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Debate

D001

Con

Clinical/therapeutic: debate: sexual addiction: does it exist?

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It has been argued that compulsive sexual behavior (CSB) similar to pathological gambling (PG), meets the criteria for addiction. There is evidence showing that compulsive sexual behavior has the characteristics of addiction such as salience, mood modification, tolerance, withdrawal and adverse consequences. There are studies that have shown that exposure to visual sexual stimuli in individuals with compulsive sexual behavior is associated with activation of reward mechanisms similar to drug addiction. Cross-sectional studies report high rates of co-morbidity between compulsive sexual behavior and other psychiatric disorders such as depression, anxiety; Attention Deficit Hyperactivity Disorder (ADHD), obsessive–compulsive disorder (OCD) and personality disorders. However, despite many similarities between the features of hypersexual behavior and substance-related disorders there are gaps in our knowledge on compulsive sexual behavior and its treatment which precludes a definite conclusion that this is a behavioral addiction rather than an impulse control disorder. Therefore, more research is needed before definitively characterizing HD as an addiction at this time. This talk will review the empirical evidence and it will summarize the arguments against considering sexual addiction as a behavioral addiction (the cons side).

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D002

Pro

Mental health policy: debate: do we need compulsory treatments in psychiatric practice?

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Mostly based on the results of the EUNOMIA study, still the largest prospective study on the use and outcomes of coercive measures (involuntary hospitalization, mechanical restraint, forced medication, seclusion) in general hospital psychiatry ever conducted, the presentation will outline that

1. Coercive interventions are a medico-legal and clinical reality in Europe, but show significant variation across countries; further, patients' views on involuntary hospitalization also differ across sites
2. There might be a link between the extent to which national mental health legislation protects patients' rights and the extent to which patients retrospectively evaluate that their involuntary admission was appropriate
3. Patients who feel coerced to admission may have a poorer prognosis than legally involuntary patients
4. Effective treatment of positive symptoms and improving patients' global functioning may lead to a reduction in perceived coercion
5. Caregivers' appraisals of involuntary inpatient treatment correlate with patients' symptom improvement

Conclusion.– If compulsory treatments in psychiatric practice are needed is an open question. Many aspects of the use of such interventions deserve deeper attention in research and clinical practice. The complexity of this field is such that simple pro-con answers are not possible. In general, we have to work on a standard of clinical practice guided by respecting autonomy and rights of our patients to the utmost.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D003

Con

Mental health policy: debate: do we need compulsory treatments in psychiatric practice?

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I shall argue that involuntary treatment can be unnecessary in the practice of psychiatry. This is the position taken by a number of UN treaty bodies, including the UN Committee for the Convention on the Rights of Persons with Disabilities (CRPD), the UN Working Group on Arbitrary Detention and the UN Commissioner on

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Human Rights. Other UN bodies' positions are less explicit about an absolute prohibition on involuntary interventions, but are framed in terms that support a central role for 'will and preferences', a key concept in the UN CRPD. They call for an urgent need to develop alternatives to coercive interventions. An important Resolution on Mental Health and Human Rights from the UN Human Rights Council calls upon States to "abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis" and to "provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent".

I shall note the huge variation, twenty- to thirty-fold, between European countries in the use of involuntary treatment, implying unacceptable arbitrariness in its use. Attention will be drawn to the negligible research effort devoted to developing treatment approaches for the avoidance of coercive interventions. I shall then show how a focus on supportive measures aimed at enhancing patients' involvement in their care, together with a focus on respecting the person's 'will and preferences' would result in involuntary treatment becoming unnecessary.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D004

Con

Mental health policy: debate: should the UHR paradigm for transition to mental disorder be abandoned?

F. Schultze-Lutter
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Current clinical high-risk (CHR) of psychosis criteria – particularly criteria relying on attenuated or transient positive symptoms and cognitive basic symptoms – are associated with conversion rates many times higher than the general incidence of psychosis. Yet, non-conversions still outnumber conversions, and CHR-relevant phenomena are not uncommon in the community, fueling an ongoing debate about their justification. This debate, however, widely disregards main general findings: persons meeting CHR criteria already suffer from multiple mental and functional disturbances for those they seek help; they exhibit various psychological and cognitive deficits along with morphological and functional cerebral changes, whereby, the majority of them fulfils general criteria for mental disorders; and beyond their association with subsequent psychotic disorders, CHR criteria do not specifically associate with any other mental disorder. Furthermore, while CHR symptoms might not be uncommon in the general population, CHR criteria almost as rare as psychotic disorders and, already at mere symptom level, are considerably associated with proxy measures of clinical relevance on community level, including low psychosocial functioning. Hence, the clinical picture defined by current CHR criteria might not be perceived only in terms of a psychosis-risk syndrome alone but rather as a psychosis-spectrum disorder in its own right with conversion to psychosis just being one and likely the worst of several outcomes and still the best available starting-point for an early detection of psychosis. Thus, the UHR paradigm clearly should not be abandoned but might rather act as a model for the early detection of other mental disorders.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

a lowering of emotions, with an average or low level of anxiety, but a safe motivation, needed only the accompaniment of a psychologist. Children with a decrease in emotions, medium or high levels of anxiety and low motivation needed the treatment of a psychiatrist and a psychologist. Children with depression, high anxiety and low motivation required the supervision and medical treatment of a psychiatrist.

