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Oral Communications
Young psychiatrists: innovation and competence

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Nowadays, the management of psychiatric patients is requiring more and more attention and competence to young psychiatrists. This is mainly due to an often incomplete training process, and also to the dramatic and non-protective contexts in which young psychiatrists, sometimes at their first work experience, are involved. These issues are becoming increasingly relevant in the last few years, in reason of critical points such as the crisis of social welfare, the economic recession, the migratory fluxes, and the emergence of new and unknown substances of abuse. On the other side, the amount of money invested in psychiatry is decreasing, with a continuous rationalization in both the national health system and in universities. These phenomena have determined a reduced amount of deliverable cares to patients and the emergence of critical cases.

Practical experience is therefore crucial in the management of complex situations. Unfortunately, however, it is often inadequate for a young psychiatrist after his period of residency. This is why the young section of the Italian Society of Psychiatry has proposed this third meeting, aimed at offering to the audience practical hints for their clinical activities, starting from a clear but up-to-date observation of the most important guidelines and theories shaped on the daily management of clinical activities. The discussion and the debate among experts in the different fields, and the possibility to create a new network of young researchers will be the focus of the meeting.

Oral Communications

Pathological dependences and suicidal risk

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Substance use disorder is one of the psychiatric diseases most often associated with suicidal behaviors: the odds ratio for suicidal attempts in these subjects was estimated six times higher than in general population. All substance use disorders increase the risk of suicide. The subgroups at major risk are: young people, males, polyabusers, subjects with co-morbid psychiatric diseases (e.g., depression or schizophrenia), subjects with recent adverse life events or with poor social environment. A major hypothesis for explaining the relationship between substances use and suicide is the disinhibition hypothesis: alcohol or illicit drug intoxications may increase impulsivity and cause the acting out of suicidal ideas. Indeed, these subjects are often intoxicated at the time of the suicide. Nevertheless, only a minor part of deceases occurs for intentional overdose of the substance abused (between the leading methods there are firearms and hanging).

A different but related problem is the frequency of suicide attempts by intoxication/poisoning with substances (licit or illicit). In the United State, half of the visits for self-harm behaviour in Emergency Departments are secondary to substances intoxication. In 95% of cases the substance used is a pharmaceutical product (prescribed by a physician or over-the-counter). The compounds more often involved are: anxiolytics (primarily benzodiazepines), pain relievers (mostly opiates and acetaminophen), antidepressants. In the United States, intoxication is the third leading method for full suicide and the first in females. Once again pharmaceutical products are the most used, while street/recreational products are used approximately in 2% of the cases. These data must empower physicians, pharmacists and health workers, because patients at risk for suicide often use prescribed and over-the-counter drugs as an improper weapon direct against themselves.

Finally, it is important to remind that currently there are warnings by FDA and EMA regarding the potential pro-suicidal effects of two pharmacological classes: antidepressants and anti-epileptics. A careful evaluation of the risk-benefit ratio and a close clinical monitoring is essential in subjects with risk factors for suicide, to which the psychiatrist deems useful a pharmacological intervention.
Oral Communications

Novel psychoactive substances and binge drinking

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Use of novel psychoactive substances and binge drinking behaviour are two emerging phenomena, especially in adolescents and young adults. Novel psychoactive substances (NPSs) are a heterogeneous group of psychotropic drugs, not included in the Single Convention on Narcotic Drugs of 1961 or the Convention on Psychotropic Substances of 1971, but that may pose a public health threat comparable to that determined by substances listed in those conventions (definition by European Union). NPSs appear to be mostly unregulated, and they continue to cause problems to drug control authorities in many countries. Since 1997, more than 250 novel psychoactive compounds have been reported and monitored by the EU Early Warning System; out of these, 41 were reported in 2010, 49 in 2011, and 57 in 2012. These substances are usually synthesized in clandestine laboratories, often changing the molecular structure of controlled substances. Regarding their spread and commercialization, in recent years the World Wide Web has emerged as a primary source of knowledge and sale of these psychoactive products. Among the most known NPS, there are: synthetic cannabinoids, mephedrone, methamphetamine, ayahuasca, phenethylamines, salvia divinorum, kratom, gamma hydroxybutyric acid (GHB), methoxetamine and desomorphine (Krokodil).

Binge Drinking is defined as the consumption of 5 or more drinks in a short interval of time, with the primary intention of becoming intoxicated. This pattern of use is widely diffused in Europe and North America, and according to a report of the European Commission, about 1/3 of Europeans citizens who consume alcohol have episodes of binge drinking at least once a week. Young people, aged 15-24 years, are more likely to report binge drinking than older people. Nowadays binge drinking is considered to be a major public health issue: for example, in subjects with major depression, recent binge drinking conducts are associated to a higher risk of suicidal attempts. Despite these considerations, NPSs and Binge Drinking are under-investigated topics: our opinion is that more research is needed to cover this gap, especially with regard to psychiatric population.

Oral Communications

Metabolic side effects induced from second-generation antipsychotics: can you do more?

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Second-generation antipsychotics (SGAPs) have multiple US Food and Drug Administration-approved indications and are frequently prescribed by primary care physicians. Despite the increasingly widespread use of second-generation antipsychotics, they are not, however, a panacea and are associated with several problematic tolerability and safety concerns. For example, emerging evidence militates against the original notion that atypical agents are without risk for extrapyramidal side effects and possibly tardive dyskinesia when compared to their therapeutic predecessors, conventional antipsychotics. On the other hand, they have a considerable clinical impact on the metabolic profile of patients, which is often associated with significant physical and psychological morbidity: these compounds show some differences inducing metabolic side effects on the basis of their receptor affinity.

