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# Live at EPA



**LIVE: EECF Symposium: How to organise acute psychiatric care?** Clio Sunday 8:00

## Mobile rapid response teams avoid hospitalisation

A mobile rapid crisis response team in France that operates 24 hours a day, seven days a week, has contributed to destigmatisation and helped to avoid psychiatrisation in acute care, delegates were told at a symposium on the organisation of acute psychiatric care yesterday morning.

Speaker Laure

Zeltner (Hôpital Charcot, Plaisir, Yvelines, France), a family therapist, detailed how ERIC (Equipe Rapide Intervention Crise), which covers an area to the west of Paris in the Yvelines department, has been providing an alternative approach to traditional hospital-based emergency psychiatric support since it was first introduced in January 1994.

*"[ERIC] helps the user realise his recovery in his everydayness."*

Laure Zeltner

recovery in his everydayness," said Dr Zeltner. "It facilitates access to care for the [primary consultation] and patients in rupture, and reinforces as well as complements devices that require it in the territory such as in old age and adolescence. It also is an appropriate response to suicidal crisis if the family cooperates."

The name ERIC was chosen because it is an acronym, Dr Zeltner told delegates, and that avoids patients facing stigma. "We wanted people to be able to come to see us," she said.

"[ERIC] helps the user realise his recovery in his everydayness," said Dr Zeltner. "It facilitates access to care for the [primary consultation] and patients in rupture, and reinforces as well as complements devices that require it in the territory such as in old age and adolescence. It also is an appropriate response to suicidal crisis if the family cooperates."

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*Continued on page 2*

**LIVE: EECF Symposium: How to organise acute psychiatric care?** Clio Sunday 8:00

## Mobile rapid response teams avoid hospitalisation

*Continued from page 1*

"We wanted for them to sound familiar with our structure, to avoid stigma for patients and family. Patients say, 'I'm going to chez Eric' as they'd say 'I'm going to the hairdresser.'"

French mental health care, Dr Zeltner explained, is divided into catchment areas or 'secteurs' of between 70,000 to 100,000 adult inhabitants. Each secteur is served by one psychiatric team whose responsibilities include continuity of care and prevention.

Emergency psychiatry is provided in general hospitals, with a psychiatrist on site 24 hours a day to provide short crisis intervention of a maximum of three days, and orientation. Access to emergency psychiatric care is obtained by telephoning the fire brigade or the

special urgent medical aid service SAMU-15.

Offering an alternative to hospitalisation, ERIC complements existing support and is organised around a crisis team of mental health experts providing a multi-sector approach, said Dr Zeltner.

The team includes psychiatrists, psychologists and 15 nurses who are available every day and around the clock. They visit the homes of service users and their families within a catchment area of 600,000 people. "It facilitates access to prevention, treatment and care for the most vulnerable segments of the population – these who don't ask for themselves," Dr Zeltner added.

"It is a big team and we are in touch with three different hospitals. It is a very integrated team and a multi-sector approach. It completes the usual response from psychiatric emergency."

For more than 20 years, the programme has supported 1,071 patients, from infancy up to old age, with the majority (n=611) aged 26 to 60. Frequent mental health disorder has accounted for the majority (56%) of cases dealt with by ERIC, according to Dr Zeltner, followed by schizophrenia spectrum (21%), bipolar disorder (11%) and

support to caregivers (7%).

Psychiatrists, general practitioners, social workers, SAMU and schools are among those involved in the multi-disciplinary response, with the process of crisis intervention

*"Patients say, 'I'm going to chez Eric' as they'd say 'I'm going to the hairdresser.'"*

*Laure Zeltner*

beginning with a phone call usually from families (33%) although general practitioners can also refer patients.

"A phone call is the way people get in touch with us," said Dr Zeltner. "As soon as the call comes we are armed with a response. The paradox of the mobile team is that, to be able to give a response we have to be careful [how] we are getting in touch with them. No one can come to see us – people have to phone us first."

Dr Zeltner highlighted how teamwork is a vital part of ERIC, by which means staff can accurately assess cases. This is achieved by discussion and reflection with the team in order to reach a creative approach for each individual

patient. The focus is on evaluation, exploration and then mobilisation.

The first interview, she explained, is followed by intensive ambulatory follow-up, lasting up to four weeks and including medical and/or therapeutic consultations, home visits and phone calls.

For patients who are non-compliant, the ERIC team will try its best to get them the support they need, according to Dr Zeltner. This could involve visiting their home and putting a letter under the door and ensuring staff come back later to speak to them.

Her presentation outlined published quantitative research evidencing that mobile crisis teams avoid 50 percent of hospitalisation, that they can lower rather than increase readmission. There is also evidence that they meet the satisfaction of users, family and professionals, as well as reducing family burden. However, other studies show there is a limit to quantitative studies and no fidelity scale.

According to findings presented by Dr Zeltner, nearly seven in ten (68%) people who come into contact with ERIC are then seen within 24 hours, and four in five (80%) within 72 hours. Concluding her presentation, Dr Zeltner said that ERIC has made a positive contribution to the severely mentally ill community.

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## New data on patient-controlled admission

A patient-centric approach in which patients with severe mental disorder control their hospital admission was presented this morning during a session on the organisation of acute psychiatric care.

Such patients can admit themselves to a hospital unit for a short stay without being assessed by a psychiatrist or contacting the emergency department. "The patient is considered the best judge of when treatment is needed," said Christoffer Torgaard Thomsen (Copenhagen University Hospital, Denmark), who presented recent study on the topic from Denmark.

"Our colleagues from Norway introduced patient-controlled admission in 2005<sup>1,2</sup>. Hopefully, by introducing this new model, we expect that we would increase patients' empowerment and their autonomy, avoiding power struggle in the emergency department. Thereby, we would like to have the patients improve their skills, and encourage self-management. They should use this

initiative as a preventative one, before deterioration and illness. Hopefully we could reduce the use of coercive measures and reduce the time spent in hospital."

The aim of the Danish study was to see if such an innovative self-referral approach could reduce the use of coercive measures – still widely used in Western psychiatry<sup>3,4</sup> – compared to treatment as usual. Previous studies from Norway are small, but have shown a tendency towards a reduction in involuntary inpatient care and length of hospital stay<sup>1,2</sup>.

The Danish study's protocol is described in Thomsen et al (2016)<sup>5</sup>. A number of patient-controlled beds were established in different centres in five regions of Denmark. Participants were adult psychiatric patients with severe mental disorder(s), who underwent assessment by health professions to ascertain whether they might benefit from the programme. The only exclusion criterion was lack of consent, and the ideal recruit was



a person with frequent service use and previous coercion. Hence, a one-year contract was established with recruited patients. This enabled them to admit themselves without objection for a maximum of five days, and also to discharge themselves.

Patients were recruited from Danish national patient registers. 422 patients were recruited to the patient-controlled admission group. Two sets of analyses were performed on the group of patients recruited. The first used patients as their own control, one year prior to index date. The second analysis was propensity score matched in which patients were matched with five control inpatients and upon which basis survival analysis was conducted.

The primary outcome was the use of any coercive measure. Secondary outcomes included hospitalisation pattern, medication used, and self-harm and death by suicide. Descriptive measures were also collected on client satisfaction, global assessment of functioning, and the frequency of conversion from patient-controlled admission to treatment as usual.

Result of the before-and-after index analysis in the patient-controlled admission group revealed a significant reduction in any coercive measures (225 vs. 139;  $p=0.0001$ ) as well as mean number of bed-days (75.2 vs. 58.2;  $p=0.0003$ ). No significant reduction between groups in medication use or self-harm behaviour. Interestingly, a similar reduction in any coercive measures was also found in the treatment as usual group (1296 vs. 808;  $p<0.0001$ ).

Propensity score matching was based on covariates including gender and diagnosis, where exact matching was achieved, and others covariates where near but not exact matching was achieved. "There were some imbalances, which is a limitation to this study," commented Dr Thomsen.

From this data cumulative risk curves were plotted on any coercive measures, where no significant reduction was identified with patient-controlled admission over the three-year follow-up period. In an analysis of specific coercions such as compulsory admission, restraint and forced treatment, no significant reduction was found either. Similarly, analysis of self harm behaviour revealed no reduction.

Turning to service use and redeemed prescriptions at one-year follow-up, Dr Thomsen commented: "We actually found that patients in the patient-controlled admission group had a higher use of services compared to treatment as usual [58.2 vs. 29.8;  $p<0.0001$ ]. These contradict the studies from Norway."

The mean patient-controlled admission stay



*"The patient is considered the best judge of when treatment is needed."*

Christoffer Torgaard Thomsen

*"We actually found that patients in the patient-controlled admission group had a higher use of services."*

Christoffer Torgaard Thomsen

was 3.6 days (SD 1.5), with admission equally distributed throughout the year, explained Dr Thomsen. The need for further healthcare was registered in 190 cases. Analysis of qualitative data from individuals from the patient-controlled

admission group revealed that mean GAF score was 42.3, and mean CSQ score was 25.

Discussing these findings, Dr Thomsen said: "This approach may only be for a selected group of patients. Patients diagnosed with schizophrenia may have some decisional impairment. Patients were included within a certain time duration of their illness, which also could have affected

these outcomes. There has been some smaller RCT studies that have similarly found no reduction in coercion or patient bed-stay.

"The strength of this study was that it was the first large-scale longitudinal study to investigate patient-controlled hospital admission. We had recruitment from five regions, and each coercion is registered by law in Denmark, which ensures high validity. The main limitations were that patients

were not randomly allocated to either groups. Although an RCT study is superior with better control of confounding indication, we tried to do our best with the propensity score matching to take these confounds into account. Also, in the registers we don't have any scale of severity of symptoms, which also may have been an issue in this study."

#### References

1. Heskstad S, Tytlandsvik M. [Patient-guided crisis admissions for severe psychotic conditions]. *Tidsskr Nor Lægeforen*. 2008 Jan 3;128(1):32-5.
2. Strand M, von Hausswolff-Juhlin Y. Patient-controlled hospital admission in psychiatry: A systematic review. *Nord J Psychiatry*. 2015; 69(8):574-86.
3. Kalisova L et al. Do patient and ward-related characteristics influence the use of coercive measures? Results from the EUNOMIA international study. *Soc Psychiatry Psychiatr Epidemiol*. 2014 Oct;49(10):1619-29.
4. Husum TL et al. A cross-sectional prospective study of seclusion, restraint and involuntary medication in acute psychiatric wards: patient, staff and ward characteristics. *BMC Health Serv Res*. 2010 Apr 6; 10(0):89.
5. Thomsen CT et al. Patient-controlled hospital admission for patients with severe mental disorders: study protocol for a nationwide prospective multicentre study. *BMJ Open*. 2016; 6(9): e013088.

