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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?

G. Szmukler
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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?

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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.

weeks before admission she is reported to have increased sexual desire, engaging with strangers over social media, planning seminars, making travel arrangements, impulsively spending money.
Results.– On admission the patient was treated with antipsychotic medication and psychostabilizer treatment was initiated. During the hospital stay, there has been marked reduction in the presenting symptoms.
Conclusions.– Differential diagnostic difficulties are encountered in patients with MS when severe affective disturbances are present. The diagnosis of bipolar disorder is secondary to the primary diagnosis of MS which proves as the candidate for the underlying cause for the affective disorder.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0270

Connection between depressive and anxiety disorders and the rate of progression of HIV infection

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Background and aims.– In recent years the world has witnessed increased attention to mental characteristics of HIV-infected patients. There is an increased risk of HIV infection among patients with mental disorders and substance-dependent. Patients with mental disorders and receiving antiretroviral therapy (ART) typically have problems with adherence, which can result in disease progression and formation of resistant strains of HIV.
Our aim was to investigate relationship between anxiety and depressive disorders in HIV-infected patients and rate of disease progression.
Methods.– Clinical method and psychological testing were used (Spielberger-Khanin Anxiety Test, Hamilton Depression Rating Scale).
Results.– First group (G1) consisted of 62 patients with a CD-4 level of 70 to 220 cells/ml and requiring ART. Second group (G2) consisted of 72 patients with a CD-4 level of 370 to 780 cells/ml. In 24 patients (45.2%) from G1 and in 20 patients (21.7%) from G2, one of depressive disorders was diagnosed. Average anxiety score in G1 was 47.4 ± 4.5 for reactive anxiety and 44.8 ± 6.5 for personality anxiety, in G2 - 36.9 ± 8.0 - reactive anxiety and 38.6 ± 0.5 - personality anxiety. HDRS score in G1 was 12 ± 2 and 6 ± 4 points in G2. Consequently, higher rates of anxiety and depression were found in group with significantly lower immune status.
Conclusions.– Results indicate higher levels of depression and anxiety in group with more rapid progression of HIV infection. First group will be assigned to ART; and therefore, people with larger manifestations of anxiety and depression may have trouble with adherence.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0271

Mild traumatic brain injury in patients with PTSD

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Background and aims.– The mild traumatic brain injury (mTBI) is often low diagnosed in combatants especially in combination with post-traumatic stress disorder (PTSD). But this traumatization influenced a lot on the quality of successful adaptation and re-socialization during the deployment and in the postdeployment period.
Methods.– Were observed 128 postdeployment men participated in the military actions in eastern Ukraine for 0.5–4.5 years before the study with the Boston Assessment of TBI-Lifetime (BAT-L), Scale for clinical diagnosis of PTSD (CAPS-5) and Sheehan disability scale (SDC).
Results.– According to BAT-L 65.2% observed persons had at least one mTBI throughout their lives, especially 41.3% ones had at least one military mTBI, with documentary evidence in only 19.8%. But 18.1% persons did not seek medical assistance at all. According to the CAPS-5 scale, 46.5% of patients with mTBI had also PTSD, and 42.1% had an adjustment disorder. Persons with mTBI and PTSD comorbidity had the higher disability in comparison with mTBI and adjustment disorders comorbidity, and mTBI or PTSD along.
Conclusions.– Boston's assessment of traumatic brain injury during life (BAT-L), PTSD clinical diagnostic scale (CAPS-5) and Sheehan disability scale (SDC) are useful for mTBI + PTSD management.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0272

Analysis of stress-potentiating factors in the dynamics of cerebrovascular pathology development

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Background and aims.– It is generally acknowledged that psychosocial stress is one of the leading factors in the development of both mental and somatic disorders, among which cardiovascular and cerebrovascular pathology occupy the first place. Purpose: determine the structure of stress risk factors in patients with different stages of the cerebrovascular pathology.
Methods.– 383 patients were examined: 122 -with cardiovascular diseases with clinically and laboratory confirmed high risk of the cerebrovascular pathology, 134 patients with transient ischemic attacks, 127 patients who had suffered from ischemic cerebral stroke. 47 healthy persons were examined as comparison group. To test the stress level the Boston Stress Test was used.
Results.– Pathological effect of psychosocial stress is realized through meaningfully different stress-potentiating factors depending on the stage of development cerebrovascular pathology. The spectrum of stress-potentiating factors is transformed with the progressiveness of cerebrovascular pathology: at the initial stages, the behavioral factors that are offset by the progression of the disease have the biggest negative effect, giving way to psychoemotional factors that contribute to progression and aggravation of the course of cerebrovascular pathology.
Conclusions.– The presence of a somatic disease is big stress-potentiating factor that triggers a cascade of psychological, behavioral reactions from the side of the person. The direction of the psychological response depends on personal, behavioral and psychosocial factors that, with favorable course of the adaptation process in patients, in the dynamics, the cerebrovascular pathology is oriented on changing the lifestyle to health-preserving, and in the case of unfavorable, it deepens existing distress and becomes a source of psychological maladaptation.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.