



## Inside today

### Page 5

Tipping the scales on coercion in mental health

### Page 6

Afzal Javed on the joint AFPA-EPA symposium



### Page 9

Primary care mental health in the elderly

### Page 14



Have we lost our way in depression treatment?

### Page 17

Timing matters - the impact of early life events



# ‘Excellence in psychiatry’: a guiding motto



The Congress was declared officially open at Saturday evening’s opening ceremony, which was infused with a number of musical interludes from outstanding local musicians Franz Bartolomey, Matthias Bartolomey and Nikola Djoric.

As part of his presidential lecture, Wolfgang Gaebel spoke of what it means to be a psychiatrist: “According to Aristotle, ‘excellence is always the result of high intentions, sincere effort, and intelligent execution.’ So *excellence in psychiatry* may thus be the guiding principle and motto for European psychiatry.”

Quoting the work of American psychotherapist Glen Gabbard, he continued: “Psychiatrists occupy a unique niche among medical specialists. They are integrators par excellence of the biological and psychosocial in both diagnosis and treatment.’ Are we generalists, or are we specialists? Are we both? Or do we have to become more and more specialist?”

Posing an answer to these questions, Professor Gaebel quoted his 2010 paper on the challenges and opportunities for psychiatry that he felt were still relevant today. “The psychiatrist is thus

the physician best qualified to disentangle the often complex relationship between biological, psychological, and social factors in both somatic and mental disorders. While next to this idea of the psychiatrist as a ‘biopsychosocial generalist’, further differentiations and specialisations are advisable in order to cope with the growing diagnostic and therapeutic complexities of the field, it is important that the identity of the profession and its integrative strength are further advanced.”<sup>1</sup>

#### Reference

<sup>1</sup> *World Psychiatry*. 2010 Feb; 9(1): 36–38.

## PsychiatrySpeaks

**Over 1600 psychiatric professionals.**

**8 countries worldwide. One goal.**

To understand the current state of mind of those working in psychiatry and schizophrenia.

**PsychiatrySpeaks. Coming soon.**

**It may challenge your perceptions.**

Visit psychiatryspeaks.com to be one of the first to know. Find out more at the EPA Cyber Corner today!

Concepts of mental disorders: time to change? Hall B Tuesday 15:30-17:00

## Concepts of mental disorders Time to change?

Our concepts and classifications of mental disorders continue to evolve amid ongoing progress in our understanding of them. During an educational symposium taking place tomorrow afternoon, session chairs Wolfgang Gaebel (Heinrich-Heine University, Düsseldorf, Germany) and Geoffrey Reed (Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland) reflect on where our concepts are headed, particularly in light of the recent emergence of DSM-5 and the impending ICD-11.

They are joined by Wulf Rössler (University of Zurich, Switzerland),

who discusses the incorporation of cultural factors in classification, in light of recent global migration and its consequences.

Dr Reed will describe the current phase of the development of ICD-11 (set for final approval in 2017) and the critical issues that arose during the development process regarding the conceptualisation of mental disorders. Speaking to *EPA Congress News*, he explained how new disorder groupings have



*"Neither DSM-5 nor ICD-11 have introduced neurobiological or genetic factors into the classification of psychotic disorders."*

Wolfgang Gaebel

### EPA CONGRESS NEWS

#### Publishing and Production

MediFore Limited

#### EPA President

Wolfgang Gaebel

#### Local Organising Committee Chair

Michael Musalek

#### Editor-in-Chief

Rysia Burmicz

#### Editors

Pete Stevenson, Aisling Koning

#### Design

Peter Williams

#### Industry Liaison Manager

Bethan Coulbeck

#### Head Office

19 Jasper Road

London SE19 1ST, UK

Telephone:

+44 (0) 20 8761 2790

editor@medifore.co.uk

www.medifore.co.uk

Copyright © 2015: 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.

been created by subdividing large conglomerations necessitated by the structure of ICD-10: "Based on a lifespan development perspective, separate sections on disorders of childhood have been eliminated," he said.

"New chapters on Sleep-Wake Disorders and conditions related to sexuality have been proposed to overcome the false dichotomy between 'organic' and 'nonorganic' disorders inherent in ICD-10. New categories have been added in several areas (e.g., bipolar type II disorder, hoarding disorder, complex PTSD, binge eating disorder), and subtypes lacking validity and utility (e.g., for schizophrenia and somatoform disorders) have been eliminated."

Continued on page 4



*"There are various regional adaptations in the use of ICD. This all will improve treatment and care, not only in various regions of the world but also the respective treatment approaches of migrants."*

Wulf Rössler





## People. That's where sustainability starts.

At Janssen, we're committed to helping people live healthier and happier lives. And it all starts with sustainability – at home, in business and beyond.

Solving society's major healthcare challenges is our aspiration. We choose to pursue it in a way that benefits the people, communities and environments we touch.

We believe our purpose is more than creating safe and effective medicines. It's about sustaining a healthier world.

We are Janssen. Our mission drives us. Our patients inspire us. We collaborate with the world for the health of everyone in it.

Learn more at [www.janssen-deutschland.de](http://www.janssen-deutschland.de)



Concepts of mental disorders: time to change? Hall B Tuesday 15:30-17:00

## Concepts of mental disorders Time to change?

Continued from page 2

Following this presentation, Professor Gaebel reviews the main differences between ICD-11 and DSM-5 with a special focus on the classification of psychotic disorders and ensuing questions that may be pertinent for the more general issue of concepts of mental disorders. In an interview ahead of the congress, he noted that both diagnostic systems base the classification of mental disorders on psychopathology rather than nosology, but he nevertheless highlighted a major difference in the role of functional impairments, mandatory in DSM-5 but not ICD-11.

Concerted harmonisation efforts have worked to minimise such differences between DSM-5 and ICD-11, as Dr Reed explained: "Most of the ICD-11 and DSM-5 Working Groups had at least one member in common. Although the DSM-5 process was ahead of ICD-11, ICD-11 Working Groups were familiar with DSM-5 changes during their deliberations and avoided unintentional differences between the systems.

"Therefore, remaining differences – which are particularly notable in the areas of personality disorders, trauma and stress-related disorders,

well-harmonised, Professor Gaebel emphasised that other areas are less so: "Differences in duration criteria lead to different approaches regarding brief psychotic disorders. And attenuated psychotic symptoms did not receive full diagnostic status.

"Neither DSM-5 nor ICD-11 have introduced neurobiological or genetic factors into the classification of psychotic disorders," he added. "And some differences still prevail regarding time course criteria and the handling of brief psychotic disorders, which may indicate different concepts of chronicity underlying these decisions. An important aspect was the non-inclusion of attenuated psychotic symptoms syndrome among the mental disorders, indicating that

the border towards normality is still uncharted terrain in both classification systems, and open for discussions about concepts of subclinical or otherwise dimensional ratings of subdiagnostic symptoms in the general population."

On the topic of cultural sensitivity, Dr Reed was keen to highlight the sensitivity of WHO to issues of global and cultural applicability as a part of the development of ICD-11 – necessary if it or indeed DSM-5 are to be usable across different regions of the world. "The International Advisory Group that is advising WHO on all phases of the current revision includes individuals from all WHO Global Regions and a high proportion of experts from low- and middle-income countries. This is also the case with all of the Working Groups responsible for making recommendations for the structure and content of diagnostic guidelines for all Mental and Behavioural Disorders areas, as well as the

Field Study Coordination Group."

Indeed, 85% of the world's population live in low- and middle-income countries; as such, field testing of ICD-11 takes a similarly robust approach, being carried out in multiple languages and in numerous countries throughout the world. "The diagnostic guidelines themselves will also include a section on culture-related issues that describes documented cultural differences in the presentation of particular disorders," continued Dr Reed. "So, we are confident that we are developing a manual that will be as useful as possible around the world and across cultures, and by the end of the process we will have a great deal of evidence to that effect."

Sharing his views on the issue, Professor Rössler felt there is "no doubt" about the need of culturally-adapted classification systems. Explaining how the two systems have dealt with this, he said:

"DSM-5 has incorporated a cultural framework considering the cultural identity of a person, cultural explanations of the individual's disorder, or cultural factors related to the psychosocial environment and level of functioning.

"Likewise, we also find cultural considerations in ICD," he continued. "And there are various regional adaptations in the use of ICD. This all will improve treatment and care, not only in various regions of the world but also the respective treatment approaches of migrants. Aside from these more practical questions, there are much more fundamental concepts of mental disorders behind them; namely, the question of the universality of mental disorders, which is implicitly linked to a biological model of mental disorders."

*"We are confident that we are developing a manual that will be as useful as possible around the world and across cultures."*

Geoffrey Reed

paraphilic disorders, substance use disorders, and somatic symptom/body distress disorders – are conceptual and intentional, based in part on the different purposes and constituencies of the two classifications."

While acknowledging that time course criteria and the introduction of dimensional assessments are



*"Most of the ICD-11 and DSM-5 Working Groups had at least one member in common."*

Geoffrey Reed

The symposium 'Concepts of mental disorders: time to change?' takes place tomorrow at 15:30 till 17:00 in Hall B.



Workshop: Coercion in Psychiatric Services in Different European Countries Hall B Monday 17:00–18:30

## Coercion: A force to be reckoned with?

The ethics, clinical practice, human rights and legal regulations of mental healthcare coercion – with particular focus on country-wide differences – will be explored this evening in a Workshop with one clear message: there needs to be more emphasis on a patient's autonomy, and a balanced and limited use of coercive measures.