Conclusions.– In 48.6% of children after severe spinal trauma there are emotional and motivational disorders requiring differentiated psychological and psychiatric care in the period of early rehabilitation with the algorithm of joint interaction in the treatment complex.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0246

The alpim (anxiety, laxity, pain, immune and mood) syndrome in adolescents and young adults- a cohort study

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Background and aims.– The ALPIM (Anxiety, Laxity, Pain, Immune, and Mood) Syndrome has been described in adults as a spectrum disorder which incorporates distinct med-psych comorbidities. We explore its occurrence in adolescents and re-assess its existence in adults. Additionally, separation Anxiety Disorder (SAD) was explored as a comorbidity.

Methods.– Medical records of patients aged 11 to 34 with a diagnosis of depression, or anxiety (panic disorder, SAD, social anxiety or generalized anxiety disorder (GAD)) seen during a 1-year period were reviewed. Data were collected on the presence of ALPIM comorbidities. Analyses were conducted to detect their co-occurrence and evaluate possible predictors of the ALPIM syndrome.

Results.– Inclusion criteria were met by 185 patient-charts. A significant association was noted between the ALPIM comorbidities with 20 subjects (10.8%), meeting criteria for ALPIM syndrome (patients with one or more diagnoses from each ALPIM domain). Patients with SAD had increased odds of being diagnosed with ALPIM (OR = 7.14, 95% CI: 2.48–20.54, p-value < 0.001). Neither MDD nor GAD was found to be predictive of ALPIM syndrome. There was no difference in the prevalence of ALPIM related comorbidities between subjects younger than 18 years vs. 18 years of age or older.

Conclusions.– Our findings replicate the association of distinct psychiatric and non-psychiatric conditions described as the ALPIM syndrome. Further, the syndrome may present during adolescence. SAD may be an independent predictive factor for the occurrence of ALPIM syndrome. Patients with individual ALPIM comorbidities should be assessed for the syndrome, especially if they have a history of SAD.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0247

Challenges in psychiatry - chronic somatic illnesses and psychiatric disorders

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Background and aims.– Numerous studies have shown great correlation between psychiatric disorders and somatic co morbid diseases. There is higher rate of comorbidity in bipolar disorder than in any other psychiatric disorder. Comorbidity is associated by severity of clinical presentation, poor prognosis, and outcome.

The aim of the study was to determine the frequency and to examine the most common somatic disorders in patients with bipolar disorder at the Psychiatric Hospital of Sarajevo Canton during the period of one year.

Methods.– The study included 27 out of 574 patients hospitalized for a stated period. The patients were diagnosed with bipolar disorder according to ICD-10 criteria. Patients' age and sex were were taken in consideration, as well as the presence of somatic disease.

Results.– Sixteen patients with bipolar disorder (59.25%) were females and 11 (40.74%) were males. All patients that were included in this study met the criteria for one or more comorbid diagnoses, of which 28.5% met criteria for one, and 71.5% for two comorbid disease. Twelve patients (44.44%) had cardiovascular disease, ten (37%) had hypertension, and two patients (7.4%) had post-stroke condition. In nine (33.3%) patients dyslipidemia was found, four (14.81%) patients had diabetes mellitus type 2, and two (4.7%) patients were diagnosed with thyroid disease.

Conclusions.– Comorbidity is a product, rather than a sum of two or more diseases, which makes this problem more demanding for treatment. An interdisciplinary approach is needed in treatment of these patients with emphasis on individual approaches, basic follow ups and introduction to a new lifestyle.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0248

Aid to patients with alzheimer's disease that is complicated by psychotic disorders

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Background and aims.–

Introduction.– Extending the life expectancy and aging of population on the globe leads to an increase of cases of dementia. The most common form of dementia is Alzheimer's disease. Patients with dementia require long-term care and treatment, which requires significant economic and social costs. Impairment of memory, speech, visual-spatial orientation, executive and motor disturbances. At all stages of the development of Alzheimer's disease there may be psychotic disorders.

Objectives.– Treatment of psychotic disorders due to Alzheimer's disease using Aripiprazole.

Methods.– A comprehensive clinical and psychopathological examination of 79 patients aged 65 to 82 years old, of both sexes (35 men and 44 women) for Alzheimer's disease with psychotic disorders. The diagnostic and research criteria of ICD-10, MMSE scale, MoCA, DAS, PANSS. Patients received therapy with Aripiprazole at a dose of 15–20 mg per day dividing it into two doses.

Results.– In patients, there was reduction of psychotic symptoms, leveling of affective stress, improvement of cognitive parameters (self-orientation, orientation in time and place, improvement of memory and concentration of attention), which affected the improvement of visual-spatial orientation, executive acts and motor activity; an increase of indicators by an average of 0.5 points by MMSE scale; improvement of values by all scales of cognitive assessment; increasing the degree of adaptation (cognitive ability, development of social and domestic skills, the use of adaptive coping strategies) and positive dynamics of the level of social functioning of the patients.

Conclusions.– The obtained results allowed substantiating the expediency of therapy of psychotic symptoms in Alzheimer's disease using Aripiprazole.