Clinicians should consider the following strategies to manage metabolic side effects induced from the assumption of second-generation antipsychotics: off-label use, identification of patients at risk of developing metabolic side effects, monitoring of metabolic parameters, switch of pharmacological treatment, non-pharmacological treatment such as psychoeducation of lifestyles at risk, specific therapies comorbidities. Patients should be screened before initiating any SGAP (or any antipsychotic medication) and monitored subsequently following standard guidelines. Healthy
lifestyle counselling should be offered to all patients. Patients showing evidence of significant weight gain should be switched to a SGAP with a lower metabolic liability. Physicians and psychiatrists should consider these topics in order to limit metabolic adverse effects in patients assuming second-generation antipsychotics. Future research are aimed at identifying any genetic risk factors; authors have suggested that overexpression of certain receptors could influence and predict the onset of metabolic side effects induced by second-generation antipsychotics.

Oral Communications

Psychiatry after residency: which are the options for young psychiatrists?

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The author briefly describes his working experience and the internships carried out during the five years of residency in Psychiatry at the University of Perugia. Despite not having had the opportunity to spend a period of study/research abroad, the author considers himself lucky for his academic experience anyway. In fact, his experiences included the opportunity to work in a Diagnosis and Treatment Psychiatric Service (SPDC, the inpatient acute psychiatric ward of the Italian NHS), but also in the psychiatric outpatient service and consultation-liaison psychiatry service of Perugia Hospital, and, finally, a complete community psychiatry experience (community mental health services, public service for drug addiction, and a prison research project experience). At present he works as a consultant psychiatrist at Ser.T. (Public Service for Drug Addiction).

The possibility and the benefits of including internships in community mental health services, public services for drug addiction, and correctional mental health institutions, in the teaching plans of the Italian Schools of Psychiatry are to be discussed. The possibility of research experience and collaborations abroad should also be offered to all trainees. Trainees should have the opportunity to receive a complete “community psychiatry” experience, and the employment of early career psychiatrists should be favored. In this sense, the possibility that the Italian Society of Psychiatry (SIP) presents guidelines or general instructions in order to support the growth of all residents is strongly suggested.

Oral Communications

Alcohol Use Disorder among patients with severe mental illness: a challenge for psychiatry

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According to the most updated evidences, about 1-2% of the Italian general population suffers from an alcohol use disorder (AUD). The rates of AUD are consistently lower than the mean prevalence of WHO European region (7-8%) and US (9%). However, also in Italy, patients with severe mental illness (SMI), such as schizophrenia and bipolar disorder, are more likely than healthy subjects to suffer from a comorbid AUD. Recent findings from Italian community mental health services show that more than one quarter of patients with SMI and comorbid substance misuse suffered from alcohol dependence. The management of co-occurring SMI and AUD often represents a key challenge for psychiatrists, since alcohol effects may worsen clinical symptoms, medication compliance, and physical health of patients. Furthermore, AUD has been also associated to the risk of violence and suicide among both bipolar and schizophrenic individuals. Nevertheless, AUD is often underdiagnosed and unrecognized in psychiatric settings. Cultural
issues, treatment barriers and lack of available pharmacological options often make it difficult to treat patients with dual diagnosis. Although integrated approach seems to be the most promising therapeutic option, in Italy integrated programmes for dually diagnosed patients are rare, and parallel or separated treatment remains standard practice because of the separation of mental health and addiction facilities within the National Health Service. This treatment system is often characterized by inadequate cooperation between mental health and addiction services, and significant training needs on dual diagnosis field has been identified among both mental health and addiction professionals. Finally, although some pharmacological agents, such as acamprosate, disulfiram, nalmefene, and naltrexone have demonstrated some efficacy for AUD, there is no gold standard for the treatment of patients suffering from both SMI and AUD. At the same time, there is a lack of psychosocial treatments clearly demonstrating higher efficacy than others. According to most recent meta-analytic findings, clinical trials in this field showed several methodological and quality issues, with scarce evidence supporting any psychosocial treatment over another in terms of alcohol reduction, treatment adherence, or mental health improvement. For all these reasons, more research addressed to analyse efficacy of both pharmacological and psychosocial interventions is required, to improve the evidence in this important and too often underrated area.

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**Oral Communications**

**The risk of suicide in affective disorders: from depression to mixed states**

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Although suicide is a rare occurrence in the overall population, there are peculiar subsets of patients, such as affective disorders patients, that require special attention from the clinicians. Two-thirds of suicide victims die in their first attempt and most of them (almost 66%) are affected by Major Depressive Episode at the time of the event. 15-20% of patients suffering from mood disorders commit suicide, and half of the completed suicides are considered as the result of a concomitant affective disorder. Among affective disorders, the diagnosis of depression is the most frequent and the population of depressed women have a higher prevalence. The most important risk factors, so-called “proximal” and related to the episodes of mood disorders, are: major depressive episode, suicidal ideation, the first attempt at suicide, the presence of psychotic features, substance abuse, mixed states dysphoria, mania with comorbid anxious symptoms. More specifically, some of the highest risks within a context of depression were found to be the presence of hopelessness, guilt and the discharge of inpatient especially after a brief hospitalization. Special attention should be addressed to a family history of suicide and psychiatric disorders, the presence of personality disorders, organic diseases; otherwise there are some protective factors such as the presence of appropriate supportive relationships, children and religious beliefs. It is always very important that the psychiatrist, detecting the presence of these various factors, determines an individual risk assessment, especially in the specific subgroups of populations (e.g. physical disorders and pain in older patients, substance abuse in young patients).