Various European accounts of coercion will be laid bare during the session, with chairman Tilman Steinert (University of Ulm, Ravensburg, Germany) taking attendees through the German perspective.

In an interview with *EPA Congress News*, Professor Steinert framed the current practices in Germany, using the UK as a comparative example. "They use physical restraint in the UK, i.e. holding people down manually, and in Germany we use belts to fix patients to a bed [as mechanical restraint]," he said. "The biggest difference is that mechanical restraint lasts much longer than physical restraint.

"Maybe the reason for this is that we have fewer nursing staff available on the wards. However, we have more psychiatric beds, and more patients with not-so-severe psychiatric disorders can be hospitalised in Germany. Also we use seclusion rooms I think a bit more than the UK – although some hospitals in Germany don't use seclusion rooms at all. The next big difference is involuntary outpatient commitment. In the UK, as I am aware, it has been legalised since 2009,

and there are many cases of community treatment orders, CTOs, that have never been legalised in Germany, except for pharma forensic patients. That means it is not possible to force a patient to take medication outside of hospital in Germany."

Professor Steinert noted that the next big difference would be involuntary treatment: "Since the decision of our constitutional court in 2011, the threshold for the use of involuntary medication has become much higher," he said.

"That means a separate decision of a judge is required by external review. There are a lot of steps, so it has become very difficult.

*"All over Europe we have a tendency for patient empowerment and patient rights, and I think that is a good development."*

Tilman Steinert

Only a relatively small number of patients now receive involuntary medication. I know that it is of very little concern in the UK, where they say, 'It is a treatment'. But in Germany it has become a big issue."

While Professor Steinert stressed that involuntary medication was still a "wrong direction" from his perspective, he conceded that it is good to evaluate it intently, in order to make sure it is in the best interest of patients. "I think to be too strict and too restrictive may lead us in the



wrong direction," he said.

Discussing the data that is now in the ether regarding how coercive measures affect patient outcomes, Professor Steinert spoke of

*"Since the decision of our constitutional court in 2011, the threshold for the use of involuntary medication has become much higher."*

Tilman Steinert

one particularly interesting study from his own centre in Suedwuerttemberg, which emerged during a period of legislative dormancy, as he explained: "For a period of seven months we had no legislation for medication at all. That meant that only in cases of acute emergency was medication actually possible. This was a quasi-experimental situation. Seven

months later the legislation was revised, therefore we had data from the period before, where medication was possible, seven months without, and then the time where it was again possible.

"In our hospital group, consisting of seven psychiatric hospitals, our data clearly indicated that the number of mechanical coercive measures, such as restraint and seclusion, increased when medication was not possible, and the number of aggressive incidents also increased. After medication was possible again, it decreased to the former level.

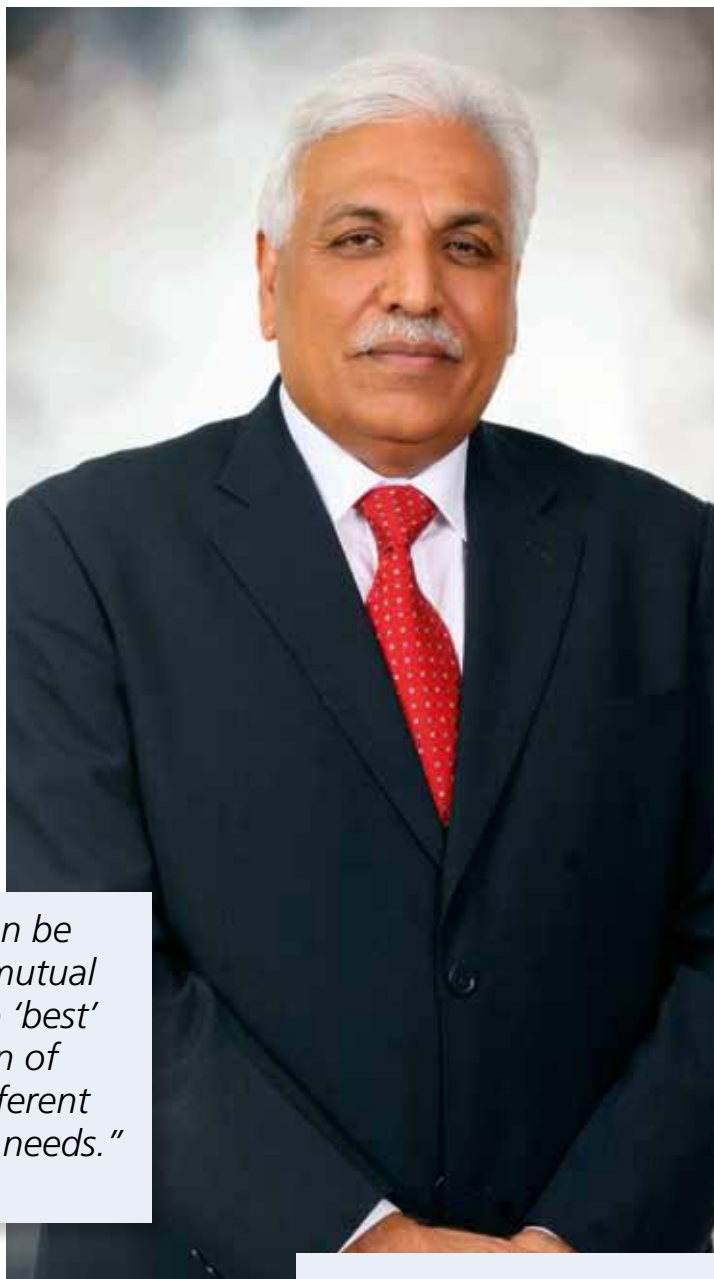
"Interestingly, all of that concerned only a small number of patients. Six out of seven patients with psychotic disorders were not involved with any coercive measure, but for this rather small number of patients, coercive measures doubled during the time where no medication was possible."

Offering his perspectives of what needs to be done in order to strike the right balance between regulation and patient rights, Professor Steinert commented: "All over Europe we have a tendency for patient empowerment and patient rights, and I think that is a good development. Of course patients want to decide their medication, so I think we do need some regulation, but we should not overregulate. It is possible to keep everything in view while also protecting the rights of staff not to be harmed during their work – I think all of that belongs together. We need 'clever regulations', taking into account all of these aspects. We need funding for psychiatry. Overall, many aspects are a question of staffing levels and of architecture."

## East meets West: The AFPA and EPA joint symposium

The Asian Federation of Psychiatric Associations (AFPA) has joined forces with EPA this year in a unique symposium that aims to highlight valuable learning points that can be translated from East to West and vice versa. The session takes place this afternoon, with European perspectives from Wolfgang Gaebel (Heinrich Heine University Düsseldorf, Germany) and Danuta Wasserman (Karolinska Institute, Stockholm, Sweden) being aired alongside those from Pichet Udomratn (Prince of Songkla University, Thailand) and Afzal Javed (Coventry & Warwickshire NHS Trust, Nuneaton, UK; and Fountain House, Lahore, Pakistan).

The AFPA was formally announced in 2005 during WPA's World Congress in Cairo, becoming a reality after its launch in 2007 in Lahore, Pakistan. Speaking to *EPA Congress News*, AFPA President-elect Dr Javed noted that the need for such an organisation had been present for many years. "The unity and collaboration of



*"There is a lot that can be learned from these mutual collaborations... The 'best' will be a combination of approaches from different regions for different needs."*

Afzal Javed

psychiatric societies in Asia was the main objective for the formation of AFPA," he said. "It has now been actively involved in the promotion of mental health and the betterment of psychiatry in Asia. AFPA has now organised a number of world congresses, the last one held in Japan in March 2015."

Naturally, a great deal of diversity exists within both Europe and Asia, but Dr Javed highlighted that considerable differences can nevertheless be drawn between Asia and Europe's practices of psychiatry in general: "Economic and financial resources vary a lot between the two continents, but in addition to

this, there are a number of conceptual differences.

"Hospital psychiatry is still a norm in most of the Asian countries with fewer facilities for community psychiatry. Manpower resources are grossly less in Asia, and Asian psychiatry is still governed by a number of socio-cultural determinants for the practice of psychiatry. So there are still big mental hospitals in many Asian countries, and patients do go to faith healers, shamans, and religious and spiritual places for

the practice of attaining mental wellbeing. In Asia, such an important role for spirituality demands a dialogue between conventional healthcare professionals and alternative healers.

These differences can be put down to resources as much as tradition, explained Dr Javed: "In the UK, for example, you can rely on the NHS. In the West, the conventional systems are more valid and approachable, and there is less reliance on non-NHS psychiatry resources. But when it comes to many countries in Asia (and even Africa), unfortunately those resources are not there. The pathway of care does not go through the professionals.

"In countries in Asia and Africa, the emphasis on other avenues is there first because of availability, and second because of cultural beliefs; for example, people might think that some mental illnesses are due to spiritual possession or something similar."

But this is not to underestimate the potential value of spiritual and religious healing. In addition, there are approaches to practices such as psychotherapy unique to Asian countries that could provide more options for patients in Europe: "The Western world can also learn the different ways of healing, overcoming stress, or how a support system can be developed and offered," explained Dr Javed. "So there is a lot that can be learned from these mutual collaborations.

