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CME Courses

Courses

C01

Problem solving in psychopharmacotherapy using pharmacokinetic and pharmacogenetic tests

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Many problems such as non-response, pharmacokinetic interactions with clinical consequences and adverse effects (pharmacovigilance) may be observed in patients submitted to psychopharmacotherapy. These risks are increased in patients belonging to the category of "special populations": elderly patients, children and adolescents, patients with a genetic particularity of metabolism or suffering from somatic or psychic comorbidities. Pharmacokinetic and pharmacogenetic tests are useful to solve problems in psychopharmacotherapy and thus improve efficacy and safety. Therapeutic drug monitoring (TDM) is particularly recommended in situations presented above and in patients who are non-compliant. In addition, the use of generics has been shown to represent a source of unexpected treatment outcomes, and TDM may help to explain pharmacokinetic particularities after switching from an original to a generic preparation (or vice versa). Finally, the increasing knowledge of the metabolism of psychotropic drugs allows taking account of the pharmacogenetic status (e.g. cytochrome P-450, P-glycoprotein) of the patients not only in adapting their medication, but also for interpreting pharmacokinetic interactions with clinical consequences. In this respect, pharmacokinetic and pharmacogenetic tests have now also to be considered as a tool in pharmacovigilance programs.

Psychiatrists who already have experience in this field will have their knowledge updated: recent progress will be illustrated by clinical situations, which will be discussed in an interactive way. A consensus paper with recommendations on the optimal use of pharmacokinetic and pharmacogenetic tests will be summarized and submitted for discussion.

C02

Psychometric evaluation in psychiatry

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Psychiatric outcome studies (POS) of treatment with psychotherapy as well as pharmacotherapy have the following three psychometric measures in common: (a) The rating of core symptoms; (b) the global clinical assessment; and (c) the rating of social functioning or quality of life.

In the psychometric evaluation of these three outcome measures, effect size is the clinically most meaningful statistic, both in placebo-controlled and in dose-response trials.

The clinically most valid outcome scales and the use of effect size statistics will be shown with reference to the literature on POS.

C03

Clinical management of physicians with addictive and mental disorders

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Introduction: Physicians presenting with addictive behaviours and mental illness can be a considerable challenge for psychiatrists. Impaired physicians usually tend to act as doctors while eschewing the role of a patient, which can result in poor compliance, self-diagnosis and self-medication. The psychiatrist confronted with such a patient may react defensively and not take into consideration the needs of the patient. On the other hand, when appropriately handled, impaired physicians can be an enormous source of help for themselves. An appropriate setting and the therapeutic relationship are key for reaching this goal.

Educational objectives:

- To identify the basic clinical problems posed by impaired physicians.
- To provide trainees with basic skills to effectively treat impaired colleagues.
- To demonstrate how to take advantage of the patients' professional status.
- To outline the basic characteristics and functioning of a specialized program for impaired physicians.

Course description:

The contents of the course will include:

- Basic concepts: the impaired physician.
- Risk factors in the medical professions.
- Some epidemiological data: Addictive and mental disorders in physicians.

- The doctor as patient: What makes him/her different?
- Attitudes and behaviours of impaired physicians.
- The most common mistakes made by psychiatrists
- Setting problems: avoiding corridor consultations.
- How to establish a fruitful collaboration: Essential elements of the therapeutic relationship.
- Taking advantage of the patients' condition: How to use her or his expertise in a constructively and collaboratively.
- Ethical considerations: confidentiality, licensure, etc.
- Basic characteristics of a specialized service for impaired physicians.

C04

Complexity of posttraumatic reactions

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Background: Our knowledge on many aspects of posttraumatic reactions is growing so are the questions that need to be answered. Today the field of psychotraumatology is spread from neuroscience through clinical issues to the social sciences.

The structure of a course: Within the four presentations we would like to put the focus on chronic and longlasting consequences of psychotraumatisation addressing new understanding of neurobiological factors and psychological background as well as therapeutic possibilities. The multicultural aspects of psychotrauma and the consequences on rehabilitation will be presented as well.

The presentations themas are the following:

- Neurobiology of chronic and longlasting posttraumatic syndromes.
- How to understand complex PTSD.
- Multicultural aspects of posttraumatic syndromes.
- Faceing complex PTSD-wath can be done in therapy?

The aim of the course is to present advances in the field but to discuss some open questions and doubts that still exist.