# A dangerous cocktail

## Understanding comorbidity in ADHD

Today, suicidality is the theme of a clinical/therapeutic symposium where JJ Sandra Kooij (Associate professor of psychiatry, VU Medical Centre in Amsterdam), will address the comorbidity between attention-deficit hyperactivity disorder (ADHD) and mood disorders.

"Suicidality is obviously a part of depression and of bipolar disorder and when it is combined with ADHD this poses several additional risks," she explained to *EPA Congress News*. "This combination can be dangerous due to low mood and impulsivity. The research shows that the suicide risk in ADHD is increased."

Dr Kooij, who is also Head of the Dutch Expertise Centre Adult ADHD at PsyQ in the Hague, specialises in ADHD study beyond childhood, known to affect 3-5% of adults and older people. She will be discussing the prevalence of depression and other mood disorders because both are evident in adults with ADHD. "Indeed, in clinical samples, 50% of those with ADHD suffer from lifetime depression. And bipolar disorder is also increased tenfold compared to the population level, especially type 2 bipolar disorder," she explained.

The choices that must be made when treating patients with multiple disorders is a hot topic at present, and Dr Kooij will be discussing new research in this area: "If you have two or more disorders there is always an issue of the order of treatment. Which one do you treat first?"

Traditionally, for example, many psychiatrists were reluctant to treat bipolar patients with ADHD because of worries about inducing hypomania on commencement of ADHD treatment. But new research from Sweden<sup>1</sup> has uncovered some very encouraging findings, according to Dr Kooij: "We now know that



hypomania risk is reduced by treatment first with mood stabilisers. So it's safe to give patients with bipolar disorder the stimulant under the protection of the mood stabiliser. That's really good news."

The use of mood stabilisers first has other ramifications, she added: "It means bipolar ADHD patients can be treated with the best treatments available to other people."

Treating patients with two disorders is challenging, especially when one disorder is more severe than the other. "Usually the most severe

*"Usually the most severe disorder is the mood disorder. And when there is a severe disorder, it should be treated first."*

Sandra Kooij

disorder is the mood disorder," said Dr Kooij. "And when there is a severe disorder, it should be treated first."

But, in patients with both ADHD

very severe and people are suicidal you have to treat that first I think."

That so much more is known about the comorbidity is down to important research published by Fayyad et al.<sup>3</sup> on the prevalence of ADHD in 20 countries around the world. The work looked at morbidity rates, depression and bipolar disorder. "They found that in 80 to 90% ADHD was first in all comorbidities," said Dr Kooij. "ADHD usually comes first because it is a heritable condition that runs in families and you are born with it, although you can develop it also by environmental factors. But genetic risk is clearly the largest contribution."

The management of ADHD combined with other mood disorders is a growing field with many research gaps, concluded Dr Kooij.

Currently, her research looks at the increased prevalence of mood swings that afflict specifically women with ADHD: "There is a very urgent and prominent problem with ADHD," she said, "That women in general have an increased risk of mood disorders compared with men,

and women with ADHD also suffer from a special type of mood disorder – in the week before menstruation starts, postnatally and during the menopause."

**Dr Kooij speaks during 'Attention-deficit hyperactivity disorder and suicide', taking place in Thalie between 10:00 and 11:30 today.**

### References

1. Viktorin A et al. The Risk of Treatment-Emergent Mania With Methylphenidate in Bipolar Disorder. *Am J Psychiatry*. 2017 Apr 1;174(4):341-348.
2. Chen MH et al Attention-deficit hyperactivity disorder comorbidity and antidepressant resistance among patients with major depression: A nationwide longitudinal study. *Eur Neuropsychopharmacol*. 2016 Nov;26(11):1760-1767.
3. Fayyad J et al. The descriptive epidemiology of DSM-IV Adult ADHD in the World Health Organization World Mental Health Surveys. *Atten Defic Hyperact Disord*. 2017 Mar;9(1):47-65.

*"In ADHD and depression, people sometimes have resistance to antidepressants when we treat with antidepressants first."*

Sandra Kooij

and depression, recent research has established that there is an increased risk of resistance to antidepressants if ADHD is not treated first<sup>2</sup>. "In ADHD and depression, people sometimes have resistance to antidepressants when we treat with antidepressants first, so this may not always be the best way," said Dr Kooij. "I thought it was, based on clinical experience, but the data suggests that the reverse route maybe a better option." Dr Kooij also cautioned against waiting too long before starting treatment for ADHD if there is resistance to antidepressants.

Adding a caveat to the discussion as a whole, Dr Kooij continued: "All this depends on this severity of the disorder. When the disorder is



# Discovering ADHD in Adults

THIS MEETING IS INITIATED, ORGANISED AND FUNDED  
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Join us for a multimedia, expert-curated, educational  
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management of adult patients with ADHD.

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This programme is not intended or eligible for continuing medical education (CME)  
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Approximately **3.4%** (95% CI: 2.6–4.2) of  
adults worldwide may have ADHD<sup>1</sup>



\*USA cohort

Many of them, however, **may not be diagnosed**.  
Fewer than **20%** of adults with ADHD are currently  
**diagnosed and/or treated** by psychiatrists<sup>2</sup>



of adults with ADHD\* have  
**received treatment** in the  
past 12 months<sup>3</sup>

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## Faculty



**Philip Asherson, MBBS, MRCPsych, PhD** is Professor of Social Genetic and Developmental Psychiatry at the Institute of Psychiatry Psychology and Neuroscience, King's College London, UK; a Consultant Psychiatrist at the Maudsley Hospital; and a National Institute for Health Research Senior Investigator



**Anthony L. Rostain, MD, MA** is a Professor of Psychiatry and Paediatrics at the University of Pennsylvania Perelman School of Medicine, USA and is Education Committee Co-Chair of the American Professional Society of ADHD and Related Disorders (APSARD)



**Martin A. Katzman BSc, MD, FRCP** is Chair of the Anxiety Disorders Association of Canada; an Adjunct Professor at Adler Graduate Professional School; and is Director of the START Clinic for Mood and Anxiety Disorders, Ontario, Canada



**Susan J. Young, BSc (Hons), DClinPsy, PhD, CSci, AFBPS** is the Director of Psychology Services Limited and an Honorary Professor at both Reykjavik University, Iceland and Bucks New University, UK. She is President of the UK ADHD Partnership; Vice-President of the UK Adult ADHD Network; and is a Trustee of The ADHD Foundation, UK



**Josep Antoni Ramos-Quiroga, MD, PhD** is a Professor of Psychiatry at Universitat Autònoma de Barcelona, Spain and is Head of the Department of Psychiatry at Hospital Universitari Vall d'Hebron, Spain

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### References

1. Fayyad J, et al. Br J Psychiatry 2007; 190: 402–409
2. Ginsberg Y, et al. Prim Care Companion CNS Disord 2014; 16(3): PCC.13r01600
3. Kessler RC, et al. Am J Psychiatry 2006; 163(4): 716–723

**Shire**

## “Women must be involved on all levels of humanitarian action”



*“Opportunities [in] humanitarian crisis, and even profiting from its transformative potential, are not understood or taken into account enough.”*

Michaela Amering

Today's Presidential symposium characterises the issues of mental health in humanitarian emergencies. Michaela Amering (Medical University of Vienna, Austria), speaks specifically on the value of empowerment of women and girls in this setting and how this can be better facilitated, as well as the unique challenges they experience.

“Women are at elevated risk of many forms of gender-based violence and have their sexual and reproductive rights and health needs undermined in life-threatening ways,” Professor Amering told EPA Congress News.

The United Nations Population Fund estimates that 34 million women of reproductive age, 5

the need to integrate safe abortion and post-abortion care into emergency care,” noted Professor Amering, adding: “While the lack of bathroom equity and the so often deplorable menstrual hygiene situation are a terrible disadvantage for women under even the best of circumstances, in humanitarian crisis situations they constitute grave extra risks for women and girls.

“The heightened interest in investment in gender responsive humanitarian programming, however, does not only stem from awareness of women's specific needs and wanting to stop failing them, but also from the experience that investment in women can impact the whole community and can make help more effective for all.”

In general, women and girls are used to keeping and expanding their roles and their resilience in the face of adversity, explained Professor Amering. However, the risk of men losing their accustomed roles or taking over traditionally female roles can create additional risks for women. Pre-existing disadvantages in rights and resources

can lead to women and girls being the first to lose access to scarce resources like food and water. Girls' education is endangered to an even greater extent than boys', and the risk of child marriage can increase dramatically for girls. The specific needs and resources

of adolescents in humanitarian crises, however, currently still feature as one of many data gaps. “The same is true for the contextual factors of risks and opportunities of having to cope with humanitarian crisis and even profiting from its transformative potential, which are not understood or taken into account enough.”

There is some knowledge on how programs can address underlying dynamics of power abuse and

violence in affected communities, continued Professor Amering, adding that these necessary efforts have nevertheless been listed as remaining data gaps in recent comprehensive reviews. Such measures allow for earlier prevention and protection, as well as comprehensive clinical and psychosocial care for survivors to be characterised and implemented.

“Evidence-base, economic as well as human rights perspectives all do agree on the fact that women must be involved on all levels of humanitarian action such as prevention, response (including search and rescue), recovery and rehabilitation, community rebuilding and peace-building.”

However, not all consequences of specific strategies to harness the increased effectiveness that women's participation in emergency aid brings are well understood. There is a risk, therefore, of unintended consequences, suggested Professor Amering, exemplified by historical and recently-reported backlashes against the gender equality movement.

Another factor in fostering positive gender relations in the humanitarian setting is female representation in leadership roles in institutions involved. “One main factor that should be a focus of change is the need for better female representation among aid workers on all levels, including local and international leadership,” commented Professor Amering. “The current sexual misconduct and abuse crises in some humanitarian organisations might be an opportunity for decisive changes in this regard too.”

Professor Amering went on to discuss a parallel development to the evolving policies and practices in humanitarian crisis situations, concerning persons with disabilities. The UN-Convention on the Rights of Persons with Disabilities (UN-CRPD) was negotiated for the first time in history with the full participation of persons with a lived



experience of disability, she said<sup>3</sup>.

"In another historic first, it explicitly includes persons with disabilities from mental health problems. Article 11 of the UN-CRPD formulates the obligations to 'ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters'.