And it doesn't mean that any particular system is the 'best' – the 'best' will be a combination of approaches from different regions for different needs. But there is a need to look at all of these treatment methodologies in a more scientific way. Rather than just purely relying

on belief, there needs to be some scientific evidence behind it."

Dr Javed's talk during the symposium focusses on rehabilitation psychiatry – the application of measures aimed at reducing the impact of disabling and handicapping

*"In many Asian countries, two important institutions – family and religion – play an important role in supporting the mentally ill."*

Afzal Javed

the treatment of mental health problems."

This poses an interesting contrast to what is the predominant situation in the West, where perhaps religion or spirituality is not regarded to the same extent within

mental health conditions, thereby enabling disabled people to achieve social integration. "Rehabilitation in general means limiting disability, minimising the handicaps and impairments," he explained. "It means a culture of healing and hope with emphasis on recovery and partnership, citizenship and quality of life, social inclusion, empowerment, skills training, and meaningful occupation and resettlement, and re-housing for mentally ill.

"In many Asian countries, two important institutions – family and religion – play an important role in supporting the mentally ill. The family provides a sense of support, and religion provides a sense of direction. However, with the current globalisation, both of these protective factors are losing their importance.

"While considering rehabilitation, these two aspects play a vital role and in many Asian countries. In contrast to many Western countries, many of the chronic mentally ill are managed by the family and religious institutions. In the Indian subcontinent, shrines

are the 'homes' of many homeless mentally ill, and children with intellectual disabilities (mental retardation) are cared at these places."

Spiritual and religious communities provide some support to sufferers, but, as Dr Javed explained, in the absence of state-run health infrastructures (as is the case in many Asian countries), the burden that falls upon the family can be weighty. Moreover, considerable shifts towards urbanisation may be dismantling these critical networks of care, and policy must be developed to swiftly bridge this gap.

"African and Asian countries are becoming more urbanised in different ways, and we are paying the price," said Dr Javed. "One of my friends jokingly said once that you might be sitting in New York, London or Paris, and when you

have a problem, you will talk to someone thousands of miles away on the phone, but you will never talk to your neighbour!

This is a fact. This is, in my view, the impact of urbanisation.

"There are many 'push' factors for urbanisation, such as poverty. People are coming into towns and cities for resources and facilities. But as a result we are losing the social fabric. That is going to have a big impact on mental health. We don't yet have any answers to this."

Of course, migration also occurs between nations, which presents issues around the separation of families and cultures amid the hope of finding a better quality of life. From the psychiatrist's perspective, these factors need to be taken into account: "For the many people that are coming from remote places in Asia and Africa to Europe, they need to retain some

*"Rehabilitation in general means limiting disability, minimising the handicaps and impairments. It means a culture of healing and hope."*

Afzal Javed

sort of cultural background," said Dr Javed. "That needs to be respected. Unfortunately, training in the West may not give enough attention to those social and cultural needs."

The symposium is set to generate a wealth of future collaborations in service provisions as well as in teaching, training, and policy development in different fields of mental health, explained Dr Javed: "We hope that it will lead not only to social networking, but also to concrete steps towards mutual training and a greater understanding of each other. It will help to implement some of the policies that can be translated from one culture to another."

**Dr Javed speaks on the topic of psychosocial rehabilitation in Asia during the joint AFPA-EPA symposium, which takes place today between 17:00 and 18:30.**

*"In New York, London or Paris, and when you have a problem, you will talk to someone thousands of miles away on the phone, but you will never talk to your neighbour!"*

Afzal Javed



## PsychiatrySpeaks – what's it all about?

**An international market research survey of psychiatrist opinion — sharing insights on current practice in psychiatry and schizophrenia**

No two psychiatrists are the same. Opinion and practice differ considerably with regards to mental health, its management and its intervention; differences that cannot always simply be explained by reference to healthcare system, nationality or culture. To support a better shared understanding and good practice in psychiatry, pharmaceutical companies Otsuka and Lundbeck have conducted an international market research survey – PsychiatrySpeaks.

PsychiatrySpeaks explores the beliefs and behaviours of psychiatrists with respect to their practice and their management of schizophrenia. With over 1600 participants from 8 countries worldwide — Australia, Canada, Germany, France, Italy, Spain, United Kingdom and the United States — it provides a valuable insight into the current state of mind of those working in psychiatry.

An international panel of psychiatrists facilitated the creation of the questions for the survey, identifying topics of interest to them with respect to psychiatry in general and schizophrenia in particular. The topics selected include the role of the psychiatrist, developments in the management of schizophrenia, informing patients,

the role of the caregiver and treatment choice.

Call out: The survey is part of a wider project created to inspire everyone — people with schizophrenia and all those who care for them — with a new sense of what's possible.

The results of the survey reveal several key themes, one of which is the focus of the first PsychiatrySpeaks report — Autonomy, choice and schizophrenia. This report explores the autonomy of the individual with schizophrenia, their caregiver and the psychiatrist managing their care, with discussion and commentary from experts in the field.

This first PsychiatrySpeaks report is expected to be available in May 2015. Along with expert commentary and video reactions, downloadable reports, articles and data infographics will also be available, giving psychiatrists the opportunity to compare practice and challenge perceptions.

Visit psychiatryspeaks.com to sign up and be one of the first to receive the PsychiatrySpeaks report and the latest updates on the release of the full survey results.

Find out more at the EPA Cyber Corner today!

**Approval Code: OPEL/0315/MTN/1218 Date of preparation: March 2015 ©Otsuka Pharmaceuticals Europe Ltd. and H. Lundbeck A/S**



## World-view and culpability within psychosis A study of “The man without qualities”

During yesterday morning’s symposium on the relationship between psychosis and violence, Giovanni Stanghellini (Università degli Studi “G. d’Annunzio”, Chieti-Pescara Italy) spoke about the nature of responsibility when the individual’s life-world is taken into account.

“To be human is to be at odds with responsibility: being aware that we cannot fully control the involuntary dimensions of our existence, but at the same being held responsible for it,” said Professor Stanghellini, adding that responsibility is both a presupposition and a task in our culture: a presupposition, because society expects a person to be responsible for their deeds; and a task, because responsibility is not an inborn characteristic for a human beings. “It is achieved through education,” he said. “As French philosopher Paul Ricœur put it, ‘education is education to responsibility’.”

And responsibility is achieved through the integration of responsibility and vulnerability, he explained, via the awareness that we are vulnerable to the involuntary dimension of our existence. The ethical consequence of this, particularly with respect to forensics, is that it is very difficult to extricate responsibility from non-responsibility.

Professor Stanghellini argued that standard procedures for determining responsibility are unhelpful, and he illustrated this through an exploration of the 20th century three-part unfinished novel by Robert Musil, *The Man Without Qualities* (*Der Mann ohne Eigenschaften*).

The novel explores a variety of human themes through the eyes of Ulrich, whose the book’s title describes. It includes, amongst many, the protagonist Moosbrugger, a murderer and rapist who is eventually condemned. Musil discusses this case in finely tuned phenomenological terms, using the standard notion of accountability and anaemic concept. Quoting this section of the book, Professor Stanghellini read: “To the judge, Moosbrugger was a universe, and it was very hard to say something convincing about a universe.”

“Musil immerses Ulrich, his hero, in the inner experiences of a murderer, and identifies Ulrich’s determination to fulfil his primary task, namely to find the vital link between thinking and doing, exploring the realm of responsibility in order



*“To be human is to be at odds with responsibility: being aware that we cannot fully control the involuntary dimensions of our existence, but at the same being held responsible for it.”*

Giovanni Stanghellini

to discover the right way to live.

“Musil commented to himself in a letter when he almost

completed his novel: ‘I am concerned with the scientific study of psychology and I believe that, in the fine reports of the French psychiatrists, for example, I can both experience vicariously, and depict every abnormality, transporting myself into the corresponding horizon of feeling, without my own will being seriously affected.’ This is of course the empathetic understanding of another’s subjectivity.”

Ulrich, explained Professor Stanghellini, is preoccupied with reality (*wirklichkeit*) and effectiveness at the same time. This manifests in Ulrich’s fascination with Moosbrugger’s subjectivity, and his pursuit Ulrich perceives as ‘intellectual dynamite’ to blow up *wirklichkeit*.

Reading the quotation from the passage describing Moosbrugger’s trial, Professor Stanghell-

ini said: “Two strategies were locked in combat, two integral positions, two sets of logical consistency.” The passage illustrates the emergence of the logic that is employed by Moosbrugger, that his act could be reasonably understood within a certain frame of reference. “Musil clearly shows in his novel is that the life world inhabited by Moosbrugger is totally different to that of our own,” said Professor Stanghellini.

Speaking of another phenomenon illustrated in the same section dedicated to Moosbrugger, so-called ‘hang-togetherness’, he then quoted the following passage from the book:

“A squirrel in these parts is called a tree kitten, it occurred to him. But just let somebody try to talk about a tree cat with a straight face! In Hesse, on the other hand, it’s called a tree fox. But oh, how curious the psychiatrists got when they showed him a picture of a squirrel and he said, ‘That’s a fox, I guess. Or it may be a hare, or maybe a cat or something.’”

“Moosbrugger’s experience and conviction were that no think could be singled out, because things hang together,” explained Professor Stanghellini. “First and foremost, we use words in order to indicate details of our life to hang together as a meaningful perception of our surroundings, linked together by meaningful connections. It is believed that a deep metamorphosis of life space also involves two or three distinct directions of objects in the life space: firstly, the separation of the object from the complete scene; secondly the experience that everything hangs together; and lastly, the concept of ‘rubber-banding’, a common sense natural attitude to reality.”