Concerning bipolar disorders, other risk factors have been reported, called “distal risks”, such as the presence of strong aggression and impulsivity, duration of depressive symptoms, rapid cycling and depressive mixed states (defined by three or more symptoms that occur simultaneously within the hypomanic depressive phase). Surely the most important among them is the mixed state, which multiplies by three fold the risk of suicide attempts and suicidal ideation. Acute and long-term pharmacological treatments, in patients with major depression and bipolar disorder, remarkably reduce morbidity and mortality from suicide in patients belonging to the high-risk subgroups. It was highlighted that the combined intervention with psychotherapy, psychosocial intervention and pharmacotherapy lower the risk of suicidality; in this sense, lithium is still considered the most effective drug, not only for the prevention of acute single episode but also for the reduction of suicidal attempts in the wider period of a long-term therapy.
Bipolar disorder in DSM 5: new challenges and new treatments

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In the DSM 5 the bipolar disorder was positioned between mood and psychotic disorders, in order to capture increasing evidence for phenomenological, biological and genetic overlap with schizophrenia, but at the same time to emphasize the differences in terms of social and occupational functioning. Although this position does not bring into question the traditional Kraepelinian dichotomy between these disorders, it still represents a new approach to the classification of bipolar disorder, with a substantial impact in several areas: epidemiology, research, treatment, education, and regulations.

Another main innovation of the DSM 5 is the redefinition of the concept of mixed state as a course specifier. This new approach is definitely overcoming the problems arising from the extreme restrictiveness provided by the categorical DSM-IV-TR: indeed, the specification “with mixed features” may be applied to different mood episodes, both within the frameworks of subthreshold bipolar disorder and in the context of major depressive disorder. This new classification, based on a mixed categorical-dimensional model, seems to reflect the concept of osmosis, which, applied in this context, interprets the boundaries between the different frameworks as porous membranes rather than as clear-cut limits. These new concepts are the major challenge for clinicians both in terms of differential diagnosis, and in terms of choice of the most appropriate treatment. If antipsychotics may be largely considered as anti-manic agents, and antidepressants are the appropriate therapeutic option for depression, the presence of mixed features requires the need to consider mood-switching risks.

The data present in the literature seem to indicate that drugs effective in the treatment of mixed episodes (as defined by DSM-IV-TR) may be effective in the treatment of the mixed features specifiers of DSM-5, although new studies are still necessary to better investigate these features.

Psychotropic drugs and QTc: clinical evidence and future perspectives

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The QT interval is an electrocardiographic measure of both depolarization and repolarization within the heart. It is defined as the time from the start of depolarization to the end of repolarization of the ventricles. Since this interval is inversely proportional to heart rate, the QT interval is typically corrected for heart rate (QTc). In clinical practice the QTc is used to assess the heart conduction status. The QTc interval of healthy persons is generally around 400 ms; the QTc interval in women is usually about 20 ms longer than that of men. QTc values greater than 450 ms are roughly considered to be “borderline prolonged.” QTc values greater than 500 ms are considered prolonged.

The QTc interval prolongation is a biomarker for pro-arrhythmic risk, especially for life-threatening arrhythmia—Torsades de Pointes (TdP). Several medications belonging to different chemical and therapeutic groups, such as antiarrhythmics, antihistamines, antifungals, antipsychotics, antidepressants or antitussives, have been associated with prolongation of the QTc interval.

Inhibition of some potassium ionic channels is considered the primary mechanism through which most of the commonly prescribed drugs delay the cardiac ventricular repolarization and prolong the QT interval. In addition to QTc prolongation, other factors that appear to be associated with an elevated risk of TdP include abnormal levels of electrolytes. Potassi-
um, sodium, and calcium are associated with repolarization; hypokalemia, in particular, appears to be associated with an elevated risk of drug-linked TdP. Depleted magnesium also appears to be associated with an elevated risk of TdP.

After the release of this alert, several national medicines agencies recommended ECG monitoring before and during treatment with these types of drugs. Psychiatrists are strongly informed about the potential of psychotropic medications to alter the electrocardiogram (ECG) and to increase the risk of ventricular arrhythmias. However, the prevalence and nature of cardiovascular side effects and electrocardiographic changes associated with specific antipsychotics are not easily discerned. Other several risk factors such as age, female gender and common cardiovascular conditions (ischemic heart disease, arterial hypertension, and primary arrhythmia disorders) predispose to the development of drug-induced arrhythmia.

At the moment it is not possible to quantify the real risk of TdP in patients under medications and this requires yet other studies. To have an appropriate focus on this allows to have under control the health of patients to better intervene at the appropriate time. In order to improve patient safety, clinical guidelines integrating these many potentially interacting factors are needed and collaboration between psychiatrists and cardiologists is to be encouraged.

Oral Communications

Suicidality: from prevention to management in emergency phase

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SUICIDE PREVENTION

Suicide is the tenth leading cause of death in the world, with estimated 800,000 to one million people dying every year, and it is continuously increasing, primarily in the developing world. In addition to suicide, we should moreover consider the large amount of attempted suicides and the considerable number of people involved in suicidal pain as family, friends, colleagues.

The World Health Organization highlights that suicide prevention programs:

1. should distinguish each country’s characteristics, taking into account social, cultural and health differences;
2. must address local solutions to local problems;
3. should prefer interventions conducted by local organizations.

According to these recommendations, the Trentino Health Service developed a community-based suicide prevention program, called Invito alla Vita, which officially started in Trento’s Province in late 2008. The project considers suicide prevention from multiple perspectives, clinical, cultural and social, and has been working since the beginning in different directions and with several partners. In fact, it tried to involve other community stakeholders besides health services, such as citizens’ organizations, institutions and associations, like AMA – mutual aid association, in the Coordination Table, which convenes regularly, to update and plan new interventions.

The targets and actions of the Project consist of:

• Information and involvement of institutions, services, community;
• Advertising campaign;
• Sensitization of the population;
• Specific training and guidelines for the so-called sensors;
• Mutual aid Groups;
• Epidemiological Monitoring of the phenomenon;
• Coordinating project in its different parts;
• Help line.