*"The current sexual misconduct and abuse crises in some humanitarian organisations might be an opportunity for decisive changes."*

Michaela Amering

"The 2017 UN charter on Inclusion of Persons with Disabilities in Humanitarian Action in accordance with the Sendai Framework on Disaster Risk Reduction specifically calls attention to multiple and intersecting forms of discrimination and the need to empower women and girls with disabilities in humanitarian crisis contexts.<sup>3</sup>

#### References

1. United Nations Population Fund. UNFPA Humanitarian Action: 2018 Overview. UNFPA website. 2018 Jan. <https://www.unfpa.org/fr/node/17056> (accessed Feb 2018).
2. Care International. Suffering in silence: The 10 most under-reported humanitarian crises of 2016. 2017. p.17. [http://www.care.org/sites/default/files/documents/report\\_suffering\\_in\\_silence\\_web\\_version.pdf](http://www.care.org/sites/default/files/documents/report_suffering_in_silence_web_version.pdf) (accessed Feb 2018).
3. United Nations. Convention on the Rights of Persons with Disabilities (CRPD). Conference of States Parties to the Convention on the Rights of Persons with Disabilities; Tenth session, New York. 13-15 June 2017. Item 5 (c) of the provisional agenda. [http://www.un.org/disabilities/documents/COP/crp/csp\\_2017\\_3.pdf](http://www.un.org/disabilities/documents/COP/crp/csp_2017_3.pdf) (accessed Feb 2018).

**Opening ceremony Sunday 18:30**

## Pascal-Boyle award goes to Anita Riecher-Rössler

**E**PA honours Anita Riecher-Rössler, the first woman full professor of psychiatry in a German-speaking country, at this year's Opening Ceremony. Professor Riecher-Rössler is well-known for starting the first specialised clinic for the early detection of psychosis in Switzerland, and has conducted important studies aimed at identifying early predictors of psychotic disorders.

During an interview with *EPA Congress News*, she began by describing how her early career developed: "I think I have at least tried to promote the field in the direction of early detection, intervention and prevention in the area of psychoses.

"Ever since I was a young psychiatrist I have been interested in women's mental health and schizophrenic psychoses," she

said. "Interest started when I was the deputy chair of a research project on gender differences in psychoses, which later was called 'ABC Study' (age, beginning, and course of schizophrenia), led by Heinz Häfner in Man-

nheim, Germany."

The group uncovered, first, that psychotic disorders start with unspecific prodromal and sub-threshold psychotic symptoms many years before the patients developed their first frank

psychotic episode. "Even then, it took long time until they sought help," noted Professor Riecher-Rössler.

The second finding was that women developed disorders on average several years later than men and

had a second peak of onset after the age of 40. "Both findings made me very curious," said Professor Riecher-Rössler.

"In the beginning, my main interest was in explaining the gender difference in age of onset, and I performed several studies on that – amongst others, on the potential influence of the female sex hormone oestrogen as one possible explanation."

"And when, in 1998, I was appointed as head of the Basel University Psychiatric Outpatient Department, I immediately started a special clinic on the early detection of psychosis with the goal of identifying patients with emerging psychoses and helping them much earlier – hopefully even before frank psychosis starts."

Professor Riecher-Rössler is the first recipient of the EPA Constance Pascal – Helen Boyle Prize, which recognises outstanding achievement by a woman working to improve mental health care in Europe. EPA President Silvana Galderisi explained to *EPA Congress News* that the award was developed last year with under-recognised achieve-

*"I think I have at least tried to promote the field in the direction of early detection, intervention and prevention in the area of psychoses."*

Anita Riecher-Rössler



*Continued on page 8*

Opening ceremony Sunday 18:30

## Pascal-Boyle award goes to Anita Riecher-Rössler

*Continued from page 7*

ments in mind: "Women have long been discriminated against, including in the fields of mental health care and psychiatry," she explained. "Through this prize, the EPA aims to publicly acknowledge and increase awareness of the outstanding achievements by women in working to improve mental health care in Europe."

"Anita Riecher-Rössler was chosen for her academic, clinical, research and leadership skills. She is constantly committed to improving and expanding knowledge on mental health. She has contributed to advancing research and care for emerging psychoses and has conducted important studies aimed at identifying early predictors of severe psychotic disorder."

"She has also provided important research contributions on specific aspects of mental disorders in women, particularly on psychoneuroendocrine and

(225 peer-reviewed), edited 28 books (15 as series editor) and has authored 98 book chapters.

The Pascal – Boyle prize was inspired by two trailblazers who lived and worked early last century. Dr Constance Pascal was a Romanian psychiatrist who became the first woman to qualify as a psychiatrist in France in 1908. By 1925, she had risen to become the first female director of a French psychiatric hospital, as chief physician at the Moisselles.

Dr Helen Boyle, an Irish-British psychiatrist, started work in 1894 in England and went on to become the first female President of the Royal Medico-Psychological Association (later to become the Royal College of Psychiatrists). "Both contributed significantly to the scientific literature in addition to their pioneering clinical work, and served as role models for generations of future female psychiatrists," noted Professor Galderisi.

A century on and modern-day psychiatrists such

as Professor Riecher-Rössler find themselves occupying similar positions: "I was very pleased and grateful to all the women and men who supported me during these years," she said. "Especially rewarding were the mails I got from young female colleagues, telling me that I was a role model for them. It reminded me that I also had many wonderful role models here in the EPA – and how important that was."

Asked how she perceives progress in gender equal-

ity, she replied: "Yes, I have seen women in psychiatry progress. Some years ago the EPA appointed the first female president, Danuta Wassermann, and right now we have the second, Silvana Galderisi. Similarly, the World Psychiatric Association now has its second female president with Helen Herrman – both associations have done so after a long tradition of only male presidents."

Despite that, there remains room for improvement: "Why is it that the majority of psychiatrists are female in most countries but they are still not equally represented in influential positions?" asked Professor Riecher-Rössler. "I have therefore tried to advance the careers of young women in psychiatry – for example by mentoring and workshops – because I think that psychiatry as a whole could gain from having leading and influential figures of both genders."

In her concluding remarks, Professor Riecher-Rössler described her priorities going forward: advancing the shift from traditional treatment-oriented psychiatry towards the inclusion of early detection, intervention and prevention; advancing the field of gender-sensitive psychiatry and psychotherapy – for both genders; and advancing young women's careers to promote them into more leadership positions.

"That is the best approach for our field and our patients," she said. "I am very grateful and optimistic. Psychiatry as a field is developing enormously positively and there are so many really brilliant and dedicated people – women and men – who will advance the field even further."

*"Anita Riecher-Rössler was chosen for her academic, clinical, research and leadership skills."*

*Silvana Galderisi*

psychosocial risk factors for mental disorders, as well as on gender-sensitive (psycho) therapies."

Professor Riecher-Rössler has been a leading figure in women's mental health associations too, added Professor Galderisi. As well as being Editor-in-chief of the Archives of Women's Mental Health, she has published about 330 original articles





How do EPA, WPA and WHO respond to the mental health consequences of forced displacement? Erato Tuesday 8:00

# Forced displacement “a human-made psychosocial earthquake”

**E**PA Board member Levent Küey, Associate Professor of Psychiatry at Istanbul Bilgi University (Turkey), will give the Congress an update this morning on the work of the EPA Task Force on Needs of Refugees and Asylum Seeker Patients in Europe, which he chairs.

In 2015 the EPA reacted to growing rates of forced displacement with a position statement<sup>1</sup> and set up the EPA Task Force on Needs of Refugee and Asylum Seeker Patients in Europe, dedicated to work on the mental health consequences of forced displacement, and the psychiatric care of refugees.

Speaking ahead of his presentation, Professor Küey told *EPA Congress News*: “By the end of 2015, one in every 122 humans was someone who had been forced to flee his home. In 2016, this number rose to 65.3 million.”

He explained that if this were the population of a country, it would be the 22nd most populated country in the world and 4th of such in Europe. During 2016 nearly 34,000 people were forcibly displaced every day.

## The psycho-social context of mental health consequences

The mental health consequences of the forced displacement of people are shaped by psychosocial, cognitive and emotional context, underlined Professor Küey.

He said: “A forcibly-displaced person is experiencing a human-made psychosocial earthquake. Nobody wants to flee forcibly, and it is not on their free will, i.e., not a choice. Furthermore, it is not pre-planned; usually the decision and action to flee are made in a short time, following one after the other.

“A refugee is under threat in all areas of attachment, mastery, and survival. Almost all attachments are left behind, degree of mastery over one’s own life is decreased; the nutrition of the self and the self-image are devastated. And basic needs for

survival are maintained mostly in the mercy of others.

“A refugee is a person who has lost the past for an unknown future. Experiences of loss and danger are imprinted in their selves, increasing their vulnerability for depressive and anxiety disorders.”

## Mental health fall-out of displacement

There is increasing evidence that a large proportion of refugees and asylum seekers residing in Europe suffer from the consequences of traumatic events, and exhibit mental health problems such as post-traumatic stress disorder (PTSD), said Professor Küey.

In general, he said, mental health consequences of forced displacement include PTSD, depressive disorders, anxiety disorders, psychosis, and dissociative disorders. Refugees resettled in western countries could be about ten times more likely to have PTSD than age-matched general populations.

“Once more, psychiatry and mental health workers are facing the mental health consequences of persecution, general violence, wars, and human rights violations caused by the current prevailing economy-politics and socio-politics,” he said.

“A serious challenge is consolidating the psychiatric/medical help on one hand and avoiding the medicalisation of social phenomena (armed conflicts, persecution and wars) on the other.”

## How the EPA is tackling the crisis

The EPA’s Task Force has been actively working on the related issues of the mental health consequences of forced displacement and the needs of refugee and asylum seeker patients in Europe, aiming to finalise its work in 2019, said Professor Küey.

Summarising the Task Force’s achievements so far, he highlighted the organisation of a series of scientific sessions including symposia, workshops and EPA CME



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Levent Küey

courses targeting psychiatrists and mental health workers, held in Madrid in 2016, and Florence and Berlin in 2017. These activities continue at the 2018 Congress.

Professor Küey said the final version of the Task Force Position Paper and report is being updated and edited and will be submitted to European Psychiatry. A critical review and a list of the current practice of e-mental health initiatives in Europe will also be published.

The EPA Task Force has also collaborated with the EU Health Policy Platform Thematic Network on Migration and Health, contributing on issues of stigmatisation, discrimination and mental health aspects. The group has prepared a general framework document and a call to action.

Other activities planned include a systematic review article on the subject of forcibly displaced people and mental health, to be prepared by the Task Force members. Professor Küey noted that proposals for scientific sessions targeting physicians and non-mental health workers will also be prepared, and possibilities of collaboration with the World Medical Association and similar organisations will be explored. In collaboration with

the EPA and national psychiatry associations (NPA), the possibility of undertaking a research and/or assigning a key person in each NPA will be investigated. Via this contact, all relevant activities and initiatives in each NPA country will be documented.