In his conclusions, Professor Stanghellini asked whether we need transformation of the life-world to determine accountability: “Is there a link between the transformations of the life-

*“Should we have a fuller reconstruction of this person’s life-world to establish their accountability when they exist in life-worlds that are not our own?”*

Giovanni Stanghellini

world in schizophrenia? Is the assessment of psychiatric symptoms and anaemic symptoms devised to assess the accountability of the patient, or should we have a fuller reconstruction of this person’s life-world to establish their accountability when they exist in life-worlds that are not our own? The tentative conclusion is that a person can be

held not responsible for their deeds, if and only if they emerge out of an ontological framework that radically differs from our own.”



Workshop: Geriatric Psychiatry and Primary Care MentHealth: An EPA and WONCA Joint Workshop Hall N1 Sunday 15:00-16:30

# Communication: The key to effective primary mental health care for the elderly

The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) and EPA are holding a joint workshop this afternoon, dedicated to the topic of geriatric psychiatry and primary care. Henk Parmentier (Croydon Out of Hours at Virgin Care Ltd, Croydon, UK) of the WONCA Working party on Mental Health, spoke to *EPA Congress News* ahead of the session to discuss the state of primary care for older persons with mental disorders in the UK.

Dr Parmentier began by addressing what primary care constitutes in the UK in the context of mental illness, explaining that primary mental health care has a different role to that of psychiatry: "Primary care is a different concept in care to any other specialty in medicine, because it involves care from the cradle to the grave, and it is not specialised.

"Sometimes the degree of specialisation in psychiatry – for example into elderly care psychiatry, biological psychiatry or social care psychiatry – can make it difficult for general practitioners to find the correct psychiatrist for a particular patient."

Indeed, this situation is worsened if the patient has comorbid health problems. A patient with schizophrenia, alcohol dependence, and some of the mental health problems associated with normal ageing, would have a complex diagnosis. As such, their needs will be similarly multifaceted.

"Because of the specialisation of psychiatric domains, the patient may fall between the remit of a specific care procedures, and end up being seen in primary care" said Dr Parmentier. "Linda Gask claims that 90% of all patients with mental health problems (including 30% to 50% of all those with serious mental illness) only use primary care services."<sup>1</sup>

He described further issues in dealing with mental and physical health, noting that a 'medical

approach' is sometimes adopted when dealing with mental health problems. In primary care, he explained, a three-dimensional, holistic approach, encompassing social, mental and general medical problems, is most fruitful.

"Often, when problems arise, what we see in primary care

*"The degree of specialisation in psychiatry can make it difficult for general practitioners to find the correct psychiatrist for a particular patient."*

Henk Parmentier

is different to that observed in secondary care," he explained. "In secondary care, a depressed patient may present mood changes, whereas in primary care we will often be presented with physical symptoms like back pain, exhaustion and headaches as the primary symptoms – which are also symptoms of depression."

Dr Parmentier then went on to discuss end-of-life care in elderly patients with mental illness in the UK, noting increasing numbers in care homes that fall under this bracket of palliative care. "This brings up some very critical and ethical issues," he said. "Other conditions such as schizophrenia, alcohol and substance dependency, or cancer can impact on life expectancy. Consequently, patients with these conditions may effectively require end-of-life care. However, dementia is the only condition in psychiatry that has an end-of-life diagnosis.

"Indeed, the most basic question regarding end-of-life care is whether to resuscitate. The ethics of whether to resuscitate are complex and the rights of patients (i.e., whether they want treatment) are central to any decisions that are made. The only way to deal with these contentious



issues is for primary and secondary care to work together."

Sharing his personal experience of this, Dr Parmentier described the importance of communication in making sure that patients' best interests are kept at heart: "When working in a care home of severely demented patients, I did joint ward rounds with the resident consultant psychiatrist. At the earliest stage we discussed end-of-life decisions and palliative care plans with relatives – and patients where possible. We found that this integrated approach clarified the wishes of the patients and relatives very well, and I would strongly recommend guidelines promoting joint ward rounds."

Yet storing and communicating any decisions regarding treatment, especially concerning end-of-life care, can be problematic, especially when multiple agencies are involved,<sup>2</sup> as Dr Parmentier described: "In my experience in out-of-hours services, I have sometimes seen a lack of communication between carers and emergency services; the carers may not be aware of end-of-life decisions, and this has resulted in hospitalisation at the last stage of life, which was not the desire of the patient nor that of the treating team."

No guidelines on recording and disseminating this kind of information are currently in place at the UK's National Institute for Health and Care Excellence (NICE), he explained, and there is considerable evidence that it needs centralisation. "This is currently being spearheaded in London using 'Coordinate My Care', a web-based clinical service coordinating information between healthcare providers and recording the wishes of patients regarding their care. This clear and modern way of communication is accessible by every doctor and nurse involved, and has already proved successful."<sup>3</sup>

"Clearly, dementia and the problems connected with it are an increasing burden on the NHS [National Health Service] and society as a whole. We need more resources and better communication to better support patients and the needs of carers."

#### References

- 1 Gask L et al (Eds.). Primary Care Mental Health. Oct 2009. London, UK: RCPsych Publications.
- 2 Moran WP et al. (2012): Where are my patients? It is time to automate notification of hospital use to primary care practices. *South Med J.* 2012 Jan;105(1):18-23.
- 3 Smith C et al. Coordinate My Care: a clinical service that coordinates care, giving patients choice and improving quality of life. *BMJ Support Palliat Care.*

Workshop: The Recent EU-Funded Imaging Projects in Psychiatry: Presentation and Update Hall L4 Sunday 08:00–09:30

## New trimodal imaging device to shine light on early schizophrenia diagnosis

A number of EU-funded projects in psychiatric imaging were laid bare yesterday morning, with a fascinating exploration of new technologies, paradigms and cutting-edge concepts.

Speaking first in the workshop, held bright and early at 08:00 in Hall L4, was Alberto Del Guerra, a physicist from the University of Pisa, Italy, who introduced his work in the development of a simultaneous trimodal (PET/MR/EEG) imaging tool for early diagnosis of schizophrenia and other mental disorders.

Known as TRImage, the basis of the technology is to make an early diagnosis of schizophrenia. "But certainly it can be used for other mental disorders," said Professor Del Guerra.

Led by an FP7-funded consortium of seven research institutions and four small and medium-sized enterprises, the project began in December 2013 with an estimated developmental timeline of four years.

"Basically what we have done up until now is we've designed exactly what we want to do," commented Professor Del Guerra. "So we are at the stage where we can start assembling

– both on the clinical side and on the construction side."

There are three sub-objectives planned as the TRImage system takes shape, detailed as follows: (a) the discovery and validation of new biomarkers, along with the definition of a suitable multimodal paradigm with currently-available PET, MR, EEG and PET/MR systems,

*"The instrument will comprise a 1.5 T, cryogen free, very compact superconducting magnet, with a PET insert with better performance than any available clinical PET scanner, and a fully-integrated EEG."*

Alberto Del Guerra

thus providing clinical evidence on the feasibility of early schizophrenia diagnosis; (b) to construct and test the planned cost-effective trimodal imaging instrument for diagnosis, monitoring and follow-up of schizophrenia disorders; (c) to validate the imaging device with regards to the

results and clinical data obtained from sub-objective (a).

"The performance has to be beyond what is state-of-the art, otherwise there is no point in doing it," commented Professor Del Guerra.

Discussing the paradigm of biomarkers and multimodal imaging, Professor Del Guerra noted that the idea would be to utilise the Loudness Dependence of Auditory Evoked Potential (LDAEP) as a biomarker. This is based on the serotonin hypothesis that states there is reduced LDAEP in patients with higher serotonergic activities.

"You really have to check if that is feasible, that the relationship holds, and there is no contradiction – and this has to be checked in healthy patients, as well as those which are already diagnosed with schizophrenia," said Professor Del Guerra.

Discussing whether, if you go for an EEG, going for a PET or MRI is strictly necessary, he stressed that it is important to validate this multimodal approach's true benefits. To that end, he noted that validation of LDAEP can be done using: fMRI, to obtain spatial correlation with EEG; PET – to study influences of other



Under the auspices of the Secretary General of the Council of Europe,  
Mr Thorbjørn Jørgensen

5<sup>TH</sup> EPA ACADEMIA SUMMER SCHOOL

COMORBIDITY BETWEEN  
MENTAL & PHYSICAL DISORDERS

ACADEMIA FOR EXCELLENCE IN EUROPEAN PSYCHIATRY

10 -13 July 2015 Strasbourg, France



European Psychiatric Association

www.europsy.net



#EPASummerSchool

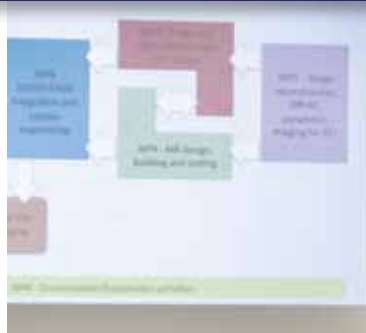
neurotransmitters; and magnetic resonance spectroscopy – to study influences of other GABA, glutamate or similar neurotransmitters.

“This evaluation will be done concurrently, while the instrument is being constructed,” noted Professor Del Guerra.