C05

Interpersonal psychotherapy of depression

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Among a variety of short term psychotherapies created to treat depression IPT (Interpersonal Therapy) by Klerman et al. (1984) is meanwhile one of the most well known and widespread used approaches. A variety of studies have shown empiric evidence of its efficacy. IPT's most influential theoretical grounds are Bowlbýs attachment theory and the interpersonal school of psychiatry (Sullivan), assuming that all psychiatric illnesses incl. depression develop in an interpersonal context: problems areas in interpersonal relations may contribute to onset and potentially chronicity of current depression or/and depressive symptoms may interfere with interpersonal well being/psychosocial functioning.

Based on empirical studies on e.g. life events, social support, stress & depression the authors defined four problem areas:

1) complicated grief
2) interpersonal conflict
3) interpersonal role conflict/role transition and
4) interpersonal deficits/isolation

The therapy is divided in 3 phases: In the initial 3-4 sessions the patients current depression is individually attributed to one of the four problem areas on which will exclusively be focused on within the main therapy section. IPT works in a "here-and-now" framework and connects state and change of depressive symptoms with state and change of (realtime) interpersonal functioning and well being through therapeutic work. The dual goals of IPT are achieving symptom remission and solving attributed interpersonal problem by promoting the interpersonal skills of patients both within and outside the therapeutic setting.

Open and focused exploration, psychoeducation (patient as expert of his/her illness), the transportation of the sick role (Parsons 1954), assessment of the interpersonal inventory/interpersonal resources, instilling hope, the definition of patients and therapist role during therapy, the explanation of the IPT concept, the agreement on the problem area and a therapy contract are basic procedures within introductory sessions in IPT.

In the main period (3/4-14 sessions) patient and therapist work on explore the agreed-upon focus. The IPT manual describes goals and treatment strategies for each problem area. Clarification, self disclosure, communication analysis, option seeking etc. are main techniques in IPT.

During termination period the patient recognizes what was gained, what impairments, problems are left. The motivation for booster sessions (maintenance) is clarified and the patient is prepared about prophylaxis and how to manage crises in the future.

This CME course is meant to teach IPT basics enabling participants of the course to start practicising IPT under supervision. It will be focused explicitly on the following aspects:

- time frame
- medical model
- dual goals of solving interpersonal problems and symptom remission
- interpersonal focus on patients affective engagement solving current life problems contributing to current depression
- specific and general psychotherapeutic techniques and
- empirical support of IPT

Short role-playing will be used to train IPT techniques. A handout will be available.

C06

Mental health care of migrants

A. Qureshi, F. Collazos. *Servei de Psiquiatria, Hospital Universitari Vall D'Hebron, Barcelona, Spain*

Multiculturalism in Europe is becoming a reality that increasingly affects most every psychiatrist. Effective mental health treatment adaptations to respond to the myriad ways in which migration impacts psychosocial development, help-seeking, symptom presentation, and all aspects of diagnosis and treatment. The bulk of research and theory in transcultural psychiatry has its origins in North America, and although highly laudable, represents a different context, history, and present with regard to multiculturalism and immigration. It is in response to this situation that the Section on Transcultural Psychiatry offers the following course.

This course will be an introduction to the general themes pertinent to the effective psychiatric care of migrant patients. The first part of the course will provide attendees with a general overview of key aspects relevant to the relationship between migration, culture, minority

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status and mental health/illness, which will then serve as the basis for the second part which will be focused on psychiatric interventions. The development of Intercultural communication and the development of a strong therapeutic relationship are key for diagnosis and treatment. Errors in the diagnosis of migrant patients is all too common due to differences in symptom presentation and meaning, as well as due to psychiatrist's lack of familiarity with this population. In addition to migration, culture, and minority status, psychiatric treatment is also affected by biological and genetic differences, which are both subtle and complex. Cultural mediation is increasingly being introduced as means of bridging the linguistic and cultural gap between psychiatrist and migrant patient, however, for a variety of reasons, effective use of this resource demands that specific steps be taken and that professionals are sufficiently well trained.

The course will be in the format of lecture, case presentations and group discussion.

C07

Infant psychiatry, its relevance for adult psychiatry

M. Keren, S. Tyano. *Infant Mental Health Unit, Geha Mental Health Center, Tel Aviv University Sackler Medical School, Petach Tikva, Israel*

The aim of the course is to give adult psychiatrists some basic knowledge in infant psychiatry that has become in the recent years, very relevant to the understanding the link between brain development, early childhood experiences, pathophysiology of personality disorders in adulthood, and psychotherapeutic transferential processes.

The course will be built as follows:

The first part will cover very recent data on the impact of early experiences in general, and attachment experiences in particular, on brain development and development of a theory of mind and empathy. Concepts of resilience, vulnerability, bio-psycho-social risk and protective factors will also be explored in length. Through these basic concepts, we will show how infant psychiatry is linked to prevention of adult psychopathology, and how the early attachment experiences reflect themselves in the psychotherapeutic process.