A critical review is also planned, as well as a list of the current practice of any health promotion activities, psycho-educational interventions, psychotherapies (including specific therapies), resilience and/or resource-oriented interventions. This information will be gathered within a section of the EPA website on forcibly-displaced people and mental health.

**The workshop, ‘How do EPA, WPA and WHO Respond to the Mental Health Consequences of Forced Displacement?’, takes place in Erato from 8:00 to 9:30 this morning.**

## References

1. EPA Position Paper on Psychiatric Care of Refugees in Europe. EPA website. [www.europsy.net/publications/position-statements](http://www.europsy.net/publications/position-statements) (accessed Feb 2018).

# "Psychiatrists do not sit in front of a brain – we sit in front of a person"

Person-centred psychiatry comes centre stage this morning in a workshop focussed on the importance of phenomenological psychopathology. Not only is a rigorous understanding of clinical phenotypes clinically relevant, but it is crucial to the development of rigorous research – such as the thinking of Giovanni Stanghellini ("D'Annunzio" University, Chieti, Italy), who speaks during the session on person-centred dialectical models in schizophrenia, and who chairs the EPA's Philosophy and Psychiatry section.

"This is actually the basis for understanding what it is like to be in the patient's shoes," he told *EPA Congress News*. "What is the universe in which that specific patient lives? We think this is the basis for good clinic and good research."

The experiential dimension of mental disorder is downplayed in contemporary mainstream approaches, he added. In contrast behaviours and cognitive traits, while part of the experiential domain, are not a complete representation of a patient's lifeworld.

Once the lifeworld is rigorously defined, the patient can then take a position in front of her experiences: "If you have a patient who hears voices, standard assessment says that this patient is hallucinating," said Prof. Stanghellini. "But one patient may be totally overwhelmed by his voices, while another may react and try to contrast them, and an-

other patient may see them from 'without'".

"This is of the greatest importance to understand the patients themselves. Person-centred psychopathology means, first, emphasis on subjective experience and, second, an emphasis on the way the person deals with, makes sense of, or copes with these subjective experiences."

Why is this relevant? "To establish a valid and reliable diagnosis, symptoms of experience are by far more reliable than behaviours. Behaviours are very unspecific. Consider the following behaviour: a person who does not eat. Can we say that she is anorexic? No we can't. What counts is the mental state that subtends her behaviour. The person may not eat because she thinks that food is poisoned (sitophobia), or because she is convinced that this sort of food is not healthy for her (ortorexia), or she may be a follower of a sort of 'religion' attributing a negative value to food and to fat (as it is often the case with people with so-called 'eating disorders' as shown in Ana blogs in the internet). You have to understand what the experience behind it is and the meaning that the patient attributes to the experience."

Prof. Stanghellini went

on to describe how person-centred dialectical principles can be applied in the therapeutic setting, relating the experiences of a patient to a balled up manuscript, upon which her lifeworld is written. In order to come to terms with it, the task of the patient (with the help of the clinician) is to first unravel this page. Second, the patient is invited to take a position in front of it. Third, patient and clinician cooperate to trace the relation of these present experiences to the patient's personal history. While facilitated by the clinician, this process has the effect of instilling a sense of agency in the patient, which goes hand-in-hand with recovery.<sup>1,2</sup>

That phenomenology and biology remain so ap-

parently at odds with one another underscores the need for structures that bridge them. Prof. Stanghellini explores this in his research, defining the abnormal bodily experiences in persons with schizophrenia in terms of abnormal spatiotemporal experience, which can then be related to brain structure and function<sup>3</sup>.

"How can I find biological correlates for something that is not properly phenomenally defined? Without doing this, I wonder what neurobiological research is looking for. It is looking for correlates of something that is only blurrily defined."

Some of his recent work looks at defining 'phenotypes' — characterisations of different types of

lifeworlds — and how these can be directly correlated to biological structure and function<sup>4</sup>. Research into pheno-phenotypical characterisation is underway in a number of different disorders including schizophrenia, major depression, obsessions, eating disorders, borderline personality disorder, addictions, said Prof. Stanghellini, adding that these are available in the most recent edition of the Oxford Handbook of Phenomenological Psychopathology that will shortly be available online.

"Of course we need to integrate the experiential data and facts with the biological data and facts," he continued. "The real problem nowadays is that most of research and fundings of research are on one leg: biological research. The need to reiterate that there is an experiential dimension that is clinically relevant, and not just ethically relevant, derives from the fact that the majority of funding is in the direction of biological psychiatry".

"The education of young psychiatrists is basically biologically oriented. But psychiatrists do not sit in front of a brain - we sit in front of a person."<sup>5</sup>

## References

1. Stanghellini G. Lost in Dialogue: Anthropology, Psychopathology, and Care. Oxford University Press. 2017
2. Stanghellini G, Mancini M. The Therapeutic Interview: A value-based and person-centred approach. Cambridge University Press. 2017.
3. Northoff G, Stanghellini G. How to Link Brain and Experience? Spatiotemporal Psychopathology of the Lived Body. Front Hum Neurosci. 2016 Apr 28;10:76.
4. Sass L et al. EAWE: Examination of Anomalous World Experience. Psychopathology. 2017;50(1):10-54.
5. Messas G et al. The contribution of human sciences to the challenges of contemporary psychiatry. Trends Psychiatry Psychother. 2017 Oct-Dec;39(4):229-231.



*"How can I find biological correlates for something that is not properly phenomenally defined?"*

Giovanni Stanghellini



# Abandoning preconception

## The sensation of the melancholic

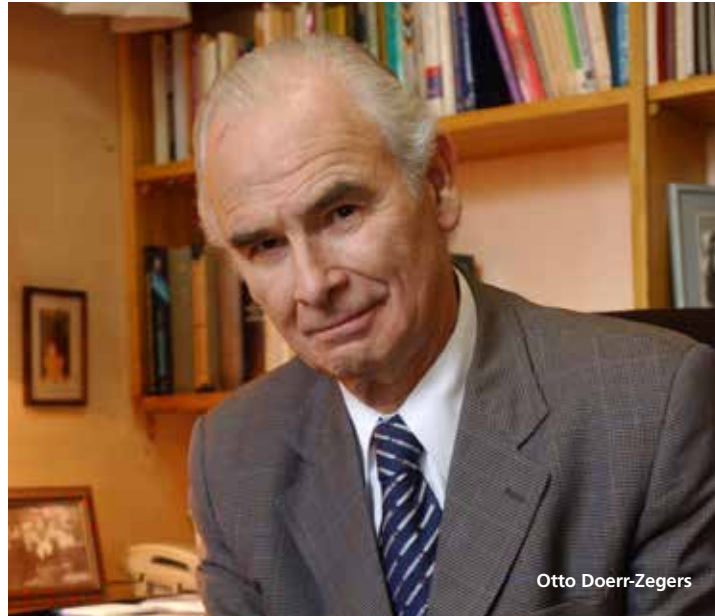
**O**tto Doerr-Zegers (Professor of Psychiatry at the Universities of Chile and Diego Portales; Director of the Center of Studies on Phenomenology and Psychiatry, Diego Portales University, Chile) continues the theme of person-centred psychiatry with an exploration of the phenomenology of depression. The underlying phenomena of psychiatric illness – experienced by the patient and intuited by the physician – can not be directly observed, he said, but should remain of central importance in psychiatric research and treatment.

### Symptoms as emergence of phenomena

In a 1958 paper, Henricus Rümke observed that all the primary symptoms of schizophrenia illnesses are unspecific, appearing in other illnesses and indeed in healthy individuals too – despite the ability of the psychiatrist to make concrete diagnoses on the basis of extensive patient evaluation<sup>1</sup>. The fact that diagnosis is possible at all, suggested Professor Doerr-Zegers, calls for a clarification of the concepts by which elements of psychopathology are distinguished: “The merit of Rümke is having pointed to the essence of schizophrenia,” he said, “In spite of the somehow necessary tautological character of the diagnostic process in psychiatry, given the fact that in these diseases no substrate has been found in which the diagnosis can be based.”

There is, said Professor Doerr-Zegers, an intuitive sensation (the ‘*praecox feeling*’) the physician has when facing patients with, for example, schizophrenia: “[In capturing] this specific atmospheric emanation, we not only arrive at a more precise diagnosis of this illness, but this intuition of the essence can lead to future research in order to discover the neurobiological fundaments of the disease.”

He pointed out that the relationship of contiguity between isolated symptoms was identified as a methodological limitation in



the current diagnostic manuals of major depressive disorders. What is important is the relation between these symptoms, and this can be uncovered by examination of the phenomenology of the illness.

Moreover, he added, the phenomenological experience brings forth the unifying, invariant characteristics of patients with, say, schizophrenia or depression. A key distinction must therefore be made between symptom and phenomenon, explained Professor Doerr-Zegers, with a symptom definable as a manifestation of the underlying phenomena fundamental to the illness. This distinction is important, he explained, because a confusion of symptoms with phenomena can lead to conceptual errors in all areas of psychiatric investigation and practice.

### Lessons from the phenomenology of schizophrenia

Illustrating the importance of a conceptualisation of psychopathology that reflects a patient's experience, Professor Doerr-Zegers used the example of auditory hallucinations that a person with schizophrenia experiences: “For a long time it was thought that if someone listened to objectively non-existent voices,

he must have a disturbance of his hearing system. In fact, many investigations were performed in search of that acoustic disturbance and all were fruitless.”

Conceptual errors are often evidenced by confused medical vocabulary. That a patient “hears voices”, explained Professor Doerr-Zegers, is imprecise: a characteristic of schizophrenic hallucination is the simultaneous experience of being invaded, overwhelmed. As such, the person with schizophrenia is not an active agent (as people may be with other hallucinogenic experiences), but experiences “being spoken to” (as described by Jürg Zutt in 1963<sup>2</sup>). This distinction unveils the feelings of perplexity and helplessness that a person with schizophrenia experiences. Such a reconceptualisation is important in marking out those characteristics specific to the illness.

### Characterising the melancholic experience

Professor Doerr-Zegers applied this same idea to his patients with depression at the Psychiatric Clinic of the University of Chile. These empirical-phenomenological investigations yielded three principle elements of the depression experience – the ‘*melancholic sensation*’ – that are consistent across its

clinical manifestations.

First, he explained, the patient's experience of their own body changes, manifesting in symptoms such as compromised mood, anxiety, lack of energy, pains and feelings of cold. Second, the relation of their body with the world is altered, resulting in symptoms such as difficulty in concentrating, decision-making and acting. Third, a change in temporality is expressed as aberrations in vital rhythms in areas such as eating, sleeping, and sexuality.