Clinical recruitment will be divided into two phases, the first, utilising currently-available EEG, PET, MR and PET/MR devices, will incorporate 40 patients with schizophrenia diagnosis (ICD-10) and 40 gender-matched healthy controls. “After this phase we will obtain, hopefully, biomarkers and a multimodal paradigm,” said Professor Del Guerra.

The second and final phase will be to validate the new trimodal imaging device using 15 schizophrenia patients, 15 prodromal individuals and 15 healthy controls matched in age, gender, education, IQ, etc.

Discussing the finer details of the planned TRImage device, Professor Del Guerra began: “The instrument will comprise a 1.5 T, cryogen free, very compact superconducting magnet, with a PET insert based on silicon photomultipliers with better performance ... than any available clinical PET scanner, and a fully-integrated EEG.”



*“The performance has to be beyond what is state-of-the art, otherwise there is no point in doing it.”*

*Alberto Del Guerra*



therefore representing a relatively compact scanner by today’s standards.

Outlining the timeframes for development of the TRImage device, Professor Del Guerra shared that the biomarkers and multimodal imaging paradigm stage of development is planned for completion in December 2016. After that, the PRT/MR/EEG prototype will be completed, tested and installed the following June (2017). The final step – clinical validation of the new prototype – will be completed by the end of 2017. “This will be a very challenging project,” he said in closing.

He added: “Altogether, the performance of the PET would be a very high spatial resolution of 2 mm, which is a factor of two higher than what is available. Its high efficiency (14%) is a factor of 2.5-3 times higher than now available. The axial field of view is 15 cm ... and the transaxial field of view is 11 cm in radius.” Further benefits of the device include a weight of only 1.5 tonnes, and a length is only 1.2 m,

# CURRENT MANAGEMENT OF PSYCHIATRIC EMERGENCIES

**EPA Congress**  
 Vienna  
 March 30<sup>th</sup>, 2015  
 13:15 h - 14:45 h - Hall C

**Chairman:**  
 Dr. Andreas Erfurth (Austria)

- EUROPEAN MODELS OF ATTENTION TO PSYCHIATRIC EMERGENCIES  
 Dr. Josep Antoni Ramos-Quiroga (Spain)
- EXPERIENCE WITH INHALATORY ROUTE IN PSYCHIATRIC EMERGENCIES  
 Dr. Oana Hanut (Romania)
- PRACTICAL & USEFUL ASPECTS OF INHALATORY ROUTE  
 Dr. Jean Marc Alache (France)



# Role of neuroimaging hotly debated

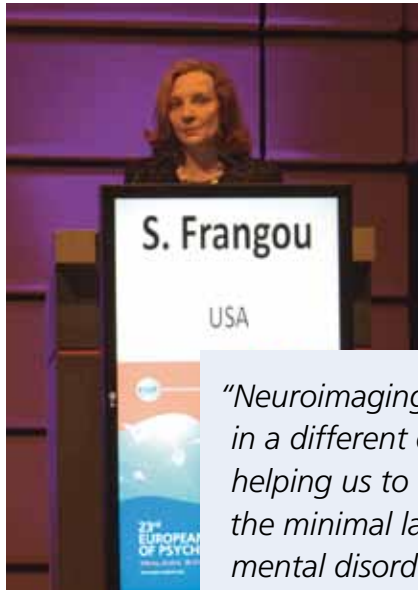
**S**ophia Frangou (Icahn School of Medicine at Mount Sinai, New York, USA) went head-to-head with Andreas Meyer-Lindenberg (Central Institute of Mental Health in Mannheim, Germany), during a debate on the topic of the place and value of neuroimaging in unravelling the causes of mental illness yesterday morning at EPA Congress.

Starting by defining the history of psychiatry itself, Professor Frangou pointed out that the discipline has evolved in two threads: of embodied psychiatry, i.e. the mind as output of the brain, aside from other organs' involvement; and disembodied psychiatry, a more abstract concept in considering mental phenomena as separate or not necessarily directly linked to a particular organ.

The evolution of these and similar concepts in psychiatry has both informed the role of neuroimaging as well as its evaluation.

"Over the years, the embodied camp has dominated the field," she said. "The most recent reinventions of embodied psychiatry involve the fact that most of the interventions that we have in psychiatry have to do with changing another biological component within our bodies, e.g. neurotransmitter functions and other related things."

Non-embodied psychiatry, on the other hand, emerged from theological thought and was more recently transformed into what is termed moral psychiatry: "When we ask this question, part of us is representing this dichotomy within ourselves and within our speciality, about what is the essence of these problems...that is part of the



opposing visions of psychiatry that makes people look at neuroimaging sometimes

as an extremely reductionist tool that can never fully capture what it is to be human and what it is to suffer as a human."

The second duality is the notion of aetiology, and Professor Frangou described that we have moved into the idea that, rather than direct causative agents of psychiatric disease, multiple risk factors increase the likelihood of a disorder occurring within a spectrum of other possible outcomes beyond the discretely categorical into a more dimensional, fuzzy approach.

As an instructive analogy, Professor Frangou looked to the field of cardiovascular medicine, noting that heart attack and stroke would be very easily characterised as discrete disorders with converging risk factors identify a common substrate, i.e. the ease of flow of blood within the veins.

With this in mind, Professor Frangou looked at what neuroimaging has achieved so far, and where its place



ses have shown that, by ignoring classification entirely, that structural and

functional neuroimaging could identify common pathologies pervaded multiple clinical diagnoses, including schizophrenia, bipolar disorder, substance abuse, and others.

"Neuroimaging has therefore helped us identify something potentially revolutionary: a superordinate neural network for mental disorder," said Professor Frangou. "We have spatial convergence between functional and structural data; we have the main general networks. These do not, of course, at this stage explain the clinical pleiotropy, so we cannot use this information to explain why someone may present with anxiety as opposed to, say, bipolar disorder. But it does explain comorbidity, which is prevalent, and it also explains the trans-diagnostic efficacy of medications.

"This is a phenomenal contribution in moving us towards a different conceptualisation of mental disorders altogether. That is

*"Neuroimaging is moving us in a different direction and helping us to reconceptualise the minimal landscape for mental disorders, regardless of the specifics of their presentation."*

*Sophia Frangou*

lies within the evolving landscape of understanding. "Neuroimaging has provided us with an unequivocal link between the brain and mental illness," she noted. "You may dispute the contribution of brain disorders, networks, neurotransmitters, etc. to mental illness – but you cannot dispute the link."

It has been demonstrated that brains of individuals with certain mental disorders can be differentiated from those of controls. Particularly pertinent to Professor Frangou was the fact that this work essentially demonstrated that there is a biological significance to currently-used clinical diagnostic labels. She added: "Neuroimaging is moving us in a different direction and helping us, as different forms of imaging did in cardiovascular medicine, to reconceptualise the minimal landscape for mental disorders, regardless of the specifics of their presentation."

More recent metaanaly-

not to negate the behavioural symptoms – but to go beyond them. Finally, the other significant contribution is providing a mechanistic link between risk and disease expression."

Professor Frangou also marked out the role that has neuroimaging has played in the understanding of the biological meaning of much of the early and ongoing epidemiological research linking risk factors to actual biological pathology, as well as offering great potential in neuropsychological therapies such as neurofeedback.

Andreas Meyer-Lindenberg then took to the stand to present his views, explaining that, from the perspective of understanding aetiology, neuroimaging cannot identify the causes of mental illness as the causes are rooted in genes and environmental factors and interactions thereof.

"The most that imaging can hope for is to find mediating mechanisms," he said. "But for arguments sake, I would be willing to entertain the potentially misguided idea that imaging might be helpful for identifying those mechanisms linking from genes to behaviour."

Professor Meyer-Lindenberg then pursued this line of reasoning by dismantling the relationship between genetics and imaging, and environment and imaging: "Genetics, of course has been extremely successful in actually finding causes. But some misguided individuals then try to use neuroimaging, for example, in trying to find out how these genes work. But it is open for debate whether that is actually quite that successful."

He then went on to speak of, what is for some, a disappointing lack in

candidate gene identification to have emerged from large-scale imaging-genetics consortia such as ENIGMA: “The is not what people would have expected if it is in fact true that structural neuroimaging gives you a privileged view on the biol-

ogy of mental illness. If that were true, there should be much higher penetrance at that level. The penetrance of genetic effects in neuroimaging is underwhelming and that argues for that being overvalued.”

Referring to the common

underlying substrate that might be a unified contributing cause to different mental disorders, Professor Meyer-Lindenberg commented that such common

features, such as enlarged ventricles, are so non-specific that they are to a large degree meaningless.

And data that have attempted to make associations between high-risk genetic variants and altered neuronal systems have not borne fruit either. “You can look at the systems that are altered; but those systems do not all overlap. There is no common core system of those high risk genetic variants that we can identify. So in that sense the complexity of the genetics of mental illness maps poorly on imaging mechanisms. The same is of course true if we go beyond genes to less biologically-defined things such as symptoms or treatment response. In all of these things, the complexity hasn't really mapped very well in these illnesses.”

Turning to the environmental interactions with neuroimaging, Professor Meyer-Lindenberg highlighted one particular line of enquiry looking at the effect on brain function of city versus rural life. Again, he noted, this has little meaning: “If you look at the immense complexity that urbanity very likely entails – from social factors, to green space, to toxins, to noise, light pollution, etc. – these are not captured in this image simply because you show that there is a correlation between the number of people living around you and aspects of brain function. There needs to be a strategy that links one to the other, but that strategy isn't obvious.