SUICIDE MANAGEMENT

Evaluating suicide risk rates is particularly difficult because of the many variables that are part of the history of each person. In scientific literature there are some questionnaires that try to assess suicide risk, but they end up being much less useful of a good conversation in which we can identify the risk factors and especially the warning predictive signs that a person may show. Predictive areas consist of psychiatric illness, personal history (past attempted suicide), psychological situation (strengths/vulnerability), suicidality factors (suicide planning, suicidal behaviours). While managing a suicide crisis we must first establish an intervention plan, which may vary from outpatient care to hospitalization, when the risk is high. A useful tool is the “not suicide contract” which is based on a therapeutic al-
liance; moreover, frequent contacts with the therapist or other mental health professionals, even by phone, are recommended, especially during critical phases of treatment. An appropriate treatment plan may be offered indeed by a multi-professional team working in synergy to ensure a variety of therapeutic interventions (psychological, psychosocial, pharmacological). It is suggested also to involve family members and significant subjects in clinical decisions, and seek their cooperation in the therapeutic program. Finally, we should not forget that suicide is a traumatic experience for family members and friends, but even for the professionals, often exceeding their psychological capabilities to front it, and it is advisable for them to actively seek the support function of the working group to which they belong.

Oral Communications

Project: “Better training - Better mental healthcare”

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The European Federation of Psychiatric Trainees (EFPT) is an independent and non-profit umbrella organization of the European national Psychiatric Trainees’ associations. Italy became a member of EFPT in 1995 and ensured cooperation in its activities thanks to the Permanent Conference for Training in Psychiatry (CFP) and the Coordination of Italian Society of Psychiatry - Young Psychiatrists and Trainees (‘SIP Giovanni’). The primary goal of EFPT is to promote and harmonize the standards of psychiatric traineeships across Europe, working in partnership with relevant international and/or national psychiatric agencies.

The active participation of the trainees of the Italian Society of Psychiatry to the EFPT projects aims at exploring the diversity and richness of current training of psychiatrists in Europe; at supporting the development of national trainees’ organizations; at promoting and representing internationally the views of the trainees in all branches of psychiatry; at translating the discussion among trainees into action at a local level to improve training.

Every year the EFPT organizes the annual Forum of European psychiatric trainees. The Forum provides the opportunity to meet and discuss relevant issues for psychiatric training in Europe, to exchange their training experiences and to produce consensus statements expressing their viewpoint on different aspects of training. During the 22nd EFPT Forum, held at the Royal College of Psychiatrists in London between the 21st and 25th of June 2014, the Italian Delegation took part at the General Assembly and was active in the e-posters session and workshops, promoting the creation of the ‘Psychoactive Substance Use Disorders’ (PSUD) working group. Italian delegates also took part to the ‘Recruitment and positive image promotion of Psychiatrist’ working group, aimed at improving the image of the psychiatrist and mental health professionals, at providing actions that can improve the image of the psychiatric profession and at creating a platform for ideas exchange and successful initiatives.

Other delegates took part to the ‘Exchange working group’, offering training positions all-over Europe. The participation of Young Psychiatric Trainees of the Italian Society of Psychiatry to EFPT projects constitutes an opportunity to improve knowledge about psychiatric training and to establish international networks across Europe, which is a precious resource to develop the professional growth of future psychiatrists.

Oral Communications

Classic and synthetic cannabinoids: risks and psychopathologic aspects

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According to the Italian Department for Antidrug Policies, 76.5% of Italian students aged 15-19 years old have smoked cannabis at least once in the past 12 months. Cannabis consumption among Italian youth appears to be i-
creasing in the last few years, while non-significant variations have been registered for cocaine, heroin and stimulants. Recent studies have demonstrated a strict connection between THC action in brain and dopaminergic system dysregulation: blocking GABAergic inhibition on nucleus accumbens, THC allows an increase in dopamine release. In light of this, it has been suggested that the use of cannabis shares a common feature with psychotic disorders, such as schizophrenia. It is likely that exposure to cannabis interacts with other factors, including genetic ones, for “causing” schizophrenia or psychotic disorders, but cannabis consumption it is nor necessary nor sufficient to induce them alone. It is therefore mandatory to further investigate the behavioural, cognitive and psychological effects of cannabinoids that may be relevant to psychosis, and analyse and clarify the biological mechanisms related to the risks.

Synthetic cannabinoids have instead made their appearance on the illicit drug market in the early 2000’s, but have gained popularity mainly since 2008. Commonly called “spice drugs” from one of their first commercial brands, synthetic cannabinoids mimic the effects of THC on brain, but their effects appear to be extremely more intense due to their greater receptor affinity. Mix of smoking cannabinoids are usually sold in sachets containing 1-3 g of dried plant material, which has been added one or more cannabinoids (presumably, a solution of cannabinoids is sprayed on the herbal matter). Symptoms reported by users include complex visual and auditory hallucinations, paranoid ideation, depersonalization/derealization, psychomotor agitation, intense anxiety, tachycardia and seizures, probably due to an inhibition of GABAergic neurotransmission greater than THC. The number of fatalities linked to “spice” consumption is increasing in both European and extra-European countries. According to data provided by the American Substance Abuse and Mental Health Services Administration, in 2010 11.406 accesses to the emergency department in the US were due to consumption of synthetic cannabinoids. 75% of the accesses involved young or very young patients, aged between 12 and 29 years, predominantly males (78 %). The relevant health threats posed by these new psychoactive substances should motivate the scientific community to intensify their researches and knowledge sharing, in order to define more appropriate preventive strategies and to improve treatment guidelines.

Oral Communications

New psychoactive substances and psychosis: the Lysergic Psychoma

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New psychoactive substances (NPSs) are currently determining a sanitary issue of growing importance, especially in relation to the dynamic and potentially unlimited nature of the market. Synthetic cannabinoids, salvia divinorum, mephedrone, methoxetamine, desomorphine, ayahuasca, bromodragonfly are only some of the newest substances available on-line. NPSs are generally undetectable by common immunoassays used for drug screening. For many types of NPSs, our current knowledge is incomplete. Their study is burdened by a number of methodological issues; controlled clinical trials are hard to be carried out, and only very few have actually been performed. Most of the available data are derived from case series of intoxication and from interviews with drug users, and are thus of limited scientific value. The attribution of peculiar manifestations to a specific substance is often difficult, because unidentified substances may be consumed and multiple substances may be taken at once. The substances in the illicit market change frequently, but their effects and toxicities tend to remain the same; different groups of substances have typical profiles, which, however, overlap. The risk of developing psychotic symptoms is often concrete, with, in some cases, the development of a full psychosis. Among the possible psychopathological consequences, a syndrome called Lysergic Psychoma has been recently proposed as typical in those subjects intoxicated by NPSs.