“These constitute the fundamental phenomena of depression and must always be present for making the diagnosis. The combination of signs and symptom can be different in each patient, but the three phenomena have to be there, because they belong to the essence of depressivity.”

These findings emerged from investigations beginning in 1971 at Professor Doerr-Zegers' clinic. 50 patients, recruited over a five-year period, were systematically characterised in terms of symptoms, observations from clinicians and family members, and patients' subjective experiences as recounted by them. Thereupon, the investigators sifted out personal, familiar and socio-cultural differences to reach a set of phenomena that were consistent.

“At the end of each morning we had a team meeting, where we studied together an average of five of the more interesting new patients,” said Professor Doerr-Zegers in describing how these studies came about: “Very soon it became evident to us that one of the more urgent tasks should be the conceptual clarification, the definition of the syndrome and the establishment of clear differential criteria in the framework of the diversity of depressive cases offered by clinical practice.

“The wilt of the lived body is the beginning of this process of becoming a thing. And so, all the particular symptoms order themselves around the disturbance of embodiment. This ‘*phenomenon*’ (and not ‘*symptom*’) must always be present for diagnosing a depression. And in the measure

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that it corresponds to the essence of this disease, it can lead researchers to future developments [reaching down to] the molecular level."

### Contrasting the phenomenological diagnosis with the atomised approach

Professor Doerr-Zegers distinguished the phenomenological diagnosis from the symptom-based diagnosis, saying that the former takes the phenomenon (e.g. the diagnosis of depression) as a holistic structure and starting point of investigation of the patient. "It does not develop from elementary entities (symptoms) towards a nosological configuration or syndrome. Rather, it starts from a complex structure (phenomenon), from which the single symptoms may be unfolded.

"In this way, the symptoms can only be described through the analysis or the composition of the holistic phenomenon, as parts of the same whole. Thus, among the advantages of the phenomenological diagnosis is that it takes into account, on the one hand, both the inner relation between the phenomenon and the symptoms, and the immanent inter-connections between the symptoms, on the other.

"These are not 'independent parts' or pieces, which are isolated and contiguous, as in the symptomatological diagnosis. They are rather 'dependent parts' or 'moments' structurally interconnected within a whole phenomenon. The phenomenon is, by definition, experienced/co-constituted by the patient and the clinician. It corresponds to the patient's self-experience and includes the way the patient's experience is lived by the clinician."<sup>3</sup>

That psychiatrists routinely draw on such intuitively-acquired knowledge speaks to its important implications for research, said Professor Doerr-Zegers. That is, knowledge from direct sensory perception – that forms the basis of the scientific method – is insufficient in adequately describing what it is like to experience something.

The methods of the natural sciences can be applied to physical

matter – a volcano, the atmosphere, or human anatomy – but are not applicable to complex phenomena such as human beings, society and art, argued Professor Doerr-Zegers. The contrast between "being spoken to" and "hearing voices" demonstrates this. "This leads us to the conclusion that in the case of acoustic hallucination, it is not a matter of a disturbance

of perception but of the relationship of a person to the other – of the intersubjectivity."

In his concluding statements, Professor Doerr-Zegers gave a call to biological psychiatry to incorporate these ideas into research practice: "The current psychiatry – so-called 'biological psychiatry' – has to direct its look to phenomenology for rising to the challenge of the complexity of its object: the mentally ill human being."

**The workshop 'Person-centred psychiatry: practical guidelines to explore what it is like to suffer from mental disorder' takes place in Uranie from 10:00 till 11:30 this morning.**

#### References

1. Rümke HC. [Clinical differentiation within the group of schizophrenias](Article in German). *Nervenarzt*. 1958;29(2):49-53.
2. Zutt J. *Aus dem Weg zu einer anthropologischen Psychiatrie*. Berlin/Göttingen/Heidelberg, Springer. 1963.
3. Doerr-Zegers O et al. Disturbances of Embodiment as Core Phenomena of Depression in Clinical Practice. *Psychopathology*. 2017;50(4):273-81.

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**Plenary lecture: High risk and resilience studies** Athena Monday 11:45

# Danish high risk and resilience studies

## Targeting the early years

**M**erete Nordentoft (Research Unit at Mental Health Center Copenhagen; iPsych - The Lundbeck Foundation Initiative for Integrative Psychiatric Research; University of Copenhagen, Denmark) presents knowledge in prevention, care and research gleaned so far from the Danish high risk and resilience study (VIA 7)<sup>1</sup> during her plenary lecture this morning at EPA 2018.

This representative nationwide cohort study is a close collaboration with the Research Department P at Aarhus University Hospital Risskov & Aarhus University, and the Child and Adolescent Mental Centre Copenhagen. It was initiated in 2013, since then establishing a cohort of 522 7-year-old children and their parents, recruited on the basis of one parent, both parents, or neither having been diagnosed with schizophrenia spectrum psychosis or bipolar disorder. The study's aim was to analyse the influence of genetic risk and environmental factors.<sup>1</sup>

Professor Nordentoft has played a leading role in the development and implementation of early intervention services in Denmark and initiated the VIA 7 study, which is currently at the stage of reassessing its cohort of children at the age of 11, along with their parents. Professor Nordentoft is also involved in the Integrative Psychiatric Research (IPSYCH) consortium, which has generated genomic data that will be linked with environmental aetiologies for a number of severe mental disorders<sup>2</sup>.

It is known that individuals whose parents have mental disorders are themselves at a higher risk of becoming mentally ill, Professor Nordentoft told *EPA Congress News* – not only of developing the same



*"There are a lot of risk factors, and it is difficult because they are not always very specific."*

Merete Nordentoft

disorder as their parent or parents, but others too: "We have looked into register based information about these children, and we can see that they have approximately twice as high a risk of getting child psychiatric disorders compared to children whose parents do not have any mental illness. The most

common mental disorders in childhood among these at high risk is anxiety and ADHD. And if both parents have a mental illness, the risk goes up again."<sup>3</sup>

In such children, unspecific symptoms such as neurodevelopmental delays, cognitive deficits and social adversities, are more common<sup>3</sup>. Professor Nordentoft stressed that clinicians should be aware of and address the issues of children of people in psychiatric treatment: "It could be that they already have developed a mental disorder, but it could also be that the children are

vulnerable more generally.

"We know that they have cognitive challenges – not every child, but on average they have a poorer level of cognitive functioning. We also know a lot about their conditions: many of them live in less stimulating home environments.

"It is needed for all the psychiatric services and the services in municipalities to focus on these children, who might need some help and whose parents might need help too. Also, the children would like to know and understand, at least at certain age, what kind of problems their parents have and how to deal with them."

These are very immediate clinical measures. In the longer term, it will be crucial to understand how these at-risk children will develop throughout their teen years – during which period illnesses such as schizophrenia and bipolar disorder can precipitate.

Indeed, the characterisation of early markers of psychiatric disorder is one objective of Professor Nordentoft's work. Last year, she and colleagues published on the presence of abnormalities in fine motor function and balance in children

*"It is needed...to focus on these children who might need some help and whose parents might need help too."*

Merete Nordentoft

with familial risk of schizophrenia<sup>4</sup>. Furthermore, she explained, more of them experience psychiatric symptoms, psychosis-like symptoms like sudden voices or visions, as well as impairments in language and other areas<sup>5</sup>.

"There are a lot of risk factors, and it is difficult because they are not always very specific," she continued. "For instance, there are

*Continued on page 14*

### References

1. Thorup AEA et al. The Danish High Risk and Resilience Study – VIA 7 - a cohort study of 520 7-year-old children born of parents diagnosed with either schizophrenia, bipolar disorder or neither of these two mental disorders. *BMC Psychiatry*. 2015;15:233.
2. Pedersen CB et al. The IPSYCH2012 case-cohort sample: new directions for unravelling genetic and environmental architectures of severe mental disorders. *Molecular Psychiatry*. 2018;23:6-14.
3. Thorup AAE et al. Incidence of child and adolescent mental disorders in children aged 0-17 with familial high risk for severe mental illness - A Danish register study. *Schizophr Res*. 2017 Nov 10. pii: S0920-9964(17)30686-2.
4. Burton BK et al. Impairments of motor function among children with a familial risk of schizophrenia or bipolar disorder at 7 years old in Denmark: an observational cohort study. *Lancet Psychiatry*. 2017 May;4(5):400-408.
5. Ellersgaard DE et al: Psychopathology in 7-year-old children with familial high risk of developing schizophrenia spectrum disorders or bipolar disorder –The Danish High Risk and Resilience Study – VIA 7; a population based cohort study *World Psychiatry*, in press

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## Danish high risk and resilience studies

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a lot of the children who have difficulties with motor function. This is not something that is only specific to children who later on develop schizophrenia. But we can identify that it is a vulnerable group. If we learn more about it maybe we can

find out if they have difficulties in several areas. This is the long-term perspective."

Professor Nordentoft and colleagues are one of several groups now working brain imaging into their longitudinal study. "If some are going to develop schizophrenia

or bipolar disorder, it will happen most likely in their teenage years," she said, concluding: "We scan them when they are 11 years old and we will follow them prospectively. That will give us more insight about what happens in the brain when children get ill."

**Professor Nordentoft delivers 'High Risk and Resilience Studies: Lessons for Prevention, Care and Research' today in Athena between 11:45 and 12:30.**

**State of the art: Advances in (adolescent) eating disorder** Hermes Monday 15:00

# Eating disorders

## Evidence and new approaches

**Treatment for 'food addiction', support for carers and early diagnosis are some new approaches to treating adolescent eating disorders.**

**J**anet Treasure, Professor of Psychiatry and Director of the Eating Disorder Unit at the Institute of Psychiatry, King's College London, and the South London Maudsley Hospital, told *EPA Congress News* about newer strategies for dealing with specific eating disorders and stressed the importance of early intervention and family involvement in treatments.

Early intervention and family/carer involvement is key to treating anorexia nervosa, but treatment for binge eating disorder and bulimia nervosa may need targeted treatments for food addiction similar to substance misuse strategies, explained Professor Treasure.

Summarising evidence of the most effective options currently in use, and newer approaches, she said: "Progress is slow, treatment takes time, and there has been little investment in research. There have been studies suggesting that early discharge to day care or family-based treatment is as good as protracted inpatient

care for adolescents<sup>1</sup>. People have been trying new training approaches – cognitive remediation<sup>2</sup>, cognitive bias training<sup>3</sup>, exposure<sup>4</sup> and training families<sup>5,6</sup> – but studies are small."

In anorexia nervosa, early intervention and treatments can improve the course of the illness, she stressed, but without effective early management profound physical and psychosocial consequences develop, and the illness has a chronic course with high morbidity and mortality. "Recovery from an eating disorder takes time.

