netherlands*
Rutger Jan van der Gaag *Netherlands*
Airi Värnik *Estonia*
Gil Zalsman *Israel*

EPA BOARD

Danuta Wasserman *Sweden* *Chairperson*
Sue Bailey *UK*
Julian Neil Beezhold *UK*
István Bitter *Hungary*
Patrice Boyer *France*
Geert Dom *Belgium*
Peter Falkai *Germany*
Wolfgang Gaebel *Germany*
Silvana Galderisi *Italy*
Philip Gorwood *France*
Cécile Hanon *France*
Andreas Heinz *Germany*
Cyril Höschl *Czech Republic*
Marianne Kastrup *Denmark*
Tamas Kurimay *Hungary*
Michael Musalek *Austria*
Wulf Rössler *Switzerland*
Rutger Jan van der Gaag *Netherlands*
Zvi Zemishlany *Israel*

COMMITTEE ON EDUCATION

Cécile Hanon *France* *Chairperson, Secretary for Education*
Olivier Andlauer *France*
Andrea Fiorillo *Italy*
Silvana Galderisi *Italy*
Christoph Lauber *Switzerland*

Nadja Maric-Bojovic *Serbia*
Michael Musalek *Austria*
Norman Sartorius *Switzerland*
Rutger Jan van der Gaag *Netherlands*

EARLY CAREER PSYCHIATRISTS COMMITTEE

Martina Rojnic-Kuzman *Croatia* *Chairperson*
Alexander Nawka *Czech Republic* *Co-chairperson*
Nikolina Jovanovic *Croatia*
Amit Malik *UK*
Olivier Andlauer *France*

COMMITTEE ON ETHICAL ISSUES

Marianne Kastrup *Denmark* *Chairperson*
Julian Beezhold *UK*
Silvana Galderisi *Italy*
Cécile Hanon *France*
Andreas Heinz *Germany*
Wolfgang Rutz *Sweden*
Henning Sass *Germany*
Norman Sartorius *Switzerland*

GUIDANCE COMMITTEE

Wolfgang Gaebel *Germany* *Chair*
Hans-Jürgen Möller *Germany* *Co-chair*
Danuta Wassermann *Sweden*
Dinesh Bhugra *UK*
Peter Falkai *Germany*
Andrea Fiorillo *Italy*
Reinhard Heun *UK*
Michael Musalek *Austria*

SECTION COMMITTEE

Michael Musalek *Austria* *Chair*
Geert Dom *Belgium*
Wolfgang Gaebel *Germany*
Marianne Kastrup *Denmark*
Nadja Maric Bojovic *Serbia*
Manuel Martin-Carrasco *Spain*
Alexander Nawka *Czech Republic*
Meryam Schouler-Ocak *Germany*

AMBASSADOR COMMITTEE

Danuta Wasserman *Sweden* *Chair*
Sue Bailey *UK*
Geert Dom *Belgium*
Wolfgang Gaebel *Germany*
Marianne Kastrup *Denmark*
Amit Malik *UK*
Norman Sartorius *Switzerland*
Zvi Zemishlany *Israel*

EPA SECTION CHAIRS

Addictive Behaviours *Falk Kiefer* *Germany*
Child and Adolescent Psychiatry *Gil Zalsman*
Consultation Liaison Psychiatry & Psychosomatics *Albert Diefenbacher* *Germany*
Cultural Psychiatry *Meryam Schouler Ocak* *Germany*
Emergency Psychiatry *Pier Maria Furlan* *Italy*
Epidemiology and Social Psychiatry *Robert Stewart* *UK*
Forensic Psychiatry *Birgit Völlm* *UK*
Geriatric Psychiatry *Carlos A. de Mendonça* *Portugal*
Neuroimaging *Sophia Frangou* *UK*

Philosophy and Psychiatry *Giovanni Stanghellini* *Italy*
Prevention of Mental Disorders *Wolfgang Maier* *Germany*
Psychopathology *Michael Musalek* *Austria*
Psychopharmacology *István Bitter* *Hungary*
Psychotherapy *Fritz Hohagen* *Germany*
Schizophrenia *Silvana Galderisi* *Italy*
Sexual Medicine and Mental Health *Marcel Waldinger* *The Netherlands*
Suicidology and Suicide Prevention *Marco Sarchiapone* *Italy*
TeleMental Health *Davor Mucic* *Denmark*
Women, Gender and Mental Health *Anita Riecher-Rössler* *Switzerland*



EUROPEAN PSYCHIATRIC ASSOCIATION

23rd EUROPEAN CONGRESS OF PSYCHIATRY

Vienna, Austria 28-31 March 2015

www.epa-congress.org

EXCELLENCE IN PSYCHIATRY ACROSS EUROPE:
PRACTICE, EDUCATION, RESEARCH



Scan this code with your smart phone
www.epa-congress.org
Need a code reader for your phone?
<http://get.neoreader.com>