The second part will be clinical and will illustrate the basic concepts learned in the first part. A clinical case will be presented to show the development of borderline personality disorder from early childhood to adulthood, its transgenerational transmission to the offspring through disturbed attachment relationship, and some of the processes that took place during the dyadic mother-infant psychotherapy. We will show how parenthood can become a new motivation for change.

The course applies who any adult psychiatrist who is interested in the field of developmental psychopathology, and no previous experience with young children is needed. Clinical experience with personality disordered patients will be an advantage.

C08

Delusions - diagnosis and treatment

M. Musalek. *Medical School, University of Vienna, Vienna, Austria*

Concluding the literature in definition, pathogenesis, nosological position and treatment of delusions we are confronted with a wide range of opinions. In the first part of the course the various definitory approaches and their value in clinical practice will be discussed. The main focus of second part of the course is dedicated to the manifold results concerning the pathogenesis of delusions, which showed that delusions are caused by complex interactions of various mental, physical and social factors. The choice of a particular delusional theme is determined by gender, age, civil status, social isolation, and special experiences ("key experiences") whereas the incorrigible conviction is based on cognitive disorders and/or emotional derailments and reinforced by social factors. But delusions cannot be longer reduced to psychopathological manifestations once established and therefore persisting. The delusional conviction is a dynamic process which only persists if disorder maintaining factors become active. These disorder maintaining factors are not necessarily corresponding with the delusion's predisposing and triggering factors. In the third part classificatory problems will be raised. Assumptions concerning nosology and classification of delusions have ranged from an independent nosological entity to the attribution to a certain mental disorder, to multicategorical classification models. Previous polydiagnostic studies indicate that delusional disorders are neither a nosological entity nor due to one particular disorder (e.g. schizophrenia) but represent nosologically non-specific syndromes which may occur superimoposed on all mental disorders. Most of the so-called primary delusions (or delusional disorders in a narrower sense - delusions not due to another mental disorder) have to be considered as diagnostic artefacts caused by the use of diagnostic criteria in particular classification systems. The final part of the course will focus on differentialdiagnostics and differentialtherapeutics. As delusions represent nosological non-specific syndromes with a multifactorial pathogenesis modern integrative treatment approaches (including psychopharmacological, psychotherapeutic and socio-therapeutic methods) have to be based on a multidimensional differential diagnosis of all the predisposing, triggering, and disorder maintaining factors. In this context the disorder maintaining factors provide the basis for effective, pathogenesis-oriented treatment of the actual symptomatology, whereas the predisposing and triggering factors provide informations for planning prophylactic long-term treatment.

C09

Cognitive behavior therapy in anxiety disorders

L-G. Ost. *Department of Psychology, Stockholm University, Stockholm, Sweden*

During the last 25-30 years a large number of randomized controlled studies have been published on Cognitive behavior therapy (CBT) for various anxiety disorders. CBT is now an evidence based treatment for all the anxiety disorders, and the only form of psychotherapy that has achieved this status.

The purpose of this course is to give an overview of CBT for anxiety disorders and for each of the disorders the following components will be presented: 1) The CBT model of the primary maintaining factor(s) for the disorder, 2) The most important CBT treatment(s) for the disorder, 3) Illustrations from current randomized controlled studies, and 4) Short- and long-term results for each disorder.

By attending the course participants will get the most current update of CBT for anxiety disorders.

C10

Taking care of ourselves: Managing stress, preventing burnout

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Work in psychiatry can be highly rewarding, interesting, and challenging in a positive sense. On the other hand, we are confronted

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with an array of psychosocial stressors. Caring for others lies at the heart of our profession: the focus is on the needs of patients. And rightly so. Nevertheless, this involves the risk that providers' own needs get out of sight.

This course provides a forum for openly discussing work-related stress and coping strategies. Participants will learn to recognise their own ''warning signs'' of excessive stress, as well as develop strategies to successfully handle stressful situations, based on their own practical experiences. The course further addresses consequences of stress, such as the risk to develop physical health problems or burnout. Instruments to gauge one's own burnout risk and stress coping pattern will be available for a self-assessment.

Learning goals:

- Understanding stress mechanisms and our own reactions to stress.
- Noticing one's own stress level.
- Gauging the risk for burnout: Where do I stand?
- Coping with stress: What helps?

Methods:

- Interactive teaching
- Exercises
- Group work
- Stress and burnout self assessment
- Guided discussion

Target group:

This course is open to all participants, but particularly addresses young psychiatrists. Young psychiatrists entering the field even experience elevated stressors. At the same time, starting out in the job is a good moment to develop self-care strategies – that are essential to maintain professional vitality and effectiveness in the long run.