A recent longitudinal study reported a recovery rate in adults of only 31% at 9 years and 62% at 22 years.<sup>7</sup>

"Whereas the recovery rate within a year from presentation is higher at between 35 and 45% in adolescents treated early<sup>8</sup>. A small study found that once three years or more of untreated illness had elapsed the response to treatments is poor even in those with an early onset."

### Recovery from anorexia nervosa

Professor Treasure acknowledged that engagement of the individual in treatment can be difficult, and that patients prefer outpatient psychological therapy which has a focus on socio-emotional and cognitive management over drug treatments and nutritional advice.

"A form of early intervention in which the family is involved to support eating

inpatient care for severe anorexia nervosa with high medical risk improved weight and give carers respite. "Clinical assessment, skilful engagement with the family and patients and determining patient preferences is of paramount importance. Treatment planning is complex and will include an accurate assessment and formulation of the patient needs.

"There are many 'known unknowns' in this field. The areas of uncertainty are how to reduce the period of untreated illness and how to support individuals with a protracted illness.

"Providing families with information and skills has potential as an early intervention. Approaches

which focus on remediating the physical such as osteoporosis, cognitive, emotional and social consequences of enduring illness are in the process of development."

Researchers at King's College London have also developed support and education for carers of patients with anorexia nervosa, including an intervention programme which has been since adapted into a workshop, a self-help

book, a DVD and a clinical handbook, said Professor Treasure.

The programme is based on a model that proposes that carer anxiety is mirrored by patient anxiety, which in turn produces more eating disorder symptoms. The model doesn't emphasise the role of weight and shape-related factors, but instead teaches carers to use reflective listening to reduce confrontation and to side step resistance. This was developed into the New Maudsley Method or Collaborative Core Skill Training.<sup>9</sup>

"Patients held positive attitudes towards involving carers in their care. The skills training approach also had positive effects on anorexia inpatients," said Professor Treasure.

### Bulimia nervosa and binge eating disorder treatment

Increasing number of people in the UK were diagnosed with bulimia nervosa (BN) in the 1980s and binge eating disorder (BED) in the new millennium. This increase in eating disorders parallels the worldwide increase in the prevalence of obesity.

"Fatness is stigmatised and 'fat talk' is associated with body dissatisfaction and abnormal eating prac-

*"Progress is slow, treatment takes time, and there has been little investment in research."*

Janet Treasure



**State of the art: Advances in (adolescent) eating disorder** Hermes Monday 15:00

tices, while thinness and muscularity are valued as the ideal body form," said Professor Treasure.

Professor Treasure says current treatments for BN and BED are only moderately effective with 30 to 50% of individuals achieving complete abstinence at the end of treatment, and a 68% remission rate at nine years follow-up.

"This suggests the transdiagnostic model that underpins cognitive behavioural therapy may require modification to accommodate the diverse eating patterns and weight across the eating disorder spectrum,"

says Professor Treasure.

New research<sup>10</sup> recently published by Professor Treasure proposes an updated model of BN and BED, stemming from the food addiction hypothesis. She said animal studies have demonstrated that manipulations of the food environment can produce 'binge eating'. Putative risk factors including a period of undernutrition followed by the intermittent addition of palatable food (high sugar and fat combinations), and stress (particularly social stress).

"Food addiction implies that there is a process of

neuroadaptation – learning which leads to craving and tolerance," explained Professor Treasure. "It follows from this model that certain foods may have an addictive potential because of a similar change in the pharmacokinetics of glucose (rapid glucose flux) and possibly fat metabolism.

"For example, foods with a high glycaemic load have the potential to cause greater fluxes in blood glucose. A survey examining the addictive potential of different foods found that

technologically processed foods with added refined carbohydrate and fat and / or with a higher glycaemic load were most implicated."

Professor Treasure said that recurrent binge eating of foods high in fat and sugar has been associated with desensitisation of opioid and dopamine receptors. This pattern mimics the neural underpinning of tolerance and dependence observed in substance use disorders.

"Greater recognition of the similarities in neural processes observed in binge-type eating disorders and substance addiction may facilitate the development of new treatments that target critical maintenance factors," she said.

Professor Treasure recommended several possible treatment targets for food addiction including: recommending patients avoid and abstain from technologically-modified foods that trigger overeating, or to manage them in a way that reduced harm rather than encouraging an absolute no dieting approach. Other treatments she mentioned included strategies to counteract impulsivity and habitual pattern of responding, using computerised approaches and virtual reality. New drugs which target the sensitisation to food cues, while preventing receptor tolerance triggered by binge eating, could also be used.

Other possible treatment models include developing positive anxiety management and coping mechanisms to deal with high levels of stress and reward seeking behaviour.

More research is needed though, and Professor

Treasure identified several areas to focus on including: discovering the most relevant 'food approach traits' determining susceptibility to BN or BED; the most relevant food avoidance traits; identifying behavioural interventions that would be most effective for breaking the automatic stimulus response association and finding out which drug treatments would be effective in curbing recurrent binge eating behaviour.

**Professor Treasures delivers her State of the art lecture today in Hermes from 15:00 until 15:45.**

**References**

1. Herpertz-Dahlmann B. Adolescent eating disorders: update on definitions, symptomatology, epidemiology, and comorbidity. *Child Adolesc Psychiatr Clin N Am.* 2015 Jan;24(1):177-96.
2. Tchanturia K et al. Cognitive remediation therapy for anorexia nervosa: current evidence and future research directions. *Int J Eat Disord.* 2013 Jul;46(5):492-5. doi: 10.1002/eat.22106.
3. Cardi Vet al. A preliminary investigation of a novel training to target cognitive biases towards negative social stimuli in Anorexia Nervosa. *J Affect Disord.* 2015 Dec 1;188:188-93.
4. Steinglass JE et al. Confronting fear using exposure and response prevention for anorexia nervosa: A randomized controlled pilot study. *Int J Eat Disord.* 2014 Mar;47(2):174-80.
5. Magill N et al. Two-year Follow-up of a Pragmatic Randomised Controlled Trial Examining the Effect of Adding a Carer's Skill Training Intervention in Inpatients with Anorexia Nervosa. *Eur Eat Disord Rev.* 2016 Mar;24(2):122-30.
6. Hodson J et al. A Pilot, Multicentre Pragmatic Randomised Trial to Explore the Impact of Carer Skills Training on Carer and Patient Behaviours: Testing the Cognitive Interpersonal Model in Adolescent Anorexia Nervosa. *Eur Eat Disord Rev.* 2017 Nov;25(6):551-561.
7. Eddy KT et al. *J Clin Psychiatry.* Recovery From Anorexia Nervosa and Bulimia Nervosa at 22-Year Follow-Up. 2017 Feb;78(2):184-189.
8. Lock J et al. Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Arch Gen Psychiatry.* 2010 Oct;67(10):1025-32.
9. Sepulveda AR et al. An examination of the impact of "the Maudsley eating disorder collaborative care skills workshops" on the well being of carers: a pilot study. *Soc Psychiatry Psychiatr Epidemiol.* 2008 Jul;43(7):584-91.
10. Treasure J et al. Are trans diagnostic models of eating disorders fit for purpose? A consideration of the evidence for food addiction. *Eur Eat Disord Rev.* 2018 Mar;26(2):83-91.

*"Fatness is stigmatised and 'fat talk' is associated with body dissatisfaction and abnormal eating practices."*

Janet Treasure



# New era of earlier diagnosis and treatment ahead for patients with bipolar disorder

**E**duard Vieta, a leading authority on bipolar disorder from the University of Barcelona, Spain, told the Congress yesterday that psychiatry is entering a new era in the treatment of bipolar disorder with earlier diagnosis, precision psychiatry and new technology, as well as patients and families, set to play increasingly important roles.

Earlier intervention in bipolar disorder may help to change outcomes of the illness and avert potentially irreversible harm to patients. Earlier phases may be more responsive to treatment and need less aggressive therapy, Professor Vieta told *EPA Congress News*. "Early intervention in bipolar disorder is gaining momentum. Current evidence from longitudinal studies indicates parental early onset bipolar disorder is the most consistent risk factor for bipolar disorder.

"There are also identifiable risk factors that influence the course of bipolar disorder, some of them potentially modifiable. Valid biomarkers or diagnostic tools to help clinicians identify individuals at high risk of conversion are still lacking, although there are some promising early results."

Professor Vieta said current research supports the idea of an at-risk state in bipolar disorder, laying the foundations for bringing early intervention to fruition. "We cannot deny however that further efforts are required to advance on the difficult road of primary prevention.

"Given that psychiatric and commonly comorbid medical disorders share common risk determinants and operative biological pathways, a shared framework for disease prevention and control is warranted."

As such, a cross-disciplinary, multi-target approach is essential for wide-scale implementation in real-world settings, with an unquestionable need for new prospective studies with a larger sample size and standardised recruitment criteria and assessment tools.

Professor Vieta explained that such studies should assess the validity of the proposed predictive factors, to better determine which individuals are at highest risk for conversion and therefore more likely to benefit from early interventions. Further studies on early psychological and pharmacological interventions, either alone or in combination, are equally warranted.

"In conclusion, considering that the onset of bipolar disorder usually occurs during adolescence – a period of personal, social, and professional development that is often truncated by the illness – introducing early interventions in psychiatry is imperative."

He went on to say that one of the critical changes of the paradigm is the emerging involvement of families in the diagnostic and therapeutic processes. "Time is over for paternalistic medicine. Patients want to know and want to decide. What they want is 'my life back', with more focus on social functioning than on symptoms."

He then highlighted research by the ENIGMA consortium's bipolar branch, which produced map-

ping of the bipolar brain showing the structural changes of patients with bipolar disorder compared to controls, showing grey matter loss in some key regions<sup>1,2</sup>.

He also suggested that pharmacogenetics will become increasingly important. He cited the ConLiGen consortium<sup>3</sup> that recently published a large genome-wide association study identifying a single locus of four linked single nucleotide polymorphisms on chromosome 21 met genome-wide significance criteria for association with lithium response.<sup>4</sup>

"An example is the increasing

role of biomarkers and, for example, pharmacogenetic tests. In a few years I anticipate that these items will become increasingly important to give support to clinical diagnosis and treatment."

"Psychiatry will become more technical, but the sensible empathic and expert clinician will always be necessary. The new developments in bipolar disorder will require that clinicians are totally up-to-date and ready to embrace innovation."