The Lysergic Psychoma is a psychopathological syndrome characterized by perception of extraneous body in one’s own mind: the residual critical ego takes position against the intoxicated part of one’s own self. This phenomenon is usually observed in transitory psychotic syndromes induced by psychoactive substances and is profoundly different from the typical phenomena observed in early onset schizophrenia, in which symptoms as auditory hallucinations, an egosyntonic erleben, an atmosphere of perplexity and a sensation of “end of the world” (Weltuntergangserlebnis), dramatically predominate. New studies are required to describe the possible short- and long-term effects of these new classes of substances. The possibility to differentiate a “bouffée délirante” from a psychotic onset may be very important from both a prognostic and therapeutic point of view. The identification of the Lysergic Psychoma could help to address the issue.
A systematic comparison of guidelines on management of psychiatric emergencies

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Management of psychiatric emergencies is one of the most controversial issues of psychiatric care. Disturbed or violent behaviour in psychiatric inpatient settings and emergency departments may result in harm to patients or others if not rapidly attended. A systematic comparison of local and international guidelines on psychiatric emergencies was performed. Major emergencies, such as suicidality and violent behaviour, and medical emergencies, such as delirium, neuroleptic malignant syndrome, serotonin syndrome, overdoses of common psychiatric medication, and overdoses and withdrawal from addicting substances, have been considered. A selective literature review was then undertaken. Considering 21 countries across Europe, no guidelines on treatment of violence and aggression were found in 11 countries. Only Germany, Bulgaria, and the United Kingdom had national guidelines, whereas 7 countries had local guidelines, and others observed the UK or German guidelines. In all the guidelines included in the comparison, no medication emerged as a gold standard. However, haloperidol and lorazepam were the most widely used drugs. Algorithms recommended three classes of medication, including first-generation antipsychotics, second-generation antipsychotics, and benzodiazepines, that should be differently used on the basis of the following different cases: agitation due to intoxication (from CNS stimulant or CNS depressant), agitation associated with delirium (with or without the suspect of benzodiazepine or alcohol withdrawal), agitation associated with psychosis in patients with known psychiatric disorder, and undifferentiated agitation or complex presentation. Adverse reactions associated with psychotropic medications were also reported as uncommon life-threatening psychiatric emergencies. In both neuroleptic malignant syndrome and serotonin syndrome, the immediate discontinuation of the causative agent along supportive care was the evidence-based primary treatment. Standardised guidelines serve to coordinate the patients’ rights with considerations of safety and good care standards. It must be kept in mind that medication has to be administered to calm, not to induce sleep or as restraint, so that patients can be engaged and more accurately assessed by clinicians. Current clinical NICE guidelines on managing violent behaviour suggest the need to follow the guidance of the Mental Health Act Code of Practice, considering rapid tranquillisation, physical intervention and seclusion as secondary treatment techniques. They should be only used once verbal de-escalation and other strategies have failed. Italian Society of Psychiatry has also recently developed its own protocol based on four phases that cover all aspects of treatment of violent behaviour, with the aim to ensure the safety and wellbeing of patients, promote their recovery and protect other service users and staff from harm.

A round table about perspectives for young psychiatrists after residency

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I participated in the round table of the conference presenting my experience of a training course in psychotherapy contextually with the residency in psychiatry. During residency, the residents are trained through lessons of psychopathology, psychopharmacology and psychotherapy, but also through supervised care activities both inside and outside the hospital, and through the research activities. However, training in psychotherapy is limited to a few introductory theoretical lessons and to a small number of patients treated with psychotherapy supervised by experts, in relation to the needs to bring together more topics during the years of training course. For this reason, already during...
the years of specialization in psychiatry, many residents feel the need to start training in psychotherapy and I was one of them. For what has been my experience, I think that a most extensive and thorough training in psychotherapy is essential for young psychiatrists for several reasons:
- to increase the self-knowledge in order to improve the therapeutic relationship with the patient;
- to improve the ability to approach subjects with personality disorders, considering the high numbers of patients with these disorders who daily approach mental health departments;
- to learn how to work in groups such as those that are created in psychiatric services;
- to have the possibility of working as a psychotherapists.

My communication was therefore aimed at proposing a reflection on the possibilities and limits related to establish collaboration projects and potential agreements between the schools of residency in psychiatry and the schools of psychotherapy, in order to create better collaboration among experts in different fields and to ensure a more complete training for young psychiatrists.

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Oral Communications

Changes from DSM-IV-TR to DSM-5: the impact on clinical practice

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The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published after more than 10 years of efforts by several international experts to “better fill the need of clinicians, patients and researchers for a clear and concise description of each mental disorder”.

One of the aims of the DSM-5 was to replace or complement the categorical diagnostic system with a dimensional approach. During the years of preparation of the Manual this purpose was abandoned and only little of these original dimensional approaches have remained, for example the transnosological specifiers (e.g. the mixed feature specifier), the severity assessments (e.g. global assessments of symptom domains of schizophrenia) and the cross-cutting dimensional assessments. Moreover, the DSM-5 consortium did not include the biological markers in the final version. A preliminary examination shows that only few changes have been made to the classification of the main diagnostic groups, apart from the elimination of the multiaxial system and some rearrangements in the overall classification. However, these changes have many more consequences than thought in the first instance.