C11

Clinical management of suicidal behaviour: From genetic to therapeutic approach

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Suicidal behaviour is a serious health problem contributed by many biological, psychological, and social factors. Besides psychotherapeutic aprroaches, psychopharmacological treatment is necessary for many suicidal patients. However, to date there is no specific treatment of suicidality.

The course will be structured in three sections. In the first section we will address the biological bases of suicidal behaviour, pointing out recent findings in molecular genetics. We will also discuss the role of the serotonergic and other neurotransmission systems in this behaviour, and the relationship between aggession, impulsivity and suicidality.

In the second section we will review psychological and clinical aspects of suicidal behaviour. Systematic clinical assessment of suicidal risk will be also discussed.

Finally, in the third section, we will go deeply in the pharmacological approaches of acute suicidality after psychosocial stress, as well as, suicidality related to psychiatric disorders, reviewing the controversial role of selective serotonin reuptake inhibitors (SSRI) in the treatment of depression in children and adolescents.

C12

How to set up an anti-stigma program

H. Stuart [1], N. Sartorius [2], J. Arboleda-Florez [1]. [1] *Queen's University, Kingston, ON, Canada* [2] *Geneva, Switzerland*

Learning Objective: At the close of this course, participants will understand the steps involved in setting up an anti-stigma program, how to anticipate and resolve some of the most common difficulties, as well how to incorporate evaluation tools as a way of monitoring program progress and outcomes.

Approach: Using a series of case presentations, course participants will work through the steps required to set up programs designed to reduce stigma and discrimination resulting from stigma. Course materials will be drawn from the World Psychiatric Association's Global Program to Fight Stigma and Discrimination Becuase of Schizophrenia. The format of the course will be highly interactive with a heavy emphasis on audience participation designed to identify, then resolve the many practical aspects of program start-up, implementation, and operation. Faculty from the course will be drawn from the WPA Global Anti-Stigma Program and will help participants work through 2-3 real-life scenarios.

References:

Sartorius N, Schulze H. (2005) Reducing the Stigma of Mental Illness. Cambridge: Cambridge University Press.

Stuart HL. (ed.) (2005) World Psychiatric Association Training Manual. How to Set Up an Anti-Stigma Program.

World Psychiatric Association, Geneva: World Psychiatric Association Global Programme to Fight Stigma and Discrimination Because of Schizophrenia.

C13

Principles of psychiatric interview: How to examine and assess personal experiences

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The aims of this Course can be summed up as follows: (1) improve the epistemological awareness of mental health professionals concerning the crucial situation of the interview, (2) provide methodological guidelines for clinicians while performing the interview, (3) provide criteria for clinicians and researchers to test the results of their interviews.

I will first shortly revise the basic tenets of the mainstream tradition, i.e. the "technical" approach to psychiatric interview, and then pass to scrutinize the large repertoire of problematic issues concerning the situation of the psychiatric interview in general, and the procedures of structured interviews in particular. The second part of the Course will be devoted to the problems arising in assessing first-personal experiences (with a special focus on psychotic experiences). Very little effort has been made until now to bring to the foreground the problem which arise in examining the psychiatric patients' subjectivity. The following are crucial questions: "Can subjectivity be made accessible for direct theoretical examination? Does each examination necessarily imply an objectivation and consequently a falsification? Which degree of falsification is acceptable?". The last part of the Course will address the issue of alternative (with respect to standard techniques) approaches to the psychiatric interview as a way to illuminate the quality of subjective experiences and behaviours, their meanings, and the pattern in which they are situated as parts of a significant whole. I will sketch

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a concurrent, phenomenologically-oriented epistemological framework for the psychiatric interview, and provide evaluative criteria.

The dispute about the family of instruments psychiatrists use or should use for assessment largely coincides with the debate about the scientific status of psychiatry. Is psychiatry in fact to be a science of the mind, or a science of something else, such as the brain or behaviour? Is it to be "science by analogy" or "physical science proper"? I will argue that the kind of science we dearly need is called phenomenology and its contribution is to complement mainstream psychopathology characterized by objectivism, emphasis on symptoms of behaviour and expression, focused on implicit biological causation and socially decontextualized symptoms. Especially the issue of contextualism is becoming particularly relevant, i.e. the role of context (cultural and historical) in knowledge, understanding, meaning and finally in assessment and classification. The phenomenological perspective, and specially the second person mode, advocates that the context of the clinical encounter should be one of co-presence (and not of dominance) whose aim is understanding (and not labelling), that is negotiating intersubjective constructs, and looking for meaningfulness through the bridging of two different horizons of meanings. This approach is relevant not only to develop the patients' self-perception, but also to rescue fringe abnormal phenomena that are usually not covered by standard assessment procedures.