“Both of those have an important further dimension that we need to consider, in the sense that many of us believe that many mental

disorders have a neurodevelopmental component and are subject to environmental influences that may hit the brain at certain vulnerable periods in the lifespan. The most important of these periods – perinatal – are not accessible to us. We can image people later and then claim that we find a correlation. And neuroimaging is always correlative. This is always something different from causation, so it cannot prove causality.”

A general problem emerging from all of this is the very reliability and robustness of neuroimaging in all its forms as a method, which, Dr Meyer-Lindenberg stressed, is an area of research that is not well patronised. Looking towards some of the technical aspects that may undermine data reliability, he noted that intra-subject variability in both structure and function has been demonstrated over varying durations of time in healthy individuals, and indeed the statistical analysis and interpretation of, for example, fMRI data must be approached with caution.

Turning to machine-learning methods that have been shown to be capable of classifying two-thirds of patients accurately, Dr Meyer-Lindenberg presented his conclusions: “I would submit that, as a clinical psychiatrist, I could probably identify more than two-thirds of the people with schizophrenia and distinguish them from the people who have no mental illness. And, even if I were at the same level, I would argue that it tells me nothing about causation. The same goes for prognosis – finding something that would be useful for prognosis has not really happened.”

*“Neuroimaging is always correlative. This is always something different from causation, so it cannot prove causality.”*

*Andreas Meyer-Lindenberg*



The poster features the EPA logo at the top, which includes a globe and the letters 'EPA'. Below the logo, it reads 'EUROPEAN PSYCHIATRIC ASSOCIATION'. The main heading is 'EPA MEMBERSHIP' in large blue letters, followed by 'Join EPA for only € 100 annual fee'. Below this, it says 'To become an individual member of EPA, you are invited to apply via the EPA website: [www.europsy.net/about-epa/individual-membership](http://www.europsy.net/about-epa/individual-membership).' The poster lists 'THE ADVANTAGES OF EPA MEMBERSHIP:' with 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). It also lists 'MEMBER BENEFITS:' including an electronic subscription to the *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 20 scientific Sections, visibility on European Psychiatric Network, personal copies of EPA Minds and Minds Online newsletters, and an Annual Member's Round Table dinner. At the bottom, it says 'Find out more at: [www.europsy.net](http://www.europsy.net).' The background of the poster shows a statue and a building under a blue sky.



# Nature and narratives of depression

## An interview with Luís Madeira

Have we lost sight of the roles of phenomenology, subjectivity and intersubjectivity in diagnosing and treating depression? In a clinically-focussed, EPA Section Symposia award-winning session dedicated to nature and narratives of depression, Luís Madeira (University of Lisbon, Portugal) will argue that broadening focus beyond objective classifications, and including the exploration of personal meaning with patients, will ultimately bear fruit in clinical therapy. In an interview with *EPA Congress News* ahead of the symposium, he explained his thoughts around the topic.

**You suggest that this group of disorders could be approached along different axes in order to better help patients' diagnosis and classification. What is the rationale for this?**

The meanings of melancholia and depression have changed hand in hand with the history of psychiatry in its search for reliability, and the selection of objective markers as symptoms has been the main focus of this process. I would risk saying that not only have we chosen objective symptoms, we have objectified everything we could (including subjectivity) and have dismissed the rest (e.g. intersubjectivity). In this effort, we haven't really gained much reliability, and we have dismissed the validity of our disorders.

Indeed, the categories we are now using for diagnosis and research have been the target of many criticisms. These include: (1) that they lack phenomenological detail – the objectiveness of objective symptoms is only apparent; (2) that if it weren't for hierarchical principles there would be many overlapping syndromes; (3) that findings in neurobiology and neuroimaging present contradicting and overlapping evidences; and (4) that, specifically, many depressive syndromes are almost impossible to segregate across their clinical presentation if we sustain just the diagnostic criteria (e.g. bipolar depression, hyperthymic depression, anxious depression, etc.).

We believe that many psychiatrists ignore a vast amount of phenomena, while others use them "off the record" (and sometimes savagely, unfortunately, as they are not part of the psychiatric curriculum) in their diagnostic endeavours. Testing the relevance of subjective and intersub-

jective phenomena and reintroducing them into our classifications might be key to understanding mental phenomena and allowing treatment.

**What explorations have been made in different psychopathological studies on the topic of segregating phenomenological particularities of each episode of unipolar or bipolar depression or dysthymia?**

In fact this work is as ancient as psychiatry itself. Most (if not all) of seminal psychiatric contributions have involved extreme phenomeno-

logical detail. More recently, there are extraordinary contributions by Giovanni Stanghellini, Matthew Ratcliffe, Massimiliano Aragona, Louis Sass, Thomas Fuchs, Joseph Parnas and John Cutting.

I've also met many other researchers who are very much into the importance of phenomenology and of subjectivity and intersubjectivity in diagnosis. We have huge amounts of input (literally "from everywhere"), which we can't fully cover in this keynote, but that should be (and are being) empirically verified in their use to distinguish affective syndromes.

I believe Professor Maria Luisa Figueira's experience with affective patients have been key to what we present at EPA Congress.

**What could the implications be in treating this group of disorders as you describe both for the practitioner (in diagnosing) and the patient (in the way they perceive themselves)? How do you see this impacting the 'nuts and bolts' of intervention?**

For classifications, we foresee many possible scenarios from withholding these inputs and remaining the same, or needing major changes. For practitioners, they might see themselves attending to other phenomena, allowing an in-depth discussion of personal meanings (semi-structured interviews) and focusing on interpersonal experiences (atmospheres, and what they are experiencing) in their process of diagnosis.

Diagnostic interviews will then focus in the (inter) personal exploration of meanings and building a(n) (inter) personal narrative for the patient's experience, rather than identifying (or objectifying) phenomena of a specific disorder. We hope that



*"Much of the meaning of having a mental disorder is having a period of life that does not make sense along one's life narrative."*

Luís Madeira

this might also help the patient retrieve meaning from his experiences. This is important, because much of the meaning of having a mental disorder is having a period of life that does not make sense along one's life narrative. Personal exploration of meanings (stitching back experiences and meanings) might therefore hold diagnostic and therapeutic properties.

**Dr Madeira presents, 'Distimia, Unipolar and Bipolar Depression: Is Modern Nosology Making Us Crazy?' during the symposium, 'Nature and Narratives of Depression,' which takes places tomorrow between 13:30 and 15:00 in Hall L1.**



Pro &amp; Con Debate: CBT - Is It Sold-Out? Hall F Monday 10:00–11:30

# Interpretation is key for CBT

A debate that will ask bluntly whether cognitive behaviour therapy (CBT) for schizophrenia has been oversold will be held this morning, with two rather opposing views being shared with the audience. Framing the debate on either side will be Peter McKenna (FIDMAG Germanes Hospitalàries Research Foundation, Barcelona, Spain) and David Kingdon (University of Southampton, UK), who have met on similar debates a few times before, most notably the British Medical Journal's (BMJ) Maudsley Debate.<sup>1</sup>

At the core of this morning's debate will be the issue of

evidence for CBT, which, as Professor McKenna noted in the BMJ 'Head to head' before, had 'run into difficulties' in terms of demonstrating its efficacy in large, well-controlled trials.<sup>1</sup>

With this in mind, Professor McKenna will be taking the viewpoint that CBT has indeed been oversold,

focusing on the more-than 50 trials evaluating its efficacy, and the journey that has led to its position in the treatment space today. "In medicine in general there is a progression from small, early, open trials – sometimes with no control group, or if there is, the control group is examined blind – to



*"The vast majority of large well-controlled studies have failed to show a significant effect on their primary outcome measures, which are generally reductions in overall symptoms, and/or reductions in positive symptoms."*

Peter McKenna

larger and better-controlled trials," he told *EPA Congress News*. "And it is probably fair to say that in most areas of medicine, if it is a promising development, it culminates

in one or more large very well-controlled trials, with lots of desirable design features built in.

"And this has certainly happened with CBT. 'Large' means up to about 100 patients in each arm, so it is

*Continued on page 16*

Paragona is one of Europe's leading providers of international recruitment services for healthcare specialists.

paragona™

## Where would you like to work?

We currently have several positions for psychiatrists at the **University hospital in Gothenburg** and other hospitals in the south of Sweden and in Norway.

**Let's meet in Vienna – visit our stand!**

## We offer:

- full time job in public hospitals or healthcare centres
- salary up to 10 000 EUR
- standard contractual conditions
- stationary, free of charge language course
- accommodation during the course
- scholarship during the stationary course
- totally new intensive language course for spouses
- support with finding an apartment Scandinavia
- support with authorization of your specialization
- assistance in relocation
- support with finding schools and kindergartens

Would you like to find out more about our services?

Please send your email/CV in English to:

agnieszka.anusiewicz@paragona.com or call: +48 600 477 986.

[www.paragona.com](http://www.paragona.com)

# Interpretation is key for CBT

Continued from page 15

not particularly large when you compare it with some other areas of medicine, but certainly these are large numbers of trials of psychological treatments."

He added: "The vast majority of large well-controlled studies have failed to show a significant effect on their primary outcome measures, which are generally reductions in overall symptoms, and/or reductions in positive symptoms."