DSM-5 contains new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder. The exclusion criterion for a major depressive episode applied to depressive symptoms lasting less than 2 months and appeared after the death of a loved one (the bereavement exclusion) was omitted in DSM-5. Obsessive-compulsive disorder, post-traumatic stress disorder and acute stress disorder were eliminated from the anxiety disorder chapter and included respectively with the “obsessive-compulsive and related disorders” and the “trauma-stressor-related disorders” chapters. The new chapter on obsessive-compulsive and related disorders includes hoarding disorder, excoriation (skin-picking) disorder, substance-/medication-induced obsessive-compulsive and related disorder, and obsessive-compulsive and related disorder due to another medical condition. These disorders are related to one another in terms of a range of diagnostic validators, as well as the clinical utility of grouping these disorders in the same chapter. DSM-5 criteria for post-traumatic stress disorder differ from those in DSM-IV. As describes for acute stress disorder, the stressor criterion (Criterion A) is more explicit regarding how an individual experiences “traumatic” events. Also, Criterion A2 (subjective reaction) has been eliminated. In the chapter of Schizophrenia Spectrum and Other Psychotic Disorders, the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations were eliminated from the Criterion A for Schizophrenia. Furthermore, it was added the requirement of having at least one of these three symptoms: delusions, hallucinations, and disorganized speech to make a reliable diagnosis of schizophrenia. In order to detect changes in prevalence and comorbidities from the DSM-IV, epidemiological studies are needed, especially for disorders with high public health relevance, such as schizophrenia, major depressive disorder, and substance use disorders. The impact of the DSM-5 on clinical practice will be better defined after a longer use of the Manual.
Poster Sessions
Decision making, central coherence and set-shifting: a comparison between Binge Eating Disorder, Anorexia Nervosa and healthy controls

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Several studies have investigated the cognitive profile in patients with Anorexia Nervosa (AN) and Bulimia Nervosa (BN); on the contrary, few studies have evaluated it in patients with Binge Eating Disorder (BED). The purpose of this study was to compare decision-making, central coherence and set-shifting between BED and AN patients. A battery of neuropsychological tests including the Iowa Gambling Task (IGT), the Rey-Osterrieth Complex Figure Test (RCFT), the Wisconsin Card Sorting Test (WCST), the Trial Making Task (TMT) and the Hayling Sentence Completion Task (HSCT) were administered to a sample of 57 women (19 AN, 19 BED, 19 Healthy Controls [HC]). Parametric assumptions were met for all psychometric and neuropsychological variables, therefore ANOVA was used followed by Bonferroni corrected post hoc tests. BED patients had worse performance in RCFT-Accuracy compared to AN (t = 2.435; p <0.05) and HC (t = -2824; p <0.01), in almost all indices of HSCT and in all indexes except on perseverative errors of WCST. Furthermore, BED patients compared to HC showed lower performance in IGT, in TMT part B and TMT Part B-Part A, and in the index RCFT-percentage of recall (t = -2357; p <0.05).BED patients have a poor performance in all tests administered. Future studies should help to understand if this impairment represents an endophenotypic trait or an adaptive mechanism and if this cognitive style can be improved through a specific treatment (e.g. CRT).

Emerging disorders: assessment and treatment of postnatal depression and depression in pregnancy

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The current project is the continuation of the interventions provided by the Regional Plan for Mental Health of Lombardia, set up between 2009 and 2012 and carried on in 2013-2014. The project involved “San Carlo Borromeo” Hospital in Milan, and particularly the Psychiatry and Clinical Psychology units within the Mental Health Department, and the Obstetrics, Gynaecology and Paediatrics units within the Mother and Child Department. Partners of the project were also Paediatricians, GPs, vaccination points, health visitors, midwives and neonatologists. We know from scientific literature that depression has a prevalence of 15 to 20% during pregnancy and between 10 and 15% in the postnatal phase. It is also known that those who suffer from depression during pregnancy in 40% of cases will develop postnatal depression and that those who have suffered from postnatal depression in 40% of cases will develop a depressive episode in subsequent pregnancies.

The current innovative project was based on the assumption that “in order to implement early prevention in the perinatal field, it is necessary to replace a culture based on damage repair with one that aims to anticipate and create parenting skills” (Missionier, 2003). Therefore this project was born with the following aims: to prevent the structuring of psychological or psychiatric conditions that can affect the experience of motherhood; to reduce the sense of insecurity of pregnant women; and to act early in preventing or otherwise restructuring the possible dysregulation of the relationship between mother and child.
The project included the following services: (i) the increase of territory awareness by establishing formal and informal networks between the professionals involved; (ii) a preliminary phase of information and awareness development for pregnant women at risk of developing postnatal depression by organising antenatal courses within San Carlo Borromeo Hospital of Milan; (iii) the provision of evidence-based individual and/or group psychotherapy treatments specific for mothers with depression. The approach adopted was based on the clinical work and research conducted at the Infant Clinic of the Parent-Infant Research Institute, Austin & Repatriation Medical Centre in Melbourne; and (iv) pharmacological treatment by local specialist services for severe cases, when identified. The main clinical aims of this project's activities were: to increase the number of women screened; to provide assessment and treatment for women at risk; and to involve fathers in the project.

