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Abstracts

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Bipolar disorder: keys to successful outcomes

SOA002

Bipolar disorder: keys to successful outcomes

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There was a time when there were no effective treatments for psychiatric disorders, and patients were locked in asylums. After the introduction of effective psychopharmacologic treatments, patients were discharged, and achieving symptomatic improvement was the goal. Later on, we learned that improvement was not enough, and remission became the new paradigm. The combination of pharmacotherapy and psychotherapy was aimed at that objective. Nowadays, we have become aware that even remission is not the right objective, because many patients suffer from psychosocial and functional impairment despite the absence of symptoms of the disease. This is particularly true for bipolar disorders. Thus, recovery (meaning functional recovery) is the actual goal in this condition. Hence, a number of studies have analyzed the risk factors involved in poor functional outcome in bipolar disorder. Moreover, a few more studies have focused on resilience and protective factors. Finally, the most recent clinical trials on pharmacological and psychosocial treatments have progressively introduced functional outcomes as key endpoints, yielding useful information on how to enhance the chance of functional success. Clinical factors such as male gender, older age, lower premorbid IQ, subdepressive symptoms, higher number of manic episodes and lower performance in verbal memory, working memory, verbal fluency and processing speed have been reported as associated with lower functioning in patients with bipolar disorder. Genetic and neuroimaging findings have also increased our knowledge on this matter. Novel treatments, such as functional remediation techniques, hold promise in combination with innovative pharmacotherapy and brain stimulation techniques.
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Eating disorders: from neurobiological factors involved to therapy

SOA003

Eating disorders: from neurobiological factors involved to therapy

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The framing of care pathways involved in management of anorexia nervosa have undergone many changes over time. In the 19th century it was mainly physicians who managed these cases and produced behavioural change through a change in setting. Later social and psychological formulations were introduced. The most recent paradigm shift has been driven by genetic studies which have shown correlations with metabolic as well as psychiatric and psychological disorders. These findings align with longitudinal studies which show lifetime patterns of leanness and depression and anxiety. This complex mix of somatic and neurobiological risk at a critical time of development can lead to a lethal, or enduring illness. The cognitive interpersonal model (Schmidt & Treasure, 2006) emphasises valued and visible maintaining factors which interact with the neurobiological underpinnings (Treasure & Schmidt, 2013; Treasure et al 2020). Targets for treatment can be derived from the model. For example, we have defined the consequences on close others (including health professionals) of living with the illness and characterised the intense emotional reactions and behaviours that follow. For the individual with an eating disorder, these counter-reactions can allow the eating disorder to become entrenched. Also,

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the consequent chronic stress from starvation and social pain set in motion processes such as depression, neuroprogression and neuroadaptation. Thus, anorexia nervosa develops a life of its own, resistant to treatment. In this talk I will describe some of the neurobiological foundations and how these interacts with social systems and how these can be remediated by treatment.

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