Cognitive Therapy is establishing itself in psychiatry as a powerful treatment for a variety of psychological disorders, including anxiety, depression, eating disorders and schizophrenia. In less severe conditions it can prove as effective as psychotropic medication, while in more severe conditions it can complement drug treatment. Follow up studies suggest that cognitive therapy has a long term effect on relapse in anxiety and depression. Cognitive therapy is a brief, structured, problem focused approach that aims to alleviate symptoms and solve problems, teach coping strategies and prevent relapse through changing underlying beliefs and assumptions. Patients learn to identify and modify unhelpful thoughts and behaviours within a collaborative relationship with the therapist. The general cognitive model as applied to anxiety and depression will be described and a method for conceptualising cases presented. Specific models for panic disorder and schizophrenia workshop will be outlined. A mixture of presentation, video and group discussion will be used to demonstrate the therapy in action and introduce participants to some basic cognitive and behavioural techniques. Empirical evidence for cognitive therapy in psychiatric disorders will be reviewed. Material will be presented in an interactive format. Basic CBT principle will be presented using Powerpoint and illustrated with VHS videotapes. Participants will be encouraged to contribute through experiential exercises and discussion of their own clinical experience.

Tuesday, April 5, 2005

C-17. Educational course: Interpersonal psychotherapy of depression

Course director(s): Torsten Grüttert (Düsseldorf, Germany)
14.15 - 17.45, Hilton - Salon Studer

Among short-term psychotherapies developed for the treatment of depression, IPT by Klerman et al. (1984) is meanwhile one of the most well known approaches. IPT has been controlled in a variety of studies proving efficacy. The interpersonal school of psychiatry (Sullivan) is IPT´s most influencial theoretical backgrood hypothesizing that all psychiatric illnesses (incl. depression and also here the therapy) develop in an interpersonal context: interpersonal problems may contribute to onset and potentially chronicity of (current) depression or/and depressive symptoms may interfere with interpersonal well being. Refering to research on life events, social support, stress and depression etc. the authors defined four problem areas that can be attributed to depression and will be focussed on in IPT: 1) retarded grief, 2) interpersonal conflict, 3) interpersonal role conflict/role transition and 4) interpersonal deficits/isolation. IPT has three parts: Within the introduction period (3-4 sessions) the patient's current depression will be attributed to one (individual) problem area on which will be focused strictly within the main therapy sections. IPT works in a here-and -now framework and connects state and change of depressive symptoms with state and change of interpersonal functioning and well being through therapeutic work. The dual aim of IPT is · symptom remission and · solving of attributed interpersonal problem by promoting patients´ interpersonal skills in and out of sessions. Open and focussed exploration, psychoeducation (patient expert of his illness), the explenation of the sick role (Parsons), assessment of the interpersonal inventory/ interpersonal resources, goal attainment scaling, the definition of patient and therapist role during therapy, the explanation of the IPT concept, the agreement on the problem area and a therapy contract are important parts of introductory sessions in IPT. In the main (3/4-14 sessions) period the patient and therapist work on the agreed focus. The IPT manual describes goals and treatment strategies for each problem area. Clarification, self disclosure, communication analysis, option seeking etc. are main techniques in IPT. During termination period the patient resumes what was learned, what still is left, clarify motivation for booster sessions (maintenance), and learn about prophylaxis and crisis management. This CME course will teach IPT-basics so that course members will e. g. be able to start practicing IPT under supervision. The following aspects will explicitly be focused on: 1) time frame, 2) medical model, 3) dual aims of solving interpersonal problems and symptom remission, 4) interpersonal focus on patient's affective engagement solving current life problems contributing to current depression, 5) specific and general psychotherapeutic techniques and 6) empirical support of IPT. Short role playing is used to train IPT techniques. A comprehensive handout will be available. Background informations about adaptations of IPT concept for depressed adolescents (IPT-A), for bipolar disorder (IPSRT) or group concepts (IPT-G) will be given.

Sunday, April 3, 2005

O-01. Oral presentation: Affective disorders I

Chairperson(s): Giovanni Stanghellini (Florence, Italy), Janusz Rybakowski (Poznan, Poland), Marianne Kastrup (Copenhagen, Denmark)
08.30 - 10.00, Holiday Inn - Room 7

O-01-01

Immediate switching of antidepressant therapy: Results from a clinical trial of duloxetine

M. Wohlreich, C. Mallinckrodt, J. Greist, P. Delgado, L. Driver, J. Watkin, M. Fava. *Eli Lilly and Company, Indianapolis, USA*

Objective: We examined the efficacy and tolerability associated with switching from a selective serotonin reuptake inhibitor (SSRI) or venlafaxine to duloxetine.

Methods: Patients with major depressive disorder entered this open-label study. Patients (N=112) exhibiting suboptimal response or poor tolerability to their current antidepressant were "switched" to duloxetine 60 mg QD without tapering or titration. A comparator group not currently receiving antidepressants ("untreated") were randomized to duloxetine 60 mg QD (N=70). Patients remained on 60 mg QD for 1 week. During the remaining weeks of the study, titration from 60 mg to 90 mg to 120 mg QD was possible. Efficacy measures included the Hamilton Depression Rating Scale – 17 items (HAMD17), Hamilton Anxiety Scale (HAMA), and the Clinical Global Impression of Severity (CGI-S) scale.

Results: The efficacy of duloxetine did not differ significantly between switched and untreated patients initiating duloxetine (mean changes: HAMD17 total score: -13.1 vs. -13.3; HAMA: -10.6 vs. -10.2, CGI-S: -2.2 vs. -2.4, respectively; all p-values >.30). However, the rate of discontinuation due to adverse events among switched patients was significantly lower than that in untreated patients initiating duloxetine (6.3% vs. 18.6%, p=.014). Treatment-

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