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**Poster Sessions**

**Novel psychoactive substances: use and knowledge among youths in Italy**

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Novel Psychoactive Substances (NPS) are new psychotropic drugs, which mimic the effects of controlled illicit drugs. NPS are currently determining a sanitary issue of growing importance, especially in relation to the fast-moving and the potentially unlimited nature and of the market. In this study, we propose to outline the knowledge of NPS and the extent of their diffusion amongst Italian youth. A questionnaire was handed out to a sample of 3,011 adolescents and young adults, aged 16- to 24-year-old, randomly selected from a representative group. Subjects resided in different Italian cities, located in the north, center and south of the country, to ensure the inclusion of youths from diverse provenance contexts. The sample was asked to fill out a survey questioning their knowledge/use of a group of novel psychoactive substances. Other items evaluated use of other drugs, smoking habits, time spent over the Internet per day. A partial knowledge of NPS was evidenced. The use of mephedrone, synthetic cannabinoids, salvia divinorum, methamphetamine and desomorphine was found in 3.3%, 1.2%, 0.3%, 0.2% and 0.1% respectively. 11.08% of the interviewed sample had one friend who experimented with one of the investigated substances and was able to refer about the effects. Use of other substances was reported by 40.3% of the sample: cannabis (84.1%) was the most common. The abuse of multiple substances during the same night was reported by 15.8% of the participants. Results evidence a partial knowledge and a low level of use of new psychoactive substances among selected Italian adolescents and young adults, even though the data may show more relevance when confronted with general population. The use of NPS represents a serious issue both from a clinical and a public health point of view. For these reasons, a careful and constant monitoring, an accurate evaluation of possible clinical effects related to their use and a development of prevention measures are necessary to tackle the wide escalation of these new psychoactive drugs.
Effectiveness of group psycho-education on patients and staff in an acute psychiatric ward. A case-control study

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In the last decade, the use of group psycho-education (GPE) in Italian acute psychiatric wards has been steadily increasing, despite little evidence being available showing the effectiveness of such interventions. Aim of the study was to assess the effectiveness of GPE, intended as: 1. ability to reduce the number of re-hospitalization in a 6-month fixed follow up for each patient enrolled; 2. change in mean ward atmosphere score; 3. degree of patients’ personal satisfaction for attending the group. This was a case-control study, approved by the local Ethical Committee. GPE was delivered according to the model of Vendittelli and colleagues (2003, 2008). All patients aged 18-70 admitted between January 1st, 2013 and March 31st, 2014 to the acute psychiatric ward at the Nuovo Ospedale Civile Sant’Agostino-Estense, Modena, Northern Italy, were eligible for the present study. Cases attended at least one GPE morning session and at least one afternoon rehabilitation activity (e.g., relaxation, drawing, music therapy). Controls did not attend any GPE, nor afternoon rehabilitation activity. A 6-month fixed follow-up after discharge for each patient recorded voluntary and compulsory readmissions. Survival analysis was used to test differences in relapses between cases and controls. Exclusion criteria were: age <18 or >70; not belonging to the Mental Health Department of Modena catchment area; being bedridden or with severe physical illnesses preventing attendance to groups; not able to speak/understand Italian; having severe intellectual disability; patients admitted from and/or discharged to prison. A 5-item ad hoc Likert-scale was used to record ward atmosphere (for both patients and nurses), as used by the Authors of the reference. The Italian version of the Simple Feedback Question Form for patients attending Cognitive Behaviour Therapy Group (Veltro and Raune 2011) was given to each patient at discharge. Statistical analysis was performed using STATA 13.0. The total sample included 82 patients, of which 39 cases, mean age 42 (±13.3), 53.9% women and 43 controls, mean age 45 (±12.8), 55.8% women. No significant differences between cases and controls were found for age, gender, diagnostic group, length of stay. No significant differences stemmed out from the survival analysis (HR 0.59, 95%C.I.: 0.13-2.75). About one quarter of cases and controls relapsed (10/39 cases; 11/42 controls). While no compulsory readmissions were recorded among cases, 3 controls out of 12 (25%) were compulsory readmitted. Patients’ and nurses’ ratings of ward atmosphere in relation to group activities did not show significant differences. Of 39 Simple Feedback Question Form for patients attending Cognitive Behaviour Therapy Group distributed, 30 (response rate: 76.9%) were returned and usable. Most patients attending GPE reported at discharge to have found it “useful”, “they would attend it in the future again”, and “group topics were not difficult”. The absence of significant results does not allow to conclude that GPE has positive or negative effects on patients and nurses. Yet, notably, such intervention seems well accepted by patients. Further research is needed to better clarify the impact of GPE on relapse and re-hospitalization.

The ‘crown jewels’ of psychiatric training in Italy

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Since 1978, when the reform law of psychiatric services was issued (Basaglia’s Law n. 180/1978), Italian Psychiatry has gradually developed to the current organization, due to the collaboration of professionals from different psychi-
atrie fields. During the last years, clinical and therapeutic approaches to mental illness have changed from a mainly psychopathological construct to a bio-psycho-social one. Furthermore, whilst the recent advances in Neurosciences guarantee evidences for a considerable role of neurobiological substratum of many psychiatric diseases, psychotherapeutic approaches do not show to lose their relevant importance and validity in the Italian psychiatric context. An integrated approach could allow psychiatrists to take into account both models in order to improve social functioning and obtain a more global enhancement of psychiatric patients.

Nowadays, the Italian National Health System provides psychiatric assistance through different kinds of services (i.e. acute patients facilities, day-centers, drug-addiction services, therapeutic communities, mental health centers and residential facilities). Unfortunately, although the same patient often attends to more than one service, in most cases, there is not a suitable communication network that allows a good integration of these activities. Moreover, there is a widely heterogeneous organization of training activities among the different Universities for each of the above-mentioned psychiatric services, so that, not all psychiatric trainees have the same opportunities to take part in practical and theoretical activities. A recent ministerial reform added one more year to psychiatric traineeship, introducing a time period to be spent in other medical facilities. This new introduction could be effective in allowing trainees to attend more psychiatric contexts, including a formative period abroad.

In conclusion, even though we do not have our ‘Crown’, we have the opportunity to spend part of the training abroad, enriching ourselves with other culture’s jewelry. A stay abroad is a great challenge in order to: - strengthen own personal and/or group identity; - develop a curious, attentive, helpful, democratic and respectful personality; - exchange cultural and professional enrichments from the meeting with the cultures and mentalities of other countries; - guarantee an open-mindedness through a non-oppositional communication with other psychiatric trainees; - become aware of the complexity, but also of the relativity of points of view; and, finally, - be able to accept and constructively live with the other, recognizing the richness in the differences and in the respect of the rights.

