FC01.08

Comorbidity of posttraumatic stress disorder and depression

M.B. Simonovic, G.B. Grbesa. *Clinic for Mental Health Protection, Nis, Serbia*

Comorbidity of posttraumatic stress disorder (PTSD) and depression offers the possibility to explore broad spectrum of interaction of mood and anxiety disorders in several domains: in the domain of clinical presentation, as well as in the treatment effectiveness and in the domain of pathophysiology of the two disorders.

The aim of the paper is to determine characteristics of the clinical presentation of the comorbid PTSD and depression.

Method: 60 patients were assessed by means of the following intruments: SCID for DSM-IV, CAPS-DX, MADRS and HAMD. The data were analyzed using the methods of descriptive statistics and of corellational and regressional analyses.

Results pointed out that comorbidity of depression and PTSD is associated with higher intensity of intrusive symptom cluster, especially with flash-backs and intrusive thoughts distinctive to either PTSD or to depression, with broader spectrum of emotional and mood experiences and with more patient suffering. The results of corellational analysis pointed out to the group of symptoms which were distinctive for depression. The results of the regressional analysis pointed onto possible connection of illness course and its severity.

Conclusion: Analysis of the clinical presentation and of complex spectrum of interactions of the depression and PTSD inclusively enabled better understanding of symptoms presented by the patients, choice of the more effective treatment strategies and shed some light onto possible mechanisms of the human reactivity to extreme traumatic experiences.

FC01.09

Diabetes and depression: The impact of fluoxetine on glycemic control

M.K. Jallo [1], N.K. Toma [2]. [1] *Department of Medicine, Al Wafa Diabetic Center, IBN SEENA (Avicenna) Teaching Hospital, Mosul, Iraq* [2] *Department of Psychiatry, IBN SEENA (Avicenna) Teaching Hospital, Mosul, Iraq*

The coexistence of depression and diabetes has serious implications for self care and long term outcomes. Fluoxetine a SSRI antidepressant has hypoglycemic anorectic effects and potentially cause weight loss proportional to the degree of inial obesity. We studied the prevalence and severity of depression and the impact of its treatment with Fluoxetine on weight and glycemic control in poorly controlled depressed type 2 diabetics in an outpatient clinic in Mosul.

Forty eight type 2 diabetic patients with depression from a total of 180 diabetics seen from Jan - Sep/2003 were treated with Fluoxetine 20-40 mg daily for 12 weeks.

The prevalence of depression in type 2 diabetics is (32.22%). A significant difference was found between the mean weight, meam FBG at inclusion and 12 weeks post Fluoxetine, $P < 0.001$. HbA1c results available only for 28 patients and showed significant drop from a mean value of 8.8% to 7.9% after 12 weeks, $P < 0.001$.

Depression is common in diabetics and should be treated, preferably with SSRIs. A high index of suspicion is needed and should be considered among the risks that contribute to poor control. The future diabetic management guidelines should include routine screening for and treatment, of depression. Further larger studies seem worthwhile.

Monday, 19 March 2007
PR02. PRESIDENTIAL SYMPOSIUM ON ETHICS IN PSYCHIATRY

PR02.01

Ethical aspects of evidence based medicine (EBM)

D. Goldberg. *Institute of Psychiatry, King's College, London, United Kingdom*

The ethical reasons for being conversant with EBM can be divided into clinical and economic aspects, each of which has ethical aspects which will be discussed. These arguments are well known, and relatively noncontroversial. But there are also strong ethical arguments for not practicing EBM all the time, and this paradox will also be discussed.

All medical procedures have both specific and non-specific effects: dummy medicines can relieve severe post-operative pain, and dummy operations can relieve both cardiac pain and epilepsy. In mental health, these effects are well known, albeit difficult to quantify. Our most potent weapon in doing so is the randomised controlled trial (RCT), and ethical aspects of such trials will be touched upon.

We are left with problems of mental disorders where the supposed beneficial effects of an active drug – we will give the example of anti-depressants – is entirely non-specific. What are the ethical aspects of prescribing potentially toxic drugs for conditions where they have no specific effect? This is a major problem in both specialist mental health care and above all, in general medical care – where the bulk of antidepressants and sedatives are prescribed. There are major ethical problems here, which will be discussed.

PR02.02

Ethics of art therapy and use of patient-produced art

C. Carbonell. *Hospital Clinico Universitario, Madrid, Spain*

The great revolution of bioethics has been the incorporation of the principle of autonomy to the ethical model and parts from the assumption of recognizing human beings as autonomous beings. A paternalistic, authoritarian ethics has been substituted by ethics of autonomy.

Some specific requirements are needed so that an informed consent can be achieved: competence and ability of the patient to understand and willingness to decide.

The WPA has made different Declarations specifying Psychiatric Ethics. Art Therapy has developed a specific set of ethical standards. The role of art making in therapy poses unique ethical dilemmas and concerns for therapists such as:

Confidentiability: Art expressions must be recognized as confidential communications. Permission to display, exhibit, publish or share art expressions must be obtained from either the patient or in the case of a child, the parent or guard.

Ownership: The patient owns the art created in art therapy.