## References

1. Hibar DP et al. Subcortical volumetric abnormalities in bipolar disorder. *Mol Psychiatry*. 2016 Dec;21(12):1710-1716.
2. Hibar DP et al. Cortical abnormalities in bipolar disorder: an MRI analysis of 6503 individuals from the ENIGMA Bipolar Disorder Working Group. *Mol Psychiatry*. 2017 May.
3. The International Consortium on Lithium Genetics (ConLiGen). <http://www.conligen.org> (accessed Feb 2018).
4. Hou L et al. Genetic variants associated with response to lithium treatment in bipolar disorder: a genome-wide association study. *Lancet*. 387(10023): 1085-1093.

*"Time is over for paternalistic medicine. Patients want to know and want to decide."*

*Eduard Vieta*





**RTMS for depression in Europe - It's time for approval from health authorities** Uranie Monday 15:00

# rTMS in treatment-resistant depression: overdue for reimbursement in France

**R**epetitive transcranial magnetic stimulation (rTMS) is of growing importance in the treatment of diverse psychiatric diseases<sup>1</sup>. For patients with treatment-resistant depression, rTMS has been approved in the US. In Europe, rTMS is increasingly used in some but not all countries, with several devices receiving CE marking<sup>2</sup>. Yet its use is not supported by routine reimbursement by healthcare systems in countries including France, despite its use both in psychiatric research and routine clinical care in the public and private sectors<sup>3</sup>.

In such a situation, said Anne Sauvaget to *EPA Congress News*, completing the transition from bench to bedside requires a collaborative effort between clinicians and health economists. "The idea of the symposium was to expose the economic and political issues of rTMS in Europe – and [specifically] for me in France, because I can't speak for other countries."

rTMS is not presently officially recognised by the French health authorities, she explained, which has created a contradiction between guidances<sup>4</sup> and what clinicians are able to deliver to their patients. Moreover, investment into rTMS systems will be worthwhile for hospitals only once it gains official status.

"I am part of the French Association of Biological Psychiatry and Neuropsychopharmacology (AFPBN; <http://www.afpbn.org>), working with the section of this society involved in non-invasive brain stimulation. It is very important that [we provide] scientific and economic [data] for the ministry of health, to help rTMS be recognised.

"That is why, with some colleagues from my hospital, we evaluated the cost for a hospital of a treatment with rTMS for depression<sup>5</sup>. For us, this economic work was the first step in providing data to authorities that the treatment has an average cost of €2,000. For France, this is not a very expensive treatment compared to, for example, cancer or hepatitis treatment. And according to scientific literature, rTMS is an effective treatment for depressed patients. So it is very important that this treatment is reimbursed to avoid future treatment resistance, recurrence and also suicide for patients suffering from mood disorders."

The methodology of this economic analysis was developed with all aspects of a rTMS session in mind. Validated by a multidisciplinary task force (of clinicians, public health doctors, pharmacists, administrative officials and a health economist), the analysis included in its remit cost of equipment, staff, and operational overhead costs. In this way, an effective treatment dura-



*"If we want to support our patients with energy, we clinicians have to be interested in economic health issues, and work with health economists."*

Anne Sauvaget

tion of 15 sessions was found to cost €1,932.94 (€503.55 for equipment, €1,082.75 for staff, and €346.65 for overhead expenses).<sup>5</sup>

"We tried to build a methodology as clear as possible," said Dr Sauvaget, adding that this study is more comprehensive than the few that appear in the literature. Notably, most economic analyses compare TMS to electroconvulsive therapy (ECT), with basic cost analysis in TMS lacking.

Asked how she would like these data to be taken forward, Dr Sauvaget said: "It would be very interesting if, for example, a private clinic could conduct the same methodology, or another university hospital, just to compare if we have done it well. But as far as I know, no other people have conducted a similar study in France."

She concluded with reference to the title of

her presentation during this session, 'A challenge for clinicians', an acknowledgement of the difficulties of getting involved in health economics in the absence of formal training. "If we want to support our patients with energy, we clinicians have to be interested in economic health issues, and work with health economists to conduct strong scientific work to be taken seriously by administrative officials."

**The Symposium, 'RTMS for Depression in Europe - It's Time for Approval from Health Authorities' takes place this afternoon in Uranie between 15:00 and 16:30.**

## References

1. Guo Q et al. Updated Review on the Clinical Use of Repetitive Transcranial Magnetic Stimulation in Psychiatric Disorders. *Neurosci Bull.* 2017 Dec;33(6):747-756.
2. Lefaucheur JP et al. Evidence-based guidelines on the therapeutic use of repetitive transcranial magnetic stimulation (rTMS). *Clin Neurophysiol.* 2014 Nov;125(11):2150-206.
3. Etcheverrigaray F et al. [Treating depression with repetitive transcranial magnetic stimulation (rTMS): Which repayment of a leading activity in psychiatry?]. [Article in French] *Rev Epidemiol Sante Publique.* 2017 Jun;65(3):241-246.
4. Charpeaud T et al. [French Society for Biological Psychiatry and Neuropsychopharmacology and Fondation FondaMental task force: Formal Consensus for the management of treatment-resistant depression]. [Article in French] *Encephale.* 2017 Sep;43(4S):S1-S24.
5. Etcheverrigaray F et al. [Hospital production cost of repetitive transcranial magnetic stimulation (rTMS) in the treatment of depression]. [Article in French] *Rev Epidemiol Sante Publique.* 2015 Aug;63(4):268-74.

**Chronic pain and risk of addiction** Erato Monday 8:00

# Intimately connected

## Pain, psychiatry and addiction

The focus is on addiction in chronic pain, during a session that sees discussion of pharmaceutical pain management, prudent prescription amid fears of opioid crisis, and the associations between pain and alcohol use.

Arnt Schellekens, psychiatrist at the Medical Psychiatric Inpatient Unit of Radboud University Medical Centre (the Netherlands) and Scientific Director of the Nijmegen Institute for Scientist Practitioners in Addiction, co-organised the symposium.

"Attending this session will provide insight in the current trends in opioid prescriptions in Europe and how to prevent and treat iatrogenic opioid use disorders, without throwing away the child with the bath water," he said during an interview with *EPA Congress News*.

"We will focus on the intimate connection between pain and psychiatry, and addiction in particular. One important question is whether the epidemiology of opioid prescriptions in Europe will follow the dramatic opioid epidemic in the US and Canada."

Such discussions are highly topical – steps on prevention of such a European epidemic must be taken: "We also see the number of opioid prescriptions rising in Europe. However, opioids are excellent analgesics and a rise in prescriptions is not necessarily problematic," he said. "In order to prevent us following the US scenario, this is the moment to take action and to be keen on prevention and treatment."

Delegates will also learn about the assessment of risk of development of opioid use disorders in patients with pain, which may be a useful preventative measure. The session will also address which treatment options are available once opioid use disorders have developed, noted Dr Schellekens, as well as the analgesic properties of alcohol.



*"It might not be a coincidence that mood disorders frequently co-occur in chronic pain patients."*

Arnt Schellekens

Addiction is a speciality of Dr Schellekens's department, which also has a strong research focus. Indeed, Dr Schellekens recalled a case that prompted much of the work that's going on at present: "A couple of years ago we were confronted with the first patient with severe iatrogenic opioid use disorder, combined with chronic pain," he said.

The patient had been admitted to various departments within the hospital, had undergone repeated operations and experienced rather dramatic complications, including a cardiac thrombus, he explained.

"She was finally admitted to my ward, where we successfully substituted her opioids, stabilising both her physical and mental condition."

After publishing a paper on this particular case<sup>1</sup>, Dr Schellekens and colleagues decided to set up a network to help patients with chronic pain and addiction. "We set-up a research line on this topic with our colleagues from anaesthesiology, the pharmacy, and addiction care," he explained. "Now we are running a clinical trial on buprenorphine<sup>2</sup> and established a regional pain consortium with general practitioners to prevent an opioid epidemic such as is taking place in the US and Canada."

Several interventions will be necessary to ensure that such an

*"It is important to personalise opioid treatment based on the risk profile of patients to develop opioid use disorders."*

Arnt Schellekens

epidemic does not precipitate in Europe, he explained: "It is crucial to further implement opioid guidelines in order to stimulate adequate or appropriate use of opioids."

"Furthermore, it is important to personalise opioid treatment, based on the risk profile of patients to develop opioid use disorders."

One example of this may be to prescribe buprenorphine instead of full opioid agonists, he said. "From a scientific point of view, it is very intriguing what the added value is of buprenorphine over full agonists in this group, and especially, why? Is it the partial agonist profile of this compound? Or is it for example its activity on the kappa opioid receptor?"

The latter might be of importance beyond the group patients with chronic pain, he suggested, since the kappa-opioid receptor has shown relevance for other addictive behaviours and even mood disorders. "It might not be a coincidence that mood disorders frequently co-occur in chronic pain patients and are associated with problematic opioid use in this group. As such, this field is of interest for psychiatry as a whole."

**The symposium 'Chronic pain and risk of addiction' takes place in Erato from 8:00 to 9:30 this morning.**

#### References

1. Reifenschweiler DOH et al. Treatment of iatrogenic opioid dependence, excellent results using buprenorphine/naloxone. *Nederlands Tijdschrift voor Geneeskunde*, 2013;157: A6439.
2. Effectiveness of Buprenorphine/Naloxone in Patients With Chronic Pain and Iatrogenic Opioid Dependence. *ClinicalTrials.gov*. <https://clinicaltrials.gov/ct2/show/NCT02882412> (accessed Feb 2018).



**New perspectives in negative symptoms: a transnosographic approach...** Thalie Tuesday 13:15

# Negative symptoms: new perspectives

A transnosological approach to diagnose and treat negative symptoms across psychiatric disorders will be addressed tomorrow afternoon at the EPA Congress. The session is opened by Armida Mucci, Associate Professor of Psychiatry at the University of Campania Luigi Vanvitelli, Naples, and head of the university's Psychotherapy unit.

Professor Mucci introduces the implications of cross-diagnostic conceptualisation of negative symptoms. With 25 years of clinical experience in treating patients with schizophrenia and other psychotic disorders, she is also Secretary of EPA Section on Schizophrenia, and a member of the ECNP Network on Schizophrenia.

"I have collaborated on all main clinical and research activities of the Centre for Psychotic Disorders in Naples (led by EPA President Silvana Galderisi), with a focus on cognitive dysfunctions and negative symptoms in schizophrenia," she said.

Professor Mucci will be addressing domains related to reduced motivation and interest, such as avolition, anhedonia, and asociality (reduced interest and involvement in work, school or pleasurable activities and reduced drive for social bonds). She will also cover the domains relevant to impaired expressive functions, such as blunted affect and alolia – the reduction of spontaneous speech, especially in social situations.

"These symptoms can be primary or secondary to other factors," she said. "For example, they may indicate depression and if we treat depression the negative symptoms will improve.

"They may indicate psychotic symptoms, where a

person does not want to see friends because of ideas of persecution," she said.