Poster Sessions

Psychopathology and theatre in Italian psychiatric training

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Current system of psychiatric training in Europe has evolved over many years. Sharing experiences with colleagues across European countries and exploring the similarities and differences of training programs can help to ensure the best possible psychiatric training. Italian psychiatric trainees are proud to have the opportunity to get a special training on psychopathology by attending the performance of classic plays at the suggestive ruins of Greek theatres in Sicily. These traditional and evocative shows bring to the scene ancient Greek tragedies of Aeschylus, Sophocles, and Euripides. Theban trilogy is considered the greatest achievement of Sophocles, and the figure of Oedipus accounts for the psychologica lpower of the opera. In his Letters to Wilhelm Fliess, Freud related his finding of the Oedipus complex to the effect of Oedipus the King: "Every member of the audience was once a budding Oedipus in phantasy, and this dream-fulfilment played out in reality causes everyone to recoil in horror, with the full measure of repression which separates his infantile from his present state." Freud characterized Oedipus complex as a universal and crucial stage in the developmental process. He offered, in “The interpretation of dreams” (1900), an influential analysis of the particular nature of Oedipus destiny: “His destiny moves us only because it might have been ours—because the oracle laid the same curse upon us before our birth as upon him. It is the fate of all of us, perhaps, to direct our first sexual impulse toward our mother and our first hatred and our first murderous wish against our father. Our dreams convince us that this is so. Here is one in whom these primeval wishes of our childhood have been fulfilled, and we shrink back from him with the whole force of the repression by which those wishes have since that time been held down within us. While the poet, as he unravels the past, brings to light the guilt of Oedipus, he is at the same time compelling us to recognize our own inner minds, in which those same impulses, though suppressed, are still to be found.” Psychiatric trainees attending the Greek tragedies can participate emotionally in the transaction of basic psychopathological principles into life and action, acquiring the insights on which psychoanalysis is founded.
Psychiatric consultations in pre-orthotopic liver transplantation patients with Substance Use Disorders: focus on timing of cessation and referral and retention by community services

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In Italy, 6 months of abstinence from alcohol/substances are required before OLT, evidence for this recommendation remaining controversial. No standard approach linking abstinence duration at the index psychiatric pre-OLT evaluation to referral to Community Services is followed. Aims of the study are to report data from the Modena Consultation-Liaison Psychiatric Service (MCLPS) for pre-OLT patients with Substance Use Disorders (SUDs), and to evaluate patients’ concordance with referrals. This was a case-control study. Data source was the database of MCLPS. Psychiatric evaluations pre-OLT from 01/01/2008 to 31/12/2013 were extracted. Patients were controls if they had a SUD and abstinent for more than 6 months; cases if they had a SUD with less than 6 months of abstinence. Chi-squared analysis was performed with STATA 13.0.

515 consultations were requested for 309 pre-OLT patients, 36.3% (N=112) of patients had a current or past SUD. Controls were 80 (71.3%), while cases - who had stopped use less than 6 months before the consultation, or were still using - were 20 (17.9%). 52.5% of controls (N=42) and 85.0% of cases (N=17) were referred to community services (Chi 5.71; p=0.02). 70.0% of cases (N=14) and 33.6% of controls (N=17) were seen at least twice (Chi 7.22; p=0.01). 16.7% (N=2) of cases and 23.5 % (N=4) of controls referred to community services reported concordance with Consultant’s recommendation at re-assessment, a non-significant difference with cases (Chi 0.00; p=1.00). Consistently with previously research in this field, no difference of concordance with recommendations emerged between patients with SUD with different duration of abstinence.

Depression and chronic medical illness: early recognition in a sample of hospitalized patients

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Depression and anxiety are common psychiatric disorders in hospitalized patients and may impair health related quality of life (including physical, emotional and social dysfunction), significantly increase mortality rate, and lead to a massive medical costs. Cancer patients may be vulnerable to depression and anxiety for many reasons. The aim of this research was to evaluate prevalence and severity of affective symptoms in a sample of chronic medical illness inpatients, their quality of life and psychological distress perceived, and to identify the clinical and socio-demographic features for patients at risk for depression during hospitalization.

A sample of 360 consecutive hospitalized patients were randomly selected from March 2013 to April 2014, and completed the following questionnaires: Hospital Anxiety and Depression Scale (HADS), Patients Health Questionnaire (PHQ), General Health Questionnaire (GHO), 12-Item Short Form Survey (SF12) and related component summary measures: PCS (physical component summary) and MCS (mental component summary). The mean age of patients was 60.1 years and 57.2% were females; most patients were married, retired, and lived at least with another person and resident in urban area. Seventy per cent of the sample was hospitalized for cardiovascular diseases, 30% for
gastro-intestinal diseases, 19.4% for uro-genital disease and 41.7% for oncologic disease. Among patients with cancer, 11.9% had a gastrointestinal type, in advanced stage (19.2%). 56.1% of patients had surgical treatment. The average duration of hospitalization was 4.7 +4.8 days. According to HADS thresholds, the prevalence of depression and anxiety were respectively 41.1% and 59.7%; 40 per cent of patients were depressed according to PHQ-9 cut-off > 10. According to PHQ severity cut-off, we found that 28.1% of patients had sub-threshold depression, 25% mild, 13.6% moderate, but nobody had severe depression. According to GHQ-12, 21% of patients had psychological distress perceived. The mean summary physical (PCS) and mental (MCS) scores of SF-12 scale were respectively 33.4+9.56 and 40.7+11.9. Variables significantly associated to HADS-D≥8 (-2Likelihood= 224,461; X2=212,580; p<.001) resulted to be: PHQ>10, HADS-A≥8, lower score PCS and MCS, prior surgical procedures, modest living conditions and positive GHQ score.

Our findings underline an higher prevalence of depression and anxiety among patients with oncologic and other chronic medical illnesses, and the importance of an early recognition, with brief screening tools, of affective symptoms and psychological distress perceived to improve quality of life and adherence to medical treatment during hospitalization.