C14

How to set up and evaluate a community mental health service for people with severe mentally illness

M. Tansella [1], G. Thornicroft [2]. [1] *Department of Medicine and Public Health, University of Verona, Section of Psychiatry, Ospedale Policlinico, Verona, Italy* [2] *Departments of Community Psychiatry and Health Services Research, Institute of Psychiatry, London, United Kingdom*

Educational Objectives:

The final Educational objective of this Course is to provide the methodological and practical skills to enable the participants to plan and evaluate community mental health services. In particular, the Course will: 1) provide a background knowledge on conceptual and methodological issues regarding community mental health services satisfaction; 2) summaries the main relevant research findings 3) present a summary of relevant research instruments, 4) give a paradigm to understand the relationship between service development and mental health service research.

Course methods and material:

The course will be delivered through lectures with a strong interactive element during each session. The course material will relate to the following background texts

- Knudsen H. & Thornicroft G. (1996) Mental Health Service Evaluation. Cambridge University Press, Cambridge. *(translated into Italian)*.
- Goldberg D. & Thornicroft G. (1998) Mental Health in Our Future Cities. Laurence and Erlbaum, London.
- Slade M. & Thornicroft G. et al (1999) Camberwell Assessment of Need (CAN). *(Translated into Italian)*
- Tansella M. & Thornicroft G 9 (1999) Common Mental Disorders in Primary Care. Essay in Honour of Professor Sir David Goldberg. Routledge, London. *(Translated into Portuguese)*
- Thornicroft G. & Tansella M. (1999) The Mental Health Matrix. A Manual to Improve Services. Cambridge University Press, Cambridge. *(Translated into Italian, Rumanian, Russian and Spanish)*
- Reynolds A. & Thornicroft G. (1999) Managing Mental Health Services. Open University Press, Milton Keynes. *(Translated into Italian)* (Highly Commended in BMA Medical Book Competition, 2000).
- Thornicroft G. & Szmukler G. (2001) Textbook of Community Psychiatry. Oxford University Press, Oxford. (Highly Commended in BMA Medical Book Competition, 2002)
- Thornicroft G. & Tansella M. & Thornicroft G (2001) Mental Health Outcome Measures (2nd Edition). Gaskell, Royal College of Psychiatrists, London.
- Thornicroft G (2001) Measuring Mental Health Needs (2nd edition). Gaskell, Royal College of Psychiatrist, London.
- Thornicroft G, Tansella M: The components of a modern mental health service: a pragmatic balance of community and hospital care. *British Journal of Psychiatry* 2004.
- Thornicroft G, Becker T, Knapp M, Knudsen HC, Schene AH, Tansella M *et al.*: *International Outcome Measures in Mental Health. Quality of Life, Needs, Service Satisfaction, Costs and Impact on Carers*. London: Gaskell, Royal College of Psychiatrists; 2006.
- Knapp MJ, McDaid D, Mossialos E, Thornicroft G: *Mental Health Policy and Practice Across Europe*. Buckingham: Open University Press; 2006.
- Thornicroft G: *Shunned: Discrimination against People with Mental Illness*. Oxford: Oxford University Press; 2006.
- Tansella M, Thornicroft G, Barbui C, Cipriani A, Saraceno B: Seven criteria for improving effectiveness trials in psychiatry. *Psychol Med* 2006, 36: 711-720

Target audience:

The Course is directed to psychiatrists, psychologists, social workers, psychiatric nurses, educators, and rehabilitation workers with a research interest.

Course level:

No specific knowledge is requested beside the basic professional skills.

Sponsor:

No other sponsor, except the individual teachers' universities

Course director's relationship to sponsor:

None

C15

The management of eating disorders

J.L. Treasure. *Kings College, London, United Kingdom*

This course will include a mixture of seminar based presentation of theory and evidence with time for discussion. There will also some practical based learning and video demonstrations. The course will also include demonstrations of some fundamental skills such as how to engage with a case of eating disorders introducing the skills of motivational interveiwing and motivational enhancement. The course will cover the theoretical and practical application of how models of behaviour change influence practice. Furthermore this course will help develop some of the core skills in managing people who are not ready to change. The basic principles of motivational interviewing will be discussed, demonstrated and enacted. Also there will be an introduction as to how to assess case and develop a case conceptualisation. There will also be an introduction to work with carers.

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