W25

The negative image of psychiatry in the medical community

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It is a very unfortunate matter of fact that mental problems and diseases are matter to societal stigmatization. In the slipstream psychiatry has a negative image in the public eye. Fighting stigma should be at the core of all professionals involved in mental health care. Self-reflection should be a primary reaction of any psychiatrist when confronted with a sensitive issue like stigmatization and negative image. It is painful to realize that the negative image of psychiatry is also present to the community to which psychiatrists belong, namely the medical community. This is strange and hurting. Psychiatrists (then closely linked to neurology) have, worldwide strongly contributed to the birth and strengthening of medical associations. Yet psychiatrists have estranged themselves from the medical community, thus, in my view, contributing themselves to stigma on patients with mental conditions and the negative image of psychiatry. So time for action, starting by self-awareness of psychiatrists that they are medical specialist, urging oneself as a psychiatrist to behave as a medical specialist by relating to colleagues in a helpful way and keeping one's own medical knowledge and skills up to standards. Psychiatrists have so much to offer in helping their colleagues in somatic medicine.
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Old age psychiatry – towards the future

W26

Training in old age psychiatry: The 30 countries' perspective

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To improve the care of older people with mental health problems it is necessary to have a highly skilled workforce who is very well-trained in the diagnosis and management of the range of the psychiatric problems affecting older people including the dementias. Key to this is the need to have an adequate number of specialists in geriatric psychiatry and a wider recognition of geriatric psychiatry training across Europe including a broad agreement on training requirements. In 2012 the European Association of Geriatric Psychiatry (Toot et al.) published the results of a Europe wide survey on geriatric psychiatry training to scope current practice and develop recommendations to begin a debate on harmonization. Representatives from 30 out of 38 (79%) representatives responded including many from countries where old age psychiatry was not formally a specialty. Training programs and duration varied between countries. Eleven countries reported that they had geriatric psychiatry training programs and most of these required geriatric psychiatry trainees to complete mandatory training for two years within old age psychiatry. Representatives from ten countries reported having specific Continuing Professional Development (CPD) for old age psychiatrists at consultant level.
The recognition of geriatric psychiatry as a specialist discipline in Europe is on the rise. The training procedures and processes in place vary considerably between and sometimes within countries. There are several options for harmonizing old age psychiatry training across Europe with advantages to each. However, support is required from national old age psychiatry bodies across Europe and an agreement needs to be reached on a training strategy that encompasses supervision, development, and appraisal of the knowledge and skills sets of old age psychiatrists. This workshop will look at options for harmonization and take first steps towards a consensus.
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W27

Harmonization of European training

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Mental health disorders, especially dementia, mood- and anxiety disorders, are among the most prevalent diseases in later life. Due to a greying European society, numbers are expected to increase over the next decades. Consequently, there is a pressing need for well-trained specialists in geriatric psychiatry across Europe in order to meet the mental health needs and to deliver a high standard of care to the aging population. In the past decades, some countries have set up specific training programs for specializing in geriatric psychiatry, whereas others did not. In order to stimulate the development of high-quality services, harmonizing specialty training across Europe will be a first step forward.
The EU stresses the need for standardizing qualifications of medical professionals to enable them to work across the EU. This workshop aims to work towards a consensus on the minimum training level required for geriatric psychiatry. We state that being able to work as an old age psychiatrist requires specific training in geriatric psychiatry and old age over and above general training in psychiatry. Therefore, discussion of opportunities to develop minimal criteria for training and practice across Europe is crucial. Taken the differences between countries into account (many countries do not provide specific training in old age psychiatry), we should finally agree on the minimal level of education and supervision, the minimum level of work experience and finally the minimal level of supervision in peer groups as a starting point.
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W28

Old and new reasons for specialization

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Mental illness is one of the largest areas of activity in the health service, with mental disorders of the elderly an important part of it. This substantial ageing of the population is a new phenomenon, occurring over the last century. It has given prominence to mental illness in old age. There is a growing interest in making decisions about how many and which services to provide to the older community.
The expertise of old age psychiatry services lies in the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioral, physical and social problems usually relating to ageing. Current evidence suggests specialist old age services are best equipped to diagnose and treat mental illness in our ageing population. However, the specialists should be integrated optimally into a service system to the benefit of the elderly. It will be crucial to improve access of older patients to the services. The service system and the partners in the system differ to those for younger adult psychiatric patients. Thus, not only knowledge and skills underline the necessity of specialization but also the increasingly complex health service structures of modern societies.

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Schizophrenia research: The necessary link between psychopathology and clinical neuroscience

W29

From Griesinger to DSM-V: Do we need the diagnosis of schizophrenia?

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The dichotomy between "dementia praecox" and "manic-depressive insanity" by Emil Kraepelin is one of the milestones of nosology in psychiatry [1].
This dichotomy reflects the necessity – particularly in the absence of effective treatment in Kraepelin's time – to differentiate (and to predict) the functional outcome of individual patients. Since Kraepelin's original division particularly the influence of Kurt Schneider has led to a full acknowledgment of the dichotomy in both ICD and DSM.
While this division has proven to be clinically useful, alternatives have been proposed covering a large spectrum from the idea of unitary psychosis as in Wilhelm Griesinger and Klaus Conrad to further subdivisions as in Karl Leonhard. Recent research in neuroscience suggests the presence of an overlap between schizophrenia and other psychiatric disorders [2–4].
Disclosure of interest The author has not supplied his declaration of competing interest.
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W30

Role of psychopathology in elucidating the underlying neural mechanisms

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Introduction Psychopathology is the systematic study of abnormal subjective experience and behaviour and it aims to give precise description, categorisation and definition of abnormal subjective experiences.
Aim I aim to demonstrate that the most appropriate approach to elucidating the biological origins of psychiatric disorders is firstly to identify elementary abnormal phenomena and then to relate these to their underlying neural mechanisms. I will exemplify this by drawing attention to studies of Delusional Misidentification Syndromes (DSM).
Results I will show that there are impairments in face recognition memory in individuals with DSM without impairments in the recognition of emotion and that there are abnormalities of right hemisphere function and of the autonomic recognition pathways that determine sense of familiarity.
Conclusions Basic psychopathological phenomena are more likely to throw light on the basic neural mechanisms that are important in psychiatric disorders than studying disease level categories.
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W31

The role of cognition in the psychopathology of schizophrenia: Assessment and treatment options

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Cognitive dysfunction is a characteristic feature of patients with schizophrenia. Traditionally, the main distinction between "dementia praecox" and "manic-depressive insanity" was in fact the cognitive outcome during the course of the disease [1].
For the assessment of cognitive dysfunction both large, detailed instruments [2] and brief screening scales for quick and multiple use [3,4] are available.
Recently, the role of social cognition has been thoroughly examined showing differential effects [5].
Treatment of cognitive dysfunction in schizophrenia comprises adherence to a therapy with atypical antipsychotics as well as specific treatment programs for cognitive [6] and social cognitive [7,8] dysfunction.
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Shaping the future of healthcare through innovation and technology

W32

New research in outcome management using apps and DSM-5 measures. Preliminary results

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The presentation is about the use of outcome measurements in combination of a newly developed app that enables psychiatrists and patients track the progress of their treatment process and adjust it if needed in an shared decision fashion.
In 2013 the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders was introduced. Around the same time there was the start of a paradigm shift in healthcare which increased the focus on patient involvement in individual health care decision-making and on measuring and improving outcomes of care (Sederer

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