A comprehensive meta-analysis by Professor McKenna and colleagues will likely also be a talking point, the conclusion of which being that while CBT has a therapeutic effect on schizophrenic symptoms in the 'small' range. This reduces further when sources of bias, particularly masking, are controlled for.<sup>2</sup>

"That was a comprehensive meta-analysis, including all possible studies," said Professor McKenna. "There was no effort at all to exclude studies. We followed a normal approach to meta-analysis which is to include as many studies as possible to give the best possible estimate of the size of the effect."

Professor McKenna went on to discuss his criticisms of the series of meta-analyses commissioned for the National Institute for Health and Care Excellence (NICE), which ultimately concluded CBT as being effecting in reducing rates of readmission to hospital, duration of admission and overall symptom severity both at the end of treatment, and at 12 months follow-up.<sup>1</sup> This led to approval of CBT for treatment of schizophrenia in the NICE guidelines.<sup>3</sup>

"The NICE guidelines are

based on meta-analyses, just like our meta-analysis, but we have quite severe criticisms of the style of the NICE meta-analysis," said Professor McKenna. "In the BMJ debate we said, and we still feel, that the NICE approach was flawed. It had hundreds of analyses, and the majority of the analyses were negative. But obviously if you carry out hundreds of analyses, some of them will come out positive, and it was those that were emphasised ... We would argue that it is a flawed meta-analysis, and the summary that appeared in the NICE guidelines was not balanced."

Offering his concluding remarks, Professor McKenna re-emphasised

*"A huge step is actually making these treatments available! Far from being oversold, they are under-available, and not being bought."*

David Kingdon

the message from his own meta-analysis, i.e. that CBT has significant limitations, also arguing that that the message seems to have been unfairly treated by peers. "These findings should be provisionally recognised," he said. "Of course, if further studies overthrow it that's fine, but what is actually happening at the moment is that this meta-analysis, which is the largest and most comprehensive analysis of CBT to date, and has five years' worth more of studies compared to the last meta-analysis by NICE, is just being ignored, or misinterpreted."



problem of interpretation: "I think there are people who see schizophrenia as being an intrinsically biological illness, which cannot be helped by a 'talking treatment', because conceptually that is not possible," he told EPA Congress News.

Commenting on the NICE meta-analyses, and eventual addition of CBT to the guidelines, Professor Kingdon said: "What we see with CBT is an enduring, longer-term specific effect, and that is why NICE have picked it up."

Backing up its benefit, he referred to a few examples of data which he feels exemplify the value of CBT, firstly the 2000 paper by Sensky et al.,<sup>4</sup> focusing on positive long-term results in particular: "They had a

nine month follow-up after treatment... then they then followed up at five years and saw benefits."

Professor Kingdon's own 2002 analysis was also described,<sup>5</sup> with an emphasis on the duration of time CBT needs to be implemented in order to see an effect. "It really was concentrating therapy into the first three months," he said. "But in retrospect now we are pretty clear that these types of therapies ... you need 6-9 months really to see an effect. And in fact in that study we could see an effect at 18 months."

In his concluding remarks, Professor Kingdon offered a succinct answer to the question of whether CBT has been oversold, saying: "A huge step is actually making these treatments available! Far from being oversold, they are under-available, and not being bought."

**Professor McKenna and Professor Kingdon will tackle the question of whether CBT has a rightful place – and appropriate evidence – in the treatment of schizophrenia in more detail during this morning's debate, held from 10:00 till 11:30 in Hall F.**

#### References

1. McKenna P and Kingdon, D. Has cognitive behavioural therapy for psychosis been oversold? *BMJ* 2014;348:g2295
2. Jauhar S, McKenna PJ, Radua J et al. Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias. *Br J Psychiatry*. 2014 Jan;204(1):20-9
3. NICE. Psychosis and schizophrenia in adults: treatment and management. NICE clinical guideline 178. 2014 (Available at: [guidance.nice.org.uk/cg178](http://guidance.nice.org.uk/cg178))
4. Sensky T, Turkington D, Kingdon D, Scott JL, Scott J, Siddle R, et al. A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Arch Gen Psychiatry* 2000;57:165-72.
5. Turkington D, Kingdon D, Turner T. Effectiveness of a brief cognitive-behavioural therapy intervention in the treatment of schizophrenia. *Br J Psychiatry* 2002;180:523-7.



Symposium: Prevention of Mental Disorders in Children of Mentally Ill Parents Hall B Monday 15:00-16:30

# Transgenerational vulnerability: Timing is key in preventing depression

**G**il Zalsman (Geha Mental Health Center, Tel Aviv, Israel; and currently EPA vice chair of child psychiatry section), will be discussing transgenerational transfer of psychiatric disorders today, during a symposium on the prevention of mental disorders in children of mentally ill parents. *EPA Congress News* met Professor Zalsman to find out about this emerging concept and how it could be applied to prevent serious mental health episodes in this vulnerable group.

"Most of the public think probably about depression as a reaction to life events," he began. "And for about thirty years this was the leading idea, because psychiatry started with psychoanalytic theories more than 100 years ago. The assumption was that you become depressed because something bad happens to you."

And such an association seems intuitive, and has been drawn as such for so long purely because depressive-type feelings in otherwise healthy individuals can usually be connected to particular negative life events. In contrast, true major depression is much more than this, explained Professor Zalsman; halting normal functioning (such as eating and sleeping) or resulting in suicidal ideation or suicide attempt. It is now understood to be the result of the complex interaction a major adverse life events and genetic makeup.

Depression is very common, occurring in up to about 20% of the population in terms of lifetime prevalence<sup>1</sup>, and family history of depression is a major risk factor: if an individual has a parent with depression, their risk of developing depression is elevated, and more so if both parents are depressed<sup>2</sup>.

Research has shown that bipolar disorder is also highly heritable.<sup>3</sup> Significantly, if an individual who has a familial vulnerability to depression is exposed to several major life events, the probability of depression is elevated.<sup>4-5</sup>

To this notion of 'gene by environment interaction', Professor Zalsman's group characterised the importance of timing<sup>6</sup>: "I am

*"I am a child psychiatrist, and in seeing children, it is very clear to me that life event is very crucial, but more crucial is when it happens."*

Gil Zalsman

a child psychiatrist, and in seeing children, it is very clear to me that life event is very crucial, but more crucial is when it happens," he said. "Children are most vulnerable to life events, and all forms of abuse have more severe consequences if they happen earlier in life. Losing a parent before adolescence is a very high risk factor for depression, and losing a parent to suicide because they were depressed is an even bigger risk."

During his presentation, Professor Zalsman will describe recent work in which he tested this gene by environment and timing interaction, in an animal model of depression using Wistar Kyoto (WKY) rats. In tests of depression and anxiety, WKY rats behaviorally demonstrate increased anxiety, anhedonia (demonstrated by poor eating and no preference for sweetened over plain water) and



learned helplessness when compared to the wild-type Wistar rats, all of which are reversible with fluoxetine.

Three groups of WKY rat were compared: one exposed to a very early life event (of two hours duration), one exposed to a later life event (during adolescence), and one which was not exposed at all (with an additional fourth group placed in an enriched environment). Measures of depression were taken before and after the study period, and MRI scans performed to detect structural abnormalities such as changes in white matter tract organisation and integrity.

"The results are amazing, we proved our hypothesis: life events in early life are much more damaging

than later life. Being genetically depressed (WKY) together with life events in childhood and not adolescence will make you much more depressed. There is damage to the development of the brain in specific areas such as the amygdala, emotional areas – all the limbic system. Although we must be careful not to say that we can translate the results immediately from animals to humans, we have used the rats to validate our hypothesis that we created from observations in humans."

Although this study used male rats, it will be repeated in females to study the effect of gender on gene by environment and timing. He explained: "Depression and suicide are gender-specific. In females, the prevalence of depression increases after adolescence.<sup>7</sup> Before adolescence, male and female depression is equal. So timing, again, is very important."

Gender also plays as a risk factor for suicide, he added, with studies showing that while females tend to show higher rates of reported non-fatal suicidal behaviour, males show a

*"This screening would be easy to do, but it costs! And the problem here is one of stigma."*

Gil Zalsman

*Continued on page 18*



**Symposium:  
Prevention of Mental Disorders in Children of Mentally Ill  
Parents Hall B Monday 15:00-16:30**

## Transgenerational vulnerability: Timing is key in preventing depression

*Continued from page 17*

considerably higher rate of completed suicides.<sup>8</sup>

If further investigation proves fruitful, the concept that early events affect depression could be used to tackle a child's subjective perception of a life event in order to reduce the risk of depression later on. "Early intervention is crucial," emphasised Professor Zalsman. "You can't treat people when they are depressed or wanting to kill themselves – at that point it is too late. You have to trace them as kids.

"We have genetics; we could define them as high risk from this and their family history. We follow them, and if one of them is exposed to a life event, they would need to go into therapy, and then we can avoid the severe depression and suicidality. You don't have to treat everybody, but you have to check to see who those at greater risk are."

Finding those individuals whose parents are known to have depression ought to be relatively easy via health records in psychiatric clinics. Suggesting that children of such parents could then undergo routine screening (as is conventional in other diseases, such as cancer) throughout childhood till after puberty, Professor Zalsman then noted that serious life events could be dealt with better, and more swiftly.

The issues around preventing depression, suicidal ideation and suicide have been scored out by the recent tragic airplane crash over the Alps, said Professor Zalsman. While the separation of suicidal ideation and suicide itself must be broad, he explained that ideation and depression ought nevertheless to be considered high-risk in certain occupations. "What can we say about bus drivers and train drivers that might have genetic vulnerabilities to depression? Nobody asks them – but with genetics and life events, we can know much sooner and treat much sooner."