The artwork of the patient, especially the plastic artwork is used sometimes with artistic and commercial aims, which raises ethical and even legal problems.

There is a large background institutional or private exhibitions of the so-called psychopathological art.

The work created by the patient belongs to him and only the patient/author of the artwork can, in principle, decides over its use.

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If the patient agrees to display of his art expression in any form the therapist must be careful to consider if this is in his best interest based on the context.

PR02.03

Ethical issues in the use of complementary and alternative medicine (CAM) in mental health

F.J. Stone. *Council for Healthcare Regulatory Excellence, London, Visiting Professor of Professional Ethics, University of Lincoln, Lincoln, United Kingdom*

Recent decades have witnessed a significant increase in the use of complementary and alternative medicine (CAM). This includes an increased interest in, and use of, CAM in mental health, both as a primary source of treatment, and to treat side-effects of conventional medication. In the UK and elsewhere, much of CAM practice is unregulated, and the evidence base is under-developed. Many patients utilising CAMs do not disclose this to their doctors, raising risks of drug and other treatment interactions. Ethical issues associated with the use of CAM for mental health include: patient choice and consent for therapies of unknown efficacy, potential risks and benefits of CAM (including who evaluates these), and equity in terms of accessing treatments which are not generally provided as part of state-funded health services. Doctors have an ethical obligation to familiarise themselves with the range of CAM therapies their patients may be accessing and the evidence base for such treatments, both to facilitate informed decision-making on the part of their patients, and to help to minimise any potential for harm.

PR02.04

Ethics of publication

C. Hoschl. *Prague Psychiatric Centre and 3rd Medical Faculty, Charles University of Prague, Prague, Czech Republic*

Ethical concerns are of a growing importance not only in clinical practice and research, but also in publication process. Every presentation of scientific data should content clear statement disclosing any possible conflicts of interests (e.g., relationship of a researcher to pharmaceutical industry). Redundant publication such as publishing the results of the same trial in several journals under different titles is regarded unethical, as well as ‘‘salami slicing’’, which is in fact step-by-step publication of partial results of a study (e.g., separately results in males and females, young and elderly etc.) just in order to increase publication output. All of co-authors must provide publisher with their written consent to avoid blind authorship. Only person significantly participating in the concept, design, drafting and reviewing of the study is eligible as an author. Others should be properly acknowledged. Fabrication of data, falsification, plagiarism and other frauds still occur in the scientific literature, although they are beyond any ethical limits.

CS03. Core Symposium: SCIENCE AND ART IN PERSONALITY DISORDERS

CS03.01

The scientific framework of personality research

J.L. Carrasco. *Department of Psychiatry, Hospital Clínico San Carlos, Madrid, Spain*

Historical exclusion of personality disorders from the medical paradigm is reflected on the existence of the DSM-IV axis II for personality disorders. Personality disorders are perceived as substrates of vulnerability for axis I mental disorders such as depression, bipolar, anxiety or psychotic syndromes. A psychobiological perspective of this model of personality disorders is based on the study of genetic predispositions, of biological bases of personality traits and of the relationship of both with environmental precipitants.

Another psychobiological view of personality disorders is needed as a consequence of clinical evidence in borderline personality disorder (BPD). Most of the diagnostic criteria for this disorder are symptoms rather than traits and seem to be associated to several pathophysiological abnormalities. Serotonin dysregulation and glucocorticoid receptor dysfunctions among other biochemical findings have been reported in BPD. According to these biological findings, BPD could be included in a similar psychobiological framework than the axis I mental disorders.

CS03.02

Posttraumatic stress and personality disorders

J.J. Lopez-Ibor. *Clinica Lopez Ibor, Madrid, Spain*

Abstract not available at the time of printing.

S17. Symposium: ADDICTION TREATMENT AND RESEARCH: NEW STRATEGIES AND FUTURE PERSPECTIVES

S17.01

Treatment of addiction: from abstinence programs to abstinence-supported treatment

M. Musalek. *Anton Proksch Institute, Vienna, Austria*

During decades abstinence has been the only major treatment goal in addiction treatment; the efficacy of addiction clinics in general and treatment programs in particular usually has been evaluated with the aid of abstinence rates: the higher the number of abstainers, the better the treatment program. But for many of the patients suffering from addiction abstinence is not a very attractive treatment goal, for some of them not even an unattainable one. For many of our patients abstinence means weakness, handicap, stigmatization, a feeling of restraint, declining, inhibition, not being accepted, suppression, tension, being ill, social withdrawal, no fun, no relaxation anymore, isolation, etc.. In any case the term abstinence is strongly connected with abstention from, loosening of and distance to something. In this way a quite unattractive form of the nothing becomes the final goal of addiction treatment. Among others, this could be considered as one of the reasons of poor patient adherence in abstinence-oriented treatment programs. A way-out of this highly unsatisfactory situation for both, the patients as well as the therapists, could be a change of paradigms to abstinence-supported treatment. In abstinence-supported programs, abstinence is no longer the final goal but one of the important steps in order to reach other treatment goals according to an autonomous and mostly joyful life: on the basis of dimensional diagnostics, which are in contrast to classical categorical diagnostics

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