However, such symptoms may simply be side effects

of medications, and hence can be ameliorated by reduction of the dose or change in the prescribed drug.

They may also be an indicator of environmental factors, such as isolation, said Professor Mucci.

"Secondary negative symptoms are amenable to treatment in most cases, while primary negative symptoms do not respond to the main antipsychotics or to other drugs," she continued. "For these symptoms, new pharmacological and psychological treatments are being developed and need further testing."

Professor Mucci's talk will review and discuss the latest data on the prevalence of negative symptoms in people with schizophrenia or other psychotic disorders, in subjects at risk of psychosis and in those with non-psychotic depression. "I will show that across diagnostic categories, negative symptoms are associated with poor real-life functioning, particularly with interpersonal problems," she explained. "In subjects at risk, the presence of negative symptoms of moderate severity, particularly avolition, which persist over the first year of follow-up, predicts conversion to a psychotic disorder. In subjects with depression, negative symptoms are associated with earlier age at onset and poor response to treatment."

*"Psychiatrists are less skilled in assessing [negative] symptoms with respect to psychotic or depressive symptoms."*

Armida Mucci



Her research in this area is broad. She has collaborated with the Italian Network for Research on Psychoses, which is led by Professor Mario Maj. "The Italian Network carried out the largest study to date on factors influencing real-life functioning of subjects with schizophrenia," she explained. "Within that study, I contributed to the introduction of second-generation instruments for the assessment of negative symptoms and to the standardisation of the MATRICS Consensus Cognitive Battery in Italy."<sup>1</sup>

Indeed, the latest publication of the Italian Network is a complete review of the challenges of the field, said Professor Mucci: "We have looked at which negative symptom domain has an impact on functioning, together with many other factors, using an innovative method – network analysis."<sup>2</sup>

Such assessment is vital for psychiatrists said Professor Mucci: "Given the impact of negative

symptoms on functioning and quality of life, it is important that psychiatrists learn how to assess them," she said. "Unfortunately, psychiatrists are less skilled in assessing these symptoms with respect to psychotic or depressive symptoms."

Indeed, the EPA Section on Schizophrenia organised an EPA Itinerant course on the assessment of negative symptoms. Professor Mucci held the course in Banja Luka, Bosnia-Herzegovina last year to disseminate information on its importance. "The assessment has clinical implications, as the recognition of secondary negative symptoms will improve the treatment and outcome of affected subjects," she explained. "In the symposium I will give an update of assessment instruments developed to improve the evaluation of these symptoms."

There may be a wealth of interventions today, but more needs to be done, she concluded: "The main challenge is to understand better the pathophysiology of

primary negative symptoms to develop effective treatments.

"With this aim in mind, research must adopt the new instruments to assess negative symptoms and researchers must carry out longitudinal studies.

"I would like to see more research funding for this issue, increased awareness in psychiatrists and all stakeholders about these symptoms and the need to improve how we recognise, assess and treat them. I hope the symposium will stimulate the discussion of this issue."

**'New perspectives in negative symptoms: A transnosographic approach to diagnosis and treatment' will be held tomorrow between 13:15 and 14:45 in Thalie.**

## References

1. Mucci A et al. The Brief Negative Symptom Scale (BNSS): Independent validation in a large sample of Italian patients with schizophrenia. *Eur Psychiatry*. 2015 Jul;30(5):641-7.
2. Galderisi S et al. Interplay Among Psychopathologic Variables, Personal Resources, Context-Related Factors, and Real-life Functioning in Individuals With Schizophrenia: A Network Analysis. *JAMA Psychiatry*. 2018 Feb 14.

# A paradigm shift in neuropsychiatry

New approaches to advancing drug development for the treatment of neuropsychiatric disorders will be outlined in this afternoon's joint ECNP-EPA symposium. The session will look at the applications of neuroimaging in this area, as well as novel methods for investigating drug effects using human models of emotional processing.

Martien Kas, Professor of Behavioural Neuroscience at the University of Groningen (the Netherlands) will talk about the latest work of a major EU project he coordinates, the Psychiatric Ratings using Intermediate Stratified Markers (PRISM) project.

PRISM will look at integrated translational approaches in psychiatric research, he explained to *EPA Congress News*: "We have seen a stagnation in the development of new drug targets for psychiatric disorders. This project puts forward a paradigm shift to accelerate drug discovery and treatment. The idea is to cluster patients on the basis of quantitative biology rather than on diagnostic criteria in order to accelerate drug discovery and treatment."

Traditionally, patients have been classified on the basis of DSM criteria, said Professor Kas. PRISM aims to cluster patients not on the basis of their initial DSM diagnosis, but on quantitative biological meas-

ures that are closer to the origin of the disease. Such measures might include EEG, imaging or behavioural assessments.

"We are assessing a whole range of biological measures within specific domains that are seen across disorders rather than in any specific disorder," he explained. For example, social withdrawal is seen

*"We are one of the first to practically implement this new paradigm in a proof of concept study."*

Martien Kas

not only in schizophrenia, but also in Alzheimer's disease and major depression. "We try to zoom in and cluster those patients according to quantitative biological measures within those domains, and see whether we can get more homogeneous clusters of patients based on biology."

Social withdrawal is a major burden to patients and their caregivers, said Professor Kas. "There is not really a treatment that can take away the burden and the suffering from withdrawal," he said. "In schizophrenia it may be one of the

earliest symptoms, so much closer to the origin of the disease."

The PRISM group is looking to understand the underlying biology of these domains, he explained. "We are looking at a different level of biology that has not been done before. For example, is there a particular neural circuit that is driving sensory processing deficits in certain patients? Is that particular circuit specific for a group of patients (within schizophrenia, say), is this relevant across different disorders, or is this seen in a wider group of patients irrespective of clinical diagnosis?"

During the symposium, Professor Kas will outline an ongoing exploratory clinical proof-of-concept study that is taking place across Europe, looking at critical patient clusters across Alzheimer's disease and schizophrenia. At the moment, the group has identified the measures that will be used. Currently, patient recruitment is underway.

And animal models are being developed concurrently: "We will implement phenotyping of biological measures in rodents that are homologous to those assessed in our clinical study," said Professor Kas. "So by the time we have identified those measures that are critical for

this patient clusters, we will be able to continue to study the underlying biology using those homologous phenotypes in animals. That is why this is a novel integrated translational approach with back-translation of human findings to rodents."

He added: "Rather than developing animal models for schizophrenia, we are going more in the direction of animal models for sensory deficits which may be underlying some elements of social withdrawal."

Many will be watching the outcome of this innovative approach, said Professor Kas. PRISM is funded by the Innovative Medicines Initiative (IMI), which calls for a reclassification of diseases based on their root cause rather than symptoms, and is also based on the recent NIH/NIMH Research Domain Criteria initiative.

"People have started to realise that to move the field further we would need novel approaches," concluded Professor Kas. "I think now both industry as well as academia has started to realise that we need novel approaches and this may be one way to go. People may have thought of this before, but I think we are one of the first to practically implement this new paradigm in a proof of concept study."

*"This project puts forward a paradigm shift to accelerate drug discovery and treatment."*

Martien Kas



**ECP Court Debate: Choose Your Career Wisely: Academia and/or Clinical Practice?** Clio Monday 17:00

# ECP Court Debate: Academia and/or Clinical Practice?

**Silvana Galderisi joins Robin Murray this afternoon to present the pros and cons of academic and clinical psychiatry practice. Professor Galderisi spoke to *EPA Congress News* ahead of the session to share her thoughts.**

**What are the positive aspects of a career in academic psychiatry, such as informing the curriculum, and directing research?**

The academic career has several advantages, including the possibility to carry out research activities, interact with colleagues from different contexts and backgrounds, and have easier access to scientific information and research instruments. In addition, teaching activities require a constant update, and offer the opportunity to interact with young students, follow their personal growth, and reconsider your knowledge and approaches with different eyes. In few words, the academic career offers lifelong intellectual stimuli. Besides this, the psychiatrist can provide clinical care, while exploring new models and tools aimed at improving her or his practice.

**What characteristics are suited to a career in academic psychiatry?**

The academic career is highly competitive, and requires a certain degree of ambition, together with a strong willingness to pursue one's own goals. The person should be interested in learning and gaining experience abroad, in challenging and stimulating environments, and prepared to ups and downs along the pathway. They should be aware of pros and cons of the academic career, and consider whether they match their personality characteristics.

**In your opinion should academic psychiatrists remain in touch with clinical practice?**

I think that clinical experience is an important, fundamental pillar of sound research and teaching activities. Combining experience in both fields results in cross-fertilisation and gives the chance to remain on the cutting edge of clinical knowledge. However, this requires time and effort.

**When we talk about making a wise choice of career, what role does timing play in terms of moving into academia?**

It very much depends on the context. Gaining experience in settings different from academia can be very useful; indeed, there are contexts

in which you can gain clinical experience also in the academic setting.

**Would you say that there are sufficient numbers of psychiatrists today that are trained in scientific methods?**

The number of psychiatrists trained in neuroscience is increasing, but still low. Their presence in neuroscience research is very important, especially to provide an input on the choice of clinical correlates of neurobiological indices, but also on clinically relevant questions the research programs need to address.

**The recently-published *Women in Academic Psychiatry*<sup>1</sup> discusses the experiences of a number of leaders in the field and what led to their success.**

**What is your advice to women?**

Women are often disadvantaged in an academic career. It can be difficult to combine roles as a mother, a professional and an academic. This is why I think that women who succeed in their careers deserve a specific recognition. In addition, women tend to be more cooperative than competitive, and this might be a disadvantage in the academic environment.

**For early career psychiatrists looking towards academia, where is the biggest need? Biological psychiatry, or social?**

If you mean that biological psychiatry favours the academic career, I would agree only partially. In fact, publishing in neuroscience still is more likely to lead to a high H index than publishing in social psychiatry. However, several colleagues working in social psychiatry do achieve great results and top positions in the academia.

**Is there a need to make practising clinical psychiatrists more aware of their role as advocates or lobbyists of policy and research goals in psychiatry? Is this an argument in favour of bringing more clinicians in closer touch with the academic sphere?**

I think this is an important role of all psychiatrists, both in clinical and academic settings.

**The ECP Court Debate: 'Choose Your Career Wisely: Academia and/or Clinical Practice?' takes place in Clio between 17:00 and 18:30 today.**

**Reference:** 1. Frangou S (Ed). *Women in Academic Psychiatry: A Mind to Succeed*. Springer International Publishing. 2016.

*"Combining experience in both fields results in cross-fertilisation and gives the chance to remain on the cutting edge of clinical knowledge."*

Silvana Galderisi





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