Acknowledging that all of these

suggested measures require much groundwork before they could be implemented, Professor Zalsman outlined the current paradigms that mar the more prominent place of mental health on the public conscience: "This screening would be easy to do, but it costs! And the problem here is one of stigma: people don't want to donate money to psychiatry; there are not enough budgets for psychiatry; and psychiatry patients are a 'weak' population. They don't go and shout at parliament, because they don't want anyone to know that they have problems."

*"We have genetics; we could define them as high risk from this and their family history... You don't have to treat everybody, but you have to check to see who those at greater risk are."*

*Gil Zalsman*

### References

- 1 Andrade L et al. The epidemiology of major depressive episodes: results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. *Int J Methods Psychiatr Res.* 2003;12(1):3-21.
- 2 Weissman MM et al. Psychopathology in the children (ages 6-18) of depressed and normal parents. *J Am Acad Child Psychiatry.* 1984 Jan;23(1):78-84.
- 3 McGuffin P et al. The heritability of bipolar affective disorder and the genetic relationship to unipolar depression. *Arch Gen Psychiatry.* 2003 May;60(5):497-502.
- 4 Kendler KS et al. Genetic risk, number of previous depressive episodes, and stressful life events in predicting onset of major depression. *Am J Psychiatry.* 2001 Apr;158(4):582-6.
- 5 Caspi A. et al., Influence of life stress on depression: moderation by a polymorphism in the 5-HTT gene. *Science.* 2003 Jul 18;301(5631):386-9.
- 6 Zalsman G. Timing is critical: gene, environment and timing interactions in genetics of suicide in children and adolescents. *Eur Psychiatry.* 2010 Jun;25(5):284-6.
- 7 Cyranowski JM et al. Adolescent onset of the gender difference in lifetime rates of major depression: a theoretical model. *Arch Gen Psychiatry.* 2000 Jan;57(1):21-7.
- 8 Canetto SS and Sakinofsky I. The gender paradox in suicide. *Suicide Life Threat Behav.* 1998 Spring;28(1):1-23.

**Early Career Psychiatrists: Symposia:  
Psychotherapy Update  
Hall N3 Monday 08:30-09:30**

## Q&A: Ana Moscoso on psychotherapy in practice



**A**n Early Career Psychiatrist session that will examine how we can apply different models and theories to any given clinical case will take place today, with Ana Moscoso (Hospital de D. Estefânia, Lisbon, Portugal) taking the lead on the topic of psychotherapy in practice.

Dr Moscoso's presentation will explore how psychotherapeutic practices vary according to their component techniques and theoretical models. Speaking to *EPA Congress News*, she spoke of the roots of this concept, with particular emphasis on the psychotherapeutic environments that psychiatrists will often wander into.

### Should psychiatrists pursue more training to better equip them for psychotherapy?

Well, I suppose it depends what kind of psychiatrist you want to become! However, at least some basic psychotherapeutic training would be useful for any psychiatrist, as it will improve communication skills, understanding of non-verbal communication, as well as understanding of psychopathology.

### You will be examining the differences in treatment

**coming from different therapists, which you will illustrate with a specific case. What techniques will you be discussing?**

The clinical case revolves around depression, and I will focus on the psychotherapeutic approach of cognitive behaviour therapy, psychoanalysis, systemic therapy and mentalisation, but other techniques will be also mentioned. The common traits of any psychotherapeutic technique will also be addressed.

### Would you say that the 'ideal' approach is one that comes from accumulated training across psychiatry and psychotherapy?

I would definitely say so! They both increase our understanding of what it is to be human, and what it is to be mentally ill. When combined they're even more powerful than alone – as Von Bertalanffy put it regarding the general systems theory.

### What is the main message you want early career psychiatrists to come away with from this symposium?

The take-home message is that psychotherapeutic treatments are alive and well in psychiatry, and will remain so in the future.

# EPA Congress Committees

Executive Committee
<b>Wolfgang Gaebel</b> <i>Germany</i> <i>President</i>
<b>Danuta Wasserman</b> <i>Sweden</i> <i>Past President</i>
<b>Silvana Galderisi</b> <i>Italy</i> <i>President Elect</i>
<b>Julian Beezhold</b> <i>UK</i> <i>Secretary General</i>
<b>Philip Gorwood</b> <i>France</i> <i>Treasurer</i>

Board
<b>Sue Bailey</b> <i>UK</i>
<b>Julian Beezhold</b> <i>UK</i>
<b>Geert Dom</b> <i>Belgium</i>
<b>Peter Falkai</b> <i>Germany</i>
<b>Andrea Fiorillo</b> <i>Italy</i>
<b>Wolfgang Gaebel</b> <i>Germany</i>
<b>Silvana Galderisi</b> <i>Italy</i>
<b>Paz García-Portilla</b> <i>Spain</i>
<b>Philip Gorwood</b> <i>France</i>
<b>Cécile Hanon</b> <i>France</i>
<b>Andreas Heinz</b> <i>Germany</i>
<b>Marianne Kastrup</b> <i>Denmark</i>
<b>Levent Küey</b> <i>Turkey</i>
<b>Tamas Kurimay</b> <i>Hungary</i>
<b>Michael Musalek</b> <i>Austria</i>
<b>Wulf Rössler</b> <i>Switzerland</i>
<b>Jerzy Samochowiec</b> <i>Poland</i>
<b>Rutger Jan van der Gaag</b> <i>Netherlands</i>
<b>Danuta Wasserman</b> <i>Sweden</i>

Scientific Programme Committee
<b>Wolfgang Gaebel</b> <i>Germany</i> <i>Chairperson</i>
<b>Danuta Wasserman</b> <i>Sweden</i> <i>Co-Chairperson</i>
<b>Michael Musalek</b> <i>Austria</i> <i>2015 LOC Chair</i>
<b>Sue Bailey</b> <i>UK</i>
<b>Julian Beezhold</b> <i>UK</i>
<b>István Bitter</b> <i>Hungary</i>
<b>Patrice Boyer</b> <i>France</i>
<b>Geert Dom</b> <i>Belgium</i>
<b>Peter Falkai</b> <i>Germany</i>
<b>Silvana Galderisi</b> <i>Italy</i>
<b>Philip Gorwood</b> <i>France</i>
<b>Cécile Hanon</b> <i>France</i>
<b>Andreas Heinz</b> <i>Germany</i>
<b>Cyril Höschl</b> <i>Czech Republic</i>
<b>Marianne Kastrup</b> <i>Denmark</i>
<b>Tamas Kurimay</b> <i>Hungary</i>
<b>Wulf Rössler</b> <i>Switzerland</i>
<b>Rutger Jan van der Gaag</b> <i>Netherlands</i>
<b>Zvi Zemishlany</b> <i>Israel</i>

Advisory Committee
<b>Siegfried Kasper</b> <i>Austria</i> <i>Chairperson</i>
<b>Dinesh Bhugra</b> <i>UK</i>
<b>George Christodoulou</b> <i>Greece</i>
<b>Sophia Frangou</b> <i>USA</i>
<b>Marc Hermans</b> <i>Belgium</i>
<b>Reinhard Heun</b> <i>UK</i>
<b>Valery Krasnov</b> <i>Russia</i>

<b>Dmitry Krupchanka</b> <i>Belarus</i>
<b>Dusica Lecic</b> <i>Tosevski</i> <i>Serbia</i>
<b>Mario Maj</b> <i>Italy</i>
<b>Manuel Martin</b> <i>Carrasco</i> <i>Spain</i>
<b>Andreas Meyer-Lindenberg</b> <i>Germany</i>
<b>Matthijs Muijen</b> <i>Denmark</i>
<b>Merete Nordentoft</b> <i>Denmark</i>
<b>Mariana Pinto da Costa</b> <i>Portugal</i>
<b>Anita Riecher</b> <i>Switzerland</i>
<b>Martina Rojnic Kuzman</b> <i>Croatia</i>
<b>Jerzy Samochowiec</b> <i>Poland</i>
<b>Graham Thornicroft</b> <i>UK</i>

Local Organising Committee
<b>Michael Musalek</b> <i>Austria</i> <i>Chairperson</i>
<b>Michaela Amering</b> <i>Austria</i>
<b>István Bitter</b> <i>Hungary</i>
<b>Wolfgang Fleischhacker</b> <i>Austria</i>
<b>Martin Holly</b> <i>Czech Republic</i>
<b>Hans-Peter Kapfhammer</b> <i>Austria</i>
<b>Siegfried Kasper</b> <i>Austria</i>
<b>Wolfgang Maier</b> <i>Germany</i>
<b>Peter Pregelj</b> <i>Slovenia</i>
<b>Georg Psota</b> <i>Austria</i>
<b>Roger Pycha</b> <i>Italy</i>
<b>Gabriele Sachs</b> <i>Austria</i>
<b>Pierre Vallon</b> <i>Switzerland</i>
<b>Livia Vavrusova</b> <i>Slovak Republic</i>
<b>Johannes Wancata</b> <i>Austria</i>

## 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



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





EUROPEAN PSYCHIATRIC ASSOCIATION

# 24<sup>th</sup> EUROPEAN CONGRESS OF PSYCHIATRY

Madrid, Spain 12-15 March 2016

[www.epa-congress.org](http://www.epa-congress.org)

TOWARDS A COMMON LANGUAGE  
IN EUROPEAN PSYCHIATRY



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